FACTS against MYTHS

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Over-population as Underdevelopment: The Myths behind "Population Control" — I

COMMENT

In India population policy is identical with the policy in population control and is women–targeted. In 1951, it launched the first official family planning programme, later renamed as the Family Welfare Programme. Subsequently, the Alma Mata Declaration (1978) of Health for All by 2001 was adopted by India in 1994 and 'reproductive' health rather than family planning was foregrounded as a new slogan from the Cairo Conference (1994) on Population and Development. But for all this, birth control continued to be the main component of the population policy. During the Emergency a policy statement was issued affirming the priority accorded and commitment to 'population problems'. The 1993 National Health Policy stated the long-term demographical goal of reducing Infant Mortality Rate (IMR) by 2000 but is yet to be achieved! And since 1991 with the imposition of SAP this Policy began to be steadily undermined. In fact SAP led to massive injections of foreign assistance in family planning like the USAID project (1992) worth $325 m. to provide 'innovations in family planning services' in UP and subsequently to the whole of the country. As a result the dangerous hormonal implant, *Norplant*, was used on migrant labour in this State the same year but withdrawn after protests by women's groups. In 1992 it again introduced another dangerous drug, *Depo Provera*, and then *Quinicrine* to produce sterility in women. The case was taken to Supreme Court leading to a ban on *Quinicrine*. The point, however, is that the 'liberalisation' of the drug policy under the SAP regime and foreign aid in family welfare programme raises such a threat, without fulfilling the urgent need for safe and cheap contraception.

Since adopting the SAP-induced population policy which is not to improve demographic balance and well being through greater government investment in the public sector the government has been implementing the neo-Malthusian solution that views birth control as the '*panacea*' for India's poverty and underdevelopment. Population policies since have been careful to avoid any analysis of the impact of SAP on demographic balance and well being.

For instance the Committee on Population (Karunakaran Committee) of the National Development Council had made objectionable proposals[1] like the bar on government recruitment of girls and boys getting married at an early age, bar on contesting election for people not following the small-family norm, and the use of army and para-miliatary forces to serve the cause of the health and population stabilisation though later some of these obnoxious proposals had been withdrawn. The government on its part while it conveniently overlooked the positive recommendations of the Swaminathan Committee it introduced the 79th Constitution Amendment Bill to the Parliament whereby people having more than two children would be disqualified from contesting parliamentary election. Such disincentives/incentive driven coercive policies and tactics, far from promoting small families, precipitates pressure on women and on the poorer classes, who, even if they are aware of the relevance of small families, have very little control over their own reproductive lives. Already, the politics of population control has become apparent in some of the States where such a exclusive and punitive policy at the panchayat and other levels is preventing democratic participation of women and the poor. According to the Indian Express (17-1-2001) an OBC woman sarpanch in M.P, Shashi Yadav, has become the first victim of this legislation. On giving birth to her third child on September 23,2001, the local District Magistrate imposed Section 36 of MP Panchayat Raj Act legislating that any elected office bearer giving birth to a third child after January 26,2001 is automatically debarred. The new law was made effective after the February 2000 panchayat election through the amendment bills adopted by the State Assembly on March 29. Since then the collector's office has received other similar complaints about violation of the 2-child norm.

In the final analysis, it is not merely issues like SAP and economic globalism but also the dominant ideological pattern, which reinforces changes in the class-biased approach to the demographic question. Historically, an important component in the demographic imbalance was the mass enforced dislocation of population following communal riots during Partition. The recrudescence of communalism and today, fundamentalism, are ideologies that seek in denying people of their basic rights in the name of religion. While unconcerned about providing access to safe contraception and improved quality of life, the approach seeks to punish the marginalised through coercive measures. Hindu communalism specifically exploits this approach in launching a special campaign to control the numbers of 'backward' minorities. By stressing the communal divide in mixed areas and fuelling tensions arising out of limited economic opportunities in a specific area or region, such engineered conflicts lead to the exodus of certain section of the people from specific localities and States resulting in demographic imbalances (via riots and displacements of people from their habitats) ultimately succeeding in ghettoising a community.

Apart from avoiding any critical evaluation of the SAP-induced analysis of the demographic balance, bilateral and multilateral aid agencies — the World Bank, USAID, UNFPA,etc. — determined to reduce "population growth" — employ various fertility control measures on women in the South. These methods[2] as Dr. S. Brahme explains are, firstly, imposing "population control" as a major condition for development aid; secondly, dumping hazardous contraceptives and techniques on women; and thirdly indulging in an incessant ideological and propaganda war. An illustration of the last is the US, which has touted population growth as a threat to its national security! Quoting the journal, the Washington Quarterly, (1989) Shiva[3] points out: "As difficult and uncertain as the task may be, policy makers and strategic planners in this country have little choice in the coming decade but to pay serious attention to population trends, their causes and their effects. Already, the US has embarked on era of constrained resources. It thus becomes more important than ever to do things that will provide more bang for every buck spent on national security. Policy makers must anticipate events and conditions before they occur. They must employ all the instruments of state craft at their disposal (development

assistance and population planning every bit as much as new weapons systems)".

These policies and ideologies fail to however consider an important aspect of religious fundamentalism viz., the fundamentalism most women are confronted with but left largely unaddressed. Despite its denouncement the Vatican for instance is not considered the best guarantor of women's interest and well being in matters of health and re-production especially in respect to women in the South. Lest we forget: the greatest challenge at the 1994 UN Conference on Population and Development (ICPD), Cairo, was – and it was not met – to transcend the politics of both Washington DC and the Vatican, and place women of the South at the centre of the 'population' discourse: as subjects, determining their lives and health, not as objects of State, or Extra-Constitutional State systems and the demographic Establishment.

In the circumstances it is hardly surprising that India's National Health Policy Draft introduced in August 2001 has been critiqued as being highly inadequate. The Draft had stated nothing significant on the population question, which the health movement has long held to constitute a major drain on primary health care. Moreover, the actual monetary involvement of these aid agencies to primary health care has been correspondingly low yet their influence on health policies is disproportionally high! Instead the Draft repeats the usual tautology that progress in public health has been nullified by population growth. However, as Prof. Malini Karakal noted in "One India, One People" (January 2002) that this *mantra* contradicts all evidence available globally that population stabilisation follows attainment of certain socio-economic standards and do not precede them.

MYTH: ***One of the major goals of India's Population Policy is to empower women by making them free to exercise choice in the variety of new family planning methods.***

FACT: This myth first emerged in the North during the 60s, 70s and in the early 80s. It was later revived into a more refined package by population "experts" by incorporating some of the progressive language of women's' and human rights groups. The former US Administration under President Clinton had focussed on the environment, population and women's rights as driving force for its foreign policy in a new global politics. The underlying motive, however, was the urgency to control population growth in the South because its natural resources must be freed for the growth of US TNCs. And above all "...the US economy will require large and increasing amounts of minerals from abroad especially from less developed countries. That gives the US enhanced interest in the political, economic and social stability of the supplying countries."[3]

What this imperialistic view — the link between resources and population growth – is conveniently blind to is that population growth is sparked off by appropriation of resources from the common people in the South. Such appropriation – which is necessary for diverting resources from people to TNCs – also fuels social and political instability and unrest, as the Zapatista uprising in Mexico highlighted on New Year's Day, 1994.

Moreover, in the liberalised economy in particular the language of 'choice' becomes a handy tool for whole variety of "population control" experts. It makes population control – the denial of the right of the individual to freely and responsibly choose to have or not have children – appear as free choice in the marketplace of contraceptives. But poor women in the South as targets of such programmes are not `free consumers'. Coercion rather than choice characterises their situation in such programmes also a major component of other global aid packages. (However, due to popular resistance to such control measures, governments have dubbed it `Family Planning' and the World Bank masks it as `Safe Motherhood'!)

In India, the myth exposes women to the danger of having hazardous drugs invaded into her, frequently in a guarded and veiled manner and without proper information or monitoring. Since all such drugs target women, she has to bear the major burden of

this "liberalised" approach. The conventional sterilisation programmes being already largely women-oriented (96% tubertomy and 3.5% vasectomy in 1993), these changes, instead of moving towards a policy that would protect her, pushes her into further pain and suffering.

Incidentally,'right choice' is also being used by unscrupulous sections of the medical fraternity to promote certain pre-natal diagnostic test for foetal sex-determination. The Pre-Natal Diagnostic Techniqus (Regulation and Prevention of Misuse). Act to regulate this and ban sex determination tests (passed in 1994) is a weak one and not checking the trend, which would, through abortion of the female foetus, not only lead to serious demographic imbalance, but also jeopardise maternal health. Increase in female infanticide in some States has already affected the sex ratio adversely.

Finally, the government by failing to take up any of the positive recommendations of the Swaninathan Committee in 1994 exposed itself as being anti-woman and anti-poor. Instead it went ahead and introduced the 79th Constitutent Amendment Bill to the Parliament, whereby people having more than two children would be disqualified from contesting parliamentary elections believing in the policy of incentives and disincentives. Undoubtedly, disincentives and indirectly coercive tactics of this nature, far from empowering them precipitates pressure on women and the poorer sections.

MYTH: Women having multiple deliveries are an important cause in the high rate of maternal deaths in the South

FACT: This view is related to the one commented elsewhere in this issue but takes into account the particular problem of grand multiparity.[4] It is a well known fact that grand multiparity is linked with inflated maternal mortality figures in the South but to a very limited extent in the more affluent North. An illustration is the very low maternal mortality in the North also in cases of high parity. Studies in Nigeria had also shown that high maternal mortality is associated to high parity only if child mortality is high. This is a parallel to the finding in most countries of the North: what kills the mother is not the parity but the poverty.

Even if it is assumed a poor country with inflated maternal mortality in the high parity range, it can still be concluded, as have been shown in various computer simulation studies, that the elimination of all grand multiparty (_> parity 5) completely will mean a less than 5% reduction of maternal deaths. This and similar findings indicate the limited value of targeting grand multiparous women with sterilisation in order to reduce the overall maternal mortality. It must be underscored, however, that the vast majority grand multifarious women actually have an unmet need, perceived by them, for fertility control. This important maternal health aspect of grand multiparty is distinctly different from one blaming grand multiparity as a major "cause" of maternal mortality.

MYTH: ***Birth control also efficiently reduces the maternal mortality ratio.***

FACT: It is clear that zero fertility, will automatically mean zero material mortality. It is less clear what the impact is of fertility regulation in the reduction of the mortality ratio. The latter ratio is defined as the number of maternal deaths to 100,000 live births. In a Bangladesh study in the early 80s it was shown that the impact of fertility regulation was unexpectedly limited. Two villages were set up for comparison, in which one was subject to an intense fertility regulation drive whilst in the other no fertility regulation propaganda was made. In the first village, the fertility was reduced by 26% in relation to the non-fertility regulation village. Unexpectedly, the maternal mortality ratio was identical in the two villages. The explanation was that the intensive fertility regulation programme had not conveyed any increase in the safety at birth in the village. That is, those pregnancies being needed did not enjoy any better protection in the fertility regulation village than in the other village.

A conclusion is that fertility regulation, while reducing the actual number of pregnancies, did not achieve a better safety at birth or could even have been counterproductive to better safe mother.[4]

MYTH: ***Birth control, after all, was an important factor in the decline of maternal mortality in the North.***

FACT: In the North the maternal mortality ratio dropped considerably from levels of around 1000 to about 5 maternal deaths per 100,000 live births over a period of 300 years. Much of this decline occurred prior to any kind of modern contraception was available. A similar pattern has been found in other situations. Much more important a factor was the advent of midwifery, particularly in remote areas and the recognition of health and hygiene for the reduction of post-delivery infection. Still further was the availability of antibiotics and blood transfusions and when antenatal care and hospital deliveries were introduced for and utilised by >90% of pregnancies.

Fertility regulation has its own value, which is indisputable. Health-oriented provision of contraceptives in order to empower women (and men) to plan for optimal reproductive health and voluntary spacing of births do not need discussion. The controversial point is when birth control is claimed to be so efficient in the curbing of the inflated maternal mortality in the South that it is given priority ahead of a more comprehensive and efficient maternal and reproductive health care. Studies have since demonstrated conclusively that "efficient health-care is more effective than fertility regulation in preventing maternal deaths."

MYTH: ***By effectively addressing the unmet demand for contraception will result in significantly reducing population growth rates.***

FACT: Proponents of the family planning approach cite data showing that in many countries of the South almost half of all women of child-bearing age want no more children but (unfortunately) lack easy access to birth control. Fertility rates would drop by a third if this unmet need were met.

This argument entails a huge assumption: without transforming social reality – especially the powerlessness of women vis-à-vis men and the meagre access of the poor to food security and other resources – women will in fact be able to act on their stated desire for fewer children. But this begs this question whether many women indeed declare their preference for fewer children yet lack the power to act on their preference – even if the technical means of birth control were available?

In other words, to believe that the mere provision of contraception will suddenly allow women to step out of their subordinate role in the family, or alter the fact that children still represent a source of security for many parents in countries of the South, is to ignore the findings of decades of fertility-oriented research.[5]

Moreover, if unmet demand were truly as great as it is assumed, why have population planners had to and still resort to incentives and disincentives? In some cases, outright coercion has been deemed necessary to get people to accept birth control, suggesting that people must be made to set aside their own judgements, about their need for children!

As part of their single-minded effort to promote birth control a number of agencies, globally and nationally along with willing governments have not only sought to respond to existing contraceptive demand, but have actively worked to increase it. While some strategies are relatively innocuous – TV sit-coms promoting new family size norms — a wide variety of incentives and disincentives are used to induce people to undergo family planning measures or to use contraception

MYTH: ***Birth control directed towards 'high risk" women will also be particularly successful to reduce maternal mortality.***

FACT: Most maternal deaths occur among women with medium number of children in the family (parity 2-4) within the 20-35 age group. This fact is, however, often overlooked in the risk approach strategy for lowering of maternal mortality.[4] The consequence is that interventions in 'high risk" pregnancies will improve conditions in small groups of women and will have limited overall impact on maternal mortality. This conclusion is derived from various findings. A Bangladesh study (1968-70) was highly revealing. It was calculated that if all births had been averted in women i) below age 20, ii) above age 39 and iii) beyond parity 6, the maternal

MYTH: ***Islam does not permit family planning.***

FACT: The basis of this myth emanates from the logic that Islam values the family and encourages procreation. In support of this conclusion, two pieces of evidence are often cited viz., that the *Qur'an* prohibited Muslims from killing their children for fear of want. Second that the Prophet exhorted Muslims to multiply. However, this argument does not do justice to the complexity of the Islamic position and the totality of its teachings. Otherwise, it would be impossible to explain the established fact that the Prophet knew that some of his companions, including his cousin Ali, practised *al-'azl* (coitus interruptus) and yet he did not prohibit the practice.[6]

The bigger picture of the Islamic position on family planning is its departure point in encouraging the life principle. Hence, the Prophet's exhortation to multiply and the Qur'anic prohibition of infanticide, a wide-spread pre-Islamic practice involving born children which was motivated mostly by economic and gender considerations. But such a basic position does not necessitate the conclusion that contraception,or even abortion, is prohibited. Indeed, historically, the majority view among Muslim scholars on contraception has been that it is permissible with the wife's consent, though perhaps disliked in certain cases. The wife's consent is required because Islam recognises the wife's right to sexual enjoyment and procreation.

A leading proponent of this view is Imam al-Ghazali (d.1111) who also notes on contraception that there are no such prohibitions. In fact, the opposite is true. His analogical logic is startling in its simplicity. In one part of his argument, he notes that, despite the prophetic exhortation to multiply, it is nevertheless permissible for a Muslim to remain single. The effect of remaining single on multiplying, he reasoned, is no different than the effect of practising al-'azl. Since the one is permitted, it follows that the other, without more, is also permitted. He further argues that although contraception is permissible, it is '*makruh*' (adjective meaning "disliked or disfavoured") if practised to avoid, for example, female offspring. One major justification for this conclusion is that preference for male offspring is frowned upon in the '*Qur'an*'. Al-Ghazali, however, supports contraception for other reasons such as protecting a woman from the dangers of childbirth, avoiding poverty, and even preserving a woman's beauty.[6]

In the case of family planning through contraception, the wish to avoid poverty does not infringe on the right to life of a born human being. To the contrary, its goal is to preserve a dignified quality of life for those already born. On the other hand, using contraception to avoid having more females reflects a worldview and a value system antithetical to that of the Qur'an. It was thus '*makruh*' and discouraged by scholars like al-Ghazali.

Other jurists agreed with al-Ghazali's basic position on contraception but disagreed on what constitutes '*makruh*' behaviour. Such disagreement may very well have been founded in their disparate historical and cultural experiences. In other words, these are the kind of differences anticipated and tolerated by the principle, viz., that laws change with changes in time and place, and perhaps the other principles of '*ijtihad*'.

Concretely, according to the 1961 and 1981 census reports the number of Muslims in comparison to the total population of India during the last 20 years (1961-81) has risen from 10.7 per cent to 11.4 per cent i.e. 0.7 percent only. Additionally, during

the 1981-89 period Muslims accepted temporary methods of family planning that was enhanced by 11.4 per cent in comparison to previous period whereas Hindus for instance such increase was only 10 percent. Family welfare Operation Camps in various districts of West Bengal during 1980-94 showed that a large number of Muslim women were getting operated along with Hindu women. Most were from low-income families and the daily grind of maintaining 3-4 children were their main driving forces while adopting the permanent method.

MYTH: ***Artificial contraception is unethical and voluntary abortion may never be licit and it is against the teaching and doctrines of the Roman Catholic Church.***

FACT: In technical terms of Catholic moral theology, the moral permissibility of artificial contraception and voluntary abortion is a "solidly probable opinion", i.e., one that all Catholics may follow in good conscience. Contraception is not only licit but may often be morally mandatory.[7] Likewise, the choice of an abortion – a choice that, *ironically, becomes more necessary* when artificial contraception is banned – is a moral option for women in many circumstances. This is common teaching among Catholic and Protestant moral theologians.

In this context it must be noted that the problems of over-population, merely dumping condoms on them cannot solve the death of women from reproductive-related causes, but they will also not go away without condoms. Furthermore, as some experts and specialists have maintained, abortion has performed a crucial role in most countries that has moved from a high fertility rate to replacement levels rates[7] Artificial contraception and abortion are not the final or main solution to these problems, but they are essential options.

MYTH: ***The Roman Catholic Church's position to contraception and other artificial forms has no negative impact on efforts to provide reproductive health care services to women and the fight against the AIDS pandemic.***

FACT: The Roman Catholic Church under the aegis of the Vatican exerts enormous power and control to foil any efforts to provide reproductive health care services for especially poor women in the South and to stop AIDS.[8] To illustrate:

- In 1999, the Vatican released an official document stating that providing Catholic women who had been raped in Kosovo with emergency contraception was equivalent to promoting abortion. Previously, in reference to women in Bosnia, the pope went to the extent of stating that raped women should "accept the enemy" and make "flesh of their own flesh";[9]
- In 1996, in Nairobi, Kenya, where the AIDS epidemic exploded among young women, Cardinal Maurice Otunga, Kenya's leading R.C. church official, burned boxes of condoms and safe sexual literature. The same year, Kenyan Catholic Bishop John Njue had even propagated false scientific information by claiming that condoms are to blame for the spread of AIDS;
- In 1996, the local R.C. church in Tegucigalpa, Honduras prevented the distribution of one million condoms by health and election officials at polling stations during a primary election. Honduras has the highest incidence of AIDS in Central America;

mortality ratio would have declined from 570 to 430 per 1000.000 live births. Even with this extremely non-realistic achievement of virtually cutting off all births from recognised "risk" groups, a very limited gain in maternal mortality would have followed. In spite of the widespread belief that age and parity are exceptionally important in any strategy for the reduction of maternal deaths can be concluded that it is not the age/parity distribution of births that explains the lower material mortality in the rich North. Instead, most maternal deaths occur to women at low risk. This seemingly paradoxical point can be explained by the fact that available risk markers are not very efficient in predicting maternal death. For instance, there are no risk markers to predict death from abundant vaginal bleeding due to a non-contracting uterus, nor to death causeway post-delivery infection. But there is one albeit an inefficient risk marker for eclampsia, that is pre-eclampsia (high blood pressure associated with pregnancy). Still, it is known that a significant number of eclamiptic deaths appear quite unexpectedly like "out of the blue."

Learning the Population Jargon[5]

Crude Birth Rates: The crude birth rate, or CRB, literally measures the number of live births for every thousand women. The CRB refers to a country as a whole or to a particular subgroup within a country. "Crude" refers to the fact that it does not take into account the age structure of a population which greatly affects the number of births in any given year. For example, if two countries have the same number of people, but one has twice as many women of childbearing age, it will have a much higher crude birth rate. For this reason, the CBR is not directly comparable across countries, or even across time. It is often used by demographers when better measures are lacking.

Total Fertility Rates: This rate, or TFR, can be thought of as the average number of children that a woman will have over her reproductive lifetime. It is hypothetical in the sense that it does not represent the lifetime experience of any particular woman or group of women, but represent a composite measure. The TFR is calculated as the sum of birth rates specific to each age group of women and assumes that each cohort's fertility will hold during the lifetime of the "hypothetical woman"

Population Growth Rate: The population growth rate is the rate at which a particular population is growing each year. It is calculated relative to a base population size (say, the population size in the preceding year), and reflects the effects of births, deaths, and migration.

Replacement Level: A population that is at replacement level will exactly replace itself over the course of a generation with no growth and no decline. In the industrialised North, replacement level usually corresponds to a TFR of 2.1; in other words, each woman would bear two children, one to replace herself and the other to replace her mate (The additional .1 births is necessary to offset a small number of infant deaths and childless women). In the South, replacement levels are somewhat higher – about 2.5 – because of the higher infant death rates.

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

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