

POPULATION POLICY AND WOMEN'S HEALTH

1

AIDWA
Publication
Series



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Preface

A positive feature of women's struggles for equality in India is the increasing range of united actions and issue based coalitions involving a large number of organisations and groups. There have been joint protests against structural adjustment policies, against communalism and religious fundamentalism, for justice against domestic and social violence, for increased representation in the political sphere. Important policy interventions have also been made. However the movement is not homogenous and there are several different trends, from Left oriented mass organisations like AIDWA to welfare based women's organisations, autonomous women's groups, caste based organisations and so on. Each has its own understanding about the roots of women's oppression and the priorities and goals of the struggle for emancipation.

Friends of AIDWA who have been following the organisation's work and interventions in various States as well as at the national level have been asking for publications which would reflect the organisation's understanding on the various issues on which AIDWA has been working. As a first tentative step towards meeting the existing gap between our work on the one hand and the lack of publications on the other, we are publishing a series of seven booklets. These include extracts from reports and commission papers presented at our national conferences, which have served as the basis for the ongoing discussions in AIDWA and also informed our interventions on these issues.

The series are (1) Women in the New Economic Order, (2) RSS: The Ideological Onslaught on Women, (3) The Triple Burden : Some Issues of Caste and Class Oppression, (4) Women's Political Participation: Issues & Experiences, (5) Population Policy and Women's Health, (6) Not a Uniform Civil Code, but Equal Rights, Equal Laws, (7) Violence and Women. The publications are a collective effort with several AIDWA members contributing to the writing of the papers. They are Subhashini Ali, Shubha, Sarla Maheshwari, Mythily Sivaraman, Kalindi Deshpande, Sudha

Sundarajan, S. Punyavati, Shamali Gupta, Indu Agnihotri, Malini Bhattacharya and Brinda Karat. We also thank Dr. Amit Sengupta for his help on the AIDWA document on health issues. Sahba Hussain and Bela Malik helped a great deal in bringing out the publication.

However, these documents do not include reports of the tremendous experience of struggles and the multifaceted work done by the organisation in different States and among different sections of women. We propose to collate some of that experience and bring out another series on issue based struggles in the different States. All this costs a lot of money. We would appreciate contributions from our well wishers towards the cost of the publications.

With greetings from all of us at AIDWA,

December 1998

Brinda Karat
(General Secretary)

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POPULATION POLICY

What is population policy?

The population policy of a nation should represent a comprehensive approach to demographic balance and well-being and should pertain to the quality of people's life as well as quantitative status. It is based on the study of influx and exodus of people, migrations such as those from rural to urban areas, accommodation, distribution of civic amenities like potable water, sanitation, ration shops, basic health infrastructure, and schooling, availability of means of livelihood, and use of environmental resources. Disaggregated and differential data about the development of human resource, like gender ratio, rates of birth and death, infant and maternal mortality rate, total fertility rate, rate of literacy, and nutritional status, tell us about the needs which must be addressed to achieve a balanced and high-quality demographic status. The question of distribution is thus very important. As for example, in some highly-developed countries, as soon as one comes to some of the disadvantaged segments of the population, the human development index drops sharply. In a populous country like India, acute differentials in distribution may severely affect demographic status. In India, as in many other third-world countries, however, population policy has become synonymous with the policy in family planning.

The Indian situation

In 1951, India launched the first official family planning programme, later known as the Family Welfare Programme, with the objective of 'reducing the birth rate to the extent necessary to stabilize the population at a level consistent with the requirement of the national economy'. Subsequently the Alma Ata declaration (1978) of Health for All by 2001 was adopted by India in 1994 and

'reproductive' health rather than family planning was foregrounded as a new slogan from the Cairo Conference (1994) on Population and Development. But for all this birth control remained almost the sole component of population policy in India. In 1976 (during the emergency), a policy statement was issued affirming the priority accorded and commitment to 'population problems'. In 1977, a revised statement, however, emphasised the voluntary nature of the family Welfare programme.

The National Health Policy of 1993 stated the long-term demographic goal, i.e. to achieve a Net Reproduction Rate of Unity (NRR-1) by the year 2000. This means achieving a crude birth rate (CDR) of 9 per thousand and a natural increase rate of 1.2 percent. While there has been a substantial decline in the natural increase rate, NRR-1 is still far off. The national health policy also envisaged reducing infant mortality rate (IMR) to below 60 per thousand live births by the turn of the century. This, too, is still an unachieved goal. While the national health policy recognised the need for comprehensive and all-sided development of human resources as a prior condition of success of the family planning programme, such development went on only at a slow and uneven pace. While the government's investment in family planning went on increasing the lion's share of health expenditure, deceleration of demographic growth was not on a par with the money spent.

Progress?

In the UNDP report, 1995, India is described as having a 'low human development index'. Its rank is 134th, other such countries preceding us being Pakistan, Ghana, Kenya and Myanmar. Our life expectancy at birth between 1991 to 1996 was 60.6 for males and 61.7 for females. While this definitely shows some improvement over earlier decades, with a degree of female advantage, a deceleration in the general rate of growth of life expectancy is observed in the last few years. Also observed is the adversity of sex ratio for women, (927/1000 in 1991) which indicates some special disadvantages for women, the source of which may be traced to the sex-ratio for the 0-6 years age group population. Sex ratio in this segment declined from 976 in 1961 to 945 in 1991. Similarly while infant mortality rate was reduced from 131 in 1978 to 80 in 1992 for females and from 123 to 79 for males during the same period, the decline in IMR has slowed down between 1990-93. Maternal mor-

tality rate in 1995 was 460 per 100,000 live births, one of the highest in the world. Only 33% of births are attended by trained personnel. The percentage of pregnant women between 15-49 years suffering from anaemia was 88 between 1975-91. Further, although there is a fairly progressive Medical Termination of Pregnancy Act, granting licenses to medical practitioners for performing MTP under certain specific conditions, out of about 6.7 million induced abortions in 1991-92, only 600,000 were legally performed. According to a World Bank Report of 1996, about 15,000-20,000 abortion-related deaths take place every year. About 90 million people in India are affected by sexually-transmitted diseases. Add to this the low literacy status, the general rate being 52.51 in 1991 and the female literacy rate being 39.29 in the same year. Add to it the lack of accommodation, potable water, sanitation, and food at a fair price. Add to it the fact that in spite of the relative success of the Universal Immunisation Programme (UIP) and the Child Survival and Safe Motherhood (CSSM) project (revamped in 1996 as Reproductive and Child Health Project - RCH) under which BCG coverage for children has risen to 97% and tetanus toxoid coverage for pregnant women to 81%, facilities for primary health and nutrition are still less than minimal. Add to it the problems of unplanned urbanisation. The need for a holistic population policy to improve the status of living of millions of our people seems as important as ever.

Drastic change in approach from the late 1980s

From the late 1980s, the results of India's increased indebtedness to foreign funding agencies began to show and the creditors tightened the screws by imposing the Structural Adjustment Programme of India. As a result of this, the already-existing tendency to equate population policy with family planning programs increased and the national health policy of 1983, which under the influence of the Alma Ata Declaration had taken a relatively holistic approach and had combined a primary health Centre-based strategy with balance between preventive and curative programme, began to be steadily undermined.

The share of the public sector in India in health expenditure had always been low. Now this was further reduced. Per capita spending on public health declined from Rs 13.90 in 1987 to Rs 10

in 1993, and per capita spending on disease prevention from Rs 9.20 in 1987 to Rs 6.50 in 1993. The apparent increase in the share of health in total revenue expenditure in the 90s merely reflects increased allocation for AIDS and TB control (after the initial cuts for TB programs, the allocation was increased). In the 1990s, most States in India had been forced to curtail their recurring health expenditure by an average of 12%. The share of Central grants in the States expenditure on health has declined as follows:

Year	Medical & Public Health	Public Health	Decrease	Family Welfare
1984-5	6.73	27.92	41.47	99.00
1992-3	3.70	17.17	18.50	88.59

There has been a deceleration of growth of PHCs in 1990-93. The concept of selective PHCs only to fight infectious diseases has diluted the earlier more comprehensive strategy. There has also been a deceleration of growth of ICDS centres, so that universal coverage has receded to the distance. New components like creche service and early childhood education are being introduced into ICDS without making necessary financial allocations so that services are being minimized. Efforts to privatize ICDS and family planning are leading to a situation where instead of checking wastage of resources, all monitoring of such programs is being withdrawn. All this is in accordance with the advocacy of the World Bank Development Report, 1993, to privatise health care in India.

The progressive drug policy of 1978 (in accordance with 1976 Hathi Committee recommendations) has been virtually destroyed by two sets of modifications made by the Indian government in 1986 and 1993. The so-called 'liberalisation' of drug policy, by exempting a large number of essential and life saving drugs from the Drug Price Control Order and by watering down the compulsory licensing system, has benefited the MNCS and allowed them to make limitless profits out of patients by hiking drug prices and by importing drugs at a high cost formulations that are quite often unnecessary and even hazardous.

A second aspect of SAP has been massive injections of foreign

assistance particularly in family planning, like the USAID project (1992) worth 325 million dollars, to provide 'innovations in family planning services' in the State of UP and subsequently to the whole of India. The lack of transparency and of accountability that characterise these projects leads us to suspect that unacceptable and hazardous family planning devices and drugs aimed at women, which MNCs are unable to use elsewhere, may be dumped in India through such projects leading to women's health being jeopardised. The surreptitious use through government agencies of a controversial hormonal implant, Norplant, on migrant women laborers in UP in 1991, although it was stopped following protests from women's organisations, reinforce these suspicions. Another aspect of the liberalisation of drug is that in recent years, the government and the ICMR have been allowing clinical trials of controversial invasive family planning devices and drugs proposed by the MNCs. It is the poorest women, laboring in the unorganised sector, who are the likeliest possible victims of such unprincipled experiments. In 1992, the government allowed the introduction of DMPA (Depo-provera), another controversial hormonal injection, in the private sector. The use of quinacrine to produce sterility in women, has been going on for a long time, and could only be stopped through efforts of women activists and medical practitioners leading to a Supreme Court ban order. The point, however, is that the 'liberalisation' of drug policy, the dominance of MNCs in the drug sector, and massive foreign assistance in family welfare programme (FWP) would increase such dangers, without fulfilling the real need for safe and cheap contraception.

This must also be seen in the context of the fact that 93% or more of working women, in the rapidly expanding unorganised sector, are excluded from child-care services and maternity benefits. They also suffer from work-related diseases, physical and mental, concomitant with low wages and seasonal employment. This is compounded by the fact that in the growing number of women-headed households, where the woman is the sole earner, the hard labour she has to do makes her think of pain, ill-health and discomfort as part of life. In such a situation the new 'cafeteria approach' to family planning, without improving her access to the basic health care system, claims to make her 'free' to exercise choice of the family planning drug or method of her preference. In reality it exposes her to the danger of having hazardous drugs pushed

into her without proper information or monitoring. Since all such drugs target women, she has to bear the major burden of this changed or liberalised approach. The conventional sterilisation programmes being already largely women-oriented (96% tubectomy and 3.5% vasectomy in 1993), these changes, instead of moving towards a policy that would protect her, push her into further suffering. This argument of 'right of choice' and 'progress of technology' is used also by some sections to promote certain pre-natal diagnostic test for foetal sex-determination. The Act to regulate this and ban sex determination tests, passed in 1994, is a weak one and is not likely to check the trend which would, through abortions of the female foetus, not only lead to serious demographic imbalance, but also jeopardise maternal health. Increase in female infanticide in some States is also going to affect the sex-ratio adversely.

A population policy to fit the changes

From 1991, the government began to make moves to formulate a population policy in accordance with the above-mentioned changes in approach and with the covert dictates of international fund-giving agencies. The objective of this projected population policy was not to improve demographic balance and well-being, through greater government investment in the service sector, but to implement the neo-Malthusian approach of rich Northern countries, pushed through the SAP, which views birth control as the panacea for all social and economic ills of the third world. The WHO's call to pay attention to reproductive health was based on the assumption that FWPs in developing countries cannot succeed until more comprehensive strategies for child survival and maternal health were adopted. The Cairo Conference of 1994 ratified this. Since this emphasis on 'reproductive health' itself was an extremely narrow approach of women's health needs, the approach was eventually pared down to a point where population control would be made the be-all of all health and education strategies. As in the 'Education for All' summit of 1993, of the 'nine most populous countries', including India, literacy and elementary education were seen from a limited perspective as the means of promoting population control. Literacy was described as the best contraceptive, its importance as a means of developing human potential remained in the background.

In 1993, following the recommendation of the Committee on Population (Karunakaran committee) of the National Development Council, the Ministry of Health and Family Welfare set up an Expert Group headed by Dr.M.S.Swaminathan to prepare a draft national policy on population. The draft policy submitted to the government in May 1994, proposed to 'integrate gender equality in plans for health and family welfare and also to arrest and reverse the declining sex ratio'. It proposed a new structure - a Population and Social Development Commission and a special fund for the purpose. But it also avoided an analysis of the impact of structural changes on demographic balance and well-being. It did not try to locate the faults in the existing approach which had a disabling effect on all such efforts. Further, it made objectionable proposals like bar on government recruitment of girls and boys getting married at an early age, bar on contesting elections for people not following the small-family norm, and the use of army and paramilitary forces to serve the cause of the health and population stabilisation. These were strongly opposed by national women's organisations, including AIDWA. Subsequently, the author agreed to withdraw some of these proposals.

It is significant that while the government did not take up any of the positive recommendations of the Swaminathan Committee, in 1994 itself, it brought the Seventy-ninth Constitution Amendment Bill to the Parliament, whereby people having more than two children would be debarred from contesting parliamentary elections. This bill went to the standing committee of HRD and in spite of a note of dissent from Left MPs, was given a nod by the committee. It has not been passed as yet but may be brought to the Parliament at any time. There can be no doubt that disincentives and indirectly coercive tactics of this kind, far from promoting small families, will put added pressure on women and on the poorer sections, who, even if they are aware of the importance of small families, have little control over their own reproductive lives. Already, the politics of population control is becoming apparent in States like Haryana and Rajasthan, where such exclusive and punitive policy at the panchayat level is preventing participation of the women and the poor. The Delhi BJP Government has also passed the Bill. Instead of providing people with their basic rights, such moves in so far as they effect disadvantaged sections like women, is turning into an attack on democracy.

It must be understood, however, that it is not merely the

pressure of SAP imposed by funding agencies, but also the dominant ideological pattern which reinforces this changed approach to the demographic question. An important early component in demographic imbalance in India was massive enforced shifts in population owing to communal riots after the partition of India, 1947. We have not yet succeeded completely in making up for its ill effects. The recrudescence of fundamentalism and communalism in India is linked up with the erosion of democracy. These are ideologies which seek to deprive people of their basic rights in the name of 'religion'. 'Liberalised' thought on population policy seeks to do the same in the name of 'science and progress'. While unconcerned about providing access to safe contraception and improved quality of life, the emerging approach to the demographic question seeks to punish disadvantaged and weaker sections of society by coercing them into submission. Majority fundamentalism by taking advantage of this and presenting what is really a war against the poor, a special campaign to control the numbers of 'backward' minorities. The 1996 BJP manifesto for example, proposed a cut in rations to all families who had more than two children. In spite of the fact that large sections of laboring classes, specially women, hindu and muslim, are today conscious of the need to have small families, the dominant ideology still keeps on making strident declarations that the poor are averse to planned families and must be coerced into it. Majority fundamentalism may easily add a communal dimension to it. Moreover, by emphasising the communal divide in mixed areas, by fueling tensions arising out of limited economic opportunities available in a particular locality or a particular State and by putting all the blame for such tension on 'aliens' who should not be there, these forces may cause the exodus of certain sections of the people, from certain localities and States, thus disturbing the demographic composition and promoting ghettoisation. We saw this approach in certain areas of Gujrat following the demolition of the Babri masjid.

A demographic approach that is basically anti-poor, will in this way, increase social tensions and encourage communalism and parochialism.

While some of the States in India are worse off than others in the matter of reproductive health, UP, MP, Orissa and Bihar being way behind others, Kerala provides an alternative model of demographic well-being, with high rates of literacy and a basic health infrastructure for all. It is way ahead even of the many so-called

developed countries so far as children's and women's health status is concerned. Kerala did not adopt any special family planning drive, but succeeded in controlling population growth by ensuring general demographic well-being. The Kerala experience is actually based on widespread land reform combined with people centered policies of development. This should provide the model for India, and might supply some of the basis of an alternative population policy.

Alternative population policy

Such an alternative population policy will have to:

- * Ensure adequate public sector investment in making basic amenities available to large section of the people.
- * Strengthen PHCs and Sub-centers with a holistic approach to health and proper balance between preventive and curative medicine, also make available enough trained medical and paramedical staff.
- * Ensure universalisation of maternity benefits for working women in the unorganised as well as the organised sector, and of ICDS and creche services.
- * Provides safe contraception without targeting women alone through a properly monitored public system. Ban all clinical trials, as well as marketing of hazardous
- * Implement the ban on sex determination tests. Follow an incentive programme to panchyats for care of the girl child.
- * Provide food and essential commodities through fair price shops.
- * Provide sanitation and potable water.
- * Make health education a component of literacy programme.
- * Compulsory free education up to age of 14 with adequate incentives.
- * Drop all efforts to curtail citizens rights by making religion and caste-based identity cards an essential condition for citizenship, and encourage mixed residential areas.
- * Drop a disincentive-based approach to family planning. Withdraw the proposed legislation to amend the Peoples Representative Act to ban candidature of those who have more than two children. Abolish such laws in Haryana, Delhi and Rajasthan.

WOMEN'S PERSPECTIVE OF A NATIONAL POPULATION POLICY JOINT STATEMENT OF WOMEN'S ORGANISATIONS.

1. This statement is in response to the request of the Expert Committee set up by the government of India to formulate a National Population Policy. It is not as if the Government has not had a population policy so far. It has been one of fertility control, pursued relentlessly, and at times coercively, through three decades, bringing disrepute to the family planning programme, compromising women's health, and accelerating the already declining sex-ratio. Now we find that more of the same recipe is being institutionalised through disincentives and constitutionally questionable legislation. Monetary incentives have already proved a corruptive influence and added economic pressure to women's powerlessness.
2. The women's movement has all along been in favour of family planning, and has advocated women's control over their fertility. Pursuing demographic goals, however, is not synonymous with family planning. We do not accept that population growth is mainly responsible for all of India's ills, i.e. poverty, environmental degradation etc. the government however, refuses to recognise that the population rise is a direct consequence of increasing inequities and dispossession among the majority and seeks to address the symptom of population rise without addressing the economic and social structures and policies which are the root cause. We maintain that demographic goals of reduced fertility cannot be imposed by a fiat of the government, as at present. Hence our demand for a national debate before any policy is finalised. While challenging the validity and limitations

of government's current approach, we offer an analysis and constructive suggestions. This statement should be read in conjunction with the memorandum dated 21st October '93, submitted by some of us to the Expert Committee on 23rd October 1993.

3. 'Sustainable Development': In the context of the existing gap between India's stated Constitutional goals on the one hand and the present increasingly iniquitous social reality on the other, the just demands for a better life and future of the deprived section of our population must be included. Since the present population policies are mainly directed at this section of the people, the inclusion of their rights to survival with dignity should not remain mere rhetoric or constitutional dreams to be misused as electoral promises. It requires definite policy measures and intervention in the areas of health, employment, education, socio-political states and the freedom to participate in decisions that affect their lives.

4. In international fora official representatives of India have rightly challenged the assumption of the developed world's definition of sustainability as being one that must guarantee the continuation of the North's profligate over-consumption of scarce natural global resources. However, the other side of this assumption - that the depletion of global resources are attributable to the over-population of third world countries which require emergency control measures - seems to have become the unseated bedrock of present government approaches.

5. On the first point, we feel that it would enhance the credibility of the government's position - nationally and internationally - if it addressed itself to the reality of the over-consumption of resources by India's minuscule elite, among whom we are forced to include the government itself. In the background of the ongoing process of restructuring India's economy we are sceptical of how such a recommendation would fit in with the present domination of 'market' considerations. However, no rational approach to population issues can ignore the total imbalance of control of productive resources and subsequent consumption patterns in India, increasing inequalities of income and consumerist values which are again fall outs of the restructuring process. The experiences of all other countries undergoing structural adjustment proves that the size of the population under the poverty line has drastically increased.

6. Although it is not the purpose of this statement to go into the details of the extremely adverse impact of the present economic policies on the bulk of our population, the references have been made necessary because of the approach advocated in the draft circulated to the Expert Group which seeks to disenfranchise further precisely those sections already bearing the brunt of the burden of the economic crisis.

7. One important aspect of the present policies is the reduction in real allocations to essential services which included the public distribution system and access to food, health, education etc. Privatisation of health services, charging of fees for tests in government hospitals are going to further worsen the already fragile health profile of India's poor. As women's organisations, our experiences indicate that the fast deteriorating position of women's health, indicated by malnutrition, anemia, increased vulnerability to illness etc., is directly related to increased levels of poverty, lack of access to primary health services and not primarily to maternity related problems as perceived by official analysts. In this context, we consider the equation of health with family planning to be nothing short of criminal. The very fact that successive five year plans have increased allocation and attention to family planning at the cost of basic health services to the extent of the former exceeding the latter in the Seventh Plan should make our point clear.

8. The other aspect is the still shockingly high figures of infant mortality. We were horrified to learn that some of the international agencies who are closely involved in 'advising' the government of India on the direction of economic policies, circulated a document advocating cuts in allocations for child survival strategies as a way of overcoming the 'population trap'. We have little indication of the government's response in this matter. The present trend of increasing child labor, in particular the labor of girl children points to the reality of children being seen as assets providing livelihood to a large number of families. What we wish to stress is the crucial role that nondemographic factors play in determining the size of the family for a vast number of India's poor.

9. Therefore to see population control as a precondition for the reduction of poverty goes counter to the history of demographic transition in other parts of the world and against the living reality of India's poor majority. Further, to see women as primarily responsible for the increase in population and to devise methods to

control their fertility at all costs, is a position that the women's movement in India can never accept.

10. We wish to reiterate that poor women in India want and need easy access to safe contraception. However, this need cannot be exploited to reach demographic goals in the 'shaping of which they have had no hand' - at the cost of their health, their earning capacities and their futures. As elaborated in our memorandum submitted to the Health Minister, the key question is not the need for easy accessibility to contraceptives peruse, but to safe contraceptives. A 'choice' which include contraceptives unsuitable for use in India is no choice at all. We have detailed our position on each contraceptive which the government plans to includes at some stage in the Family Planning Programme in the said memorandum. Further, as an example of government policy, we refer you to the agreement signed with USAID of 30th September 1992. It specifically relates to fertility control of women in Uttar Pradesh (one of the worst states as indicators of women's status or infant mortality demonstrate), and the measures suggested include hormonal implants to be carried out with a grant of US dollars 385 million over a ten-year period. We consider this agreement, signed in secrecy and still not publicly available to be both anti-women and anti-national and strongly recommend its cancellation.

11. It is astounding that the government of India in setting the demographic goals, seems to have ignored the vast body of literature which identify the status of women as one of the crucial factors influencing demographic trends. During the last two decades the shocking increase in female infanticide, sex determination tests followed by abortion of female foetuses, proves that setting of such demographic goals without tackling the roots of the problems of women's inequality will have the most disastrous impact on the already unbalanced sex ratio prevailing in this country, and further depress their status, apart from providing rationalisation to the unethical practices and misuse of science by a section of the medical profession.

12. We strongly recommend the end of the target oriented, disincentive approach of the government of India and reversal of all related policy decision e.g. the reduction of maternity benefits to only two children. We also recommend withdrawal of the present Bill before parliament disqualifying persons with more than two children from standing for election. We believe that such a measure will automatically disqualify precisely those economi-

cally deprived sections of our population, including women who most need political empowerment. This measure could also become an instrument of discrimination against minorities who already feel threatened because of recent political developments. We also see this measure as militating against the concept of grassroots democracy as enunciated for instance in the 73rd Constitutional Amendment an Panchayati Raj which, for the first time has sought to expand women's participation in decision making at these levels of government, on the demand of the women's movement.

13. There has been a demand from some sections that the increased number of women members in the local self government bodies under the new amendments should be made responsible for programmes of women and child development. We oppose this demand. We recommend that women should be inducted into all the important standing committees with a views to ensuring the much needed co-ordination through their personal knowledge and stakes in the success of policies for education, health care, child development, environmental improvement, livelihood improvement etc. They would also need the support of women's organisations (local, block level, district, state etc.), educational/research/scientific institutions to respond to their articulated information/training /technological/ other needs.

14. We believe that not enough attention has been paid to the adolescents in Indian society. Recent attempts to identify discrimination against girls have only noted their deprivations but not examined the psychological consequences of their being forced to assume adult roles from a very young age, particularly among the poor. Many in western industrialised countries (whose model we adopted for economic growth and the education's of our youth) are admitting (a) collapsing social cohesion, (b) declining desires to participate constructively in economic/social/political life and (c) proneness to violence as serious problems among their youth. Some sensitive leaders relate the rising tide of xenophobia also to the same sources. Our youth have not yet come to share all these tendencies but the situation, especially in metropolitan cities is changing rapidly and increasing violence is manifesting itself in many forms. A Population Policy for the 21st century cannot and must not continue the mistakes of the 20th century, and ignore the critical importance of the generations that must be the leaders for the next century.

15. Conventional demography generally includes fertility, mortality, labour force participation and structural distribution of the population between age-groups and geographic areas (e.g. rural, urban). Even gender is not always included as a significant variable for all purposes. We feel morbidity and malnutrition need to be included in this basic list, particularly in view of the questions being raised in the context of Kerala and Tamil Nadu where the demographic transition has been rapid. In the Indian, the regional and global context of today, migration- seasonal, long term, internal and international - have emerged as critical, even explosive issues. There are distinct class, gender and age differentials, with vital consequences on the structure of the family, the distribution of livelihood, work burden and responsibilities for the care of children and old dependents, which have yet to find a place either in demographic research or in population policies.

16. We wish to reiterate the importance we give to grass root level institutions like gram sabhas and district councils for participatory decision and interventions in the non-demographic factors that ultimately affect family size. We therefore recommend certain incentives to local bodies for positive achievement like the following:

- * improving the rate of child survival; provision of centers for child care and development;
- * improving maternal and other health services (our reach and quality) for all -ensuring fully staffed adequate primary health centers;
- * achieving full enrollment of all children in the appropriate age group in primary and middle school;
- * organising informed participation and achieving support- ing from the people in implementing all connected policies;
- * eradication of child marriage and illiteracy;
- * reversing declining trends in the sex-ratio especially at birth and in early childhood.

We feel provision of such incentives to local bodies would strengthen the spirit of the Constitutional amendment and provide a sense of direction and possible changing cultural attitudes at the grassroots level, thus enabling the local bodies to play an effective role in achieving the desired broad policy objectives that we suggest. However, this will only be possible provided the govern-

ment of India makes enough resources available to state governments to strengthen the financial capacity of the local bodies. This would mean altering the present trend of curtailment of funds. Secondly, we recommend that the transfer of resources for various purposes must not be linked to meeting demographic targets.

17. Research and Development in Health and Reproductive Technology: We have already requested the Expert Group to look into this aspect and make information on this area available to the public for scrutiny and debate. We are aware that even Members of Parliament do not have this information. Marketisation of R&D in these vulnerable areas should be resisted at all costs. India's experience in sex-selection tests alone should provide enough evidence for this position.

18. Conclusion: At the higher levels of government, the multi dimensional tasks/needs of a population policy call for some major restructuring of the machinery - (a) to achieve holistic coordinated functioning (as conceptualised in the theory of 'collective responsibility') - and improve its capacity to respond to the demands coming from the lower levels; (b) to evolve a smooth process of transfer of authority, power, and resources (including knowledge) - to make decentralisation a reality; and (c) to reorient its functioning and thinking in order to exchange its present self-image as leaders of 'the nation', to one of catalysts to assist the people and their democratic institutions to function legitimately. Without the major restructuring and devolution of power/resources/ authority, we do not think cosmetic changes like creation of a Population Commission, or Cells within various ministries, or a National Institute for Research/Training/Documentation etc. can create any serious impact. It is time for the government itself to practice some fertility control in reproducing bureaucratic infrastructures.

To,
The Minister for Health and Family Welfare,
Nirman Bhawan,
New Delhi - 110 001.

Sir,

Women's organisations have for a long time been voicing concern over the new trend of introducing hazardous, long-acting, provider controlled, hormonal methods of contraception.

We have repeatedly approached the government for restraining them from the use of such contraceptives because in the name of giving women a better choice, they in fact take choice away from women and subject them to short-term side effects such as cardiac problems, hypertension, depression, clotting disorders and a number of long-term hazards as well.

These contraceptives require sophisticated procedures for screening and monitoring users, since contra-indications are numerous and include liver disease, diabetes, hypertension, suspected malignancy etc. among other conditions. Services to carry out screening and follow up do not exist in our country for the vast majority and existing services are being dismantled or privatized at fast pace.

These contraceptives have a high potential for abuse because they can be administered without a woman's consent and not removed either by the very design of the contraceptive (as in injectibles) or by the choice of the medical practitioner (as in implants).

These contraceptives are being promoted in the name of reducing maternal mortality. However, with their life threatening side-effects and the inability of the health system to deal with the same, they are going to lead tremendously to morbidity as well as mortality. Target orientation, social marketing and camp approach are in fact a pointer that the concern is more with meeting demographic objectives than with peoples health. Not enough is known about the mechanism of these contraceptives which upset the entire bodily function by acting on the higher brain centres. Only one of the effects is that of preventing conception.

Under Indian conditions, lack of patient records, inaccessibility of the health system to the vast majority means that effective

service delivery is also not possible, leading to high failure rates, which would mean pregnancies and birth of children with congenital malformations - thereby adding a new problem for the society.

The contraceptive need of women differ, however, all these contraceptive methods are catering to women who need continuous protection. None of these contraceptives contribute to the prevention of AIDS and STDs which has to be an important criterion for new contraceptives particularly when an epidemic is said to be imminent.

We are only aware that women in our country have a need for birth control, and are asking for safe methods to control their fertility. But this need cannot be met by any of these methods.

We have repeatedly asked for the promotion of barrier methods and have available at our disposal adequate data to show that these methods in conjunction with back up abortion services provide the safest contraception. We fail to understand why methods like the diaphragm, despite being approved in India are not promoted. There is a similar disinterest in the promotion of vasectomy and male condom. We also fail to understand why women are targetted with a whole range of cafeteria, where each product is of dubious value, while new methods of vasectomy such as no-scalpel vasectomy are limited to one or two premier institutions in the country.

The world over, there is enough experience to show that contraceptive provision is useful only for people ready to adopt a small family norm when their life circumstances improve. In the absence of this contraceptives are used as weapons to meet targets set by the government and do little to meet the reproductive needs of people. There is also enough evidence to show that maternal mortality is reduced not merely by fewer births, but much more when health services reach people and they have enough to eat, clean water to drink and education to be aware of their health needs.

We find that conditions are being created in our country which will lead to a growth in population, because there are increasing cuts in the area of basic necessities. Prices of all essential commodities are rising. People are being forced to pay for services in public hospitals and essential drugs are out of the reach of a majority. Thus, the well accepted maxim that social development

leads to decreased growth of population, is not being followed in our country. The only programme being given great impetus is the family planning programme where increasingly, sophisticated and expensive drugs for contraception are being introduced.

In this context we were particularly alarmed when we were informed of the new plans to promote family welfare, at a meeting called by the secretary, family welfare on 18th june 1993. We were informed that Depo provera and cyclofem are going to be introduced into the country without any trials. NET EN is also to be introduced despite a case pending against it in the Supreme Court. We were told that oral hormonal contraceptives were going to help NGOs /private practitioners to set up sterilization centres in areas where PHCs do not have this facility.

Last year women's groups had specifically raised an objection against the introduction of NORPLANT. This year ICMR has reversed its plans and is going to carry out a trial even though the sheer volume of biased promotional literature makes us believe that the decision to introduce this contraceptive has already been taken.

Time and again we are told that these contraceptives are approved in the US. However, we like to point out that the right to information as well as the protection of patients, systems of screening and follow up are very different and these can make a vital difference to safe delivery.

We demand that :

1. The Drugs Controller be restrained from licensing untested contraceptives.
2. NET EN not be introduced till the questions raised before the Supreme Court are satisfactorily resolved.
3. Testing on NORPLANT be immediately stopped and all biased literature on NORPLANT be destroyed.
4. No provider controlled method, hormonal or immunological, be introduced within the country.
5. Social marketing of oral pills be stopped immediately.
6. Money earmarked for sterilization centres be diverted to upgrading PHCs and CHC where other needs of people can also be met.
7. End the target oriented and camp approach where there is no

possibility of meeting the needs of the people.

8. Appropriate contraceptive technology be promoted which can be used without coercion, is safe, and takes care of other infections i.e. barrier methods.

Joint Memorandum - 1994

AIDWA RESOLUTION

16th April 1996

The All India Democratic Women's Association expresses its strong objections to the fascistic family planning programme proposed in the BJP's manifesto which is the true face of the BJP's approach to poor women. The relevant clause 3 in the population policy section reads. 'At the same time, the BJP will also introduce disincentives like limiting subsidised ration and maternity benefits to two children with 1996 as the cut off year. These disincentives will apply to all sections of society, irrespective of their social, economic or religious status to discourage large, unsustainable families.' The BJP has also threatened an all India legislation to prevent all those who have more than two children from contesting the elections. It has also proposed to reintroduce the infamous measure earlier proposed by the Congress government to cut maternity benefits to women.

In the context of family planning, the term 'disincentives' conceals what is a direct assault on women's status, as women who have little or no control over family size will bear the brunt of the punishment. Further, in a situation where son preference is backed by abortions of female foetuses such a policy of disincentives will further worsen the alarming gaps in the sex ratio.

It is now widely accepted that the large family size is directly related to nondemographic factors such as poverty and underdevelopment. Nowhere does the BJP manifesto mention the steps it will take to reverse the high infant mortality rate- 2 million children under the age of five die every year in India due to poverty and disease. By cutting their rations the BJP proposes to punish the poor for their poverty. In the name of family planning the BJP therefore suggests a complete abdication of responsibility of the government to provide food security for the poor.

Last year the Congress government had moved an amendment to the Maternity Benefit Act on similar grounds which had to be withdrawn because of the unanimous opposition by all women's organisations. It was pointed out that such a step would have extremely adverse consequences for the health of the mother and the infant.

In their appeal to political parties a large number of women's organisations had opposed the retrograde proposal to deny the right to stand for elections to those who had more than two children as a measure which would affect the poorer sections. It would also undermine the reservations policy as it would limit the numbers of those women who could benefit from it, particularly poor women. But this is not of a concern to the BJP.

Another point in the manifesto needs to be specially noted. The BJP talks only about giving property rights to women-not equal property rights. This is not just a semantic omission. The BJP manifesto is silent on the crucial question of equal rights in land, including the demand for joint pattas. Thus on questions which concern the mass of Indian women the BJP has, in spite of all its rhetoric, failed to conceal its anti-poor and anti-women approach.

The BJP proposals are profoundly undemocratic and could be challenged as being unconstitutional and prove once again why women should reject this party in the coming elections.

HEALTH FOR ALL - REDEFINING PRIORITIES

AIDWA Infomation Document 23, July 1993

India was a signatory to the Alma Ata Declaration adopted by the World Health Assembly in 1978, which gave the call 'Health for all by 2000 AD'. Today, several years after the Alma Ata declaration, the state of health in India makes the country one of the most backward in this respect. The facilities in some of our hospitals may be among the best in the world and the same can be said about our doctors. This, however, does not determine the health of a nation. The only true index of a nation's health is the state of health of the vast majority of people, and not that of a privileged few. In this regard the government's own 'Statement on National Health Policy' (1982) states 'The hospital based disease, and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society specially those residing in the urban areas. The proliferation of this approach has been at the cost of providing comprehensive primary health care services to the entire population, whether residing in the urban or the rural areas'.

Post-Independence Expansion in Health services

However, this should not detract from the fact that since Independence there has been improvement in many areas, both in terms of growth in infrastructure and in terms of their actual impact on the health status of our people.

It is nevertheless important to understand both the content and the process involved in this progress made in the health sector.

The health services at the time of Independence were a function of the socio-economic and political interests of the colonial rulers. Consequently they were highly centralised, urban-oriented and catered to a small fraction of the population. Public health services were provided only in times of outbreaks of epidemic diseases like small pox, plague, and cholera. The post independence era witnessed a real effort at providing comprehensive health care, and in extending the infrastructure of health services.

Even the West went through this rapid phase of improvement of health services, after a period of stagnation, at the turn of the century. In the early days of the Industrial Revolution the bulk of workers who came to work in factories from the countryside suffered from malnutrition, communicable diseases and high rates of infant and maternal mortality. When it was realised that the very suffering of the people was endangering industrial production (and thereby profits), active steps were taken to dramatically improve public health services. Economists who had considered medical expenditure as a mere consumption item, realised that allocation on health care was actually an investment on increasing productivity of labour. Another major thrust was provided in the aftermath of the second World War, when with the rise of organised working class movements and the consequent development of democratic consciousness in many European countries the concept of 'Welfare State' was mooted. For example, the National Health Scheme in Britain, which is now under attack in the Thatcherite phase, took shape under the Labour Government just after World War II. A rough analogy can be drawn with this and the Indian situation after Independence. Consequent to the transfer of power in 1947, the character, and as a result the long term interests, of the ruling classes changed and consequently their interests and motivations were qualitatively different from those of the British. Their own interests require a major thrust towards building of an infrastructure to provide some basic facilities to the people. This thrust was both an expression of the need felt by the ruling classes to rapidly increase the industrial base and agricultural production and consequence of the concessions they required to make towards the genuine aspirations of the people. This basic difference between colonial India and free India, however non-egalitarian may be the latter should be understood.

Balance Sheet of Health

The following statistics give a picture of the state of health of our people:

- Only 20% of our people have access to modern medicine.
- 84% of health care costs is paid for privately.
- 40% of our children suffer from malnutrition. Even when the foodgrain production in India increased from 8 million tonnes in 1961 to 124 million tonnes in 1983, the per capita intake decreased from 400 gms of cereals and 69 gms of pulses to 392 gms and 38 gms respectively. Due to increasing economic burden on a majority of people, they just cannot buy the food that is theoretically 'available'.
- Of the 23 million children born every year, 2.5 million die within the first year. Of the rest, one out of nine dies before the age of five and four out of ten suffer from malnutrition.
- 75% of all the diseases in India are due to malnutrition contaminated water and non-immunization.
- Life expectancy is 57 years. This is less than even that in many Third World countries like Nicaragua, Brazil, Vietnam, Burma and Peru.
- 50% of children and 65% of women suffer from iron deficiency, anemia.
- Only 25% children are covered by the immunization programme. 1.3 million children die of diseases which could have been prevented by immunization.
- 1/3 of the total population of India is exposed to malaria, filaria and kalazar every year.
- 550,000 people die of tuberculosis every year. About 9000,000 people get infected by tuberculosis every year.
- About half a million people are affected with leprosy, which is 1/3 of the total number of leprosy patients in the world.
- 70% children are affected by some intestinal worm infestation.
- 1.5 million children die of diarrhoea every year.

Inadequate Resources Allocation

One of the principal reasons for the state of health of our people lies in misplaced priorities of resource allocation. This is

Plan Period	% Share of Health Budget
1951-56	3.32
1956-61	3.01
1961-66	2.63
1966-69	2.11
1969-74	2.12
1974-80	1.92
1980-85	1.86
1985-90	1.88

The government spends just Rs 3 per capita every month on Health. (This may be contrasted with the estimated average expenditure, incurred privately, of Rs.15/- per capita every month).

Even this meagre amount is not equitably distributed. 80% of the resources are spent on bit hospitals and research institutions which are situated in metropolitan cities and large urban centers. They cater to less than 20% of the population. On the other hand, just 20% of the resources is spent on primary health care, which caters to over 80% of the people.

Of the total number (just over 2 lakhs) of allopathic physicians in the country, 72% are in urban areas. Further, only 15.25% of all health personnel work in the rural primary health sector of the government. As a result of the highly inadequate government intervention in the health sector people are forced to take recourse to the private sector in health care. Health has been converted to a commodity to be purchased in the market. Only those who can afford it can avail of the existing health facilities. It is clear that health is perceived by the government as a low priority area with grossly inadequate resource allocation, and a skewed pattern of utilisation of these meagre resources. This fundamental problem in the health sector calls for reviewing the whole developmental process in this country.

Towards Privatisation-Government Abandons its Constitutional Duty

Another disturbing trend of the last few years is the large scale investment by the private sector on curative services. With en-

couragement from the government, for the first time in India big business houses are entering the field of health care. In addition to catering exclusively to the elite, the trend is also an indicator of a certain kind of philosophy within government circles regarding health care. It is the kind of thinking which draws inspiration from a World Bank report which says 'present health financing policies in most developing countries need to be substantially re-oriented. Strategies favouring public provision of services at little or no fee to users and with little encourage of risk-sharing have been widely unsuccessful.' (de Ferranti, 1985). This, in other words, is a prescription for increased privatisation. The National Health Policy Statement says 'With a view to reducing governmental expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encouragement the establishment of practice by private medical professionals, increased investment by non-governmental agencies in establishing curative centers.....'. Is this not tantamount to an abandonment of government's duty in providing health care to all? Increased privatisation in health can only serve to exclude the most impoverished sections, precisely the section who need health services the most! The answer to the government's inability to divert sufficient resources for health programmes certainly cannot lie in taxing the community for provision of health care.

Today the government is openly saying what it has practiced for many years. Latest government documents speak of the need to involve the private sector and NGOs in the health sector and in family planning . In other words the government has finally admitted that it is abandoning its constitutional duty to provide free medical care to the people of this country . It is not surprising that this is exactly what is suggested by a recent World Bank document. With welfare expenditure being severely restricted, based on the World Bank/IMF prescriptions, significant changes have been set in motion. Government hospitals have started charging for facilities which were earlier free . Now NGOs are being invited to take up target oriented projects in family planning . A recent report cites the case of a surgeon who has performed 2,50,136 laproscopic sterilisations in camps in less that ten years noting that, 'the women were numbered by small stickers on their foreheads and then arranged in two long lines on the verandah of the school leading to the operating table, thus facilitating speedy

recovery'. We can look forward to more such cases, now that added incentives are being offered to reach targets.

Lack of Holistic Approach

Health services, in the traditional sense, are one of the main but by no means the only factor which influences the health status of the people. Today the concept of social medicine recognises the role of such social and economic factors on health as nutrition, employment, income distribution, environmental sanitation, water supply and housing. The Alma Ata declaration states 'health, which is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector.' Flowing from this understanding, health is not considered any more a mere function of disease, doctor and drugs. Yet even today the existing public health infrastructure in India is loaded in favour of the curative aspects of health.

For a country like India, it is impossible to significantly alter the health status of our people unless preventive and promotive aspects are given due importance. An overwhelming majority of diseases can be prevented by the supply of clean drinking water, by providing adequate nutrition to all, by immunizing children against prevalent diseases, by educating people about common ailments and by providing a clean and hygienic environment. It has been estimated that water-borne diseases like diarrhoea, poliomyelitis and typhoid account for the loss of 73 million work days every year. The cost in terms of medical treatment and lost production, as a consequence, is estimated to be Rs 900 crores which is about 50 percent of the total allocation on health!

Yet according to the government's health policy statement (1982) 'Only 31% of the rural population has access to potable water supply and 0.5% enjoys basic sanitation'. The situation is not much better in urban slums. A recent study conducted by the National Institute of Health and Family Welfare points out 'the existing health and morbidity patterns in the urban slums is even worse than the rural areas of India.'

How preventive measures can alter the course of diseases is typified by tuberculosis. Drugs for treating tuberculosis were discovered after 1940. Yet, 20 years earlier, the disease had been almost totally eradicated from Britain due to improvement in conditions of living. But even today, when numerous drugs have been discovered for treatment of the disease, more than half a million die of it every year in India.

We have seen earlier that resource allocation is heavily biased in favour of urban areas. Similarly the emphasis on curative services also reflects a bias in our planning process in favour of such services vis-a-vis preventive and promotive services. An in other walks of life, health services are a function of the political system of a community. They reflect the needs of the ruling classes, in terms of resources and manpower allocation and in regard to the choice of technology. A holistic approach towards health care, taking into account the socioeconomic factors influencing health, demands a level of consciousness which is lacking in our planning process.

Primary Health Care System

The Rural Health Scheme launched in India in 1977 is seen as the major component in the primary health care system. It is essentially a 3-tier system of health care delivery. The three levels are:

- 1) Village level - includes the community Health Worker (CHW) Scheme and the Integrated Child Development Scheme (ICDS)

- 2) Sub-Centre level-manned by one male and one female Multipurpose worker. Target is to have one sub-Centre for every 5000 population.

- 3) Primary Health Centre Level - has a staff of doctors (One female and two male) and other auxiliary staff. PHCs have facilities for laboratory tests, minor surgical procedures etc. They are also responsible for training of health workers, maintenance of records and for liaising with various National Health Programmes.

While this 3-tier system is supposed to provide basic health care, there are a number of 'national health programmes'. These cover areas requiring special attention and include immunisation, family planning, tuberculosis, malaria, leprosy, blindness, child

health (ICDS programme) etc. These programmes, also known as 'Vertical Programmes', are technically not part of the rural health scheme but are organised along independent lines with centrally administered control.

We have dealt earlier with the problem of resource constraints and their inequitable distribution. This has its severest repercussion on the rural health scheme. Even based on government claims, the coverage of sub-centers and primary health centers are less than 50% of the total rural population. Where these centers have been set up, they are under-staffed and suffer from lack of medicines and equipment. Another major drawback has been the difficulty in attracting doctors to serve in the rural health scheme. By and large doctors opt to work in rural centers only as a last resort. This reflects on both the quality and motivation of medical personnel manning primary health centers. Unwillingness of doctors to serve in the rural sector is also an indictment of our medical education system. The curriculum is heavily loaded in favour of curative medicine and within this in favour of diseases conforming to the mortality and morbidity profile in the West. During their period of training medical students are taught to rely on sophisticated diagnostic aids. Such training ensures that medical graduates are ill-equipped to work in conditions prevailing in the rural areas. Moreover the medical profession is invested with an aura of glamour, which unfortunately is seen to be missing while accruing in the rural sector.

It needs also to be understood that entry into medical colleges is by and large limited to those coming from a higher socio-economic strata, predominantly from urban areas, who consequently find it difficult to conceive of working in rural areas. Even when unemployment among doctors is not uncommon, doctors are unwilling to take up jobs in PHCs. A two pronged strategy is required to tackle the situation. Medical curriculum has to be reoriented and entry into medical colleges needs to be regulated in a manner which ensures a more balanced 'mix' of students. Side by side incentives have to be worked out to attract doctors to the rural health schemes. After all it is impractical to believe that doctors are naturally fired by altruistic motives or with feelings of 'service to the poor'. At the same time, within the medical fraternity, there is a strong resistance to changing the age old concept of health as a function of doctors and drugs. Implementation of the recent concept of primary health care requires a certain degree of demystifi-

cation of medical science. But within the established medical bureaucracy and in the entrenched sections of the medical fraternity there is a vested interest in maintaining the status quo. This outmoded position within the medical fraternity needs to be countered.

The interaction of the various 'vertical programmes' with the rural health scheme is another area which needs attention. These programmes are all centrally administered with separate administrative controls, staff and budgetary allocations. However all these programmes need to operate through the rural health scheme, but as they have separate administrative controls, they are not accountable to the rural health scheme. As a result there is needless duplication of administrative manpower, costs and often confusion regarding aims. While the basic aim behind the vertical programmes of giving emphasis to problem areas is laudable, they need to be administratively integrated with the rural health scheme. Otherwise they will continue to work at cross purposes with the rural health scheme, often at great cost to the available material and human resources.

Community Participation

The slogan 'Peoples health in peoples' hands' has today received universal support. Diverse agencies cutting across all kinds of ideological positions accept that community participation is vital to the sustenance of any comprehensive health programme. The government's statement on health policy also recognises this position while stating that "... over the years, the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory/ health status for all our people cannot be secured without involving the community in the identification of their health needs and priorities as well as in the implementation and management of the various health and related programmes'. Unfortunately there is a basic lack of clarity on the concept of community participation. Often, especially in official circles, it is taken to imply that the community participates in collectively receiving health services.

A major misconception has been to view rural communities as homogenous units. As a result there is no clear vision regarding how community participation can be ensured in vast tracts on rural India which is divided on the lines of class, caste and religion. The

tendency is to solicit support for any health programme from the village 'sarpanch' or other influential members of the village which in most areas mean the upper caste and landed sections. A similar modus operandi is applied while choosing the community health worker 'acceptable to all sections' from the village community. This almost invariably means excluding the landless and poor peasants, who form a bulk of the population and are most in need of health services from the decision making process.

To sum up, for any tangible transformations in the field of health, radical redefinition of priorities in the whole health care delivery system have to be initiated. Hard political decisions have to be taken to greatly increase spending on health care. For the Primary Health Care system to function adequately, it has to be made answerable to local bodies. This in turn would require steps to democratise the functioning of the panchayat system and much greater decentralisation of administrative and fiscal powers. In the absence of such measures, one can only hope for some sporadic cosmetic changes to take place.

Women and Health

It has been conventional practice to view women's health in relation to the process of conception - pregnancy, child birth, child health, contraception and termination of pregnancy. Women are thus viewed as mere production line appendages for delivering children, to the exclusion of all other roles and associated problems. That this would be the approach of the medical profession is not surprising, considering that it continues to be one of the most durable bastions of conservatism all over the world. Add to this are predatory nature of the health and drugs industry today, and one is confronted with a thriving behemoth which is accountable neither to the individual nor to society.

In a country like India it is repeatedly argued that the low health status of women is related to child-birth. It is in this context that the focus on reproductive behavior of women is sought to be justified. A closer look at different studies done in this area would serve to debunk this myth. Data on life-expectancy shows that life-expectancy of females is lower than that of males for all age groups upto 40 years of age. Further 26% of female mortality occurs in the age group of 0-9. It has also been shown that even in the reproductive age group, only 11% of deaths are due to pregnancy and related

causes. Numerous studies have shown the generally lower level of nutritional status among female infants and male children. Females have also been shown to make use of health services far less than males.

In spite of such clear cut evidence that ill health in women is not necessarily linked to child birth, the health system is concerned with women's health only when women are pregnant or lactating. Even the terminology of health programmes and health personnel is revealing in this context. Thus we have a Maternal and Child Health Programme and Maternity Hospitals but no Women's Health Programme or Women's Hospitals. The female health worker is termed as a ANM i.e. Auxiliary Nurse Midwife.

Today urgent rethinking is required on the whole strategy of family planning. Expenditure in this area has increased by leaps and bounds. From a meager 0.14 crores in the first plan it went up to 409 crores in the fifth plan, 1426 crores in the sixth plan and finally to a proposed 3256 crores in the seventh plan. Yet the birth rate has remained static at around 30 per 1000, for the last decade. How then is the continued increase in expenditure on family planning to be justified?

Actually the basic problem lies in the inverted logic that a falling birth rate precedes socio-economic development. The experience in countries all over the world has shown that exactly the reverse is true. The family planning programme as it stands today is another example of attempting to find technological solutions to social problems which require societal measures. Moreover, the family planning programme with its fetish for target, places an added burden on the health care deliver network, which it is ill equipped to carry. As a result there is a further whittling down of the already meager relief that the primary health care system provides. As noted in the case of other vertical programmes, the family planning programme too needs to function in an integrated manner with the rural health scheme.

Contraceptive Technologies

Today the whole strategy of family planning, irrespective of the measures propagated, is coming in for criticism. In India, for example, in spite of the family planning budget having gone up at an exponential rate, the birth rate has stagnated in the last 15 years. It is now realised that mere technological inputs do not ensure low

birth rates as the latter has a number of socio-economic dimensions. It has been shown that high birth rates have a relationship with high rates of infant mortality, female literacy, dependence of poor families on child labour and other related economic factors. In fact reduction in birth rates have always followed socio-economic development, though modern day demographers continue to harp on the necessity of limiting family size in order to improve socio-economic conditions. In our country it is significant that the state with the lowest birth rate, Kerala, is also the state where widespread land reforms were first implemented and where literacy rates are the highest in the country.

However, in spite of this, planners continue to push family planning programmes with a zeal that borders on hysteria. Matters have come to such a pass that it appears as though the principal concern of the health system in the country is to monitor the reproductive behavior of women. It must also be remembered that the thrust of all these programmes is on women and women are thus the targets of all that medical technology throws up to manipulate reproductive behavior. Many of these technologies would today merit a closer look and some of these are discussed below. Most of these technologies, when introduced, were claimed to be absolutely 'safe' and concerns about their safety were articulated years after they were in use.

Hormonal Preparations

The first hormonal preparations used were essentially preparations of female hormones progesterone or oestrogen, either in combination or separately. In common parlance they were known as the 'Pill'. The pill has been in use now for more than 30 years and it is only now that some of the long-term side effects have started expressing themselves. When introduced it was argued that as the pill mimics the action of naturally accruing hormones, they were free from serious side-effects. Now it is widely documented that the pill has a wide range of side-effects which include depression, headache, weight gain, raised blood pressure, increased risk of thrombosis (i.e. formation of clots in blood vessels), impairment of liver functions, pigmentation of the face etc. Evidence is mounting that long term users of the pill are at a significantly higher risk of developing breast cancer.

Many of the above problems were commoner in the earlier

high dose preparations and, in fact, many countries have legislated against use of higher doses. As a result the preparations available today contain much lower doses of hormones than earlier. What is significant however is that it took so many years for these side-effects to be identified and for the dosage to be limited. The medical establishment is guilty of having paid scant attention to these problems earlier. Whether its silence was an act of omission or commission is not really the case in point. What is important is that for years women have been told that a drug, which has now been shown to have serious side-effects, was entirely safe. If today we know that lower doses of the pill are equally effective, why were higher doses tried in the first places? It is a matter of grave concern that under the agencies of the WB-IMF print for the Indian people, the government of India is eagerly soliciting funds for family planning with conditions attached. Recently US AID has a ten year aid programme worth Rs. 800 crores for family planing in Uttar Pradesh which specifically stipulates the use of Norplant. It is important to note that this money will be used to import Norplant which is produced by a Swedish company but marketed through the US. Though the government of India had earlier assured women's organisations that Norplant would not be used, now the thinking is the Health Ministry is, population control at any cost. Not only Norplant but other contraceptives like Depo Provera, an injectable contraceptive, the use of which was earlier stayed by the Supreme Court, is now being recommended for use. Even more serious is the recommendations made by the Indian Council for Medical Research that Deps Prover may be used in India without the mandatory clinical trials. This is unethical and is directly in with the approach of USAID, the main family planning aid agency. In a recent communication, USAID asked family planning associations to 'discourage unnecessary tests aid medical barriers especially in the case of hormonal contraceptives.'

There is thus a definite shift in government policy in so far as there is a reversal of its earlier policy to go in for clinical trials in India. This was essential because the health profile of Indian women cannot be treated as being identical to countries where the trials may have been done.

Our position on the introduction of such hazardous hormonal long acting invasive technologies, which are beyond the control of the user is clear. We unambiguously oppose the moves of the government. Our main objection that such contraceptives require

close, regular monitoring of the user which India's health delivery system just cannot do. It would be cheaper, better and safer to propagate the use of barrier methods. This would also have the added benefit, which is so important, of preventing the spread of AIDS.

Now the government is in the process of introducing a number of 'new' hormonal preparations, which have two things in common. They are long acting—from weeks to 2-3 years - and their use requires medical expertise at the time of introduction and as a follow up measure. Such preparations include Net-En, Depo Provera, Norplant etc. The side effects of these preparations are essentially similar to the commonly used combination Pill. But the difference in these cases is that unlike the pill, because the drugs are long acting, they cannot be discontinued by the user in case of side effects. This means that the use of these preparations must go side by side with a well developed and sensitive health care delivery system. Unfortunately such a system is almost non-existent in rural areas—the principal thrust area for the introduction of these technologies. In fact during trials of some of these preparations, it has come to light that a large percentage of patients could not be followed up. If this can happen in metropolitan centres, one can well imagine what would happen if these preparations are given the go-ahead for widespread use.

Intra-Uterine Devices (IUD)

The use of IUDs (commonly known as Copper-T or the loop) started in Germany about 50 years ago. IUDs are either inert, copper bearing or hormone releasing plastic or metal device inserted into the uterus. They act as a block to the implantation of fertilised egg, although the exact mechanism is not certain. Common adverse effects of IUDs include heavy or prolonged periods, pain and discomfort, increased risk of spontaneous abortion and pelvic inflammatory disease (PID). The last condition requires some elaboration. PID is an infection which spreads to the uterus, fallopian tubes and ovaries. The condition may be life-threatening at times and may also lead to sterility. The danger of PID is highlighted by the experience with one brand of IUD which became particularly controversial — the Dalkon Shield. Introduced in 1970, this product was finally withdrawn in 1975. Robins - the company manufacturing Dalkon Shields - had already paid more

than one billion dollars to victims. It may be noted that though doubts about the Dalkon Shield were beginning to be raised by 1972, the product continued to be sold for more than three years after this.

The Dalkon Shield saga again points to the manner in which contraceptive technologies have been pushed through without adequate research on its consequences. That this could happen in the US with a strong drug regulatory mechanism like the FD, has dangerous implications for countries like India with extremely weak drug regulatory mechanisms. In fact in 1972 Robert W. Nickless, Robins's director of international marketing, wrote to the population office of USAID to encourage placing this 'fine product' with population control programmes and family planning clinics throughout the third world. Practitioners in third world countries were expected to sterilise the Shields, yet Robins provided only one set of instructions for each pack of 1,000 Shields, printed in only 3 languages - English, French and Spanish - although the devices were destined for some 42 countries (mercifully India was not one of them), not all of which used those languages. This again points to the trend of dumping hazardous technologies and drugs on third world countries by the developed world - thereby using the populace of these countries as human guinea pigs. In this context it would be pertinent to add that the International Planned Parenthood Federation (IPPF) - a major force behind the family Planning programme across the world - draws its funding from USAID, Ford and Rockefeller Foundations and the World Bank. On the board of IPPF sit representatives of Duping Chemicals, the US Sugar Corporation, General Motors, Chase Manhattan bank, Newmont International Nickel, Marconi RCA, Xerox and Gulf Oil. Can we believe that the motives of bodies such as these are purely altruistic?

Terminal Methods of Contraception

Till now we have talked of the reversible methods of contraception, that is methods which can be withdrawn if pregnancy is desired. In India there is a trend towards propagation of terminal methods like vasectomy for men and tubectomy for women. Here, again the policy implementations are lop-sided. The number of tubectomies being performed today have been steadily increasing and have far outstripped the number of vasectomies performed.

This is so inspite of the fact that vasectomies are far safer and simpler to perform than tubectomies. Part of this trend is related to the negative connection associated with vasectomies due to its link with the most coercive phase of the family planning programme in India during the Emergency (1975-1977). However that is definitely not the full story. It is obvious that health planners find it easier to pitch their campaign at women, who are viewed as more ease to manipulated and less likely to resists. As a consequence tubectomy camps are being organised all over the country, with poor supervision and hygienic precautions. One can only guess the consequences of such camps.

Contraceptive Vaccines

Lately, researchers have begun to promote contraceptive vaccines as a safer alternative to hormonal contraceptives. One variety which is likely to come into the market in the near future is the injectable anti-HCG vaccine. When injected with an anti-HCG vaccine, a woman develops antibodies against HCG (Human Chorionic Gonadotrophin) - a hormone which is produced for a limited period after fertilisation and is necessary for a pregnancy to develop. The vaccine inhibits development of pregnancy. Already doubts are being raised about the efficacy and effectivity of this vaccine, but work has been continuing on it at an inordinately fast pace.

Effect on Women

So far an overview of the prevailing trend in use of contraceptive technologies and the consequences thereof have been provided. The list is by no means exhaustive but would serve to focus on a common thread in the way these technologies are propagated and used. When contraception came to be widely used in the sixties, it was viewed by the women's movement in a positive light. It was believed that such methods would provide women with more control over their bodies in other words, it would contribute to the process of empowerment of women. There is no gainsaying that many of the technologies discussed, while being associated with hazards, are by and large much safer than multiple unwanted pregnancies. The question however remains as to how much these technologies have contributed towards helping women gain greater control of their biological processes.

In India it can be stated without doubt that this has not happened. Women have no choice over the kind of contraceptive technique they would like to adopt. This because the technology to be propagated is dependent on the periodic whims and fancies of planners in this area. There is an almost total absence of information regarding various methods. Many programmes are veiled in secrecy, so much so that it is possible to start doubting the real motives. Further most technologies continue to be 'provider-dependent'. Women depend on providers (health infrastructure, doctors, health worker etc.) to get them and in the case of implants and IUDs. also to have them taken out. Such methods have the potential of being abused, and are being abused because the providers do not give women a free choice from a wide range of contraceptive methods as well as in the case of coercive family planning programmes. An element of coercion is inherent in a programme that focuses on a potentially more hazardous method like tubectomy, rather than target on a less hazardous method like vasectomy. Probably the women's movement in this country could take a closer look at its role vis-a-vis the planning process when such technologies are propagated in an arbitrary manner.

Another aspect is that while the effects of contraceptive technologies have been discussed there are many other technologies whose introduction is against women's health, women's rights and women's position in society. Two recent examples in this country would be the controversy surrounding the sale of E-P Forte drugs and the practice of amniocentesis. The former was a case of group of hormonal drugs, known to be hazardous to women and to the unborn foetus, and without any therapeutic value, being sold in the market. In the latter case the technique of amniocentesis is being used to selectively abort female fetuses. Both had the sanction and at times vociferous support of the medical establishment. From such instances it is easy to draw the conclusion that technology is inherently exploitative (some also use the term violent) towards society in general and women in particular. In fact such conclusions have been drawn by some groups and individuals working in the area of science and society interface. Such a view, would be too simplistic and misses the framework in which technology is being propagated today. The same problems that women face vis-a-vis technology are being faced by, for example, Afro-Americans in the US and South Africa. On a global scale it is possible to see similar trends in the relation

