From Population Control to Reproductive Health: Learning from Policy Change in India and Pakistan

Extended Abstract

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10 years have passed since the reproductive health (RH) approach was formally adopted by the international community at the International Conference on Population and Development (ICPD). In the decade that has followed, numerous national health and population programs have been restructured to reflect the precepts endorsed at the ICPD. This paper examines the experience of two countries that were among the first to adopt this approach, India and Pakistan, in order to understand how and why the tenets of RH are implemented at the national level. These findings shed light on how the Cairo conference influenced policymaking shortly after the ICPD, and suggest ways in the RH approach can be further integrated into the policies of participating states.

As an international agreement, the 179 countries that endorsed the ICPD also conceded to implementing the reproductive health approach at home. Within less than five years of the conference both India and Pakistan, two of the original pioneers in the population control field, fulfilled this commitment. But the substance of these two approaches to reproductive health policy was markedly different. While India's Reproductive and Child Health Programme closely resembled the ICPD approach, Pakistan's Reproductive Health Service Package represented little more than a rhetorical change in the country's population control strategy. In order to explain these differences, as well as to offer insight into the politics of implementing the Cairo agenda, this paper provides an in-depth examination of the process of policy change in each country.

Drawing on nearly 100 personal interviews conducted in India and Pakistan by the author, the discussion carefully reconstructs the policymaking process in each country in order to identify the factors influencing the nature and direction of such policy change. It finds that three factors were central in shaping the policy process in both countries: civil society demand for reproductive health programs; policymakers' recognition of the need to change; and the impact of the Cairo process on the domestic level. When these three factors were positive, as in the case of India, meaningful policy change took place at a rapid pace; and when they were not present, change was sluggish and superficial. Such a model of policy change in these two countries provides useful insight to those working to understand the implementation of the Cairo agenda within other national contexts.