194-195-196 medico friend circle bulletin

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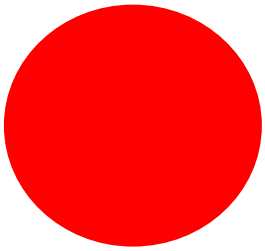

Editorial

The long overdue MFC bulletin is in your hands and I sincerely hope that the relief of seeing the bulletin will make you overlook the long wait. I, nevertheless, sincerely apologise for my contribution to the delay.

The next three issues of the MFC bulletin are being brought out as briefing documents for the MFC AnI1ual Meet to be held in Wardha from 12-15 January 1994, the theme of the Meet being Reproductive Health. As the articles we received covered a very wide variety of topics pertaining to reproductive health we have organised them, subject-wise, into three separate MFC issues. The forth coming issues of the MFC bulletin (following shortly!) will focus on reproductive health and reproductive technologies. The issues will include articles on specific contraceptive technologies as well as comments on clinical trials. Other important articles expressing views and concerns which don't find a place in-the 'population bomb explosion' propaganda, will also be featured. Besides giving you an insight into the various dimensions of population control politics, these three can serve as a basis for discussion at Wardha.

The articles in this issue cover various aspects of the global politics of population control. Several statements and declarations made by women's organizations have been included for information, analysis and discussion at the AnI1ual Meet.

The population issue is being given high priority by both the aid agencies as well as women's groups and health, groups, though each for very different reasons. Womens groups & health groups are deeply concerned by the issue for several reasons :

- It is primarily directed at Third World peoples and the poor, especially poor women, and therefore needs to be addressed not only as a women's issue but also as a health and development issue.
- Almost all multilateral and bilateral aid is being tied to population control.
- The prevailing shift from primary healthcare to a few selected programs which are heavily funded, e.g. AIDS and population control - thereby distorting national and local health priorities.
- The NGO sector is being actively wooed with funds to collaborate with the population control lobby.
- The increasing reliance on women-specific, provider controlled, potentially hazardous, long term contraceptive technologies is making any serious search for alternative measures to decrease the birth rate, that would simultaneously meet women's contraceptive and health needs, increasingly difficult.
- The population policy of India itself is being formulated. The possibility of ensuring integration of health services and contraceptive services will become much more unlikely later if integration and provision of comprehensive health services is not ensured now. .
- At the UN Conference on Population to be held in Cairo in September 1994, "Development" will be used to push through certain solutions to the demographic trap 'population problem', sometimes that are derived from reflecting a particular world view which chooses to ignore issues pertaining to over-consumption, unjust trade practices, increasing control of Third World resources by TNCs, denial of basic needs and rights of more and more people who are thereby forced to find their only source of social security in their children.
- If "Development is the best contraceptive," as was stated by Dr Karan Singh in Bucharest, the increasing impoverishment caused by the Structural Adjustment Programmes will undoubtedly result in increasing the birth rate.

We hope to see groups from the women's movement and the health movement join hands to work towards a Rational Health Policy in which women's health and reproductive needs are integral components, ensuring the availability of user-friendly, safe, effective and simple contraceptive technologies.

Mira Shiva

Are you Against Family Planning?

Mira

Sadgopal

Have you ever been asked this question? I have been-asked it, many times. It is often a person's first response when I begin to talk about Fertility Awareness Education. It has always caused me discomfort. I selected the topic of "population" for a paper' to present at the IAWS National Conference on Women's Studies held at Mysore University in June this year. This was an attempt to come to -grips with one of the stickiest, prickliest of topics today. The effort, I feel, has led me and some friends into a forward direction, and I would like to share this little bit of progress with you.

Let me try to organise what I have to say into sections:

1. the mindset behind population control
2. a total picture of development
3. the crisis of male identity
4. natural drop in people's fertility
5. democratic policy and health
6. current health-related initiatives
7. woman-controlled barrier contraception with fertility awareness (a proposal)

Much of what I am sharing is tentative and it needs discussion and more research. Also, I have not had time yet to understand the thoughts and calculations of some others, notably, Vasant Gowarikar's projections of lower than expected population growth rates.

1. The Mindset behind Population Control

There is a paradigm at work a set of values and a world view which assumes the inevitability of uprising and conflict. It spans the spheres two of production and reproduction.

As an exercise, let's try to freely associate about these two aspects of human activity. This is what happens when I do it:

SPHERE OF PRODUCTION: progress, rising profits, ascending graphs of GNP, stock market, inflation, exploitation of resources and labour, waste, pollution scam...

SPHERE OF REPRODUCTION: rising births, population exposition, people breeding like animals, exploitation of women's bodies, maternal mortality...

When I do this I realise that my thoughts are constrained within the dominant paradigm of modern western-oriented culture: Why is there always such a tendency to think in the upward direction, and then to find on self (and society) sliding downward? What is it about this verticality?

Such a worldview seems to be historically rooted in the European Industrial Revolution, although my friends point out that its' origins are earlier, with the European "Age of Reason" which led to a scientific revolution and an' age of mechanistic invention. Capitalist factory production arose and required exploitation of cheap human labour to keep the wheels of progress turning. Control over nature by the use of machines was intended to benefit human life, but some were more "equal" than others, and the mass of human beings got to be confused with nature, to be controlled and used.

It was this disturbed, miserable and struggling population, displaced forcibly from their agricultural peasant traditions, which Rev. Malthus considered as he wrote his Essay on the Principle of Population. His theory' fit into the interest and perception of the rising capitalist class. The poor were seen to lack brains and culture and to breed like animals. (In our Indian context we know that people's high birth rates always accompany high child mortality and signify that they are waging desperate struggles through women's bodies to survive and grasp control of life "in absence of secure food, employment, old age and other social buffers.)

Today at global level, the dominant paradigm behind production has caused so much damage to the environment, that people worldwide are forced to begin to think differently to save life on earth. The idea of sustainability is something we are getting used to by necessity. We find that for most cultures in the past and for tribal and indigenous people generally, sustainability is not new. It was and is integral to their views of life and the world, and in their activities of production which sustained the fertility of the soil and the regeneration of resources.

Likewise, with regard to reproduction, it appears" that in traditional populations there were (and still are) unconscious and conscious ways by which the fertility has been regulated. We know relatively little about this. However, certain archeological studies have unearthed evidence that ancient and tribal societies were to always plagued by high mortality believed up to now. In fact, longevity appears to have been common. If their population size did not "explode".

The dominant (or western) paradigm is vertical. It depends, in fact, upon domination and subordination. Exploitation, wast, conflict and oppression are inherent in it. Its basis is competition and its pinnacle is achievement. It supports mechanisation, militarism and "uniformity. It purports to be rational and scientific, and identifies these traits with man as opposed to women. It often equates woman with fickle and emotional nature, to be harnessed for mankind's benefit and pleasure. Valuing strength, it prefers to see women as weak and dependent. Hence, it is patriarchal.

In contrast, the alternative new-old paradigm of sustainability is, horizontal. Rather than dominating, it relies upon natural harmonies, interdependence is and' balances. Therefore, it is holistic rather than mechanistic. Participation and partnership is its basis rather than competition. Diversity is valued and respected, and creativity has space to grow. It appreciates the balance of male and the female qualities in human beings, and does not force people into strict roles. It values resilience more than rigid strength and intuition over cold logic. It values nature and does not see human beings as intrinsically separate from it. It is not patriarchal, nor is it matriarchal.

Some have observed that a paradigm shift must take place, and is perhaps taking place. Population Control Policy is an

area of established- belief where the dominant paradigm is barely shaken, and we are yet to see cl1ange. And there are many practical considerations.

2. **A Total Picture of Development**

According to a vertical paradigmatic framework, reproduction gets subjugated to production. Interestingly, in the socialist or Marxist feminist concept, this is depicted diagrammatically with the woman's sphere of reproduction at the base, with the male world of production above it, and with capitalism/ state at the top. One of the challenges of the paradigm shift is to be able to see production and reproduction in a horizontal relationship of balanced importance. Neither is production positioned superior to reproduction, nor any longer is the specter of reproduction overpowering production inevitable.

A horizontal paradigm of considering production and reproduction in equal and balanced relationship has two important implications:

(i) Activists for alternative 'development' can no longer consider sustainable production, as" in agriculture and water resources management, yet ignore sustainable reproduction.

(ii) Conscientious men will find it harder to dismiss reproduction as a "women's issue", and to avoid their full share of responsibility for fertility.

With reference to the contemporary debate on development, I find the new population control technologies especially NORPLANT and AFV (Anti Fertility Vaccine) are parallel and equivalent to Major Dam and Green revolution technology. They-are offspring of the same dominant paradigm which surely needs to be overturned.

Escalation of international population control strictures linked to economic structural adjustment in the NEP should be another strong clue to us that reproduction is a development issue.

3. **The Crisis of Male Identity**

So far we have talked of production and reproduction. Let's now consider politics, culture and religion. The growing menace of communalism, and indeed fascism, is generally perceived in terms of religious intolerance .and lack of political clarity or will, and the communalists are busy focussing on what they perceive as cultural revival. All of these avoid focussing on the uncomfortable but common underlying factor, it seems to me. This is the modern crisis of male identity. The crisis of male identity seems to parallel the crisis of development alluded to above.

Increasing violence is' the prime sign of this crisis. It takes multiple forms, like criminalisation of politics, rape, dowry deaths, female foeticide, religious fundamentalism, etc., etc., all of which victimize women. Unless men in general, beginning with our progressive friends and colleagues, face the question of their identity and begin to define something clear and positive for all to recognise, I am afraid the rising tide of Hindutvabranch fascism is going to take the cake and more.

The women's movement since the sixties was revolutionary for many, many women in defining a positive, diverse and creative identity and in achieving a sense reality and human purpose. In this, all of us women remember men who supported us and even taught us. Some of them are genuinely feminists, as much as any man can be. But do they never wonder what is there positively for them as men? Is it enough to be "progressive" and supporters of feminist values? These are sincere question of mine, and I hope they will get heartfelt response from some men.

We can predict that aspects of 'male liberation' or whatever it may be called will be more complicated and challenging than what women faced in the search for identity. Women fought (and fight) against oppression a male-structured society. Men will have to fight against the oppression of being pressed into oppressive roles and ways of thinking and acting which are inhumane. (I wonder whether I've put that right! Can I leave the job of improving it to a man who experiences it?)

4. Democratic Policy and Health

Several eminent writers, including Prof. Ashish Bose and Dr. N.H. Antia have argued that the Department of Family Welfare is redundant in the Ministry of Health. They argue logically that if there is health, there is automatically family welfare. I'm not sure if this is saying exactly the same as not needing a population policy, but let's leave that aside just now.

Dr. Bose gives a convincing critique of the family planning programme as well, highlighting its dependence on technology and numbers rather than a genuine concern for people and families, particularly women who bear the brunt of and blame for everything. He argues that, in addition to disbanding the Family Welfare Department, the most important policy step would be an across-the board programme of positive discrimination in favour of women in every sphere, be it education, law, health, or whatever.

Safe contraception should be part of comprehensive health care which is the right of every citizen. It is absurd that the Government should resist, as it does today, supplying woman-controlled barrier methods on the grounds that women will not be able to use them. Who is the Government to decide this?

Clearly there is a limit to Government policy and imagination. It is almost like flogging a dead horse, at times. The time has come for Indian women to take more initiative in solving problems from their own perspective, with their own abilities and with the support of the broad women's movement. And, after all, there is a saying that "if the people will lead, the leaders will follow."

Let us see what we know already about people managing to control their own fertility.

5. People Dropping their own Fertility Rates

Now, I don't know much about this, but I want to say enough to stimulate debate against the current. I have already mentioned traditional societies, whose fertility practices and patterns we need to study more. We also know that rural women depend heavily on breast-feeding to space their children (even though it is not failsafe), and that switching to bottle-feeding causes havoc for women without further contraceptive protection. More about that another time.

What I would like to begin to focus on here is the dropping fertility of several societies and parts of society during the last fifty years or so. Particularly interesting are the instances of lowered fertility when the population of

couples involved have used mainly withdrawal, abstinence, non-penetrative sex, and at the most a barrier method like the condom or diaphragm but who did not have either IUD insertion or sterilisation surgery. (Only one may have had access to oral contraceptives since the sixties) Again, I feel limited for lack of data. My two examples are anecdotal:

(i) **CUBA**: The source of this is Ms. Sonia Diaz, Ambassador to India for the Cuban Government, who visited Pune last year and spent an evening with women social workers and activists. Some of us were interested in knowing whether Cuba has a population policy. Without directly answering our question, she elaborated upon the changes in Cuba after the evolution in 1959, particularly those that significantly affected the status of women. These included education, guaranteed employment outside the home, child care support, comprehensive women's health services including contraception, and the right to divorce, etc. Since the country was formerly Catholic, being able to divorce was a big enough leap forward, but in addition, a woman could sue her husband for divorce if he refused to practice contraception!

But we still wanted to know if Cuba has "family planning?" She seemed to se what we wanted, but said she would like to tell us about her family. She was one of her parents' thirteen children. Her husband and she decided to have four, and her daughter, about to get married, says if she has a child she wants a girl. Now things have come to pass that Fidel Castro addresses the people on television imploring them to not stop having children as they are needed for the culture and economy. All this was without a singly day of a family planning campaign or population "control".

(ii) **THE INDIAN MIDDLE CLASS**: Ruminating over the above story, one of my friends said, why do we have to go so far? What about our own parent's their parents and ourselves? Many of our parents were able to stop at two or three children, and as far as we know, many of them never had recourse to IUDs or sterilisation. In fact, they often didn't even have barrier methods, we think. Shall we start delicately asking them what they had?

Some will say, well that is the middle class. What about the poor? I can only comment here that, 1) people should not be made to stay poor, and 2) in my own experience teaching fertility awareness starting with village people in Hoshangabad District of Madhya Pradesh, poor rural women were quicker to catch on to "listening" to and interpreting the language of their bodies than the middle-class, so-called educated women of the town. In fact, the poor women who had never been to school became teachers (with blackboard and chalk, mind you) of the town women. Middle class women today have the was disadvantage of being severely alienated from their bodies, placing more faith in doctors, stethoscopes, injections, ultrasound, etc.

The main thing that poor women say is, OK, many of us have learned to detect our ovulation and time of fertility, but not all of us can get our men to co-operate. They also need fertility awareness education! That, again is another important story.

6. **Current Health-Related Initiatives of Women**

As part of the women's liberation movement, women's groups in Government programme, in NGOs, in mass movement sand mass organisations, party-affiliated and non-party, are struggling for health rights and trying to build new alternatives for health care. From Madurai to Manipur, Arrakkonam to Ajmer, Dalli-Rajhara to Delhi, Goa to Gadchiroli, Tehri to Tirupati, women are taking steps to paint a new picture of health over the old background of exploitation, abuse and servitude. Many of these initiatives include anti-alcoholism struggles, targeting the liquor contractors and merchants who benefit, pulling men in line and pressurising the Government.

In the cities like Delhi, Calcutta, Madras and Bombay, with the spectre of AIDS growing, health activists working among sex workers (a new name replacing "prostitute") have enabled these women to convert their imposed self-image of being "highest risk" to "most at risk" from men infected with HIV and other STDs. With life and death at stake, and stereotypes to break, health care initiatives among sex workers in the major cities may well form a cutting edge of the new women's health movement in the coming decade.

On another front is the struggle against coercive Government population control policies and programmes, particularly against the pushing of "long-acting, invasive and systemic" contraceptive methods at the cost of women's health and undermine the functioning of the 'government health care system. Despite stiff resistance from women's groups, but with heavy international pressure and funding from population control agencies, the Government is going ahead with its programmes to launch NORPLANT (below-skin hormonal contraceptive implant) and AFV (anti-fertility vaccine) at mass level. At the same time expansion of facilities for IUD insertion and for the terminal method of laparoscopic sterilisation continues.

The serious job of sharing information about the body, fertility, reproduction and sexuality has been carried out by quite a few, especially since the eighties, and some god communicating materials have been produced. My favourite is the little red book Sharir ki-Jaankaari, Pahali Kitab Mae with the sathins in the Rajasthan Women's Development Programme by the Ajmer Mahila Samooh, and published by Kali for Women. Some of these field groups included fertility awareness education and monitoring as a special activity. Among these have been the Ajmer Samooh, Kishore Bharati where I myself worked, the Sabla Mahila Sangh associated with Action India in New Delhi, and now Sabla and Kranti's group of NGO sangham women from Andhra Pradesh who met currently for monthly self-help training at Hyderabad.

Over the last few years, a project called SHODHINI was conducted with the guidance of Rina Nissim of the Geneva Women's Health Clinic. The three-year all-India project brought together more than a dozen local groups of women health workers, mostly associated with different NGOs in various region's into an experiment of self-help/self-exam training and field validation of indigenous herbal and home remedies in women's ailments. They have made a beginning at training themselves to be "barefoot gynaecologists", as one member explained of the project explained to me.

7. **Woman Controlled Barrier Contraception with Fertility Awareness (and an Appeal)**

Slow to start but soon to accelerate is the initiative of women's organisations and networks to teach and monitor the use of barrier methods. These include the male condom, the diaphragm, the cervical cap, the vaginal sponge, and the female condom. Women-controlled barriers are often used in conjunction with spermicides, and are considered to be far safer than the long-acting

methods. They are temporary and can be used discriminate in conjunction with fertility against reproductive tract infections, including AIDS. This is not true of the longeracting invasive methods which may even predispose women to RTIs.

Particularly interesting are the barrier methods controlled by women (all the methods listed above except for the male condom). Since the Government has so far resisted including these methods in the family planning programme, women's organisations planning to start test-using them will have to have channels of supply opened up from elsewhere. The feasibility of indigenous manufacture may be looked into where appropriate. Some methods of monitoring use will be necessary.

Let me appeal to persons who are in a position to support this particular initiative with ideas, information, expertise and contacts. Shall we form group to support the effort? An organisation of women community health workers in Delhi, the Sabla Mahila Sangh, wants to acquire and test-use these methods soon and I have promised to help. I am confident that the response from other women's organisations will be enthusiastic if they come to know that women controlled barrier methods are becoming available. Would you also like to help? Do let me know right away, as much has to be decided.

Conclusion

The Conference at Cairo next summer will be a chance to contradict population control by presenting safe alternative birth control approaches developed with and by ordinary people and in control of' women. Let us do what we can to make best to the best of this most crucial opportunity to show results that matter.

Paper presented at the Seminar on Population Policy held at Tata Institute of Social Science held on 18th Sept. 1993.

Note: The author holds an Ashoka Fellowship (1992-95) for research and training in Fertility Awareness Education. She is a member of the Medico Friend Circle.

The paper referred to is *'Women, Fertility and Planetary Sustenance' presented at the Sixth National Conference on Women's Studies* (IAWS) *at Mysore University, June 1993.*

Population Growth and Food Production in the Third World

- Annual median population growth in non-developed countries. 1973-1984 2.6%
- Annual median growth in food production in non developed countries. 1971-1984 3.2%
- Annual median growth in agricultural production in non-developed countries. 1971-1984 3.0%

Needing Some Rethinking on Population Policy

Imrana Qadeer

The debate on population size and growth is old and has been enriched by thinkers of various hues. It originated between two opposing ideological perspectives on growth of population; first, considering it primarily natural phenomenon, and the second, an outcome of the social nature of human organisations. Both have contributed to knowledge in such a way that today almost everyone is agreed on some basic concepts.

Population in Theory

Population growth is no more seen as an independent variable affecting development. It is the outcome of a complex process of socio-political and economic interactions. It also affects development differently in different socio-economic conditions. History has demonstrated that high population growth rates are not necessarily associated with poverty. Population experts today are questioning theories based on assumptions like: economic performance and progress depend critically on resources per head; income per head is a measure of wellbeing; and that population forecasts for decades ahead can be reliable[1] In other words, the dominant concept of development as a purely economic entity is itself being questioned.

The focus of the debate thus has shifted' to the relative influence that population growth exerts in the process of development. Theoretically, population is no more the all-or-non-important factor in dealing with the problem of underdevelopment and poverty. It is said today that the rapid population growth in most times and places is a relatively minor factor in reducing per capita income. Even then population may be easier and "cheaper to manipulate" than other influences on development.

Global Practice and Politics

The crux of the matter then revolves around questions such as: What is the cost of Family Planning Programmes (FPP) and the way these costs are defined? Why these programmes are considered" cheaper" and for whom? Why the developed world is ready to transfer its reproductive control technologies but not its productive techniques? Why the less developed countries (LDCs) wish to have aid and access to markets but are not willing to alter some features of their social, legal and political organisations?

These issues are obviously political in nature. At different levels, different social configurations exist. The dominant sections of the Developed Countries (DCs) are not ready to see the links between the patterns of growth in the two halves of the world. Similarly, the elites of the LDCs resist change in their own social and legal structures, largely remain silent on issues of economic self reliance and on the artificial economic boundaries created by the developed nations and would have no hesitation in taking away the gains made by the poor in their own country.

In this prevailing political scenario, characterised by the self-interest of the dominant classes, mere recognition of the not-so-critical role played by population numbers remains only in the realm of theory. In practice, growing population of LDCs is seen to be a serious threat to the privileges acquired by Des. The former attempt to appease and to adjust invariably al the cost of their own less-privileged.

For the elite of both halves, then, population control becomes a key factor in their own development. Not necessarily because this is a panacea for poverty, but perhaps because it is the best way to contain the unmanage-able load on their conscience.

National Level Efforts

Historically, both control of numbers as well as women's health and rights have been inspiration for the contraceptive movement. India's FPP has focus on the control of numbers either explicitly or under the cover of family welfare. The mass camps of the late 60s and the forced sterilizations during the Emergency were the two points in history where it became openly and aggressively Malthusian. The consequences continued to affect the programme negatively for a long time while the strategies vacillated between genuine and not so genuine efforts at integrating FPP with developmental efforts.

An integrated package of Family Planning, Nutrition and Maternal and Child Health (MCH) was introduced by the Fifth Five Year Plan. This however, did little to improve the nutritional status or health of even the vulnerable groups. These services became appendages of the FPP and were used primarily to increase its acceptance. The stagnation of Infant Mortality Rate (IMR) and nutritional status over the seventies are evidence of this tragedy.

At the end of the Fifth Five Year Plan the problem was realised by the National Working Group on Population. It argued for an integrated approach which, by providing all basic services, created demand for family planning rather than using it as a bribe. The Group however was working within a set of political constraints and could not go beyond the limits of the Minimum Needs Program (MNP). The Group's strategies to help women also operated within the domain of the MNP and "maternal health". It left aside all other issues of women's health and at best pushed them into the unorganised sector without giving them any real assets.

Lessons from Practice

In the process of re-assessment over the 70s and the 80s, many lessons were learnt. A number of studies showed that acceptance of family planning was based on different levels of motivation. Each level, in turn, required different kinds of inputs.

For example, the high infant and child mortality rate was recognised as inhibiting the acceptance of the small family norms. The health of the mothers was understood to be critical in post-partum acceptance of contraception as well as in its regular use. Thus, at one level improvement in health services which could contribute to the reduction of the load of morbidity and mortality among women and children was seen as necessary. At another level, studies revealed a strong correlation between education and socio-economic status of women and acceptance of family planning, revealing the transforming potential of these inputs for participation in decision making. These help them to see beyond their reproductive roles, thus enhancing their acceptance of family planning.

At a third level, it was agreed that in a traditional agrarian society where the proportion of self-sufficient peasants is high, the need for family labour determines the basic family unit size which is generally higher. Only when the structure of agriculture changes and the self sufficient peassants units yield to rich farmers and landless labourers, is the labour demand sufficiently altered to affect the desired number of basic family size. This differential too was recognised.

In other words, decline in infant and child mortality through improved status of women and transformation of agrarian structure were accepted as some basic pre- requisites for family planning. These called for a reevaluation of the developmental strategies.

Experience if FPP thus showed that for the sake of population itself, it was necessary to deal with a complexity that went beyond reproductive technologies and demographic targets. A narrow vision led to a waste of resources and failures. It was also apparent that the political constraints did not permit interventions other than those that were' technological or managerial. Caught in its contradiction, the programme experimented with short-term narrow strategies over the 80s that often became self defeating. Some of these are discussed here.

Integration of FP Programme

The dismantling of single purpose institutions of family planning the Regional Family Planning Training Centre, the Urban Family Planning Bureaus and the Mobile District IUD Team -was followed by their integration with the General Health Services. However, family planning continued to receive singular priority.

The result was that now, instead of the FPP structure alone, the entire structure alone, the entire structure of the health services was geared to achieve the targets. It received a further bonanza when the 6th and the 7th Five-Year Plan went in for the expansion of rural infrastructural facilities. Expansion of health services was actually accompanied by a decline in the proportion of funds going to the main public health problem, i.e. communicable diseases. Even in the 8th Five-Year Plan, Rs.547.6 Crore and Rs.759.4 Crore were spent on Health and Family Planning in the year 1991-92. In 1992-93 these expenditures were Rs.560.3 Crore and Rs.1010.4 Crore respectively. The much acclaimed increase in the health budget reflected the heavy pouring of resources into AIDS control programmes for which the World Bank earmarked Rs.58 crores. Thus integration instead of leading to multiple services, become in fact, the means of exploitation of other programmes. The FPP snatched their resources and human power and enhanced its own drive for targets.

What this strategy failed to acknowledge was the fact that weaker public health services contributed to an increased load of morbidity and a concomitant fear of infant death. This by itself becomes a reason for non acceptance of family planning.

Revised Strategy for FP

Amidst an on going frenzy to meet family planning targets yet another shift in the strategy was announced in 1986. There was little 'new' in it except for a reiteration of objectives proposed by many previous committees of : increasing age of marriage, strengthening health services, improving child survival and safe motherhood programmes, inter-and intersectoral coordination improved management, relevant socioeconomic interventions, promoting population education and research in better contraceptives.

Of these, the maximum attention was paid to the promise of improved management. The bureaucrats and professional managers thus became the key figures in streamlining FPP. Child-spacing through the use of hormonal contraceptives and MCII Services became the mainstay of the new

strategy MCII was awarded the privilege of seeking targets while the relevant socio-economic intervention and health aspects of family planning got relegaged to the background. Women and children became the focus of technological interventions.

Focus on Children

Aspart of the integration drive of the Seventies the Intergrated Child Development Services (ICDC) Programme emerged in 1975 and attempted to provide nutritional, educational, medical and social services to the vulnerable. While the programme was still struggling with its own inner contradictions of double control, conflicts between Programme officers and medical Officers, inefficiency and inadequate coverage, the emphasis shifted. UNICEF's child survival strategy of 1983, despite a multi-pronged approach, became the basis for pushing a vertical immunisation programme. (An evaluation of this programme reveals that neither is there adequate data to epidemiologically justify the programme nor is there adequate coverage of children to justify the programme.

Again we see that even when the concern for child health was correct, first the child was treated in isolation from its family. Then choices were made for the family even in the kind of services the child was to receive. The justification of this choice remained technological feasibility rather than the real needs of the majority of children who became vehicle for the FPP.

Focus on Woman

Programme promoting women's welfare lagged behind as they got caught in the conflict between welfare and economic adjustment. The FPP's experiment with popularising vasectomies was brief. It soon revived its focus on women, excluded their ill-health and dealt with their reproductive capacity. The logic behind the approach is stated to be the greater extent of suffering-borne by women as a consequence of the frequent pregnancies and births. It is also argued that ill effects of currently introduced hormonal contraceptives (HCs) are likely to be much less than the negative impact of numerous pregnancies.

The HCs considered for extensive use are Depot medroxyprogesterone (DMPA), NET-EN and Norplant. Of these, currently, Norplant is the most favoured one and has been claimed as safe, reversible and long-acting. There are problems with these assumptions and they need to be examined.

Brushing aside side effects by saying that they are less problematic that they are less problematic the complications of pregnancy itself has some basic problems:

i) Assuming safety on the new HCs on basis that MMR is much higher than the possible mortality due to HCs is premature for two reasons:
Firstly, the limited data on HCs trial precludes a thorough understanding of the complications that may develop over time. Secondly such a comparison treats lightly the side effects reported by the trials.

ii) International trials of norplant report high prevalence of menstrual problems and the side effects such as headaches, skin reactions, weight gain, depression, mood changes and dizziness. These are labeled as minor problems. These side effects in fact, assume a serious dimension in the Indian context where women are known to have a high prevalence of conditions such as anaemia, where HCs are contra indicated. Norplant used on a large scale here may cause serious complications.

iii) The pre-introduction trials in 46 countries were conducted largely in the urban centres where side-effects could be tackled. In India, where emergency maternal care and follow up services are weak the implications are obvious.

iv) The limited data from India already indicates that the numbers of users experiencing complications is going to be high. 40 /per cent women under ICMR trials of norplant 2 discontinued its use after 36 months due to menstrual problems while 10 per sent women were lost to follow up. Once the trial was stopped, none of the 1466 worn under trial were followed up.

v) Anthropological data shows that the events that affect women's daily routines can seriously influence the acceptance patterns. This is particularly true of the menstrual disturbances which create special problems in carrying out her functions domestic, religious and social particularly in the LDCs where traditional social norms prevail. The so-called minor problems and all types of menstrual problems brought on by HCs can have far-reaching consequences for acceptance.

vi) The Population Council trails for developing the Norplant system used IUD users as controls. Problems like bleeding, rejection and infections are very high in the case of IUD. There fore, when in comparison to IUD, Norplant is projected as safe, it does not say very much.

Despite all these problems, the official experts have justified the use of norplant. Bleeding due to Norplant is said to pose no risk to health. "In fact implant reduces the risk of anaemia by overall reduction in blood loss". In other words, for Indian women it better to have amenorrhoea as a protection from anaemia and Norplant offers an advantage rather than a risk. It is also argued that in the LDCs, irrespective of the medical infrastructure, the women can take hormonal contraceptives (oral pills) as, 'For those few women for whom they are contraindicated, pregnancy or illegal abortion is even more dangerous.

This choice to "protect' some women at the cost of others may appear statistically rational but it neglects the fact that the vulnerable women will definitely have more complications. Their suffering can become a cause for rejection of HCs by other women in the community. This was the case when induced bleeding became the source of rumours and rejection of IUD in the villages.

The so-called protection of the majority from the dangers of pregnancy may actually be an added danger for women users who have poor access to the health services and higher prevalence of conditions in which HCs are contraindicated. Even the post-introduction trials of norplant in 100 medical colleges covering 20,000 women are not sufficient for they do not test HC in the rural setting where they are ultimately to be delivered.
These lesions could have been easily learnt from the experience of IUDs inclusion in the FPP. In 1965, IUD was provided on an extensive scale immediately after some pilot studies in urban centres and city populations. In the rural areas its acceptance declined within five years of introduction because of the serious nature of compilations and lack of infrastructure to take care of users.

Though the normal contraceptives are being pushed in the name of a woman's right to have more choices, it is clear that she has no role in the making of these choices. The funding agencies are call1ing the shots and setting directions of research. Thus while traditional and barrier methods-that contributed to the demographic transition in the West -have been neglected. HCs have been patronized. The Population Council has spent 20 million dollars to develop and introduce Norplant.
Women are thus denied the chance of using a really safe and user controlled contraceptive because research funds are diverted to find surer though not safer, contraceptives which are provider-controlled and which make women dependent.

Focus on Voluntary Sector

The latest strategy of Funding voluntary agencies to open operation theatres to provide sterilisation, IUD and spacing services is yet another attempt to avoid confronting the challenge of enhancing informed services choice, providing safe contraceptives and integrated services especially for rural areas and slums. By shifting responsibility this strategy raises a host of questions. Can the Government actually prevent diversion of these resources into private practice? Can the inadequacy of primary Health Centres be made up by opening sterilisation wards? Where will these resources come from? What is the logile of investing in independent institutions at the cost of PHC network? The Official documents are silent on these questions.

This review shows that only the initial failure of the FPP led to some efforts at integration in the early seventies. However, the primacy of this programme was never questioned. The post-emergency shock led to withdrawal, but very soon better techniques of forces were discovered to push for targets. Thus whatever the strategy choices the tactics of dangerous but more definite methods, inadequate information and tagging fertility control to a variety of health programmes became common and when nothing worked independent agencies are now being tapped to bail out the programme.

At one end of the socio-economic system lies the political imperative of the privilege which recognises the theoretical linkages between development and population but continues to push in practice at the level of technique. At the other end liles the growing need of the people for noninvasive, humane, and women- empowering methods of birth control. The equation of power between the two transforms force it is time we learnt from the experience of the past that for population control the issue is not of choices between the two approaches. There is only one way humane way to success.

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The Biases in Population Control Policies

Farida Akhter

The population control programmes carried out in different countries had been based on coercive methods like forced sterilisation of the poor, black immigrants, and other ethnic groups (especially women), targeting women for use of harmful contraceptives usually banned or rejected in the West, and making women an experimental ground for the development of newer methods of contraception. Women all over the world have protested against such forced population control programmes. They did not accept the dumping of harmful contraceptives and raised questions about the ethical issues of experimenting newer methods on women's bodies.
Although women's groups have been rejecting the coercive aspect of the population control programmes, many feminists did not take the time to question the basic ideological premise of these depopulating strategies. Many of them in fact believed that population needs to be 'controlled'. In the name to bring women's perspective into the programme they campaigned for less harmful and less hazardous programmes.
The viewpoints of these feminists have been incorporated into the programmes and many ideas of this school of thought have been accepted since the world population conference in 1974. In order to keep women in the centre of focus, the population control programmes adopted policies for women's development, maternal-child health, and maternal mortality campaigns. Through these programmes depopulating strategies gained a better image which was acceptable to many. It appeared much better to have a woman’s development programmes with a strong population control component rather than having only a sterilisation programme which scared people.

But the irony was that the basic acts of coercion remained the same even under women's development, MCH and maternal mortality-based population control. Intervention of the feminists for a good depopulating programme had shifted the main burden from men to women in a subtle manner without the realisation of these feminists. Women had to fake on the entire responsibility of population control on her shoulder.
The depopulating strategy was aimed solely at the 'reproductive machine' of women. The target is to make 'it' dysfunctional with 'modern' and 'improved' technologies. On the other hand she has been caught between the two claws of patriarchy: one in which the patriarchal social situation demands that she should bear children according to the will of the husbands; while the other, the state and the international population control agencies (male institutions) want her to stop childbearing. Since the targets of the population control programmes are the poor and the vulnerable people, the state and its sponsors win over the patriarchal but poor husbands.
The main aspect of the population control programmes is

the contraceptive prevalence rates; that is, in the statistics of how many women have taken the pill; how many are inserted with IUDs; how many have been sterilised; and how many were given injections. There are two methods offered for men, condom-and vasectomy. Statistics are also indicating the involvement of men through the adoption of these methods.

Among women's groups, discussions on reproductive technologies have started because women themselves demanded the reproductive technologies; in the past for birth control and presently, for the treatment of infertility. Reproductive technologies used for the control of fertility are called contraceptives; while those for infertility and other related technologies ate now knows as New Reproductive Technologies (NRTs). Undoubtedly, the demands for both contraceptives and for NRTs came from Western elite women. Unfortunately, reproductive technologies offered to the Western women in response to their demands have been received by the counterparts in the poorer countries under the population control programmes. The latter did not have to demand for it.

Western Feminist Views

Western feminist groups believing in reproductive technologies as a means to achieve reproductive rights are raising the demands of 'choice'. Choice means choice of contraceptives or NRTs which are presently offered by the pharmaceutical companies. In order to control reproduction, women demanded reproductive technologies and wanted an assurance on the availability of these technologies to them by profit making pharmaceutical houses.

A section of feminists having the concern for women's health and her lack of control over body are demanding access to services such as contraceptives. They are also demanding this for the poor women in the Third World and consciously supporting the depopulating strategy. They are against coercion associated with population control but they are suggesting a soft line approach which some of them recently termed a 'feminist population policy'.

Despite the known eugenic and racist basis of depopulating policies Western feminist movements almost always remain imprisoned in these ideas. To refresh the memory let us take a look at the history of the Western birth control movement and reflect on a few remarks of leaders like Margaret Sanger, founder of International Planned Parenthood Federation (IPPF), one of the leading international population control agencies.

Her famous dictum, 'more children from the fit, less from the unfit that is the chief issue of birth control', is clearly imbued with eugenic overtones. Margaret Sanger was initially affiliated with the socialist party in the United States. But she lacked a clear identification with working class demands for political power and control over production and therefore became more involved with non-class women's issues. In the second phase of her active life, when she was raising women's issues, Sanger came up openly for eugenic and racist principles. She and her associates set up the American Birth Control league (ABCL) in 1921. As early as 19.19 Sanger's birth control review published eugenicist arguments including the famous one mentioned above. She warned in her book The Pivot of Civilization, 'the illiterate degenerate masses might destroy our way of life'. By 1932, she was calling for the sterilisation or segregation by sex of 'the whole disgenic (those who are suspected of being producers of unfit offspring) population'.

The Western birth control movement demanding women's right was from its inception based on eugenic, racist and an anti-poor foundation. This foundation has never been effectively challenged. During the short progressive climate of the 19705 and 1980s there was silence among the women's movement on the explicit racist programme of population control. The cold was ideological struggles have also contributed to keep eugenic, racist and anti-poor ideas invisible among feminists. But it appears that in the post-cold world era fared differently. The slogan for a 'feminist population policy' hints at that danger.

It must be clear to us that women are not a homogeneous population and they never were. There are class and race differences among women and accordingly the historical differences reflect the ideological and political divisions in the international women's movement. We can observe distinct trends in the feminist movement with regard to the reproductive technologies.

Despite the eugenic racist and anti-poor basis of Sanger's birth control movement, the demand for the right of women to control fertility is definitely a progressive demand. It was raised against the patriarchal and repressive social relation where the reproduction of the children was exclusively controlled by patriarchal men. The historical progressive content of this demand soon collapsed on the very premise of patriarchy because the Western women's movement basically failed to link their demand for birth control right to the necessity of the final destruction of patriarchal society with all its associated forms of repression including racism, eugenicist bias and the class question.

The demand was raised at a time when feudalism had been definitely defeated and world capitalism with its imperialist ascendancy was gaining global ground. The agents of world capital, multinational companies and the business house soon co-opted the birth right demand to their profit. Pharmaceutical companies started to produce contraceptives for the women and decided exclusively the form of research and the kind of contraceptives to be used by women. So-called 'choice' has sold out to capitalist-patriarchy functioning on the world scale. Women demanded 'choice', but choice now lies with the multinational pharmaceutical companies, population controllers and the state.

Rights Undermined

With regard to the right of women over her reproductive function the demand was raised as an 'individual' right, not as a social right. That means 'the reproduction of the human species will have to be left to the 'individual' decision of self-centred women with a middle class, selfish world view. Capitalist-patriarchy can leave an individual space for women without fundamentally changing its nature.

It will also become an individual right of women to sell her body for surrogate motherhood. Women's organs could be sold and bought in the commercial market as long as her right over the property of her body is recognised. Indeed, the reproductive rights movement can only rearrange the existing capitalist-patriarchal order in a form suitable to itself, not for women.

On the other hand, it is a fragmentary and self defeating slogan, because women must demand the right not only for her body, but in every sphere of human existence: the earth, the forests, and the sky, in fact the whole universe. That brings us to the whole issue of ecology and the environment. The rights must also be established in both the econom1c and political spheres, in private and the public. Raising demands only for reproductive right excludes all other spheres, allowing capitalist-patriarchy to reign supreme.

The development of reproductive technologies therefore has this contradictory historical background. The contraceptives were first developed not only for the population controllers but also to meet the demands raised by Western women for birth control and reproductive rights. They needed devices and methods to control their own fertility.

Therefore the companies found a good market in the uterus of the women. Soon women realised that the cry for birth control only reached the pharmaceutical companies and not the society in general. It did not give the power to the women to protect themselves from the hazards.

These methods were then made available to the women in the Third World without even them demanding for it under population control programmes. Owing to the availability of the methods for women, women could become the 'target' of these programmes. They became the victims of the side effects of all the methods imported from the Western countries which did not suit their bodies. They had no 'choice'. The governments of these countries receiving foreign aid have to carry out such programmes. While contraceptives are dealing with fertility 'problems', the advancement in reproductive technologies then dealt with another aspect of the problem, the infertility among women in the developed countries and the possibilities of having a disabled child. The reasons for infertility and the possibility of having malformed babies are various including the use of pesticides and chemical fertilisers in food production, environmental pollution by the nuclear plants, etc. Instead of creating a healthy environment, the technologies were developed to treat infertility and to screen the malformed foetus.
With the advent of technologically assisted surrogacy, that is egg donation from one woman to another, the definition of 'mother' has been undermined, post-menopausal women in their fifties can now give birth, and we are close to the day when foetuses can become 'mothers' by removing immature eggs from the developing ovaries and maturing them in the lab!

The shift in the depopulating strategy is now clearly towards ecology and the environment. The poor of the Third World like Bangladesh is now being blamed for the destruction of the environment. The external argument used to justify the elimination of a section of the world population cannot hide the eugenic, racist and anti-poor premise of a historic trend which is becoming stronger.

The irony is that we cannot save our environment and be developed without destroying the regenerative capacity of Nature unless we can defeat this trend. Modem civilization is based on exploitation and the destruction of Nature for the consumption of a definite class: and nature is a external thing to be exploited by this class. The reproductive power of women is similarly seen as a 'natural power' to be exploited for benefit. The position of women and nature is similar in this respect.

The women's movement is there fore inherently linked with ecological and environmental concerns in the sense that the regenerative and life producing principles should be freed from the capitalist-patriarchal greed of the existing world order.

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Population Control in the New World Order

Betsy Hartmann

I believe strongly in women's right to have access to safe, voluntary birth control and abortion and who is deeply concerned about attacks on that right by the Vatican and other conservative forces. However, I am equally concerned about the ways population control programs can violate basic human rights and can be a form of violence against women. It is that issue which I will address here.

The Intensification of Population Control

In the so-called New World Order, the Cold War obsession with military expenditures is giving way to other means of social control. Population control ideology is being refurbished, polished with a feminist and environmentalist gloss, and marketed with the latest in mass communication techniques.

Thus, in the 1990's we are witnessing an intensification of population control efforts in both South and North.

In the South the main mechanisms of population control are:

1. Structural adjustment. Government commitment to reduce population growth is often a condition of IMF and World Bank structural adjustment loans. This is most recently the case in India, where government expenditure on population control is slated to increase and, international agencies are accelerating their efforts in the wake of an IMF agreement.
2. Targeting population assistance at countries with the largest population sizes. The U.S. Agency for International Development (USAID) is planning to double its aid to 17 so-called 'big countries' (India, Indonesia, Brazil, etc.) in a move hailed as "bringing a demographic rationale back into the program"
3. Rapid introduction of long-acting, provider-dependent contraceptive technologies, such as Norplant and possibly the new contraceptive vaccine, in health systems which are ill-equipped to distribute term safely or ethically. In addition to targeting women and minimizing user control, these technologies, unlike

barrier methods, do nothing to protect women from sexually transmitted diseases, notably' *HW*. They perpetuate the notion that contraception is a woman's responsibility, furthering the neglect of male methods such as the condom and vasectomy.

4. Renewed pressure on governments to remove prescription requirements and dispense with basic medical standards for hormonal Contraceptives. For example, in a leaked letter from USAID to the International Planned Parenthood Federation, USAID criticized "medical barriers" to providing hormonal contraceptives such as "excessive physical exams (e.g., pelvic and breast)" and "holding the oral contraceptive 'hostage' to other reproductive medical care (e.g. pap smears and SID tests).. With respect to contra-indications," the letter continues, "we prefer not to even use the term" since it "May have very negative connotations and a major inhibitory effect."
5. Mass marketing, both of contraceptive brands and neo-Malthusian messages, through social marketing programs and U.S. financing of Southern popular performers, radio and. TV shows, and media networks through the 'Enter-Educate' project at Johns Hopkins University. This neatly converges with the interests of pharmaceutical companies.
6. Continued data collection and analysis designed to persuade Southern officials of the need for population control. This ranges from the highly simplistic computer graphics and presentations of the RAPID project of the U.S.-funded Futures Group to the 'gray cover' reports of the World Bank.

Meanwhile, in the North, .intensification takes these forms:

1. Expensive and sophisticated lobbying and propaganda efforts by population agencies trying to increase aid allocations for population control. European governments and parliamentarians have become a new focus of these efforts. European women's health activists report that their governments' aid agencies are under pressure to change their relatively progressive stances on population to ones more in keeping with the UNFPA and World Bank agenda.
2. Alliance building between population agencies and mainstream environmental organizations, which accelerated in advance of UNCED. "Because of its pervasive and detrimental impact in the global ecological systems, population growth threatens to overwhelm any possible gains made in improving living conditions," reads a recent 'Priority Statement on Population' signed by many U.s. population and environmental groups. Such messages put out through the media and local activist networks, fuel racist fears of Southern peoples and communities of color within the North. Images of the population bomb and explosion are back in vogue; dark-skinned babies are portrayed as "mouth to feed", and rarely as potentially productive human being.
3. Immigration restrictions. In the U.S and Europe immigrants are viewed as a threat to the economy, white dominance, and even to the environment.
4. Coercive population control of poor women, especially women of color. In the U.s., at the same time that abortion rights are being seriously eroded, state legislatures are considering proposals to give cash incentives to women on welfare to use Norplant; courts in California and Texas have ordered women to accept Norplant as a condition of probation. An editorial in the Philadelphia Inquirer, a prominent U.S. newspaper, suggested that Norplant should be used as "a tool to fight against black poverty" and "reduce the under-class."

The language in this editorial was so openly racist, misogynous and anti poor that the newspaper was ultimately forced to apologize. Often, however, the language of population control is more subtle and seductive, a kind of Orwellian doublespeak which plays on people's genuine concerns about the status of women and the environment. On the positive side, this language sometimes represents a genuine change in thinking; on the negative side it coopts and obscures. To avoid that pitfall, I believe feminists and progressive must constantly expose the contradictions of population doublespeak and clearly articulate our own meanings so they cannot be turned against us.

Population

Doublespeak

First in the doublespeak lexicon is the concept of choice. The difficulty with this term is that opponents of abortion and 'artificial contraception have made anyone who supports access to them appear to be pro-choice. Thus, population agencies claim that they are expanding women's reproductive choices by developing and promoting new contraceptive technologies that are available, the logic goes the more choices for women.

Perhaps the greatest master of this particular language is the Population Council, which developed Norplant and which is now promoting its use in countries with large top-down population control bureaucracies, such as Indonesia and India. With input from women's health activists, the Population Council has developed nice-sounding guidelines for Norplant providers regarding informed consent, respecting women's request for removal in demand, etc.

Yet the fact is that such guidelines are essentially meaningless in demographically-driven family planning programs where women's needs have never been adequately respected. Examples abound of women being refused Norplant removal on demand as well as being denied adequate information and health back up. Is it technocratic hubris, political naiveté, disingenuousness, or a combination of all three, which make population agencies so intent on promoting Norplant in systems where 'choice' is last in the list of priorities and population control first?

Interestingly, one of the population establishment's new strategies is to involve women's groups and health advocates in the introduction and monitoring of Norplant and other new technologies. Referring to a series of such meetings in India, an activist writes that although they were ostensibly designed to open up a dialogue, their main purpose was "to divine (women's) arguments, appropriate their language and finally exhaust them."

Although dialogues can at times be useful, women's groups must insist on their own terms as a precondition for

participating. In particular, this must include the right to make dissenting reports, which are published, unedited, in the official reports of the population agencies concerned.

And then there is the larger question: Don't women's groups have more pressing work to do than to monitor the introduction of easily abusive technologies in already abusive systems?

Shouldn't the focus be on changing the systems themselves?

Contraceptive vaccines, which immunize women against a hormone produced early in a pregnancy, are likely to prove even more medically and ethically problematic than Norplant. Although an Indian vaccine, developed by G.P. Talwar with support from the Population Council, the Canadian IORC and the Indian government, has been tested on only 180 women, it is being billed by the Family Planning Association of India as "safe, 'devoid of any side effects and completely reversible". Even the scientific community knows that such assertions are patently false - for instance, many questions still remain about the vaccine's long-term impact in the immune system and menstrual cycle. There is also documentary footage of women being denied information about the vaccine in clinic trials. Nevertheless, the Indian vaccine is being prepared for large-social use.

Meanwhile, the Human Reproduction Program of the World Health Organization is also testing its own contraceptive vaccine. At a 1989 WHO symposium on the vaccine, the chairperson summarized the debate:

Foremost in my mind during these discussions was our difficulty in assessing urgency of the demographic crisis. To the extent that the impact of that crisis increases, the need for more effective family planning methods must increase. At the very least, failure to develop something that might provide a more effective technology would be' to take a grave and unnecessary risk.

What about the grave and unnecessary risks taken with women's health? Genuine choice entails real power, not being on the receiving end of a system designed to control your body as a means of controlling world population growth.

Another key term in population doublespeak is improving women's status. Even the most die-hard Malthusian are for it, providing of course it doesn't upset the global race and class status quo. Female literacy, after all, is closely correlated with lower birth rates - educated women use family planning more effectively.

While trumpeting their commitment to raising women's status, many.., the same people who bring us population control are bringing us structural adjustment programs, slashing health and education budgets, laying off workers, raising food prices and occasionally casting a few moth-eaten World Bank safety nets to catch the poorest of the poor. The result is disastrous for women and children's health. The solution? Family planning programs.

Miraculously, family planning will somehow lift women from their sorry status in the absence of any meaningful social and economic change. In fact, why not spend even more of the health budget on family planning? And by no means, in the words of the Population Crisis Committee, should organizations such as USAID "diffuse or weaken" family planning "by shifting to a broad reproductive health or maternal and child health orientation.

Ironically, despite their zeal to reduce birth rates, the population controllers leave many of the determinants of high fertility in place: the need for children as a source of labor and security, high infant mortality, limited economic opportunity for the poor. In the New World Order, even the saying "Development is the best contraceptive" has an old-fashioned revolutionary ring, like basic needs, equality and human rights.

There is yet another constellation of doublespeak terms, the environment, for example. Preserving the environment is the latest ideological rationale for population control, even though the major causes of global environmental degradation lie elsewhere, with inequitable economic systems, corporate agriculture and logging, military and industrial toxic wastes, and inappropriate technology. Why are the rich always missing from the neo-Malthusian picture of the environment? Are they so invisible?

And then there's sustainability, a word so easily manipulated that Dr. Maurice King can write in The Lancet that where there is unsustainable population pressure on the environment, public health systems shouldn't orally rehydrate poor babies suffering from diarrhea. He calls his 'let them die' strategy "Health in a Sustainable Ecosystem." And The Lancet's response? No indictment, but rather an editorial entitled "Nothing is unthinkable". I would like to expand the definition of sustainability to include moral sustainability. Dr. King's Malthusian ecofascism is morally unsustainable. So are theories which claim AIDS is a good thing since it reduces population pressure on the environment. These views exceed the earth's carrying capacity for racism and injustice.

I would like to conclude with another slippery term: consensus. This is a favorite word of the United Nations Fund for Population Activities, which is proud of the way it has forged an international consensus around the need for population programs. But whose consensus is it? I am not part of the grand UNFP A consensus.

Yes, women and men need access to safe birth control including abortion. But when family planning is designed and implemented as a tool of population control, it undermines health systems, targets women, fosters abuse, and perpetuates the 'technical fix' mentality which has distorted contraceptive research and development, leading to the systematic neglect of barrier and male methods and a lack of concern for health and safety. This is not to negate the need for contraceptive research, but present priorities must change and women must have control over the technological process before research truly expands reproductive 'choices'. Within family planning programs, efforts at reform by improving 'quality of care' are a step forward, but for the poor there is not likely to be real quality of care until there is better quality of life.

In the end, blaming poverty and environmental degradation on population growth obscures the real causes of the current global crises: the control of resources - economic, political, and environmental - in the hands of an ever more tightly linked international elite.

Two centuries ago Thomas Malthus put forward this analysis:

"... The principal and most permanent cause of poverty has little or no direct relation of forms of government, or the unequal division of property; and that, as the rich do not in reality possess the power of finding employment and

maintenance for the poor, the poor cannot, in the nature of things, possess the right to demand them; are important truths flowing from the principle of population..

In the New World Order the essence of population control remains this simple political imperative.

Behind the Population Debate

Evelyne Hong

In recent years a sinister argument for population control has been touted which defines Third World population growth as a threat to US national security and that 'draconian measures' must be taken to stop Third World population growth.

According to Hassan Ahmad and Joseph Brewda in their study this is found in a military strategy document released in 1988 during the Reagan-Bush administration. Although the section of the document which deals with the demographic threat is still classified, a summary of its contents appeared in the spring 1989 issue of the Washington !Quarterly, the organ of Washington-based Center for Strategic and International Studies, under the title 'Global Demographic Trends to the Year 2010: Implications for US Security'.

In a National Security Council memorandum authored by Henry Kissinger in 1974 entitled Implications of Worldwide Population Growth for US Security and Overseas Interests', 13 Third World countries were specially targeted by the US. They are India, Bangladesh, Pakistan, Nigeria, Mexico, Indonesia, Brazil, the Philippines, Thailand, Egypt, Turkey, Ethiopia and Colombia.

This document also goes as far as to express the hope that AIDS may be a possible remedy to the Third World population threat. The document states: "The WHO estimates that 5-10 million people are infected with the virus worldwide, a count that could reach as high as 100 million by 1991. Some analysts argue that if 100 million people were infected, total deaths from AIDS in the 1990s could be 50 million. The number of infected then could double several more times after that and wipe out some countries in 10 to 20 years. If the number of infected increased to 20% of the world's population, the delayed deaths could begin to cancel global population growth."

Exhorting policy makers,' the document further says. They must employ all the instruments of statecraft at their disposal, development assistance and population planning every bit as much as new weapons systems.

A new war of genocide is being waged on the Third World as the population crisis is linked to US security.

This assault on Third World peoples by the US has been extended to include the- UN as well, thanks to US influence. Early this year both the UNDP and the UNFP A have stated that population control in the Third World will be a top priority.

According to the UNFP A report *The State of the World Population 1991* sterilisation has made significant in roads in the Third World and the largest number of sterilisation users - 152 million - are in Asia and the Pacific. In Panama and Puerto Rico, 80% of child-bearing women could be sterilised in the near future. Other methods of growing importance include injectables and some of the more recently introduced methods. The number of women using contraceptive implants (like Norplant) expected to increase from one million presently to over 17 million in the next decade."

There is yet another emerging population agenda that argues that one has to be cruel to be kind. Within this mind set, population pressure is leading to an environmental crisis. So to protect the health of planet earth the poor and the weak in the Third World should be left to die to save them from a bleak future and a life worse than death, - thus lowering the birth rate.

Of course population control must be carried out vigorously but other merciful methods like the withdrawal of oral rehydration and immunisation for Third World children should be implemented to attain health in a sustainable-ecosystem for the year 2000.

Underlying these arguments is the belief that the Third World needs to be controlled and put in its place so that the North can continue to gain access to its resources.

The Third World needs to be controlled because it poses a threat to Western industrial civilization. In the age of scarce resources if every citizen in India or China wants to own a fridge, two cars and a flush toilet, the North will not be able to continue to maintain its way of life.

The basis for this triage-like thinking is the belief that Third World peoples are less than human and therefore dispensable. This view of Third World peoples has been perpetuated for the last 500 years when the first genocidal practices were perpetrated on Third World peoples. These prevailing ideologies on population control are thus racist, fascistic and antihuman.

Population control is a key issue on the North's agenda for the Third World. In this new offensive to control the Third World, the women are the primary targets for more coercive methods of population control, dangerous and life threatening technologies and unethical experiments. As sterilisation measures and long acting contraceptives (Norplant) gain increasing currency with the population controllers, women lose whatever measure of control they may have had. Over their fertility whilst the population controllers become the final arbiters of women's well being

This is an excerpt from an article which appeared in Third World Resurgence No. 16, Dec. 1991.

Reproduced below some of the Statements and declarations brought out by Women's organisations

STATEMENT NO.1

People's Perspectives on "Population"

(Preparation for World Population Conference, 1994)

The next World Population Conference is going to be held in Egypt in the year 1994. In the past world Population Conferences, (1974 and 1984) the rich countries of the world and the international donor agencies took comprehensive plans to control the number of "undesired" people of the world. The United Nations Funds for Population Activities (UNFP A) has been actively supporting such racist and anti-poor activities of the dominating countries of the world. In each of the past world population conferences, the population growth in the developing countries was put forward as a problem and various actions were proposed. In any case, population remained as a "problem" even with more and more intensive population control programmes exercised in the developing countries. In the past the argument for population control was put forward to achieve" development". This time, a new agenda has been added that is "environment". Now population has to be controlled for the sake of saving environment.

At the Earth Summit '92 held in Rio de Janeiro, Brazil, there was a lot of discussion on population. The countries of the North in the face of attack from the South about their over consumption counteracted by blaming the population in the South as the main cause of environmental degradation. However the attempt was not much successful because of the false and weak basis of the arguments. In the Earth Summit population could not be established as the main culprit. Just two years after the Earth Summit is the next International Conference on Population '94, which is going to address the triad of rapid population growth" increasing environmental degradation and pervasive poverty. We will have to organize ourselves to actively oppose, discard and resist any attempt to bring back the racist, anti-poor and imperialist ideologies, policies and programme at the centre of the policy dialogue and negotiations. .On the other hand we will have to redefine the paradigm and reconstitute the terms of the discourse from a perspective that can truly reveal the processes of pauperization and environmental degradation propelled by the dynamics of global economic systems. The world economic system is dominated by the corporate power in alliance with militarized State and global institutions of money or finance. In addition, capitalist economy, functioning at the world scale has been reinforcing as well as constantly restructuring patriarchy to fit its logic of expansion and accumulation. We believe that to organize our acts together we need to draw experiences from the struggle of women around the world and of all the oppressed classes and nations including the indigenous people. It is a struggle to change the world for all of us to live and prosper in a system of interrelated but diversified global communities. The population issue must addressed from this vantage point of people's struggle.

Few of us who were present in the Rio conference and Global Forum discussed among ourselves the need to develop a strong opposition to the population control policies practiced in different countries of the world.

Discussion with others. In October, 1992 we held a small planning meeting. The following points were noted as the guiding principles for the various activities planned:

a. No to population control
b. Avoid using the terms and phrases impregnated with population control ideologies, discourse and policies.
c. Clearly reveal that the population control is racist, sexist, imperialist and clearly aims at eliminating the poor b, their number. In practice the population control programmes are targeting women and the poor.
d. Family planning non-patriarchal relation between the couples to decide collectively to have or not to have children in a specific life situation can not be equated with population control. Consequently population control programmes should not be allowed to hide its racist, anti-poor and anti-women face behind the mask of "family planning". Countries which have an officially declared population control policy cannot/do not have a family planning programme.
e. Science and technology are not neutral. They are produced by capitalist-patriarchy to reinforce and reproduce capitalist patriarchal relation. Moreover, in most cases they are the products of military industrial civilization of the North, which is the major threat for all the population of the world forcing the communities to make it the main focus of their struggle. Resistance of people against so called science and technology is often termed as "anti-technological" or "anti-science" by the protagonists of capitalist-patriarchy racist establishments and the military-industrial civilization. Resistance and critique of this science and technology is imperative to liberate the wisdom and the art of ordering Nature to set up the new principles of Science and Technology for a liberated world. So far an array of destructive technologies has been produced and marketed in the name of containing population explosion. For example so called "green revolution" technologies, biotechnology and genetic engineering, etc. The evolution of unsafe and coercive reproductive technologies should be seen in link with all such developments.
f. Safe and people-controlled (women-controlled) contraceptive methods should be searched and conditions should be created through movements for proper research and development free of the control of multinational corporations and populations controllers.

The main activities to be undertaken include:

1. Research and documentation: e.g. collection of information on the previous world population conferences (1974 and 1984) information on countries with pro-natalist policies, immigration policies of the northern developed countries, role of international agencies and their policies, pharmaceutical industries, information on countries with decline in fertility rate etc.

2. To prepare country reports, specially for the countries with declared government population control policies.

3. Publication of a book with articles on crucial issues concerning population control ideology, policy and the programmes.

4. Holding an international symposium towards the end of 1993. The title of the symposium is "Whose Population? Whose survival? Critical Perspectives on International Population Policies".

The, participants will be from different regions and communities of the world - those who are actively involved" in the issue of resisting population control and are working on women's health issues.

The Symposium will be held at Comilla, Bangladesh, from 12-15 of December, 1993.

The organising committee for the Symposium:

UBINIG
Research Foundation
People's Health Network

Third World Network The objectives of the symposium are :

1. To create awareness about the existing coercive and anti-people population control programme.

2. To create pressure groups nationally, regionally and internationally to influence the policy makers

3. To highlight critical perspective on population issue to be presented at World Population Conference; 1994

UBINIG will act as the secretariat for the international symposium. For more information please contact them at :

5/3 Barabo Mahanpur
Ring Road, Dhaymoli Dhaka 1207
Bangladesh
Tel: 811465, 329620, 816420
Fax: 880-2-813065

STATEMENT NO.2 **"Women's Voices '94**

Women's Declaration on Population Policies

(In preparation for the 1994 *International Conference on Population and Development)*

Preamble

Just, humane and effective development, policies based on principles of social justice promote the well-being of all people. Population policies, designed and implemented under this objective, need to address a wide range of conditions that affect the reproductive health and rights of women and men. These include unequal distribution of material and social resources among individuals and groups, based on gender age, race, religion, social class, rural-urban residence, nationality and other social criteria; changing patterns of sexual and family relationships; political and economic policies that restrict girls' and women's access to health services and methods of fertility regulation; and ideologies, laws and practices that deny women's basic human rights.

While there is considerable regional and national diversity, each of these conditions reflects not only biological differences between males and females, but also discrimination against girls and women, and power imbalances between women and men. Each of these conditions affects, and is affected by, the ability and willingness of governments to ensure health and education, to generate employment, and to protect basic human rights for all. Governments' ability and willingness are currently jeopardized by the global economic crisis, structural adjustment programs, and trends towards privatization, among other factors.

To assure the well-being of all people, and especially of women, population policies and programs must be framed within and implemented as a part of broader development strategies that will redress the unequal distribution of resources and power between and within countries, between racial and ethnic groups, and between women and men.

Population policies and programs of most countries and international agencies have been driven more by demographic goals than by quality of life goals. Population size and growth have often been blamed inappropriately as the exclusive or primary causes of problems such as global environmental degradation and poverty. Fertility control programs have prevailed as solutions when poverty and inequity are root causes that need to be addressed. Population policies and programs have typically targeted low income countries and groups often reflecting racial and class biases.

Women's fertility has been the primary object of both pro-natalist and anti-natalist population policies. Women's behaviour rather than men's has been the focus of attention. Women have been expected to carry most of the responsibility and risks of birth control, but have been largely excluded from decision-making in personal relationships as well as in public policy. Sexuality and gender-based power inequities have been largely ignored, and sometimes even strengthened, by population and family planning programs.

As women involved directly in the organization of services, research and advocacy, we focus this declaration on women's reproductive health and rights. We call for a fundamental revision in the design, structure and implementation of population policies, to foster the empowerment and well-being of all women. Women's empowerment is legitimate and critically important in its own right, not merely as a means to address population issues. Population policies that are responsive to women's needs and rights must be grounded in the following internationally accepted, but too often ignored, ethical principles.

Fundamental Ethical Principles

1. Women can and do make responsible decisions for themselves, their families, their communities, and, increasingly, for the state of the world. Women must be subjects, not objects, of any development policy, and especially of population policies.

2. Women have the right to determine when, whether, why, with whom, and how to express their sexuality. Population policies must be based on the principle of

respect for the sexual and bodily integrity of girls and women.

3. Women have the individual right and the 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 social conditions have a right to information and services necessary to exercise their reproductive rights and responsibilities.

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

5. Sexual and social relationships between women and men must be governed by principles of equity, non-coercion, and mutual respect and responsibility. Violence against girls and women, their subjugation or exploitation, and other harmful practices such as genital mutilation or unnecessary medical procedures, violate basic human rights. Such practices also impede effective, health and rights oriented population programs.

6. The fundamental sexual and reproductive rights of women cannot be subordinated, against a woman's will, to the interests of partners, family members, ethnic groups, religious institutions, health providers, researchers, policy makers, the state or any other actors.

7. Women committed to promoting women's reproductive health and rights, and linked to the women to be served, must be included as police makers and program implementers in all aspects of decision-making including definition of ethical standards, technology development and distribution, services, and information dissemination.

Minimum Program Requirements

In the design and implementation of population policies and programs, policy makers in international and national agencies should:

1. Seek to reduce and eliminate pervasive inequalities in all aspects of sexual, social and economic life by:

- providing universal access to information, education and discussion on sexuality in gender roles, reproduction and birth control, in school and outside;
- changing sex-role and gender stereotypes in mass media and other public communications to support more egalitarian and respectful relationships;
- enacting and enforcing laws that protect women from sexual and gender-based violence, abuse or coercion;
- implementing policies that encourage and support parenting and household maintenance by men;
- prioritizing women's education, job training, paid employment, access to credit, and the right to own land and other property in social and economic policies, and through equal right s legislation;
- prioritizing investment in basic health services, sanitation, and clean water.

2. Support women's organizations in that area committed to women's reproductive health and rights and linked to the women to be served, especially women disadvantaged by class, race ethnicity or other factors, to:

- participate in designing, implementing and monitoring policies and programs for comprehensive reproductive health and rights;
- work with communities on service-delivery, education and advocacy.

3. Assure personally and locally appropriate, affordable good quality, comprehensive reproductive and sexual health services for women of all ages, provided on a voluntary bais without incentives or disincentives, including but not limited to:

- ☆ legislation to allow safe access to all appropriate means of birth control;
- ☆ balance attention to all aspects of sexual and reproductive health, including pregnancy, delivery and postpartum care; safe and legal abortion services; safe choices among contraceptive methods including barrier methods; information, prevention and treatment of STDs, AIDS, infertility, and other gynecological problems; child care services; and policies to support men's parenting and household responsibilities;
- ☆ nondirective counseling to enable women to make free, fully informed choices among birth control methods as well as other health services;
- ☆ discussion and information on sexuality, gender roles and power relationships, reproductive health and rights;
- ☆ management information systems that follow the woman or man, not simply the contraceptive method or service;
- ☆ training to enable all staff to be gender sensitive, respectful service provides, along with procedures to evaluate and reward performance on the basis of the quality of care provided, not simply the quantity of services;
- ☆ program evaluation and funding criteria that utilize the standards defined here to eliminate unsafe or coercive practices, as well as sexist, classiest or racist bias;
- ☆ inclusion of reproductive health as a central component of all public health programs, including population programs, recognizing that women require information and services no just in the reproductive ages but before and after;
- ☆ research into what services women want, how to maintain women's integrity, and how to promote their overall health and well-being.

4. Develop and provide the widest possible range of appropriate contraceptives to meet women's multiple needs throughout their lives:

- ▪ give priority to the development of women-controlled methods that protect against sexually transmitted infections, as well as pregnancy, in order to redress the current imbalances in contraceptive technology research, development and delivery;
- ▪ ensure availability and promote universal use of good quality condoms;
- ▪ ensure that technology research is respectful of women's right to full information and free choice, and is not concentrated among low income or otherwise disadvantaged women, or particular racial groups.

5. Ensure sufficient financial resources to meet the goals outlined above. Expand public funding for health, clean

water and sanitation and maternity care, as well as birth control. Establish better collaboration and coordination among UN, donors, governments and other agencies in order to use resources most effectively for women's health.

6. Design and promote policies for wider social, political and economic 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.

Necessary Conditions

In order for women to control their sexuality reproductive health, and to exercise their reproductive rights, the following actions are priorities:

1. Women Decision Makers

Using participatory processes, fill at least 50 percent of decision-making positions in all relevant agencies with women who agree with the principles described here, who have a demonstrated commitment to advancing women's rights and who are linked to the women to be served, taking into account income, ethnicity and race.

2. Financial Resources

As present expenditure levels are totally inadequate, multiply at least four-fold the money available to implement the program requirements listed in the Declaration.

3. Women's Health Movement

Allocate a minimum of 20 percent of available resources for women's health and reproductive rights organizations to strengthen their activities and work toward the goals specified in this declaration.

4. Accountability Mechanisms

Supporting women's rights and health advocacy groups, and other nongovernmental mechanisms, mandated by and accountable to women, at national and international levels, to:

- investigate and seek redress for abuses or infringements of women's and men's reproductive right;
- analyze the allocation of resources to reproductive health and rights, and pursue revisions where necessary;
- identify inadequacies or gaps in policies, programs, information and services and recommend improvements;
- document and publicize progress.

Meeting these priority conditions will ensure women's reproductive health and their fundamental right to decide whether, when and how many children to have. Such commitment will also ensure just, humane and effective development and population policies that will attract a broad base of political support.

For information contact the International Women's Health Coalition, 24 East 21st Street, New York, New York 10010, Tel: 212-979-8500, Fax: 212-979-9009.

STATEMENT NO.3

A critical appraisal of the Women's Declaration on Population Policies

The International Women's Health Coalition (IWHC), in cooperation with as many other signatories as possible, have formulated a declaration that will be presented at the World Population Conference in Cairo in 1994. This declaration is intended to represent the position and demands of feminists for a population policy with a sympathetic viewpoint.

We, the undersigned, being feminists actively engaged for a period of years with the issues of population polices, find ourselves incapable, in any way, of expressing support for the IWHC declaration. In the following points we will illustrate in what ways we find the IWHC declaration to stand against women's rights and to be politically reactionary.

We are critical of:

1. The lack of principle criticism of population policies

The IWHC declaration considers population policies to be an unquestionable necessity that merely require a little feminizing.

Population policy is an instrument of the ruling power, designed to eliminate the "useless" poor instead of justly redistributing the world's wealth, and thus it serves the existing status quo of exploitation. Since those who wish to reduce the world's population must control the reproductive capabilities of women, population policies are directed against women.

Population policy is sexist, racist and imperialist.

2. The linking of women's right to reproductive self determination with population policy even though they are tow completely separate concerns.

Reproductive rights encompass the right of each individual woman to determine, for herself, how many children she wants and when.

Population policy is, however, an attempt of governments and international agencies, through the use of political measures, to manipulate the populations of particular countries, whilst having no consideration for the' needs of individual men and women. Population policy therefore excludes the right of women to reproductive self determination. The conscious mixing of reproductive rights and population policy is a strategy to restrict women for the purposes of population policies.

3. The integration of population policy within developmental politics

To an increasing extent the promise of developmental aid and projects is being tied to population policy programmes; because of this a 'false consciousness'

develops that insinuates that population policy is an integral part of development. Development is then only possible with a parallel reduction of the population, since population growth is then postulated as being the main cause of poverty, hunger and environmental destruction, instead of naming the real cause, the existing patterns of exploitation.

The integration of population policies within developmental policies leads to an application of development in favour of population policies, which has devastating consequences for the respective counties, and especially for the women concerned.

Through developmental aid, all countries in the South can be forced to accept population policy programmes. At the same time more and more financial resources are being channeled into population policies, and also family planning, leaving little or no money for other sectors such as health care.

4. The postulation of fundamental ethical principles without their inclusion in a real political context (see Fundamental requirements in their declaration)

There cannot be a population policy that respects these ethical requirements because these policies are inevitably racist, sexist, imperialist and directed against the poor. The postulation of general ethical principles within the context of avoiding the real power structure comes down to a reactionary policy, since it serves only one goal and that is the legitimization of population policy.

5. The demand for the improvement of the position of women in all sectors of life as a basic condition of population policy programmes (see Minimum programme requirements in the declaration)

The right to a life with dignity, including sexual integrity, a respected social position and a secure economic basis are basic right and separate from population policy. The list of demands refers to the effects of the patriarchal system itself. To change this system is an issue for feminists, not the task of population strategists. Population policy is based on the patriarchate, with the intended aim of achieving a broad control over the reproductive capabilities of women.

The connection of birth control with a small credit allocation and the use of education or health care as a population policy measure is already in practise today in so-called 'integrated' programmes, and as a result of this more and more areas of women's lives are becoming the target of population policies.

6. The attempt to have accepted the demand for the inclusion of women's grass-roots organisations in the planning' and implementation of population policy programmes (see Minimum programme requirements in the declaration).

Women's grass-root organisations arose out of women's needs and resistance to the existing conditions. Should they now be enlisted and misused for the purpose of gaining acceptance of population policy programmes? It is cynical to respond to women's demand for contraception and abortion with population policy.

7. The demand for reproductive and sexual health services for women (see Minimum programme requirements in the declaration)

Women need an efficient health care system where all relevant aspects of health care are available for themselves and their children. The demand for a special health care system, centred on women's reproductive abilities, makes sense only in the context of a population policy.

In reality, money for the development of health care systems is already being withdrawn while, at the same time, expenditure on family planning is being increased.

The demand for the development of women-orientated health care systems within the pretext of population control is a further concealment of the political relationships. For example the demand for "fully informed choices", for women, in relation to contraception possibilities is diametrically opposed to the intentions of population policy planners who are seeking long term, provider controlled methods.

8. The demand for a four-fold increase in financial resources allocated for population policy purposes (of which 20% is for the Women's Health Movement) together with a quota system that guarantees a minimum of, at least, 50% female participation in all important population policy organisations (see Necessary conditions in the declaration) Basically, we are of the opinion that the participation of feminists in population policy programmes (with or without quota) can advance the career of individual women, but does not change the character of population policy, as it exists, as Ian instrument of the ruling power.

In the existing political situation such demands indicate that the power structures are being deliberately ignored. It is completely unrealistic to believe a 50% quota can be achieved in the near future, whereas the demand for a massive increase in the financial resources for population policies will find extensive support in population policy circles. For this reason these demands, that have already legitimised the increase of financial means for population policy purposes for women, are, to a large extent, already being worked towards.

A declaration by women for the World Conference on Population and Development 1994, in Cairo, must clearly reject population policies and a so-called feminist population policy as well.

Further, such a declaration must illustrate why population policy is sexist, racist, imperialist, targeted against the poor by its very existence and directly contradicts the right of individual women to reproductive self determination.

Undersigned by:

Aktionsgemeinschaft Solidarische Welt eV (ASW), Berlin, Germany;

Feminist International Network of Resistance to Reproductive and Genetic Engineering (ICG-FINRRAGE), Hamburg, Germany;

Forum Against Oppression of Women, Bombay, India;

Forum Against Sex Determination and Sex Preselection, Bombay, India; and

ANTIGENA, Women's Group Against Genetic Engineering, Reproductive Technologies and Population Policies (member of FINRRAGE), which can be contacted for further information at: c/o Frauenzentrum, Mattengasse 27, 8005 Zurich, Switzerland.

Note

This refers to the Women's Declaration on Population Policies, which has been enclosed in this issue of the MFC Bulletin. The International Women's Health Coalition can be contacted at: 24 East 21 Street, New York, NY 10010, USA.

STATEMENT NO.4

Women, Population and the Environment : Call for a New Approach

We are an alliance of women activists, community organizers; health practitioners and scholars of diverse races, cultures, and countries of origin. In our respective capacities, we have been working for women's empowerment and reproductive freedom, and against poverty, inequality, racism and environmental degradation. We invite you to lend support by signing and publicizing the following statement.

We, the undersigned, are troubled by recent statements and analyses that single out population size and growth as a primary cause of global environmental degradation. 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.

War making and arms production which divest resources from human needs, poison the natural environment and perpetuate the militarization of culture, encouraging violence against women.

The disproportionate -consumption patterns of the affluent the world over. Currently, the industrialized nations, with 22% of the world's population, consume 70% of the world's resources. Within the United States, deepening economic inequalities mean that the poor are consuming less, and the rich more.

The displacement of small farmers and indigenous peoples by agribusiness, timber, mining, and energy corporations, often with encouragement and assistance from international financial institutions, and with the complicity of national governments.

The rapid urbanization and poverty resulting from migration from rural areas and from inadequate planning and resource allocation in towns and cities.

Technologies designed to exploit but not to restore natural resources.

Environmental degradation derives thus from complex, interrelated cause, 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 growth helps to lay the groundwork for the re-emergence and intensification of top-down, demographically driven population policies and programs which are deeply disrespectful of women, particularly women of color and their children.

In Southern countries, as well as in the United States and other Northern Countries, family planning programs have often been the main vehicles for' dissemination of modern contraceptive technologies. However, because so many of their activities have been oriented toward 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 programs have frequently fostered a climate where coercion is permissible and racism acceptable.

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 world 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.

National governments, international agencies and other social institutions must take seriously their obligation to provide the essential prerequisites for women's development and freedom. These include:

1. Resources such as fair and equitable wages, land rights, appropriate technology, education, and access to credit.

2. An end to structural adjustment programs imposed by the IMF, the World Bank and repressive governments, which sacrifice human dignity and basic needs for food, health and education to debt repayment and 'free market', male-dominated models of unsustainable development.

3. Full participation in the decisions which affect our own lives, our families, our communities and our environment, and incorporation of women's knowledge systems and expertise to enrich these decisions.

4. Affordable, culturally appropriate, and comprehensive health care and health education for women of all ages and their families.

5. Access to safe, voluntary contraception and abortion as part of broader reproductive health services which also provide pre-and post-natal care, infertility services, and prevention and treatment of sexually transmitted diseases including HIV and AIDS.

6. Family support services that include childcare, parental leave and elder care:

7. Reproductive health services and social programs that sensitize men to their parental responsibilities and to the

need to stop gender inequalities and violence against women and children.

8. Speedy ratification and enforcement of the UN Convention on the Elimination of Al Forms of Discrimination Against. Women as well as other UN conventions on human rights.

People who want to see improvements in the relationship between the human population and natural environment should work for the full range of women's rights; global demilitarization; redistribution of resources and wealth between and within nations; reduction of consumption rates of polluting products and processes and of non-renewable resources; reduction of chemical dependency in agriculture; and environmentally responsible technology. They should support local, national and international initiatives for democracy, social justice and human rights.

For more information write to :

144 Ridge Ave.
Newton Centre, MA 02159 USA
Phone/Fax (617) 969-8444

STATEMENT NO. 5

Treaty on Population, Environment and Development

— NGO Forum, Rio '92

Preamble

We reject and denounce the concept of control of women's bodies by governments and international institutions. We reject and denounce forced sterilization, the misuse of women as subjects for experimental contraceptives, and the denial of women's free choice.

We affirm and support women's health and reproductive rights and their freedom to control their own bodies. We demand the empowerment of women, half of the world's population, to exercise free choice and the right to control their fertility and to plan their families.

The international community must address problems arising from the relationship between population, environment and development within the framework and boundaries set by ethics, human rights, and democratic principles, and in recognition of the fact that one-quarter of the world's population - predominantly in the industrialized nations consumes over 70% of earth's resources and is responsible for most of the global environmental degradation.

Demands and Commitments

Birth rates decline when a woman’s social, economic and health status improves and general living standards rise. The political and economic mechanisms operating within the prevailing world order and within each country, which create and perpetuate poverty, inequality and marginalization of people in the South - and increasingly in the North - must be transformed.

Militarism, debt and structural adjustment and trade policies being promoted by corporations and international financial and trade institutions such as the International Monetary Fund, the World Bank and the General Agreement on Tariffs and Trade, are degrading the environment, impoverishing the majority of the world's people and perpetuating the inequity of the existing world order. We condemn these policies and call for the immediate adoption of alternative policies based on principles of justice, equity and sustainability. .

Nuclear testing and toxic waste dumping are poisoning the environment, threatening food security and causing sterility, births defects and disease. We demand an end to environmental hazard that deprive women and men of their right to health and healthy children.

Patterns of consumption and production in the North and among the privileged of the South, which are the main threat to the survival of life in Earth, must be changed in order to halt the squandering of natural resources and the exploitation of human beings.

We condemn and call for an immediate end to policies and programs, whether by governments, institutions, organizations or employers, that attempt to deprive women of their freedom of choice or the full knowledge or means to exercise their reproductive rights, including the right to interrupt unwanted pregnancies. We denounce and reject the violence against women, who are victims of racial and class discriminations and suffer from extreme poverty, who are subjected to coercion, sterilization abuse, experimental drugs, and lack of proper medical care and information about health risks and alternatives.

We pledge to expose and oppose and coercive population control programs supported or conducted by governments, funding agencies, multilateral institutions, corporations and NGOs, and to hold them accountable.

We demand women-centered, women-managed and women-controlled comprehensive reproductive health care, including pre-and post-natal care, safe and legal voluntary contraceptives and abortion facilities; sex education and information for girls and boys, and programs that\also educate men on male methods of contraception and their parental responsibilities.

We demand child care facilities, parental leave and care for the elderly and disabled, as family support services.

We demand that scientific experimentation related to reproduction, particularly in the fields of genetic engineering and contraception, be transparent as well as accountable to women's concerns and ethical criteria rooted in the defense of the human species and human rights. We demand that governments honor international law and commitments on reproductive rights, and fulfill their responsibilities in implementing the Nairobi forward Looking Strategies, the report of the 1984 Conference on

Population and the UNCED agreements we also demand the urgent and full ratification and implementation of the United Nations Convention of the Elimination of All Forms of Discriminations Against Women.

We demand that national and international communities act now to integrate them into our lives and our organizations' practices and policies. We further pledge to see that these demands are met at all levels, locally, nationally and internationally. And we pledge to work together on this treaty, affirming our solidarity and our cultural diversity.

Announcements

XX: Annual Meet of MFC

The xx Annual meet 0 the MFC will be held in Yatri Niwas, Sewagram, Wardha from the 12th of January to the 15th of January, 1994. This year, the Women and Health cell of MFC will organise the meet, with the theme topic being Reproductive Health. The major focus will be on the challenge before women's groups and health groups regarding controversial issues such as contraception, abortion, population policies and sexuality. Allocation of resources for AIDS versus that for maternal care and the 'expert' western knowledge versus local wisdom will also be focused upon. Community based experiences as well as theoretical issues are going to be discussed, and many of the papers have already been prepared by various members of the Women and Health cell and also by friends from women's groups. Some campaigns related to reproductive rights in India will be focused upon by members of the respective groups.

In view of the 1994 Cairo meet on Population, it becomes imperative that we come together and think about a common statement to make on the issue that is going to be crucial for the 1990s.

Various women's groups have been invited to participate in the forthcoming meet and we hope that all MFC members will attend the XX Meet. Please send us names of groups or individuals you would like to be invited, and p1ease also extend the invitation to your friends on behalf of MFC

The programme for the Annual Meet is as follows :

(Venue: Sewagram, Wardha).

Jan. 11 : Visit to Bhopal

Jan. 12 : Annual General Body meeting of the MFC

Jan. 13 to 15 : Annual meet on Reproductive Health.

Please write to Ulhas Jajoo or to S.P. Kalantari for accommodation. Their address is : B-8, Vivekanand Nagar, Sewagram, Wardha, 442 102.

Padma Prakash is the coordinator of the Women and Health cell. You may write to her for details about the Annual Meet. Her address is : 19, June Blossom Society, 60 A, Pali Road, Bandra (West), Bombay 400 050.

On behalf of MFC I invite all of you and like-minded friends to participate in the Annual Meet. I also take this opportunity to invite all MFC members to the Annual General Body meeting to be held in Sewagram, Wardha, on the 12th of January, 1994.

Looking forward to meeting all of you, once again and with regards,

Manisha Gupte,
Convenor, MFC,

11, Archana,
163, Solapur Road,
Hadapsar, Pune 411 028.

An Appeal to all MFC Friends

It is tragic that the problems related to the Bhopal gas tragedy are not over as yet. To highlight the ongoing trauma (and deaths) of the gas victims, as of today, an International Medical Commission has been set-up. Earlier, this Commission was to be in Bhopal during November-December, 1993, for a period of a fortnight, but recently, the final dates have been postponed to the middle of January, 1994, because Dr. Rosalie Bertell from Canada, who is an active supporter of the Bhopal victims is unable to come this year.

We feel that the Int. Medical Commission is a sound idea, because it will lend credibility to many of the studies and observations that researchers and activists have made about the state of people's health in Bhopal over the past eight years. As the MFC, we feel committed to the work that our friends are carrying on, so diligently among the gas affected people, and therefore would definitely like to stay involved. Many MFC friends including Thelma Narayan, Anant Phadke, Mira Sadgopal, Sathyamala, Madhukar Pai, and Mira Shiva have agreed to be in Bhopal before and during the proceedings of the Commission. Many of us have planned to go there in relay, so that we are more useful to the people. Unfortunately, the dates also clash with our Annual Meet (this is due to the postponement of the Commission's visit to Bhopal), but we hope that many more friends from MFC will actively support and participate in various ways.

It would be ideal if some doctor(s) could stay in Bhopal for a month before the Commission's visit, and compile information on the unjust refusal of the administrative authorities to grant compensation to gas affects persons who are still dying in Bhopal, due to TB and related 'cause.

Would someday be interested?

We are publishing the write-up on the Commission, prepared by the Bhopal Group for Information and Action (Contact person: Sathyu, 18/ 1, Nagar Nigam Colony, Berasia Road, Bhopal, 462 018). Please consider the appeal as one from the MFC, and do participate in the proceedings in Bhopal. An organising committee is being constituted, and those of you who would like to stay actively involved, should please write to Sathyu, directly. He has been constantly in touch with many of us, and many MFC friends have had discussions with him during the past six months.

On behalf of MFC, I earnestly appeal to you to actively cooperate with the activities of the Commission.

Manisha Gupte,
Convenor, MFC.

Proposal for an International Medical Commission on Bhopal

More than eight years after the toxic leak at Union Carbide's pesticide plants in Bhopal, India, death continues to stalk the shanty towns around the factory. Recent local newspaper reports indicate three to four gas related deaths every week in Bhopal. At least one fifth of the over five hundred thousand people exposed to Methyl Isocyanate (MIC) and other lethal chemicals continue to suffer acutely from a range of diseases. Breathlessness, loss of acuity of vision, menstrual irregularities, muscle aches, fatigue, and loss of appetite, anxiety and depression are the most common symptoms. There are manifestations of new diseases as well. Incapacitated by the gas exposure, over fifty thousand survivors are still unable to resume their usual jobs but are often forced to work to earn a livelihood. In July last year, the State government closed down the last three of the forty eight rehabilitation centres, thus putting an end to the gestural initiatives towards much needed economic rehabilitation. Interim monetary relief at the rate of Rs. 200 per month per individual provided by the Central government since March 1990 has been the only means of sustenance for a majority of the gas victims. Distribution of this relief has stopped since March 31, 1993 and this stoppage has started taking its, toll. Subsequent to the Supreme Court's final order of October'92, disbursement of compensation has begun since October'93. The survivors however, have little to look forward to. Compensation sums currently being awarded against death claims are disproportionately small - Rs. 100,000 (U.S.$3,300), in almost all cases, and over 70% of the claims taken up so far have been arbitrarily rejected. Contrary to the findings of medical research carried out in Bhopal so far, 'the government's Directorate of claims considers over 94% of the victims to have either suffered temporary injuries or none at all. Apart from being unjust, compensation distribution is also utterly slow. At the current rate of processing of claims, it will take at least thirty -years for compensation disbursement to be over.

The attitude of the present State and Central governments towards Bhopal continued to be the same as it has been for so many years. Neglect towards the problems of the gas affected people, repression against organizations raising the victims' demands and by all means protecting the interests of the US multinational. A Hindu fundamentalist party has been in power in the state till recently (December '92) and the Muslims' who form over 40% of the exposed population have suffered governmental discrimination. Union Carbide Corporation continues to deny medical information on MIC and other toxic gases presumably because of its close connection with the Pentagon and the military significance of these gases. The ex-chairman of the Corporation accused of manslaughter by the Indian investigation agency is still ignoring the summons of the Bhopal district court. Five organizations of gas victims continue to struggle for justice and adequate rehc1bilitation. Women form an overwhelming majority of the victim-activists who continue to demonstrate in large numbers at least once every month in Bhopal and occasionally in the national capital seven hundred kilometers away. Though internal conflicts have eroded their support base, victims, organizations still remain powerful enough to be effective. However, issues of medical care, rehabilitation and compensation are as unresolved as they have been and there is an urgent need for support to the Bhopal victims.

According to reports of the Indian Council of Medical Research (ICMR) the health damage caused to the Bhopal victims are "multisystemic in nature" and are "progressively deteriorating". This government institute has been carrying out studies on the toxic injury caused to the respiratory, gastro-intestinal, reproductive, musculo-skeletal and nervous systems as well as that to the mental health of the people. The ICMR has now wound up 21 out of 23 of its study projects and current information on the health status of the gas victims is becoming scanty. Research conducted by Dr. Neil Anderson of the London School of Hygiene and Tropical Medicine has identified permanent damage caused to the immune systems of the gas affected people and has outlined their proneness to secondary infections. An October '92 report of Professor S.R Kamath of K.E. Medical College, Bombay, has estimated that at least fifteen thousand gas exposed people

are permanently disabled due to lung injuries alone. ICMR studies have also indicated exposure related chromosomal aberrations and possible anemic defects in children born to gas affected people. In line with apprehensions earlier expressed by researchers, there is an increased incidence of cancer among the gas victims now. Despite such a miserable health situation there is an appalling lack of governmental attention to medical care of the victims. Medical treatment has remained unchanged over the last eight years and consists of symptomatic and supportive drugs that offer only temporary relief if they offer any relief at all. The inefficacy of this treatment is evident from the long queues that form daily at the three government hospitals and sixteen dispensaries even till today. According to a prescription audit done in 1990, over 35% of the drugs given at government hospitals are either unnecessary or hazardous.

Need to Build a Unified Campaign

Having drawn attention to the government's failure to provide adequate medical care it needs to be mentioned that given the magnitude of the problems and the resources required it is only the Indian government that can carry out long term medical care of the Bhopal victims. Its lack of political will in this regard necessitated mobilization of public opinion through a national and international campaign. If this campaign is geared towards making the Indian Government commit itself to the continuing live problems of the gas victims, then the campaign should be backed by a solid health study done by an internationally reputed medical team of experts.

A professional report that outlines the current health problems evaluates the medical care available and suggests remedial measures can be of key importance for such a campaign.

Accordingly a proposal is being made here for an International Medical Commission to visit Bhopal.

The objectives of the visit of the International Medical Commission to Bhopal are as follows:

1. To generate a written report which would promote an understanding of the current health situation of the people of Bhopal affected by toxic gas exposure since December'84?
2. To assess the current state of medical care available to victims.
3. If requested, to outline recommendations for improvement of medical care for victims.
4. If possible, to establish clinical criteria which might be used to identify the gas victims in the event that they do not have documents to verify their exposure.

It is envisaged that these objectives would be addressed through the following stages :

A. **Selection of team members:** Between five to ten specialists in areas such as epidemiology, pulmonary medicine, ophthalmology, gynecology, paediatrics, gastro-entrology, neurology, genetics, oncology and mental health with special reference to toxic exposure will have to be chosen from different countries, including India. Given the nature of the job, it is likely that the number of members and the composition of the team will be dependent on the availability of volunteer specialists. Arrangements will have to be made to send medical information generated on Bhopal to the team members well in advance to enable them to familiarize themselves with the health situation of the victims since the disaster. Team members will also be expected to suggest organizational initiatives that need to be made prior and during their visit.

B. **Organizational initiatives in Bhopal:** A team of voluntary Indian doctors preferably those associated with medical intervention in Bhopal will be involved in the project. In addition to sharing their findings and opinions these volunteers will extend help towards fact finding in Bhopal by the Commission. Other organizational efforts will include arrangement of meetings of the visiting team with researchers in ICMR and other institutions, doctors in government hospitals and private clinics, bureaucrats and representatives of victims' organizations. Diagnostic equipments as well as facilities to carry out specific tests that may be required for the project may also have to be arranged.

C. **Visit to Bhopal:** The visit to Bhopal is likely to take between ten to fifteen days excluding travel time. A brief stay in New Delhi may be necessary for meetings with ICMR researchers and government officials. During their stay in Bhopal specialist and other doctors are expected to gather information on the current health situation of the victims as well as that of the medical care available to them. Such information will be gathered through examination of victim patients, discussions with doctors and researchers engaged in their medical treatment and visits to the hospitals and clinics. The Commission will also meet with representatives of victims organizations in Bhopal.

D. **Publication of report:** The visiting team will be expected to produce a report of their visit outlining their findings, opinions and recommendations. The publication of this report will be followed up by a campaign for implementation of these recommendations by the government and may include lobbying, advertisements, writing letters and demonstrations by the survivors and their supporters.

Update

The idea of the International Medical Commission on Bhopal emerged during the Permanent People's Tribunal's sessions on Industrial and Environmental Hazards and Human Rights in Bhopal in October last year. In listing remedies to the appalling spread of industrial and environmental hazards worldwide, the need for an international community of professionals and non-professionals was highlighted in the verdict of the Tribunal. In line with the idea of setting up such a "Green Cross", a proposal was sent by the Bhopal group for Information and Action, a Bhopal based victim's solidarity organization, to Dr. Rosalie Bertell of the International Institute of Concern for Public Health, who was one of the judges at the Tribunal's October session. She was requested to take initiative in setting up such a Commission. Dr. Bertell wrote to about 60 specialists in different countries seeking their participation in this effort. Finally a list of 12 members of the International Commission has been made by Dr. Bertell with help from Dr. Gianni Tognoni who is the Secretary General of the Tribunal. If we can make all go well, the Commission will visit Delhi and Bhopal from 7th to 22nd January, 1994.

The Organizing Committee will primarily facilitate the Commission's visit in January. About 24 names of medicos and others involved with Bhopal was proposed for the Organizing committee (list enclosed). It was decided that the Organizing Committee will have 18/1, Nagar Nigam Colony, Berasia Road. Bhopal, 462 018 as its address and Satinath Sarangi (Sathyu) will coordinate its functioning. An Advisory Committee of eminent individuals who have played significant roles in raising issues left by the Bhopal disaster, was also proposed.

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The references that were included as part of the orgina1 articles have been omitted for lack of space, but readers interested can obtain them by writing to us.