

Proceedings

ICPD+15 Issues and Concerns in Orissa, State Level Meeting, 5th May, 2009, Pantha Niwas, Bhubaneswar, Orissa

In the 15th year since the International Conference on Population and Development (ICPD), the Plan of Action is being revisited to take account of the gains and emerging challenges in the fields of population and reproductive and sexual health and rights. The purpose of this initiative is to enable a constructive engagement with the Government, and push the boundaries of conceptual thinking around reproductive health. This is to be done through holding dialogue on various health related issues and establishing linkages with different groups and movements within civil society and create synergy. The concerns and the objectives of the review process were chalked out in the meeting. These include a major component of consultations and roundtables at the regional/ State level.

INTRODUCTION TO ICPD, GAINS AND GAPS:

Dr. Abhijit Das

Mr. Abhijit Das introduced the members to ICPD, its significance and follow-ups in the Indian context. He highlighted that although India was a signatory to almost all international conventions and conferences, the effective implementation of the proposed plan of action remains uncertain, a fact that was also pointed out by Mr. Shiva Mohanty in the introductory speech. He continued by listing out the key areas of concerns and suggesting various means to address the same.

The significance of ICPD, as contained in its following tenets, was listed:

- Comprehensive approach to women's health
- Located within a human rights and gender equality paradigm
- Provides reproductive autonomy for women
- Makes reference to sexuality independent of reproduction
- Includes an essential service package which is linked to comprehensive primary health care

The limitations of ICPD were identified in its focus being largely on families and its being equivocal about abortion related rights.

It was pointed out that as a consequence of the Conference, the following developments were seen at the national and international level:

In India,

- Political and Economic changes
- Plethora of social sector policy making
- Introduction of many idea, such as RCH / HSR, NRHM
- HIV/ AIDS – wax and wane
- One point FP One point MH-ID-JSY

At the international level,

- Reduction of all international development aspirations into a common, very minimum MDG
- Limited agenda
- No reference to human rights

In Civil Society,

- Moved from primarily service providers to promoters of rights based approach
- Increased acceptability by Govt.
- Increased sophistication in approach
- Large no. of INGOs
- Fragmented / Co-opted

ICPD concepts and paradigms have also found expression in the NHRM conceptualization, viz.:-

- Emphasis on FP has declined; but the question remains are to whether adequate FP services are available
- Maternal mortality and morbidity: an old unsolved issue has come back into focus
- Primary health care approach with decentralization was emphasized
- Quality of care standards – IPHS

- Focus on adolescence, gender, RTIs, VAW and other RH/WH concerns, however, are still missing. There remained a single point agenda of maternal health at the field level. There is still no regulation for private sector provisioning. Though insurance based financing has been introduced, it has been done without clarity about provider base and claim mechanisms for the rural poor.

Key areas of concern were identified as:-

- Population control continues – 2CN, incentives and disincentives continue in many states
- Coercion in health service delivery – MH and FP
- While HIV related fear mongering has reduced there has been no integration with PHC
- Sexuality education backlash; Section 377 unresolved
- Abortion - lack of services; MTP – PCPNDT confusions
- Obsession with Polio –declining routine immunization
- Women’s health reduced to womb (from tubes)
- Reproductive rights concerns continue to be missing
- Gender related concerns missing in service provision
- Men’s involvement limited to NSV
- Needs of Adolescents not yet addressed, needs of elderly not acknowledged
- Acknowledging the health concerns of sexual minorities
- Child marriage, early pregnancy, short periods between child births continue – failure of FP program, Civil registration and child marriage laws
- Issues around new reproductive technologies – ART/Surrogacy, Clinical trials etc.

- He concluded by suggesting the mechanisms of the ICPD+15 process which will geared to addressing the key areas of concern.

POPULATION POLICY AND TWO-CHILD NORM – PROMISES AND REALITY

Dr. Almas Ali

Dr. Ali stated that India was the first country to introduce a population policy in 1952 which was implemented only in 2000, the reason being changes in thinking of population and development issues.

The NPP announced in 2000 derives its basic philosophy from ICPD, and is an affirmation and articulation of India's commitment to the ICPD Agenda. It forms the blueprint for Population and Development Programmes in the Country, and favours a more open information, awareness and empowerment approach. Population stabilisation is seen as a multi-sectoral endeavour. In principle, it is against incentive/disincentives. The NPP talked of:

- Universal education,
- RCH,
- Delaying marriage,
- Counseling,
- Communicable diseases,
- Decentralized planning,
- Quality of services,
- Adolescents/ ageing – an outlook which was pioneering in many ways.

He entailed that stabilising population is as much a function of making reproductive health care accessible and affordable for all, as of increasing the coverage and outreach of primary and secondary education; extending basic amenities like sanitation, safe drinking water and housing; empowering women, with enhanced access to education and employment; providing roads and communication.

Then he talked about the influence of ICPD on NPP. The strategic themes described in the NPP reflect the spirit and language of the principles agreed upon in ICPD and the Plan of Action (PoA) thereof. The idea that people are and should be the center of all concerns regarding sustainable development brought a radical change in the idea of setting goals for population and health and in our perspective on the process to be adopted to attain these goals. The idea of population being subsumed comprehensive reproductive and child health had been emerging in India, but also received a major impetus after reproductive health and rights were given a proper definition applicable to all countries and contexts at the ICPD.

Concerns regarding the state population policies came up for discussion:

The idea of a State Population Policy was to identify and address priority issues pertinent to the specific state within a broad framework of the National Population Policy, keeping the letter and spirit of the ICPD's PoA intact. However, most State Population Policies (SPPs) reflect the population control mindset viewing population growth as a human crisis. Although almost all use the term "target free" but many use clear incentives/disincentives. As a whole, SPPs present a mixed picture in their espousal of incentives and disincentives. When the policy translates into programme implementation, it has negative implications on the whole idea of informed choices, individual decision making and even in violation of human dignity, especially of women.

Whatever the reason, the unfortunate fact is that some of SPPs are innocent of the major paradigm shift that population policy has undergone both globally and nationally, because either they are unaware of the ICPD paradigm shift (which is indeed difficult to believe in this age of information technology) or the "old population control mindset" is so ingrained, it is still very hard to discard.

With reference to the two child norm, he pointed out that many states have enacted legislations that bar women with more than 2 children from contesting election to PRIs. Introduced with the intention of controlling family size and stabilizing population growth, the two-child norm has become a cause of anxiety for human rights activist and women's organizations. The measure is seen as being implemented in an environment, where women and the marginalized do not have adequate access to health care or reproductive rights, and thus tends to penalize women who anyway have little control over reproductive decision-making. There is enough data and documentation to establish that disincentives tend to be coercive. It has also been noticed that the disincentives always hit the poor and down trodden especially those who belong to scheduled castes and tribes and backward classes much harder. Debarring such women from contesting elections or from public employment opportunities makes a mockery of policies to empower women.

Given the crucial importance of *Population Momentum* (which assures further population growth in near future), given unwanted fertility in our country, imposing norms to pressurize people may simply be barking up the wrong tree. This may be neither relevant nor particularly effective in bringing down the growth rate. The single most important factor that can reduce momentum is raising the age at marriage/ cohabitation especially for girls. The strongest impact of this can come through increasing years of schooling for girls. Therefore, population momentum can only be eased out significantly by policies that encourage women to delay child bearing as this stretches out the time between generations.

The obvious route to population stabilization is through social development through women's empowerment through greater gender equality. Women's empowerment is critical to human development.

He then moved on to discuss key challenges in implementation of NPP, 2000. Following a rights and equity based approach is as challenging as bringing the fertility levels to the desired 2.1. Implementation of NPP therefore puts forth the dual task of 'meeting the desired goals' by 'following the desired process'.

Some of the key challenges are transforming the mindset and style of functioning of the people working with the system; strengthening community needs assessment beyond FP and including other health issues; ensuring community participation in monitoring of health services (social audit of services) and developing practical indicators for assuring Quality of Care (QoC)

Then he talked about opportunities for achieving NPP Goals through necessary convergence.

NRHM appears to have brought back the primacy of Alma Ata declaration and comprehensive Primary Health Care, and provides a platform for fostering inter-sectoral co-ordination, decentralized planning and implementation, strengthening of Primary Health Care and involving communities in monitoring services and convergence at the village level. All of these have a potential to contribute towards achieving socio-demographic goals of the NPP.

MATERNAL HEALTH ISSUES & CONCERNS IN RURAL ORISSA

Biswajit Padhi

Some data were presented:

- 10.48% of all women deaths are maternal Deaths
- 60% of maternal deaths take place in the home
- Prohibitive cost of ANC & ID - 65% BPL families
- Lack of Blood transfusion facility- 69% of pregnant women are anemic and 44.2% deaths take place within 24hrs of delivery

He expressed his concern by stating some facts about early marriage, child marriage and also family planning.

He then suggested some initiatives that can be taken such as having an independent data generating authority whose reports can be relied upon accurately; a rational transfer policy; improved ANC services; strengthening referral services; avoiding multiple referrals; operationalisation of FRUs; social audits by community; continuous CB of lower rung health service provider (SAB); interest free loans to pregnant women (NANO FINANCE). *Some of these need more explanation*

Some community driven initiatives have taken place, such as dialogue with political representatives, male Participation though BCC(**Did not think she was sick enough: 66.2%**)

); addressing malnutrition by SHGs; demand generation; health seeking behavior encouraged, and social audit ?

He concluded by saying that the need of the hour is to start acting upon the aforesaid issues.

VIOLENCE AGAINST WOMEN

Manju Dhal

Mrs Dhal started by stating that abuse of woman and child spreads like an epidemic disease and affects the society in multiple ways Violence against women takes many forms and is perpetrated at many stages, viz., female feticide; discrimination in food, education, health and emotional care; child labor; child marriage; child prostitution; child trafficking; denial of education, health and mobility; eve teasing; rape; forced prostitution; forced labor; trafficking/bride selling; incest; domestic violence; marital rape; dowry; sexual harassment at workplace; discrimination in access to health, food and work; repeated pregnancy and forced abortion.

She made a concluding note of putting up efforts and striving to achieve a violence free world

EMERGING ADOLESCENT ISSUES

Dr. Dipti Pattnaik

The talk was centred on the alphabets of the word 'ISSUE' in the context of adolescents, viz.,

I → identity crisis

S → self-consciousness

S → sexuality

U → understanding, i.e., cognitive development

E → establishment

GROUP DISCUSSION

The for group discussion wherein many key issues were identified:-

- 1) Lack of infrastructure or no infrastructure
- 2) Declining sex ratio
- 3) Low budget allocation for health sector

- 4) No plan/scheme regarding health at the State level but mere following of Central Plans.
- 5) Emigration
- 6) Sex selection
- 7) Increased economic aspirations
- 8) Lack of documentation
- 9) Formal acceptance of the civil society by the State Govt.
- 10) Initiative for a movement oriented process
- 11) Individual centered approach rather than organizational level approach

Major Issues for Advocacy were identified

- Two – child norm
- Citizens charter
- Status report (1.Population & development 2. Food & Nutrition)
- Declining sex ratio

Core Group Formation

Five groups of five members each, formed on a regional basis were formed. The regions were identified as the Western , Southern, Costal, Northern and Bhubaneswar regions.

Issue specific groups were formed on the two-child norm, declining sex ratio, the Citizen Charter (meeting on 6th May at 11AM), and the preparation of status reports on 1. Population & development, and 2. Food & Nutrition.

MINUTES OF THE MEETING ON CITIZENS CHARTER

The members presiding in the meeting were Sashiprava Bindhani, Mr. Biswajeet Das and Mr. Jiban along with Ananya , Soubhagya and Soumya INTERN OF HRLN Bhubaneswar.

The discussion started with defining what Citizens Charter is, i.e., it is an instrument which guarantees entitlement to the citizens who intend to access health services. It guarantees certain rights to the patients which will ensure the quality of health care services.

Then they moved on to discuss its relation to ICPD as it serves the above purpose of safeguarding the rights of the patients and ensuring them quality access to health care services.

They raised concern about the fact that it has already been accepted by the Govt. as a document but has not been implemented effectively and also the unawareness of even the medical officers about the charter.

Then they strategized plans to proceed with filing of an RTI application to provide with information regarding the display of Citizens Charter in different districts at the PHCs, CHCs and finally at the District Headquarters level. And if there has been no display, then they continue to ask for reason behind the same. And if displayed, then whether the same has been done according to the guidelines mentioned in the Charter?

In order to validate the information provided by the Govt. and also to be acknowledged about the ground realities, they plan to prepare a questionnaire seeking information as to the display of the charter and if the answer comes in affirmation, whether it is effectively implemented and level of citizens awareness about it.

For the above purpose, they sorted out a plan to cover 30 districts in the State along with the Capital Hospital being a separate focus area.

They divided the districts into:-

- 1) 5 District Headquarters
- 2) 10 PHCs
- 3) 15 CHCs

Sl. No.	DIST. HQs	CHCs	PHCs
1.	MAYURBHANJ	BOLANGIR(GOURANG)	NUAPADA
2.	JHARSUGUDA	CUTTACK(NIHAR)	
3.	KENDRAPADA	PHULBANI(BALIGUDA - SHARAD)	
4.	ANGUL/DHENKANAL	BOUDH(YCDA - RAJENDRA)	
5.	GAJAPATI	SONEPUR(RARE)	
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It was decided and agreed upon unanimously that the aforesaid RTI application and the questionnaire is to be prepared by Mr. Jiban subject to the approval by the group members.

The questionnaire will be circulated on 19th May, 2009 after the field test. SODA and SRUTI take the responsibility to undertake the field test and the finalized report to be submitted by June 5, 2009.