

FACTS

against MYTHS

VIKAS ADHYAYAN KENDRA

SEPTEMBER '93. VOL. 1#2

INFORMATION BULLETIN

COMMENT

Population Myths On Minorities

In a letter to the editor of a New Delhi based national daily a reader, Ram Bharose, wrote:

Sir:

Hindus all over the world are getting sick and tired of being pushed around in their own country....We are tired of the Governments appeasement of the Muslims. Why should they be allowed to have four wives in order to procreate more so that one day they will out-number our Hindu brethren?

Yours faithfully,

Ram Bharose.

The letter hardly says anything new that has not been said before, 'ad infinitum', by especially communal propagandists. Bal Thackeray too, reportedly, alleged that Muslims had increased from 10 to 25 crores in the last two years.

Communal forces of especially the Sangh Parivar have pilloried the Muslim minority community in particular for the explosive growth of the Indian population, spawning a grotesque population thesis. With great conviction they will express reasons why Muslims will soon outnumber Hindus. Their reasoning goes like this :

* As Muslims are allowed to have four wives, they invariably have more children.

* as they generally are opposed to family planning, the birth rate among them is much higher than other

religious communities.

* their growth-rate is higher (than that of Hindus) because of their religion, Islam.

* their numbers have also been increasing due to conversions.

* their growth rate being higher they will soon outnumber the Hindus.

These and other allegations are made so often that they become cliches accepted as facts. And when communal forces take control, the dividing line between myth and reality gets blurred. True facts, on the other hand, are deliberately ignored and suppressed.

Appeals are made not to people's minds but to their passions, emotions and deep-seated fears and prejudices. Logic, history, facts and figures, will however indicate where such allegations, etc. end, and facts begin.

MYTH*Muslims do not practice family planning because of their religion"***FACT**

The disapproval of family planning is largely due to the influence of the fundamentalist Muslim clergy. Does this mean that Islam as a religion prohibits family planning?

* Islam does not prohibit family planning. Several 'ulemas' of different countries infact have actually issued 'fatwas' saying that all temporary forms of family planning for medical or economic reasons are permitted. In Islamic countries like Turkey and Indonesia, for instance, family planning methods are quite popular. In Turkey, 63 per cent of the population uses contraception and in Indonesia, the figure stands at 48 per cent.

* Islam (like the Catholic Church) forbids abortion and other permanent family planning methods, like sterilisation but several 'ulemas' permit it on grounds of health.

* According to the Operation Research Group (ORG) of Baroda, the number of Muslims practicing birth control is increasing:

Couples Practicing Family Planning**1. Couples in child bearing age -**

YEAR	AMONG HINDUS	AMONG MUSLIMS
1970	14.0%	09.0%
1980	36.1%	22.5%
1988-1989	46.0%	34.0%

2. Eligible couples

1970 - 1980	22.1% increase among Hindus 13.5% increase among Muslims
1980 - 1989	10.0% among Hindus 11.0% among Muslims

* According to a 1980 ORG survey, 52% among Muslims and 9% among Hindus refused to accept family planning but for the period 1980- 1989, (i) 11.5% additional Muslims began to accept permanent family planning methods, and for the same period 10% more Hindus accepted permanent methods of family planning and (ii) acceptance of temporary birth control methods increased by 5 to 10% Evidently, Muslims are increasingly taking to family planning especially in recent times, contrary to what communal forces deliberately misrepresent.

MYTH*Muslims have a higher growth rate (and will soon outnumber Hindus) because of Islam.***FACT**

On the basis of a statistical survey of population growth figures do not support this claim by communal forces. The growth rate of Muslims is only marginally higher than Hindus. There has been no dramatic increase in the Muslim population, as compared to Hindus. The following will corroborate this point:

* In 1951 there were 3.5 crore Muslims and 32.2 crore Hindus.

* In 1981 there were 7.6 crore Muslims and 55 crore Hindus.

The percentage of population according to religion is as follows:

Percentage of Hindus: 1961 Census - 83.45%
 1981 Census - 82.35%
 Percentage of Muslims: 1961 Census - 10.69%
 1981 Census - 11.73%

In spite of these facts, sectarian and other forces attempt at undermining the intelligence of the masses by creating the bogey of Muslims eventually outnumbering Hindus in the not-too-distant future. On this grand figmentation a report in the Sunday magazine however stated that if both communities continue to grow at the present rate, Muslims will account for only 13.55% of the population in the year 2000. According to social scientists and demographers there is therefore no possibility of Muslims outnumbering Hindus. In fact according to Vasant Govariker, a cryogenic expert and former scientific advisor to the Prime Minister, the Indian population will begin to stabilise by 2001 and will not even overtake China.

Trends In Fertility Levels

	RURAL			URBAN		
	1971	1981	% Decline Between 1971-81	1971	1981	% Decline Between 1971-81
HINDUS	174	141	20.0	119	123	20.1
MUSLIMS	191	163	17.3	178	145	18.5

Source: *Census of India, 1991.*

Muslims will Never Outnumber Hindus

On the question of the link between religion and fertility, demographers etc. also point out that the former has no significant impact on fertility. Sociologist, R.A. Chaudhary, states, "The observed differences in fertility are mostly due to socio-economic differences between Muslims and other religious groups. Once these differences are accounted for the fertility differences between Muslims and other religious communities will largely disappear."

Worth noting too is the curious reversal of the pattern in Jammu and Kashmir, a Muslim majority State. The fertility rate of Hindus here is almost twice that of Muslims. According to recent figures for 1989-90, the State had a lower birth rate (31.4 per 1000) than U.P. (36.5), M.P. (36.4), Bihar (34.8), and Rajasthan (33.4).

If religion is the sole or the most important yardstick for fertility, this could not have happened?! Further, the situation in more advanced States -- advanced in social terms-- like Kerala, Tamil Nadu, and Karnataka, the fertility rate is low for both Hindus and Muslims. This suggests that socio-economic backwardness leads to higher fertility. That it is indeed so is borne out by data given by the Registrar General of India: fertility levels in the population decline with an increase in the level of education and per capita monthly expenditure (i.e. higher the per capita expenditure, lower the fertility).

Other crucial factors influencing growth rate include (i) Education and (ii) Infant Mortality Rate (The number infant deaths per 1000 children born alive in a year).

(i) According to R.H. Cassen, a social scientist with the London School of Hygiene and Tropical Medicine, "The contribution of education to fertility decline is not just by the alternation of parent's aspirations, but by the spread of rationality itself. The basic differentiator of those for whom babies just come and those for whom the number that come as a result of more or less deliberate choice, seems so often to be education."

According to a National Survey Sample of 1990 the level of education for every 1,000 persons, in every age group, is lower for Muslims (compared to Hindus) both in rural and urban areas -- and this is particularly true among women,

(ii) On the relationship between IMR and fertility Cassen further observes, "...what people want is not just children but surviving children. When children are known to be likely to die, the whole psychological nature of child-bearing is likely to be far removed

The age of mass conversions is over, especially in a plural, multi-religious society. Such events might still take place, but they will obviously be subject to the most searching scrutiny. These are, anyway, rare incidents nowadays.

Book Review (Reviewed in "People And the Planet", Vol. 2, #2, 1993, p. 5)

A new book, *Family Planning In the Legacy of Islam*, by the Islamic scholar, Prof. A R Omran, Chief Population Advisor to Al-Azhar University in Cairo, dispels the myth that Islam is inherently opposed to family planning and fertility regulation. Prof. Omran spent five years researching and writing the text, covering 1,400 years of religious pronouncements on birth control, with many references from the Koran itself. The United Nations Population Fund (U N P F) helped underwrite this project. Since the book is a work of scholarship and therefore 'neutral', it does not contain any conclusions. The closest thing appears on page 238, where the Grand Imam of Al-Azhar University proclaims seven points about Islamic law and family planning :

- * There is no text in the Koran prohibiting prevention of pregnancy,
- * pregnancy prevention is not killing,
- * modern (birth control) methods are, by analogy, permissible,
- * temporary sterilisation is permissible, but permanent is not,
- * abortion after 120 days is prohibited except to save the mother's health,
- * artificial insemination with the husband's sperm is allowed, and
- * no law should coerce people to use contraception or to fix the number of children.

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Facts Against Myths is a monthly bulletin of factual information on a number of development myths and fallacies, etc., including information against disinformation campaigns, propaganda and canards spread by communal and fundamentalists forces.

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from the careful consideration of supportable numbers... The gradual decline in mortality might have played a part in inducing parents to have fewer children--not probably because they consciously perceived that their children were more likely to survive and they therefore did not need to have so many, but rather because it is gradually found that more of them were surviving and were thus harder to support, or one generation had memories of the numerous families in which they grew up and resolved to make things easier for their own children".

The following Table will show that in Urban areas the IMR is higher for Muslims than for Hindus and lower in rural areas.

Infant Mortality Rate By Religion, All India, 1978

RELIGION	RURAL	URBAN
Hindu	138	70
Muslim	126	76

(Source: "Levels, Trends and Differentials in Fertility", Office of the Registrar General, India, 1979.)

Thus in terms of IMR, again, Muslims are poorly placed compared with Hindus in urban areas where their concentration is comparatively higher. This high rate of fertility has IMR behind it as a strong causative factor.

In sum, the real reason for high fertility rates among Muslims are low socio-economic achievements in terms of literacy and education, health and nutrition, and the status of women. It has nothing to do with religion as such.

MYTH "As Muslims are allowed to have 4 wives they invariably have more children"

FACT

The fallacy of this statement (briefly dealt in the last issue of this Publication) needs further elaboration. That is,

* Polygamy exists among both Hindus and Muslims. It is legally sanctioned among Muslims, to marry up to four wives (provided they can do equal justice to both). Among Hindus and other communities though it is illegal there is virtual social sanction for such marriages.

The question however is: how many men actually marry four times? According to the Government census of 1961 its survey of polygamous marriages the findings were as follows:

* Polygamous marriages were highest among adivasis, Buddhists, Jains, and Hindus, in that order. Muslims figured last on the list.

Myth Of Polygamy (Decline in %)

Adivasis		15.25
Buddhists		7.97
Jains	6.72	
Hindus	5.80	
Muslims	5.70	

Source: The 1961 Census Report (subsequent Census Reports do not include this issue)

*The National Survey Commission on the Status of Women in India (1975) found that incidence of bigamy and polygamy is higher among Hindus than Muslims.

Year	Polygamous Hindu families	Polygamous Muslim families
1931- 41	6.79%	7.29%
1941- 51	7.15% (0.09% more than Muslims)	7.06%
1951-61	5.06% (0.65% more than Muslims)	4.31%

* Moreover, according to this Report, this practice was low for Muslims than for Hindus for the later two decades. Infact, Indian Muslims generally don't have four wives barring exceptions.

* One striking evidence of the falsity of the population thesis of such communal organisations like the Sangh Parivar is the fact of the lower birth rate of Muslims in J & K,(already referred to above.)

* Dr.Mercy Muricken, a medical practitioner who has been working in Puntamba in Ahmednagar district of Maharashtra, reports several cases of Hindu men marrying many times to have sons for religio-cultural reasons despite daughters through previous marriages. Apart from its serious implications, such illegal acts not only aggravate the growth rate of the Hindu population but is also a severe affront on women themselves.

On the impact of polygamy on fertility, demographers K.C. Seal and P.P. Talwar have argued that in polygynous marriages fertility rates are expected to go lower as compared to monogamous marriages as the number of coiti which a man can have remain almost unchanged whether he has one wife or more than one. If the coiti are randomly distributed over the menstrual cycle of a woman, a fixed number of coiti per man are likely to lead to higher chance of fertilising a woman in case of one wife compared to the case of more than one wife, depending on their ovulatory cycles. Death of a man in a polygynous marriage prevents reproduction among more than one women for a period.

Moreover, Kanti Parkasi holds that on the basis of fertility differentials, polygamy is not important as the proportion of women marrying into polygyrous marriages is negligible. He also adds that "in the selection of second wives, the Muslims depend more on relatively aged women and this should have its due effect on reproductive achievements of their second wives. On the other hand, Hindu polygynists are noted to prefer very young wives below 15 years in age in both first and second marriage relatively more strongly than the Muslims. In comparison Muslim males with first wives only maintained the highest average of children born alive, but with second wives, they yielded the lower average. Hindu polygynists produced through their second wives distinctly more live births on the average than their Muslim counterparts. Polygynous forms of mating does not appear to be an essential prerequisite to invest the distinction of superior 'fertility' with Muslims of India"

Thus it is very clear that the extent of polygamy among Muslims is either same or less than among Hindus and secondly due to polygamy the Muslims population growth cannot be higher than the Hindus population growth. Lastly, the logic of polygamy leading to a population explosion has no basis since the reproductive rate is dependent on the number of women in the reproductive age group. Whatever one may think of polygamy, it is clear that the question of whether four women share a common husband or have separate ones is immaterial to their reproductive capacity.

MYTH *Muslim population is also rising due to conversions. Witness Meenakshipuram in Tamil Nadu in 1981. And was not the right to propagation of religion included in the Constitution at the insistence of Christians and Muslims?*

FACT

Article 25 does indeed permit "freedom of conscience and free profession, practice and propagation of religion." The "propagation" aspect was debated in the Constituent Assembly. But it was pointed out that propagation was in any case inherent in the fundamental right to "freedom of speech and expression" (Art.19(1)a) and that including the word "propagation" in Art.25 conferred no additional right.

In any case, the right of propagation is universal and available to Hindus as much as to any other community or denomination. And that right has reportedly been exercised by Hindu bodies as well to convert or reconvert adivasis, Muslims and Christians in different parts of the country, including Meenakshipuram. The Statesman of April 10, 1992 documented one such case in a cluster of Muslim villages in Hatras district of U P. The reporter, Vidya Subramaniam, found BJP and RSS involvement.

Conversion by force, fraud or inducement is barred and the rights conferred by Art. 25 are specifically made subject to "public order, morality and health" and to all other fundamental rights.

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VIKAS ADHYAYAN KENDRA

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INFORMATION BULLETIN

COMMENT

The Myth Of Population Control

Much has been written, debated, etc., on the so-called population problem in the South. More of all this will escalate in the coming weeks and months as the International Conference On Population and Development scheduled for September 1994 at Cairo draws near. "Population Explosion" is considered to be the major reason for the poverty of the "Underdeveloped" South with "Overpopulation" as the malaise and "Family Planning" as the "solution". This kind of thinking gained world-wide currency, among Indian elites as well, in the writings of Paul Ehrlich who coined the rubric, "population bomb".

Pressure against the growth-rate in the South is already mounting, with the public in the North in a belligerent mood in helping the poor (in the South) who are blamed for straining the 'carrying capacity' of the earth. This skepticism and the fact that their own economies are stagnating have made the Northern Public hostile to immigrants from the South. Liberals too are joining in the anti-South tirades. The French

Socialist, Jacques Attali, blasts the South for looking to the North for their prosperity, "migrating from place to place for few drops of what we have in Los Angeles, Berlin or Paris, which for them will be oases of hope and high-tech magic". Another Northerner, Joseph Fletcher argues that famine relief in the Sahelian region should be withheld and development aid to be offered on condition that contraception and vasectomies "will go with the groceries". Lawrence Summers, chief economist of the World Bank advocated the dumping of toxic wastes in the South. Individuals like these including Maurice King continue to view people of the South as weeds who breed like rabbits.

To talk of "population explosion" is to say to people: you are poor because you are too many. Based upon such reasoning, birth control studies in the South mushroomed from the 50s onwards. The finding of these studies is vital to our understanding the significance of the population problem. What they share with Ehrlich is his distortion

of social reality in the South: that it is the large size of the families that explains the poverty in the South. What they share among themselves is a misinterpretation of their results: that is, if an area has a birth control programme and if the birth rate in the area declines, it is concluded that the programme is responsible for the decline. Research findings however have shown that fertility instead tends to decline even before the start of any family planning programmes. "No matter how primitive he may be, man seems to have the 'rationale' to adjust his numbers in accordance with the resources available, and the environment to which it is subjected".

Racist remarks and imperialistic statements evoke alarm because today when more complex approaches to the population issues are needed, the Northern public have become psychologically disposed towards such simplistic draconian attitudes and proposals. Whilst not denying facts themselves it is necessary to denounce the misuse of facts in such a manner.

MYTH**IN TERMS OF PHYSICAL CAPACITY TO NOURISH ITS INHABITANTS, THE EARTH CAN NO LONGER PROVIDE FOOD FOR ALL****FACT**

First of all, this is no longer an issue let alone a key one. There is no physical shortage of food today. Even according to the U.N. and World Bank, the world has enough food. At the height 1972 crisis, the shortfall in production of the five Sahelian countries most affected was less than 0.5 per cent of the grain fed to livestock in the industrialized countries. For the large majority of the sufferers, the surpluses actually exist right in their own vicinity. The largest absolute number of severely malnourished people in the world are in South Asia, in India and Bangladesh. Both have made great strides in food production in the last 20 years. India which has been self-sufficient in food grains since the mid 70s holds food reserve stocks of 20 million tons and more, apart from being a net cereal exporter.

Moreover, contrary to the Malthusians, world food supplies could be increased to meet the needs of practically any conceivable growth in population provided major and appropriate structural changes are made in the industrial North. According to FAO, the potential in raising food production is enormous. Africa, for instance, has the potential in raising food production from 43 million tons (in 1975 - to 1979) to 108 million tons in 2000.

In fact, food sufficiency is nothing new. Twenty years of statistics, 1964-83, support this statement, which furthermore is valid not only for the whole world but also for each continent.

See following tables:

Growing Availability Of Calories, Per Capita

	1964 - 66	1969-71	1974-76	1981-83
World	2.409	2.452	2.506	2.665
Asia	2.044	2.096	2.171	2.422
L America	2.257	2.338	2.391	2.495

Source: FAO Production Yearbook.

Growing Availability, Per Capita, Of Calories From Vegetables And Animal Sources :

	1964-66	1969-71	1974-76	1981-83
Calories from vegetable products	2.028	2.062	2.111	1.153
Calories from animal products	381	390	395	412

Source : FAO Production Yearbook.

It is a fact that population growth in the South is more rapid than in the North but even limiting the comparison to merely the countries within the South, food production has grown at a rate of 3.2% while the rate of population growth has been 2.6%.

The strikingly political slant of the myth in question, which lends legitimacy to the campaigns for birth control in the South, becomes evident on realising that the reduction of the fertility in this region will not bring about any significant drop in food consumption. The poor consume hardly anything, and those who die of hunger, even less. On the other hand, a decrease of just 5% in the population of the North, and the rationalisation in the diet of their privileged pets, would surely lead to an even greater food surpluses than our planet already has.

The problem therefore is not food scarcity but massive over consumption by the rich in both the North and the few rich in the South, including their capricious waste.

MYTH**"A POOR COUNTRY'S ECONOMY JUST CANNOT KEEP UP WITH POPULATION GROWTH, SO PEOPLE WILL JUST GET POORER AND POORER"****FACT**

Proponents of this myth argue that countries with increasing per capita incomes, like Japan (21% increase from 1980 to 1988), have low population growth rates (0.7% a year), whereas those with declining incomes, like Nigeria (28% decrease from 1980 to 1986), have much higher population growth rates (3.0%). They therefore conclude that population growth causes poverty. This myth can be countered on its own terms: first by pointing out that the impressive economic performance of countries like Malaysia, whose per capita incomes have grown by an average of 3.0% a year in the last few decades, took place along rapid population growth; second by showing that Africa's 10 richest countries have similar population growth rates to the continents' 10 poorest countries. But the myth is also based on the assumption that people are consumers rather than producers of wealth. For instance, Japan fears that providing for its growing proportion of dependent old people (an increase in the over 65s from 9% in 1985 to 21.3% in 2025) will destroy the economic miracle of the last 45 years. But the real problem is employment opportunities, not absolute numbers. The retirement age in Japan is often as low as 50 years, so Japanese old people are turned from producers into consumers long before their time.

A related myth is that the reproductive capacity of especially rural women is the cause for the rise, for instance, in India's population and subsequently her poverty. In her research paper Dr. Mercy Muricken, a medical practitioner with experience in rural Maharashtra has shown how this discriminatory mendacity ended in the neglect of the role of women in family planning programmes. Based on her wide experience Dr. Muricken believes that the only humane approach is voluntary acceptance of family planning though safe-pregnancy with improved mother and child-care facilities. Most of all "the overall improvement of the socio-economic status of the family is a pre-condition for a successful family planning programme..."

MYTH**FAMILY PLANNING PROGRAMMERS ARE AIMED IN REDUCING THE FERTILITY RATE SO AS TO ALLEVIATE THE PROBLEMS OF HUNGER****FACT**

Regulating the fertility of its population has been a feature of every society and at all points of time in history. Since the 50s however limiting population growth in the South has become a major concern and obsession of the North, pressing for family planning programmes and projects. This implicit faith in family planning has generated a massive body of published material by various international Institutions like the UN and its agencies, Rockefeller Foundation, USAID, International Planned Parenthood Federation, among others. These bodies are actively engaged in shaping and influencing population policies as well as aiding various governments and NGOs in the South to go in for family planning programmes.

As population policies for planning government action to affect demographic variables were formulated, immense efforts went into multi-disciplinary research into various aspects on family planning. The finding however proved to be negative on the whole. Yet, optimism in family planning programmes as a means of reducing fertility and consequently population growth - rate continues. Fertility control in fact has become a standard component of development policy. Both direct and indirect approaches to achieving the goal of reduced fertility have been adopted,

Dr. Malini Karkal former consultant to WHO & ILO in her research on such studies has documented the various impact of family planning programmes. Her study shows that

** Family planning alone is inadequate and further inputs into cannot solve the "population problem" At best they have a very limited impact. By themselves, such programme do not influence growth rates;*

** A study carried out in Kenya showed that inspite of such programme fertility has increased. In fact, fertility among the Kenyans is higher than what it was in 1950 and it was at peaks rarely attained inspite*

MYTH

"POOR PEOPLE WOULD BE MUCH BETTER OFF IF THEY HAD FEWER CHILDREN TO FEED AND CLOTHE."

FACT

This depends on whether children are an asset or a liability. In the US, for instance, the cost of supporting a child to the age of 18, excluding college fees, is over \$100,000 and 50% of American women using contraception are doing so because they feel they cannot afford another child. But in countries of the South boys are already producing more than they consume by the age of 10 and have repaid their parents' investment in their upbringing by the time they are 15. This is one reason why sons are so important in some countries; girls usually leave home when they marry, so no longer contribute to their parents' income.

Statements by UBING Bangladesh and Women's Voices '94, New York, on People's Perspectives on "POPULATION"

- * No to population control.
- * Resist terms and expressions lined with population control ideologies, discourses and policies.
- * Expose the racist, sexist and imperialistic aims of population control policies targeting women and the poor.
- * Decisions on family planning must be decided jointly on non-patriarchal relationship and must not be equated with population control.
- * Safe and people-controlled (women controlled) contraceptive methods should be searched and conditions should be created through movements for proper research and development free of the control of TNCs and population controllers.
- * Develop technology women can control that protects against STD diseases and unwanted pregnancies.
- * Guarantee all women access to quality reproductive health care, including wide contraceptive choice, pregnancy care, safe abortion and prevention/treatment of STDs.
- * Balance efforts to stabilize population with equal efforts to reduce conspicuous consumption by the North and the rich as their consumption currently causes more global environmental damage than population growth in the South.
- * Make men take responsibility for births, their sexual behavior and their partners health and well-being.

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of two decades of fertility efforts of the government. Researchers have argued that this is owing to the family system in which patriarchal control of households is combined with little economic responsibility on men for their children. Policies have always overlooked these important features of the social structure. Kenyan experience also showed that the authorities enacted laws that weakened the position of women. "The traditional (land) rights of women were virtually ignored as a complex system of use-rights included women was converted into a system of western-style 'ownership' from which women were for the most part excluded". On the death of her husband, custom dictates the division of land among sons.

** The present population control policy favours technological interventions instead of examining the problem in its holistic perspective. In a desperate quest to meet lofty targets set by the planners and decision makers, the bureaucrats rely on technology. The casualty of this approach is individual dignity and freedom, and the worst victims of this assault on human dignity are women. The government sponsored sterilization camps, which provide the medical bureaucracy an opportunity to fulfill these targets, present an atmosphere of deprivation and insensitivity.*

Ostensively, the rationale for promoting family planning programmes in the South, to quote Robert McNamara, ex-President World Bank, is that "Family planning programmes are less costly than conventional development projects. Successful projects of this kind will yield very high economic returns" Pronouncements, promulgations etc., like these made by such overpopulation theorists in the North and political elites in the South continue to be raised despite contrary results.

What is relevant however about such explanations is not only that it clarifies the scientific basis of the optimism but that it also underlines the political reasons behind that same optimism: family planning is considered a substitute for structural and social transformation of society as a whole. Optimism concerning the possibility of population control without fundamental change in the underlining social reality is, in fact, a weapon of political conservatives including communal and fundamentalist forces today.

MYTH

WOMEN'S AND HUMAN RIGHTS GROUPS IN OPPOSING POLICIES THAT CUT DOWN ON THE NUMBER OF PEOPLE ARE AGAINST FAMILY PLANNING WHICH HAS LITTLE TO DO WITH HUMAN RIGHTS.

FACT

Population control and family planning are not equivalent concepts. Studies show that where people are poor, there is so much insecurity that having more children makes economic sense. When there is high mortality, the poor will have more children who will be able to grow up. Once there are better amenities, and people are economically more secure, almost automatically the number of children is reduced. So family planning is something that every relatively secure family or couple begins to exercise as a natural course anyway. Where there are large number of people, it is because there is poverty, and poverty is created not by the poor being useless and helpless, but because they have been deprived of resources, which have been taken away for a few other people, the rich.

Fertility control is a violation of human rights when it involves forced contraception and sterilization including dumping of hazardous contraceptive products like Norplant in the name of population control. For instance, Indonesia, is praised by the FAO for its success in the population policy programmes. Women's and human rights groups whilst admitting this "Success" have however pointed out that Jakarta's family planning programme involved negligence of health standards and women's rights. Family planning staff swoop down in villages, escorted by the army and village chiefs, and persuade people to use up the supply of donated contraceptives like IUDS etc. Even those women who need no contraception, such as menopausal women, are forced to agree to get a perm it.

* In the Rajasthan Assembly it was revealed that 44 women died in the cause of family planning operation since 1986. This figure is likely to be a serious underestimate, not only because it is official, but because it does not account for casualties due to later complications. Though the concerned minister took great pains to argue that the death rate in Rajasthan was only 1.1 per 10,000 cases as against a national average of 1.7, it would be well to remember that the acceptable death rate as per the WHO is 1 per 1 lakh operations, making the Rajasthan figure 11 times higher than the internationally acceptable figures.

In October 1990, according to the **Independent**, the Rajya Sabha reported that 363 women died from faulty tubectomy operations during the year 1989-90. It also revealed that "in the last 3 years, the Union Ministry of Health reported at least 1,1000 persons as victims of sterilization". This is much more than the death rate of 0.5 per cent per lakh sterilization cases, as accepted by doctors, statisticians, etc.

In their book 'Whose Sacrifice, Whose Survival' S.G Kabra and Harsh Sethi reveal that in a sterilization operation, the woman submits to a surgical procedure from which she does not stand to benefit healthwise. The operation is, however, justified on the grounds that the risks of pregnancy are greater than that those of sterilisation.

The authors also point out that mass sterilization camps end up resembling a butchery. Given the vast number of women who present themselves for sterilization, the doctors are pressurized to clear the quota as fast as they arrive: everything scientific and safe is sacrificed in the interest of speed, with an inevitable decline in standards that emanate from these camps.

Lest one forgets, between July and December 1976, over a million people were forcibly sterilized in India during the infamous Emergency. In the US too indigenous tribals were forcibly sterilized in their millions resulting (partly) in their ultimate decimation.

A health activist has reported of a woman in Baroda who received Norplant during Phase II trials of the drug in the 80s. Because of constant bleeding she was being physically abused by her husband for denying sex, and by her mother-in-law for not being able to work in the kitchen. When she decided to have it removed the local hospital denied her right to "Removal On Request." Only on her eighth attempt with the threat of committing suicide did the hospital finally remove the implant.

Moreover, there a number of groups working on how population control polices funded by USAID and other such Institutions have caused a lot of human rights violations. For instance Institutions like WHO, the Population Council, the Contraceptive Research and Development Programme and the National Institute for Child Health and Development will be clinically testing various anti-fertility vaccines on women patients at a reputed public hospital in Delhi under the guise of other medication. These are anti-fertility vaccines being launched this month in November. India is also trying to develop an indigenous vaccine along these lines using the most advanced technique - neutralizing the human pregnancy hormone HCG (Human Chorionic Gonadotrophin), produced in a woman's body by a fertilised egg shortly after conception. Women's health activists have pointed out that this vaccine did not work for 20 per cent of the women while its effect lasted from half a year to 2 years in other women. Any interference with the immune system for contraceptive purposes is indefensible at a time when primary health-care systems in many countries are being dismantled and incidence of infectious diseases is on the rise.

According to Dr. A.R. Desai in his research work, "Urban Family and Family Planning in India", the real aim of family planning programme is to control the population as this is presumed to be the main culprit towards underdevelopment. Family planning programmes convey the message that poor people are themselves to blame for hunger; their irrational procreative propensities are responsible for impeding efforts by the Government in overcoming backwardness and providing the necessities for poor to survive even to distribute goods and services essential for families to perform their other functions properly.

The opposition to population policies is that these policies instead of showing the desired effects on the growth of population, have ended up actually empowering patriarchal controls over female sexuality, and thereby weakened the power of women. This in turn has seriously hampered promotion of the smaller families and few birth per women. Since it is women who are more concerned and desires reduction in the number of children born, their loosing power has serious implications.

FACTS

AGAINST MYTHS

VIKAS ADHYAYAN KENDRA

January '94 VOL I # 6

INFORMATION BULLETIN

COMMENT

THE MYTH OF HEALTH AND HEALTH CARE

The World Bank-influenced liberalization policy and market forces that is already taking a toll of the economy is now manifesting itself in the domain of public health with all its inherent and attendant ills. Malpractices are increasing with alarming frequency :

* *Action is being taken against an MNC, Johnson & Johnson, by the Food & Drug Administration (FDA) for marketing a new feeding bottle in open contravention of the Feeding Bottles Act that outlaws ads and promotion of feeding bottles in any form;*

* *The State Government recently ordered suspension of the license of another MNC, Glaxo, and its closure for 110 days for allowing rejected drugs to be siphoned off into the market without destruction.*

Another offshoot of this policy is making public health services the domain of the private sector which the World Bank considers "more efficient" than the public sector which admittedly offers abysmal services to the poor. Despite the element of truth private hospitals are, however, unregulated and profit-driven, preoccupied with the chase for Dollars in the name of "earning foreign exchange for the country"(!?). Patients at best either have to fend for themselves or be content with being at the mercy of the nursing staff who may be incompetent and unscrupulous as the above illustrations is an indicator of this growing trend. This indiscriminate transfer of public health services to the private sector is something unheard of even in the West which the health-care system in the country is trying to emulate. In Germany and the U.K. for instance 6% of the GDP continues to be retained by the public sector.

With hunger and malnutrition still widespread the promo-

tion of the private sector in the health field has encouraged the practice of importing costly medical technologies — and at concessional rates (!). A Bombay hospital for instance has imported seven Magnetic Resonance Scanners costing a massive Rs.5,80,00,000. This sort of promotion has led to the drastic change in public perception of health-care: good health is now understood as hi-tech and together with curative medicine is looked upon as the only viable health-care available. Clients therefore end up with the misimpression that their lives inevitably depends upon such hi-tech equipment.

The health-care industry has become a virtual preserve of the Western health-care system and with globalization is looked upon as a potential market for attracting health and health related products.

Providing basic health-care especially to the poor has so far failed. One reason for the failure is that health planners have imposed technocentric solutions to problems that are basically socio-political and cultural. When they, however, *do* succeed in examining the human causes of ill-health, all too often they focus on the behaviour and attitudes of the poor rather than those of the privileged minority.

This fact and the abysmal health situation makes it necessary to evolve an alternative paradigm of health-care, far removed from the current biomedical model and nearer to a socio-political and spiritual one. Contemporary health-care has become more of a consumer product to be bought and sold freely in the market, slickly and aggressively packaged and marketed like (say) soap. It is no longer an organic part of community-care as it once was. The need is to move from free-for-all, consumerised medical care, providing excellent but costly services for the few who can pay, to a genuine-commitment to 'Health For All'. It is essential to look for a more humanistic model that encompasses a sociocultural perspective. In the process, however, false notions and misimpressions about modern medicines and health-care systems need to be cleared and demystified.

MYTH:

THE UNDERLYING CAUSE FOR ILL-HEALTH AMONG PEOPLE IS DISEASE.

FACT:

Doctors and drugs do not bring health today any more than they did in the heyday of the development of allopathic medicine. What they do bring is the notion that disease is what ails people and medicine is what cures them. They hold out the hope of an end to pain. But in almost every case that hope is unfounded; the medical profession usually ends up just playing with the pathetic, disintegrated bodies of people as they die. In the US for instance, 60 percent of the expenditure on health is spent in the final years of peoples' lives: not to ease their deaths but to the effort to keep life in their disintegrating bodies for a few more days.

No wonder that allopathy has little success against the rich world's degenerative diseases like cancer, heart diseases and now AIDS. Imagine an average American worker in his death bed: every cell and fibre thoroughly permeated with food additives, pesticides residues, heavy metal pollution and radiation, his thoughts rebounding from the pain in his body to worries about his credit-card loans to frustrations with domestic life. The electron microscopes, infibrillators and lasers of medical science are about as relevant to him as they are to a local slum dweller. A few hospitals in the South, premature baby units have achieved rates that rival the best in the West. Yet 70 percent of these tiny newborns die within three months when they are taken home to overcrowded, ill-ventilated slums by their poor and undernourished mothers. Just as the lives of those tiny-tots could have been saved if their mothers had enough food when they were pregnant and if slums had drinking water with effective drainage and sewage systems, so the overweight American worker dying of cancer at 52 could have been saved if he had had a diet free of carcinogens and a job providing satisfaction and joy rather than frustration and pollution.

Far from being a riddle, the causes of cancer and heart disease, prime killers of the affluent classes, are as well-known as the cause of TB. If this is surprising it is mainly due to the knee-jerk tendency of looking for the cures of illnesses rather than for their causes.

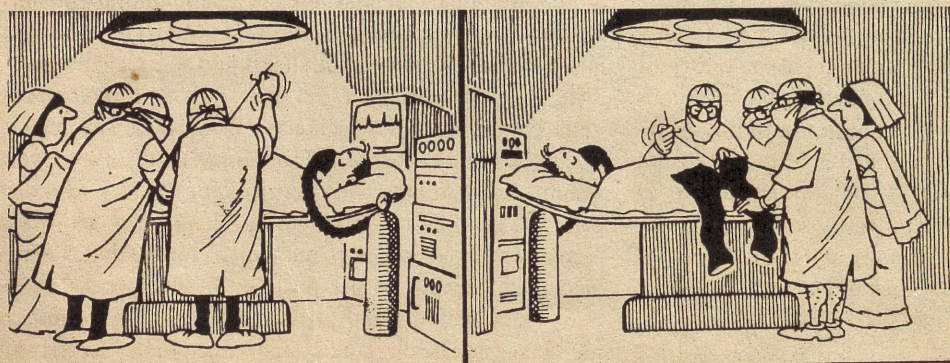
It is well-known that cancer is almost a totally preventable disease caused by smoking, food additives, alcohol, workplace and environmental pollution and radiation. The same is true for heart disease caused by faulty diet, lack of exercise and stress. In spite of all this knowledge, the search still goes on for the so-called cancer virus, a search that takes 50 times the amount of money spent on researching of the diseases in the South. There is no cancer virus. Hunting for such a virus is as crazy as looking for the parasitic worm that leads to (say) unemployment in the country. Moreover, environmental hazards have set up a barrier to further improvements in life expectancy. And if a cancer 'germ' is to be discovered that germ would be like any other germ—flourishing in bodies weakened by pollution, by faulty diet and discontentment.

MYTH:

THE HIGH RATES OF DISEASES, ILL-HEALTH AND DEATH IN THE SOUTH ARE LARGELY DUE TO NATURAL CAUSES E.G. BACTERIA, CALAMITIES, VIRUSES, ETC.

FACT:

Today more than 'natural causes', man-made causes are more to be blamed for high rates of illness and death in the world. Many of these causes are related to avarice: the efforts of some to prosper at the expense of others. A number of MNCs, both international and national, are taking a massive toll on the health and lives of billions of people with enormous negative impact on the health and survival of children. These health-affecting industries include pesticides, infant formula, tobacco, alcohol, drugs, non-essential, dangerous, overpriced pharmaceuticals, arms and military hardware; including international finance. Each of these represents a huge, powerful and massive profitable multi-billion dollar industry. Their cost in terms of human life and health is inestimable. The weakened physical resistance and the economic, mental and social problems provoked by these unscrupulous businesses add enormously to the impact of infection and malnutrition. And as



COURTESY: INDIAN EXPRESS: AJIT NINAN

usual, it is the poor who bear the brunt of the damage, especially as these industries have all increasingly targeted the South as their new, most valuable market, with India as the latest prize catch.

Human rights and action groups, the UN and some governments of SAARC and other countries have tried to control the damage caused by these powerful industrial agglomerates. But in the case of each and every one of these killer industries, TNCs for instance, the US government has defended their interests at the expense of health, quality of life, and often survival of millions.

Clearly, in view of these massive, officially condoned assaults on life and health, ranging from the IMF-mandated hunger to poisoning for profit, technological interventions like the "Green" "White" or "Blue" revolutions including UNICEF's Child Survival Revolution are less than enough. In fact, with their apparent simplicity of coping with the biological causes of poor health, they distract and lure people away from confronting the far more deeper and deadly social causes of the plight of the poor.

MYTH:

THE HEALTH AND SURVIVAL OF CHILDREN IN THE SOUTH DEPENDS PRIMARILY ON A FEW SIMPLE INTERVENTIONS, VIZ. GROWTH MONITORING, ORAL REHYDRATION THERAPY, BREAST-FEEDING AND IMMUNIZATION.

FACT:

The plight of children will never improve on just these "few interventions". A number of other more relevant factors are essential. These include health of parents, family survival skills, peace and violence in communities; on the availability, quality and cost of education, health services, water, shelter and transportation; the ability of people to organise and defend their rights; on local consumption of alcohol, tobacco and drugs; on who has power over whom; on war; on military expenditure relative to public service expenditure; on international trade economic relations; on the preservation and destruction of the environment; on the distance the mother has to trudge for cooking fuel; on the undermining of grassroot movements; on terrorism etc.

This myth is largely the brain-child of UNICEF whose analysis of the cause of poverty etc., has otherwise, been highly commendable. On offering solutions, however, it chickened out by proposing and promulgating stopgap technocentric interventions and measures. In trying to change the underlying causes of poverty it instead launched a "safety net" approach to the issue via the

strategy called "Child Survival Revolution", — dubbed "the revolution that isn't" — aimed at specific diseases rather than improving the quality of life. The strategy, not surprisingly, has the blessings of the World Bank, IMF, USAID, including a number of government and large international agencies.

Apart from being a blatant reversal of the Alma Ata Declaration this approach based on epidemiological foundation, is extremely fragile, and its logistical designs contains serious flaws. No one who is concerned would suggest that immunization of children against communicable diseases is itself an undesirable act. However, in this case, an obviously poorly designed and dependence-producing programme is an impediment to the implementation of primary health-care as enshrined in the Government's National Health Policy. There are also serious sociological and political implications. Because of the distribution of power, the ruling bloc in the industrialized North have long used access to health services as a means of perpetuating their social and economic control over the peoples of the South.

Besides, past experience with special programmes has shown, again and again, that they do not have an impact due to overestimation of the likely epidemiological impact on selected disease and major problems in implementation. Yet planners and powers that be consciously choose to ignore past experience and use their politico-economic clout and media hype to sell their cause.

There is also the possibility that even in the very unlikely eventuality of it being able to implement the immunization programme in such a way as to give satisfactory coverage and make an epidemiological impact, the children who might have benefited from the programmes would fall prey to other diseases caused by the unhealthy environment in which they are forced to survive. Thus even in the most optimistic situation, it can be claimed that the operation was successful but that most of the patients died.

MYTH:

ALLOPATHIC MEDICINE IS THE ONLY RATIONAL ANSWER TO ILL-HEALTH.

FACT:

Modern medicine has had only a minor role for instance in reducing mortality both in the West and rest of the world. Available data show that specific medical technology for each of the various infectious diseases in the West developed after a major decline in mortality had already taken place. (Cf. The Sociology Health and Illness,

tistics inspite of very low national income. For instance, Kerala, has achieved good health at a low cost.

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Average annual deaths in British India
(excluding Burma) 1932-1941

Disease	Average annual deaths	%
Fevers (including malaria)	36,22,869	58.4
Respiratory disease (including tuberculosis)	4,71,802	7.6
Dysentery & diarrhoea	2,61,924	4.2
Cholera	1,44,924	2.4
Smallpox	69,474	1.1
Plague	30,932	0.5
Other causes	15,99,490	25.8


SOURCE: BHORE COMMITTEE, Vol I, 1946

Facts Against Myths is a monthly bulletin of factual information on a number of development myths and fallacies, etc, including information against disinformation campaigns, propaganda and canards spread by communal and fundamentalist forces.

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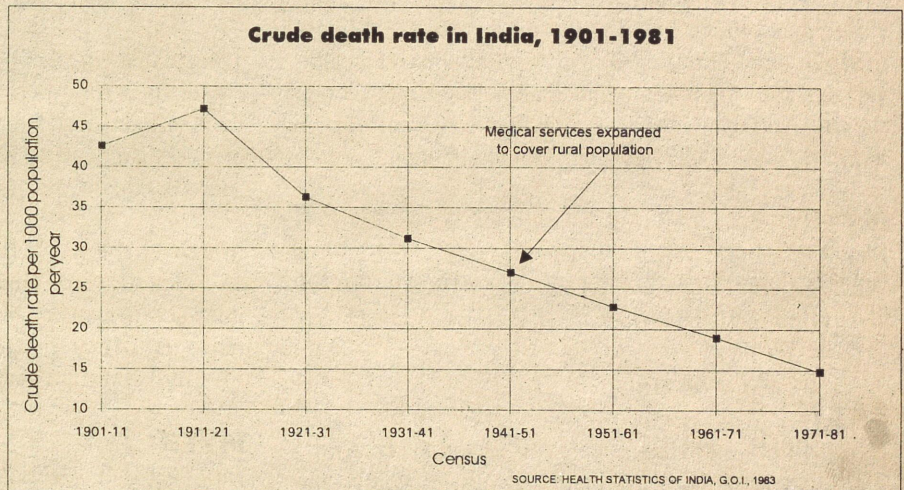
Conrad & Kern, 1981). Medical interventions for TB, Typhoid, Measles and Scarlet fever were introduced when death rates for each of the diseases were already negligible and still high. None of these death-rates, except polio, however showed the sharp decline that would have been expected if medical interventions had had the intended impact (Cf. Conrad & Kern above). In fact, it has been estimated that only 3.5% of the decline in mortality due to infectious diseases took place because of medical interventions. What this means is that more money for food, clean drinking water, sewage and drainage systems to flush away diseases-ridden filth had cut down deaths from infectious diseases significantly by 80 percent before medical interventions discovered 'cures' for them. (Present medical technology, incidentally, does not have any effective solutions to 'killer' diseases like cancer, etc., let alone AIDS.)

The same is the status regarding health in India. That is, mortality statistics show that the death rates also followed the same pattern as in the West. Death rates began to decline long before any effective medical technologies were accessible or used in the country. The only medical technologies that were available in the early years were vaccinations against smallpox and cholera. And although it has been considered a major disease, smallpox accounted for only 0.1% to 0.8% deaths per thousand population between the years 1880 to 1940. This disease was considered major because the then League of Nations had reported that the rate of incidence of smallpox in India was highest among all the countries for which statistics were available. But in the context of overall death rate, smallpox was not a major disease.

The same again is true for cholera and plague. The death rate due to cholera was between 2 to 8 times the average death for smallpox. But research showed that cholera vaccination during cholera epidemics was of little consequence. Epidemics could not be prevented. Similarly, with plague. Only after it had begun to decline, did the anti-plague vaccine become widely used.

Apart from the fact that most medical technologies were at the time either ineffective or unavailable, death rates in the country had anyway begun to decline from 1921 onwards. (Cf. Health Statistics of India, Govt. of India, 1983). It was only after Independence that medical technologies were extended to the general public. If technology, had

made a dramatic impact on the health status of the people, as claimed, there should have been a sharper decline in death rates in the period following Independence. This however was not the case, (Cf. Bore Committee Report, Vol.1, 1946). In fact, death rates have declined at a slower rate during the 30 years after independence as compared to the decline of death rates during the 30 years before independence.



The same is true for malaria. Despite enormous resources allocated to eradicate the disease, the impact of the malaria vaccine has been limited. Besides, the result of the anti-malaria strategy has been to produce DDT and other drug resistance while the incidence of malaria has increased. In fact, as per the latest report of the Parliamentary Committee on the National Health Programme, the evidence of malaria in urban slums has risen to 2,11,890 in 1991, i.e. around 2 million people in the country are affected by malarial fever. This has led to renewed efforts to develop new vaccines to combat the disease.

Medical technology therefore, has not made any dramatic impact in the country. Infectious and parasitic diseases are still leading to mortality. Even though the technology for controlling many of these diseases have been developed, these technologies have left diseases pattern in the country unchanged. The success in improving the health of the people has been marginal, at best.

MYTH:

THE TRADITIONAL HEALTH-CARE SYSTEM PRIMITIVE AND STEEPED IN MYTH.

FACT:

Traditional systems like Ayurveda, Sidda, Unani and Yoga as other such prevailing indigenous systems elsewhere in the South are highly advanced indigenous systems of

health and medical care. This fact is now recognised and Scientists in the West have begun exploring and experimenting with these indigenous systems. TNCs are already exploiting and even patenting some of the indigenous plants like neem, turmeric and garlic. Therefore it is important to look at such systems and guard against some of the dangers inherent in the Western model in attempting to evolve an alternative health-care system. Therefore it is important to look at such indigenous systems and guard against the pit falls of the western mode in an attempting to evolve an alternative health-care system. At the same time there is need to be alert to the attendant danger of exaggerating the efficacy of such a system; neither idealising nor romanticizing it.

MYTH:

PRIVATISATION AND INCREASED COMPETITION WILL "DELIVER THE GOODS AND ALSO IMPROVE THE GENERAL STATUS OF HEALTH-CARE IN THE COUNTRY".

FACT:

Competition in the health-care profession leads to false expectations. With the health industry being rapidly converted into market economy with hi-tech inputs and the profit motive as the driving force, widespread malpractices have crept into the whole industry, costing patients' lives, with malpractices becoming rampant. So much so, one such malpractice led a High Court Judge to order a survey of the 500 private hospitals and nursing homes in Bombay. One-third were found to be unregistered. On January 31, 1994, *Indian Express* reported the High Court ordering suspension of the license of Torrent Pharmaceuticals Limited in Gujarat on "Cardiwell Plus" tablets, for treatment of cardiac attacks and paralysis, that were found to be unconsumable following lab tests. Thoughtless privatisation of the health-care system has led to a great deal of damage. For instance in China where over 36,000 people die of TB ever year. Through the 60's and 70's the country had made good progress on TB control. Since the early 80's however the infection rates have either stagnated or increased mainly due to its decision to make patients pay for their treatment. But as soon as it reverted to free treatment for TB, the situation improved.

Apart from enjoying public subsidies in the form of free training of their personnel and various tax concessions, private hospitals have been responsible for distorting the country's medical as well as social values and influencing medical education away from care to super-specialization.

Intense competition is also leading to unnecessary and even dangerous over-investigation, over-medication and

over-surgicalisation. And yet many of their services are no better and sometimes even worse than that of the government and municipal medical college hospitals which have much better resident staff and no personal monetary consideration in providing services. With the exception of a few, nursing homes are mere converted apartments attracting those who can afford the expensive private medical care or who avoid going to public hospitals crowded by the poor.

Trained in medical colleges, medical practitioners today, especially in rural areas — lacking in most basic facilities for investigation and treatment — "practice a form of blunderbuss therapy with medical representatives as their chief source of the latest information and education."

Moreover, the World Bank's worldwide promotion of its so-called structural adjustment programmes which introduced cost-recovery and reduction in health services had led to rise of maternal mortality rates as poor women can ill-afford clinic attendance. Zimbabwe is a case in point.

MYTH:

MEDICAL TECHNOLOGY AND ECONOMIC DEVELOPMENT ARE MAJOR DETERMINANTS OF HEALTH.

FACT:

The major determinants of health are social and political. Far reaching improvements in the health of the people have instead occurred with gradual improvements in the quality of life; everything from fairer wages, improved working conditions to better water supply, public education, and social guarantees to meet people's essential needs.

The accompanying myth that the answer to widespread poverty and ill-health was imposed on the poor countries by the World Bank, IMF, among others, as a strategy to promote national growth through large scale industry and agribusiness. They however, realise that such an equation would mainly benefit the industrialists, the bureaucrats, the rich landlord and farmers. So they floated the theory that by stimulating the growth of a poor nation's total Gross National Product (GNP), the fruits of development would 'trickle down' to the poor. But this did not take place. As the economy and production grew, the gap between the rich and poor widened; more trickled up than trickled down; the rich grew richer and the poor poorer. In the process, the problems of poverty, homelessness and the diseases of poverty worsened. Obviously then neither medical technology nor economic growth are determinants of sound health. Some countries, in fact, have even achieved favourable health sta-

FACTS

AGAINST

MYTHS

VIKAS ADHYAYAN KENDRA

February '94 VOL I # 7

INFORMATION BULLETIN

COMMENT

THE MYTHS OF DUNKEL & GATT

Way back when he was a Senator and later US Vice President, Hubert Humphrey reportedly had remarked,

"If you are looking for a way to get people to lean on you and be dependent on you, in terms of their cooperation with you, it seems...that food dependence would be terrific".

In almost every respect this tip has not only been followed up to perfection by the convenors of the GATT negotiations but they have even improved upon it. The GATT Treaty is an illustration.

GATT (General Agreement on Tariffs and Trade) was established in 1947 to liberalise and promote trade between countries. It holds negotiations between participants to reach agreements at sessions, called the Uruguay Round, held twice a year, on issues that are worked into a draft agreement, the Dunkel Draft Text (DDT), to be shortly dubbed the Dunkel-Sutherland Treaty. GATT's whole structure is such that it is very top-heavy, i.e., dominated by the rich North, with the South having no right to make amendments to DDT. The South has either to reject or accept it *in toto*. The DDT is a cruel shift in the global focus set in the previous decades. Back then, GATT was to aid the South close the gap between them and the industrial North, a gap made even wider by the debt crisis. The Draft goes way beyond the original contours and mandate set for it at the 1986 start of the Uruguay Round. The changes now being pushed are the lowering of subsidies given to various agricultural inputs, such as fertiliser, electricity, and water; importing a given percentage of domestic consumption even if the country is able to meet its entire consumption needs from domestic production; introducing patent rights in agriculture and scrapping of priority sector credit programmes that will directly affect agriculture.

At the GATT negotiations concluded in December 93, a

new text came into operation, the Dunkel-Sutherland Document on the Declaration of Rights of Transnational Corporations (TNCs) endorsing TNCs with an international official seal and which is to be ratified into a on April 15, 1994. This Treaty will pave the way for TNCs to monopolise and dominate industry and agriculture. It will also severely damage the prospects of new technologies for especially the countries of the South. It states that process patent should be replaced with product patent. Any patent taken out by a firm in any member-country of the new GATT treaty, will be valid in any other member-country i.e., all patents will be automatically valid in countries who are members of the new Treaty. Under this Treaty a patent will be considered to have been worked in any country as soon as that country is able to import the product resulting from that patent. On the other hand it implicitly prohibits all patents in alternative processes leading to the production of an already patented product.

It also allows patents in newly found micro-organisms, and genetically engineered plants or animals.. All this means that anybody who wants to use a method using micro-organisms, that is already patented, will have to seek a licence from the patentee. This treaty virtually abolishes the provision of compulsory licensing. Thus a TNC does not feel unduly threatened if it cannot license or use a particular patent within a year or two. It has another 18 years in which to reap profits. In fact, its power preempting other innovations that may require the use of the patented inventions has increased enormously. The net result is that not only may the diffusion of the patent product accompanying processes be greatly slowed down, the rate of innovation itself may be slowed down in all the (GATT) treaty-bound countries, that is, effectively the whole world. According to the Centre for Holistic Studies, Bombay, acceding to this demand "could mean much worse terms for technical collaboration and may even lead to technological blackmail in critical issues".

This development is clearly one of the most massive power grabs in modern history and its next step will be

to replace nation states as dominant geo-political actors. Already the merger of TNCs and State power is evident in major industrial countries. Besides, they are well ensconced in most UN agencies including the IMF and World Bank and checkmate any legitimate decisions against their dubious activities. They also openly use the US Government as their agent in dealing with other governments in international negotiations. Nowhere has this been more vividly revealed than in the Uruguay Round of GATT negotiations.

Such lobbying tactics is also resorted to by their Indian corporate allies as also the bureaucracy and industrial trade organisations. Unlike their 'pardeshi' allies, however, these "nationalists" engage in demagogic stunts — "Swadesi", "threat to India's sovereignty", and the like — to conceal their real intentions: their support of the new Dunkel Sutherland Treaty and to also extract as many concessions, bargains and deals as possible from the GATT power-brokers: assurances of protection of their domestic markets and share of foreign ones.

Strategies like these and other misleading positions on GATT including claims and sophisticated arguments — with illusionary offers of a new millennium — need to be bared and exposed for what GATT, in reality, is and what it really represents to especially the countries of the South.

It is obvious then that it is not so much their concern for millions who go hungry each day but rather on the one hand the sharpening trade conflicts between the main economic powers and their efforts to hold onto their part of an ever-shrinking world market; and on the other, to appropriate the natural resources of the South. It is partly this reality and other implications that lie behind this (four-letter) word, GATT!

MYTH:

DISMANTLING PROTECTIONIST MEASURES AND OPENING UP MARKETS WILL LEAD TO WORLD ECONOMIC RECOVERY AND BOOST WORLD TRADE TO \$213 BILLION, THUS, BENEFITING ALL COUNTRIES.

FACT:

This is merely an assumption! It rests partly on the belief that by concentrating on resources within each country into the most productive and competitive sector, free trade will assist countries to maximise their 'competitive advantage', and partly on the belief that the more people trade, the better off they will be.

Both these beliefs are false. Firstly, the nature of

'comparative advantage' in the modern world has more to do with absolute price advantage than, (say), the differences in climate often cited in economics textbooks: those who can keep wages lowest and minimise intrusive social and environmental regulations will reap the highest profit and gain the greatest market share for their goods. In a world where markets have been wrenched open to all-comers, such cut-and-thrust business practices benefit those who own successful companies, but leave workers and the environment in a miserable state. Secondly, on the global market, it is not individual buyers and sellers who set the national and international rules that determine who benefits from trade: that role has passed to the most economically powerful governments and their political allies, the TNCs that control 80 percent of world trade. Is it any wonder, therefore, that the so-called Dunkel Draft reflects these interests?. In fact, throughout the negotiations for the Uruguay Round, the concerns raised by the South — the issues of debt and declining terms of trade, etc., - were declared "off limits" or sidelined to the status of a 'circus' (Cf. K. Watkins, *Fixing the Rules*, cited in "Cakes & Caviar" the Ecologist, #6,93). Meanwhile, the rich North, headed by the US, have imposed an agenda tailored to their strategic needs, using the UR "to restructure the rules of world trade around the interests of powerful TNCs, (forcing) developing countries to open up key economic sectors, and to surrender a large of their sovereignty in economic policy to foreign companies and international institutions" (Cf.K.Watkins, above.) The result is a regime that, whilst protecting corporate interests, pauperizes millions in the South, increases environmental degradation and strips away the rights of national governments to protect their citizens' interests. The main beneficiaries will be the rich North. Indeed, as the Ecologist of London points out, two-thirds of the expected increase in 'global income' attributable to GATT will accrue to the OECD countries where just one-third of the world people dwell. (Cf.I.Goldin, et al, *Trade Liberalization*, OECD/World Bank, Paris, 1993). In Indonesia, Sub-Saharan Africa, North Africa and the Mediterranean countries, on the other hand, real incomes are expected to fall - together they will lose around \$7 billion a year in earnings. The GDP of African countries is expected to decline by between 0.2 and 0.5 per cent.

Such losses are due largely to GATT's clauses on agricultural liberalization and hence are opposed by opposition parties, action groups, among others. These clauses — particularly those covering reductions in domestic support for farmers and access to markets - are illustrative of the so-called new world order that the GATT agreement will impose, which India has decided to ratify on April 15, 1994. Finally, as an aside, the \$215 bn boost to world trade and other numerical reveries

“was a mendacious concoctions of the GATT Secretariat — a super sales-promotion fraud” but which served its purpose!

MYTH:

EXPORT MARKETS IN THE NORTH, OPENED UP BY GATT, WILL BE MOST BENEFICIAL TO FARMERS IN THE SOUTH.

FACT:

The extent to which a country benefits from trading is regulated not so much by the volume of its trading as by the terms of trade, which for the countries of the South has been steadily declining since the last two decades especially since the vigorous imposition of SAP which apply unilaterally almost the very steps that GATT will apply globally. Often this decline is directly linked to SAP. Third World Network of Malaysia reports that in Ghana, for instance, the main thrust of SAP was towards reducing imports and increasing exports, particularly cocoa. Not surprisingly several other countries applied just about the same policies. Consequently, cocoa-prices fell by 48 per cent between 1986 and 1989, leaving Ghana's terms of trade in 1990 only 75 per cent as favourable as they were in 1987. On the other hand, this decline, correspondingly, became a major gain for the rich North whose grain TNCs — CARGIL, CONTINENTAL GRAIN, LUIS DREYFUS, BUNGE, ANDRE & Co. and MITSUI & Co - manipulate agricultural prices in a manner similar to the method OPEC used to control of oil prices in the 70s.

Meanwhile, the benefits will hardly percolate down to the poor in the South, the real producers of food that will be exported. Thus, GATT will really make TNCs fat — not the poor farmers of the South — with TNCs dominating the export economy. As the export economy grows, poor farmers will have little option but to bend to the dictates of the TNCs simply to survive, growing and exporting crops, for them on contract. Lest one forgets, increases in exports means less production for local consumption forcing the need to import food, thus promoting food dependency.

This focus on growing export-crops has already led to more and more farmers moving away from the production of food crops to the production of more lucrative oilseeds, tobacco, cotton etc. Farmers in Punjab for instance, are growing tomatoes and potatoes for the TNC, PEPSI; in Karnataka farmers have shifted to maize and sunflower cultivation for CARGIL; in Andhra Pradesh, farmers have taken to farming prawn and carp.

The ill-effects of such an export-oriented agricultural production will be further aggravated under the GATT clauses prohibiting countries to impose bans upon food exports even during periods of food crisis. This is

nothing but legalised crime.

The related myth that exports will, in the long run, lead to prosperity, prompted the Agriculture Secretary, M.S.Gill, to say (in an interview with India Today): “Food security is not grain in the go-downs. It is dollars in the pocket...If farm exports earn us enough money, then like Marie Antoinette, I can provide not only bread but cake and caviar”. The following illustrations however prove Mr. Gill wrong:

- * The Bengal famine of 1942 — when 2 million people died - occurred at a time when the country's market was highly liberalized, producing cash crops like cotton, tobacco, tea, coffee, jute, indigo and opium for export; and it was precisely in areas devoted to such cash crops that the famine was most felt;
- * Thousands died in Ireland in the 1840s while Irish grain continued to be exported to England;
- * Thousand died in Ethiopia in the 1970s and 80s while Ethiopian lentils, coffee, cotton and beef continued to be exported to the North.

Unfortunately, our Agriculture Secretary's knowledge of history is apparently poor. Comparing himself to Marie Antoinette, he promises our people “cakes and caviar”. He would do well to remember that the unfortunate queen failed to provide bread — which was what the people demanded — let alone cake!

MYTH:

PATENT PROTECTION IS ESSENTIAL AS IT STIMULATES INNOVATION.

FACT:

More often than not, patents actually stifle innovation. In “Biotechnology and the Environment” the author Vandana Shiva points out that one of the results of property rights over living systems has been secrecy in plant breeding, plant genetics research, and restrictions on the exchange of germ plants. Secrecy for patents and exclusivity together, she points, out will choke off all scientific exchange in plant genetics. Besides, rather than merely stimulating innovation, the patent system applied to living matter redirects attention towards those products that provide for the broadest and easiest patent protection, not for the largest public good.

Another researcher, Jack Doyle, observes that “patents and intellectual property rights are more a statement of territory than a measure of innovation. But when those “territories” are food and the substances behind the

enshrined within GATT, can be and are, actually used as a non-tariff barrier against exports from the South. For instance, Philippine coconut and copra exports have been denied access to US and European markets on the grounds of alleged aflatoxin content — a reportedly cholesterol ridden substance being banned by the industrial North. But the aflatoxin argument is purely a non-tariff barrier masking as a "sanitary" standard!

MYTH:

GATT IS ALL ABOUT MARKETS, TRADE LIBERALISATION, NEGOTIATIONS AND AGREEMENTS. ISSUES LIKE ECOLOGY, ENVIRONMENT, ETC. THEREFORE DO NOT COME UNDER ITS SPHERE OF ACTION.

FACT:

Trade and environment are inextricably linked. The consumption of natural resources and the resulting impact on the environment is very much influenced by patterns of international trade. Trade practices, thus, play a vital role in determining the scale and character of resource exploitation. The ability to control the export of resources is vital to any country to establish conservation policies to protect its natural resources. This ability will be undermined if export controls that now limit resource exploitation are eliminated. It could then be "GATT illegal" for a country to take steps to preserve scarce resources, if they are judged to be obstacles to trade. Limiting the rights of nations to limit the export of their resources will greatly benefit TNCs who are only keen that the world's natural resources be freely and cheaply available.

For the South, import-export deregulation will also benefit private companies producing export-goods, not

food for the masses. The destruction of rainforests is a good example. Demand from fast-food chains (e.g. McDonalds, etc.) for vast amounts of beef stimulates the clear-cutting of rainforests, land and its conversion to cattle grazing and single-crop export agriculture. Little is grown for local consumption. And resources vital for the preservation of global and local ecological balance are put in ever greater stress.

The most damaging aspect of such international trade is the subsequent lowering of the world's prices of goods. Reducing prices adds pressure on natural resources in several ways. Farmers are forced to intensify their production in trying to make up in volume what they lose due to lower prices. The only quick way to do this is to use more agricultural chemicals to clear more forests and open up more land.

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production of food, there is an order of protected power that is broad and far reaching."

Besides, patent protection is essential for innovation in so far as it brings profits for the TNCs. But what about traditional farmers who have been carrying out innovations over centuries - - as also public institutions over decades, e.g. ICRISAT and all public sector agencies - without any patent protection or property rights?

MYTH:

PATENTS WILL SIGNIFICANTLY ADVANCE NOT ONLY AGRICULTURAL DEVELOPMENT BUT ALSO EARLY COMMERCIALISATION OF PRODUCTS, AND WILL IMPROVE HEALTH AND FOOD SUPPLY IN THE SOUTH.

FACT:

This rhetoric is put forward by TNCs and their governments in the North. It is not the countries who are supposed to benefit from worldwide intellectual property protection who are demanding patent protection. It is the TNCs!



The imposition of strong patent protection for monopoly ownership of life processes will, instead, undermine agriculture in the South, including the cultural heritage and the ethical fabric based on agriculture in which the basic life processes are considered sacred, not as commodities to be bought and sold in the market. It will discredit and destroy traditional knowledge-systems about seeds and livestock including methods of soil rejuvenation and water management. The cow for instance will give way to patented livestock and according to the US patent law, the offspring of the patented livestock will be subject to royalty charges. Patents will also affect plants. Seeds which have been treated as sacred, as gifts, exchanged freely between farms, will become patented products. Such seeds which have been part of an agrarian ethos, interwoven with different farming

systems and have adapted over centuries to local conditions, and have been drought-resistant will now, through patenting, be appropriated from traditional farmers who will henceforth have to buy patented seeds each year! This loss will lead these farmers to enormous hardship. Biotech seeds are neither drought nor disease-resistant. Farmers will not be able to afford the high cost of patented seeds, that too for each sowing, nor the cost of patented biofertilisers and biopesticide which will follow if micro-organisms are patented. They will be forced to sell their land and become landless labourers, sliding still further into poverty and misery. Some will migrate to cities and swell the ranks of the unemployed.

Way back in 1991, Dr.K.S. Gill, Vice Chancellor of Punjab Agricultural University, Ludhiana, stated that agri-business TNCs were dictated by short term gains which is a long-term and continuous process. He added that in India where plant variety protection is non-existent, the private sector would be tempted to breed and sell hybrid seeds of crops rather than working on self-pollinated crops. "The farmer cannot plant back the saved seed from his crop for hybrid varieties unlike the self-perpetuating varieties of self-pollinating crops." Private seed companies will succumb to the big TNCs if the IPR regime is acceded to by India and this will reduce the genetic diversity among seed varieties reaching the traditional farmers.

A more ominous situation are threats from seed institutions in the North: Hans Leenders of the World Seed houses demand abolishing farmers' rights to save seeds. He says "Even though it has been a tradition in most countries that a farmer can save seed from his own crop, it is under the changing circumstances not equitable that a farmer can use this seed and grow a commercial crop out of it without payment of royalty. The seed industry will have to fight hard for a better kind of protection". Elaborating on this, N.Riding of the TNC, MONSANTO, adds, "the major challenge to genetic engineering...is to support uniform worldwide property rights". In short, to hand over the global monopoly of agriculture and food-system to the TNCs; a desperate urge to have a uniform patent system that allows them to control and own life on earth as their private domain!

Patent protection in agriculture is really therefore for protection from traditional farmers, the original breeders and developers of biological resources in agriculture. As Vandana Shiva warns, it will displace the farmer as a competitor, transform him into a supplier of free raw material, and make him dependent on industrial supplies for vital inputs like seeds.

MYTH:

THE SOUTH HAS BEEN ENGAGING IN 'PIRACY' AND 'UNFAIR TRADE PRACTICES' THUS NECESSITATING IPR PROTECTION.

FACT:

This is merely a motive for the US to manipulate trade as an instrument to enforce patents and IPRS on sovereign countries of the South! Patents after all bring in massive profits for TNCs, the political allies of the US Government: Hence, the argument that potential profits - royalty payments from farmers amounting to \$7 bn for patent holders - are not being made owing to an absence of a worldwide implementation of US patent law. The US claims it is losing \$100 to \$300 bn in patent rights. However, the US conveniently overlooks the fact that the South already reeling under debt and interest payments, leading to \$50 bn transfer of funds to the North, any further revenues generated for TNCs by proprietary rights is an impossible demand, though a typically outrageous one!

The US and rest of the North also conveniently overlook the fact that traditional farmers of the South too have proprietary rights. According to the Rural Advancement Fund International, the 'pirate' roles are substantially reversed. The US owes the South \$302 million for royalty for farmers' seeds and \$5.1 billion for pharmaceuticals. In other words, in just these two biological industries the US owes \$2.7 billion to the South. Even the US Department of Agriculture Report states that germplasm import has contributed \$70 billion to the US economy. A wild tomato variety (*Lycopersicon Chomrelewski*) appropriated from Peru in 1962 has contributed \$8 million a year to the American tomato processing industry by increasing the content of soluble solids. Yet none of the benefits is being shared with Peru, the original source of the genetic material.

Indeed, these genetic resources have provided genes of enormous commercial importance to agriculturalists in the North. Wild plant varieties contributed \$340 million per year between 1976 and 1990 to the US farm economy with wild germplasm contributing \$ 66 billion, which is more than the total international debt of Mexico and the Philippines combined! The wild varieties are owned by sovereign States and by locals.

The losses to the South due to this unequal and asymmetric biological exchange are illustrated by the following:

- * Of the 127 base collections of genetic resources, 81 are in the industrial North, and 17 in the national

collection of developing countries in the South;

- * The value of the South's contribution to the US wheat farmers in any year is not less than \$500 million. It is \$120 million for rice, and \$60 million for beans. In total, American farmers receive for these three crops alone the value of \$680 million from the South;
- * A Turkish barley landrace resistant to barley yellow dwarf virus was donated free saving US farmers \$150 million a year;
- * The Indian selection that provided American sorghums with resistance to greenbug has resulted in \$12 million in yearly benefits to American agriculture;

These illustrations merely hint at the losses being suffered by the South in an unfair exchange of genetic resources. If royalty payment is unjustly added to this uncompensated flow, the debt burden of the South will increase tenfold.

MYTH :

THE DUNKEL DRAFT ACT STIPULATING REDUCTION OF SUBSIDIES TO AGRICULTURE IN THE NORTH WILL GIVE A BIG BOOST TO INDIAN AGRICULTURE.

FACT :

On the contrary! The GATT conditions are framed in a manner favouring countries that are net exporters of farm products whereas India is a net importer. Besides, the GATT rules are meant for countries where agriculture is a purely commercial activity and where vulnerable sectors like our small and marginal farmers are totally unknown. Third, India cannot take advantage of such new markets because with the penetration of TNCs in the farm and food processing sectors, it will be the TNCs and not Indian farmers who will reap massive dividends of any subsidy-relaxation. Fourth, on entering the global market for agricultural produce, price and supply will not be regulated by Indian agencies but by international grain cartels like CARGIL and CONTINENTAL which control the market. Furthermore, even if the country is able to export its surplus, it does not follow that markets will be there automatically for the asking especially in the rich North which is the target of the Cairn's group (countries from both the North and South that have united together to protect their interests as primary exporters of agricultural produce). This group because of their far superior competitive advantage will grab markets far more effectively than India. Still further, this group is known for insistence on strict product standards which,

FACTS

AGAINST

MYTHS

VIKAS ADHYAYAN KENDRA

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INFORMATION BULLETIN

COMMENT

DEPO-PROVERA AND THE FERTILITY CONTROL MYTHS

"What is happening to the female body...is like what is happening to the balance of life on the planet".

- Naomi Wolf, "The Beauty Myth".

In recent months two crucial issues affecting women very drastically have become the focus of intense political debate. Directly or indirectly both relate to the technologies of fertility control which in the context of the forthcoming World Conference on Population and Development (in Cairo) is being given an inflated relevance. Instead of zeroing in on the less-publicised fact of the over-consumption patterns and lifestyles of the rich that seriously threaten the carrying capacity of our planet, the population control lobbies are more obsessed with the so-called over-population problems in the South.

The issues in question involve the Government's decision to sanction the marketing of the harmful contraceptive, Depo-Provera; the other is the recent scandal of mass hysterectomies on mentally handicapped women. With biotechnologies, genetic engineering, the new reproductive and contraceptive technologies, they are being hailed and promoted as the great hope of the so-called hi-tech revolution. In their implications, however, they are ominous. Women's and health groups, among others, are making it amply clear that contrary to claims, these technologies are not leading to any significant gain in the lives and status of women generally. Instead, they are leading to era of technological re-organisation of human reproduction; promoting and mandating intervention into women's very personal lives - that is, into their reproduction, on the basis of ('unborn children') embryos, and as hope to the infertile and relief to the mentally disabled women.

Paradoxically, these "scientific breakthroughs" are occurring at a time when women's all-round health situation continues to dip alarmingly with women subjected to various forms of oppression likes sex-determination (e.g. amniocentesis) etc.; later persuaded to undergo abortion. The Government recommendation to stop maternity benefits — for women who, for instance, choose to have a third child — further strengthens the pressure on them to undergo such tests. With the unbalanced sex-ratio, high mortality of girl children and discrimination against the female-child, makes these issues a matter of grave concern. Yet, contraceptives like Depo-Provera, Norplant, etc., are allowed to be promoted and dumped upon women in the South where, women unlike those in the North, lack informed choice. The rationale, however, of marketing such harmful drugs in the country is, as P.Dasgupta the Drug Controller of India frankly admits, "...part and parcel of the liberalisation of the (Indian) economy". Ultimately, however, these technologies are devious interventions into women's lives — instruments of fertility control: be it through sex-determination, contraceptive devices or hysterectomies. Such interventions are legitimised further on humanitarian grounds: as benevolent means of expanding women's choices in contraceptives that have no 'side-effects': be they injectables like Depo-Provera or surgeries like hysterectomies. And also, as hope for infertile couples; as help to women against bearing handicapped children minimising the risks of pregnancy and child-bearing; and as relief to parents and caretakers of mentally disabled women. The methodological principle is to highlight the plight and unhappiness of a single individual, and appeal to the public to help such an individual, disabled or otherwise. All kinds of pressures including emotional blackmail are resorted to. However, more than being a "choice", these so-called advances are more a means of social control; a form of involuntary imposition. New Reproductive Technologies, (NRTs), for instances, are invasions into women's lives that lead to their de-personalisation and loss of control over their bodies.

Moreover, women in the South serve as guinea-pigs for scientific research and the South itself as dumping grounds for Depo-Provera. And whether in relation to controlling or enhancing fertility these technologies also burden women with total responsibility of fertility. Thus, more than an advance to women's overall well-being such technologies are clearly sexist, racist and caste-class in their orientation: a direct response of the philosophy of selection and elimination. In the context of religious fundamentalism spreading in the country with the accompanying chauvinistic ideologies, the implications of such invasions into women's reproductive rights make all such "advances" all the more sinister. And last but not least, marketing of such contraceptives is big business. The annual sales of Depo-Provera, for instance, amount to a massive Rs.300 crores the bulk of which is repatriated as profits by TNCs like Upjohn.

Besides, the issue of Depo-Provera in particular, has opened up a Pandora's Box — of global corruption and payoffs, with countries in the South having to face its disastrous impact. To illustrate:

- *The Pioneer* (New Delhi) of May 23, 1994, reported that Upjohn Inc., a healthcare MNC and manufacturer of Depo-Provera paid \$2,710,000 in bribes to government employees for the purposes of obtaining sales to governmental agencies. Bribes by Upjohn to hospital staff amounted to \$1,388,000. These figures exclude "small amounts paid to minor government employees to expedite governmental services". The MNC admitted all this, finally, in a submission to the US Securities and Exchange Commission;

- In another (unpublished) case a reporter S.Gagenson cites a statement presented on August 6, 1987, at the US House of Representative Committee Affairs Hearings on the use of Depo-Provera by the Indian Health Service (IHS). It asks why the IHS is distributing Depo-Provera; why it does not place limitations on its use; and why it fails to ensure that Indian women who receive the drug are informed fully of its risks. The IHS confessed it has provided Depo-Provera for contraceptive purposes to approximately 150-200 women over the past several years and supplies it to about 35 women many of whom are mentally retarded and unable to protect their rights.

In this situation it becomes imperative to uncover as far as possible such surreptitious maneuvers on the part of powerful corporations and the government's abetment of such unethical practices. On the other hand it is necessary to resist the increasing medical/scientific definition of and control over women's reproductive nature by decoding the implicit (medical/scientific) notions and power-structures of these technologies; exposing how "official knowledge" makes dangerous drugs like

Depo-Provera acceptable to women and how its advocates pay bribes for worldwide distribution. Finally to raise awareness on the illusions of the safety of such contraceptives.

MYTH:

DEPO-PROVERA HAS BEEN SCIENTIFICALLY TESTED AS SAFE, CONVENIENT AND THE BEST CONTRACEPTIVE CHOICE

FACT:

The argument is based on a premise that may be partly true but dangerously false. In 1978 the US Food and Drug Administration (FDA) declined to approve Depo-Provera as a contraceptive. The drug TNC, Upjohn, appealed for a re-examination of all relevant studies on Depo-Provera. The Public Board of Inquiry, an independent body, that re-examined the case recommended that FDA stick to its decision and *not* approve Depo-Provera for contraceptive use. This report, exposing the quality of scientific research on Depo-Provera, was an eye-opener. "The collection of data from the women using (Depo-Provera) has been too haphazard and uncoordinated ..." Yet, the drug continued to be administered, particularly to women in the South. The Board's indictment of the quality of research refers to the manner in which Depo-Provera advocates selected studies to perform on this drug. The way they chose procedures and statistical tools for those studies, selected data to highlight or ignore, classified and evaluated information from the studies, presented data and distributed the information yielded by the studies were seriously challenged.

Gena Corea, of the Feminist International Network of Resistance and Genetic Engineering (FINNRAGE) interviewed witnesses and checked on court hearings, etc., on the Depo-Provera study. She uncovered highly questionable methods to conduct the scientific research. Her investigations appeared in the book, "*Restructuring Babylon: Essays on Women & Technology*". Corea shows how, under the mask of scientific research, the TNC Upjohn and its collaborators manufactured results of the studies on Depo-Provera favouring their position. The following illustrates how Upjohn researchers and manufacturers used techniques to achieve this objective.

1. Selection Procedures

Certain procedural norms were selected that influenced what information became available on Depo-Provera. Selective facts were publicised and the more negative but relevant ones kept secret. For instance, the crucial information on the study of the monkeys. The tissues from these animals that died before the sched-

uled 10-year exposure period were not examined by the same pathologist who had examined the tissues of the 10-year surviving animals. "The different background, experience and orientations of the two different pathologists would magnify the unnecessary 'background noise' introduced in the study", according to one researcher investigating the case.

2. *Selective discrimination.*

Instead of providing the necessary information on the study of the beagle dogs, the Upjohn researchers did not reveal the gall-bladder lesions that were found in these animals owing to the intake of all the doses of Depo-Provera. They highlighted only selected findings of this drug on these animals.

3. *Mode of classifying information.*

What were really very serious physical damages to women's bodies, as a result of taking Depo-Provera, the Upjohn researchers codified this important piece of knowledge as merely "side-effects" e.g.

- Depression is a side-affect of Depo-Provera which merely destroys the entire quality of women's life;

- It is doubtful that in a male hormonal contraceptive the risks of "loss of libido and/or orgasm" would be judged "acceptable" or labelled "minor". Certain male physicians, at previous Depo-Provera hearings, have expected women simply to endure intercourse without sexual arousal. On this, Gena Corea says, "The fact that many men have accepted with equanimity that women will routinely endure this horror, the fact that they name this issue a "minor" "side"-issue, an issue barely worth mentioning, is not only a testament to their ability to define social reality by excluding women and women's experience, but is also a powerful statement of their valuation of women".

"Medical ethics treats interference in male sexuality as an atrocity. Depo-Provera, a drug that lowers the libido of (males), is controversial because it is barbaric to intervene in male sexuality. But female sexuality is still treated by all institutions as if it were a hypothetical one" - Naomi Wolf, "The Beauty Myth".

4. *Data presentation*

In presenting data on the study the researchers stated that the effects of Depo-Provera has "no known risks". Their statement, instead, should have been "Inadequate data available".

5. *Dissemination of information*

In disseminating the pros and cons of Depo-Provera, the researchers went overboard in mentioning merely the pros of Depo-Provera, using media-hype and propaganda for publicity. The wider negative qualities of the drug on the other hand were de-emphasised. Some of

the damages of Depo-Provera which they failed to state :

1. Women can experience some immediate effects of the drug including significant weight loss or gain; depression; menstrual abnormalities; amenorrhoea; diminution or loss of libido and/or orgasm; nausea; headache; fatigue; dizziness; loss of scalp hair; oedema; and allergic rash.

2. Depo-Provera's long term effects on women are unknown. Among suspected risks of the drug are: cervical, endometrial and breast cancer; suppression of immunological response; sterility; masculinization of female foetuses, feminisation of male foetuses and congenital abnormalities leading to the birth of "monster-babies".

That the risks of these long-term effects may be substantial is demonstrated by

- Evidence of lowered host resistance to infection in Depo-Provera-treated dogs. The drug is also suspected to suppress immunological mechanisms. This may make those treated with the drug more susceptible to illness;

- Upjohn's first dog study which reveals that Depo-Provera kills animals;

- A finding that 2 animals out of 12 in Upjohn's monkey study developed cancer in the uterus. (In rhesus monkeys, uterine cancer is very rare);

- Suggestive, though not conclusive, evidence that Depo-Provera may increase a women's chances of developing cervical cancer;

- Concern that Depo-Provera, which concentrates in breast milk, may impair the pituitary gland of the nursing child;

- Concern that women who are already pregnant while on the drug may, as a result of the progestin, bear deformed children.

MYTH:

WOMEN THEMSELVES FREELY CHOOSE DEPO-PROVERA, AN ANIMAL CARCINOGEN, WITHOUT ANY FORM OF IMPOSITION

FACT :

One of the few advantages of Depo-Provera is convenience. On being injected with the drug the patient is rendered infertile for 3 months or more. The patient, not the doctor, pays the price of this convenience. Since the effects of Depo-Provera may last for 18 months or longer, it limits the control and responsibility a woman may exercise over her decision to use a contraceptive. Also, the long duration of the drug's effect means that a woman's exposure to Depo-Provera cannot be curtailed should complications arise or should the side-effects prove unacceptable to her. To illustrate, the Indian Health Service (IHS) prescribes Depo-Provera to

to be between 60 to 80 percent. Dr.N.Motashah, who introduced it in Bombay, has been quoted in *The Hindustan Times* as not favoring its general use among especially mentally handicapped women. Next, there are inherent risks linked with uterus removal and Bidwai cities Dr.Mira Shiva of VHAL, New Delhi, who observed that removal of the ovaries for use in *in-vitro* fertilisation experiments is increasing. "It quickens the aging process". Third, hysterectomy often produces a major adverse psychological effect. The sense of loss of womanhood and emotional disturbances, in not only hype-sensitive women, can be serious. It is false and paternalistic to believe that mentally disabled women do not have an emotional life or a sense of womanhood. According to Prof.Sunil Pandya of KEM Hospital, hysterectomy carries all the risks that are inherent in any surgical intervention. The risk in this surgery is that the ureter may be accidentally severed. If repaired during surgery, the ureter is somewhat narrowed and may cause urination problems. However, if this mistake is overlooked, after surgery urine will pass into the abdominal cavity. The most difficult risk to measure is the psychological outcome of the surgery. Everybody reacts naturally to the loss of any part of one's body. Some express a feeling that they are not themselves, or have been robbed of

something vital. It also matters how a woman has lived with her body, how she feels about periods, birth control and child birth, etc. Sometimes a hysterectomy looks like an answer to all these problems at once, both to a woman and to the doctor. Afterwards it becomes clear that only physical frustrations have been removed.

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6. Hysterectomy and the Mentally Retarded Women : Issues and Debate, National Addiction Research Centre (NARC), Bombay, 1994.

Our thanks to Lakshmi Menon for her comments and help with this issue.

What You Can Do.....

Write letters of protest asking for a ban on Depo-Provera in India, to the **Drugs Controller of India**, Ministry of Health & Family Welfare, Nirman Bhavan, New Delhi - 110 001.

Organise meetings of youth, women, NGOs and student groups at various levels to discuss the implications of Depo-Provera.

Write letters to **Max Pharma India** to withdraw

from this project. Address: 12th floor, Devika Tower, 6, Nehru Place, New Delhi.

Write letters in the newspapers, magazines and journals expressing your views on this controversy.

Contact the following groups working on this issue::

- **Saheli**, Under Defence Colony Flyover, New Delhi - 110024.
- **Jagori**, C-54, South Extension II, New Delhi - 110 049.
- **Forum for Women's Health**: 2, Vishwadeep, 95, Bhau Daji Rd, Matunga, Bombay 400 019.

Facts Against Myths is a monthly bulletin of factual information on a number of development myths and fallacies, etc, including information against disinformation campaigns, propaganda and canards spread by communal and fundamentalist forces.

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mentally retarded (to eliminate menstruation) on the rationale that they cannot be relied upon to use other forms of contraceptives, but the mentally retarded cannot themselves appreciate the risks and are unable to give the type of informed consent necessary for the use of the drug ..." (cited in "Hysterectomy and the Mentally Retarded Women").

Above all, as one of the tools of patriarchy, the supporters of Depo-Provera used this myth as an argument to control consciousness and whereby vital facts of reality are rendered invisible, viz., the socio-economic and cultural forces at work constructing a woman's will, limiting her options and controlling her motivation to choose a life based on something other than her sex-class functions. If women consumer and human rights advocates, rather than professional physicians, population-control lobbies and powerful drug TNCs, were the primary framers of the deliberations over Depo-Provera and other dangerous contraceptives, a totally different process for analysing the problems of women's reproductive lives would be in operation.

MYTH:

DEPO-PROVERA IS DISTRIBUTED AMONG THE POOR BOTH IN THE SOUTH AND IN THE NORTH BECAUSE "THESE PEOPLE" LACK MOTIVATION TO CONTROL THEIR REPRODUCTION"

FACT :

Those with women's values or valuing a woman's individuality and her control over her own person would instead have a more objective cognizance of this issue. There are very valid reasons for women being "unmotivated" in using these and other contraceptive aids. Perhaps she wants more children. Poor women value children highly and have no alternative to the value that children fill (cf. Issue # 3 & 7/1994 of this Publication for an elaboration of this point). Whatever her reasons for having children, they are *her* business. She is seen as a subject living her own unique life, not an object to be controlled. A Depo-Provera project for so-called unmotivated women would foster dependence in women and undermine their decision-making capacity and control over their own lives.

MYTH:

PHYSICIANS AND OTHER PROFESSIONALS ARE THE BEST PEOPLE WHO KNOW HOW TO CONTROL WOMEN'S REPRODUCTION AND THE MEANS TO ACCOMPLISH IT

FACT:

Depo-Provera, one shot of which lasts from three to six months is certainly an attractive contraceptive if the

above myth is the belief. Unlike the barrier contraceptive, it requires little initiative on the women's part. Its effectiveness in preventing the births of poor women in the South and the poor babies does not depend on the individuality of the woman or on her individual motivation — more or less strong — to prevent pregnancy. Women can be queued-up like on an assembly line and injected, one by one. Professionals then need not be bothered about "unmotivated" women who will not use their diaphragms as often as they want them to because after all the underlying motive behind the assumption, a racist one at that, is that blacks, dalits, adivasis and other poor women in the South "lack motivation to control their reproduction".

MYTH:

IN PRE-INDUSTRIAL SOCIETIES IN AND OUTSIDE EUROPE, CONTRACEPTION WAS UNKNOWN AS NATURAL FERTILITY WAS THE NORM

FACT:

Since ancient times women worldwide have known methods and techniques of birth control; men, too, were aware of practices that precluded conception. There are well documented records that clearly show the existence of the practice of contraception and even abortion in the ancient world. The Roman author, Quintus Serenus, in the second century AD, recorded the anti-fertility properties of certain medicinal plants. For instance, the aromatic mint plant, pennyroyal (*mentha pulegium*) contains pulegons, a powerful abortifacient, one which will lead to death in higher concentrations. Chemical means of birth control are as old as the oldest surviving medical records. The Kahun medical papyrus from Egypt dating back to 1850 BC contains information on three contraceptive methods which are referred to in the renowned 'Kama Sutra' and 'Chikitsa Chandroddaya'.

It was also well-known in medieval Islamic societies. B.F. Mussalam in "Sex and Society in Islam" shows details of birth control methods especially 'coitus interruptus' that was allowed by the Koran and widely practised in Islamic society. Moreover, techniques, mainly the barrier methods, were used by women in these societies. Feminist historians provided ample proof that the so-called witches, who for several centuries were persecuted and brutally murdered not just in India but in Europe also, were highly knowledgeable in medicine and midwifery including various methods of controlling birth. In her book "A Social History of Birth Control in America" Linda Gordon stated that as early as 1877 birth control was practiced in America.

Over the years, scores of compounds and preparations have been tested in anti-fertility drugs by institutions like the ICMR, findings of which have been published in a two-volume set, "Medicinal Plants of India". Among its listings, 'asafoetida' is mentioned, which is related to silphion the first well-known example of an oral contraceptive from ancient times. There are then the ayurvedic contraceptives. For instance 'garbhaniva-rana aushadan' about which, however, a controversy is currently on with regard to its actual efficacy. Dr.R.R.Choudhury, emeritus scientist at the National Institute of Immunology has identified three plants - the large hibiscus flower, the *Vicoa indica* shrub, and *Embelia ribes* — as effective contraceptive medicinal plants. The first has an antivolatory effect which prevents the egg from forming in the ovaries, the second leads to early abortion, while the seeds of the last prevent the embryo from getting implanted on the walls of the uterus.

Neem oil has also been discovered to be a potent contraceptive. On being injected the effect lasts for several months, and has been found to be safe by the Post Graduate Institute of Medical Research, Chandigarh. According to Dr.Shashilala S. Khopikar, (GFAM), a gynecologist for Podar Ayurvedic Medical College, Bombay, in the *Clarity Weekly* of May 22, 1994, the efficacy of Ayurvedic medicine largely depends on certain rules of living defined as *Swasthavruttha*. For instance, *Kadulimb* and *Karbiz* oils applied in small quantities before sexual intercourse in the vagina makes an effective contraceptive with no side effects. Dr.Khopikar also suggests the combination of *Vidangan* + *Tankan* + *Pim plee* (herbal medicines) in powdered form is the best contraceptive offered by Ayurved with only a 10 percent failure rate. She also mentioned China Rose flower with starch given within three hours of delivery leads to permanent sterility without any side-effects. Even if any conception occurs it does not grow and gets automatically terminated. The indigenous people of this country, the adivasis too are a storehouse of information on birth control means intrinsic to their culture and civilization.

MYTH:

HYSTERECTOMIES ON MENTALLY HANDICAPPED WOMEN IS A SAFE, HUMANITARIAN APPROACH, TO PROTECT THEM AGAINST RAPE, UNWANTED PREGNANCIES AND TO SOLVE THE PROBLEM OF MENSTRUATION

FACT:

Even standard literature in medical institutions the world-over never recommend hysterectomy as the only option for the handicapped. The known difficulties of

training especially handicapped women to independently look after themselves and their periods can be achieved through sensitivity, patience and understanding. This is evident from the experiences of some institutions in the city and elsewhere in the country.

The standard textbook, "Sexuality and the Mentally Handicapped: A Manual for Parents and Teachers" (published by the Family Planning Association of India, FPAI) stresses that a drastic measure like a hysterectomy may be considered after due consideration; only after every effort has been made to teach the women to handle her periods with little or no success" and only if "it is not possible for somebody else to do so for many years". Another FPAI publication, "Marriage and Social Alternative for the Mentally Handicapped" states, "Before undertaking methods like hysterectomy...the ethical and legal aspects...must be carefully considered...so as to provide adequate protection by right, for the mentally retarded who are not usually judged as competent to give informed consent to such therapeutic procedures". The report also admits the lack of knowledge regarding the education, care and training of the severely handicapped and mentions that most of the expertise has been with the mildly (IQ 20-25) and moderately (IQ 20-50) handicapped,

For justification, hysterectomy is projected as a humanitarian act (the doctors who divided the 'less traumatic' technique of vaginal hysterectomy as "noble") affording the mentally handicapped women protection from the indignity of public exposure of a private process and double trauma of pregnancy after sexual assault. Secondly, the ethical aspect of removing a healthy organ can hardly be called humanitarian as also the mechanical mind-set and approach to a woman's womb. Can a womb which is not useful for procreation be deemed 'useless' and therefore dispensed with? Does it not then enhance the escape for stretching this principle to all other 'non-useful' parts of the individual and/or society? Today it might be the uterus, tomorrow it could well be any other organ?! While hysterectomy or tubectomy may protect a woman from pregnancy, it would hardly defend her from rape.

The establishment considers hysterectomy a safe method. Reliable though it is at times it is generally an operation whose result is permanent. It is however a major surgery resulting in the disruption of a women's hormonal balance.

In *Frontline*, Praful Bidwai pointed out that trans-cervical resection of the endometrium - as the operation performed in Pune is termed - is a sophisticated expensive hi-tech procedure whose success rate is said

FACTS

AGAINST

MYTHS

VIKAS ADHYAYAN KENDRA

July '94 VOL I # 12

INFORMATION BULLETIN

COMMENT:

THE MYTHS ON AIDS

AIDS and its social impact is a tragic reality, especially in the South. Disturbing developments are reported regularly e.g. the link between HIV and TB. As is well-known, the cost of care of a TB patient is around Rs.1,500 per patient. With the link being established, the cost will escalate unbelievably. The drug, AZT for instance, costs around Rs.30,000 a month for a life-sustaining dose. Cost-wise, the impact of HIV and TB on the economy can therefore easily be discerned. India has already received a US\$ 85 million loan from the World Bank for its AIDS control programme and has sought another US\$ 125 million for TB control. According to UNDP, the country may have to spend US\$ 1.6 million on AIDS by 2000; according to P.R. Dasgupta the director of National AIDS Control Organisation (NACO), the Government "will not be able to provide all the money". This therefore poses a cruel dilemma of whether such resources be utilised for combating AIDS when they are insufficient for combating the old ones. But when the Government commits vast resources to launch space and nuclear programmes there can be no lack of resources for essential needs like health care.

This dilemma increases with the existing bias towards the urban rich. Money will be channeled from basic healthcare services for AIDS patients in luxury private hospitals. This has already been assured by the State withdrawing basic healthcare services from the poor through the so-called Liberalisation Policy. With the commodification of healthcare, safe-tested blood will also go to those who can afford the high costs.

From a humanistic outlook, AIDS is certainly a serious problem. When viewed from the West's perspective of economic liberalism however, AIDS presents a huge lucrative investment. The market for products like AIDS testing kits, anti-AIDS drugs and vaccines against HIV will rake in billions of dollars. Already a number of drug TNCs are feverishly scrambling over each other for the massive market that AIDS is expected to usher in. Indeed, along with vested

interests, drug TNCs are already exploiting the fear and vulnerabilities of people who are HIV-positive or have AIDS. They have kept results of drug trials secret, released information selectively, or have even delayed trials in the single-minded drive for profits. Some have not bothered with trials at all before peddling cures or palliatives of dubious value. For instance:

- Centre for Holistic Studies (Bombay) quotes *Consumer Confrontation* to illustrate the case of Boehringer Diagnostic a subsidiary of the German TNC, Hoechst, which supplied defective AIDS kit to India and thousands of tests were carried out with these before detection. The kits "...gave misleading negative results which made an infected blood sample appear free of the AIDS infection..."

In all this however, the greatest consequence is on the AIDS sufferers. Not only must they contend with a ravaging disease but also the stigmatised social response that makes the coping with AIDS difficult. AIDS has indeed been responsible for much hysterical discrimination, even racism. Racial interpretation of the origin and transmission of AIDS have led to discrimination under the facade of combating the disease, raising crucial legal and ethical questions. At another level, ethnocentric paradigms of AIDS control and prevention are not uncommon. One such "theory" from the US is that "AIDS is a disease of poverty". As if lack of Western model of industrialisation, rather than the virus, was the cause of AIDS.

AIDS is also a political phenomenon. How society reacts to AIDS is the yardstick for its understanding about sexual pluralism — including individual freedom in all ways, not merely sexual to be different. In this sense, AIDS tests how a society balances the right of a few with the good of the many. On the other hand, until all people, and women and children in particular, share equal rights in society and sexual citizenship, AIDS programmes designed exclusively on individual and private rights cannot represent the needs of all groups. Gays, women, and children were especially protected by the AIDS programme, for instance, in socialist Cuba where there are no deaths through AIDS. A strong and humane public health system has just as often protected the lives of socially vulnerable groups including sexual

minorities as it has denied them their personal liberties. Efforts so far to deal with these issues have not only been ineffective but also questionable. The fear of AIDS — rather than AIDS itself — is part of the wave of reaction that is widespread. This has led to assaults on the rights and dignity of HIV infected persons in areas of work, education, housing and travel. Educational campaigns by Government and NGOs too are limited by moral prejudice: they do not inform correctly, and therefore, they do not prevent. Consequently they are largely useless.

The effectiveness of such campaigns depends upon the challenge of an alternative to the existing medical health-care system. It is not enough that education itself is the “key to effective AIDS prevention” or that the “best friend is the condom”. ‘Safe Sex’ campaigns with posters, calendars, booklets, videos including the so-called technological approach of developing a vaccine are relevant but not enough. The colossal expenditure on sophisticated research and vaccine trials is also inappropriate. It is difficult to determine a vaccine’s effectiveness without tests lasting several years.

Priority in the control and prevention of AIDS must be on prevention. Effective and creative educational programmes, easy availability of cheap and high quality condoms, additional investment in clinical sterilization techniques, women-controlled contraceptive choices, universal blood screening, clinics and health awareness have benefits that will increase the general welfare of the people. Condoms means lower STD (sexually transmitted diseases) rates in general; improved clinical procedures reduce a variety of iatrogenic illnesses; and health awareness creates baseline knowledge and interest that other health-related programmes can build on.

There is need to also consider the more holistic health-care systems indigenous to societies of the South which emphasises that it is the basic balance and health of the body which determines whether a person succumbs to a disease.

The immediate need however is for strategies like harm reduction (rather than focussing on war on drugs). Simultaneously, the struggle against the iniquitous social structures that lie at the base of the AIDS crisis — that uproot and make the impoverished migrate to urban centres to eke out a living, and in the process disrupts families and separates husbands and wives.

Dr. A. Hatar, Head of Radio Theater Service in Rwanda’s Office of Information maintains that it is also necessary to “...carefully study the best ways to reach societies whose basic ways of seeing things are not written in any textbook...”.

MYTH:

AIDS ORIGINATED IN AFRICA.

FACT:

When the West was first confronted with AIDS, its origin then unknown, it sought the source elsewhere. Nothing of this sort, it maintained, could arise in “their” germ-free environment. So, its best researchers made a beeline to Haiti and Zaire because it was in these countries that the first non Euro-American cases were diagnosed. Suddenly, there was a whole continent to blame, and “African AIDS”

was manufactured. No “cause” had been recognized for AIDS and no timeframe had been established for disease progression. There was no scientific reason to therefore believe that these Haitian and Zairean nationals had “acquired” this theoretical virus in their own countries rather than in the countries where they were then residing — the US and Belgium.

Indeed, it was only the fact that AIDS was already well-documented among white Europeans and Americans that enabled the unusual illnesses of Haitians and Zairean nationals to be classified as AIDS. The data collected by Western researchers on prevalence in selected Central and East African countries proved equivocal: the HIV antibody test, developed in the US, could not distinguish between antibodies to HIV and antibodies to malaria.

This construct of “African AIDS” was based on tests and clinical definitions developed in the North that assumed a Northern hemispheric distribution of pathogens (i.e. which assume that the common cold and flu viruses are endemic, ordinary, and “clean” pathogens, but polio or malaria viruses are rare, exotic, and “filthy”). The vaguer systems of AIDS (nightsweats, weight loss, malaria, even thrush, diarrhea, respiratory problems) are typical of any number of ailments common to tropical countries (and in Western inner cities, one might add). It is not so much that the medical facilities in these regions are flawed but that the definitions of AIDS is itself problematic.

African clinicians, for instance, had diagnosed an epidemic of “slim disease”, characterised by rapid and fatal wasting, but Western scientists viewed this diagnosis as quaint and pre-scientific. The problem western scientists set for themselves in Africa was to map slim disease against AIDS, a procedure which served their own epidemiological aims but did precious little for local clinical practice.

The HIV antibody test used in early epidemiology cross-reacted consistently with the antibodies to malarial plasmodium, endemic to these regions, leading to large numbers of false positive results. To make matters worse, there has been little medical investment in Africa and certainly little basic result. Blood samples that had been stored in Kinshasha (Zaire), for example, which became the anchor for this myth, had no patient history attached to them. These might easily have been the blood of Europeans, or of their sexual or injecting drug partners.

AIDS therefore did not originate in Africa. After all, it is difficult to explain why a virus born in Africa led to an epidemic in the US without first decimating the people of its place of origin. Moreover, the results of research by Canadian scientists Allen Ronald, G. Hammond and Frank Plummer show that AIDS is new to Africa. (Third World Guide)

MYTH:

THE PRIME CAUSATIVE AGENT OF AIDS IS NOT THE HIV VIRUS BUT POVERTY AND THE DENIAL OF SOCIAL JUSTICE.

FACT:

This is not wholly correct. Poverty and injustices are merely symptomatic of the real cause of the crisis. Until and unless these inequalities and, more importantly its causes are tackled will there be any hope of checking the spread of the pandemic. The spread of AIDS is very much

related to the endemic pattern of rural landlessness that drive the poor to urban centres for sustenance. Having left their wives behind in the villages, these itinerant workers seek sexual gratification with sex workers (hailing from destitute situation themselves). On returning, these men infect their wives. The result is the spread of AIDS. The same situation applies to migrant labour in the Gulf countries.

This is nothing but a direct result of the destructive polarised class system, a legacy of colonialism. The situation has since worsened with the polarisation having widened further especially in the wake of foreign debt, the market economy and IMF/WB imposed strategies of SAP. The myth fails to comprehend the real mechanism in the spread of AIDS among the poor. It thus fails to clarify how rural landlessness and rural migration of the exploited workers directly leads to AIDS.

The other assertion that there is no proof of the HIV virus leading to AIDS is like the repeated claim by cigarette companies: "There is no proof that cigarette smoking causes cancer". However, as the well-known health activist and author, Dr. David Werner, maintains the HIV virus is the biological cause of AIDS. The remarkably consistent history of exposure to HIV among persons with AIDS, Dr. Werner elucidates, clearly points to a causal link between HIV and AIDS. For example:

- In many countries and circumstances, the incidence of AIDS in hemophiliacs transfused with un-screened blood has been very high compared to the very low incidence in hemophiliacs who have received only HIV screened blood;

- The incidence of HIV in persons injected with unsterile needles (both drug users and recipients of ordinary medicines) has been much higher than in persons injected with sterile needles. (And providing free, sterile needles to illicit drug users has dramatically reduced the incidence of AIDS);

- The occurrence of HIV (and subsequently AIDS) in healthy wives of HIV infected men refutes the claim that AIDS only strikes those who lead unhealthy lives;

- Above all, HIV and subsequently AIDS, occurs in a substantial percentage of babies of mothers who had HIV during pregnancy. This includes mothers who were clinically quite healthy throughout pregnancy.

MYTH:

AIDS IS A HOMOSEXUAL DISEASE, INDULGED IN BY PROMISCUOUS MEN AND WOMEN.

FACT:

While it is true that it was first detected among homosexuals, AIDS has however rapidly spread among heterosexuals. It does not discriminate and knows no frontiers. Recent studies in the States clearly indicate that half of those with AIDS in the US army are married. In India according to data collected by the national network of reference and surveillance centers, cited in *Seminar*, showed that heterosexual promiscuity was the major mode of transmission. In the following years there was evidence that the infection was not confined to promiscuous people either. HIV infection was detected among blood donors, spouses of promiscuous persons, children born to sero-positive women and persons receiving blood/blood product infu-

sions. It was also clear that the seropositivity rates among promiscuous men and women and blood donors had shown a steep rise between 1986 and 1991. The investigation also covered low risk groups to expectant mothers. Detection of a symptomatic seropositive person in the low risk group had to a large extent led to the realization that the virus can affect all segments of society. According to National AIDS Control Organisation (NACO), studies in Bombay and Manipur further revealed that between 1 per cent and 2.5 percent of pregnant women as well were HIV infected, which means their new born child will also be affected. (*Indian Express*, 10-2,1995)

Implicit in this myth is also the moralistic assertion that promiscuity too leads to AIDS because of its prevalence among them. However promiscuity *per se* does not cause AIDS but it could affect the chances of catching the virus which could lead to it. Besides, it is not primarily the number of people one has sex with that creates the risk for infection with HIV but rather what one does. It is unprotective, irresponsible sex — sex that allows an exchange of infected semen, vaginal and cervical secretions, or blood — that allows HIV transmission.

Finally, the word 'promiscuous' means different things to different people. The difference also depends on whether it is used about a man or a woman. As part of the sexual 'double standard' that operates in society it is generally condoned when men engage in multiple sex and at all ages than it is for women in whom it is seen as reprehensible in a way that it is not for men (unless they happen to be gay). This has important implication for who gets the blame for spreading AIDS. For example, it is women as prostitutes, and not their male clients who have been singled out as being responsible in the heterosexual transmission of HIV.

MYTH:

AIDS IS A DISEASE AND HIGHLY CONTAGIOUS.

FACT:

AIDS is not a single disease but a 'syndrome' or group of specific infections, cancers and other conditions which occur because the body's immune system has been compromised. Examples of possible specific diseases include 'pneumocystis carini pneumonia' and 'cytomegal virus'. Because AIDS is a syndrome it is a diagnosis, not a disease. AIDS cannot, therefore, be 'caught', although people with HIV can transmit the virus to others. That is, the infection does not spread through air or water or simple social contact. It is not contagious in the same sense as measles, chicken pox, influenza, common colds, TB, typhoid, cholera even plague and small pox. On the other hand transmission of HIV require a heavy exchange of body fluids from an infected person, which in everyday contact situation does not reach the critical stage.

HIV infection like hepatitis B or syphilis spreads through blood-to-blood contact or through a sexual route. Therefore, it cannot be contacted through the sharing of cutlery, shaking hands, swimming pools, or toilets; or through coughing, sneezing or spitting; sharing of public places or using amenities like transport; or by attending the same school or workplace, etc. Even if people live and work in the same household or worksite with an infected individual, the HIV virus cannot be transmitted. Nor is it spread by

social lip-to-lip kissing. This is because when the virus is present in saliva (and that is unusual) it is only in very small amounts, insufficient to infect anyone. Moreover, according to the US National Institute of Dental Research this is also because a protein in saliva protects the white blood cell from infection.

As such a person with HIV does not need to be isolated or quarantined. Even in situations where one is in direct contact with blood from someone infected with HIV e.g. giving first aid at a road accident, that blood would have to enter the bloodstream to be infected. If an infected person is injured and spills some blood this can be cleared up perfectly safely by using diluted household disinfectants or bleach which will kill any virus present; even by hot water and washing-up liquid.

MYTH:

CONDOMS ARE THE BEST PROTECTION AGAINST AIDS.

FACT:

Condoms do not offer unqualified protection against AIDS. In the US, for instance, condoms no longer carry the label, "Safe Sex But Safer Sex". The FDA no longer certify condoms because of its significant rate in preventing pregnancy. In a survey of 20-24-year olds, 32% of the women got pregnant although condoms were used consistently. About 75 percent college women over a four year period also became pregnant despite using condoms. In Bangkok too where condom usage has been successfully promoted the spread of HIV continues. Similar reports have come in from Hong Kong as well. Indeed various studies have recorded a failure rate of 10 - 30%. Even from a medical perspective, condoms are not very effective. Moreover, in a country like India according to the ICMR Bulletin (11-12,94) where condom acceptability is low in the so-called Family Welfare Programme it might be unrealistic to depend heavily on its protective effect against HIV infection. One implication of heavy advocacy of its use is its inherent method-failure (5-20%). This has not been clearly explained and hence when persons who have been using condoms, regularly develop HIV infection, there might be a backlash against its use.

MYTH:

MANDATORY TESTING OF HIV-EFFECTED PEOPLE AND PLACING THEM UNDER QUARANTINE IS NECESSARY TO CHECK THE SPREAD OF AIDS.

FACT:

Mandatory testing is unethical! Moreover, under Article 21 of the Indian Constitution, it is also unconstitutional.

When read with Article 14 (equality and non-arbitrariness), this has been held to mean that firstly there has to be a law, i.e., a statutory enactment, providing for deprivation of liberty; and that law must be fair, just and reasonable, both substantively and procedurally. For instance, taking recourse to the Public Health Amendment Act, the State of Goa had enacted a law providing for mandatory testing and isolation of HIV positive persons. This was challenged on the grounds of violation of Article 14 and 21 of the Constitution. The Goa bench of the Bombay High Court rejected the challenge except on the limited ground of allowing the persons affected an opportunity to rebut the findings of the

HIV test. An AIDS Prevention Bill was introduced in the Rajya Sabha on August 18, 1989 on similar lines but had to be withdrawn after protests by human rights groups as it had focussed on sex-workers, gays and drug users as "high-risk" groups.

Apart from this aspect of human rights violations, testing of (say) prisoners for HIV infection will however not arrest the spread of the infection. It could well be counter-productive. If the test is mandatory as opposed to voluntary, the spread of AIDS might actually get aggravated.

In 1992 at a Meeting convened by WHO on the issue, the conclusion was that there was sufficient evidence that such testing was not in the interest of public health in any way that voluntary testing cannot. HIV testing it says can be classified as being done with or without informed consent. "Mandatory testing and other testing without informed consent has no place in an AIDS prevention and control programme". The modes of HIV transmission are limited and known and specific action can be taken for checking its spread. Instead, such patients should be integrated within the community and helped to take up responsibilities in not infecting others. Isolating them would jeopardise the educational and other efforts to prevent the spread of HIV, causing extra burden and unnecessary human suffering. The Committee of Ministers of Europe also similarly recommended that "there should be no compulsory screening (for HIV infection) of the general population, nor of particular population groups".

There is however no disagreement on testing for HIV for which clear indications exist. However, it appears counter-productive and, at times, disastrous to test each and every person seeking help of counseling agencies, etc., for HIV. An otherwise healthy and carefree person will be reduced to a cowering mass of despair on being told that s/he suffers from an incurable disease. Worse, society at large and even those considered near and dear will be treated with the same revulsion that was once the fate of the leper.

Apart from the fact that this would be irrational (as HIV infection is not related to sexuality but to unsafe sexual practices) and reinforce prejudices against HIV carriers, thereby provoking discrimination, it will defeat the very aim of the programme in as much as it will drive persons of the 'high risk' groups underground. Such an isolationist approach is thus bound to boomerang.

MYTH:

VACCINE TRIALS ON AIDS ARE ESSENTIAL IN ESPECIALLY THE SOUTH. APART FROM THE DIRECT BENEFITS OF A SUCCESSFUL AIDS VACCINE, THESE TRIALS WILL CONFER SUBSTANTIAL AND LASTING BENEFITS TO THESE COUNTRIES.

FACT:

AIDS vaccine trials in the South are highly dicey proposition! Cindy Patton, in "Inventing Aids" shows how Phases One and Two of these trials are focussed on low-risk Western subjects but Phase Three is aimed at determining whether the vaccine actually works on 'high-risk' persons in the South, as a deterrent to HIV infection. In other words, the trials will determine whether the vaccine is harmful to

bodies of Western subjects. On the other hand, citizens from the South in the Phase Three trials will discover whether they have received enough vaccine to stay uninfected. The logic of the Phase Three trials is that these are urgent as the people in the South face a great danger of exposure to the HIV virus. And anyway, the protagonists maintain, the vaccine's effectiveness cannot be tested until and unless people are subsequently exposed to the agent!. What is, however, cleverly masked is the high risk these Phase Three trials involve which do not effect Western subjects! Further, as Patton observes, there are a number of crucial questions apart from the ethnocentrism linking these trials. First: if people are dying of AIDS in huge numbers, as western news reports are wont to exaggerate, who then is left to serve as trial subjects? Second: if preventive steps are certainly possible (and here, ethicists must explain where and why prevention works — if it works in the Sodom of New York, why not the Eden of Zimbabwe), then who benefits from the risks of the vaccine trials? Third: if some important number of the HIV cases in the South are attributable to poor blood screening resulting from the low efficiency and high cost of the Western developed tests, are vaccine trials being funded instead of improved screening methods? Is the moderately high (an unavoidable) risk of receiving an HIV-infected blood transfusion to be another route of exposure for potential vaccine trial subjects.? Finally: what provisions ensure that citizens in the South and their societies as a whole, will actually be first to receive the vaccine, once developed? Here, the precise arguments about the problems in rural clinical practice — “They cannot properly diagnose AIDS” — come into play as alibis for not distributing the vaccine. Obviously the AIDS vaccine trials focuses disproportionately on strengthening the scientific and medical infrastructures of the South in preparation for such trials — at the expense of ensuring proper ethical review of such trials in these societies. Finally, if every one participating in the trial is successfully educated towards protection and correct condom use, etc., how will scientists be able to tell if a vaccine protects against HIV infection.

The contradictory nature of some of these racist perceptions associated with these vaccine trials renders them all the more insidious.

MYTH:

MOSQUITOES AND INSECTS ALSO SPREAD HIV JUST AS THE INFECTION IS SPREAD THROUGH INJECTIONS AND SYRINGES.

FACT:

At this stage of the development of AIDS research, etc., it is not possible to maintain emphatically that mosquito bites do not lead to AIDS. As of now all evidence, etc., do not indicate any definite threat though this could possibly change in the future. Many agents like saliva, breastmilk are involved in HIV transmission. Nevertheless experiments by artificially infected mosquitoes have so far shown that unlike the malaria parasite or dengue virus, HIV has neither a life-cycle nor does it multiply in mosquitoes. The doubt that mosquitoes may take blood of an HIV infected person and may act like a 'flying needle' has also been debunked on the basis of epidemiological studies (Observation

based on large-scale population surveys/trends as against lab evidence) Studies in a large number of households of PWAs or HIV infected persons revealed that transmission to uninfected persons occurred only through sex. Children and other adults in the households remained free of HIV, despite having casual contacts with HIV/AIDS patients and despite the large number of mosquitoes in the environment.

Further, the virus does not spread by such insects or even animal bites because it thrives only in specific kinds of cells that are found only in the human body. HIV is not secreted in the saliva of a mosquito. Moreover, mosquito proboscis does not have enough volume to act as a 'flying needle'. Extensive study in Belle Glade, Florida, in the US — an intensively mosquito-infected area where HIV is also prevalent — has not shown any evidence of its spread through the insect. Thus, if mosquitoes could transmit HIV there would be many more people with HIV and AIDS especially babies and small children. However, the situation could change as the HIV virus keeps mutating. As the mosquito continues to vex humans — as efforts to eradicate malaria is any indicator — it is wiser to be on guard and not take the mosquito lightly .

MYTH:

PROSTITUTES ARE "HIGH-RISK GROUP" IN THE SPREAD OF AIDS.

FACT:

Historically, prostitutes have always been accused (and later victimised) for directly being responsible in the spread of STDs and, today, AIDS. It is a long-standing stereotype. The chances of a HIV-infected man transmitting infection to a woman are higher than a HIV-infected woman doing so to a man. Besides, about three-quarters of the AIDS cases in the country due to HIV infection are through unprotected multi-partner heterosexual relationships with more men than women indulging in multi-partner sexual relationships. If female-to-male transmission of infection is lower than that of male-to-female transmission (as studies show) the sex workers are at a lower risks of getting infected by them. They enter the trade, disease-free. Only in the course of prostitution that women and increasingly children get afflicted with STDs and HIV from male clients. More than being a "high-risk" group, a sex worker is thus more of a group at risk. When they do receive and transmit HIV and AIDS, it is totally involuntary. Unlike their male clients women lack the right to use condoms or the power to negotiate safe-sex. The existing unequal power-equation among the sexes in society is the obstacle. Sexual transmission being one of the main modes of HIV transmission it was erroneously believed that it was multiple sex partners that led to HIV. Recent studies however indicate that general sexual activity and unprotected sex leads to the infection. Thus, sex workers are not the source of AIDS or a so-called high risk group.

Trying to track the spread of HIV from sex workers flies in the face of both epidemiology and genitourinary data. "Even with the hypothesized greater transmission from women to men if men have genital ulcers, the probability of transmission cannot, and in the epidemiology does not, become equal". If prostitution is one of the main explanation

tion for the spread of AIDS, even if each "prostitute" "infected" several men, each one of those men could in turn be expected to infect several other women (his wife, other prostitutes, and others) since the odds of male-to-female (or male-to-male — it is the receptive partner who is at the increased risk) infection are still greater. Combined with the increased infection of women due to blood transfusion, there should be more women than men, not the same number — Cindy Patton, "Inventing AIDS"

MYTH:

BREASTFEEDING BY HIV-INFECTED MOTHERS IS SAFE

FACT:

At present, the risk of HIV transmission from mothers to infants through breastfeeding has not been conclusively established. It is not yet clear whether or not HIV is transmitted during pregnancy, delivery, or breastfeeding. It is almost impossible to know. Researchers are often careless about defining breastfeeding; exclusive breastfeeding is ideal but rare. Mothers may say they are purely breastfeeding but sometime give extra water or herbal teas. Many mothers and health workers mistakenly consider this practice to be harmless.

However, breastfeeding is not as contagious as HIV contaminated blood transfusions, as there is no infection despite breastfeeding by an HIV infected mother. Moreover, in contrast to semen or blood in needles — where a few drops may transmit HIV — breastmilk is a body fluid delivered in substantial amounts (upto a liter a day for many months) yet the majority of breastfed babies by such remain infection-free. A major significant reason for this phenomenon is all breastmilk, regardless of the mothers's HIV status, contains a unique substance which prevents the virus from attaching itself to cells, according to a report in *Pediatric Research* (31, 1 pp22-28, 1992).

According to a WHO/UNICEF statement, where infections diseases and malnutritions are the main causes of infant deaths and that infant mortality rate is high, breastfeeding should be the useful advice to even HIV infected expectant mothers. This is because their baby's risk to HIV infection through breastmilk is likely to be lower than its risk of death from other causes if the baby is not breastfed. And if an alternative feeding method is possible then such mothers may use it but not if a serious risk is involved. According to the above WHO/UNICEF group the choice of the alternative method of product must not be influenced by commercial pressures, and they demand that companies and TNCs (Nestle, Glaxo, etc.) manufacturing baby food must strictly follow the WHO/UNICEF code of marketing of breastmilk substitutes. If breastfeeding is discontinued, the result would be more devastating than the present impact of HIV. There would be a vast rise in infant illness and also deaths. "Moreover, there would be a huge rise in pregnancy: worldwide, more births are prevented by breastfeeding then by all other forms of contraception put together", states Gabrielle Palmer in *WORLD AIDS* (November 1992).

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against MYTHS

VIKAS ADHYAYAN KENDRA

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INFORMATION BULLETIN

COMMENT

MYTHS ABOUT SEX DETERMINATION TESTS

CONTRIBUTED BY R.P. RAVINDRA

*'Choosing the sex of one's child
is the most sexist sin.'*

We live in an era of paradoxes and contradictions — the reality was never so multifaceted, the issues never so complex. Everything around us seems to be melting and unfortunately the new forms acquired by the congealing of the molten mass leaves us little to rejoice at. Forces which had opposed amendments in the Hindu Code Bill are today clamoring for a Uniform Civil Code; a new policy for women in Maharashtra has been followed by the sordid events of the Jalgaon sex scandal and the mirage of women's empowerment raised at the Cairo Conference is evaporates in the heat of a Delhi tandoor!

From local to global levels, we find the feminist expressions being hijacked by the Establishment while the *real* women's issues continue to be relegated to the backstage. The period of two decades spanning Nairobi to Beijing has witnessed greater visibility, sharpening and focussing of women's issues but little progress in terms of concrete action. Drafting of new legislations (sex determination tests) and amendments in existing laws (dowry, rape, prostitution etc.) leave much to be desired while implementation of these laws, even in their present forms is almost nil. While the New Economic Policy has started taking its toll in terms of growing unemployment, neglect of health and education, devastation of natural resources and environment and marginalisation of the 'children of a lesser God', the worst affected are women. The declaration at the International Conference on Population and Development (ICPD), Cairo notwithstanding, several new Long Acting Contraceptive (LACs) are being added to the armour of hazardous contraceptives targeted at women. New Reproductive Technologies (NRTs) which would further reduce whatever little control women have retained over

their bodies and bodily processes are being projected as "hi-tech solutions" to women's problems. There is an urgent need to fight on each of these issues separately and also within a unified frame of reference.

A Myriad Questions

Sex Determination (SD) represents a focal point for thinking and action at various levels. It is the violation of women's foremost, basic human right — the right to survive. SD is the most subtle and hence the most potent weapon of women's elimination which takes discrimination against them to the womb. It negates the fundamental right to equality. It also

GUILTY ... of being a girl. Sentenced to death.

Her parents wanted a boy.

Having a girl would be a lifetime burden.

They used amniocentesis, an innocent pre-natal test meant to detect genetic abnormalities in the foetus, as an instrument for sex-determination.

When the tests showed the foetus to be a girl, they unhesitatingly ended her little life.

Her parents turned into executioners.



**Your daughter is your child too.
Let her be born.**

raises important issues on the interfacing of technology, health and society, of misuse of medical technology, of using technocentric solutions for social problems, of violation of the principles of medical ethics, of social and demographic implications of such technologies, of the decision-making processes involving technology, which can have far-reaching social effects, of regulating the medical profession (specially reproductive technology) both internally and externally, of limits to research and the techno-docs' power 'to play God', of the role and limits of social legislation in tackling social problems; of 'informed consent', and patients' rights and doctors accountability, of the possible fall-out of the advent of New Reproductive Technologies (NRTs) from Sex Pre-Selection Techniques (SPSTs) to non-coital reproduction through IVF-ET or GIFT, surrogate motherhood to genetic engineering; of decision-making process in family and society and women's role (or lack of it) in them. All these issues affect us all directly or indirectly. They determine how we define and interpret our past and shape our present and future. Like ecological issues, they question the wisdom of interfering with nature's method of selection and of disrupting its subtle balances.

It is difficult to find another issue which could raise so many complex interrelated issues and yet touch human beings directly and intimately. Perhaps, in the Indian context, it is the most appropriate example of the 'Personal Is Political'. However, it is difficult to refocus the nation's attention on this issue. The earlier two nationwide campaigns and the resultant enactment (but non-implementation) of a nation-wide law have strengthened the ethos of cynicism and frustration prevalent today. The law has also given an alibi to the government to escape international humiliation and condemnation on this issue. While China and S.Korea, facing similar situations, have advanced to some extent on the paths chosen by their respective governments, the Indian government and society are simply not ready to confront this issue. However we would be able to tackle the more complicated questions raised by the advent of NRTs only by using the space and insights gained by effectively confronting SD tests.

We are running out of time. We do not have more than a decade to effectively curb (if not eliminate) this problem, which, even now has acquired the status of 'a social phenomenon'. Thousands of clinics are already in operation, spanning the entire north, central and west India, many of them in smaller towns and villages. The region most affected by this phenomenon coincides with the demographically sensitive region- where for economic, social and culture factors, female mortality is much more pronounced. The SD phenomenon and with it, the danger of a demographic catastrophe is rapidly spreading to newer geographical territories. The economic stakes in this growing business involve few hundred crores of rupees today.

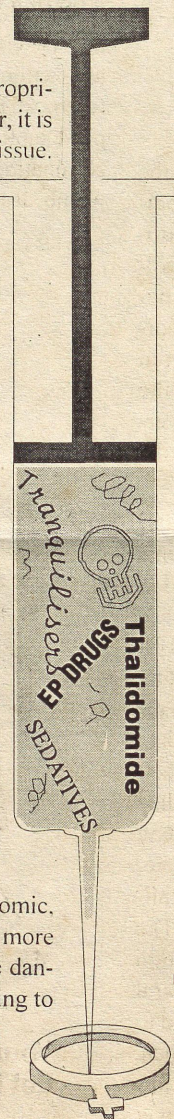
As it grows, the vested interests would become very powerful and they would counter all efforts to control it.

Accordingly to the 1991 census, four States and five Union Territories report sex ratios less than 900, the situation is worse in certain rural districts and castes with a tradition of female infanticide. New simpler techniques for pre-natal sex prediction are being searched throughout the world. Such a technique, say, of predicting an offspring's sex through analysis of a pregnant mother's blood would make proliferation of SD much beyond monitoring and control. Evolution of a simple, effective and cheap SPST would also make our campaign redundant and futile. In the meantime, people's acceptance of sex-selective abortion as 'a part of social-cultural practice' and the frustration of non-implementation of laws on this issue might further stall our efforts.

However, it is still possible to fight and win. The earlier campaigns have already raised consciousness on this issue. Lakhs of people have directly supported the campaign through their action. Artists, moved by this issue have expressed themselves through films, cartoons, posters, slideshows, theatre and street-plays, songs, poems, social advertisements and classical dance. Experience in

Maharashtra underlines the fact that the pressure of campaign can close down most SD clinics (and that, in absence of such pressure and with the government's lack of political will, such clinics resurface). Although the Centre is yet to implement the nationwide law passed by the Parliament in 1994, lately the National Human Rights Commission and the National Commission for Women have taken some initiatives on this issue. The Department of Women and Child Welfare has taken steps for the study of selected districts with very low sex ratios.

It is time for all of us to rise to the occasion. Activists, academicians and common people, women and men, people working on health, gender, development, ethics, human rights, demography, public policy and consumer rights- all should join hands to analyse, debate and solve this issue. Each small success gained in this struggle would have a great spin-off effect in several related issues e.g. exposing the role of medical councils in safeguarding the interests of the pro-SD lobby would strengthen the ongoing feeble campaign to uphold medical ethics, effective monitoring of vigilance committees may lead to their replication in other fields, and curbing research on SPSTs would raise the issue of limits to research in all NRTs.



R.P. Ravindra is the founder-member of Forum Against Sex-Determination and Sex Pre-Selection (FASDSP); Member, Expert Committees on SD Tests appointed by Government of Maharashtra and the Union Government; Lecturer in Pharmaceutics at SNTD Women's University; and actively involved on issues related to health and gender.

MYTH

Sex-selective abortion is an effective tool for population control/family planning.

FACT

Many people believe that due to the son-preference deeply engraved in the Indian psyche, a large number of people keep on increasing the family size with the hope of begetting a son. SD tests according to them, is the best measure of Family Planning. Several others, including certain policy planners consider women as 'procreation machines'. Hence, 'decreasing the number of machines would automatically lower their total output' is their logic. It has resulted in fixation of NRR1 (Net Reproductive Rate = 1) i.e. each surviving female should be replaced by only one daughter-as an important target earmarked for India's population programme.

- Son-preference (and conversely, criminal neglect of daughters) in Indian society is an established fact. However, that is not an important determinant of India's rising population. Several studies have shown that poverty is an important cause rather than an effect of population growth; that poor people produce more children because their chances of survival are less and because most of them, residing in third world countries are not supported by any system of social security, specially in old age;
- Global consensus, as outlined in the Declaration of ICPD held at Cairo considers Women's empowerment to be the best contraceptive. Women mostly want a small family. However, their secondary status and inability of participation in decision-making processes prevent them from enforcing the small-family norm. Women's education, awareness and participation in economic activities, leading to their development and empowerment can effectively curb population growth. Kerala is the best example;
- Sex-selective abortions strike at the very root of women's dignity and the principle of equality. How can women be empowered in a milieu which denies them even the right to life? SD tests, would thus oppose the process of family-planning through women's empowerment;
- SD tests (and subsequent sex-selective abortions) can only eliminate the 'undesirable' sex; they do not guarantee the birth of offspring of a 'desirable' sex;
- Family planning and family welfare go much beyond the narrow concept of numbers. 'Quality of life' is inseparable from them. What would be the quality of life of the Indian woman (mostly anaemic and a young mother) who is made to pass through a vicious cycle of conception, SD tests, abortion and subsequent conception?
- Women, like men, are full and equal human beings, capable of participating and contributing in each walk of life. Reducing their worth to 'reproductive machines' has deep sexist connotations. Attempting to solve the population problem through reduction in women's numbers would justify dowry murders and 'femicide'!

MYTH

Sex determination tests are safe and accurate

FACT

SD techniques consist of two components—methods for removal of foetal cells and chromosomal analysis of these cells to identify foetal sex. Presently, amniocentesis and Chorionic Villi Biopsy (CVB) are being used for the former, while the latter part is carried out by geneticists in genetic laboratories. (Sonography being a different technique would be discussed separately).

- Of the various techniques used for SD, amniocentesis and CVB carry the risks of spontaneous abortion and infections leading to further complications. Amniocentesis carries the added risk of injury to placenta, or to vital organs of the foetus even when performed under ultrasonic cover by trained experts. In India, both these techniques are being performed by untrained persons in conditions which are far from ideal, thus increasing the chances of immediate/delayed complications.
- Following SD tests, abortion is normally performed in the second trimester of pregnancy. Abortion at such an advanced stage is hazardous to the mother. In India, 70% women are anaemic; average maternal age at first pregnancy in rural areas is around 17-18 years and the maternal mortality rate in India is one of the highest in the world. The risks of repeated abortions and the vicious circle of pregnancy—test—abortion—pregnancy must be viewed in the context of this morbidity—mortality data.
- Sonography, although used commonly to monitor pregnancy is not totally free from side-effects and hence should not be used routinely.
- Chromosomal analysis of material derived from amniocentesis or CVB has an accuracy of up to 97% with highly skilled operators, the accuracy is much less for poorly trained persons as are working in India.
- Sonography cannot be relied upon as a technique for predicting foetal sex. Identification of the offspring's sex, using this technique, becomes possible only after four months of gestation, after which abortion would become complicated (and illegal after 20 weeks). The probability of false positive and false negative results is too large to make this method dependable for sex prediction.

MYTH:

Sex determination tests would not alter the sex ratio of the population

FACT:

The general impression is that SD is resorted to only by those in need of sons to balance their families and that they stop soon after getting a son.

- Studies in different parts of India show that though SD tests are first adopted by a section of the population where preference for a son is extremely pronounced, they are soon accepted by other sections of society. People having no living daughters or those with one or more sons

are also known to adopt SD techniques to pre-eliminate women from their families.

- The average desirable family composition in India is 2 sons and a daughter. While there have been no incidence of people aborting sons till a daughter is born, lakhs of daughters have been aborted with the hope of begetting a son. This process of abortion of daughters may continue even after the birth of a son in the family till at least two sons are born.
- Sex-selective abortions are more acceptable in castes/regions where son-preference is more pronounced. In these regions/castes, the sex ratio is already precarious owing to the discrimination against daughters. Abortion of unborn daughters is bound to accelerate the downward slide of females along the demographic ladder.

Secondary Sex Ratio (SSR) i.e. the number of males born per 100 females can be taken as a sure indicator of sex-selective abortions in a given population. Universally normal values of SSR vary between 104 and 106 to account for a slight excess of biologically weaker male sex at birth. Thus, a SSR consistently greater than 107 can be taken as a sure indicator of occurrence of sex-selective abortion of females. SSR values for Ludhiana from 1981 to 1988 are as follows:

Year	1981	'82	'83	'84	'85	'86	'87	'88
SSR.	105	105	113	113	113	112	114	122

Similarly, corresponding values for a cluster of villages around Ludhiana are as follows:

Year	1984	1985	1986	1987	1988
SSR.	116	101	117	114	119

1982-83 was the year when SD started proliferating in that region. According to a study by the Morrison Institute for Population and Research Studies at Stanford University, California, the SSR for India is 108.7 males per 100 females. More accurate micro studies from different regions of India substantiate the fear of demographic damage due to SD tests.

MYTH

Reduction in the number of women would enhance their worth.

FACT

A perverse logic doing the rounds is that reduction in women's number makes them more 'wanted'. In fact, SD proponents claim that in future bridegrooms may have to pay dowry, due to shortage of females of marriageable age.

- Applying the economic theory of 'demand and supply' to complex social issues reflects two facts: patriarchal prejudice and the ignorance about fundamental concept of social organisation and social dynamics. It is an obnoxious view to equate women with grains and cereals whose value depends upon their being in short supply!
- In several regions, especially in most South Asian societies, low sex ratios (deficit of females in population) reflect their lower status and secondary role in society.
- Historically, a drastic reduction in the number of females resulting in the disruption of sex ratio balance has occurred only in a few small societies. Sociologists fear that

such a phenomenon would result in greater incidence of rape, forced marriages, polyandry, in general in making women's lives more insecure and sex stereotyping more pronounced. Women would be compelled to stay within the four walls of their homes and avoid contact with the insecure and hostile 'outside world' for 'their own benefit'. Thus all the advances made by women through their struggle for emancipation would come to a zero and women would have to fight for their most basic right of survival.

- In a society like ours, powerful men would maintain a 'zanankhana' to demonstrate their power and influence while several men, finding no companions might resort to any means to force a woman for a sexual/marital relationship. In either case, a woman would have no control over her life. Recently, several instances have come to light in which young men have killed women in cold blood for refusing to marry them or having sex with them. A large number of young people find this is 'normal', 'macho' behavior. In future, it might become a respectable norm!

MYTH

Laws cannot curb sex determination tests.

FACT

True, progressive legislation *alone* cannot solve any social problems like SD tests. However, they *can* create space within which solutions could be explored and implemented. Legal action, if coupled with measures for creating awareness and suitable policy interventions can at least check large scale sex-selective abortions. The ultimate solution of this problem lies in the fundamental restructuring of our society on the foundations of gender equality and justice. Ultimately, a socio-cultural revolution would be needed to *solve* this problem. Nevertheless short term measures including a stringent and workable law can surely *curb* it

- Unlike other problems related to women's status in society (e.g. dowry, *sati*, child marriage), this issue has an additional player in the game viz. the doctor. Doctors, although no more ethical than other members of society, are definitely law-fearing (provided they are convinced that the law would be implemented) *It is in their professional interest to follow laws*. The negative publicity resulting after 'getting caught' acts as a major deterrent for most doctors. *In Maharashtra, most of the SD clinics stopped business immediately after the enactment of the State level law against SD tests*. (They, however, gradually reappeared when the Government, through inaction and lethargy demonstrated a lack of political will to implement the law.)
- Sex of the unborn is mostly predicted by chromosomal analysis of foetal cells, which is carried out only by a small number of well-equipped genetic laboratories situated in large cities. Hence, monitoring SD business, in effect, means monitoring these few laboratories in cities.
- If licences for prenatal diagnosis are granted only to government institutions, the task of vigilance would be further simplified. *The ban on misuse of techniques for SD imposed upon government institutions has not been violated for the past 15 years*.

MYTH

Banning SD would infringe upon women's right to choose the sex of the offspring.

FACT

The pro-SD lobby argues that the right to choose the sex of the offspring is a logical culmination of the 'pro-choice' theory as the woman should decide how many children she should have, when to have them, so also their sex. It would be worthwhile to ask a few questions. Did the common women of the poor South Asian countries (where SD tests are most common) or the women's movement in this region ever ask for such a right? Who asked for it and who gave it? Do these women enjoy basic human rights such as the right to equality? Can they decide whether and when to get married?, can they demand the right to education, health, nourishment, & equal treatment? Can they say 'no' to a sexual relationship forced upon them? In the absence of all these rights, does the right to decide the offspring's sex serve any purpose?. The answers to these questions would reveal the following facts:

- Women from poor countries have never asked for a right to decide the offspring's sex. It is a bogey raised by the pro-SD lobby, specially doctors whose interests are served by proliferation of SD tests.
- In a social milieu where a woman cannot take even the most basic decisions related to her life, viz. education, health, marriage, economic freedom, it is downright insulting to talk of the choice to decide whether to have a son or a daughter!
- In reality, a woman does not have such a choice: The decision about children-when and how many to have, etc. is taken largely by her in-law's family. She cannot say 'No' to undergo a SD test for the fear of being deserted, divorced or alienated in the family. Moreover, after the SD test, the choice of undergoing abortion is not her own; she cannot opt to continue the pregnancy if the foetus is detected to be a female nor can she decide to abort a male foetus. Hence, the choice doesn't exist.
- At times, we find women supporting/asking for SD test. But, is their 'choice' totally free and fully informed? It is often based on subtle or not-so-subtle pressures operating in the family and society. The fear of being driven out of family or having to lose one's status in family weighs heavily on the women's mind when they ask for SD
- On the basis of their experiences, women have been demanding 'choice' in various walks of life. However, our society does not seem to be keen to furnish them. Even in the field of health, several of women's demands have remained unfulfilled: women want safe deliveries with the least medical interventions (but most hospital-based deliveries involve as Caesarean section); safe, simple, contraceptives in their control (what they get are hazardous long acting contraceptives); their gynecological problems to be attended to with sympathy and concern (but they are labelled as psychosomatic)...
- It must be remembered that in a consumerist culture, the demand for a choice could be created and nurtured and a choice be marketed as fulfilling an important social func-

tion. The number of choices doesn't reflect the degree of autonomy of an individual or a group e.g. asking Indian women to choose from Norplant, Depo Provera or contraceptive vaccine (without improving women's status, obtaining their informed consent or upgrading the health-care setup) would decrease rather than improve their control over their bodies. In the words of the noted thinker Dada Dharmadhikari, "providing a chicken a choice between getting roasted or fried is no choice"

SEX RATIO: INDIA*

Year	1901	'11	'21	'31	'41	'51	'61	'71	'81	'91
SR	972	964	955	950	945	946	941	930	934	927

* No. of females/1000 males in population

States/U.T.s with low sex ratio: 1991 census

Chandigarh	793	U.P	882
Andaman & Nicobar	820	Punjab	888
Delhi	830	Sikkim	888
Arunachal Pradesh	861	Nagaland	890
Haryana	874		

What Can You Do ?

- Write to the Minister for Health and Family Welfare, Minister for State for Women and Child-welfare, Minister for Law and Justice, demanding:
 - ✓ implementation of the Regulation of Prenatal Diagnostic Techniques Act, 1994,
 - ✓ ensuring proper representation of voluntary groups active on this issue at all levels of the implementing machinery viz. Appropriate Authority, Supervisory Board and Vigilance Committees;
 - ✓ amending the Act in the next session of Parliament so as to restrict licences for prenatal diagnosis to government/municipal institutions;
 - ✓ removal of the clause of punishment to women undergoing SD test;
 - ✓ automatic suspension/cancellation from the Registry of Medical Practitioners of the name of doctors found guilty by the court without referring the matter to the Medical Council.
- Pressurise the concerned State governments to speedily implement the Act.
- Maintain vigilance over authorised/unauthorised centres/laboratories using prenatal diagnostic techniques for SD.
- Highlight the biological fact that the mother is not responsible for the sex of the offspring.
- Create awareness and help explode myths about SD and NRTs.
- Publicise social/cultural alternatives which strike at the root of son-preference (nomenclature system doing away with clan/caste indicating surnames, adding mother's name to one's own name, daughters performing last rites on parents, daughters supporting parents in old age etc.)

MYTH

How can you oppose selective abortion if you are not opposed to abortion?

FACT

This twisted argument has been used by different people to suit their purposes. On one hand, the pro-life lobby tried to appropriate the campaign against SDtests under their logic while the pro-SD lobby tried to use the argument to divide and confuse the supporters of anti-SD campaign. Some feminists in the West chose not to support this campaign lest their stand be misinterpreted or misunderstood as pro-life. There is an additional danger that our support to abortion as a women's right could be misused in its indiscriminate use as a family planning tool.

Amidst all these conflicting realities, we believe-

- We oppose sex-selective abortion not because it violates life, but because it violates the dignity and negates even the existence of women. The issue is discrimination, not right to life. If a woman chooses to abort her offspring, irrespective of its sex, we have no objection. But aborting a child only due to sex is discrimination and hence should be opposed.
- Abortion, if used routinely as a F.P tool is detrimental to women's health. Moreover, it shifts the responsibility of contraception completely to woman, if she doesn't want to undergo abortion. Contraception and child-rearing should be the common, shared concerns for both men and women.
- However, women should have the right to abortion as an extension of their right over their bodies and specially because in the Indian context, abortion represents women's last defence against an unwanted pregnancy. Quite often, she cannot oppose a relationship forced upon her, nor can she use or make her partner use contraceptives. Ultimately, she may have to face social stigma (if the birth for the child is socially unacceptable) or opposition from family (if the child is unwelcome) so she must have the last option, of abortion, available to her.

- We are also opposed to SPSTs in which there is no apparent bloodshed and stigma attached to 'kil ling'. Nevertheless, SPST is simply an extension of SD, based on the same principle - of selection based on discrimination.

MYTH

Sex-selective abortions are more humane than dowry murders and sati.

FACT

- Can poverty be eradicated by bombing slums or minorities problems be solved by eliminating minorities? Women aren't the problem. The problem is society's attitude towards them. The remedy lies in making daughters 'wanted' and 'welcome' and not in refusing them their existence.
- If this fatalistic argument is extended to all walks of life and we start eliminating 'unwanted people', the earth would soon turn into a gigantic graveyard.
- Why this deceptive choice between getting killed at birth or later? Women do have a choice to lead a full, healthy, dignified life.
- Nobody stops producing sons for the fear of a nuclear war, riot or a road accident. In fact, a basic motivation behind procreation is humankind's undying optimism. We always hope for a better tomorrow, for a more beautiful humane world for our children. Why presuppose that a daughter born would be subject to atrocities? It is better to work towards making daughters 'wanted' and happy.

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Facts Against Myths is a monthly bulletin of factual information on a number of development myths and fallacies, etc, including information against alien development models, paradigms and false concepts on caste, creed and gender.

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FACTS

against

MYTHS

VIKAS ADHYAYAN KENDRA

July '95 VOL II # 4

INFORMATION BULLETIN

BEAUTY AND BEAUTY CONTEST MYTHS (Part I)

COMMENT

Beauty is a global mega-industry today. Billions in profits are made on every aspect of beauty: cosmetics, designer wear, hairdos, slenderising and beauty salons, cosmetic surgery, etc. With the victories of Sushmita and Aishwarya the 'beauty industry' has received an extra boost with even excise on cosmetics and toiletries being reduced, from 120 to 40%, within three years! One result of this is the influx of a number of cosmetic TNCs to India. For instance:

- *Revlon* has already begun marketing a few of its famous products, with a sales target of Rs.100 crores for the next 3 years;
- the Swedish cosmetic firm, *Oriflame*, in a joint venture with *Rollson* (India) will manufacture and market its products with an initial investment of Rs.21 crores;
- *Benckiser* (India) has launched its range of skin-care products under the brand name, *Coty Vitacare* with 'deep penetration moistures', 'active cleansing concentrate foam' and 'active refresher toner'
- *Bergerac N.C.* of France has tied-up with *My Fair Lady* of New Delhi to launch nail enamel, lipsticks, etc.

The 'beauty industry' has discovered feminine beauty to be a very flexible formula. To maximise their profits they frequently "discover" a new ad to beauty, persuading women that they "want" or "need" such a product. With high-pressure advertising they seduce them into buying beauty aids with false claims of 'removing wrinkles' or 'changing skin texture' etc. The seduction often turns out to be outrageously expensive. This is hardly surprising as the cost of the ad must be covered by the price of the product, which is further inflated by the cost of the glamourised design and packaging. The gullible thus often pay for little more than a famous brand name. That is only a fraction of amount paid for goes into what has been so opulently and gossily advertised.

The 'beauty industry' is known to be involved with a number of projects of a dubious nature. From "research" into so-called miracle projects (often involving dubious tests on animals) to its packaging, pricing and marketing. Little is known, however, of the massive "research costs" that account so much for the differential. Apart from such practices, they also indulge in plain cheating. For instance, Centre for Holistic Studies, Bombay, in its publication, *Indranet*, (#1, 94) carries the exposure by N.G Wagle of the Consumer Guidance Society of India on the blatant malpractice by *Hindustan Lever*. It had mixed clay and other impurities to produce *Lifebouy* soap. It then marketed the soap at reduced price with the ad lie: *Lifebouy! The World's Largest, Low-priced Soap!* - despite the sharp rise in costs of inputs and levis. *Godrej* including the TNC *Proctor & Gamble* had also contravened Government regulations by manufacturing adulterated bath soaps e.g. *Limelight*, *Vigil* and *Ganga*. On being exposed they withdrew the first two and P&G re-manufactured *Ganga* as per legal specifications.

In some instances, the 'beauty industry' viciously oppose any Government regulation; even refute scientific studies showing that elements, for instance, in cosmetics cause cancer. With their political and financial clout they frequently prevent research or legislation into their products for fear of losing profits, adverse publicity, and opening a tin of litigation worms. Lest we forget: the Bhopal disaster vividly illustrates this point.

The worldwide environmental consciousness has also exposed other harmful activities of these TNCs. The *Telegraph*



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(13-1-85) had reported that the production of perfumes - *Charlie* and *Number 5* - by *Revlon* and *Chanel* led to erosion of the top soil of the Islamic Republic of the Comoros Island, off the coast of Mozambique. The perfumes are manufactured from the Island's high-grade flower obtained from the tree, 'Ylang-ylang' (*Cananga odoratum*) with the lower-grade being used for making soap. The industry's insatiable demand for fuel-wood from these trees, to run the distilleries producing the oil from its flowers, led to 44% deforestation between 1969 and 1974 and 69% in other areas.

More disturbing, however is the industry's promotion of the feminine and beauty cult; encouraging women to pursue the 'beauty ideal' that often leads them to 'cosmetic surgery'. The gruesome technique, frequent mishaps and horrific prices are in themselves emblematic of the extent women are manipulated into the quest for this illusive ideal. But this mania is indispensable for the industry in projecting the 'feminine' look. It in fact encourages the beauty game as women are made to feel inadequate in failing to look the way the ad media would have them believe they ought to look, so the search is always on for quick-fixes, miracle changes, etc.

It is this form of oppression — making women so dependent on their appearances that they often accept what is given to them than demand what they think they deserve or need — is what feminist and women's struggle is largely all about. Rejection of such socially imposed 'ideal' thus becomes all-important. It means the need to expose the myths propagated by the so-called beauty industry.

MYTH

As evidenced in primitive societies women have adorned themselves with herbal paint right since time immemorial. Using makeup to compete with each other over males is an inevitable, biological law.

FACT

In "*Problems of Women's Liberation*",³ Evelyn Reed disproves this claim as merely propaganda by the industry to maintain and expand the bonanza it rakes in for the purveyors, etc. of beauty and fashion products. The claim goes against the very basis of biology and anthropology. That is, sex competition among females does not exist either in nature or in so-called primitive societies. It is unknown in even previous epochs, which means for almost a million years of human existence. What exists is competition imposed by nature between males instead — in the struggle for females. This is simply nature's way of assuring perpetuation of the species.

The emergence of class society based on the acquisition and competition and the degradation of women into dependency upon men and the competitive struggle for property and wealth among men also affected women. It led to competitive struggle even among them for wealthy and powerful men. Thus, this social affliction of sexual competition imposed upon women is not



natural or biological but purely "artificial"; historically manufactured and conditioned. A consequence of class society.

With the rise of capitalism, "free enterprise" not only led to industrial competition but also to free sex competition. (op.cit) Marriage led to mergers among the wealthy which developed as a form of property mergers. It soon became the norm among the ruling American plutocrats.

These peculiarities of American life under capitalism prepared the socio-psychological bedrock for the mass commodity market, the mass sex market, and mass sex competition among females. Reed illustrates how American pulp literature, for instance, became the handbooks for men on how to rise from rags to riches, and how romance stories for women advised on how to get and marry the boss's son, or even the boss himself. All she had to do was to rush to the beauty market and buy all the products guaranteed to transform Cinderella into a Princess. Consequently, the cosmetics and fashion world gradually became a gold mine with virtually unlimited possibilities. Entrepreneurs had only to change the fashions often enough and invent more and newer aids to beauty to rake in profits. That is how, the sale of women *as* commodities under feudalism was displaced by the sale of commodities *to* women under capitalism. Correspondingly the myth was manufactured: that beauty depends upon fashion and that all women have identical fashion needs because they all have identical beauty needs.

MYTH

Make-up and fashion etc., to look beautiful is not just a woman's prerogative but a basic right — woman, after all, just wanna have fun.

FACT

Wearing make-up and latest fashions is a powerful social statement and signal. That is, women are accepting their role as sexual beings; and stressing this sexual side of themselves. This also, always, entails a certain degree of conformity with the existing allocation of social roles, even if they do not necessarily comply with being confined to a strictly sexual role. Indeed, a woman who beautifies herself may also be an entirely successful career woman and still object being reduced to her biological function. Even so, changing or beautifying the outward appearance is a way of conforming to a prevalent ideal and it mainly depends on the character of this ideal whether this act of conformity can be seen as perfunctory broadening or repressive restriction of female individuality.²

Wearing makeup etc., is only fun if the woman is *free* to *choose* this kind of sexual existence which involves narcissism and seduction as a 'way of life', instead of being forced to lead that kind of life as the *only* option open to them.

The so-called right of women to use cosmetics, etc. is meaningless when such a right is not clearly distinguished from women being socially compelled or persuaded to conform through manipulation in submitting to this kind of exploitation which leads directly to the trap of advertising propaganda.

MYTH

Cosmetics serve as a therapeutic value for women and also as an aesthetic activity, enables them to express their individuality, apart from other benefits. Thus, they perform a vital social service.

FACT

This is simply puffery and advertising hype. The therapeutic value of cosmetics is not doubted provided treatment through it is prescribed by legally approved medical authorities, etc. Otherwise it is a criminal offense on the part of the 'beauty industry' to persuade women to spend a bomb on their products, the contents of which cost merely just a few rupees.

Such claims raise crucial questions: How fair are the business practices of these cosmetic firms? How ethical is it for the cosmetic TNCs to trade in women's susceptibilities and in using thousands of animals as lab experiments to produce non-essentials like cosmetics.

On enabling women to express their individuality the fact is that while cosmetic styles change rapidly, applying makeup is a highly stylised activity that gives very little space for self-expression with hardly any variation and very little latitude being available. The stereotyping of so many women in this way with the same designer fashions and Sushmita/Aishwarya-type look gives a superficial appearance of unity and conformity. Regional differences are minimized by the all-over covering of cosmetics. The general effect is the same sort of healthy mindlessness that are conveyed by American and Hindi 'soap operas' like 'Bold & the Beautiful' or 'Hum Aap ke Hain Kaun'

The claim of removing wrinkles, etc, or changing the texture of skin is one big lie.

This is no more possible than changing the colour of the eyes. The skin and its quality is genetically determined. Moreover, the way it works and its structure do not permit anything from outside to affect the health of the skin on the inside. For the skin grows from within outwards. To effect the health of the skin it is necessary to affect the health of the person wearing the skin. The skin is nourished from within, it is fed from within, and the only way that can change it is by changing it from within.

So if a Revlon product can change the skin in any measurable way it can do so only transiently and this is never spelt out in the ad. And transiently, in terms of the skin, is no more than a few hours. Scientists know of no way in which cosmetics, particularly those having so-called hormones and collagen, can penetrate to the single layer of living cells deep in the skin and affect them in any way. Hormones, by law, can only be sold under prescription. It follows that if a consumer buys a product with 'hormones' without a prescription it does not have any hormonal effect.

MYTH

Beauty products are so safe that there isn't any need to ask the industry to conduct any additional safety tests.

FACT

Safety claims of a large number of cosmetics are mostly false. Hair dyes for instance use coal-tar dyes which include many of the petrochemical-based brands in dark, brown and black are a risk for various types of cancer. A study has shown that women who use hair colouring products have a 50% higher risk of developing a cancer called non-Hodgkin's lymphoma (*Third World Network Feature, Goa, #98/94*).

- Some years ago the All-India Institute of Medical Sciences, New Delhi, discovered in its extensive studies, lead in several of the 28 samples of 'surma' it had randomly examined. In one sample the lead component was as much as 84.5 %;
- In 1979 the Consumer Guidance Society of India, Bombay, on testing 13 brands of 'surma' found all the brands except one, contained 29.7 % to 85.7 % of lead,
- Tests commissioned by *The Sunday Times*, London revealed that some skin lotions claimed *sun-protection-effects* (SPEs) up to 75% higher than they actually provide, leaving consumers at risk of serious burns. A 6-year-old girl from Hampshire who used the lotion was affected by second-degree burns. Others were more than twice as strong as their packaging led to Lloyds being fined £ 3, 000 with £ 4, 237 costs for making such false claims.

Citizen & the Law: Cosmetics (*The Tribune*, 19/7/87)

The term "cosmetic" has been defined in *Section 3* of the *Drugs and Cosmetics Act*, 1940, to be any article meant to be applied on any part of the human body for cleansing, beautifying, promoting attractiveness or altering the appearance, and includes any article intended for use as a component of a cosmetic but does not include soap;

In the "*Objects and Reasons*" the Act states that contact dermatitis is one of the ill-effects of using certain cosmetics like deodorants, pomades, lipsticks and nail polishes.

Section 17-A deals with misbranded cosmetics. It describes under what circumstances a cosmetic would be deemed to be misbranded;

Section 18 imposes a prohibition on manufacture and sale of drugs and cosmetics which are not of standard quality or are misbranded or adulterated;

The Act prescribes that no such drug or cosmetic shall be manufactured for sale, sold, stocked or exhibited for sale, except in accordance with the conditions of a license issued for such purpose.

Section 18-A, states that every person who distributes a drug or cosmetics must disclose these to the Inspectors appointed by the Central or State Government by means of notification in the Official Gazette;

Section 27-A provides for penalty of imprisonment of up to

one year and a fine of up to Rs.500 on those who sell, stock or exhibit for sale any cosmetic violating the provisions of the Act or its rules.

The citizens for Toxic-Free Marin, citing a 1988 study revealed that several fragrance chemicals are toxic that also lead to cancer, biological mutation, reproduction disorders, acute toxicity, central nervous disorders and MCS (Multiple Chemical Sensitivity) which is found also in deodorants which when sprayed underarms increases the risk of breast cancer. Other toxic chemicals in fragrances are ethanol, benzene derivatives, acetone, formaldehyde, methylene chloride and limonene.⁴

* *Toluene* is a toxic solvent was found in every fragrance sample collected and proven to cause cancer, birth-defects, damage to the nervous system. It has been declared as a hazardous waste. Surveys show that brands of *Revlon* and *Cutex* contain toluene.

MYTH

Using the right type of cosmetics e.g. creams, lotions, gels, etc., and the benefit of liposuction surgery will help women eliminate cellulite.

FACT

Excessive layers of fat on a body is not something abnormal as the so-called cosmetic surgeons and the "beauty industry" make it out to be. It is a variant of normal. No amount of massage, electrical stimulation, or medication will correct it. The very idea of "spot reducing" is both scientifically unsound and cruel, for it raises expectations in women that can never be fulfilled; the pattern in which fat is deposited or removed is genetically determined. Fat is the only nutrient for which the human body has virtually infinite storage capacity and this is not the only problem high society ladies have in handling.

Liposuction on the other hand is a cosmetic surgical technique. It is unnecessary and women are mostly not informed or discouraged from undertaking it. They are seldom warned of risk and pain-levels, breast hardening, re-operation costs, or cancer-detection difficulties. It can also produce permanent bagginess in the skin and oedema, pulmonary fat embolism syndrome, a life-endangering condition in which fat can lodge in the heart, lungs and eyes, a risk whenever layers of epidermis are scrapped, no matter how proficient the scrapper⁵. Yet, cosmetic surgeons maintain that "the benefits far outweigh the risks". This is a value judgment about the relative importance of their version of "beauty" to that of women's life. To dwell on a small degree of risk involved, they maintain, is a feminist over-reaction, creating unnecessary panic; deaths are a fraction of a percentage of the whole. Surely, for a medically necessary operation. But for the re-construction of a healthy woman? How many will die before it is too many, before a line of safety is drawn?

The *New York Times* had reported that 11 women died in 1987 and in 1988 a US Congressional sub-committee placed the death toll at 20. In India, the *Asian Age* of (14.6.95) reported of a 46 year old woman, Sheela Khanna, who died

following liposuction and abdomino-plasty on May 20, 1994 after being operated by Dr. Amarish Kapasi at the Jewel Nursing Home, Andheri.

During the operation 2.5 kg of fat was sucked out from her body with a high vacuum pump after she had paid Rs.35,000 for the operation.

MYTH

Cosmetic surgery overcomes the ravages of aging in women and helps to conform her body to the required beauty ideal.

FACT

Another ad induced fallacy, advising a woman that she is morally bound, to both herself and others, to remove those wrinkles and dark patches, and bags, "tuck in that tummy" raise those breasts"! It unnecessarily instills anxiety in women about aging and hence women do not wish to look at or confront maturity — their own or others'.

Growing old is a natural phenomenon but it is not accidental that the ad industry refers to the process as "ravages". There is nothing intrinsically revolting about bags and wrinkles. In both sexes, it indicates experience and that s/he is knowing or knowledgeable. Yet, in a man it is considered an attractive trait but in a woman it is unpleasant. So the 'ugliness' of aging in women is not appreciated. The ad propaganda therefore is that she should be unblemished innocent etc. distinguishing her clearly from the male, who should not. Anything that obscures that line is ugly — inhuman, scary etc. Because of this largely induced fear of old age — or rather of looking old, women frequently undergo face lifts which has to be redone every 5 years and is very costly.

The most common form of cosmetic surgery in the US today is breast augmentation. But it has no discernible health or (physical) comfort benefits, and may keep the patient from nursing children later. Moreover, it has a very high (60%) rate of complications even when responsibly and competently performed.⁵

The problems this procedure causes are horrendous. Apart from being unnecessary it is caused by the physician's ignorance, carelessness, or simple greed.

MYTH

Animal tests and experiments of ingredients for cosmetics are essential as there are no alternatives to it.

FACT

Despite progress made by animal rights groups against the practice, the cruelty of animal testing, etc. continues. PETA (People for Ethical Treatment of Animals) confirms that cosmetics in ingredients do still, originally, achieve acceptance as 'safe' by cruel animal tests. Further, Gerald McKnight⁶ confirms this when he had visited the research laboratory of the Japanese cosmetic TNC, *Shiseido*, in Yokohama. He observed "white rats held by collars and 'restrainers', being force-fed with white cream...".

Some cosmetic firms however declare that they do not use animal-tested products any longer. The claim however involves a complicated difference of what is, or can be claimed as "animal tested". In order to market an ingredient for use of cosmetics, cosmetic firms meet safety standards provided the material used have not been tested for a specified period of 5 years, after 1976. If these tests have been prior to that period then there is no legal requirement for the firm to say "No".

Cosmetic barons like Albert Kligman state that they use animal tests in the "rarest of cases" with utmost care, with the least possible amount of pain to the animal under tests. No one is however certain of what that really means, and what pain it causes?! Moreover, they also hold that "limited" testing is imperative. "There just are no 'in vitro' systems (under which cell culture are grown in the laboratories to stimulate animal tissue used for testing) which can possibly mimic all the complex biology of the living organism".

But there are alternatives! Animal fats can be replaced by non-edible vegetable oils as is the practise in India for the manufacture of soaps, etc. Sperm can be replaced by Jojoba oil (got from the shrub '*Simmondsia chinensis*'). Beeswax can be got from apiary combs which do not require the loss of lives. There are 80 synthetic choices to musk. Nylon and synthetic bristles can be used instead of hog hair. Cell cultures, and isolated eyes (after slaughter) can be used to do way with the redundant LD50 (Lethal Dose 50%) and Draize Tests. There are also computer modelling, physiochemical and biomolecular tests, the use of micro-organisms and plants and organotypic tests.

A 1985 report of the EEC Scientific Committee on Cosmetology recommends animal tests only when there is a danger of 'human exposure to dermatotoxicity (skin reaction), and carcinogenicity (cancer).

MYTH

Feminists and the women's movement who oppose femininity and feminine behaviour e.g. using make-up etc., are teaching women to abandon their femininity.

FACT

We are born male or female; not masculine, or feminine. Further, Sandra Lee Bartky, in "*Femininity and Domination*" maintains that femininity is an artifice, an achievement. Femininity is thus a social construct. She reveals how in Western patriarchy the female body is manufactured through very specific disciplinary modes, viz.

i) *those that aim to produce a body of a specific size and general configuration.* Styles of the female form vary over time and across cultures; they reflect cultural obsessions and preoccupations in ways that are still poorly understood. Power in women is anathema in any male-defined society. In a society obsessed with feminine beauty and sex the current body of fashion is taut, small-breasted, narrow-hipped and of a slimness bordering on emaciation. Since ordinary women have normally quite different dimensions, ad media's advice to them is: "Diet"!

Dieting disciplines the body's hungers: Appetite must be closely monitored all times and governed by an iron will. Since the innocent need for food is needed, the body in observing such a discipline becomes one's enemy, an alien bent on foiling the disciplinary project. One dangerous result of this is '*anorexia nervosa*'. The other discipline which the female body is subjected to – the 'tyranny of slenderness' – is exercise. Weight-lifting, yoga, calisthenics, aerobics and 'jazzercise' are its various forms. There are also variety of machines, each designed to call forth from the body a different exertion: Nautilus machines, rowing machines, ordinary and motorized exercycles, portable hip and leg cycles, belt massagers, trampolines; treadmills, arm and leg pulleys, etc. Then there are exercises to resculpture its various parts on the prevailing beauty ideal. There are the so-called 12 basic facial exercises that can erase frown lines, smooth the forehead, raise hollow cheeks, banish crow's feet and tighten the muscles under the chin. There are, further, exercises to build the breasts and exercises to banish "cellulite". There are "spot reducing" exercises, an umbrella term that covers dozens of punishing exercises designed to reduce the so-called problems areas — thick ankles or "saddlebag" thighs.

ii) *those that bring forth from this body a specific array of gestures, postures and movements.* A women's mobility is subject to even more finer disciplines: women's faces, as well as bodies, are trained to the expression of deference. This "nice" girl is trained to avoid the bold and unfettered staring of the so-called loose woman. Women are trained to smile more (than men,) too. In many typical women's jobs graciousness, deference and the readiness to serve are part of the work as in the airline professions; this requires the worker to fix a smile on her face for a good part of the working day, whatever her inner state. For instance, in the airlines where even when she is unwell the airhostess has to smile. Feminine movement, gesture, and posture must exhibit not only constriction, but grace as well and a certain eroticism restrained by modesty: all three. A woman must stand with stomach pulled in, shoulder thrown slightly back and chest out, this is to display her bosom to maximum advantage. While she must walk in confined fashion appropriate to women, her movements must, at the same time, be combined with a subtle but provocative hip-roll. But too much display is



taboo. From time to time, women's glossies, fashion magazines and grooming institutes offer instructions on social etiquette which includes proper way of walking, etc. These instructions combine all three compulsions of women's movement: a woman must not let her arms and legs to flail about in all directions; she must try to manage her movements with the appearance of grace — no small feat when one is climbing out of the back seat of a *Fiat!* Contestants in "beauty competitions" have to learn to take the narrow ramp, the 'cat-walk', in 3" to 5" spike heels and prance at tandem to piped music — performing frog marches and pirouettes.

iii) *those that are directed towards a display of their body as an ornamented surface — as pretty objects to be regularly polished and exhibited.* A woman's skin must be soft, supple, hairless and smooth. Ideally, it should betray no sign of wear, experience, age or deep thought. Hair must be removed not only from face but from large surfaces of body as well from legs and thighs, an operation accomplished by shaving, buffing with fine sandpaper. With high-leg bathing suits and leotards, a substantial amount of pubic hair must be removed too. The removal of facial hair can be more specialised. Eyebrows are plucked out by the roots with a tweezer. Hot wax is sometimes poured into the mustache and cheeks and then ripped when it cools. The women who want a more permanent result may try electrolysis which is painful and expensive.

"Good skin-care habits" requires cleansing lotions, astringents, toners, make-up removers, night creams, nourishing creams, eye creams, moisturizers, skin balances, body lotions, hand creams, lip pomades, suntan lotions, sun screens, facial masks. Provision of the proper facial mask is complex: there are sulfur masks for dry areas; tightening masks; conditioning masks; peeling masks; cleansing masks; mud packs; etc. These habits also call for a variety of aids and devices: facial steamers; faucet filters to collect impurities in the water; borax to soften it; a humidifier for the bedroom; electric massagers; backbrushes; complexion brushes; loofahs; pumice stones; blackhead removers; implements and techniques in manicure and pedicure.

Hair-care, like skin-care, requires a similar investment of time, the use of a wide variety of preparations. A woman must know how to use the blow dryer, styling brush, curling iron, hot curlers, wire curlers, eyeliners, lipliner, lipstick brush, eyelash curler, mascara brush — foundation toner, covering stick, mascara, eye shadow, eye gloss, blusher, lipstick, rouge, lip gloss, hair dye, hair rinse, hair lighteners, hair "relaxer", etc.

It is precisely these regimens of time-energy-, and money-consuming efforts which hamstring women into a status of domesticity and subordination that feminists and women's groups are up against — against an imposed femininity.

Evidently, therefore, fashion, etc, and social definitions of femininity have limited the potential of individual women.

Rejection of such socially imposed feminine standards of beauty promises empowerment, as women create their own image of womanhood not measured against any ideal.

The criticism that feminists appear as "untidy creatures" has to be therefore viewed in the context of feminist struggle, both on the personal and societal levels, against sexual objectification of women's bodies, for the abolition of society's superficial stands on femininity, even masculinity. Gender stereotyping, in appearance, also dictates that women conform to the prevailing beauty ideal, and men to standards of virility like for instance the clarion call to Hindu men by the likes of Sadhvi Rithambharas!

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