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CONTRADICTORY DISCOURSES, STATE IDEOLOGY AND POLICY INTERPRETATION:

A Feminist Evaluation Of The Reproductive And Child Health
Programme (RCH) In Kerala, India

A thesis
submitted in fulfillment
of the requirements for the Degree

of
Doctor of Philosophy
at The University of Waikato
by

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The University Of Waikato
2000

For Naomi,

*Winds
foreign shore
You
once more*

*Change
Time, Divine
Completion
I, sublime*

*Fate
Life's Cross
Within
Darkness's loss
(SJW, November 2000)*

ABSTRACT

The Government of India in 1995 introduced the Reproductive and Child Health (RCH) policy, as part of a paradigmatic shift in its ongoing population programme. The shift in policy came in the wake of the International Conference for Population and Development, 1994, which had espoused a rhetoric of reproductive health and empowerment for women in the planning and implementation of population programmes. This thesis explores the process of institutionalization of the 'gender-sensitive' discourse of reproductive health within the national population programme in India. This study offers a feminist political analysis of this phenomena; therefore, rather than study reproductive health as demographic or health outcomes, the emphasis is on the analysis of ideological frameworks of the state (and those policy makers who embody its values) that provide particular *interpretations* of reproductive health. The political analysis of ideology is significant to understanding the translation of global discourses into norms of local practice.

The focus on interpretive frameworks opens up a theoretical exploration of the state's inherent ideologies. Arguing that India, like many other countries in both the developing and developed world, is moving to a broad political, economic and social ethos of neo-liberalism, I explore the implications of this ideological shift for the process of policy interpretation. There are two dimensions of the neo-liberal ideology that are pertinent to this research. First, the assumptions of the role and functions of the state under neo-liberalism is antagonistic to that which is, *prima facie*, demanded by reproductive health as a gender-empowering discourse. Second, the discourse of neo-liberalism has implications for women's positioning as citizens within the developmental state, challenging their claims to access the state. The interactions of both these dimensions, that is, contestation of discourses regarding representation of women, and the definition of the state's obligations under market development, are critical to the outcome of policy design and practice.

The empirical analysis in this research is fundamentally qualitative in approach. I primarily undertake an analysis of discourses in the RCH policy documents and interviews with key officials in charge of the programme in Kerala. The analysis seeks to explore the discursive manifestation of the neo-liberal/market ideology, particularly in the way that users of public health care are positioned in the programme, and the state's broader ideology regarding gender and development.

In conclusion, this research seeks to renew a focus on the state as a negotiator of gender discourses in the formulation of development policy. Development policy design and practice cannot be viewed as independent of the ideologies around gender that dominate the state. I argue in this thesis that it is only by addressing issues of political identity that we can develop policies that are more accountable to women, and that are gender-sensitive.

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Glossary of Acronyms / Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrome
ANM	Auxiliary Nurse Midwife
CBR	Crude Birth Rate
CC	Conventional Contraceptives (Condoms)
CSSM	Child Survival and Safe Motherhood Programme
Cu-T	Copper – T (an I.U. D)
CHC	Community Health Centre
DANIDA	Danish Development Assistance
DAWN	Development Alternatives for Women in a New Era
DFW	Department of Family Welfare
DHS	Directorate/Director of Health Services
DMO	District Medical Office/Officer
DPIP	District Project Implementation Plan
DPP	Decentralized Participatory Planning
DRCHS	District Reproductive and Child Health Society
EC	Eligible Couple
FPP	Family Planning Programme
FRU	First Referral Unit
FWP	Family Welfare Programme
GAD	Gender and Development
GHI	Gender Health Index
GoI	Government of India
GoK	Government of Kerala
HDI	Human Development Index
HIV	Human Immuno-Deficiency Virus
ICMR	Indian Council for Medical Research
ICPD	International Conference for Population and Development
IIPS	Indian Institute of Population Studies
IPC	Indian Penal Code
IUD	Intra-Uterine Device
ISM	Indian Systems of Medicine
IPD	Integrated Population and Development Project
IEC	Information, Education and Communication programme
IUD	Intra-Uterine Device
JPHN	Junior Public Health Nurse
MCH	Mother and Child Health
MoHFW	Ministry of Health and Family Welfare
MPW	Multi-Purpose Worker
MTP	Medical Termination of Pregnancy
NEP	New Economic Policy
NGO	Non-Governmental Organization
NHP	National Health Policy
NRR	Net Reproduction Rate
ODA	Official Development Assistance
OP	Oral Pills

ORT	Oral Rehydration Therapy
PHC	Primary Health Centre
POA	Plan of Action of the ICPD
PPS	Post-partum Surgery
PSA	Procurement Support Agency
RCH	Reproductive and Child Health Policy
RHI	Reproductive Health Index
RTI/STI	Reproductive Tract Infection/Sexually Transmitted Infection
SAP	Structural Adjustment Programmes
SCOVA	State Committees on Voluntary Action
SIP	State Implementation Plan
STD	Sexually Transmitted Diseases
TC	Target Couple
TFA	Target Free Approach
TOA	Target Oriented Approach
TODA	Text Oriented Discourse Analysis
TT	Tetanus Toxoid
UIP	Universal Immunization Programme
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Assistance
USAID	United States Agency for International Development
WB	World Bank
WED	Women, Environment and Development
WHO	World Health Organization
WID	Women in Development
WGNRR	Women's Global Network for Reproductive Rights
WRPE	Women's Role in Political Economy

Indian words used

Anganwadi	state sponsored childcare facilities
Crore	10 million
Dais	local midwives
Lakh	a hundred thousand
Mahila Sangh	women's groups
Panchayat	local government
Pradhans	community leaders
Sati	the (now illegal) practice of burning widows on the funeral pyre of their husbands
Swadeshi	the Gandhian concept of national self-reliance

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I

INTRODUCTION

If there was a ‘paradigm shift’ at Cairo, women were at the very heart of it.

Johnson 1995, p. 29

The International Conference for Population and Development (ICPD), Cairo, 1994, is a landmark event in the history of population and development thought. A notable feature of this conference was the unprecedented shift in the discourses around population policy. The range of concepts used and their interpretations reflected a perceptible move away from a Malthusian focus on population control to a broader concern with reproductive health and rights. The ICPD, in many ways, marked the start of a global rhetoric of reproductive well-being that draws considerably on feminist visions of women’s empowerment and reproductive agency¹. By the end of the nine-day conference, approximately 179 states had ratified the resolutions negotiated at the conference. Individual states, as a result, have begun to review the foundations on which their population policies have been conceptualized.

The questions that I address in this research have developed against the backdrop of this recent history. My interest in this area relates to the political implications of the emergence of the global discourse for reproductive health in local level policy implementation in India. The reproductive health discourse brings with it ideological² norms that are radical in content, and at the very least, calls for a re-evaluation of the paradigms on which conventional population policy has tended to be framed. At one level, this thesis is a study of development policy in India. It aims to explore the

¹ See Appendix A for a background of the politics of population discourses in the 1974, 1984 and 1994 International Conferences for Population and Development.

² The concepts ‘ideology’ and ‘discourse’ will be discussed in Chapter 2. For the purposes of this introduction they are being used interchangeably to denote the social, political and moral values, norms and belief systems that are the foundations on which text and practices are based (see Holloway 1997).

ideological foundations on which post-Cairo population policy has been formulated in a developing country context. The post-Cairo period is especially significant because, in most developing countries, the 1990s have ushered in a phase of economic globalization, restructuring and neo-liberal thought, which has touched most aspects of economic and political life, especially in conceptualizations of public policy and governmental interventions. The spread of restructuring has had implications for the Indian state's provision of social services, particularly, education and health. How population policy discourses, en route to institutionalization in these contexts, integrate the vastly different ideologies of restructuring and reproductive health are analyzed in this research. The questions that this study addresses are: how does the government in India incorporate international population ideology into its national policy? How is ideology of reproductive health diffused and institutionalized within the government's structures, particularly, given the dominant economic discourse of neo-liberalism? This research, therefore, enquires if ideology is transformed during the process of diffusion. In empirically evaluating the ideological content of the reproductive health policy in India, I define 'ideology' as the norms that govern the thinking and practice of the health providers at various levels of policy making and enactment.

From another perspective, in examining the ideological frameworks within which policy is institutionalized, this study moves beyond the specific context of reproductive health to the role of the state (and its various structures) in producing particular *interpretations* of the discourse of reproductive health. As an interpreter of policy, the role of the state is significant. Undeniably, a reproductive health discourse is also a gender discourse. The state's interpretation of policy will invariably reflect ideologies surrounding gender (drawn from economic, nationalistic, cultural, etc. discourses) that the state subscribes to. This study implicitly builds on the proposition that the discourses around reproductive health subscribed to by the practitioners of policy are intimately associated with discourses around women, and gender per se, that the state in India embraces. Women's identity in the state, therefore, forms the main theoretical foundation for exploring the expression of ideologies around reproductive health. The discourse of neo-liberalism is, again, significant here. Feminist critiques of neo-liberalism (e.g., Afshar and Barrientos 1999; Brodie 1996; Elson 1994; Gallin 1998; Kelsey 1993, 1997; McDowell 1999) have articulated lucidly that neo-liberalist tendencies of the state will compromise

women's social rights, and jeopardize efforts to represent women as equal citizens within the public sphere. The state's perception of women's political identity under dominant neo-liberalism is central to the way that a reproductive health discourse is likely to be interpreted. Thus, a second objective of my research is to explore elements in the state's political discourses of gender that have implications for the institutionalization of the two dominant discourses on reproductive health. A substantial part of this theoretical argument focuses on the production of discourses around women as subjects of the state, the political positioning of women³ within these discourses, and their consequent claims upon the state. The thesis, in sum, is both an evaluation of policy, and an attempt to develop a feminist analysis of how women are positioned as citizens within a developmental state in transition to market-directed growth.

The complexity of the social arena in which reproductive health as a political discourse has made its entry underscores the relevance of a study that examines the process of policy interpretation within specific political and economic contexts. The present research, which is both a theoretical and empirical exploration of this process, employs an interdisciplinary approach to unravel some of these complexities. As a prelude to the discussions that follow in each of the chapters in this study, this introductory chapter will set out some of the major strands of arguments that inform this research. The relevant literature used in this study is drawn from various fields of social analysis, specifically, development studies, gender and development, feminist political theory, reproductive health, and post-positivist policy analysis, to name a few. It is the emerging research in these literatures on the foundations and consequences of ideology in political rhetoric, with special emphasis on women, which has particular bearing on this study.

Transnational Ideology and Third World Policy: Emerging areas of gender research

The critique of ideology is not a mainstream approach to evaluating developmental or population policy. This perspective has gained momentum since the 1980s with a

³ My use of the terms 'women' and their 'needs' may seem to obliterate the differences between various groups of women in India with regard to their cultural, geographical, religious and social backgrounds. I would, however, defend this usage by arguing that population policy in India, by and large, does not recognize differences among women other than in terms of their reproductive needs at various stages of their reproductive cycle. Therefore, the 'differences' that matter are based primarily on age, marital status, parity, and so on. Other social differences are relevant to policy in as much as they influence patterns of reproductive behaviour.

growing body of literature that examines the ideological foundations of development discourses, and its implications for the Third World (see Crush 1995; Escobar 1984, 1995; Rahnema 1997; see also Marchand and Parpart 1995). A bulk of this literature is a critical commentary on the production and diffusion of assumptions about people in developing societies and their needs, and particularly, how such discourses perpetuate conditions of disproportionate power relations within and between local and international communities. By and large, these studies point out that international discourses affect the way in which development policy and practice is likely to be organized at the local level; that is, the knowledges that form the basis of state praxis are drawn from the international domain.

The various ways in which the international context provides a framework for population policy intervention in developing countries is also a recent area of research. The discourses around population debated at international conferences are particularly significant in this regard. There is strong evidence to suggest that national level policies, in both developing and developed countries, are directly influenced by debates in the international arena (Barret and Frank 1999). According to Barret and Frank, what are likely to be codified as national programmes and policies would have been discussed in earlier international conferences and forums. International discourses, in effect, “precede and predict” national population policy (Barret and Frank 1999:217).

A number of scholars since the mid-1970s have documented the North-South conflicts that marked international conferences on population and development (Correa 1994; Finkle and Crane 1975, 1985; Grimes 1994, 1998; Gulhati and Bates 1994; Johnson 1995; Cliquet and Thienpont 1995), and their specific impacts for population policy in developing countries. Others have provided insights into the history of the field of demography itself and how political interests deemed what was legitimated as science, and what was set as the intellectual foundation for policy, especially Third World policy (Demeny 1988; Greenhalgh 1996; Grimes 1994, 1998).

There is also the recognition that the magnitude of material and institutional support provided by international actors had persuasive effects on developing countries to accommodate certain population strategies (Hartmann 1987, 1995; Jaquette and Staudt

1988; Williams 1995). Gould's (1995) study of the Kenyan population policy, particularly, emphasizes the role of ideology in population policy making. Gould argues that the Kenyan government implicitly founds its population policy on the basis of its perceived link between fertility decline and contraceptive prevalence. Its population policy, therefore, primarily encourages programmes to increase contraceptive use among people. According to Gould, "these policies have been formulated more from ideological presumptions and preferences than from explicit dependence on systematic policy analysis"(p. 213), and reflects the neo-Malthusian ideologies of the state and international development agencies that aid these programmes.

Scholars have also pointed out that developing country policies exhibit western ethnocentrism in their objectives (Grimes 1998). Most developing country population policies reflect a western paranoia of unrestrained population growth in the Third World (Grimes 1994; Sen 1995) and endeavour to impose qualities of 'rationality' valorized in the western liberal subject on to reproductive decision-making capacities of people in the south (Amalric and Banuri 1994). There is also a genre of thought that contends that the institutionalization of international population discourse is a means to ensure neo-colonial ideological dominance of the Third World (Dubois 1991).

My own research interest in the global ideological influences on Third World policies relates to what such a perspective on population policy can offer the existing scholarship on gender, located in several disciplines of study, such as gender and development, reproductive health, women and the Third World state, restructuring, and public policy. I will consider the links of this research project with some of these areas of study in what follows.

Women and Development

The study of Women and Development burgeoned in the 1970s following the seminal work of Ester Boserup, *Women's Role in Economic Development* (1970), which highlighted, for the first time, that the processes of development in Third World countries have differential impacts for men and women. Her argument that mainstream development ignored the social and economic contributions of women, and that such developmental activity had detrimental effects for women, encouraged considerable research in

subsequent decades on how best to make development gender-sensitive. Women in Development (WID) research and programmes have focused on efforts to make mainstream development more inclusive and responsive to the needs of women in developing societies. However, in practice, the efforts of WID and its variants⁴ have not been altogether successful; the awareness of the gendered nature of mainstream development has not automatically translated into programmes and modes of practice that benefit women wholly. In fact, the chequered history of WID programmes challenges the efficacy of the whole project of WID itself (Simmons 1997). Often, the failure of WID initiatives was attributed to ill-planned programme management prompting the need to focus on better techniques for mainstreaming gender issues in developmental organizations (Jahan 1995; Razavi and Miller 1995b; Snyder, Berry and Mavima 1996).

Of late, the focus of some researchers aiming to develop contextually-sensitive gender development policy has shifted from technical precision to the role of ideology; they explore how the values inherent in specific discourses - either at the level of society, the state, or intervening agencies - occlude an understanding of needs of women in various developing contexts (e.g., Afshar 1994). It has been noted that First World researchers have a preconceived image of Third World women as 'victims' of oppressive cultures, and without political agency or capability for resistance (e.g., Chowdhury 1995; Goetz 1991; Mohanty 1991; Parpart 1993, 1995; Sen and Grown 1987). Others have pointed to the dominance of masculinist (and western) notions of development objectives that have influenced the way WID policy has been strategized in agencies that conduct developmental interventions in the Third World (e.g. Kurian 1995, 2000; Staudt 1998). Developing contextually sensitive gender (and reproductive health) policy would necessarily involve being cognizant of these externally imposed ideologies and their implications for women's claims to the state.

⁴ Some of the schools of development that focus on the relationships of men and women in society are WAD (Women and Development), GAD (Gender and Development) and WED (Women, Environment and Sustainable Development).

Women and the Third World State

The relationship between the Third World state and women in developing societies has commanded scholarly attention in the last decade or so⁵ (see Chapter 3). The state, as Rhode (1994) notes, is more than the central government. It includes all the “administrative, legal, bureaucratic, and coercive structures” that organize social relations (p. 1182). The state is not a unified entity but a convergence of multiple institutions that have specific histories (Rhode 1994). Feminist theorizations of the state (see Chapter 3), which have been developed in the context of the western state, have sought to reiterate that the state is not a neutral arbiter in the realm of policy making; it actively interprets ideology in ways that suit its national goals and appeases diverse power groups within society. In implementing the discourses of development, the state has the power to unify the national economy, establish a common national market, and impose linguistic and cultural norms (Parajuli 1991). As a result, in enforcing women’s rights, norms that govern democratic participation and empowerment have often been compromised on the grounds of cultural relativism (Gaspers 1996; Nussbaum 1995). If, as pointed out above, international ideologies have tended to marginalize Third World women’s voices, then locally prevailing pre-conceptions and value-based judgements about women’s roles are equally an impediment that subverts gender-sensitive policy. The state, as mediator between feminist agendas, conservative interests and its own national goals, is liable to endorse policy that perpetuates the ideology of women’s subordination and limit women’s access to emancipatory opportunities. The ideology embedded in policy is an important indicator of the kind of power that the state, and officials in positions of power in the state, exercise in relation to making resources available for women.

⁵ There is no uniform approach to defining the state. Authors define the state differently, depending on whether they assume Marxist, radical, liberal or post-structural positions. For a review of the various feminist perspectives of the state, see Connell (1990), and Witz and Savage (1992).

Political Discourse and the Construction of Women

The turn, in feminist political theory, to a post-structuralist conceptualization of the state and processes of policy making is another body of literature that this study draws on and contributes to. In essence, as noted above, the state is not seen as a monolithic institution; instead, it is constituted as a series of arenas or as a plurality of discursive forums (Connell 1990; Franzway et al. 1989; Pringle and Watson 1992). Rather than conceptualize the state as a unitary body, these theorists emphasize the contradictions and internal fragmentations that mark its everyday functioning. In this view, the public spaces of political deliberation are sites of contestation between contending social discourses (Fraser 1989a, 1989b, 1990). The outcomes of these deliberations are critical to the shape of policy, but conversely, the shape of policy is indicative of the strength of the various discourses in the public arena as well (and by implication, the people situated in these discourses).

Women's roles in most state discourses have taken one of two positions. Either women are rendered invisible, as if terms such as 'citizens', 'individuals' or 'workers' are gender neutral or imbued with characteristics attributed to males (Paterman 1989; Pettman 1996). Alternatively, state discourses also emphasize women as the phallocentric 'Other', justifying the regulation of women's bodies, sexualities, mobility, and so on. For feminists, one of the lasting struggles has been to influence the nature of the socio-political discourses and to re-position women in the dominant discourse in a way that will be advantageous to their claims for rights to the state. This is important because the state and gender have a dynamic relationship. The state not only reflects gendered ideologies, it also constitutes and reproduces them. Women's identity in the neo-liberal state is both a consequence and an indicator of the ideologies that converge in the state. There is, therefore, a mutuality between the claims or access that women have upon the state, on the one hand, and the form of gender policy that is articulated, on the other.

The Present Study

The nexus between ideology/discourse and policy, particularly gender policy, is therefore a critical relationship that has guided the design of the present research. In this study, I set out to explore the process and outcome of the institutionalization of an

internationally produced policy within state structures of a developing country. Specifically, I aim to demonstrate the processes by which this international ideology has been institutionalized in the geo-political context of India. The Indian Family Welfare Programme (FWP) is one of the largest and the oldest in the world. The programme operates within a broader democratic political order in India and, in recent history, has been a key player in discussions around population policy in the international arena. The Indian government has been sensitive to the changing moods of international population discourse; in 1995, in the wake of the ICPD the previous year, the Family Welfare Programme officially renamed its programme the Reproductive and Child Health Programme (RCH), signalling a responsiveness to an international discourse on reproductive rights. This study will examine what the adoption of the international discourse has entailed for the family welfare system, and how, in institutionalizing reproductive health as an ideology, the state has been a negotiator of diverse ideologies. The specific research questions undertaken in this dissertation follow, but I will first substantiate the analytical and empirical direction this study will take.

My analysis starts with the acknowledgment that the Indian government's RCH has, indeed, made sincere efforts to be gender-sensitive (Anita 1996; Chatterjee 1996). My evaluation of the policy will, therefore, not undertake a 'gender-analysis' of policy (Moser 1993; Jahan 1995), i.e., the issue is not whether structured steps have been taken to include women's perspectives and needs into the policy. The process of formulation of the policy, particularly consultations with the local communities and women's groups in India, if anything, indicate that this has been done (see Chapter 5).

Instead, my approach to policy analysis is drawn from Fischer (1995), whose framework for policy evaluation includes a first and second order of evaluation. The first order of policy analysis is primarily a technical analysis of policy, where the focus is on ensuring that the outcomes and outputs of policy correspond to the goals and objectives that were set out before the policy was implemented. The second order of policy evaluation is not so much concerned with material outcomes, as much as it is with enquiring why certain outcomes and objectives are preferred over others, and what this reflects about the agency (the state) that makes these issues a policy concern. The second order, therefore, involves a critical examination of the normative values on which a policy is

founded. Fischer provides a set of organising questions that guides this normative analysis, namely:

- Does the policy goal have instrumental or contributive value for the society as a whole?
 - Do the fundamental ideals (or ideology) that organize the accepted social order provide a basis for a legitimate resolution of conflicting judgments?
- (Fischer 1995: 18).

The focus of my policy analysis is informed by Fischer's second order of policy evaluation, i.e., it aims to evaluate the ideological foundations of the RCH in India. These questions provide a guide for my own research focus on the ultimate purpose of the reproductive health policy; that is, who is more likely to benefit from the purported gender-sensitivity of the policy - women or the state? And, can women's interests be truly represented within the ideologies of the state? The latter question frames the basis for my empirical and theoretical analysis of the nature of the developmental state (as exemplified in the case of the Government of India (GoI)) and the various interests it pursues. The main form of policy analysis that I undertake in the study, a qualitative exploration of discursive themes, reflects this methodological position.

A second clarification is with regards to my theoretical position. In providing a critique of policy I locate myself in a feminist epistemology. I draw on Acker, Barry and Esseveld (1991), who point out that the goals of research are to contribute to women's emancipation, that the method of gaining knowledge should not be oppressive, and that the objective of knowledge should be to develop a critical perspective of dominant intellectual traditions. These principles have lent to the development of methodology and analytical frameworks that seek to enquire into the nature of relationships rather than to measure of variables. The body of literature that I draw on for my theoretical work can be broadly classified as feminist political theory (see Chapters 2, 3, and 4).

As a third clarification, I must also point out that although the core issue in this research is reproductive health, the perspective employed for the following analysis does not refer to the demographic dimension of reproductive health but, rather, the political

dimensions of the discourse (see Chapter 2 for a detailed review). Thus, my focus shifts away from the specifics of contraceptive use, levels of infant and maternal mortality, abortions, immunization, and knowledge of contraceptives, to how each of these statistics have been used to portray a particular picture of women's reproductive health, and the construction of their needs. This picture, I argue, is a political act. The process and ramifications that lead to the articulation of these needs are what I focus my attention on.

A fourth clarification is that in using the term 'the state' and its 'ideology', an assumption that I make is that providers of reproductive health care in India embody the ideological positions of the state. The practices, prejudices, beliefs, and constructions of the providers of policy are not merely individual attitudes but rather an expression of the ideological perspectives perpetuated and reproduced within the structures of the state (Connell 1990; Franzway et al. 1989). Further, in focusing on the state, I do not deny the significance of other entities that influence the discursive space of reproductive health, such as women's movements, international donor agencies (like the World Bank (WB), United Nations Fund for Population Assistance (UNFPA) etc.), local NGOs, community political parties, religious groups and users of the state's public health system. However, this study is less about how the discourse of reproductive health is constructed by these competing/complementary voices, than about how the state interprets these dynamic voices. While the discourses of other social actors within the competing public space of policy discourses, such as those from the women's movement, would undoubtedly have had an impact on the state's interpretations of policy, I deliberately delimited the scope of my analysis. By focusing on the documents generated by the state and interviews with policy makers, I sought to explore the particular paradigms, which the various actors situated within the state deployed, through which a selected discourse of reproductive health was produced and legitimated. As the conceptualizations in my theoretical chapters will show, I see the state as dominating the field of competing discourses on reproductive health at the level of national policy.

Against these clarifications, the objectives of this study are:

- (a) to empirically examine how the Reproductive and Child Health Policy in India integrates the international discourses of reproductive health and neo-liberalism in its policy text and practice;
- (b) to explore the significance of the policy's interpretation from a feminist perspective of women's emancipation; and
- (c) to provide a theoretical analysis of the political implications of the above for women's reproductive interests in developmental contexts.

There has been recent work evaluating the implementation of the Reproductive Health Policy in India (Pachauri 1999) but the focus of research papers in the volume is on the success of implementation of a particular policy directive of the Government – taking the form of Fischer's (*op. cit.*) first order evaluation. The underlying norms and ideologies of the policy are not questioned.

The Case for India

As noted above, the present study is based on the reproductive health policies in India. The case study of India provides an illustrative site to examine the manner in which internationally produced gender discourses are interpreted in national policies. The choice of India arises out of several considerations. Apart from the size and history of its official programme, the Indian government has always been a key voice in the international arena of population policy debates. In the 1970s, the Indian stance in international forums that 'development is the best contraceptive' (see Finkle and Crane 1975; Gulhati and Bates 1994; Harkavy 1995) was a critical rallying concept for developing countries who were pushing for the First World to consider development as prior to, rather than isolated from, the issue of population control. The Indian Family Planning Programme (FPP) has traditionally reflected the shifts in international discourses on population: in the 1950s it was called the Family Planning Programme but in the 1970s changed its name to Family Welfare, incorporating a strong emphasis on Maternal and Child Health services. In the 1980s, greater emphasis was given to provision of health and family planning services at the Primary Health Care Centres

(PHCs). India was also a signatory to the Programme of Action at the ICPD, 1994. In keeping with its status as signatory, the Ministry of Family Welfare took decisive steps to reformulate its family welfare programme. The introduction of the Reproductive and Child Health Programme (RCH) in 1995 was a direct response to the shift in discourses in the international arena. The shift in policy was, in large part, prompted by the government's concern that there was a "neglect of the quality of services" in the existing family welfare programme (GoI 1997:1)⁶. Moreover, the government's new policy was intended to make "the RCH programme gender-sensitive or responsive to the needs of women" (GoI undated)⁷. The government's current approach to family planning is seen as more than the initiation of new services; increasingly, the government and the donor agencies refer to a shift in 'ethos', 'paradigms' and 'ideology'. Pachauri (1996) notes that, "implementing reproductive health services within the national programme in India would, therefore, require an *ideological shift...*" (p. 245, emphasis mine).

This apparent move towards a more gender-sensitive reproductive health policy needs to be viewed in the light of the on-going transformation in the Indian economy. In 1991, India adopted the New Economic Policies (NEP), which was a response to the World Bank -IMF Structural Adjustment Policy (SAP) imposed on the country. Many aspects of the economy function within market paradigms. Since 1991, the state has deregulated trade practices, increased emphasis on export oriented growth, reduced state subsidies and emphasized efficient public administration. Indeed, India is now seen as a neo-liberal development state (Byres 1998b). The implication of the Indian restructuring for social sector expenditure has been, in general, critically viewed (Dreze and Sen 1995; Gupta 1995). As Dreze and Sen (1995: 188) comment: "...[t]he removal of counter productive regulations on domestic production and international trade can form a helpful *part* of a programme of participatory and widely shared growth, but it may achieve little in the absence of more active public policy aimed at removing the other social handicaps that shackle the Indian economy and reduce the well-being of the population" (emphasis in original text).

⁶ Government of India (1997), *Manual on Target Free Approach*, Ministry of Family Welfare.

⁷ Government of India (undated), *Reproductive and Child Health Programme*, Ministry of Health and Family Welfare.

Similar critique has marked the appraisal of government expenditure in family welfare programmes (Rao et al. 1995; Duggal et al. 1995; Alternative Survey Group 1997). In addition, the Government is also under pressure to streamline the administration of the health sector, subsidizing only the most fundamental of services, like family planning and prevention of communicable diseases (*World Development Report*, World Bank 1993; Antia 1993). More recently, the Approach Paper to the Ninth Five Year Plan in India (1997-2002) notes that containing the growth of population is one of the nine priority objectives of the Ninth Plan (Reddy 1998)⁸. Thus, overall, there are strong reflections of neo-Malthusian and neo-liberal ideologies, which are likely to subvert the gender-sensitive outcomes of the reproductive health discourse. These politico-economic conditions make the study of the interpretation of a reproductive health discourse relevant and topical.

To probe meaningfully into how ideology manifests at the local level, however, it becomes necessary to narrow the geographical focus further. In the present study, I examine the institutionalization process of the RCH programme in the context of Kerala, in southern India. Kerala, in the 1950s and 1960s, caught the attention of political and economic theorists worldwide, for providing an atypical model for development, popularly referred to as the Kerala Model of Development⁹. The intriguing feature of Kerala's development pattern was the unusually high levels of achievement in social indicators (especially, education, fertility and mortality rates)¹⁰ despite the stagnant economic development in the state. The population is also particularly noted for its high

⁸It is to the document's credit that, unlike the earlier Plans, the Ninth Plan has not made mention of the system of incentives and disincentives as a means to persuade people to partake of the family planning services offered by the state.

⁹ For a review of literature on the 'Kerala Model of Development' see, among others, AKG Centre for Research and Studies (1994), Centre for Development Studies (1975), Franke and Chasin (1989), Kannan et al. (1990), Krishnan (1976) and Zachariah et al. (1994).

¹⁰ According to the 1991 Census, Kerala had a sex ratio favouring women at the ratio of 1036 women to every 1000 men (the equivalent for India is 927). The literacy rate for Kerala in 1991 stood at 89.8 percent of the population as against an all-India average of 52.2 percent. The infant mortality level in Kerala was 16 for every 1000 live births as against the Indian average of 80. The life expectancy in Kerala in 1991 averaged 67 years for men and 72 for women. In India as a whole, the corresponding figures were 60.6 and 61.7 respectively. The total fertility rate in Kerala was 1.7 children per woman while in India the rate was 3.9 children born to a woman. The average age at marriage for women in Kerala was recorded as 21.9 for 1981 and for India for the same period, 18.7. (Government of Kerala 1997, 1994).

levels of political awareness and skill levels of its labour force (Heller 1996). What has made Kerala particularly interesting in the field of development, however, has been the general absence of gender differentials in these achievements. Women, as much as men, have benefited from government's investment in health and education (Dreze and Sen 1995; Jeffrey 1987; Kumar 1989; Sen 1992, 1995; Simon 1992)¹¹. The higher status of women in terms of development and social statistics has reflected directly in increased quality of life indicators for the population as a whole (Sen 1995)¹². In demographic statistics, in particular, Kerala has been highlighted for having restricted its fertility to near replacement level through improvement in levels of literacy (especially female literacy), and life expectancy and mortality levels comparable with that of 'advanced' nations. The state has also recently implemented the Panchayati Raj system, which emphasizes decentralization in the functions of the state government and has devolved greater administrative powers to local communities (Government of Kerala 1997). The Panchayati Raj reinforces and supports the participatory forms of development that is recommended under the RCH.

In the context of the present research, Kerala ranks the highest among states in India on the Reproductive Health Index (RHI). The Kerala value is at 87 while the all-India value is 46¹³. According to 1993 figures, only 6.5 percent of women in Kerala have had more than three children. Further, 92.3 percent (24.5 percent in India) of births in Kerala were conducted in an institutionalized setting (Population Foundation of India 1996). The

¹¹ Although women have benefited from post-Independence development in Kerala, it is widely accepted that the organization of society in Kerala that predates Independence has had implications for the better quality of life that women enjoy. The majority of the population in Kerala has followed a matrilineal form of familial inheritance pattern whereby family land and wealth was passed on from mother to daughter while the male head of household (usually the oldest brother in the family) was primarily the caretaker of the family properties. What ensued was that women commanded greater access to resources and enjoyed better social recognition than perhaps in other parts of India. The present day development achievements of women in Kerala are undoubtedly embedded in the state's historical context (see, for instance, Kumar 1989).

¹² The literacy rate for women in Kerala is 86.2 percent while the all India figure is 39.2. On the Human Development Index (HDI), computed on the basis of the United Nations Development Programme (UNDP) criteria, Kerala had an HDI value of 62 as against an Indian average of 42. The Gender Health Index (GHI), which is a composite indicator that includes the male-female gap in education, infant mortality rate and life expectancy at birth, places Kerala at the highest in the country at a value of 89 while India has a value of 49 (Population Foundation of India 1996; Government of Kerala 1994, 1996, 1997).

¹³ The RHI is computed by including the following variables: infant mortality rate, life expectancy, type of medical attention received at birth, birth order and birth interval (Population Foundation of India 1996).

Maternal Mortality Rate (MMR) was approximately 87 (deaths per 100,000 live births) whereas in India as a whole it was 453 (Population Foundation of India 1996). Kerala has the record for having one of the most efficient health systems in the country (Kannan et al. 1991). Its Family Welfare Programme is considered the most successful; Kerala was one of the two states in India where the Target Free Approach (TFA), which is a significant component of the RCH programme, was introduced on a trial basis in 1995.

The choice of Kerala as a study site was not made, as most research questions are conventionally posed, on the basis of a shortcoming in the reproductive health indicators or provision of services¹⁴. It is precisely because of its strengths in family welfare that I feel the context of Kerala would be suitable to test my research questions. Kerala has already achieved many of the fundamental indicators of population set by the GoI. With low levels of fertility and mortality, a strong health infrastructure in place, and relative absence of gender discriminations in development and social indicators, Kerala presents a fertile ground for the ‘best case scenario’ possible in the interpretation of a reproductive health discourse in India. Without the pressing need to provide for basic health levels as in the rest of the country, the health department in Kerala can, in principle, address fundamental issues ingrained within the global discourse of reproductive health.

Conceptualized as a research problem, the study aims to examine the manner in which the current programme has been interpreted by the state of Kerala in all levels of policy formulation and implementation. A caveat regarding the conceptualisation of centre-state relationship is in order at this juncture. The central Government of India (GoI) and Government of Kerala (GoK) are simultaneously interdependent and autonomous entities. The GoI sets policy directives whereas the GoK implements them in accordance with the needs of the state. GoI policies are not directly ‘slapped’ onto the state in Kerala; the process of implementation in Kerala is unique, just as its socio-cultural milieu is unique. In fact, it is arguable that the developmental context of Kerala would render the replication of an analysis of the process of policy implementation impossible and problematic to anyone searching for universal principles to see how the

¹⁴ It must be noted here that there have been critiques of the quality of Kerala’s delivery of family welfare programmes. See, for example, Ramanathan (1995).

state operates. Yet, there is continuity in the administrative norms of the state that links the national government with the state. Investment in women's development, the forms of funding and resource allocation for women's well-being, initiated at the Central level, help to evolve particular expectations and end-goals for women in India as a whole. The functioning of the state, and its bureaucratic norms of administration can universalise, to an extent, the development experiences of women regardless of where they are geographically located. For officials and providers who are part of the structure of the state, both the GoI and GoK form frames of ideological reference. Therefore, in this thesis I deliberately move back and forth from the policy context of the Indian State to the interpretative localized settings within the public health system in Kerala.

Chapter Organization

This thesis is organized into nine chapters, which reflect the theoretical and empirical emphases of the study. Chapter 2 offers an overview of the historical emergence of reproductive health as a recent political discourse in the global arena. In exploring this history, this chapter identifies the two contrasting discourses – the feminist one, and the dominant global economic ideology of restructuring – that provide the context for reproductive health policy. This chapter is intended to establish the present research's focus on the political dimension of reproductive health policy. However, policy is not implemented in a vacuum. It is institutionalized through the structures of the state. The state, as feminist political theorists contend, interprets policy based on its own perceptions and constructions of women. Policy evaluation cannot be studied apart from an analysis of the state and its dominant ideologies around gender, and women. Chapter 3, in a sense, presents a second dimension to this research. This chapter reviews feminist theorizations around the nature of the state and women's political identity, first, in the context of the western state, and second, in the developing country context of India. The way women are constructed as citizens in the state, I argue, is relevant to the way the state interprets development policy, in this case, reproductive health policy.

The latter chapters focus specifically on the RCH in India. Using the theoretical arguments as a foundation, I examine how women's needs and claims have been constructed within this particular reproductive health policy. I emphasize that the RCH

is an outcome of two dominant strands of ideology, the state's neo-liberal agenda and the international discourses on reproductive rights. The policy's integration of these divergent discourses reflects the state's perception of women's political identity in contemporary Indian society. Chapter 4 reviews methodological literature, particularly around the use of discourse analysis in evaluating policy. Chapter 5 provides an overview of the RCH policy; it describes information regarding various aspects of the policy, from the government's implementation plan to the major donors and proposed budget allocations. The unique features of the RCH, compared with the earlier population programmes in India, are particularly emphasized. Results of the qualitative analysis of the RCH policy are offered in Chapters 6, 7, and 8. Chapter 6 discusses the enunciation of the neo-liberal discourses of the state, exploring how the state transforms itself into a quasi-market agency in the provision of health and family welfare services. The chapter argues that the ideologies of market reinforce certain relationships between citizen and the state, which can have implications for the state's constructions of women's needs. Chapter 7 focuses on the dominant gender ideologies that are reflected in the RCH. The chapter throws light on, and critiques, the state's understanding of gender-sensitivity in reproductive health policy. In Chapter 8, I continue the qualitative evaluation of the ideologies in the RCH, examining, in particular, how the gender and market ideologies form an interpretive framework that influence health providers' interpretation of key elements of the feminist discourse on reproductive health, namely, empowerment, rights and choices. The analysis offers significant insights into how ideology colours the norms and thrust of policy. The evaluation of policy ideologies, however, is not the sole end product of this research. This research also attempts to theorize the implications of policy ideology on women's claims to the state and, ultimately, on their political conditions. Chapter 9 collates the implications of the neo-liberal and gender discourse and explores if the extant ideologies of the state can actually, through the RCH, effect positive improvements in the fundamental political conditions of women. The chapter concludes that the state's discourses actually offer limited chances for women's empowerment, and further that these ideologies contribute to reifying discriminatory notions of public action and private reproduction.

Conclusion

The primary objective of this study is to evaluate the institutionalization of feminist discourses around reproductive health in a context where the state has pursued neo-liberal and market-led development strategies, and the implications for women. This chapter set out the various themes that will be picked up in later chapters, emphasizing, in particular, the diversity of methodological and theoretical literature that is drawn on in this thesis. The following chapter will begin the elaboration of these themes, focusing on this study's emphasis on reproductive health as a political discourse.

II

REPRODUCTIVE HEALTH AS DISCOURSE

Theorizing the Political

In setting out the research questions, the opening chapter emphasized the focus of this study on reproductive health as a political discourse. The present chapter develops this idea: through an overview of the recent history surrounding the emergence of reproductive health as a global discourse, I emphasize that the discourse of reproductive health cannot be viewed apart from its emphasis on rights and emancipation for women. Further, I also show that as a political discourse, reproductive health is neither homogeneous nor uniform. It is in an ongoing process of transformation, being interpreted, contested, and staked claim to by multiple bodies in the social arena. As Walt (1994) emphatically points out, the formulation of health policy is about *process* and *power*. In the end, the processes of implementation of reproductive health as policy and practice are, at every level, influenced by political decisions. The notion of reproductive health as ‘political’ emerges in several contexts: for instance, the decision to institutionalize reproductive health within the health system is political, the interpretation by policy makers at every stage is political, the context in which policy is institutionalized is already politically imbued, and the implications for women (in particular) are political. This chapter attempts to situate the political discourse of reproductive health within a framework that critically interrogates the process of policy interpretation.

Reproductive Health as a Political Discourse

Mosse (1994) identifies three broad phases in international approaches to population policy since the 1950s: (a) the 1950s and 1960s emphasized a *family planning approach*¹⁵, (b) the 1970s saw the emergence of the *maternal and child health approach* and (c) the late 1980s were the beginnings of a *reproductive health approach*. The genesis of reproductive health as

¹⁵ The family planning approach placed inordinate focus on fertility control through the promotion of contraceptive use. The maternal and child health focus emphasized conditions for safe maternal and child health, both as a health objective and because of its indirect implications for people’s fertility decisions.

a population discourse can be traced to several sources. A key influential force was the transnational women's health movement¹⁶ of the 1970s and the 1980s (Correa and Petchesky 1994; Dixon-Mueller and Germain 1994; Garcia-Moreno and Claro 1994; Johnson 1995). With the spread of second-wave feminism in the west in the 1970s, one of the issues that emerged as a focal lobbying issue was women's health. The issue of reproductive rights was central to the activities of the women's movement, in the wake of the political and legal debates at the time in Europe and North America, especially those surrounding women's right to abortion¹⁷. In the mid-seventies, spurred in part by the start of the UN focus on women's issues world-wide (Dixon-Mueller and Germain 1994), there was an effort to link the North American and European feminist movements with women activists from other parts of the world. There was an increasing visibility in the presence of activists from the South at international conferences and as part of informal transnational networks. The diversity of women in the international arena brought to the fore various forms of reproduction-related oppressions faced by women. Women from the South highlighted, in particular, that oppressive family planning policies infringed their rights to reproductive freedom. DAWN (Developmental Alternatives with Women for a New Era), the women's group spearheaded by women in the South, pointed to Third World women's concerns in the way reproductive freedom was being denied to them.

Control over reproduction is a basic need and a basic right for a woman. Linked as it is to women's health and social status, as well as the powerful social structures of religion, state control and administrative inertia, and private profit, it is from the perspective of the poor women that this right can best be understood and affirmed. Women know that child bearing is a social, not a purely personal, phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and institutions by the end of this century. But our bodies have become a pawn in the struggles among states, religions, male heads of households and private corporations. Programs that do not take

¹⁶ What is loosely referred to as the international women's health movement comprises several groups from various countries coalescing or networking through a few key organizations. One such key organization was the Women's Global Network for Reproductive Rights or WGNRR (with headquarters in Amsterdam); another was the International Women's Health Coalition or IWHC (see Garcia-Moreno and Claro 1994).

¹⁷ Abortion was an important fuelling issue in the West in the 1970s given, among others, the landmark decision on the 1973 Roe vs. Wade case by the Supreme Court of the United States. The decision was the first in the country that allowed a woman, under certain conditions, to make the decision to terminate a pregnancy.

the interests of women into account are unlikely to succeed (Sen and Grown, 1987: 49)

The heightened consciousness about the detrimental effects of mainstream population policy was increasingly a rallying point for women from various regions at international women's forums. The women's movement was critical of narrowly constructed definitions of family planning programmes; a central tenet of the women's health movement is that women's health and rights, not macro demographic objectives, are of paramount concern (Correa and Petchesky 1994; Freedman and Isaacs 1993; Garcia-Moreno and Claro 1994; Hartmann 1987, 1995). The international women's movement emphasized the notions of rights of a woman to have control over her own body, her sexuality, and her reproductive life. At the International Women's Year Conference, 1975, it was noted that, "...it should be one of the principal aims of social education to teach respect for physical integrity and its rightful place in human life. The human body, whether that of woman or man, is inviolable and respect of it is a fundamental element of human dignity" (United Nations 1976, cited in Freedman and Isaacs 1993: 23). The women's health movement drafted the 'Women's Declaration on Population Policies' in 1992¹⁸. Over 100 women's organizations affirmed that:

[w]omen's fertility has been the primary objective of both pro-natalist and anti-natalist population policies. Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy.... [P]opulation policies must be based on the principle of respect for the sexual and bodily integrity of girls and women

(Women's Declaration on Population Policies, cited in Germain, Nowrojee and Pyne 1994 : 32)

The movement defined their key philosophy in their definition of reproductive rights, that women should have the right to decide "whether, when and how to have children, regardless of nationality, class, ethnicity, race, age, religion, disability, sexuality or marital

¹⁸ The 'Women's Declaration on Population Policies' was drafted in 1992 in time for the Cairo Population Conference. The Declaration was intended to convey the women's health movement's stand on a variety of issues around development and reproduction in the Third World. Between 1992 and October 1993, the Declaration was modified and finalized by over 100 women's organizations in 23 countries (Johnson 1995: 138). The Declaration was finally adopted in January 1994. The singular achievement of the Declaration was the values and agenda set forth therein were supported by the women from all over the world who deliberated over it. It must be noted that there were women's groups such as WGNRR, FINNRAGE, UBINIG, among others, that were opposed to the Declaration.

status in the social, economic and political conditions that make such decisions possible" (Women's Global Network for Reproductive Rights (WGNRR) newsletter 1993). To the feminists, reproductive health is expected to encompass four dimensions: (1) to be able to enjoy sexual relations without fear of infections, unwanted pregnancy, or coercion, (2) to regulate fertility without the risk of unpleasant or dangerous side effects, (3) to go safely through childbirth, and (4) to be able to bear and raise healthy children (Germain and Antrobus, cited in Graham 1993). Ensuring high standards of reproductive health is thus central to the idea of reproductive rights. The movement adopted the WHO definition of reproductive health which was defined not in the negative as the "absence of disease or infirmity", but as a condition to aspire to, that is, "a state of complete physical, mental and social well-being" (WGNRR newsletter 1993). Some of the issues that the movement addressed as reproductive health concerns were (a) information about sexuality as well as reproduction and contraception, about reproductive health and health problems, and about benefits and risks of drugs, devices, medical treatments and interventions, without which informed choice is impossible; (b) good quality comprehensive reproductive health services that meet women's needs and are accessible to all women; (c) safe, legal abortions and safe, effective treatment for infertility; and (d) freedom from population policies and social codes that pressure some women to have children and others not to (WGNRR newsletter 1993).

The movement, therefore, pointed out that a reproductive health approach to population policy should be committed not to fertility decline but to expansion of human rights and the improvement of human welfare; in other words, reproduction was firmly embedded within a framework of human rights (Bunch 1990; Cook 1993, 1995a, 1995b; Correa 1994; Dixon-Mueller 1993). In terms of programme strategy, this would mean instituting a host of services that would enable individuals to enjoy satisfactory reproductive lives; that is, it would both broaden the scope of services (expand access) and deepen the impact (enhance quality) of existing family welfare programmes (Dixon-Mueller 1993; Aitken and Reichenbach 1994; Sai and Nassim 1989).

The research and activism emerging from the women's health movement was reflected in a change in the thrust of mainstream demographic scholarship. The medical

understanding of fertility behaviour that had primarily focused on maternal health, was beginning to acknowledge a host of other influences on a woman's reproductive life. Sai and Nassim (1989) pointed out that the foundations of health were laid down during childhood and adolescence. A reproductive health approach, in principle, recognized aspects of nutrition, development, education and the socio-economic environment as key determinants of the health of women at the time of pregnancy and childbirth. According to Sai and Nassim, a reproductive health approach recognizes that maternal mortality, the main indicator of women's health, is just the tip of the iceberg of problems caused by sexuality and pregnancy. The focus on reproductive health, in many ways, compelled the medical community to review critically the fragmented approach to health that was conventionally provided in developing countries and the advantages of integrated health programmes which focus on the social determinants of people's lives (Graham 1993).

International donor agencies also began to recognize that a reproductive health approach was a key development in population policy. In the mid-1980s, the Ford Foundation redefined its framework for thinking about population policy. In 1985, the Foundation's work on population acknowledged the narrow conception under which most policies work and recognized that fertility decisions were influenced by factors such as "a woman's education and her sense of her own opportunities" (Harkavy 1995:188). By the 1990s, reproductive health became the fundamental theme for all grants made under population-related activities of the Ford Foundation (Harkavy 1995: 190). Although donor organizations such as the Rockefeller, and Mellon and Hewlett Foundations did not move into the area of reproductive health, the MacArthur Foundation since 1988 has put primary emphasis on funding reproductive health programmes (Harkavy 1995). The United States Agency for International Aid (USAID), under the Clinton administration, also chose to work in areas around women's status, although not directly labelled reproductive health. The United Nations Foundation for Population Activities (UNFPA), alongside, collaborated closely with women's groups and was responsive to the change in direction that was impelled under the ethos of reproductive health (Harkavy 1995).

The rhetoric of reproductive health, which began in the women's movement, thus began to challenge and redefine existing values that defined population policy. The final affirmation of their efforts was the adoption of ideas espoused in the reproductive health approach by the international population community¹⁹. The movement's participation in international conferences and, especially, the processes that led to the International Conference for Population and Development at Cairo, 1994, were particularly significant in influencing the text of the document that emerged from the conference. The Programme of Action at Cairo (POA) centred women's well-being and rights as the pivotal concern that would impel the design and implementation of population policy. The phrase 'quality of care' was a new addition to the text of the POA, while concepts that had emerged from the women's discourses around reproductive health like "bodily integrity" were implicitly acknowledged within the broad agenda of women's empowerment. The preamble of the POA notes that "...advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development related programmes" (United Nations 1995a: 8). It was the first time that reproductive and sexual health, and reproductive rights of women were central to an international agreement on population (Germain and Kyte 1995). As Correa and Petchesky (1994) point out, "[y]ears of organising and advocacy by women's health groups throughout the world have clearly had an important effect *at the level of official rhetoric* on inter-governmental forums concerned with population issues" (p. 119, emphasis in original).

Not surprisingly, the text of the POA of the ICPD is an interesting mix of ideas that have been drawn from feminist visions of reproductive freedoms and earlier international charters that enunciate criteria for reproductive rights. The POA adopted the World Health Organization's (WHO) definition of reproductive rights as the "right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children..., the right to attain the highest standard of sexual and reproductive health ..., the right to make decisions concerning reproduction free of

¹⁹ Interestingly, the process of diffusion of reproductive health ideology within the international community has followed the path taken by population control discourses as identified by Barret and Frank (1999). They found that population control discourses originated in social movements, then were adopted by the international population community, before becoming accepted by national governments (Barret and Frank 1999: 215).

discrimination, coercion and violence" (POA, Chapter 7.3; United Nations 1995a). The POA also makes specific references to women's reproductive rights within reproductive health programmes. Chapter 4.4 (c) of the POA notes that "...countries should act to empower women...assisting women to establish and realise their rights, including those that relate to reproductive and sexual health". It also emphasizes the promotion of the notion of rights in programme strategies, stating that "...[i]nformation, education and communication efforts should raise awareness...on such issues as: safe motherhood, reproductive health and rights...." (Chapter 11.9). The POA further asserts that "...reproductive health programmes should be designed to serve the needs of women...and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services" (Chapter 7.7).

Thus, the ICPD 1994 locates reproductive health and rights within a broader context of women's self determination and control over their reproductive and sexual lives (Petchesky 1995). This is evident in the generous attention that the POA gives to women's empowerment and equality issues within reproductive and sexual health. The POA rejects the view of women's equality as simply a means to the goal of fertility control as is evident from the following quote: "...the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself" (Chapter 4, cited in Petchesky 1995: 153). The POA links empowerment to decision-making capacities for women, thus implying reorganization of existing gender relations in society (Chapter 4.4). It also emphasizes the importance of male responsibility within the traditional sphere of women's activities (such as child-care, house work and sexual responsibility) (Chapter 4.11). Further sections like 4.17 aim to point out that "the value of girl children to both their family and society must be expanded beyond their definition as potential child-bearers and caretakers...". Thus, as Petchesky (op. cit.: 154) highlights, the POA replaces both anti-natalist and pro-natalist ends with those of personal well-being, pleasure and freedom.

The adoption of reproductive health as the ideological basis for population policy was significant, in part, because of the potential implications for the institutionalization of policy. Reproductive health is not merely a population discourse, its emphasis on empowerment and control over the body reflected a rights discourse as

well²⁰. It challenged existing ideas of how population policy ought to be addressed, particularly, that women's well-being superseded the objectives of the nation-state and local communities. The institutionalization of the discourse of reproductive health, as a result, involves a marked shift to a novel set of discursive themes. The state's negotiation of this discourse, and its consequent assimilation into the state's pre-existing ideologies, is a critical moment in the institutionalization of reproductive health within health systems. At this juncture, it would be profitable to theorize the effects of a political discourse that enters a predetermined socio-political realm, challenging existing discourses, as reproductive health evidently has. Towards this end, the rest of this chapter reviews pertinent literature that will provide an understanding of how discourses affect the political landscape and the implications for policy. Fraser's (1989a, 1989b) critical feminist model of discourse interpretation is a useful framework for this purpose that I will review at some length below.

Theorizing the Political

Fraser's (1989a, 1989b) model of social discourse is intended to bring a critical perspective to the way discourses around needs are articulated in late twentieth century welfare states²¹. There are three aspects of this model that are particularly useful for examining the processes by which certain discourses attain currency in political life,

²⁰ The positioning of reproductive health as a rights discourse has been a debated one among feminists. In a less contested way, women's reproductive rights have been unequivocally declared as human rights (Cook 1993; Bunch 1990; Freedman and Isaacs 1993). Staking a claim for reproductive rights as an individual's right within a liberal framework has been less convincing; such a claim raises problems about the underlying individualistic bias which may be unacceptable in many cultural contexts. The alternative has been to reframe reproductive rights from a social rights perspective, that is, that the exercise of reproductive rights requires a socially enabling environment that must be provided by the state (Correa and Petchesky 1994, Petchesky 2000). The latter position has tended to be the favoured one among Third World scholars and activists.

²¹ It may be productive at this point to justify the use of Fraser's model for the post-colonial context of the Indian State. There are elements of the Indian state, which is comparable to the conditions that Fraser outlines. First, the state following Independence was the central entity that brought many diverse political, communal, regional groups together. Although the state does, on occasion, reflect the biases of these groups, it nonetheless overshadows the power of any other social entity. Second, the state was also the key agency that conceptualised and implemented development. As Chatterjee (1998) persuasively argues, the Indian state's immersion in development activities tied it directly to the economic well-being of the people. While there are differences from the welfare state (see Chapter IX), admittedly, the Indian state is a formidable figure in the social lives of its citizens. Third, the state is also the primary source of instituting a developmental ideology (see Chapter III). From the start, post-Independence India has focused on a modernization strategy, which has inadvertently led to the expansion of a public (as opposed to a private and domestic, see Chapter III for definitions) sphere. Simultaneously, the state is also embedded in cultural and religious norms, limiting women's (among other groups) access to the public space of legal restitution (see Chapter III). The state's shifting interests in economic strategies and cultural values have resulted in fluidity in the boundaries between these lines, suggesting, as Fraser has in the U.S. context, that there is an ongoing struggle for establishing dominance in the discursive space of public politics.

namely: (1) the concept of runaway needs, (2) the three moments of needs interpretation, and (3) the major forms of needs-talk discourses and their functions. To gain an understanding of these three components of her model, I will first elaborate Fraser's conceptualization of the discursive structures in society.

According to Fraser, the late twentieth century welfare state is marked by claims by various groups in society for satisfaction of what they perceive are crucial needs. For Fraser, the actual content of the needs and how these may be satisfied is secondary to the discourses surrounding needs; that is, the focus should be on how needs are interpreted rather than only focusing on implementation of programmes to satisfy what have already been interpreted as needs. Among the reasons she gives for this shift of focus is that needs are not determined or satisfied isolated from the social and political processes in society. She draws on Foucault's notion of discourses constructing individuals as subjects, and emphasizes the importance of giving due attention to the role of institutions and authorities that determine which groups' claims are articulated in the public arena²². She points out that mainstream political theorists by focusing on satisfaction of established needs "...assume that it is unproblematic who interprets the needs in question and from what perspective and in the light of what interests; they thus occlude the fact that *who* gets to establish authoritative thick definitions of people's needs is itself a political stake" (1989a: 162, emphasis in original). Fraser also sees the establishment of needs discourses as closely tied to demarcated zones in society: the political, economic and domestic dimensions. Fraser positions the domain of the "political" or "public-official" in opposition to the "private" spheres of the economic and domestic.

According to Fraser's model, an issue that has not become a matter for political debate or action is entrenched within the personal sphere - either within domestic or economic institutions. Women's issues usually tend to be contained within the domestic sphere. However, the boundaries between the political and the personal are porous; under a variety of circumstances, an issue that is conventionally regarded as private escapes into the public sphere - a "runaway, leaky issue" that then becomes politicized. Furthermore, Fraser sees society being constituted mainly by three kinds of discourses that influence

²² While Fraser's model draws on Foucault's fundamental definitions of discourse and power, there are also specific points on which she diverges from his theories. See note 43.

“needs-talk”: “oppositional discourses”, representing the voice of subordinate groups or discourses from “below”, such as, feminist movements; and “reprivatization discourses” and “expert needs discourses” - from “above”- that represent the discourses of the institutionalized “problem solving” structures in society. The discourses from “above” seek to deny the claims of oppositional movements of the legitimacy of a “runaway need”. “Reprivatization discourses”, representing the reactionary forces in society or the forces of economic gain, are in continuous conflict with oppositional claims to political legitimacy. “Expert needs” discourses depoliticize oppositional needs by trying to institutionalize and ‘normalize’ them through the state’s bureaucratic apparatus. Expert needs discourses are the vehicle for translating “sufficiently politicized runaway needs into objects of potential state intervention” (1989a: 174). Both the reprivatization and expert-needs discourses serve to depoliticize runaway needs that are articulated by oppositional groups. However, the struggle to establish a needs-discourse, or endow an issue with a political status, according to Fraser, is only the first of three interrelated *moments in needs interpretation*. A second stage in the needs struggle is defining the means to satisfy the need or the interpretation of the need. The third moment is the struggle to satisfy the need, or the process of allocating the resources and making provision for the satisfaction of the need.

Reproductive Health as an Oppositional Discourse in the Third World

Reproductive health discourse, emerging as it has from the struggles of the women’s health movement, in many ways resembles the characteristics of an oppositional need²³. The interpretation of the reproductive health discourse is particularly sensitive to the ideologies of other socially dominant discourses that mark the same international and national terrain. Both materially and ideologically, the discourses of neo-Malthusianism and neo-liberalism²⁴, which are fundamentally at odds with the reproductive health discourse, are likely to affect the way that it will be interpreted.

²³ Kabeer (1994) also analyses reproductive health as an oppositional discourse. She applies Fraser’s model of needs interpretation to the contestations of discourses around population and points out that conventionally women’s needs and choices have been usurped by the long-standing concerns of the population community (pp. 192- 194).

²⁴ The present section offers a brief account of the essential features of the neo-liberal discourse. A detailed section in Chapter IX engages critically with the implications of this discourse for women’s reproduction, particularly in the Third World.

In the aftermath of the Cairo conference, there has been concern that the gains made for reproductive freedom has been compromised by dominant discourses that seek to delegitimize the political validity of the reproductive health discourse. Certainly, the protests at the conference itself were an overt and belligerent manifestation of these influences (Weigel 1995; see also Gulhati and Bates 1994; Johnson 1995). However, the subtlety of other prevailing international discourses was also influential in the process of re-interpretation of the reproductive health discourse. Grimes (1998: 389), for instance, notes that, “[w]ithin the feminist movement there are clear divisions between those who regarded the 1994 Cairo Conference as a step forward in the promotion of a more liberal approach towards the provision of ‘reproductive rights’ and those who regard the politically correct language of reproductive choice, women’s empowerment and environmental concern as a clever repackaging of the population establishment’s old agenda of fertility control”. Correa and Petchesky (1994: 119) point out that, “perceiving the history of population control policies and programs as all too frequently oblivious to women’s needs...they [feminists] fear the language of reproductive rights and health may simply be co-opted by the Cairo process to support business as usual”. Of the discourses from ‘above’ that are likely to negate the effect of the political dimension of reproductive health, the pervasive neo-Malthusian ideology continues to play a significant role (Grimes 1994; Sen 1995)²⁵. The fear that the world would be engulfed by a population growth that it cannot sustain is still a crucial determinant of the population ideology. Neo-Malthusianism finds support at the national level in the strategies endorsed by states to ensure economic development. For most countries of the developing world, in particular, the course of modernisation is liable to be hampered by population growth and any population policy that advocates reproductive freedom must be tempered by the sobering, grim facts of the ‘population problem’. It was not that neo-Malthusianism was abrogated at Cairo; scholars have pointed out that the consensus between the population discourse that focuses on rights and that which stressed control of population was possible only because the fundamental conflict between the two discourses - that is, to stabilize world population and respect people’s

²⁵ Although neo-Malthusian and neo-liberal discourses are distinct ideological influences (the former emphasising fertility control and the latter economic rationalism), it may be argued that in the context of developing countries the two are intricately intertwined. In India, for instance, the ideology of economic growth is inseparable from an anti-natalist agenda. Neo-Malthusianism becomes a component of the neo-liberal economic ideology of the state. For this reason, I present the essence of these ideologies together under the broad general label of Neo-Liberal Discourse.

rights - was never addressed (Amalric and Banuri 1994). The evidence from Cairo, the authors point out, seem to indicate that the global discourse on population will still continue to be dominated by Neo-Malthusian ideology – as they note, “[...] success of the [Cairo] action plan rests on the belief that more contraceptives, more health services and more schools will be sufficient to bring down fertility rates” (Amalric and Banuri 1994: 703).

Yet another dominant discourse that most international economic and political systems currently adhere to in some form or the other is the neo-liberal discourse²⁶. Bangura (1997) summarises the foundations of neo-liberalism as follows:

Neo-liberalism is primarily concerned with market discourse...[which]... is primarily concerned with market efficiency, limited government, balanced budgets, private ownership of assets, trade liberalization, and unregulated competition. Its view of society is derived from a reading of individuals who are believed to be capable of making rational choices and maximizing opportunities It is believed that a free economy would allow the various production factors to be efficiently rewarded, raise national output, and in the long run, lift even those in poverty out of their misery (p. 21).

The invariant focus of the neo-liberal discourse on the supremacy of market and the absence of interest in issues of social equity or participation stands in opposition to a reproductive health discourse that emphasizes government intervention, both socially and financially to ensure both equity and participation (Bangura 1997). The ideologies of neo-Malthusianism and neo-liberalism predominate contemporary population thought in developing countries. These ideologies direct economic plans and programmes of most contemporary governments. Structural Adjustment Programmes (SAPs), in particular, ideologically drawn from neo-liberalism, aim to promote economic growth by cutting down ‘wasteful’ expenditure and reducing government spending in social programmes and creating conditions for market-led economies. Within the adjustment package, control of population growth is a key goal, as population growth is seen to impinge strongly on the other economic strategies undertaken in the package (Palmer 1991; Grown 1994; Mason 1993). In fact, the introduction of family planning policies has often been part of the conditionality of SAPs (Pearson 1997). At the same time, studies from developing countries indicate that auxiliary social services for women are on the

²⁶ Chowdhry (1995) argues that WID epistemology is also deeply entrenched in the liberal discourse of the market.

decline (Hatem 1994; Dixon-Mueller 1993; Waylen 1992). Governments are keen to divert investment to sectors that directly produce outcomes that can be traded in the global economy. Thus, the economic context in most developing countries can hamper the efforts to institutionalize the discourse of reproductive health.

Institutionalizing Reproductive Health as Policy

As a policy discourse, therefore, reproductive health is likely to be interpreted from within the ideological standpoints of feminism and neo-liberal/neo-Malthusianism, in what Smyth (1998:217) refers to as the “feminist vs. population control” debate. In this section, I attempt to trace some of the elements of the two discourses - epistemological foundations, manifest objectives, action plans and constructions of women - and their likely implications for the way reproductive health is likely to be interpreted and institutionalized.

A feminist discourse on reproductive health is based on the belief that one should have the “power to make informed decisions about one’s own fertility, child bearing, child rearing, gynecological health and sexual activity; and resources to carry out such decisions safely and effectively” (Correa and Petchesky 1994: 107)²⁷. The key concept here is ‘power’ - in terms of control over one’s own body and in terms of control over resources so as to make decisions about one’s body. A feminist discourse on reproductive health is grounded in the language of freedom - both of personal liberties (domains where the government should leave individuals alone) and social entitlement (domains where affirmative public action is required to ensure that rights are attainable by everybody) (Correa and Petchesky 1994). Moreover, Keysers (1995: v) adds that it is “woman’s individual right to be free from unwanted sexual contact and pregnancy” and that this right “prevails above the rights of other parties”. Thus, embellished as it is with notions of rights, freedom and power, the feminist discourse on reproductive health may be charted along a wide canvas - from attaining the highest possible standards of health (United Nations 1995a) to the elimination of violence against women, and ensuring women’s equality in society (Sadik 1997).

²⁷ This is not to suggest that all feminists have a unified understanding about the various social and personal aspects of reproduction and reproductive health. Smyth (1998) provides a brief description of the ways in which the various major schools of feminist thought perceive reproduction.

A neo-liberal discourse on reproductive health, on the other hand, is informed by the neoclassical economic perspective on growth. 'Efficiency' is stressed in that all possible barriers hampering economic growth should be removed allowing the forces of the market to prevail – and unbridled population growth is one such barrier (Palmer 1991; Pearson 1997). The restructuring objective sees women's reproductive capacity as critical to its objectives: regulating women's fertility and management of social reproduction are central to the success of the programme. For instance, *the Report of the State of World Population* (1989), points out that some of the costs of ignoring the needs of women are uncontrolled population growth, high infant and child mortality, weakened economy, ineffective agriculture, a deteriorating environment, a generally divided society and poorer quality of life for all (Sadik, cited in Palmer 1991:4). So also, it is assumed that women's reproductive work is "inelastic"²⁸ (Elson 1994) and is used as the rationale for cutting down 'inefficient' investment in public services. The language of restructuring makes little reference to an individual's rights or claims to the state; if anything, the claims to people's social rights are diminished²⁹. Social programmes are seen as creating a 'distortion' within the efficient market economy (Elson 1994) – the investments of the state in public programmes must be justified on productive outcomes, and thus the state rationalizes reduced support for such programmes. The neo-liberal discourse on reproductive health is likely to instrumentalize women.

Population control as a significant factor of development is an intrinsic feature of this debate, yet authors equivocate on how the two issues – population regulation and individual freedom that are overtly contradictory - may be reconciled³⁰. Within the restructuring debate, there is unequivocal consensus that population control is important to the success of economic growth. Feminists are less clear as how to reconcile

²⁸ Elson argues that restructuring agencies believe that women will take on added work within and outside the home to ensure that basic needs of their families are met; that is, their contribution for the maintenance of quality of living of their household is inelastic. This provides a sound justification to reduce government spending on subsidized and welfare programmes - women, it is assumed, will somehow make up for services no longer available. However, Elson points out that this is a false assumption, and women can make up for losses only up to a point. Beyond this, the quality of lives will be adversely affected.

²⁹ Afshar and Dennis (1992), Bakker (1996), Beneria and Feldman (1992), Dalla Costa and Dalla Costa (1995), Elson (1991, 1992) Kelsey (1993, 1997), Sparr (1994) provide theoretical discussions and country case studies to illustrate how social programmes have undergone drastic reviews under restructuring with the attendant implications for people's lives.

³⁰ The Programme of Action (ICPD) itself lays no specific quantifiable goals for population growth. However, it does assert that early stabilisation of world population would make a significant contribution to realizing the overarching objective of sustainable development.

individual rights with population control. Some believe that every right is linked to responsibility and larger social obligations (Dixon-Mueller 1993) while others deem that the right to decide when, how often and with whom to have children is purely an individual choice (WGNRR newsletter 1993). Official population agencies, on the other hand, find that meeting reproductive health needs of people will lead to voluntary fertility reduction (Sadik 1997: 4).

Another issue on which the two discourses raise debate is translation into policy. A gender discourse on reproductive health is at odds with the principles underlying most contemporary population policies. Population policies mostly emphasize fertility control, and programmes such as contraceptive distribution and community education are designed to meet this objective. In contrast, the features of a reproductive health policy would ideally reflect the feminist assertion that “reproductive autonomy cannot be obtained by means of birth control alone even when delivered in a comprehensive and caring way” (Dixon-Mueller 1993: 204). The aim of reproductive health programmes, therefore, would be linked but not necessarily limited to the provision of a range of reproductive and sexual health services provided as primary health care. The real challenge lies in transforming existing services in a manner that places women’s physical and emotional security as the centre (Dixon-Mueller 1993) and in focusing on meeting personal reproductive goals in a “healthful” manner (Jain and Bruce 1994: 195). At a minimum, such a perspective would involve a shift in the primary objective of family planning programmes from merely fertility reduction to assuming responsibility for reducing unplanned and unwanted child bearing and associated morbidity. It would also necessarily encompass a focus on empowering women and providing services delivered with care.

Berer (cited in Smyth 1998) argues that from a woman-centred point of view, increasing women’s currently limited life choices as well as reproductive rights are the first principles upon which any policy or programme on fertility should be based. Dixon-Mueller (1993) identifies ten aspects that should comprise a reproductive health programme. They include, among others, building on women’s experiences, linking with women’s NGOs, increased choices, changing discriminatory practices and instituting a philosophy of care. Kabeer (1994) also lists essential features that should be

encompassed into a gender-sensitive reproductive health programme. They include provision of information on new contraceptive technology, an approach that focuses on users' perspectives, greater involvement of men in reproductive decision-making, and an emphasis on maternal and non-maternal reproductive and sexual health. Jain and Bruce (1994) put forward three aspects that should form the basis of a reproductive health approach to family planning - legal and policy frameworks to create conditions conducive to voluntary fertility decline (such as, girls' education, increased women's access to resources, etc.), redefinition of family planning programmes to focus on meeting individual's personal reproductive goals, and a focus on preventing unwanted fertility.

In such a set-up, the notion of 'rights' plays a central role in the design of reproductive health programme; a human rights/equal rights policy, for instance, would allow women centre stage in social welfare and development (especially those that help women make independent choices about marriage or effect changes in customary laws)³¹. A reproductive rights policy (like laws related to abortion and voluntary sterilization) would support women taking control over their own reproductive and sexual decisions (Dixon-Mueller 1993: 201-202)³². Rights can also be regarded from the perspective of state action - whether the state should take positive action or refrain from action (Dixon-Mueller 1993). In the case of 'natural' rights or 'individual' rights, it is expedient for the state not to intervene into the private affairs of its citizens, whereas in the case of 'social rights', the state is expected to contribute to citizen welfare through affirmative action of some sort. For individuals to exercise their right to make informed decisions about their reproductive lives, a combination of both negative and positive action on the part of the state is required. What is important to note is where the lines between the two are drawn in policy and programme.

³¹ Petchesky (1990) offers a valuable review of feminist conceptualizations of women's right to reproductive choice.

³² This is not to suggest that there is unanimity in the idea of what kind of rights are relevant for women. The notion of 'rights' is known to be conveniently distorted to advance sectarian interests. Buss (1998), for instance, shows how at the Beijing Conference (1995), the Vatican transformed the slogan of 'women's rights are human rights' to represent a conservative perspective of women's rights. Other problems with the use of the term 'rights' refer to the interpretations of First and Third World feminists; the former are accused of individualistic interpretations, which do not define the social realities of women in developing contexts (Lingam 1995).

Further, a feminist policy encompasses several dimensions of reproductive health, such as efforts to reduce reproductive mortality and morbidity, promote relevant changes into legal and policy frameworks that will address issues of women's inequality and discrimination, and enhance quality of care and outreach of clients (Jain and Bruce 1994; Dixon-Mueller 1993; in general, Sen et al. 1994). All of this would require greater involvement and investment of the state (Zeitlin, Govindraj and Chen 1994). The feminist discourse on reproductive health emphasizes increased links with non-governmental organizations (Sadik 1997); a feminist assertion has been that programmes would be more effective if implemented in conjunction with women's grassroots organizations, especially health organizations (Correa 1994). The neo-liberal discourse on health, on the other hand, favours a diminishing role for public services, including health. The *World Development Report* (1993) emphasized that the health sector in most developing countries was badly in need of reorganization. Among the recommendations of the report was the massive reduction of government investment in curative medicine and medical training making way for the private commercial sector to perform these activities, and diverting funds instead into preventive activities (such as, immunization and control of communicable diseases) and family planning. Case studies from around the world (Waylen 1992; Hatem 1994) show that health sector activities had been pared down to essential services following the onset of restructuring programmes. Auxiliary services for women such as Maternal and Child Health (MCH), pre- and post-natal care, and maternity privileges were among the facilities that were drastically reduced. Cost recovery is a prime objective of most social sector services in restructuring economies (Beall 1997). The imposition of user charges is encouraged to maintain efficient running of the health services. In sum, the implied substance of restructuring is withdrawal from providing services, rather than further investment into public health. A feminist discourse, meanwhile, makes no explicit reference to user charges, but is not supportive of a programme that will exclude sections of population³³.

Both the discourses see the primary health care centre (the PHC) as the locus of family welfare activities. In the case of restructuring debates (as indicated, for instance, in the

³³ According to the ICPD POA, the primary objective in the area of primary health care is to increase the "accessibility, availability, acceptability and affordability" of health care services and facilities to all people in accordance with national commitments to provide basic health care for all (see United Nations 1999).

World Development Report (1993)), the cost effectiveness of the decentralized structure and greater potential for reaching the rural areas has been emphasized as the reason for this recommendation. The feminist discourse on reproductive health favours the PHC as the site for delivery of a comprehensive set of reproductive health services from contraception distribution, reproductive health counselling, treatment of infertility, reproductive tract infection and STD treatment, abortion services, and education and counselling, on human sexuality reproductive health and responsible parenthood (United Nations 1995a). The ultimate objective of the reproductive health approach is expanding access and enhancing quality (Aitken and Riechenbach 1994). Often, the PHC is seen as the first in a multi-rung hierarchy working as part of an integrated system. The PHC is the first point of health access to clients in rural locations that delivers essential health services to the local population. It is backed by a referral system that allows a client to access advanced health facilities of the state. The PHC is also favoured as a point of health delivery because of the greater interpersonal links between the functionaries of the PHC and the local population.

However, critics of the PHC system point out that PHCs are inadequately funded and equipped, and lacks competent managerial skill and political commitment (Beall 1997). Women, particularly, have been disadvantaged in the PHC system as it is usually women's reproductive health needs related to child birth and fertility reduction that are most emphasized. Menstrual hygiene, for instance, is a non-issue. Women in reproductive ages who are unmarried or not mothers, elderly women, and young girls are all sidelined in terms of services and care (Beall 1997). For the most part, the PHC system is the inferior offering of a two-tier health system, a palliative to which low-income communities are required to contribute, by a social system which places scant value on the health of the poor (Beall 1997: 77). It is expected that economic restructuring led by neo-liberalism will only exacerbate some of these negative features. Ultimately, policy paradigms dominated by one of the two discourses discussed above have distinct implications for population policy and its women beneficiaries. The

feminist discourse on reproductive health centres women as a constitutive category within the state and realigns their bargaining position in society whereas the neo-liberal debate sees women and their reproductive health as instrumental to the priorities of economic growth. A population policy interpreted from the feminist perspective of reproductive health thrusts women's needs into the centre stage of social rights and legal reconstitution to uphold these rights. Conversely, a population policy interpreted from the neo-liberal perspective hovers dangerously on the verge of being subsumed as an add-on policy, marginalizing women's position vis-a-vis the state even further. Table 2.1 summarizes the points that I have discussed above.

Conclusion

Overall, as I have argued in this chapter, reproductive health is a political discourse, and the institutionalization of reproductive health is the outcome of interpretations made by bodies in the policy arena embracing diverse and, often, contradictory ideologies. The potential policy outcomes for reproductive health under contending ideologies are analysed in Chapters 6, 7, and 8. In the next chapter, I attempt to provide an understanding of the state and the significance of its ideologies around gender that are reflected in policy.

Table 2.1**Theorising Elements in the Neo-Liberal and Feminist Discourses of Reproductive Health**

Characteristic	Neo-Liberal Discourse	Feminist Discourse
Underlying principle	<ul style="list-style-type: none"> improved reproductive health leads to lower fertility 	<ul style="list-style-type: none"> access to Reproductive Health is a basic right
Services	<ul style="list-style-type: none"> restrictive: family planning, safe child birth, adolescent sexuality stressed 	<ul style="list-style-type: none"> broader range of services: reproductive health on a day to day basis
Population growth	<ul style="list-style-type: none"> undesirable-hampers economic growth 	<ul style="list-style-type: none"> individual decision
Construction of women	<ul style="list-style-type: none"> conduits for fertility control: instrumentalist 	<ul style="list-style-type: none"> reproductive decision maker: a value in its own right
Site for services	<ul style="list-style-type: none"> PHC; decentralised system; cost-effective 	<ul style="list-style-type: none"> PHC; potential for more accessibility
User charges	<ul style="list-style-type: none"> stressed 	<ul style="list-style-type: none"> not explicitly mentioned, however, principle of greatest access prevails
Resources	<ul style="list-style-type: none"> minimal use of 	<ul style="list-style-type: none"> multiply investment
Non-govt involvement	<ul style="list-style-type: none"> private sector 	<ul style="list-style-type: none"> women's health organizations
Accountability	<ul style="list-style-type: none"> economic accountability 	<ul style="list-style-type: none"> social/individual accountability
Quality of care	<ul style="list-style-type: none"> emphasized to increase use 	<ul style="list-style-type: none"> emphasized as a human right
Private-Public divide	<ul style="list-style-type: none"> does intervene processes social transformation 	<ul style="list-style-type: none"> not in of requires social transformation

Source: Author

III

THE STATE AND THE IDEOLOGIES OF GENDER

Women in Indian Development

Just as sexing chickens requires a close inspection of the genitalia of the bird, sexing the state involves a study of that entity's reproductive mechanisms.

Charlesworth 1997, p. 254

In the South Asian context, the nation is represented as a motherland and the state as the father. In some cases, the patriarchal state exercises control with benevolent paternalism, and in others, in an authoritarian fashion. The paternalistic state offers protection to "its" women and children on the assumption that they cannot protect themselves. In return for this protection, it demands control over women's sexuality.

Basu 1998, p. 6

Fraser's model of needs interpretation provides a useful analytical perspective to evaluate the process of policy making by states. As Fraser (1989b: 173) notes, "[t]he struggle for hegemonic need interpretations usually points toward the future involvement of the state...", usually as the agency that institutes political discourse into policy. Fraser also points out that contestation of discourses takes place not just between the state and other social groups in society, but amongst the various structures of the state. The state, independently, subscribes to discourses around women and gender. These discourses will influence the interpretation and institutionalization of oppositional discourses (here, the reproductive health discourse). The analysis of the state and its gender discourses, in effect, becomes the focal point for understanding aspects of gender policy.

The state has been at the centre of decades of feminist political theorizing in the 'west'. In contrast, the idea of the state has not commanded similar attention in conventional

theorizations around women in developing contexts³⁴. For the most part, WID literature is founded on the primacy of the market in women's lives; women's political and social status is linked to their ability to participate in market production. A growing body of literature (for e.g., John 1996), however, acknowledges the role of the state and its discourses in constructing women as economic beings, and situating women in development policy.

This chapter argues that the Indian state is a significant source of ideology that has an impact on the constructions of women's political and economic identities, the claims that they can make on the state, and ultimately, the shape of development policy that is designed. I focus here on the constructions of women's identity in the state since the 1990s, when, in the wake of neo-liberal development, economic and political discourses have converged to define notions of citizenship, rights and obligations of individuals and the developmental state. In this chapter, I first review feminist theorizations of the state and the ideological contexts in which women's political identities are defined. Although these conceptualizations are pre-dominantly drawn from theorizations made in the west, I argue that there are parallels that can be made in the context of India as well.

The State and Gender Identity: Western Feminist Theorizations

The Concise Oxford Dictionary of Sociology (1994) defines the state as a “distinct set of institutions that has the power to make the rules that govern society.... [t]he state is not a unified entity...[I]t is rather a set of institutions which describe the terrain and parameters for political conflicts between various interests over use of resources and the direction of public policy” (G. Marshall 1994: 635). Feminist descriptions of the state have traditionally drawn on existing left or liberal political theorizations of the state, underscoring MacKinnon's (1983, 1989) comment that feminism has no theory of the state. These traditional theorizations have been critiqued for the simplistic portrayal of

³⁴ Scholars like Chacchi (1991) Kandiyotti (1991), Moghadam (1994), Hasan (1994), Uberoi (1996), Yuval-Davis (1989), among others, do offer non-western feminist perspectives on the Third World state and women's identity. However, this literature predominantly focuses on women's cultural backgrounds and their consequent representations in the state. This literature is useful in emphasising the state's reflection of cultural biases but, unfortunately, does not directly deal with the issue of how women are positioned within economic and developmental discourses, which is my primary focus in this thesis. To elaborate on women's political identity vis-à-vis development, I find it useful to draw on ideas that have been advanced by western feminist definitions of the state and its functioning.

state actions, particularly, that the state is unilaterally oppressive to women (Pringle and Watson 1992; Watson, 1992). In contrast, contemporary feminist theorists favour a post-structuralist view of the state (Allen 1990; Connell 1990; Franzway et al. 1989; Pringle and Watson 1992; Rhode 1994)³⁵. At the heart of the post-structuralist perspective is the acknowledgement that the state is not a monolithic entity with unitary influences, but rather a plurality of forces. The post-structuralists see the state as a “process rather than...as thing” (Connell 1990: 509) and as a “network of power relations existing in co-operation and also in tension” (Rai 1996b: 5). Brown (1992: 12) also notes that the state is a “significantly unbounded terrain of powers and techniques, an ensemble of discourses, rules and practices, cohabiting in limited, tension-ridden, often contradictory relation with one another”. This ‘process’ that is the state, operates within a culturally defined ‘public’ realm, but this is not historically or culturally fixed (Franzway et al. 1989).

The dispersed view of the state implicitly acknowledges a series of arenas that constitute the state both discursively and through practices. As Connell (1990) points out, because the state is not unitary, neither are the practices that connect the various capillaries of the state body. At different points in time, different kinds of connections mark the structures of the state. Depending on how intense these networks are, more or less power would accrue to the state (Watson 1990:7). Yet, the state, as post-structuralists note, is the “...node within that network of power relations that is one of the principal sub-structures of the gender order. The state is the main organizer of the power relations of gender” (Connell 1990: 520). The state’s impact on sexual and gender politics is, in the post-structuralists’ view, dynamic, in that there is no one linear direction of oppressive activity or ideology. Inherently, though, the state functions as an institutionalization of the power of men (partly because historically it has been masculinist and the modern state carries this legacy), and to that extent may be said to be patriarchal (Connell 1990; Franzway et al. 1989). Similarly, Brown (1992 :14) points out that “the state can be masculinist without intentionally or overtly pursuing the ‘interests’

³⁵Some of the ‘older models’ of the state are provided by liberal feminists, Marxist feminists, radical feminists, and dual theorists. Their specific views on the state are not relevant to the argument that I make here, and therefore, I will not elucidate their theories of the state. Reviews of each of these schools are found in Connell (1990), Franzway et al. (1989), and Witz and Savage (1992). See also Burstyn (1983) for a Marxist feminist perspective of the state; MacKinnon (1982, 1983, 1989) for a post-Marxist perspective; and Daly (1978) for a radical feminist perspective.

of men precisely because the multiple dimensions of socially constructed masculinity have historically shaped the multiple modes of power circulating the domain called the state". Yet, the institutionalization of patriarchy, according to post-structuralists, generates paradoxical outcomes rather than only oppressive ones as, for instance, conceptualized by Marxist feminists.

Another feature of the state that post-structuralists point out is that it plays a key role in *constituting* women's needs (Pringle and Watson 1992). As Connell (1990: 527) notes, the state "do[es] gender". It is not a neutral institution that merely reflects the sexual politics prevalent in society; it equally shapes desires and plays a role in "legitimating, suppressing, or redirecting" women's preferences (Rhode 1994: 1189). Being the central locus of power, the state has "a considerable, though not unlimited, capacity to regulate gender relations in society as a whole" (Connell 1990:527). Brown (1992: 29, emphasis in original), in her essay, demonstrates convincingly that the state "mediates the *discursive*, *semiotic*, and *spatial* terms of women's political practices". Thus, although the state need not deliberately oppress or discriminate against women, by building policies "according to prevailing assumptions and ideologies about the role of women, the nature of the family and the proper relations between man and woman...the state [does have] a role not just in regulating people's lives but in defining gender ideologies, conceptions of 'femininity' and 'masculinity', determining ideas about what sorts of persons women and men should be" (Moore 1988:129).

Finally, the post-structuralist position veers away from an authentic notion of the category 'woman', but focuses instead on the multiple positions and identities that women (and men) assume in a social context. In this view, there is no longer a need to emphasize 'women's interests' as an essentialist need. Instead, it would be more fruitful to deconstruct the context in which needs are articulated. As Pringle and Watson (1992: 69) point out "[i]nterests are produced by conscious and unwitting practices by the actors themselves in the processes of engagement. Feminists who engage with the state do so within a set of parameters that are discursively constituted and will formulate their interests accordingly".

Defining Women's Political Identity in the 'Western' State

Women's political identity has conventionally been theorized in relation to the social spaces they occupy, viz., the public and/or the private³⁶. Classical liberal theory constructed women as beings of the private sphere. Based on notions of women's purported natural flair for reproductive work, women's relationships with the public sphere tended to be seen as an elaboration of their private domestic task. By the 'natural' make-up of the domestic world, women faced exclusion from the sphere of men. Pateman (1989: 120-122) and Fraser and Gordon (1994a, 1994b) scour the writings of the eighteenth century to show that arguments for the separation between the spheres were associated with differential citizenship rights for men and women. Although the early utilitarians advocated the idea of the liberal individual/subject, the notion was never intended to include at least three specific categories of persons: offspring, slaves and women. Of these, male offspring could be expected in due course of maturity to evolve into independent subjects. As women (the same was true also in the case of slaves) lacked the attributes and capacities of individuals who can enter civil society and sell their labour power, they were denied the right to equal citizenship. The idea of coverture was prevalent; it was taken as 'natural' that women's political inclinations could be played out through their husbands. Therefore, upon marriage, women were considered to have undergone a 'civic demise' (Thornton 1995), and their identity subsumed under the legal identity of their husbands.

Fraser and Gordon (1994a, 1994b) discuss other implications of the gendered public sphere on women's political identity. With the evolution of the gendered discourses of the private and the public from the eighteenth century, they argue, there emerged two

³⁶ There is a debate amongst scholars regarding what constitutes the public and the private spheres. While the domestic or household has categorically been assigned to the private sphere, other social spaces such as the state and the market are not easily reduced to either public or private. Conventionally, feminists have tended to label the public sphere as anything outside the familial or domestic sphere - the state, official economy of paid employment, and arenas of public discourse like the media, cultural discourses informed by literary, artistic and scientific circles (Fraser 1997:70). Jennings (1993) offers two classifications: in the first, the markets are "public" along with the state in relation to the family but were "private" vis-à-vis a public state. Thornton (1995) suggests that the dichotomy of public vs. private might be too simplistic to explain various social exchanges and that a trichotomy of family/economic-social/polity might be more tractable. I do not take a particular definition as applicable to my research; instead, I would like to emphasise that the very indeterminate nature of these spaces are relevant to our understanding of how the state positions certain issues as public or private. In this thesis, I demonstrate that the state's positioning of women's reproduction as either public or private (see Chapter IX) impinges on women's status as citizens or agents in the public sphere.

kinds of exchange within these spheres. As the public sphere was dominated by 'liberal' subjects and imbued with the attributes of rationality, the main form of individual interchange was accepted as contractual – that is, "resources were exchanged for exact equivalents in discrete, monetarized transactions between self-interested independent individuals" (Fraser and Gordon 1994a: 100). Within the domestic sphere, resource flow was influenced by intimate social and kinship relations, which were outside of the circle of equal exchange. The contractual exchange was privileged over the domestic exchanges as it was predicated on the motives of rational self-advantage (Fraser and Gordon 1994a). As society developed, all significant relationships had been assimilated within the contractual exchange, except perhaps for labour and resource exchange within the domestic sphere. Any extra-familial relationship that could not be made contractual was defined by its opposite: charity. In charity, the exchange was not between equals, instead it was between a donor and a recipient – the latter had no claims on the donor's 'gift' and the donor was under no obligation other than voluntarism to provide one.

The representation of gender identity in western states has conventionally been framed within the 'contract/charity' dichotomy. Men's relationship with the state has a direct political basis as they are seen as individuals and as representatives of a family (B. Marshall 1991), while women do not enjoy a similar status. B. Marshall (1994: 136) points out "men are individuals, women are related to individuals". The main reason for the differential positioning of men and women in relation to the state has been traced to the places they hold in the public and private spheres. Men are seen to have capabilities that are exchangeable under the contractual doctrine, and it was usually these capabilities that formed the criteria for citizenship. Under nationalistic discourses, for instance, male constructions of citizenship have been tied to their capacity for military service – a notion that was resonant of 'independence' and exchange in a contractual relationship (Fraser and Gordon 1994a; Pateman 1988, 1989). The masculinized form of 'citizen-soldier-protector' (Fraser 1991: 263) model is one that is reflected through constructions of 'ideal' citizens. Women's relationship to the state, on the other hand, has been much less direct. Women have the capacity to produce future soldiers for the country (Sarvasy 1992), be caregivers for future and past generations (Pateman 1988) or be represented as symbols of nationalism (Yuval-Davis and Antias 1989). For women, their predominance in the domestic sphere entails that most of their exchanges with the public sphere are

indirect and in their capacity as reproductive beings. These roles of women did not qualify for direct interchange with the state; as a result, women are seen as secondary citizens of the state.

With the emergence and development of capitalist ideologies within the state's discourses, the criteria of validity as citizens were increasingly linked to productive worth in the market. Jennings (1993) argues that the first separation of social spheres in Anglo-American society was between the family and the state, which developed in the seventeenth century. By the nineteenth century, however, the state was steadily losing ground to the primacy of the market. The market was increasingly the reference point for defining the public/private split, in which the public (the market) was privileged. As Jennings points out, "...the prominence of the 'economic man' is an artifact originating in nineteenth century cultural interpretations, which conflated man with dynamic market activity and woman with unchanging familial roles" (Jennings 1993: 122). A new definition of women as non-economic beings emerged, and this was more critical to the interpretation of their identity in society whereas their former definition as non-political beings was no longer essential to that interpretation (Jennings 1993)³⁷. Therefore, the development of the market went hand in hand with a definition of women's political identity that was tied to their perceived economic value.

The notion of economic worth continues to be the dominant value that frames citizenship, and distinguishes the status of men and women in the state. Women's relationship with the western welfare state in the twentieth century is a case in point. Feminist scholars have noted that women's relationship to the welfare state has tended to be dominated by the ideology of charity (Fraser and Gordon 1994a; 1994b; Nelson 1990)³⁸. In most social policies dealing with welfare, women are positioned as 'dependants' of the state and, therefore, as recipients of the state's charity. Contrarily, men are designated as deserving of the state's welfare. Critics of this 'dual-welfare standard' point out that this biased perception of the state arises because women's

³⁷ Jennings argues that the shift of political identity in terms of economic value could explain why women were able to win political rights (like the right to vote) since the nineteenth century rather than economic rights. Fraser and Gordon (1994c), in their analysis of the idea of dependency in welfare states, also point out that it was with the rise of industrial capitalism that women as 'housewives' or non-wage earners were transformed from "partners to parasites" (p.11).

³⁸ The effect of the welfare state on women's lived reality is debated among feminists. See Orloff 1996 for a discussion.

contributions to housework and childcare are not perceived as economic work, whereas men's engagement in paid work – no matter how sporadic or unskilled – still qualified them as better citizens.

Although much of the work relating to women's identity in the state has been done in the context of welfare states in the west, parallels can be drawn for analysing women in developmental states as well³⁹. Certainly the foundations of development theory is founded on the relationship of men and women to economic work or spheres of production, spurring a critique of the advantages that this implicit link had for men's political and material access to the state (Boserup 1970).

Scott (1996) analyses the way in which the public and private spaces have been conceptualized in development theory, particularly in modernization theory, which informs much of WID practice. Modernization theorists see the public realm as aligned with the symbols of modernity: industrialization, urbanization, progress, governance by a state and bureaucracy, and essentially the economic sphere of the market. The private realm is the tradition-bound village, family and household. Not surprisingly, the public realm has been populated by the men who left their villages to participate in the modern life of urbanity (Scott 1996: 9). The earliest WID critiques of development, grounded in a modernization paradigm (Blumberg 1991; Rogers 1980; Boserup 1970), pointed to the exclusionary potential of capitalist modernization and technological development for women in the Third World. WID writing seemed to indicate that these exclusionary tendencies were an aberration, an inadvertent slip of development. Development policy makers were erroneously 'blind' to the economic and productive contributions of women (Blumberg 1991), resulting in the deterioration of women's economic and social status largely because their labours were not accounted for under the marketed economy of the public realm. Boserup's thesis, particularly, challenged modernization theorists' claims that women's rights and status would automatically improve as modernization proceeded (Jaquette 1990). The thrust of WID efforts had been (and still is) to justify

³⁹ I have argued elsewhere that regardless of the apparent differences in these societies, most developing countries in the twentieth century (and this is certainly true for India) have instituted political (mostly liberal democratic) and economic structures that produce differential gender access to the state (Kumar 1999). As Staudt (1986:330) notes, although states have been organized in a variety of ways, "... one constancy is that ... women are never central to state power ...[indeed] state formation appears to aggravate or create female subordination".

women's contribution to economic production (Razavi and Miller 1995a; Blumberg 1991) and to integrate them better into mainstream development processes as a precursory step to liberation (Bandarage 1984). Boserup (1970) saw women's participation in economic productivity as resulting in greater association with the public realm and pointed that women needed to be prepared for this entry, through skill training and education:

It follows that in the future, when a large proportion of women may have jobs, it becomes an important task to devise new educational and training programmes, which can help to reduce the productivity gap between male and female labour thus fitting *women to their new way of life* (Boserup 1970: 225, emphasis mine)

Women and the 'feminine' as entities in transition from the 'unproductive' private to the 'productive' public are reflected in the shifting constructions of women in the various approaches to WID embraced by developmental institutions. In the pre-WID period, women were solely seen as important in their roles as mothers and caregivers in the private sphere but as their productive 'masculine' relevance was recognized, developmental agencies constructed women as active agents involved in the 'public' development of their communities (for details of the various approaches to WID, see Goetz 1991; Kabeer 1994; Moser 1993; Rathgeber 1990; Razavi and Miller 1995a). Contemporary developmental practitioners and international donor agencies also emphasize economic identity as a step to gaining political recognition. The World Bank, for instance, refers to the "inside/outside" spaces (World Bank 1991: xvi). The Bank's recommendation for reducing women's dependency is "to alter the economic environment [T]his means that market forces should be allowed to influence the boundaries of culturally acceptable women's activities" (World Bank 1991: xvi).

Micro-level studies of women's position within the household also give high premium to women's engagement in productive work *outside* the household. Amartya Sen (1990) emphasizes that women's bargaining power within private transactions will be enhanced by the perceived worth of their entitlements. Their entitlements, in turn, would be directly reflected in women's potential to exchange their labour power for earnings outside the household, in the realm of the productive economy. According to Sen, "[o]utside earnings can give the woman in question (1) a better breakdown position (point

of an individual's vulnerability), (2) possibly a clearer perception of her individuality and well-being, and (3) a higher 'perceived contribution' to the family's economic position " (p. 144). Sen attributes the lower social status prevailing for female children in north India, where women have traditionally not been part of the dry-cultivation agricultural workforce, to their potential for only lower earning powers (see also Miller 1981) in contrast to women in Southern India who have traditionally predominated wet-farming cultivation of crops like rice.

This definition implies that for women to enhance their position in the state, they must integrate their lives with the productive sphere. By the same token, women's loss of social, economic and political status has been linked to the non-integration of women in the productive sphere. Once women, in principle, are fully integrated with the sphere of production, through participation in the productive economy and the socialization of their reproductive work, their status would be 'restored'. As Tinker points out, WID /GAD legitimated efforts to influence development policy "with a combined argument for *justice* and *efficiency*" (cited in Razavi and Miller 1995a, emphasis mine). Further, 'visibility' is a key part of the process of emancipating women. Most WID literature emphasizes making women's presence visible in both the public/productive and private sphere. A substantial literature in the 1980s emerged that pointed out that women were the 'invisible' producers (e.g., Byrdon and Chant 1989; Dixon-Mueller and Anker 1988) in an economy— their work was not known, or recorded, and in consequence, their role in economy and society undervalued (Waring 1989). Subsequently, efforts have been on to make recording processes and statistics more gender-sensitive and 'visible'. Beneria and Sen (1981, 1982) recommend making reproductive work more visible, that is, although located in the domestic sphere, such activities as child rearing and child bearing are to be given the recognition of a public sphere/productive activity.

Thus, there is an almost complete absence of mention of the role of the state in these theoretical paradigms of development. Evans (1996:1033) notes that "...[t]oo often development theory has operated, de facto, on the premise that the only institutions that mattered were those directly facilitating market transaction". In the framework of economic productivity, it is the markets that are central in women's relationship with the public sphere and ultimately, their political identity. As Sen (1996: 824) notes, "markets

are the linchpin of economic activity”, affecting women’s lives in both positive and negative ways. According to Sen, the state has an important role to play in a regulatory and mediatory capacity, but its actions are constrained by the need to be not seen as “market-unfriendly” (Sen 1996: 825).

The downplaying of the role of the state is a gap in mainstream developmental literature. There is, however, a growing body of theorists who acknowledge that polity and economy are not dichotomous; they, in fact, sustain each other. Individual relationships with the market are, indeed, derived from the wider social, cultural, juridical and political fabric of specific contexts. Leftwich (1994) argues that,

[t]he distinguishing characteristic of developmental states, then, has been that their institutional structures (especially their economic bureaucracies) and political objectives have been developmentally-driven, while their developmental purposes have been politically driven. In short, fundamentally political factors have shaped the thrust and pace of their developmental strategies through the structures of the state (p. 380).⁴⁰

As Leftwich points out, polity and economy in developing countries have been inextricably tied together. The state controls and actively regulates the economy - the legitimacy of the state depends on doing so. In particular, in the era of neo-liberal development and SAP management, ‘good governance’ is a criterion that is supported by international aid agencies (Pugh 1997; Leftwich 1994; World Bank 1997). Development decisions (especially of investment) are significantly swayed by the ability of states to ensure political stability. Thus, the state in neo-liberal development occupies more than a tokenistic role; it is an active agent in shaping the features of the economy and market.

In WID research, therefore, it is imperative to examine the influence of the state in determining the kinds of roles that women undertake within market development. While as conventional theorists maintain, women’s economic roles will define their political status, it is now equally important to focus on the reverse, i.e., how political identities inhibit or facilitate the construction of women in the economic sphere. For the gender ideologies that maintain the state are reflected in the gender relations that structure

⁴⁰ Although Leftwich’s argument primarily focuses on the High Achieving developmental states, as for example, the Newly Industrializing South East Asian countries, his arguments are valid for both democratic and non-democratic developmental states.

women's role in economy and development. Thus, women's relationship with the state substantially influences their representation in the market/sphere of production. For instance, state legislations are critical in determining the wages and the kinds of benefits that women receive in the labour market, and so on. To minimize the influence of the state on Third World women's lives undermines its power in negotiating gender ideologies in the productive economy. In the context of the present research, the institutionalization of discourses around reproductive health in the state must be analysed against the historical, political and economic ideologies that have defined women in the Indian state.

The Indian Developmental State and Women

Post-Independence India, with its colonial legacy, was essentially an agglomeration of multiple ethnic, religious and communal identities bound together under a common nationalist umbrella. The nationalist agenda emerged from a common enemy - the colonial rulers - and a common goal - nation building through economic development. The latter, in particular, was a significant focus in creating images of both a unified nation among its citizens (Deshpande 1993) and the role of citizens in the newly independent state. Chatterjee (1998:86) notes that the Indian state "was connected to the people-nation not simply through the procedural forms of representative government, it also acquired its representativeness by directing a programme of economic development on behalf of the nation". Chatterjee also points out that the two forms of representativeness and legitimacy of the state, through the political process and through economic intervention, were likely to be in contradiction to each other because "[w]hat the people were able to express through the representative mechanisms of the political process as their will was not necessarily what was good for their economic well-being; what the state thought important for the economic development of the nation was not necessarily what would be ratified through the representative mechanisms"(p. 87). The important point he makes is that the 'rational' world of development planning was constantly overrun by the 'irrationalities' of politics in India. In the making of a modern, unified India, the political apparatus gave shape to the state's economic policies.

The progress of India's economic development is worth describing briefly to explicate the critical role played by the state since Independence. Indian development tends to be demarcated broadly into two broad eras: the years following Independence until the mid-1980s were pre-dominated by a Nehruvian socialist planning, and, thereafter, a market-oriented development has steadily begun to replace development programme strategies. The Indian state, in the 1950s, was envisioned as a 'mixed economy', that is, as having a set-up in which both private capital and a state-owned public sector would play a key role. This vision of a planned economy, which was enshrined in the Constitution, was guided by the socialist principles of the first Prime Minister of the nation, Jawaharlal Nehru. A major objective of this strategy was "to promote rapid and balanced economic growth with equity and justice" (Dandekar cited in Currie 1996: 793). The planning strategies in the early 1950s and 1960s were premised on *import substitution*, where the government sought to reduce dependence on imported goods by building up its own capital goods and infra-structural sector. It was hoped to endow Indian industry with facilities that would make it a vibrant competitor in the international market, while also serving domestic needs⁴¹. Successive governments, therefore, laid the foundation for a centrally administered public sector. The Indian Government acquired and developed areas of steel, mining, agriculture, civil aviation, railways, insurance and banking, health and education, to name a few. Further, until its abandonment in 1991, the state also managed a rigorous system of licenses and regulatory mechanisms. Industrialists had to obtain government permission to enter into a broad range of economic activities, and there were strict controls on the amount of equity that could be owned by domestic and international companies. Certain sectors like civil aviation and energy were completely state-controlled. With 'liberalization', many of these systems are now defunct, but despite the commitment by successive governments to economic de-regulation, for the most part, private participation in industrial development still faces hurdles. The government has also encouraged the development of small scale and labour intensive industries, such as handicrafts, handloom, sericulture, etc. Substantial tax and other subsidies are offered to these industries, not only because they offer employment to a large number of semi-urban and rural based labourers, but because these industries reflect the traditional and cultural distinctiveness of Indian skills. In addition, equity was a foremost objective of early development planning; alleviating rural poverty was a

⁴¹ This approach to development was driven by a desire for *swadeshi* or self-reliance for the state.

focused strategy of the state. In the early years, it was assumed that the productivity in the primary and secondary sectors would ‘trickle down’ and reduce poverty levels. However, by the 1970s, it was felt that more direct intervention by the state was needed, and the government implemented specially targeted poverty alleviation programmes for various sections of the population.

Overall, defining the characteristic of the Indian developmental state is no easy task. It has followed an overtly socialist strategy in centralising the power structure. However, despite the favouring of a planned approach to development and the emphasis on economic and social equity, the Indian state has also been criticized as a post-colonial state that serves capitalist interests (Byres 1998b). Currie (1996) emphasizes that the public sector was designed to complement and support private enterprise, rather than substitute it. The state’s huge investments into products like steel and railways were expected to cover gaps in investment decisions made by industrialists who were not willing to invest in long term and low return sectors. The state has been critiqued for acting in the interests of the ruling classes, contributing to a view that it is elitist and semi-feudal (Byres 1998b).

In 1991, India officially adopted the New Economic Policy (NEP) or Liberalization Programme. It was the initiation of a series of measures that complied with the International Monetary Fund (IMF) – World Bank (WB) Structural Adjustment Policies. Trade regulations were liberalized, protectionism relaxed and the Indian Rupee made a partly floating currency. Simultaneously, the government has been emphatic about trimming ‘wasteful’ expenditure - social spending, especially in subsidies, have been drastically cut and public sector industries which are seen as unviable have been sold to private investors. Private enterprise and multi-national investment are being rigorously encouraged and the Government strives to integrate India into a global environment. The public sector is being pruned, and social spending made ‘prudent’. In sum, there has been a move away from a planned economy that characterized Indian development for four decades to market-based development.

My brief exposition of selected aspects of the developmental state is intended to illustrate that the state has actively regulated politics and economy in India. I have shown

that the state and market have been closely associated in the recent history of Indian development. The next section will examine the implications of these features for gender ideologies and women's claims within the state in India.

Gender Identity and the Indian state

Feminist scholars are divided in their opinions regarding the role of the modern Indian state in the lives of its millions of women. Some of them point out that the state responds in ambivalent ways to the vulnerable conditions in which women live in Indian society, while other scholars present a uni-dimensional characterization of the Indian state. Rai (1996a, 1996b), for instance, feels that the Indian state plays no significant role in women's lives. Unlike in many western contexts where the state provides for social services of which women are prime recipients, the state in India provides for little or no such access for its women. Despite its claims to being interested in social justice, the Indian state's engagement with welfare activities, particularly for women, are restricted by inadequate resources (Rai 1996a: 13). Further, there is also the issue that at a much deeper level, limits are put upon the claims that citizens, including women, can make on the state (Jayal 1994), a point which will be discussed below. In fact, Rai (1996a, 1996b) argues that, with respect to what it offers women, India is a "weak" state. She points out that when the state does intervene in women's lives, it is usually in oppressive and brutal ways.

Similarly, Misra (1997) contends that India's liberal democratic polity has played an ambivalent role in women's lives. Political and civil liberties have allowed for the development of an articulate and visible feminist movement, while state action and inaction in individual cases have been less than reflective of an interest in women's well-being. Likewise, long-term structural changes have benefited certain sections of women while pauperizing others. In a more rigid view of the Indian state, Agarwal (1988:14) points out that India, like other South Asian states, perpetuates patriarchal relations with two express intents - to domesticate women and control their sexuality. Kasturi (1996), too, demonstrates in the context of India that the "evolution of a political understanding of the process of development ...[indicated]...that the development process has actually strengthened patriarchal structures in India" (p.100). Others (e.g., Hasan 1994) have highlighted the constitutive characteristics of the state. Hasan (1994) points out that

contemporary politics in India with its focus on community identities, religious traditions and cultural practices have made women a prime site around which political claims are contested - a politics in which the State is a complicit actor. It is along these lines that Rai (1996a) and Basu (1998) argue that the state is an inconsistent actor - on many occasions, the state and traditional patriarchy are in binary opposition while in other circumstances, the state *is* the patriarchy that oppresses women. John (1996) puts it succinctly:

The state may thus respond- at times with alacrity - to the claims made upon it by the women's movement, whose spokespersons are invariably middle class and upper caste, and who are also familiar with its structures. The story is quite different when it comes to implementing policies or laws in favour of a woman of a different class and caste, especially when it involves opposing those with whom the state identifies (p. 3075).

Thus, feminist evaluations of the functioning of the Indian state have highlighted its contradictory nature, and tendency to operate in ambiguous ways.

Within this complex network of relationships, women's citizenship has been constituted primarily along two axes: (a) their communal and religious identity, and, (b) their role in development and nation building. My aim in the rest of this chapter is to only briefly address the first component, and make a comprehensive study of the latter. Although John (1996) points out that the state's ambivalence in implementing gender policies has decisive roots in caste and class compositions, I would argue that the state's underlying development ideologies play an equal - if not more obvious - part in constituting women's political identities. This is particularly true in an age when India's economy and nationalistic traditions have become more obliged to compromise in the global environment in which they are increasingly becoming embedded. Thus, while internal features do shape the conditions by which women access the state, various international forces, especially in the 1990s, have helped define women as development constituency⁴².

⁴²This is borne out by John's (1996) own analysis of two government reports on women, one written in 1974 and the other in 1994. A striking difference between the two reports that she herself points out is that in the latter, the international context of development was used to frame India's experiences in the field of gender development while the 1970s report either made no reference to the international scenario or actively suppressed it.

The Indian state's ambivalence to women's interests can be demonstrated through a review of its responses to legal and political issues in recent history. The Shah Bano case of the 1980s is a classic and oft-cited example, where the state placed partisan and electoral interests above the welfare of Muslim women in the country. In order to appease conservative Muslims, the government overturned a Supreme Court ruling and withdrew legal provisions that entitled divorced Muslim women to claim for maintenance from their husbands (Engineer 1987; Kumar 1993). The state has also been criticized for its ineffective handling of the 1987 case of *sati*, when a young widow was burnt on the funeral pyre of her husband. Although the government passed a Commission of *Sati* (Prevention) Act, 1987, it is a legal provision that is fraught with problems. While prohibiting the glorification of *sati*, the Bill treats the act as suicide, placing the onus of responsibility on the victim (Kasturi 1996; Kumar 1993). In cases of rape, the state has, despite the existence of harsh penalties for the aggressors, tended to place the onus of proof on the women victims (John 1996; Swarup et. al 1994). Similarly, where laws protecting women exist, their enforcement is weak. Dowry was officially made illegal since the passing of the Dowry Prohibition Act in 1961, but the practice still continues widely. In response to the widespread abortion of female foetuses, the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuses) Act (1994), was passed which prohibits all genetic counselling facilities, genetic clinics, and laboratories from divulging information about the sex of a foetus. Its efficacy still remains to be examined. Agnes (1998) highlights the lacunae in various protective legislations for women that have been passed by the Indian Government in the 1980s. Although, as she argues, the 1980s was a period when the most number of protective laws were passed, in process and implementation they have not proven to be effective for women.

On the other hand, the Constitution of India recognizes the equality of the sexes and acknowledges in its Directive Principles that women are a vulnerable group that requires special rights. The state encourages the political participation of women in the electoral process. The state recently passed the 73rd and 74th Amendments to the Constitution of India, whereby one-third of all seats in three-tier elected local government bodies (*panchayats*) in the country were reserved for women. Similar legislation is being pursued for national bodies as well (the Women's Bill), but this is still under debate in parliament following opposition to the Bill from several political parties. In the case of community

based laws, the rights of Christian women were strengthened in the Supreme Court Mary Roy case in the early 1980s, which conferred equal rights to property for both male and female offspring in the Christian community. In addition, in late 1999, the state set out stringent regulations regarding sexual harassment in the work place. Recently, it also came out with a proposal to ensure maternity benefits for women labourers who are daily wage earners in the informal sector of the economy (*The Hindu*, March 9, 2000).

A second axis along which women have been constituted within the Indian nation has been through their economic identity and role in nation building (Agnihotri and Mazumdar 1995; Chaudhuri 1995; Desai 1986; Kasturi 1996). From pre-independence days, the nationalist movement advocated freedom, dignity, justice and equality as essential attributes for women to participate in nation building (Agnihotri and Mazumdar 1995). In 1938, the Congress party set out to state 'Women's Role in Planned Economy' (WRPE), a document that shaped the foundations of women's role in post-Independence nation building. Chaudhuri's (1995) analysis of the document reveals that there are strong references to women playing equal roles as men in nation building - their citizenship is affirmed in their capacity as producers and labourers: "...the only social status to be recognized in planned society will be that of the individual worker...neither motherhood, nor wifehood, nor, *a fortiori*, widowhood matter at all" (cited in Chaudhuri 1995: 219, emphasis in original). Every aspect of a woman's life was seen in terms of 'the larger good' that it would contribute to the state. For example, with regard to women's health: "...any steps taken to protect the health of the women workers should not be considered as for their exclusive benefit only, but as taken in the interests of the whole nation" (Chaudhuri 1995: 220).

Yet, juxtaposed against this image of citizen is another role that women have to play - as emblems of national (primarily an idealistic image of a 'pure' Hindu woman) culture and tradition. Alongside the image of the socialist worker abstracted from religion and community was another image portrayed by the official channels of the state; the image of a self-sacrificing wife and mother assuming her 'natural' place in the home for the upbringing of India's 'greatest asset' - her children - has been valorized. This opposing image of woman is, in fact, far from secular - it hearkens back to a lost Vedic time and reflects notions of a recovered Hindu Brahminical ideal of woman (Uberoi 1996: xii;

Chaudhuri 1995: 223)⁴³. This was partly the reflection of Gandhi's own conception of women's roles in post-independent India (Jayewardene 1986). Gandhi felt that self-realisation for men and women had to be conducted in separate spheres - for women, it was in the private sphere involving the upbringing and education of children. Chaudhuri (op. cit.) points out that the WRPE states that a woman's responsibility would equally be to "create a cultural environment in the home for the proper nurture of the children" and "...[not become] a cheap imitation of man or render her useless for the great tasks of motherhood and nation building" (cited in Chaudhuri, op. cit.: 233, 224). In the 1960s, a substantial number of development programmes and policies of the state reflected this role. A typical example was the Community Development programme supported by the USAID. The programme run in rural communities aimed at enhancing women's lives by educating them about better hygiene and nutrition.

In contemporary India these two images of women – as socialized mother and abstract worker – still co-exist and are in tension. Scholars argue that these constructions are reproduced in the state's developmental policies related to women. The political climate of the 1980s and 1990s, in particular, have encouraged reactionary images of women's roles in society. Agnihotri and Mazumdar (1995), for instance, argue that the "...the mid-eighties have seen an onslaught on even existing rights of women through a harking back to 'tradition' and 'culture' and posing of images which emphasize women's reproductive role as the only natural, historical one". Agarwal (1988: 14) notes that this is the ideology of gender - the assumption that women are (or should be) primarily housewives and mothers and, secondarily, workers - that permeates most policies of modern developing states like India. Women, in most policies related to productive and reproductive functions, land/property holding, and technology control are located within the context of the nuclear family, thereby assigning primacy to male 'heads of households' (Kelkar 1987). Swaminathan (1991) further argues that the tendency to demarcate certain provisions in the state's Plan Documents as 'women's issues' (especially, those related to reproduction and child care) reinforces gendered assumptions about women's roles in society. Kasturi's (1996) evaluation of three national

⁴³ Although pre-dominantly drawn from classic Hindu religious texts, this representation resonates with pre-existing images of women's roles in other religions. Moreover, images of female characters drawn from Hindu religion, mythology and folklore, such as, Sita, Laxmi, and Savitri, are widely accepted as part of the national psyche and cultural representations.

documents at different historical periods point out that the government has been less inclined to work towards fundamental changes in law and politics. She notes, “over time the political leadership grew away from the promises made to women in the nationalist era...[and]...the entire social system and state structure followed a particular path of growth in the course of which the whole gender question was jettisoned” (Kasturi 1996: 141). She asserts that the “Indian state is not gender neutral[S]tate and society are influenced by patriarchal values”, and that “gender bias, in pernicious forms, unfortunately encouraged by the state in various ways, has weakened the social and economic position of women” (Kasturi 1996: 141).

On the other hand, women’s identity in the state’s development policy has also been determined by their economic roles. The construction of women since the genesis of WID has ranged from women as ‘recipients of welfare’ to ‘contributors within the productive economy’ to the post 1980s depiction of women as ‘efficiency managers in the household and community’ (Kabeer 1994; Moser 1993). The idea of ‘gender’ and ‘women’ has commanded greater significance in the state’s policy as the productive capacity of women are being emphasized. Vasavi and Kingfisher (forthcoming) point out that the World Bank’s interest in Indian women’s productive capacity has influenced the promotion of developmental programmes that reflected these constructions. The Government has promoted a number of regional and state level ‘Women’s Development Corporations’ which encourage women’s entrepreneurial activities (Vasavi and Kingfisher forthcoming). Further, the Government of India’s *National Plan for the Empowerment of Women* (1996) emphasizes the state’s commitment to the economic empowerment of women. The *Report of the Working Group on Women’s Development (1997-2002)* stresses that the “advancement, development, and empowerment of women is the central issue in the context of Social Development” (Vasavi and Kingfisher forthcoming: 7). With the recognition of women’s quintessential role in development, poor women are increasingly being represented in policy as “good subjects” who make “sound economic sense” whereas men are seen as “bad subjects” who exercise their rationality and individuality, contesting the supremacy of nation building as the primary objective of development (John 1996: 3076).

In summary, therefore, I would like to emphasize that the state in India produces and situates itself in constructions and ideologies of women. These ideologies are not fixed, but are fluid depending on the broader context in which the state defines itself. Political and economic identities are intertwined; women are located within intersection of these two realms.

Conclusion

This chapter has covered extensive literature, offering firstly, a review of contemporary theorizations around the idea of the state, and the construction of women's identity within it. The chapter argued that the state's discourses surrounding gender influence the nature of developmental policy formulated by the state. In the case of India, the state proliferates contending constructions of women in progressive and traditional roles. Both of these constructions find a place in locating women within the neo-liberal discourses of the Indian state. This literature provides useful ground to begin the task of analysing ideologies within the RCH documents. The following chapter provides an analytical and methodological background that led to the design of the present research.

IV

IDEOLOGY AS A FRAMEWORK FOR POLICY EVALUATION Issues in Methodology

While dominant science views things as static, dualistically ahistorical, mechanical, and additive, feminist science, which has not lost sight of its political goal, strives for a new view of the whole societal constellation in which things appear as historical, contradictory, linked to each other, and capable of being changed.

Mies 1991, p. 63

The theoretical review in the previous chapters provided a feminist account of the state, and how women are constituted within the modern state. I also explored the broad discursive dimensions that have influenced the production of discourses around women in India and how these are mirrored in law and policy. A point that I sought to emphasize was the critical role of the state in constructing and proliferating specific ideological climates within which all policy and, more specifically, gender policy is formulated. The implications of the ideologies of the contemporary state raise questions about the prospects that market-led development offers for gender-sensitive public policy in India. This is significant to my own analysis of how reproductive health as an oppositional discourse is disseminated in an institutional context steeped in the values of a neo-liberal doctrine.

My focus, in this research, is to explore state ideology as manifested in public policy. In this chapter, I outline the way in which I developed my field research; how issues and questions raised in the abstract have been translated into specific research decisions regarding choice of study sample, methods of data collection and strategies for analysis. I begin with a review of literature that sets up the foundational assumptions underlying some of these decisions and explicate my perspective on policy evaluation. This chapter

has three parts. In the first part, I provide an overview of the methodological foundations that guide my analysis of ideology in the RCH. The second part specifies details of my research methods and activities. The final part of this chapter is devoted to the methodological issues of the analysis that was undertaken in the rest of the thesis.

Discourses and Gender Policy

Discourses: A Brief Overview

The term *discourse*, widely associated with the work of Michel Foucault, draws on the post-structuralist understanding that language constitutes the social world. The term discourse has been defined as a “series of rules” (Fischer 1995:208), “system of statements” (Coyle 1995: 245) and “set of referential terms” (Coyle 1995: 245) to construct the object to which they refer. It is argued that discourses set parameters to the way people are able to describe and act within their ‘knowable’ world. It is the term ‘discourse’ rather than ‘language’ that is used to emphasize the constructedness of individual worlds because “discourse connotes the actively political and strategic role of words and how they are connected to form sentences and construct meanings” (Grace 1991: 330).

For Foucault, the meanings that a particular society espouses do not emanate from social institutions and the values they subscribe to. A level below the threshold of institutions - that is, discourse - prescribes and creates the fundamental concepts of culture that are institutionalized over time. The fundamental codes of culture, namely those governing its language and its practices lay the parameters within which individuals understand and act in their worlds. Individuals evolve within the discourses of institutions and social structures; they form the ‘discursive field’ wherein individuals develop their subjectivity (Weedon 1987). Foucault argues that because all human beings are constituted in discourses, their knowledge of the world is set by the system of language statements that particular discourses offer them. Discourse, through language, not only expresses the social reality of an individual, it equally constructs it. To study discourse is to understand how a social order in a particular context is defined - it reveals the ‘common sense’ reality that underlies social practices. Using examples of madness, sexuality, criminality

and penalty, Foucault showed that the very foundations of society and the world-view of individuals are produced as part of discourses, which had long been evolving (see among others, Foucault, 1979a, 1981).

Foucault used the concept of a discursive field to understand the relationship between language, social institutions, subjectivity and power. He contended that discourses are established on the principle of *exclusion* – that “in every society the production of discourse is at once controlled, selected, organized and redistributed according to a certain number of procedures, whose role is to avert its powers and dangers to cope with chance events, to evade its ponderous, awesome materiality” (Foucault 1972a: 215). Certain discourses, therefore, become historically fixed over time as ‘truth’ and ‘fact’, constituting the formation of a dominant discourse or “truth regime” (Foucault 1980). Foucault’s later ‘genealogical’ works sought to understand the ‘analytics of power’; i.e., how power was tied to the production of discourses⁴⁴. In particular, he studied the ways in which the organization of knowledge in human sciences such as statistics had been co-opted by the institutions of the state for making certain kinds of knowledge and discourses more valid than others. The more entrenched in the language of knowledge, such as medicine or law, the more likely that a particular discourse would be credited as being truthful. To be situated within a dominant discourse means that only certain types of realities are highlighted while others are not. This partial vision of the social world is reflective of power relationships in society, and is manifest in individual and institutional bodies of knowledge and practice. The key to unravelling the power embedded in society is to analyze society’s discourses (represented in talk, text, visual or other forms).

⁴⁴ Feminist scholars, in particular, have been critical of Foucault’s conceptualisation of power. As Hartsock (1990) notes, as a reaction to the modernist (and perhaps also Marxist) perspectives of power, Foucault’s post-modernist version of power (a good description may be found in *History of Sexuality*, 1981, pp. 92-94) is detached from social structures and, even, individual domination over others. Foucault (1981: 93) notes that “[p]ower is everywhere ... because it comes from everywhere....[P]ower is not an institution, and not a structure”. Hartsock (1990) argues that in conceptualising power thus, Foucault claims that individuals are constituted by power relations, but does not see this constitution as resulting from domination of one group by another. In contrast, feminist scholars, while drawing on Foucault’s association of power and discourse, seek to understand the constitution of gender relations from a more critical perspective. Fraser (1989a: 160-164) explicitly argues that the inability to have control over production of discourses is related to the social location of individuals and groups, and that in challenging dominant discourses social relations can also be altered. Such a perspective is more suited to the feminist project of social transformation. My own understanding of the relationship between discourse and power is drawn from this feminist perspective.

The analysis of discourses allows the social scientist to

view the strategies implicit in the creation of different discourses and shows the links between how it is constructed and how it can function to establish a group's political power. By examining their structures, we can determine the political practices that these discourses engender and exclude (cited in Fischer 1995: 208)

Although the terms 'discourse' and 'ideology' has tended to be used synonymously, there are important distinctions between the two. According to Purvis and Hunt (1991), the similarities between the two are that they refer to the same aspect of social life - that is, it is the way that people understand and comprehend their social worlds. Both ideology and discourse set directions for the ways in which people think and act. Within the policy sciences, ideology is used to denote a particular "vision" that impels policy scientists to conduct their enquiries in a particular way (Diesing 1982:4)⁴⁵. The idea of discourses, advanced by linguists, has been employed to emphasize that language is not just reflective, but has constitutive potential. Discourses set in place a "*system of linked signs*" (Purvis and Hunt 1993: 485). Once in place, people experience life and communicate those experiences within the boundaries of that system.

The focus of this thesis on *discourse analysis* to reveal policy *ideology* requires an explanation of how I see these two terms may be linked. Purvis and Hunt (1993) suggest a use of the notions of 'discourse' and 'ideology' not as oppositions or in exclusion of the other but as complementing each other, so that discourse is a *process* of constructing social meanings and ideology the *effect* of such constructions, especially if they maintain relations of domination-subordination. Not all discourses are ideological (Fairclough 1992: 91); however, it is ideology that develops a particular system of linked signs. As Purvis and Hunt (1991: 497) point out,

...what makes some discourses ideological is their connection with systems of domination. *Ideological discourses* contain forms of signification that are incorporated into lived experience where the basic mechanism of incorporation is one whereby sectional or specific interests are represented as universal interests.

⁴⁵ There is a substantial literature, which is drawn from the Marxian notion of "ideology" as "a form of false consciousness" (Ward 1995: 242). I do not, however, engage with this conception of ideology in my thesis.

Fineman (1991), on the other hand, sees *ideology* as the rationalizing set of principles and concepts that link discourses to power. According to her, an examination of discourses will reveal an underlying ideology. Ideology, therefore, defines and structures the contours of a discourse.

Discourse, Politics And Gender Policy

The notions of ‘discourses’ and ‘ideology’ are increasingly gaining currency in the analysis of political life. As Fraser notes, the public spaces of political deliberation are sites of contestation between contending social discourses (Fraser 1989a, Fraser 1989b). These spheres of struggle are seldom fair or equal; for the most part, they represent the interests of the powerful voices or dominant discourses. Discourses of marginal or oppositional groups are, at best, the “challengers” (Fischer 1995: 209) to dominant discourses. Dominant discourses are institutionalized in the key discursive sites of society such as parliament, academie, courts and the mass circulation media (Fraser 1989a, Fraser 1989b) and become reference norms that exclude some discourses and include others. As a result, it is important to recognize that policy is not about satisfying needs of various groups of people, but equally of issues such as, *who* has deemed certain concerns as needs and how these are interpreted (Fraser 1989a, Fraser 1989b).

Discourse also directs the language that constitutes politics. Fraser (1989a, 1989b) emphasizes that the language of the dominant discursive paradigm penetrates political reality in a variety of ways: from the officially recognized idioms in which one can press claims to the ways in which various discursive positions of people are defined, and the paradigms that are considered authoritative, in case of conflicting interests. In a democratic society where premium is placed on the use of language and debate in every stage of the political process, the transformative power of language cannot be undermined. Fischer (1995: 225), however, cautions that an important distinction be made: political discourse is not political power itself. He points out that, “discourse has a complex relationship to power.... [w]hile it is not power per se, political discourse produces and transmits power”. Since discourse is not immutable, neither is power.

Thus, political discourse can serve as a “tool of either domination or liberation” (Fischer 1995: 225).

Discourse also gives validity to specific knowledge systems that political and policy scientists work within. Both politicians and policy analysts have enduring visions of what constitutes public interests and policy interventions. The tendency for policy analysts to work within a technocratic framework, or for politicians to emphasize certain kinds of policy outcomes is a consequence of the entire institution of politics being steeped in a particular discursive paradigm. Because discursive frames are mutable, challengers to a dominant paradigm can expect to make inroads into existing value systems, but these are likely to be gradual and incremental.

Ideology As An Alternative Framework For Policy Evaluation

Conventional policy analysis is founded, in the main, on the assumption that policy making is the output of rational choices and empirically founded decisions (see, for example, Buhrs and Bartlett 1993; Stone 1988). The rationality approach to policy analysis assumes that political behaviour is an outcome of the actions of the ‘rational individual’ located broadly within the model of the market. The behaviour and expectations of the rational individual are considered amenable to scientific inquiry through a systematic reduction to (usually) quantifiable variables and determinate, generalizable relationships; as a consequence, policy evaluation is embedded in a positivist frame. Buhrs and Bartlett (1993:17) describe seven assumptions that characterize positivist policy analysis: (1) that politics is about problem solving, particularly with regard to allocation of resources; (2) that policy making is synonymous with decision making; (3) that policy making is instrumentalist, concerned with end results; (4) that rationality is instrumentalist and purely intellectual; (5) that policy makers are unitary decision makers; (6) that policy makers and policy analysts have immense information processing capacity; and (7) that available theoretical and empirical policy knowledge is reliable. Buhrs and Bartlett (1993) argue that these are problematic assumptions that greatly undermine the “validity and applicability” of policy research. The endeavour of economic models of policy analysis has been to avoid the irrationalities and value conflicts that, in reality, riddle political decision-making (Fischer 1995; Stone 1988). In terms of Fischer’s (1995) framework that I outlined in the

introductory chapter, policy analysts are, therefore, more likely to engage in policy evaluation that appraises policy in terms of outcomes and outputs. The study of ideology does not form a part of this conventional approach to policy evaluation.

There has been growing discontent with such static analysis that is reflected in the recent literature on post-positivist policy evaluation (see Ascher 1987; Fischer 1989; Majone 1989; Stone 1988 for an overview of this literature). This burgeoning body of work argues that it would be more realistic to view policy making as a site where various political, social, ideological and value judgments influence the shape and design of policy. The post-positivist critique of “technocratic” analysis (Fischer 1989, 1995) or of the “analycentric” approach (Buhrs and Bartlett 1993) to policy is that policy is misrepresented as an “orderly sequence of stages as if on an assembly line” (Stone 1988: 7). Policy is constructed as if progressing systematically from a phase of problem definition, analysis of alternative solutions, the adoption of a solution, and its testing and evaluation (see; Buhrs and Bartlett 1993; Hogwood and Gunn 1984; Parsons 1995 for descriptions of the policy cycle approach).

The post-positivist position, on the other hand, is based on the premise that “politics is as much about communication, power, moral action and the construction of preferences, values, and meaning as it is about problem solving” (Buhrs and Bartlett 1993: 17). Rather than adhere to set stages, policy, in reality, arises from political conflict; it is a “struggle over ideas” (Stone 1988: 7; see also Fraser 1989a, Fraser 1989b) where concepts, definitions and criteria are susceptible to continuous scrutiny and compromise. They also contend that rather than the cold detachment of reason, policy decisions are more likely to be swayed by the power of argument (Majone 1989) and policy deliberation (Fischer 1995: 207). The ‘non-empirical’ factors cannot only decide what the objectives of policy should be, but also how resources may be allocated to satisfy these needs (Fraser 1989a; Stone 1988). Post-positivists, therefore, advance an interpretive analysis of policy to complement empirical ones. An analysis at this level requires a “meta-policy” approach to policy analysis, which involves “a critical perspective on and analysis of policy knowledge systems - analysis of world-views and frameworks within which we do policy research and create policy knowledge” (Buhrs and Bartlett 1993: 30).

The emphasis here is that no policy is value or ideology free and, further that, ideological systems are constructed by and support power structures in society. Fischer (1995), in particular, stresses that policy analysts need to acknowledge, at the very least, the normative assumptions underlying the policy knowledge they operate within. Policy, therefore, can never be about technical analysis alone; as Fischer (1995: 173) points out “ideological belief systems provide the basic data for policy evaluation”. In many ways, this school of policy sciences has much in common with a ‘critical’, ‘post-modern’ or ‘feminist’ approach to policy analysis (Stone 1988) whose intent is to critically appraise the epistemological and theoretical underpinning on which policy is purportedly designed.

Policy Discourse and Gender Outcomes

The intersecting field of discourse and political outcomes is important to gender policy. Feminists, particularly, are concerned about how oppositional discourses translate into policy in contexts where values and ideologies are overwhelmingly male/mainstream. Fraser (1989a, 1989b, 1991), for instance, argues that institutionalization of oppositional feminist discourse tends to two possibilities: a pressure to reprivatize politicized issues, or conversely, appropriate them into the existing structures of bureaucracy, nullifying their political impact. In either case, the consequences for women are not to their interests. In the latter, in particular, the institutionalization of policy in specific contexts has an ominous outcome - women’s issues can become ‘depolitized’ in the course of assimilation within public discourse. Beall (1997), similarly, contends that policy changes are never completely new; she notes that fresh approaches, particularly gender perspectives, to policy are always introduced and implemented in the context of the legacies of the past, as well as current conditions (p. 70). In the case of health policy, of which she writes, gender-sensitive recommendations are likely to become add-ons⁴⁶ to an ongoing policy legacy. There could also be several orientations to policy, which may operate co-terminously within the various levels of state, from global to local levels. In this form of policy accrual, there is a real danger that consistency in addressing women’s issues could be compromised, and women’s needs could well be marginalized.

⁴⁶Harding (1995) also points out a similar tendency in science policy to ‘add-on’ women’s issues. In development literature, a significant criticism in the strategy to integrate women has been the appending of women’s development programmes to on-going development policy (see Moser 1993).

Bangura (1997) applies the idea of “policy dialogue” to understand the negotiation of diverse values among various groups, including those committed to gender issues. According to him, policy dialogue is an “organized deliberation between two or more actors on the allocation of values that is likely to result in new policies or modification of existing ones” (Bangura 1997: 2). Policy dialogue assumes willing negotiation and compromise without head-on confrontation so as to achieve the best possible gender outcome. The success of policy dialogues depends greatly on the institutional context in which deliberation occurs, but equally on value and discourse systems embraced by institutions⁴⁷. Bangura concludes that given the existing nature of policy systems, mainstreaming gender was not likely to be easy and outcomes may not be satisfactory for all participants; for instance, “progress in mainstreaming gender at the top may not easily translate into progress in enforcing gender practices at the bottom” (Bangura 1997:3).

A widespread challenge to the institutionalization of gender as policy is the discourse of neo-liberalism. Bangura (1997) argues that there exists a fundamental incompatibility between the basic values, premises and goals of neo-liberalism and gender discourse, making the task of integrating gender into existing policy systems a particularly contested process of struggle. Neo-liberalism makes little or no concession to the problems of disadvantaged groups, communities and countries, and is indifferent to questions of equity and participation as outcomes that should be actively sought by policy makers. These tenets are at discord with the aims of a gender discourse, which is founded on the principles of achieving equity and social justice among women and men. Although in development, arguments for inducting a gender dimension into policy has always carried with it a justification from an efficiency point of view, this collapsing of equity and efficiency was, in large part, to garner resource allocation for women’s issues (Razavi and Miller 1995a). Social transformation and empowerment still continue to be the bedrock on which gender policy is to be based. Further, such objectives can be achieved only through equitable intervention from the state (Connell 1990). A gender discourse, therefore, broadly is “interventionist, very multi-faceted in terms of the issues it tackles,

⁴⁷ According to Bangura, a prerequisite to successful dialogue is information about who participates in dialogues, what the terms of participation are, how power is distributed among participants, what kinds of relations exist between participants and their base constituencies, which institutions have been established for dialogue, and what underlying discourses direct the dialogue process (p. 30)

flexible in approach, and strongly rooted in issues of social transformation and the dynamics of the moral economy" (Bangura 1997:21).

Bangura argues that there are specific issues on which the two discourses of neo-liberalism and gender can converge, as for instance, in the area of human capital development. Research in human capital development argues in favour of investment in education and nutrition to bolster economic productivity and parallels similar official efforts to raise women's status in society. However, where gender theorists have used the neo-liberal ethos to justify action for women's development, they also seek state interventions to help women maximize market opportunities. The attempts to bring convergence between the two discourses have, Bangura argues, only been at the margins. The foundations of neo-liberalism have not been undermined by the gender discourses of equity, intervention, justice and rights. In the end, Bangura's argument is that all gender policy is a negotiated one, and therefore, a compromise to ideologies already present in social discourse. However, despite the obvious challenges to the institutionalization of gender discourses in the political and policy making machinery, to see policy dialogue as a necessary compromise of gender interests is to have a narrow view of policy outcomes. Stone (1988) argues that the essence of policy making should not be solely the production of problem solving policies per se, but instead a struggle over ideas that set up subtle yet tangible changes to the process of definition of ideals that guide people's behaviour. These changes, then, feed into the way discourses structure institutions and, eventually, again into policy. Discourses, as Fischer pointed out, can indeed be tools of liberation or domination.

Research Design

The research design is a critical moment in the development of a research project. It is the plan of action for research in which researchers describe how they propose to operationalize their research questions, which are usually enunciated in the abstract. Formulating a research design involves, mainly, outlining the nature of the data required to address the research questions, methods for collection and for the analysis of data. At the outset of the development of my research design, I realised that the chosen design must conform to certain parameters that were imposed on the project both by the nature

of research questions that I had raised and the peculiarities of the social context of the chosen site of study. Three relevant issues gave shape to my decisions regarding research design.

Research Perspective

Given the focus of my research questions on the manifestation of ideology in policy, it was apparent that a qualitative approach to research was called for. In the case of this project, such an approach entailed a focus on descriptive methods of analysis as opposed to explorations for numerical, causative relationships. Qualitative methods employed to evaluate policy, in general, include direct observation, localized surveys, secondary documents, case studies, detailed descriptions, field notes, and in-depth personal interviews (Fischer 1995). According to Fischer (1995: 77), qualitative methods in policy evaluation can "... be useful 'tools' to uncover the operative definitions of a situation, describe the ways in which policy goals and program objectives fall under the applicable social rules that are available to the members of society, and to understand the institutional support and opposition to the imposition of specific criteria". The main point that Fischer emphasizes is that such an approach requires policy evaluators to seek information in field settings and to obtain the opinions of stakeholders involved with the policy under consideration (Fischer 1995).

Qualitative forms of research are particularly of significance in feminist research⁴⁸. In the initial years of development of feminist research methodologies, many feminists were opposed to the use of quantitative methods for the sexism and exclusions that have been identified as endemic to this form of research (Jayaratne and Stewart (1991) offer an

⁴⁸ There appear to be certain 'pre-requisites' that characterize feminist research. A typical checklist, according to Siebold et al. (1992) includes the following: the principal investigator is a woman, the purpose is to study women, and the focus of the research is women's experiences, the research must have the potential to help the subjects as well as the researcher, it is characterized by interaction and non-hierarchical relationships, concern for values, the word feminist must be used in the report, non-sexist language is used and the bibliography includes feminist literature. Cook and Fonow (1991) in their review, focus on four attributes of feminist research. First, it should be reflexive, viz., there should be the tendency to "reflect upon, examine critically, and explore analytically the nature of the research process (p. 2). Secondly, there must be an emphasis on action that is the research should translate into policy or political action. Third, feminist research acknowledges the emotional dimension of participants in an enquiry (see also Mies 1991). Finally, there is an emphasis on creative methods in selection of both topic and method (p. 11). Reinhartz (1992) raises the issue of men conducting feminist research, and accredits any male who takes on the label of feminist as a feminist researcher. R.W. Connell's work on the state (see Connell 1990) is an outstanding example. However, the involvement of men in feminist research is a strongly debated issue.

interesting overview of feminist critiques of the quantitative methods). More recently, however, feminist researchers have recognized that the use of numerical or statistical data, or even a quantitative procedure is not the issue - that “methods in themselves aren’t innately anything” (Stanley and Wise, cited in Jayaratne and Stewart 1991: 90). Rather, an emphasis on feminist values in research should be maintained. In the context of my research, I recognized the imminent value of a reflexive, qualitative feminist research design. By reflexive I mean that, as a researcher, I am not positioned as detached to the research ‘object’. On the contrary, in my research, I have tried to see interviews and interactions with people as grounded in, not abstracted from, the social contexts of their occurrence. This fundamental assumption underscores a conviction that people speak from specific social positions and the interrelationships between people, including the researcher, and their positions must be recognized as part of the research.

The qualitative perspective in my study pushed me to reconsider the need to prove reliability, validity and generalizability⁴⁹ of empirical analysis. My focus was not to identify laws that could be applied universally, but to tease out salient features of a context that might help explain peculiarities of institutional and individual behaviour. This acknowledgement allowed me the freedom to adopt a flexible research design, and make decisions about the need for depth of sample studied rather than for wide coverage. It also permitted me to be open to theorize events on the basis of associations and connections that emerged in the field rather than enter the field with a rigid mindset of what to look for. The latter was particularly important in decisions around my choice of methods of analysis.

Site Of Study

The second decision that I had to make in drawing up a research design was to situate the site of study, not only geographically, but also institutionally. Studying the discourses of the state offers a wide range of choices, and drawing institutional boundaries is important. In my study, I wanted to trace the elements of ideology at the national, state

⁴⁹ The concern of non-generalizability - that the outputs of qualitative research may not be applied to a larger population - has always followed qualitative research. Researchers assume a range of positions on this issue, but most emphatically that generalizability alone should not be a criterion for judging the value of qualitative research (see Schofield 1993, for a review).

(provincial) and local levels, while simultaneously looking at influences from, and implications for, other institutions in the discursive arena. The main agency of the state that produces discourses of population policy in India is the Ministry of Health and Family Welfare (MoHFW) situated in Delhi. The extension of the Government of India's MoHFW at the state level is located in the Department of Family Welfare (DFW), in Trivandrum, the capital of Kerala. The DFW provides the administrative control for the functioning of the Directorate of Health Services (DHS) in which family welfare services form a significant component. The DHS supervises the office of the District Medical Office (DMO) in all the fourteen districts of Kerala.

In Kerala, as in the rest of India, rural health delivery has, since the Seventh Five Year Plan (1985-90), been built up as a three-tier structure – the sub-centre, primary health care centre (PHC), and the community health centre (CHC) (see discussion in the next chapter). I tried, in my project, to cover all of these levels of the state's institutional structure as much as possible - MoHFW, DFW, DHS, DMO, and PHC/CHCs. In addition, I had to make a selection of which DMO (of the fourteen districts) and PHCs (of approximately 961 state-wide) to study. My selection in both these instances were partly arbitrary and partly necessitated by issues of logistics. I was interested, as far as possible, to draw on data resources as close to the capital Trivandrum as possible, preferably within Trivandrum district. At the time that I was doing field-work, the RCH had only just been recently initiated in the state. The programme was in the process of being instituted at various levels of the organization, and key staff was only just being trained in the precepts of the programme. Most of the trained staff had been drawn from hospitals or administrative wings of the DHS - only a handful of doctors from the PHC level had undertaken the training programme. From conversations with administrators, I found that doctors from two rural health centres, Vellanad, located in Trivandrum District and, Palathara, in the neighbouring district of Quilon had been exposed to RCH training⁵⁰. While the two health centres were comparable in that they served populations with similar socio-economic characteristics (see Table 4.1 for details of the PHCs), Palathara was a PHC, while Vellanad was a CHC. In the context of my

⁵⁰ On the grounds of comparability (as different regions in Kerala have their own peculiar backgrounds), I tried to find rural health centres that had social and cultural similarities. Vellanad and Palathara are both located in the southern part of the state, and are the closest relevant centres to the capital Trivandrum where I was located.

research, this difference did not pose a problem as it was more important to me to see how individuals interpreted the policy's ideology at the local level rather than the number of people treated or volume of services offered at the micro level. My choice of DMO was also dictated by similar circumstances. My district level data collection was done at Quilon (where Palathara is located) as the position of Trivandrum DMO (District Medical Officer) was vacant at the time of my research.

In addition to the state and its various agencies, I also contacted institutions active in family planning, women's health and social work in India. These included the Family Planning Association of India, a feminist activist group monitoring the implementation of the Cairo resolutions in India called HealthWatch, the World Bank, and the Population Council. In some instances, my efforts were successful and I was able to establish contact with members of these organizations; in others, I was either allowed informal conversations that could not be recorded or repeated or given reading material that established the organization's position regarding the RCH.

Boundaries Of Research Activities

A third issue that I had to contend with was the multiple forms in which discourse is produced and disseminated in the state and the various institutions related to family welfare policy. The shift to a RCH programme could be manifest, among others, in training methods and content, services provided at family welfare centres, resource allocations in the budget, the focus on adolescent education programmes, apart from the policy's own manifest ideology in textual forms. In my aim to understand the shifting discourses, I opened myself (through visits, conversations and observations) to a variety of situations that would enhance my knowledge of how the policy was being implemented and interpreted in various contexts. For the actual analysis, however, I have restricted (as will be seen in the following chapters) my sources to specific oral and textual sources. A broad list of activities that were part of my research methods included: (a) collection of policy documents, (b) in-depth interviews, (c) observation of interactive

Table 4.1
Baseline Information of Selected PHCs

Characteristics	Vellanad	Palathara
Area	22.19 sq. kms	-
District	Trivandrum	Quilon
Population	25,306	2,54,143
Males (no. of)	12,511	1,26,657
Females	12,795	1,27,486
Density of Population	1069/ sq. km	-
Literacy	20,434 literate people (80.7% of total pop.)	-
Under 5s	2168 children (8.56% of total pop.)	21,177 (8.33% of total pop.)
Birth rate	12 per 1000 population (1997)	-
General causes of death in area	Asthma (Acute Respiratory Infection), Cancer (Lung and Liver), Suicide	Gen diseases: Asthma, Rheumatic complaints
Maternal mortality	One in 1997; none for three previous years	No deliveries conducted for a year
Type of health centre	CHC	Mother/Block PHC (comprises 4 PHCs)
Number of doctors	4	3 posts
Number of ANMs	5 (out of 6 vacancies)	30 including all the PHCs, 6 at the Mother PHC alone

Source: Interviews, and data supplied by the PHC staff. Note that as I had to rely largely on oral information or data computed by the staff at the centre, some of the information was not available.

sessions between health provider and user, (d) participation in state-run workshops, and (e) questionnaire surveys. However, the basis of my research analysis was interviews and policy documents. I provide details of these in the following section.

Data Collection

I conducted my field-work in India from August 1997 to March 1998. Apart from the three weeks that I spent in Delhi in January 1998, most of my time was spent exclusively in Kerala - in Trivandrum and its neighbouring district of Quilon – collecting documents and conducting interviews.

Collection Of Secondary Material⁵¹

In the initial phase of my research design, I had decided to collect two kinds of secondary material. First were policy and related documents that offered details about the RCH programme. Second, I had planned to collect data on indices of reproductive health (such as, maternal mortality, number of hospitalized abortions, infant mortality, etc.) to examine if a shift in policy had an impact on any significant indicator of women's reproductive well being. However, early on in the course of data collection, I realised that the programme has begun so recently that it was far too soon to notice any marked improvements in reproductive health statistics, and therefore, focused instead on descriptive material.

In collecting documents and literature around the RCH policy, I tried to be as thorough as possible. Unfortunately, because regulations in India are lax about making Government policy documents available to the public, access to these documents is usually at the discretion of officials in charge of departments. As such, I encountered difficulty in collecting descriptive documentation. I tried several alternative sources to ensure that the best possible sample had been collected. While in Delhi, I visited the Centre for Policy Research, the National Institute for Health and Family Planning, the World Bank and Population Council libraries, and also the library at Nirman Bhavan, which houses the MoHFW. There was no catalogued document on the RCH at any of these libraries. I approached bureaucrats in the MoHFW in charge of policy and was informed that a policy document on the RCH was currently being published. I left an address asking for a copy to be sent to me but I did not get any response to my request.

⁵¹ I use the term 'primary data' to denote that data which I generated on my own, in this case, the interviews. Secondary data refer to material (in this case, primarily documents) which had already been published by other sources.

The documents that I did manage to procure from official channels were publicity brochures that had been put out by the GoI in connection with the start of the RCH. In the end, my main sources for collecting policy documents were through unofficial and informal avenues – from people I was familiar with in the ministries, or the rare, magnanimous bureaucrat who was willing to assist a research student. Although I cannot state for certain that I have all documents generated by the Government on RCH until 1998, I am confident that my collection is a representative sample of the GoI's policies. In addition to policy documents from the MoHFW, I also collected documents published by other agencies in the family planning field, such as the World Bank, Family Planning Association of India, HealthWatch, and others. Counting documentation from all sources, I ultimately had a total of 40 documents that formed the main corpus of policy data for analysis.

In-depth Interviews

Fischer (1995: 80) notes that interviews are an important technique to evaluate policy. Interviews provide the opportunity to “tap the cognitive realities of those knowledgeable about the situation, particularly ‘policy stakeholders’” (Fischer 1995:80). The cognitive realities of policy stakeholders are not entirely autonomous opinions. As Schiappa (1989) argues, the “‘individual’ is one *effect* of discursive texts” and therefore, individuals are also “power’s *vehicle*” (p. 48). Fischer (op. cit.) points out that interviews offer the potential to explore individual and collective experiences and interpretations of a policy perspective; it is assumed that subjective experiences of policy are shaped greatly by the expectations and understandings of the people who enact them.

My interviews were conducted between October 1997 and March 1998. The interviews sought to capture the views of major stakeholders who would be affected/influenced by the change to a new RCH policy. The aim of my interviews was two-fold: first, to gather factual information and clarification about the RCH programme and the nature of its implementation in the state. Second, my questions also aimed to gauge individual perceptions and values about the programme, the people it is intended to benefit, and generally, issues regarding the state’s obligation to its citizens. In particular, I also inquired about specific implications and assumptions made about women and women’s

needs in the state institution of the programme. The elements of gender and neo-liberal discourses of reproductive health that I had teased out in Chapter 2 proved to be useful: a semi-structured guideline of questions and issues to be raised was drawn up prior to my interviews (see Appendix B). Each interview took between 20 minutes to an hour, depending on the participants' availability. The interviews were conducted in the setting of the participant's institutional location; I interviewed policy makers, for instance, in their offices, and the ANMs at local health centres.

I deliberately tried to keep the interviews conversational and, often, they were interactive (see Potter and Wetherell 1987: 165). Although I had a pre-prepared set of questions, I did not go through all the questions with each participant. In many cases, this would have been inappropriate as different officials in different positions in the health system had a different perspective and understanding of the RCH. For instance, medical doctors in the PHCs failed to understand the nuances of policy shifts from an aggregate point of view, while senior officials in the Ministry could not answer how the shift in policy would affect quotidian activity in the health centres. Therefore, what I did instead was, after a few general questions, let the participant's perceptions of the situation lead me to ask specific questions. Often, participants asked me to clarify my own position on issues, especially on the feminist conceptualizations of reproductive health concerns; I tried to be as candid as possible without seeking to influence or antagonize the interviewee.

The choice of interviewees was not random; I purposively selected a group of people who seemed best located within the policy implementation process to comment on various aspects of the RCH. I drew up an initial list of participants that included officials from the state (I explain each category at length in the following paragraphs), representatives of local and international organizations involved in reproductive health issues, the local and national women's movement, local community leaders and women users of the health services. However, the list was later revised once I was in the field. I eliminated the members of the local women's movement in Kerala because they were not involved in any significant way in the RCH consultation process. Similarly, often it was impossible to access officials in international agencies and they too, were removed from my list. I interviewed a total of 21 officials, and approximately 12 users randomly drawn from the community around the PHC. Save for three, all the interviews were

tape-recorded. Apart from this number, I also spoke informally to other people involved with the RCH in some way or the other. Most interviews were conducted only once; in some instances, it took me more than one contact meeting to establish the trust of the official to be interviewed. I also sent out, on the request of three official participants, a questionnaire asking key issues highlighted in my guidelines. However, despite repeated reminders, they were not returned to me. According to the guidelines of the ethics committee of the university, I was required to obtain signed consent forms from participants. However, I found that this practice made participants uncomfortable and less likely to be forthcoming with me. I found it more useful to verbally assure people at the start of the interview of my intention to maintain confidentiality and anonymity of the participants. In total, I identified four main groups of people who formed my information base. A brief description of each category of interviewees is given below:

Policy makers/officials in the administrative wings of the state

I interviewed a total of nine administrators at various levels in the DFW, DHS and DMO, Government of Kerala. There was no specific selection process in my interviewing method, other than that I aimed to be as representative of the organizational hierarchy as possible (see Appendix D for the organizational chart of the DFW and the DHS). I was open to interview all officials related to the programme, from heads of staff training programmes to state mass media officers. A bulk of my interviewees was middle-level bureaucrats, who were more implementers of policy (that is, programme implementers) rather than formulators. There was an obvious gender bias in the participants - other than two women, all other bureaucrats interviewed were male. My questions to this group covered assumptions made in the programme, the inherent contradictions in what the policy aimed to provide for women and the state's national objectives, and anticipated problems in implementation.

Interviews with local level practitioners in the health system

Interviews with local level practitioners were drawn primarily from medical officers and auxiliary nurse midwives in the rural health centres. As I had mentioned above, only a few of the rural health staff had received training under the RCH programme, so the ambit of questioning was restricted. What I focused on was if there were any changes in

practice, institutionally and individually, with the initiation of the RCH. I also enquired about potential benefits for their clients and if the policy reflected grassroots-level needs of individuals, couples and women. A total of nine interviews, individually and in groups were conducted in this category.

Non-state key actors

In addition to state administrators, I also spoke to individuals, at the national and state level, involved directly with reproductive health issues in the country. Some of the people in this category I interviewed belonged to feminist activists groups, non-government family planning agencies, and international donor agencies. I also interviewed consultants who provide research input into the government. The number of individuals in this category was six. Four of these interviews were tape-recorded.

Women in the vicinity of the PHC/CHC⁵²

Finally, I also accompanied ANMs as they visited rural women who lived in the catchment area of the PHC and used its services. Here too, I did not adhere to any particular selection choice, I allowed the ANM to take me on her routine rounds. The sample of women I encountered, however, covered various socio-economic groups and stages in the reproductive cycle - some women had two grown children, some had young children, some were awaiting their first birth, and in one case, there was a joint family situation that included two generations of women. Asking the women about their perceptions of the RCH proved meaningless, as it was clear that they did not perceive or experience policy -shifts the way the health systems do. My questions to them, therefore, centred on their needs and expectations from a health care system.

Although the interviews in the latter two categories were vital in that they provided useful background information (and competing viewpoints of the state's programme), it will be seen in the chapters that follow that it is the interviews from the officials of the state's health services that I have relied extensively on for analysis. There are two main reasons for this decision. First, the interviews with women were conducted when the

⁵² Although my interview sample was intended to be primarily women, in one case I also talked with a woman's husband who happened to be at home at the time.

programme was still in the early stages, and users had not yet been introduced to the shift in the government's policy. So, apart from indicating satisfaction with the existing system, for the most part, the women were unable to comment on the specifics of the PHC's programmes and functioning. Secondly, and more importantly, as the focus of my analysis is the manner in which the various voices within the state interpret the policy, it seemed appropriate to examine the discourses emanating from the interviews with officials and documents.

Analytical Framework

Thompson (cited in Wetherell and Potter 1992) argues that the analysis of ideology should involve three stages: first, an exposition of the social setting; second, a systematic analysis of the pattern of discourse; and, third, in an interpretive act, an indication of a link between the first and second. The final stage is critical if one is to argue that certain forms of discourse are implicated in the sustenance and maintenance of particular social patterns. Given the focus of my research questions on the study of discourses, it was imperative for me to design my strategies of analysis around a broad form of discourse analysis. Discourse analysis, as a term, is not easily amenable to definition, meaning as it does different things to different social scientists (see Fairclough 1992 for a review). There appears to be a general consensus that discourse analysis involves searching for patterns of discursive formations in text, speech and visual material. Grace (1991) refers to a method of lexicology; it entails a process of discovering a structural logic within a discourse that may not be manifest at a surface level but is nonetheless present at a discursive level. Foucault (1972a, 1972b) in his earlier archaeological works sought to identify the rules of discursive formations. Foucault (1972b) identifies four possible hypotheses for understanding discursive formations: the possibility of defining regularities between a number of statements regarding objects, types of statements,

concepts and thematic choices⁵³.

From the structure of discourse, there have been recent attempts (see for example, Fairclough 1992, and Wetherell and Potter 1992) to draw together language analysis and social theory. According to Fairclough, any discursive event (be it text, speech or graphic data) should be viewed as an instance of social practice. Every enunciation of discourse is to be contextualized within an organizational or institutional base, which in turn has constitutive effects on the discourse. Wetherell and Potter (1992) offer a method of analysing discourses that is similar in its assumption to Fairclough's Text Oriented Discourse Analysis (TODA); however, they prefer to call it "interpretative repertoires" rather than discourses (p. 90)⁵⁴. Like Fairclough, they too argue that discourses should not be analyzed in the abstract; their sense is derived from their situated use. Wetherell and Potter (1992) focus, therefore, on the implementation or use of discourses in actual settings. They describe interpretative repertoires as:

...broadly discernible clusters of terms, descriptions and figures of speech often assembled around metaphors or vivid images. In more structuralist language [we] can talk of these things as systems of signification and as the building blocks used for manufacturing versions of actions, self and social structures in talk. They are some of the resources for making evaluations, constructing factual versions and performing particular actions (p. 90).

⁵³ Foucault's hypotheses were as follows. First, statements different in form and dispersed over time form a group if they refer to the same object. Foucault realised that no object is ever defined in exactly the same way at all periods of time. The way 'madness' has been defined may differ in the eighteenth and nineteenth century. Thus, he felt that it would be more productive to group together all the different objects that have been defined under the same relations. For instance, perhaps similar parameters may have been used to label something as 'crime' in one epoch, and 'madness' in another. A second hypothesis that Foucault advances is to examine a group of relations between statements is their form and type of connection. He found that medical statements in the nineteenth century were associated in a particular "style" (1972b: 33), that is, "...the system that governs their division, the degree to which they depend upon one another, the way in which they interlock or exclude one another, the transformation that they undergo, and the play of their location, arrangement and replacement" (p. 34). Foucault's third hypothesis centres on the study of grammatical connections between concepts used in a discursive statement. He does not advocate examining language in a general and abstract manner, but in the "simultaneous or successive" emergence of concepts (1972b: 35). Finally, a fourth hypothesis that he puts forward to understand discursive formation is the identity and persistence of themes. Statements that overtly refer to different objects or concepts can be linked by a similar theme. Foucault, for instance, identifies an 'evolutionist theme' in the works of philosophers from Buffon to Darwin, despite their overtly different concerns of theorizations (p. 35).

⁵⁴ Fairclough argues that his method of TODA is more refined than Foucault's discourse analysis. A weakness that has been pointed out in Foucault is that he never subjected "real texts" to linguistic and discursive analysis (Fairclough 1992: 56). TODA attempts to improve the link between text and social practice.

My own analytical strategies have been informed both by Foucault's structural rules of discourses, and by Foucault's, Fairclough's, and Wetherell and Potter's idea of the social situatedness of discourse. First, because social practice is so diverse, there is no one tried and true technique of discourse analysis that I apply in broad strokes to all my data. I read the data to look for themes, metaphors, discontinuities in ideas, or relationships. I treated quantitative information as reflective of institutional practice. This approach is, to a large extent, a 'non-formulaic' procedure and often specific to the institutional setting in which it is being articulated. However, I did employ general methods used in the analysis of qualitative data, such as reducing and organizing data through coding and writing memos, making notes, drawing up possible connections between statements, and so on (see Denzin and Lincoln 1994; Neumann 1994, for approaches to analyzing qualitative data).

Overall, my analysis in subsequent chapters show that I have an eclectic approach to data analysis: I have explored links between concepts, examined how statements are connected to each other and what roles they play in text, striving to demonstrate multiple meanings and perspectives in relation to a particular object. And, above all, I explored the contextual use of a particular discursive formation, and what it reflects about a particular social setting. I also used Wetherell and Potter's (1992) criterion for validity of qualitative analysis - that an analysis should impart coherence to a text, that is, that the discourses should fit together in its context, functions and effects. In the course of my analysis, this was established through identifying similar themes and thematic interrelationships in multiple kinds of texts and spoken interviews.

Organising Policy/Interview Documents

Prior to actual analysis of the documents, it was necessary to collate, classify, sort and organize the database that I had collected. When I started collecting policy documents, I deliberately kept my definition of the term 'policy document' a liberal one. The documents that I collected included actual policy statements and reports, minutes of meetings held by officials, communication between administrators, proposed sectoral and regional plans for implementation of the RCH, and letters and presentations made to the donor agencies that fund the programme. To classify and catalogue the material

that I had collected, I developed an indexing scheme involving three sets of characters. The first two sets of characters were letters while the last was a numerical marker. The logic I used was as follows. The collected documents were first sorted according to the place of origin - 'goi' meant that the document originated from the Government of India and 'gok' meant that the document originated from the Government of Kerala. Having separated the documents thus, I found that all the *goi* documents often had a date and were almost exclusively policy statements of the government. *Gok* documents tended to be state-initiated proposals for implementation plans in specific district/towns/cities. The Government of Kerala did not, apparently, issue policy documents, but enacted them in their local contexts.

The second set of characters denoted the kind of communication that the document was - 'obp' indicated an 'official background paper', 'oc' was an 'official communication', 'tm' referred to 'training materials', and 'om' was an 'official meeting'. The last set of characters was a number and was randomly attached to a document of a particular kind that I happened to sort. Thus, 'goi.oc.3' referred to the third GoI document that was an official communication. 'Gok.obp.1' is the first official background paper initiated by the Government of Kerala, that I had sorted out. Not surprisingly, most of the 'oc's originated from the 'goi' while the 'gok' was more likely to present 'obp's. A comprehensive list of documents and their classification numbers have been appended (see Appendix E).

Once the classification numbers were fixed, I catalogued all the documents that I had collected. The catalogue included information regarding the following: (a) serial number – the classification number that I had assigned the document, (b) status of the document – if it was a background paper, communication or training material, (c) date, (d) title, if any provided on the document, and (e) a brief description of the document (see Appendix E). In general, the documents presented four kinds of details regarding the RCH: justifications and rationales for implementing the programme, information regarding institutional modifications to institute the programme, the various strategies and interventions planned under the programme, and a listing of the actual services that would be provided under the programme.

With the interviews, I followed a two-step process for consolidating the data. As a first step, I indexed the interviews by subject, i.e., rather than do a word for word transcription, I noted, quite generally, turns in conversation, topics raised, etc. I then selected portions of catalogued transcripts that seemed relevant to my study (and eliminated, for example, pleasantries at the start of interviews) and transcribed these portions completely. Many of my interviews were in Malayalam, the local language. Therefore, transcribing involved initially translating the text as well. For the sake of maintaining confidentiality, I assigned arbitrary numbers to the interviewees. Profiles of the key participants are given in Appendix C. By and large, the interviews provided information and views regarding objectives and services, women and the RCH, funding aspects, the various relevant concepts that were being made current, training under the programme, and perceived benefits and obstacles. I used the interview transcripts (and policy documents) in two ways: as sources of information, and as data for critical analysis.

Preliminary Analysis

Subsequent to organizing both interviews and documents, I began preliminary analysis by broadly coding the data according to main themes. The themes were not pre-determined but developed along with patterns and ideas that emerged with the reading of the text. I also began to note irregularities in the data - contradictions, specific kinds of language used to define terms and objectives, and the kinds of cause-effect relationships that were sought to be established. From this broad array of interesting possibilities, I began to identify significant trends. Mostly, I looked for: (a) rhetorical terms and keywords that were repeatedly used in the documents and interviews, (b) thematic clusters and (c) genres, where I tried to trace the origins of certain themes/terms, i.e., which socially prevalent discourses they were most likely to be drawn from. I also traced the multiple uses of certain words that emerged as critical references to the RCH; by ‘multiple’ I mean that I was keen to see how differently located people understood a word, and also the multiple references made by the same people.

Through repeated readings and re-readings of the data, patterns began to form. I noted the meanings that these patterns indicated, and the contradictions and cause-effect relations that were used to support some of these meanings. I organized themes that

referred to a particular idea into clusters and sought to see how these ‘clusters of ideas’ were related to each other or what larger picture they supported. Where appropriate, these ideas were diagrammatically represented to show the various linkages.

Conclusion

The present chapter provided the theoretical rationale for the methodology that was used in designing the research study. It also elucidated the analytical framework that was used in the study to identify strands of neo-liberal and gender discourses in reproductive health. Finally, the chapter gave a detailed account of how the data was collected, organized and prepared for analysis. The actual analysis of the documents begins from Chapter 6 onwards. The following chapter first gives an overview of the various aspects of the RCH programme in India and Kerala.

V

THE RCH PROGRAMME IN INDIA

An Overview

In this chapter, I present an overview of the RCH programme, focusing on the historical, demographical and institutional contexts in which the programme is being instituted. The RCH claims to offer a population programme that is different from programmes pursued in the past by the state. In emphasising its uniqueness, I aim, first, to briefly trace the historical development of population programmes in India since the mid-1950s. Second, and more central to this thesis, I shall describe the various aspects of the RCH programme; in particular, I will examine the steps proposed, and already undertaken, by the Government of India (GoI) and the Government of Kerala (GoK) to implement the RCH programme.

Population Programmes in India: A Brief Historical Overview

Although population control became an official subject of interest in India with the initiation of the Family Planning Programme in 1951, the role of the programme within development policy – in terms of budgetary and planning commitment – was prioritized only in the Third Five Year Plan (1961-66)⁵⁵. For instance, only Rs. 6.5 million were allocated to family planning in the First Five Year Plan (1951-56), compared with Rs. 50 million in the Second Plan, and Rs. 250 million in the Third Plan (Indian Institute of Population Studies (IIPS) 1995)⁵⁶. When first initiated, the programme was designed to be a Clinical Approach, which largely meant that people desiring information or methods of contraception approached a clinic-based family planning unit. The main emphasis of the programme was the promotion of the rhythm method of contraception.

⁵⁵ The Indian state is a planned economy. Successive governments since Independence have followed Five Year Planning strategy, where specific economic and developmental goals are set to be achieved within a five-year period. Political circumstances have at times necessitated altering the Five Year Plans to shorter terms, and occasionally, there have been Plan Holidays – periods of breaks when no plans were in operation. Population programmes have conventionally fallen under the directive of the Indian Plans.

⁵⁶ One U.S. Dollar is approximately 44 Indian Rupees.

The operational thrust of the programme was restricted to the provision of advice in Government hospitals and rural medical centres. There was also a focus on gathering information on the motivational aspects of family planning (Jolly 1986). By the Second Plan, it was clear that population growth had far exceeded the government's expectation and that more stringent measures to control population were needed. Sterilization as a method for permanent contraception was promoted. Family planning clinics were increased from 147 to 4167, and the number of sterilization conducted from 1956-1960 totalled 152,677 (Jolly 1986). During the Third Plan, the clinical approach was replaced by the Family Planning Extension Education Approach, which was initiated in 1963, when intensive educational measures were introduced to motivate the population to adopt family planning methods. This approach involved active outreach strategies to the masses - a key tool employed by the MoHFW was the Information, Education and Communication schemes (IEC). The IEC basically were messages, related to family planning, propagated through a variety of means ranging from mass media (like television, radio, newspapers and magazines) to door-to-door campaigning by health workers. The IEC messages contained information on a range of issues, from norms of ideal family sizes, appropriate methods of childcare to birth control methods. The idea of the 'Small Family Norm' was introduced in the 1960s; the ideal family size of two children was promoted (Jolly op. cit.). Besides sterilization and natural methods, the Lippes Loop (an Intra Uterine Device) was introduced on a large scale in 1965⁵⁷. The Third Plan also set, for the first time, numerical demographic goals that were to be achieved within a specific period⁵⁸. During the period from January 1961- March 1966, the 'performance' of the family planning programme had increased substantially; 1.37 million sterilizations were performed and 0.81million IUDs were inserted (Jolly 1986). The Inter Plan Period (1966-69) saw an emphasis on the development of family planning infrastructure. In 1966, the Department of Family Planning was formally set up. The practice of fixing annual 'targets' decided by the central government was initiated during

⁵⁷ Since the 1960s, three considerations seem to influence the government's decisions to make available select contraceptive methods: (a) high reported rates of efficiency (b) compatibility for mass use and (c) cost effectiveness. Sterilizations, apart from their efficiency, were a one-time operation. Condoms could be made available for mass use at little cost and needed no medical supervision. The IUD was introduced with the expectation that it would comply with these criteria. In addition, IUDs could be inserted by auxiliary medical staff, thereby not requiring the presence of physicians (Kumar 1997).

⁵⁸ In 1962, the demographic goal was to reduce crude birth rates (CBR) to 25 per 1000 population by 1973. This goal could not be achieved and by 1968, the goal was to reduce CBR to 23 per 1000 population by 1978-79. As this second goal could not be achieved either, yet another goal was set. In all, between 1962 and 1992, demographic goals were set at least 11 times (Reddy 1998).

this period. In 1968, the Social Marketing Programme was made operational. The aim of the Social Marketing Programme was to promote and distribute at affordable prices contraceptives through a wide range of private outlets. The scheme sought to endorse specific brands of contraceptives, so that people would automatically associate a name with a product. The scheme was first used to market condoms, under which the brand 'Nirodh' was popularised and made available at a highly subsidised price⁵⁹. The total expenditure on family planning at this time had gone up to Rs. 705 million, a budget increase of nearly three times the Third Plan (Jolly op. cit). The mid-1960s was also the time when the state expanded (and experimented) with a broader range of contraceptives. The emphasis on the rhythm method, which characterized the earlier stages of the programme, was increasingly being replaced by 'modern' contraceptive methods - the Lippes Loop, the diaphragm and the contraceptive jelly (see Cassen 1978)⁶⁰.

In the Fourth Plan (1969-1974), the Extension Education Approach was substituted with the Integrated Approach; the essential component of this shift was a merging of the family planning services with the maternal and child health services being run by the Ministry of Health. It was felt that family planning services would be better accepted if presented in the context of maternal health. The Medical Termination of Pregnancy Act (MTP), 1971, which liberalized abortion⁶¹, came into force in 1972. Also during the early 1970s, the camp approach was adopted. Camps were short duration (a day to a few days) temporary, mobile units that went from place to place advertising and delivering contraceptive services. Surgical methods of contraception, in particular, vasectomy, was

⁵⁹ Verzosa and Kakkar (1996) provide some statistics of the usefulness of the Nirodh distribution scheme. According to figures from Operations Research Group and Family Health International, condoms distributed through the social marketing programme represent one-third of all condoms distributed annually in India. Approximately 525,000 outlets including pharmacies, general stores, grocers, paan-bidi shops and bakeries are involved in the programme. Finally, annual sales for condoms grew from less than 16 million condoms in 1968-69 to 320 million in 1990-91.

⁶⁰ Most of these earlier modern contraceptive methods were later withdrawn from the government's programme for a variety of reasons. Officials felt that women did not know how to use the diaphragm or the jelly appropriately, and they proved to be logically unsuitable. The IUD, after initial enthusiasm, declined in acceptance (Cassen 1978). Women's groups in the 1990s are seeking to make the diaphragm available in the public health system as it is a contraceptive for women that do not require dependence on male partners or service providers.

⁶¹ The MTP Act permits the legal termination of pregnancy up to 20 weeks under specific conditions, such as rape, health of the mother as well as failure of family planning methods, in a recognized institution with a qualified physician. Though the Act does not recommend abortion as a means of family planning, its liberal clauses are interpreted to favour women who choose to terminate pregnancies even when continuation of the pregnancy is not a threat to their lives.

promoted through camps. The camp approach was abused during the Emergency⁶² Period of 1975-77, involving cases of forced vasectomies, among other problems. There was a sudden increase in the number of sterilizations carried out from 2.67 million in 1975-76 to 8.26 million in 1976-77 (IIPS 1995). The new Government, which came to power in 1978, re-emphasized the voluntary nature of the family planning programme and the commitment to community welfare. The Family Planning Programme was renamed the Family Welfare Programme and focused on maternal and child health services.

An army of health personnel, meanwhile, was being built up alongside the development of the family planning programme to motivate and deliver the contraceptive services. In the early 1970s, the idea of the ‘multi-purpose’ worker was promoted. The multi-purpose workers were expected to provide a range of family planning, maternal and child health, and public health services. During the Seventh Five Year Plan (1985-90) the Government envisaged a three-tiered outreach health system. Family Welfare Sub-centres formed the lowest rung of the ladder; they were staffed by one male and one female multipurpose worker/auxiliary nurse midwife (MPW/ ANM) and were expected to serve populations of 5000 (or 3000 in particularly undeveloped, tribal, or hilly areas). On the next level is the *Primary Health Centre* (or PHC), which serves a population of 30,000 and is staffed by a medical officer, staff in supervisory positions and multipurpose workers. At the top is the Community Health Centre (CHC) covering a population of about 100,000 (the area of a community development block) and staffed by specialists in paediatrics, surgery, and obstetrics and gynaecology. CHCs serve as ‘first referral units’ (FRUs) that provide essential obstetric care, including caesarean sections and blood transfusions (World Bank 1996: 71-72).

The National Health Policy (NHP) was drawn up in 1983. The Policy document lays down the long-term demographic goals that are to be achieved. The NHP aims to achieve a Net Reproduction Rate (NRR) of 1 by 2000. For this the FW Programme must achieve a birth rate of 21 per thousand, death rate of 9 per thousand, natural growth rate

⁶²The Congress government led by Indira Gandhi declared a state of emergency in India in 1975, citing national security as the prime reason at the time. Under Emergency, an individual's constitutional rights (e.g., freedom of speech) are temporarily suspended. It should be noted that the Congress government failed to come to power in the next election in 1978 largely because of its abuse of power in forcing family planning on men and women.

of 1.2, infant mortality rates that are below 60 per thousand live births and couple protection rate (number of sexually active people using contraception) of 60 percent⁶³. The NHP also lays down maternal and child health goals of reducing maternal mortality ratio to 200 maternal deaths per 100,000 live births, supplying 100 percent of pregnant women with tetanus toxoid immunization and antenatal care, and ensuring that trained personnel attend 100 percent of deliveries. In 1985, the Universal Immunization Programme (UIP) was launched with the aim of universal coverage of vaccinations to pregnant women and children. A Programme of Social Marketing of Oral Pills began in 1987. The 1980s was also the time when ‘modern’ innovative methods of female sterilization such as, the laparoscopic method and tubal ligation were introduced into the programme.

A major goal in the Eighth Five-Year Plan (1992-97) was to strengthen child health services. In 1992, the Child Survival and Safe Motherhood Programme (CSSM) was started to strengthen the achievements under the UIP and ensure that the maternal and child health goals listed in the NHP were fulfilled (World Bank 1996). The CSSM is designed to address major causes of morbidity and mortality in women and children; the achievements under UIP were sought to be strengthened along with providing better facilities for safe motherhood. The latter included measures to prevent anaemia, provision for safe delivery kits, training of Traditional Birth Attendants or *dais* to conduct delivery, and measures to strengthen referral services for pregnancy-related complications.

Contraceptives and Legislation in India⁶⁴

The Indian legal code with regard to contraceptives is not a comprehensive body of law, but instead comprises jurisdictions scattered throughout various codes, policy statements, and fields of law (such as criminal or penal codes, public health codes, press laws, and consumer laws). As such, there is no specific statute in India governing or

⁶³ The Seventh Plan Document (1985-90) admitted that to expect the country to achieve this goal in the specified time was unrealistic. To quote the document, “[i]n the light of the progress made in the initial period of the Sixth Plan, the health policy targeted a net reproduction rate of one by the year 2000 AD; a review, however, indicates that this goal would be reached only by 2006-2011” (Planning Commission 1985: 281 cited in Reddy, 1998).

⁶⁴ Parts of this section have been published in Kumar (1997).

controlling the manufacturing, advertisement, sale or use of contraceptives, their standards, or quality in any direct or exclusive way. All regulating guidelines in national law relate primarily to the approval of contraceptives as drugs. The key central statutes are the Drug and Cosmetics Act (1940) and the Drug Control Act (1947). Provisions in these Acts are administered by the Ministry of Health and Family Welfare. Testing and trial introductions of new drugs are conducted by the Indian Council of Medical Research (ICMR)(Centre for Reproductive Law and Policy 1995).

The weaknesses in the legislations related to contraception have been a key focus of struggle among feminists in India, and has become particularly intense in recent years. Questions have been raised as to the government's role in ensuring accurate information, and the legality and quality of contraceptives. Ravindran (1993), for instance, notes that misleading information is provided on the packaging of the popular oral contraceptive, Mala-D. Another oral contraceptive, Centchroman, marketed under the brand name 'Saheli' as the revolutionary once-a-week pill has been declared in the marketing brochure as "free from side effects" (Kumar 1997: 83). So also, in 1994-95, a leading news magazine in India, *The Week*, carried articles on private medical practitioners who had been conducting non-surgical sterilization through the insertion of quinacrine pellets into a woman's uterus. The method is not legally permitted in India, yet the practice continues at private clinics, and there are inadequate checks in force by the government to ensure that such practices are not continued (Berer 1994, 1995; Pollack and Carignan 1993)⁶⁵. Similarly, there are no central statutes that explicitly set forth universal principles of informed consent, non-discrimination, confidentiality and right to humane treatment. At most, patients can claim compensation under the Criminal Law (Indian Penal Code, IPC) if death has occurred by a doctor's negligence or under the Consumer Protection Law, which seeks to protect consumers from faulty or hazardous products.

From responses that I received from medical officers in Kerala, enforcement of the Consumer Protection Law was a highly contentious issue among doctors. One of my interviewees (#2), for instance, told me that as a result of this Act, doctors were now more hesitant at rural clinics to undertake risky treatment and preferred instead to refer them to the larger hospitals. The delay in treatment could potentially affect the outcome

⁶⁵ The Supreme Court of India, in early 2000, banned the drug quinacrine in response to public interest litigation. There are fears among women's activists that the ban has pushed the practice underground.

of the patients' illness, yet doctors now preferred to avoid taking responsibility for such cases, for fear of inviting lawsuits against them.

The RCH Programme: A background

The introduction of the RCH forms part of the more recent changes to the Family Welfare Programme. The impetus to initiate the recent round of changes to the population programme in India came from both external and internal sources. A key external motivation for the government to review its population policy was the tangible shift in international ethos following the ICPD, 1994. For the Indian government what this meant was that there was pressure from donor organizations to review the institutional structure of the population policy; the move towards the RCH was, undeniably, donor driven (Interview, I#5). Alongside, there were also domestic catalysts that set the stage for the government's acceptance of a policy change. Since the 1990s, there has been growing discontent within the Ministry of Family Welfare that the Family Welfare programme does not reach its desired population goals. In January 1992, the MoHFW issued *the Action Plan for Revamping the Family Welfare Programme* in India, a document which identified several weaknesses in the extant programme (Merrick 1996). The Action Plan recommended a twelve-point strategy for improving the effectiveness of the Family Welfare programme. Some of these recommendations included (a) generating a national consensus and policies for the F.W. Programme, (b) improving the quality and outreach of family welfare services, (c) implementing special initiatives for ninety 'backward' districts, (d) modifying the system of targets and incentives, and devolving more responsibility to the states, (e) upgrading and improving the performance of immunization and maternal and child health services, (f) revitalizing training for staff, especially field level workers, (g) involving non-governmental organizations, and (h) strengthening intersectoral co-ordination between the FWP and other relevant government agencies (Merrick 1996).

In order to address the shortcomings identified in the report, the government set up two independent committees to review the population situation and to advise it on policy changes. The second committee, in particular, comprised largely of experts in the field of demography and planning, was headed by Dr. M.S. Swaminathan. In May 1994, the

Swaminathan Committee submitted to the MoHFW a draft report with recommendations for a new population policy. The report proposes establishing population and social development committees at the national, state, district and local levels of government to promote a participatory political environment and community involvement in addressing family welfare issues (Merrick 1996). It also recommended withdrawal of the target approach, empowering women by increasing their opportunities to participate in paid work, and shifting the emphasis of the programme from national goals to helping couples achieve their reproductive goals (Khan and Townsend 1999). Among suggestions for implementing the new population policy was establishing a Population and Social Development Fund to replace the Department of Family Welfare (Merrick 1996). Critical appraisals suggest that the government has not wholly accepted the recommendations of this committee and many aspects are still “under discussion” (Merrick 1996: 15; Visaria and Visaria 1999).

A tangible result of such revisionary discussions was the decision in 1995 to eliminate the state’s practice of enforcing numerical targets, popularly called the Target Free Approach or the TFA. The system of targets in India was adopted in the mid-1960s, and was largely an incentive scheme for acceptors of specific family planning methods (mostly, sterilizations and IUDs) and field workers in order to motivate greater acceptance rates. The numerical targets for each state were fixed by the Central government arbitrarily, and these were passed on to the state governments, districts, and community level centres to be achieved within an annual period. The government religiously adhered to the target system for decades because “it was quantitative, easy to monitor and because it was expected to have a direct link with reduction in fertility” (Khan and Townsend 1999: 44). The system of numerical targets have been criticised widely on human rights grounds (see, among others, Freedman and Isaacs 1993). In India, the incentive system has been seen as a key factor in encouraging poor service provision by health providers (Khan and Townsend 1999; Interview I#1)⁶⁶. The TFA was introduced on an experimental basis in one or two districts of major states in India in 1995. A year later, in April 1996, the government declared the entire country as target

⁶⁶ For instance, respondent I#1 told me : “...to achieve that figure often we have had to compromise the quality of the services. For example, there have been instances of Copper-T (an intra-uterine device) [being] introduced, removed and re-introduced in the same beneficiary. A lady in her 43rd year of life used to be brought for sterilization. People who [are] ...well past their, productivity...those who are in the 50 or 60 year olds also used to be brought for vasectomy, male sterilization”.

free. Khan and Townsend (1999) point out that the target free approach has generated mixed responses in various groups. Women's groups have, by and large, welcomed the government's shift away from the target-oriented system. Meanwhile, demographers have argued that the removal of targets is, by and large, ineffective (Khan and Townsend 1999). The Population Foundation of India felt that it was premature to remove targets; it was first necessary to ensure that all eligible couples, and adolescent boys and girls were educated about modern contraceptive methods.

Another element of the TFA has been dismantling methods of work performance that health workers were used to. For instance, apart from abolishing method-specific targets for field workers, the government has also scrapped the practice of provider and motivator incentive for IUDs and sterilization and giving motivator certificates for achieving targets set for staff⁶⁷. As one policy document notes, the change in approach will now be reflected, for example, "in how workers interact with clients, how communities participate in the identification and monitoring of service delivery, and how workers' performance is measured" (goi.tm.3: 1). In the absence of targets, work is to be assessed using achievement of indicators of quality. For instance, the registration of pregnant women will be measured not in the numbers registered but the numbers registered before 16 weeks of pregnancy (Government of India, n.d.).

Subsequent to the institution of the TFA, the government has closely studied the impacts of the approach on conventional indicators of demographic performance. The results have not been totally satisfactory for the government. In the year following the removal of targets, 1996-97, performance indicators for acceptance of sterilizations, condoms and IUDs registered a sharp decline. In 1997-98, the declining trend appeared to be reversing – the proportion of people accepting these methods had increased over the 1996-97 figures, but was still lower than in the pre-TFA period (Khan and Townsend 1999)⁶⁸. These figures, and the concern that field level staff were misinterpreting the removal of targets to mean no more work for them (Interview I#2) compelled the MoHFW to review its TFA policy. The government shifted from a TFA

⁶⁷ The earlier practice was to reward health personnel (both the ANM and medical doctor) for every IUD that was inserted or sterilization conducted.

⁶⁸ Khan and Townsend point out that this decline should not be of any concern as most of the data published by the state during the target-oriented period were inflated statistics anyway.

approach to a Decentralized Participatory Planning (DPP) approach for population programmes (goi.oc.6). In the latter, the targets were brought back; the only difference was that unlike pre-TFA times, instead of the Central Government fixing targets, this would be done by communities themselves and relayed to the state. The DPP was emphasized as a *bottom-up* approach to population planning, involving the community in the setting of goals⁶⁹.

The TFA, in many respects, was a significant paradigmatic shift for the GoI. Alongside emphasising a shift away from quantitative measures, the TFA fostered the emergence of a discourse of quality in population programmes. The de-emphasis on target achievements also opened the programme framework to address a broader range of reproductive health issues. There was wider recognition that health care provided by the state did not address women's reproductive needs (Jeejeebhoy 1997; Ramachandran and Visaria 1997). As Jeejeebhoy (1997) points out "...what is urgently required ...[is] specifically a health and family planning programme that is based on what women want and need and appropriate and culturally sensitive ways of addressing these needs. By this we mean ... such needs of Indian women as domiciliary services, sensitive probing of obstetric and gynaecological problems, interaction with service providers which is not threatening, and above all, a more holistic approach to their health rather than the current stress on family planning" (p. 476).

In October 1997, the GoI formally launched the Reproductive and Child Health Programme, the RCH, a policy and programme initiative meant to replace the existing Family Welfare programme. Government documents note that in comparison to the Family Welfare Programme, the RCH aims to be gender sensitive, that is, grounded in the realities of overall health needs of women and children, implementation needs of health workers, and local demographic needs and conditions (Government of India, n.d.). In lieu of the target-motivated programme, which primarily emphasized fertility

⁶⁹ In the bottom-up planning approach, the health worker or the ANM will determine her own work load on the basis of the 'felt needs' of the community, and the 'service needs', as determined by the number of pregnancies and births in her area, rather than fulfil the targets set by the Central government and state authorities. Plans formulated at the sub-centre and the PHC level will be integrated to form a District Action Plan. The State Action Plan will, in turn, be an aggregation of the District Action Plans. The National Plan that will be the All-India programme of action in reproductive health will be a consolidation of State Action Plans. In Chapter 7, I critically examine this process of determining 'felt needs' of the community.

reduction, the RCH service provision has alternate purposes. These are to increase service coverage, so as to make accessible health facilities to the population, to focus on reducing unmet needs⁷⁰, and to improve the quality of services, defined according to specific standards (goi.oc.6). It is expected that these goals could be achieved through increasing community participation in decision-making around reproductive health issues, and improved institutional management in programme delivery. The RCH is also intended to institute services that were earlier neglected, such as counselling and a better referral system (Visaria and Visaria 1999). Another new introduction was the greater interdependence with the NGO and private sector, so as to fill gaps in public health sector services (Visaria and Visaria 1999).

A key element of the RCH approach is the provision of a package of reproductive and child health (RCH) services. The RCH programme is expected to build on the success of the UIP and the CSSM programmes, related to concerns around child and maternal health, and in addition, cover all aspects of women's reproductive health across their reproductive cycle, from puberty to menopause (Government of India n.d.). A second emphasis of the RCH programme is on accentuating community participation in planning for services and prioritising needs and strategies (Government of India n.d.). Under the RCH, the government plans to disband the erstwhile approach of top-down planning and substitute in its place a bottom-up planning approach; that is, it will move from a *Target Based Activity* to a *Client Centred Demand Driven Quality Services Programme* (goi.oc.6). The participatory approach to family planning requires a strong partnership and communication networks between the PHC health workers and other village level functionaries like representatives of the panchayats, non-governmental organizations, pradhans, primary school teachers, and practitioners of traditional systems of medicine, to name a few. To prepare ANMs for these additional organizational tasks, the state governments have embarked on a state-wide training programme that has at its focus participatory methods of needs appraisal of the local community (I# 19; goi.tm.1). A third prospective aspect of the family welfare programme under the RCH approach is the stress on providing good quality care to the users of the programme. Quality of care is assessed along various dimensions, particularly, service delivery (such as, promoting informed choices and follow up care), interpersonal communication, technical quality (in

⁷⁰ Unmet needs refer to services for couples who do not want to have any more children or who wish to space their next child but are not currently practicing contraception.

the competence of the providers and equipment) and social relevance of programmes (as in encouraging male participation, and increasing role of women in the programme).

Since the introduction of the RCH was among the several related changes to the Indian family welfare programme that occurred almost around the same time, the government clarified the distinction of the idea of the RCH from the TFA. According to government documents, the RCH refers to two major shifts in the Family Welfare Programme:

... from targets and money incentives to client based and high quality services, [and] by expanding services to cover an integrated package which includes family planning, CSSM, RTIs/STDs and AIDS, the approach shifts from vertical programme based objectives to objectives of a client based approach. TFA is a management approach to achieve these shifts in the FW programme towards an RCH approach. Based on the principle of decentralization and grassroots participation, TFA is well suited to achieve an RCH approach (goi.tm.3: 1-2).

Apart from the need to revitalize the programme through a shift in work methods and perspective, policy documents also point out that a major reason for introducing the RCH programme has been to facilitate the integration of various similar programmes running concurrently and inefficiently. The implementation process of the RCH is therefore designed to ensure that outcomes are optimised for the minimum of cost inputs (goi.oc.3; goi.oc.5).

What seems clear from all these efforts is that the GoI is aiming to introduce into the ongoing programme a new direction and new perspective. Documents often refer to a “paradigmatic” shift in the government’s programme (e.g., goi.tm.3), a change in policy ethos. Pachauri (1996: 245) notes that the reproductive health programme cannot be operationalized without a paradigm shift in the family welfare services. What is required is an ideological shift, “which in turn would necessitate *a change in the existing culture* of the programme” (Pachauri 1996: 245, emphasis mine). The World Bank’s (Measham and Heaver 1996) appraisal of the GoI’s efforts is that new signals usher in the new programme (see Table 5.1 below).

Table 5.1
Changing the Signals (Reproductive and Child Health)

	Old Signals	New Signals
Primary goal	Reach two child family size norm	While still encouraging smaller families, help clients meet their own health and family planning goals
Priority services	Family Planning especially female sterilization, immunization	Full range of MCH services
Performance measures	Number of cases	Quality of care, client satisfaction, coverage measures
Management approach	Top down and target driven Male driven	Decentralised and client needs-driven Gender Sensitive
Attitude to client	Motivate and persuade	Listen, assess needs, and Inform
Accountability	To the bureaucracy	To the client and community, plus health and family welfare staff

Source: Measham and Heaver (1996), p. 5

This chapter, thus far, has attempted to provide a general historical overview of the evolution of the Reproductive and Child Health programme, its objectives and philosophies. In the following sections, I continue this description, focusing on the government's strategies for implementation, especially specific areas of the programme, namely, programme design, services, funding, and monitoring that have been proposed.

The RCH and Implementation

This section highlights some of the key features of the programme. The descriptions that follow are meant to be an overview of various relevant aspects, rather than an exhaustive account of the government's implementation of the RCH.

Programme Design

The RCH programme is a centrally funded programme of the GoI. Its implementation will be spread over two phases, RCH-I, and RCH- II. The first phase of the programme will commence in 1997/98 for a five-year period culminating in 2001/02. The implementation strategy of RCH- I will have three components. First, in terms of service provision, the programme has essentially two parts. The first and large part is the national part, which will be implemented in all districts. Interventions such as child survival and safe motherhood, facility for safe abortions, minor civil works, enhanced community participation, adolescent health and reproductive hygiene, are to be offered in all districts. The national part will be covered in a phased manner with 178 districts being covered in the first year, 202 districts being covered in the second year, and, an additional 127 districts being covered in the third year (I # 18). The second part of the programme will be restricted to only specific districts; interventions like screening for RTI (Reproductive Tract Infections)/ STI (Sexually Transmitted Infections), improved delivery services and emergency obstetric care will be offered only in selected districts. Further, the World Bank is also funding the development of reproductive health projects in certain districts, called the District Project Implementation Plan (DPIP). All states are to prepare State Implementation Plans (SIP) indicating the interventions to be taken up in various districts. In Phase I, 24 project plans in districts have been proposed by state governments, and have been approved by the World Bank. More districts are to be covered by the Bank in Phase II subsequently. The World Bank project is intended to assist the GoI to "improve management performance... and to strengthen institutional structures for timely, co-ordinated utilization of project resources" (wb.2: 2).

Service Provision

The services that are proposed to be offered under the RCH are not entirely new; a bulk of the ‘package’ is an extension of services already being provided under the state’s programme. The government has added, on to existing family welfare and child health programmes, newer services intended to address reproductive morbidity and sexual health. As one document points out : “RCH is equivalent to Family Planning + CSSM + prevention of RTI/STD and AIDS + client approach to providing FW and Health Care Services” (goi.tm :3). The MoHFW distinguishes between two kinds of service packages, an Essential Package of service, and a special package⁷¹. The essential package includes services related to (a) prevention and management of unwanted pregnancy, (b) maternity care, including prenatal services (registration at the health centre, at least three pre-natal check ups, folic acid tablets, and tetanus toxide injections), delivery services, and post-partum services (breast feeding support, early identification of post natal sepsis, nutrition counselling, neonatal problems, etc.), and (c) child survival care, such as immunization, detection of high-risk cases as in low birth weight, etc. Special interventions relate to emergency obstetric care (in case of complicated pregnancy cases), and special programmes that have been sanctioned by the government for specific populations, like urban slums, tribal populations, and adolescents.

Not all the services provided by the government will be uniformly available throughout the country. Allocation of services is determined by two criteria. The first consideration is the *site of provision*, whether the point of service delivery is a sub-centre, PHC, CHC or district hospital. Not all the services available at the level of PHC will be available at the sub-centre, and not all services provided at the CHC/FRU will be provided at the PHC, and so on. For instance, tubal ligations, vasectomies, and medical terminations of pregnancies upto 8 weeks, will be available at the PHC level, but not at the sub-centre. Medical termination of pregnancies up to 20 weeks, on the other hand, will be provided only at district hospitals. The second consideration pertains to the characteristics of the population in which the health centre is located. For this, the government has

⁷¹ Pachauri (1996) distinguishes between an essential and an expanded package of resources. The essential package covers many of the services discussed in the text, while the expanded package includes prevention and treatment of gynaecological problems including cervical cancer and infertility, and screening and treatment of breast cancer.

categorised all districts in the country into 3 types - A, B, and C. This distinction has been made on the basis of Crude Birth Rate and Female Literacy Rate, which according to one policy document “reasonably reflect the RCH status of the districts” (goi.oc.5: 4)⁷². The categorization reflects the levels of reproductive health in various districts. In ‘C’ category districts, the status of RCH is poor, and is accompanied by low awareness, low education status and, often, low economic status as well. The infrastructure, roads and electricity are also generally weak in these districts (goi.oc.5). A and B level districts have better statistics to begin with and may not need the same kind of interventions that are proposed for C level districts. For instance, referral transport for women with complications in delivery, and belonging to indigent families has been proposed for C category districts (goi.oc. 5: 16). Women in these districts are likely to belong to lower income households and are at risk as they are likely to be assisted in delivery by untrained persons. However, the services of consultant gynaecologists will be made available to all the three category districts (wb.1). In all, there are 58 ‘A’ category districts, 184 ‘B’ category districts and 265 ‘C’ category districts.

The project also envisages phasing in interventions under the RCH by selecting certain districts for intervention in the first year, some more in the second, and so on. According to one document, in the first year, only those districts will be chosen which have the infrastructure to ensure that activities can start within six months of commencement of the project (wb.1).

The RCH also focuses on services that are not directly medical related. Counselling, and IEC activities form a core of the state’s services. Counselling refers mainly to issues around family planning, and also around broader concerns, such as identifying RTIs/STIs, appropriate nutrition, breast care, etc. One of the respondents in my interviews told me that the counsellor in the health centre would be a non-judgemental person whom women can turn to with their reproductive problems. He gave the example of a teenage girl who is pregnant. Given the social censure associated with pre-

⁷² Quite interestingly, in early draft policy documents (around 1995), the criterion for categorizing various states was intended to be the proportion of home to hospital based deliveries since neo-natal maternal and infant mortality is known to be closely linked to the level of hospital deliveries. If the above concept was accepted, the various states in the country would be divided into three major categories namely (1) states which have a very high proportion of home based deliveries (around 70 to 80%) (2) states which are evenly placed (50/50 of each type), and (3) states with a high proportion of hospital based deliveries (70 - 80%). These states would be C, B, and A respectively.

marital sex, it is likely that the girl will have nowhere to go. The counselling centre, in such a situation, will provide information about MTPs and related counselling under the strictest confidentiality to the person, with no requirement that parents be notified (Interview, I#7). IEC activities are proposed to be stepped up under the RCH. According to another respondent, unlike the pre-RCH days, when the messages for community propangada focused exclusively on the two-child norm, under the RCH, the messages are broader in the topics they cover (Interview, I#8). Special care is also taken for adolescent education. Topics related to the physiology and anatomy of the reproductive body, menstrual hygiene, conception, contraception, safe sex and sexually transmitted diseases were to be taught from high school level onward (approximately from age 14 onwards) (Interview, I# 2). Further, social issues, such as gender equality in sexual relationships, and responsible male sexual behaviour were also to be discussed with adolescents (Interview, I#13). In addition to IEC, the state also plans to invest in research and development, and especially aims to garner the resources of Indian Systems of Medicine into mainstream reproductive health interventions.

In sum, the state's provision of services encompasses a wide range of interventions that cover medical, social, organizational and management needs identified within the existing family welfare programme. The services that will be provided at the various sites of provision are given in the Appendix F.

Financing the RCH

The RCH is part of the overall Family Welfare Programme of the GoI, which is a centrally-sponsored programme. The financial commitment for the RCH programme during the first phase is expected to be around Rs. 5112.53 crores. In addition, the sub-projects funded by the World Bank will cost approximately Rs. 547.50 crores out of which Rs. 283.88 crores would be disbursed for projects in the first phase, and the remaining funds by the second phase period (goi.oc.3). The central government's programme is expected to be funded with external assistance from major international donor agencies. The major funding bodies for the RCH are the World Bank (total funds US\$ 480 million and US\$ 240 in Phase I and II, respectively), European Commission (ECU 200 million), UNFPA (US\$ 50 million), UNICEF (US\$ 150 million), ODA- UK (US\$ 21.1 million) and DANIDA (US\$ 9.00 million). The World Bank (WB) is the

largest external funder of the RCH. Kerala will receive approximately Rs. 4996.58 lakhs (approximately US\$ 120,000) in the first phase of the RCH sub-project. Agencies such as the ODA, DANIDA, UNFPA and UNICEF will support a limited number of budget items, mainly, training, institutional development, vaccines and selected equipment. The WB funds are proposed to be used for orientation workshops on RCH, institutional development through training, modified management information systems, local capacity enhancement, some operational costs and IEC activity (wb.1).

The funding scheme under the RCH must be critically evaluated against gaps and needs in the existing programme. Ravishankar (1996) points out the following shortcomings in the Indian Family Welfare programmes: (a) per capita expenditure on family welfare services in India is low by international standards, and has declined in real terms since 1991; (b) physical and human infrastructural ratios fall far short of prescribed norms, and operational costs such as fuel, drugs, and maintenance do not receive adequate funding; and (c) the most critical needs are for capital enhancement, mostly construction works. Ravishankar goes on to argue that funding for the RCH must be developed keeping in mind these weaknesses in the existing structure, and the proposed shift in emphasis of the programme. For instance, the move by the RCH towards quality oriented reproductive health will require greater contact between health providers and the community. This would then entail greater mobility for the providers. The government would then have to consider provision of vehicles as a necessary part of the programme. In Ravishankar's estimate, the funding for the RCH currently allocated will need to be supplemented with private sector services to fully address reproductive health requirements in the country.

Institutional Development

The institutional context in which the RCH is implemented is significant on three counts. First, the RCH as a programme of the MoHFW is a new creation within the ministry, and builds on new and existing organizational and institutional structures within the MoHFW and other government departments. A key aim of the RCH is to integrate the various programmes that are functioning alongside to achieve the same objectives in the field. An integrated health service is being seen as a primary institutional objective of the programme. In this regard, the MoHFW seeks the involvement of the

Ministries of Welfare, Urban Development, Rural Development, Departments of Health, Women and Child Development and Education. For instance, the MoHFW proposes to co-ordinate its programmes with the District Literacy Programme, headed by the District Magistrate, to link its messages of RCH and population control with the Total Literacy Campaign (goi.oc.3: 14). New institutions are also proposed to be set up for the operationalization of the RCH. For instance, the government plans to set up a Procurement Support Agency (PSA) at the national and state level to ensure supply of goods (equipment, medicines etc.) and services (of consultants, trainers, etc.) (goi.oc 3: 19; wb.1). A state level society called the State Committees on Voluntary Action (SCOVA) with the Chief Secretary⁷³ as Chairman and State Health Secretary as Vice-chairman for the disbursement of funds will also be activated under the programme. On another plane, relationships between existing institutions are being reviewed and reworked. At the district level, the RCH is being implemented at a time when the Panchayati Raj or local self government is also being operationalized, calling for closer ties between the health centres and local administration. Under the new system of self-government, the health centre administration and funding is a local community or panchayat concern. As a government document points out, the "...panchayati raj system will have a greater role in planning, implementation, and assessment of client satisfaction" (goi.oc.5, p. 4). Elected representatives of the panchayat discuss and decide service and administrative aspects of the local PHCs. In Kerala, at least, this has led to resentment among the medical staff, and a fractious relationship between the health system and local administration is an ongoing reality (Informal Interview).

Alongside these social and political liaisons, the government, under the umbrella of the RCH also proposes to enhance networking with local non-governmental organizations (NGOs), especially women's organizations and the private sector of health provision, especially those that provide Indian Systems of Medicine (ISMs). With regard to NGOs, the RCH documents note that the government system and the NGO functioning are actually "complementary in nature" (goi.oc.5: 34). The government proposes to capitalize on the NGOs' flexibility and rapport with the local community to attempt to set in place innovative programmes which may not be successful if undertaken by the state. At the village level, the RCH envisages small, grassroots NGOs being utilised for

⁷³ The Chief Secretary is the highest-ranking bureaucrat in each state.

advocacy of RCH/family welfare practices. 'Mother NGOs' or umbrella organizations for the smaller agencies are expected to provide training for grassroots NGO staff, so as to be more effective counsellors for family welfare. At the national level, the RCH sees a limited number of NGOs assisting the MoHFW in select programmes, such as running a baby-friendly project in hospitals. Similarly, these NGOs could help in enforcing the Pre-Natal Diagnostic Technique Act, which bans the sex determination of foetuses through amniocentosis. Finally, a limited number of NGOs may be mobilized for mobile clinics offering contraception (goi.oc.5).

The government also proposes to have closer liaison with the private non-voluntary health sector, both in western and traditional forms of medicine. In many states the private hospital system is far more developed than the public sector. In Kerala, for instance, 78 percent of hospitals are managed by the private sector, while the state provides 22 percent of hospital beds (Interview, I#4). The government proposes to capitalize on this advantage that the private sector has, and provide only those services that cannot be offered by the private sector (see Chapter 6 for a critical analysis of the public-private discourses of the state). Similarly, the government sees closer ties with indigenous systems of medicine, providing funding for research, and development of plantations of medicinal plants in wastelands, and denuded forests (goi.oc.5: 24).

Monitoring and Evaluation

One of the most important changes with the shift to a reproductive health programme has been the need to find appropriate methods to monitor and evaluate the programme, especially the quality oriented aspects of the programme. The family welfare programme has a tradition of recording elaborate statistics in various registers; under the RCH an attempt is being made to integrate related information into one report (Murthy 1999). The government constituted a committee to study and recommend appropriate measures that could be used to evaluate performance and service quality. The committee evolved a new monitoring and evaluation system, which has three main components (Pathak, Ram and Varma 1999):

1. Monthly activity reports from the sub-centre, primary health care centre, and first referral unit: The monthly activity reports record information on a range of activities, including, antenatal, natal and postnatal care, childhood diseases, maternal deaths, immunization, communicable diseases, etc. Alongside these conventional indicators some new ones have also been added, that is complicated deliveries referred to the FRUs, RTIs/STIs detected, adverse reactions to immunization, interactions with panchayat health committee, anganwadis, mahila sanghs, and the community.
2. Technical assessment of sub-centre level services by a woman health visitor: A woman health inspector is expected to conduct a technical assessment of sub-centre level services. They will check, for instance, the accuracy of ANM records, the technical skills of the ANM, availability of equipment and supplies, and clients' knowledge and perceptions of service delivery. This information will also feed into ANM training.
3. Rapid Household Surveys and Facility Surveys by Independent Agencies: The government intends to undertake household surveys in 50 percent of the districts each year. The sample for the survey consists of about 1000 households in each district. Two sets of questionnaires are to be used. The first examines service coverage and quality of public health services, and targets married women in the reproductive age group, and women who have given birth in the previous three years. In addition, a second set of questions explored clients' perceptions about the government's services and questions on awareness about RTIs, STIs, and HIV/AIDS. This questionnaire includes male respondents as well, regardless of marital status. These surveys are expected to provide not only managerially useful information, but also give the clients an opportunity to express their views about the reproductive health services.

Assessments of these monitoring indicators have, by and large, been seen as a step in the right direction (Murthy 1999; Pathak et al. 1999; Townsend and Khan 1996). It is expected that with the various levels of evaluative data that is collected, individual states can chart their own priorities and modify their services in an appropriate way.

Design of the RCH programme in Kerala

The RCH programme is administered in Kerala under the Department of Family Welfare, and the Directorate of Health Services (DHS) of the Kerala government. Kerala became one of the first states to be declared target free in 1995. The RCH programme was formally instituted in August 1996. One of the primary activities under the RCH (at the time of my field work) was the state-wide training of trainers and ANMs in the TFA and RCH programmes. Given Kerala's achievement in the population field, it is not surprising that in the district categorization schema used by the GoI, Kerala has 12 out of its 14 districts in the 'A' category, while the remaining two are 'B' category districts⁷⁴. This categorization is reflective of the high levels of health, and low levels of mortality and morbidity that prevail in the state. My interviews revealed what the policy makers and enactors felt about the introduction of the policy in Kerala. By and large, the respondents felt that the RCH was an important introduction that would benefit the existing health system, although not quite in the way that the Central government was expecting the RCH to impact in other states in the country. As Kerala had already achieved most of the goals the GoI had set for the country to achieve by 2000, the officials in the state saw the RCH as facilitating the "extension" of these existing indicators. As a consequence, the aim of the RCH in Kerala is, purportedly, focused on improving the quality of health services (Interviews). Some of the following comments from officials underscore this view:

I#7: Of course, we have attained a lot of the parameters that are expected to be covered by 2000 A.D. But whatever things we have achieved, we have to sustain that achievement and not only that we have to go for a research set up so that more areas [are] to be addressed.

I#4: I see it [the shift to the RCH] as providing an opportunity for the state to make a kind of transition which is dictated by the present state of development of health provision in the state.

The "present state of development of health provision" that the official refers to is indicative of the widespread view amongst providers that the RCH, with its emphases on

⁷⁴ Both the health centre sites that I had chosen for grassroots interviews were located in 'A' category districts.

child and maternal health, is more relevant for the less developed areas of Northern India (Interviews I#9; I#12). The RCH is seen as an opportunity to focus on the improvement of the quality of the services provided, rather than strive to meet the basic requirements of a health system prescribed by the GoI.

The implementation of the RCH programme in Kerala is being undertaken as two projects, one funded by the UNFPA and the other by the World Bank. The World Bank project in Kerala itself has two components: (a) a State-wide Implementation Plan (SIP), and (b) two districts, Palaghat and Kozhikode that have been selected under the World Bank RCH project in India. The proposal for funding to the WB was for a total of Rs. 35 crores, with Rs. 18 crores meant for Palaghat District, Rs. 12 crores for Kozhikode, and the rest for the SIP (Interview I#2)⁷⁵. The SIP submitted to the WB has been prepared along strict guidelines set out by the World Bank in conjunction with the GoI. I was told by respondents (e.g., interview I#2) that the Government of Kerala had little flexibility over the items and agenda that had been set as priority areas for improvement. The SIP contains proposals for improving infrastructure, training, IEC activities and equipment purchases.

The UNFPA project in Kerala also has two sub-projects. The first, which was the implementation of a RH project in the 'B' category district of Malappuram, was already underway at the time of my fieldwork in 1997. Under the Malappuram project, the UNFPA had sanctioned around Rs. 2.6 crores for the Kerala Government to carry out an approved programme in the selected district. In addition, the UNFPA had also sanctioned a sum of Rs. 24 crores to the Kerala government for the implementation of Integrated Population and Development (IPD) projects during 1998-2001. The IPD projects are to cover Kasargod, Waynad, and Kannur districts (gok.obp.9)⁷⁶. The IPD projects are to consist of two kinds of intervention, the first of which is a Reproductive Health Intervention (for which 75 percent of funds will be set aside). This will be supported by sectoral interventions in population education, information,

⁷⁵ These statistics are based on information provided to me in 1997-98. The actual amounts subsequently sanctioned by the World Bank are not available.

⁷⁶ The original proposal also included Alleppey urban slums, but I was informed in interviews (I#2) that the UNFPA had rejected Alleppey as it could not strictly be classified as a backward area.

communication, advocacy, gender equality, equity and women's empowerment and youth, for which 25 percent of funds will be used.

The approach to designing a reproductive health intervention is different in the WB and UNFPA projects. While the WB project is a Norm Based one (in that the project design follows strict pre-determined guidelines and objectives), the UNFPA project follows a Need-Based assessment (Interview I#2). In the Need-Based assessment approach, rather than work with pre-set norms, the UNFPA constituted a team of experts, that included reproductive health, gender, and educational consultants. The UNFPA team conducted a situational analysis, namely, they assessed the needs of communities through visits, interviews and consultations in various parts of the state, and used these assessments as the basis for planning interventions in the state. In addition to these programmes, the Government of India had also selected Malappuram district for a Social Safety Net scheme. Under this scheme, the government plans to spend Rs. 10 lakhs a year to improve infrastructural facilities in 15 PHCs over a period of three years in this district.

The RCH schemes formulated for Kerala strive to give representation to women's reproductive health needs. The World Bank project plans to constitute a District Reproductive and Child Health Society (DRCHS) that includes a representative each from a developmental NGO and a women's organization (wb.1). The UNFPA project gives attention especially to issues of gender equality and equity. Their interventions include programmes for empowering women for increased participation in decision-making within the community and family (gok.obp.9). These programmes (in the proposed format) aim to contain elements of personality building to increase women's self-assurance and self-esteem, provision of information on their rights, government social and economic schemes, and special schemes for adolescent girls (gok.obp.9).

In my interviews with officials and health providers, I also probed what might be the advantages of instituting the new programme in Kerala. Respondents pointed out that women stood to benefit from the RCH (elaborated in Chapter 8) as did the health system. In particular, the removal of the regime of targets was seen as a great relief for the grassroots providers – as one middle-level policy maker in the DFW commented:

I#1: They seem to understand that some burden has been taken from their shoulder. That element of compulsion – they used to be punished earlier. If their achievements were low, if it was below 29 percent, they used to get punishment transfers. The best performing persons would receive State or District level awards...the removal of that element is a big relief.

I also asked participants about the obstacles that would be faced in implementing the RCH in Kerala. Most of the responses reflected intra-organizational issues as crucial to the successful implementation of the programme. There were those who felt that personnel shortages were the most pressing need in Kerala, and unless vacancies in the various organizational levels were filled, it was unlikely that the implementation would be absolutely successful (I#2). Other responses suggested that the attitudes of ANMs to the new work ethos was likely to be met in the initial stages with resistance – in the immediate context, their workload had increased, and they had to adopt interactive relationships with individuals which they have not been used to in the past. There was also the fear that now elaborating on the disadvantages of contraceptive methods (when earlier they had deliberately not educated local people about these adverse reactions) could raise ill feelings in the community towards them.

The RCH in 1997

From my interviews and informal conversations, it was clear that the RCH in Kerala was still in its early stages. In August 1997, the Directorate of Health Services had begun a series of training programmes for health providers at various levels of health system. The first phase of orientation programmes, the training of trainers, had already been completed. In addition, grassroots workers – the ANMs – had undergone training related to the TFA. At the level of policy, the state government was anticipating the outcome of the various proposals that had been put forward to the World Bank and the UNFPA.

In an informal follow-up interview that I had with a senior level bureaucrat in April 2001, I learnt of the state's activities since 1997 under the RCH. The World Bank's RCH project, I was told, was particularly beneficial to the DFW's services. The WB funding

for the project is a flexible one, allowing the state-level DFW to utilize grants for needs that the state identifies. Under this project, the state was able to improve obstetric services in the PHCs in the peripheral areas so as to reduce the load on larger hospitals. The DFW was also able to institute a hospital level monitoring strategy (thus far, any monitoring of health services had been done at the district level). Under the UNFPA funded projects, a gender specialist had been appointed at the Kerala Institute for Local Administration (KILA) who trains local leaders in gender issues as part of the state-wide Panchayat or local government training programmes. The State Women's Commission had also been commissioned by the DFW to conduct around five studies on various gender issues such as violence, legal frameworks, etc. As part of the Life Cycle approach, a cervical screening programme for women over 45 years of age is being instituted. Under the European Commission's grants to the state, there has been a focus on health sector reforms particularly an evaluation of the tasks undertaken by the various functionaries of the state.

Conclusion

This chapter presented an overview of the family planning programme in India, in particular, the Reproductive and Child Health programme. Aspects related to services, budget, training, and institutional change were examined. The chapter also attempted to examine some of the salient features of the programme as it is being instituted in Kerala. While it was too early (at the time of my interviews) to evaluate the success of the programme in Kerala, it was, by and large, felt that the various objectives in the RCH were likely to be met in the current phase of the programme. The following chapters present my analysis of dominant discourses found within the text of the RCH document and interviews with policy makers. The next chapter focuses on the various manifestations of a neo-liberal discourse in reproductive health policy.

VI

TRACING NEO-LIBERAL RHETORIC IN THE RCH Constructing State and Citizen within Market Paradigms

Mr. Thakur [Union Minister for Health and Family Welfare in India] said the National Population Policy 2000 envisaged a paradigm shift in programme management and implementation. *For undertaking such a gigantic task, the Minister sought the participation of the corporate sector.*

The Hindustan Times, Wednesday July 12, 2000 (emphasis mine)

This chapter presents the first of my analytical investigations into the kinds of ideologies reflected in policy documents and interviews. In the present chapter, I explore traces of neo-liberal discourses in the RCH policy. A foremost demonstration of this discourse is seen in the way the state seeks to set up the health system as a market operation in which it (the state) is a provider. I demonstrate that traces of the market are reflected primarily along two discursive locations in the policy, namely, (a) in discussions of what is perceived as the functional role of the state as provider of family welfare services, and (b) in the construction of users of the programme.

In what follows, I argue that the ‘paradigmatic’ shift to a Reproductive and Child Health programme is situated within the broader context of the state’s adoption of a market model to deliver family planning services. As the language of the market dominates policy objectives and strategies, a critical dimension that has undergone re-evaluation is the individual or the user’s role in relation to public health services and, eventually, the state. Following Fairclough (1992), I contend that the individual in the context of market development in India is confronted by antagonistic influences challenging her/his position

in the state – that of democratization, on the one hand, and commodification, on the other. The preponderance of one over the other has discursive as well as material implications. This chapter is organized as follows. The first section examines the state's rationale for introducing the RCH. The second unpacks the manner in which users are positioned in the policy. In the third section, I demonstrate the implications of the constructions of state-individual relationships vis-à-vis family welfare and reproductive health care. A discussion of the analysis and a concluding section sum up the chapter.

Discursive Locations: the Intent of the Programme

The RCH documents indicate that the government's reproductive health policy is informed in its programme objectives and strategies by two kinds of rationales: a first is drawn from a systematic assessment of the earlier programme shortcomings and the second, from a concern with the satisfaction of programme's users. As noted in the earlier chapter, the RCH programme aims to provide a range of both relevant and quality services to the users of the state's programme, to develop community-level structures for participation in the planning and implementation of programmes, and finally, to improve the efficiency of the programme delivery system. These objectives were derived from the observation that there were specific lacunae in the existing programme that needed to be addressed. First, there has been concern that people "have not availed family welfare services to the desired extent" (Department of Family Welfare n.d.), a testimony to the poor quality of services that has been proffered by the government. Second, there has also been concern that "deficiencies in the implementation of the maternal and child health services have been responsible for a high incidence of maternal mortality and child/infant mortality and low health status of women and children" (goi.oc.5:1-2). This concern, statistically supported, has ramifications for the number of children that are likely to be desired by families, and ultimately, birth rates for the country as a whole. A third lacuna cited in the policy documents reflects deficiencies in the family welfare delivery system. Documents (e.g., goi.oc.3; goi.oc.5) note that over the years several programmes co-existed with similar objectives but were being run simultaneously under different identities, either by the same government body or various agencies, tending to diffuse the efforts of the state and its agencies in the specific area of family welfare. As the document goi.oc.5:1 notes, "[w]hile...these programmes did have a beneficial impact...the separate identity for each programme was causing problems in its effective management and...was also reducing somewhat the outcomes". What is

recognized as a pertinent need is the integration of these several programmes for efficient management and optimum outcomes. Most of the programmes introduced under the CSSM, for this reason, had resulted in “indifferent success” (goi.tm.2:2). Further, it was pointed out that an “integrated RCH would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would optimise outcomes at the field level” (goi.oc.3:2). Specific weaknesses in the existing programme are seen especially in the area of neonatal care, reproductive tract infections/sexually transmitted diseases, obstetric care, MTP, delivery of services to urban slums and tribal areas and inadequate promotion of traditional systems of medicine.

A fourth shortcoming identified in the policy documents is the “inadequacy of the investment made for Family Welfare” (goi.oc.5:2). This has severe implications when considering that, “in almost all respects, the health care system needs up-gradation and it needs to reach out to many more people” (goi.oc.5: 2). The Approach Paper to the Ninth Plan, the document notes, has highlighted that there is a severe inadequacy of investment in the family welfare sector in comparison to the 7th and 8th Plan (goi.oc.3: 4) and is likely to hinder the government’s objective of “reducing the unmet need, increasing service coverage and ensuring quality of care” in its programmes (goi.tm.2:1).

It would seem that the RCH is juxtaposed between two imperatives of the state. On the one hand, the state acknowledges that user-satisfaction and needs are central, and that the state must be responsive to those needs. On the other, the state recognizes system-specific weaknesses that need to be addressed through institutional reform. The concern with strengthening the institutional base of family welfare services reflects the language of health sector reforms that are being implemented around the world. Against a backdrop of structural adjustment or restructuring since the 1980s, the health sector in countries of the North and South has been subject to debates about financing, resource allocation and efficient management (Standing 1999, 2000). What is increasingly recognized is that these reforms are not merely organizational or structural but involve redefining relationships between sets of institutional actors in the arena of health delivery - the state, service

providers, other health bodies and users (Standing 1999, 2000)⁷⁷. In the context of the RCH, the intent to reform the health and family welfare system has been motivated by the objectives resonant of market conditions: quality improvement, efficiency outputs and optimum results. However, the improvement of the family welfare delivery system is also substantially dependent on reworking the relationship between the state and individual in the provision of public goods, i.e., family welfare services. Document goi.oc.5:3, for instance, points out the various kinds of institutional arrangements that will ensure success of the RCH, such as *gaining support* for the policy through interventions by local leaders, *increasing accountability* of health workers to citizens, and increasing inter-sectoral collaboration with other government departments that are involved in *improving literacy* and economic conditions of the population⁷⁸. The face of the health sector reforms demands considerable re-writing of the public health service's conventional relationships with its users, especially with respect to devolution of rights and increasing accountability to citizens.

As the RCH adopts the language of reform, there is a clear shifting of discursive locations for the individual user of family welfare services. In the following section, I examine the references made to users of the family welfare programmes in the policy. Arguing that these references reflect a particular positioning of the user, I unpack the implications of this positioning. By positioning, I mean the manner in which users of the programme are constructed, and the relationship, especially in terms of rights and obligations, that the state defines on the basis of this construction.

The RCH and Construction of Individuals

The RCH policy documents tend to refer to users of Family Welfare services as 'individuals', 'beneficiaries', 'citizens', 'consumers' and more dominantly, as 'clients'. The policy documents emphasize that the RCH programme is "need based, *client-centred*, demand driven, high quality and integrated" (goi.oc.5:3) and that the family welfare system will take a "*client-centred* approach to service provision" (Department of Family Welfare n.d.). A World Bank report evaluating the RCH in India pointed out that India's Family Welfare

⁷⁷ Standing (1999) notes that there are two agendas leading to health sector reform: the regulation of health expenditure is an outcome of economic expediency, whereas specific issues of institutional reform reflect deeper concerns with role of the state and public governance.

⁷⁸ Unless otherwise stated, all emphases of document and interview texts are my own addition.

Programme aims to carry out the commitment given at Cairo “to implement a *client-centred* approach that responds more effectively to the reproductive health and family planning needs of women and men in India”. (Measham and Heaver 1996: 1). Further, the Target Free Approach emphasizes:

- Bottom-up planning from sub-centre to national level with a focus on *client choice* and high quality service
- A *participatory two-way interaction between workers and clients* to assess the felt needs of clients
- *Helping clients meet their needs* on the basis of existing services, and
- Improving the quality of services to meet *client needs* both on a priority and long term basis (goi.tm.3:2)

The use of the term “client” to refer to users is an innovation within development/welfare policies in India where targets of programmes have been conventionally referred to in the Government system as “recipients” or “beneficiaries”, underscoring an unequal if altruistic relationship between the state and the individual (Jayal 1994). In contrast, the use of a client-provider relationship is typical of the language of reform, especially in restructuring public services (McGuire 1997), where altruism has given way to the rhetoric of contractualism. The incorporation of the term “client” in the Indian family welfare service cannot be seen merely as a cosmetic change in the semantics of officialese. The entire approach to programme management in the family welfare services is built on assumptions of client behaviour, client needs, and services that will satisfy clients. The user is recognized as the key person in the planning process (“...they [users] are also planners for the providers”, according to interviewee I#4). One policy document, for instance, notes that, “...the shift in the philosophy of the programme calls for community participation for planning, implementing and monitoring” so as to make it a “*people’s programme*” (goi.tm.1:1).

In the context of the RCH programme in India, the use of the terms ‘consumer’ and ‘client’ appears to be a deliberate step-up for the users of the family welfare services. The shift in construction of users from mere ‘beneficiaries’ to ‘clients’ is one that is resonant with the notion of rights in terms of decision-making and participation in the programme design. For instance, I asked a senior bureaucrat at the Family Welfare Department about the predilection for the use of the term ‘client’ instead of ‘beneficiary’. His response was that:

I# 4:

Beneficiary means charity, we are not charity. *This is not charity...they are not beneficiaries.* They are getting the results of what they are paying for. *And they have a right to [it]...they have a right to decide what kind of services they get.*

I asked similar questions to middle-level bureaucrats within the DFW and DHS to understand their interpretation of the construction of the notion of the “client” in the family welfare services in Kerala. Their responses (reproduced below) established that the kind of relationship that was expected between the State and the user in the new set-up was distinctly different from the one that had prevailed prior to the institution of the RCH. For instance, some middle-level bureaucrats told me that:

I#2:

Now it is emphasized that it should be quality services, and it should be client-centred approach. We should know the needs of the clients...*the decision should be from the clients' side.* It shouldn't be that we make the decisions for them. All they need is help to make the decisions- that is the attitude.

I # 7:

[The] decision is taken by the clients themselves. It is a client-centred one. You just help them, you just make them aware these are the services we are giving them. They decide which one is suitable. That kind of change is come....

I#6:

The quality service should be given to the acceptors of the family welfare programme. And the Government of India has already discussed and [has made . it] in the Plan discussion that *the client should be given the quality service* to the maximum possible level at their door step or to the institution where they prefer to conduct that...

The policy makers construct the position of the “client” as that of an individual who has agency within the production and implementation of policy. The client was the centre of the policy, and the satisfaction of the client was projected as the key objective of the RCH. Even when policy makers referred to users as “beneficiaries”, it was to denote a sense of empowerment among the users of the services. There was a distinct positioning of users as being the ones who direct the course of action in the programme.

I#1:

Now [after the RCH] *the decision-maker is the beneficiary* himself or herself. It is the recipient. Whoever is coming to receive it [contraceptive methods] is the decision-maker. It is not ours. We [just] tell them all the methods....

I#12:

So it is aimed towards people, towards *the beneficiary*...how well a service [can] be given to them.

The use of the term ‘clients’ was not restricted to the government sector of policy makers. The representative of a non-governmental women’s activist group, whom I interviewed used similar language to refer to users. For instance:

I#5:

...we also wanted, through dialogues and discussion...to understand...how things have changed for both *the providers and the clients*.

In one case, an official referred to the users as “consumers”, and I clarified the usage:

I#4:

We are using this opportunity to move away from a provider-oriented provision of services towards something *where the consumer* has at least a slightly more important role than what he has right now.

Q: Is that how you see your clients – as consumers?

You know, consumer... means anyone in any economic transaction – you are person who provides and you are the person who consumes. And now these persons are consumers.

The client, for all practical purposes, has been made the pivotal figure on which the policy’s strategic interventions has been rationalized. In this set up, the state is positioned as a provider who is not an “outsider” but someone whose main interest is the user’s well being. Its role was to guide and help, but never to make decisions for the clients. The policy asserts that the “thrust of the programme *will be to satisfy* the communities served by the health facilities”(goi.tm.2: 1). As the RCH document states,...”[i]n the final analysis, *what people want is the same as [what] the health administrators*, health providers and reproductive health researchers want, ‘a happy and healthy life for men and women without fear of disease and unwanted pregnancy” (goi.obp.1: 37). These comments indicate devolution of responsibility for designing people-friendly policy from the state to the community. The sense of

partnership between the state and citizens, increased grass-roots participation and community involvement are evident in the comments below:

I# 8:

[The community's] representatives would have discussed their needs with them. *So we should try and do according to that...now there is much importance for community involvement...*

(I ask the interviewee to define community involvement)

[Earlier]...according to the government, suppose you have to do an ORT (Oral Rehydration Therapy) programme...so the ORT programme will be done. We did not enquire into their needs. It is not like that now. When we say community involvement -- community leaders, voluntary organizations, local bodies, etc. will draw up a plan of action.

I# 11:

Now, first they [the ANMs] have to go and make contact with them [the community]. Contact means find out their needs. Go to each place and understand. Now there is more community participation. I think there will be more benefits because of it.

I#3:

...because the RCH is being implemented under the target free approach, one hopes that there will be much more community involvement. I mean the plans are made from the sub-centre, then it goes up to the district level. What is to be achieved is set at the state level and the district level. So that way it is quite different. *We're supposed to [involve] the NGOs and people in the community and make the plans at the sub-centre.*

As is clear from the various excerpts above, the participants drew on a range of terms to refer to the users. In so doing, the policy makers unwittingly assigned specific attributes and roles to the main actors: the state and the users. Note the words that accompany the use of the term client, on the one hand, - "decision-maker", "right", "payers" - and those which describe the state's role, on the other, - "help", "we do according to their needs", "decisions are not ours", "find out their needs". At first reading, the erasure of the arcane State-Individual relationship of altruism/charity is striking. In its place, a client-provider relationship denotes a non-hierarchical professionalism. It also lays down the ground rules for the kind of claims that the individual can make on the state. The excerpts (particularly, I# 4) indicate that the user as consumer/client has the right to expect goods and services from the state. The user also has the right to demand the kind of services s/he expects. And

finally, s/he has the right to expect that the goods/services s/he receives will address her/his specific needs. As respondent I#4 pointed out: "...they [the clients] are also *planners* for the providers".

Two significant analytical insights can be drawn from the reference to and positioning of users as clients/consumers. First, a pre-dominant trend was the tendency to draw on market/neo-classical economic frames of references to construct users. The 'client' is akin to the idealised consumer of the market place, an individual who by virtue of her/his paying capabilities has the right to set the rules for the kind of goods s/he needs. All the attendant terms associated with the use of the term 'client' such as quality services, rights, and needs, ground the user as an actor/agent in a market-operated context. Second, the RCH documents also tend to move between the terms 'clients' and 'citizens', collapsing the rights of the client with that of the citizen - "[i]t is the legitimate *right of the citizens* to be able to experience sound Reproductive and Child Health..."(goi.oc.5:3). The notion of "*nights*" in this context marks a fluid terrain that portrays users as consumers/clients and citizens; as citizens, they have the right to reproductive health⁷⁹, and as consumer/clients within a market paradigm, they have the right to the services they demand. The public space of citizen rights, therefore, becomes merged with the market place of consumer tastes.

Further, by the continuous invoking of the imagery of consumer/client, the state situates the citizen within a broader framework of contractual relationships that are typically associated with neo-liberalism (Hindess 1997). From the comments of the official I#4, "...[t]hey have a right as people who paid for it. They have a right to decide what kind of services they should get", it would seem that the fundamental criteria for entering into this contractual relationship with the state is the ability to participate in monetary transactions with the state. This last aspect will be explored at length below, but first I review some literature that examines client/citizen-State relationships under market paradigms.

⁷⁹ This 'right' can be interpreted from within T.H. Marshall's (1950) definition of social citizenship, i.e., the right of citizens to have a basic level of well-being, and from the international charters that affirm that people have human rights to health and benefits of scientific progress (see among others, Boland et al 1994, Cook 1993).

Market Rhetoric And Citizens As ‘Clients’: An Overview

The use of a market analogy to redefine the state’s social services in the wake of economic restructuring in both the North and the South, especially in health and education, has been an increasingly common strategy since the early 1980s (McGuire 1997; Whitty 1998). The strategy imposes market or economic criteria on resource allocation decisions and public accessibility conditions, and tends to focus on efficiency and effectiveness of outcomes of services provided by the state (Standing 1999). The language and strategies of corporate management has filtered liberally into public service administration. Cost recovery, increased linkages with the private sector, and the institution of insurance schemes, for instance, are among the strategies that have become familiar in economies that have restructured their health services.

Locating the user has been an especially important part of this process. The positioning of users of public services as ‘clients’ has had ambivalent connotations in the context of western societies. As consumers of the state’s restructured user-payee services, ‘clients’ are revered as investors of a growing enterprise, whereas as recipients of the states’ social welfare benefits, the term ‘clients’ is reduced to an official condescension. As consumers, the state has often enough propagated the ‘empowerment’ of clients by offering them ‘choices’, and the benefits of competition. In the 1990s, changing the culture of public access to a client-oriented one is widespread (McGuire 1997).

By the same token, ‘clients’ also refer to people who are dependent on the government for social welfare provisions. Fraser (1989b: 152) examined the US social welfare system and found that social welfare claimants get positioned either as “purchasing consumers” or “dependent clients”⁸⁰. Both these subject positions tend not to empower recipients, largely because these constructions do not construct them as active co-participants involved in shaping their life conditions. Instead, bureaucracy imposes administrative definitions, hindering opportunity for individuals to define their own conditions, and thereby, needs. In contrast to the construction of the rights bearing ‘client/consumer’ of the market-state,

⁸⁰Fraser points out that although both these subject positions are disempowering, the latter i.e., dependent clients, is considered to be an inferior position. In the case of purchasing consumers - who incidentally are predominantly male - they are assessed for benefits on the basis of their monetary contributions as workers and, hence, their claims upon the state are rights bearing or they are seen as possessive individuals. Dependent clients who are assessed in terms of their ascriptive status (as mothers or spouse) are in Fraser’s words, “negatives of possessive individuals”(1989b: 152).

there is a repressive aspect to the relationship between clients and bureaucracy. The derogatory status of welfare 'clients' has worsened under the discourse of the market and Reagonomics, and the deterioration of the welfare state. Individuals unable to be workers or producers in the economy are considered as unfit citizens (Hindess 1997).

Despite the allure of improved quality of services, the imposition of market standards on public goods has been critiqued for re-orienting state-citizen relationships in ways that are problematic for the exercise of rights of individuals as citizens. McGuire (1997) argues that in projecting citizens as clients, the state rescinds its obligation to citizens to pursue goals of social justice. McGuire notes that the function of public services is not to produce efficient outcomes but to enhance social justice and facilitate collective consumption, namely, that "efficiency must be subsumed to equity" (Deming, cited in McGuire 1997:114). By detracting from an objective of equity, the gap between the 'haves' and 'have-nots' in society can only be aggravated. Imposing the criterion of purchasing power for public services restricts accessibility to the state's public goods, just as the dictum of economic independence from the state positions welfare recipients within a forced and unequal bargaining relationship as citizens within the state (Hindess 1997). Often, beneath purportedly gender-neutral norms, the marketized health systems have disproportionate impacts on women and other disadvantaged groups (Whitty 1998). Standing (1999) points out that in developing contexts, there have been specific gendered impacts in the wake of health sector reforms aimed at efficiency. For example, she notes that, when cost recovery through institution of user charges were effected in Nigeria, maternal deaths in the Zaria region rose by 56 percent along with a decline of 46 percent in the number of deliveries in the main hospitals. Similarly, the reduction of preventive services (as opposed to paid curative services) is likely to have more implications for women. Examining the 'rights' to efficient services of the 'client' should be within a framework that considers these larger determining factors (Standing 1999).

Similarly, McGuire (1997) also questions the politics of positioning users of public services as 'clients'. She argues that the relationship between consumer, customer (who purchases services), client (who co-produces) and provider (who delivers) is more complex in a public service than in the private sector. In the latter, the customer pays for the services that the firm produces. In public services, there are multiple stakeholders and each of them has

multiple identities simultaneously. For example, as citizens, individuals want equitable access to public services. As owners, they have the right to expect efficient outcomes for the investment they make into services (as tax). As the ‘consumer/client’, they would expect reliability and quality as outcomes of services. Given these multiple interests of citizen/individuals, it is not easy to separate one set of needs or privilege one identity of the citizen/individual. In projecting the citizen as primarily a consumer or owner, the state narrows the concept of citizen and citizen-needs to a limited set of issues.

The critical review of the use of the term ‘client’ in specific contexts underscores the multiple subject positions (and resulting differential implications) that a user of public services can have. The initial excerpts that I examined above seemed to give a broad agenda of decision-making abilities (in terms of how the programme should be tailored for individuals, couples and communities) to the client in the RCH programme. What exactly are the terms of the ‘contract’ that the clients of the family welfare programme are bound by? In this regard, it proves meaningful to unpack the notion of ‘client’ as it has been used in the RCH documents and as interpreted by policy makers within the family welfare system in Kerala.

Unpacking The ‘Client’ In The RCH

The use of the term notwithstanding, the RCH policy’s ‘client’ holds a unique discursive space in the ideology of the state and eventually, in the material form of policy. In this section, I propose to demonstrate the ways in which policy documents and interviews construct the ‘client’s’ agency, and facilitate (or limit) the opportunity for the citizen/user to behave as a purchasing consumer. I examine the characterization of the client with respect to four attributes: (a) freedom to represent individual needs, (b) endowment of rational behaviour, (c) potential to have access to health, and finally, (d) ability to identify needs.

Freedom: individual needs versus national needs

The policy documents are clear that the RCH has been instituted to fulfill specific national goals set down as priorities by the Government of India. The policy reiterates that the government’s fundamental focus on fertility reduction remains a central concern, and continues to be a major consideration in the design and promotion of family welfare

programmes. Document goi.oc.5:1 points out that “the main objective of the Family Welfare Programme for the country has been *to stabilize population at a level consistent with the needs of national development*”. Similarly, document goi.tfa: 1 categorically underscores that the “objective of the Family Planning Programme is to *reduce the birth rate*”. The RCH programme’s primary objective is informed by this national need: “the RCH Programme intends to integrate fertility regulation, Maternal and Child Health with reproductive health services such as screening, diagnosis and treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Infections (STIs), *with the aim to reduce infant and maternal mortality and morbidity and unwanted fertility, thereby, eventually contributing to stabilization of population growth and improv[ing] the health status of women and children*”(goi.oc.1:1). Another document lays out a similar objective: “...[t]he Approach Paper to the Ninth Plan brought out by the Planning Commission has identified reduction in infant mortality, [and] maternal mortality *for bringing about reduction in the desired level of fertility as one of the most important objectives during the Ninth Plan*. It has identified the RCH at the Primary Health Care (PHC) level as part of the strategy for achieving health goals in the Ninth plan” (goi.oc.3: 4). So also, another core policy document of the RCH notes that the fundamental obligation of the Indian Government is to the state’s national goals:

...the RCH Programme will seek to provide relevant services for assuring Reproductive and Child Health to all citizens. *However, RCH is even more relevant for obtaining the objective of stable population for the country. The overall objective since the beginning has been that the population of the country should be stabilized at a level consistent with the requirement of national development* (goi.oc.5: 3).

The state’s commitment to re-organizing state-individual relationship and centring the ‘client’ is mitigated, as seen above, by the overriding concern with population control and national development.

Against the above emphasis of the state, the government statement that “the overall strategy of the Government of India (Department of Family Welfare) is to *simultaneously* strive for obtaining Reproductive and Child Health arrangements for the whole of the country *and* to promote and make available contraceptive/terminal methods for desirous couples” (goi.oc.5: 3) must be deconstructed in terms of individual rights. The simultaneous emphasis on the dual focus of enhancing individual freedoms and reaching state goals can result in an inherent contradiction in the state’s commitments. Its commitment to individual

interests, for instance, can potentially be at odds with its national needs, while enforcement, of any kind, of national goals is in direct opposition to individual freedoms which form the foundation for individuals to exercise their legitimate rights as citizens. The quotes above from goi.oc.5, in particular, clearly indicate the potential for conflict in the policy; the ‘legitimate right’ of the citizen only partially justifies the functional significance of the RCH. In the final analysis, the RCH gains validity because it is ‘even more relevant’ for obtaining the objectives of fertility control and eventually, national development and economic growth. There is a subtle tension in the policy, and an undeniable privileging of national needs over individual needs.

In my interviews as well, the privileging of national objectives was evident. I reproduce some of the comments made by senior and middle-level bureaucrats:

I #6:

Two-family norm⁸¹ is a Government of India policy. Limit the family size. So whatever it is, whatever policy we have addressing [to the] family identities, it is always addressing the limitation of the family. *That has not been changed.* But we are changing the service-provider point of view and the client service - that is, [providing] quality service.

I#1:

Fertility control certainly is an objective but then we differ because we assess the need, you explain whatever fertility control methods are available to the beneficiary, to the eligible couples. You present them the whole different methods, maybe temporary or permanent. You present all this to them and you allow them to choose the method they want to adopt.

It is interesting that upon clarification, the initial enthusiasm for expressing that “clients are decision-makers” has been muted. The officials above, confronted with the need to frame individual rights against the state’s agenda of fertility control, interpret “freedom” within the broader commitment of conformity to the state’s priorities. The individual/citizen’s freedom to exercise her/his rights was posed as the state’s ability to try to be sensitive to consumer needs. In this case, it becomes an issue of service delivery – client “rights” becomes an issue of improvement in the way public service is produced, distributed and accepted.

⁸¹ The two-family norm refers to the Government of India’s ‘propaganda’ that the ideal family should not have more than two children.

The question that becomes the key issue at this point is: as the citizen evolves into a consumer, is the right to well being enhanced or limited by the imperatives of the market? The comments by the policy makers in the excerpts above would suggest that the client does not control the terms of the market discourse, but can operate with some freedom within its parameters. In the language of contractualism, the relationship between the state and individual established discursively is less underwritten by the presumption of the autonomy of individuals, than it is by the assumption that populations need to abide by the terms of the market contract. In the context of reproductive health, the terms of the contract are explicitly in favour of population control and economic stabilization rather than the development of individual autonomy. The subsequent illustrations reinforce this argument in the context of the RCH.

The following excerpt from my interview with a senior-level officer underscores the state's limited interpretation of individual freedom. As the official points out, where fertility levels are not a huge worry, there is greater scope for individuals to exercise their 'freedoms'. Where it is a concern, the state holds greater control over the kind of decisions (and forecloses the opportunity for the exercise of individual rights) that people make. Note the following excerpt:

I#4:

As far as Kerala is concerned, what we believe is that it [*fertility decision-making*] is an option that can safely be left with women...the earlier style of advocacy and persuasion is prescribed only for two districts - that's Malappuram and Kasargode. In the rest of the place, all that we will do in the new RCH is to have the information available to them. Let them make the choices. But in *Malappuram and in Kasargode* where we believe that fertility rates are unnaturally high, the advocacy would still go on.

The official's response shows the conditional "freedom" permitted to the client. In the same breath, the official could say that in Kerala (the reference is to the generally low levels of fertility prevalent in the state), birth control was an option "that could safely be left with women". But where fertility rates were considered high in Kerala (here, Malappuram and Kasargode), "advocacy" or persuasive tactics in promoting fertility control were still likely to

continue⁸². Thus, to the policy makers, the notion of individual freedom prevails only as long as it does not counteract the government's programme of population control.

Perhaps the most jarring instance of state priority versus individual choices is the introduction (almost at the same time the RCH was introduced) of the slogan 'One is Fun' by the Ministry of Family Welfare, an encouragement for families to have only one child (Wadhwa 1997). There seemed to be no obvious recognition among the policy makers that there were two potentially incompatible discourses at play here. I asked one of the interviewees, a researcher and a consultant to the Government of India, about the contradiction between individual interests and state goals. The response of the consultant was to suggest that the idea of population control was not seen as inimical to individual rights – that these are not discourses in conflict or in opposition to each other, but co-existed in a hierarchy. Individual rights were always (from the start of the ICPD) subsumed within the umbrella of population control.

I#3:

No, I don't think that even the ICPD talks about pushing *it* [population control] down under the carpet. It talked about approaching *it* [population control] in a broader context rather than with a narrow focus. The ICPD definitely talks about improving the quality of life of men and women and helping them to make their own decisions.

The response of the consultant reinforces the argument made by Amalric and Banuri (1994) that the "apparent contradiction between the two main principles of the draft [ICPD] document – to stabilize world population and to respect people's rights – is never acknowledged" (p. 702). As long as that contradiction is not addressed or left ambiguous, national governments and local providers can interpret it in a way that suits their purposes. Clearly, in the case of the Indian context, individual rights are subsumed within the discourse of population control.

⁸² While advocacy or persuasion does not denote the excessive kinds of coercive tactics that the Government has used in the past, the state can still regulate the landscape of opportunities that constrain people's reproductive freedoms. These regulative strategies go directly against the idealized norms of freedoms in the market, but are implicitly written in the sub-text of regulative behaviour that underlies the manifest ideology of neo-liberalist 'freedoms'. Some of the concrete ways in which the state's providers are likely to act out this regulation are illustrated in Chapter 8.

In another instance, however, when I pointed out the apparent contradiction to a policy maker, there was an attempt to reconcile the incompatibility:

So doesn't this [One is Fun] contradict the RCH in any way?

I#8:

Yes, because we are not supposed to insist [what clients should do] in any way, right?

Q: So how will you [reconcile] the contradiction - will you talk about both?

I#8:

"Now we [in India] have the one child norm" - we can say it like that. In the methods we say "there is the cafeteria approach, you can decide according to your own choice". Like that, we can give education - if the number of children is high these and these are the problems. But the choice is theirs.

This particular official, in attempting to reconcile the contradictory discourses of freedom within the reproductive health policy, positions the state as an educator, while permitting people to make individual choices. In general, however, the state never sees the client as having sweeping powers to determine the shape of its services. This is most evident in contexts of *conflict*; policy makers are clear that the state's inherent interests will prevail. For instance, in my interview with a senior-level official at the DFW, he made it clear that the provider's needs "may not coincide with the view point of the consumer per se..." (see below). As a provider, the policy maker, then, will have a "real dilemma" - of not knowing whether to provide what the people want or to provide what is important from the national point of view. The full excerpt from which I have drawn these comments is given below:

I# 4:

The real problem [there] is - unlike the normal consumer - where he has freedom in the market -here there is a question of 'merit good' coming in. Now from the national point of view or from past experiences of providing health services, the service planners have emphasis on certain items, which may not coincide with the view-point of the consumer per se. Options which are found to be more cost effective may not be accepted by the consumer because he might want a costlier option..Now as a planner who claims to stand at a distance, you believe that need and demand do not coincide. Now where do you strike a balance? Do you have the right to decide that this is your need - you shall get this. Or do you want to respond to the demand and provide what is there?

The excerpt clearly points out that the client of the family welfare service in India is not a "normal" consumer who has "freedom" in the market – the client's freedoms are obviously

more limited. Therefore, in the event that “needs” and “demand” do not coincide, the implicit preference would be to privilege the state’s priority. That is why “merit good” has to be applied to the needs expressed by a client. The merit good is likely to be an evaluation by the policy makers of the general benefit that accrues to several actors in the family planning field by fulfilling a particular need. The benchmark for this criteria is drawn from “national objectives” and “cost effectiveness”, both very likely to contradict individual interests. What emanates from a perusal of these excerpts is that only a limited opportunity is offered by the state to determine the course of the policy based on the clients’ needs structure. In the end, as one of the bureaucrats pointed out, it is like saying “the consumer can have a car of any colour so long as the choice of his colour is black” (I#4).

The problem for the state, then, is to reconcile the apparent contradiction in its own discourse of user-centred policy. I demonstrate below that in a bid to resolve the tension between individual needs and national goals, the state has had to employ two key strategies. First, it questions the capacity of individuals to make ‘rational, objective’ decisions. Second, it re-invents its relationship with the individual in a way that suggests devolution of rights to the individual while retaining core decision-making facilities –especially as to what is permissible reproductive behaviour - for itself.

Rationality: capabilities of the client

The tendency to question the capacity of the client to act in a rational fashion is a strategy that is repeatedly used in the interview data by policy makers to establish the pre-eminence of the state’s objectives. ‘Rationality’, by implication, appears to be the capacity of the individual to converge her or his own sense of well being with that of the state. Documents that paid lip service to individual interests as the priority of the RCH programme, simultaneously also expressed a ‘concern’ about the long-term effect of permitting individuals to make decisions about the number of children they should have. Document goi.oc.6:1, points out that “...while there are no two opinions about the need to remove numerical targets⁸³ for the sake of quality of service, *there is a concern* that such a move, when taken country-wide, may lead to decline in *performance* [acceptance of contraceptives by

⁸³ The reference is to the dismantled target oriented system that was in place prior to the TFA.

users] initially". When I asked the consultant to the Government which priority was likely to prevail - individual or national interests - the response was:

I#3:

...well, the government talks about that too...not to pressurize to accept family planning. That's what they tell their health workers too. But *there is this concern* ...I don't think that the population control crisis is forgotten...

The success of the TFA, especially, relies heavily on the 'responsible' fertility behaviour of couples given that ANM strategies for 'recruiting' volunteers for contraceptive acceptance have had to change drastically. I was told in interviews that, since 1995, one of the concerns of policy makers was that the grassroots workers in the field had interpreted the absence of numerical quotas as an indication that they need not do outreach motivational work. Instead, they only needed to attend to clients who actively sought reproductive health services. For the contraceptive acceptance levels to be maintained, an expectation that individuals and couples would make responsible reproductive decisions was implicit.

I questioned the interviewees about this implicit assumption about the average person's ability to make judicious fertility decisions (such as, the size of the family and spacing). The responses fell into two categories. Some of the interviewees felt that people, especially in Kerala, had the capability to make such decisions, whereas the other participants doubted that people would make decisions that would tally with the state's intention. Below is the former kind of response. When a policy maker emphatically told me that the state entrusts the decision-making of their reproductive lives to the clients themselves, I asked:

Do you think that people are actually capable of making these decisions - what is most appropriate for them?

I#7:

Actually, they are much capable of making the decisions. We thought previously they are not in a position to come to a decision. But now we find that they are very much capable of making a decision especially in Kerala because most of them are educated and about 86% literacy is there.

I#12:

In Kerala, especially in these parts, I think that people have a good awareness, they have a consciousness, they have the awareness. As for the small family norm, they have already adopted it.

What is interesting about these comments is that although respondents believed that people were “capable”, individual capability was shaped by people’s “awareness” to adopt the small family norm. ‘Capability’ corresponded with the state’s explicit drive to control the population. Even in the case of the first quote, although not explicitly stated, the association with education and literacy clearly shows that the official is drawing on conventional development wisdom that increase in literacy and inclination to use contraception go hand in hand. The ability to behave in a responsible fashion was not innate; if it exists, it is largely as a result of the externally imposed educational process. Awareness was evident because people opted for small families. The corollary would be that any decision not to have a small or two-child family is an expression of ‘irrationality’.

To that extent, as the excerpts below indicate, the responses of officials who doubted individuals’ capabilities to make informed decisions are grounded in almost similar considerations of ability to ‘control’ births. For instance:

You said that you are going to leave decision-making completely to the client. In this situation, do you think that our women or couples are capable of making such responsible decisions?

I# 1:

... *we are still in the experimental stage.* Or as you call it, this will be the running in period. For a year or so. So we can only say in a year or two how successful we are.

I#2:

That time - for it to come - it will take some time. When the Panchayat Raj itself came, we gave them the decision-making capacity...the people have not come to that stage yet. But *they will come there gradually.* If we never give them (the chance), they will never reach that stage. Like that, even here, in the beginning there may be problems - that may be why *some achievements are going down.* That we are expecting in this stage.

I#11:

...that depends on the area. For example, in city areas there are mostly highly educated people - they know well. But in our rural places, *we have to insist.* For example, this is not completely a city area...of that, a proportion at least will come only if we insist...

...but still, *I think we still have to give a little push,* I don’t think that people will come along voluntarily (for family planning methods).

One gets the sense that the average policy maker is reticent in constructing the average individual/couple as capable of making rational reproductive decisions. The inherent ability of the ‘client’ to restrict the number of children s/he has is suspect – the state still had to “push” or “insist”. A truly target free approach could be, according to the interviewees, adjudged successful only if the outcomes matched the projections of the state (especially with regard to stabilization of population). That correspondence was likely to come “gradually”, and the present programme was in that sense only “experimental”. Only those people who were “educated” or who lived in urban areas (and unwittingly, imbibed the values of development) could comprehend the significance of a two-family norm. Although the average Keralite, perhaps, was a shade ahead of her/his counterparts in other parts of the country (or even, ‘backward’ districts like Malappuram and Kasargode in the state itself), the state’s acceptance of the “client” as a responsible citizen was conditional. Perhaps the following comment by an official within a non-governmental population agency well exemplifies the construction of rational behaviour from a capable user:

I#17:

Yes it is a woman’s decision but you see, if we go that way, it becomes philosophy. You see, I want to commit suicide. It is my right...a woman who wants to have 10 children...we don’t find that she is very normal (*why do you say that?*) Because in that concept, having that many children will have many problems. But if you want to have all that you can’t be normal. We went to one place and there was a woman there with 6 children. She told us it is an asset to me.

The official has a very modernist conception of rationality. Anyone who wants to have 10 children, in his perception, falls outside of those parameters of rational behaviour. His assumption prevails contrary to his experiences with real people; his own example of the woman with 6 children illustrates that people do have alternative values about the worth of children - “...it is an asset to me”. But this clearly does not alter the dominant perception that associates less children with the rational individual.

What both sets of responses indicate is that policy makers’ interpretation of rationality is tied to the idea of low levels of fertility. My emphasis in this analysis is not to support large families, but instead show how the perception of rationality acts as a prohibitive factor for the ‘consumer/client’ to participate as an equal member in market exchanges. The implications of such a construction is seen in the quote by I#4 on p. 150 where the overruling of individual “client” interests is justified because the policy makers are more

capable of seeing objectively, given that they are capable of “standing at a distance”. The client/ user (unless educated) is not quite on par with the policy makers.

Accessibility: purchasing power in the health market

A third dimension for assessing the characteristics of the ‘client’ is to examine how the user fits the requirement of a purchasing customer/consumer. In the analysis above, I already established that the ability to pay for services is implicitly woven into the discourse of being constructed as a consumer-client. Non-paying clients, on the other hand, do not necessarily pay for services and, often in public service parlance, are recipients or dependents who meet eligibility criteria (Fraser 1989a; McGuire 1997). Further, I also showed that the shift in the discourse to user charges is gaining currency within the public health care and family welfare services in India. In this sub-section, I explore the implications of the discourse of purchasing power for accessibility to reproductive health care.

In India, the user of the family welfare services is not yet a paying client. All family welfare services in the public sector are provided free of charge. Any payment is only indirect, through the taxation process. And, according to Indian tax laws, there are many segments of society that are exempted from taxation – the poor (defined as people who fall below a certain income level) and those whose main income source is from agriculture, are among them. It is usually this segment of the population – the rural population and poor, incidentally, that is dependent on the government’s services⁸⁴. Therefore, a majority of the users cannot claim the status of purchasing consumers, in the strictest sense. The senior bureaucrat I spoke with at the DFW acknowledged this point although he had earlier pointed out that users were “consumers”, and that “...they are getting the results of what they are paying for....” When I asked explicitly what proportion of people using FW services actually pays for it, the response was:

I#4:

No, they pay for it in the sense, when you look at the public finance angle - ultimately, this comes out of the state exchequer. And... frankly - there is no direct payment -no direct payment involved. But ultimately the tab is borne by everybody, the taxpayer.

⁸⁴ It is a well-accepted fact that government services are of poorer quality than the private sector. Those who can afford it prefer utilizing private health services.

The official's perception of who has the right to be purchasing customer is aptly put. It is true that there is no direct payment to the family welfare programme for its services. So, although the tab is to be borne by "everybody", in reality, it is primarily the "tax payer" who funds the state's programme. The family welfare service, then, is not a *purchased commodity* but rather a *subsidized one*. The tab is not, unlike the interviewee's response, borne by everyone. It is actually borne only by a few, and it is only these who can claim to be purchasers of the service. The rest can either be 'citizens', exercising their right to health, or 'beneficiaries' of a service that the state finds important to provide.

The distinction between 'right bearing citizen' and 'welfare-beneficiary' of the state in health services is an issue that will clearly arise in the wake of the state government's interest to effect cost recovery under health sector reforms. Although, as of 1998, user payee health care was not introduced in the state's health system, there was strong support for it in the government sector and in non-governmental organizations providing family planning services (Interview I#17). The World Bank project proposal notes that

[t]he new family welfare approach being implemented by GOI will result in some *savings* within the current budget. Real expenditures on the free distribution of contraceptives, as well as compensation for sterilization and health guides, are already being reduced and will be reduced further during the project period....[T]he financial implications of going beyond these measures and charging for a proportion of the costs of medical services, drugs and vaccines have been calculated as part of project preparation. The opportunity to charge for activities which require universal coverage for effectiveness such as immunizations, and which help implement the right of every woman to have safe deliveries, is limited. However, cost recovery is being piloted....[T]his may escalate and result in the recovery of a small share of the costs of reproductive health drugs (wb.2, emphasis in original).

With an emphasis on cost recovery, the state (and the non-state funders that support the programme) is seeking to find all possible avenues to raise income from investment into the reproductive health programme. The excerpt above indicates a dilemma that faces the state - how to maintain a commitment to reproductive well being while being in a position to charge for services. For instance, the World Bank excerpt above notes that "*the opportunity to charge for activities which require universal coverage for effectiveness such as immunizations, and which help implement the right of every woman to have safe deliveries, is limited*". Evidence from the field has demonstrated that where user charges have been implemented, use of services and health conditions has deteriorated (see, Sparr 1994). Standing (1999) provides a critical

commentary on access to health care and the introduction of cost recovery. Anecdotal evidence suggests that where health benefits depend on social wage, vulnerable groups in society, especially the poor and women tend to lose out. In developing countries, where household health expenditure is, as a rule, disproportionately allocated to women, the adverse implications of financial stratifications in access to public health care is likely to have more damaging implications (Standing 1999).

In a bid to resolve the conflict between cost recovery and maintaining conditions of reproductive well being, the state appears to be moving to a context of stratification of health services. According to the strategy of stratification, all citizens are entitled to some basic services from the state. However, the citizen can access more advanced or sophisticated care only if s/he has the purchasing power to do so. For instance, the senior health official in the following extract describes a hypothetical situation of user payee health care and underscores what the woman client has the right to demand from the state under the current context of prudent servicing of health care:

At the PHC level, what does this mean for a woman user? Would the state system be free at all at any level?

I#4:

We believe that any woman should have an access to free family welfare services - totally free....[c]ertain things like a delivery - an ante-natal check up should be free for her. But going from there, if she wants to have an ultrasound done... that is not part of the basic antenatal care. This is something that will give us an opportunity to charge...And since safe delivery is a first priority - in RCH, this (ultrasound) will become part of trying to provide those services...But since it will not form part of the basic services and because it will mean certain investment in terms of maintenance - in terms of hiring personnel - the cost of that we'd like to come from ultrasound. So we will be charging for that.

In the marketized health care system, the divergence between the 'client/consumer' and the 'client/citizen' is vivid. The individual who can access a technologically sophisticated health system is the one who can purchase it. The 'right' to health, which the client-citizen is entitled to is clearly different from what a client-customer in the state's services is capable of accessing. The woman in the example given by the official above will have to pay for advanced care, whereas basic care will be made free. *Uniform* health care is, therefore, not envisaged as a universal right of all citizens elevated to the status of clients. There are apparent income-linked differentials among citizens that the state not only accepts but also

needs to encourage if its investment in health is to be financially viable. In the following excerpt, the senior official notes that:

I#4:

But I am just trying to show you the distinction between the primary care, which will be his *[sic]* (*the client*) right - which he *[sic]* will get free. And something = primary care plus -which he *[sic]* will be paying for.

In effect, two points can be emphasized. First, the evolution of the state into a marketized public health care provider is implicitly built on the assumption of differentiation within the population. The state will serve different segments of society differently, and will tailor its services in the same way. At a fundamental level, some services will be deemed 'core' and free, while others will be classified 'secondary' and to be purchased⁸⁵. Accessibility to these latter services will be restricted and contingent on the purchasing ability of citizens rather than their entitlements as citizens of a state. Within this stratification, the state as market sets criteria as to what comprises basic and what comprises secondary care.

A second point is that health-care, even reproductive health-care, is increasingly individualized. Apart from the few areas where the state will ensure that certain objectives are achieved, the discursive shift towards constructing clients is also a shift towards devolving responsibility of health care onto the individual her/himself. As a market provider, the state is bound to *provide* reproductive health services, not *ensure* that all citizens access them.

Articulations: constituting user needs

A fourth point around which I unpack the idea of the client is in the ability of the user to formulate and articulate her/his own construction of needs independent of the intervention of the state, which could then become the basis for service provision. However, as revealed through the RCH documents, the client does not occupy a space outside of the state's ideological framework. Analysis of the state's policy ideology repeatedly indicates that the state will *constitute* the clients' needs as much as it seeks to satisfy them. This last aspect is

⁸⁵ Interestingly, it is at points where the state's interests coincide with individual needs that the state does not propose to withhold free health services. For instance, fertility regulation or contraceptive methods and immunization are expected to be offered free (Interview I#4).

evident in the use of the term *felt need*. In doing away with the target oriented scheme, the current policy has been replaced with other concepts that grassroots workers like ANMs should use as guiding principles – “Requirement of the Area” and “Felt Need” are two important ones. The “Requirement of the Area” for a particular service is a complete coverage of services offered by a PHC (including prenatal care and contraceptive distribution) whereas the “Felt Need” is the actual use or demand for services at a particular time (goi.oc.6: 12). The Felt Need may often fall far short of the service requirement. It is the task of the grassroots workers to ensure that clients’ “felt needs” are increased through motivational tactics of the IEC programmes. The excerpts below come from doctors at a local level PHC and the last from a middle-level bureaucrat at the Department of Family Welfare, respectively.

I#12:

The approach right now is that we should not insist and force things on people. Apart from that, the beneficiary should have that feeling...it is *their need, it is their issue, on that basis they have to be made to feel that it is their felt need. That should be made clear in our other activities, of course in motivating them and in making things clear to them. We have to create awareness and make felt need and give that service. And then we have to offer that service.*

I # 7:

We are increasing the felt need by awareness and other factors and once it becomes 100 percent, it also becomes [service requirement]. That is the aim of the RCH...there is no need to push it [contraception]. You just give awareness...so that means by giving awareness to people, more and more Information, Education and Communication facilities, naturally more and more people will come forward and it can be successful.

I # 11:

When you talk of motivation, anyway there will be some group somewhere who won't have it. No matter how you try - it is hard. But through this [RCH], we should be able to bring in some more - a lot more people, for sure.

The comments of the policy-makers in the upper rungs of the institutional hierarchy and of health providers at the local level demonstrate that *creating a need* is as much a part of the policy's objective as *satisfying the need* is. Family planning services have always aimed to alter the behaviour of individuals with respect to their reproductive behaviour. However, what the present system suggests is that state structures should strive to meld state needs with that of individuals. Once again, there is a contradiction here between what constitutes free, informed expression of needs and regulated construction of needs. A senior official at the

DFW seemed to sense this discrepancy as he explained to me what a felt need was. The essence of the description is given below:

I#6:

Actually now the felt need is *addressing their...* felt needs means the service *which we are giving* or the acceptor desires to get from the provider. So suppose in an area - 100 people...are available and [only 60 or 70] come in for the service from the provider. That is actually - put in terms of the felt needs - that is not the real service. If you are providing the quality service, of course, the unmet need also will be taken care of. Naturally as the quality of service increases, the felt need will also be getting increased. It is a misnomer - felt need. It has to be changed.

The official starts out by explaining “felt needs” from the point of the user but then shifts the description to the provider’s point of view – from “addressing their...” to “the service we are giving”. It is only after the shift to a provider’s perspective of felt needs that the conceptualization of a need as a service issue is followed through. To this official, too, a felt need is something that should be “increased” in individuals, rather than understood. The use of the term “felt need” connotes contradiction in two respects. First, the official has realized that there is a discrepancy in the use of the term “felt need” to depict a value that is imposed on individuals. Second, the term ‘felt need’ suggests that the family welfare programme responds to the clients’ needs rather than regulates them. To do so would be to accede control to the client. However, the state’s conception of services is not only about being responsive to individual’s demands for services (as the official puts it, if only 60-70 people out of a 100 people come for services from the provider “that is actually – put in terms of the felt needs – that is *not* the real service”) but about being responsive to the state . targets. He ends by saying that “it is a misnomer- felt need. It has to be changed”.

Other officials linked increasing felt needs through IEC work. The IEC is the MoHFW’s mass media organ and the main source of propaganda about the state’s ideas on contraceptive use and reproductive behaviour. The official below equates increase in mass media work with identifying felt needs. For instance:

I#8:

And...but according to the target free approach, we are giving much importance to the felt need of the community. And these ‘felt needs’ can be identified only through IEC work.

I#6:

We will be giving them awareness. And giving some increases in the IEC activities.

Despite what the official in the first excerpt says, IEC is not so much to identify felt needs as it is to “give them awareness”. The primary objective of IEC is to communicate to the population at large the state’s current philosophy of birth control.

What we see, therefore, is not the informed, bargaining relationship that is supposed to take place ideally in a market place but a more complex inscription of state power in subtle forms. One possible, and relevant, reading of the state’s aim to constitute individual needs can be drawn from the Foucaultian perspective of governmentality. Foucault (cited in Burchell 1996) describes the art of government as the “conduct of conduct”, of shaping, guiding, correcting and modifying behaviour of individuals and the way they conduct themselves so that it converges with the ideologies (or, in Foucault’s words, political rationalities) of the state. Rose (1996:43) argues that the power of the state is in the ability to translate political programmes articulated, for example, as national efficiency, democracy, and equality from a central point into diverse localized points – it is in a sense, the “ability to govern at a distance”. The successful art of governmentality is not one that imposes itself on individuals – “it’s not a matter of imposing laws on men, but rather...to arrange things in such a way that, through a certain number of means, such and such ends may be achieved” (Foucault 1979b: 13). For this to happen the state organizes “...forces (legal, architectural, professional, administrative, financial, judgmental), techniques (notation, computation, calculation, examination, evaluation), devices (surveys and charts, systems of training, building forms)...” (Rose 1996:42) that would regulate the decisions and actions of individuals and groups. What entails is the translation of the techniques of domination into techniques of the self, viz., the state establishes its domination when the individual no longer recognizes that the values and ideologies that form the basis for her/his actions are anything but her/his own.

There appear to be echoes of Foucaultian governmentality in the way the family welfare structure has been organized. Increasingly, the strategy of the MoHFW is to make individuals feel that the state’s needs are their own, thereby effacing the distinction between

acts of compliance and acts of empowerment. A singular advantage of this tactic is that the chances of resistance to external ideology will be minimal.

A parallel situation where the state appears to ‘create needs’ is in the provision of services for the treatment of RTIs. Screening and treating for RTIs is among the foremost provisions in the RCH. Both in documents and interviews, I found enthusiasm in addressing the “problem of RTIs” all over the country because “infections are very high” (goi.oc.5: 20). Setting up special RTI clinics and special training for medical and auxiliary staff has been envisaged (goi.oc.5). The focused action in this service emerged from the evidence by Bang et al. (1989), who examined incidence of RTIs in the northern state of Maharashtra amongst a sample of 650 women. The study reported high rates of gynaecological diseases⁸⁶ in two villages in a “backward district” (Bang et al. 1989: 85). Later studies (for a review, see Mamdani 1999) also indicate that RTIs affect the reproductive health of women in India. There is less congruence among the various studies, however, as to the exact magnitude of the problem. Mamdani (1999) notes that the high levels of infection in the Bang et al. (1989) could include “possible selection bias, variations in questionnaire wording and the extent of probing, variable reference periods” (p. 445).

Further, there is also the fact that there is no standardization as to what the clinical definition of RTI is. The “problem” of “white discharges” which is widely reported in the field is also seen by many as common to the organic constitution of women⁸⁷. In conclusion, Mamdani (1999) notes that there can be no firm conclusions that can be drawn regarding the prevalence or nature of RTIs among women in India. In contrast, the tone of the RCH would suggest that the problem of RTIs is widespread and requires immediate programmatic intervention and educative measures on the part of the government. Yet, the state’s epidemiological statistics reflect the inconsistencies that are seen in other studies. For instance, document goi.oc.3: 5 notes that,

[T]hese (RTIs/STIs) conditions are proposed to be added in the RCH programme now. Studies have shown that 90% of women suffer from one or

⁸⁶ 92 percent of all women were found to have one or more gynaecological or sexual diseases. Only 8 percent of all women had undergone any gynaecological examination in the past. The study goes on to recommend that in the rural areas of developing countries, gynaecological and sexual care should form part of primary health care.

⁸⁷ One of the doctors that I interviewed in the rural PHC referred to the “harmless leucorrhoea” or ‘yellow discharge’, which some women experience.

more gynaecological problems including RTI/STI and the level of such infections is in the order of 15-20%.

Document goi.oc.5: 20, on the other hand, reports that

The incidence of Reproductive Tract Infections and Sexually Transmitted Infections is *very high* and according to *some small area studies*, the incidence is *around 20-30% in most parts of the country*

Not only do the two documents contradict each other in terms of the rates of incidence, there also appears to be some confusion as to what exactly both the documents seem to refer to. The first extract refers to gynaecological problems which 90 percent of women suffer from – although, the level of these infections were only 15-20 percent. The percentages in the second document do not tally with the first, but importantly, it claims on the basis of “some small area studies” that in “most parts of the country” the incidence of 20-30% is “very high”. Inconsistencies were also evident in my interviews. I spoke to medical doctors at the two local PHCs about how they perceived the problem of RTIs. Their responses are given below. Notice how there is a contradiction in the comments of the two doctors. As background, I should qualify the attitude of the two doctors to the RCH programme. The first was an enthusiast and saw great benefits in the RCH, whereas the second tended in his interviews to offer critiques and appraisals.

Medical doctor #1:

Like that, another thing - reproductive tract infections. *That is a big problem*, especially in rural set ups... there is the infections of the reproductive tract. Because of that...there can be sterility. The RCH programme makes effort to address issues like this early and treat it.

Medical doctor #2:

RTI... in the general OP... the women come occasionally...but how far their rates are, I am not sure.

But have you ever heard of it as a problem?

No, I haven't heard of it as a problem.

The inconsistency in the responses of the two medical doctors is interesting – both the doctors work amongst a similar population of women, yet have contrasting views in terms of the prevalence of reproductive tract infection. I also asked ANMs what their experience regarding reported RTIs was. I asked:

Q:

One thing that this RCH says is that we should detect RTI...now when we go to houses (on field visits) do women complain about it?

ANM#2:

Not really...

The point that I am trying to make is not that RTIs don't exist in Kerala, or that the RCH's focus on RTI treatment is misplaced or irrelevant. However, it is interesting that there is no clear definition of the "problem" (whether it is a general gynaecological problem or specific diseases, whether the rates are high or low or significant) or even that, there does not seem to be a consensus that a problem exists. It is thus worth considering if indeed the 'problem' is in a stage of construction and of being defined, first within the medical community and, in due course, amongst the larger public. Feminist enquiry into conditions such as anorexia nervosa has focused on similar issues; it seeks to examine how the spate of medical, legal, research, and therapeutic interest have served to pathologize the female body.

How would the state gain if it were to pathologize the discourse of RTIs? While research needs to be done to examine state intentionality, there are a few points that might be considered. As the discourse of the RTI problem develops, it is likely to gain validity among the people. The fact that the state is constructing the dimensions of the disease as it goes along (such as, what exactly is atypical discharges, for instances) emphasizes the potential to normalize women's bodies. Dubois (1991) notes in the case of fertility control programmes that scientific normalization (such as correct family sizes – "too high" or "too low") preceded the ideological dissemination to the wider public as to what their own family sizes "ought" to be. In the case of RTIs, the discourse of the condition has already entered public discourse⁸⁸, but in being appropriated by "expert-needs" discourses (Fraser 1989a, 1989b) it

⁸⁸ In fact, the demand for including RTIs within government reproductive health programmes came from women's health movements.

also re-constitutes the way women think about themselves. There is paradoxical process at work here – as women become conscious of the significance of RTIs and avail themselves of the state services, their reproductive identity is being further constituted by the state. Creating awareness, like the transcripts above noted, could also be the process of creating a need. A possible outcome of the creation of the ‘discourse of RTIs’ is that the visibility given to this problem marginalizes other reproductive issues that the state chooses *not* to address. One of the ANMs I interviewed told me that a while back (a decade or so ago), health workers had a similar experience with scabies. Scabies was highlighted as an urgent need to address, and the health sector had focused programmes to identify cases of scabies. The ANM continued that now, there was hardly any focus within the state or the health system’s functioning to examine scabies as a community problem.

Discussion

Studies in international health restructuring (e.g., Grace 1991; Goltz and Bruni 1995; Whitty 1998) have demonstrated neo-liberal ideological strains embedded within the use of specific forms of language and discursive statements within health policy. Grace (1991) analysed health promotion discourses in New Zealand and showed how an overt commitment to ‘empowerment’ of consumers masked an equally strong objective to *plan, change and control* individuals’ perception of health. Grace notes that the object of the discourse, i.e., the consumer, is seemingly positioned as being in control while the health promoter is simultaneously positioned as controller. This contradiction is played out in the discourse of management and marketing. She argues that the use of management language to define the relationships between consumer and provider “shifts the ground from the sphere of political challenge and struggle to the ground of market relations” (Grace 1991:334). Whitty’s (1998) analysis of the National Health Service policy in the United Kingdom found similar strands of market ideology ingrained within the broader overt objectives of “empowerment” and “participation”. She quotes critiques of so called participatory planning in the National Health Service in the United Kingdom by pointing out that mere transformation of “I” into “we” does not entail empowerment (Whitty 1998: 145). If anything it can “easily mask subtle forms of control” (Whitty 1998: 145). Her analysis goes on to argue that the dominant market ideology, rather than elements of equitable access to resources, guides the state’s allocation of resources in health care.

Goltz and Bruni (1995) similarly analyze the knowledges and practices of nursing professionals and their relationships with patients in Australia. A key underlying ideological theme within such practices is that health is seen as a matter of control and responsibility of the individual. Therefore, the aim of nursing practices is to encourage patients to reduce 'risk-taking' behaviours. In the end, such notions aid the privatization and individualization of health experiences.

The outcome of the adoption of the market analogy in family welfare services in India may have implications that have little to do with serving citizen interest or enhancing the structures of democratization. From the evidence provided above, the state as market-provider stratifies health services, distinguishes between paying and non-paying clients, and seeks to control the process of articulation of citizen needs. Further, in redefining the role of the state and user under the framework of the market, a tacit contract that limits the scope of the state's intervention in universal public health emerges. Alongside, the invocation of analogy of the market asserts that individuals have only limited legitimacy for claims upon the state. As the citizen metamorphosizes into a consumer, the citizen has less access to the public space of political debate.

Given the analysis and discussion of data above, it would seem inappropriate to equate the client/citizen depicted in the RCH policy with the purchasing consumer of the market place. What I have tried to show is that the subject-position granted to users of the family welfare services is not, despite the use of similar language, consonant with the fundamental characteristics of a consumer in the market place. Though not quite a candidate for charity, the client nonetheless does not have the bargaining capacities of a customer. In the recent turn of the state towards neo-liberal development planning, the imagery of the market is accompanied by notions of devolution of power, participatory planning and mutual agreement. Yet, alongside the picture of client-rights, the user is also simultaneously positioned as a recipient of the state's benevolence. The status of the client is simultaneously contradictory : s/he controls/is controlled, s/he decides/has decisions made, s/he plans/is constituted by the programme. The 'client' in the Indian Reproductive Health programme, in effect, holds a rather fluid, uncertain relationship with a state service that is, as Whitty (1998) comments in the context of the UK, a 'hybrid' of both public/private and

state/market. The acknowledgment of a rights-discourse (inherent in a feminist discourse on reproductive health) is questionable within this hybrid space.

Conclusion

This chapter sought to trace the rhetoric of neo-liberalism within the RCH policy. Arguing that the neo-liberal discourse was situated within the wider shift of the state's health services to a market-oriented provision, I demonstrated that the neo-liberal rhetoric was located primarily in the construction of the user of the family welfare programme. I showed that the RCH was replete with references to the user as a client of the state's services, much as a purchasing consumer of any marketed product. I argued that in constructing the user as a client, the state actually removes some of the rights of citizenship and conflates empowerment with ability to provide 'consumer feedback' to the state. But just as a consumer does not dictate the terms or the politics of a company, likewise, the consumer-client of the state loses her/his entitlement to politically challenge the operations of the state. This examination of the ideology of the consumer supports the analysis in the next chapter where I examine specific ideologies around gender that proliferate in the RCH policy.

VII

GENDER SENSITIVITY AND REPRODUCTIVE POLICY

The Ideology Of Gender In The RCH

But is there such a thing as women's point of view? Who speaks from it? How can it emerge validly self-reflective from an invalid condition? How can it be identified? How distinguished from delusion? How can anything any woman thinks be false in a theory that purports to validate all women's experience? If every woman's views are true, regardless of content, how is feminism to criticize the content and process of women's determination, much less change it?

Regardless of the weight or place accorded daily life or women's insight, feminist theory probes hidden meanings in ordinariness and proceeds as if the truth of women's condition is accessible to women's collective inquiry. The pursuit of the truth of women's reality is the process of consciousness...

MacKinnon 1989, p. 39

This chapter continues the analysis of the dominant strands of ideology in the RCH in Chapter VI through an exploration of gender ideologies prevalent in the policy. The term 'gender ideologies' is a broad one, and can pertain to various aspects associated with the construction of women, and the social relations between men and women⁸⁹. The analysis in this chapter has developed against the background of contention in recent years that has followed the efforts by state and non-state development agencies to construct 'gender-sensitive' development policies, that is, those policies that in process and outcomes most

⁸⁹ The term 'gender' itself has been defined differently by different feminist authors. For a review of this literature, see Hawkesworth (1997), Nicholson (1994) and Kurian (2000). A widely accepted definition is that gender is a social construction of roles, functions and obligations of being male or female, while sex pertains to the biological reality of the human anatomy.

benefit women. Feminists have been critical of exercises that focus on a technical approach to assimilating ‘gender’ within programme and institutional contexts, undermining the relevance of addressing issues of power that contribute to women’s subordination (see, for instance, Baden and Goetz 1997; Kabeer 1994; Koczberski 1998). Developmental organizations often assume that gender issues can be effectively tackled through carefully crafted programme design without substantially questioning the dynamics of power and inequity in society. What need to be critically examined are the fundamental understandings about gender that these gender-sensitive policies propagate – their ‘ideologies of gender’ – and if these values can indeed be mobilized for the emancipation of women.

The RCH has claimed, by and large, to provide services that are gender-sensitive. This claim is an important one, for the bulk of the programme is directed at women’s health and to enhance women’s ability to make appropriate reproductive decisions. For this analysis, some of the questions that I set out to ask in the exploration of gender ideologies in the RCH were: How does the state construct gender and women in the programme? How have women’s interests been developed within the context of reproductive health? Is the state’s emphasis on gender issues a sign of its commitment to equality and equity for women? And finally, what, eventually, can women hope to gain from the state’s reproductive health programme? As in the earlier chapter, the data corpus for this analysis is drawn from government documents and interviews.

The chapter is divided into three sections. The first offers an overview of the policy’s description of gender sensitivity. The second section analyzes four persistent discursive themes about ‘gender’ and ‘women’ in the RCH, and discusses the implications of these discourses. The third and final section evaluates the implicit interpretation of gender-sensitivity in the RCH and its ramification for the articulation of gender discourse on reproductive health.

Gender Sensitivity and the RCH policy

In keeping with the resolutions of the ICPD, 1994, the Government of India gives special consideration to the provision of gender-sensitive services under the RCH programme.

Gender sensitivity, which is seen as integral to the provision of good quality services, is defined as being “responsive to the needs of women” in planning and implementation (goi.nd). Interestingly, the concept of gender-sensitivity appears to have gained currency in the documents in the wake of the ICPD. There is, for instance, no mention of providing ‘gender-sensitive’ services in the *India: Country Statement* that was presented at the ICPD in Cairo, in 1994 (goi.obp.1)⁹⁰. By 1996, however, the documents emanating from the MOHFW, DFW and the major funders of the RCH programme in India elaborate plans to provide services that are gender-sensitive (see goi.nd).

The need for gender sensitivity in designing reproductive health policy has arisen from widely accepted facts about women’s physical, social and economic constraints in obtaining health and family welfare services in India. Chatterjee (1996: 30) identifies some of these:

- Women bear their health problems in a ‘culture of silence’ and do not seek timely health care
- They often cannot travel beyond the area of their normal activities to obtain services
- They cannot usually approach male health providers
- In general, families, including women themselves, spend less time, effort, and money seeking health care for women and girls than for men.

Chatterjee goes on to argue that the Department of Family Welfare’s concern with meeting targets had, thus far, resulted in a delivery system that views women primarily as *reproducers* rather than as *producers* in the economy. According to Chatterjee, this construction of women has had two implications for women: (a) the health delivery system tended to ignore the provision of general health care for women, and (b) the system tended to overlook those women who did not fall into the category of the typical reproducer in society, such as, adolescent girls, unmarried women, post-menopausal women and infertile women. Chatterjee points out that the recognition of the needs of these women requires considerable improvement in the supply side of services. Other areas that Chatterjee points out where there are gender imbalances in access and provision of services are in the earlier programmes’ focus on female sterilization as the main form of

⁹⁰ This is not to suggest that there was no mention of women or women-specific programmes in the document. Rather, a coherent, well-defined strategy of gender-sensitivity had not been articulated at that point by the government.

contraception, inadequate number of female health personnel whom women can approach, insufficient support for existing female workers, and the need to emphasize male involvement in the programme.

These lacunae seem to be accepted and efforts have been made to address them in the RCH. The inclusion of gender-sensitive components in the policy is interesting for the various dimensions along which the state addresses this issue. Conceptually, the policy's efforts to be gender-sensitive are located simultaneously within women's rights to reproductive health care, and the broader context of women's social development. The RCH draws on the philosophies of the ICPD and defines the reproductive health approach as, "...people [having] the ability to reproduce and regulate their fertility, women [being] able to go through pregnancy and child birth safely, and the outcome of pregnancies [being] successful in terms of maternal and child survival and well-being, and couples [being] able to have sexual relations free of pregnancy and of contracting diseases" (goi.oc.5: 2). Alongside, the documents recognize that the knowledge and use of reproductive health services is inextricably tied to the level of social development within a community and, therefore, gives importance to issues of women's empowerment, especially through education. For instance, document goi.oc.5: 2 notes that "...[w]hile there is steady improvement due to economic development, spread of education/literacy and empowerment of citizens, substantial problems in regard to education/literacy...and particularly in regard to empowerment particularly of women, remain". A key activity proposed by the state under the RCH is better collaboration with other government departments that deal with women's affairs. At the level of the state in Kerala, as well, issues around gender and development have been recognized as critical to the success of the programme. In its proposals submitted to its major funders, the World Bank and the UNFPA, the state makes specific mention of the relevance of pursuing activities such as women's empowerment within the ambit of the programme. For instance, the Integrated Population and Development (IPD) project of the UNFPA for Kerala notes that, "[t]he major focus would be on education of girls, the health of the women, the survival of infants and young children, and, in general, the empowerment of women" and that "areas of concern which are to be addressed in this context are education, especially of girls, and *gender equity and equality*" (unfpa.obp.2: 1). Approximately 25 percent of the UNFPA's funds to Kerala are expected to be set aside for the implementation of gender-related

activities of “equity, equality and women’s empowerment” (gok.obp.9: 2 and Interview, I#2).

Strategically, too, the programmes’ interventions are founded on principles that can be viewed as sensitive to the needs of women. First, the government takes a life-cycle approach to women’s health in the RCH programme; that is, the state aims to provide health services that address women’s health across their life cycle, from childhood to adulthood (goi.nd). The documents recognize that “[g]ood health is cyclical in nature. In a woman’s lifetime, her health status during any phase of life impinges upon the next phase” (goi.nd). The life cycle approach includes the health of the girl child right from birth through the reproductive years and into menopause and geriatric health. As one of my respondents commented, the RCH programme intended to provide health care from “womb to the tomb” (Interview, I#1). Secondly, the programme recognizes that, thus far, the Indian family welfare programmes have focused on women in reproduction to the exclusion of male responsibility. Therefore, a key project under the programme has been to ‘en-gender’ the reproduction process; that is, it seeks to make men visible in the process of reproductive decision-making and contraceptive use.

At the level of the programme, the RCH provides services that are critical to women’s reproductive well being. The programme has extended its services from family planning and maternal health to include the treatment of women-specific diseases like Reproductive Tract Infections (RTIs). The provision of a universal essential obstetric care package and the crisis interventions proposed under emergency obstetric care would be important for preventing maternal mortality. There is also a special emphasis on providing counseling services for women and men (Interviews, I#7, I#3). It is proposed that the PHC should be equipped to handle round the clock delivery services (goi.oc.5: 15). Further, the state will also cover transport charges for referral obstetric cases for women from indigent families to First Referral Units (FRUs) (goi.oc.5: 17). The MoHFW also plans to improve the facilities for Medical Termination of Pregnancy (MTP) at the level of PHCs, by deputing a medical doctor weekly or fortnightly to PHCs to perform MTPs (goi.oc.5: 18-19).

Over and above this provision, under the scheme for Decentralized Participatory Planning, there is an emphasis on enhancing the processes of participation between ANMs and individuals and the community, respectively. ANMs will spend more time with clients so as to understand their needs. An adolescent programme is also envisaged under the RCH – education for young girls about sexuality, menstrual hygiene, contraception, safe sex, pregnancies and infection would be offered to the community (I#2). In addition to services, the RCH also recognizes the importance of providing facilities, such as privacy during counseling and treatment, as a key aspect of gender-sensitive care.

The state also recognizes that gender sensitivity is reflected through changes at the organizational level. The state has made provision to appoint women doctors to attend to RTI/STI cases in the PHCs (goi.oc.5: 21) and the appointment of a gynecologist in every PHC is being considered (I#16). There is also integration of gender-sensitive components in the training of grassroots workers, such as sensitizing them to the importance of privacy during interviews, listening to clients, being patient, using a friendly tone of voice, and readily clarifying questions that may be asked (goi.tm.3: 3). As one respondent noted, women would have a better option of exercising their own free choices.

If you say we have this new policy, what would it mean for the woman in the villages?

I #3:

What it means is that at least there is no more coercion. We hope that with better counselling she's being given a chance to decide on what she should use, whether she should control her fertility. If she decides to do so, what is the method she should use. It is not that an ANM tells her - go and use an IUD. She makes the choice⁹¹.

The state also recognizes logistical inconveniences in its female staff's work pattern; for instance, the state is willing to financially support the purchase of mopeds (light motor vehicles) for ANMs so as to be able to increase the reach within their coverage area (goi.oc.5: 12-13). Finally, the state, in the effort to ensure representation of women's voices within the community, plans to network with, and work alongside women's

⁹¹ Note the similarity in describing the qualities of gender-sensitivity and customer freedom that I had pointed out in Chapter VI.

organizations and local NGOs to mobilize the community's support for the planned projects under the RCH (I#4, I#6).

The responses to my interview questions, like the documents, also indicated similar ideas of gender sensitivity in the RCH. One of my interviewees, a representative of a women's organization, identified the institutional problems of the ANM staff as important to providing a gender-sensitive service.

You said the key areas in which it (RCH) could be gender-sensitive - could you elaborate a little bit?

I#6:

One of these areas where we have addressed the issue is that the female health workers ...once the programme becomes target free...she should be much more concerned about women's health needs [and] help women articulate their health needs.... [s]o we have done all these series of ways in which a health worker can provide better services to women. So that women won't run away from her, women are able to confide in her. We also touched on this issue of health care providers vis-à-vis her supervisors and the higher level authorities as to how she can be empowered... in order to be able to take her clients to the referral centres and where she would be heard also and in turn provide better services to women.

This particular respondent has drawn attention to the role of the ANM in providing a gender-sensitive reproductive health services, mostly with regard to helping women articulate their needs better and giving the ANM autonomy to make decisions about her patients. As such, the recognition in the RCH policy that the ANM is the linchpin for the success of the programme, may contribute to allowing greater autonomy in their work. For instance, goi.tm.1: 1 notes that, "the success of the new approach will depend greatly on the ANM, the backbone of the health programmes in the rural areas of our country".

Yet another senior bureaucrat at the DFW, when asked about the benefits of the programme (especially to women), said:

I #4:

One thing is that providing information itself will have a certain beneficial impact. And the second one is that...the reality as of now, as things in Kerala [stand] is that the sterilization or the temporary methods have become the responsibility of the woman. Now given that situation - improvement of the quality of services will be to her interest to a certain extent.

The official picks up two other dimensions of the RCH that will prove particularly useful to women. The first is the provision of information in the programme, which would make a tremendous difference to women's capabilities to make informed reproductive decisions. A second factor that he points to is the improvement in the quality of service given, which has been considered under the general upgradation of the services of the state, and will nonetheless benefit women more than men, because they primarily use the state's services more intensively than men⁹².

In sum, some of the strategies aimed at providing gender-sensitive quality services are:

- Focusing on women's health problems such as reproductive tract infections
- Encouraging male participation in family planning
- Keeping clinics open at times suitable to women
- Training in gender sensitivity for service providers
- Getting women's feedback in monitoring
- Encouraging involvement of panchayats that now have thirty percent women members (goi.nd)

From the accounts reproduced above, there are certainly strong elements of 'gender sensitivity' in the programme, viz., women's needs as a distinct set of requirements, and the various aspects that could enhance the benefits for women have been considered in the RCH. It must also be noted that the MoHFW/DFW's efforts at making the programme gender-sensitive are fairly broad; they are inclusive of measures to improve the health delivery system, enhance women's personal and social autonomy, and address women's health needs. However, my argument is that the state's interventions are bounded by its understanding of women's roles within society and development and by what it favours as appropriate gender outcomes by prioritizing 'women' and 'gender' needs within policy. The following section presents my analysis of the state's gender ideologies reflected in the RCH.

⁹² The linking of quality services with gender-sensitivity is important, as I argue later, because it is a key point where market ideology is integrated with feminist discourse.

‘Gender’ Themes in the RCH

The qualitative analysis that I employed revealed four intersecting value structures that inform policy makers’ constructions of women and gender. These were, the instrumental construction of women, firstly, as mothers, and secondly, as vehicles for development objectives. A third theme was the negotiation of the idea of equality and the fourth was the tendency to construct the notion of gender in sex-neutral rather than sex-specific ways. These discursive themes, I argue, are pivotal in a particular positioning of women within the reproductive health policy and, ultimately, questions the concept of gender-sensitivity itself.

Women as Mothers

The first dominant theme that emerged from the data was that women were not treated as a category for development in themselves but for their usefulness in achieving certain ends. The instrumentalist construction of women was apparent in two contexts: (1) in the policy’s reference to women in terms of their roles as mothers, and, (2) the policy’s focus on women’s health because of the larger implications for society and the population.

The policy makers in my interviews noted the centrality of the ‘mother-child’ dyad, the ‘natural’ role of women in reproduction, and the relevance of this nexus in the design of the programme. That the RCH was built on this principle seemed only ‘natural’⁹³. Of the responses below, the first was made by an official in administration while the latter three were made by PHC medical officers⁹⁴.

I#1:

...the emphasis is always on the *mother and child*. There may be some reason for the planners for deciding or taking such a decision considering this mother and child as a unit. So the role played by the *mother in the family, in the society and probably in the nation*. So that is how it goes.

⁹³ This portrayal of women has been pointed out about pre-WID development policies as well. For example, development policies in the sixties defined “womanhood” in terms of “motherhood”, and positioned women as recipients of welfare programmes (Kabeer 1994). Within the WID discourse of efficiency, the instrumentalization of motherhood has other connotations as is argued in my analysis.

⁹⁴ It was interesting that regardless of the position occupied by the official or the sex of the official, the common sense acceptance was that women were significant in their social roles as mothers. One of the respondents in the excerpts is a woman.

I#12:

Only a *strong mother can have a strong child*. That way, a strong child when brought up like that [healthily] when it has its own child or is married, can have healthy children. So, we should think very fundamentally and we should begin at a basic level.

I#11:

Mainly, [the programme is meant] for women's health...that is, there should be a healthy mother. Only then, we will have healthy children. Mainly women will benefit more from it. All these programmes will *first benefit women, then from that children will get it...* Our aim is to improve maternal and child health, that is the final aim.

I#9:

Content [of the RCH]? ...it's that right now the Family Welfare programme is concentrated more to the women and child health. Health (services?) should be more concentrated upon the care of maternal and child health care ...[so that] the *population that is born should be healthier...*

Policy makers argued that the construction of woman-as-mothers was not an artifact of the policy machinery; rather, the state was reflecting what was portrayed as natural by society and by women users themselves. One of my interviewees, a woman middle-level policy maker, characterized women in Kerala as perceiving no identity for themselves outside of their roles as mothers:

I#2:

But, our women have a problem - not just ours, but all over India - if we tell them to do something for the mother, they are indifferent but if we tell them that it is for the child as well, they will do it. That is a peculiarity of our women.... [I]f we give them iron tablets, many women do not eat them because they think that the children will become dark. Even if they know that it has benefits for the mother, there are those who do not eat it because the child will become dark. So also, when we insist that they take TT [tetanus toxoide] immunization, they are interested only if we tell them that even the child will not get sick because of this. So they are interested that the child gets more care than the mother.

The primary focus on women as mothers, according to this official, is not one that is imposed by the state or state's policy. Women's responses to the state's health programme indicated that women identified their role as mothers as their primary identity; the state in

turn tailored its policies making the implicit assumption that programme efforts would be accepted if the benefits to children were emphasized. Women's interest in medical care is contingent upon the benefits that will reflect on their children. For women, "they are interested that the child gets more care than the mother"⁹⁵.

The comments above are reflective of the dominant role that women in Indian society are traditionally constructed in and the basic unit that the programme is premised upon – the mother and child. While there are no surprises here, the choice of the policy-makers' focus is interesting for two reasons. First, the focus on the mother and child is a deviation from the various fundamental social categories that have been identified internationally as central to population programmes. At the international population conferences since the 1950s, the international community has toyed with various 'units' that population programmes should be targeted towards. In general, the language of the conferences has moved from policies meant for 'families', 'parents', and 'eligible couples' to 'individuals' (Freedman and Isaacs 1993; Dixon-Mueller 1993; Kumar 1997)⁹⁶. However, from the comments of health workers in India, the 'mother-child' unit seems to be the basis for the development of a reproductive health programme. Such constructions, Chatterjee's critique notwithstanding, continue to cast women as biological and social reproducers; the implications are vividly demonstrated in the conception of programme interventions that are relevant under the RCH. Note what the following middle/senior-level officials indicate about their perception of the RCH's services for women.

I#1:

The primary objective is child survival and safe motherhood is the most important component. So anything which comes in between. Anything which is an impediment to child survival, or for safe motherhood or for the health of the mother... Remove those obstacles. It may be RTIs, STDs, AIDS, [or] infertility, for example. So anything - any diseases or disorder or any problem which prevents the mother or child from surviving - gaining good health. That is our primary aim.

⁹⁵ Note that this is a policy maker's construction of women, which may or may not be a 'true' representation of women's identity. This research primarily focuses on policy makers' (the state's) perspectives, and although I draw on women users perspectives, this is only as secondary and supplementary information.

⁹⁶ The ICPD, 1994, also adhered to the categories of 'eligible couples and individuals' as people who had a claim to reproductive rights.

I#3:

But you got to admit the Ministry of Health's focus [on reproductive health] would be purely on stuff related to health. So therefore it boils down to *safe motherhood and family welfare and RTIs and STIs*.

I#4:

And *since safe delivery is a first priority* - in RCH, this [ultrasound checks] will become part of trying to provide those services.

The comments above represent the core of the state's philosophy of reproductive health – that it is about “any problem that prevents the mother or child from surviving and gaining good health”. The official position is quite clear that women's health is significant to the extent that it supports “safe motherhood” and “safe delivery”. One cannot miss how the instrumentalist construction of women has bearing on programme objectives - *safe delivery is a first priority* (I#4). Reproductive health of women has dangerously narrowed in scope to maternal health and the privileging of services that profit pregnant and lactating women. The continued emphasis on antenatal check-ups, ensuring provision of tetanus shots and iron and folic acid tablets in the RCH training programmes (Interview, I#9) reflects the state's keen interest in the *physical health* rather than reproductive *well-being* of mothers. One could, for instance, critically question the health department's lack of interest in promoting ante-natal classes for preparing women to handle the actual process of labour. For all practical purposes, the maternal and child health service is the strongest component of the RCH. There are arguments in favour of and against an emphasis on maternal health. My interview respondents in favour of a maternal health focus argued that the most significant identity that women have in society is as mothers and this is something that is accepted by women themselves (Interview I#2). However, critical appraisals have pointed out that despite the label of MCH, the 'M' in the 'MCH' tends to be ignored in reproductive health service provision (Beall 1997; Bang and Bang 1989). Maternal health is relevant to the extent that it nurtures children's physical and social environment. It could be argued that the state's focus on maternal health does not render women's health as a public concern; in fact, it could serve to negate women's visibility within policy. Bruce and Dwyer (cited in Kabeer 1994) note how the construction of women in development policy has changed over time. They point out that “the invisible women of the economic theorist become the all powerful mothers of the health and

welfare advocates" (Bruce and Dwyer cited in Kabeer 1994: 269). It is worth considering if in this metamorphosis as mothers, women's invisibility continue to be subtly reinforced.

A second ramification that of the construction of women as mothers is that it directly contradicts the policy's claim to recognize that women need reproductive health care throughout their lives. Despite policy claims of being operationalized under a 'life-cycle' approach to health, there is a tendency to provide for service interventions around women's fertility and child bearing. The two notions, in this context, – the 'mother-child' unit and a 'life cycle' approach to health – are necessarily antagonistic to each other. The emphasis on women as mothers contradicts the state's commitment to consider women of all ages and stages of life as equally needful of public health care. There are two perceptible outcomes arising from the state's inclination to set women's fertility as a parameter for health provision. First, it encourages policy makers to continue to think of a stratified approach to services for the population. Note, for instance, the responses to my queries on target groups by middle-level officers at the DFW.

What is the age group and the sex that you are focusing on in your new package -your approach?

I#7:

That is in the *reproductive period* mainly from 15-45.

I#2:

...for different programmes, different age groups are targeted. In the AIDS programme, they have [targeted] people who have high-risk behaviour. In that there is this idea to give adolescent education - you must give sex education and adolescent education. In the Family Welfare, *married couples in the age group 15-44 are the eligible couples. Our IEC activities start from newly married couples...*the mean age at marriage [in Kerala] is above 22. So usually we approach people only after that age group for family planning.

The policy makers' responses indicate that they are steeped in the mind-set of the pre-RCH period, when different social categories of people were targeted for the state's different programmes. For instance, family welfare programmes are focused towards 'couples/individuals' in the reproductive ages. A second outcome related to the social reality within which women exercise their fertility, is that marital status determines the state's concern with women as 'targets'. Women's reproduction, from a programme point

of view, has always tended to be seen within the institution of marriage. At the PHC level, the 'Married Couple Registers' are the basic records for issuing contraceptive or health care. Note that the second official in the excerpt above notes that the target group of women are *married couples* (I#2). The criterion for falling within the state's programme is primarily the status of marriage; sexual activity is not a legitimate criterion for approaching the health system. For the policy makers, an atypical client (a sexually active unmarried woman or man) is a 'problem' and can only be discussed under the umbrella of ill health. The following transcript reveals this problematic location of un-married clients:

What about unmarried women? Are you saying anything about them or do you always speak in the context of husband-wife?

I#8:

Sex is usually mentioned within marriage.... [T]hen within adolescent behaviour, we can talk about unmarried women.

For these unmarried women, suppose - do you give education as to where they can obtain condoms?

I#8:

Yes, we are giving that.

Even if they are not married, you are giving information on what is what...

I#8:

Not just unmarried women, but also men.

How do you convey it? Do you say that if they go to PHC, they will get condoms?

I#8:

If we want to talk about sex, we can only [do it] in the general context of STD/AIDS. We can't tell them to go there [to the PHC] when they want sex. Because there is STD/AIDS, we tell them that sometimes people cannot control themselves ... in such situations they should go to the PHC.

The above remarks of the official offers a wealth of information regarding the construction around non-marital sex, and sexual activity in general, which unfortunately does not form the objective of this research. However, what is relevant is that from a policy perspective the stigma attached to non-marital sex is fundamental to the way that sexual/reproductive health care is formulated. Sexual health services are offered as part of

a package of ill health. A disadvantage of this strategy is that it is unlikely to draw people to the programme unless they consider themselves to be a ‘risk’ category when engaging in sexual activity. In the end, both of these outcomes tend to exclude rather than encompass a wider range of women.

Women Posited As Instrumental To State’s Objectives

The second instrumental construction of women that the policy makes is based on women’s role in supporting development efforts of the state. Three excerpts from the documents exemplify this connection:

Deficiencies in the arrangements for mother and child health care lead to higher incidence of maternal mortality and child/infant mortality and these also lead to low health status of women and children and in the long run is a costly burden on the national system (goi.oc.3: 2).

The RCH Programme intends to integrate fertility regulation, maternal and child health with reproductive health services... with the aim *to reduce infant and maternal mortality eventually contributing to the stabilization of population* and improve the health status of women and children (goi.oc.1: 1).

“... [w]hen she [woman] gives birth, she passes on the gift of good health to the next generation...if implemented in an integrated manner, the RCH programme will go a long way towards improving the *overall health of women and that of society as a whole*” (goi.nd).

According to these extracts, maternal health is not just significant from the perspective of the privacy and intimacy of the child-mother relationship, but from a larger socio-economic perspective as well. The first piece indicates that failure to provide for maternal health is likely to have repercussions for national health, both demographically and financially. The second firmly sets the government’s perspective on the rationale for the efforts to increase “safe motherhood and child survival”, which, eventually, is to “stabilize” population. Document goi.oc.5: 3 explains at more length that this is likely to happen because “[I]t is now well established that *parents keep the family size small if they are assured about the health and longevity of children, and there is no better assurance of good health and longevity of children than health care for mothers and young children*”. The willingness of the government to spend on reproductive health was also echoed in my interviews. As I#4 emphasized:

I#4:

We believe that any woman should have an access to free family welfare services - totally free. *Because the benefit as much as it accrues to her, also accrues to society.*

A value that supports this construction of women is the unequivocal acknowledgement that women in Kerala, as a result of higher levels of literacy and education, are aware of the benefits of small families (for instance, I#12 noted: “we have 100 per cent literacy...women’s literacy... so because of all that, there is a good awareness”). Women, therefore, form viable conduits for the state’s population programmes. The medical officers at the PHCs were particularly emphatic about women’s awareness of contraceptive and child health knowledge, and capability to take timely health measures.

I#9:

Once they [patients] have a baby, mothers come to us and ask - is there a problem if we use Cu-T? Even before we educate them, they ask us these things.

I#11:

Women, to be frank, because they have some information and ideas...they would like to do sterilizations. They know the difficulties [of continued pregnancies] more.

I#1:

Now that [intense propaganda] is not necessary. Now the mother comes to us - the family comes to us, the husband and wife comes and tell us - we want to adopt permanent methods.

In all these ground level accounts, it is the woman in her role as a mother who is the key person enacting the state’s expectation of its population programmes⁹⁷. The instrumental construction of women has its foundation in efficiency arguments for women in development, which originated in Ester Boserup’s argument that women’s exclusion from development was detrimental not only to women but to the development process itself

⁹⁷ The enthusiasm in these comments of the policy-makers counters the reluctance in the transcripts that I had reproduced in Chapter VI, where officials doubted the ability of people to make ‘rational’ choices. Although overtly contradictory statements, the policy makers’ constructions of individual’s/women’s capacities are intended to serve a similar purpose, namely, to limit the notion of individual capability. As long as rational behaviour is defined in terms of acceptance of fertility methods (or not), the state’s services are indispensable and apposite to the ‘needs’ of people.

(Boserup 1970; see also Razavi and Miller 1995a; Jackson 1996). Arguments favouring the efficiency rather than equality arguments were consolidated in the 1980s against the background of Structural Adjustment Programmes (SAPs). The primary concern that has been raised about an efficiency argument is that it undermines conceptualizations of outcomes for women on the basis of justice and equity. Women may have access to work or even credit as a result of development projects, but these may not in any way translate into transformed gender relations. For instance, Jackson (1996) cites an argument by Jeffrey (1994) regarding the widely accepted nexus between education of women and low fertility, which is seen as a statement of the empowerment of women who are now 'capable' of making decisions about contraception. Jeffrey argues that this link may speak less of empowerment of women and more of the impact of the propaganda of nuclear family ideology that is being disseminated by the state (Jackson 1996: 491). Similarly, Kabeer (1994) points out that the construction of women as mothers is a deliberate move in development to capitalize on women's work for community health purposes. By assuming that women have a 'natural' willingness to undertake health responsibilities and work in the interests of the family and community, the state has the advantage of dispensing with the need to offer women any material incentives.

A critique of the efficiency and instrumentality in development policy is located, fundamentally, not at the level of programmatic offerings, but in the positioning of women at the level of discourse. What may, at a superficial level, seem gender-sensitive is rendered antithetical to women's interests when analysing the discourses that frame these services; unless embedded within the discourses of equity, the programme can effectively limit women's agency. Some of the policy-stakeholders comments indicate that the threat of instrumentality to the idea of agency implicit in gender-sensitivity is very real.

I asked respondents if they thought that the RCH tended to instrumentalize women, and if it did, what long-term consequences would be apparent. By and large, respondents accepted that the aims of the RCH was the result of a genuine focus on women, but at the same time, there was a recognition that the commitment to women did not go all the way. For instance, in the following exchange, the independent researcher for the government said:

You don't see the RCH as [yet another] instrumentalist sort of policy?

I#3:

Well, it can work out that way, but at least the government is not - I don't think that they are thinking in that way. At least that is the impression that I get from Secretary, Family Welfare or from other people.

There is an uncertainty in the respondent's reply – although the government is not actively thinking of the policy as an instrumental one, it is possible that it may become one. The one reason for this, as suggested by another respondent, could be an issue of the state's commitment. In my interview with this middle-level official in the DFW, I asked:

The commitment to gender issues - is it a commitment to women or is it because of the larger problem of AIDS? Like what they used to say is that behind the CSSM and safe motherhood programmes was really a concern with the child welfare. More than the mother's welfare it was the child's welfare. So is the RCH something like that?

I#2:

No I think in the RCH I think the focus is in the larger interest of the women- that's how I think. When implementation comes, how far it will be will depend on the commitment. And right now I don't think there is that commitment.

At first reading, the official's statement appears self-contradictory. The first part of the response emphasizes that women's well being is a goal in itself, while the final sentence is critical of the state – *and right now I don't think there is that commitment*. The response can be interpreted as the recognition of the elements in the policy that can be marshaled for women's empowerment, but which would depend largely on a deeper philosophical shift on the part of the state. I would see the official as articulating a tension in the principles and practice of the policy; in the end, the values extraneous to the policy itself, such as the aims of women's development, will have significant bearing on women's reproductive health outcomes.

Ultimately, instrumental constructions in the policy influence the representation of the personhood of women within the state. In the RCH, women's instrumentality as mothers, who are seen committed to the same objectives of development as the state, underscores their invisibility as persons within the state. They continue to be 'targets' of what the state constructs as health needs. What ensues is that these limited conceptualizations limit the state's interests in women's long-term welfare.

Equality' As A Guiding Principle In The Policy's Strategies

The third prominent theme that emerged from the data was the government's keen interest to restore reproductive 'equality' and 'parity' between the sexes. In a tone that is almost inimical to the instrumental construction of women above, the RCH also simultaneously makes emphatic gestures to define women as a distinct group whose interests have to be served, outside of any larger ends that need to be reached. 'Equality' and 'equity' of women seems to be one such goal. The policy, for example, outlines gender specific interventions to help in consciousness-raising of women in the community and among workers within the health system. In my conversations with the Mass Media department of the DFW, I was told that sex education classes being offered in the colleges in Kerala included discussions around shared decision-making and equal partnership in reproductive matters, alongside information about sexuality and reproduction. Furthermore, proposals by the Kerala Government to the UNFPA included enhancing library resource materials on gender and development, participation in seminars and workshops, increased surveillance and recording of violence and crime against women, to name a few (gok.obp.15 (g); gok.obp.12).

However, in exploring the interpretation of 'equality', my analytical interest is in the state's proposed recommendation (and interventions) in enhancing the presence of males in the reproductive health programme. The strategy to increase male presence – variously called 'male involvement', 'male participation', 'male responsibility' and 'men's role in decision-making' is intriguing because it has made current a novel discourse for engendering population policies. Conventional seminar/educative efforts of the state rarely address male roles and responsibilities; the discourse of equality based on male participation is new to the organizational structure of the state that normally shies away from potentially controversial issues in gender relations. In examining the discursive ethos around male involvement, I do not plan to make a study of how well such a plan has been conceived or implemented by the state. Other analyses (see for example, Raju 1999) have already critiqued the government's feeble attempts at increasing the programmatic role of men. Raju's analysis shows that the state's propaganda on male involvement has not translated into written policy or concrete plans (Raju 1999: 319), and that there is no clear understanding of how to operationalize the joint responsibility of men and women.

Instead, what I explore is how the state positions women in its discursive rhetoric of gender equality.

The role of men has been, by and large, ignored in the mother-child dyad that forms a crucial foundation for the RCH. Men do not directly form a part of the sacrosanct mother-child relationship. It is, therefore, interesting to follow the lines of argument that strive to make men an inclusive part of a reproductive health agenda of the state. Chatterjee (1996), for instance, elucidates the principles behind increased male participation in the Reproductive and Child Health Policy. She states that a basic tenet of the reproductive health approach in India is that reproduction should be based on joint decision-making between “husband” and “wife” [*sic.*] (p. 38). As women bear the costs of pregnancy, the responsibility for planning or averting births, and for parenthood should be shared by men and women. Chatterjee identifies four ways in which male responsibility can be enhanced. First, the family welfare programme needs to give men information about family and their wives’ health needs, child health care, and so on. Second, the programme must motivate men to take responsibility for obtaining preventive and curative care, including family planning. Third, it needs to propagate male methods of family planning more widely, and increase the accessibility of services to men. Finally, the system needs to focus on young males in an effort to inculcate responsible sexual behaviour and improve ‘gender relations’. Pachauri (1996) argues for male involvement in programmes given the growing concern about HIV/AIDS and the unequal power that men and women wield in sexual relationships. In addition, my interviewees (e.g., I#7) suggested that deployment of more male workers in the area of family planning might also help to engender the programme⁹⁸.

My analysis of the interview data was more revealing in terms of the health department’s shift to a strategy to involve males. Policy makers offered explanations as to why male participation was a timely and relevant concept. A recurring theme that they alluded to was the discriminatory processes that have conventionally marked women’s participation in the state’s family planning programmes. Through male participation, the state strives to help

⁹⁸ Conventionally at the PHC level the ANM is involved in family planning while the JPHN (Junior Public Health Nurse), who is the male counterpart of the ANM, engages in public health, such as ensuring appropriate sanitation practices are followed in houses, etc. There is now a feeling amongst policy makers that JPHNs should also undertake family welfare related work.

women's representation be fair and equal with that of men. Some of the comments that reflected this view are given below:

I#2:

Then, more male involvement is also sought - in their sexual behaviour they (men) need to be more responsible. So also in family planning, there should be more male involvement. When the programmes first started, there were a lot of vasectomies - around 75% were vasectomies. After 1975, tubectomies were done more. We get around 500- 600 vasectomies in a year, of the total sterilizations. So we need more male involvement in that - rather than burden only women about these things.

I#1:

In the target free and participatory planning approach, this has been emphasized. In the nine months of child bearing, women bear the brunt of all the discomfort. After that, in the lactating period, women bear the responsibility. *Without using that same woman for sterilization again, but the benefits of population planning fall on women and men equally.* So men should accept vasectomy and other male sterilization. As such, we are hoping to propagate this through the IEC. In the 1970s, vasectomy camps and PHC sterilizations were there. After that, there were institutional problems. Now with RCH, male sterilization will be given more importance.

I#4:

Now, even this question of making a gender bias in the case of family welfare operations was not inadvertent - it was deliberately done. Because it was found easier...to persuade the *decision-maker* in the family *to ensure that the woman gets sterilized than to make a man do it.* So the easier option was taken...Now...one of our targets is trying to persuade - increase male participation in family welfare measures.

I#3:

Both men and women are (affected) and one has to look at that too. I mean involvement of men is extremely important. Years of working at field level and various levels, I think without men's involvement nothing can happen. So that is very important. We tend to focus just on women and forget men but we have to drag them into this too. Otherwise women are not going to go out or take decisions or they are not going to be given the kind of freedom they have. Its not only that, you know, the question of getting them vasectomized or using other contraceptive methods, its also giving support to the women and recognizing their needs and giving women the freedom to make their own decisions which is not there.

The passages offer interesting insights into why the state has suddenly espoused a male involvement strategy. All the respondents above (they are all middle or senior-level officials or consultants to the government) refer to a discriminatory attitude of the

government that the state is now trying to rectify. Women have been targeted for every reproductive intervention of the state, largely because they are easier to persuade (I#4). This had become more intense following “1975”. The reference here is to the period of Emergency that was declared during the Indira Gandhi government from 1975-1977. Family planning excesses, especially forced vasectomies, were conducted during that period, mostly on young men. During the Emergency, compulsory sterilization focused on men and the police force was used to round up young men for compulsory vasectomies. Ever since the government’s actions became an international embarrassment, the Indian state has tried to highlight the family welfare programme as a voluntary one. The other side of this ‘voluntariness’ was, as the official I#4 points out, to take the easier option – i.e., “persuade” women to undergo sterilizations. Against this history, the RCH is posited as a reprieve from an ongoing legacy; through the state’s efforts to increase male participation, parity and equality between the sexes will be established.

A second reason why the state is embarking on a programme to ensure male participation is because without men’s active involvement “nothing can happen” (I#3). The state may educate and persuade women but unless men are convinced of the benefits of the programme, “women are not going to go out or take decisions” (I#3). On the basis of the account of this respondent, we may infer that male involvement is another means to ensure male co-operation in the acceptance of family planning methods and family health strategies. The respondent goes on to clarify that male participation is advantageous not just directly (in that they can be vasectomized), but because male “support” is important to women, if they are to recognize their own needs or make their own reproductive decisions.

What do these ideologies of ‘equality’ propagated by the state imply for women? The notion of equality in feminist theory is an oft-debated issue. In the early years of the second wave of feminism, equality with men, viz., being offered the same privileges as men was the dominant interpretation of equality. The emphasis was on a formal notion of equality – same rights to vote, same status as citizens, and so on. However, recent writings have challenged this limited vision of equality because, it is argued, even though formal equality offers some protection from discrimination, it fails to recognize the substantial disadvantages suffered by marginalized groups in society (MacKinnon 1989; Majury 1987;

More 1993)⁹⁹. Feminists argue that formal equality should become the starting point for rights talk -- the plank from which law and policy can begin to offer opportunities for substantive change in the relations between men and women.

Yet, various groups tend to liberally use the concept of ‘equality of women’ while advocating interests that are likely to stymie the very efforts to help women gain an equal voice in society. The notion of equality is interpreted so that its progressive senses are usually substituted for more narrow, restricted meanings. Buss (1998), for instance, makes an interesting study of the use of the concept ‘equality’ by the Vatican during the 1995 Beijing Conference on Women (1995). She argues that the Vatican used the language of gender equality to promote conservative views on women’s roles. For instance, equality was not equated with ‘sameness with men’; such a connotation was rejected on grounds that it would taint the unique richness of femininity (Buss 1998: 347). It was easier to encourage an interpretation of equity for women, meaning ‘similar’ but not ‘equal’ rights. Some Islamic countries argued for granting women ‘equitable’ succession and inheritance rights – intended to mean ‘not the same as men’ (Buss 1998). Majury (1987:186) argues that the primary value of equality for women is the “forum it provides for the raising of issues and presenting of arguments on behalf of women”. However, in many contexts, the notion of equality is the “packaging through which one attempts to sell a particular end result”, and is used in many political and legal contexts because it is “highly marketable” (Majury 1987: 186).

A cursory reading of the RCH’s offer of equality – “*but the benefits of population planning fall on women and men equally*” (I#1 above) and “*both men and women are (affected) and one has to look at that too*” (I#3 above) – shows that the idea of ‘equality’ is embedded within a framework of wanting to offer equal treatment to both sexes. What women have always

⁹⁹ The argument for equal treatment of the sexes as against specialized treatment for women has been a particularly contentious issue in feminist legal theory and practice. The debate favours, on the one hand, meting out equal treatment for men and women (a gender-neutrality of law where *sameness* between men and women are emphasized) and, on the other, privileging special rights on women (focusing on gender specific needs and *differences* from men). MacKinnon (1989) argues that a problem that has to be grappled with in this debate is that both sameness and difference of women are measured against a male-norm, and that the entire debate of equality is trapped in a male biased perspective. Majury (1987: 172) offers a perspective on equality that shifts the onus away from defining a universal framework that can be applied in case of all issues; instead, she advances that equality should be used as a strategy to rectify inequality. As she notes, “[e]quality is more effectively seen as a means that can be used to address the inequalities that women in our society experience”.

experienced must be shared by men as well. The aim of the male involvement policy is driven by a desire to achieve ‘sameness with women’, a reversal of the conventional feminist assertion. By making the role of men in the programme more visible, the state creates the illusion of addressing women’s discriminatory position in the programme – ‘formal equality’ has been attained. Nothing in the policy’s aims seem to suggest any radical interpretation of equality; most importantly, it fails to refer to any aspect of the relationship between women and men, or between women and the state. For instance, the policy’s reconciliation of past (and likely, present) discriminations against women is to target men, rather than address the unequal relationship that exists between women and the state. So also, equality as a notion that involves men and women is referred to in the context of sharing of the impact and benefits of population planning. The discourse of male participation positions men and women as partners in a common purpose – the pre-existing relationships between the two are not the concern here. It would appear that the state is trying to emphasize *equality of* the sexes rather than *equality between* the sexes. The former interpretation limits the conceptualization of women’s unequal status in reproductive health as a programmatic mal-design; the RCH is, then, positioned as a policy that has rectified this anomaly. The deeper layers of social processes that contribute to women’s reproductive and sexual subordination are effectively left unquestioned, and are not factored into the notion of joint responsibility. Increasing the number of male vasectomies may bring a statistical parity between men and women, but in the long run, has little impact on women’s position of inequality. And, as I argue in the next subsection, this has ramifications for the way the notion of ‘gender’ itself was treated and depoliticized.

‘Engendering’ As ‘Sex-Neutral’ Rather Than As ‘Sex-Specific’

A fourth dominant theme that emerged from the policy related to the construction and development of the idea of gender. The concept of ‘gender’ has been used in development literature over the last decade or so to draw attention to the socially constructed roles that have been assigned to men and women and their implications for social, economic and political life (Moser 1993; Kabeer 1994; Rathgeber 1990; Razavi and Miller 1995a)¹⁰⁰. The

¹⁰⁰ The approach to the study of gender is commonly referred to as Gender and Development or GAD. It draws its theoretical insights from socialist feminism and its fundamental tenet is that the social construction of productive and reproductive activities is the basis for women’s oppression (Rathgeber 1990).

turn towards the concept of gender was based on the recognition that gender roles and prescribed social relations have a significant influence on the outcome of developmental efforts; in short, the ‘gender’ lens offered a dynamic analytical tool for women’s development. The adoption of ‘gender’ in the development community has had mixed responses. There is, on the one hand, appreciation for the depth of understanding that accompanies an evaluation of gender relations. As Rathgeber (1990) says, “[a] gender and development perspective does not lead only to the design of intervention and affirmative action strategies to ensure that women are better integrated into ongoing developmental efforts. It leads, inevitably, to a fundamental re-examination of social structures and institutions and, ultimately, to the loss of power of entrenched elites, which will affect some women as well as men” (p. 495). On the other hand, the ‘ab/use’ of the notion of gender has also drawn criticism from scholars. Feminist critics have expressed reservation about the tendency in recent years for official development agencies to overwhelmingly adopt the use of the term ‘gender’ instead of ‘woman’ (Baden and Goetz 1997; Buss 1998). The main problem with this tendency to substitute one for the other is the danger that a notion that is inclusive of men could gradually edge out the interests of women. As Baden and Goetz (1997: 6) point out, “...the focus on gender, rather than women, had become counter-productive in that it had allowed the discussion to shift from a focus on women, to women and men and, finally, back to men”. The engendering of development could, it seems, have either empowering or depoliticising consequences for women.

Gender, by and large, tends to be used as a synonym for women in the text of the RCH policy. For instance, gender sensitivity was defined as being responsive to women’s needs (goi.nd), and programmes designed to address gender issues largely consisted of issues around women’s rights (gok.obp.12). However, my analysis of the gender dynamics espoused in the policy does not aim to analyse the use or context in which the term gender is used. Instead I focus my attention on the process by which the state re-writes its commitment to ‘women’ as a social category as it embraces the gender dimension of reproductive health. I argue that the language of equality between men and women, viz., gender equality, in the RCH has evolved into arguments for neutralizing sex-specific concerns.

My interview responses showed a clear tendency among the participants to acknowledge that the RCH was an ‘engendered’ policy instrument. Respondents were quick to point out that the RCH, and reproductive health itself, was not the exclusive claim of women alone. For instance, a senior official highlighted that “...[s] ee, reproductive rights is not for the females, but the males, too, isn’t it?” (I#6). Similarly, a consultant for the Government of India pointed out to me, “Why do you say only women? – RCH is for men too” (I#3). Both the respondents are making a valid argument here; without doubt, both men and women have the right to reproductive well-being. Consistent with the argument made in favour of equality above, the government strives to open up women’s unique role in reproduction to males; recognising the gender dimension of reproductive health, to the state, means nullifying the sex specific claims to reproduction and homogenizing the experiences of men and women as reproductive beings within society. The officials are, in effect, positioning themselves within a liberal framework that advocates that all human beings have rights to freedom, regardless of sex. However, the move to equate men and women under the same umbrella is not that simple, or even desirable. The social context that has led to the consciousness for the need to have a right to reproductive health has historically been different for women and men. To assert that reproductive health (and the whole gamut of relations around it) as a right holds the same implications for women and men undermines this history of women’s subordination. By according equal roles to women and men in the policy, and in the reproductive process generally, these officials are not legitimizing male reproductive freedoms; they are *de-legitimizing* female rights to claims for special privileges within the RCH¹⁰¹. The attempt to ‘engender’ the policy, in effect, de-genders reproductive rights. This was affirmed by other comments that were made by officials. For instance, I#6 (above) in a later part of the interview responded to my question:

When you say ‘felt needs’, are you talking about felt needs of women or felt needs of couples or...

I#6:

Felt needs of the woman or ...the individual. The individual.

¹⁰¹ Young (1990) argues against a notion of universal citizenship, and contends that the concept of equality in citizenship can, in some cases, be achieved only by according special rights to certain groups in society. Maternal benefits for women would be a case in point. See also Lister (1997).

From a claim that both women and men had a right to reproductive health, the discourse has moved to substitute the individual for woman. The concept of gender is gradually being abstracted to the general, unsexed ‘individual’ within society. Feminists have often pointed to discriminatory connotation for women of generalized concepts like ‘citizen’ and ‘individual’ that form the foundations for liberalism (see Fraser and Gordon 1994a, 1994b; Pateman 1988; Young 1990), arguing that the history of any society is organized around dissimilar positions for men and women. The term ‘individual’, or ‘citizen’ (or even, the idealized ‘client’ in the neo-liberal market place) privileges a masculinist perspective and orders social organization around a male subject. The adoption of the general subject only effaces the notion that there is discrimination, rather than the discrimination itself.

In the context of reproduction in India (and Kerala), there is a further ramification of introducing the generalized (male) subject within the discourse of gender. The ‘individual’ has always been entrenched within the community that he comes from, usually a rural context. This is a tension within the policy (which I do not address at length here); on the one hand, the policy discourse refers to the client as an isolated individual whose freedoms, choices, decisions, and rights are her/his own insulated from the social context which s/he inhabits. On the other hand, the policy also repeatedly positions the individual as part of the community, so that the individual no longer has needs-claims outside of her/his community context. The state interacts essentially with the ‘community’, where individual interests are represented through locally elected representatives at the panchayat level. Some instances of this latter positioning of individuals are given below:

I# 8:

Their representatives [the community’s] would have discussed their needs with them. Now there is much importance for community. When we say community involvement, community leaders, voluntary organizations, local bodies, etc. will draw up a plan of action.

I# 11:

Now, first they (the ANMs) have to go and make contact with them (the community). Contact means find out their needs. Go to each place and understand. Now there is more community participation

I#7:

...through this participatory planning approach [with] more community involved...

Clearly, the community and the community's voice is also a central facet of definition of individual needs. In my analysis, I found that the shift from '*women's*' reproductive issues to '*men as well*' to '*the individual*' had one more ominous step – with the individual becoming discursively merged with the community, the distinct identity of women and their needs was being replaced by community needs. My conversation with a middle-level official in the DFW is particularly revealing in this regard. The official was telling me about the advantages of the RCH where community participation was emphasized. At that point, I asked:

Will the Panchayat members [community leaders] ask women what their needs are?

I#13:

No, all the representatives will sit together and take decisions. For example, it may be that the hospital is far away. So their need may be that there should be a sub-centre where there is a high population- *so that will be their need*...it is not necessarily that a hospital should be built everywhere having speciality care. It may be prevention of water borne diseases. In Alleppey, it is water contamination. *So that is their need. Safe water is their need.*

A key point from the passage is the shift in the way that reproductive health needs are being subsumed into larger developmental needs – “safe water is their need” or a “sub-centre is their need”. Reproductive health is no longer exclusively a discussion of women’s reproductive or sexual needs - instead it now encompasses community needs¹⁰². It is ironic that the reproductive health movement, which began as a reaction to the neglect of women’s bodies, has been subverted away from women’s needs totally. Yet, such subversion is likely to find support within developing countries where the definition of women’s needs has been an issue of debate amongst feminists. Many Third World feminists resent the strong implication of individualism present in the use of the term reproductive rights as used by First World feminism. Lingam (1995) points out that

¹⁰² A secondary issue that is revealed in the excerpt is that there seems to be uncertainty whether women will be a direct part of the discussions of the community leader. One may assume that even if there is a female presence in the leadership, women's issues are likely not to be directly on the agenda. In the continuation of the conversation, the official stated that the ANM would be the liaison between women and the community bringing their needs to such forums, but it is not established if ANMs are a part of the *panchayat* discussion process and if so, what their standing in such groups are.

“...women not only want to make an informed ‘choice’ about contraceptives...but also want control over their life situation, sustenance, safe work place, clean drinking water, sanitation, secure living space, harmonious gender relations, no violence, and no abuse”. While these are valid arguments especially in contexts of poverty, the state can employ the community’s claims for development-needs as a way of detracting from women’s centrality within a reproductive policy.

Another step in the gradual process of abstraction away from women’s reproductive health was evident in comments made by a senior policy maker about the need for similar approaches (as the RCH) in general health as well. His comment was that:

I#4:

As I told you RCH is providing an opportunity for doing this *in reproductive health*. We are looking for other options so that we are able to have this quality provision *in all our health services...*

According to this bureaucrat, the context of reproductive health can be replicated in areas of general health, because ultimately the lesson to be taken from the RCH is about quality provision of health services. The RCH and reproductive health become merely “an opportunity” – no different from cardiology, public health, curative medicine, etc., thereby, trivializing the social context of struggles around reproduction. In reducing the significance of the RCH to an improved form of health provision, the importance of reproductive rights to women is obliterated. The process of gendering reproductive policy increasingly becomes a euphemism for edging women’s specific interests out of the agenda of development policy.

Gender Sensitivity, Women and Gendered Policy: A discussion

Let me summarize the essence of the gender themes that I examined above. The analysis demonstrated the prominent ideologies that frame the RCH policy’s perspective of gender, and especially, women, namely: (a) the policy strives to homogenize men and women in terms of reproductive experiences, (b) the policy promotes a conception of gender that is abstracted from embodied woman and generalized as an individual who is the member of a community, and (c) when women are referred to as a separate category, it is usually in instrumental terms, with reference to their usefulness. The analysis showed

that the gender ideologies found in the RCH constitute a particular rhetoric about gender, women and their needs; the state's interpretation of gender is located within a discourse of homogeneity¹⁰³. The discourse of gender homogeneity is dual: first, women are equated with men, and secondly, women are equated with the social and cultural context in which they live. Even when the policy recognizes women's unique role as a mother, it is a process of negation of an individual identity outside of society.

These discourses around gender are important in our understanding of what the state adjudges as acting in the 'interests' of women. Feminist political theory has been swaying towards a conception of women's interests that is socially contingent and reflects the multiple positions that women occupy in society, both in a material and discursive sense (Pringle and Watson 1992, 1996; Mouffe 1995). The emphasis on the different interests arising out of differential location in society is also fundamental to recent theorizations of women and development (Marchand and Parpart 1995). The recognition of the different social positions for need articulation supports an analysis of 'gender' in that it questions the validity of an abstracted, individualized notion of woman out of her social settings (and which resonates with the idealized notion of the Woman in western liberal feminism). Koczberski (1998), for instance, asserts that women in developmental societies cannot be compartmentalized, and must be seen as part of a larger, interactive socio-economic context. To quote her,

[w]omen's work activities, their access to resources and their needs are not isolated fragments, rather they are intricately embedded within the communities in which they live. To ignore these linkages predisposes simplistic and unrealistic analyses and constructs images far removed from reality (p. 404).

The production of a homogeneous conception of gender in the texts and practices of the RCH emphasizes that women's reproductive needs are determined by their social roles and conditions. Implicitly, the state promotes the idea that women may have more in common with men (and their society, in general) than with a feminist ideal of universal sisterhood. As far as the state is concerned, there is no Woman outside of certain prescribed developmental roles – as mother, as wife, and as community member – and therefore, there is little need to provide a discursive space for women's reproductive

¹⁰³ The homogeneity that is referred to here is between men and women. However, this process of discursive homogeneity belies the differences among women as well.

interests in abstraction. To do so could, in fact, be antithetical to the state-defined norms of gender-sensitivity. The gender discourses in the RCH, therefore, destabilize 'Women's' interests from the centre of the reproduction process. What happens is that women cannot be extricated from the needs and expectations of social institutions – women and women's needs in exclusion of their social settings are constructed as inimical to the purposes of the exercise of their reproductive rights. In effect, for the state to engender policy, the notion of Woman must be effaced.

A difficulty in critiquing the idea of 'gender' rather than 'Woman' is that it is seen to reflect a 'realistic' picture of the Third World woman. Through the 1980s and 1990s, Third World feminists have been resisting the valuation of cultural practices in developing contexts using the norms of the West (Mohanty 1991; Lazreg 1990). These arguments are forceful and reflect the tension in the literature on women in developing contexts between critiques of a universalistic conception of women's rights and a culturally embedded perspective of women's needs. Increasingly, therefore, there is a move to define women's rights from within a framework of social appropriateness (e.g., Bunting 1993), that is, it should specify "gender, class, cultural, and other differences and recognize social needs" (Correa and Petchesky 1994: 107).

On the other hand, other feminist theorists have retained the value of a universalistic-based notion of rights as more effective for a politics of women's advancement (Schneider 1991; Nussbaum 1995). Schech (1998), for instance, describes instances in WID policy implementation where women were marginalized for the sake of cultural sensitivity, and points to the need for a cohesive sense of women's collective interests. Keyser (1995) makes an argument for focusing on the similarities of women's reproductive needs. She argues that:

Despite differences in conditions, views, and power, women share an interest in sexuality and reproduction. Sexuality and reproduction are matters of life and death, of the highest fulfillment and of deep suffering, of passion and of cool calculation, of intimacy and of public policy making.... [W] omen's decision-making in sexuality and reproduction becomes a matter of balancing personal desires and needs against socially, economically, politically defined norms and regulations which in today's world are hierarchical, patriarchal and exploitative, and not geared to people's well-being (p. v).

As Keyser notes, the ability to “balance” personal desires and needs against the norms of society (which are inherently patriarchal) is crucial to an interpretation of gender-sensitivity. The notion of autonomy must be factored into an argument for ‘culturally-sensitive’ interpretation of gender needs (Gaspers 1996). As Gaspers argues, “[b]asic rights include the requirements of autonomy of agency, not least the capacity and confidence to decide and act” (Gaspers 1996: 655). The requirement of an autonomous choice need not entail an atomistic self-focused individualism (Gaspers 1996: 654) but would allow women the ability to negotiate their reproductive needs within the decision-making process, including the ability to reject the choices that are offered to her. A gender-sensitive perspective must allow for women to express their autonomy even within a patriarchal cultural context. The notion of this autonomy has been articulated within the debate of culturally sensitive reproductive rights dominantly as the right to experience sexual pleasure. Petchesky (1998:7) reviews some feminists’ concerns that there has been greater focus not on rights but on reproduction, which may reinforce ideological bias that reduces women to one aspect of their being and marginalize others, especially (nonprocreative) sexuality. At a regional meeting HealthWatch, a medical practitioner from Kerala associated with the women’s movement noted that reproductive rights should not only mean the right to have a child but should include the right to sexual pleasure (HealthWatch 1996). Sexual pleasure is but one manifestation of women’s autonomous voice – the possibilities for women to express others can arise only in a discursive regime that permits the construction of women as having an interest in their reproductive well-being outside of their roles as mothers or fertility controllers of the state.

The discourse of gender in the RCH is clearly located within the broader debate on the need to appraise gender-sensitivity from within the context of the social setting. The point to consider is if this interpretive frame is likely to advance the reproductive interests of women. My own interviews indicated that women did seek to express an identity independent of their roles as mothers. For instance, one of the ANMs replied to my questions about women’s needs as follows:

Do our women desire to know more about FP when we [you] approach them?
Yes.

What do they want to know?

They want to know about complications after doing this (sterilization). It's about laparoscopy. They have no problem with PPS [post-partum surgery]. About laparoscopy, most people say we are burning it [the uterus].... [I]f we really compel them, they will come.

Sister, when you go to your ward, what do you see are the women's needs related to FP?

After this (sterilization) is over, they want tonics and tablets - they want medicines to recuperate. Every time we have to keep giving them medicines, if they come to PHC.

Women's requests for tonics, and resistance to having a laparoscopy done are indicators that women do have an awareness of their bodies, and a desire to do what is best for them. In some of my interviews with women, they expressed a keen interest in improving the interactive relationship between provider and user, especially when it came to providing information regarding contraceptives and their effects on women's bodies. One young mother told me that she was afraid of using any contraceptive (such as the birth control pills, IUD, etc.) other than a condom because she was afraid that it would adversely affect her health and body. She said that she would definitely attend any class or educational programme that permitted an opportunity to obtain information about these matters. Women's consciousness of their bodies in these instances is important because (as the illustrations above show) it is an articulation of interests that is contrary to what is suggested as normalizing contraceptive behaviour advocated by the state. In sum, there are specific issues to be concerned about in advancing a 'gendered' perspective of women's needs. It is imperative to ensure that the notion of gender is not used to the state's advantage, i.e., in providing for contextually relevant needs, the state is liable to focus on practical needs and ignore the issue of strategic needs (Moser 1991). Universalistic assumptions underlying women's (and human) rights can, therefore, be undermined.

What I want to emphasize is not that socially-defined rights are not relevant, but that we should be conscious of ideologies that frame certain contexts, whether they support women's ability to negotiate their needs even if contrary to the dominant discourse. As Schech (1998: 389) so rightly points out, "a space between opposing universalist and relativist claims" can be identified. She demonstrates in the context of Australian Aid projects, the significant point to examine is who or what is being excluded when the notions of 'universality' or 'culturally appropriate' frames of reference for identifying

needs are invoked. The analysis, thus far, seems to indicate that the RCH does not recognize women's reproductive autonomy outside of the norms or parameters of acceptable behaviour that the state itself defines. The discourse of gender in the RCH supports the broader rhetoric of the market, and the statist discourse on development. These, in fact, are crucial to the definition of 'socially contingent' gender needs. Policy makers working within the RCH policy, in particular, envisage that a market paradigm is likely to further women's interests. Quotes by policy makers (see, for instance, pages 152-153) indicate that notions of gender-sensitivity are closely intertwined with the values of consumerism. Quality services, the ability to 'choose' specific contraceptive methods, and pleasing service interactions with providers are the primary criteria of gender-sensitivity. However, the market, arguably, is embedded in a masculinist discourse and does not emphasize the ideology of equity and social transformation that should ground any gender-sensitive policy. Compliance with dominant discourses, no matter how socially accepted, cannot be made the yardstick for articulating women's needs. The concluding line to MacKinnon's quote that began this chapter is particularly relevant here – "[t]he pursuit of the truth of women's reality is the process of consciousness; the life situation of consciousness, its determination articulated in the minutiae of everyday existence, is what feminist consciousness seeks to be conscious of" (MacKinnon 1989: 39). As long as a gender-sensitive policy does not seek to foster this consciousness, women's interests will continue to be marginalized.

Conclusion

This chapter has analysed specific ideologies around gender that have emerged from the text of the RCH. Four dominant ideological themes were abstracted; women's instrumentality as mothers and objects of development goals, erasure of women's needs as a distinct category, and the interpretation of equality for men and women in reproductive health matters. A key finding is that these ideological considerations seemed contrary to the enormous efforts of the state to ensure gender-sensitivity in the RCH. The results raise questions regarding what constitutes gender-sensitivity in development policy, and suggests that deeper layers of ideological bias can thwart the best drawn up gender policy. The next chapter goes on to analyze the implications of these subtle constructions of gender on aspects of women's empowerment and rights.

VIII

IDEOLOGY, INTERPRETATION, AND POLICY IMPLICATIONS

Co-option in the Discourses of the RCH Policy

Twelve voices were shouting in anger, and they were all alike. No question, now, what had happened to the faces of the pigs. The creatures outside looked from pig to man, and from man to pig, and, from pig to man again: but already it was impossible to say which was which.

George Orwell, Animal Farm, 1986, p. 95.

The analysis in Chapters 6 and 7 argued that the RCH, as a reproductive policy, is the articulation of diverse ideologies, especially those around the market and gender. The former – the market discourse - increasingly commodifies the subject-position of the user of the state's health services, while employing the discourse of democratization of citizenship. The ideologies of gender encourage a conceptualization of gender that negates women's interests as a specific set of needs within the policy. As a policy of the GoI, therefore, the RCH is not a direct translation of the ICPD's resolutions for population policy. The Indian reproductive health policy is clearly the outcome of the active negotiations between competing globally and locally produced discourses and, drawing on Fraser's model elucidated in Chapter 2, is an 'interpreted' discourse. In this chapter, I evaluate the implications of these ideologies for the policy as an aggregate instrument. I argue that, *prima facie*, the prevalence of these ideological standpoints has ramifications for the way the policy is interpreted by those who enact it. My premise is

that such re-interpretations eventually increase the chasm between the norms set in place for a reproductive policy at the ICPD¹⁰⁴ and the reality of practice in local contexts.

The analysis in this chapter has been informed by Fraser's model (see Chapter 2) that the state's inherent ideologies will be used to interpret the rhetoric of the oppositional discourses, and Pringle and Watson's (1992) argument that the state's representation of 'people's needs' can never be pure – it is coloured by the state's own particular ideological perspective. I have already elaborated the ideologies of the market and gender that form a dominant discursive framework for the GoI. This chapter will examine the implications of these ideologies for reproductive health as a gender discourse, and ultimately, as a political discourse. This chapter has two broad analytical objectives. First, I analyze how the neo-liberal market ideology positions the state as a health provider, especially, how it constructs the state's obligations to the client/consumer/citizen. Secondly, I demonstrate that policy makers, located within this construction, interpret the feminist language of reproductive well-being from within the ideology of the market. The process of policy interpretation is simultaneously also a process of discourse co-optation.

The Market as an Interpretive Framework for Reproductive Health

Chapter 6 considered at some length the discourse of the market that pervaded the construction of the user of the family welfare services as a client of the health system. Here, I look at some of the institutional outcomes - immediate and potential - of adopting market criteria. I show that in the case of the Family Welfare Services in India, the trappings of the market ideology have been central to the kinds of interventions that the state has chosen to make (or not) - some of which may positively affect users and some which may not.

A significant outcome of the integration of the discourse of market with reproductive health that emerged from my analysis is that there is a perceptible shift by the state to

¹⁰⁴ This is not to suggest that the international norms for a reproductive health policy are a 'pure' discourse that addresses a woman's perspective absolutely. Even though the ICPD resolutions have themselves been actively negotiated (often through acrimonious debate), the emphasis of the Conference on addressing gender inequality, nonetheless, provides a firm base for promoting women's reproductive interests (see Presser 1997). For a critique of the ICPD, see Copelon and Petchesky (1995) and Petchesky (1995).

situate its operational efforts within a ‘management’ driven paradigm. The state’s reproductive health policy increasingly blends the discourses of development with that of management, so that it re-writes its own and the ‘client’s’ obligations, expectations, rights and duties within the framework of management. It is interesting to follow how the state’s policy simultaneously articulates the discourses of management with efforts to improve the developmental status of the socially disadvantaged. To emphasize this point, I employed a ‘structural’ approach to my qualitative analysis¹⁰⁵. I selected an extract from document goi.oc.3, as it is easier to work with a smaller piece of text in such analyses (see Appendix G). The excerpt was chosen because it stated the rationale for the implementation for the RCH; in the words of the document, it provides a “description of the proposal/scheme and its objectives”. I reduced the selected text by categorizing sentences and parts of sentences (as long as they were meaningful) into one of three predominant thematic discourses: management discourses, development discourses, and feminist discourses. Examples of the three kinds of discourses are given in Table 8.1.

Management discourses were identified by the use of key words belonging to the discipline of management like ‘integrate’, ‘facilitate’, and ‘optimize’, all used to describe desirable outcomes in the programme¹⁰⁶. Further, sentences that referred to organizational and systemic modifications were also sorted as belonging to a management discourse. Feminist rhetoric included statements that were gender-sensitive; as shown in Table 8.1, the definition of reproductive health used in the RCH policy came from within the World Bank (Fathalla 1988), but reflects the discourse of reproductive empowerment produced within the women’s health movement. Development discourses reflected issues of health and social development, drawing on theorizations widely accepted within the discipline of development. In the example above, the sentence draws on the evidentiary link between perceived survival of child and fertility levels.

¹⁰⁵ I use the term ‘structuralist’ approach drawing on Silverman (1993). Silverman uses a structuralist analysis to analyse a text from within the reality of the authors of the text, rather than critiquing it using an alternative version of reality. Silverman uses simple techniques of counting, classifying and sorting to identify the ideological positions taken by authors of text. Note that this technique is not the same as the one that has been dominantly employed as part of the qualitative (theme) analysis in this thesis.

¹⁰⁶ These terms may be used in all disciplines without any overt resemblance to the functional meanings of management. However, my analysis will show that in context (in the RCH) there is a strong indication that the interpretations of the meanings (and desired programmatic effect) are from a management perspective.

Table 8.1
Examples of Feminist, Management and Development themes

Theme/Discourse	Examples
Feminist	<ul style="list-style-type: none"> • ...the basis of the RCH has been defined as "people have the ability to reproduce and regulate their fertility..." • women are able to go through pregnancy and childbirth safely... • the outcome of pregnancies is successful in terms of maternal and infant survival and well-being... • couples are able to have sexual relations free of fear and pregnancy, and of contracting diseases..."
Management	<ul style="list-style-type: none"> • integrated implementation would optimise outcomes at the field level
Development	<ul style="list-style-type: none"> • ...health of women in the reproductive age groups and of small children...is of crucial importance for effectively tackling the problem of growth of population...

Once I had classified statements as belonging to one or the other discourse, I examined the data for two specific trends. The first was to see which discourse was most frequently repeated and the second, to examine the purpose for which each discourse was being used. Using a simple count, it was clear that terms relating to the management discourse were most often repeated in the text. Some of the uses in which the management discourse emerged are as shown in Table 8.2.

The word 'integration' and its variants appear around eight times in the text, and 'efficiency/effective' around five times. However, it is in the way that the management discourse was deployed that was particularly significant. I found that each of the discourses had a distinct role to play in the text. The Development discourse was presented to establish concerns and social problems, and the Management discourse was used simultaneously as the cause for these social problems, as well as solutions to these developmental problems. The Feminist discourse was sandwiched in between these two other discourses to assert a gender perspective. But the Feminist discourse too was used primarily to support the management theme as a solution for development problems.

Some examples of how these Cause-Effect relationships were supported are given in Table 8.3.

Table 8.2
Samples of management discourses

Sample of text	Line No.
• <i>separate identity</i> causing problems	(In.15)
• (problems in) <i>effective management</i> reducing outcomes	(In.16)
• programmes were <i>integrated</i> under CSSM	(In.17)
• process of <i>integration</i> was taken a step further (at Cairo)	(In.20)
• participant countries should implement <i>unified</i> programmes for RCH	(In.23)
• an integrated approach to programmes	(In.29)
• integrated RCH programme	(In.31)
• reducing costs of inputs	(In.31)
• overlapping of expenditure would no longer be necessary	(In.32)
• integrated implementation	(In.33)
• optimise outcomes	(In.33)
• (RCH programme conducted) within a framework of such integrated approach	(In.38)
• (the proposal) integrates all the related programmes	(In.39)
• an efficient arrangement	(In.42)
• effectively tackling (population growth)	(In.43)
• Deficiencies in arrangements	(In.44)
• Effective RCH is crucially important	(In.48)
• (RCH) intends to attain integration	(In.54)

The conjunctions ‘lead to’, ‘is a prerequisite’, and ‘aimed at’ links the management discourses with development problems. By merging the discourses of management and development, there was the tendency for the policy to promote management solutions for development problems – an “integrated approach”, for instance, would improve the “health status of young women and children” (see Table 8.3). As in the case of other arguments made in this thesis, the improvement of institutional facilities *per se* is not being contested in this analysis. What I attempt to point out is that the management perspective overshadows the *causes* of developmental problems. Thus, it need not necessarily be deficiencies in the institutional arrangements alone that lead to maternal mortality, but, as Sen (1990) suggested, the ineffective entitlements that women are given in society that make it impossible to access these facilities. The broader developmental context in which poverty, unemployment and unequal social relations are crucial factors

of health conditions is effectively superceded by managerial and organizational modifications.

Table 8.3
Linking Development and Management Discourses

- Deficiencies in the arrangements for mother and child health care *lead to* higher incidence of maternal mortality...
- An efficient arrangement for implementing RCH programme *is a prerequisite* for tackling the problem of population growth...
- ...an integrated approach to the programmes *[is] aimed at improving* the health status of young women and children...

In emphasizing managerial outcomes, the state emphasizes that the client's (by virtue of being a consumer in the market place) prime expectation from the health care system is that of *quality*, i.e., effective and efficient services. To quote one bureaucrat in the Ministry: "...quality service... means we have to give the quality service...technology and *modern line of management*" (Interview I#6). The "modern line of management", pointed out by the official, was associated with the idea of efficiency. As document goi.oc.5: 3 notes, "...without such efficiency (of the health system), the *quality of services* to citizens or *even effective access to health services cannot be assured*". Ineffective institutional structures are directly linked to the failure of the state to meet the user/client's needs. Documents, for instance, note that a major flaw in the existing infrastructure is lack of effectiveness - which is that "in almost all respects, the health care system needs upgradation and it needs to reach out to many more people" (goi.oc.5: 2). Similarly, the documents claim that, over the years, several programmes co-existed with similar objectives independently administered so the "separate identity for each programme was causing problems in *effective management* and this was also reducing [somewhat] the outcomes" (goi.oc.3: 1). The "indifferent success" of the state's programmes is also attributed to the inefficiency in service delivery (goi.tm.2: 2). Further, it was pointed out that an efficient health system could be achieved by integrating various services, which "would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would *optimise* outcomes at the field level" (goi.oc.3: 2). The use of the notions of efficiency and effectiveness also permeates the state's efforts to organize institutional change. For instance, the documents note that the

various health functionaries must “...acquire the knowledge and skills to *deliver the services effectively and efficiently* under the new dispensation”(goi.tm.2: 1), and that “...the achievement of these [demographic] goals necessitates improvement in the knowledge and skills of health providers both in clinical *and managerial spheres*” (goi.tm.2: 1). The discourse of management forms the epistemological backdrop to resolve developmental concerns.

The implications of the managerial paradigm is clearly under-written in the state’s interpretation of its obligation to provide for the users of the family welfare services; the state, in the RCH, constructs its primary obligation as one of providing for *efficient* and *effective* services. The RCH, purportedly aiming to overcome the shortcomings of earlier programmes, claims to operate under the conditions of efficiency and effectiveness. The documents equate efficient management with the basis of the reproductive health approach - “this concept [the definition of the RCH]¹⁰⁷ is in keeping with the evolution of an *integrated approach* to the programmes” and its centrality in the national programme - “...*effective RCH programme* is crucially important for more than one consideration in the national system” (goi.oc.3: 2).

In sum, the integration of managerial efficiency is the state’s expression of neo-liberalism. The adoption of the managerial/market/neo-liberal norms, as I demonstrate below, forms the paradigmatic foundations for interpreting and designing elements of gender-sensitivity in the policy.

Policy Interpretations and Reproductive Health Discourse

The analysis above aimed to highlight that the design of a gender-sensitive reproductive health policy in India is also the articulation of neo-liberal values embraced by the state. The policy suggests a re-writing of the roles of the state and of citizens – their expectations, rights and obligations. The ethos of the RCH – in particular, the emphasis away from the state as an agency of social equity but rather of institutional efficiency -

¹⁰⁷ Document goi.oc.3 notes that the basis of the RCH has been defined as “people have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and child survival and well-being and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases”.

forms the framework that guides policy makers' interpretation and enactment of policy. This ethos is critical to the localized interpretation of the values of gender and reproductive equality that was propagated at the ICPD conference, and which was expected to be the basis for the practice of reproductive policy in local and micro-contexts. The analysis of the local institutionalization of the policy is, in Fraser's (1989a, 1989b) words, an analysis into the process of 'de-politicization' and 'bureaucratization' of the oppositional discourse of feminist reproductive agency. In this section, I analyze three keywords associated with the production of a feminist discourse of reproductive health that were widely used at the ICPD - empowerment, rights, and choices - as have been interpreted in the RCH documents and by policy makers.

Interpreting 'Empowerment'

The concept of empowerment is embedded in the text of the RCH as a goal that has to be achieved within the context of development, for citizens, in general, and women, in particular. For instance, document goi.oc.5 points out that "...while there is steady improvement due to economic development, spread of education/literacy and *empowerment of citizens*, substantial problems in regard to education /literacy particularly among the weak performing States and in regard to *empowerment of women*, remain" (goi.oc.5: 2). The emphasis on women's empowerment is a central focus of the UNFPA programme in India which asserts "[e]mpowerment of women and improvement of their status are important ends in themselves and are essential for the achievement of sustainable development" (unfpa.obp.2: 1). The MOHFW's references to women's empowerment are more recurrent in recent documents. The document that was presented at the ICPD 1994 (*India Country Statement for the UN Conference on Population and Development*) makes only one passing reference to women's empowerment. In contrast, the RCH documents (produced by the state in the wake of the ICPD) and plan proposals to the donor agencies are more forthcoming in concrete plans to address this issue. In the Kerala government's IPD (*Integrated Population and Development*) project, for instance, the state proposes to set up a core group of resource persons in each district, who can train educators on "gender issues" (gok.obp.12). The Government of India documents note that the state plans to address empowerment of women through its IEC (Information, Education and Communication) work. Doc goi.oc.5: 31 notes that the

government will encourage private filmmakers "...to make films of one to one-and-a-half hours on any of the themes relating to *women's empowerment*...[and] issues relating to the girl child...".

The government's efforts to push women's empowerment onto the mainstream agenda of population policy have, by and large, been applauded. For instance, a volume on the implementation of the RCH in India published by the Population Council of India (Pachauri 1999) has praised the role that NGOs play in addressing issues of empowerment and, particularly, the partnership between the state and NGOs that has marked the design of the RCH programme from the outset (Mukhopadhyay and Sivaramayya 1999). Similarly, the concept of community needs-assessment has also been highlighted as a significant aspect of empowering individuals (Mukhopadhyay and Sivaramayya 1999). Further, the authors point out that the RCH was implemented at a time when the Indian State was passing the 73rd and 74th Constitutional Amendments, which made women's representation in local government bodies (the *panchayats*) mandatory¹⁰⁸. Thus, by the time the RCH was initiated over 800,000 women, many from socially and economically backward classes, had been chosen as people's representatives in villages across the country. The implications of women's local representation for the institutionalization of empowering programmes under reproductive health, these authors argue, are tremendous (Mukhopadhyay and Sivaramayya 1999: 341).

In addition to textual references, I was keen to explore policy makers' perspectives on empowerment. In particular, I focused on how they conceptualized the idea of empowerment in the context of the RCH, its relevance in a population policy, and how it would be strategized in implementation. From my interviews, it was clear that, by and large, policy makers were cognizant of the relevance of the concept of empowerment for reproductive policy. One middle-level bureaucrat at the DFW assured me that "...we are giving more importance to women's empower[ment]" (I#6). I was keen to examine how far the policymakers were willing to stretch the idea of empowerment. From my interviews I extrapolated the various interpretations that policy makers used to define

¹⁰⁸ According to the Bill, one-third of all seats in local bodies must be occupied by women.

“empowerment”. Some of the more frequently recurring descriptions of the idea of empowerment as expressed in my interviews are tabulated below¹⁰⁹:

Table 8.4
Descriptions of Empowerment by Respondents

- | |
|---|
| <ul style="list-style-type: none"> • Increasing employment facilities • Increasing educational facilities • Addressing issues of violence • Seminars for women and adolescents • Increasing role of women's NGOs • Legal framework within the RCH (as a Consumer Protection Act) • Addressing intra-household gender biases • Information about reproduction • Reservation of seats in government bodies |
|---|

I found that the most common references pertaining to empowerment were to increase opportunities for education and employment for women. Respondents also pointed to the changes in the political climate and the increased opportunities for the participation of women in the political system as empowering for women as a collective group in the nation. Some of the respondents also talked about the various forms of ‘atrocities’ that were being committed against women and associated measures to reduce such crimes with empowerment (Interview I#2, I#7). Within the context of the RCH, seminars and local level training for staff of the health system, and for members of local communities were also proposed as part of a multi-pronged strategy to increase women’s empowerment (Interview I#1). Still other officials felt that the provision of information within the RCH itself was empowering to women (Interview I#4).

In contrast, respondents were less forthcoming when they had to associate empowerment with transforming gender relations within the family. Although there were references to empowerment as the politics of social transformation (as is indicated

¹⁰⁹ It must be remembered that the interviews were not surveys or based on multi-choice questionnaires. Therefore, the responses I have tabulated should be read as trends rather than as based on numerically significant values. Also, the references have been ranked in terms of frequency of repetitions, i.e., generally, the interpretations I have mentioned first were the more recurring one, the one below, less mentioned and so on.

in Table 8.4), often this was admitted only after I asked probing questions. Several of my respondents admitted that not enough is being done to change conditions for women in Indian society. For instance, I#1 notes "...at present they (women) do not have a bargaining power. Now, as it is, to...negotiate – that power to change things – they still don't have it. I still agree that there is male dominance." There was a recognition among policy makers that issues of reproductive decision making, in particular, were determined by intra-household power hierarchies, and that women, quite often, did not have control over these decisions. For example, the following transcripts point out that policy makers are aware that women have restrictive control over decision making within the family.

I#4

...so whatever is the power equation within the family, it [reproductive decision-making] could rest either with *the husband, or the mother-in-law or with the woman, the wife*

I#6:

No, this [decision making for women] is...a problem just consisting ...within the family – just limited in the family circle. *It has not come out [been made public]*

I#8:

When there is a problem in the family, decision-making may be equal. But when we consider sex behaviour, *decision-making rests with the man only...*

The responses indicate that policy makers did recognize that the issue of women's roles and decision-making within the conjugal and family unit was a serious one to be reckoned with. By implication, any wholistic approach to reproductive well-being cannot escape addressing issues of power and substantive transformation. However, when my questions sought to ask them how the RCH had incorporated issues of power into its strategies, policy makers were resistant to the idea that a population policy should deal with such issues. The independent consultant referred to another project that she was involved with in another part of the country, and where empowering women was undertaken seriously:

I#3:

...but the way, once women have been made aware of their rights – their legal rights, their property rights, right to health. The way they

have come up and the way that they are mobilizing other women...it is fantastic...that kind of thing is not there in the RCH project...

Do you think that it is a major lacuna?

Well, it is one of the lacunae. I can't say that it is the major.

The consultant's undermining of the significance of a component in the RCH on educating women to take control over their lives is surprisingly not an isolated one. There seems to be a pattern of thought amongst the policy makers (see the following quote) that such activities were beyond the responsibility of the state because there were social boundaries that the state was obliged not to transgress, for the sake of safeguarding the sanctity of the private sphere. As the senior official told me, the state has a "hands-off policy" on power issues within the family (I#4). While the acknowledgement of the domain of the private is in itself not unusual, it is *where* the state positions itself with respect to this domain that is important. The senior official in the following excerpt categorically states that the power equations within the family were not something that the state was willing to address:

I#4:

[Now]... why isn't it that the government doesn't want to work in this area (of addressing power relations) which, by my own admission...is an important area. The [answer] is that we will be generating *too much hostility*.

How?

Trying to tamper with any power equation in any society is going to engender hostility from the people who are in power

...[so] the state right now is not in a position to tamper with the empowerment issues of women?

The state has not chosen to, let's put it that way

...[so] does the state have a hands-off policy?

Yes, a 'hands-off' policy on that (I#4).

The transcript demonstrates that despite the recognition ("by my own admission...is an important area") by the official that women's inferior position in society was an issue to be addressed within reproductive policy, there was reluctance for the state to take on

that responsibility. The state's decision not to intervene in such matter – the hands off policy – is a conscious one because it “is going to engender hostility”. The implication of the official's response is that the state produces and maintains a separation between two spheres in society – one where it can intervene in people's reproductive lives, and one where it can't. The state draws a line marking the 'private' beyond which the state sees intervention as liable to induce hostility. It is a domain marked by power relations that is sanctioned by society. The social dichotomy that the state refers to is important because it is based wholly on gender.

A similar position was taken by the consultant that I had interviewed. She felt that the processes that marked the private sphere were not the state's responsibility; rather it was the role of non-governmental organizations to take up such activities.

I#3:

I don't believe that the government can do [it]. The government can do a lot of things like providing infrastructure and training for staff, but these sensitive issues, I think NGOs and you know, other organizations will have to play a major role. Governments are not equipped to do that. They do not have the support. So the NGOs definitely have to play a role. The NGOs cannot just sit back and point their finger at the government and say “Come on, you do it”. You can't. It has to be a partnership.

The respondent points to the impotence of the state in “these sensitive issues”. The state can provide infrastructure and staff sensitized to issues of women's reproductive empowerment, but it cannot be charged with enforcing these changes. This task can effectively be done by NGOs or women's organizations. The consultant, in this instance, constructs the state outside of the private-public divide that prevails in society.

The contradiction in the sub-text of the policy is apparent. On the one hand, the RCH is touted as an instrument that will alter the conditions under which women live and make reproductive decisions. On the other hand, there is a reluctance to permit issues of women's empowerment to take a front seat in the discourse of reproductive health. The state is comfortable about promoting 'empowerment' measures for employment and education because it does not necessarily lead to volatile transformations. After all, these efforts at empowerment are expected to alter conditions in women's economic status

enough to give them leverage as social bargainers in the long run. However, this passive approach to empowerment, on its own, is clearly an ineffectual strategy to address women's subordinate status in society (see Sen 1994a; Kabeer 1994). Unless accompanied by active efforts on the part of the state to address power relations within the household and communities directly, there is going to be little substantive changes in the lives of women, even with education and employment.

Interpreting Reproductive Rights'

Another fundamental concept that I examined in the RCH was the perception of the state to provide for 'rights' as part of a gender-sensitive reproductive policy. It was noted in Chapter 2 that the POA of the ICPD locates reproductive health and rights within a broader context of women's self determination and control over their reproductive and sexual lives. It was also pointed out that the ICPD valued women's equality and empowerment as end goals of a reproductive policy. The notion of 'rights', therefore, is central to the formulation of a reproductive health policy. Feminists argue (Cook 1995b; Dixon-Mueller 1993; Correa and Petchesky 1994) that there are two kinds of actions that the state can undertake to provide for reproductive rights for citizens. First, there are positive actions or areas where the state actively intervenes and, second, there are negative actions or areas where the state refrains from acting so as to permit citizens to act in privacy. What is important is where the state draws the line regarding when or when not to intervene.

I analyzed the data corpus of the RCH to assess the policy's perspective on issues of women's reproductive and sexual rights. It is striking that the policy documents (not the interview transcripts) do not make any direct reference to women's rights or reproductive rights¹¹⁰. In my interviews, I tried to gauge policy makers' perceptions of these notions of reproductive and sexual rights through direct questioning. The term 'reproductive rights' is a generic one and, despite formal definitions (as, for instance, that used by the human rights charters), is open to interpretation. In my interviews, I deliberately used the term 'reproductive rights' without expressing it as a composite of other rights (like the right to decision making, right to choice, etc.). In two cases,

¹¹⁰ As I noted in Chapter 6, the documents do refer to 'rights' of citizens and clients. My focus here is on any references to women's rights and/or reproductive and sexual rights for women.

respondents asked me what I intended to convey in using the term 'reproductive rights'. In all other cases, the officials had formed an opinion on the basis of an interpretation that they had already formed.

As will be seen from excerpts reproduced below, the officials sat uneasily with the notion of reproductive rights. The responses that I have reproduced come from the entire cross-section of respondents. They include both male and female middle-level bureaucrats, local providers and even women activists from NGOs. Some of their responses follow:

I#7:

Now, every human being has certain rights - international rights, some reproductive rights. *But at the present stage of economic level in India we will not be able to provide all those rights to people.* Everybody should be able to have a better living, better standards of living, all those things. This can be envisaged in this 'rights', reproductive rights, of the people. But these you cannot in one fine morning achieve all this things. It will take a long time, it will take some time first to achieve that. Those countries that are rich enough, it is all right for them but for us it will take some more time to reach that level...

I# 6:

There are national ethics, and all have to be observed. *Along with that our cultural traditions are to be observed.* It's not just taken ... because our cultural constraints, our traditions are there and all.

I # 3:

It's [reproductive rights] incorporated but I can't say that's the main focus. See you also must understand one another thing – it's really easy for you and I to talk about reproductive or sexual rights...[*I persist with the question - that the policy itself does not have any legal framework to it or any way that one can seek redress]* **No...[s]ee that is - it has nothing to do with the RCH...**

I# 9:

Since I am a person who likes old-fashioned things, my opinions may be different from other people's. *But when we speak of rights, I don't think that it is a good thing.*

I#5:

I don't think that ...*But rights - reproductive rights and sexual rights issues is... I think it is much more of a concern in Latin American countries...than it is here...but more than that, I don't know...I keep...whenever I read of*

rights, that is, when I read it in the context of Latin American countries...

It is interesting that there is relative unanimity in the way that the notion of ‘reproductive rights’ was rejected across the board. The concept was seen as either alien to the Indian context, detrimental to the harmony of the family, or in some cases, as a western ideal, which could be reached at some future stage. Reproductive rights were associated, by the respondents, with culture, society, family, and even economic conditions and the nation¹¹¹. And, all of these dimensions of life were, according to these responses, likely to be jeopardized by integrating the concept of reproductive rights into a reproductive health policy. ‘Reproductive rights’ was naturally assumed to be a concept that could rend the fabric of society. This could explain the cautionary note about upsetting “tradition” and “culture” and wanting to retain “old-fashioned” values that are repeatedly mentioned in the interviews (I#6, I#9, I#7).

A second point is that when the respondents spoke of reproductive rights, it was automatically assumed that it was something that would be endowed upon women, even without my explicitly affirming this. All of their concerns of the detrimental effects of reproductive rights were implicitly drawn because of the association of reproductive rights *with women*. It seemed as if reproductive rights could trigger a gender revolution, as an outcome of powers that women receive. Interestingly, the officials I interviewed were conscious of the discriminations that women face in the sphere of reproduction. Many of my respondents acknowledged that women, especially in marital relationships, could not make decisions about their bodies – they would have to succumb to the expectations of husbands, in-laws, and the community (see, for example, I# 8 in the section above). The disparity between women and men in matters concerning sexuality and reproduction is widespread and part of the cultural landscape of Indian conservatism (for example, Dube 1986; Krishnaraj 1995). But, despite this recognition, policy makers were more comfortable with dealing with the issue of rights as a ‘community’ problem

¹¹¹ Underlying these concerns of ‘destabilizing’ society, there is an implicit construction of women’s sexuality as needing to be restrained or protected. Although not explored in this thesis, the construction of women’s sexuality (particularly, as heterosexual, passive rather than expressive and almost wholly within conditions of marriage) underpins the way women are located within the programme. The Life Cycle Approach, for instance, will not fit the sexual patterns of single women or widows who are sexually active. These statements on reproductive rights made by these officials are a manifestation of some of these ideological beliefs.

rather than as a ‘woman’s’ problem. As the following excerpt shows, there is a reluctance to address rights specifically for women. Note the way the consultant simultaneously collapses women *with* and as *apart* from the community.

I#3:

... the point is that we need to educate the community about...their right --the right to abortion, that no doctor can charge a woman in a government sector, their right to question. Their right to whatever it is...*(but) we have not reached that stage where we are educating, will be educating women.*

The respondent vacillates between “their” or “community” rights and “women’s” rights. She recognizes that the community needs to be educated about “their” rights – be it to abortion, or questioning the workings of the health system. A similar assertion is absent when referring to women. Notice how the consultant shifts positions when referring to the ‘community’ and ‘women’. With the former, the respondent argues in favour of their rights- *we need to educate* – but when the issue is women’s rights, the consultant replaces affirmative thought with negation of action – *we have not reached that stage*. It is not clear if the respondent refers to the state, the health sector or the Indian society, as a whole when saying that “we” have not reached *that stage* when women will be educated. The obvious reason for the reticent attitude to educating women is that women’s rights (as demonstrated in the section above) is always a cause for volatile and reactionary responses from the community, and it would not augur well for the state to be embroiled in gender politics. As in the discussion of the concept of empowerment above, the state’s hesitancy to broach the public-private divide is clear. However, drawing on the ideological themes that were discussed in Chapter 7, what is interesting to note is how the community is seen as apart from women. Women are not discussed as ‘the’ community, but as a community within the community - a group with minority status within the community.

The third point that must be highlighted is that not one of the respondents whom I presented above felt that rights as a concept or strategy could be integrated within the ambit of a policy. The issue of reproductive rights was so embedded in a conception of upsetting the public-private divide, that it could find no place within a population policy. Their attitude indicated a tendency to distance the state and policy from ‘sticky’ issues of

gender relations. One respondent even dismissed outright the notion that reproductive rights have anything to do with a reproductive health policy: "...that is, it has *nothing* to do with the RCH" (I#3). Only one of my interviewees, the official in charge of mass media, who is not included in the excerpts above, seemed to grasp the sense in which reproductive rights could be translated into policy. When I asked the official how the concepts of reproductive and sexual rights could be integrated in the policy, I was told:

I #8:

How we mention reproductive rights in the messages? We say in classes *that in a house to have a child, it is the right of the woman*. That is how we say it. So it has to be the mother who decides when the child has to be born.

A fourth point is the reference that was made to Latin American countries by I#5. The association with the Latin American context shows that the idea of reproductive rights is associated with rights to legal abortion and contraception. Since these are already legal and available in India, 'reproductive rights' is not seen as having relevance for Indian society. The conceptualization of reproductive rights, subscribed to by this interviewee, is also fairly narrow and exclusive. It does not understand the concept of rights as issues that must be addressed at the level of society, rather than merely a legal formality. In this view, the state is absolved from ensuring conditions for satisfactory fulfillment of reproductive freedoms (positive freedoms/social rights) because it has, through legislation, permitted individuals to exercise their reproductive rights in private. Issues around enabling conditions and access are not included as part of this discourse on reproductive rights. In sum, this view perpetuates specific ideas around state's and individual's roles in reproductive health. The former legitimises the exercise of private rights. The state, however, is not obliged to see rights as an ongoing, daily struggle for women.

To summarize the respondents' views on reproductive rights, I found that there was a universal tendency to portray the notion as anathema to the very purpose of a gender-sensitive reproductive health policy. I also found that the resistance was largely because the term was associated with emancipation for women.

Interpreting 'Choices'¹¹²

The concept of 'choices' is central to a feminist notion of reproductive well-being. The women's movement has seen the opportunity for women to make choices as the key to having control over their bodies. Pine and Law (1995) argue that a feminist concept of reproductive rights is constituted of three interrelated components: (a) a principle of freedom from State control, i.e., the woman, rather than the state, must have the right to make decisions that affect her reproduction; (b) a principle of governmental neutrality, which is that the State must assume an even-handedness with respect to reproductive choices; and (c) a principle of affirmative reproductive liberty, that is, the state must support a social context that enhances human freedom to make reproductive choices. The right to choice, for feminists, goes beyond an abstract conceptualization or liberal ideal. The freedom of choice is grounded in material and social reality, and is relevant only as long as there is the opportunity to exercise that freedom. As Petchesky (1986: 11) points out, "[t]he critical issue for feminists is not so much the content of women's choices or even the (abstract) right to choose, as it is the ... conditions under which these choices are made. The 'right to choose' means little when women are powerless". International charters and documents on human rights also endorse the centrality of a right to choose as integral to reproductive rights. The WHO, in defining reproductive rights, specifies that individuals must have the right to "have information and means" to control fertility. The ability to make informed decisions about the suitability of a contraceptive would depend greatly on how much impartial information is given to users and the range of choices offered to them. Ideally, the state ought to encourage women to make informed choices and, to aid them in decision-making should provide necessary information and conditions. Coliver (1995) argues that in the past the freedom to expression has meant the right to impart and receive information without government interference. But this freedom has evolved to the point when it is both obligatory for states to provide, *and* refrain from interfering with the communication of, information that is necessary for the protection and promotion of reproductive health and choice. Population policies, in particular, have been known to promote certain contraceptives or restrict access to others by not making them available, or by giving inadequate information.

¹¹² Portions of this section were originally published as a monograph (see Kumar 1997).

The term ‘choice’ has also come to be a part of everyday conversation from another quarter. The word ‘choice’ is a part of the growing discourse of marketization and the consumerist culture and has, of late, trickled down from the domain of consumption of articles and services, to the organization of social and political life. Phillips (1996) examined the Thatcherist discourses of the early 1990s, and pointed out that choice was a key word of the Thatcherist discourse, employed by the Conservative party. Her findings showed a persistent linking of the term ‘choice’ with words like consumer, rights, quality, citizen and efficiency, so that the vocabulary of the market and consumerism began to define the relationships of citizenship and rights. Phillips also pointed to the novel linkages between keywords, leading to a hybrid political discourse that consisted of elements of the Thatcherist and welfare discourses.

The text of the RCH policy documents did not make explicit reference to the word ‘choice’ (although the interview transcripts did so). Save for a passing mention that “...couples should be able to choose from various contraceptive methods including condoms, oral pills, IUDs, male and female sterilization” (goi.nd), the documents do not elaborate on how choices may be made, or how the cafeteria approach¹¹³ has been modified so as to improve choice under the new programme, etc. However, since reproductive health as a political discourse is ineffective without the opportunity to exercise choice, whether explicitly or implicitly mentioned, the question of ‘choice’ formed part of my interview questions. As in the case of the concept of ‘rights’, the word ‘choice’ was used loosely in my interview questions. The statements of the respondents helped me organize the various discourses around the notion of choice, and its interpretation in policy and practice. My analysis of the interview data indicated that most interviewees were likely to interpret the concept of choice as an attribute of a consumer in a market place. However, this interpretation was mitigated by the need to be compatible with belief structures that give priority to the state’s ideologies around fertility control and its developmental consequences. At the same time, they were also cognizant of its meaning in an expansive sense that was associated with autonomy, freedom and liberty. Both these perspectives influenced respondents’ perspectives of the idea of choice – sometimes they were complementary, but often they contradicted each

¹¹³ The family planning programme offers a (limited) range of contraceptives that users can choose from – this is the programme’s cafeteria approach.

other. Thus, for the most part, the interpretations of policy makers and non-governmental personnel were marked by inconsistencies. A vital aspect of these inconsistencies was that they reproduced a discourse (and eventually, projected models of practice) that subjected individual behaviour to state ideology¹¹⁴.

At the outset, in general, policy makers were quick to point out that the RCH offered more opportunity for users of the family welfare services to exercise choice. The words ‘informed decisions’ accompanied the general understanding of the word ‘choice’. For instance, I asked a PHC-level medical officer if the current cafeteria of contraceptive methods offered by the government was adequate to ensure people had a choice. The response was that:

I #12:

...earlier, it was not a situation where people were told everything and *could choose*. It was more like this: “this is what is appropriate for you... [Y]ou have now two children, your younger child is this old, you are only so old, so the permanent method may be more suitable for you”. We tell them that and try to promote the method. Now instead of that we [now] say... “this is what is available to you, *you can choose* what is suitable to you. These are the pros and cons of this. This is the advantage and disadvantage of this”. So they are able to say, *this is what I want*. This is what is convenient for me.

The doctor’s interpretation of choice could be interpreted as falling into both a feminist understanding of choice, and a consumerist interpretation. As the former, it is reflected in the passage about removing coercive practices, and providing information so that the user can choose what is suitable to her/him. As a discourse of the market, it indicates a new set of opportunities (particularly of options) that were earlier not available to users. The doctor mentions that “earlier” it was a different situation from what it is “now”. In the following passage, the independent consultant also expresses a similar understanding of choice, that it facilitates women’s abilities to make decisions in a non-coercive setting.

I#3:

She is being given a chance to decide on what she should use, whether she should control her fertility. If she decides to do so,

¹¹⁴ In fact, Smyth (1998) notes that the population establishment sees ‘choices’ as an increase in the number and types of contraceptives primarily to ensure that all segments of the population are ‘covered’.

what is the method she should use. It's not that an ANM tells her, go and use an IUD. *She (the woman) makes the choice.*

An issue to point out in these accounts is that both stress the act of verbally or physically expressing a desire as the substantive content of choice. In the doctor's and consultant's view, the fact that women can, at the point of interaction with the provider, make a selection from options presented to her is indicative of choice. However, the act of choosing between alternatives is the final step in a chain of conditions that will support the individual's decisions or choice. Some of the other requisite conditions are, for instance, the range of contraceptive choices/methods available in the public sector, and adequate information under the programme so as to ensure that the individual can make informed choices. I specifically raised both these issues in my interviews. With regard to choice as an issue of having multiple choices, respondents did not see the expansion of the range of contraceptive methods as an important aspect of a reproductive health policy. A medical officer in the PHC found the question difficult to comprehend, as if increasing the contraceptive range had never been an issue to reckon with. When I asked if,

In our government system itself we don't have injectables. Now Depo-Provera is there, which is not available here. So as far choice is concerned, do you think that when we say reproductive health and people's needs, that this choice should be increased?

I#9:

Do you mean number of choices?

Yes.

I#9:

I don't think so.

A more articulate response came from the consultant for the government. When I asked her:

How much of choice does it really open up for women? Are we all of a sudden talking about a cafeteria approach that broadens the number of contraceptive methods that she (a woman) has access to?

I#3:

Its not that - one has not really increased the methods - let me put it that way. For various reasons, when India wanted to introduce the

NORPLANT, women's groups were very much against that. Women's groups had some legitimate concerns, but I also think that they didn't give it a chance to come into the country. Of course, now the NORPLANT is also banned by the American FDA. But the injectables, which is being used in every other country - again the same problem. All these methods - it all boils down to counselling. If you do proper counselling, you know your drop-out rate will be much less. Side effects will be much less. And when you make a choice, fully realizing what it can do for you. So that was one of the things. So, as far as choices of methods we still have five methods - we still have the condoms, the pills, intra-uterine device and male and female sterilization.

There are two interesting perspectives in the consultant's response. First, the consultant responds to the question in a way that is both defensive and offensive. In admitting that the government had not really increased the number of methods, she launches into an offensive attack at the women's groups that resisted the introduction of the NORPLANT and injectables in India. The women's groups were concerned that in the name of increasing contraceptive choices, the government was succumbing to the pressure of global pharmaceutical companies to open up the Third World markets for their products and that women's contraceptives would be provider controlled (Rao et al. 1995; Sarojini n.d.). The women's resistance obviously was well placed, because as the consultant herself points out, the NORPLANT is banned by the U.S. Food and Drug Association (FDA). However, she follows a similar line of attack for justifying the absence of the injectible drug in the Indian family welfare services¹¹⁵, and censures the women's groups for the lack of 'choices' for women.

The consultant's condemnation of the women's groups is not meant as a wild accusation. By employing a tactic of reproaching the women's groups, she manages to shift the meaning of the word 'choice'. Notice how she says -- "*All these methods – it all boils down to counseling...and when you make a choice, fully realizing what it can do for you*". She shifts the discussion away from the material provision of contraceptive methods to the individual act of making decisions. The consultant's interpretation of the term choice moves the discourse of *choice* from what the government must provide (methods) to what 'you' can do (individual decision-making). According to the consultant, the

¹¹⁵ The injectibles were briefly being offered by the Family Planning Association of India, and were also being marketed privately by the US based company UpJohn and its Indian partner, Max-Pharma (subsequent to Government approval in 1994).

individual's moment of knowledge that choice has been exercised is 'realizing' what the various contraceptives 'can do' - in other words, advantages and disadvantages of each contraceptive method. This information is provided by government's counseling services. By the end of her response, she had justified that choice was not so much about what one had access to, but how well the individual (or woman) could discriminate between what was available. In the final line of the passage, when the consultant reaffirms that the contraceptive choice has not changed, "*So, as far as choice of methods...*" it is not in the same defensive tone as when she first admitted a lack of contraceptive range.

The consultant's enthusiasm about women exercising choice once information about contraceptives is provided is a bit more optimistic than is warranted. Interview questions to other participants about choice yielded a set of responses that indicated that the state interprets individual exercise of choice in a narrow sense. The officials emphasized knowing the various options rather than being wholly transparent to the users about the effects of various contraceptives. According to a senior official,

From what I've read they (ANMs) are going to be the ones who are going to have to learn a lot of skills, have a new attitude in approach, go back to the same clients and talk about disadvantages of contraceptives where once upon a time they would talk only of advantages? ...

I #4:

No, we are not adopting the cafeteria approach even now. That has not been adopted in the RCH. They will not be going back and talking about disadvantages of contraceptives, they will be trying to put it to the woman and the man...

You mean they are not going to talk about disadvantages? So, it's still going to be a persuasive...

I#4:

No, as of now we are not planned that we will be talking about the possible side effects of IUD insertion, but they (grassroots workers) are not going to scare people off by saying that.... [S]ee, what now happens is that after an IUD is inserted everybody forgets about that woman. But we are trying to built up is to ensure that the JPHN visits the woman a week later, six weeks later and then provides services in getting over the problem. But the other question of - are

the different options going to be explained to her - the options will be explained to her.

The official points out that there is an element of choice presented to the woman – the options will be explained to her. But as far as talking about side effects or contraindications, the government policy is that “they are not going to scare people off”. What appears, *prima facie*, to be an inconsistency of thought is actually indicative of a process of interpretation of the term ‘choice’ by the official. The official suggests that side effects are a result of ineffective follow up services, and if those services are built up, then side effects (and the need to dwell on them) decrease. If the consultant above had shifted the discourse of ‘choice’ from a *public issue* to an *individual concern*, this senior official’s understanding of ‘choice’ moves it from the realm of *political empowerment* to *medical intervention*. Side effects should be treated as a matter of public health, but such interventions will not decrease the relevance of information (not simply options) that is offered to users.

I also perceived contradictions and inconsistencies in other participants’ understanding of ‘choice’ when I asked several respondents specifically how choice would be interpreted in practice in interaction with a client. The following represents three responses, one from a middle-level official and the other two from PHC-level ANMs.

Excerpt 1:

In this target free method, is it that we do not tell them what contraceptive method to use?

I#2:

It’s not like that. This is the basis. Now if they have only one child, they will be told about temporary methods. Or else there are newly married couples. They want the first delivery only after a while. Especially we have what is called Birth Timing. Now Family Planning is expressed in three ways: Birth Timing, Birth Spacing and Birth Limiting. Limiting permanent methods, Spacing is for after one child, Timing means even if they have married early, between the age of 20 and 30, one looks for the best time for the first delivery. So, suppose they want the first delivery only after the first year - then we advise temporary methods. Even after one child, they can use temporary methods. So they have to be targeted for temporary methods. Then to them we tell about all the temporary methods.

Excerpt 2:

I#10:

What ever they are willing to do, whatever is acceptable for them, that we have to encourage. Target - there is the TC1, TC2, yes¹¹⁶? Within the targets itself there are those with one child and with two children. *The mothers with one child we encourage mostly to accept a Cu-T [Copper-T], a CC [Condoms] or OP [Oral Pills]. Within those three which ever they like, we leave it to their wish.*

So even if is target free...

I#10:

They can do only so much.

So we are only giving them this many choices.

I#10:

Yes, from these three we let them make their own choices. Those who want Cu-T, can have that. Or OP, CC. *After that, those who have two children, we let them have a choice of mini-lap, laparoscopy - it is their wish. What ever they like, we encourage that.*

Excerpt 3:

I#15:

... when we interact directly with the public, we have to provide according to their need. We won't compel them. *Now those with two children we don't need to compel. Only if there is three or more - four or more we should compel them - we should direct them and bring them around.*

Before I examine each of these excerpts separately, I will first highlight the inescapable similarities in the responses of the participants. In all three cases, the interviewees are describing the conditions of choice that are available to users. In each case, the description of choice is constituted by an inconsistency. The three participants speak simultaneously in terms of absolute freedom of the user and restrictive boundaries of

¹¹⁶ The terms TC1, etc. refers to the informal way in which the ANMs refer to their clients. Every couple (contraceptive needs are assessed primarily for married couples) is classified in terms of the number of children they have TC1 is a target couple with one child, TC 2 is a target couple with 2 children, and so on. The classification is significant because each TC is targeted by the state for specific kinds of contraceptives. ANMs would try to promote spacing contraceptive methods like condoms and IUD among TC1, while TC2 would be urged to accept more permanent methods of contraception, such as sterilization.

choice. In Excerpts 1 and 2, the ANMs state the pre-determined set of options that are available to users, within which the idea of absolute freedom is constructed. For I#2, if a couple has one child, they are told only about temporary spacing methods, and their choices are limited to the frame of temporary methods. The ANM's description of choice in Excerpt 2 is more graphic - *from these three we let them make their own choices... it is their wish*. The state provides the set of options within which 'freedom of choice' is exercised. The ANM was right in pointing out that *they (a user) can only do so much*. The Excerpt 3 also depicts this almost hilarious scenario of contradiction. The ANM in this account begins by saying that "*we will not compel*", only to supplement this with *if they have two children, we don't need to compel*. Having more than two children means that the grassroots workers can intervene into the nature of their choices. These excerpts suggest that to the provider, the idea of 'choices' was not framed in the language of rights but in terms of normalizing behaviour. Consider two comments from the interviewees about choice:

I#2:

Couples are given...freedom of choice – *freedom for informed choice*

I#12:

But along with that freedom – how many children to have and all – along with that thought and freedom, we should tell them the pros and cons of the problems and help them to come to *a right decision*.

Respondent I#2's statement is significant as she replaces the terms 'freedom of choice' with 'freedom for informed choice'. Choice is defined in terms of responsibility of users rather than in terms of liberty of users. A similar sentiment is expressed in the next passage where the PHC doctor emphasizes that freedom of choice is contingent on the ability of users to make the "right decision". These comments reinforce the idea that *choice* is interpreted within a *discourse of normative behaviour* rather than a discourse of freedom and autonomy.

Other studies where field level interviews with clients and health providers were conducted in Rajasthan and Tamil Nadu (two other states in India) it was also affirmed that a similar approach is followed to the interpretation of choice. Visaria and Visaria (1999) note that a 'client segmentation' method is followed by the health provider, that is, based on the reproductive history of the client (whether s/he has one child, or two, or

none), ‘choices’ are offered accordingly. The tendency to interpret choice in this way demonstrates a continuity of thought with the state’s ideology regarding the primacy of national objectives of fertility control and economic growth already explored in Chapter 6. It also supports the theoretical conceptualizations regarding state interest in regulating citizen behaviour reviewed there. The consequence of the operation of the two discourses appears to be the interpretation of the language of choice in a way that supports a neo-liberal discourse.

The Politics of Reproductive Health Needs Interpretation: A Discussion

The previous section offered arguments linking ideological constructs that the state embraces, and its effects in the translation of the rhetoric of ICPD to micro-level practice. In this section, I draw on the framework of the neo-liberal and gender discourse of reproductive health that I had developed in Chapter 4, and appraise the diverse elements of the ideologies of the RCH. On the basis of the analysis so far, we can chart the list of attributes of the RCH as given in Table 8.5.

Comparing the ideological elements within the RCH with the analytical framework that was developed in Chapter 4, it would appear that the RCH as a population policy is defined by the characteristics of a neo-liberal framework for reproductive health policy. The emphasis on better management of programmes, and the construction of women as instrumental to the larger purposes of national development are indications of a discourse of neo-liberalism supported by management strategies.

The positioning of the RCH within the ambit of neo-liberal discourses has, at the level of programme, ambivalent implications for women. The post-structuralist’s depiction of the state as functioning contradictorily is borne out in the institutionalization of the RCH. For instance, one of the decided advantages of the state’s paradigmatic shift to a discourse of reproductive health is the acknowledgement of the significance of providing *quality services* to its clients. The documents and the interviews repeatedly emphasize that a primary action that is to be taken by the state is improvement of quality of public

Table 8.5
RCH as an integrative policy

RCH emphasizes	RCH does not emphasize
• Cost effective interventions	• Substantive social transformation
• Better co-ordination of programmes	• Viewing choice from standpoint of autonomy
• Better interaction between client & provider	• Reproductive rights/ legal rights
• Instrumental view of women	• Reproductive health as gender political discourse
• Regulation and normative behaviour	
• Reproductive health as a medical discourse	

family welfare services¹¹⁷. According to one document, “...reducing the unmet need, increasing service coverage, and ensuring quality of care will be the focus of implementation”. (goi.tm.2: 1). Document goi.nd notes that, “[p]rovision of good, quality care is the crux of the RCH [p]rogramme”. The independent consultant to the Government, my interviewee, saw quality as “...the centre of the [RCH] services” (I#3). A World Bank report reviewing the Reproductive and Child Health Approach identified “issues of access and quality” as “the key elements of the unfinished agenda” (Measham and Heaver, 1996: 3).

The idea of quality is a significant component of change in localized policy practice. For many health providers, it was perceived as among the more vital purposes of the paradigmatic shift. Health providers were quite conscious of re-orienting their

¹¹⁷ In the documents (see for instance, goi.oc.6; goi.nd), quality is comprised of four components: service delivery (for instance, providing needs-based service delivery), interpersonal communication (i.e., friendly and co-operative attitudes of providers, caring for client's privacy and dignity), technical factors (such as, competence of service providers, use of quality equipment and drugs, and hygienic conditions), and social aspects (such as providing gender-sensitive services). Quality is also not seen as a one-time effort, but as an ongoing process.

interactions with their “clients” in a way that reflects “quality” service. The following are some of the responses of medical officers who worked at the local PHCs:

I#9:

Yes, we were told that we are giving importance to quality rather than quantity. Before, the numbers were important. The targets, the targets meaning how many. *Now it is that whatever we do, do it well. Do things in ways that won't harm patients.*

I#11:

That is useful, improving the quality of care is the most important service...at the PHC level, for e.g., the things we do...IUD insertion and other things. Now with what we have we can do it. You don't have to increase supply for that. *What we used to do before, to the best of our ability - be more understanding...the JPHN should make them more understanding.*

I#12:

...when you talk of facilities, when we teach health personnel that “you should be attentive to such matters [treating people nicely]”, that itself is a big difference. There will be a change in their perspective that will be beneficial...

The excerpts above emphasize the quality of interactions that should mark client-provider relationships – being understanding, treating people nicely, and providing the same services in a better way. These grassroots interpretations of quality services corresponds with the government’s explanation of what quality is - that is “...what we want for ourselves and our family. The manner in which a client is treated determines quality of care. Even though quality may seem like a minor thing in front of the mammoth task of service provision, *it's the little things that make a big difference*” (goi n.d.).

However, these are small gains that have been made against the wide mandate of a gender/feminist discourse of reproductive health. The larger political and economic environment in which the principles of a gender discourse on reproductive health are being implemented cannot be ignored. This is particularly so as the discursive make-up of the context is decisive in the institutionalization of policy, especially, what features of the programme will be emphasized and what will not.

For instance, officials within the health sector were skeptical about the ability to provide quality services when the state had not allocated extra funds for equipment and manpower (Kumar 1999c)¹¹⁸. Then there is also the issue of the motive of the state for wanting to promote quality of services. Document goi.nd for instance states "...[g]ood quality of care ensures satisfied clients, *who in turn come back for services if they are satisfied*". In almost similar language, an interview respondent replied to my question regarding the state's interest in promoting quality: "...one of the reasons why there is *low level of acceptance* of any service is because of poor quality of services"(I#3). Other respondents also added that it was quality services that could reduce drop-out rates and unmet needs (I#7). It might be worth arguing that the notion of quality is being interpreted to promote the state's objectives rather than individual (or 'client') empowerment. Smyth (1998) argues, "should the difference in the motive behind the support for improvements in quality of services worry the women's health movement? I'm inclined to say that if the population establishment can translate quality of care statements into good, comprehensive and free reproductive health services for women, which respond to their varied needs, and which are provided by adequately qualified personnel in a dignified and respectful manner, perhaps it is immaterial that this is done to achieve maximum effectiveness, rather than adhere to genuinely held feminist principles" (p.231). It is in instances like this, however, that the issue of mere provision of services must be distinguished from and matched with underlying intent and ideology. It is not the integrity of the state's intent that is being questioned here, but the apprehension that the state's various 'gender-sensitive' measures will continue only as long as conditions of efficiency are viable. For instance, the emphasis on quality is contingent on the outcomes of acceptance of fertility behaviour by users. Basing a reproductive health programme on neo-liberal foundations weakens women's position in society, both in material terms and politically (the political implications for women will form the main argument of the following chapter).

¹¹⁸ In fact, one of the officials told me that: "In terms of obstacles, we talk so much of quality improvement. *We have to improve upon existing facilities, we have to manage, we have to give the best quality service with the facilities existing at present.* But then, there are limitations. Many of the institutions are old dispensaries, which then became Mini-PHCs, then block PHCs, then community health centre. The infrastructure is remaining the same. No extra facilities [have been provided]. *In such a circumstance, when we have to give quality service, be quality conscious, be quality oriented we are unable to cope up with the requirements, we cannot provide the services as we expect to...*" (Interview, I#1).

In the end, as the following quote from a senior official shows, the neo-liberal framework informs the various dimensions of reproductive health policy in India:

I # 4:

You have seen the goals that we have defined for ourselves. They *do not - may not tally* with the Cairo declaration. *Our goal is highly restrictive* in terms of trying to ensure safe pregnancies, safe delivery, safe child who passes through the infancy and goes on to childhood. So these that we have set for ourselves do not need...yes, to ensure safe pregnancy - if the power equations could be changed - if the woman could have access to better nutrition [and] better service...but other than that - most of the goals that we have set for ourselves will be - can be achieved even independently of trying to work on the power equations.

This telling passage is at the heart of the Indian state's interpretation of the global change in social policy to reproductive health. In out rightly stating that the state's objectives are "highly restrictive", the official is clear in what the state sees as its role in enhancing individuals' reproductive well-being. It is also clear that the state's ultimate objective of a reproductive health policy is very health focused which, "can be achieved even independently of ...trying to work on power relations" in the society. The passage also points out that any changes in women's strategic positions are outside of the policy's direct intent. If women were to benefit from improved pregnancy care or better service and nutrition, that is a bonus, not a developmental goal. India's interpretation of a reproductive health policy "may not tally with the Cairo Declaration" and women's empowerment and rights issues are not a concern of the RCH. Gender-sensitivity in reproductive policy is limited to "stuff related to health. So therefore, it boils down to safe motherhood and family welfare and RTIs and STIs" (I#3). The official's statement demonstrates the outcome of translation of the norms of the ICPD (and the feminist conceptualizations around reproductive health) as it is institutionalized in a context that subscribes to particular ideologies. Concerns around rights, security, choices and equity have been supplanted by interventions that emphasize efficiency and optimal effect. In course of this translation, the notion of women's interests has effectively been replaced by development priorities, and the state promotes the assumption that addressing development issues automatically will benefit women (foundational to the modernization theories in development). In effect, the state capitalizes on the essence of the theories of gender and development that advocate women's interests are grounded in their social

contexts. The discourses of reproductive health ‘needs’ of women are, not surprisingly, also the discourses of state’s reproductive health objectives.

Conclusion

This chapter brings to a conclusion the key task in this research – that of understanding how the state would interpret the various dimensions of feminist rhetoric espoused prior to and at the ICPD. The analysis and discussions have shown how the interpretations have veered considerably from the precepts envisaged by feminist scholars and activists. This chapter also examined the implications of the co-option by neo-liberalism of feminist rhetoric for the final shape of the RCH policy. The analysis has demonstrated that the main thrust of the policy is neo-liberal in tone. The issues then become one of appropriation of feminist rhetoric; the analysis of keywords of feminist discourses of reproductive agency demonstrated that the process of institutionalization of reproductive health within a neo-liberal health system signified a process of co-option. If, as Stone (1988:7) noted that policy is a “struggle over ideas”, in this round at least, feminism seems to have lost ground.

IX

REPRODUCTIVE POLICY AS POLITICS OF THE STATE:

Theorizing Women's Emancipation in Needs Construction

Maybe the target nowadays is not to discover what we are, *but to refuse what we are....* [T]he conclusion would be that the political, ethical, social, philosophical problem of our days is not to try to liberate the individual from the state, and from the state's institutions, but to liberate us both from the state and from the type of individualization which is linked to the state. We have to promote new forms of subjectivity through refusal of this kind of individuality which has been imposed on us for several centuries.

*Michel Foucault in Dreyfus and Rabinow 1982, p. 22,
emphasis mine*

The aims and the conduct of this research have been at two levels. The first focused on the evaluation of ideologies in the RCH. The second explored the political implications for women (and perhaps, for feminist politics) of the finding that the state, in deference to the wider discourse of economic rationalism of its developmental strategies, infuses neo-liberal ideologies to an agenda of reproductive health and rights. It is important to consider political implications as a distinct issue, because *prima facie*, the RCH claims (and with some justification) to provide for women's reproductive health needs. In fact, the provision of material resources under the policy is prioritized over political endowments. As one interviewee told me, "...you can't just have that (rights and empowerment) and no services either" (I#3).

The ideological context in which reproductive health services are provided, therefore is not only invisible, it is also deemed irrelevant. Yet, it is precisely in defining this context – its limitations and constraints - that we can formulate a point of critique of a gender

policy founded on a neo-liberal discourse, for a larger politics of women's emancipation¹¹⁹.

Yeatman (1993: 230) notes, “[p]olitics is the space between established policy and an emancipatory movement's claims on equality.” These claims can be made only as long as the terrain of politics does not prohibit a space for contesting voices. If, as Yeatman (Yeatman 1993: 230) argues, “the custodians of established policy move to foreclose politics in favour of a quick and dirty adoption of new protocols of inclusion, we can be sure that the inclusion is token only and that the core policy order remains unreformed”. To be assured that reproductive health is not a co-opted discourse of the state, which even oppositional movements subscribe to, it is important to investigate the discursive conditions that the “core policy order” operates within. The point that I explore is not if ‘needs’ or ‘rights’ or ‘interests’ of women are articulated in the political arenas of the state, but rather, the features of the political spaces that permit particular articulations and meanings of these terms.

In this chapter, I argue that the ideology of the neo-liberal state does not permit a public space of political contestation that allows for articulation of women's emancipatory discourses, especially around reproduction. The instances of co-option of feminist language that were revealed in the analysis of Chapter 8 are symptomatic of wider processes of regulation in the public space. The initial sections of this chapter explore literature on regulation of individual behaviour in public spaces; my quest is essentially to consider theoretical possibilities that would augment our understanding of women's political position in the state. I also try to link these theorizations with my own analysis of the RCH undertaken in the last three chapters.

The Public Space and the Politics of Gender Emancipation

Feminist political theory and activism has been predicated on the notion of an emancipatory space in society where women's issues may be debated and rights reclaimed. For the large part, this ‘space’ has been associated with the notion of the

¹¹⁹ My understanding of the term ‘emancipation’, as I pursue it analytically in this chapter, pertains to a change in relationship between women and the state that ensures that they have greater access to social and political rights in the state.

'public' that emerged with the development of classical liberal politics. Feminists have debated exactly what spaces are included in the notion of the public (Fraser 1997; Thornton 1995). Going by a general yardstick that women's privations are harboured largely within the private or domestic sphere, feminist politics has demarcated an amorphous arena of the 'public' as loosely constituted by the outcome of interactions amongst the state, market, and the civil society. The 'public' realm is not defined by the state but, because the state has the ability to constitute gender relations that are then reproduced in society (Franzway et al. 1989), the politics of the state will be reflected in this public space.

The history of feminist negotiation of the idea of the public sphere as emancipatory is instructive. Feminists, at the turn of the nineteenth century, relied heavily on the premise that political emancipation would result from participation in public affairs of society and state. Women's struggles for the rights to enfranchisement, education and acceptance in male occupations well into the twentieth century were symbolic of this belief. Both the liberal feminist focus on legislative change¹²⁰, and the Marxian proposition linking women's emancipation with the public space of production (Engels 1972; cited in Moore 1988)¹²¹ implicitly assume a political primacy of public space. The second wave of feminism in the late 1960s and 1970s, however, broadened feminist understandings of processes of subordination and emancipation within the social dichotomy¹²² of the public and the private. As opposed to a singular attempt to hasten entry into the established realm of the public, feminists recognized the complexity of the relationships that tie public and private spaces. They questioned the characteristics of the public sphere and its overwhelming expression of masculinist values. Landes (1988,

¹²⁰In fact, some of the more significant freedoms for women were gained through employing the channels available in the existing public sphere. In the US, for instance, women's reproductive freedoms were battled in the courts of law. Pay equity and Equal Rights Amendment (ERA) issues are still being debated within the political arena there.

¹²¹To quote Engels, "[t]he emancipation of women becomes possible only when women are enabled to take part in production on a large, social scale, and when domestic duties require their attention only to a minor degree" (cited in Moore 1988: 138).

¹²²Landes (1998) points to two opposing views of freedom in the public sphere as articulated by the Republican and Liberal traditions of political theory. Liberal theory locates freedom within the private sphere and in the opportunity to exercise their rights without interference from state or society. The republicans, however, associate the public with freedom and with actions that enhance common good. Landes argues that feminist conceptualizations of women's empowerment cannot be directly translated into either of these notions of individual or collective freedom in the public or private sphere. It is, instead, necessary to review the characteristics of the public and the private, and its emancipatory potential for women on specific issues.

cited in B. Marshall 1994: 141) points out that it is unclear if feminists can simply “take possession” of a public sphere that has been enduringly constructed along masculinist lines. Alongside, feminists also acknowledged that since women spent most of their lives in the private sphere, issues that were hidden within the guise of the personal or familial needed to be projected into public discourse. Thus, there was the call for the political recognition of activities and violations undertaken within the private or domestic sphere. The catch phrase reminiscent of the time, that the ‘personal is political’ was expressive of this recognition. Feminists contended that keeping things out of the public eye accentuated the subordination of women in society. It was not that they undermined the value of political participation in the existing ‘masculinized’ norms of the public¹²³; however, they saw the extension of the political privileges of the public as a requirement to enable women’s access to justice in both private and public spheres.

Yet, in the 1980s and the 1990s, in a surprising reversal of thought, there were calls by some feminists to actually retain a separation between the public and the private, for varying reasons. In her book, *Public Man, Private Woman*, Elshtain (1980) contends that to collapse the private and the political is to diminish the effectiveness of political process. She points out:

...a political perspective requires that some activity called “politics” be differentiated from other activities, relationships, and patterns of action. If all conceptual boundaries are blurred and all distinctions between public and private are eliminated, no politics can exist by definition (cited in Siltanen and Stanworth 1984: 203).

Similarly, she argues that the sacrosanct attributes present in the private sphere like love, parenting, and sexual intimacy would all fall under a politicized agenda. That is, what will exist “... is pervasive force, coercion and manipulation: power suffusing the entire social landscape, from its lowest to its loftiest points” (Elshtain 1984, cited in Siltanen and Stanworth 1984: 203).

¹²³In fact, some of the more significant freedoms for women were gained through employing the channels available in the existing public sphere. In the US, for instance, women’s reproductive freedoms were battled for in the courts of law. Pay equity and Equal Rights Amendment (ERA) issues are still being debated within the political arena there.

More recently, in the 1990s, feminist political writers also argue that the private be protected from the gaze of public discourse and institutions (Benhabib 1998). However, their concerns arise from the growing consternation that visibility within the public sphere increases the likelihood that women would fall under the regulatory process therein. This concern is drawn from feminist post-structuralist analyses that suggest that by encroaching on the state's public sphere, women risk the regulatory powers of the state to create 'feminine subjects' (Brown 1992; Landes 1998; B. Marshall 1994). The experiences of women in relation to the western welfare state, in particular, has been significant in the emerging critique of the manner in which the state re-draws public/private boundaries "as a complex regulatory strategy" (Valverde and Weir cited in B. Marshall 1994: 136) to advance specific masculinist ideologies. Landes (1998) points out that feminists are cautious in their demand for calling private issues to public forums, because they are now mindful of the "use of state power to regulate the individual body and to restrict personal freedom" (p.3). Brown (1992: 30) notes that the "disruption of the boundary between household and economy, and the politicization of heretofore private activities such as reproduction and sexuality...do not automatically generate political consciousness...because the state does not simply address private needs or issues *but configures, administers and produces them*" (emphasis mine). The argument emphasizing the regulatory potential of the state, therefore, is its power to constitute gendered identities through control of ideologies. This argument gathers support from the Foucaultian notion of the operation of the modern state which represents a totalizing and individualizing form of power (B. Marshall 1994), and it can, through non-brutal and non-aggressive means, "shape, guide, correct and modify the ways in which they [individuals] conduct themselves" (Burchell 1996: 19). The critical question for feminist politics is as Brown (1992: 8) asks, "... [I]f the institutions, practices, and discourses of the state are as inextricably, however differently, bound up with the prerogatives of manhood in a male-dominated society, as they are with capital and class in a capitalist society and white supremacy in a racist society, what are the implications for feminist politics?".

However, this interrogation of the public space is not a suggestion that it is a redundant concept in feminist political theory or activism. As Landes (1998: 3) points out, it is not that feminists are abandoning the political in favour of the private - "[r]ather, feminists

have shown how the line between public and private is constantly being renegotiated”¹²⁴. This is not to suggest that the private sphere is beyond the effects of state regulation (indeed feminist critiques of the welfare state’s propensity to regulate the private lives of its beneficiaries would attest otherwise; see, for instance, Fraser 1989b). Rather there is a concern that the public space, earlier seen as a space of emancipatory politics, is now a sphere of regulation. A significant move, therefore, in contemporary feminist theorisations around the public/private spheres has been towards understanding not just where the lines have been drawn, but *how* and *who* draws them. It is in critically reviewing the latter that we can begin to question the credibility of the public sphere as a space that guarantees women’s political emancipation.

Similarly, Schiappa (1989) warns that the ways in which the discourses that emanate from the public and private are positioned are pivotal to women’s emancipatory agenda. He argues that discursive strategies that subvert the dichotomy of the public and private are more likely to be politically liberating than those that reproduce it. When an issue is declared as a private or public one, the act involves either declaring the issue as a matter of public concern, or removing it from the public eye altogether. While there are merits in being protected from the public gaze, the isolation of the private equally has adverse implications for women. Thus, when an issue is located as public or private, Schiappa cautions that it would be meaningful to explore the power relations that are being transformed or reified by that positioning.

It is in light of this that the idea of constitution and regulation by the state has significance for our theorizations of reproductive health as an oppositional discourse. It would be instructive to consider the overall outcome for an oppositional discourse into the public realm of the ‘social’ (Fraser 1989a), if the state has the ability to constitute women’s needs. This capacity of the state is particularly evident in the current discourse of neo-liberalism subscribed to by many states in both the First and Third World.

Gender Identity and Neo-Liberal State Discourses

This section examines the nature of discourses of neo-liberalism and its likely implications for the constitution of the public space. Although neo-liberalism is touted

¹²⁴ Franzway et al. (1989: 41) correctly note that “...[t]he boundaries of the private and public realm can explicitly become a stake in political struggle”.

as primarily a shift in economic ordering, its sub-text of the minimal state and maximizing space for individual self-interest has direct implications for the make-up of the political public space, political representation, and citizenship rights, especially for women. Brodie (1996:13) notes that it is in the... “[c]hanging public expectations about citizenship entitlements, the collective provision of social needs, and the efficacy of the welfare state” that the transformation of the constitution of the public space has been brought to light. The dominant ethos regarding citizen rights in neo-liberalism is that the “...new ‘ordinary’ citizen does not make ‘special’ impositional claims on the state based on difference or systemic discrimination because one should be able to take care of oneself” (Brodie 1994; cited in Bakker 1996: 5).

Waylen (1986) examines the masculinist assumptions of neo-liberalism. She points out that the neo-liberal philosophy only focuses on market-based economic activity, thereby creating a false separation between production and reproduction¹²⁵. Neo-liberals subsume women within the family and the private sphere; the ‘individual’ who is the economic agent freely mobile in the market is unmistakably the male head of the household. Waylen also argues that the separation between production and reproduction in neo-liberalism “obscures the role women play in subsidizing costs for capital” (p. 98). Further, the neo-liberal doctrine would like to shift the responsibility for social reproduction – which is now being shared by the family, state and the market in many societies— to mainly the family (i.e., women) and the free market.

I would like to extend some of Waylen’s arguments and examine potential implications of the ideology of neo-liberalism for women’s emancipation in the state. First, Waylen’s analysis is grounded in an idealized notion of a public sphere, where under- (or mis) representation of women and their activities is the major problem underlying their denial as rightful citizens¹²⁶. If women’s reproductive and productive activities are adequately and appropriately represented, they will be better acknowledged as economic beings and their claims to the state will also be enhanced. In critiques of the neo-liberal discourse in its various forms, Waylen and others (for e.g., Brodie 1994) are concerned about the

¹²⁵ Although Waylen does not explicitly make this distinction, it is necessary to see reproduction as comprised of both biological and social reproductive activities.

¹²⁶ I would like to clarify here that although I refer to the category ‘women’, it is in no way intended to signify that similar processes affect all women in the same way. Neo-liberalism, undoubtedly, affects different women differently. There is, however, a general set of assumptions that direct the organization and functioning of the neo-liberal state; these values are perhaps universalistic in their stereotypic norms.

shrinkage of the public sphere and the expansion of the sphere of the private. As Brodie (1994:55) points out:

[I]t is clear that the current moment of restructuring can be viewed as a concerted discursive and political struggle around the very meaning of the public and private. The proponents of globalization seek radically to shrink *the public – the realm of political negotiation* – and at the same time, expand and reassert the autonomy of the private sector and the private sphere (emphasis mine).

Brodie's reading of the implications of restructuring is that, with the spread of neo-liberal ideology, the space for the civil society/bourgeois public diminishes, and furthermore, is taken up by the private sector. She also sees an expansion of the private/domestic sphere, where the claims of social rights are limited. While I concede that this is a serious issue, my own proposition is that neo-liberalism has transformed the very nature of the public sphere for women, and it is the *re-constitution* rather than the shrinkage of the public space that should form the focus of feminist political enquiry. Critiques of the neo-liberal state should question the emancipatory potential of the public space; in particular, it should take into account the regulative characteristic of the public sphere in neo-liberal states, and the implications for women's reproductive roles.

Regulation in the neo-liberal state

Feminist analyses have directed critique at the various manifestations of regulation in the western capitalist state. For instance, critics of the welfare state (see, for instance, Fraser 1989a; Silverblatt 1988), have pointed to its tendency to intrude into the private lives of welfare beneficiaries and those dependent on the state. Rowbotham (1979; cited in Silverblatt 1988) referred to the state's control over women as "welfare patriarchy". Under neo-liberalism, the terms of regulation perhaps do not change but the emphasis on regulative processes for the enhancement of market growth or "the logic of accumulation" (Gallin 1998) is underscored¹²⁷. The regulation of individual and social behaviour in neo-liberalism arises on three counts. First, the market principle or capitalism itself thrives on the premise of regulation, that although in theory individuals

¹²⁷ The neo-liberal discourses simultaneously prescribe and proscribe regulative processes. There is a deliberate effort to de-regulate state economic controls for the unrestrained operation of the free market. The sub-text of this freedom is the regulation of the individual.

are free, for the market to expand and, thereby, maintain itself, individuals must be persuaded to consume and produce in particular ways. To quote Gallin (1998: 6): “[w]hether labeled structural adjustment or economic restructuring, their [neo-liberal discourses] intent is to reshape production and consumption, thereby promoting a well-functioning market”.

Second, market-oriented growth that underwrites the discourse on neo-liberalism must be distinguished from a laissez faire economy: market development consciously promotes the creation of markets and involves all necessary human, capital and institutional reform to aid this promotion (Leftwich 1994). Promoting the market does not mean that the state rescinds its control over the economy and polity - on the contrary, since the state has the added responsibility of ensuring a stable political climate or good governance for the development of the market, it seeks to increase its control over the society (World Bank 1997). The discourse of good governance being promoted by the World Bank in the 1990s augments the regulative rationale of the state. Beneria (1999: 67) argues that the neo-liberal development in Third World countries has led to greater integration with global markets, so that many acts to foster market development have “represented the use of a *strong hand* on the part of national governments and international institutions intent on building the neo-liberal model of the late twentieth century” (emphasis mine). It is ironic that for the freedom of the market to be assured, what is demanded is increased control over the lives of individuals, communities and society.

Thirdly, under neo-liberal restructuring, the state assumes features of the market. With the concern for reducing unproductive investment and increasing efficiency, the state establishes itself as primarily an agency of economic growth rather than equity. In consequence, the basis of citizenship moves from one of claims to rights *from* the state to obligations *towards* the state (McDowell 1991; Lister 1997). Citizens are rightfully those who can participate in a productive capacity in the state’s growth, and there is an increasing tendency for political representation to be made on the basis of economic identity of individuals (Lister 1997). The significance of the idea of regulation is that, indirectly, the state fosters the creation of ‘subjects’, both in reproductive and productive

activities. Contrary to the assumption of Waylen's argument, the public sphere is not totally emancipatory and, as shown below, the private sphere is not beyond regulation.

The Regulating State And Reproduction

The regulation proposition raises the question: what kinds of individual activities are brought under the surveillance of the neo-liberal state? From Waylen's analysis, economic activity in the public sphere unequivocally falls within the state's domain of surveillance, while reproductive activities – she notes particularly the case of social reproduction – are considered as private and beyond the state's interest. Gallin (1998: 16) suggests that, contrary to this conventional wisdom, the “control of women's reproductive powers is crucial to the maintenance of the global economy.... [T]he imperatives of this economy demand that women (and men) adjust so that they can *produce and reproduce efficiently*” (emphasis mine). She draws on the framework of the “three different reproductions” identified by Edholm, Harris and Young (1977) - biological reproduction, reproduction of the labour force, and social reproduction- and argues that all three kinds of reproduction fall under the regulative gaze of the state.

With regard to the social reproduction of the labour force, regardless of the overt rhetoric, the state is anything but disinterested in the family, its nurturance of past and present labour force, and unpaid work in the household, because these, as rightly argued by Waylen (1986), subsidize the costs of capitalism. Overwhelming evidence that restructuring in the First and Third World contexts have increased women's burdens in the reproductive sphere is indicative of cost shifting from the state to women (Afshar and Dennis 1992; Sparr 1994; McDowell 1991).

The focus on biological reproduction under a neo-liberal discourse is not widely discussed in critical literature, but I would argue that it is of vital concern to states. Restructuring efforts in Britain, for instance, have been accompanied by state propaganda to reinstate the idea/l of the (heterosexual) family. Conservative concerns about rising levels of illegitimacy, divorce, single motherhood, and teenage pregnancies seem to be recurring themes in developed societies (McDowell (1991) writes about the UK; Fraser and Gordon (1994c), and Fineman (1991) about single motherhood in the

US, and Simms (1997) on teenage mothers in New Zealand, among others). Overtly, the concern is drawn from the state's desire to withdraw from supporting these groups of people, and to make them 'self supporting'. But, as Gallin (1998) argues, the state's concern is not just about reducing the 'size' of the population that it has to support; it is equally interested in the 'quality' or the eugenicist concern with selective breeding of the population that is born¹²⁸. As she argues, the aim of population policy (be it pro-natalist or anti-natalist) is to construct a labour force that meets the exigencies of contemporary capitalism. The conduct of women's reproductive activity, therefore, has economic value and is equally important to the state's neo-liberal economic agenda.

Market Development and Women's Rights in India

The institution of market development or restructuring (the New Economic Policies, NEP) in 1991 was the start of a new era in Indian development. While there are adverse material implications and impacts for women, my aim is to examine how the shifts in the public sphere discourses that accompany these economic changes affect women's political identities and claims as citizens¹²⁹. For this, I will examine at some length how the idea of rights and claims to rights were, and continue to be, expressed within development. Jayal (1994) points out that attaining political 'rights' is not directly a consequence or even a factor in developmental change in India. She points out that the history of developmental intervention in welfare activities in India cannot be seen as akin to the social programmes of a welfare state. The welfare state is motivated by a conceptualization of rights (both liberal and social rights), which is absent in the case of India. The aim of development intervention was not to maximize welfare, or enhance rights of a collective, but to provide a foundation for the project of modernization and growth. The outcome of developmental change is directed more towards improving the status of the people so as to ensure some level of parity within the population (especially, in health, education, poverty alleviation and so on). As Jayal (1994) points out:

¹²⁸ Similarly, developed states are also concerned about the regulation of reproduction by immigrant groups in their countries. For example, see London and Yuval-Davis (1984).

¹²⁹ The direct and indirect impacts of the institution of this liberalization/structural adjustment on the lives of women in India have been amply documented. There is evidence, for instance, that more women are likely to be engaged in low paying, informal sector activity and that their caring activities have increased considerably. The reduction in food subsidies has meant that women spend more time in preparing cheaper food or in travel to cheaper shops and markets. In some cases, women also eat less in relation to other members of the family. Girl children spend more time doing chores around the house and spend less time in education (Dietrich 1997).

The primary purpose of interventionism, and indeed its inspiring and guiding force, was developmentalist. This was not a state that self-consciously and deliberately took on the responsibility of providing for its citizens in clearly defined areas which bore some relationship to the idea of needs, especially basic needs (p. 20).

Therefore, development welfare is not expressed in the language of rights; there are implications that follow this ‘oversight’. There is no obligation for the state to provide for development and likewise, citizens have no foundation other than grounds of morality, to claim for development. The state in a sense becomes a paternal benefactor, and casts its relationship between citizen and state as one of “giver and receiver, benefactor and beneficiary” (p. 23). This exempts the state from direct involvement or liability and makes no reference to access to the state - it is nowhere suggested that development will increase claims to rights for its citizens. However, the state does, through constitutional obligation and desire for development, undertake the task of providing welfare interventions. Welfare was cast as an economic component of development and was privileged over its social and political aspects (Jayal 1994: 21). Women’s development, and the solution to their subordination, was also cast in terms of improving women’s contribution to the economy - whether by improving women’s access to education and health or removal of inherent barriers within the labour market. Issues of political rewards are, therefore, outside the debate of development; gaining access to the state, say, through visibility of a specific group, is incidental to the intention of the state’s intervention in development.

The debate surrounding access to rights through development has been gaining momentum since the 1990s, when there have been perceptible shifts in the developmental state’s attitudes to its obligations to its citizens. The fundamental philosophy of neo-liberal discourse exhorts the citizen to be a rational, self-interested, competitive and productive individual. The state’s role is primarily to provide conditions for unfettered economic interaction; it aims to be non-interventionist. ‘Rights’ of the individual are represented in terms of non-interference as he/she makes choices. In India, the period of economic reform has set into motion a period of deregulation in trade practices, greater efforts to link up with the international economy, increased emphasis on export oriented growth and attempts for an efficient administration. In

terms of its welfare activities, the state has not reneged on its obligation to provide state-subsidised health and education, despite criticism that state expenditure has fallen in the 1990s (Alternative Survey Group 1997) and that poverty levels have risen (Byres 1998b). However, the state has instead begun increasing efficiency by reducing "... the 'menu' of subsidised services and standardi[zing] their quality" (Jayal, 1994: 23) rather than intervention in wider arenas of social and economic life. One consequence of such rethinking is that welfare will increasingly assume a competitive dimension and resources will be distributed among various groups either on the basis of identity politics or on how the state defines development imperatives. It is in the latter that women's interests and access to the state become significant.

For women, the adoption of neo-liberal discourses has come at a critical juncture. Internationally women's roles in development have been undergoing serious reconsideration. Since the 1980s, there has been a move to adopt the "efficiency approach" - that is, a recognition that women are efficient producers and managers of the household and community (Moser 1993). The positioning of women as productive agents within the public space (especially the market) is not framed within a discourse of rights and access to the state but rather in their capacity as agents for local-level development. In fact, evidence points to the diminished access to the state that is being popularized in the current neo-liberal discourses. In matters related to obligation to provide for its citizens, the state draws on a neo-liberal ideology of restricted intervention and permits market play. John (1996) in her textual analysis of recent government reports in India, for instance, demonstrates that the World Bank and the state both agree that women play a quintessential role in the economy and, as such, should have better access to resources, especially credit and social services. She points out also that both these agencies simultaneously agree that the multitude of women's tasks need not be safeguarded by legislation similar to that in the formal labour sector - indeed, to do so would stifle productivity. Misra (1997) also argues along a similar line. She points out that, contrary to expectations, development in its capitalist form has limited the impact of changes in juridical norms or educational opportunities for women. John (1996) notes that in recent development rhetoric, what was once "exploitation" of women's labour has now become an issue of "efficiency". The discourses that draw

women into the productive public sphere is shifting from those of justice to those of efficiency, where the two are positioned as antithetical to each other.

The Public Space and the RCH

The RCH is an interesting illustration of a policy arena where, through the construction of collective identities, the state constitutes the political space that defines the claims that individuals, particularly women, can make on the state. There are two issues to consider in this context: how does the state draw its public/private lines in the case of reproduction in Kerala? Does the state's constitution of the public space in which reproductive health discourses are located necessarily imply regulation of individual behaviour?

In considering if the RCH and the ideological context in which it is being implemented offer an emancipatory space for women to exercise claims to equality, it would, firstly, be instructive to chart out what the Indian reproductive policy distinguishes as public and private reproductive concerns (see table 9.1 below). The table is based on material that has been analysed in documents and interview transcripts.

Table 9.1
Charting the Public and Private Spheres of Reproduction

The Public Sphere of Reproduction is concerned with:	The Private Sphere of Reproduction is concerned with:
Awareness (knowledge of contraceptives, male-female physiology, child health, pre-natal care, etc.)	Intra-household hierarchies
Actual use information (use of contraceptives, etc.)	Who actually makes decisions within household
Continuation of use	If decisions are voluntary
Widely accepted reproductive values (pertaining to number of children, when they should be born, etc.)	If reproductive and sexual health involves freedom and pleasure
Who may be incorporated as eligible (adolescents, married couples, etc.)	If decisions result in changes in gender-relations

As Table 9.1 indicates, the state primarily constitutes, as its public reproductive concerns, issues around fertility: the reproductive body, how to control fertility, maintenance of a

healthy body in so far as it can affect conditions of fertility. The state also considers as a public issue *who* is addressed in the state's programmes; this decision, too, is associated with perceived fecundity of individuals. On the other hand, issues such as power, gender relations, and the ability for women to exercise decision-making powers are considered as 'private' concerns of the individual/couple/household/community. Issues which seemingly fall within the public sphere, such as legal recourse systems, are seen as outside the state's perception of 'public' reproductive concerns.

Most of the public sphere's interest is in overt and covert unitary reproductive behaviour, while the private sphere of reproduction addresses the social processes that contextualize these behavioural responses. It takes little imagination to see that the public sphere of reproduction is comprised of activities that feed into state concerns with regulating sexual and reproductive behaviour of individuals/couples. The state's interest in behavioural responses underscores the priority that is given to outcomes of reproductive decisions rather than processes by which these decisions are made. The state as a mediator of gender relations focuses on acts of individual regulation rather than acts of transformation.

From one perspective, the listing of the various public and private reproductive interests in the context of Kerala highlights widely accepted conventional wisdoms about state involvement in women's development. The state prefers to associate itself with practical rather than strategic needs/interests¹³⁰ (Moser 1991, 1993). The state's involvement in the public acts of reproduction (such as enhancing awareness, or ensuring that clinics open at times convenient to women) can positively influence the material conditions under which women make their daily reproductive decisions.

From another perspective, the separation of public-private reproductive concerns of the state has implications for the way that women, as claimants to the state, are constituted within development policy. Let us review some of the results of the analytical work so far. It is apparent that the RCH simultaneously advocates a focus on individual rights

¹³⁰ Strategic gender interests arise from an assessment of women's subordination, and an effort to change structural and institutional arrangements so as to alter women's fundamental positioning within society. Practical needs are usually a response to an immediate perceived need, and do not generally entail a strategic goal, such as women's emancipation or gender equality (Molyneux cited in Kabeer 1994: 294).

and social rights. The stress on the capability of individuals to make choices, be decision-makers, and even, financially address their own reproductive needs, grounds the state's discourse on reproductive health within a framework (in principle) of individual rights. Simultaneously, the state's interpretations of the discourses of market and gender privilege the construction of individuals as grounded in their social contexts – therefore, to address social concerns is to empower individuals as well. For instance, in Chapter 7, officials were equating reproductive health needs with provision of safe water. However, the way that the state employs these discourses is, in fact, inimical to the production of an emancipatory public space.

In the analysis in Chapter 6, it was shown that in adopting the language of market efficiency the state actually succeeds in blurring the lines between client rights and citizen rights - the citizen as client is a statement of the state's negation of itself as an agency of equity and social justice. Further, in the identity of the 'client', the user is encouraged to act in accordance with the state's objectives – in fact, this is promoted as 'empowerment'. For women, the implications of constituting the identity of 'citizen-client' are particularly significant for the conceptualization of their empowerment. By promoting the idea that women's rights are contextually determined, the state seeks to merge women's reproductive identity with the state's own construction of women as economic actors (Chapter 7). Against a backdrop of the neo-liberal discourses that dominated developmental thinking in the 1990s, the merging of the identities of reproduction and production has a special significance. The growth of the neo-liberal markets extends control of the state not only over market production but also the domestic sphere as well: the private sphere activities, the household, and women's bodies. Reproduction gains a tacit significance of economic activity.

Thus, under neo-liberalism, it is apparent that there is a re-inscription of women as bearers of reproduction. In particular, the construction of 'mothers' and 'responsible reproducers' positions women as economic and developmental agents – actors in the population drama. In effect, drawing on my review in Chapter 3, the imagery of both the 'worker' and 'mother' are blended in the reproductive policy. Unlike in conventional nationalistic discourse, where mothers and workers were polarized identities in women's economic relationships with the state, in the reproductive health policy, to be a mother is

to be a productive worker in nation building. In constituting women as mothers in the reproductive health policy, the state converts women's social role/reproductive identity (within the 'personal' domain of home and family) into an economic/productive (and public, developmental) identity. As the RCH is embedded within a strong discourse of obligations that women are to discharge, for them, to be 'responsible mothers and reproducers' in development policy is also to define their political identity.

This construction may not be drastically different from the constructions of women's roles under pre-market development, especially as women have always been targets of population policy. Yet, the context in which women are targeted has changed. In place of the patrimonial relationship that women (and citizens) had with the state, reproduction and women's reproductive behaviour is defined as part of a state-citizen contractual relationship. The objective of this contractual relationship is not parity among citizens to foster development; instead, its focus is on system efficiency and institutional survival, which can be accomplished regardless of social justice. One key ramification of the change in the discursive context of the productive sphere in India for policy initiatives directed at women is that the notion of rights and emancipation, which was always peripheral to the discourse of development, is further marginalized. Instead, it seems to be increasingly apparent that the idea of rights is appropriated quite deliberately by the neo-liberal state. The rhetoric of socio-political rights is used to draw women into the public sphere. What the play on words has done is to allow for consensus/co-option between the state and women's groups but, in effect, has suppressed the legitimacy of their claims to rights (John 1996). This is a significant critique because, ironically, the 1980s and 1990s has also been a period when the state has been most cognizant of international feminist philosophies and activities, and engaged with women's groups to achieve developmental objectives (Desai 1986; John 1996).

Conclusion

This chapter attempted to bring together the two distinct threads of research objectives undertaken in this study – an evaluation of policy, and the implication of the neo-liberal ideology in development policy for women's emancipation. I explored feminist critiques

of the public space of political debate that influences what Yeatman (1990) calls the “core policy order”. I argued that in the context of neo-liberal development in India, the state is eager to draw women into ‘public’ gaze - because, it is here that women’s productive capabilities be channelled for broader economic growth. Women’s reproductive abilities under neo-liberalism is an important pivot around which the success of market development hinges; therefore, their ‘visibility’ in the public space underscores the state’s regulation of their bodies. The implication is not that women should not be drawn into public polity and economy, but that the terms on which women enter this space should be better elucidated and negotiated. Else notions such as ‘empowerment’ and ‘women’s rights’ could be easily co-opted by the public sphere and reduced to tokenisms. This would only make the goal of women’s emancipation in developing contexts all the more elusive.

X

CONCLUSIONS

[T]he fault line in the ICPD Programme of Action [is] a highly dangerous one for feminists, especially those in the North, because it configures a gap too often present in our own thinking between the politics of the body, sexuality and reproduction on the one hand and the politics of social development and social transformation on the other...we have barely begun to make explicit the concrete links between macroeconomic policies and the materialization of reproductive and sexual rights for all the world's women.

Petchesky 1995, pp. 157- 159, 160

The analysis of political rhetoric is an unconventional approach to developmental research. It reflects an emergent body of critique within the discipline that questions the ideological foundations on which development theory and practice bases itself. This critical literature asserts that the collective values and beliefs held by individuals in an institutional context manifest themselves in day-to-day practice, and colours their interpretation of what constitutes the developmental needs of a community. In social contexts where there are unequal power relations, these ideologies can decide access to political bargaining and, ultimately, resources. The present study is set against the unequal relationship of power between two groups of people in the provision of public health, namely, providers of policy (or the state) and beneficiaries (or users, specifically women users). This study is framed by the fundamental assumption that the ideologies that the providers subscribe to are critical determinants of the outcome of any decision to allocate resources to users.

Against this epistemological assumption, I will recapitulate the main objectives of this study, and in so doing, bring together the various strands of arguments that this research has addressed. In 1995, the Government of India embarked on an ambitious plan to

revamp the way that it had been providing family welfare services to the population. At the heart of the many changes that it proposed was the assimilation of the feminist rhetoric of sexual and reproductive health and rights that had been in vogue in international discourses around population policy since the International Conference for Population and Development, 1994. The present study has attempted to evaluate the process of institutionalization of the ICPD's ostensibly feminist rhetoric in the GoI's existing health and family welfare system. There are several dimensions to this process, which have offered germane topics for enquiry in this research.

First, the state and its ideologies have been a core focus of this study. The Indian state has, in its recent history, taken ambivalent stances on issues related to women. In some instances, it has proven exceedingly progressive and protective of women's rights, whereas on other issues, there has been evidence of distinct patriarchal values. The outcome of feminist rhetoric under these circumstances is explored in this research. A second dimension that has been explored in this study has been the effect of the competing discourse of neo-liberalism that has, in the last decade or so, seeped into the economic and social organization of life in India. The neo-liberal discourse not only threatens to overturn the conventional state-citizen relationships in India, it has also proven to be a dominant ideology that influences the interpretation of reproductive health as a discourse. The emphasis of the neo-liberal discourse on efficiency, cost-effectiveness, and measurable returns to investment is an important determinant in the Indian state's decisions around designing any policy, and in this context, reproductive health policy. A third aspect that has been evaluated in this research is the formulation of gender-sensitive policy, or policies that are likely to have maximum benefit for women. A key aim of women/gender and development scholarship has been to provide the knowledge base to develop policy initiatives that are sensitive to the needs of women (as much as other subordinated groups). In this study, through the appraisal of the ideologies that have bearing on the institutionalization of reproductive health policy in India, I hoped to bring to light the deep-rooted nature of biases in development policy that pose a challenge to developing gender-sensitivity in policy. A point that I argue repeatedly in this study is that gender sensitivity is not something that can be 'fixed' merely through technically sound methods of policy design. Gender biases in policy (as much as gender-sensitivity) occur at the level of ideology and discourse.

A foremost factor that has an effect on how well gender sensitivity is incorporated into development policy is the political identity of women. In this thesis, I contend that the state produces certain constructions of women and their roles in society, which determine the way that they are positioned in policy, i.e., their political access to the state. Women's constructions as political beings, I further argue, are simultaneously framed by their roles in economic activity, and by notions of femininity and womanhood accepted within a dominant patriarchal society (Chapter 3). Given that identity, as much as ideology, has significant bearing on policy outcomes, this research also devotes attention to how women's political identity has been constructed within the contemporary Indian state. The implications of these constructions for the representation of women in the reproductive health policy are a fourth perspective that is considered in this thesis.

A fifth dimension is the global-local connection. This research provides an assessment of what ensues when a globally accepted discourse is contextualized in a local setting. What is lost in translation, what is accepted, and what new variants of discourse are produced is empirically demonstrated through the analysis in this research. Finally, this research also offers an opportunity to debate the implications for feminist politics when empowering rhetoric is appropriated by the state and employed to benefit its own agenda, which may not directly benefit women as a collective.

Overall, this thesis also presents development (and particularly, reproductive health) policy as an arena of political conflict and debate. Policy goals and strategies are not determined as isolated, rational, unbiased decisions. Pre-existing biases around what women need, what the state needs, what is perceived as effective strategizing, all permeate into the formulation of development programmes. As these biases (and ideologies) get institutionalized, they 'locate' users (women) and providers (the state) in unequal positions of power.

Drawing Conclusions

In this section, I would like to elucidate some of the broad conclusions that can be drawn from this study. I will not recount at length the major findings of each chapter as these have already been presented in the concluding section of each chapter. My aim here is, rather, to consider some of the overarching implications that have emerged as the various links between the analysis of data and theoretical literature become clear.

Briefly, the review of literature in the earlier chapters focused broadly on two kinds of issues. It first explored scholarship around how political discourses are interpreted by dominant power groups in society. Chapter 2, in particular, introduced reproductive health as a political discourse that originated from within a feminist framework. As a gender discourse, reproductive health emphasized women's well being, empowerment, and substantive transformation in gender relations so as to be able to make sound reproductive choices. The initial chapters also explored, in theory, the outcomes of such 'oppositional' discourses as they are institutionalized within social contexts that have pre-existing ideologies - in the context of my study site this was identified primarily as neo-liberal and neo-Malthusian discourses - which may be contrary to the essence of a feminist discourse.

I also explored the idea of the state and the ideologies of gender that the Indian state subscribes to. In developing countries like India, in particular, the discourse of neo-liberalism has, in recent years, emphasized the economic potential of women. Women's economic contribution at the level of the household and community are critical for the success of developmental programmes. Given the significance of population control to these states, women's reproductive capability is to be seen as a productive capacity, which must be regulated and controlled for the gain of the neo-liberal state. Consequently, the neo-liberal development state's embracing of the reproductive health discourse must be viewed with caution, and women's representation in the public sphere, under such circumstances, must be deliberately negotiated at every step.

The empirical analysis of the GoI and GoK documents formed a major focus of this study. The analysis identified strong strains of neo-liberal and market discourses within

the text of the documents and the interviews (see Chapters 6, 7, and 8). The evidence of the neo-liberal discourse was demonstrated partly in the direct use of neo-liberal/market rhetoric but also in the redefinition of the idea of (a) the user of family welfare services, and (b) the state and its services. In terms of the idea of the user, the health user was positioned as a consumer as if in a market place with the ability to make choices from a range of options proffered by the state and private sector. The analysis of the discourses of consumer freedom, however, suggested that the identity of the consumer was determined by a deceptive sense of freedom; the state, in fact, exercises considerable control over individual decision-making. Users have entitlements to the family welfare service. Unfortunately, these entitlements are not based on a universal right as citizens but what is possible within the parameters of the market; *affordability* is one such parameter (services for those who can afford) and *priority* (as defined by the objective of the state's development) is another. The package of services is designed in terms of 'who' is entitled to what. In other words, for the state, issues such as who is entitled to services, and what they are entitled to, assume prominence within the discourse of the market.

Another role of the state, the results demonstrated, is to ensure conformity to specific norms. Anyone outside of the state-defined system of norms is constructed as deviant/irrational or lacking in rational capabilities. In the end, the neo-liberal discourses indicated tendencies for the state's health sector to focus on the provision of services that were efficient and effective, but could also be exclusive to certain groups in society. The market discourses also indicated that there was a strong tendency for the state to want to regulate reproductive behaviour; an entire set of training and educative programmes continues to be offered that aims to get people to conduct their reproductive behaviour in a manner that suits the state. The presence of the neo-liberal discourse, in the end, raises concerns that the individual's position in the state veers towards commodification as part of market strategizing rather than towards democratization.

The second analytical chapter (Chapter 7) focused on the positioning of 'gender' in the RCH. The analysis of the RCH demonstrated that women's well being was not treated as an end objective in itself. Women were cast as instrumental to other aims of the state.

Further, the documents also showed that the state sought to erase a distinct set of needs for women, and instead tied women's needs with larger societal and developmental objectives. As a result, women's representation as a special group with special needs tended to be lost. The analysis also revealed that even as this discourse of universal reproductive health needs for men and women was accepted, the discussion of the basic feminist concepts that founded the discourse of reproductive health – such as rights, choices, and empowerment - was transformed to suit the fundamental tenets of neo-liberalism.

It would be instructive to explore how these ideological themes around gender feed into the larger movement of the state's health policy towards neo-liberalism. I would argue that the institution of a market framework for reproductive health gives the impression that the policy is designed in an apolitical environment, where allocation for women is prioritized. On the contrary, 'woman' is constructed in a way that supports the discourse of the market. The instrumental construction of women's reproductive identity sets the basis for a gendered prioritization of reproductive health services - the question of "*who*" gets services. Reproductive ability becomes a currency of the market, an economic criterion. For instance, those users with high 'fertility risk' (especially women in the ages 15-39) have more services or are seen as more deserving of reproductive health services.

Chapter 8 also demonstrated that the idea of the role of the state is defined by the market discourse, particularly, in terms of obligations to consumers, or what the state is obliged to provide. The discourse around obligations of the state was significant in the climate of devolution of services to the private sector. While earlier, the private sector flourished alongside the public sector – permitting users to have a choice between public or private services – the private is increasingly being constructed as an extension and replacement of public services. What follows is that only those users who can afford private services as readily as they can access public services can consider the health system an idealistic market place. For a majority of people, this linking of the private and public actually limits their access to health services.

Chapter 9 centred on an analysis of aspects that influence representation in public policy against a background of conflicting political discourses. Given that decisions

surrounding policy making, such as who receives what, is largely made at the level of ideology, discourse, or rhetoric, individuals/groups who can establish their right to make claims to the state stand a better chance of representation in policy. For women, in particular, claims to the state are influenced by their representation in the public sphere. The notion of the public space and its relationship to an emancipatory process has been a central analytical category in feminist scholarship. This literature (for e.g., Fraser 1991, Landes 1998, Pateman 1989) argues that women's political identity, in particular their visibility, has critical implications for the claims that they are able to make on the state. In contexts where neo-liberal ideologies are rife, however, 'visibility' is not an unconditional goal that women could aspire to. Neo-liberal states have the tendency to regulate all individual behaviour so as to further the objectives of market development. Under such circumstances, visibility for women may lead to exploitation for the state's gain rather than any guarantee of claims to the state's resources.

The state's positioning of women as a developmental category is also significant to the market/developmental agenda. The state both upholds and effaces women as a specific category in reproductive health - gender is both negated and reinforced. In conditions where obligations to the state are stressed, gender is emphasized; it is negated where claims to special rights may be made. So the state shifts between universal and specific constructions of citizenship rights under 'gender'. Finally, gender claims are also limited by construction of the state/public space as not the primary site for the articulation for issues of social justice. Instead, the values of the market instilled in the better functioning of institutions is promoted as being more suited to ensuring access to basic needs. Thus, issues of rights and empowerment are secondary issues for debate, if permitted at all. In the end, the construction of women's reproductive needs is made on the basis of what facilitates development (and the market).

Thus, the discourse of reproductive health as institutionalized in India very clearly indicates the pre-dominance of a neo-liberal ideology. The implications of the merging of the discourses of rights with that of the market cannot be universalized; however, in the case of reproductive health in India and in the context of Kerala, it seems that blurring the discourses of the market with that of citizen/women's rights can potentially

retard women's political claims to the state. In sum, that very distinction is essential for women to articulate their own needs and perspectives.

Appraising reproductive policy in Kerala

How do we appraise the RCH – do its discourses absolutely deny transformation for women? Does the state offer no possibility of recourse for women? What alternative strategies can a study such as this recommend for policy makers and feminists?

Rai (1996a, 1996b) after offering a post-structuralist analysis of the Indian state lucidly argues that cognizance of the masculinist discourses does not necessarily mean a paralysis of transformative processes for women located within the state. What is essential for feminists to recognize is that because the state is not unified, and because its discourses are not static, there are “spaces that are available, and can be created for and through struggle for retrieving, reconstructing and regaining control over the meanings and signifiers in women’s lives” (1996b: 19). Similar conclusions may be drawn from my analysis of the RCH in Kerala. Unraveling the underlying ideologies and the manner in which the state deploys its discourses is not to suggest that the policy is wholly faulty and that there can be no alliance with the state in order to address issues of women’s emancipation. The role of the state in the reproductive lives of people is significant. The MoHFW is the primary, if not the only, agency of the state that propagates messages about reproduction. To the community at large, the institution of the public health service is a dominant source of reproductive values and ideologies. The health system’s ability to influence even gender considerations of reproductive behaviour is tremendous (e.g., encouraging male involvement). Certainly, the introduction of the discourse of reproductive health in Kerala, as the interviews with providers have shown, has begun an incremental shift (however marginal) towards conceptualizing a population policy that is focused on individual well-being. The significance of this shift cannot be undermined. Moreover, the neo-liberal framework is fruitful to women’s reproductive health at some level. The potential improvements in the structure of the system, and focus on quality of care are the likely positive outcomes in the wake of the RCH¹³¹.

¹³¹ See HealthWatch (1999).

However, to ensure that providers and eventually, users,¹³² actively engage in an emancipatory discourse of reproductive health, feminists scholars and activists must be vigilant against the negative facets of neo-liberalism. By identifying official discourses that may thwart women's access to the state, feminists are in a stronger position to set in place a counter-discourse that challenges some of these fundamental biases. The solution may not be so much to set up frameworks for action alternative to the state; in fact, post-structuralist feminist recommendations for policy action include working both within and outside the state. As Rai (1996b) has pointed out, feminists must identify the various spaces that are opened within the post-structuralist state. In the case of reproductive health, the state holds a certain legitimacy in society that is as yet not equalled by NGOs and women's groups. For instance, in informal talks with officials, I was told that the state, concerned with the rise of AIDS through heterosexual practices, has recognized that women's inability to negotiate safe sexual practices constituted a major problem. It was felt that the state would have to start intervening in these 'private' areas before the AIDS problem reached epidemic proportions (informal interview, I#4). It is for women's groups to capitalize on the state's advantageous position, and surmount the debilitating discourses of economic rationalism to introduce emancipatory discourses into the existing programmes of reproductive health care.

Study Appraisal and Future Research

An appraisal of the design and conduct of the study would be relevant at this point. The unique feature of this study was the emphasis on qualitative analysis, with a focus on grounded theorization and interpretive data analysis. The listing (through the review of literature) of the discursive interpretations of reproductive health from feminist and neo-liberal perspectives that was developed in Chapter 2 proved to be a helpful tool. It helped to clarify specifics of two contradictory discourses when applied to the particular context of reproductive health. Yet, data from the field indicated that existing literature in reproductive health has not developed several significant themes that are relevant to reproductive health policy formulation and design. The construction of women's

¹³² Even the most recent reports evaluating the RCH in various states in India indicate that users do not seem to have experienced a perceptible shift in the operations of the health providers (see HealthWatch 1999).

identities, the significance of transforming user-state relationships into 'client-provider', and political outcomes of health services for women are but a few of these themes.

One area that I see direct implications for a study of this nature is in developing gender-sensitive accounting and public budgeting methods. A trying problem that has faced public institutions has been to develop methods that will judiciously and effectively allocate resources so as to benefit both men and women. Before one can begin the task of gendering budgets, a body of critique of present systems will have to be developed that will begin to throw light on the lacunae in the present systems. I see this study contributing to such a body of literature. A corollary of this study is that the rhetoric espoused by the state will be evidenced in effect, and budgets are one such manifestation of state ideology. The ideological stance of the state, be it influenced by neo-liberal or gender discourses, will be reflected in the state's allocation of funds.

Another area for extending the results of this research is in the study of co-optive processes. The present study was limited to exploring co-option of feminist rhetoric in state institutions alone. In reality, the state is but one development actor. Other agencies, international and non-governmental, are also powerful in the development arena. Their contribution to co-opting and producing hybrid discourses that then lay the framework for development practice from global to local levels is worth pursuing.

Finally, a word on the limitations of the study. This research sought to extend western feminist critiques of the public-private spheres and the determination of political identity to the context of contemporary developmental states. Despite the paucity of supporting literature, this study has attempted to link the theoretical argument made about the regulatory nature of the neo-liberal state with empirical evidence from the field. The idea of the limited emancipatory powers of the public sphere could have been further substantiated through analysis of documents from other realms of the family welfare institutions, for instance, training materials, process of consultation followed, and so on.

Further, the analysis in this study is drawn from data generated at an early stage of policy implementation. Many objectives and plans may have been reconstituted, revised and re-planned. The timing of field-work also limited my choice of local level PHCs and

participants. Similarly, more interviews with the officials in the MoHFW in Delhi, and international aid agencies, would have greatly enriched my understanding of the rationale for the design of the policy as it is. Still, it is important that as of February 2000, there were no project appraisals or reports that consolidate the state's perception of its successes or its failures, its methods and outcomes. Another issue in methodology that would have improved the quality of data collected would have been a pilot study. The strains of market discourses, and the state's perception of public-private reproduction were understood after analysis began. More information on these issues would have been useful, but by then, a second round of fieldwork was not feasible. Furthermore, other sites within Kerala or outside the state for comparative studies would also provide insight into the ways that providers in other contexts perceive the discourse of reproductive health. Although the purpose of qualitative research is not to ensure replicability and generalizability, there are strong reasons to extend the analytical methods and concepts used here into other socio-political contexts.

In addition, this study has focused on the health providers' interpretations of the reproductive health discourse. The analysis based on these interpretations could be enhanced by studying local women's understanding of their reproductive health needs. While I had interviewed women, for reasons cited in my methodological chapter, this material was not extensively relied on. However, there is potential to research the contrast in the ways women construct themselves as opposed to how health providers construct them. Women's perceptions of their bodies, reproductive agency, and identities would certainly help to illuminate the gaps between the constructions of the state and women outside of these constructions. Further, future research can also be sensitive to the issue of "differences". Responses of women from urban and rural areas, and upper and lower socio-economic classes regarding their reproductive health status and needs would throw light on the shortcomings of the state's seeming uniformity in constructing women in reproductive policy.

Drawing Lessons

The final section of this concluding chapter will explore the possible theoretical and empirical lessons that may be derived from this study.

Theoretical Reconceptualizations

Theoretically, this study contributes to a critical evaluation of gender and development policy. WID policy and practice has conventionally steered away from a contentious path of confrontation with sexism, patriarchy and issues of subordination, divorcing itself from its feminist origins (Newland 1991). WID promotes a vision of empowerment of women without challenging power structures. As a result, WID policy has tended to take two forms; first, an accommodationist form, where policy focuses on practical needs of women and families. A second form is a separatist kind of policy, where WID focuses on women who are out of the traditional structures of society, such as, female-headed households, female migrants, abandoned women, etc. (Newland 1991). The underlying principle in both these forms of policy is that efforts to improve the status of women must be localized, incremental and reflect a change in their immediate material life. Undeniably, this WID approach has made a difference to the lives of some women. Yet, without a challenge to the roots of political power, gender will always assume a fragile position on any developmental agenda. WID theory needs to broaden the reach of its theoretical insights to include an analysis of power and control, both localized and of the state. This, in turn, would demand an understanding of the constructions of women's roles in the state and development policy; the discourses that construct women in policy would set limits on the conceptualization of their abilities to be agents in society and the nation.

The link between political identity and policy outcome is a crucial one, although relatively under-researched in the context of the Third World. As the empirical evidence in this thesis showed, women's representation in the RCH policy and the systematic foreclosure of their claims to rights other than those tied in with the state's developmental aims are a direct result of the positioning of state-citizen relationships on the basis of market contracts. The state is 'contracted' to provide for only certain aspects

of citizens' economic and material welfare - the public domain of action - whereas the private domain is left to the domestic sphere or civil society. This study offers another critique of the move towards market development in India by emphasizing that the current re-orientation of the ideologies of public institutions has effects that go beyond controlling public expenditure.

Another significant conceptual lesson for developmental researchers that can be drawn is the need to focus on the state as the central body that governs gender relations in society. In tracing the institutional source of gender biases, developmental theorizations have targeted the household, local community, the ubiquitous 'society', and, even, the labour market. Scholarly analysis of the role of the state in mediating gendered allocations of resources, particularly, public resources, need to be developed. Development theory, conventionally, does not focus on the role of the state as a mediator of public resources. As this study showed, however, not only does the state reproduce existing ideologies of gender relations prevalent in the public sphere, it also produces new sets of relations through the institution of its policies that support these ideologies.

This research also provides lessons to the relevance of ideology as a legitimate category of gender and development research. At first reading, for instance, the government's policy appears gender-sensitive. No doubt, when the first interim project appraisal is due, the quantitative statistics may support the claims of the state to have proffered gender-sensitive services. However, it is only by unpacking the layers of gender ideology as this research has done that the state's inadequate provisioning can be questioned. The case of the RCH is one example only. Similar exercises will, are needed to examine the state's policies in other areas as well, such as agricultural or industrial policy, social welfare, and labour policy, to name a few. Studies such as the one undertaken here will help to shift focus away from statistics to the politics of creating statistics. Simultaneous quantitative and qualitative analyses can provide distinctly different pictures of the same situation.

Evaluating Policy Implementation

This study, in questioning the assumptions of the state in designing policy, highlights issues that the state has not considered in designing the RCH. The state's failure to recognize 'differences' between women is a major issue. The implicit assumption of a normative sexuality and arising from this, women's reproductive health needs, reflects that the state is embedded within the cultural expectations around women. Women's needs differ depending on their cultural backgrounds, sexual habits, and social location. In being directed by an economic paradigm, the state forecloses the possibility for women in the margins (for instance, sex workers, women in extramarital relationships, single women, etc.) to stake a claim to the services that the state provides. It is only when these women are of significance to the state's health agenda (for example, given the rise in AIDS in the state, there is a focus on sex workers as a group) do their needs also emerge as a 'public' issue.

This research also offers an opportunity to debate recent trends towards public and community consultation in the making of gender-sensitive policy in many contexts in India. The RCH is an example of a well-consulted policy. Consultative processes had been (and continue to be) a part of policy making - with the community, with women in the community, and with feminist groups outside of the community. Yet, the policy falls short of what was conceptualized as an emancipatory discourse of reproductive health at Cairo¹³³. What has contributed to this breakdown despite the open communication channels? Why do the emancipatory goals set at the stage of policy formulation fail to be grounded in similar foundations when being implemented? There are three possibilities that I advance. One, I contend, has been the seeming inability of the state to comprehend that fundamental ideological shifts are fundamental to bringing about long-term changes through gender policy, both at the level of formulation and practice. In the RCH, the state accepted only partially the feminist rhetoric of reproductive health. Its selective appropriation reproduced discriminatory practices rather than diminished it. A second, and perhaps more pessimistic, possibility could be that in the negotiation

¹³³ Sen et al. (2000) note that although in the initial phases post-Cairo, the MoHFW was keen to work with women's groups in India, the early enthusiasm from the ministry gave way to a silence. NGOs are now readily 'contracted' by the state to deliver reproductive health services at the grassroots level, but not as a consulting partner in policy formulation.

between a gender ‘oppositional’ discourse and a dominant discourse, there has been, as Fraser warned, an inevitable de-politicization of feminist discourses. In the course of this de-politicization, feminist ideological perspectives have also been co-opted by the state. While Fraser’s negativity can be challenged, from a practical point of view, this sobering truth again raises the question about how feminists should position themselves to be most effective. They must be conscious of when to work with the state and when to continue to remain outside its processes of policy-making and provide only critique.

A third possibility reflects another blind spot in the way the government enacts policy. The Indian state needs to focus better on inter-sectoral co-ordination for effective practice of gender policy. In other words, for policy in one sector, such as health, to be effective, it is necessary to provide mechanisms in legislation that will support these changes for women. This lacuna has been a major failing in the RCH. There are no processes to ensure that women’s rights to quality treatment or informed choice will be protected through mechanisms outside the health sector; these checks are essential if actual changes at the level of practice are to be seen. The public health system wields considerable authority, especially in rural areas, which is often unchallenged. Part of the process of guaranteeing that women have rights in healthcare is the institution of formal processes to ensure those rights. In the context of the RCH, there have been few links with policy-enforcing mechanisms outside of the sector itself, either through the Auditor-General’s auditing, or other *in situ* legislative reform. Women’s groups, consulted during policy formulation, are given no monitoring powers. What is required is a co-ordination at multiple levels both within and outside the government; else, there will be a dwarfed progression towards women’s welfare.

Finally, the consequence of state appropriation of feminist discourses is another lesson that is worth examining. Some of the recent events around population policy in India are worth mentioning as a case in point. The GoI in February 2000 released its Population Policy 2000, which continues with the shift away from the incentive-disincentive approach, and focuses on devolving the power to manage health systems to local governments. This policy also emphasizes reproductive health (Jain 2000). Given this rhetoric, it is interesting that in late 1999, doctors in the public health sector in Kerala went on a strike for a number of issues, including their concern that “Kerala is losing

ground in the area of implementing national health and family welfare programmes" (*The Hindu*, Dec. 14, 1999). The Directorate of Health Services' response was to assure the public that "the number of sterilizations, which represent a major component of nationally-implemented programmes, had registered an increase over the previous year" (*The Hindu*, Dec. 14, 1999). The saga of conflict between reproductive gender discourse and neo-liberal/neo-Malthusianism is an ongoing one.

In sum, to answer the research questions raised in the introductory chapter, the integration of the neo-liberal and feminist discourses on reproductive health has resulted in policy initiatives that are interpreted contradictorily at the local level. The rhetoric of reproductive health has, primarily, been an add-on in a programme that has focused on population control. In the course of implementation of the RCH, the discourses of neo-liberalism and neo-Malthusianism, that are inherent in the state, succeed in pre-defining sets of needs for women and marking off certain areas of action, and inaction, by the state. While it would be wrong to underestimate the benefits of the new programme, it would be equally naïve not to question what political benefits women would gain from a policy that is increasingly taking on an 'add-on' quality. It is not that the state has a diminished interest in investing in family welfare services for women that is the concern. What is more important is that, as a gender policy, the implementation of the RCH has not advanced the political representation of women in the public space. For the present, the reigning discourses of the state only reinforce a construction of women as 'economic agents', whose worth is decided in terms of potential usefulness to the state.

APPENDIX A

BACKGROUND OF THE POPULATION ISSUE

From the days of Malthus, population growth as a problem has never been seen as confined within national boundaries. Yet, what is especially significant since the 1950s is the international attention that this issue has received. International conferences have debated potential growth and strategies for population reduction, international agencies were formed to undertake research and funding, and international assistance was scaled up to meet this global concern.

The U.N. sponsored decennial Conferences on Population and Development (hence, ICPD), held first in 1974, subsequently in 1984 and most recently in 1994, was one such platform where the global dimensions of national population growth has been discussed. It is also the forum where diverse and often contending opinions on the population issue have emerged. In a sense, the Conference has been a microcosmic reflection of the prevailing discourses on population and development issues.

Critical writings that have emerged from the Conference have highlighted that the conference has been distinctive for all the ideological fissures that have come to the fore during its proceedings (Gulhati and Bates 1994; Correa 1994; Cliquet and Thienpont 1995; Johnson 1995). At the first Conference held in Bucharest, a sharp divide was evident between the countries of the North and those of the South (Freedman and Isaacs 1993; Gulhati and Bates 1994). The division lay mainly in two popular notions that surrounded the global problem. The first was drawn from theoretical and academic postulations that highlighted the inverse links between population growth and economic and social development. A second widely acknowledged association was the regional interdependence between population and development. Put together, what these two notions reinforced was that unbridled population growth in developing countries would, in the medium to long term, hamper global economic growth, especially for developed countries.

The suggested recommendation, therefore, was to strengthen population regulation programmes in the 'population-ridden' countries. The developing countries rallied

together against this obvious discriminatory rhetoric and countered with the reverse argument; that countries who achieved a certain level of economic and social development automatically seemed to register falling fertility rates. The solution in their view was for the West to support development in these countries. In the words of the Indian delegate to the Conference: "development is the best contraceptive" (Gulhati and Bates 1994). The Conference all but broke up in the first week and was saved only by a compromise in the World Population Plan of Action. The much-redrafted document placed population growth in the context of social and economic development and a restructured world economy. The strong references to fertility regulation were also eliminated (Gulhati and Bates op. cit: 51).

At the 1984 conference, the roles were drastically reversed. Beset by lack of economic growth, most developing countries had accepted that population was a deterrent to the success of their development programmes, and that the population problem with the help of international support would have to be tackled at the earliest. Contrary to the expectations the other side, led by the U.S, withdrew from its previous position that population was a serious obstacle to economic growth. The U.S. now felt that population was a 'neutral' factor in development. The real route to economic growth was the free market and privatization. The main reason for the volte-face of the United States stand was the growing pro-life lobbies within America who were a significant voting body. The immediate consequence of the U.S. stand on the Conference proceedings was minimal (Gulhati and Bates 1994: 55); the conference did debate the customary strategies to manage population growth. What was significant was that under the U.S. influence, notions of reproductive choice were undermined within the international arena (Dixon-Mueller 1993: 70-74; Freedman and Isaacs 1993: 23). The U.S., soon after, cut aid for population programmes in developing countries for fear that these programmes supported abortions (Dixon-Mueller 1993). The impasse in the discussions was evident; in all, the draft version of the Mexico Declaration was "vague, non-committal, poorly documented and badly structured paper. A working group was created and instructed to re-write the draft version and formulate a plausible text" (Cliquet and Thienpont 1995: 62).

The most recent ICPD in Cairo, on the other hand, is upheld as symbolic of an emerging consensus among the various nations on the population issue. When the three years of preparatory work that led to the Conference began, it seemed that not very much had changed; old concerns were reiterated and few new ones expressed (Gulhati and Bates 1994). The plan of action, at the preparatory meetings, had expanded from the conventional focus on contraception and economic development with a new emphasis on the connections between population, poverty, inequality, environmental damage and the need for sustainable development. It is in this context that female education is seen as the link pin to a solution. However, the negotiations began with promise. Both developing and developed countries came to the table in agreement that population was a key ingredient in efforts to promote sustainable development; the Clinton administration, had in the previous year restored most of its funding to family planning programmes (Gulhati and Bates 1994; Roush 1994).

The nine days of deliberation at Cairo, however, were full of surprises. The entire tenor of the discussions moved from strategies for population control to population and women, and the consensus that emerged centred on this theme. The essence of the Cairo consensus was that it moved away from a modified Malthusian approach (that highlighted the need to curb population growth at all costs) towards a holistic approach, which takes in poverty, women's status, and the structure of society as well as fertility per se (Johnson 1995:29). 'Gender equity', 'informed choice and consent', 'reproductive and sexual health' and 'empowerment' were seen as important but not critical to the management of population at the start of negotiations. Yet, the conference culminated advocating a novel approach to population management, and even thinking about population. The Conference Programme noted that

advancing gender equality and equity and the empowerment of women and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development related programmes. ..[S]tates should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health. (United Nations 1995a, *Principles 4 and 8 of the ICPD, 1994*).

To the optimist, the Cairo summit, in effect, represented, “a quantum leap forward in the way the population issue is to be handled” (Johnson 1995:9). Even more so, the Cairo conference legitimated and gave credence to an entirely different discourse surrounding population. The conference can be interpreted as reifying a growing global discourse in population, one that centred women as the focus of population policy intentions.

APPENDIX B

Guidelines for Interviews for Various Categories of Participants

Official Policy makers

Conceptualizing the RCH:

What was India's role in the ICPD, what have we taken from it?

The Government of India (GoI) mentions the RCH as a paradigmatic shift - why and what does it mean?

What is to be gained by a shift to Reproductive and Child Health Programme (RCH)?

How is the present policy different from earlier ones?

In terms of health sector functioning, what does the shift involve?

Women and the RCH:

Who are the main target population of the RCH's services ?

What are the benefits/advantages for women? Fourth Five Year Plan called women Partners in Development - how are women viewed in this new policy paradigm?

How will issues of equality and discrimination, violence against women, informed choice, male responsibility be treated within the context of the health system?

What does the GoI understand to be reproductive rights? What kind of reproductive rights will women be able to exercise?

What are 'sexual rights' in the context of RCH?

Integrating contradictory discourses:

Will the principles of reproductive rights clash with GoI objectives of population control?

What are the GoI's long-term population objectives?

Implementation Issues:

How will HIV/AIDS/STDs be treated?

What does quality of care mean under the programme?

How will the MoHFW's population education be affected?

What sort of contraceptive-related services will be there? Has the cafeteria of contraceptive methods increased?

Is the staff prepared to handle the changes of the RCH? What forms of training are given?

What legal reconstitutions may be expected to take place?

What are the financial implications under the RCH?

What agencies outside the GoI will be involved and in what way?

Will women's groups be involved and how?

How does the RCH extend to the private sector hospitals and commercial availability of contraceptives?

Are PHCs equipped for the changes with RCH?

How will state address issues of adolescent sexuality and reproductive health?

How is the RCH proposed to be evaluated?

Official provider (medical doctors/nurses at the PHCs):

What does new policy mean at PHC level?

Is there enough funding/ equipment/ trained staff?

Is this a necessary shift? Why?

Who will it benefit? How?

What does your motivation/education programmes now contain?

Do you think fertility control should be a personal matter? What implication for country's population growth?

Would you now advise sterilization for women with two children?

Do you think Kerala's population advances are under threat?

Do you have unmarried people coming for counselling? How do you treat them?

Any change in women's contraceptive pattern with change in policy?

What sort of information of contraceptive use is requested by the GOI now?

What is quality of care? How is it addressed here?

NGO/academic/ activists:

What does this shift to the RCH indicate?

What are the benefits for women?

Will there be provision to exercise reproductive rights?

What is missing in the policy?

How has the GoI modified recommendations of ICPD?

Have women's groups participated in policy making? Are the views of women's groups adequately considered in policy process?

How do you perceive the role and presence of international agencies?

Are PHCs in Kerala equipped to implement reproductive health?

Women clients

Why do you use the PHC?

Any changes in the services offered to you at the PHC in the past year? What sort?

What do you want the PHC to provide you?

Are you able to express your wishes to the staff at the PHC?

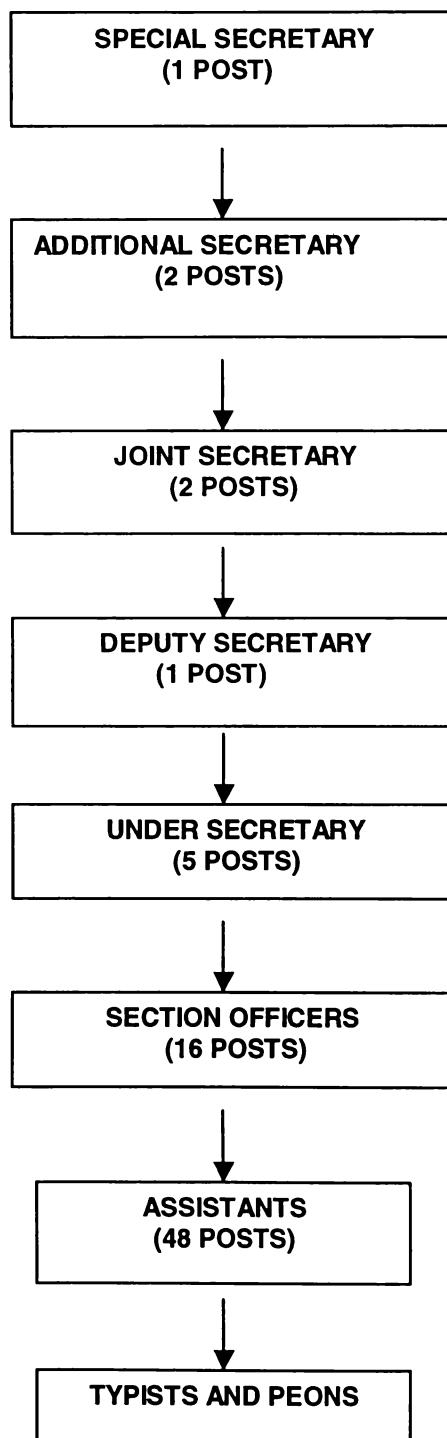
How does the staff treat your requests?

APPENDIX C**PROFILE OF INTERVIEWEES**

<u>INTERVIEWEE</u>	<u>SEX</u>	<u>DESIGNATION</u>
I#1	Male	Official, DFW, Kerala Middle-level bureaucrat
I#2	Female	Official, DFW, Kerala Middle-level bureaucrat
I#3	Female	Independent Consultant for MoHFW, Delhi
I#4	Male	Official, DFW, Kerala Senior-level bureaucrat
I#5	Female	Feminist activist
I#6	Male	Official, DHS, Kerala Senior-level bureaucrat
I#7	Male	Official, DHS, Kerala Middle-level bureaucrat
I#8	Female	Official, DHS, Kerala Middle-level bureaucrat
I#9	Female	Official, Medical Doctor PHC, Vellanad
I#10	Female	Official, ANM, Vellanad
I#11	Male	Official, Medical Doctor, Palathara
I#12	Male	Official Medical Doctor, Vellanad
I#13	Female	Official, ANM, Vellanad
I#14	Female	Official, ANM, Vellanad
I#15	Female(s)@	Official, ANMs, Palathara
I#16	Female	Feminist Activist
I#17	Male	Family Welfare Provider Non-Government Organization
I#18*	Female	Official, MoHFW in Kerala Senior-level bureaucrat
I#19	Female(s)@	Official, DFW, Kerala Middle-level officers
I#20*	Male	Researcher, International Development Agency, Delhi
I#21*	Male	Official, MoHFW, Delhi Senior-level bureaucrat

*: These interviews were not recorded

@: These were group interviews involving between 2-6 participants.

APPENDIX D**ORGANIZATIONAL CHART**
DEPARTMENT OF HEALTH AND FAMILY WELFARE (DFW), GOVERNMENT OF KERALA

APPENDIX E

DESCRIPTION OF POLICY DOCUMENTS USED IN ANALYSIS

1.

Serial No. : GoI/ OC /1
Status : Officially marked and numbered
Title : No. M. 14015 / 7/ 97- RCH (DC)
Date : 3. 12. 1997

Description: Memo from the Deputy Director of the MoHFW notifying the administrative approval of the RCH programme. Definition of programme objectives and strategies outlined, states and districts that qualify for the various aspects of the programme noted, outlay of funds and donors mentioned. Attachments include category-wise year-wise phasing of districts at the state and district level, the proposed outlay for each chosen district, details of facilities sanctioned under the scheme.

2.

Serial No. : GoK / OM / 1
Status : No official marking
Title : The minutes of the meeting held on 07/10/1997 in the office of the Secretary to Govt. H&FW
Date : 7.10. 1997
Description : The meeting describes the some problems that PHCs are experiencing with respect to infrastructure in Trivandrum, Trichur and Kozhikode . Mentioned in this meeting are problems of washing, electricity, water supply, drainage, disposable syringes and recreation.

3.

Serial No. : GoI/ TM/1
Status : Official seal of GoI/MoHFW
Title : *Training of Auxiliary Nurse Midwives (ANMs) for 'Building Effective Community Partnerships for Implementing the Reproductive and Child Health (RCH) Programme'*
Date : 1997
Description : This is a training material for facilitators of the RCH training programme. The programme is meant to be a six-day training. The introduction to the training programme outlines the rationale for the training - mainly, that there is a shift in the 'philosophy' of the family welfare programme. Material includes theory of calculation of decentralized targets, role-play guides and group discussion guides.

4.

Serial No. : GoK/ OBP / 1
Status : No official marking
Title : *District Reproductive Health Projects*
Date : pre - 1996 (?)
Description : This document appears to be some form of background paper to a pilot study of the RH project. It covers the rationale of a reproductive health approach, the services to be offered by the government under the RCH, operationalization of the approach at the district level, a Reproductive Health Quality Framework and suggestions for implementation. The tri-level service package is also mentioned. An attached front page (could be accidental) outlines in a tabulated form the immediate objectives of the RCH programme.

5.

Serial No. : GoI/TM/2
Status : Sealed with GoI symbol
Title : *In-Service Training under Family Welfare Programme. Guidelines for Developing in-service training plan at district level*
Date : 6. 6. 1996
Description : This is more an outline of the proposed shift in training requirements rather than a training manual per se. The introductory sections mention how the training requirements are going to be different under the new government approach. It also outlines the new skills that would be expected at the various levels of health functionaries.

6.

Serial No. : GoI/ OBP/ 1
Status : Official document
Title : *India: Country Statement (ICPD)*
Date : 1994
Description : A pre-RCH report. A demographic outline of the country's population and health status. Looks at age and sex ratios, contraceptive use, the organization of the family welfare system, the programmes achievements and goals.

7.

Serial No. : GoI/ TM/3
Status : Official marking
Title : *Decentralized Participatory Planning in Family Welfare Programme under Target Free Approach*
Date : March 1997
Description : A facilitator's guide to training ANMs. Brief in comparison to the earlier facilitator's guide. The aim of the guide is to train ANMs to develop an annual sub-centre action plan under the TFA. Contents include assessing felt needs and using the work book to assess felt needs. The training guide is for a two-day training programme.

8.

Serial No. : GoI/OC/2
Status : Officially marked
Title : D.O. NO. M. 14015 / 7/ 95-UIP (B&A)
Date : 25th July, 1996
Description : Letter to the Health Secretary of Kerala from the MoHFW requesting an action plan for the state so as to make appropriate requests for funds. Also attached is an annexure that outlines the essential package of the RCH services and a descriptive comment on the institutionalization of these services.

9.

Serial No. : GoI/ 0C/3
Status : Official marking
Title : M. 15012/ 3/ 96 - UIP (B&A)
Date : 31. 3. 1997
Description : This official communication outlines the RCH scheme for the financial commission so the content is more a presentation of strategies, donor involvement and other institutional arrangements that must be made under the new scheme. Annexures include the new staff that must be added under the CSSM scheme, description of the Local Capacity enhancement component, social safety net and construction details for infrastructure improvement.

10.

Serial No. : GoI/ 0C/4
Status : Official marking
Title : DO No. 59 O/JS (AM) / 95
Date : 21. 12. 1995
Description : A letter to the Health Secretary asking for comments on the proposed RCH package. Annexures include a draft concept paper that explores the central aim of enhancing service delivery and training and suggestions for selection of sub-projects in States.

11.

Serial No. : GoI/ 0C/5
Status : Official marking
Title : *Reproductive and Child Health Programme: Schemes for Implementation*
Date : October 1997
Description : The nearly 100 page document does appear to be very official policy outline of the RCH project; its objectives and strategies. The content with tables covers various issues, among them, the immunization projects, obstetric care, infrastructural requirements, funding details, etc.

12.

Serial No.	: GoK/ OBP/1
Status	: Official marking
Title	: <i>Reproductive and Child Health Project: State Implementation Plan</i>
Date	: undated
Description	: The fifty odd page document lays out the rationale for the RCH programme in Kerala, and the various interventions that will be undertaken within a five year period to have “quality based reproductive health services and to create awareness among all sections of the people”. Budgets and required infrastructural equipments, training needs, construction plans, are among the attachments.

13.

Serial No.	: GoK/ OBP/2
Status	: No official marking
Title	: <i>Guidelines for Pilot Projects on Reproductive and Child Health</i>
Date	: undated
Description	: The document outlines the minimum criteria for selection of blocks for taking up pilot projects. The services, infrastructure and supplies are mentioned. The target group for the project is explicitly mentioned. Specific skills of health functionaries at village, sub-centre, and PHC level mentioned. Integration with existing programmes noted. Guidelines for monitoring the programme are also mentioned.

14.

Serial No.	: GoK/ OBP/3
Status	: No official marking
Title	: <i>IPD Project-Waynad district</i>
Date	: undated
Description	: Gives a detailed idea of the health status in Waynad and the justification of an UNFPA funding. Issues covered include status of the health services, status of maternal and child health, quality of health services (as measured by access to health care, service environment, client provider interaction, informed decision making, equipment and supplies, professional standards and technical competence, continuity of care, integration of services). Local level institutional support, specific indicators of gender status and economic status are also mentioned. The specific strategies and goals of the project in this district noted.

15.

Serial No.	: GoK/ OBP/4
Status	: No official marking
Title	: <i>IPD Project-Kannur district</i>
Date	: undated
Description	: Gives a detailed idea of the health status in Kannur and the justification of an UNFPA funding. Issues covered include status of the health services, status of maternal and child health, quality of health services (as measured by

access to health care, service environment, client provider interaction, informed decision making, equipment and supplies, professional standards and technical competence, continuity of care, integration of services). Local level institutional support, specific indicators of gender status and economic status is also mentioned. The specific strategies and goals of the project in this district noted.

16.

Serial No. : UNFPA/OC/1
Status : Official marking - letter head
Title : untitled letter
Date : 21.4.1997
Description : Letter from UNFPA to the Health Secretary of GoK mentioned arrival of technical consultants to Kerala for situational assessment for the integrated population and development projects (IPD). Attachments mention the amount of funds that UNFPA is willing to commit and for what sort of activities. A table outlining the interventions at the district level is also attached.

17.

Serial No. : UNFPA/OBP/1
Status : Official marking - cover page identification
Title : *Improving Quality of Care of Reproductive Health and Family Planning Programmes (version 4)*
Date : June 1995
Description : As suggested by the title, the document is a country programme strategy paper authored by S D Iyengar and V Srinivasan for the UNFPA. The paper covers significant issues such as why quality improvement is an important issue, the strategies to be employed to deal with quality improvement in the Family welfare department and the financial, technical and infrastructural support that is envisaged for the proposed strategies.

18.

Serial No. : GoI/OBP/2
Status : No official marking
Title : *India: RCH project - GoI Draft of adapted essential package*
Date : September 1995
Description : Tabular column showing essential reproductive and child health services at different levels of the health service system, mainly the community, sub-centre, primary health center and first referral unit/district hospital level.

19.

Serial No. : WB/ 1
Status : No official marking
Title : *India: RCH project - Criteria for Appraisal of District/ City Proposal*
Date : May 9, 1996

Description : A criteria list that identifies indicators for proposals for funding to be evaluated. Indicators include submission of relevant data on staffing, infrastructure, existing resource sources and expenditure, objectives of the proposal, proposed activities, and assessment methods.

20.

Serial No. : GoK/ OBP/5
Status : Official marking-covering page
Title : *State Project Proposal for Reproductive and Child Health Programme for World Bank Financing - Kerala State*
Date : undated
Description : Official proposal to the World Bank for the request of funds to implement the RCH in Kerala. A budget of 21 crores has been estimated. The document shows some of Kerala's basic health statistics, basic components and the long and short-term objectives of the programme. A significant proportion of the proposal is devoted to the various strategies proposed to be undertaken to fulfill each of the components of the project.

21.

Serial No. : GoK/ OBP/ 6
Status : No official marking
Title : untitled
Date : undated
Description : Appears to be presentation slides. It is possible that the presentation was meant for members of the World Bank

22.

Serial No. : UNFPA/ OBP/1
Status : No official marking
Title : *Integrated Population and Development -- Concepts*
Date : undated
Description : The UNFPA's stand on the RCH (or rather the IPD) is stated in this brief (really brief). The goals to be achieved under the IPD and their idea of a RCH package are stated. Also their criteria for the planning of an IPD project are stated.

23.

Serial No. : GoK/ OBP/7
Status : No official marking
Title : *Integrated Population and Development, Kerala. Situational Analysis - Wayanad District*
Date : undated
Description : Proposal for project implementation in Wayanad. Wayanad's health status (including contraception and unwanted pregnancy), tribal population, health service system, and proposed interventions are among the issues covered in the document.

24.

Serial No. : GoK/ OBP/8
Status : No official marking
Title : *IPD Project-Kasargod district*
Date : July 1996
Description : Gives a detailed idea of the health status in Kannur and the justification of an UNFPA funding. Issues covered include status of the health services, status of maternal and child health, quality of health services (as measured by access to health care, service environment, client provider interaction, informed decision making, equipment and supplies, professional standards and technical competence, continuity of care, integration of services). Local level institutional support, specific indicators of gender status and economic status are also mentioned. The specific strategies and goals of the project in this district noted.

25.

Serial No. : GoI/ OBP/3
Status : No official marking
Title : *Guidelines to prepare State Implementation Plan under World Bank supported Reproductive and Child Health Project.*
Date : undated
Description : The document is supposed to be the guidelines to be employed by states when demarcating various districts for specific programme interventions. Mention has been made of programme efforts for special groups such as Tribal and Urban populations. Time period phasing of the project in various districts has also been charted in the annexure. Brief explanatory notes of how the funding will be operationalized are also included.

26.

Serial No. : UNFPA/ OBP/3
Status : Cover page credit to the UNFPA
Title : *Project Formulation Manual: district/ city Integrated Population and Development Projects by the Technical Support Unit*
Date : March 1997
Description : The document outlines the UNFPA objectives and strategies for implementing the IPD in India. It identifies problem areas in India's family welfare programme and the manner in which a project plan can be formulated to address these needs. Notable are the nine-week project formulation process. The document emphasizes the process of planning as much as the kinds of interventions to be undertaken. Specially mentioned are the Reproductive Health Quality Framework and a matrix to identify the magnitude of 'gender' issues.

27.

Serial No. : GoK/ OBP/9
Status : unmarked
Title : *State and District Project Formulation Exercise: Kerala*
Date : undated but refers to a period of July- August 1997

Description : Outlines the proposed activities of the multi-sectoral team that is to visit selected districts in Kerala. The output expected from the field visits are listed in detail. This includes a proposal that presents a situational assessment using SWOT, future and ongoing plans of the government and local bodies, a Sectoral Action Plan, institutional arrangements and a 'demand-supply' appraisal of the district and state level health system.

28.

Serial No. : GoK/OBP/10
Status : unmarked
Title : *A Situational Analysis of Population, Development and Reproductive and Child Health in District Kannur, July 1997*
Date : July 1997
Description : The document is a background paper present to the UNFPA for selection of a district for the implementation of the IPD. The paper outlines the health status of Kannur (includes health indicators like infant mortality, crude death rate, maternal mortality, diarrhea diseases, TB, STDs, cancer, anaemia, birth weights, adolescent health). The report also examines the status of the health services in the district. Further, the report outlines the main issues (problems) in the health services. The annexure gives the names of the team that visited the district.

29.

Serial No. : GoI /TM/4
Status : unmarked
Title : *Decentralized Participatory Planning in Reproductive and Child Health Programme*
Date : Introduction from April 1996
Description : The training materials that were used at the core groups training. Mentions relationship between RCH and TFA, concepts underlying TFA, goals of the RCH, the mathematical calculations to arrive at "felt needs" (worksheets as examples to do this) and how to assess community needs.

30.

Serial No. : GoK/OBP/11
Status : unmarked
Title : untitled
Date : undated
Description : Appears to be slides from a presentation meant for a UNFPA audience. The slides examine previous UNFPA programmes in Kerala, the current IPD programme in Kerala, the time period and financial outlay for the programme, the principles underlying the formulation, the process of formulation, the results of the situational analysis in the various districts, the goals derived from this assessment and the manner in which these formulations will be implemented.

31.

Serial No. : GoK/OBP/12
Status : unmarked
Title : *Integrated Population and Development project : Kerala State level Interventions)*
Date : undated
Description : The document is a tabulated plan of action that examines the goals of the IPD, the verifiable indicators, means of verification and the risks and assumptions in the implementation. Purposes include strengthening the health services at various level and various kinds of functions, the strengthening of services for the management of reproductive cancers, and for ensuring the capacity of local self-government representatives to collaborate in planning and managing programmes.

32.

Serial No. : GoK/OBP/13
Status : unmarked
Title : *Integrated Population and Development project : Kerala (district Kasargode)*
Date : undated
Description : The document is a tabulated plan of action that examines the goals of the IPD, the verifiable indicators, means of verification and the risks and assumptions in the implementation. Purposes include having contributed to improving utilization of quality reproductive health and neonatal health services, and having contributed to improving the quality assurance in the primary health care.

33.

Serial No. : GoK/OBP/14
Status : unmarked
Title : *Integrated Population and Development project : Kerala -Health care services for the urban poor in selected districts.*
Date : undated
Description : The document is a tabulated plan of action that examines the goals of the IPD, the verifiable indicators, means of verification and the risks and assumptions in the implementation. Purposes include improving the coverage and quality of RCH services for poor communities in 13 towns in Kollam, Trivandrum and Alappuzha district, established a system for supervision of CHCs in 13 towns, designed/produced training material and management information systems MIS, to have equipped women from poor communities to take informed and responsible decisions on reproductive and sexual health matters, provide information Reproductive and Sexual Health matters to women and men from poor communities in selected towns, and to upgrade counselling and legal aid services for women from poor communities in selected towns.

34.

Serial No.	: GoK/OBP/15 (various)
Status	: unmarked
Title	<i>: Integrated Population and development project :</i>
(a)	District Wayanad (RCH)
(b)	Kasargode
(c)	District Kannur
(d)	District Waynad : Gender population and development
(e)	Project Wayanad: Adolescent Reproductive and Sexual Health Education
(f)	District Kasargod
(g)	Capacity building for local self-government representatives
(h)	Operations Research on Establishment of a District Programme for Early Detection and Management of Reproductive Tract and Breast Cancer
(i)	Strengthening Logistic Operations, Systems and Management of the Reproductive and Child Health Programme
(j)	Strengthening Institutional Capability for Performance Based Training in RCH
(k)	Goals, purposes, outputs and activities for state level interventions for gender issues.
Date	: undated
Description	: The eleven documents listed above are parts of the practical implementation plans of actions of the IPD. Each has different focuses as is evident from the titles above. The highlights of the purpose of each are given below
(a)	to contribute to increased utilization of quality RCH services in district Wayanad, establish neonatal care unit at District Hospital, strengthen facilities for antenatal and postnatal care, increase access to temporary and permanent contraception.
(b)	to equip young persons to make informed and responsible decision about R and Sex. health matters, to build capacity in the district to prevent and manage atrocities against women, to build capability and capacity of the women groups to plan and manage viable economic project to cater to certain needs of the health care service systems and for generating income.
(c)	to have contributed to improving utilization of quality reproductive health and neonatal health services, quality assurance in the PHCs
(d)	to have contributed to the enhancement of poor women's capability to improve their economic status, to build capacity in the community to prevent violence against women.
(e)	to equip young persons (13-24) of Waynad to make informed and responsible decisions in connection with their reproductive and sexual health
(f)	to contribute to improving utilization of quality reproductive health and neonatal health services and PHCs

- (g) to have built the capacity of local self-government representatives and development personnel to collaborate in planning, monitoring and evaluating programmes for the improvement of reproductive and child health, gender equity and equality.
- (h) to have assessed the feasibility of establishing a system for early detection and management of cancers of the reproductive tract and breast in a district of Kerala
- (i) to have established an integrated, unified, and dynamic logistic system in the state of Kerala through the Dept. of Health and FW, which can support the reproductive and child health goals of the IPD and GoK, to have assisted the GoK to strengthen its health and family welfare programme to the level at which quality contraceptives, vaccines, drugs and equipment are procured, stored and distributed in a manner responsive to the demands of the clients in a target free environment
- (j) to have contributed to strengthening the capability and capacity of the DHFW to plan, implement, and evaluate all the training activities in the state
- (k) to build capacity of institutions and community organizations to enable women to exercise their rights, including those related to the prevention of violence.

35.

Serial No.	: GoK/OBP/16
Status	: unmarked
Title	: <i>RCH project: Implementation Plan</i>
Date	: undated
Description	: The document is a tabulated plan of action that examines the goals of the RCH. The main goals are to improve the reproductive health status in India. This includes improving women's reproductive health, reducing maternal mortality, reduce infant and child morbidity and mortality, stabilize population growth, implement policy change, to develop institutional capacity for management of the RCH project.

36.

Serial No.	: GoI/OC/6
Status	: Official Marking
Title	: <i>Manual on Target Free Approach in F.W.P</i>
Date	: 1/97
Description	: The document outlines the various aspects of the Target Free Approach in Family Welfare. The appendices include the various forms that are to be used by ANMs.

37.

Serial No.	: HW/1
Status	: Conference Proceedings of HealthWatch
Title	: <i>HealthWatch National Consultation</i>
Date	: April 11-12, 1997

Description : The conference proceedings outline the ethos, strategies, evaluations and ideology of the women's groups in India monitoring the implementation of the RCH in India.

38.

Serial No. : HW/2
Status : Conference Proceedings of HealthWatch
Title : *HealthWatch Regional Consultation*
Date : June 1996-January 1997
Description : The papers outline activities and critiques of women's groups from various regions in India – Andhra/Karnataka, Shillong, Goa, and Maharashtra, Gujarat, Madhya Pradesh and Rajasthan, Kerala, Pondicherry and Tamil Nadu, Uttar Pradesh and Bihar, Haryana, Chandigarh, Himachal Pradesh and Punjab.

39.

Serial No. : GoK/OC/1
Status : Note from an official communication
Title : *Model Family Welfare Health Care Project for One District in Kerala*
Date : undated
Description : Has a couple of attachments. One is an addendum to a letter stating the arrival of the World Bank team to Kerala, and features of the proposed project. There is a Ten Programme Strategy to meet women's needs that is outlined. Also included is a brief statement of male responsibility and participation. There is also a tabular column that shows the applicability of quality elements in Family Planning Services.

40.

Serial No. : wb/2
Status : World Bank document
Title : *Project Appraisal Document: India, Reproductive and Child Health Project*
Date : 1997
Description : This document provides a description of the World Bank's RCH project in India. The document offers the objectives of the World Banks project that is to "assist the Government of India [GoI] to improve the performance of its Family Welfare Programme [FWP] in reducing maternal and infant mortality and morbidity, and unwanted fertility" (p. 2). The document also describes the various forms of assessments that will be undertaken to evaluate the project, the components that will be funded by the Bank and the policies of the Bank that will guide the design and implementation of the project in India.

APPENDIX F: Essential Reproductive and Child Health Services at Different Levels of the Health Service System in India

<i>Health interventions</i>	<i>Community level</i>	<i>Subcenters</i>	<i>Primary Health centers</i>	<i>First referral units and district hospitals</i>
Prevention and management of unwanted pregnancy	<ol style="list-style-type: none"> 1. Sexuality and gender information, education, and communication 2. Community mobilization and education for high-risk adolescents, newly married youth, men, and women* 3. Community-based contraceptive distribution ** (through Panchayats, village Health Guides, Mahila Swasthya Sanghas, etc. with follow-up). 4. Motivating referral for sterilization. 5. Social marketing of condoms and oral pills through community sources (oral pills to be distributed through health personnel including GPs to women who are starting pills for the first time). 	<p>No. 1 as in Community level</p> <p>2. Providing oral contraceptives (Ocs)* and condoms</p> <p>3. Providing IUDs after screening for contraindications</p> <p>4. Counseling and referral for medical termination of pregnancy.</p> <p>5. Counseling/management/ referral for side effects, method-related problems, change of method where indicated</p> <p>6. Add other methods to expand choice.</p> <p>7. Providing Treatment for minor ailments and referral for problems.</p> <p>*Social Marketing of pills and condoms through ANM may be explored by permitting her to retain money.</p>	<p>Nos. 1 - 7 and</p> <p>8. Performing tubal ligation by mini laps on fixed dates*</p> <p>9. Performing vasectomies.</p> <p>10. Providing first - trimester medical termination of pregnancy up to 8 weeks</p>	<p>Nos. 1 - 10 and</p> <p>11. Providing services for medical termination of pregnancy in the second trimester (up to 20 weeks) where indicated</p> <p>* PHC should have facilities for tubal ligation and mini laps including OT</p>

<i>Health interventions</i>	<i>Community level</i>	<i>Subcenters</i>	<i>Primary Health centers</i>	<i>First referral units and district hospitals</i>
	<p>6. Free supplies to health services.</p> <p>7. Motivating referral for sterilization.</p> <p>* to be piloted</p> <p>** Panchayats to distribute only condoms</p>			
Maternity care <i>Prenatal services</i>	<p>1. Awareness raising for importance of appropriate care during pregnancy and identification of danger signs.</p> <p>2. Mobilize community support for transport referral and blood transfusion.</p> <p>3. Counseling / education for breast-feeding, nutrition, family planning & rest, exercise, and personal hygiene, etc.</p> <p>4. Delivery planning</p>	<p>Nos 1 - 4 and</p> <p>5. Three antenatal contacts women either at the subcentre or at the outreach village sites during immunization / MCH sessions.</p> <p>6. Early detection of high risk factors and maternal complications and prompt referral.</p> <p>7. Referral of high risk women for institutional delivery</p> <p>8. Treatment of malaria (facilities including drugs to be made available at subcentres)</p>	<p>Nos. 1 - 8 and</p> <p>9. Treatment of T.B.</p> <p>10. Testing for syphilis* for high risk group and treatment necessary</p> <p>* Training for laboratory technicians, equipment and reagents required.</p>	<p>Nos. 1 - 10 and</p> <p>11. Diagnosis and treatment of RTIs / STIs.</p>

<i>Health interventions</i>	<i>Community level</i>	<i>Subcenters</i>	<i>Primary Health centers</i>	<i>First referral units and district hospitals</i>
		*The need for IEC support and establishment of FRUs.		
<i>Delivery services</i>				
	1. Early recognition of pregnancy and its danger signals (rupture of membranes of more than 12 hours duration, prolapse of the cord, hemorrhage)	Nos. 1 - 4 and 5. Supervising home delivery 6. Prophylaxis and treatment for infection 7. Routine prophylaxis for gonococcal eye infection	Nos. 1 - 7 and 8. Modified partograph 9. Repair of episiotomy and perineal tears	Nos. 1 - 9 and 10. Treatment of severe sepsis 11. Delivery of referred cases 12. Treatment of high risk cases 13. Services for obstetrical emergencies, anesthesia, cesarean section, block transfusion through close relatives, linkages with blood banks and mobile services
	2. Conducting clean deliveries with delivery kits by trained personnel.			
	3. Detection of complications, referral for hospital delivery			
	4. Providing transport for referral.			
	5. Resuscitation for asphyxiated new born.			
<i>Postpartum services</i>	1. Breast-feeding support	Nos. 1 - 5 and	Nos. 1 - 5 and	Nos. 1 - 5 and
	2. Family planning counseling	6. Referral for complications	6. Referral to FRUs for complications after	6. Management of referred cases*

<i>Health interventions</i>	<i>Community level</i>	<i>Subcenters</i>	<i>Primary Health centers</i>	<i>First referral units and district hospitals</i>
	<p>3. Nutrition counseling</p> <p>4. Resuscitation for asphyxia of the new born</p> <p>5. Management of neonatal hypothermia</p> <p>6. Early recognition of post partum sepsis and referral.</p>	<p>7. Inf-Ergomethine after delivery of placenta</p>	<p>starting an I.V. line and giving initial dose of antibiotics (Equipment for resuscitation of new born)</p>	<p>* PHCs and FRUs would require additional equipment and training for asphyxiated new borns and hypothermia. These include a resuscitations bag and mask and radiant warmers</p> <p>Nos. 1 - 9 and</p> <p>10. Handling of all pediatric cases including encephalopath</p>
Child survival	<p>1. Health education for breast-feeding & nutrition, immunization, utilization of services, etc.</p> <p>2. Detection and referral of high-risk cases such as low birth weight, premature babies, babies with asphyxia, infections, severe dehydration, and acute respiratory infections (ARI), etc.</p> <p>3. Immunization by ANM</p>	<p>Nos. 1 - 6 and</p> <p>7. Treatment of dehydration and pneumonia and referral of severe cases</p> <p>8. First aid for injuries, etc.</p>	<p>Nos. 1 - 8 and</p> <p>9. Management of referred cases</p>	

<i>Health interventions</i>	<i>Community level</i>	<i>Subcenters</i>	<i>Primary Health centers</i>	<i>First referral units and district hospitals</i>
	<p>4. Vitamin A supplementation by ANM</p> <p>5. Detection of pneumonia and seeking early medical care by community and treatment by ANM</p> <p>6. Treatment of diarrhoea cases and ARI cases.</p>			
Management of RTIs / STIs	<p>1. IEC counseling for awareness and prevention.</p> <p>2. Condom distribution</p>	<p>Nos. 1 - 2 and</p> <p>3. Identification and referral for vaginal discharge, lower abdominal pain, genital ulcers in women, and urethral discharge, genital ulcers, swelling in scrotum or groin in men</p> <p>4. Partner notification/referral</p>	<p>Nos. 1 - 4 and</p> <p>5. Pilot testing of the syndromatic approach.</p> <p>6. Treatment of RTIs/STIs</p> <p>7. Syphilis testing in antenatal women</p>	<p>Nos. 1 - 7 and</p> <p>8. Laboratory diagnosis and treatment of RTIs/STIs</p> <p>Syndromic approach to detect and treat STD in antenatal post-natal and risk groups.</p>

MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF FAMILY WELFARE

MEMORANDUM FOR EXPENDITURE FINANCE COMMITTEE

1. (a) TITLE OF THE PROJECT PROPOSAL

Reproductive and Child Health (RCH) Programme in the Ninth Plan and World Bank (IDA) assisted and European Commission assisted Projects for Reproductive and Child Health.

2. (b) DESCRIPTION OF THE PROPOSAL/SCHEME AND ITS OBJECTIVES

The Family Planning Programme was started in 1951 as a purely demographic programme. Subsequently the element of public education and extension as included to facilitate outcomes under the Family Planning Programme. In the 80s, the experience of implementing the programme in previous decades in India as well as the international experience persuaded the country to realise that the health of women in the reproductive age group and of small children (up to 5 years of age) is of crucial importance for effectively tackling the problem of growth of population. Therefore, in the 7th Plan the Universal Immunisation Programme (UIP) was started in 1985-86. Oral Rehydration Therapy, (ORT) was also started in view of the fact that diarrhoea among young children was leading to a large number of deaths among children. Various programmes under Maternal and Child Health (MCH). were also implemented during the 7th plan. However, the objectives of all these programmes was convergent and it was to improve the health of the young mothers and children and to provide to them facilities for major disease conditions. While these programmes did have a beneficial impact, but the separate identity for each programme was causing problems in its effective management and this was also reducing somewhat the outcomes. Therefore, in the 90s, i.e., in the 8th Plan, these programmes were integrated under Child Survival and Safe Motherhood - (CSSM) Programme and it was implemented from 1992-1993. Substantial assistance for implementation of the programme was made available in the form of project funding by UNICEF and World Bank. This process of integration of related programmes was taken a step further in 1994 when the International Conference on Population and

Development in Cairo recommended that the participant countries should implement unified programmes for RCH.

3. The basis of the RCH has been defined as "People have the ability to reproduce and regulate their fertility, women are able to go through pregnancy and child birth safely, the outcome of pregnancies is successful in terms of maternal and infant survival and well being and couples are able to have sexual relations free of fear of pregnancy and of contracting diseases". This concept is in keeping with the evolution of an integrated approach to the programmes aimed at improving the health status of young women and children which has been going on in the country. It is obviously sensible that integrated RCH programme would help in reducing the cost of inputs to some extent because overlapping of expenditure would no longer be necessary and integrated implementation would optimise outcomes at the field level. Therefore, the Department has been developing the concept of RCH and programmes there during last about 2 years and the negotiations with the World Bank and European Commission (EC) who have shown interest in providing funding Support for the RCH programme, have been-conducted within the framework of such integrated approach for RCH. This proposal for the 9th Plan having RCH Programme accordingly integrates all the inputs of the composite buget as well as funding support indicated by the World Bank and the EC.

4. An efficient arrangement for implementing RCH Programme is a prerequisite for more effectively tackling the problem of population growth. Deficiencies in the arrangements for mother and child health care lead to higher incidence of maternal mortality and child/infant mortality and these also lead to low health status of women and children and in the long run is a costly burden on the national system. Poor prospect of health and life of the children is one of the prominent factors leading to birth of more children per family. Therefore, effective RCH programme is crucially important for more than one consideration in the national system. The RCH programmes as has been envisaged in this proposal incorporates the earlier components covered under the Universal Immunisation Programme, Maternal and Child Health and Chid Survival Safe Motherhood Programmes and includes two additional components, one relating to sexually transmitted diseases and other relating to reproductive tract infection. Thus, the RCH-Programme intends to attain integration of fertility regulation, maternal and child health- with reproductive health services such as screening, diagnosis and treatment of RTIs and STIs and depends upon decentralised participatory planning and the target free approach.

[*: The line numbers used in the analysis in Chapter 8 will not tally with this reproduced copy]

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