Workshop on

POPULATION, FAMILY PLANNING & WOMEN'S HEALTH

Bangalore, December 1993

A REPORT

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State-Level Workshop on

POPULATION, FAMILY PLANNING AND WOMEN'S HEALTH

December 10 - 11, 1993
Bangalore, India

Organized by

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RATIONALE FOR THE WORKSHOP

The population debate invariably points to population 'explosion' as the cause of India's poverty and developmental backwardness -- unemployment, food insecurity, inflation, communal violence. Following from this, the second assumption is that the only option is for the country to intensify population control measures and use whatever means available to bring down our birth rates.

Based on these assumptions, India was the first country to adopt family planning as an official government programme as early as in 1952. Over the years enormous human and financial resources have been pumped into the programme in an effort to reduce the birth rate. But time and again planners were forced to revise targets after each deadline was crossed and missed. Now, the aim is to reach Net Reproductive Rate of one, by reducing the birth rate to 21 per 1000, by the year 2010.

Meanwhile, the basis of these assumptions are being questioned by women's groups, health activists and others concerned by the negative fallout, especially for poor rural women, of the official family planning programme. Is population the cause of poverty and underdevelopment? Or, are large families a consequence of poverty and lack of access to employment, education, safe water supply and sanitation, education, health care and other resources? In fact, research findings conclusively prove that there is no correlation between population growth and per capita income.

Secondly, we need to understand why the family planning programmes have not succeeded in spite of massive deployment of human resources, funds and technology and enormous political will.

Is it because the main focus of the programme -- women -- are mere 'targets' on whom are thrust contraceptive technologies like the IUCD, the pill, injectables, and lately, Norplant? Technologies which were not designed in keeping with the needs of illiterate, undernourished women suffering from a host of health disorders, with little or no access to modern healthcare? Do women see family planning strategies as encroachments on their human right to choose when and how many children they would like to have?

The forthcoming International Conference on Population and Development, ICPD, in September 1994, would be focusing world attention on the population question and the agenda for the following decade. In this context it is vital for social activists working among people to become increasingly aware of the connections between the population question and the issues they are grappling with. To work towards making women's interests a high priority item on the population control agenda.

It was towards providing a forum for a free and honest exchange of ideas on these subjects that Madhyam Communications, a development and communication group in Karnataka, India, organized a two-day state level meeting on Population, Family Planning and Women's Health on December 10 and 11, 1993.

The workshop was funded by the United Nations Agency for Population Activities (UNFPA), which has increasingly come under fire from development groups for supporting population control at the cost of women's health. It is hoped that UNFPA will take note of the concerns expressed at this and other similar meetings in India and other countries, and reorient its policies.

OBJECTIVES OF THE WORKSHOP

The workshop brought together NGOs, medical personnel and social researchers working in the areas of women's health and population, from different districts of Karnataka state, in an effort to :

* provide information to the NGOs on the relation between development and population, women's reproductive rights, population policy and approaches to family planning, as well as a specific analysis of the Karnataka situation.

* to discuss the impact of the present population control strategies on women, identify common problems and strategies to address them.

* obtain information from these groups about the field reality regarding women's health and population control programmes.

Based on this workshop, a state-level statement would be formulated, and then woven into a cohesive perspective for India, which could then be articulated strongly by accredited NGOs at the Cairo Conference on Population.

The workshop would also start a process of re-examining existing premises on the population issue and initiate NGOs to take up relevant activities on women's health and birth control information.

SCOPE OF THE WORKSHOP

Our effort would be to advocate:

* sensitive response to people's felt needs, experiences and opinions related to contraception and women's health;

* the introduction of a family welfare programme that lives up to its name, by working towards the creation of the social and economic conditions which will enable people to opt for small families.

THE PROGRAMME

The workshop venue was Ashirwad, a convention centre in the heart of Bangalore, but secluded from the noise and bustle of the city. Participants were medical professionals, women's groups and NGOs from across the state. Ms. Vimala Ramachandran and Ms. Ena Singh of the UNFPA were present as observers.

The preliminary session, devoted to an information update on the workshop theme, was followed by group discussions on specific questions such as women's health -- determining factors, access and utilization, women's control over their bodies, safe and acceptable fertility regulation methods, the role of men, role of the state and of voluntary organizations.

This participatory process ensured that every person's viewpoint, based on experience, was heard and went towards formulating a concrete statement (page15) to be presented to the Secretariat of the ICPD'94. The workshop was conducted in English and Kannada, the state language, to facilitate full participation of all.

SUMMARY OF PROCEEDINGS

The following is a report of the four sessions of the workshop. The specific presentations by resource persons were followed by discussion and clarifications. This was supplemented by participants breaking up into smaller groups to discuss the key issues identified. Deepa Dhanraj's film, 'Something Like a War' gave participants an almost first hand feel of the real situation.

DECEMBER 10, SESSION I

Chairperson :Ms. Srilatha Batliwala

Ms. Sucharita S Eashwar, Executive Director, Madhyam Communications, welcomed participants to the workshop, and set forth the objectives and the agenda for the workshop. Participants were invited to briefly introduce themselves.

In the opening session, Dr. Mohan Rao of Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi, spoke about the dangers of attributing poverty and underdevelopment to population 'explosion' -- a widely accepted theory. Dr. Rao urged that in supporting this argument, one should not 'miss the wood for the trees' and highlighted the conceptual and methodological drawbacks of this theory.

Tracing the growth and development of India's official family planning programme introduced in 1952, Dr. Rao pointed out that excessive reliance on technologies and targets have led to the programme losing out.

Dr. Malini Karkal, a researcher and consultant on women's issues, called for a better understanding of the role international

agencies play in population control programmes of the Third World. Demography, essentially an inter-disciplinary science, has "come to be dominated by statisticians who see human issues as the issue of numbers." Industrialized countries have interests entirely different from those of Third World countries -- for instance women in these countries emphasize the need for women's empowerment and for recognizing their reproductive rights. Ignoring this, population programmes continue to manipulate women to fit technology.

Summary of Discussions

Dr. Mohan Rao briefly explained the neo-Malthusian theory which originated in the West and is characterized by concern about Third World population growth rates and heavy reliance on technology for population control. On reasons for failure of the family planning programme, Dr. Rao said the government is now reluctantly accepting its failure.

Though this programme has received an abundant share of manpower, resources and political will, the drawback is because the small ruling section of the population wants family planning programmes and the other section (on whom it is thrust) does not want it. This section of the population, which comprises the majority, invariably suffers from high infant mortality rates and morbidity rates, and therefore motivation for family planning cannot be expected.

The limitations of the cafetaria approach, which apparently offers a wide choice of contraceptives for women, but in reality always focuses on tubectomy, was raised by participants.

Dr. Rao felt the present network of health personnel was inadequate, as health workers were already overworked and could not take on any more duties.

The role of literacy was controversial, and drawing from his study in Mandya District in Karnataka, Dr. Rao noted that despite low literacy levels in that district, family planning acceptance was high.

Regarding targets fixed for the family planning programmes, Dr. Rao pointed out that this has not been viable, as birth and death rates and other factors vary nationally and within same sections of the population. He argued for the need for micro-planning to take in individual needs and the many variables influencing population growth. The government was also considering regionalization of targets, dividing the country into three regions, with differential targets for each.

Ms. Srilatha Batliwala added that while the obectives of the Panchayati Raj bodies was to decentralize planning and budget allocations, in fact this has been subverted by the Centre to propagate the status quo. It is, however, a potential resource for genuine decentralized planning, she added.

The Karnataka Scenario

Dr. Shirdi Prasad Tekur, Coordinator, Community Health Cell, Bangalore, focused attention on the workshop theme with specific reference to Karnataka. He noted that the state compares well with India's national average on indicators such as population density, population growth rate, etc. However, the state falls behind Andhra Pradesh, Tamil Nadu, Kerala and Maharashtra, in terms of sex ratio. Relating this to factors like literacy, employment, urbanization, health services, fairweather roads, and poverty, Dr. Tekur pointed out that the poor rural woman is particularly at a disadvantage, as statistics clearly show.

Karnataka's family planning programme has achieved success in meeting most of its targets. However, women -- the target of this programme -- have been bearing the brunt of this. For instance, for every man undergoing vasectomy, 15 women are sterilized! The impact of this on poor rural women, already burdened with many health disorders, and poor healthcare facilities made inaccessible by poor roads, is disastrous.

Dr. Tekur concluded that unless factors affecting the survival of women change, family planning measures would continue to impose an additional burden on their lives.

Summary of Discussions

Dr. Tekur remarked that information relating to women's health in Karnataka is sadly lacking. No reliable statistics are available even about common conditions like anaemia.

Ms. Batliwala, quoting from Shireen J. Jeejeebhoy's paper titled "Population, Health and Women in India : Background and Priority Areas", said only 40 to 50 per cent of Indian women received ante-natal care, and no more than 42 per cent women were supervised by trained pesonnel during delivery. The average age at marriage is 18.3 years, but only 16.5 in the BIMARU states -- Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. The rest of India averaged 19.5 years.

She added that reproductive tract infections were widely prevalent among Indian women; nearly 90 per cent, according to a study by Dr. Rani Bhang, a health activist working in Gadchiroli District of Maharashtra. Only eight per cent of these women have sought medical treatment. Despite this, no study relating this to women's rejection of contraceptives has been undertaken.

Referring to the obsession with numbers, Ms. Malini Karkal decried the tendency to compare Third World country data to those of developed countries. For instance, the UN reports the crude death rate for India as 11 per thousand -- the same as that for the United Kingdom, Germany, Belgium and Austria. This paradox can only be explained by the fact that there are differences in who dies in these countries and in India.

Dr. Karkal added that new indicators have been coined; for instance DALY -- disability adjusted life years -- which projects life expectancy on the basis of socio-economic group, gender, and other such factors which can affect the longevity of individuals.

Definitions and meanings have been distorted to suit the needs of programme planners -- for example, family planning 'acceptors' are hardly acceptors out of free will but more out of coercion. Similarly, 'unmet needs' of women are taken to mean a need for smaller families. Why women have more children is not analysed, nor is it considered a necessity to create conditions that will promote a smaller family, she added.

Responding to this, Dr. Mohan Rao quoted a leading health expert who has argued that, in view of the poor health and nutritional status of women, the undesirable side-effects -- such as amenorrhoea and weight gain -- of injectable contraceptives and implants may be precisely the reason for including these dangerous drugs in the national family planning programme!

On the obsession for sons in most families, Mr. Arasu, a development worker from Dharmapuri, a backward district in Tamil Nadu adjoining Karnataka, quoted figures from a study on female infanticide district, where incidence of this is very high. The study, conducted over a one-year period from March 1991 to March 1992, reveals that out of a population of 97,000, there were 116 deaths for 956 births. Of these deaths, 73 were female, and as many as 53 cases were attributed to infanticide.

Crude abortion practices also lead to high maternal mortality -- there are many instances where women have undergone abortion four or five times, even in advanced stages of pregnancy. The MTP regulations seem powerless in the face of such practices, and need to be re-examined, Mr. Arasu said.

Responding to this, Dr. M K Vasundhra of Karnataka Medical College, Hubli, wondered whether women have any say at all in matters like family planning and reproduction. She urged for better care of the girl child and for strategies to empower women for change.

Mr. M K Bhat from Mangalore felt it is not true that family planning has been oriented towards women and that there is nothing to stop research on male contraceptive methods. To this Ms. Batliwala countered that a critical analysis of research on male hormonal contraception by Dr. Mahtab Bamji of the National Institute of Nutrition, Hyderabad, showed that research was dropped after first phase clinical trials because some men developed headache. The reason given was "poor acceptability". Particularly after the Emergency, vasectomy has become unacceptable and politically unviable.

Ms. Karkal, commenting on the unwillingness of men to opt for vasectomy, said Maharashtra was the first state to adopt the camp approach. Prior to passing a Bill for compulsory sterilization

for men, men pushed their wives to undergo tubectomy to avoid vasectomy themselves.

Counter to such perceptions and practices, the group felt that women's health and survival chances need to be given high priority, arguing that "development is the best contraceptive" and "look after people and the population will look after itself."

Summing up the first session, Ms. Batliwala presented the key issues that were raised.

* Different socio-economic indicators cannot be randomly put together and treated as causal factors.

* There is no evidence that the poor, due to their larger numbers, are the main agents of environmental degradation.Higher consumption and consequent impact on the resource base is a problem caused by the rich of all countries.

* Different stages and priorities of the family planning programme, particularly reliance on technology.

* Interests of international lobbies, especially USA, in promoting population control programmes.

* Information about women's health is lacking. Indian women, already suffering health disorders, are further burdened by the family planning programme.

The text of the presentations by resource persons is in Annexure I of the report.

SESSION II

The session began with the screening of '**Something Like a War,**' a film by Deepa Dhanraj, a feminist film maker. The film, weaving together three strands, touches on a fertility awareness workshop with women in Rajasthan, the scene at family planning (read sterilization) camps and interviews with men who witnessed the Emergency excesses, as well as the status of contraceptive research in India and the urgency in pushing hormonal contraceptives on women without proper trials.

Summary of Discussion

Discussions centred around discrimination between the approach to family planning in Third World countries where technology is relied upon as a means to reduce birth rates. In developed countries, however, socio-economic development has led to reduced birth rates, despite opposition to family planning and contraception.

On vaccines and the urgency with which it is being introduced into the family planning programme, Ms. Karkal argued that pregnancy is

not a disease against which women need to be protected, and questioned the need to push invasive and harmful contraceptive vaccines. A women's fertile period being only about 13 days a month, surely a much safer alternative would be advisable.

Ms. Karkal further argued that the long-term effects of vaccines on the immune systems could never be guaged, and therefore could not be advocated as a safe contraceptive. Further, the vaccine can be effective only three months following the first administration, and therefore some other temporary method would have to be advised. But given the earlier experiences, would this be possible, she wondered.

Referring to the Norplant trials under way now, Dr. Rao mentioned that in Delhi nearly 1000 women who had been in the trials were untraceable, and feared the consequences of retaining Norplant even after the stipulated five years.

Dr. Rao also noted that in the USA Norplant was compulsorily administered to women on welfare, who had been accused of child abuse. These women were mainly blacks and Hispanics, he added.

The group's consensus was that it was wrong to assume that rural women are unintelligent and that harmful contraceptive technologies could be thrust on them.

Participants then broke into smaller groups to identify key issues relating to population, women's health and family planning, and discuss these issues to formulate group presentations.

The day's proceedings paved the way for the next day's sessions to identify key issues pertaining to population, family planning and women's health.

DECEMBER 11, SESSION III

Following from the previous day's deliberations the group identified key issues for discussion. Listed in order of priority, they were:

1. Women's health
   - determinants (knowledge)
   - access and utilization of health services
2. Control over bodies
   - decision-making autonomy, fundamentalism,
   - empowerment
3. Access to safe fertility regulation methods; impact of harmful contraceptive technologies
4. Role of men
5. Role and responsibility of the state
6. Role of voluntary organizations
7. Strategies for achieving acceptable standards of women's

health and a healthy population, not necessarily by reducing population growth.

Working in four small groups, participants shared their experiences and ideas to thrash out the above questions and come out with group presentations. Individual group conclusions and recommendations were later synthesized into a cohesive statement (See Annexure II).

SESSION IV

This was a plenary session where each group presented its conclusions and recommendations. The strong consensus which emerged adequately stressed the real needs of women vis a vis population, family planning and health. The following is a summary of the group presentations. The recommendations appear on page 16 under the head 'Statement and Recommendations.'

I. Women's health

a Determinants (knowledge about health

* Women must become aware of their bodies, their functions and purpose, and feel that their health is their responsibility. Presently they avail of health services only if free of charge or if some incentives are given. This makes them easy targets for population control programmes.

* Factors such as employment, income, nutrition, water, sanitation and education play an important role in influencing women's health.

* Low age at marriage has a negative impact on women's health.

* There is an awareness and a need for smaller families but societal and family pressures force women into bearing many children.

* Sociocultural factors such as gender bias regarding who needs medical attention within the family.

* The awareness level of the mother influences the extent of her daughters' awareness about health, and utilization of healthcare services.

* The inefficiency of the government primary healthcare services make way for quacks and private medical practitioners to exploit poor women.

* "Medicalization" of the human body and of even normal processes like pregnancy and childbirth and the obsession with technologies, viz. ultrasound sonography, in-vitro fertilization and amniocentesis, take healthcare out of women's hands.

b. Access and utilization

* This is interdependent on the awareness mentioned above, and the availability of healthcare services.

* Grassroots workers pointed out that girls and women are the last to receive healthcare, and then in extreme cases, when it may be too late. Even men, they said, are reluctant to avail of medical services in order to avoid expense.

  These workers pointed out that even among high-income families, utlization of medical services is poor. Mismanagement of family income (on festive celebrations, liquor) and perennial indebtedness leave them with little resources for healthcare.

* Physical access to health services depends on the existence of fairweather roads and employment. The latter is important since facilities are often present in the workplace.

* Remote rural areas are the last priority of health workers who find it physically impossible to cover all villages and hamlets. Women workers cannot use bicycles as this is not acceptable to villagers, and other means of transport are often not available.

* The public health system being obsessed with women as reproductive beings, only care during pregnancy is highlighted.

* Health workers only look on pregnant women as possible 'cases' for sterilization following delivery -- this would enable them meet their "targets".

* Though private medical care may offer a seemingly viable alternative, this is really not the case; it is more expensive and exploitative, often avoidable treatment being prescribed.

* The health of the infant and the adolescent girl are equally important, as this is the formative period. But the adolescent girls particularly is neglected, both by the family and the health services.

II Control over bodies

a. Decision-making autonomy

* Though women often express a desire for small families, decisions about when and how many children to have is not in their hands. There is a strong son-preference syndrome -- to propagate the family and care for parents in old age -- and the view that daughters are a burden because of dowry. Most families say at least two sons are preferred.

* Women are often unwilling partners in marriages; rape, the ultimate violence on women, goes unchecked; in this situation, women suffer severe consequences.

* The participants felt that the resurgence of fundamentalist forces all over the world was leading to a curtailment of personal freedom and legal rights, with its consequence on women's well-being.

b. Women's empowerment

* This may offer some solution to the above problems, but the group stressed that men too have to be drawn into the empowerment process. This alone would enable them to recognize women's health and reproductive rights.

* The empowerment process should include fertility awareness and health education. This will empower women to make their own decisions.

* Women's status is determined by the family, religion, society and by each individual. Pressures from these sources result in a sense of helplessness and dependence on others for decision - making. Women need to be empowered to stand up to these pressures.

III. Access to safe fertility regulation methods; impact of harmful contraceptive technologies

* The groups' consensus was that women were not provided with any information about the various contraceptive methods or their side-effects. No follow-up is available for women who have opted to use contraceptives.

* Common complaints of sterilization and IUCD 'acceptors' such as backache and disturbed menstrual cycles, are not heeded by health workers.

* Pushing hormonal and other harmful contraceptives with serious side-effects on poor rural women with little access to healthcare would only increase the morbidity load on them.

* Pushing women into sterilization, and the target approach have not led to the desired reduction in birth rates. Though vasectomy acceptance among men was initially high, the Emergency excesses have made it almost unacceptable now.

A woman activist from Kollegal Taluk in Mysore District cited an instance where the wife of a man who had undergone vasectomy, conceived. The man, suspecting his wife's fidelity, refused to accept the baby as his own and harassed her to the extent that she resorted to blood tests to prove that the baby was indeed theirs! This raises some important issues.

a. the absence of follow-up to ensure that vascetomy acceptors were advised to use some temporary contraceptive for a period of three months following surgery.

b. The wrong message that such instances send to others - viz. that vasectomy is not a reliable method of birth control.

c. The woman is again the victim.

IV Role of men

* Patriarchal attitudes towards women and family need to give way to a recognition of women's rights.

* Men have a personal and social responsibility for their own sexual behaviour and fertility, and for the effects of that behaviour on their families' health and well-being.

* Safe methods of male contraception need to be developed and made available.

V. Role and responsibility of the state

* The government should not renege on its responsibility of delivering primary healthcare to the people.

* Budget cuts on education and health will affect poor rural women the most. No development can take place without these basic inputs.

* Local Panchayati Raj bodies can ensure decntralized micro-planning and resource allocation based on local needs.

* Individual rights need to be recognized and legislation to ensure these rights formulated.

* Public health programmes lack direction and efficiency as they are administered by bureaucrats and generalist administrators and not health administrators.

* Health personnel are not trained in gender issues and lack sensitivity in their approach to women's health and family planning.

* While government is now using the language of women's groups its fundamental philosophy and agenda remain much the same. Therefore 'spacing' is easily achieved through injectables or Norplant, it is claimed!

* Development and income generating programmes of the government look good on paper; proper implementation of these programmes alone would go a long way in increasing employment and income-earning potential in rural areas.

Role of voluntary organizations

* Voluntary organizations are not completely free from the charges usually levelled against government bodies, viz. inefficiency, corruption and lack of sensitivity.

* Their presence at the grassroots level and close contact with the people can be useful in providing health and fertility awareness, training health workers particularly on gender issues and facilitating government in its health programmes.

* Voluntary organizations working in the field of health need to be made more accountable to their constituents; agencies receiving government support need to be screened and monitored at various stages of their work.

CONCLUSION

At the conclusion of the workshop, Ms. Sucharita S Eashwar expressed satisfaction that the two days had been well-spent and the objectives of the workshop fulfilled. The participation of NGOs from various districts in the state, with their considerable experience in the field of women's health, population and family planning, lent the right perspective to the discussions, she added.

Ms. Eashwar commended the group's efforts in crystallizing a statement on population, women's health and family planning. This would be synthesized into a cohesive perspective and put forward as a statement to be sent to the Secretariat of the ICPD 1994 for consideration during the PREPCOM meetings and the Cairo conference.

The statement would also be sent to the state and central governments, and national and international agencies involved in population activities, to back advocacy for a re-examination of policies and programmes, Ms. Eashwar added.

Thanking participants for their contribution, Ms. Eashwar hoped this was only the beginning of an effort to work for a more holistic and innovative approach to women's health. She expressed gratitude to UNFPA, and Ms. Vimala Ramachandran who made the workshop (for which Madhyam Communications had already planned) possible. Ms. Eashwar thanked Ms. Ena Singh, also of UNFPA, for being present as an observer. Ms. Srilatha Batliwala's expert chairing was acknowledged, as well as the resource persons' presentations which set the right note for the deliberations. The staff of Madhyam Communications in particular had worked hard to ensure that the programme went on smoothly.

On behalf of the participants, Ms. Chitra Stephen thanked Madhyam Communications for having given them the opportunity to learn from each other and share experiences.

STATEMENT AND RECOMMENDATIONS

Recent statements and analyses that single out population size and growth as a primary cause of global environmental degradation are misleading and troubling. We believe the major causes of global environmental degradation are :

* Economic systems that exploit and misuse nature and people in the drive for short-term and short-sighted gains and profits.

* The disproportionate consumption patterns of the affluent, the world over. Currently the industrialized nations, with over 22 per cent of the world's population, consume 70 per cent of the world's resources.

* Technologies designed to exploit but not to restore natural resources.

Environmental degradation therefore derives from complex, inter-related causes. Demographic variables can have an impact on the environment, but reducing population growth will not solve the above problems. In many countries population growth rates have declined yet environmental conditions continue to deteriorate.

Moreover, blaming global environmental degradation on population helps to lay the ground for the re-emergence and intensification of top-down, demographically driven population policies and programmes which are deeply disrespectful of poor women and men.

Many of the activities of family planning programmes have been oriented towards population control rather than women's reproductive health needs, they have too often involved sterilization abuse; denied women full information on contraceptive risks and side effects; neglected proper medical screening, follow-up care, and informed consent; and ignored the need for safe abortion and barrier and male methods of contraception. Population programmes have frequently fostered a climate where coercion is permissible.

Demographic data from around the globe affirm that improvements in women's social, economic and health status and in general living standards, are often keys to declines in population growth rates. We call on the governments to recognize women's basic right to control their own bodies and to have access to the power, resources, and reproductive health services to ensure that they can do so.

Women's health is an outcome of the interaction of a large number of factors such as employment, income, nutrition, safe and adequate water supply, housing sanitation, education.

Availability and access to a comprehensive, integrated, sensitive healthcare system is also an important factor.

RECOMMENDATIONS

We recommend that there should be an increase in the Union budgetary allocations for health from the present 1.1 per cent to at least 5 per cent.

Given the disease patterns in our country, allocations towards promotive and preventive services should be adequate.

The separate department of family planning needs to be disbanded; this will release resources towards primary healthcare which should be accessible to all irrespective of their caste, class, gender and religion.

The existing structure for curative care must be enhanced in quality through better management and by strengthening the peripheral health institutions for preventive and curative health care.

Health programmes should be administered by health administrator and not by generalist administrators or bureaucrats.

All the personnel in the health services system must be trained towards gender sensitivity.

Decentralized planning, implementation, monitoring, evaluation by Panchayati Raj institutions is essential to have a responsive health care system.

Tried and tested indigenous medicines and practices and self-help relying on proven home remedies need to be encouraged.

Women's empowerment is a process of greater control over material, financial and informational resources to attain greater power to decide about issues that concern themselves. It relies mainly on greater self-esteem achieved by establishing equal property rights, opportunities for access to education, nutrition, occupational training and remuneration equivalent to their contribution to the economy.

Women can and do make responsible decisions for themselves, their families, and their communities. They must have the individual right and social responsibility to decide whether, how and when to have children and how many to have. No woman can be compelled to bear a child or be prevented from doing so against her will. All women, regardless of age, marital status, or other special condition, have a right to information and services necessary to exercise their reproductive rights and responsibilities.

Men also have a personal and social responsibility for their own sexual behaviour and fertility and for the effects of their behaviour on their partners' and their children's health and well-being.

Women should not be the targets of the family planning programmes. Safe and user-controlled contraceptive methods should be utlilized, free of the control of multi-national companies and population control agencies.

Reliance on terminal methods must be discouraged, and a greater reliance should be placed on spacing and barrier methods. This includes greater emphasis on breast feeding and scientific natural methods of fertility regulation.

Appropriate and thorough screening is neccessary before offering contraceptive choices. Too often in the past this has been neglected to the detriment of women's health. All technology which potentially lowers the sex ratio must be adequately monitored and regulated.

Incentives, disincentives, and the camp approach have no place in family planning. Hormonal contraceptives like injectables and implants which add a further morbidity load on the female population should not be included in any health and family welfare programme.

Contraceptive technology such as vaccines, must be thoroughly studied, the study findings published and discussed with the people -- women's groups, consumer groups and health groups -- before consideration for inclusion in any health and family welfare programme.

Women's health must require attention not just during the reproductive period of their lives but for all ages beginning with infancy.

The government should not renege on its commitment to provide universal primary health care. Equally, the solution does not lie in privatization or relegation of its responsibilities to voluntary agencies or NGOs.

The recommendations of the Shramshakti report on occupational health for women must be implemented.

Voluntary organizations working in the field of health and family planning also have the reponsibility of greater accountability of their services to the people. Proper monitoring of the projects undertaken by NGOs is essential.

Women should be given the responsibility to decide and promote policies, provide a social, economic and political transformation that will allow women to negotiate and manage their own sexuality and health, make their own life choices, and participate fully in all levels of government and society.

ANNEXURE I a

THE INDIAN FAMILY PLANNING PROGRAMME: A CRITIQUE

Dr. Mohan Rao

All of us, by and large, subscribe to the Neo-Malthusian notion that population growth causes India's poverty. This understanding of the relationship between population growth and economic development lies at the heart of the family planning programme in our country. In this paper I shall focus on some conceptual, methodological and empirical problems which underly this understanding, briefly touching on the family planning programme in India.

I commence with the problem of method in establishing causality in the relationship between population growth and economic development. A famous analogy will illustrate the problem at the heart of this method of establishing causality.

Socrates, unable to bear political persecution due to his supposedly heretical writings, committed suicide by drinking poisonous hemlock. A person utilising Neo-Malthusian logic, when asked to examine the cause of Socrates', death would argue as follows:

All men are mortal.
Socrates was a man.
Therefore Socrates was mortal.

This syllogism, used to account for Socrates' death, makes no reference to heresy, political persecution or hemlock. The logic of course is impeccable; and it is empirically true that all men are mortal as indeed that Socrates was a man. A syllogism like the above does not in fact focus on the <u>cause</u> while appearing to offer an explanation. To take this illustration a bit further:

Drinking hemlock causes death.
Socrates drank hemlock in 399 B.C.
Therefore Socrates died in 399 B.C.

This explanation for the cause of Socrates' death may be acceptable to an expert in forensic medicine but not to a social scientist. This apparently logical process again offers only a partial explanation of the <u>cause</u> of the phenomenon under study.1

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1. Gordon, Scott, the History and Philosophy of Social Science, Routledge, London, 1991.

Explanations of this nature lie at the core of the Neo-Malthusian understanding of the relationship between resources and population growth. That is, they offer only a partial explanation for events while appearing to explain a larger one. Given Neo-Malthusian assumptions, the solutions to the problem follows axiomatically. In other words, out of a complexity of historically determined interactive variables, this method takes into account a few isolated variables, makes some asumptions regarding the behaviour of their relationship, tests empirically the validity of the outcome of the association and then arrives at a deduction of causality. But association is not cause. The problem of the method, to put it metaphorically, is that it misses the woods for the trees.

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There are other problems as well. Demographers such as Coale had argued that population growth leads to high dependency ratios; that is, a larger proportion of children dependent on more productive adults in the population. This would call for larger investments in such sectors as health and education, diverting resources that could otherwise have been more productively invested. There was therefore a need to cut down population growth as it would be a demographic stumbling block to economic development. Hodgson notes that when the "catastrophe" predicted by such demographers in the fifties never arrived, their assumptions were subjected to scrutiny with startling results. 2

Coale's model had measured the costs of high dependency ratios and found them considerable. But Paul Schultz found no clear relationship between the percentage of gross national product invested on education and the age structure of the population. 3

Similarly, demographers assumed that high fertility would produce low rates of saving, but Kelley 4 found the actual relationship more complicated. Mason confirmed Kelley's findings that children were not just a short-term source of expenditure for parents;5 they could often be a long-term form of "risk protection"6 or even a kind of saving.

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2. Hodgson, Dennis, "Orthodoxy and Revisionism in American Demography", **Population and Development Review,** vol 14, no,4, Dec'1988

3. Schultz, Paul, cited in Hodgson ibid

4. Kelley, Allan C., "Population Growth, the Dependency Rate, and the Pace of Economic Development", **Population Studies,** vol.27, No.3, 1973.

5. Mason, Andrew, "Saving, Economic Growth, and Demographic Change," **Population and Development Review,** vol.14, no.1, 1988.

6. Cain, Mead, "Fertility as an Adjustment to Risk", **Population and Development Review,** vol.9, no.4, 1983.

One important underpinning of the Neo-Malthusian argument is that population growth eats into resources which are finite. That some resources are finite is a truism. But what the more general and abstract statement does is gloss over the actual picture on **who** is consuming the resources. Social problems -- of hunger and poverty -- are then attributed to that part of the population which is said to grow the fastest. But this is precisely the population which consumes the least -- totally as well as per capita. This is true from both the national and international perspectives.

It is argued, for instance, that a reduced population will **ceteris paribus** lead to reduced energy consumption, less resource use and less pollution. This is strictly true in **ceteris paribus** arguments alone and cannot be used in reality. In reality, according to U.N. sources, consumption of energy in coal equivalents in 1975 amounted to close to 11,000 kilograms per capita per annum in the United States and merely close to 200 kilograms per capita per annum in India.7 Yet population controllers worry about the consumption of resources by the poorest of the Indian population.

The rich nations of the globe, constituting 18 per cent of the global population, consume 66 per cent of the gross world product, whereas the poorest nations of the globe with 50 per cent of the world's population consume 14 per cent of the gross world product.8

Population growth in the periphery is a drop in the ocean compared to the consumption of the populations of the rich nations. Neo-Malthusian views focusing on birth rates in the periphery obscure this critical issue, and it diverts attention from the fact that resources are being exploited from the Third World by the first world nations, and that there is a net transfer of resources from the developing world to the industrialized world of the order of forty to fifty billion dollars every year.9 This does not occur naturally or fortuitously; it is the product of social, economic and political institutions both in the first world and the developing world. In other words, the ruling classes in the world are part and parcel of this arrangement of the utilization of resources.

Intra-national figures in India are equally startling. The bottom 20 per cent of the population has a share of about 8 per cent in total consumption in the rural sector, and 7 per cent in the

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7. Hofsen, Erland, "Is There a Population Problem in the Industrialised Countries?", in Bondestam, Lars, and Bergstrom, Staffan (eds), **Poverty and Population Control**, Academic Press, London, 1980.

8. Bondestam, Lars, "The Political Ideology of Population Control" in Bondestam and Bergstrom, ibid

9. UNICEF, The State of the World's Children, O.U.P., Delhi, 1992.

urban; while the top 20 per cent has a share of about 39 per cent in the rural sector and 42 per cent in the urban.10 It is simply not true then that the poor are consuming resources disproportionately. What the data also indicate is that by cutting down the numbers in the lower decile groups, which is the avowed objective of population control, the quantum of resources generated would be miniscule.11 Population control, then, is not even an efficient or effective manner of raising resources. There are more effective means to raise these resources even within the same political and social set-up.

Demographic trends in the developing countries have quite clearly revealed the conceptual and empirical weaknesses of Neo-Malthusianism. Bauer observed:

> Both economic history and the contemporary scene make it clear that the conventional reasoning fails to identify the principal factors behind economic achievement. Rapid population growth has not inhibited economic progress either in the West or in the contemporary Third World. The population of the Western World has more than quadrupled since the middle of the eighteenth century. Real income per head is estimated to have increased by the factor of five. Most of the increase of incomes took place when population increased as fast, or faster than in most of the contemporary less-developed world. Similarly, in what is now called the Third World, population growth has often gone hand-in-hand with rapid material advance.12

Simon has called attention to the "large body of scientific work showing an absence of the supposed negative relationship between population growth and economic development in the long run. And the effect of higher population density actually seems to be positive. 13

Similarly Preston, observing the association between population growth and increasing rates of per capita income growth in large parts of the developing world, concludes that "rapid population growth in most times and places is a relatively minor factor in reducing per capita income and other measures of welfare."14

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10. Bardhan, Pranab K., "Some Aspects of Inequality" in Bose et al (eds), Population in India's Development 1947-2000, Vikas, Delhi, 1974

11.Qadeer, I., "Population Problem -- Myth and Reality" in M.F.C.'s In Search of Diagnosis, Vadodara, 1977.

12. Bauer, Lord P.T., in Wattenberg and Zuismeister (eds), **Are World Population Trends a Problem?**, American Enterprise Institute, Washington, 1984.

13. Simon, in Wattenberg ibid.

14. Preston, Samuel, in Wattenberg, ibid.

Indeed it has been suggested, on the basis of empirical evidence, that population growth may in fact be desirable as it appears to accelerate technical change and innovation.**15**

The near-zero correlation betwen population growth and per capita economic growth in the Third World, which became apparent in the seventies and the eighties, had in fact been noted twenty years earlier by Kuznets**16** and Easterlin**17**. But in the full tide of Neo-Malthusianism, their views had been largely ignored.

Meanwhile anthropologists and sociologists also pointed out the gross limitations of a Neo-Malthusian understanding of the population question which has proven to be a theoretical red-herring. Caldwell, for example, concluded that the most critical factor was the motivation to bear children and that in most primarily agricultural societies this motivation, moulded by socio-structural factors, was limited.**18** Djurfeldt and Lindberg furnished data questioning the belief in the high fertility of marginalized peasants.**19**

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But facts are not enough; their existence has not laid to rest the shadow of Neo-Malthusianism in practice. It is this which continues to guide policy and programme formulation in our country. I shall briefly touch upon the programme. India was the first nation in the world to officially commence on a family planning programme in 1952, with what was called the 'clinic' approach. This formed the basis of the programme in the first two Plan periods.

The limits of the clinic approach however soon came to light. In the Third Five Year Plan, at the behest of international experts, the programme was considerably expanded, based on the 'extension education' approach. Budgetary allocation to family planning shot up. But even before the extension education approach could be consolidated, foreign experts including Mr. Jack Lippes, inventor

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15. Boserup, Ester, **Population and Technological Change: A Study of Long Term Trends,** University of Chicago Press, Chicago, 1981.

16. Kuznets, Simon, "Population and Economic Growth", Proceedings of the American Philosophical Society, vol. III, no.3, 1967.

17. Easterlin, Richard A., "Effects of Population Growth on the Economic Development of Developing Countries", Annals of the American Academy of Political and Social Sciences, 369, 1967

18. Caldwell, John C. and Caldwell, Pat, Limiting Population Growth and the Ford Foundation Contribution, Francis Pinter, N Haven, 1986.

19. Djurfeldt, Goran and Lindberg, Staffan, "Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village," Macmillan, N. Delhi.1980.

of the Lippes loop, convinced Indian planners that a magic bullet had been discovered for the population problem in the form of the loop.

At this point in time, the World Bank was increasingly concerned about population trends among countries who were prospective borrowers. In line with the recommendations of a World Bank-sponsored committee report, programme alterations were made, incorporating the I.U.C.D. This formed the cornerstone of the programme in the mid-sixties. Within a few years the I.U.C.D. had proved to be a failure under the conditions prevailing in India, and reliance on it was soon abandoned. Allocations to family planning continued to increase. The programme now relied on vasectomy camps. But the camp approach was not sustainable, and after deaths due to tetanus at a camp in Gorakhpur, it was quietly abandoned. Vasectomy however was at the centre of the programme during the seventies; coercion was rampant and was largely responsible for the overthrow of the government.

From the Sixth Plan onwards women have been at the forefront of the programme's attempts to bring down birth rates. Over the Sixth and Seventh Plan periods, allocations to family planning continued to mount. Yet towards the end of the Seventh Plan there was increasing realization that the programme had failed. The Mid Term Appraisal of the Plan noted that the birth rate had not fallen despite considerable rise in couple protection rates. The Public Accounts Committee, in its 139th Report, observed that despite massive financial inputs into the programme, the birth rate had remained stationary. Indeed the late Prime Minister Rajiv Gandhi observed in his inaugural address to the XXI International Population Congress in 1989 that "there was inadequate causal connection between our family planning programme and the impact of these on our birth rates" and that "the rate of increase in financial outlays in family planning is not matched by a commensurate decline in birth rates."

What has occured is that a programme strategy is adopted with enthusiasm; it appears to work, then rapidly runs aground. A new strategy is then adopted, frequently centering on some new technology, often inspired by international agencies. Again it appears to work; then runs aground. Now the programme planners are thinking in terms of yet another technical solution: hormonal implants. This will add to the morbidity load of the female population in the country, perhaps even an epidemic of cancer in the years to come.

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ANNEXURE I b

POPULATION CONTROL AND FEMINIST PERSPECTIVE

Malini Karkal

The Margaret Sanser League, Social Democrats and the Fabians were promoting birth control in the interest of women's health during the 1920s. In 1952 John D. Rockefeller founded Population Council, which served as a lobby for activist demographers committed to redefining the goals of contraception in an age of explosive population growth.

By definition demography is a multi-disciplinary science. However, with the support of population lobbyists it has come to be dominated by statisticians who see human issues as the issue of numbers. They described population growth as hampering development efforts . The purpose of birth control was only one -- **Population Control.** And this in turn meant achieving demographic targets by increasing contraceptive prevalence and reducing birth rates.

Planning of the population programmes is essentially through societal goals. In reaching the largest number of people, to meet the societal goals, the programme has ignored the needs of individual clients and sacrificed service quality. The programme is directed towards women since the prevailing patriarchal society finds it easy to target them. As women are recognized only in their mothering roles, the programme promotes its interests by highlighting the maternal and child health problems. The demand of women activists that emphasizes the need for women's empowerment and for recognizing their reproductive health and reproductive rights, is still ignored by the population programmes. Currently women are manipulated to fit the technology, whereas women are demanding that their needs be given priority.

In view of the forthcoming International Conference on Population and Development (ICPD), to be held in Cairo in September 1994, it is essential to understand the basic issues and the roles that the inter-national agencies have played so far in discussing the population and development issues.

Experience so far shows that the interests of the Third World countries and those of the industrialized countries are distinctly different. On the population issue, whatever be the decisions of the international gatherings, the USA has persisted and succeeded in promoting population control. In the forthcoming conference women are hoping to promote their point of view, including issues related to economic development, environment and women's health.

In the 1960s and 1970s, political leaders and intellectuals in the developing countries have come to perceive the relationship between the Third World and the industrialized countries as essentially "feudal" -- in which the rich countries dominated and

the poor countries were dependent. Third World leaders wanted to reduce the disparities and transform the feudal character of the international order.

In the decade from 1962 to 1972, a series of resolutions, initiated by the USA, were passed by the UN bodies, saying that rapid population growth was a serious impediment to development and that programmes to control population were urgently needed. Family planning was legitimized as a human right, and governments were motivated to provide family planning services. Ultimately the notion of setting targets for population control was accepted as a development policy. Major functional agencies -- WHO, UNESCO, FAO, ILO, World Bank -- acquired mandates that roughly paralleled those emanating from the UN.

At the 1974 Bucharest conference on population, Third World countries were well organized and opposed the official draft resolution that was designed to promote American interests; 300 amendments were introduced and debated. The final version of the World Population Plan of Action had undergone extensive changes in spirit and substance, especially in the provisions relating to fertility and population control. Its stated "basis for an effective solution of population problems is, above all, socio-economic transformation." Efforts were to point out that population problems are not a cause but a consequence of underdevelopment.

Inspite of Bucharest asking for more equitable distribution of resources, population control programmes were promoted during the periods intervening between 1974 and 1984. In the 20 years preceding Mexico, the US had pushed harder than any other Western government to promote population policies in the developing countries. It had contributed most to population research and, through USAID, had mounted the largest population assistance, maintained a corps of 60 professionals in Washington, with advisors in more than 40 countries, and provided support for family planning in over 90 countries. Countries accepting family planning received aid from the USA.

The Declaration adopted at Mexico was in strong conformity with the official draft. It stated that the governments should "as a matter of urgency" make family planning services "universally available." The Declaration also added that "social and population pressures may contribute to the wide disparities in the welfare and the quality of life between developing and developed countries." The goal of the population policies, as enunciated at Mexico was the stabilization of population within the shortest period possible.

UNFPA, the official UN agency working for population issues, emphasizes that population size and growth have an impact on environment and sustainable development. Since the impact of consumerist life-styles on the depletion of resources is repeatedly discussed, UNFPA does mention it but it imphasizes the

need for reduction in population growth rates. It therefore promotes contraceptive technologies that are expected to target demographic goals.

From 1974 to 1984 the rate of growth of the world's population has declined from 2.34 per cent to 1.67 per cent per annum. However, there is no evidence that there was any relationship to the decline in the growth rate and the promotion of technologies such as foam, the pill or the IUCDs.

The population crisis theory implicitly assumes that population growth has a simple, direct, and inexorably negative impact on welfare, which means that even crude and incomplete data from developing countries should show at least mild to moderate negative correlation between the two categories of factors. No such correlation has appeared and it suggests that either population growth has little or no effect on welfare, or that the effects are contradictory or self-neutralizing. Such a conclusion has important implications for family planning programmes.

Population control is being vigorously promoted in spite of absence of evidence supporting its relationship to economic development. As early as the 1960s, data from developing countries showed that there was no relationship between population growth and per capita income. Economists Simon Kuznets and Richard Easterlin concluded from their research that the relationship between population growth and economic development is complex.

In 1973, Julian Simon cited evidence that moderate population growth is a stimulus to economic development, rapid population growth only a slight deterrent, and zero growth and population decline strong deterrents. World Bank data showed that in the 1970s and 1980s, the populations of the developing countries increased and yet, with the exceptions of a few, there was an improvement in income per capita, in literacy, in level of nutrition as well as in life-expectancies.

Samuel Preston, a demographer and one of the senior participants in a National Academy of Sciences study, said that because the relationship between population growth and income per capita is about as random and unstructured as any relation in the social sciences, there was no basis for the doomsday scenario' used by the family planning advocates to promote their cause. He further added that it gets public attention and brings money, but it is simple minded and incorrect, to casually attribute any human problem to there being too many humans. He warned that those who use it may crash with it when it is finally shot down.

USA has played an important role in promoting population control. Today it is the major funder for the programmes in the Third World countries. Interest of the USA in population control is

relatively new. In December 1959 President Eisenhower declared : "Birth control is not our business. I cannot imagine anything

more emphatically a subject that is not a proper political or governmental activity, or function or responsibility."

The situation changed dramatically in the following ten years and President Nixon issued in July 1969 the First Presidential Message on Population. The message said: "This administration does accept a clear responsibility to provide essential leadership." In the next five years the responsibility had turned into a manifest mandate. George Bush, then US representative to the UN, declared in 1973: "Today, the population problem is no longer a private matter .... It commands the attention of the national and international leaders." Thus the US changed its stand from an outside observer to being committed to family planning and then to the population problem.

Since the 1970s the crisis view is losing ground among professionals, though ironically it is gaining ground among the general public. Many demographers and family planning advocates are clinging to it as though it were a life preserver -- which, in one sense at least, it is. Compassion does not elicit as much public support as does fear of disaster. Alarm brings in money. The general perception of an impending population crisis has resulted in an influx of research funds into demography and of project money into family planning. For both, it has proven to be a goose that still lays golden eggs even after becoming a dead duck, and they are in no hurry to dispose of the caracass!

The supporters of the population crisis view, who have invested heavily in what they thought were moral causes, are reluctant to believe their perceptions were flawed and their energies were misdirected. It is quite often experienced that when personal or professional advantage and ideological commitments conflict with intellectual integrity, the conflict is all too often resolved at the expense of integrity. Such an approach often leads to public deception, withholding of information, such as was experienced in the inflated population figures of Nigeria and attempts to suppress opposing views as well as promotion of blatant hypocrisy.

In the population and family planning field, demographers and family planners deny or excuse use of coercion and appear to support only voluntary acceptance. It is important to note that the UN honoured Indira Gandhi, the late Prime Minister of India, who had permitted local officials to use control over permits, licences, employment and school admissions, denied food rations, brought about salary forfeitures, threats and physical force to compel people to submit to sterilization programmes, and was able to force over six million persons to be sterilized between July and December 1976.

The honour was also bestowed at the same time on Qian Xinzhong, Minister-in-charge of the State Family Planning Commission of China, who was able to reduce Chinese fertility by 62 per cent in the 1970s through compulsory IUCD insertions in women with two or more children. The achievements of the programme were 21 million

sterilizations, 18 million IUCD insertions and 14 million abortions. In 1983 the figure was brought down to one child. As a result of adoption of the one-child family programme, China experienced a resurgence of female infanticide. In December 1992, the recorded sex-ratio at birth was 114 males per 100 females, well above the normally expected ratio of 105:106. It is estimated that each year about 800,000 female infants are missing. The connection between forced one-child family in a culture that prefers sons is obvious.

Population control is so important to UN that it has no hesitation in overlooking, and even overtly supporting, violations of rights of couples. This is evident from the fact that in spite of assurances by the world bodies UNFPA chiefs are known to make statements infringing on reproductive freedom. The 1974 World Population Conference had acknowledged "the basic human right of all couples and individuals to decide freely and responsibly the number and the spacing of their children."

A decade later the 1984 Conference reaffirmed that right and added that the parents should be allowed to fulfil their responsibilities "freely and without coercion." And yet Raphael Salas, then UNFPA chief, stated in 1985 that ".. countries are and must remain free to decide on their own attitudes and responses to the question of population... The UN system is not equipped to go behind this principle and judge the moral acceptability of programs... The relationship of individual freedom to the needs of society as a whole is a matter for each country to decide." In the view of Raphael Salas the principle of sovereignty eclipsed the principle of reproductive freedom. Reproductive freedom was no more a universal right but it was whatever the national government decided.

In 1986, Nafis Sadik, UNFPA President, said: "Any limitation on the exercise of personal and voluntary choice of (family planning) methods represents violation of the right to have access to family planning." However, she further added, "judgements about what constitutes free and informed choice must be made within the context of a particular culture and the context of the overall government programme for social and economic development..." Freedom and informed consent that should be universal principles limiting government encroachments on human rights are transformed by the UNFPA into an authorization for governments to control childbearing.

With the past experience in mind, one must look forward to the deliberations of the IPCD in Cairo. One needs to be cautious about the outcome for the Third World as well as for women.

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ANNEXURE I c

THE KARNATAKA EXPERIENCE

Dr. Shirdi Prasad Tekur

Karnataka ranks eighth among the Indian states in terms of population and land area. We occupy 5.84 per cent of land area, with 5.31 per cent of the Indian population, with an average of 234 people per Sq. Km. This compares well with the national averages and the surrounding states, except Kerala and Tamilnadu, where more people live on less land.

The rate at which this population has grown over the last decade (1981-91) is 20.7 per cent -- a decrease from the earlier decade (1971-81 -- 26.8 per cent). The rate of decrease is more than in the surrounding states and the country as a whole. Which means, our population is growing at a slower rate.

Population size and growth are related to the status of women in society:socio-economic status, literacy, employment opportunities, and several other factors of development, other than medical and health services in an area. Family planning efforts make a marginal impact, though specifically designed to control population growth.

Family planning has been on the national agenda since before Independence, and Karnataka has been one of the earliest to appreciate and adopt policies meant for the same. The details of the evolution and modification of these programmes is beyond the purview of this paper.

Nature favours the survival of the female in any species, including the human. This is seen in the fact that more female children are born than male, especially in a growing population like ours. They do not seem to survive well, as the statistics given below show.

Females per 1000 males

	INDIA	KAR	A.P.	T.N.	KER.	MAH.
1991 -	929	961	973	972	1040	935
1981 -	934	963	975	977	1032	937

There are less females per 1000 males in Karnataka than the surrounding states except Maharashtra, though we are better than the national average.

The woman in Karnataka survives less better, meaning that she suffers from more inequalities than her sisters in the neighbouring states. The situation is worsening too, except in Kerala.

What is this related to? Literacy, employment, urbanization, health services, poverty, or whatever -- let's have a look at the situation in Karnataka's districts.

Females per 1000 male population : district-wise

District	1981	1991	District	1981	1991
Bellary	973	957	Chickmagalur	953	977
Bidar	968	953	Kodagu	933	989
Bijapur	982	965	D. Kannada	1059	1063
Gulbarga	981	962	Hassan	987	1000
Kolar	971	962	Shimoga	947	961
Raichur	988	978	U. Kannada	958	967

In the districts listed on the left, we see a worsening survival for women, while it is improving with those listed on the right. Why and how does this difference arise?

One of the major factors cited is literacy among females. Excepting Andhra Pradesh, the Karnataka woman is not as literate as women in the neighbouring states. We are of course better than the national average.

Karnataka - Total literacy - 56 per cent of population
Female literacy - 44.3 per cent of females

Let us examine this factor vis a vis the districts listed earlier for female literacy.

District	Rural	Urban	District	Rural	Urban
Bellary	19.50	42.13	Chickmagalur	40.39	62.13
Bidar	19.66	46.48	Kadagu	49.98	67.05
Bijapur	29.58	46.70	D. Kannada	55.45	68.84
Gulbarga	12.94	43.05	Hassan	33.83	65.62
Kolar	29.56	56.74	Shimoga	37.16	61.26
Raichur	13.16	35.79	U. Kannada	43.27	63.42

Figures are percentages to population

The above figures highlight the differences in literacy levels of the rural woman and her urban counterpart.

The urban woman appears to be more literate, but faces all the problems of urbanization, from congested living spaces to pollution and the crunch of resources to unequal competition.

How many people live in cities and towns, and how fast is this problem increasing?

Ratio of Urban Population to Total (%)

	INDIA	KAR.	A.P.	T.N.	KER.	MAH.
1991	25.7	30.9	26.8	34.2	26.4	38.7
Increase (%) during 81-91	36.2	29.1	42.6	19.3	60.9	38.7

Three out of ten people in Karnataka live in cities and towns, and it is increasing at the same rate (i.e., three more are added to ten already in the city/town) over the last decade.

Which are these rapidly growing urban areas in Karnataka? What is the health status of women here?

Place	**Population ('000s)**	**Decennial growth rate (%)**
Bangalore	4,087	39.9
Belgaum	402	33.7
Hubli-Dharwad	648	22.9
Mangalore	426	39.1
Mysore	652	36.2

Wherever the people live, poverty is a major factor to be considered, and for people living in villages, their ability to reach places in the state for employment, healthcare etc., is important.

Let us see how Karnataka fares in these aspects.

	INDIA	KAR	A.P.	T.N.	KER.	MAH.
Population below poverty line (as%) of total (1987-88)	29.9	32.1	31.7	32.8	17.0	29.2
% villages (1987-88) connected by fairweather roads	40.7	32.9	43.0	63.2	100.0	52.9

We seem to be as poor as our neighbouring states except Kerala, while the villages of Karnataka are less well connected by fairweather roads than all of them, even by national standards!

Since a majority of mobile population is male, the Karnataka woman has even less opportunity to do so in this situation compared to her sisters. This means that the Karnataka woman has lesser chances of reaching facilities away from her village, whether for health or for employment.

When we consider the participation rate of female workers in employment, the Karnataka woman is marginally less well off than in neighbouring states. Karnataka as such provides lesser opportunities for "main" employment too! Also, 70 per cent of main work is done by males in the country.

The 'marginal' sector of employment, where a person has work for less than 180 days per year (less than 1/2 the time in a year) is what we need to focus on, since 10 per cent of all employment available is in this category. Nine out of ten 'marginal' workers are women, with the attendant insecurity and impact on survival.

Does the status of women's health depend on hospital facilities? Yes, at least for disease care and public health measures. Where do we stand on this in Karnataka?

	Hospitals		Beds ('000s)		Population
	Total	Govt.	Total	Govt.	Per Bed
India	15,067	8,290	645.9	462.8	1316
Karnataka	288	237	34.5	27.1	1299
Andhra Pradesh	615	349	36.4	25.3	1613
Tamilnadu	408	289	48.8	38.4	1136
Kerala	2,924	137	70.3	26.5	413
Maharashtra	2,104	785	111.4	73.6	667

Needless to point out that we are worse off than our neighbours, but marginally better than Andhra Pradesh.

The Family Welfare Programme in Karnataka has been consistently meeting most of the 'targets' laid down for it, and has been 'successful' in that aspect. The burden of this is borne by the woman, since the 'targets' are:

- Sterilization - where the number of women undergoing tubectomy is 15 times the number of men undergoing vasectomy.

- I.U.D. insertion - it is the woman again

- Birth control pills - and again

- Medical Termination of Pregnancy - and again

Injectable contraceptives have now been cleared by the government for use on women, and the implantable ones (Norplant) have completed their 'trials' for use. This focus is on women; more than half of Indian women suffer from anaemia, while the morbidity due to gyanaecological problems are not even well studied or quantified. On the one who utilizes all her earnings for the benefit of the family, if and when she can earn. On the one who has little access to healthcare facilities and has to struggle against many odds for mere survival.

It is clear that unless factors affecting the survival of women change, family planning measures are an additional imposition on her life.

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ANNEXURE II

REPORTS OF GROUP DISCUSSIONS

G R O U P I

We the members are disturbed by the marginalization and victimization of women as "targets" of family planning programmes. We also do not approve the macro level trends -- rationalizing population size and growth as the primary causes for global enivronment degradation.

Demographic data and trends in India and Karnataka confirm that improvements in women's social, economic, and health status and in general living standards are the keys to decline in population growth. We call upon the government to recognize women's basic rights to control their own bodies and to have access to the power, resources and reproductive health services to ensure that they can do so.

The following conclusions and strategies emerged from the discussion, centred around six themes.

1. Women's health -- determinants, access and utilization

Health is an outcome of the interaction between education, income, social, cultural and political factors. Health is also the cumulative effect of basic necessities -- water, nutrition, housing and access to and availability of existing services.

The group evolved the following recommendations to improve the health status of women by increasing access to and utilization of services.

1. There should be an increase in the Union of budget from the existing 1.1 per cent of the allocation to 5 per cent.

2. There should not be any budgetary cut for preventive health programmes.

3. Family planning must be treated as part of women's health and should not be compartmentalized.

4. The existing health services are very poor, with too much reliance on family planning; this must be stopped forthwith. There is an urgent need to improve the quality of services by way of:

   a. Gender sensitization training among staff delivering primary health care.

   b. Panchayat members' orientation to women's health and fertility regulation methods.

   c. Demedicalizing and demystifying healthcare.

d. Upgradation of multipurpose health workers; the P.H.C. staff must be oriented to safe, affordable, culturally appropriate and comprehensive healthcare and health education for women.

5. Inclusion of family support services that include child care and care of the adolescent and the elderly must be woven into the health system.

II. Women's empowerment - control over bodies and decision making

The group conceives women's empowerment as a process of greater control over material, financial, physical and informational resources, with a view to attain greater power to decide about issues of concern to them, by themselves. The group recommends the following:

1. Information and education should be made available and greater access to them in a comprehensible form must be ensured.

2. Regulation of fertility of women must be one of the roads to empowerment.

3. Women should not be the targets of family planning. Instead their free consent and informed choice for family planning must be the decisive factor.

4. Women must be given the absolute right to determine pregnancy, abortion, spacing and family size preference.

5. Counselling and support services for women must be promoted to ensure comprehensive healthcare.

6. Women's health must be built up from infancy and childhood through to adulthood. It should not be viewed as reproductive health alone.

7. Greater emphasis on breast feeding and nutrition must be laid.

8. Older women and their health must be given importance.

III. Access to safe fertility regulation

1. Fertility regulation technology must be user-controlled and people regulated.

2. Reliance on terminal methods must be discouraged. Instead spacing and barrier methods must be promoted.

3. Compensation for tubectomy must be provided, to compensate the working days lost.

4. There must be greater research on other health systems to bring out safe contraceptives.

5. Proper screening for disorders such as anaemia and reproductive tract infection must be made, before advising contraception.

6. Incentives, disincentives and the camp approach must be stopped.

7. Hormonal contraceptives like injectables and implants must not be included in the family planning programme.

IV.Role of men

The group considers that men have personal and social responsibility for their own sexual behaviour and fertility and for the effects of their behaviour on the health and well-being of their spouse, children and parents.

V. Role of Government

1. The group's consensus was that the state should not renege on its commitment to universal healthcare. Nor does the solution lie in privatization or delegating its responsibility to voluntary organizations.

2. Decentralized planning in which people's bodies must decide on the priorities, resources needed and the types of services required, should be introduced.

3. The Shramshakthi Report's recommendations on occupational health of women must be enforced.

VI. Role of voluntary organizations

1. There should be greater accountability of their services to the people.

2. Proper screening of voluntary organizations must be ensured prior to extending grants or support by the government for health programmes.

3. Proper monitoring of the health projects taken up by NGOs through government support is essential.

VII. Strategies and approaches to promote equitable health

1. Health programmes need to raise women's consciousness and self-esteem and enable them to organize themselves and address their problems by themselves rather then the present dependence on the health system.

2. All the health programmes must be linked up with other programmes of employment and education and provision of basic amenities.

3. In the list of duties of Panchayat Raj institutions, ensuring the health of infants, children and women must be included.

4. There must be regulation of all technology which potentially worsen the sex ratio.

* * * * *

G R O U P 2

I. Determinants of women's health

1. Health awareness, where a women feels her personal health is important

* Women still feel their own health is not their responsibility, and healthcare is availed of only if it is free or some incentive is given to obtain it.Therefore population control programmes find easy targets in these women whose minds are conditioned to such means.

* Awareness is many a time perceived as "programme" related, or being "for a fixed period of time" ; "focuses on specific aspects of health", and not as a process that must have a holistic dimension.

* Awareness must also mean knowledge of the basic requirements for a woman to stay healthy, before which she must be aware of the science of her body.

2. Employment

Working women tend to have lesser children; therefore creating area specific income generating activities for women is a positive approach towards giving women more access to resources, increasing their self-esteem, status, decision making capacity and more say in health matters -- their own and also their families'.

The basis fo creating employment opportunities for women should not be the control of the size of the family, but the improvement of women's income earning potential. Co-operatives have proved to be a success in this context.

3. Education

It is seen that women who have had minimum primary education are very receptive to development messages.

Policy should find innovative means to make formal and non-formal education more accessible to women.

4. Availability of health services

The group concluded that health infrastructure does exist, yet the facilities to provide services of reasonable quality, do not. Therefore PHC's need to be better equipped, for which steps can be taken to ensure better implementation on a macro level.

II. Control over bodies and reproductive rights of women

Decision making rights are integral to health education and health awareness. Fertility awareness then follows.

III. Access to safe fertility regulation

* Information on side effects should be provided and informed consent for fertility regulation need to be emphasized. Individual needs and preferences should be borne in mind, instead of pushing harmful contraceptives on women.

* Natural methods of fertility regulation should be promoted.

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G R O U P 3

. Determinants of women's health

1. Access to both healthcare and knowledge about its delivery is determined by other factors, the foremost being education.

2. Access to education is synomymous with access to knowledge and as a consequence, healthcare. This access is often denied by the lack of facilities, particularly for the adolescent girl whose family expresses insecurity about her leaving the home in search of knowledge. This is compounded by conditons such as lack of separate toilets for girls which play a crucial role in deciding the duration of a girl's education.

3. Education is inter-related to other issues -- a more educated girl needing a better educated mate, thereby enhancing the dowry amount required to settle her.

4. Access and utilization are also improved by a <u>mother's level of awareness</u> and her own utilization of health services. Reluctance on her part to seek medical advice and care breeds in her daughter the same tendency to suffer in silence till a crisis point is reached.

   The mother's phlegmatic attitude is a product of both her social and cultural heritage which affects healthcare, nutrition and various other aspects of a young girl's life.

5. Physical access to healthcare plays a crucial role and is in turn governed by factors such as all-season roads and marginal

employment vs. full time employment (ref:Dr. Tekur's paper), The last is important because of facilities which are often present in the work place.

Focus on adolescence -- often provides a firm foundation for future use of health services. The aim must be to treat the girl/woman when she is not just pregnant (the only time she receives iron, tetanus toxoid (T.T.) and other essentials).

Anaemia is detected only in pregnancy, when it is often too late. T.T. for injuries is as important as giving it in the context of neonatal/puerperal sepsis.

Sex education -- awareness of one's own body is slowly being exploited by the industrial sector; as a clever marketing technique and under the guise of "reproductive" education, manufacturers are promoting their brands of sanitary napkins in schools.

Government services -- focuses on health of the woman when pregnant and thereby builds up the illusion that it has nothing to offer to women with any other ailments.

Local persons -- currently utilized for healthcare delivery are often providers of misleading if not false information and in fact may propagate values not necessarily productive.

II. Women's empowerment, control over bodies

1. This relies mainly on self-esteem and can be achieved only by establishing equal property rights, and equal access to edcuation about their bodies and health. Vocational training would have the final objective of enabling women to become financially independent.

2. Women's empowerment has its roots in

- the family
- religion
- society
- each individual

* Societal pressures make them get married for an identity as some one's wife or mother.

* Family and religion force them to stay married because of the total lack of alternative options.

* All these finally lead to a situation of helplessness, making them vulnerable to decisions made by others -- for example women succumb to the common belief that it is preferable for women rather than men to use some contraceptive method for fear men (particularly those who have accepted vasectomy) would become weak and consequently the marriage adversely affected.

III Access to safe fertility regulation

1. Other safer methods such as scientific natural methods need to be included in the government programme. The group added though that this would curtail cooperation of the man and the ultimate reproductive right -- the strength to say "no" -- both to unacceptable contraceptives and to their husbands.

2. Under the impact of harmful technology, the implications of trends such as ultrasound scanning, amniocentesis and indiscriminate promotion of in-vitro fertilization -- IVF were considered. It was agreed that the final control of these may arise only as a result of consumer action and consequent bad press.

IV. Role of men

1. The man must be made to appreciate his role as both father and husband. He must realize that a healthy woman can contribute more to family and work. He must begin to take responsibility for methods supposedly labelled "male methods" but which are in fact provided and bought by women as in the case of condoms, given to women by ANMS in rural areas and bought by women in urban areas.

2. Men are more vulnerable to incentive schemes and are susceptible to such tactics which lure them into accepting family planning methods which affect their women.

V. Role of government

1. **The state** must acknowledge that each individual has a right to have as many children as governed by her needs and circumstances.

2. Legislation must be clearly biased towards women's issues such as maternity leave and breast feeding.

3. Qualified medical personnel must be the decison-makers in the civil service hierarchy, as opposed to non-medical individuals who are not oriented to health and are not posted long enough in any one department to obtain this orientation.

4. Unethical advertisement by doctors promoting unnecessary practices is to be strongly condemned and penalized by disciplinary measures.

5. Care of the living child must become a priority and must go hand in hand with all attempts to regulate fertility. For every intervention planned in family planning there must be one accompanying step in improving child care.

6. A change in the medical education syllabus was urged to stress issues discussed above.

VI. Voluntary organizations

1. Their primary role is to create awarenss in three main fields health facilities available, rights of the woman, and women's health.

2. Voluntary organizations must orient general practitioners (from whom most people seek medical treatment) to women's health as a priority and also update them regularly.

3. Voluntary organizations must develop innovative methods in field teaching and training both people and healthcare personnel in the of women's health. These methods/modules could be adopted by the government and thus enable a free exchange of material and ideas.

VII. Strategies

1. The focus must shift to the school which becomes the source of information in terms of health services available and education on health, nutrition and hygiene. Preferably this would be complusory and free for girls.

2. Girl dropouts must be followed up, causes studied and whatever deficiency which has led to girls dropping out must be remedied.

3. Zilla parishads must have a large representation of women -- preferably upto 50 per cent and implementation of health and family planning programmes must be channelised through them.

4. Responsibility among men would improve if there were more male grassroot level workers who are right now restricted to malaria and filaria control programmes.

5. The health budget must be considerably increased

6. Legislation already in existence with respect to breast feeding and age at marriage must be monitored, facilitated through voluntary health organizations.

7. The role of media must be to provide information in a different tone from that of the government even if funds are given only for work on family planning. Material preparation must be regionalized and decentralized such that local and linguistic features are taken into consideration.

8. Mulitinational investors who are supposed to allocate some money for development work must be urged to support health programmes in preference to others.

9. Alternative indigenous methods of fertility regulation known to be in existence in India must be explored.

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G R O U P 4

I. a. Determinants (knowledge about health)

1. Poverty, poor hygiene due to lack of basic amenities such as drinking water, sanitation, housing

2. Low age at marriage and early and frequent child-bearing

3. Lack of awareness about the importance of timely preventive and curative healthcare.

4. Poor public health services and attention only to pregnant women, discourage women to use these services. In fact PHCs are only associated with sterilization and health workers attend to pregnant women as possible 'cases' for sterilization.

b. Access and utilization

1. Remote areas are poorly covered by health workers, because of lack of public transport. Women on cycles are ridiculed by villagers and therefore LHVs cover only easily accessible villages.

2. Most often people resort to treatment by local quacks or 'medicine men' who exploit villagers' superstitious beliefs and practices. Professional help is sought only in extremely critical cases, when it often is too late.

3. There is a clear gender bias which makes the health of women and girls last priority. Even in high-income families, there is lavish spending on festivals and celebrations, but reluctance to spend on preventive/curative healthcare.

II. Women's empowerment, control over bodies

1. This is possible only when women are aware of themselves -- the structure and functions of their bodies; this awareness can be created by informal education for both men and women.

2. Control over bodies is closely linked to empowerment, which can be made possible by increasing their awareness levels and their skills for economic activities, in order to increase their economic independence.

3. It is essential to involve men in the empowerment process and increase their understanding of women's health and reproductive rights.

III. Safe fertility regulation methods, impact of harmful contraceptive technologies

1. There is a total lack of information on the various contraceptives available --their proper use, possible side-effects and suitability to individual needs.

2. Most women in both urban and rural areas are not aware of new technologies such as vaccines, injectables and implants.

3. Even the widely used spacing methods such as IUCD result in several often serious health disorders ranging from disturbances in menstrual cycles to pelvic infections and back-aches.

4. The public health system has no sympathy for women with such complaints. They are dismissed as common complaints, some pain-killers are prescribed and the woman left to suffer. Therefore introduction of long-acting hormonal contraceptives would definitely damage women's health further.

5. More importance should be given to research on and promotion of self-help methods, using locally available plant material and other home remedies. Indigenous medicines and health practices should also be promoted after establishing their authenticity and usefulness.

IV. Role of men

1. Men have an equal responsibility in ensuring that girls and women receive adequate healthcare.

2. Women's health and reprodcutive rights must be recognized.

3. Men should realize the importance of spacing, and of their role in determining family size.

4. Men must be encouraged to help their wives during delivery. This will sensitize them to women's needs and recognize their role in the family.

5. Men should avoid any behaviour which will put their family at risk. This assumes greater importance vis a vis sexually transmitted diseases and the HIV/AIDS virus.

V. Role of the government

1. The development schemes of the government look good on paper, but are poorly implemented. For instance, the IRDP -- Integrated Rural Development Programme, envisaged to generate employment and income in rural households, may lead to a family's increased indebtedness. Instances of families purchasing hybrid cattle in dry districts (of course the cattle die very soon) and others making debts to repay bank loans, setting off a vicious cycle of indebtedness, are quite common. Under these circumstances, health is last priority, as medical treatment costs money.

2. Therefore government schemes and programmes must be realistic, suited to local and individual needs and implemented with sincerity. Only then can it meet its purpose of economic development and income generation.

3. Panchayati Raj bodies can ensure a more decentralized and need - based healthcare system. Women members must be encouraged to bring women's issues to the forefront.

V. Role of NGOs

1. NGOs already having a field base can work closely with the government in :

a. facilitating the proper implementation of its health programmes -- prophylaxis, pre and post natal care, family planning.

b. in identifying beneficiaries and disbursing loans for development programmes.

c. conducting health and fertility awareness programmes for the public.

d. training of health workers, including on gender issues and sensitivity to women's problems.

e. encouraging households to utilize tried and tested home remedies and maintain herbal gardens. Care must be taken to caution against unsafe practices such as smearing cowdung on the newly-cut umbilical cord of infants.

f. encouraging promotive and preventive healthcare through proper nutrition -- for example, the use of greens, lentils, easily affordable fruits and vegetables.

ANNEXURE III

NOTE ON RESOURCE PERSONS

DR. MALINI KARKAL retired as Professor and Head of the Department of Public Health and Mortality Studies from the International Institute for Population Sciences which is a deemed university sponsored by the United Nations and the Government of India, at the Bombay University.

Dr. Karkal, formally trained in public health, health education and demography, has been a consultant to the Indian Council of Medical Research ICMR, in New Delhi, and the (World Health Organization (WHO) in Geneva. She has completed research projects and written research papers on various aspects of population -- fertility, family planning, mortality, health issues, urbanization, and population policies affecting women and children. She is actively involved in the women's movement and undertakes academic work on women's issues at present.

DR. MOHAN RAO teaches at the Centre of Social Medicine and Community Health at the Jawaharlal Nehru University, New Delhi. He is particularly concerned about the lacunae in India's public health system and the assumption that population growth is the cause of poverty, underdevelopment, and environment degradation.

Dr. Rao's study of the health and family planning services in Mandya, a wealthy agricultural district in Karnataka, exposes the lacunae in the health system.

The resurgence of fundamentalist forces in the country and the need to promote secularism are also of concern to Dr. Rao.

DR. SHIRDI PRASAD TEKUR is a peadiatrician by training. A student of St. Johns Medical College in Bangalore, he had a brief stint in the Department of Community Health at his alma mater. He has also served in the army.

Dr. Tekur is presently the coordinator of Community Health Cell (CHC), a Bangalore based voluntary organization promoting and facilitating community health among voluntary agencies. CHC also interacts with the government on various issues and is part of a network of organizations, concerned with community health in the country.

Dr. Tekur is also interested in alternate and indigenous systems of medicine. He practises homeopathy, and teaches the subject to medical students and health workers. He is also the Vice-President of the Drug Action Forum in Karnataka.

MS. SRILATHA BATLIWALA, a women's activist and researcher, has been involved in grassroots development programmes for the last 20 years in Maharashtra and Karnataka. She was till recently the State Programme Director of Mahila Samakhya in Karnataka. She has also worked with the Tata Institute for Social Sciences and the Foundation for Research in Community Health in Bombay.

Presently she is India Coordinator for Development Alternatives with Women for a New Era (DAWN), an international network of women researchers and activists.

ANNEXURE IV

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ANNEXURE V

PROGRAMME SCHEDULE

December 10

9.00 am : Registration of participants

9.45 am : Invocation song
Ms. Kavitha, Ms. Amruthavalli

Welcome and introduction
Ms. Sucharita S Eashwar
Executive Director, Madhyam Communications

10.00 am : **Information Update**
on population policies, family planning strategies and impact on women's health in Karnataka

- **Dr. Mohan Rao**
  JNU, New Delhi

- **Ms. Malini Karkal**
  Researcher and consultant
  Population and women's health

- **Dr. Shirdi Prasad Tekur**
  Coordinator, Community Health Cell
  Bangalore

LUNCH

2.00 pm : Focus on birth control and women's health

Screening of 'Something Like a War', a film by Ms. Deepa Dhanraj

TEA

4.30 pm : Setting the agenda for discussions the next day

Led by Ms. Srilatha Batliwala
Former State Director, Mahila Samakhya (Karnataka)

5.30 pm : Close for the day

December 11

9.30 am : Identifying key issues for discussion

Formation of groups

Discussion in groups of issues identified by participants

Drafting of statements and recommendations

LUNCH

2.30 pm : Plenary

Presentation of group statements and recommendations

Discussion

5.00 pm : Conclusion