Contraception As If Women Mattered

by Vimal Balasubrahmanyan

CONTRACEPTION

As If Women Mattered

A critique of family planning

by Vimal Balasubrahmanyan

(FOR PRIVATE CIRCULATION ONLY)

Centre for Education & Documentation **May 1986**

Cover: Sketch by **Shirley Alex**

CED & author are grateful to **Abu Abraham** for the cartoon on page six, which he has done specially for this publication.

Composed & printed at M/s. Off-Set, 16 Chitra, Nava Shrinagar, P.L.Lokhande Marg, Chembur, Bombay 89.

CONTENTS

		Page
I	From the user's end	1
II	Ideology of population control	7
	1. Anatomy of India's FP policy	8
	2. The "population problem" dissected	15
III	Women as targets	19
	1. The IUD	21
	2. Sterilisation	26
	3. Abortion	35
	4. The pill	41
	5. Injectables	46
IV	Women and FP: further issues	55
	1. Areas of neglect	56
	2. Human guinea-pigs	61
	3. Sex selection: no girls please	67
	4. Babies are beautiful	75
	5. Religion, the state and women's rights	79
	6. Operation brainwash	84
V	1. Do women want FP?	89
	2. By and for women: a US example	92

I. From the user's end

To most members of the literate society in India, the word "population" has come to mean largely this country's most pressing "problem", and the major reason for all the social and economic ills which afflict the majority of our people. The "solution" is seen as a population control programme which, by supplying contraception, will bring down the birth rate through the adoption of the small family norm. The Family Planning (FP) programme administered by the Union Ministry of Health is the instrument for realising this objective of population control.

Because the "problem" is more or less visualised in the neuter gender, it is not adequately acknowledged that the FP programme is overwhelmingly aimed at women. Because of its integration with the maternal and child health (MCH) component of health policy, the programme fails to reach out to those who might be interested in male contraception. This bias has been reaching frightening dimensions during the years after 1977 when the forced vasectomy campaign of the emergency resulted in an election debacle for Mrs. Indira Gandhi's government. Since women today are the primary targets of FP policy, it is time the programme was critiqued from the point of view of those at the receiving end.

At the international conference on "FP in the 80s" held in Indonesia in April 1981, perhaps for the first time, the focus was placed on "the user's perspective." The conference[1] stressed that "FP programmes need to tailor their services and the contraceptive methods they offer to the needs and preferences of the people who use them". A women's perspective of India's FP programme is a necessary starting point for proper monitoring of this programme by women's groups and health groups in this country. This booklet is an effort towards outlining such a perspective. What do women want from the FP programme and what are they actually getting? Proceeding from this question, one can begin to think of action strategies towards demanding that the government does indeed tailor FP services to meet the felt needs of the people in this country, and especially the women who, besides constituting one half of the population, bear the

BOX 1

Contraception: back to square one

Sundari Ravindran from India describes in the narrative below her experiences and the barriers she encountered in trying to obtain birth control methods:

"It's a Curse to be Born a Woman..."

I first sought contraception a few days before my wedding. Birth control was not a topic I could discuss freely with my mother, and my women friends had little experience in the matter. I turned to a doctor friend, a woman, and she injected me with Depo-Provera.

I was told that it was a very effective contraceptive. The only side-effect I was likely to experience was absence of periods, but that was nothing to worry about. It might be a few months after I went off the contraceptive before I conceived and I was not to worry.

A few weeks went by, when I accidentally came across an article about the possible side-effects of Depo-Provera, and I panicked. My first dose was to be effective for three months, and I decided I would not go back for subsequent shots.

At the end of three months, I went to another gynaecologist, seeking birth control advice. She wanted to know why I needed birth control when I had no children.

"You need some sound advice from your elders," she said "Childbirth is not something you can choose at will. You may choose now to put it off, but who knows if you will conceive at all when you really want to."

I was very upset. I did not want a child at least for the first two or three years and was not even sure I wanted one eventually! I sought help from a general practitioner, a man, who gave me a couple of packets of contraceptive pills and a prescription for future purchases. I started on the pill and continued to be on it for the next two years. I had no problems, no side-effects.

Then, I decided I wanted a child, and I stopped taking the pill. I little anticipated what was to follow. I suffered from nausea and dizziness, felt very weak and drained out and even had some spells of fainting. I became flustered at the least pretext, cried very often, and could hardly carry on my regular activities.

I consulted a doctor and was told that my problems had nothing to do with going off the pill; I was probably going through a bad period and was probably under stress. Worse still, I did not menstruate for the next two months and worried that I had become sterile.

Becoming pregnant became an obsession over the next few months, and, fortunately, I did get pregnant at the end of six months.

brunt of child-rearing as well as contraception.

In order to understand why the government has adopted such an aggressive population control policy, it is first necessary to examine the myth and reality of the poverty-population syndrome and to see how the FP programme has evolved over the years; why did it choose the directions it has taken? What is the role played by the world population control establishment in influencing this policy, and why at a global level are the rich countries so desperate to reduce the population growth of the developing nations? The first section in this booklet provides a brief overview of this background.

The second section examines the impact on women of the government's policies regarding the promotion of the Intra Uterine

After my baby was born, I was back at square one: help needed for birth control, please! I decided to try the Copper T this time, which was being inserted free-of-cost at the Government's Maternity Hospitals and Family Planning Clinics.

The first time I went, I was asked to come back on the fifth day of my period. I was sent off with a prescription for B-Complex tablets and a general health "tonic." I was treated like a dumb creature, with no explanations given for any of these instructions. When I attempted to raise questions, the doctor made impatient gestures, as if to say there was no time. And there was a long queue waiting to be attended to.

The next time I went, I was guided into the waiting room of the family planning clinic. A clerical assistant filled out my name and address, age etc. in a form and asked me to wait till I was called.

The waiting room was a cramped little place adjoining the room where IUDs were being fitted. The room was partly open, and one could get glimpses of what was going on inside. One by one the names were called out, and the women went in and out, each taking barely five minutes.

After a while, I was asked to empty my bladder and get ready for my turn. There was just one toilet for the entire maternity out-patient wing, and women were going in about five or six at a time. I was horrified and stood around for more than fifteen minutes. Finally, I gathered courage and walked in with four or five others and finished my business.

When I went back, I got a good chiding for taking such a long time. My name was eventually called out, and I went into the room. I was asked to lie down and put my legs up on the stirrups. The doctor was talking about something else with her nurse assistant all the while and suddenly remarked to her that I had not shaved my pubic hair before coming for the insertion.

I felt dizzy and nervous. And before I knew what, something was inserted into my vagina. I was then told, "It's over. Next!" The next person was already coming in. The many questions that I'd almost begun to ask were stifled in my throat. I walked out of the room feeling angry, defenseless, as if I had been stripped naked against my wishes and close to tears.

I am educated, middle-class, and have access to some information on contraceptives from magazines and journals published in English. Yet, this was what I had to endure to obtain birth-control. I dread to imagine the lot of the many poor and illiterate women in this and other countries. It's no wonder that many women believe that "It's a curse to be born a woman..."

*– **Women's World**, ISIS June 1985*

Device (IUD), sterilisation, abortion, the pill and the injectable. The third section covers a further range of issues relating to the topic of women and FP: the neglect of male contraception, barrier methods and natural family planning (NFP); the use of human guinea pigs in contraceptive research; the selective abortion of female foetuses; how religion and state policy on FP attack women's rights; the neglect of safe childbirth and lack of help to overcome infertility under an aggressive anti-natalist policy; the use of media and now, population education to strengthen the myth that population is the root cause of all social and economic evils.

The final chapter sums up the dichotomy between women's demand for birth control as a human right and FP programme which ostensibly exists to meet this demand. What are the areas of conflict and convergence

BOX 2

Controlled by Patriarchy

One woman whose mother-in-law was against her son having himself sterilised, expressed her willingness to undergo the operation if her husband permitted. It appears that even on the question of family planning women do not, by and large, feel they have an independent decision to make and take their cues from men or elder women. One young woman had already borne four children and was pregnant with the fifth. Her husband was a gambler and did no work, she and her mother-in-law worked in the field and in the house. On being questioned, though her husband admitted that they did not have the means to support so many children he laughed and said, "How can we stop having children? This is God's gift." Any attempt to talk directly to the wife was forestalled by the mother-in-law who said, "What is the use of his getting operated? She can still bear children by other men." One 23 year old woman had evolved a very unique and effective method of birth-control. She was a devotee of Kali and claimed that if her husband touched her he would be struck down by the wrath of the goddess. A small boy from the neighbourhood narrated to the team how her husband had actually collapsed when he approached her. He was later reported to have said: "I felt as though I was struck hard by an invisible hand." The way this woman had, consciously or unconsciously, used religion and superstition, and manipulated it in her favour, is remarkable.

-**Women in Focus** (Kumud Sharma et al) 1984

and what is the women's movement's stand on family planning?

To keep this booklet down to an optimum and manageable length, I have avoided including the kind of details and information about contraceptive methods which are readily available to the target readership from other sources. The CED Health Cell itself has already produced two Counterfacts on the injectable and the pill which are additional sources, and most women's groups and health groups have access to copies of *Our Bodies, Ourselves,* published by the Boston Women's Health Collective, which has indeed become a sort of Bible for the global women-and-health movement. In this booklet priority has been given to discussing policy implications and issues, and I have included the kind of information which will contribute to making the total picture of the **politics** of FP clearer. It is hoped that the book will provide ideas for action by activist groups through a broad framework for monitoring the FP programme. Hopefully also, women's studies units will be stimulated into initiating research in those areas where information gaps exist. Wherever possible I have indicated the existence of such gaps and the need for further data collection.

I have also outlined WHO norms for safe provision of different FP services as well as various policy statements by the population control agencies. These will give monitoring groups a basis for demanding that the FP providers conform to the safe and humane criteria laid down by their own authorities. Lessons from other countries have been cited wherever relevant.

I have tried to give as many examples as possible for women's actual experiences with the FP programme and its personnel, many of which illustrate the sharp contrast between stated policies and what happens in reality. Some of the examples from Bombay were sent to me by an activist friend from information which was gathered during the field work of the Society for Promotion of Area Resource Centre (SPARC). It would be useful if the women-and-health movement were to set up a central clearing of information regarding the experiences of women from different socio economic sections and regions in their search for, and use of, contraception. Micro-level studies in social science research abound with examples of the total lack of rapport between health personnel providing FP services and the women they are expected to reach. But we

BOX 3

Double Burden

Once a couple attains the desired family size, it is mainly the woman who bears the on-going fear of further pregnancies, knowing that the responsibility for additional children - or abortions - rests upon her. The physical risks and hardships for women as they resort to village-level abortions for unwanted pregnancies are predictably high. That women usually feel obliged to seek abortions without their husband's knowledge reflects the oppressive degree to which their lives are controlled by men. This subordinate position of women also partially explains why the number of "official" abortions performed in medical institutions continues to be only a tiny proportion of the estimated total. The reasons for this are several: transportation expenses, lost wages and a general suspicion of the government FP activities are all important factors. But it is also true that for most village women it is unthinkable for them to ask "permission" from their husbands to seek abortions at these centres, or equally as unthinkable for them to make such a journey alone under some other pretext. As a result, safer, institutional abortions remain for the most part out of their reach. Thus, in the general effort to limit family size, women bear not onlya greater burden than men, but in addition, an entirely unnecessary physical burden and this is so precisely because they have so little control over their lives, reproductive and otherwise.

- Sheila Zurbrigg, ***Rakku's Story****, 1984*

need a mthod by which information related to women and FP can be sifted out from these larger studies and put together in a body of information which in turn will form a wide data-base for action.

It should not be forgotten that patriarchy and oppressive living conditions greatly inhibit women's access to birth control. No FP programme imposed from above can help unless there is fundamental social change. Abuses have crept into the programme precisely because FP personnel seek to control women's reproduction while leaving every other aspect of their lives unchanged. Therefore, even as we demand that FP policy be made accountable to the people, we must remember that birth-control is but one aspect of the total women's movement whose goal is structural, social and economic change.

Reference:

1. *Studies in Family Planning*, Vol.12, No.6/7, June/July 1981.

If they can't get bread, let them eat the Pill

"To control the reproduction of the poor people is a piece of cynicism unless they have themselves asked for it and unless they are allowed to take active part in the planning of such a programme. To facilitate people to plan their families according to their own wishes is a different matter of course. If a women finds it essential to limit her number of children, she should be given the opportunity to do so, but she should also be given the right to education, a productive job, a stable economy, a meaningful social standard and other fruits of a well-planned development. Population control means people are controlled by others. Family Planning means that people control themselves. The two concepts are irreconcilable."

- Lars Bondestam, *Poverty and Population Control*, 1980

"If anyone accepted we were beaming with joy": One more acceptance! "People used to say birth control was written on our foreheads." - A field official involved in one of the earliest FP projects in Punjab, quoted in ***The Myth of Population Control****, Mahmood Mamdani, 1972.*

II. Ideology of population control

The Indian Government's overriding emphasis on the small family norm and the consequent trends in its FP policy need to be understood in the context of the world Population Control Establishment's obsession with bringing down birth rates in the developing countries. So total is the hold of the population bogey on the minds of the literate sections in this country that it is also necessary to examine the myth and reality of the poverty-population syndrome. The two sections in this chapter attempt to outline the total picture which in turn will offer a basis for a critique of the FP programme.

Anatomy of India's FP policy

The year 1921 marked the beginning of rapid population growth in India mainly because of the change in mortality and fertility rates. Life expectancy rose and death rates declined as a result of plague eradication, famine relief and control of malaria and smallpox. Public health measures and medical technology also helped. However, while various health programmes have had an impact on the survival of children crossing the age of five, infant and child mortality are still very high and this remains a crucial factor determining the trends in birth rate.

The 1981 census placed the current population of India at 685 million, second only to China's 971 million. The present growth rate is estimated at 2 per cent which means that about 13.7 million people are being added to the population every year.

The World Population Plan of Action (UN 1974) had stated that "countries which consider that their present or expected rates of population growth hamper their goals of promoting human welfare are invited to consider adopting population policies". Most developing countries today, including India, pursue an "anti-natalist" policy to discourage fertility. The concept of 'planning' or 'planned parenthood' coupled with a policy of using incentives and disincentives is a characteristic of the anti-natalist policy.

India was the first independent country in the world to adopt in 1951 a policy of reducing population growth through a government sponsored national family planning programme. Earlier, in 1941, the population sub-committee of the National Planning Committee had already identified population growth as a *cause* of poverty and underdevelopment. (This false equation remains the basis of the population ideology of the Establishment.)

Plan period 1951-85: FP has been given a progressively higher priority in each plan, and higher budgetary allocation. **However, at least in principle, the Planning Commission has never considered population control as a substitute for socio-economic development.** (As many writers have pointed out, the Indian FP scene is characterised by a yawning gap between stated policies and actual goings-on at the field level.)

An FP cell was set up in the Planning and Development section of the Directorate-General of Health Services in 1952. FP from the beginning has been the responsibility of the Health Ministry, a Centrally sponsored and financed programme implemented by the states. By the Third Plan, a full-fledged department of FP was established within the Health Ministry under a Minister of cabinet rank. It was also redesignated as the Ministry of Health and Family Planning. ('Planning' was changed to 'Welfare' by the Janata Government in 1977 in an effort to neutralise the unsavoury aura which came to surround the very phrase 'family planning' after the excesses of the Emergency.)

In 1966, the Central Family Planning Council was set up with the Health Minister as Chairman, with similar councils in the states. The same year, a Commissioner of FP was appointed to head the Department of FP, whose rank was elevated in 1974-75 to that of a Joint Secretary. Though the commissioner's post was held by a medical doctor, the upgraded post has always been held by an IAS officer.

In the states, the State Family Welfare Bureau is headed by a Joint Director of FP and Maternal and Child Health, with an officer of the rank of Secretary to head the cell in the Secretariat. Implementation of the FP programme is through the PHCs while the urban family welfare centres have patterns of staffing varying with the size of population to be covered.

Four different styles of approach have been tried out over the decades in an effort to bring down the birth-rate.

BOX 4

Too many people?

Doesn't the fact that there are now at least 500 million undernourished and starving people prove that there isn't enough food or land for everyone to be adequately fed?

To diagnose the cause of hunger as scarcity of food and land is to blame nature for people-made problems. In doing the research for ***Food First: Beyond the Myth of Scarcity*** *we have learned that the earth's natural limits are not to blame. Hunger exists in the face of abundance; therein lies the outrage.*

The world is producing each day, two pounds of grain - more than 3000 calories and ample protein - for every man, woman and child on earth. A third of this grain now goes to feed livestock. On a global scale the idea that there is not enough food to go around simply does not hold up. But global figures mean little. What counts is whether adequate food-producing resources exist in countries where so many people go hungry. The resources ***do*** *exist, we have found that they are invariably underused or misused, creating hunger for many and surfeit for a few.*

According to the FAO, less than 60 per cent of the world's cultivable land is now being cropped. Grain yields in the underdeveloped countries could more than double before reaching the average yields of the industrial countries. In most of these countries, land presently harvested once yearly could provide two or even more harvests. Barriers to unleashing this productive capacity are economic: Wherever there is unjust, undemocratic control over productive resources, their development is thwarted.

In most countries where people are hungry, large landholders control most of the land - and they are the least productive. Land monopolised by a few is inevitably underused. The wealth produced is invariably ***not*** *reinvested for rural development but drained off for conspicuous consumption and for investment in industries catering to the fancies of urban and foreign well-to-do.*

Low productivity also results from economic and social injustices. The influential landowners monopolise access to extension services, markets and non-usurious credit. Without individual or shared ownership of land, how can tenants, sharecroppers and landless labourers either be motivated or have the wherewithal to conserve and improve the land for better crops?

Co-operation is the most essential ingredient for development. To build and maintain irrigation systems or control pests, everyone in a village must work together to be effective. But, co-operation is unlikely when there is grossly unequal ownership of land and productive resources.

Apart from measuring underused potential, we must also assess the ***misuse*** *of resources. When the majority do not have the buying power, agricultural resources will be made to serve those who can pay the domestic upper strata and high-paying markets abroad. Luxury crops expand while basic food crops are neglected. In 1973, 36 out of 40 of the world's poorest countries - those classified by the UN as being the most seriously affected by inflated world food prices - exported agricultural commodities to the U.S.A.*

When the earth's tremendous productive capacity is underused and when its bounty is increasingly siphoned off to feed the already well-fed, scarcity can hardly be considered the cause of hunger.

Condensed from: ***Food First: Beyond the Myth of Scarcity****, 1978, by Frances Lappe and Joseph Collins with Cary Fowler. (Institute for Food and Development Policy, USA)*

CHRONOLOGY OF THE AMERICAN POPULATION MOVEMENT: 1921-1974

Related developments in history	Focus of concern for the population establishment	Strategy for control of world population	Year	Important events of American Population Control Movement
Russian Revolution (1917) Great Depression (1929-39) World War II (1939-45)	Fear of "race suicide" Eugenics	Birth control "to stop multiplication of the unfit", more children for the rich and the superior; immigration restriction policies	1921-1945	Establishment of American Birth Control League (1921) Passage of Immigration Restriction Act (1924) Establishment of first research instituion on population (1922) India considers national birth control programme (1935) Large-scale birth control programme approved in US possession Puerto Rico (1937) Merging of eugenics and birth control movements (1940)
Independence movement of colonies (1945-55) Chinese Revolution (1949) Korean War (1950-55)	Scarcity of resources from countries with "exploding" populations	Formulation of strategies to control the "exploding" world population	1946 1948 1949	UN accepts Joint Anglo-American proposal for establishment of Population Commission Establishment of International Planned Parenthood Federation (IPPF) US State Department's Malthusian explanation for the "loss of China"; Vogt's book "Road to Survival" published
Cuban Revolution (1959) Alliance for Progress (1961)	Preparation of necessary means to implement strategy of world population control, development of contraceptives, collection of demographic data, social science research to identify determinants of population growth	"Conquest of public opinion" and building of coalition to pressure US government to fund population control programmes in developing countries Efforts to win international support for world population control; "population control is necessary condition for development"	1952 1954 1958 1959 1960 1961-1963	Williamsburg Conference for establishment of the Population Council World Population Conference (Rome); widespread distribution of Hugh Moore's "The Population Bomb" Ford Foundation grants $9 million to assist India's national family planning programme Draper Committee urges US government to give foreign aid for control of population in developing countries Rockfeller pleas to shift burden of population control from private sector to government Beginning of series of full-page advertisements in major newspapers by Moore Fund to urge public to pressure government

Related developments in history	Focus of concern for the population establishment	Strategy for control of world population	Year	Important events of American Population Control Movement
				to finance world population control programmes; advertisements such as "Population Explosion Nullifies Foreign Aid" refer particularly to failure of Alliance for Progress in Latin America
Escalation of Vietnam War Spread of national liberation movement	Implementation of population control programme (mainly bilateral programmes) Debate on "Will family planning programmes succeed?"	Pressure on developing countries to accept population programmes, on developed countries to join in financing them, and on UN to endorse them	1965	President Johnson's historic announcement to "deal with the explosion in world population"; AID begins to fund population control programmes; famine in India (1965-1966)
			1966	UN resolution to assist nations upon request in field of population
			1967-1968	Population control condition ("self-help") tied to US food aid, World Bank Pearsor Report coincides with UNA-USA Report and subsequent establishment of UNFPA in 1969
			1969	Moore's Campaign to Check Population Explosion continues from 1967 to 1969, culminating in President Nixon's message to Congress on population
Rise of nationalism and intensified opposition in Third World countries to foreign control of resources, UN Special Session on Raw Materials and Development; UN Ocean Conference (both in 1974)	Growing recognition of failure of "family planning" approach; need for broad-based "development" approach	Intensification of pressure.	1970	Marked progress in AID funding of population control programmes in developing countries
		Toward the climax; WPC and adoption of the WPPA; legitimization of global population control.	1971	UN designates 1974 as World Population Year and schedules World Population Conference (WPC) in 1974
			1972	Commission on Population Growth and American Future headed by Rockfeller advocates "stabilization" of US population
			1974	World Population Year, World Population Conference, and World Population Plan of Action (WPPA)

Source: Bonnie Mass; **Population Targets: The Political Economy of Population Control in Latin America,** 1976 pp 44-45.

Clinical approach: When the Indian FP programme started, the Western Clinic model was initially adopted. Voluntary agencies like the Family Planning Association of India (established in 1952 and affiliated to the International Planned Parenthood Federation) and the Red Cross established FP clinics. It was assumed that those who wanted advice on contraception would unhesitatingly visit these clinics. These were heavily funded from abroad. The rhythm method was the officially sanctioned method in the First Plan. (But information on barrier methods was also offered.)

Extension approach: Since clinics had little impact on the birth-rate, the Third Plan stressed a change in approach to "extension" which would include an educational slant aimed at changing knowledge, attitude and behaviour of people in regard to family planning.

Camp approach: Mass vasectomy camps were introduced in 1961 when the first such camp in the world was organised by the Maharashtra government - 1,400 men were sterilised in three days. In 1970, another massive camp was held in Kerala where 15,005 vasectomies were done in a one month period. During 1971-72, about 61 per cent of the 2.19 million vasectomies performed were done in mass camps. Government personnel at all levels were involved in organising camps and an element of coercion soon began to appear in the way some of the camps were organised.

In 1973-74, the camp approach was officially played down and the budget was reduced by Rs. 6 crores. The reason given was that, in a larger perspective, camps were counter-productive as they needed careful management and precaution. Insanitary conditions had already resulted in several deaths. (Despite this, sterilisation camps were the highlight of the Emergency years.)

The National Population Policy announced in April 1976 outlined long-term measures like raising the marriage age and improving female education. The most controversial part of the statement was the proposed legislation for compulsory sterilisation of couples who had had a certain number of children. Only Maharashtra actually tabled a Bill to this effect.

During the Emergency, in 1975-77, the number of sterilisations shot up. In 1975-76 it was 2.65 million, a 97 percent rise over the figure for the previous year. In 1976-77, it went up even more to 8.11 million, an increase of 210 per cent. Targets were over-achieved, especially in the north, which is traditionally an area with low acceptance. The capital city of Delhi surpassed all other areas with 477.6 per cent achievement of the 1976-77 target.

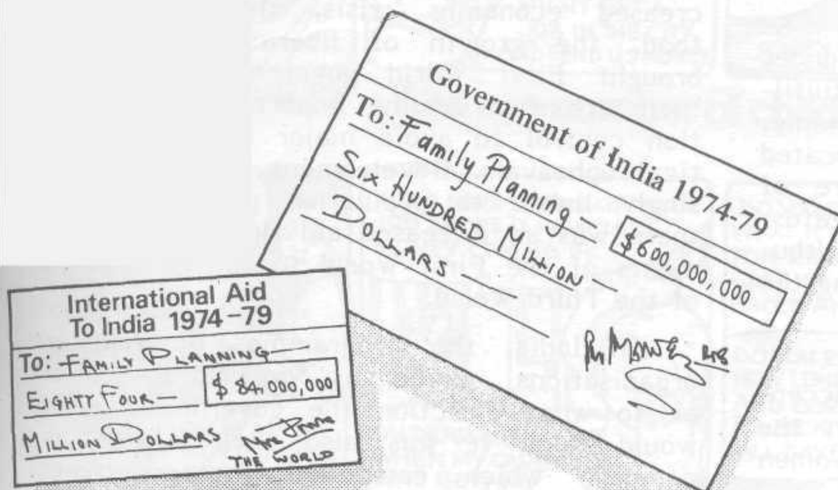
The intensive sterilisation period was characterised by the use of incentives and disincentives. The range of penalties was large and the sterilisation operation became a pre-condition for jobs, promotions, pensions, housing, education for one's children, ration cards and licences. (Social Science research studies done subsequently abound with examples of how unscrupulous motivators lured by the motivation money, thrived during the period, and brought unsuspecting young men without children to the operating table.) Several deaths resulted from insanitary arrangements. "The National Population Policy was implemented in a manner that was an assault on human dignity."

The integrated approach: Although it was recognised in principle even in the first two plans that FP needs to be associated with maternal and child health, the approach to the Fifth Plan spelt out a formal integrated approach reflecting a change in strategy. The Minimum Needs Programme set out in the Fifth Plan covered areas like education, health etc. and initiated this process of integration. At present the FP programme also includes immunisation of infants and children with triple antigen, immunisation of expectant mothers against tetanus, and prevention of nutritional anaemia and Vitamin A deficiency. The multi-purpose workers' scheme, started in 1973, is expected to carry out the integrated FP-cum-health education programme through the PHCs.

In principle, the FP policy is based on a

'cafetaria' approach of offering all available methods of contraception, but at different points of time different methods have been given emphasis. The Medical Termination of Pregnancy Act was passed in 1972. (Abortion is not technically under Family Planning and is not officially described as an FP method but as a health measure. However, it is definitely used as a population control tool.)

During the brief tenure of the Janata Government, FP had a low profile but with the return of the Congress (I) government to power in 1980, the integrated approach found a place in the revised 20 point programme. There has been a renewed stress on the target approach, reviving with it, the disturbing question of coercion, incentives and disincentives. The official approach to FP remains dominantly a camp approach, and is a far cry from the enlightened stand taken by India at the Bucharest Population Conference where Development was described as the best contraceptive.



From the First to the Fourth Plans, the allocation for FP steadily increased while the health sector allocation remained almost stagnant. The trend changed for the first time in the Fifth Plan with its focus on minimum needs and with the recognition in world population control circles that the high rate of infant mortality must be tackled before any impact on birth rate can be made.

During the decades from 1951 onwards, India, *like* other developing countries, has also received liberal foreign aid for FP from governments, UN agencies, and private agencies. These funds have fluctuated between 8 per cent to 23 per cent of the public expenditure on FP during the 70s. The quantum of aid appears to have been directly related to the stress on target achievement.

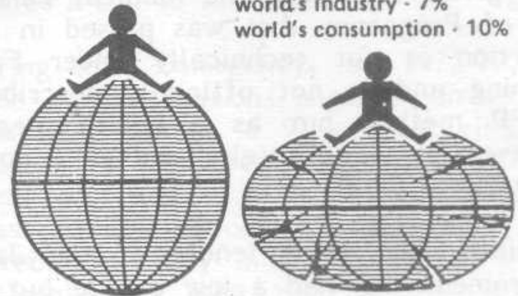
The FP programme, as it exists today, aims at containing population growth not overtly through coercion but by taking advantage of the poorest sections of society. The poor, especially in the rural areas, are enticed into accepting sterilisation because the "compensation" attached to it is much more than what an entire household could have earned in one month. The poor fall prey to this carrot, especially during the lean December-March period when no work is available and their savings are ebbing and survival is precarious. This is also the period when FP personnel mount pressure to achieve their own allotted targets which have to be completed by the end of March. In Maharashtra, for example, in one year i.e. 1982-83, 53 per cent of sterilisation and 69% of IUD insertions were done in the December-March period.

"This bracketing of the poor and under privileged sections of society for fulfilment of the population control programme, along with the rationale that the educated and middle classes generally take care of their own fertility because they are status-conscious, amounts to serving the Malthusian (or neo-Malthusian) end of assuring the survival of the fittest."

Over the years the burden of FP acceptance has also shifted increasingly on the shoulders of women (see Section 2 on *Women as Targets).*

Adapted and condensed from -

Population, Health and Development, (Ravi Duggal, FRCH, 1985, under publication.)



Each child born in industrialised world consumes 20 to 40 times as much as child born in developing world. So small population increase in rich world puts 8 times as much pressure on world resources as large population increase in poor world.

New Internationalist, Sept. 79.

Also see, *The Price of Assistance: FP Programme in India* by Ramala Bauxamusa, Socialist Health Review, March 1985. In this detailed article based on her PhD thesis, the author shows how the evolution of the FP programme has been influenced by foreign aid. Not only FP policy but the methods of contraception promoted were determined by the aid received directly from donor agencies or through international bodies like the UN agencies. She writes: "In the 60s the increased economic crisis, the shortage of food, the growth of liberation movements brought First World governments to focus their attention on the importance of population control to avoid major social and political upheavals. Development aid was increasingly linked to population programmes and there was an increased aid flow from governments of the First World to the governments of the Third World.

"In India, the programmes of voluntary organisations served as important pointers as to what direction the government policy would take. It was also their advice and donation which compelled the government to change prescribed contraceptives during each Plan period. It gave or promoted what it received, and tested what it was asked to, as the economic crisis made them helpless and forced them to accept assistance which led often to indebtedness."

The "population problem" dissected

The entire rationale of family planning is geared towards persuading the poor to accept birth control. If the small family is indeed a happy family, why do the poor reject a programme which is ostensibly for "their own good"? Here are some rational answers to relevant questions.

Why do the poor have so many children?

For millions of people in developing countries where there is no unemployment pay, no sickness benefit and no old-age pension, children are their only security in periods of unemployment, illness and old age. Children are not an economic liability but an economic asset and can be net contributors to family income by the age of seven or eight. They perform essential household tasks like fetching firewood and water, tending animals, cooking, cleaning and looking after siblings, thereby freeing adults in the family to take on wage labour outside. They are thus essential for the survival of the poor family. Because infant mortality is so high in this socio-economic section, and so many babies die before the age of five, it is important for these couples to have more babies to ensure that at least a few survive to adulthood. Rafael Salas,

HOW MANY CHILDREN SHALL WE HAVE?

POOR WORLD Average number of children per family – about five

RICH WORLD Average number of children per family – about two

New Internationalist, Sept. 1979

Chief of the UN Fund for Population Activities (UNFPA) has acknowledged: "Large families in the Third World are an intelligent response to people's economic circumstances."[1]

Would the poor benefit if they could be persuaded to have fewer babies?

The small family norm is a middle class concept directly arising from the cost of raising children. For the poor, whose living standards are already so low, an extra mouth to feed is not seen as a calamity, especially since the economic value of the child will soon be much greater than the cost of raising it. The poor will not benefit from having fewer babies unless the state and society are able to fulfil those economic roles now performed by children. Also, only when wages earned by adults are high enough to ensure the fulfilment of a family's minimum needs, will the cost of raising children be seen as a negative factor by the parents.

Besides, if today a couple agree to have only two or three children in "national" interest, as they are constantly urged to do, that will not necessarily mean a better life for them and their small family. As D. Banerji of the Centre for Social Medicine, Jawaharlal Nehru University puts it:[2]

"A little understanding of the social, cultural and economic profile of our country is needed to realise that to a majority of our people, life is a continuous grim struggle for existence ... If they agree to have only three children, who is going to guarantee that these children would not die and they would lead a healthy life? Who is to guarantee that they will get a better deal from society and their living conditions will be any better than now?"

Umpteen studies and experiences from other countries have shown that when living conditions improve, birth rates fall. People whose basic needs are met do not require persuasion to adopt a norm which will then be in their self interest.

Do the poor then have no felt need for contraception?

People do want to stop having babies when they have completed *their* desired family size. The FP programme, however, does not always succeed in meeting this felt need. People may want a spacing method even if they want no more babies because they want to make sure of the survival of existing children. They may not, therefore, accept the terminal method urged on them. If a single method is promoted aggressively because it is cost efficient, those who find it unacceptable for cultural or medical reasons are rarely offered viable alternatives. Besides, the entire health structure, through which FP is dispensed, is so unsympathetic to poor people's needs, their feelings, fears and anxieties, that they don't get the supportive care they need while using different methods which means they often reject contraception even though they want it.

Would the poor practice birth control if contraceptives were made freely available through mass distribution?

The experience of both Bangladesh and India has shown that a mass distribution programme tends to adopt a method oriented rather than a client oriented strategy and therefore fails to meet individual needs. Poor health-care infrastructure ensures that even those who accept a method drop out soon. In the Bangladesh experiment with the Pill, it was assumed that once the target area was flooded with the oral contraceptive, people would be induced to try it, satisfied users would influence others and so on. "While this may be true with commodities providing tangible immediate benefits and no side effects like soap, tea or soft drinks, the opposite occurred with oral contraceptives which have side effects and no immediate tangible benefits."[3]

What does "planning" mean in the context of poverty?

Deciding when to have the first baby, visualising the desired family size, and the appropriate time interval between births -

all this means "planning" as the very phrase family planning implies. Such an approach to life appears to have no place in the minds of those who struggle for survival. The UNICEF sums it up well:

"Whether or not a husband and wife will decide to plan the number and spacing of their children is closely related to their own sense of control over their lives and circumstances. Malnutrition, illiteracy, ill-health and oppression can leave people with so little sense of control over their own lives and circumstances that they are alienated from the very idea of 'planning'. To expect adults who cannot control or plan any other major aspect of their lives to suddenly start planning just their families is to misunderstand what powerlessness means. If on the other hand progress in health and education, in political participation and economic activity has helped to create a greater sense of mastery over one's own destiny - a sense that decisions can be taken, circumstances changed and lives improved then the idea of family spacing is likely to be welcomed as another opportunity to take more control over one's life."[4]

Why are the rich so concerned over the birth rates of the poor? How does this concern affect the directions of FP Policy?

The developed nations are anxious that Third World population growth should be curbed. In individual developing countries the rich elite minority are keen that the poor should accept birth-control. In India, for example, people like J.R.D.Tata have urged more investment in FP programme while big business houses like Godrej etc., have been introducing incentives and disincentives to persuade employees to accept the small family norm. Why this interest in the birth rate of the poor?

At the heart of the population control ideology is the theory of Malthus who in his *Essay on the Principle of Population* (1926) said that population grows at a much faster rate than food supply. The Malthusian theory offers a convenient explanation for poverty and hunger which actually result *from social injustice* but which are attributed to population growth. "Where unemployment, misery and famine spread and deepen, Malthus' theories offer a rescue."[5] When the exploited grow in numbers, then social upheaval, even revolution may be precipitated. The best way for the rich to maintain the status-quo is to promote the ideology that population control rather than social and economic justice will avert "disaster". Active propagation of this ideology was stepped up by the rich nations around the time when China went 'Communist' in 1949. It shocked the imperialist world which decided it must "Save India at least."[6] Since then, with the propagation of the population bogey and the theory that the poor are poor because they are too many, what is being effectively masked is that it is the rich minority which consumes the greater share of the earth's resources and that their concern over population growth is really because they want to maintain their own privileged position. This is true at the international level as well as within individual countries where economic power is wielded by a small minority. Hence, the tying of international aid with population control schemes and the phenomenon of Third World industrialists pressing for aggressive FP programmes.

Because of this pressure to achieve a drastic fall in birth rate without equally strenuous efforts towards raising living standards through equitable distribution of wealth, the elements of coercion, disincentives, monetary rewards and unleashing of unsafe contraceptives have characterised Third World FP programmes including the Indian programme. The Lyndon Johnson formula that five dollars spent on FP is equal to 100 dollars invested in development has meant in India a coercive vasectomy campaign, a mass IUD drive unsupported by adequate health care, unsafe laparoscopy camps, a proposed mass Pill distribution scheme despite the dangers inherent in such an approach and the imminent introduction of the hormonal injectable and implant neither of which has been approved for contraceptive use in the West. Arguments regarding the safety of hormonal contraception in mass-drives are always countered with the statement that the benefits outweigh

the risks. The question which remains unanswered by population controllers is: Whose benefit? Whose risk?

Won't FP acceptance result in a higher status of women?

It is often argued that birth-control will result in raising the status of women, but the Report of the Committee on the Status of Women[7] had rejected such a simplistic causal relationship. The report referred to several studies which have shown that improved status of women, results from a rise in age of marriage, education, employment, better living conditions and greater general awareness and that all these together *have an impact on adoption of FP methods.* The mere adoption of birth control does not necessarily mean better status although better status will make it possible for women to take decisions on birth control. The lack of control which women have over their reproductive role within the patriarchal family structure is often used as an argument by population controllers to promote methods like the injectable because these can be used by women without the knowledge of their husbands and mothers-in-law. Even if women are so desperate as to choose unsafe contraception as preferable to repeated pregnancy, to justify promotion of such methods as being specially responsive to women's situation is to perpetuate the sexist status-quo and in no way enhances the real status of women or their right to make informed and free choices regarding their bodies and their lives.

How does the stress on FP affect other aspects of health care?

Since health services have been geared to give top priority to the achievements of FP targets, all the activities of health personnel are subordinated to the fulfilment of their FP quotas. Their entire career prospects rest on FP performance and inevitably the health care needs of people take a back seat. In Madhya Pradesh in 1984, a government doctors' association threatened an agitation if doctors suspended for "poor FP performances" were not reinstated. The report said that a *dentist* (!) of Chhatarpur district hospital had been suspended for negligence in his duty to implement the FP programme! (Indian Express, March 3, 1984).

Another side to this picture is the mutual perceptions of people and the health personnel, and the inherent inability of the health system to meet either health needs or felt contraception needs. Monica Das Gupta has described this in her study of Rampura village near New Delhi where the PHC is relatively well equipped and well-staffed because of its closeness to the Capital.[8] Yet, the staff are not able to cope with the volume of patients. The PHC is always short of drugs and thus the doctor and medical system don't inspire confidence. Even basic after-care of women who have been sterilised or have IUDs inserted is not done. The clinic workers feel superior to the villagers whom they see as illiterate and ignorant and as persons who need to be harangued to do anything rational. The patients on the other hand need recognition and fulfilment of their individual needs. The doctors' approach to FP is to catch women as they come to the clinic for treatment of a health problem and try to persuade them to accept FP. They have no time to sit and explain the mechanics of different methods. "Faced by a team of people constantly hectoring them, the villagers have become defensive in their attitude, feeling that their own values and needs are not understood, that the gap is unbridgeable - that somehow if only they can get their medicine and escape, they will be happy."

References:

1. *New Internationalist*, Sept. 1979
2. D. Banerji in *Population in India's Development* (Ashis Bose *et al* eds, 1974)
3. *Studies in FP*, Vol.II, No.6, June 1980
4. *State of World's Children*, UNICEF, 1984
5. Political Ideology of Population Control, (Lars) Bondestam, in *Poverty and Population Control*, 1980
6. Ramala Buxamusa in *Socialist Health Review*, March 1985
7. *Towards Equality* (1974)
8. Monica Das Gupta in *Feasibility of Fertility Planning* (Epstein and Jackson eds) 1977

III. Women as targets

The burden of FP acceptance has, over a period of years, shifted increasingly on the shoulders of women. From the fiftees to the sixties there was a gradual decline of female acceptors, but in the post Emergency period the acceptance of sterilisation has shifted back to the female with a great spurt. Similarly, IUD acceptance is also increasing, further adding to the number of female acceptors (see table).

There are several reasons for this shift of the burden on women. Firstly, a myth has been successfully circulated that if men accept vasectomy they become weak and, therefore, are unable to be economically active. Secondly, if a man is vasectomised and his wife becomes pregnant (it could be due to failure of vasectomy or due to vasectomy taking place immediately after fertilisation or even because of coitus within a short period after vasectomy) then the wife could become a target of harassment and her husband of humiliation - this reason has very strong support in the rural areas because several cases of vasectomy failure or 'transitional' fertilisation have occurred and as a consequence women ill-treated. Therefore, women voluntarily or otherwise prefer to accept tubectomy to protect themselves from any such eventuality. Thirdly, the main thrust of the FP campaign is through Maternal and Child Health (MCH) programme, thus women automatically become targets. Fourthly, in rural areas, where infant and child deaths are high and there is every possibility of attrition of children occurring at a future point in time, there prevails a notion, given the adverse status of women, that a man can take another wife and therefore will only be able to procreate if he is not sterilised. Fifthly, women who have to bear the burden of child-bearing and rearing, quite often voluntarily accept a non-terminal FP method (sometimes even terminal) without the knowledge of her family members. And sixthly, vasectomy as a method has been discredited because of the way it was abused during the Emergency and subsequently the Janata Party campaign made out vasectomy as an issue of an assault on male virility! Such developments are inevitable given

the approach and manner in which the FP programme is run.

Quoted from:

Ravi Duggal, **Population, Health and Development**, FRCH, 1985 (under publication)

The chapters in this section cover FP policy and the experiences of women regarding IUD, sterilisation, abortion; the Pill and the Injectable. It is women's right to decide when to have a baby, how many, and what method of contraception they wish to use. This right is denied to them not only by the patriarchal family but also by the FP establishment because of the manner in which it functions although the latter is supposed to exist primarily to meet women's contraception needs. Women are thought of as "acceptors" rather than as human beings. Women may begin by using one method and may wish to change to the other methods because of side-effects but such choices are not freely available to them although theoretically they should be according to the 'cafeteria' FP policy. Often distance and inconvenient clinic timings plus indifference of clinic staff prevent women from seeking and getting proper after-care with consequent abandoning of an FP method. Women seeking sterilisation are often turned away on the whims of health personnel, but when a 'camp' is organised, women are exhorted to come in the hundreds and they are offered incentives and other prizes so that FP targets and quotas can be met. The following pages will show how birth control methods which could work well for many women, if the total health infrastructure were receptive to their needs and problems, have failed because of the callousness with which women are treated.

The IUD

The introduction of the intrauterine device (IUD) or 'loop' in 1965 marked the beginning of the Indian family planning programme's special focus on women. Although initially popular, the programme failed for three major reasons: careless insertions by paramedical staff; women were not warned in advance of side-effects; there was no proper back-up medical care to deal with problems like bleeding and pain.[1] IUD insertions which rose from over eight lakh in 1965-66 to about nine lakh in 1966-67 quickly showed a sharp decline and fell to less than five lakh by 1968-69.

A UN mission which evaluated the programme noted that the medical staff had not been trained to deal with complications and that it had been a mistake to promote the IUD on a mass scale without the required preconditions in terms of health facilities.[2] Some commentators feel that there is little likelihood of the IUD ever staging a "comeback". The UN team, however, suggested that the IUD should be 'rehabilitated' and rescued from its state of disrepute through measures like: retraining of staff, better dissemination of information to the public and to individual clients, careful screening of potential users, through follow-up of cases, analysis of problems encountered and corrective measures at short notice.

Today the IUD appears to be recovering somewhat from its unsavoury past, especially since the new copper-T devices have been introduced. However large figures of IUD 'acceptance' do not take into account subsequent removals. In 1984 there was a major Press expose of fake IUD figures cooked up to claim achievement of targets in Maharashtra.

But to some extent women are indeed once again expressing interest in the device and many who can afford to have access to good medical care and advice are reportedly satisfied with the IUD as a convenient method of contraception. However, as will be seen from some case histories narrated later in this chapter, the measures suggested

BOX 5

Facts about IUDs

In principle an IUD is any foreign object inserted into the uterine cavity and left there in order to prevent a pregnancy. The earlier devices were simple coils of silk or metal threads. Modern IUDs are either medicated or non-medicated. Both are usually made of polyethylene or other polymers. The medicated ones release either copper or progestational steroids at a constant rate and were developed to reduce side-effects, especially bleeding. In India, the first IUD used was Lippe's Loop but now various types of copper IUDs are available. The medicated IUDs need to be changed after a time (2 to 3 years) to maintain their effectiveness.

The exact way how IUDs work is not fully clear. The most widely accepted view is that they cause a foreign-body reaction in the uterine lining which results in the rejection of the fertilised ovum and its failure to implant. Copper appears to enhance this cellular response and thus adds to the anti-fertility effect.

WHO offset publication No. 75, 1983

Early IUD Danger Signals

- ☐ Period late, no period
- ☐ Abdominal pain
- ☐ Increased temperature, fever, chills
- ☐ Noticeable discharge, foul discharge
- ☐ Spotting, bleeding, heavy periods, clots

Contact us if you develop any of the above problems.

IUD users are more likely to develop pelvic inflammatory disease (PID), which can impair fertility. Thus they need to know the early signs of PID and where to find medical help quickly. IUD users at the Emory University Family Planning Program in Atlanta, US, receive this card as a reminder. (Courtesy of Robert Hatcher)

Population Reports: Series J, No.28, 1984

by the UN team for making IUD use acceptable to the larger public have not at all been implemented.

Whose fault?

When the IUD drive was evaluated by the Indian government authorities, the blame was placed squarely on the over-enthusiastic foreign experts. While it is true that foreign (including UN) agencies had eagerly recommended the loop as 'ideal for Indian conditions, no voices of caution had been sounded by the Indian experts, who ought to have known better. As one writer points out,[3] the possibility of side effects was without doubt known in India before the mass programme was launched. There were all the pre-1966 published studies of IUD performance plus the government's own 30 clinical trials all over the country during 1962-64. *"The results were not dissimilar to later experience."* (my emphasis).

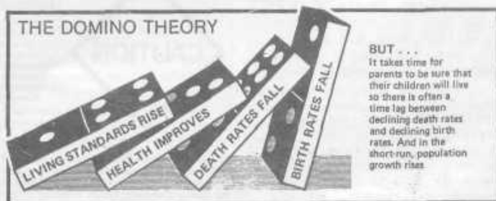
And yet, the Advisory Committee on Scientific Aspects of Family Planning which met in Aurangabad in 1965, recommended on the basis of their clinical trial that IUD be made available on a wider scale. (This phenomenon of the family planning establishment disregarding the lessons of its own proclaimed safety norms and experimental findings and going ahead to 'push' a particular method is part of an ongoing pattern. It was repeated in the case of the proposed pill and injectable programmes and also in the mass laparascopy camps as will be seen in subsequent chapters.)

WHO norms for safe IUD programme

Wherever IUD insertion is carried out, optimal back-up facilities should exist to deal with immediate complications like cramps and bleeding. A referral system must be established for cases such as perforation, excessive bleeding and where follow-up investigation and treatment is necessary. The referral centre should be staffed with a qualified gynaecologist and should have facilities for abdominal surgery and also laparascopy. Skilful insertion of the IUD is important, and whether done by doctors or paramedics, the medical personnel concerned should be adequately trained and efficient in the technique.

Counselling is important to prepare a woman for the possible initial side-effects which, if tolerated, are likely to clear up in a few months. Before leaving the clinic she should be given an appointment for a check-up and should be told how to make an earlier appointment if she has problems. According to WHO, side effects like spotting, heavier periods and cramps are common but tend to decrease after three months. The woman must be taught how to check the strings of the IUD to make sure that it's in place and what to do if she cannot feel them or suspects that she is pregnant.

The IUD should be inserted during or soon after a menstrual period so as to rule out pregnancy. Alternatively, a pregnancy test should be done and should be found



New Internationalist, Sept. 1980

BOX 6

Indications for removal of IUD

Indications for removal may be medical or personal.

Medical

- *pregnancy (only if the threads are visible and removal is easy),*
- *excessive bleeding,*
- *unacceptable lower abdominal pain,*
- *signs of pelvic inflammatory disease,*
- *known or suspected uterine or cervical neoplasia.*

Personal

- *desire for pregnancy,*
- *change of method,*
- *no further need for protection against pregnancy.*

Follow-up procedures

The objectives of the follow-up are:

- *to provide reassurance and to assist the patient is she wants to change to another method,*
- *to assess the patient's general health, including anaemia, and to treat any problems that arise,*
- *to diagnose unnoticed expulsion of the IUD*
- *to detect translocation or displacement and to reinsert an IUD, if necessary,*
- *to replace medicated devices at specified time intervals.*

The first follow-up examination is usually carried out within three months of the insertion. Subsequent visits to the clinic can be made at six-month to one-year intervals, depending on the facilities and resources of the clinic and the convenience of the patient. At each follow-up visit a history should be taken with special reference to menstrual problems, pain, possible expulsion, or removal. A speculum and bimanual examination should preferably be carried out to see whether the threads are visible and to exclude pelvic inflammation or vaginitis.

If the woman cannot, or is unwilling to come to the clinic where the insertion was performed, supportive visits and further examination could be carried out by trained community health workers, if available.

WHO offset publication No. 75, 1983

negative before insertion is done. While the plastic or inert IUDs can be left in place for as long as desired if they have been found satisfactory to the user, the copper IUDs need replacement once in two or three years. The newer, smaller copper IUDs are described as appropriate for younger women, who have never given birth, but the WHO suggests that the IUD should only be a last-choice method for such women who may try the device if no other method is acceptable to them.

The WHO notes that IUD insertion immediately after child-birth is associated with a high rate of expulsion and that six to eight weeks after delivery would be more appropriate. Regarding post-abortion insertion, the possibility of sepsis and perforation exists but insertion after first-trimester abortion has been found safer than insertion after second-trimester abortion.

IUD users are exposed to the risk of ectopic pregnancy and hence they must seek immediate medical help if they suspect they are pregnant. Often spontaneous abortion may occur. If the pregnancy continues with the IUD in place, the chances of septic abortion, premature delivery, still-birth and low birth weight are high.[5]

It has been pointed out that IUDs may increase the likelihood of anaemia because

they cause heavier menstrual blood loss.[6] This may not affect well-fed women but can have serious impact on women who do not get enough food.

IUDs and infertility

One of the 'advantages' of the IUD which is touted widely is that it is a reversible method unlike sterilisation. However, recent studies cast serious doubt on this assumption. According to two studies published in 1985 by the *New England Journal of Medicine*, young women using the IUD run the risk of being rendered infertile. Nearly 90,000 women in the USA have already lost their fertility through IUD use. According to the researchers, IUDs are more appropriate for mothers over 30 years of age who do not want any more children but do not want to be sterilised. (Patriot, May 9, 1985).

Pelvic inflammatory disease (PID)

A decade of research suggests that IUDs increase a woman's risk of PID and this may render her infertile. In 1983, the *Medical Digest*, called for careful assessment of IUD acceptors to screen out women most at risk of developing PID.[7] Younger women, women with a previous history of pelvic infection and women with several sexual partners are most likely to be affected. The report states that IUD is **not** the first-choice for women who want to be sure of having children later on.

The above information on IUD and the norms for its safe use make it obvious that it is not a method to be promoted through a 'camp' approach. Yet, as can be seen from periodic news items as well as DAVP ads, during Family Planning 'weeks' and 'months', IUDs continue to be offered through camps during "intensive family welfare" drives. 'Welfare' being a singularly inept word in this context. A typical example is a report from Warangal district (Indian Express, June 19, 1985) which boasted a record performance of 635 IUD insertions during a Family Planning drive, which was more than double the target of 300.

WHO admits that IUD use worldwide falls far short of its potential mainly because of shortage of skilled personnel and unacceptable incidence of bleeding and pain.[8] In the Indian context may be added a third reason - lack of sympathy and concern on the part of the personnel offering IUD service.

Indian women's experiences with IUD:

An activist working in the area of health sends me the following examples -

In a Family Planning clinic on the outskirts of Bombay, the IUD is promoted by extolling the virtues of the metal copper. When women experience heavy bleeding they are told the uterus is being cleaned. An IUD is rarely removed on a woman's request but if a husband puts pressure, because heavy bleeding prevents him from having sex, the device is promptly removed.

In some areas, local *dadas* bring groups of women to have IUDs inserted and part of the incentive money of Rs. 9 is pocketed by them. A month later, the women return for removal of the devices. Cases in Pune have been reported of women alternating between hospitals, getting IUDs inserted and removed. It is also reported that private practitioners do *not* get *adequate supply* of copper Ts and there are cases of women getting IUDs inserted at government centres and then "selling" these to private doctors.

Women are also being coerced into having IUDs inserted as a pre-condition for abortion. What happened to a Bihari Muslim migrant woman in Bombay, who had been deserted by her husband, is typical. Though she insisted that she did not need contraception, she had to submit to the IUD insertion or be denied abortion. Her subsequent complaints of bleeding were dismissed as a "psychological" response to desertion by her husband. Six months later, after she had endured non-stop bleeding for 15 days, an X-ray revealed that the IUD had got dislodged in the fallopian tube and an operation had to be performed.

Dr. D.N.Kakar, who has done case-studies of women's experiences with different methods of contraception, givesmany examples

of the callous treatment they get when they experience side effects.[9] These are instances of women, with a felt need for contraception and not merely those lured by incentives or coerced into accepting IUDs. In one case the woman could not contact the doctor who had done the insertion, the health worker in-charge was indifferent and so she eventually went to a private doctor and paid Rs. 10 for removal. Often women with problems seeking help at the government clinic are told to "come another day." One woman with abdonimal pain was told her discomfort was "psychological". Another woman, who was having severe bleeding, was getting no relief from treatment and paid a private doctor Rs. 15 for removal. The reason she did not approach the government doctor was because she had heard the latter tell another patient that it had become a "habit" with women to ask for removal on one pretext or another and that she was not going to remove any more IUDs.

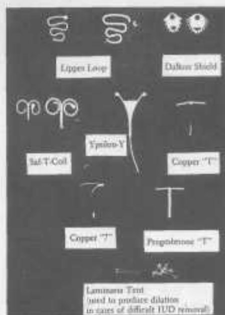
As one doctor remarks: "It is not surprising that IUDs are not popular. A health system that is unsympathetic to vaginal discharge and cervical erosion cannot be expected to be sympathetic to the needs of women with a IUD. Hence, acceptance is very low. Instead of putting up with backpain, bleeding and infection, many women prefer to complete the family and get operated."[10]

The IUD is an example of a birth cotrol method which could be acceptable to many if they also had access to sufficient medical care and advice. As will be seen in subsequent chapters, this latter aspect is the weakest spot of the FP programme, and tightening of which needs more attention and priority, if FP is to meet women's needs at all.

References:

1. *Towards Equality*, 1974.
2. *Studies in Family Planning*, No.56, August, 1970.
3. *India: Population, Economy, Society*, R.H. Cassen, 1978.
4. *WHO Offset Publication*, No.75, 1983.
5. *Population Reports* Series J, No.28, 1984.
6. *People*, Vol.10, No.3, 1983.
7. *People*, Vol.10, No.4, 1983.
8. *World Health*, Feb-March 1981.
9. *Women and Family Planning*, D.N.Kakar 1984.
10. *Women and Health*, Veena Shatrughna, SNDT University, 1985.

Different type of IUDs



Courtesy: Our Bodies, Ourselves

Sterilisation

Since the time of the first vasectomy camps of the 60s, the FP programme has continued to lay special emphasis on sterilisation as a major tool for population control. With one difference, though. The earlier pre-occupation with vasectomy has now almost totally been replaced by an obsession with tubectomy, mainly through laparascopy camps. This shift of emphasis on women, which is a backlash of the Emergency excesses on men, is likely to have serious long term consequences for the health of women, and needs urgent action by the women's movement to demand a major change in sterilisation policy.

Before the laparascopic method was introduced in a big way in this country in the early 80s, tubectomy was not a convenient option for women. Sterilisation after delivery has been popular with middle-class women who have access to hospital delivery and have been able to decide before or during the pregnancy that they wish to be operated upon after delivery. But for the majority of women who do not go to hospital for child-birth, "cold sterilisation" when they were not pregnant has meant hospitalisation and post-operative convalescence both of which they could not afford in terms of actual costs as well as time taken off from wage work and household duties. Laparascopy then arrived on the scene apparently as an answer to women's prayers and as a population controller's dream come true. An outpatient procedure, women could go home the same day and be back at their duties without any inconvenience to their households. This was the selling-point in laparascopy, and did it get the hard-sell! In 1980, there was a press report of women lining up in long queues outside a district hospital in Gujarat when they heard about this 'wonder' method.

A clear idea of the popularity graph of laparascopy emerges from a study of news items during the latter half of the Women's Decade. Late 1981 and 1982 saw a spate of press reports eulogising the new method for sterilising women. An item in the *Hindu* (January 3, 1982) entitled "Back to Camp Technique", describing the advantage of the new method and its introduction in Tamil Nadu hospitals, says: "With the number of vasectomies steeply falling after Emergency, the government has realised that women are indeed the target group for sterilisation." Two senior doctors are quoted as saying that "total absence of morbidity and mortality" is the special feature in this method. (A totally disproved claim as the rest of this chapter will show.) After headings like "Safest way of sterilising a woman" and "New FP method well-received" one also saw the emergence of items like "Scramble for higher FP incentive" and "Laparascopic camp ends abruptly" as a result of women coming in their swarms, attracted by the method as well as the handsome incentive money of Rs. 150 to Rs. 200. Organisers often ran out of funds, unable to cope with the rush. "Women outnumber men in sterilisation" said an item from Uttar Pradesh where 1.14 lakh tubectomies were performed in the latter half of 1982 compared to only 3,000 odd vasectomies.

The first indication to the public (which is not in close touch with what really happens at camps and with the women's un-published post-operative problems) that all was not well came around early 1983. The Health Minister cautioned state governments *(Hindu,* April 24, 1983) not to conduct laparascopic operations in camps and said that these should be done in proper hospital conditions with adequate pre- and post-operative care. He also warned that otherwise the method itself would fall into disrepute. The next month, *Patriot,* May 9, 1983), the Health Ministry issued a directive to all states to observe all precautions and check against dangers and complications.

However, there was no respite in the number of announcements regarding "over-achievement" of targets, with camp organisers flaunting the large figures of operations done. In June, two months after the Health Minister's warning, a "laparascope mela" was reported from Kumbakonam *(Hindu,*

BOX 7

Advantages of minilap

Laparascopic sterilisation involves the insertion of a viewing instrument and a tubal occlusion instrument into the abdominal cavity through one or two small puncture-type incisions. The Fallopian tubes are occluded either by electrical methods or by applying a clip or ring. In ***minilaparatomy****, or minilap a small incision is required but unlike laparascopy the method permits direct visualisation of the tubes. Each tube is brought to the incision and occluded by tying it with a suture or a clip. Post-operative procedure is the same for both: observation for several hours and then discharge. There are possibilities of injury to major blood vessels in laparascopy. Bowel injury is reported in both. Bladder injury is more common in minilaparatomy.*

Injuries during minilap are detected readily during the procedure and are usually repaired through the same incision. Injuries during laparascopy are less likely to be noticed. This method also needs introduction of gas which adds to the risk of morbidity. Incomplete sterilisation is higher in laparascopy - the risk of accidental pregnancy depends on the tubal occlusion technique.

Laparascopy is technically more complex than minilap and should only be done by gynaecologists with specialised training who also have experience in diagnostic laparascopy. The rate of complications is less when the procedure is done by experienced surgeons.

Minilap can be safely performed by physicians with only basic surgical experience after minimal training. Even paramedics can be trained to perform minilap as seen from the successful scheme at Dr. Zafarullah Chowdhury's Gonoshastya Kendra in Bangladesh.

In laparascopy, the equipment is expensive, sophisticated and complex to maintain, and also needs supporting equipment in the form of a gas delivery system, light source etc. In minilap, standard surgical equipment is sufficient and requires only cleaning and sterilising. Laparascopy poses the risk of infrequent but life-threatening complications (including blood vessel injury, bowel injury, gas embolism and cardiac arrest). The major risks of minilap are of minimal clinical impact. (The authors of this study conclude that minilap is safer.)

(From ***Studies in Family Planning****, Vol. 11, No. 4, 1980)*

June 25, 1983) where 1,225 women were operated upon in one day which, the District Collector boasted, was world record for a single day.

In December 1983, Mrs. Gandhi announced that the prize money which she received as part of the UN Population award would be utilised for buying laparascopes. And on Sanjay Gandhi's birthday she presented 12 laparascopes to leading hospitals to promote family planning, a cause dear to her late son. (*Patriot*, December 15, 1983)

Since then the newspapers have carried more reports about the adverse fall-out of laparascopy camps than glowing descriptions of the wonder method. Some inkling was in fact already emerging even before Mrs. Gandhi's much publicised presentation of the laparascopes.

In Chittoor district of Andhra Pradesh a poor turn-out was reported at laparascopy camps (*Indian Express*, July 1, 1983) and one of the reasons given was failure of operations resulting in pregnancy among earlier acceptors. Some months later, the A.P. government announced that a study would be done to assess the reasons for a fall in

acceptors (*Hindu*, Nov. 20, 1983). The newspaper reported a few reasons which had begun to emerge: The health assistants on duty at the camps were all males: the doctors did not give any individual attention to the acceptors; method failure and pregnancy occurred among earlier acceptors. A news item the next year (*Hindu*, April 27, 1984) said there was a steep-fall in sterilisation and in turn-out at camps in Anantpur district of A.P. citing one more reason "hurried enthusiasm to motivate more number of cases without going into the background of the acceptors".

Around late 1983 one also began to read news item of deaths at Laparascopy camps. In May 1984, the Rajasthan unit of the Peoples Union of Civil Liberties (PUCL) alleged six deaths of women during a sterilisation campaign, resulting from negligence by doctors. In Tamil Nadu, one 25 year old woman (*Indian Express*, June 8, 1984) died at the government hospital in Tiruttani, one week after undergoing a laparascopic operation. She had suffered a major rupture of the bladder during incision, had failed to get prompt and proper treatment during her subsequent stay in the hospital, and when she died her death was recorded as resulting from septicaemia and renal failure. The newspaper hinted at many unreported cases of complications and said that a government order had banned doctors from talking to the press. According to the reporter, the doctors themselves seemed unhappy over the continued stress on camps and "the tendency of government agencies to take disciplinary action if protests were made in the interest of public health".

The first major public indictment of the irresponsible organisation of mass camps came from the Indian Association of Gynaecological Endoscopists (IAGE) in December 1984 at a symposium in Bombay (*Patriot*, Dec. 12, 1984). The IAGE said that great pride was being taken by the authorities over the performance of 300 to 500 operations in 10 hours on a single day which worked out at one patient every two minutes. This was being done to meet "targets" and as a result the laparascope was not cleaned and sterilised properly. The doctors too made mistakes because of the pressure and load. (Hence the complications and method failures.) A detailed report on the symposium said that post-operative death rate at these camps was 10-12 per 100,000 which is far above the acceptable risk of 0.25 to 0.5 per 100,000 operations. The IAGE felt that these mass camps would lead ultimately to discarding of the procedure itself. ICMR norms allow only 25 cases per day per laparascope and the IAGE guidelines based on ICMR research have been ignored by the state governments. In fact the association, the only expert body in this country, is not even represented on the government's advisory body on laparascopic sterilisation.

The use of incentives and motivators is resulting in abuses similar to the happenings of Emergency days. In A.P. (*Hindu*, April 27, 1984), training camps are reportedly held for "dhobies, tailors, barbers and vegetable sellers to educate the masses on family welfare programmes." This appears to be a not very subtle euphemism for the practice of employing motivators, since the same item also referred to "hurried enthusiasm to motivate." In Tamil Nadu (*Indian Express*, April 9, 1984) four women were arrested for forcing an unmarried girl to get sterilised at a camp and then forcing her into prostitution. And in Buldhana district in North India, a poor widow was trapped into sterilisation (*Hindustan Times*, July 11, 1985) by the gramsevak of Gomednar village. The woman was destitute and had been told that if she had the operation she would qualify for a permanent income of Rs. 60 per month.

In Vijayawada (*Hindu*, March 14, 1984), the police registered a case when a 25 year old mother of three died after an injection before the sterilisation operation could be done. But few such instances of deaths or complications are reported or investigated. However, it would be important to follow-up the case of Sairoonbi (*Hindu*, April 4, 1985) of Dharamapur district in Tamil Nadu, who has sued the District Medical Officer and District Collector for Rs. 20,000. Despite her sterilisation operation on May 16, 1982, she conceived and gave birth to a son. She has claimed damages for failure of the

BOX 8

Feedback

A gross experience I had recently was witnessing a mass sterilisation camp at the local government health centre. About 100 women were operated on, by the new superfast method of laparascopy. The only counselling before the operation was: ***Nothing will happen to you. You can be active after the operation.*** *After the operation the women were given routine supply of antibiotics and pain killers. No other follow-up. One woman from an outlying village was operated upon. When I saw her a week later, she was not able to move about freely, still had swelling and pain, and her bandage had not been changed. The wound was not cleaned, she was unable to visit the clinic and when her husband went to enquire he was told to apply warm compresses. They bought antibiotics from their own money as the routine supply was not enough to fight infection, especially when there is lack of hygiene. When I made enquiries at the centre, the nurse in-charge could only say: "They are illiterate. It's all psychological."*

- Mangala

Condensed from ***Manushi****, No.21, 1984*

A qualified nurse who with her doctor husband is working in the area of primary health care in a Bihar village sends me this account of a 35 year-old woman who had seven children:

"She was a particularly daring and determined type and persuaded me to take her for sterilisation. We walked five miles and then caught a train to reach Giridih government hospital. The lady doctor I had earlier spoken to was away but a male doctor agreed to do the operation. She was given ether anaesthetic. Soon after the operation started it was apparent that the doctor wasn't confident or competent. He found it very difficult to find the fallopian tube and kept enlarging the incision. The technician giving the ether began to help him. Then another doctor came in, smoking a cigarette. He stood over the woman's open abdomen smoking - apart from the risk of infection, we might have all been blown up! She had a lot of pain afterwards and had to spend a good deal of the Rs. 90 she was given for buying antibiotics. She refused to stay in the hospital and came home and I took the stitches out. Not surprisingly, I haven't taken any more women for sterilisation."

operation.

It is relevant to point out here that in 1984, the IPPF and the Centres for Disease Control did a global mail survey of 1,298 doctors from 80 countries to study sterilisation-associated deaths.[2] It was found that most deaths resulted from surgical complication, septic conditions and anaesthetic complications and could have been prevented by ensuring adequate training of staff, use of sterile equipment and proper follow-up procedure. The study suggested that surgical teams need to be taught how to deal with complications and should be able to transport the patient to a place with proper equipment if complications develop.

Regarding anaesthetic complications, Dr. N.D.Motashaw of IAGE is quoted[3] as saying that oversedation is the most common error, with doctors overlooking the fact that thin, under-nourished women cannot take the amount of sedation that well-fed city women can. She also says that simple pre-operations examinations to rule out contra-indications are not being done because of the targets and quotas to be fulfilled at mass camps.

The above account shows that the tubectomy drive of the 80s suffers from the same problems and abuses which characterised the vasectomy drive of the 70s - luring of acceptors, pressure on doctors to achieve

targets, neglect of minimum precautions, and poor after-care. The 'come-and-be-sterilised' hard-sell in laparascopy followed its initial PR build-up as a method which will guarantee absolutely no interruption of women's work routine and domestic responsibilities. It should be noted that apart from the complications described, women who undergo sterilisation often experience altered menstruation and back pains and laparascopy **does not eliminate** these side-effects. This is something that they are not made aware of when they are encouraged to accept the operation on the strength of its ease and speed.

Two other aspects of the current stress on laparascopy need attention:

One is its impact on rural women whose work involves a lot of bending and stretching and who therefore experience much pain in the pelvic area and lower back region after the operation. Joyce Pettigrew's case study of a woman in Ferozepur district of Punjab[8] shows how the tubectomy operation affects her work capacity and thereby her relationship to her children and family. Since the work-conditions to which a woman returns after her operation are not altered in any way and since her own status within the family does not allow her to demand her post-operative rest as a right, the sterilisation operation places an additional and unjustified demand on her. This same finding was made by another researcher in a study of women in UP and Haryana (*Statesman*, Jan. 10, 1985).

The second feature which causes concern is the government's studied neglect of programmes aimed at men. This has meant that women are being compelled more and more to shoulder the burden of contraception and sterilisation. Alaka Basu describes this[9] as the unanticipated consequence of FP and the Emergency. She says that tubectomy figures are higher today primarily as a result of government policy identifying women as targets and not simply because women themselves are eager to opt for it. Her argument is that vasectomy is not being promoted at all while tubectomy is being promoted vigorously. She quotes the conclusions of the First International Conference on Vasectomy at Sri Lanka in 1981:"The greatest hindrances to increased acceptance of vasectomy appear to be lack of services in appropriate settings, reluctance of programmers to initiate services and lack of specific information on what vasectomy is and what it is not. The conference felt strongly that in no society or culture are male attitudes to vasectomy so negative as to be unamenable to change and reiterated that vasectomy is even safer and more widely deliverable than female methods of surgical contraception."

If vasectomy is to be revived adequately by the FP programme, not only men but women also need to know enough about it and understand its advantages over tubectomy.

BOX 9

Counselling is important

*According to the WHO (**Offset publication** No. 26, 1980) counselling before sterilisation is important, and those choosing this terminal method should be made to understand clearly the permanent nature of the operation. Further, the WHO recommends that the attitudes and concerns of both partners should be explored, and the relative merits of male and female sterilisation or other contraceptive methods should be discussed.*

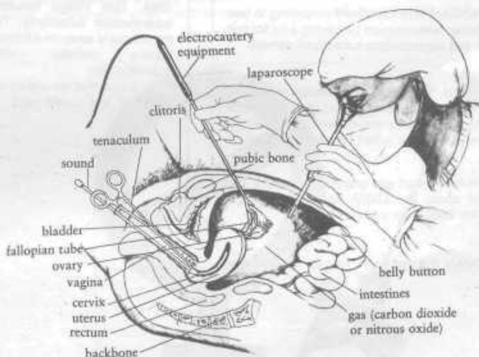
*One study of sterilised men and women seeking recanalisation (**Journal of Family Welfare**, Sept., 1984) showed that of the 100 cases reviewed, almost half had no children at the time of sterilisation and about 4 per cent had only one child. Activists frequently report cases of sterilised women bitterly regretting the operation after the death of one or more living children. Though one does come across occasional newspaper reports of successful recanalisation, the extent of success as well as the extent of availability of the procedure being low, for all practical purposes men and women who opt for sterilisation need to mentally accept the permanence of their decision.*

In a study on factors affecting the decisions to undergo tubectomy,[6] it was found that women themselves often prefer tubectomy to vasectomy for the husband because of considerations for the husband's health, especially if he is the sole bread-winner, and fear that his work may suffer or that he will be unable to perform particular kinds of activities like cycling etc. The author suggests that both men and women should be educated that vasectomy has no harmful effects on a man's physical, psychological or sexual health and that his capacity for hard work will not be affected.

Against this backdrop of information what should women's groups and health groups do? One, we should insist that ICMR guidelines for safe laparascopy be adhered to. Two, demand that sterilisation should not be done in 'camps' and that targets should not be fixed and thereby try to minimise the scope for abuse and negligence. Three, we must demand that equal attention be paid by FP officials to the promotion and provision of vasectomy, use of media to highlight the many advantages of vasectomy, to allay fears about the effects of this operation and to urge men to share the responsibility of birth control. In addition, we need to demand wider availability of hospital childbirth so that women wishing to undergo tubectomy can have it done after delivery when they would be able to have the required rest and freedom from physical strain. This minimum respite from customary chores generally is not denied them at least for a short period after delivery.

References:

1. Padma Prakash, *EPW*, March 17, 1984.
2. *IPPF Medical Bulletin*, October 1984.
3. *Eve's Weekly*, March 23, 1985.
4. *EPW*, June 30, 1984.
5. *EPW*, March 9, 1985.
6. *Journal of Family Welfare*, March, 1984.



Courtesy: The New Our Bodies, Ourselves

Christine Bondante

Some true

An Indo-American encounter in a Punjab village

ROPAR — A newly-married American couple abruptly stopped their tourist van outside a Govt. health-centre in a roadside village near here and anxiously enquired about the availability of Nivaran (abortion) and Taambi (Copper-T). Both the services were already well-advertised in newspapers. But the question was of a foreigner's eligibility. Their offer of handsome fees was politely refused. The freezed husband and wife were in dire need of the services. This led to an argument between the American lady and an educated woman-patient present there.

AMERICAN WOMAN: Perhaps you don't know that this costly Taambi is manufactured and supplied by my country. Any woman can easily buy this service for about Rs. 1000/- there.

PUNJABI WOMAN: Perhaps you don't know that every married eligible woman here can get this service not only free of any charge, but with some cash incentive also.

AMERICAN WOMAN: It is absolutely surprising to hear this all. But the Indian women must be paying a lot for purchasing Nivaran and laparoscopic tubectomy service.

PUNJABI WOMAN: No, I had a laparoscopic tubectomy only yesterday. Rather, I was paid a good cash compensation in addition to a top-quality service and a free two-day conveyance. Few days back, I had free Nivaran also.

AMERICAN WOMAN: Had you been in my country, you would have paid about Rs 3,000/- for a laparoscopic tubectomy and Rs. 2000/- for a Nivaran.

PUNJABI WOMAN: It is really shocking for me to hear all this.

Setting a honeymoon controversy

A simple Punjabi woman has triggered a world-wide controversy over the meaning of honeymoon. Here are facts: 1980 she was married; 1981: She had first baby; 1983: She had second baby.

Thanks to top-quality care, she looks more beautiful than before. Her young husband looks stouter and smarter, 1984. This village beauty accepted laparoscopic tubectomy. These days, the couple is away on a honeymoon trip, leaving children with their grandmother.

"It is now that we realize what honeymoon is", the couple says.

life stories

The beautiful landlady without mercy

She was not feeling at home in her newly-built big farm-house and wanted to have a good tenant for a portion of the bungalow. One fine morning, a lady teacher, who was recently transferred to the village approached the landlady.

"Number of children?" asked the landlady frowningly.

"Only one, it is three months old", said the lady teacher in a trembling voice.

"What is the guarantee that you won't multiply soon. My previous house was awfully spoiled by a football team mis-called family. The helpless parents could not afford to pay the rent even. I forewent two years rent to get the house vacalted.

"But I shall pay the rent punctually".

"I can consider your case provided you get a Taambi (Copper-T) inserted".

".........?"

"Don't worry, I have very pleasant experience of this method. It is not only aesthetically acceptable, but 100% effective also; now it is available near here".

"But...."

"What pregnant again!! Did you want all this!!!"

"No, not at all, I am rather panicky. Even my husband is angry with me".

"Then, first get a Nivaran (abortion) from the primary health centre, near nere. Do you agree?"

"Yes, I do".

"And you must have the second child within four years, followed by a tubectomy".

"I agree".

"O dear then come in and be seated in the drawing room, (yells) O Preeto's Papa, here is our house-partner. (Landlady's husband comes) Preeto's Papa, this young lady teacher is quite sensible. Would you kindly prepare some tea for us? (to the lady teacher). Since I accepted laparoscopic tubectomy last month the landlord has become a little more obedient".

Landlord: (to his wife) "After all, you underwent", a big operation. I avoided a small one. So I must respect you. Is this henpeckedness?"

Landlady: (to her husband) "Who says the laparoscopic tubectomy is a big operation. It is far simpler than a Taambi insertion, however, I appreciate your humility".

Happy worth-day to you

This is a true life story. A young married couple with two children hosted a big party for their near and dear ones. Their home was flooded with presents. The occasion was not a birth-day, nor a wedding anniversary.

"On this particular day three years back, we re-discovered ourselves', the boy-looking handsome husband said.

"On this day, I adopted a miracle of modern surgery—laparoscopic tubectomy", the girl-looking lovely housewife added, "it is our worth-day because we realised our worth on this day".

Then, the wife introduced the guests to a woman, "She is our guiding angel—she is an auxiliary nurse-midwife (ANM) of our area. She is today's chief guest. We request her to sing us a song, she calls it a nursery song for adults".

Then, the ANM started pointing towards the couple and sang the following song on the tune of twinkle-twinkle little star.

Rosy, cosy winter season.
Stupid cupid knows the reason.

Let there be a little romance.
Not like England or France.

Here, in the Indian life.
Between husband and the wife.

Free from fear of family way.
Free from worries work-a-day.

Happy, healthy, they have two.
They have two and this will do.

Bed of roses, pink canopy.
Through the magic 'laparoscopy'.

Family welfare amply covers.
Total health of married overs.

Let this winter be a spring.
She is queen and he is a king.

Issued by DIRECTOR, HEALTH AND FAMILY WELFARE, PUNJAB

Patriot, 13 April 1985

SEX-WISE BREAK-UP OF STERILIZATION OPERATIONS PERFORMED SINCE 1956 & IUD INSERTIONS SINCE 1969-70

Year	Number of Sterilisations			Percentage of tubectomies to total	IUD Insertions
	Vasectomy	Tubectomy	Total		
1956	2,395	4,758	7,153	66.5	--
1957	4,152	9,584	13,736	69.8	--
1958	9,189	15,959	25,148	63.5	--
1959	17,633	24,669	42,302	58.3	--
1960	37,596	26,742	64,338	41.6	--
1961	63,880	40,705	104,585	38.9	--
1962	112,357	45,590	157,947	28.9	--
1963	114,621	55,625	170,246	32.7	--
1964	201,171	68,394	269,565	25.4	--
1965 Jan- 1966 Mar	576,609	94,214	670,823	14.0	--
1966-67	785,378	101,990	887,368	11.5	--
1967-68	1,648,152	191,659	1,839,811	10.4	--
1968-69	1,383,053	281,764	1,664,817	16.9	--
1969-70	1,055,860	366,258	1,422,118	25.8	459,000
1970-71	878,800	451,114	1,329,914	33.9	476,000
1971-72	1,620,076	567,260	2,187,336	25.9	488,000
1972-73	2,613,263	508,593	3,121,856	16.3	355,000
1973-74	403,107	539,295	942,402	57.2	372,000
1974-75	611,960	741,899	1,353,859	54.7	433,000
1975-76	1,438,337	1,230,417	2,668,754	46.1	607,000
1976-77	6,199,158	2,062,015	8,261,173	25.0	581,000
1977-78	187,609	761,160	948,769	80.2	326,000
1978-79	390,922	1,092,985	1,483,907	73.7	552,000
1979-80	472,687	1,305,237	1,777,924	73.4	635,000
1980-81	438,909	1,613,861	2,052,770	78.6	628,000
1981-82*	572,595	2,218,984	2,791,579	79.5	750,000

Source: Government of India, **Year Book of Family Welfare Programme in India 1981-82**, Ministry of Health and Family Welfare, New Delhi, 1982, Tables D.2 & D.5.

Abortion

A DAVP ad. which appeared in a weekly journal in January 1984 advocated abortion with the following text: "Carrying again? You need not worry. Get your pregnancy terminated. Abortion is legal. Two is enough. Stop the third." This was a government ad. and it clearly shows that abortion is regarded by the authorities as an FP method and as a tool for population control. Officially however, on paper, abortion is not part of the FP programme and is ostensibly only a health measure. What are the consequences of this ambivalence and how does it affect women's access to abortion?

The Medical Termination of Pregnancy Act, 1971, which came into force in 1972 was aimed at reducing the incidence of criminal abortion which was taking a heavy toll of women's lives. The Act allows termination of pregnancy on therapeutic grounds (risk to the mother's physical or mental health), eugenic grounds (if the child is likely to be born deformed or handicapped), humanitarian grounds (pregnancy resulting from rape) and social grounds (as a result of contraceptive failure.) It is this last provision which enables the government to provide abortion as an FP service though it is not technically placed under the FP category. This provision also enables women to seek abortion for birth control and for limiting family size.

The Report of the Committee on the Status of Women quoted a number of studies which show that most women who have abortions do so to limit their families. The committee deplored the manner in which many hospitals agree to do the abortion only if women will accept sterilisation and the fact that often it is the doctor who decides whether or not the woman can be allowed an abortion. The report clearly asserts: "We feel it is a woman's right to have control over the size of her family." Because of these attitudes of public hospitals, despite abortion being legal, in practical terms it appears to be freely accessible only to those who can afford to go to private clinics, many of which charge exhorbitant rates. For the rest, who do not wish to accept the condition of sterilisation or IUD insertion, unauthorised abortionists are the only resort, which is why, 13 years after the MTP Act came into force, deaths from illegal abortions remain high.

> **BOX 10**
>
> ***Abortion techniques***
>
> *Induced abortion can be performed using a variety of techniques, all of which expose the pregnant women to a certain amount of risk, which, however, varies in degree. The duration of the pregnancy is the most important determinant of the magnitude of risk. Mortality and morbidity in second trimester termination are many times higher than when abortion is carried out in the first trimester. Also, termination in the first trimester is both technically and administratively very different from, and much simpler than, termination in the second trimester (see table).*
>
> *In situations where expertise and facilities are not widely available, terminations should be limited to pregnancies of less than 12 weeks, preferably 10 weeks. Even then, because of lack of equipment, the physician may have to resort to dilatation and curettage (D&C) in place of the more favourable procedure of vacuum aspiration.*
>
> ***Menstrual regulation:*** *This is a variation of vacuum aspiration which can be used in early pregnancy only up to the 42nd or 49th day after the last menstrual period, or even before a pregnancy has been confirmed. No anaesthesia or dilatation of the cervix is normally required. A cannula is introduced through the cervical canal into the uterine cavity and the contents are aspirated by a special syringe.*
>
> ***WHO Offset Publication** No. 49, 1979.*

In April 1985, the Minister of State for Health, Yogendra Makwana, told Parliament that about 4.35 lakh cases of MTP were reported during 1983-84. He said there were no precise estimates of the number of illegal abortions or the number of deaths resulting from such abortions. According to the **Parivar Seva Sanastha** which runs the Marie Stopes clinics, about 6.6 lakh women die every year because of illegal abortion. (*Times of India*, June 3, 1984).

In 1981, activists who attended a workshop on Women, Health and Reproduction organised by the Feminist Resource Centre in Bombay formed an Action Group for safe abortions which listed two major demands: inclusion of MTP as an FP service and safe abortion services for all women. The group also hoped to be able to train women activists in "Menstrual Regulation," a simple method which can be used 15 days after a missed period. A leaflet circulated by the group raised the following points:

Apart from deaths, many women have infection, bleeding, injury and other complications after abortions which are avoidable. Abortions are often carried out dangerously late (after the first trimester) because of lack of services, late diagnosis of pregnancy and social stigma. "The abortion services suffer from all the ills of the nation's health services. The problems are lack of information, limited publicity and the widely held belief that abortion is illegal." (I should point out here that the DAVP ad. in English mentioned at the outset does not reach the people who really need the information. Nor is there enough publicity to enable women to know that they must seek abortion early to avoid the health risk.)

The safe-abortion leaflet says that absence of adequate facilities and trained persons in rural areas renders the MTP Act ineffective. Even in cities, 50 per cent of the beneficiaries are the better off while mortality and morbidity rates also seem to have a definite socio-economic gradient.

Another important point raised by the action group is this: a large number of the the so-called illegal abortions being performed by **dais** and local abortionists are the only services most poor women can turn to. These have been available for centuries. By dubbing them as illegal, nothing is done to improve the situation. Mira Savara in a paper read at the Bombay workshop had suggested that women's groups should demand training for **dais** and nurses in safe abortion techniques. She also called for: vigil squads of activists who would visit hospitals regularly to see how women asking for abortion are being treated and to demand proper services; leaflets on abortion by activist groups, listing the places where these services can be obtained free.

It is relevant here to point out that although 'illegal' abortions by **dais** and non-medical people are freely condemned by the establishment, the fact remains that women who visit registered practitioners are not necessarily trouble-free. A study of complications after MTP at a civil hospital in Surat[1] showed that even abortions by 'specialists' can have complications. Out of 608 cases, 203 reported late complications including menstrual disturbance, bleeding, backache, white discharge, fever and weakness. Out of 20 cases of bleeding, six sought advice from private doctors and were diagnosed and treated as cases of incomplete abortion. In 14 cases, the women had accepted IUDs which could have caused the bleeding but despite continued bleeding the IUD was not removed. (Acceptance of an FP method is often a pre-condition for abortion in the government hospitals.)

How many cases of deaths at the hands of qualified doctors are ever investigated by the police? A few are indeed reported in the media, but it is not clear what the position in law is if the doctors are prosecuted. The Status of Women Committee had pointed out that Section 8 of the MTP Act provides an overriding protection to the doctor for any damage caused by the operation. The report says: "Since no such protection is given for other operations, this seems an unnecessary clause and may lead to negligence." Thus, apparently, **authorised** abortionists can evade conviction; but we need more information on this aspect.

Recently, two registered doctors of Delhi who caused miscarriage and eventual death of a pregnant woman were sentenced by a sessions court to 10 years RI *(Patriot,* Dec. 25, 1983). Earlier in Bombay, a 56 year old surgeon was sentenced to life imprisonment by a sessions court for causing the death of a young girl after he conducted an abortion on her *(Times of India,* Nov. 4,1979). According to the newspaper reports, in neither instance were the doctors authorised to carry out abortions. (A doctor can qualify for such authorisation after he has performed 25 successful MTP cases under supervision.) And yet, the fact that the Bombay surgeon had a flourishing abortion practice shows that the law-enforcing machinery does not of its own initiative prosecute unauthorised practitioners and it is only when a woman has died and her relatives take recourse to the law that these doctors are brought to book. The authorities are obviously content to look the other way as long as individual clients don't complain, perhaps because of the overall approval of abortion as a population control measure. This is why a doctor couple in Hyderabad is able to plaster all state-owned buses with their hand-bills advertising "abortion without D&C, only drugs" and also claiming that their services are in the furtherance of the national FP policy. This couple also has cinema slides publicising their abortion clinic. Apart from the ethics of this (and there is no known instance of the Medical Council taking action against unethical advertising) there is also the question how abortionists can use an experimental drug so widely and freely. The use of drugs (probably prostaglandim) to bring about abortion is still under trial.

One other aspect of the abortion anomaly is the moralistic and patriarchal attitude. The Status of Women Committee had found that many doctors are unwilling to perform abortions for unmarried girls. Though the law doesn't require it, a husband's consent is often made a pre-condition. Women are frequently humiliated by health personnel for seeking abortion. According to a letter to the editor *(Hindustan Times,* April 14, 1985), although a married female government employee is entitled to six weeks special leave in case she gets herself aborted, many women don't avail themselves of this leave because of fear of their colleagues' censure. Incidentally, this rule appears to deliberately exclude an unmarried government employee's right to rest after abortion, which is again a moralistic overtone, and totally unjustified.

Reportedly, the Maries Stopes clinics, which have been set up in a few cities, offer competent and reliable abortion services in a sympathetic manner, and also cater to

> **BOX 11**
>
> ***Norms for humane service***
>
> *In late 1983, the IPPF issued policy guidelines on abortion (**IPPF Medical Bulletin**, Feb., 1984) which said that in countries where abortion is legal, family- planning associations should be encouraged to ensure its provision through adequately trained personnel. First-trimester abortions carried out by skilled staff carry a very low risk of complications. The guidelines also call for sympathetic and supportive counselling to women, responsive to their circumstances and informing them clearly of the possible side-effects and complications of the procedure. Young unmarried girls need special counselling and follow-up care to deal with "residual feelings of guilt, anxiety or fear." The IPPF points out that any decision on sterilisation after abortion needs careful reflection on the part of the woman and providers of abortion should not make it conditional on acceptance of sterilisation.*
>
> *The WHO (**Offset publication** No. 49, 1979) has stressed the need for publicising information about abortion services "to allow free, easy and safe access to those who are most in need of the facilities provided. For this, the first requirement is the dissemination of information with regard to the liberalised law, the locations where free, legal and safe services can be obtained, the safety of early terminations as against the risk of later ones, and how to utilise the services."*

BOX 12

The price women pay

The following examples have been condensed from an article in **People** *(Vol. 5, No. 2, 1978) which focused on India and measured the price paid by women seeking abortions - in terms of mental anguish, physical harm and cash.*

**An ad executive, mother of two, just settled in a full-time job, found herself pregnant. She had experienced problems with both Pill and IUD and the pregnancy was a result of condom failure. Her family, husband and the doctor tried to dissuade her from having an abortion, but she managed to have her way. "I think the knowledge that under the MTP Act the woman is the sole arbiter of this decision helped." She was operated on in a private nursing home and paid a four-figure bill for two days' stay. Back home she developed high fever but the doctor refused to make a home call for "something as minor as abortion," and prescribed medicines on the phone. Three weeks later she went for a check-up since the fever persisted and she had been in bed for a fortnight. While examining her, the doctor made a point of commenting: "Really, our upper middle class women fuss so much about small things. The village women are back in the field within 24 hours but we seem to think that unless a great big fuss has been made, life is not normal."*

**A 35 year-old Harijan woman with five children, who works as a sweeper in several big houses, narrates her experience: After her fourth child, one of the memsahibs had been after her to get herself or her husband sterilised. Her husband would not consider it and she was nervous about how the operation would affect her work capacity. Many women of her acquaintance had become chronic sufferers with stomach pain and other problems. "In my work I have to pick up heavy loads, squat, bend, and be very active all the time. I can't afford not to be fit. Besides, I would have to be away from work for at least two weeks and how can I do that? They say it is only two days but I have seen so many women have the cut go septic that they are in trouble for weeks and weeks."*

When she conceived again, she was desparate and went to an old woman who had earlier helped others like her. The latter gave her a herbal medicine and there was a little bleeding but nothing more happened. Then the old woman tried to help by inserting a stick, which caused a lot of pain but again nothing happened. Eventually she picked up courage and went to the memsahib who was very angry, but she did give her a letter and sent her to hospital. The doctors said it was too late to do anything but she said she could come for delivery and be sterilised. "But I didn't go to the hospital for the delivery because I didn't want an operation."

Dr. Pramilla David, Director of the Centre for Population Concerns, Hyderabad, says in the same issue of* **People: *"Older gynaecologists who believe that abortion is morally wrong and medically undesirable still hold influential positions in hospitals. A new problem is the complication scare - incomplete or septic abortion. Lack of adequate on-site training of doctors in use and maintenance of equipment has led to more of these cases than are recorded in the statistics."*

---

unmarried girls, but the problem is that the cost of Rs. 150 to Rs. 300, which is reasonable for the middle-class, places the service beyond the reach of the poor. The organisation which runs the clinics has started a training programme for doctors to enable more MTP services to be offered. It is significant that funding for this will be done by a "Population Crisis Committee" (*Times of India*, June 2, 1984) and this once

again unlerlines the fact that abortion is very much a part of FP policy though it is never described or acknowledged as such.

Postscript

It will be recalled that during the press and public furore of 1982 against selective abortion of female foetuses, the medical establishment had more or less defended the practice as a socially responsible way of catering to women's desperate desire not to give birth to girls. And yet in early 1985, when activist groups demanded provision of MTP to gas victims in Bhopal as there was a distinct danger of foetal deformities, the authorities turned a deaf ear. According to activist reports, those who could afford it did seek and get abortion while hundreds of poor women were neither officially informed that there was a danger of birth defects nor provided abortion when they sought it. Reportedly they were compelled also to accept copper T as a precondition. The MTP Act's inclusion of "eugenic" grounds is thus nothing more than a paper provision, only meant for the rich. In April 1985, the Medico Friend Circle on the basis of a survey by a team of doctors issued a press release saying that the government must publicise the dangers to the foetus, allow women to make an *informed* choice on MTP and provide facilities for abortion. The MFC also said that conception should be avoided until all symptoms of gas poisoning disappear, and since affected women were already suffering from increased gynaecological troubles, the condom should be promoted and publicised as the contraceptive of choice of gas victims rather than the Pill or IUD. The government, whose FP propaganda has been otherwise deafening, has responded to all these demands with an ominous silence.

Reference:

1. *Journal of Family Welfare*, June 1984.

Abortion: A sketch by **Era Roy**

Relative Effectiveness and Short-Term Safety of some Common Methods of Induced Abortion

Method	Stage of gestation (weeks)				
	6 or less	7 - 10	11 - 12	13 - 15	16 or more
a) Suction curettage only	Safe, simple method, requires no dilatation. Not always effective	Safest method	Safe	High degree of manual dilatation necessary. In <u>skilled</u> and <u>experienced</u> hands safe and effective	
b) Dilatation and curettage	Safe and simple. but does require a certain degree of dilatation	Very safe	Safe	Increased riks of cervical incompetence in subsequent pregnancies	Not used in most countries
c) Curettage (a) or (b) plus preoperative cervix dilatation	Not applicable	Reduces or avoids need for manual dilatation			
		Desirable particularly in primigravidae at 9-12 weeks, women with tight cervix, etc.		In <u>skilled</u> and <u>experienced</u> hands safe and effective. Late effects unknown.	
d) Prostaglandin. Currently available preparations. In some countries only	Vaginal suppositories safe and simple. Not always effective.	Currently less effective than methods (a)-(c)		Shorter interval between instillation and abortion than with (e) and (f)	
				Extra-amniotic technique, simpler than intra-amniotic	Intra-amniotic and extra-amniotic both effective
e) Saline or other hypertonic solution	Not appropriate			Longer inverval between instillation and abortion than with (d)	
				Extra-amniotic technique, simpler than intra-amniotic	Safer than intra-amniotic prostaglandin not yet known
f) Ethacridine lactate extra-amniotic	Not appropriate			Lower sepsis rate than (d) and (e)	

WHO Offset Publication No. 49, 1979.

The pill

The oral contraceptive pill has been available in India since around the mid-sixties but was for a long time not 'pushed' in a big way by the FP programme. The Pill needs to be prescribed by a doctor, potential users have to be carefully screened to rule out contraindictions, and women on the pill need access to medical advice and care not only for coping with side-effects but also to be advised to discontinue the pill if certain other disease conditions should develop e.g., diabetes or hypertension or liver problem etc. Under the present health structure in this country, mass distribution of the Pill would not be safe, because these precautions cannot be met. The government and medical authorities had themselves acknowledged this and for many years, even though some of the South East Asian countries had liberalised Pill distribution, the medical Establishment in India had refused to recommend a mass Pill drive.

Obviously, at some point of time India too would succumb to the pressure of the World Population Control Establishment and all of a sudden decide that a mass Pill drive is indeed safe after all. In 1981, an ICMR task force suggested that the government should adopt a relaxed policy and allow personnel other than doctors to distribute the Pill after "adequate training to screen potential users at field level." Unwilling to learn the lessons of the IUD drive, knowing fully well that the theoretical paper plan would be far removed from the actual field situation, the ICMR also chose to ignore the findings of its own earlier Pill studies which had shown a high drop-out rate because of side-effects. In 1981, the government allowed auxiliary nurse midwives (ANMs) to distribute the Pill and less than a year later in 1982 the newspapers splashed the Health Minister's announcement that Pill distribution by village level health workers would be introduced very soon so as to raise Pill acceptance from the prevailing 1.1 lakh to two million by 1983-84. The programme was supposed to have been initiated in selected states and the results of the experiment are not yet known to the public. We must demand information on how the pilot programme worked, and exactly how potential acceptors were screened and recruited; what kind of support and care they got while they were on the Pill, how many are continuing to use it, what were the reasons for discontinuation among the drop-outs, what was the incidence of irregular or incorrect use of the Pill, and what were the consequences of the latter. This should be made public knowledge in much the same way that the mass Pill programme was announced with so much advance publicity.

BOX 13

Norms for a safe Pill programme

The WHO has drawn up extensive guidelines for screening potential Pill users, monitoring them while they are on the Pill, a check-list of contra-indications as well as indications for discontinuation. (*WHO* ***Offset Publication*** *No. 64, 1982*). *According to these norms, women should be re-examined three months after starting the Pill and again at six-monthly intervals. They should have a Pap smear every two years and an annual examination of breasts and pelvis. Women with certain side-effects need to be seen more frequently and if a change in type of pill is needed, it should be carefully explained to them. Women with depression need special observation and the Pill discontinued if necessary.*

Low-dose pills with 30 or 35 mg of estrogen should be used and a higher dose 50 mg Pill should be considered only if there is unacceptable breakthrough bleeding. A minimum of four types of pills should be stocked to enable a switch-over in type to deal with specific side-effects. Lactating women should not be given the pill. If irregular pill-intake results in pregnancy, there is a possibility of birth-defects. The need for regular intake should, therefore, be carefully explained to the Pill user.

In March 1983, the Hyderabad branch of the Indian Women Scientists' Association (IWSA) wrote to the Health Minister urging him not to go ahead with the proposed Mass Pill programme.[1] Many IWSA members were doctors, some of them were ICMR scientists and they knew from their field experience, the way the health system in this country functions and the kind of access women have to health care in the rural areas. They said that a mass Pill programme under these conditions would be positively dangerous. A look at the WHO's guidelines and norms for safe Pill distribution by non-medical staff will show how unrealistic it is to expect that these criteria will be observed adequately all over the country (see box). Besides, past Pill studies have persistently shown that mass Pill promotion has no place in the Indian FP programme under the present health-care structure.

According to one writer,[2] the government has earlier conducted trials at 300 centres all over India, covering about 10,000 women to study the medical and social acceptability of the Pill, the object being to decide what should be the FP policy regarding this method of contraception. "The special committee which reviewed the experience considers that the Pill may not be accepted in any mass programme, but should be administered in closed communities under medical supervision." Its continued use is not advisable. There should be intervals of non-use. The National Institute of Family Planning analysed the experience of 1,512 acceptors and found that 46 per cent discontinued after six months, 61 per cent after 12 months and 73 per cent after 18 months. Those who found the Pill acceptable were from educated and middle class background.

Various Pill studies have shown that side-effects are cited as the main reason for discontinuation:[3] Dizziness, vomiting, nausea and irregular bleeding have been found hard to cope with when there is no access to sympathetic advice and treatment. Individual case studies[4] show how women who fail to get advice and treatment feel discouraged and give up the Pill. The disruption of household work as a result of what the FP people always describe as "minor side-effects" is something that doesn't seem to weigh very heavily with the health personnel when their help is sought. One feminist doctor tells me that during the early years when Pill effects were being studied, women in the West who complained of "depression" were not taken seriously because depression tends to be readily dismissed as psychological or just plain imaginary. But now medical research has conclusively shown that depression is indeed a very distinct side-effect of hormonal contraception (including injectables). Unfortunately any side-effect which is not "life-threatening" is always listed last, under the 'minor' category and the fact that conditions like dizziness or depression make it impossible for women to carry out their many arduous tasks at home and at the work-place is never seen from the user's point of view as a problem of considerable magnitude.

Besides, when women on the Pill, experience problems, very often relief can be possible if they are able to switch over to a different brand which contains a different variety of synthetic steroids. In a mass programme which relies on bulk buying it is hard to see how much such facilities will be made available. PHCs are known to run out of stocks of even life-saving and basic drugs. In the Indian context there are also questions like: Will the government ensure distribution of only low-dose safe Pills? (High-dose pills have been dumped in Bangladesh and Sri Lanka in the past). Since the Pill is known to cause nutritional deficiency, what will be the impact of Pill consumption on the malnourished? The Pill's effectiveness is reduced when taken along with certain other curative drugs - including the TB drug rifampicin; under the present health care structure, can such situations be adequately taken care of?

The Orwellian overtones and Double-speak of Pill policy are best illustrated if one compares the remarks of two Health Ministers at different points of time. In 1982, B. Shankaranand, who announced the mass Pill drive, was quoted in the *Telegraph* as saying: "All side-effects of the Pill have been eliminated." Six years earlier, in 1976,

Dr. Karan Singh, the then Health Minister, in an interview to *People*[5] had explained why the Pill could not be promoted in a big way in India: "Contrary to Western belief, the Pill is not all that simple. It's a remedy for affluent urban society but is not at all suitable for mass consumption in the villages. It is expensive; it requires constant daily motivation which is impossible, when a village woman has a hundred domestic chores to attend to, apart from having to work in a field several miles away, and it **has undesirable side-effects.**" (my emphasis)

The fact is, if the FP wallahs are not interested for the moment in pushing a certain method, they are willing, even eager to acknowledge the truth about its problems. At that time when Dr. Karan Singh made these remarks, India was poised for its infamous sterilisation campaign. The Health Minister was then busy convincing the world about the need for "civilised pressure but not coercion." Between 1976 and 1982 not only has the Pill *not* become safer (nor its side-effects eliminated), but newer studies are casting further doubts about its long-term risks. But the Indian media image of the Pill is curious. In 1982 when the new Pill policy was announced, the papers were full of the news of a WHO study suggesting that the Pill might actually protect against ovarian cancer. The *Hindu* even had a half-page article in its Sunday section with the heading: "Not causative but preventive." At that time, Indian doctors, who had worked with the WHO, published articles in leading newspapers playing up the "positive" effects of the Pill and playing down the dangers. However, when in 1983 the *Lancet* published two studies which linked pill use with both breast cancer and cervical cancer, the Indian media more or less ignored it except for a cursory news item, although the findings created an uproar in the West.

The fact is that emerging Pill studies are throwing up confusing and conflicting evidence about long-term cancer and other risks. Every such study is being assessed by WHO and other agencies. Meanwhile, in the West, women are getting tired of putting up with the side-effects of the Pill and questioning why they should be endlessly tampering with their bodies' natural function and why should not men and women share the responsibility of birth control, by using safer, less invasive methods. The swing back to condoms, diaphragms and spermicides in the developed countries will have its impact on the Pill sales of the drug multinationals. The spurt of activity towards increasing the level of Pill consumption by Third World women should also be seen as part of the quest for markets and profits by drug MNCs.

> **BOX 14**
>
> ***Selection of type of Pill***
>
> *Every woman should receive a pill that is effective yet possesses the greatest possible safety margin for her. In accordance with current medical knowledge it would be advisable to start with one of the combination pills containing 30 ug of estrogen. At the present time this amount of estrogen is the lowest dose required for reliable inhibition of ovulation in every cycle. One of the problems seen with the use of low-estrogen pill is a slight increase in the incidence of breakthrough bleeding, especially in the first few months of use. The patient should be informed of these side-effects and only if they persist beyond 3 months should an alteration in the hormonal dosage be considered. Concetraceptive pills containing more than 50 ug of estrogen have been withdrawn from use in most national programmes. Since the risk of accidental pregnancy is likely to be higher when low dose pills are missed for one or two days than when one or two higher dose pills are missed, the importance of regular pill-taking should be emphasized to all patients.*
>
> ***WHO Offset Publication** No. 64, 1982*

A word about advertising. The new Pill policy aims at roping in the private sector, using the help of drug firms to reach out to chemists and doctors through their network so as to increase Pill use and to

promote "social marketing"[6]. We need to monitor the promotional activity and literature envisaged under this strategy. Examples from other Third World countries show the unethical extremes to which drug firms can go while promoting their products, to both doctors and the public.

In Bangladesh, the Pill, with the apt brand name of *Maya* (illusion) is advertised to the lay public as a product which will "keep the woman in you alive and young" besides improving the complexion[7]. The promotion leaflet supplied to doctors omits any warnings of side-effects or precautions for use. Population controllers are very much in favour of non-medical distribution of the Pill and its sales promotion to the public. Malcolm Potts, for example[8], notes with approval such consumer advertisements for the Pill as *"Minovlar* costs less than a packet of cigarettes and is safer - see your doctor" and "Eat *Anoblar*, the edible contraceptive" in some South East Asian countries. Before the Ershad regime came to power, I remember seeing a Pill commercial on Dacca TV which was no different from the usual soap, cosmetic or soft drink ads. We not only have to investigate the nature of promotional literature being prepared in conjunction with the mass Pill drive but also be vigilant to prevent unethical promotion to our public through the mass media.

So far one has seen the pitfalls in mass Pill promotion. Does the pro-Pill attitude mean that at least those who actively want the Pill will be able to readily get it? Not necessarily. The government's stress on sterilisation of those whom the government considers as already having "too many" babies means that these mothers will not be given the Pill even if they beg for it. As this example shows: Maimuna, a Bihari migrant in a Bombay slum has six children and a drunkard of a husband. Her eldest son is 12, she is desperate not to have another child, refuses to have tubectomy because she feels she must wait for a few years to ensure survival of her children and... *she wants the Pill.* She is confident she will not "forget" to take it regularly and that she can consume it without her husband's knowledge. Her motivation is very strong, but she has been refused the Pill. *Women like her do not need spacing methods, they must accept a terminal method.* This being the policy, it is the doctor who has abrogated the right to decide what contraception women like Maimuna may be allowed to use. So what she does now is to pray that Allah will keep her husband away with his drink and not enter her hut or bed.

BOX 15

Indications for discontinuation of the Pill

Medication should be discontinued under the following circumstances:

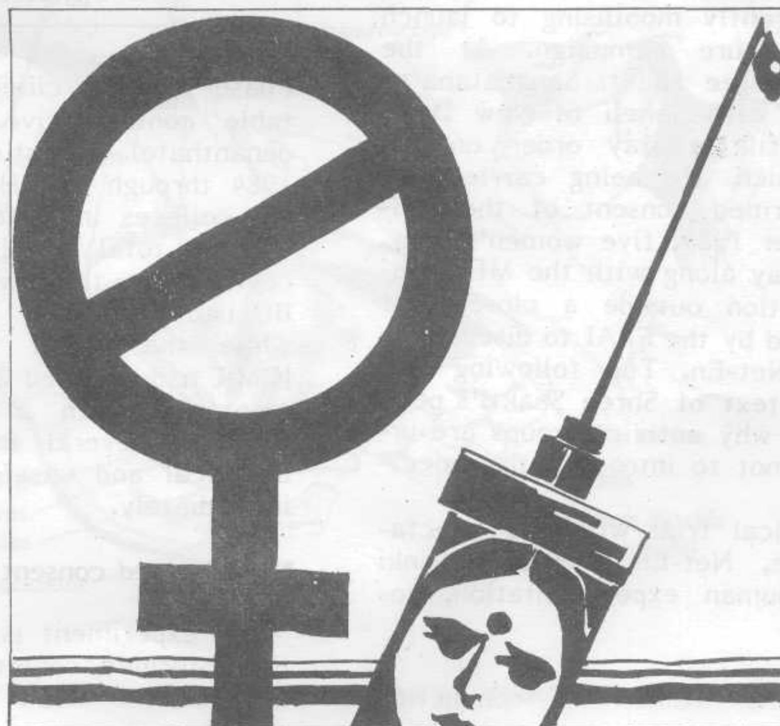
- *Suspended pregnancy;*
- *Thromboembolic disorders, such as thrombophlebitis, pulmonary embolism, cerebrovascular disorders, myocardial ischaemia, mesenteric thrombosis, and retinal thrombosis;*
- *Visual defects, partial or complete, proptosis, diplopia, papilloedema, or ophythalmic vascular lesions;*
- *Severe headache of unknown etiology or migraine;*
- *Epilepsy, if aggravated;*
- *Migraine when requiring treatment with vasoconstrictors;*
- *Elective surgery;*
- *Jaundice;*
- *Appearance of hypertension;*
- *Occurrence of apparently hormone-related depression; and*
- *The woman reaching 40 years of age.*

Pill policy is also affected by the incentives and monetary rewards given for sterilisation. At a Family Planning Foundation workshop in October 1982, one of the presentations was a review of a Karnataka study which revealed the negative attitude of PHC doctors and ANMs towards the Pill (*Hindu*, Oct. 10, 1982). Some of these health personnel deliberately decry the Pill to persuade contraception seekers to accept sterilisation, as a result of which they, i.e., the personnel, can earn motivation money as well as advancement in their career.

And finally, the risk-benefit argument. It is the policy of population controllers and also the WHO to suggest that the health hazard factor, which is weighed so carefully in the West, is not relevant to Third World countries where maternal mortality is high. We are told that in countries like India, the risks of child-bearing are far greater than the risks of hormonal contraception (one hears this argument in case of both Pill and injectables. The scientific approach, however, would be to weigh the risk of one contraceptive against the risks of *another contraceptive.* One could thus assess whether the Pill is safer than, or less safe than, IUD, barriers, injectable and so on. If the argument were *contraception* is safer than child bearing, one could still consider the statement for its logic, but one must ask: Why should only the Pill be promoted as safer than child-birth? Why not other methods? Keeping this in mind, consider the following statement by Dr. D.N.Pai, who wants the Pill to be widely distributed in 567,000 villages by the non-medical community: "Our pregnancy mortality rate of 300 per 100,000 is far higher than the pill's mortality rate abroad of 35 per 100,000 in the West and widespread oral contraceptive use will actually help save lives[9]." This is the sort of spurious argument women's groups have to counter especially because without scrutiny the argument may actually be believed by many people - including doctors, the editorial writers and the literate public.

References:

1. *CED Counterfact No. 7,* Pills for All?
2. *Status Study on Population Research* (Demography), S.P.Jain, 1975.
3. *Status Study on Population Research* (Behavioral Sciences), Pareek and Rao.
4. *Women and Family Planning,*D.N. Kakar, 1984.
5. *People,* Vol.3, No.4, 1976.
6. *People,* Vol.10, No.2, 1983.
7. *Bitter Pills,* Dianna Melrose, Oxfam 1982.
8. Potts, a medical doctor, is a leading figure in World FP circles. These examples are from his introduction to *New Concepts in Contraception* (eds Malcolm Potts and Clive Wood, 1972), where he cites this approach as a "radical" solution to the "problem" at individual and community level.
9. *SNDT Newsletter,* Feb. 1984.



Injectables

Two injectable contraceptives, Depo Provera and Net-En are being used in a number of Third World countries. They contain different types of progestins, or synthetic hormones, and their 'advantage' over the Pill is that the latter has to be taken every day whereas one injection confers infertility for several months. Since injectables don't contain estrogen (one of the ingredients of the Pill), the estrogenic side effects of the Pill are avoided. However, menstrual irregularity is the major side effect of the injectable and when bleeding is excessive, the treatment frequently consists of administering estrogen. Therefore, the alleged advantage is often neutralised.

The Health Ministry is poised to introduce Net-En very soon in the FP programme. Clinical trials have been going on all over the country under an ICMR programme initiated in the early 80s. Women's groups, and health groups like the Medico Friend Circle and the Drug Action Network, are opposed to the injectables experiment and its proposed introduction in the FP programme. In Bombay, Women's Centre focused on the injectables issue as a topic for the International Women's Day on March 8, 1985, and is currently mobilising to launch an all-India signature campaign. At the time of writing, Stree Shakti Sanghatana of Hyderabad, along with Saheli of New Delhi is preparing to file a stay order on the present trials which are being carried out without the informed consent of the subjects. In December 1984, five women's organisations of Bombay along with the MFC staged a demonstration outside a closed-door meeting organised by the FPAI to discuss the introduction of Net-En. The following is a slightly abridged text of Shree Shakti's petition and explains why activist groups are urging government not to introduce the injectable:

ICMR's unethical trial with the injectable contraceptive, Net-En, flouts Helsinki declaration on human experimentation, violates Article 21:

Currently the ICMR is conducting Phase IV of a clinical trial with the injectable contraceptive Net-En (norethisterone oenanthate). The study was started in August 1984 through 45 PHCs attached to 15 medical colleges in different parts of the country. A total of 2,250 women are to be covered by this experiment. Earlier, Phase III had covered 1,553 subjects in 1983 while the initial 1981-82 pilot study of ICMR had enrolled 2,602 women. This experimentation with a hormonal contraceptive drug on several thousand Indian women is unethical and unsafe and should be stopped immediately.

BOX 16

Training of personnel

T'e training given to personnel who will be responsible for providing injectable contraceptives in any FP system must ensure that the participants:

- *understand the concepts and rationale of FP;*
- *are capable of describing the different contraceptive methods available and their risks and benefits;*
- *identify the cases that present a contra-indication to the use of the injectable contraceptives or special problems that require medical intervention and/or supervision;*
- *know how to instruct the women effectively on the expected side-effects and on the need to return for follow-up;*
- *recognise the complications and make necessary referrals;*
- *maintain basic records for management of patients and programme evaluation.*

***WHO Offset Publication** No. 65, 1982*

No informed consent

The experiment is being conducted without the informed consent of the women recruited for the trial. The drug has not been

approved for general contraceptive use in either UK or USA. The WHO scientific group convened in 1977 to review neoplasia (cancer) and steroid contraception concluded that "there are no adequate data from studies in women to assess whether progestogens used as contraceptives in the form of progestogen-only pills or as injection have any effect on the risk of neoplasis." *(Memorandum from a WHO meeting in October 1981 reprinted in Bulletin of WHO, 60(2): 199-210, 1982).* It is not conclusively proved that the drug is not cancer producing. The drug's immediate side-effects are unpleasant in the countries where it is being tried out, and has been a major reason for discontinuation by Indian women recruited for the ICMR trial. These recruits come from among the most deprived, illiterate sections of society. Women seeking abortion are also recruited for this trial, their participation being spelt out as a condition for getting MTP. This attack on human rights must stop.

We believe that every individual is entitled to knowledge of, and access to, safe birth control. The women who are receiving the injectable in the current trial are not given a chance to make an informed choice. Nor is their consent to participate in the trial informed consent as spelt out in the guidelines laid out by WHO's 1964 Helsinki Declaration (later revised at the World Medical Assembly, Tokyo, Japan 1975). We have the evidence of our own eyes and ears to vouch for this.

Members of Stree Shakti Sanghatana visited Patancheru PHC near Hyderabad where on April 1, 1985 a 'camp' was organised to inaugurate the injectable experiment. This PHC has been selected by the Osmania Medical College for the Phase IV trial. The para-medics we spoke to said that they had been assigned the task of procuring 20 recruits for the trial from the nearby areas. They told us that if they had informed any of these women that they were subjects of an experiment or that there were possible side-effects, no one would have volunteered. The women who assembled that day at the PHC were from the poorest class. They told us that the only information they had been given was: *"Injection le lo, bachcha nahin hoga."*

We believe that by experimenting on Indian women with the injectable contraceptive, the ICMR is only serving the interests of the West German drug firm Schering A.G. This is a subsidiary agency of German Remedies and some of their well-known products are Anovlar-21, Colsipar, Cumorit Oral, Testoviron and so on, most of which are hormonal preparations. The promotion of Net-En is part of the larger prernicious practice of Western multinationals which are dumping in Third World countries products that are banned or heavily restricted for use by their own governments.

History of NET-EN

Schering began clinical trials of Net-En in 1957. The first major field trials were conducted in Peru and in 1967 the drug under the brand name of Norigest went on the market in Peru. It was withdrawn in 1971 and field trials suspended after pituitary and breast nodules were found in experimental rats. Although WHO norms require that safety be demonstrated in a rodent model, Schering conveniently decided that the findings in rats were not applicable to human beings and the drug went back on the market

Today Net-En is commercially marketed as Norigest, and as Noristerat when supplied to donor agencies. Although it is known to be 'available' in at least 35 countries, it is not clearly known in how many countries it is 'approved' for use. Clinical trials with Net-En are going on in several Third World countries. However, it is significant that in none of the advanced countries, which have stringent safety standards and where there exists a vocal health and consumer movement, is Net-En or Depo Provera (the two major injectables) allowed for long term contraceptive use. On the other hand, there is enough documented evidence that injectable contraceptives have been used in some advanced countries in a racist way on coloured immigrants and other disadvantaged sections.

Side effects

The most common side-effect is menstrual irregularity which is also the most commonly observed reason for discontinuation. The irregularity occurs in several forms: unpredictable bleeding, spotting, frequent and heavy bleeding, and sometimes amenorrhea or absence of bleeding. Besides being extremely disruptive of working life and hard to cope with for labouring women, all these conditions are totally unacceptable in the Indian cultural mileu where menstruation is associated with ritual pollution. More importantly, excessive bleeding is a serious problem in a country where anaemia in women is a major disease. The ICMR's own study has shown evidence of liver damage which again is a serious contra-indication.

Among the side-effects which are known to occur but are being dismissed as 'unimportant' are dizziness, headaches and weight gain.

Cancer risk

According to WHO, the cancer causing effects of Net-En are not fully known. This is of course the main reason why the drug is not approved for use by white women in the advanced countries. Studies are being conducted in different countries (India is one) to assess the cancer risk. This means that the women being recruited for Net-En trials are guinea pigs for determining the long-term safety of Net-En. It will be recalled that in the 50s the oral contraceptive was extensively tried out on the poor, illiterate Puerto Rican and Mexican women, to assess its side effects as well as its required dosage before the pill could be declared safe for women in the advanced countries. The trial with the injectable in the Third World countries is following a similar pattern.

Return of fertility

The WHO has said that since return of fertility after discontinuation has not been clearly proved, "women who do wish to have children later should be advised to use another method." *(Memorandum from WHO meeting 1981 Bulletin of WHO* 60(2) 199-210.) (One of the women who was brought to Patancheru was young and hadn't yet had a baby.) In the Indian context, where there is a high rate of infant mortality, the risk of possible infertility is an unaccepted risk - especially among that class of women who are recruited for the trial.

Effects on progeny

It is well documented that such steroids are excreted in the breast-milk. It has therefore been recommended that mothers who breast-feed infants should not be given these steroids till six months after delivery. But women in India breast-feed upto two years after delivery according to studies conducted by the National Institute of Nutrition. Also, there is no information on the possible effects of progestogens on hypothalimic and liver function in the neonate. The WHO also gives a list of other serious contra-indications, and says that a careful screening of prospective acceptors is needed to identify women at risk. In an atmosphere of general indifference towards patients within the present medical set-up, we fear that women at risk will not be properly screened out while being recruited for the trial. (One of the women at Patancheru had a two-month baby in her arms. Considering the manner in which she and others were brought there in the first place, we have serious misgivings about the safety with which the trial is being carried out.)

Why an injectable?

It is often argued that women themselves want an injectable contraceptive since it need be taken only once in two or three months and can be taken without the knowledge of husbands and families. Even if women want an injectable, the government has no right to promote a drug unless it is established that it is totally safe. Doctors in favour of injectables argue that since all contraceptives have side-effects, why only oppose the injectables. The answer to this is that a woman who decides to accept the risks and side-effects of a particular contraceptive must be given a chance to

make an informed choice and should be given full information on the possible risks that she chooses to accept. This criterion is not being fulfilled at the current time. We oppose the pushing of any contraceptive method, be it IUD, Pill, injectable or tubectomy, where women may be lured by incentives, not given adequate counselling, do not receive supportive care for the problems caused by the method accepted, and are generally seen only as specks in the columns of statistics which go to make up the FP 'performances' of a particular state, or nameless numbers adding up to this or that health personnel's 'quota' or 'target'. It is true that IUDs, Pills and even tubectomy have side-effects. The answer is to make the use of current methods safer through better medical research and medical care rather than introduce one more hormonal method which not only has side effects but has many more long-term question marks against it.

Potential for abuse

It is easy to see why the government is eager to introduce injectables. From active decision makers (regarding contraceptive choice) women can be rendered into passive recipients, especially in a milieu where anything coming from a needle is equated with "good medicine." Women cannot 'forget' the injectable like they can forget the Pill. Nor throw it away if they can't tolerate its side-effects. Nor can it be pulled out like an IUD if it causes infection and bleeding.

The injectable ensures transfer of control from the hands of the user to the hands of the health personnel who wield the syringe. The possible scope for abuse in a system where health personnel are pressurised to achieve targets is tremendous. There is recorded evidence of similar abuses in the past when different methods were 'pushed' at different points of time - in particular, abuses in IUD promotion and sterilisation are well documented. Women receiving an injection need not even be told that it is a contraceptive drug that they are getting. Infact this kind of abuse of the injectable has been widely documented in UK where

> **BOX 17**
>
> ***Facts about Net-En***
>
> *Net-En is administered as an oily preparation by intramuscular injection. Its contraceptive action appears to include inhibition of ovulation, premature luteolysis when ovulation occurs and progestogenic effects on the cervical mucous. Effects on tubal function and the endometrium may also be involved in reducing fertility. It is most effective in preventing pregnancy when administered every 60 days for the first four injections over a period of six months, after it may be given either every 60 days or every 84 days. Doubts that have been expressed regarding the safety and appropriateness of an injectable hormonal contraceptive for widespread use are related to their possible carcinogenicity, impairment of future reproductive function, adverse metabolic effects, potential teratogenicity and other possible adverse effects on the progeny as a result of exposure either* ***in utero*** *or via breast milk.*
>
> ***WHO Offset Publication*** *No. 65, 1982*

the recipients have invariably been poor, coloured women.

The ICMR's own study strenghtens our fears in this issue. The circular to medical colleges selected from the Phase IV trial refers to high discontinuation rate during Phase III. The ICMR's own deduction is that the women discontinued because of the absence of counselling, lack of educational material given to the subjects and "very casual behaviour of clinical staff." When the disastrous IUD drive of the 60s was evaluated, the same reason was revealed - lack of back-up medical care - for the rejection of the IUD and its fall in popularity after the initial spurt.

Repeating past mistakes

No programme promoting an 'invasive' contraceptive method (like injectable, Pill

or IUD) is safe or acceptable without sympathetic medical care. Women in this country do not get even minimum primary health care; they still have no access to safe obstetrics or safe abortion. This being the case they are not likely to get adequate counselling in a high-pressure contraceptive injectable programme.

The pre-conditions which did not exist in the 60s for a safe IUD drive do not exist even today in the 80s for a safe injectable trial. The ICMR has no right to continue repeating its past mistakes at the cost of the health of this country's women.

In addition to all the above arguments, it is important to place this issue of the injectable trial in the broader perspective of people's control over the technologies that affect their lives. And this is what Article 21 of the Constitution is all about.

Shroud of Secrecy

Ever since 1983, after the first ICMR press release on Net-En, women's groups in this country have been trying to get hold of more information about the trials. They have systematically been denied access to the relevant documents. The two ICMR documents quoted in this article were procured with great difficulty - one from a highly specalised scientific journal and the other from friendly hospital sources. The object of such exclusive control by the medical authorities appears to be to prevent any informed public debate on the appropriateness of the contraceptive research policy. For too long have the people in this country been told that expert knowledge can be understood by experts only.

It is a basic right of the people of India that information affecting large sections of the public be demystified and made available to all sections of the community.

(The petition then goes on to question the rationale of using women as targets of FP since 1977, the intensive research on various female methods of contraception being carried out without informed consent and the fact that women and women's groups have no say in the decisions regarding any of these policies. See also chapter on *Human Guinea Pigs* for box item on 'Ethics of Experimentation' extracted from this petition.)

Among the grounds cited for filing the petition are: the injectable should not be administered without making public all the information regarding the drug; the authorities have no right to initiate an injectable programme without adequately equipping the rural and urban health centres and providing adequately trained staff for follow-up care; the experiment with the injectable violates women's fundamental rights under Article 21. The petition also states that the respondents "despite their knowledge of the dangers inherent in the drug have willingly agreed to undertake these trials that have and will produce havoc in the lives of thousands of women who are being experimented upon ... Population control may be one of the laudable objectives but while implementing it the governmental agencies have no authority to violate human dignity or the right to be informed or the right to a healthy life".

The respondents cited in the petition are: Union Ministry of Health, ICMR and AP State Ministry of Health. The principal petitioner is Stree Shakti and six other signatories include five prominent doctors of Hyderabad and one journalist (this writer).

Since 1983, many articles have appeared in the media highlighting the implications and politics underlying the pushing of injectables. Among the literate public, therefore, a fair amount of awareness is likely to have been created. However, the targets of the injectables programme do not belong to this section and hence the need for women's groups, civil liberties organisations and health activists to take action on behalf of the uninformed subjects. This is why public interest litigation seems to be the only way to tackle the problem. (For further reading see: *MFC Bulletin*, May 1985 and *Sunday Observer* April 14, 1985 for articles by Padma Prakash and *Eve's Weekly* July 6, 1985 for this writer's report on the campaign against Net-En.)

In addition to the issues detailed in the petition some further facts also are relevant. Ammu Abraham of Women's Centre writes[1]: A case has been registered in Bombay High Court against the Drug Controller of India and the Union of India by one Dr. C.L.Jhaveri for being refused licence to import Depo Provera from Belgium where the Upjohn company has a plant. Jhaveri is Chairman of 'The Indian Association of Fertility and Sterility' and runs a family planning clinic in Bombay. He applied for licence to import a limited quantity of Depo in its injectable form for the purpose of 'examination, test and analysis.' He argues that denying him the licence, when the government has not even issued a notification banning the drug, on the basis that the Drug Controller has 'with-held his approval' smacks of arbitrariness and that his fundamental rights under Article 14 and 19(1)(g) of the Constitution have been violated.

"The Women's Centre, Bombay and the Medico Friend Circle had applied to be made respondent parties to the petition. On February 12, 1985, the application was accepted. They have argued that Jhaveri intends to use Depo on women for family planning purpose and not for examination, test and analysis. Dr. Jhaveri has been an ardent advocate of Depo-Provera and had organised a press conference in 1984 to propogate its use in the FP programme. If Jhaveri is allowed to import the drug, then any general practitioner anywhere in India would also be allowed to do the same."

Clearly the Drug Controller's failure to issue a proper notification offers scope for litigation and ambiguity. It may be mentioned that Depo has indeed been used by certain non-government health centres in India. Dr. Hari John of Deenabhandhupuram has admitted to offering the drug to women coming to her health centre in Tamil Nadu and at an international women's health meeting in Geneva in 1981 had defended its use saying that women in India who are oppressed by the patriarchal family need a contraceptive which can be used without the knowledge of their husbands[2]. One question is, how does Dr. Hari John procure the drug when its import is illegal, and surely her using it on Indian women is also illegal? The second question is: perhaps at Dr. Hari John's centre she ensures informed choice; even assuming that this is so, how can a similar informed choice be ensured under a nationwide FP programme which has a bad track record in the manner in which it has pushed all earlier contraceptive methods?

BOX 18

Other long acting progestins

Apart from injectables like Depo and Net-En, medical researchers are working with other 'long acting' hormonal methods using progestins. These include: hormone-releasing IUDs, implants placed under the skin, vaginal rings and once-a-month oral pills.

**Natural and synthetic progestins were first added to IUDs in the early 1970s. These release progesterone daily and remain effective for about a year. Their advantages over non-hormonal IUDs are less menstrual bleeding and less painful menstruation. Their disadvantages are higher cost, need for yearly replacement, spotting and more ectopic pregnancies.*

**Implants consist of silastic rods or capsules inserted under the skin, which slowly release a progestin. Menstrual irregularity has been noted by users.*

**Vaginal rings which release hormones are of two types:*

1. Ovulation inhibiting rings which can be used for three weeks followed by removal for one week. Each ring may be used for six months.

2. Low-dose rings which do not prevent ovulation but make cervical mucus impenetrable to sperm. They can be used for several months without interruption. Rings are sometimes expelled and may be uncomfortable to either or both partners during intercourse.

***Population Report** - Series K No.2 May 1983*

Postcript:

In Dr. Kakar's book, *Women and Family Planning* (1984) he has recorded case studies of women who chose the IUD, Pill or Injectable at government FP clinics after they were given a "balanced presentation" of the three methods. (Women opting for the injectable were, however, not told that it is an experimental method which is not yet approved for general use.) Out of 34 "injection adopters" 25 had discontinued within a year. The case studies of "discontinuers" all cited unpredictable or prolonged bleeding as reasons. Some mentioned that husbands were dissatisfied with the method because of denial of sex during days of bleeding and one woman is quoted as saying that she feared marital problems as a result and hence discontinued. Thus, the argument that women can use injectables without their families knowing seems to be of doubtful validity. Further, menstruating women observe segregation and it is difficult to understand how women with unpredictable bleeding can hide the fact from the rest of the family or deny that the irregularities are caused by the injectable. In the ICMR's pilot study on 2,600 women, 68 per cent had dropped out at the end of 24 months of which 40 per cent discontinued because of menstrual disturbances.

References:

1. *Women's Centre Newsletter*, March 1985.
2. *Space Rib*, March 1982.
3. Padma Prakash, *EPW*, December 8, 1984.
4. *ICASC Newsletter*, July 1984. (International Contraception, Abortion and Sterilisation Campaign, London).

Photo by Mark Edwards *UNFPA 'State of World Population' Report 1984*

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.

References:

1. *Population Reports,* Series D, No.4, 1983.
2. *People,* Vol.12, No.2, 1985.
3. *Women, Health and Reproduction,* 1981, (ed Helen Roberts)
4. *Studies in Family Planning,* Vol.12, No.10, 1981.
5. *Studies in Family Planning,* Vol.10, No.3, 1979.
6. *Status Study on Population Research in India* (Behavioral Sciences, Pareek and Rao).
7. *Population Reports,* Series H, No.7, 1984
8. *ICASC Bulletins,* No.11 and 12/13, 1983.
9. *Fertility Control in India* (NFP as an alternate strategy) 1981, Kathleen Dorairaj.
10. *Population Reports,* Series I, No.3, 1981.
11. The Natural Way is Best, *Sunday Express,* Aug. 28, 1983.

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 noncompliance 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:

1. *People*, Vol.3, No.3, 1976.
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).

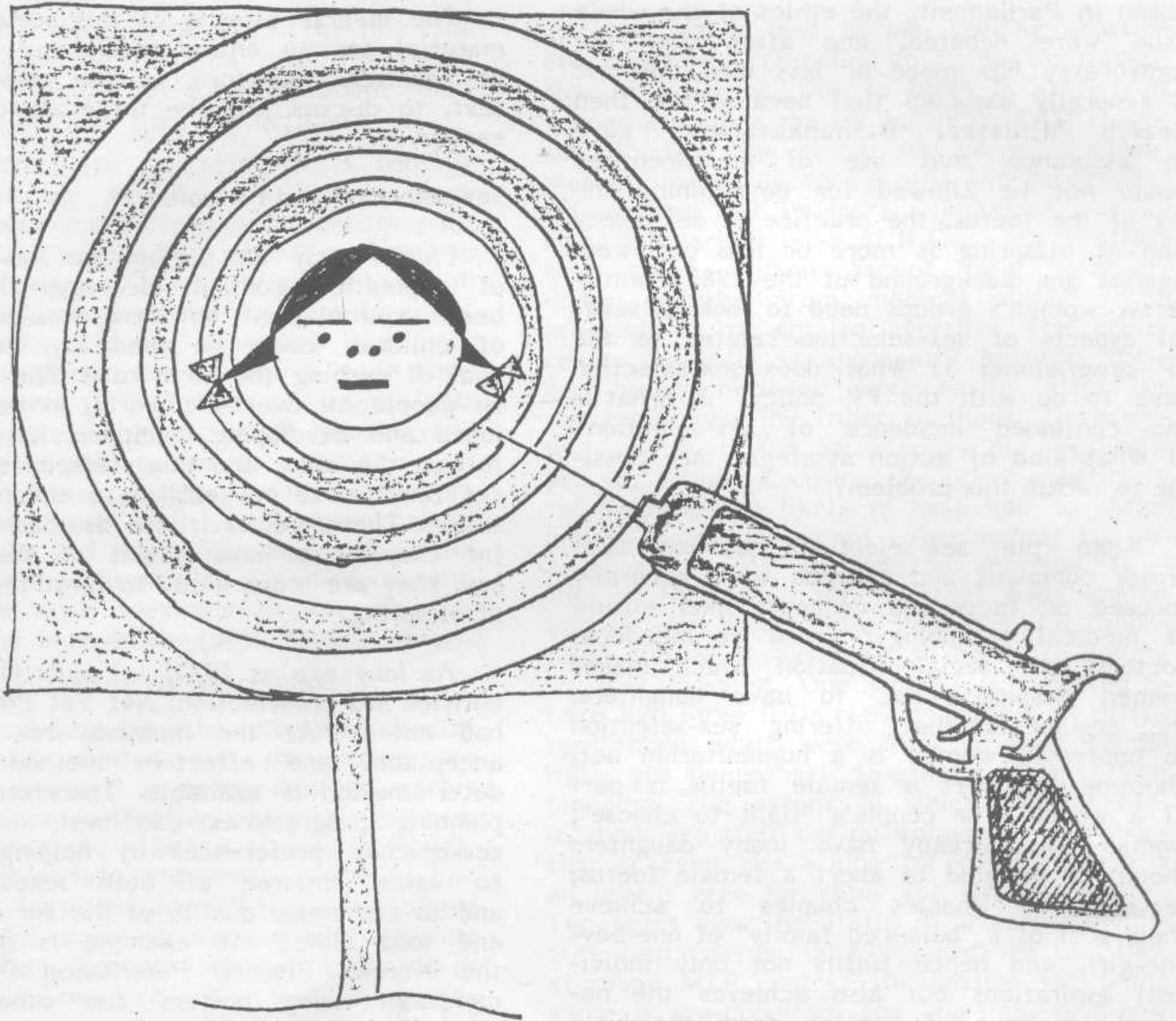
The diverse aspects of this subject offer material for an entire thesis and it would be practical therefore, in the present context, to discuss just the three aspects listed earlier.

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 pre-planning 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.

References

1. *Population Report*, Series I, No.2, 1975.
2. *Women, Health and Reproduction*, 1981 (Ed. Helen Roberts)
3. *SNDT Newsletter*, Feb. 1984.
4. Quoted in *Poverty and Population Control* (Lars Bondestam, 1980)
5. *Women's Centre Newsletter*, Feb. 1984.
6. *Personal Communication.*
7. *Women's Centre*, cyclostyled report by Ammu Abraham and Sonal, 1982
8. Vibuti Patel in *Socialist Health Review*, Sept. 1984.
9. *Pre-natal and Pre-conception Sex choice Technologies: A Path to Femicide?* (Helen Holmes and Betty Hoskins, 1984)
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.

References

1. Quoted in *The Myth of Population Control*, Mahmood Mamdani (1972).
2. Quoted in "FP in a Tamil Village" (Djurfeldt and Lindberg) in *Poverty and Population Control* (1980).
3. *IPPF Medical Bulletin*, December 1984.
4. *Rakku's Story*, Sheila Zurbrigg, 1984.
5. *Women in Focus*, Kumud Sharma with Sahba Hussain and Archana Saharya, 1984.
6. "Training of Dais" by Mira Sadgopal in *Health Care: Which Way to Go?* (1982)

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.

Reference

1. *Eve's Weekly*, Jan. 21, 1984.
2. *WHO Bulletin* 61(3), 1983.

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.

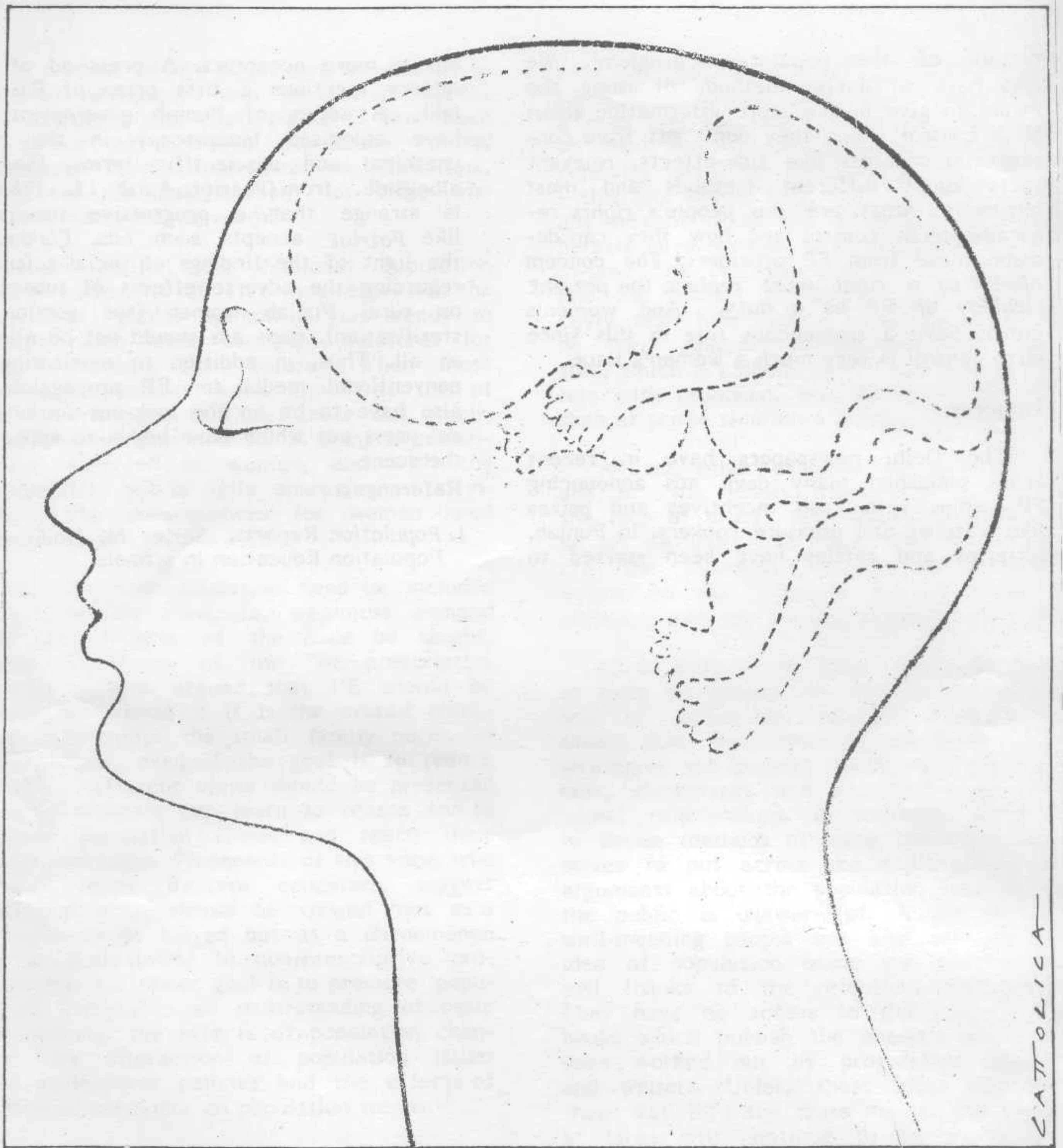
If population education need be included at all in the curricula, we must demand that all aspects of the issue be taught. Some proponents of the "non-prescriptive approach" have argued that PE should be "value-fair", even if it is the overall objective to promote the small family norm. "In other words, 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

V. Do women want FP?

Because such a thing as an FP programme exists, most women from the better-off sections, who also have access to sympathetic and competent medical advice, are more or less able to use birth control methods of their choice. The preceding chapters have shown that because of the ideology of population control and its objective of curbing the birth-rate of the poor, women from the disadvantaged sections are often not helped but exploited by the FP programme. To sum up briefly they don't have access to methods of their choice inspite of the policy statement that the Indian FP programme believes in the "cafeteria" approach. They are not given full information about the possible side-effects and long-term risks of the methods they accept. They fail to get sympathetic treatment when they experience side effects, and particularly no follow-up care. In the enthusiasm for achieving targets, basic safety norms are flouted and women's health is allowed to suffer. Abortion is often denied unless the women agree to sterilisation or IUD insertion. And sterilisation is promoted as being quick and easy without reckoning the adverse impact on women who have to resume heavy manual labour soon after the operation. Unsafe mass programmes with hormonal contraception are being contemplated although these will create further havoc in the lives and health of the target women. At the same time, the responsibility of men in family planning is totally ignored, thereby increasing the burdens on women. Women are FP targets whose felt needs regarding primary health care are not met and who still don't have access to safe child-birth or safe abortion.

Whenever women's groups protest against the directions in FP policy, they are often accused of being anti-birth-control. This is ridiculous. It is the demand of the women's movement that FP service providers should treat women as human beings without violating their dignity and their human rights. Besides, as stated at the outset, women want not only birth control, they also want equality, better status, the right to work and decent wages, and a transformation of the present oppressive patriarchal structure of society. To leave all these needs untouched, and to only offer family planning

as a universal panacea is to reject the very rationale of the women's movement.

In recent years, the population controllers have realised that education, employment, higher age at marriage, and a general enhanced female status have an impact on family size. Women's welfare programmes are drawn up *because* they may result in a drop in birth rate. On the other hand, the women's movement regards these indicators - education, employment etc. - as goals in themselves and access to birth control as one more goal in the larger campaign for equal status and control over our lives. It so happens that despite the widely disparate motives, the population control establishment may sometimes draw up policies and plans for women which are broadly in line with what women's groups are also demanding. Thus there exists a confusing dichotomy. It is vital for the movement to fully understand the women's perspective of FP in order to adopt appropriate action strategies. We should know clearly what to demand and what to reject; what to support and what to oppose.

For example, it is asked why do women's groups oppose the mass Pill programme and the injectables programme. After all, all contraceptive methods have side-effects, why oppose only injectables. The entire rationale of pushing hormonal contraception is based on a desire to control women without giving a thought to any consequences to their health. The lesson from Bangladesh is poised for repetition here. In the 70s, Bangladesh introduced a programme of "inundation" with the Pill. It was a failure and created havoc through irregular intake, especially by lactating mothers. Then an injectables programme was introduced, which has revealed that women are unable to tolerate the side-effects. Now trials are going on with the implant. This will "fix" the women effectively for two to three years. The same pattern is being repeated in India. Because of the failure to promote and encourage safe barrier methods, failure to reach safe abortion to all, failure to offer sterilisation backed by proper health care, and failure to provide IUD and Pill with adequate follow-up care, women have been *driven to* ask for an injectable, and the authorities are eager to oblige. Past failures in offering FP services are being made the rationale for promoting injectables and implants without correcting the fundamental reason for the past failure. This basic fault, which lies in the health service and the class bias of its personnel, remains unchanged and this same fault will render any programme with long-acting hormonal methods totally unsafe.

Women in the West have had to fight for birth control while here in India the FP programme began to offer contraception even before the women in this country thought of demanding it as a right. The MTP Act was passed not because abortion was considered a woman's right but because it was seen as a useful tool for population control. In fact the entire concept of birth control as a human right is submerged under an ideology of FP as a "national duty."

And yet, women do want contraception and they do want the right to safe abortion, both of which are theoretically in line with FP policy. Thus the FP progrmme and women's demands sometimes appear to converge and this is a fact we must use to our advantage and we can do this only if we clearly understand the difference in motivation. Women do want birth-control but on their own terms, as a means of controlling their lives. The women's movement rejects the use of FP as a means for government to control women's reproductive function, in isolation from other measures to improve the quality of women's lives. The movement also rejects the notion that FP is a cure for the country's many problems and demands that fundamental changes in the socio-economic structure accompany the provision of birth-control services.

A word about abortion: It was pointed out in the section on the "Population Problem" that the sense of powerlessness induced by poverty makes the very concept of "planning" unthinkable. As long as this situation is unchanged, abortion will remain the only acceptable option to many women who

want to have no more babies. Safe abortion for the masses is an urgent necessity even though the long-term goal of structural social change will hopefully, eventually, enable all people to feel confident of planning families through contraception. An activist paramedic friend working in a Bihar village writes to me: "Family planning is a virtually unknown thing for the women here. They may have some vague frightening ideas about an operation but that is about all. I doubt if the majority know it's possible to control the number of children you have. It's more common for women to ask for medicine to bring on a period than to ask for contraception. The death-rate from induced abortion is very high ideed."

Friends sometimes ask: why do women's groups emphasise abortion rights so much, though they oppose certain hormonal contraception policies. It is almost as though they consider abortion safer and better. It would be incorrect to say that the women's movement advocates abortion as the best contraceptive. But as long as basic conditions in women's lives remain unchanged, access to safe abortion would indeed be the most humane method of family limitation for many women whose lives are so deprived in so many respects.

A final point which needs to be made is the manner in which the FP programme has relentlessly succeeded in alienating large sections of the population. Examples have been given in the preceding chapters of the fear and distrust felt towards the entire health system as a result of FP policy. Because of this, even when there exists a potential for women, including poor women, to benefit from FP services, they may be unwilling to avail themselves of it. The Status of Women report had noted: "During our tours we found that wherever the medical personnel and the village level workers were mature and sympathetic in their approach and worked with a sense of social commitment, their persuasive power evoked a great deal of response. On the other hand there was considerable criticism of the 'motivators' most of whom are very young and inexperienced as well as purely untrained persons... An analysis of the tour reports reveals that the message of FP has reached almost everywhere, but access to health and FP services was most inadequate." To this, one may add that even when there is access, alienation may nullify it.

Because of past and continuing abuses, the sense of powerlessness is strengthened and so also the sense of resignation to one's "fate" regarding the number of children one might give birth to. To quote my activist friend again: "I would say the FP programme has not simply failed to make progress and create confidence, but has had precisely the opposite effect of frightening women. I had a discussion with some women here not long ago and asked whether they thought it was better to have a lot of children or a few. They answered it was best to have as many as God gave."

To explain away this attitude as arising from illiteracy or superstition or fatalism would be both simplistic and cynical. Nobody can blame these women for considering Fate to be a lesser evil than governmental FP.

By and for women: a US example

There are today some 200 women's health centres in the US providing information and in many cases direct health and FP services to women in a manner responsive to their needs and preferences and that involves them in the design and provision of services. This approach to delivering services was specifically recommended by the International Conference on FP in the 1980s, held in Indonesia in April 1981. In addressing the challenges facing FP programmes in the decade ahead, the conference noted that in many parts of the world, women often have little control over their decisions related to their own fertility. Furthermore, low levels of acceptance and use of FP, which are characteristic of many programmes, often reflect a failure to design and provide services in a manner that is responsive to the needs and perceptions of the users.

In a special report entitled "Women-Oriented Health Care", Judith Bruce of the Population Council describes how women-oriented services are designed and provided at the New Hampshire Feminist Health Centre.

The centre serves approximately 10,000 women and was started because the women organising and receiving these services have been dissatisfied with the established health care system. How does the women's health care movement provide services and how do these differ from conventional services? What services do they offer and how do women respond? What is the ideology of the women's health care movement and how does it influence service delivery? Are these services viable as a sustained option? The answers are of potential interest to service providers in both developed and developing countries.

The New Hampshire Centre is an important example of women designing, managing and directly providing health, contraceptive and abortion services to other women. The centre has 31 regular staff members plus one female and two male doctors hired on a continuous as-needed basis. The core members of the staff rotate responsibilities as much as possible so as to acquire diverse skills. The staff are trained in emergency medical techniques through a ten-week state sponsored course. Moderate fees are charged for abortion and gynaecological services and minimal or no fees for other health promotion activities.

Despite the Supreme Court ruling of 1973 making abortion legal in the USA, there is an unmet need and this the centre fulfils - especially of some groups of women - the poor and adolescents.

Vacuum aspiration is used and the centre has emergency back-up agreement with local hospitals. A low complication rate is seen of under 2 per cent, mostly post-abortion infections and treated with antibiotics. The rate is equal to or lower than the national average for first trimester legal abortion. Women are permitted to leave after 20 minutes if their blood pressure and pulse are normal. They leave with an instruction sheet and an appointment for follow-up care in two weeks.

The centre also provides gynaecological service and contraception information and counselling. Materials on these topics are published along with a quarterly journal on women's health and related issues with informative tips on self-care in health.

Perhaps the centre's most important research effort is the reintroduction of the cervical cap as a contraceptive device. The centre's interest in the cervical cap grew over time. Initially a New Hampshire nurse-practitioner obtained a supply of caps and fitted herself and a few of her friends. The method worked very well for them. She then incorporated the method into a college health service where she was working. The centre heard about cervical cap through her, discussed it and a number of the staff got fitted with caps to see how they felt about it. At that time caps were hardly avai-

lable in the US though they are as effective as diaphragms. Satisfied that it is safe and effective (their own experience proved it - a difference between them and conventional health service where service providers are not necessarily users), they decided to make it part of their gynaecological services. Demand became so high that prospective users are told they will be examined in groups of four and not individually. Not all women are good candidates for cap use: those with an active cervical infection, abnormal pap smears, a flat cervix or one that is hard to fit etc., are not appropriate users.

Women are fitted with one out of four sizes and are instructed that the cap should be half to two-thirds full of cream, should be left in place at least six to eight hours after intercourse and be removed at three-day intervals. A cap costs $7.50 and rarely needs to be refitted and can last as long as 40 years. Thus, the intial time spent in instructing the women in its use is very cost-efficient.

The work of this and other women's health centres has led to a revaluation of the cervical cap by the FDA. Currently it is classified as an experimental contraceptive though it was widely used until about 20 years ago.

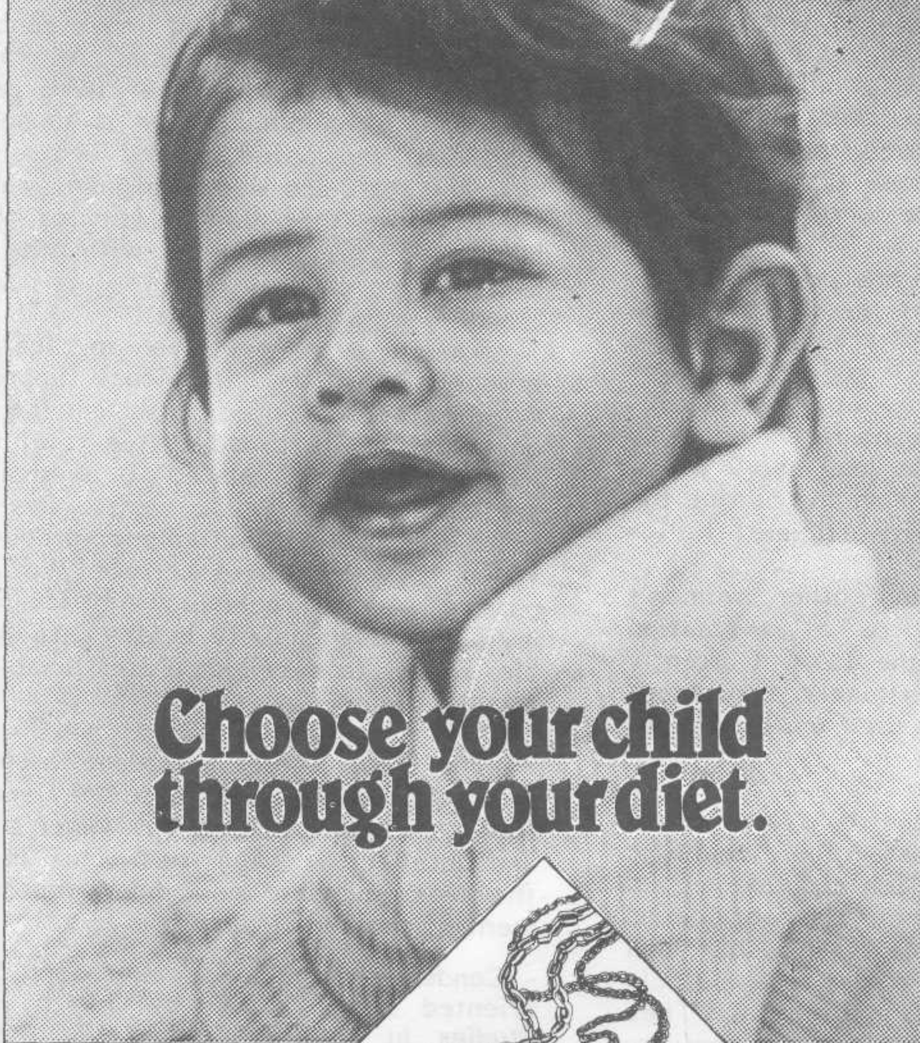
The New Hampshire centre is also involved in campaigns against rape, domestic violence and the struggle for abortion rights. The lesson offered from its services is that these are accessible, affordable and delivered with rapport. Women seeking help feel no 'social' distance from the staff. They have a choice of 16 models of fertility control including abortion. Sterilisation is available on referral. Enough information is given to make a self-determined choice. Questions and sharing of personal experiences are encouraged.

The word "patient" is not used when referring to a woman seeking a service. The service is built around the concept of a "Woman's culture". Women naturally seek out other women when they have problems. This kind of communication is supported rather than supplanted by the centre's services. The staff are women in many ways similar to those they serve. Many of the staff had their first contact with the centre as users.

Women are receptive to learning in groups. Also the individual approach is retained where needed. Although the focus is on health needs, broader aspects of women's lives not directly related to physical health are also discussed. The centre has tried to erase the artifical and counter-productive division between active service providers and passive service receivers and challenge the myth that high quality health care is available solely from male professionals serving female clients.

The role these providers assume and their attitude towards those they serve reinforce the value placed on women's physical and intellectual capacities. This is perhaps the least tangible and most important element of the centre's work.

- Condensed from a special report, "Women-oriented health care" by Judith Bruce in *Studies in Family Planning*, Vol. 12, No.10, Oct. 1981



An invaluable book for all expectant couples, those aspiring for motherhood, parents and doctors. Simple to read, easy to understand.

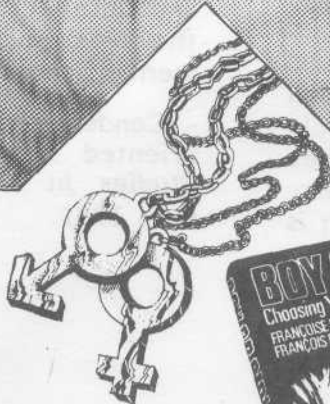
Will our child be a son or a daughter? It's a question that interests most expectant couples. Thanks to the pioneering work of Dr. Papa, they can now decide on the sex of their child, before conception.

Whether you conceive a boy or girl, is not merely a matter of chance. One of the most influential factors is the chemical climate inside the woman's body, resulting from the food she eats. Dr. Papa has proved that by following a particular diet, it is possible to predetermine the sex of the child and this method has been practised by thousands of women successfully.

"Boy or Girl?" is more than just a diet book. Dr. Mrs. Kutar, an eminent Delhi gynaecologist considers this book a revolution in modern medicine. It discusses how best to conceive according to the contraceptive method you've been using, how to tell when you are ready for conception and the moral implications of choosing the sex of your children. Scientifically devised and tested, Dr. Papa's method will not affect your health or that of the baby.

If you want to plan your family wisely, decide now. With no drugs or artificial methods involved, this book provides a natural and healthy way to choose your child.

Please rush me a copy of "Boy or Girl? Choosing your child through your diet".
I am enclosing M.O./Demand Draft/Cheque for Rs. 105 (Rs. 95+ Rs. 10 for postage and packing) in favour of RITANA BOOKS New Delhi.
Or send me by V.P.P.
Name ....
Address ....



REPRINTED ON POPULAR DEMAND. RUSH YOUR ORDER TODAY
Rs. 95/- Hardback. 192 pages.

RITANA BOOKS
Publishers, 81, Defence Colony
Flyover Market, New Delhi-110024.
Phone: 619901 Cable: RITANAPUB

MAADHYAM

Full page advertisement in Stardust, July 1985

Publications being distributed at CED:

1. Health and the Work-place - Counterfact No. 4 - Rs. 2/-
2. Asbestos - The Dust that Kills - Counterfact No. 5 - Rs. 2/-
3. Health Sans Multinationals: The Bangladesh Crusade - Counterfact No. 6 - Rs. 2/-
4. Pills for All - Counterfact No. 7 - Rs. 2/-
5. ORT and the Credibility Gap - Counterfact No. 8 - Rs. 2/-
6. The Scarcer Half - Counterfact No. 9 - Ravindra R.P. - Rs. 3/-
7. Injecting NET-EN into India - Counterfact No.10 - Mira Savara - Rs. 5/-
8. Aspects of the Drug Industry in India - Mukarram Bhagat - Rs. 15/-
9. Operation Flood: Development or Dependence? - C.E.D. Research Team (A CITE Publication) - Rs. 15/-
10. Land Degradation: India's Silent Crisis - Mukarram Bhagat (A CITE Publication) - Rs. 15/-
11. The Tenth Month: Bombay's Historic Textile Strike - Factsheet 1 - Factsheet Collective - Rs. 20/-
12. Communalism: The Razor's Edge - Factsheet 2 - Factsheet Collective - Rs. 20/-
13. The Government of India and Hindustan Lever - Controlling Multinational Monopolies - An Anti Case Study - H.K.Paranjape - Rs. 8/-
14. Socialist Health Review - Rs. 5/- per copy - Rs. 30/- subscription
15. Forests and the People - Rs. 15/-
16. Poverty, Development and Poverty - Rs. 45/-
17. Medico Friend Circle Bulletin - Rs. 2/- each
18. The Bhopal Disaster Aftermath - with Summary Report - Rs. 10/-
19. Prescription for Change, by Virginia Beardshaw - Rs. 42/-
20. Reaching for Half the Sky - a Reader in Women's Movement - Antar Rashtriya Prakashan - Rs. 12/-
21. My Story - Our Story of Re-Building Broken Lives, by Flavia - English/Marathi - Rs. 10/-
22. Shiva's Plight - A Story of a Child Worker - ICRA - Rs. 10/-
23. The State of India's Environment 1984-85. The Second Citizen's Report - C.S.E. - Rs. 285/-
24. Issues in Environmental Health: The Case of Pesticides. Papers for the MFC Annual Meet 1986. A CED-MFC Publication - Rs. 15/-
25. Here Lies Your Motherland, by Birendra Chattopadhyay - Rs. 15/-
26. Forests in India's Heritage - Chipko Movement - Rs. 10/-
27. Ecological Audit of Eucalyptus Cultivation by Vandana Shiva & J. Bandopadhyay - Rs. 75/-
28. Chains of Servitude - Bondage & Slavery in India, by Utsa Patnaik & Dingwaney Manjari - Rs. 70/-
29. Abuse of Women in Media - CAP - Rs. 18/-
30. Seeds & Food Security - SAM - Rs. 18/-
31. Rajiv Era - A Historical Perspective, Ed. A.R.Desai - Inquilabi Communist Sangathana - Rs. 5/-

ABOUT CED

The Centre for Education and Documentation (CED) is an independent organisation involved in documentation and research-cum-action oriented programmes catering to the needs of scholars, professionals, students, development workers, and other concerned individuals.

Established in 1978, and registered under the Societies and Public Trust Acts, the CED collects, collates, researches and disseminates information on a wide range of subjects of social importance.

Above all, the CED provides a focal point for like-minded individuals and groups to interact with one another in order to relate theory to experience and action, in their respective areas of involvement.

CED's occasional publications are part of our effort to generate and spread awareness on important social issues in order to encourage further study, reflection and action. CED also maintains a distribution service for material brought out by different groups.

CED has also begun DOCPOST, a facility which provides you with xeroxes of material from our documentation culled from 10 national dailies, 100 periodicals and journals and 250 other sources of reports, data, analyses etc. from India and abroad. The speciality of this service is its low cost, range and selectiveness. It has been designed to meet specific as well as general needs.

The three types of DOCPOST services:

a) DOCPOST (Regular):- Here you choose your topics of interest and receive fortnightly xeroxes from our files

b) DOCPOST (Spot):- If you have a spot need for background information on a particular topic

c) DOCPOST (Selective):- You can get selective information or documents as and when you ask for it.

Write to us for more information.

CENTRE FOR
EDUCATION AND
DOCUMENTATION

3 Suleman Chambers, 4 Battery St., Behind Regal Cinema, Bombay 39 - Tel. 2020019