III. Women as targets

The burden of FP acceptance has, over a period of years, shifted increasingly on the shoulders of women. From the fifties 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

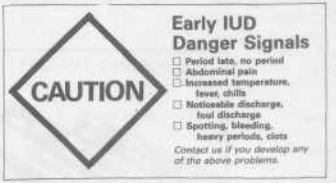
BOX 5

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



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).

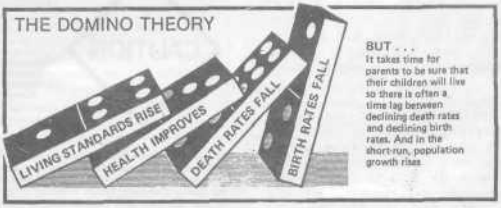
And yet, the Advisory Committee on Scientific Aspects of Family Planning which met in Aurangabad in 1965, recommended on the basis of their clinical trial that IUD be made available on a wider scale. (This phenomenon of the family planning establishment disregarding the lessons of its own proclaimed 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 if 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, gives many 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.

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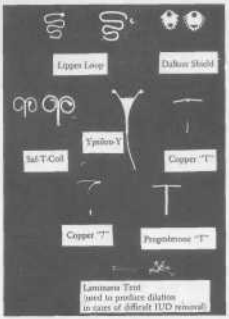
Different type of IUDs



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 out-patient 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 Gomedhar 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[4] of a woman in Ferozepur district of Punjab 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[5] 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.

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2. *IPPF Medical Bulletin*, October 1984.
3. *Eve's Weekly*, March 23, 1985.
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5. *EPW*, March 9, 1985.
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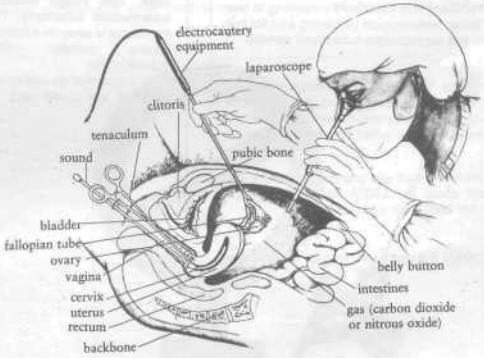


Courtesy: The New Our Bodies, Ourselves

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 miscalled family. The helpless parents could not afford to pay the rent even. I forewent two years rent to get the house vacated.

"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 rediscovered 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 tubecto-mies to total	IUD Inser-tions
	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 skilled and experienced hands safe and effective	Not used in most countries
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	
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 skilled and experienced 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.

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

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*

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 T.V 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,

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.*

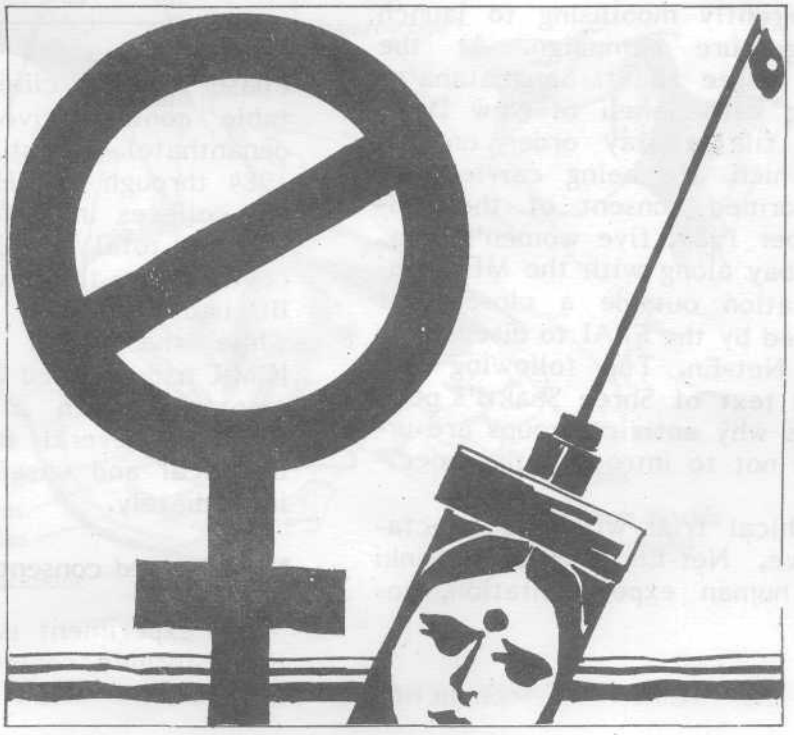
but she has been refused the Pill. *Women like her do not need spacing methods, they must accept a terminal method.* This being the policy, it is the doctor who has abrogated the right to decide what contraception women like Maimuna may be allowed to use. So what she does now is to pray that Allah will keep her husband away with his drink and not enter her hut or bed.

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

The 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 contraindication 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 the recipients have invariably been poor, coloured women.

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 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.

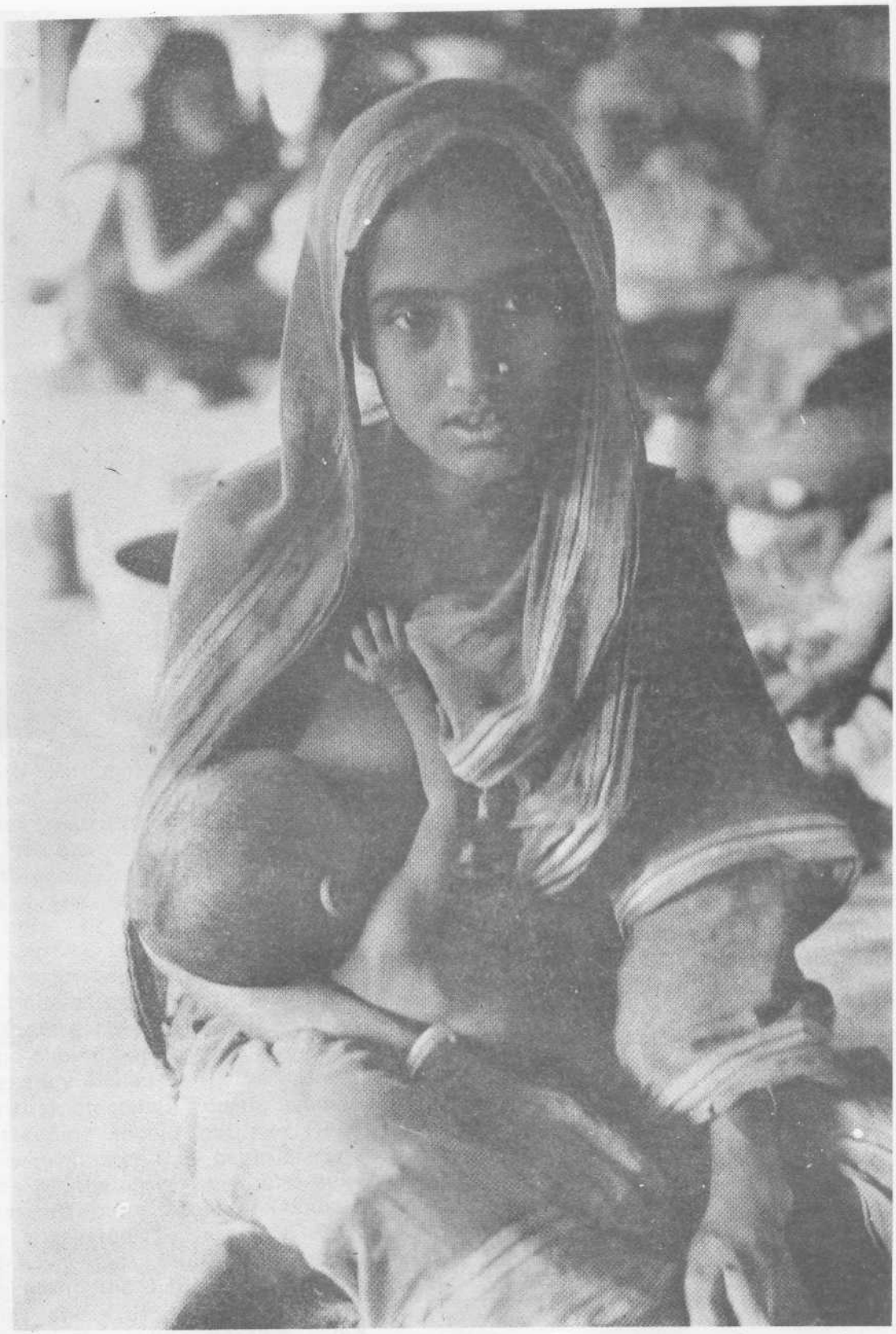
***Population Report** - Series K No.2 May 1983*

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).



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UNFPA 'State of World Population' Report 1984