# IV. Women and FP: further issues

The previous two sections show how population control ideology has resulted in aggressive promotion of different contraceptive methods with consequent abuses and attacks on health and human rights. The pre-occupation with achieving a drastic fall in birthrate has had its impact in other areas too, which will be discussed in this third section: methods of contraception which are not 'invasive' and can be controlled by the users have not been encouraged; contraceptives not approved for use in rich nations are being extensively tried out on the disadvantaged sections in the Third World countries; the selective abortions of female foetuses is tacitly encouraged because it will keep the numbers down; women's right to birth control is subordinated to the goals of state policy and the authority of patriarchal religious leaders; high technology is being developed to prevent births, but safe child-birth is still beyond the reach of the majority. The media and text-books are being co-opted to spread the ideology that the poor are poor because they are too many and this is preparing the way for coercive FP programmes of the future and the introduction of unjust disincentives which will encroach on women's rights to maternity and other benefits.

# Areas of neglect

Official FP policy in India and elsewhere tends to underplay the potential, and over-emphasise the shortcomings, of male contraception, barrier methods for women, and Natural Family Planning (NFP) involves recognition of, and abstinence during, the fertile phase. In India, although promotion of condom and vasectomy services do form part of the FP programme, there is comparatively much less emphasis on male contraception, while NFP and barrier methods for women are hardly ever spoken of or heard about.

### Male contraception

After the 1977 election debacle, which has been directly attributed to the forced vasectomy camps of the Emergency days, the stress in sterilisation has been on women. Throughout the country male sterilisation is readily available but poorly utilised. The continued absence of *promotion* of vasectomy on the part of the government in the post-1977 period has obvious political reasons and the backlash is seen in the mounting pressure on women as the almost exclusive "targets" in FP programmes. (See also chapter on sterilisation).

It would be useful at this juncture to examine the larger international background on this issue of male responsibility in family planning. The picture which emerges reveals the utter lack of interest among the authorities to aim their FP messages and programmes at men.

One of the findings of the First International Conference on Vasectomy at Sri Lanka in 1982 was that FP personnel too often assume that men will not accept vasectomy for cultural or psychological reasons[1]. A major reason for the worldwide decline in vasectomy is the lack of interest among FP providers who are usually trained in maternal and child health. Hence, there is a need for male-oriented vasectomy centres where men feel comfortable and free to have their doubts and fears dispelled. It has also been found that when FP programmes do emphasise information and services for men, many men are indeed willing to share in FP and will choose the permanent method of vasectomy *if good services are available*, (it is worth recalling here that just as the IUD got discredited because of poor follow-up care, vasectomy too has fallen into disrepute not only because of coercion but also because of cases where sepsis and even death have occurred as a result of careless and indifferent handling.)

Two examples from abroad offer some pointers to the demands we should make in India. In Latin America, where vasectomy was earlier not widely accepted, two programmes specially launched to promote and provide male services met with good positive response. And in Hong Kong, a major campaign has been launched to promote male participation and responsible fatherhood using a he-man image to 'sell' vasectomy as being perfectly compatible with virility. While the impact is yet to be fully evaluated, these examples show that governments can, if they want to, reach out to men constructively and imaginatively.

At the Sri Lanka Conference, the point was made that strong leadership is needed by prominent national figures committed to male responsibility in birth control. Feminist writer Perdita Huston too makes this and another point in her article, "Who should talk to whom?", where she says that often women keen on contraception are thwarted by macho husbands.[2] She writes that men need to be convinced not only that contraception is good for their wives but that they too have a duty in sharing this responsibility of birth control. For which, "both male leadership" is needed, leaders who will "dare" to use their persuasive powers to change male attitudes. Needless to add, our local male leaders have so far confined themselves to talking only of population as a 'problem' and of the benefits to maternal and child health that will accrue from family planning. Fathers are nowhere as yet in the picture.

### Barrier method

At a meeting in Hyderabad in March 1983

## BOX 20

### *Role of men in FP*

*In the US, as recently as the early 60s, only a few thousand vasectomies were performed annually. Then a rash of adverse publicity appeared about the health effects of oral contraception. About the same time, a number of popular magazines published articles allaying some of men's fears about sterilisation. All this coincided with efforts on the part of many women to encourage greater male responsibility in fertility control. The result was a quantum leap in the number of vasectomies. Then simpler surgical techniques for female sterilisation were developed and now vasectomies account for less than half of all sterilisations in the US.*

*R.J. Ericcson, an early pioneer in male reproductive studies, points out: "Male contraceptive research has a dismal past. For the most part, the brightest workers avoid it and those who do work in the area are looked on as rather strange fellows." When Ericcson wrote these words in 1972, governments and pharmaceutical firms were concentrating on well-known female methods that offered the promise of cheap marketable contraceptives in a short period of time. The bias dates back to FP pioneer Margaret Sanger who encourated doctors to develop female contraceptives to help women gain control over their fertility. Of the people who visit birth control clinics in the US, less than one per cent each year are men.*

*Many couples understandably weigh the effectiveness of the birth control method they are considering against the health-risks connected with its use. In the light of these concerns, the condom or the diaphragm, often used in conjuction with a spermicide is an increasingly attractive contraceptive option: neither poses a threat to the health of the user. Studies by Christopher Tetze of the Population Council indicate that short of sterilisation, the condom or the diaphragm, backed by legal abortion performed early in pregnancy is the safest means of FP.*

*Ultimately men will change their ways only if society expects more of them. Stringently enforcing child support laws will make men feel more directly the economic costs of having children. And eliminating the legal distinctions between children born in and out of wedlock would equalise rights of inheritance and support.*

*Paradoxically, feminism can come in conflict with greater male involvement in birth control. Women, at least in industrial countries, have long struggled to gain control they now have over their fertility. The use of modern female contraceptives has been a cornerstone of this movement. At the same time, some women have loudly demanded that men take more responsibility for contraception and that a male pill be developed. But as men finally assume a more active role in FP, individual women are going to be asked to trust someone who says he has had a vasectomy or has taken a birth control pill. Many may find they are reluctant to once again place their fate in a man's hands. In casual sexual relationships, women may always want to take sole responsibility for protecting themselves against unplanned pregnancy.*

*- Condensed from Worldwatch Paper 41 by Bruce Stokes (**Science Today**, March 1981).*

when members of the Indian Womens' Scientists' Association met to discuss the implications of the government's proposed mass pill programme, several doctors commented on the total absence of emphasis on barrier methods in the official FP programme. Some doctors, who are perturbed by the increasing stress on hormonal methods like the pill, injectables and implants, have called for a revival of attention to barrier methods like the diaphragm, cap, spermicides, and of course, the condom. In the Indian context, we need to consider the lesson from abroad regarding the use of barrier methods to determine what should be the demands of women's groups.

First let us look at the trend in the developed countries. Barrier methods are gaining in popularity both because of concern over the side-effects of the pill and the IUD and because many FP associations are campaigning for men to participate in birth control. However, the initiative in promoting diaphragms and caps comes more from women's health centres than from clinics run by 'medical' personnel. For example, Jill Rekusen writes[3] that some medical colleges in the West no longer teach students to fit these devices. Some doctors discourage barrier methods because it takes time to fit them properly while a pill needs only a quickly written prescription. In contrast, there is the example of a feminist health clinic in New Hampshire (USA) where not only has *interest in the cap been revived, but it is also being promoted* by satisfied users, who run the clinic, who have themselves tried it and found it acceptable[4]. (See also last chapter, *By and For Women: A US example.)*

According to Dr. Elizabeth Connel, recent studies in the US show that the safest form of FP is use of a barrier method, backed by early suction abortion if failure occurs[5]. She says that if barrier methods are publicised their use will increase and that people need to be told that these methods can be effective if used properly and consistently.

In India it is often argued that barrier methods are not feasible because they need privacy and that illiterate women cannot be taught their use. How valid is such a contention? - this is what needs to be tested. Considering that primitive contraception in traditional societies consisted of various homemade vaginal barriers, we need to investigate the truth of the assertion that use of modern barrier methods cannot be taught and learnt. Does such an assumption have enough basis? It is true that problems of hygiene will exist in homes where no facilities for washing exist. But what about foaming tablets which can well be used even in such settings? In some countries like Egypt, Bangladesh and Nepal, this spermicidal method is included in a social marketing programme but there is no mention of it in this country. According to one study in India, the method was found acceptable in some villages because it needs less privacy than the diaphragm and jelly[6]. However, it is pointed out that there is not enough data on the problems associated with its use. Thus, there appears to be a total lack of initiative in offering and promoting potentially useful barrier methods, or in conducting research on their use.

It is generally found that FP programmes in developing countries have been reluctant to promote vaginal methods[7]. Both providers and users of FP services know little about these and assume that they are unacceptable and ineffective. However, it is interesting to know that a Mexican women's group, CIDHAL, which has been campaigning for a supply of diaphragms, has found that even women from lower socio-economic classes have been able to use them satisfactorily[8]. It is relevant to note here that because of the overall class bias of FP programmes, which are primarily aimed at curbing the birth-rate of the poor, barrier-methods (other than the condom, which needs no medical fitting) are in practical terms not easily available even to those women in the middle and upper socio-economic strata, who would be able to use them as effectively as their Western counterparts. Since 1983 a vaginal sponge, which needs no prescription or medical fitting, has been introduced in UK and USA. It could well be used by those Indian women who can

## BOX 21

### Current research

**Although the condom and vasectomy are the only available male methods, newspaper reports periodically mention various other methods of male contraception under trial: An extract from cotton seed called gossypol, a pill based on "cyproterone acetate," a synthetic hormone called LHRH, and a new method of sterilisation being tested in China which involves no surgery but only an injection. Since the problem with invasive male methods is not only a question of persuading men to accept them but also a question of their effect on sexual potency, in the foreseeable future male contraceptive research is likely to remain literally a subject of academic interest only. Hence the need to promote wider acceptance of existing male methods.*

**The Malaysian FP Board has called for more information and availability of spermicides because: they have no serious side-effects, they can be easily obtained and do not need medical prescription, they are convenient to use, and they give some protection from sexually transmitted diseases. The report says that spermicide use is minimal in Asia and calls for community-based and social marketing programmes in 17 Third World countries.*

*- (quoted in ICASC newsletter No. 12/13)*

**Research is going on to develop various practical ways of recognising when ovulation takes place so as to identify the fertile period: a test to detect the presence of an enzyme in the cervical mucous just before ovulation; an electronic temperature recording device which indicates the fertile phase; measuring blood flow in the finger-tips by means of a photodetector which will indicate the variations before ovulation; saliva test to monitor changes prior to ovulation etc. All these have been reported in the newspapers and the search is towards perfecting a fertility guide which women can use not only to avoid conception but also, more positively, to plan for conception. NFP is thus described as playing a role in helping the childless also to conceive.*

afford it. But is it ever likely to be introduced in this country?

### Natural family planning

In India, studies by Dr. Kathleen Dorairaj[9] found that the "modified mucus" method for birth-control is acceptable to and workable even among illiterate women in slum areas. (Basically the method consists of examining the cervical mucus daily, identifying the fertile days before and after ovulation and practising abstinence on those days.) All over the world, population controllers as well as the medical profession are sceptical about NFP and believe it to be a method with a high failure rate[10]. Although NFP has been widely promoted by Christian groups, which oppose other forms of contraception on religious grounds, in recent years, feminists in the West have also begun to turn to NFP as a method which gives them total control over their bodies, freedom from invasive birth-control as well as manipulation by the drug industry and medical profession.

NFP needs to be taught patiently by committed teachers, which practically rules it out in a callous, conventional FP programme. In 1982, an ICMR team which evaluated an NFP programme by Mother Teresa's Missionaries of Charity in Calcutta slums said the 'performance' was 'remarkable' and that going by this example NFP could indeed have a role in the national FP programme.[11] Of course, one heard nothing more about it subsequently. However, in the context of an emerging women-and-health movement in this country, the possibility of women's groups acquiring knowledge about and spreading the use of NFP is an important option to keep in mind.

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# Human guinea-pigs

Between 1983 and 1985 alone, I have come across not less than eight news items on the testing of various types of female contraceptives by premier medical research institutes in this country. Periodically there are reports of WHO or Health Ministry statements on the need for research to find the ideal contraceptive which will be easy to use, effective and safe. (The condom fulfils all three criteria, but there appears to be a tacit assumption that the ideal contraceptive must be a female method.) Editorials and articles by researchers on the population issue stress the need for better and more contraceptive research. It is assumed that contraceptive research is unquestionably for everyone's good and is in national and international interest. Announcements of new trials with new methods are made with much fan-fare by ICMR luminaries who become media heroes for a while after each such press conference.

**Nobody cares to ask**

Who are these women who are being experimented upon? How are they recruited? Are ethical norms being observed? Do the subjects know that they are participating in an experiment? Are the researchers trained in taking genuine informed consent from the subjects? If method-failure occurs during a trial, and women become pregnant, are they compensated and are they offered early safe abortion if they desire it? What are the risks of foetal defects if pregnancy occurs as a result of method failure during trials of hormonal contraception?

In 1981, probably for the first time in the history of the Indian women's movement, some concern was expressed over contraceptive trials at a Workshop on Women, Health and Reproduction organised by the Feminist Resource Centre of Bombay. The report, which summed up the discussions at the workshop, called for the setting up of an independent organisation of feminists to monitor contraceptive trials and ensure that harmful drugs are not tried out on Indian women. So far no such group has been set up but there is some awareness today on this issue among women's groups all over the country who are (at the time of writing) organising to oppose the trials and imminent introduction of Net-En, the injectable contraceptive (see section on injectables).

In May 1985, the Union Minister of State for Health, Yogendra Makwana, told the Lok Sabha that the National Institute of Immunology is developing a contraceptive vaccine and that clinical trials would begin soon.

There has been periodic focus on this vaccine and some years ago a controversy arose over the trials being conducted by Dr. G.P.Talwar at the All India Institute of Medical Sciences. In 1976, a WHO expert had questioned the safety of the particular vaccine being tested by Dr. Talwar[1]. His own trials with animals had shown undesirable side-effects. Another researcher from Edinburgh had found adverse effects in monkeys. "As the vaccine protection wore off, pregnancies occurred which ended in progressively later abortion." It is crucial to note that no debate has yet been initiated within the women's movement, or even among health groups, about the justification in continuing to experiment with the contraceptive vaccine. According to one source, tampering with the body's immune-response system may also have other dangerous repercussions unconnected with contraception and reproduction, especially in a malnourished population.

Among the contraceptives being tried out in India, as gathered from press reports, are: the injectable Net-En, the hormonal implant Norplant, a once-a-week contraceptive pill, a pill which can "interrupt" a 6-8 weeks old pregnancy, a variety of herbal abortifacients, vaginal rings, hormone-releasing IUDs, a cervical dilator developed by the Central Drug Research Institute, prostaglandins for inducing abortion and for use as "morning-after" pills. Till today no "investigative reporting" has been done to find out

## BOX 22

### *Playing the MNC's game*

*Stree Shakti Sanghatana of Hyderabad has filed a petition in the Supreme Court asking for a stay order on the current ICMR trials with the injectable contraceptive Net-En manufactured by the West German firm Schering AG. The petition lists the reasons for opposing these trials and also raises the question of the ethics of medical research in this country. The following is an extract:*

*"We demand that the whole issue of medical experimentation, which we believe to be necessary, be debated publicly and safeguards against abuse introduced. We know from press reports as well as from sources within the medical research fraternity that in India as in many other Third World countries, the concept of 'informed consent' is non-existent in practical terms, though many paper guidelines pay lip-service since the 70s and 80s after press reports have been exposing trials with human guinea pigs. Third World populations are ideal research material for field trials, especially since the norms for such research are extremely stringent in the advanced countries, and the public there are far too vocal and well-informed to allow rampant trials of potentially risky drugs. The research establishment in our country, wittingly or unwittingly, collaborates with the drug multinationals in conducting human trials to get the data and feedback required by the firms. It is only the literate and socially conscious sections in this country who can protest and put an end to this unethical practice since the subjects of these experiments are ignorant and unaware that they even have a say in this matter.*

*"We are often told by medical researchers that there can be no medical advance without human experimentation. That all trials on human beings are only for 'their own good.'*

*"Our contention is: let the researchers recruit articulate, well-informed, literate volunteers from the middle and upper classes, recruits who can give truly informed consent, who will be vocal in demanding back-up medical care and who will reject a drug or device if its side-effects are intolerable. For starters, it would be good if the medical researchers recruit volunteers from among their own medical community."*

who the women in these trials are and how they are approached and recruited. Nor has the human rights and civil liberties movement raised any question about any of these trials. It is apparently assumed that all these trials are "for the good" of the subjects involved. (A news item on prostaglandins as a "wonder" drug has the heading "Abortion Without Tears".) While some indignation has been expressed over the trials of other drugs (not contraceptives) on unwitting human guinea pigs in the Third World, including the widely condemned testing of pesticide effects on Egyptian children, there is hardly any consciousness even among progressive activist groups about the violation of human rights by those who conduct contraceptive trials on Indian women.

There are three issues related to these trials: (1) informed consent, (2) directions in contraceptive research, (3) compulsion to participate.

**Informed consent**

This is best illustrated by the incident at Patancheru PHC neary Hyderabad on April 1, 1985, when a women's group appealed to the doctors in charge not to go ahead with a Net-En trial on 20 women. These women had been brought from outlying areas by paramedics entrusted with the task of producing 20 subjects for a gala inaugu-

ration of the trial which was part of an ICMR programme. The women said that all they had been told was: *"INJECTION le lo, bachcha nahin hoga"*. The paramedics admitted to the activists that if they had mentioned that this was part of an experiment and that there were possible side-effects, no one would have volunteered (see section on injectables).

A yawning gap exists between ICMR's professed norms for ethical experimentation and what actually happens during contraceptive trials. In this particular case, the ICMR's own circular to medical colleges conducting the trial says:

"Women who come to the PHC seeking family planning advice will be recruited." Rounding up 20 women and producing them on the day when the Collector would come and inaugurate the *tamasha* is not quite what the recruitment norms in the circular suggests.

In 1980, after some medical scientists at the cholera research institute in Calcutta had objected to unethical anti-cholera vaccine and drug trials on slum-dwellers, the ICMR published some guidelines for ethical experimentation on humans[2]. These endorse the norms on informed consent spelt out in the Helsinki Declaration of 1964 (updated in 1975) to which India is a signatory. Among other things, the ICMR's Ethical Committee says that before any institute or college undertakes a clinical trial, its own ethical committee should scrutinise and assess the project. Such a committee should include non-medical people like a lawyer or a judge to guide the members in matters of ethics and law. (Incidentally, a retired Calcutta High Court judge, whom this writer spoke to, has expressed the opinion that medical experimentation without informed consent violates Article 21 of the Constitution, which protects life and liberty.)

It is important for women's groups to demand that these paper norms are put in practice. They must also insist on being represented in ethical committees which decide on contraceptive trials and demand the right to full information, whenever there is news of any trials with contraceptives. For example, when news of Net-En trials was first published in January 1983, all efforts (including by the CED) to get more information were met with an obstinate silence. A shroud of secrecy has descended, ever since some noise was beginning to be made to question the activities of the contraceptive research units. As the following information on contraceptive research suggests, these units have much to hide.

Kusha, who has worked with a contraceptive testing unit (CTU) in Bombay has described how initially the testing of barrier methods in the 1950s and early '60s was integrated into other welfare activities at the clinics and was done with proper consent and with rapport between the women and the unit[3]. Subsequently, with pressure to test IUDs and hormonal methods, the approach changed and the genuine needs and welfare of the subject women were disregarded. In hormonal drug trials women have to give blood samples at intervals, for which they are paid. The effect of this on the malnourished and the anaemic can be imagined. Vaginal rings (which she described as absolutely inappropriate for women who have no toilet facilities) were tried out "for the prestige of an individual scientist." Ironically, anasal spray for men was planned for trial, but no men could be persuaded to participate "despite VIP treatment".

Regarding prostaglandins, Kusha writes: a woman wanting abortion cannot decide by which method she will be aborted. Even though there are safe methods, which could be improved by research, prostaglandins are being tested. The drug causes cramps, abdominal pain, vomitting and diarrhoea. "Women under the trial suffered tremendously "It is a chilling thought that the Nobel Laureate for medicine (1982), Dr. Sune Bergstrom, got his prize for his work on prostaglandins. The ICMR will reportedly carry out further trials in association with this 'eminent' scientist. In the 1970s, clinical trials had already been done by the All India Institute of Medical Sciences in collaboration with Dr. Bergstrom. (*Patriot*, April 9, 1983).

According to another activist in Bombay,

## BOX 24

### *Contraceptive research*

Judy Norsigian, a member of the National Women's Health Network (NWHN) USA and of the Boston Women's Health Book Collective, and one of the authors of **Our Bodies, Ourselves** gave the following testimony on contraceptive research before the USA Congress House Select Committee on Population in March 1978.

*There are three basic issues we would like to address:*

1. *What kind of contraceptive research receives priority.*
2. *Who carries out that research.*
3. *Who makes policy decisions in the area of contraceptive research.*

*First, as you may know, contraceptive research at present focuses heavily on hormones, drugs, and invasive devices, such as hormone-releasing IUDs, prostaglandins, injectable progestogens, silastic hormonal skin implants, and anti-pregnancy vaccines. At the same time, there is relatively little research on safer and cheaper mechanical and barrier methods. on contraceptives which act totally rather than systematically, or on methods which require no mechanical intervention whatsoever. Examples of such safer methods include the cervical cap, diaphragm, contraceptive sponge, ovulation method, and thermal sperm control.*

*The safer contraceptive methods also tend not to require physician intervention, thus providing low cost, easily accessible birth control for more people. Particularly good examples are the contraceptive sponge, which requires no fitting, and the ovulation method, which requires non-mechanical intervention.*

*Those of us active in the women's health movement are concerned that present funding is too heavily weighted toward drug and device research. Too often such research has exposed human subjects, mostly women, to serious adverse consequences. In cases where insufficient research has resulted in premature approval of contraceptive methods, much larger female populations have been exposed unnecessarily to dangers. The sequential Pill and Dalkon Shield are two well-publicised examples of this, although all Pills and IUDs might well be classified as unjustifiably hazardous in light of the extensive and increasing documentation of Pill and IUD risks. This latter point is further corroborated by hundreds of letters sent to those of us who co-authored* ***Our Bodies, Ourselves.*** *In addition, adverse consequences of contraceptive drugs and devices account for a surprisingly large number of hospital admissions, which are both expensive and traumatic for the women involved.*

*It is alarming to note that in 1976 out of 70 million dollars spent worldwide on contraceptive research outside of the drug industry, only $50,000 was spent on barrier method research. (From fact sheet prepared by the staff of the Population Council, 1978). Safe birth control methods do not receive priority by those who control the research dollars, while potentially dangerous methods do attract the majority of funds. We urge a major reordering of priorities, so that research on the safer birth control methods mentioned above receive the greatest emphasis.*

*New priorities would also include research on better ways to communicate information about birth control methods. How well a method is understood weighs heavily on how effectively it is used. Too much emphasis has been, and continues to be, placed on the presumed passivity of women and on the desirability of methods requiring little or no active participation. Too little attention is now paid to basic body education and to those settings in which we learn best. For example, the self-help model used in many women-run health centres improves use-effectiveness of barrier methods as well as the ovulation method. Also the intensive*

education model used with teenage women in some family planning clinics demonstrates that existing barrier methods, like the diaphragm, are much more effective than previously thought. (See Lane, Mary E., et al, "Successful Use of Diaphragm and Jelly by a Young Population: Report of a Clinical Study." Famil Planning Perspectives, March/April 1976).

With respect to the question of who does research, I call your attention to a 1976 GAO report to the Congress entitled "Federal Control of New Drug Testing Is Not Adequately Protecting Human Test Subjects and the Public". This report concludes that lack of adequate monitoring and lack of compliance with testing equipments failed to protect thousands of human subjects from unnecessary hazards of new drugs and has failed to guarantee that test data used in deciding whether to approve new drugs for marketing is accurate and reliable. I quote from page nine, which discusses a special FDA survey completed in 1974: "Our review of the inspection results indicated that of the 155 clinical investigators inspected, 115 (74 per cent) failed to comply with one or more requirements of the law and regulations". We believe that this problem of non-compliance exists in the narrower area of contraceptive drug research.

In this context it is interesting to note that most contraceptive investigators are male and hence have little direct understanding of the practical impact of their research on women. According to the inventory of population research projects listed in the NIH report, **Inventory and Analysis of Federal Population Research,** over 80 per cent of federally funded investigators in the areas of contraceptive development and contraceptive evaluation during 1976 were males. It is of no small significance that these male investigators will never have to use the methods that they develop. Moreover, we believe that their focus on the biological model and their fascination and involvement in the research process sometimes overshadows their concern for the well-being of research subjects.

In our opinion, there needs to be more research conducted by community-based women's health centres which have worked directly with those who are intended to benefit from this research.

Furthermore, subjects should play a major role in designing and/or approving the research design. We believe that such an approach would result in stricter adherence to research protocol. Research of this kind is already taking place at several women's health centres, but on a limited scale. (For further discussion of this, see "Emergent Modes of Utilization: Gynaecological Self-Help", by Sheril K.Ruzek, in the Proceedings of the Conference on Women and Their Health: Research Implications of a New Era - U. of California, SF, August 1975). It should be expanded and should receive further support from both public and private sources.

Our third area of concern is policy-making. Private organizations like the Population Council, Ford Foundation, the Rockfeller Foundation, Planned Parenthood, and drug companies, as well as the federal government, sponsor practically all current contraceptive research, setting priorities for this research as well. Policy-makers for these organizations are also primarily males, who make decisions with little or no input by the many users of contraceptives, who supposedly benefit from the research. I call your attention to the composition of the Interagency Committee on Population Research, established in 1970, which makes federal policy recommendations regarding population research. Among the eighteen Committee members listed in the **Inventory and Analysis of Federal Population Research** only one is a woman. Similarly, in the case of a private organization, only 4 women sit on the 18-member Board of Trustees of the Population Council.

there are two types of women on whom research takes place. One group consists of lower-middle class but literate women actively seeking contraception. They are not given incentive money but the birth-control method is free of charge. They have rapport with the doctors and get adequate follow-up care. (However, it is not clear whether they are aware that the methods they accept are experimental ones.) In this type of research, the doctors are reportedly willing to disclose information about their work to an outsider (like the activist).

The second type of research is done by some institutes where poor women from adjoining slums are lured with monetary incentives. One researcher, who is reported to have been engaged in trials in Bombay with various contraceptives for the past 10 years, is supposed to have described the poor women who participate as being "well-motivated" for this sort of thing. A subject gets Rs.10 for every blood sample drawn, and this money is paid to her as a lump sum of about Rs.200 every other month. It is very difficult to get full information about the subjects and the modus operandi. Quite apart from the absence of informed consent, such trials raise questions on the ethics of enticing the impoverished with monetary baits.

### Directions in contraceptive research

Kusha's article in the *Socialist Health Review* had pointed out that since the 1960s no research is being done to evolve safer, more effective barrier methods or to improve the efficacy of older methods, or to evolve safe indigenous methods. The condom is harmless and effective, but there is no serious study to assess its acceptance and rejection. Decisions on the directions in contraceptive research are thus made regarding new invasive female methods without any opportunity for women or women's groups to have a say. This happens in the West too. In her testimony to the U.S. Congress Select Committee on Population, Judy Norsigian of the Boston Health Book Collective had questioned: what kind of contraceptive research receives priority? Who carries out this research? And who makes policy decisions in the area of contraceptive research[4]. These are questions which women's groups in India too must ask. Apart from this, we need to demand that existing methods be made more readily available (to those who choose them), more safe, and with better medical care to cope with side-effects. *Our priority at the moment is not more research on newer methods but better and more sympathetic delivery of existing methods.*

### Compulsion to participate

It is learnt that women seeking abortion are sometimes compelled to accept contraception as a precondition to MTP. In a study of women attending the FP centre at KEM Hospital, Bombay, the author has recorded examples of women accepting pills and experimental methods like implants, injectables, vaginal rings and various types of IUDs. She mentions that many women accept pills "probably under pressure from medical staff," as a precondition to get an abortion. The preference for pills is apparently because these can be discontinued more easily (after the abortion) than the other methods. Nevertheless, although the study does not explicitly say so, women choosing the other experimental methods are likely to have had no option but to agree to accept experimental contraceptives if they wanted the abortion. Doctors in Hyderabad tell me that poor women coming to government hospitals for abortions almost always have to agree to having an IUD inserted. One women is reported to have had three IUDs pushed into her at different times, which were detected when she finally got sympathetic treatment for excessive bleeding. The extent to which experimental methods are tried out on women seeking abortion or even just asking for contraception is an urgent area for study and data collection. Ten years ago, the Status of Women Committee had observed (and deplored) the fact that at many MTP centres sterilisation was being made a pre-condition for abortion. And now MTP seekers are being made to serve the cause of contraceptive research.

References:

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2. *ICMR Bulletin*, September 1980.
3. *Socialist Health Review*, Vol.1, March 1985.
4. *ISIS Bulletin*, No.7, 1978 (see also box).
5. *Journal of the National Institute of Health and Family Welfare*, New Delhi (Shiela Divekar et al), April-June 1983.

# Sex selection: No girls please

In 1982 after it was found that two doctors in Amritsar were running a thriving clinic openly advertising amniocentesis followed by selective abortion of female foetuses (see box) there was a lot of media exposure on this practice, questions were raised in Parliament, the ethics of the whole issue were debated, and after that the controversy has more or less died down. It is generally assumed that because the then Health Minister, B.Shankaranand, gave an assurance that use of amniocentesis would not be allowed for determining the sex of the foetus, the practice of sex-selection of offspring is more or less outlawed. Against the background of the 1982 controversy, women's groups need to look at several aspects of sex-selection related to the FP programme: 1) What does sex-selection have to do with the FP policy? 2) What is the continued incidence of sex-selection? 3) What kind of action strategies are possible to tackle this problem?

When the sex-selection question first arose, comment and analysis were generally focused on facts and concepts like: misuse of medical technology; greed of individual doctors; the social situation which makes women desperate *not* to have daughters; the arguments that offering sex-selection to oppressed women is a humanitarian act; choosing to abort a female foetus is part of a woman's or couple's "right to choose"; women who already have many daughters should be enabled to abort a female foetus; sex-selection enables couples to achieve their goal of a "balanced family" of one-boy-one-girl, and hence fulfils not only individual aspirations but also achieves the national objective of keeping down the birth rate, i.e., prevents couples from going on having babies in order to have a son. In addition, there were some sociological articles in the **Economic and Political Weekly** during 1983 which tried to analyse and understand the 1982 controversy against the background of the age-old phenomenon of son-preference in India, the practice of female infanticide in the past, speculating whether the availability of sex-selection methods would result in a serious imbalance in the male-female ratio, and what would be the consequence of such an imbalance. (India already has an adverse female-male ratio of 1000/1069).

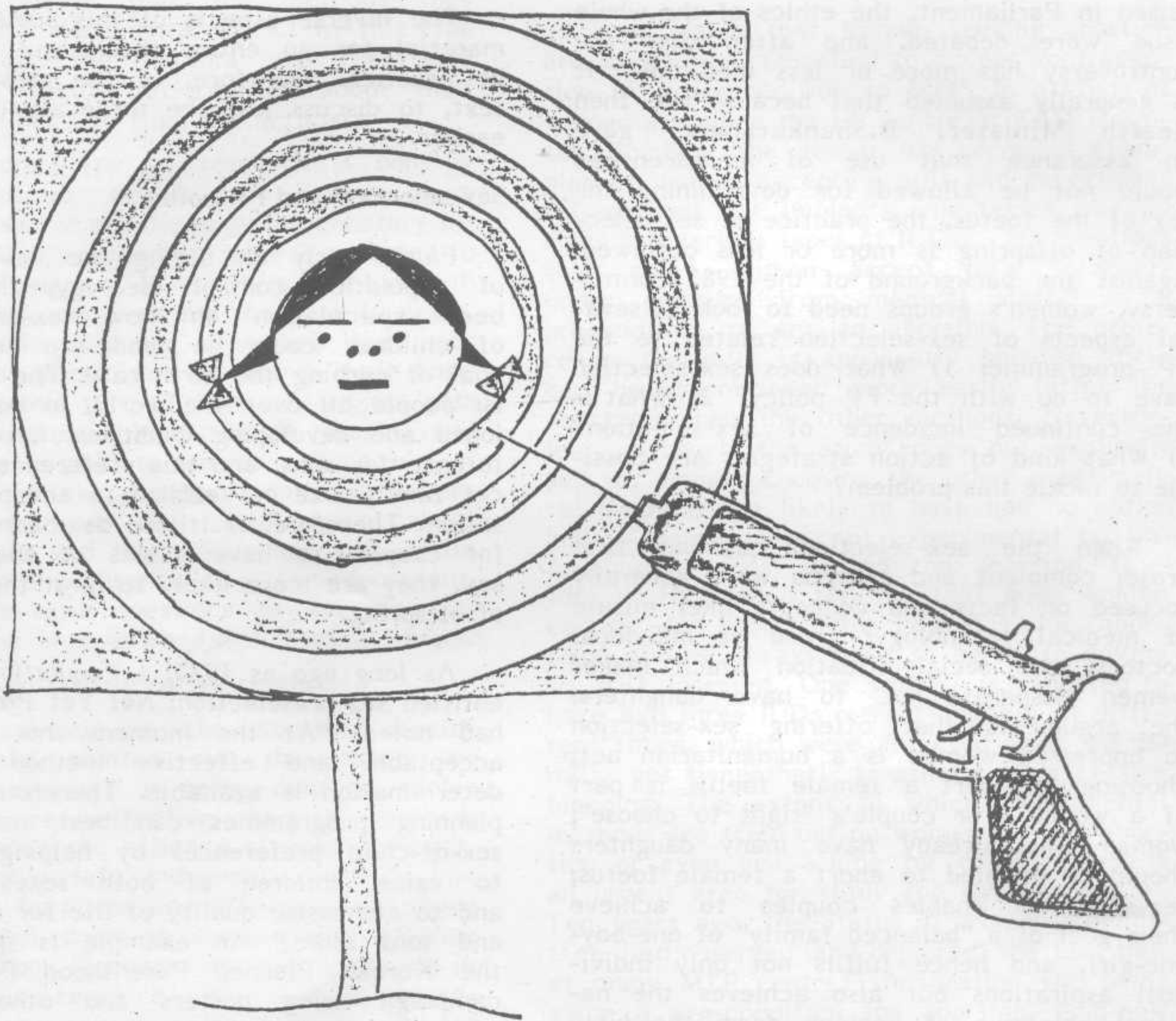
The diverse aspects of this subject offer material for an entire thesis and it would be practical therefore, in the present context, to discuss just the three aspects listed earlier.

### Sex-selection and FP policy

Fairly early on during the development of population control ideology, there had been speculation on how sex-preference of children could be made to serve the goal of curbing the birth rate. The rationale is: people all over the world, in both developed and developing countries, have a preference for sons, and this preference influences family size or decision to accept sterilisation. Therefore, if it can be made possible for couples to have babies of the desired sex, they are more likely to limit the number of offspring.

As long ago as 1975, a *Population Report* entitled *Sex-preselection: Not Yet Practical*[1], had noted: "At the moment, no generally acceptable and effective method of sex determination is available. Therefore, family planning programmes can best respond to sex-of-child preferences by helping couples to value children of both sexes equally and to emphasise quality of life for daughters and sons alike." An example is quoted of the Korean Planned Parenthood Federation campaign using posters and other media with slogans like: "Daughter or son, stop at two and bring them up well." Meanwhile, however, research goes on towards making sex pre-selection more easy and feasible and where it is found that existing methods are acceptable in certain cultural settings, then efforts are made to offer these or promote them - as has happened in India and China.

Sociologist Jalna Hanmer, who has



– Mohan Deshpande

researched sex-selection extensively, writes[2], quoting a Chinese medical journal: "The Chinese report that since 1970, they have performed sex determination tests by examining cells along the uterine wall for sex chromatin. Their stated purpose is to help women desiring family planning, and as should be expected, the results of the 100 cases reported show that more female foetuses were aborted than male. Of the 53 males predicted, one was aborted and of the 46 females, 29 were aborted. The Chinese report a 94 per cent accuracy with this test performed between the seventh and fourteenth week of pregnancy, but there is some risk of spontaneous abortion." This is an example of governmental acceptance of selective abortion for population control purposes on grounds that foetal sex is not in accordance with the parents' wishes - a choice which is exercised within a cultural setting where there is a strong preference for sons. (Today female infanticide has gone up in China after the imposition of the one-child norm).

In India, Dr. D.N.Pai, an influential and vocal figure in the FP establishment, is a strong advocate of sex-determination tests which, he feels should be implemented in the FP programme[3]. At a conference in Stockholm (ironically soon after the Bucharest population conference where India had won laurels for emphasising that development is the best contraceptive), Dr. Pai had described amniocentesis followed by abortion of female foetuses as a possible 'solution' to India's population growth[4]. This was in 1974, eight years before the furore in India compelled the Health Minister to give a token assurance to angry women MPs that misuse of amniocentesis would be stopped. The point to note is that in FP circles, sex-selection was never thought as wrong or bad or undesirable. In fact it was, and continues to be, regarded as one more tool to be utilised for achieving the larger governmental objective of keeping the numbers down. Against this background, it is possible to understand why medical research concentrates on perfecting sex-selection methods and why clinics offering amniocentesis are proliferating in this country.

In October 1984, Larsen and Toubro's welfare department organised a seminar in Bombay where the participants included doctors who are pro-sex-selection as well as members of an activist women's group[5]. One doctor is quoted as saying that "from Kashmir to Kanya Kumari" he gets phone calls all day enquiring about the sex-test. Generally, the doctors at the seminar felt that women who "suffer" by having six or more daughters need "help" - don't they deserve to try at least for one son? (Of course that doesn't answer the question: if one or more daughters are destroyed at the foetal stage, does that guarantee that the next one will be a son? The point obviously is: every foetus destroyed is one less baby born, and this is what counts in the numbers game.) The climate of opinion at the Bombay seminar is generally representative of the establishment attitude and is summed up by the statement of one FP official: "Our population growth has reached such an explosive situation that desperate measures are called for. So we must allow them (sic) to have the test." As Ammu Abraham of Women's Centre points out: "The government's despair about population growth has found an ally in poeple's despair about producing daughters." Which is why the Health Ministry is not doing anything to carry out the promise made in Parliament in 1982.

**Continued incidence of amniocentesis**

An academic in Bombay who is researching on this issue has found that new clinics have come up in the hitherto untouched places[6]. Dhule, a remote town in Maharashtra, has three clinics, (two fairly recently started) where amniotic fluid samples are withdrawn and sent to Bombay for testing. He adds that in Bhandup, a suburb of Bombay, three such clinics exist. A survey done by Women's Centre in Bombay in late 1982[7] revealed that Harkisondas Hospital not only continues doing the test, it has a brochure describing it as "humanitarian." The demand at this centre is so great, so many requests come from out-station, that "booking" has to be done in advance. Another clinic in Bombay, Pearl Centre, also does thriving business. Various doctors at other city clinics

reportedly take samples and send these for testing. Thus, there is an urgent need for data collection to identify the number of clinics all over the country which take samples, carry out the test, and conduct abortions on the basis of the result. It is also important to record the costs of testing and aborting at various places, plus the socio-economic cross-section of people among whom the existence of the test is known and who have the resources to undergo it.

It is reported that even women in Bombay slum areas are going in for the test, the cost of which ranges from Rs.80 to Rs.500. Women tend to weigh the cost of the test against the potential costs of bringing up a daughter and spending on her dowry. Even those who had not heard about the test are now aware because of the 1982 media coverage, and demand has thus gone up.

**What can women's groups do?**

One of the points often raised, even by those sympathetic to the women's movement, is that when women, who are being harassed and tortured by in-laws desperately ask the doctors for help to enable them not to produce daughters, can such doctors (I am not referring here to those who favour drastic population control or who are in this business for the profits it brings) remain unmoved? When they get a crisis case, a woman who is sure to be thrown out of her house, may be driven to suicide, if she gives birth to a girl, can a doctor refuse to help when he/she knows that a test can reveal the sex of the foetus and that selective abortion could mean that one woman's life will be saved? These are very difficult questions, but they are being asked and there are no easy universal answers.

We in the women's movement know what our answers are. What can we do to make our answers more widely acceptable as the answers? Even as we lobby to prevent the proliferation of sex-determination clinics, we have to work towards making the ideology of women's movements a dominant ideology which the majority of women and men will subscribe to. The fight against sex-selection consists not just of a protest against misuse of amniocentesis but is part of the larger struggle against patriarchy.

It is interesting that in the West, where "femicide" or destruction of the female sex through sex-selection, is not a threat, so much analysis has already been done by feminist researchers on the implications of this practice if it were to become widely available. Among the points they have made are[9]: Sex choice technologies will nurture patriarchy. To choose the sex of one's children is the original sexist sin - because the most basic judgement about the worth of a human being is made to rest solely on its sex. The most reasonable stance is not to choose a boy or a girl, but to welcome each child for what it is. Sex selection implies equating biological sex with social gender roles. Thus, sex-selection is a perpetuation of the ideology of sex-role stereotypes- where sons fulfil certain roles and daughters certain others, totally ruling out the interchangeability of roles and the fact that biology need not be a determinant of social roles. These are concepts that feminists in India also believe in. Our role is to see that these concepts spread and are also promoted by the government controlled media.

Thus, a lasting solution to the sex-selection problem lies very much in the pattern of social change which the women's movement can bring about in the long run. However, are there no short-term action plans to adopt?

As mentioned earlier, we need to collect data on the extent of prevalence of sex-selection by clinics or hospitals and demand that the Health Ministry issue directives to prevent such clinics from functioning. (Mr. Shankaranand had claimed that the practice was not widespread and we know this statement to be false.) Perhaps, we should demand that amniocentesis should be made available only at Government controlled hospitals with stringent norms which will ensure that the

test is used only to detect genetic defects. There should be a clause that the sex of foetus will *not* be revealed to the couple. It is also necessary to examine the MTP Act and see if a provision could be added to make it illegal to abort a foetus on grounds of sex alone. We need to discuss with legal experts on the feasibility and advisability of these measures so that they don't backfire on women's existing rights to abortion. We can also demand that the FP publicity machinery give more attention to promoting the worth of daughters in a more meaningful way than is being done at present. We can insist that the Health Ministry orders its FP personnel, including prominent personages like Dr. D.N.Pai, not to make public statements extolling the uses of sex-selection. Better enforcement of the Dowry Prohibition Act and protection of women from family violence are also relevant demands.

**The blatant and the bizarre**

Below is a round-up of news items and other published material which will give readers an idea of the emerging aspects of the sex-selection issue. It is important to note that amniocentesis is a comparatively crude approach for it involves selective abortion and this can invite criticism from activist groups. The more sophisticated methods of research involve *conceiving* babies of the desired sex, whereby females will not be destroyed at all (a repugnant idea) but simply programmed out of existence. The latter is being done by artificial insemination with male producing X-chromosome sperm (the female-producing Y-chromosome sperm having been separated out earlier.) It is also being attempted through timing of intercourse since certain phases in the menstrual cycle (and nature of vaginal environment) are believed to be conducive to Y-chromosome sperm fusing with the ovum. Experiments are going on with all these methods (see box).

**BOX 26**

**Sex-choice technologies**

*Research on sex pre-selection has concentrated on areas like:*

**Timing of intercourse in relation to ovulation and alteration of acidity conditions in vagina.*

**Separation of X-chromosome female sperm from Y-chromosome male sperm in vitro, followed by artificial insemination. Sedimentation, centrifugation and electrophoresis have been tried to carry out the separation.*

**Determining the sex of the foetus in utero. In addition to amniocentesis, ultrasound and now, chorion biopsy, can be used to identify sex of the foetus. The search is on to develop simpler, safer ways which can be done early in the pregnancy so that abortion after sex detection can be performed safely in the first trimester. (Foetal sex determination carries with it the unspoken choice of selective abortion.)*

**"Child's sex-selection as FP method suggested" (Patriot, Aug. 6, 1984)**

Population growth can be controlled by techniques that enable parents to choose the sex of their children according to Dr. Frances Batzer of the University of Pennsylvania who was speaking at the 19th Congress of Medical Women's International Association. The method (involving separation of male Y-chromosome sperm) was being tested in eight U.S. clinics and would enable couples to refrain from having babies of unwanted sex. The issue was expected to come up for discussion at the Population Conference in Mexico.

**Helping couples to have a male-child**

*Savvy* (a women's magazine published from Bombay) April 1985, has an interview with Dr. Gita Pandya, who works in the field of reproductive endocrinology and teaches couples to have sons through preplanning of the time of intercourse. The interviewer suggested that this practice is a negation of all that the women's movement

is trying to achieve and the good doctor's response was to liken sex pre-determination to beauty treatment or curative therapy! Some excerpts: "Planning the sex of a child is better than determining it after conception and aborting it. It is like helping a couple to get what they want. It is like going to a beauty parlour to make your skin look better." To the question why not leave the sex of the child to nature, the reply was: "If your eyesight gets bad, don't you wear glasses? Do you just leave it to nature? Don't you have bypass surgery after a coronary attack? Do you just wait for the next attack and die?... We are dealing with science and progress. We are not tampering with nature... I don't think my work is in any way diminishing the status of a woman."

"Abortion of female foetus increase" *(Indian Express,* Women's Page, Hyderabad Edition, March, 1985)

Dr. Neela Govindraj, a forensic expert from Madras, drew the attention of world legal experts meeting in Delhi to the increasing incidence of selective destruction of the female foetus over the past two years. Speaking at the World Congress on Law and Medicine, she said that whereas in earlier days people in India resorted to female infanticide now they destroy the foetus itself.

"Want a son?" (item in *Patriot's* 'Capital Cameos' feature, October 22, 1984)

Describes the slogans plastered on walls all over Delhi's low-income Trans-Jamuna area where a doctor has made the claim that he can enable couples to have male children.

"Life's hard, little girl" *(Times of India, Sunday Review,* June 23, 1985)

Article on conditions of women and girls which states, "In a sample survey conducted in Bombay, it was found that of 8,000 abortions carried out following pre-natal sex determination, 7,999 were of female foetuses.

"Boy or girls, the choice is yours" *(Statesman,* September 26, 1982)

Interview with Dr. Bhairalo Bhattacharya on a visit from the USA, where he claims he has perfected a method to separate Y-chromosome from X-chromosome sperm and enables women to deliver babies of their choice. He is quoted as saying that his method would be of special value in an "over populated" country like India.

"Parents can soon choose sex of child" *(Patriot,* May 13, 1983)

Japanese scientists have developed a new method to enable parents to choose the sex of their child which will soon be subjected to clinical trials. The method involves separation of Y from X-chromosome sperm.

"Choice on child's sex may become possible soon. *(Indian Express,* May 31, 1983)

Techniques developed for farm animals may ultimately allow parents to choose the sex of their children, according to researchers speaking at the annual meeting of the American Association for the Advancement of Science. When the method is ultimately available, even in a country like America it might result in 140 boys being born for every 100 girls. In countries like India, the ratio could become even more lop-sided. This method was currently being used with dairy animals, where huge profits are involved and where dairy cows **could be made to produce females only.** (my emphasis). The conference also discussed the possibility of developing vaginal foams which would selectively kill either male-producing or female-producing sperm.

"Ultra sound - a wonder machine" *(Telegraph,* Nov. 4, 1982)

Article describing the use of ultrasound scanning which can diagnose, prevent and cure. "It can even reveal the sex of an unborn baby." Ultra sound had revealed early, during Princess Diana's first pregnancy that the royal baby to be born would be a prince,

not a princess.

The above items give a rough idea of the "neutral" attitude generally prevalant in reportage regarding choice of the sex of babies, which in turn perpetuates the myth of value-free research on sex selection. Some of the items show how such research is linked with ideals of population control. In comparison, there is a relatively low-key focus on the continued incidence of selective abortion of female foetuses which really ought to be, in India at least, a topic for intensive investigative reporting. The following pieces of information collected from an assortment of published sources add to the above mosaic:

*A new medical procedure called chorion biopsy may be available to replace amniocentesis for detecting genetic defects and sex of an unborn foetus. It can be done as early as seventh week of pregnancy and the results could be available overnight.

*Researchers of *in-vitro* fertilisation (test tube babies) have said that in future it would be possible to screen embryos (before implantation) and eliminate those with birth defects or those whose sex is not what the parents wanted.

*Unani researchers in Andhra Pradesh are trying to find out more information about a herbal extract used by tribals which enables them to have babies of their sex-choice.

*The journal of the International Institute of Ayurveda in Coimbatore has published an article on the ayurvedic way to conceive a baby of the desired sex by having intercourse on specific days of the menstrual cycle.

*A team of Israeli doctors in a Jerusalem hospital has successfully used a method to treat human sperm before insemination to produce a baby of the desired sex. An Israeli mother with six daughters is now expecting a son.

Widespread availability of sex predetermination could mean not only more

BOX 27

**Foetal sex identification and induced abortion**

*"The sex of the foetus in utero can be identified and selective induced abortion used to assure that only a child of the desired sex is born. Methods of ascertaining foetal sex have been available since mid-1950s. They are used on a limited scale to identify the possible victims of sex-linked hereditary diseases (such as haemophilia) which in most cases strike only males, but their use for sex pre-selection probably will not be adopted."*

*"Foetal sex can be identified by examining foetal cells found in amniotic fluid ... obtained by amniocentesis or withdrawal of amniotic fluid by a needle inserted through the abdominal wall... Amniocentesis can only be safely performed after 16 weeks of gestation, past the period when relatively safe and simple early abortion methods can be employed. It seems unlikely, therefore, that foetal sex-determination and induced abortion will be widely adopted as a sex pre-selection technique. (A prediction proved wrong.) Only 5 per cent of US doctors recently surveyed would perform amniocentesis for sex-pre-selection."*

***Population Reports**, Series I, No.2, May 1975*

*(N.B. Amniocentesis is also done to test for Down's Syndrome, a disability which will result in a retarded baby being born. There is thus a choice to abort, to prevent such a birth. Expectant mothers over 40 years of age are recommended to have this test done as they are more likely to give birth to Down's Syndrome babies. It is a moot point how many Indian women are aware of this, and how many who need to have the test do have access to it. It would be worth collecting data on how many such afflicted babies are born in this country entirely because the parents had no knowledge of how to prevent these births. This could be contrasted with the number of foetuses aborted for no reason other than that they were female.)*

boys than girls being born, but also more first-born males and second-born females. Those who argue that it is beneficial for girls to know that they were born because they were "wanted", overlook the possible effect of the knowledge that they were "planned-to-be-second". However, it is interesting that the medical establishment is in its own way trying to sell the idea that sex-selection can indeed be a good thing for the status of women. As this gem of the tailpiece reveals, from no less a source than the ICMR Bulletin, as recently as 1985, three years after the Amritsar clinic incident:

The lead article is on "Sex-selection of Offspring" by a team of researchers from Bombay's Institute for Research on Reproduction, an ICMR unit. The piece sums up the various methods being researched and under "Implication of sex choice", says that daughters born out of choice could be made to feel specially wanted. "It may also result in reversing the chronic prejudice against females, in removing some of the social evils associated with marriage of a girl. Girls may be given equal opportunities for education and jobs, resulting in improving the economic status of the family".

Do we have to wait for sex-selection in order to treat girls as human beings and as equals to boys? We can and should make our daughters feel wanted, and care for them as much as we do for our sons. Sex pre-selection need not at all be a pre-condition for giving daughters their due.

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10. *ICMR Bulletin*, Feb. 1985.

# Babies are beautiful

"It's strange they gave free medicine to stop women from bearing children, but had nothing to help those who could not bear children. That's where medicine could be of use to us."[1]

"A Swedish nurse and former volunteer in a health programme became famous in the village for her ability to help women overcome infertility. During her time people came from far away to be treated by her."[2]

In spite of its professed integration with maternal and child health (MCH), the FP programme has come to mean a programme for preventing births. In 1983, inaugurating a workshop for state level MCH officers in Delhi, Mohsina Kidwai (then minister of state for health) called for new and more effective strategies to meet MCH goals and added: "Let the people understand that the FP programme is not only a programme for preventing child birth" (Patriot, July 5, 1983). But neither good intentions nor policy statements can neutralise the actual reality of high maternal and infant mortality rates and the failure of the MCH component. Considering that women not only want contraception but also want to have babies, a critique of the FP programme must look at the following aspects: 1) help and advise to prevent and overcome infertility; 2) antenatal care and safe child-birth; 3) child survival.

**Infertility**

In 1984 the IPPF issued policy statement on infertility which said[3], "The IPPF believes that individuals and couples should be helped to have the number of children they want, either through contraception or by trying to correct infertility." Since there may be various organic causes of sterility which may not be curable, in the Indian context where wives are often discarded or ill-treated for not bearing children, it would be necessary not only to create consciousness of the fact that husbands too can be "at fault" but also to work towards creating a culture which makes adoption a more acceptable practice. Apart from this, there are some important references in the IPPF statement regarding causes of infertility and how this should be handled by the FP programme.

"Many conditions leading to impairment of fertility are preventable. These include sexually transmitted diseases (STD) and infections following child-birth or abortion. Tuberculosis may also cause infertility." Although the IPPF does not admit it, there is strong evidence that pelvic inflammatory disease among IUD users can cause infertility and the WHO itself has said that return of fertility after discontinuation of injectables is still under study. (See sections on IUD and injectables). For this reason, women who have not completed family size should not be advised to use these two methods.

The IPPF also suggests that FP services should play an active role in reducing preventable infertility by promoting: "programmes for control of STDs; better obstetric care at primary health care level including adequate training of traditional birth attendants; improved access to effective contraceptive services to reduce the incidence of illegal abortions; better management and humane treatment of the consequences of illegal abortion; availability of reproductive health services (including information and education) for adolescents; and programmes for control of diseases which may have a definite causative relationship to infertility eg. tuberculosis."

At present, expert and expensive gynaecological advice is indeed available to infertile couples who can afford it. The above guidelines have been listed to show that such advice is a legitimate right of all women, who are the targets of birth control advice, especially since some methods of birth control may often be the primary cause of infertility. The example of Anjana of Bombay, however, shows how total is the lack of rapport between the formal health services and women's varied health needs, including the need for babies.

Anjana had been trying for four years to have a baby but could not conceive. Tests at the government hospital revealed TB of the uterus. She was not told this but was put on drugs. After she started taking the medicine she experienced increased bleeding during her period and also spotting. Her discomfort was dismissed as psychological and the doctor told her to continue the drugs and come again after nine months. Anjana was not aware that she had TB and that she was being treated for the disease. In any case she thought that TB is only a disease of the lungs and had no idea that it could affect her uterus. Besides, she had sought treatment to be able to conceive and had assumed that the drugs were meant to help her have a baby. When she found that she could not cope with the bleeding, which she attributed to the pills, she stopped taking them.

**Maternal and child health**

The idea in integrating FP with MCH is obviously to ensure better credibility for FP promotion. But since FP performance has targets while neither MCH nor primary health care are allotted any targets, health personnel have invariably been more preoccupied with FP than any other health care service. This has backfired on both aspects as countless examples from social science research have shown. Sheila Zurbrigg writes of the alienation between health workers and villagers because of the monthly sterilisation quotas set for all PHC workers[4]: "For the average labouring family, children represent the only wisp of security for their lives. For this to be threatened by the health workers promoting family planning - and this coming from workers who are enviably secure themselves - is often the 'last straw' in breaking any bond of understanding or trust between them. Preventive services, such as DPT and Tetanus immunisation, have thus been tainted by the forced eagerness of field workers for sterilisation recruitment. Villagers have come to view most health services with the suspicion and negative feelings they have for FP and therefore tend to reject both."

The pressure on ANMs and other women paramedics to achieve their FP quotas makes them unpopular with the village folk, with the result that their services for MCH tend to be utilised by the local elites only. There is also a cultural gap and the contempt often expressed by health personnel for "illiterate villagers" intensifies that alienation. In a study of a UP village[5] it was found that women had more faith in the local *dai* than in the ANM whose method of delivery was alien to them. "The emphasis on her role as an FP worker also created problems as the women did not want to call her for delivery for the family feared that she may do some mischief and make the women infertile."

The authors add:

"Only at the time of crisis women turned to health care institutions. Not much attention is paid to the cultural and social dimensions - life style, value system, local customs, beliefs and practices relating to pregnancy and child-birth - in the delivery of MCH to women."

The shortcomings of MCH services have to be seen in the total context of how the formal health services function in an unequal society, and the low status of women within a patriarchal structure which affects their access to health care. For this, a complete discussion on Women and Health (reproductive health being only one aspect) would be necessary, which is not feasible here. In the present context it is necessary to understand that the integration of FP with MCH is a hollow claim. A great deal of current FP propaganda is aimed at creating a totally false picture of a complete package of services for pregnant women and mothers of which FP is supposed to be only one of the ingredients. It should also be noted that since FP is part of MCH, it leaves outside its purview other groups like the unmarried, divorced and widowed and of course, men.

**Training of *dais***

The WHO and the Health Ministry have been constantly emphasising the importance of the *dai* training scheme so as to reach better obstetric care to the large majority of women who are not able to avail of formal health care service for child-birth. One trained *dai* for every village is the

## BOX 28

### *Coping with infertility*

*Infertility can be defined as the inability to conceive, impregnate or carry a pregnancy to term, including a history of spontaneous abortion or still-birth. Sterility means complete and permanent inability to conceive or impregnate, even after treatment. Infertility of women is said to account for 50-70 per cent of all infertility. But men are less likely to be examined, and usually only after all possible sources of infertility in the women have been investigated. Many men refuse to be examined, believing that sexual potency is proof they are fertile.*

*A major cause of infertility is sexually transmitted disease. In men STD can lead to genital infection causing blockage of sperm ducts or impaired sperm production. In women infection can lead to pelvic inflammatory disease (PID) which starts in the vagina and cervix and spreads to the upper reproductive tract if untreated.*

*PID can also result from infections following birth or abortion if these are not done in safe conditions. Infection after birth not only causes infertility, it is also a cause of many women's deaths.*

*Some studies have shown that heavy drinking of alcohol, smoking, use of narcotics, barbiturates or marijuana may vigorously reduce fertility in both men and women.*

*Exposure to toxic substances especially at the workplace can also affect fertility. Radiation impairs sperm production and can also affect women's ability to conceive. Exposure to heavy metals such as lead or cadmium and exposure to pesticides can affect fertility. Thus infertility can be closely related to occupational health hazards.*

*Public health programmes to combat and treat STDs, improved care during and after birth and pregnancy, safe abortions - all would help to reduce infertility by preventing infection. Health and safety measures at work would make a difference. Use of condoms or diaphragms as contraceptive methods also help by helping to prevent STDs.*

*Some causes of infertility are untreatable while others are easily dealt with. Some treatments may be prolonged and costly, thus only available to the rich. Counselling and support should be available to help people cope with infertility in a world that demands childbearing from all women. Social attitudes need to be challenged on this, and men's belief that childlessness is cause for violence and divorce should be opposed.*

*- Condensed from* ***ICASC Newsletter*** *No. 12/13*

proclaimed goal of the Sixth Plan. There is not enough evaluatory feedback on this programme but available information suggests that there are many hurdles[6]. There is a lot of hostility between 'trained' health workers and 'untrained' *dais* and the process of 'training' fails to take into account the rich experience the latter already have, as well as their knowledge of beneficial traditional practices (such as squatting during labour.) Besides, the *dais* often belong to 'untouchable' castes and hence their role in aspects of MCH other than management of labour and delivery cannot be integrated so easily in traditional settings. Curiously, in the official statements on *dais* training in safe obstetrics, and their possible potential as FP services providers, no mention is made of training *dais* in safe abortion techniques.

It is well known that large numbers of women who lack access to legal abortion (which should be but is not freely available) seek abortion services from *dais*. Many, who can go to hospitals, don't for fear of being sterilised. The possibility of imparting abortion training to *dais* needs serious consideration, but this will require much lobbying by women's health groups because the official health system is unlikely to be willing to impart technological expertise to a section which has so far been effectively kept out of the formal health structure.

Some other aspects of child-birth also deserve attention. It is often argued that high maternal mortality is a result of excessive child-bearing, and so are anaemia and malnutrition. The answer offered, therefore, is "family planning" which really means acceptance of contraception. Lack of antenatal care, lack of enough food, poverty, over-work and ill-health plus women's lack of control over their own lives are the real causes. To imply that contraception is an answer to women's social and economic problems is cynical to say the least. However, this being the overall philosophy in linking MCH with FP, a great deal of effort goes into researching and introducing new contraceptive technology. And yet, a simple technology for early pregnancy testing, which is something women desperately want, is beyond the reach of most. The continued misuse of the combination hormone drug for pregnancy testing, in spite of the fact that it may cause birth defects, is a reflection of the level of concern the health authorities have for mothers and their babies. This drug, which was banned in 1982 after health groups all over the country campaigned against it, continues to be sold today because the drug firms have got a stay order from the High Courts and the government on its part is apathetic in pushing this case through a long legal battle.

**Child survival**

Ever since 1980 and the WHO code on promotion of breast-feeding, much emphasis is being laid on "child survival" as a strategy to keep down the birth rate. (It sounds cynical but the calculation is: If fewer babies die, fewer babies will be born.) Even if the basic motive is population control, any strategy aimed at preventing babies dying needlessly is to be welcomed. But we must ask: at whose cost? The child survival strategy consists of prolonged breast-feeding (which helps the baby and also provides natural contraception), immunisation against childhood diseases, growth monitoring and oral rehydration therapy to prevent diarrhoea deaths. The 1984 Unicef report on the State of the World's Children called for "empowering mothers" with the knowledge of these four formulae. But mothers cannot shoulder this big responsibility unless there is radical change in their living conditions.

Sheila Zurbrigg has shown how the conditions and hours of work for labouring women are directly responsible for the high levels of malnutrition and illness in children. A major factor leading to childhood malnutrition is the absence of the mother from the home during the day. She can neither breastfeed the child adequately, nor ensure supplemental feeding and she is in no position to administer round-the-clock ORT to a child with diarrhoea. The Unicef in its 1985 report admitted clearly all these problems and stated: "Progress in women's rights is possibly the most important of all advances for improving the lives of women themselves and for supporting mothers in the task of using the new techniques to bring about a revolution in child survival."

Thus, breastfeeding and ORT by themselves cannot be touted for child survival without better working conditions for women, minimum wages, maternity leave and, most important, the *leisure* to be able to care for one's baby. It appears that we need a revolution in women's conditions first, before the revolution in child survival can be achieved, and through that a possible fall in birth rate.

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# Religion, the state and women's rights

The well-known slogan of feminists in the West fighting for abortion rights is: "Not the Church, Not the State, women shall decide our fate." Women's rights to contraception and to contraceptive methods of their choice has been endangered by state policy as well as by the religious establishment in different countries and this applies not only to abortion but to reproductive rights as a whole. In India, because of the government's anti-natalist policy, access to contraception is theoretically without any curbs, but it has been seen that women are often denied the methods of their choice, denied full information about side-effects or are used as unwitting guinea-pigs in contraceptive research. The world-wide picture on reproductive rights shows that access to contraception is often dependent on whether the authorities wish the birth rate to fall or rise. In countries which seek to achieve a drastic fall in birth-rate the use of disincentives often constitute an attack on individual rights. In the Indian context, numerous suggestions have been frequently made to withhold various amenities and facilities (housing, bank-loan, increments etc.) to couples violating the two-child norm, including denial of educational opportunities to the third and subsequent children. Among the most heinous of suggestions made by the Khosla Committee in 1983 was a proposal to deny maternity benefits to women who bear more than two children, and increase in hospital charges for the delivery of the third and subsequent children.

We need more information on what precisely are the prevailing rules regarding maternity benefits in relation to family size enforced by various state governments and private employees and challenge all curbs as unconstitutional. The Status of Women Committee report mentions that some state governments do have such rules affecting women with more than three children. "In Madhya Pradesh, we met a group of women teachers who complained bitterly that this measure has resulted in a number of them having to work till the day before the child was born." Denial of jobs to pregnant women or to women who might become pregnant (like sacking girls when they marry) is also an attack on reproductive rights, and such curbs are likely to exist especially in countries with anti-natalist policies. In 1983 there was much press coverage on how married interns of Lady Hardinge Medical College Hospital (a government institute) were made to take pregnancy tests before appointment and if they become pregnant during the tenure were told to abort or quit[1]. To the best of my knowledge the rule remains unchanged despite protests and questions in Parliament.

Another aspect is breastfeeding. With research findings having clearly established the contraceptive effects of breastfeeding and its importance for child survival, the WHO has emphasised that breastfeeding should be encouraged as part of FP policy[2]. Since a great deal of high-power FP is directed at women who have just given birth, through the post-partum programme, it is important to ensure that hormonal methods like the Pill are not given to lactating women since it can affect milk output and may also affect the baby through the breast-milk. However, it is unrealistic to talk about breastfeeding promotion without making it feasible for working mothers to breastfeed their babies adequately, through suitable maternity legislation, and job protection especially for women in the unorganised sector. Thus, in India, in addition to the struggle against forced contraception or conditional contraception (like abortion only on acceptance of sterilisation or IUD), the issue of reproductive rights is closely related to the question of married women's right to work and right to protection from dismissal and just working conditions for pregnant women and mothers.

In addition to state policy and its impact on reproductive rights, we in India have to be vigilant about communal politics and the stand taken by religious leaders regarding FP, because of its possible impact on women. One of the constant bogeys being

raised by Hindu communalists is that FP is being thrust on Hindus while Muslims are allowed to breed freely. Besides fanning dangerous communal passions, a trend is emerging of glorifying Hindu mothers who bear many children.

Recently, in Kancheepuram, four women who had borne 10 children, all alive, were honoured by the 'Hindu Munnani' with the title of "Veerathai" (Brave mother). They were given a cash prize of Rs. 500, a saree and a blouse. *(Patriot,* January 19, 1985). The awards were distributed by the Kanchi Sankaracharya and the four mothers were selected from 67 who had entered the "contest." The other 63 were given a cash prize of Rs.100 and a saree each.

Earlier, the Sankaracharya is reported to have told the Press *(Indian Express,* July 4, 1983) at Vijayawada that "though Hindu dharma is against family planning" he would not hesitate to recommend it to Hindus in the "national interest" provided it was "made compulsory for all Indians irrespective of their religion." (Note that there is no mention of birth control as a right.)

Against this, we must see how emerging fundamentalism in Islamic countries is coming down heavily on birth control and the possible impact this may have on orthodox Muslim circles in this country. Communal hatred holds the possibility that the male religious bastion of both communities may create fear of birth control as being 'sinful' and thereby erode the reproductive rights which Indian women at present enjoy because of the government's anti-natalist policy.

It is also necessary for women's groups to collect data on how existing religious pressures in different communities affect women's rights to contraception. There is hardly any information for example about the Catholics of this country and how Catholic women are affected by their church's stand on contraception and how they cope in the face of these curbs. Recently I came across an instance of a Catholic domestic servant who was desparate to have an abortion but had to seek help without the knowledge of either her husband or her community. She was further intimidated by the ultimatum reportedly circulated among her community by the priests that anyone who violated the church's instruction forbidding contraception would be denied burial in the cemetry. The legality of such a directive seems dubious, but as I mentioned, a lot more information is needed before this issue can be meaningfully discussed. Similarly, we need to know more about curbs on contraception as preached among the other religious communities in India, and the problems faced by women of both rich and poor classes.

**The world scene**

In many Western countries, especially where the Catholic Church has clout and where conservatives are politically powerful, abortion is either illegal or heavily restricted. Cases of sterilisation abuse against the poor are rampant in those developing countries which are aggressively anti-natalist and where sharp economic inequities exist. In this regard the treatment of black and coloured immigrant women in the USA (through conditional abortion and forced sterilisation) is similar to the treatment of the poor in the developing countries.

An ironical factor is the alarm over falling birth rate in the developed nations and the state machinery's efforts to encourage the women of these countries to have more babies. While in some countries like Russia, France, Hungary, West Germany etc., this anxiety has taken the form of offering liberal maternity benefits and inducements to have more babies, in a country like Romania the pro-natal government has imposed heavy restrictions on contraception and abortion, thus attacking reproductive rights. Again, on the one hand there is a country like USA where conservatives are powerful and lobbying hard to restrict the right to abortion and on the other, there is a country like China which is aggressively promoting one-child policy and trying to achieve it not only through strong disincentives but also, reportedly through forced abortion of a second pregnancy, forced acceptance of IUDs and heavy pressure to accept sterilisation. And finally, there

### BOX 29

### *Abortion laws and politics*

*Over the past 15 years, a large number of countries have liberalised their abortion laws to various degrees, notably Austria, Canada, the People's Republic of China, Cuba, Denmark, Finland, France, GDR, West Germany, India, Italy, Netherlands, Norway, Singapore, Sweden, Tunisia, UK, USA and Yugoslavia. Four countries in Eastern Europe adopted more restrictive legislation than previously in force: Bulgaria, Czechoslovakia, Hungary and Romania. Four other countries liberalised their abortion policies and later made them more restrictive: Iran, Israel, New Zealand and USA.*

*Major reasons advanced by advocates of less restrictive legislation in matters of abortion and especially of abortion on request, have been consideration of public health, social justice and women's rights. A desire to curb population growth in the interest of economic and social development has been an explicit reason for the abortion of non-restrictive abortion policies in only a few countries, such as Singapore and Tunisia and more recently China.*

*Opposition to the liberalisation of abortion laws has come traditionally from conservative groups, mainly on moral and religious grounds with the Roman Catholic Church the most vigorous and articulate opponent. Anti-abortion policies are also favoured by fundamentalist Protestants and Muslims and by orthodox Jews. Concern about low birth rates has been a major reason for recent restrictive legislation in Eastern Europe.*

*Many countries have "conscience clauses" exempting physicians, nurses and/or other staff from participating in abortion procedures if they have religious or philosophical objections. A statute authorising abortion on request does not guarantee that the procedure is actually available to all women who may want their pregnancies terminated. Lack of medical personnel and facilities or conservative attitudes among physicians and hospital administrators may effectively curtail access to abortion especially for economically or socially deprived women, as in parts of Austria, France, W.Germany, India, Italy and USA.*

*- Condensed from* ***Induced Abortion, A World Review,*** *1983 by Christopher Tietze, Population Council, New York*

are countries like Singapore which have adopted the eugenic policy of urging the educated to have more children while enforcing curbs on the population growth of the poor. The following round-up of news items gives an idea of the current world reproductive rights scene:

"Pretoria government sterilising black women" (*Patriot*, July 20, 1985)

Addressing delegates at the UN Women's Decade Conference in Nairobi, Ms Gertrude Shope of the african National Congress said the South African government was trying to curb the growth of the Black population through forced sterilisation of women and by administering Depo Provera, an injectable contraceptive banned in most Western countries. White women on the other hand are being encouraged "to have a baby for Botha."

"Reagan wants decision on abortion reversed" (*Patriot*, July 17, 1985)

US President Ronald Reagan's administration has asked the Supreme Court to overturn its landmark 1973 decision legalising abortion. The Justice Department has asserted that States must be allowed to place some restriction on abortions.

"Special incentives" *(Hindu,* May 22, 1984)

Each family of nine or more children in Sudan will be awarded a gold medal, those with seven will receive silver medals and bronze medals will be given to parents with five children. The Sudanese President has ordered special incentives to promote a birth boom in his country.

"Pakistan bans birth control" *(Patriot,* March 22, 1984)

Pakistan's "Council of Islamic Ideology" has outlawed birth control saying that contraception is forbidden by Muslim tradition.

"Malaysia: Looking forward to population explosion" *(Patriot,* January 14, 1985)

The Malaysian government has begun to offer *financial awards for large families.* The country's young women have been urged to marry early and have more children. According to an item in *Newstime* (August 11, 1984) Malaysia's new policy places an added burden on married women by increasing their traditional role of child bearing and rearing. "Women are worried their husbands may marry more wives under the pretext of abiding by government policy." Muslim husbands in Malaysia are allowed four wives.

"Ostracised for birth control" *(Patriot,* January 1, 1984)

When Sameda Khatun of Bangladesh died, her husband could not bury her in the community graveyard because 'village elders objected. She had undergone a tubectomy two years earlier which had enraged conservative elders in their village where many people believe birth control is anti-religion.

"Romania orders women to have three children" (quoted from *The Guardian* in *ICASC Newsletter,* July 1984)

On International Women's Day the Romanian president told women it was their patriotic duty to have three or four children. None of the usual contraceptives are available in Romania. The country which had a liberal abortion law in the 1950s banned it in 1966 because of the drop in birth-rate. (The 1984 World Development report of the World Bank says that in Romania maternal mortality due to illegal abortions has sharply risen and continues to rise). At present pregnant women are monitored to ensure that their pregnancies are not interrupted.

"Japanese anti-abortion bill shelved" *(ICASC Newsletter* 12/13

A Bill to take away women's right to abortion on economic grounds was shelved by the Japanese Parliament after a campaign by 70 women's groups.

"Sri Lanka abortions cause concern" *(People,* Vol. 11, No.2, 1984)

Abortions are heavily restricted in Sri Lanka where other FP methods are freely available. Complications and deaths resulting from illegal abortions are high, especially among the poor. Religious opinion, both Buddhist and Christian, is strongly opposed to any relaxation of the abortion laws.

"Graduates urged to be mothers" *(People,* Vol. 11, No.1, 1984)

Quoting birth statistics, the Singapore Prime Minister has noted that educated women have fewer children and if the pattern continued, "the quality of the population will be lowered." The scientific basis of such an assertion has been questioned by intellectuals. A former deputy prime minister has said that educated women *will not want* to be treated as *queen-bees* nor was there any justification to assume that children born to parents with lower education will not emerge as talented leaders. *(ICASC Newsletter,* July 1984 adds: the Singapore government has changed the rules for school admission so that women with a university degree and three children may send their children to any primary school they want. An 'uneducated' mother officially described as having no 'O' levels, must have no more than two children and be sterilised to have similar school privileges. The policy has been condemned by activist groups as racist and elitist.)

"Iran turns back the clock" (*People*, Vol. 10, No.3, 1983)

More babies are being born in Iran's hospitals and the government is proud that its population growth rate has almost doubled. The Islamic government began by stopping education about contraception and encouraging people to please God by having as many children as God enabled them to. Contraceptive supplies are difficult to get, tubal ligation and vasectomy are illegal and abortion carries stiff penalties for everyone concerned.

Some lessons from the world scene for us in India are in the nature of warnings of how state and religion can curb reproductive rights. Where religious heads are powerful, even when state policy on contraception is liberal, there may be pressure on women under the patriarchal family structure in which religious structures hold sway, and where husbands and mothers-in-law may regard contraception as sinful. In countries offering incentives for more babies, once again there can be pressure from husbands and patriarchal families on women to become pregnant and there may be a consequent denial of contraception. And finally, when state policy is eugenic, there may be withdrawal of contraceptive facilities from the better-off who are urged to breed more, while continuing to pressurise the poor to get sterilised. Countries which initially liberalise abortion for the purpose of population control rather than for protection of women's rights are equally capable of withdrawing abortion rights either to meet their demographic goals (raising the birth-rate) or because of political pressure from conservative and religious groups.

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# Operation brainwash

The FP propaganda machinery has come a long way from the days of innocuous slogans like *Do ya teen bus* and *Delay the first, stop after the second*. In addition to using various print and audio-visual media to plug the message of family planning, the state's educational set-up is being geared up to utilise in a big way the curriculum from primary school level upwards, through what is called "population education." The dominant ideological content of the FP message which is thus sought to be propagated is: the small family is a happy family; family planning is in national interest and a veritable duty to one's country; all prevalent social and economic evils as well as the backwardness of major sections of the people are a direct consequence of population growth; the solution to this is birth-control; and, this country cannot progress unless population control is effectively implemented. We need to examine which sections of the people are being bombarded with these messages, what kind of attitudes are thus being shaped and fostered and what will be the impact of this on the direction and content of FP policy.

It has already been seen that drastic population control measures lead to erosion of human rights while leaving untouched the socio-economic structures of injustice which make the small family an unrealistic norm for the masses. Aggressive FP promotion has also been seen to aim at women of the poor sections as targets. The backlash of aggressive FP is felt more severely by women who are victims of the patriarchal society in addition to being victims of an unjust social order. The use of media and population education by the establishment contribute to the strengthening of the ideology which results in drastic population control measures and hence this aspect needs to be understood and countered by all progressive sections.

**Population education**

This programme of PE is being worked out by the Government of India in collaboration with UNESCO and UNFPA and, as can be seen from frequent news items on seminars and workshops, the dollars are being lavishly poured into the programme. To give just one example, a population education cell in the Directorate of Education in Delhi plans to have 112 workshops during a six-month period to train 5,600 teachers. PE will be introduced as part of social science and life science subjects (*Patriot*, August 23, 1984.)

It is obvious that PE will reach mainly the comparatively more privileged class which has access to formal education. (One need not quote statistics on literacy, economic background of school attenders, drop-out rates etc., to prove this fact to people familiar with the Indian scene.) A large number of the children, possibly the majority, will be coming from homes where the small family is already likely to be a norm since small families are a direct result of better living standards. In effect, therefore, Operation Brainwash will help to convince the children of the better-off that it is the poor, the illiterate and the uneducated who are breeding irresponsibly. That these people don't know what's good for them and they don't know that they are harming the country by their thoughtless behaviour. Therefore, the poor should be 'educated' into accepting family planning. If they do not respond to education, then the unspoken approval will be for compulsion for their own and for the nation's good.

PE in its present conceptualisation does not include a discussion on why the poor have large families, how socio-economic inequalities contribute to this phenomenon and how poor people fail to get contraception of their choice when they seek it. An activist who was formerly at the NCERT and is now working with Kishore Bharati in Madhya Pradesh has sent me a paper which she and two colleagues read at a PE seminar in Bhopal in 1983. Some of the examples they quote of "lessons" which may be incorporated into school level curricula are disturbing to say the least.

BOX 30

**Birth control, population control, whose control?**

*With the development of contraceptive technology, a contradiction developed between potential self-control by women and control over women's bodies by husbands, physicians, religion, state and finally, multinationals. The use of the words 'birth control' today is confusing.*

*On the one hand it may refer to the feminist view that birth control is the material basis of women's emancipation, since it can eliminate control of men over women's bodies; it is seen as the crucial effort at sexual and reproductive self-determination and at control over her own person and her own environment.*

*On the other hand, birth control has become associated with population control and so with its prescriptive, even coercive programmes, urging birth rate reduction.*

*Although population control and feminist birth control seem to have some common interests, such as better and legalised contraception, spreading of information about contraception etc., these interests diverge when we have a closer look and population control can be seen as strongly opposing reproductive self-control. Birth-control could lead to women's freedom; but when it is presented by population controllers, then a heavy sexist patriarchial bias becomes manifest.*

*Population controllers encourage the development of contraceptives because of their effectiveness and the possible health hazards are hardly taken into account. Women of minority groups or in the Third World are often used as guinea pigs in the name of "development through birth rate reduction programmes." Population controllers support legislation of contraception and sterilisation, but not forms of birth control that let women make their independent decisions. The feminist birth control movement wants of course effective contraceptives, but is very alert on possible harmful side-effects. It advocates for general women's health care and control over their own bodies through appropriate knowledge, care, medicine and contraceptives.*

*- Loes Keysers, condensed from* ***Background Papers*** *1981, BUILD Documentation Centre*

Poverty, unemployment and pollution are all described as consequences of population growth. Simplistic causal relationships are drawn. "In a house with many people, dry food is eaten, children become labourers and cannot go to school. If we have small families, we can give children food, education and clothing." Images from mythology are freely adopted - "Rama had only two sons, God Himself is pleased with small families and He destroys big families like those of Ravana and the Kauravas." There is no critique of the existing socio-economic system and population alone is depicted as the root cause of all problems.

Students exposed to this kind of reasoning from an early age are likely to accept and approve of future coercive trends in FP policy as necessary in national interest. Young people are already receiving from all quarters FP messages with a distinct class bias. At a workshop in Hyderabad *(Newstime*, February 21, 1984), the Director of the Centre for Population Studies in Osmania University, is reported to have said that educated youth must come forward to explain to uneducated youth about the need for population control. And the Vice-President, Mr. R.Venkataraman, while laying the foundation stone for a condom factory near Belgaum, stressed the need for "educating the poor" on FP programmes. *(Hindu*, Oct. 17, 1984).

A random study of letters to editors of national newspapers will show that already the literate middle-class public is very much in favour of stringent population control measures. (One letterwriter in *Newstime*, advocates life imprisonment for those who violate the two-child norm!)

Much earlier, the National Population Policy statement of 1976 had expressed the view that "public opinion is now ready to accept much more stringent measures for family planning than before." When these stringent measures were aimed at men of the disadvantaged sections, there was a political disaster. But now FP is being overwhelmingly directed at women, and with the middle-class public fully approving of stringency, the consequences for women need hardly be spelt out.

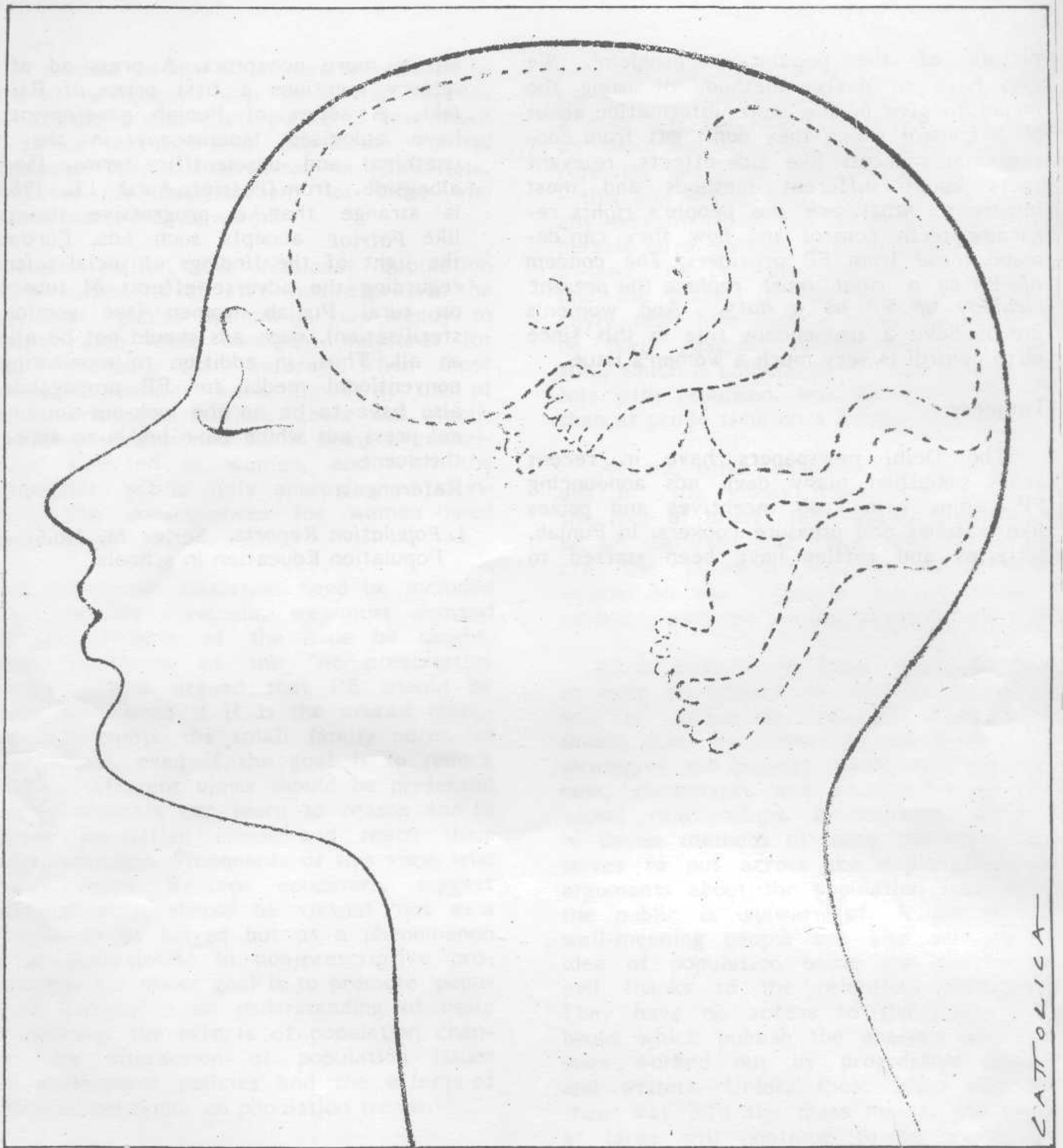
If population education need be included at all in the curricula, we must demand that all aspects of the issue be taught. Some proponents of the "non-prescriptive approach" have argued that PE should be "value-fair", even if it is the overall objective to promote the small family norm. "In other words, even if the goal is to reduce fertility, different views should be presented so that students can learn to reason and to analyse population issues and reach their own conclusions. Proponents of this view, who include many Western educators, suggest that population should be viewed 'not as a problem to be solved but as a phenomenon to be understood.' In non-prescriptive programmes, the major goal is to promote 'population literacy' - an understanding of basic demography, the effects of population changes, the interaction of population issues and government policies and the effects of individual behaviour on population trends."[1]

**Audio-visual media**

At present, the government controlled media of radio and television use jingles, commercial spots, short films, documentaries and animation films to propagate the FP ideology, and all these suffer from the same bias described in PE. Some of the short films besides being appallingly crude, also propagate sex-role stereotypes. A particularly odious short film on FP shows a man and his mother scrutinising answers to their matrimonial advertisement. After rejecting girl after girl, the 'ideal' is chosen - this girl writes that she would not expect any servant to do the housework but would herself be a servant to husband and mother-in-law. The boy then 'interviews' this girl and the match is clinched when the girl coyly tells him that a small family would be their passport to heavenly bliss. This film, which is calculated to leave one speechless with repulsion, was shown by Doordarshan at prime time on a Sunday morning.

At the other extreme are the condom ads in the glossy magazines which sell the idea of brute male aggression bordering on an instigation to rape. And in between are the numerous cartoon films which equate all the country's pressing economic problems with the population explosion.

It is difficult to know where to begin in order to counter this massive media hard sell of population ideology. Perhaps we should start by monitoring all these media strategies and protest loudly against crudeness, stereotypes and propagation of false causal relationships. In addition, we have to devise methods of using the media ourselves to put across the explanations and arguments about the population issue which the public is unaware of. A lot of very well-meaning people are also sold on the idea of population being the root of all evil thanks to the relentless propaganda. They have no access to the journals and books which publish the analysis and critiques worked out by progressive thinkers and writers. Unless these ideas also find their way into the mass media, the people at large will continue to be brainwashed by the establishment ideology. Articles in the print media, letters to the editor, TV panel discussions, especially through the women's programmes, short films, video, documentaries - we need to **co-opt** all these media, demand radio time and TV time to state our views and also make more effective use of the press to present the people of this country with a more balanced




*Drawing by Hector Cattolica*

*UNFPA 'State of World Population' Report 1984*