F P PROGRAMME: WOMEN AS 'TARGETS'

This discussion note addresses the following:

1. Women have been the focus of the family planning programme not just in the last decade but ever since its inception. In the last decade this emphasis has been intensified. Whatever the changes in the policy over the years women have remained the 'target population' for the family planning programme.

2. This focus on women has had several consequences for women - on the one hand while it has made contraception available and legal, it has placed a heavy burden on them of having to deal with the coercive practices incorporated in the programme, and of the high load of morbidity associated with the unsafe methods and practices being promoted. And it is highly debatable whether the mere availability of contraception has given them any control over their reproduction.

2. What do we do about this situation? Should we oppose the programme for its large ideological fundamental ideological reasons and in so doing also accept that we would not then may not then have access to contraception at all? Or do we seek to make it less coercive and more relevant to our needs?

Women as focus of programme.

India was one of the first countries to promote family planning as a national programme, Even before the formal process of planning began, it had been recognised by the health committees that were set up that in order to ensure the health of the mother, it was necessary to bring down the number of pregnancies she underwent. Towards that end contraceptive advice was one of the components of the maternal and child health programmes. In the 50s family planning was made an integral part of the MCH programmes. In the early years when the family planning unit and its several clinics were set up the only method promoted was the rhythm method; but soon the FPU began to test contraceptives for efficacy, safety and acceptability and to undertake work to develop newer contraceptives. Between 1958 and 1962 the clinics of the FPU tested a variety of foam tablets, spermicidal jellies and diaphragms. The emphasis right from the beginning was on getting women as acceptors. So much so that at the end of the first plan when an evaluation study was carried out it was found that the clinical approach which had been adopted had 'medical, feminine and middleclass bias'.

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By the third plan family planning was a more serious issue and became more firmly integrated into the national programmes with an allocation of forty times that of the previous plan. The approach also changed - on the advice of the Ford Foundation. It was during this time that sterilisation was adopted as part of the programme and Lippe's loop, which had already been discarded in the west, was introduced with manufacturing facilities set up with the help of the Population Council. The changes in approach also included the starting of the post partum family planning programme, funded by the Council and put into action around 1968. The programme was launched with the intention of using the hospital base to promote direct fp assistance to women either after child birth or after MTP. Inevitably this reinforced the female bias of the programme. At the same time it brought with it an element of coercion - services could be and were withheld if women did not accept sterilisation.

The accompanying table shows these various trends in this period. After an large increase in the number of IUD acceptors, the device fell into disrepute and even the incentive schemes could not revive it. From a record number of over 910,000 IUDs acceptors, in 1966-67 it fell to about 459,000 by 1968-69. The initial emphasis on sterilisations showed up as a sharp increase in the number of vasectomies which constituted 55 per cent of all methods. By 1969 a combination of factors served to push the only other female method (other than IUD) female sterilisations - which constituted 26 per cent of all sterilisations. In 1967-68 with the USAID supplying condoms for the Nirodh marketing programme the number of condom users went up comprising 40 per cent of all acceptors. At the same time, the introduction of the newer methods also meant a deemphasis of the diaphragm (the diaphragm-jelly combination had shown good results in the FPU tirals). From combination ~~had shown good~~ onwards the device almost disappeared from the scene although on paper at least, it is one of the methods offered in the 'cafeteria' approach of the programme. The last half of the 60s thus saw the introduction of two new contraceptive methods for women neither of which really took off at this stage; at the same time it also saw the demise of the then, but the stage was set for a tremendous expansion of the fp services.

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By the Fourth Plan population control became an integral and important component of development programmes. The government policy set definite goals - bringing down the birth rate to 25 per cel000 in 10-12 years. The fp programme from this point has made no pretensions of being anything other than a means of reducing numbers - since goals have to be achieved in specified periods 'targets' had to be set and the evaluations were in terms of 'births averted'. The objective of providing birth control measures is thus a far cry from the current fp objectives directed at controlling population growth.

The 70s was the decade of the camp approach introduced to get quick results. In the early 70s the technique of conducting tubectomies by the vaginal method which did not require more complicated surgical procedures was only just being introduced, and most tubectomies were conducted at hospitals on part of the post partum service. The sterilisation camps therefore were for vasectomies. While the first such camp was in Maharashtra in the early 60s, it was the 1971 vasectomy camp in Kerala which was spectacular - 15,000 vasectomies in a one-month period. The fact that it was during the lean period and that higher compensations and extra rations were given had not a little to do with these numbers. Several other states organised such camps until 1972 when in one such camp, 11 people died of tetanus, and the camps were promptly discontinued. In the two years between 1971-72 and 1972-73 the number of vasectomies jumped by 197 per cent. But as a backlash of the camp-associated deaths there was a drastic drop in vasectomies and the programme only 'recovered' during the emergency. Tubectomies constituted only 16 per cent of all sterilisations in 1971-72 although in the following two years they made up about half not because there was any major increase in their numbers but because of the reduced total of sterilisations.

The early 70s also saw the introduction of the MTP act which was aimed at reducing the number of illegal abortions. It resulted in servere problems including death. It allowed for abortions not only for therapeutic reasons but also for 'social' reasons - contraceptive failure. However, the committee which was constituted to formulate the Act categorically stated that this was not being mooted as a family planning measure. It is possible that because of the non availability of safe and effective contraceptive methods MTPs are being resorted to as an fp measure.

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The impact of the emergency on the fp effort is too well known to need elaboration. It must be mentioned that during the period 1975-77 there was, of course, a fantastic increase in vasectomies, but also an increase in tubectomies and condom users while the number of IUD users actually dropped in 1977 after a 40 per cent increase in 1975 and 76, probably because the pill which was introduced in 1974-75 was being pushed vigorously then. The post -emergency period brought a drop in all acceptors and the fp programme was on a low key for a while. In 1976 a National Population Policy was formulated. It advocated a set of incentives and disincentives and also stipulated that for grante allocation to the states the 1971 population figures would be taken into consideration and some proportion of the aid would be linked to fp performance. This led to all kinds of atrocities in achieving 'targets' and Maharashtra even tabled a Bill to make sterilisation after two children compulsory.

The fp programme in the Sixth Plan was directed at aspects other than merely the control of population. However it also set the target of achieving Net Reproductive Rate (NRR) of unity; in order to achieve this the birth rate had to be brought down to 21. Other components of the programme included other targets- death rate to 9, infant mortality to 60. FP targets were set as sterilisations 22 million, IUD 7.9 million acceptors.

The Sixth plan targets have been over achieved in the case of IUDs and very nearly fulfilled for sterilisations. The new policy for the seventh plan has set more fantastic targets especially for oral contraceptives and IUDs.

Since the 1980s the fp programme is being pursued with a new intensity and has finally 'recovered from the emergency excesses. There has been an 129 per cent increase in all acceptors since 1980; a 239 per cent increase of IUD users; 140 per cent increase in tubectomies; and a 365 per cent increase in equivalent pill users as against a mere 50 per cent increase in vasectomies and 106 per cent increase in condom users. There is every reason to believed that of late the emphasis has shifted from terminal methods to specing methods such as IUDs and oral contraceptives. The IUD has found new acceptors for the first time after its 70s debacle. This has become necessary partly because of the changing age structure whereby a larger number of younger women

are making up the eligible age group where terminal methods are not acceptable. Another reason is perhaps the realisation that despite the increasing numbers of sterilisations, this has not made much of an impact on numbers mainly due to the fact that acceptors have already had more than the 'right' number of children.

There can be no doubt that women have been the targets of the family planning programme - as acceptors and as gunguinea-pigs for a variety of testing programmes involving contraceptives ahormonal and devices. But strangely there has been very little interest in investigating simple barrier methods such as diaphragms - there seem to be no evaluation on whether the device is in fact, as inconvenient to all sections of women. Moreover, there has been little research on male methods.

However, not withstanding all this the total number of acceptors of female methods comprise only about 44 per cent in 1983-84 of all acceptors and in fact have never been more than that since 1965. In some years as in 1971-72 proportion has been as low as 15 per cent. But this however, is not so much because there was a deemphasis on female methods as because there was a tremendous increase in vasectomies during the 'camp' phase. Similarly it may be argued that tubectomies although they comprise 0 per cent of all sterilisations only make up 26 percent of all acceptors. Are we then justified in stating that women are the major focus of the family planning programme?

Here we must go beyond the numbers on apaper.

Firstly, it is generally known that of all fp statistics on acceptors those for sterilisations are the most reliable. The figures for condom users is based on number of piece distributed and not on any feedback on usage. It is also well known that the targets for condoms is the easiest to achieve because all the officers have to do is dispose of them. The statistics on IUD users too is something of a myth. In 1984 - for these numbers include a large number of women who have had the device removed. In 1984 an Indian Express report revealed that the number of acceptors of Copper T was much larger than the number of eligible couples in the state; and there are innumerable accounts of how the numbers have been fudged. Oral contraceptives users again are based on numbers distributed. Effectively therefore, it is the number of sterilisations which are indicative of what is really happening.

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Secondly we see from the table that there has been a steady and almost consistent increase in the number of tubectomies (ignoring the aberration of the emergency years 75-78). No such trend is seen in the number of vasectomies which has been exwith sudden and large increases when it was being vigorously promoted followed by sharp decreases in the aftermath. In other words it is not unreasonable infer that regardless of other features of the policy, female methods sterilisations have been consistently promoted. Interestingly also the introduction of the laporoscopic method and the camp approach in 1980 has not resulted in the kind of increases which occurred for casectomies in say, 1971-73. This, probably indicates that the steady increase in tubectomies is not really a result of the camp approach.

In evaluating the impact of fp on women, we must take into consideration the risk associated with each method. Apart from vasectomy the only other male method being offered is the condom which has no risk whatsoever. Vasectomies too cause fewer problems than do tubectomies. And it is significant that vasectomies camps were promptly given up when there were deaths in one such camp in 1972, whereas tubectomies camps are being actively promoted despite the increasing incidence of morbidity and mortality associated with these camps. Since early 80s the introduction the simpler and shorter procedure of laparoscopic sterilisation has parodoxically contributed to the increasing risk involved. According to surveys the infection rates in these camps is as much as per cent when the theoretical incidence rate is only about . Sathyamale's paper describes the incidence of risk associated with each of these methods. In short all the methods being offered in the mass programme add to the women's burden of ill health. Even if they comprise only 44 per cent of all acceptors the fact remains that women face is far greater risk than men in using the available means of contraception. And the irony is that it is some extent avoidable risk. For instance, with proper checks for contraindictaions and good supportive health care some of the IUDs may be very effective. Similarly, tubectomies particularly laparoscopies, can be safe and effective (although they do not do away with the other problems of sterilisation) provided enough attention is given to the women during and after the operation.

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Table: Family Planning Ac
(Since 1965.
(Numbers in Th

Year	I U D Insert-ions	% Total Accep-tors.	Sterilisations				
			Vasectomies		Tubectomies		Tote
			No	%TA	NO	%TA	No
March 1965 Jan. 1966	813	39	577	28	94	5	671
1966-67	910	40	785	35	102	5	887
1967-68	669	22	1648	55	192	6	1840
1968-69	479	15	1383	45	282	9	1665
1969-70	459	14	1056	31	366	11	1422
1970-71	476	13	879	23	451	12	1330
1971-72	488	10	1620	32	567	11	2187
1972-73	355	6	2613	44	509	9	3122
1973-74	372	9	403	9	539	13	942
1974-75	433	10	612	14	742	17	1354
1975-76	607	9	1438	21	1230	18	2668
1976-77	581	5	6199	50	2062	17	8261
1977-78	326	7	188	4	1761	17	949
1978-79	552	10	391	7	1093	20	1484
1979-80	635	12	473	9	1305	24	1778
1980-81	628	10	439	7	1614	25	2053
1981-82	751	9	573	7	2219	27	2792
1982-83	1097	10	585	5	3398	31	3983
1983-84	2131	14	661	4	3871	26	4532

Source: Compiled From:
Family Welfare Programme Year Book 1983-84
and Annual Reports of the Department.

Note: Figures for Condoms, Diaphragms and Oral Pills are i
For Condoms and diaphragms Equivalent user, is deriv

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	Condoms		Diaphragm		ORAL PILLS		Total Acceptors (TA)	Total Female Acceptors (FA)	FA as percent of TA
%TA	No.	%TA	No	%TA	No	%FA			
33	582	28					2066	907	44
39	465	21					2262	1012	45
62	475	16					2984	861	29
54	822	27					3105	778	25
42	1366	40	17				3390	837	25
35	1846	49	7				3769	934	25
44	2262	45	5				5029	1060	21
53	2321	40	5				5875	869	15
22	2449	68	5				4324	916	21
31	2490	58	3	26	0.6		4308	1206	28
39	3479	51	2	32	0.5		6804	1872	28
66	3623	29	1	58	0.5		12534	2702	22
21	3164	70	1	78	0.7		4528	1166	26
44	3371	61	1	82	1.5		5505	1728	31
32	2976	54	0.5	82	1.5		5482	2023	37
32	3707	57	0.5	91	1.4		6490	2334	36
35	4428	55	0.5	120	1.5		8102	3091	38
36	5757	52	0.5	183	1.7		11028	4679	42
31	7652	51	0.5	555	3.7		14876	6557	44

terms of Equivalent Users.

by dividing off take by 72 and 2 resp.

Another factor which must be considered is the fact that the newer methods being introduced - such as injectables or implants - are not only harmful potentially but are also methods which a woman has little control over. What do we then do about this: There is no gainsaying the fact that women need contraception and it is our right to demand that the Government make safe and effective contraception available on demand. In that sense, that the government is making available a choice - at least theoretically - of methods for women is not objectionable. What is to be criticised and condemned is that women today are coerced, overtly and covertly, to accept certain method irrespective of their personal and specific needs both in respect to the size of their family and the choice of method. And then again can a mass programme in a country like ours can only be useful, effective and safe if supported by an efficient public health system? Should there must be a greater emphasis on encouraging men to accept and use birth control measures? Would this necessarily tilt the balance the other way so that there are fewer contraceptive choices for women. And most importantly, the introduction of long acting hormonal contraceptives, which are known to be a health burden on the women, must not be allowed. The note has drawn on data, ideas arguments from the following:

1. Socialist Health Review Issue on Politica of Population Control, March 1984.
2. Vimal Balasubrahmanyan: Contraception as if women mattered and Towards a woman's perspective on F.P.E.PW. Jan.11, 1986.
3. Alaka Basu- Family Planning Leacy of the Emergency E P W. March 9, 1985.

All these are available for sale or are on display at the Meet.

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