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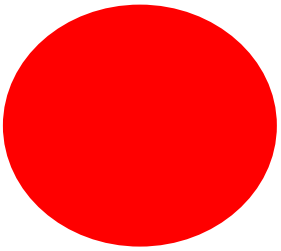

Women's Empowerment and Health Experiences In a State Sponsored Programme*

Arti Sawhny

At the turn of the century, with the fruits of development still eluding a bulk of the rural masses, who continue to be gripped in poverty, malnutrition, ill health, illiteracy, unemployment, and so on, the focus of policy planners has now shifted to women. Campaigns for female literacy, women's awareness, women's empowerment and focusing on gender concerns are being increasingly looked upon as crucial inputs for overall development.

WDP (The Women's Development Programme)-a programme exclusively for the empowerment of women':

Rajasthan was the first state in India to boast of a programme exclusively for the empowerment of women. The programme was launched by the Government of Rajasthan in 1984, as part of the Sixth Five Year Plan. It aimed to empower rural women and integrate them into the process of mainstream development. WDP was visualised as a collaboration of three kinds of inputs, "a structure which would have the inner strength and grass-root linkage of voluntarism; the security and stability of the government; and a continuous incorporation of critical reflection from research bodies" *(Exploring Possibilities)*.

Grass-root level village workers called *'Sathins'* were selected and trained. The training programme was formulated to provide conditions for these rural women to re-discover themselves as active participants of the development process. By generating experiences which facilitated altered perceptions of self-image as well as the social image of women, the programme helped them to re-discover lost faith and confidence and discover collective strength. Conceptually, development was thought of in terms of internal growth rather than in terms of the handing out of schemes.

Questions Emerging from Collaborating with WDP:

Two years after the inception of the programme in response to the needs of women at the grass root level, a health project was formulated and supported as part of the Women's Development Programme, by State IDARA (Information Development and Resource Agency) for a period of one year, from April, 1986 to April, 1987. Working in close coordination with the functionaries of the Women's Development Programme in Ajmer, Jaipur, and Jodhpur districts, the Project made an attempt to evolve an understanding of women's health in the context of the larger socio-economic reality. During the course of project work, the health team also gained insights into the functioning of WDP vis-a-vis its stated objectives. With time the clash of interest between the hierarchies of the programme sharpened. The experience of working with the health project threw up the following questions:

1. What did empowerment of women mean in the context of their changing life situation?
2. What was the difference between a State sponsored women's organisation and an organisation that has emerged from the grass roots?

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3. Whose priorities and interests were ultimately being served?
4. While promoting population control and increasing access to contraception in order to provide women a 'choice', what had been the response in situations where women had chosen to de-link their fertility and sexuality?
5. How and why had the State succeeded in forging alliances with NGO's (non government organisation) and how had it succeeded in co-opting activists from the women's movement?
6. How could a programme which had the prime objective of women's empowerment devalue and exploit its women workers, particularly workers at the lowest rung, without whose labour the programme would cease to exist?
7. What has been the role of funding and how has it served as a means of control?

Women's Empowerment: in whose interest?

a) The initial phase of the Women's Development Programme: The initial three to four years saw a lot of enthusiasm. Collective strengths were channelised to redefine gender roles and relationships; to break the confines of the family; and to facilitate participation as equals in the productive process. Spontaneous struggles ranged from fighting domestic and sexual violence to demanding minimum wages; from demanding employment opportunities to agitating for the fulfillment of basic needs like drinking water, education and medical care, Women's forums sprung up in many villages, and it appeared that women had found space to articulate their oppression and had begun to organize themselves to recognize their own power. The existing cultural forms began to be used as a means of expression and women became increasingly visible.

(b) Genesis of the Health Project: Following the success' of a "Shivir' (meeting). focusing on 'Famine' as its theme in February, 1986, the authorities of WDP in Ajmer district decided to make the "Shivir' on annual feature, to address the problems and needs of the time. Two areas of work were identified - 'Land' and 'Health'. The former being sensitive and overtly political was dropped and, towards the end of 1986, it was decided to focus on women's health and organise a Shivir on this issue.

The health Shivir, held in February, 1987 in Ajmer District, was the starting point of a year-long health project. Based on a survey of the prevailing health problems amongst rural women conducted by the *Sathins* and *Prachetas* (Supervisors), it was revealed that a significantly large number suffered from menstrual disorders, vaginal discharges and- problems related to child birth. The Shivir focused on these three areas. Information was shared in the context of personal experiences, beliefs and practices. The local language and idiom was used along with the visuals and models. Existing beliefs were explored and myths exploded. For instance, a pregnant woman was not allowed to have curd or butter milk as it was supposedly deposited on the foetus; menstrual blood was considered impure; conception during the waxing phase of the lunar cycle was said to result in the birth of son, and conception during the waning phase in the birth of a daughter. An insight into bodily functions, particularly those related to fertility and sexuality, resulted in the expression of a feeling of liberation, of clarity, of being strengthened, and of being in control. A need for carrying forward the information to their respective villages was expressed by the Sathins and culminated in the formulation of a year-long health project.

(c) *The emerging understanding:* Since it is the woman's body that is used against her as a weapon of repression, a struggle for improvement necessarily needed to begin by identifying the origins of this repression and the forms of control that are being used. Bodily function such as fertility and sexuality were seen from a point of view which accounted for social attitudes to women as expressed in relations within the family and in society, including the attitude of the medical establishment and the State. Health problems were often related to food intake which was determined by the position of the woman within the family, her economic class and the existing famine situation. . The process of dialogue and information-sharing and feed-back, was the basis on which the health project was run, as a step towards an understanding of the situation in which most rural women find themselves.

The development of visual material was central to the evolution of this understanding. "Shareer-ki-Jankari" (understanding our bodies) Book I" and an incomplete "Japa-ki-Kitab. (Book on child birth) were the products of a year-long process, the former dealing with fertility and sexuality and the latter with child-birth. Realisation of the essential issues involved increasingly focussed on two major attitude shifts. Information disseminated had to integrate itself with life situation, beliefs and practices of the women who were receiving it. There was a huge body of local knowledge that had to be built upon and existing local cultural forms were more effective and less alien. Secondly, the health project could no

longer retain a separate identity, and had to integrate itself into the larger reality: the overall famine situation, employment situation, payment of wages, and family planning excesses.

(d) Fertility Vs. Sexuality-Open discussions on fertility and sexuality, and the de-linking of the two, provoked strong responses. For some, it was the starting point of increasing control over their existing life situations. The questioning of some of their existing beliefs and practices led to a feeling of liberation. Information began to be acted upon and, in some cases, there were concrete results. For instance, a woman in village Tehri recorded her fertility cycle and conceived after ten years. A Regar woman in village Mewda Khurd, on spotting a blood-stained vaginal discharge, got herself examined and cancer cervix was detected at an early stage. Information dissemination also resulted in a growing pressure on the medical establishment and there were instances where ANMs (Auxiliary Nurse Midwife) too were challenged. On the other hand, there were those who were opposed to such information. As age-old beliefs and practices began to be questioned, the open discussions on fertility and sexuality were said to have a corrupting influence. Information related to child birth was more easily accepted. By and large, most *Sathins* and younger women took a keen interest in deepening their insight into their sexuality as well as observing their fertility cycles. Recording of fertility cycles with the help of an indigenously developed menstrual calendar, however, did not meet with success, as the concept of record keeping was difficult to grasp.

After a lapse of about six months, the health project work began to be disapproved of by the authorities within WDP as well as the medical establishment. The project was accused of instigating and. corrupting rural women; of preventing *Sathins* and *Prachetas* from performing their duties; of demotivating family planning cases; and of working against national interests. Women controlling their fertility by an awareness of their fertility cycle were not approved of. They were under a lot of pressure to accept the population control strategies being promoted by the State. On the other hand, young widows, wanting to express their sexuality, or asking for contraception for fear of rape within the family, were denied access to contraception.

(e) The Famine Situation: Apart from a few normal years, the decade of the 80s saw severe famine in Rajasthan. From 1985 to 1988, Ajmer district was witness to the failure of rainfall and a crop failure of over 88 %. With employment opportunities being scarce, the government-run famine relief works became the major source of employment. Despite government reports and notifications on extensive provision and thorough management of relief works opening during the scarcity years spanning from 1986 to 1988, the actual state was desperate, and the plight of the rural labour force remained unmitigated. In almost all cases, workers at the famine sites were initially unaware of the legal provisions regarding the measurement and type of task assigned and completed; the declared minimum wage and its form and amount of payment due to them; and legal provisions for safety and basic facilities at work sites. Lack of information was widely used by the executing authorities to their own advantage at the implementation level. So rampant were these irregularities that anyone who protested had her name struck off the muster roll and was not given employment the next fortnight. Gradually, with sporadic attempts to organise themselves women workers, particularly from some villages, began to challenge these practices and evolve their own coping mechanisms.

(f) Family Planning Excesses: The famine-struck people's desperation for employment was taken advantage of by government officials at every level in order to complete the family planning operation targets assigned to them. Availability of employment at famine relief works was made conditional to having family planning operations performed on virtually each and every labourer. It became the norm not to register names of such women for work who did not comply, or, if they were already operated, to have their names struck off the muster roll. Another practice was to reserve four to five jobs on each muster-roll for women who would subject themselves to such operations, often against their free choice, in order to get employment. There were instances where, since no family planning cases were forthcoming, works already sanctioned for the village were sent back. Coercion reached a pitch and several people already sterilized were forcibly operated upon for the second and third time. A death during operation was reported. The situation of the sterilization camps was no better. At the make shift operation theatres (located in the village schools) the mere hanging of a curtain on the door seemed to guarantee sterile conditions. The laparoscope was sterilized by dipping in Lysol solution, flies, food and dust were all part of the scene. No resuscitation equipment was available and cycle pumps were used freely to pump in air.

(g) Information as Power: In response to the famine situation and family planning excesses, two

information sheets called 'Sathin-ro-Kagaz' *(Sathin's* newsletter) dealt in detail with the famine relief works i.e. the existing norms of measurement, rules and regulations related to payments, the sanctioning of relief works, and the provisions of basic amenities of work sites. The other was on family planning instances of excesses and irregularities were gone into, and information was given on procedures and norms for carrying out sterilization operations. Information was also shared, regarding a government circular specially stating that employment at famine relief works should not be linked to sterilization operations. Workshops were conducted, where, with the help of simple card-board box models, the procedure of the sterilization operation was explained.

Sathins having fallen prey to both irregularities at the famine relief works, as well as the excesses of population control, responded along with their village women in the form of spontaneous protests. A critical factor in these sporadic spontaneous struggles was the availability of information. Information gave them the basis to confront officials. While in a majority of cases the so *thins* took on active leadership roles, most *Prachetas* preferred to remain in the background'. They were caught between catering to community needs on the one hand and pressure from the authorities on the other.

Population Control: In whose interest?

The *Prachetas* expressed a desire to understand the reason for population control. They' raised the question that, if one were to examine the arguments in favour of a small family size, it seemed illogical for people not to see its advantages. Why then did people not' opt for it voluntarily? If the government was acting in the interest of the people, why was it using force? It was felt that population control as the main cause of poverty was a sentiment that appealed to middle class interests. What was the opinion of the poor? What were the compulsions that led the poor people in the villages to desire a large family as well as those that led them to accept sterilization?

In order to systematise the form of collection of information, it was decided to carry out a survey which would focus on post-operative health problems in women, and the process of decision-making which led to their acceptance of sterilization. The objective of the survey was not merely collection of information, but to use it as an agenda for discussions in the village. The authorities within WDP and the state administration strongly disapproved of work of this nature. They forbade *Prachetas* from holding meetings with members of the health team. The *Sathins* were also put under pressure and subjected to restrictions. As a consequence, team work became increasingly difficult. It was also not possible to finally analyse and report on the information collected during the survey. The hostility of the authorities towards the health project work and team members grew and, finally, decision was taken to withdraw the book on sexuality and fertility awareness i.e. 'Shareer-ki-Jankari" -Book I.

The Clash of Interests

Over a period of time, the clash of interests of the grass-root and the higher level functionaries of the programme became more pronounced. Empowerment at the grass root level, which was the prime objective of the programme when it started, was now being viewed as a threat by the State. Any attempt at changing the power balance began to meet with resistance from the authorities. The emphasis began to shift from fulfilling community needs, to implementing State policies from the top.

One year of the health project was drawing to a close. A decision had to be taken about its future. From its very inception, demand from the grass-root level had been a guiding factor for the health project and was the basis on which issues were taken up or dropped. Activities were evaluated on the basis of their having helped strengthen village-level processes. Information was collected, keeping these principles in mind, so that information from the grass-root level was analysed and fed back, to deepen a growing understanding.

The objective of the health project now seemed to be at variance with the direction and policies being pushed by the State authorities. Awareness raising, empowerment, mobilisation and internal growth were no longer indicators of development. Development now began to be measured in terms of achieving tangible results. The pressure on *Sathins* and *Prachetas* to achieve pre-fixed targets now increased. *Sathins* and *Prachetas* were now caught between catering to the community demand on the one hand, and succumbing to pressures from above on the other.

So, when a decision on the future of the health project was to be taken, at a "Samuhik Jajam" (collective meeting) in village Devlia in April, 1988, the atmosphere was charged with tension. The Project Director and other officials were openly hostile to the project, and accused it of being disruptive; of instigating the people; of working against programmes of national importance such as the population control programme, and so on. The *Sathins* on the other hand, despite threats and stiff opposition, were of the

firm opinion that the health project had helped strengthen processes at the grass-root level, that work had gained momentum and that there was a continuing need for such programmes. The Project Director of Ajmer was put under a Jot of pressure and finally agreed to inform the State Authorities of the Sathins beliefs, while however adding a personal note of reservation.

Funding Constraints: To take a final decision on the health project, a meeting was called on May 2, 1988, in Jaipur, and was attended by representatives from the State Directorate, UNICEF, State IDARA, Distt. IDARA Ajmer, Institute of Development Studies, Jaipur, and the Project Directors of Ajmer, Jaipur and Jodhpur. The detailed health project report was presented. The project work was praised and a decision was taken to keep the project operational as an integral part of WDP. It was now to be integrated with the overall programmes and budget received from the different districts.

Funds for the health project stopped coming for from April, 1988, onwards while work continued. Proposals for further work were drafted along with the concerned authorities in the different districts as part of their annual proposals, and were submitted by May 1988. No intimation was received till the end of September 1988, at which point members of the health project team took the decision to continue work, while officially disassociating themselves from WDP.

Co-option of Women Activists: In October, 1989 at the National Workshop on 'Women and Health' held in Jaipur, women activists from State IDARA and IDS were confronted and asked to explain their silence vis-a-vis the health project as well as their *failure* to respond to the family planning excesses in Ajmer district. The following explanation was put forward-"The Women's Development Programme is a government run programme. In this programme, the basis for taking up issues and forming an opinion is not based on whether it is anti or pro-government. It has been our conscious and constant desire to stay out of this polarised categorization and work to evolving and maintaining a feminist perspective."

They further stated that—

"An open stand with the government on linking up family planning operations on women to the government run famine relief works was not taken up at the district and state level. At that time IDARA's very existence in the programme was threatened. Therefore, the priority at that time was to resolve the issue so that all components of the programme structure could be kept intact."

Survival became the sole question of top level functionaries of WDP, IDARA and IDS. And the village women on whom the atrocities were being committed and the workers of the programme *(Sathins* and *Prachetas* on whom there was pressure to bring 'cases' were betrayed, thereby betraying the very objectives of the Women's Development Programme.

The health project team however continued work outside WDP. 'Shareer-ki-Jankari' Book-I' was published with the support of well wishers and was very well received. It has now been translated into many languages and is being widely used in different parts of the country as well as abroad. It was only much later, on seeing the response in other parts that the authorities within WDP decided to distribute the book to the *Sathins,*

Organisation

The emergence of organisations followed the process of empowerment of women. WDP witnessed the growth of many such organisations, the nature of the organisation being determined by the process of evolution.

State Sponsored Organisations: So long as rebellion and discontent is at a local level and is directed at challenging local vested interests or petty officials, the government bureaucracy is helpful. Some amount of confidence building and empowerment is an essential pre-requisite for government policies to reach the grass root. However, decentralisation of power in any form will not be tolerated.

Urban-Rural Linkages: While supporting struggles of the rural women for her rights as a worker, there were many instances of women struggling for their rights as women, within the home and in society at large. These so called 'personal' struggles were seen to be inter-related and formed an integral part of the struggle of the working class woman. The rural woman had almost no access to the legal system and most often justice was sought through the male dominated traditional 'jati' (caste) Panchayats, The urban woman had access to the family court and. other courts, but she too seemed to be at the mercy of her family members, lawyers and caste leaders. A need for a women's support group was strongly felt to build the confidence in urban women and to provide access to the legal system for rural woman. Thus *Mahila Samooh* Ajmer, an Ajmer based women's group was born.

Organising for better service conditions: In 1990, *Sathins* from eight districts gathered in Padampura to share their experiences in a mela. Apart from sharing of work experiences, the *Sathins* had an opportunity to discuss their exploitative service conditions where a blatant disparity existed in the salary structure. The Sathin considered the backbone of the programme, did not even enjoy the status of a worker. To date, they are called voluntary workers, and are paid a measly honorarium of rupees two hundred per month, and enjoy no legal rights. A collective demand was raised for improvement in their service conditions. To press for their demands, the *Sathins* went on strike. The functionaries of IDARA and IDS, instead of helping the *Sathins* articulate their demand and giving direction to their struggle, became vociferous defendants of the State and played an active role in breaking the strike.

Grass-root Organisations: Later, in December, 1990, rural women from village Kekri organised themselves into an autonomous group under an independent banner, and participated in the National Women's Meet in Calicut, Instead of being rewarded for practising their empowerment, they were humiliated and punitive action was taken against them. The services of five *Sathins* and one *Prachetas* were terminated. Support from women's groups from different parts of the country has helped the group survive and challenge the termination in the High Court.

Unionizing: Over a period of time, contradictions began deepening and the clash of interests between the grass root and the higher level of the programme became sharper. Most women activists within the programme took clear pro-establishment stands i.e., opposing any effort on the part of the Sathins to unionize. Having made inroads into the rural areas, the State no longer seemed to require the facade of empowering women. There is now a clear shift from raising grass-root level issues to an extension of the State and its policies at the village level. There is now an open collaboration with the population control lobby and WDP has now become a vehicle for transporting, communicating and inundating the village with information and programmes that would promote market interests. Training programmes are being conducted to promote methods of modern agriculture practices and the use of pesticides and fertilizers. *Sathins* have been given booklets with information on the injectable hormonal contraceptive 'Net-en' as well as the hormonal implant 'Norplant'.

Despite stiff opposition, *Sathins* and *Prachetas* have organised themselves into separate union to raise demands for basic rights as workers; to protest against the exploitative service conditions; to resist pressures for the implementation of anti-people policies and the meeting of pre-fixed targets. The *Prachetas* union was registered in 1992 and was affiliated to the *Rajasthan Karamchari Mahasangh.* For the *Sathins,* the initiative to unionise came first from Bhilwara District. However, in January, 1993, it was the Ajmer district *Sathins* who first registered a district level union. They got active support from *Mahila Samooh* Ajmer. Within six months, the union spread to other districts and in July, 1993, the first All Rajasthan Convention of the Sathins Union was held in Jaipur. There was strong opposition from authorities within WDP, who have taken on the process of dismantling the union almost as a challenge. The union is at present struggling for survival.

Conclusion

In the final analysis, it is amply clear that if the existing power equation is challenged, no form of collective strength, whether in the form of an autonomous .women's group at the grass-root level or a worker's union will be tolerated by the State. It is also clear that there is no scope for real decision making and that women can have no control over their lives, even if it is only in the area of sexuality and fertility. Using the tone and tenor of the women's movement, the State has succeeded in drawing upon the strengths of the activists from the women's movement and NGOs. It has succeeded in creating a progressive image to gain access to the invisible woman of the feudal society, and bring her within the reach of the government's machination. Challenging basic feudal and patriarchal structures has succeeded in bringing women out of the oppressive family structure, a necessary prerequisite for the acceptance of population control measures. This has led to the widening of the role of the woman, without however really changing it. With no clear cut ideology and an emphasis just on processes, the net result seems to have been the evolution of a highly motivated willing work force of women who can very easily be manipulated. Women's oppression is seen only in its gender politics, negating their class and caste reality. Women's economic role as workers, even in State run programmes be they famine relief works or development programmes like WDP-is not recognised. With an analysis and understanding limited to gender issues, forging links with(C wider class and caste struggles remains largely sporadic and isolated to crisis situations. It is obviously in the

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Poor Women's Health Remains Poor

(Putting Health Issues of Third World Women in Perspective)

Imrana Qadeer

F or the Women at the Beijing Conference:

* When the Questions around development become one with the straitjacket of the market and its needs, can women be saved?
* When the poor health of women arises out of their subordinate status in a given socio-economic structure, can making the same structure even more stable and unrelenting, open up possibilities for the liberation of women?
* When 'justice' is being restricted to the narrow residual spaces left by structural adjustment; when the majority of the poor are pushed to the wall; and the choices poor women are permitted is between dying earlier or dying with their menfolk, suffering acutely as women or suffering intensely as all the poor: must women let the international community have the right to narrow the choices for the women of the third world countries?
* To correct structural malformations in the process of development, to strengthen democracy and to improve the conditions of life of the majority is one thing, but to "adjust structurally" so that the privileged could draw more benefits is quite another. What is the politics of the 3rd world's women being denied the right to define their own structural adjustments? Why must they be seen as agents of reproduction alone?

In the era of 'advocacy' these questions are labeled as 'wasteful' and 'digressive'. Pragmatism demands that the poor realise they have no real choices and accept existence within the boundaries created by the international order.

Is this what the 4th World Conference on Women, 1995, is all about? If not, then it is binding on all thinking people to speak out at this juncture and reaffirm that no international forum or its member nations have the right to restrict choice that people of other nations may want to make. This is doubly important for the health of women, which in the *out*come of their social, economic, and political existence within their homes and in their respective-societies.

The havoc created by structural adjustment for women and children are no more a figment of one's imagination. Studies from African countries, Philippines, South Korea, and Brazil have shown increasing morbidity due to diseases such as malaria" pneumonia, tuberculosis, diarrhoea, measles and schistosomiasis. There has been a deceleration in the rates of decline in infant mortality. The health services costs have escalated and investments in health have declined. Resource allocation within health has been such that basic services and public health have suffered. The institutions dealing with the so called diseases of modernity such as cardiac centres, kidney transplant units, cancer institutes etc have mushroomed. Nutrition status has declined specially for children and women and food intakes have gone down. '

The outcome of the Social Summit has already been sealed as, instead of the promise of contributing 0.7% of the national income to overseas development, most developed countries including the US are trying to back out. They scuttled the issue at the ICPD and they are trying their best at the Social Summit. UK's aid, for example, is expected to fall to a new low of less than 3 % of the GNP!

In the present international power balance, there is no discussion on possible steps to reduce the debt burden on the 3rd world countries. Markets alone are seen as the answer to their poverty. It is argued that without economic growth poverty cannot be removed. But there is no discussion any more on distributive justice. There are no answers to the question how the "benefits" of the market will reach those who are not a part of it. Or, what happens to those sections who are actually going to bear the brunt of the new economic policies? According to the UN, 1.3 million people in the world live in absolute poverty and 70 % of these are women. The poor of the world today seem to be nobody's concern.

Even the issue of trade liberalisation is being tackled selectively. It is acceptable when it is convenient for the developed countries and not acceptable when it goes against their interests. At the social summit the developed countries have used the weapon of 'Social clause' to restrict competition. They have refused to contribute 0.7% of their GNP to ODA. Will such apathy at the macro-economic front be conducive to tackling the problem of poverty and health of the most deprived of the world-its poor women? At the same time, can the issue of growth with equity be so completely overlooked?

In view of the above it is imperative that instead of splitting hairs on protection against the onslaught of the diseases of modernity and the dangers of pregnancies, our concern for women's health should be expressed in demands for gainful employment for all women and men. This is critical in the light of the fact that in India the minimum wages of a single individual are calculated on the basis of an assumption that both adults of a nuclear family are employed. Stopping wasteful over exploitation of natural resources such as land, forests, and water which constitute the livelihood of a large number of people, building food security systems and ensuring that people retain their rights over natural resources are central to survival and health.

This is no simple issue of distributing nutrient pills but of ensuring people's right to protect their land, grow their own food and to have public distribution systems that extensively cover the deserving and cater to their needs.

Central to health are the following:

* Demand for potable water supply which is gradually becoming a scarce resource threatened or polluted by the uncontrolled growth of hazardous industries.
* Better living and working conditions for women who are increasingly being pushed to take up jobs in the unorganised sectors of industries at low wages and high risks to their health.
* Social justice for women through strengthening legal and institutional support structures.
* Education for the sake of learning and not a means to bring down fertility and controlling births.
* Demand for comprehensive Primary Health Care with a special focus on making these services accessible to women who are the first to get marginalised in conditions of scarcity and financial constraints.
* Adequate supportive services to make the Primary Health Care services effective.

For women's health then two basic requisites are: (1) a multipronged attack on poverty, social injustices, and cultural myths (2) Identification of critical areas of health needs and developing around them basic as well as secondary and tertiary support services to provide Primary Health Care. Both these prerequisites however, are impediments to structural adjustments as proposed by the IMF and the World Bank, the main fund providers to the 3rd world countries.

After the Nairobi conference in July 1985 that attempted to talk of forward looking strategies for women's development, efforts are on to circumscribe women's development. Thus while ICPD converted women's health into an issue of 'safe abortions' and 'reproductive rights', it marginalised the issues of comprehensive Primary health Care, social security and investments in building infrastructural facilities. The Economic and Social Commission for Asia and the Pacific has attempted to camouflage the same effort by using 'gender sensitive' language. Despite its apparent concern for women it does not fail to state unambiguously that more than women, its concern is for the "Health care provider within households" and for the potential of the "children they bear".

The emphasis is on women's special health care needs. The special health care needs no doubt are the "reproductive needs". It is argued that the concept of reproductive health broadens the original theme of maternity health. When not more than 13 % of the rural home deliveries in India are conducted by a trained personnel, what is the point in expanding the scope of maternity services to reproductive health services? The Indian experience shows that such changes in language heralded shifts in emphasis of a dwindling health infrastructure. Services for contraception, and AIDS research, get larger and larger shares from the Maternal and child health care sources.

The justification for other components of re-productive health such as reproductive tract infection, sterility, abortion and contraception, arises not out of any epidemiological reasoning but out of a cultural argument. These are "unexpressed needs" due to the 'culture of silence' and therefore they should be provided for, even though there is no data to generalise.

In India, of all deaths among women, obstetric deaths constitute only 2.5 %: 26 % of the deaths are due to old age, 7 % due to injuries and accident, 65 % of the deaths are caused by other diseases predominantly infectious in nature. When resources for health sector are being curtailed, epidemiologically significant and socially expressed needs must first be attended to. It must also be realised that these infections directly or indirectly contribute to problems in child birth.

Given the fact that the present health service infrastructure is unable to provide the most needed public health services for controlling communicable diseases and providing maternity care, both pre and post natal, including additional responsibilities is illogical. In any case, obstetric, gynaecological and contraceptive services have always been a part of the

maternity care and should be provided as an integrated package rather than as special services.

The issue of accessibility-specially for the poor rural and urban population is yet another aspect that is not tackled by the various international bodies. Accessibility is a complex of economic, social and geographical (physical) factors and presence of service alone is not sufficient. The increasing gaps between classes are bound to affect the access of women in the disadvantaged class to health care.

The feminisation of poverty is recognised but the justification of poverty per-se is not questioned. Consequently palliative measures for women worker's health problems are talked about as more and more of them will be sucked into "unhealthy and stressful work environments".

The only communicable disease that is emphasised' is AIDS but its links with poor health service systems are not adequately emphasised. Even the draft for the platform for action to be discussed at New York in a preparatory meeting for the Beijing conference has problems. The responsibility of the State in providing basic preventive and curative services, specially for the poor, is being undermined. When the developed countries are moving towards State control of social services, the 3rd world's people must not permit their governments to handover this responsibility to NGOs and private sector.

Similarly, the urgency to deal with communicable disease is being over shadowed by concerns such as mental illnesses and heart diseases. These are outcomes of the current, epidemiological transition rooted in the pressures of daily life and social tensions for which pills are no answers.

The priority of a comprehensive approach over a selective approach to Primary Health Care is blurred by using the terminology of Primary Health Care but being selective in its content. In other words a concerted effort is there to undermine the very concept of Primary Health Care.

More important than the inadequate treatment of each of the above, is the complete separation of women from the mainstream. Emphasis on their "special problems'" and their "cultural marginalisation" over shadows the shared problems of women and men. Thus from ignoring women's special problems the pendulum has swung to recognising only their special problems.

(Contd. on p. 16 *col.* 1)

(Contd. from p. 6 *col. 2)*

interest of the ruling class and the State to subsume the class question under gender concerns and direct energies away from major structural contradictions in society.

(Collective work of the health project team is duly acknowledged. The team members-C Sathyamala, Malika Virdi and Arti Sawhny.)

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An Alternative Viewpoint About Depo- Provera

Anant Phadke

Issue No. 214-15 (Jan-Feb '95) of MFC-Bulletin contains statements from some reputed private sector gynaecologists from Bombay and Delhi, in which Inj, Depo-Provera has been declared as a very good contraceptive. Dr R.P. Soonawalla has been quoted at length. She is the Principal Investigator, Post marketing Surveillance study, Depo-Provera. She is thus probably on the pay-roll of the manufacturers. This may affect her stand. She has castigated the "ill-informed so called feminists" for asking for a ban on Depo-Provera. She has claimed that "all research has proved these contraceptives to be safe."

Despite these claims of safety of Depo-Provera by these learned gynaecologists, standard sources of drug information do not think so. This can be seen from some quotations given below:

Opinion of textbooks and formularies:

Standard textbooks of pharmacology, do not discuss DMPA in detail because all the indications, contra-indications, side-effects and adverse reactions for DMPA are similar to those of other progestogens. The only additional point made by Goodman & Gillman is that DMPA should be used only if the possibility of permanent infertility is acceptable to the patient (eighth edition, page 1404). This is quite a significant remark, because in India, unlike in the West, DMPA will be used for contraception for years and not for a few months. Hence every woman using DMPA in India should be clearly told that she may become· permanently sterile due to DMPA use.

Product information literature in the Physicians Desk Reference, Martindale's' Extra pharmacopeias, and the British National Formulary give a little more detailed information on DMPA. Given below are the quotations from these standard sources.

I. Latest, 30th Edition or' Martindale's Extra pharmacopeias, 1993: The quotations given below (emphasis added) show that DMPA has been studied much less compared to the pill, especially as regards risk of cancer and hence it is premature to approve DMPA as a routine contraceptive. It should be used only in exceptional situations.

"With regard to injectable contraceptives, *smaller* studies have indicated again that there are no long-lasting effects on fertility but it has also been suggested that a return to ovulation occurs significantly earlier in prior norethisterone enanthate users than in med-droxyprogesterone users". (Page 1172)

"Experience relative to the use of medroxy-progesterone acetate as a long-acting injectable contraceptive is *much less* than that accumulated from oral contraceptive use but a study by Liang et al, and *preliminary* evidence from the WHO Collaborative Study of Neoplasia and Steroid Contraceptives have failed to indicate any increased risk. An update of the WHO study published in 1991 indicated that, overall, depot medroxyprogesterone acetate did not increase the risk of breast cancer (relative risk compared with never users 1.21) and that risk did not increase with duration of use. However, the report noted that there appeared to be slight increase in risk within the first 4 years of use, especially in women under 35 years of age. These findings agreed with those of a smaller study by Paul et al in which women who had used depot medroxyprogesterone acetate for 2 years or longer before the age of 25 had a relative risk of 4.6" (page 1174).

"Evidence of an increased risk of developing uterine cancer has been found in women receiving medroxyprogesterone acetate injections as a long acting contraceptive but one study did note that sufficient data had not accumulated to assess the risk in long-term users or the risk long after initial exposure" (page 1175).

"Results from a WHO study provided no evidence that use of medroxyprogesterone acetate as a long acting injectable contraceptive altered the risk of developing liver cancer but *the power of the study to detect any small alterations in risk was accepted to be low"* (page 1175).

"Preliminary evidence also suggests that there is no increased risk of ovarian cancer in women receiving medroxyprogesterone acetate depot injections as a method of hormonal contraception. One study did, however, note that the *data was insufficient* to assess the influence on risk among *long-term users* or risk after long-term exposure" (page 1175).

II. Latest edition of Physician's Desk Reference (page 2544): Apart from the usual contraindications of progestogens, PDR gives the following warnings which are specific to DMPA.

1. *"Bleeding Irregularities:* Most women using DP experience disruption of menstrual bleeding patterns".

In India, due to cultural taboos, the life of women would become miserable, due to menstrual disturbance, since cooking, doing pooja or participating in religious functions is a taboo during menstruation.

2. "Bone-Mineral Density Changes: Use of DP may be considered among the risk factors for development of osteoporosis. The rate of bone loss is greatest in the early years of use and then subsequently approaches the normal rate of age related fall".

This demineralization is of special significance in the malnourished Indian women from poorer class who would be enticed to use DMPA as a spacing method in young age.

3. "Cancer Risks: Slight or no increased overall risk of breast cancer and no overall increased risk of ovarian, liver, or cervical cancer and a prolonged protective effect of reducing the risk of endometrial cancer in the population of users.

An increased relative risk (RR) of 2.19 of breast cancer has been associated with use of DP in women whose first exposure to drug was within the previous 4 years and who were under 35 years of age. However, the overall relative risk for ever-users of DP was only 1-2".

Since Indian women would be using DMPA for contraception below 35 years of age, the increased risk of cancer is real in Indian situation.

4. "Ocular Disorders: Medication should not be read ministered pending examination if there is a sudden onset of proptosis, diplopia, or migraine".

5. "Accidental pregnancies Chromosomal anomalies were observed among infants of DP users, the former being most prominent in women under 30 years of age".

Several reports suggest an association between uterine exposure to progestational agents in the 1st trimester of pregnancy and genital abnormalities in male and females".

6. "Ectopic Pregnancy: Health care providers should be alert to the possibility of an ectopic pregnancy among women using DP who became pregnant or complain of severe abdominal pain".

In India, there is high likelihood of violation of the guidelines to start DMPA within the first five days of menstruation to eliminate the chance of pregnancy. The chances of accidental pregnancy in DMPA users are thus more in India, with disastrous consequences. This makes DMPA eminently unsuitable for use especially' in a family planning programme in India where adequate care is less likely to be taken for its proper use.

7. *"Weight changes:* There is a tendency for women to gain weight while on DP therapy. From an initial average body weight of 136 lbs. women who completed 1 year of therapy with DP gained an average of 5.41b; 2 years 8.11b; 4 years 13.8Ib; 6 years 16.5 lb."

All these problems are in addition to around dozen of 'not-so-significant' iatrogenic health problems in DMPA-users.

III. Latest edition of British National Formulary (No. 28, September 1994), page 317,-

"OMPA should never be given without full counseling backed by the manufacturer's approved leaflet. It is useful for short-term interim contraception, for example before vasectomy becomes effective. It may also be used as a long-term contraceptive for women who are unable to use any other method or for those in whom other contraceptives are contraindicated or have caused unacceptable side-effects (or have otherwise proved unsatisfactory)".

These quotations from some standard sources of drug information show that DMPA is not as safe as our learned gynaecologist would want us to believe. Safety is a relative concept and it is not clear whether DMPA is safer than oral contraceptive pill. As will be seen from the above quotations, DMPA is much less studied compared to the pill. Given the lack of appropriate, sufficiently large, long-term studies on DMPA, it should not be used routinely as a contraceptive. As recommended by the British National Formulary, DMPA should be used only under exceptional circumstances, with full counseling backed by the manufacturer's approved leaflet. An educated woman who finds other methods unsuitable and who can afford the cost of DMPA may decide to use DMPA by consulting her gynaecologist, with full knowledge of side effects.

Not suitable for mass Family-planning programmes:

All this is not possible in case of mass-family planning programmes in India, whether in the Govt sector or in the NGO sector. Women served in these programmes are generally illiterate or less educated, poor and cannot make an informed choice about use of DMPA. They are more likely to be lured by an

injectable contraceptive, given the magic-like power attributed to injections in the minds of the poor and the illiterate. Lastly, since the government is so obsessed with the so-called population explosion, that experience has shown that contraceptives have repeatedly been pushed recklessly in Government Family Planning programme to achieve targets.

The government health-care-services are grossly inadequate and insensitive to properly monitor the health of the DMPA-users. DMPA is thus simply not suitable for use in the government Family-planning programme unfortunately, in many NGOs, the situation is not much different as regards attitude towards women, F.P. Programme, and female contraceptives. Hence, the use of DMPA should be banned in such mass-F.P. Programmes.

Studies in India:

In the ongoing Supreme Court case to urgently ban some of the hazardous drugs, one of the co petitioners, Saheli, in their additional submission on DMPA and NET-EN, have pointed out the following alarming data from Indian Studies.

1. The Indian studies so far have not been able to properly decide the appropriate, minimum dose for effective contraception in Indian women.

2. In the Indian study provided by Max-Pharma, Mukherji et al report heavy and prolonged bleeding in 17.7% of cycles. This is alarming in the Indian context with the high prevalence of anaemia in women.

It is no surprise, that in Indian studies, the dropout rate in DMPA users is high, (around 50%) indicating its unpopularity.

A technically strong case?

I am, however, not sure whether there is a strong enough technical case for a complete ban on its use as a contraceptive. (Since DMPA is useful in the treatment of endometriosis and as an adjuvant in the palliative treatment of inoperable meta-static endometrial and renal carcinoma, DMPA cannot be totally withdrawn from the market). Such a ban primarily on technical scientific grounds can be argued only if it is found that DMPA is more unsafe than the oral contraceptive (O.C) pill. The O.C. pill has a much longer list of side-effects, because it contains both oestrogen and progesterone. Some of these side effects are life threatening, frightening. Yet O.C. pill is recommended by all standard textbooks and. hence is in wide use in the west. Thus possibility of life threatening side-effects in itself is not a reason to ask for a ban on a drug. The question is do these risks outweigh the benefits and whether the drug under review is better or worse than the alternatives available. It is worse than what *is* already available, it should not be used. Incase of DMPA, there is a need to compare rigorously its efficacy and safety with that of the O.C. pill. If DMPA is found to be worse than the O.C. pill on this score, then that makes a strong technical case for non-approval of DMPA for contraceptive use.

Here, I am not undertaking the detailed, technical exercise of comparing the O.C. pill and DMPA. But I would like to point out four basic features of DMPA as compared to the O.C. pill Viz.; (i) It contains only progestogens and hence has side-effects of only progesterone; (ii) One injection of DMPA acts for 90 days. This may be seen as an advantage. But it may be pointed out that once injected, DMPA cannot be withdrawn from the body for 3 months, even if one wants to stop its action due to undesirable, dangerous side-effects; (iii) DMPA circulates in the body uninterruptedly. This uninterrupted suppression of pituitary-ovarian axis may explain the delayed return to fertility, observed in DMPA users. Other consequences, if any, of this uninterrupted exposure to progestogens need to be looked for; (iv) DMPA has great abuse potential especially in a country like India, where any injectable medication carries with it a halo of almost magic-remedy. The danger of this fourth specificity of DMPA can be eliminated by banning it from Government and NGO F.P. Programme. To decide about totally disallowing DMPA for contraceptive use, we will have to weigh the advantages of the first feature with the disadvantages of the second .and third feature of DMPA. To my knowledge no such rigorous comparison has been made.

Socio-political considerations

A ban on DMPA as a contraceptive can be argued more on the basis of its abuse potential mentioned above. Drug Companies would first get it approved for use in the private sector and after a few years, would lobby for its inclusion in the mass FP Programme. Given the official and popular obsession with the so-called population explosion, DMPA may be pushed into the FP programme. Given these socio-political considerations, it is a better strategy to ask for non-approval of DMPA as a contraceptive. Despite such non-approval, DMPA would be available for use in the treatment of endometriosis and as an adjuvant in the palliative treatment of inoperable, metastatic endometrial carcinoma and renal carcinoma. Those gynaecologists, who are convinced about safety

of DMPA for contraceptive use, can use it for contraception in their educated and well-to-do patients. However, they will have to take an assurance from their patient that they would not be sued if any mishap occurs due to the use of DMPA for this non-approved indication

A. perspective on contraceptives

A stand against approval of DMPA as a contraceptive in India is tied up with an overall perspective about contraceptive policy in general. Let us therefore dwell a little on this issue at the end.

1. Role of Female Contraceptives

Availability of safe, effective contraceptive can become one of the important measures for women's liberation. But a contraceptive which is adequately, safe and reliable does not exist. Secondly, most of the contraceptives available today are directed at women primarily because most men do not see contraception as their responsibility also.

Yet, strangely enough, in a way, female contraceptives are a step forward in the Patriarchal society because these female contraceptives make women independent in their choice about getting pregnant or not, free from the cooperation of unwilling, if not adamant husbands/male partners. That the existing female contraceptives are not adequately safe puts severe limitations on this choice and hence this freedom. Yet, compared to say a hundred years back, the situation for women is much better as regards contraceptive choice. This choice is further dependent upon class, and social status, educational status, geography etc. Moreover female contraceptives have made women more "available" for sexual use and abuse by their husbands because now, the "fear of pregnancy" can no more be cited a reason to avoid unwanted sex.

In spite of all these limitations, the search for effective, safe, female contraceptive must continue as they offer a defense for women in face of uncooperative husbands.

2. Research on Male Contraceptives

More than 90% of funds for contraceptive research are devoted to female contraceptives. This is not out of concern for protecting females; but because women offer a softer, more pliable option to do research on; and to be pressurized into accepting even unsafe contraceptives. Getting volunteers for research on male-contraceptives has been a problem. This is apart from the medical-technical problems in devising a contraceptive which can be used in the male-system. If the problem is difficult, it does not mean that efforts should not be made. On' the contrary, more efforts, funds should be employed. Since males are less likely to accept troublesome contraceptives, or subject themselves to unethical, uninformed trials, more research on male-contraceptives would raise the ethical quality of contraceptive research. Thus funding policy for contraceptive research should be changed to give adequate funds for male-contraceptives. Repetition of hazardous, unethical trials should be strictly avoided.

3. Vigorous Push to Non-invasive Contraception

Given the basic problems of safety of invasive contraceptives, there is a need to focus on the non-invasive, barrier methods of contraception. Top priority must be given' to the research for improving the efficacy of condoms and (male or female) and the efficacy, convenience, and safety of spermicidal, A combination: of good condom and spermicidal offers the best prospects. In the era of AIDS, condoms have an additional advantage. An extensive and intensive educational programme needs to be launched on a sustained basis to effect attitudinal changes in males so that more and more men agree to use barrier methods themselves. Unlike in other issues like sharing of domestic work etc; the resistance of men can be more easily overcome if sufficient education, persuasion is employed. The powers be have devised all kinds of innovative methods to popularize the need for "family-planning". Minus the co-ercive part of this so-called family-planning campaign, the Governments and NGOs all over the world should focus their energies on promoting the male and female condom along with the spermicidal. Men must be told clearly, forcibly about the serious, potential side-effects of invasive methods on their beloved partners and compare this with the advantages of the condom. The use of "mucus method" which can reliably and accurately tell the women's fertile period can also be popularized much more as an aid to non-invasive methods so that couples can once in a while safely enjoy intercourse without any barriers.

A campaign which appeals: "Don't you care for your wife? Then use a condom" can be successful. Use of barrier methods is an indicator of mutual understanding between the partners. In an ideal society, the "Safest is the Best" motto should rule; the 'safest' would mean some mutual adjustment and responsibility, which is not easy to come by in today's society.

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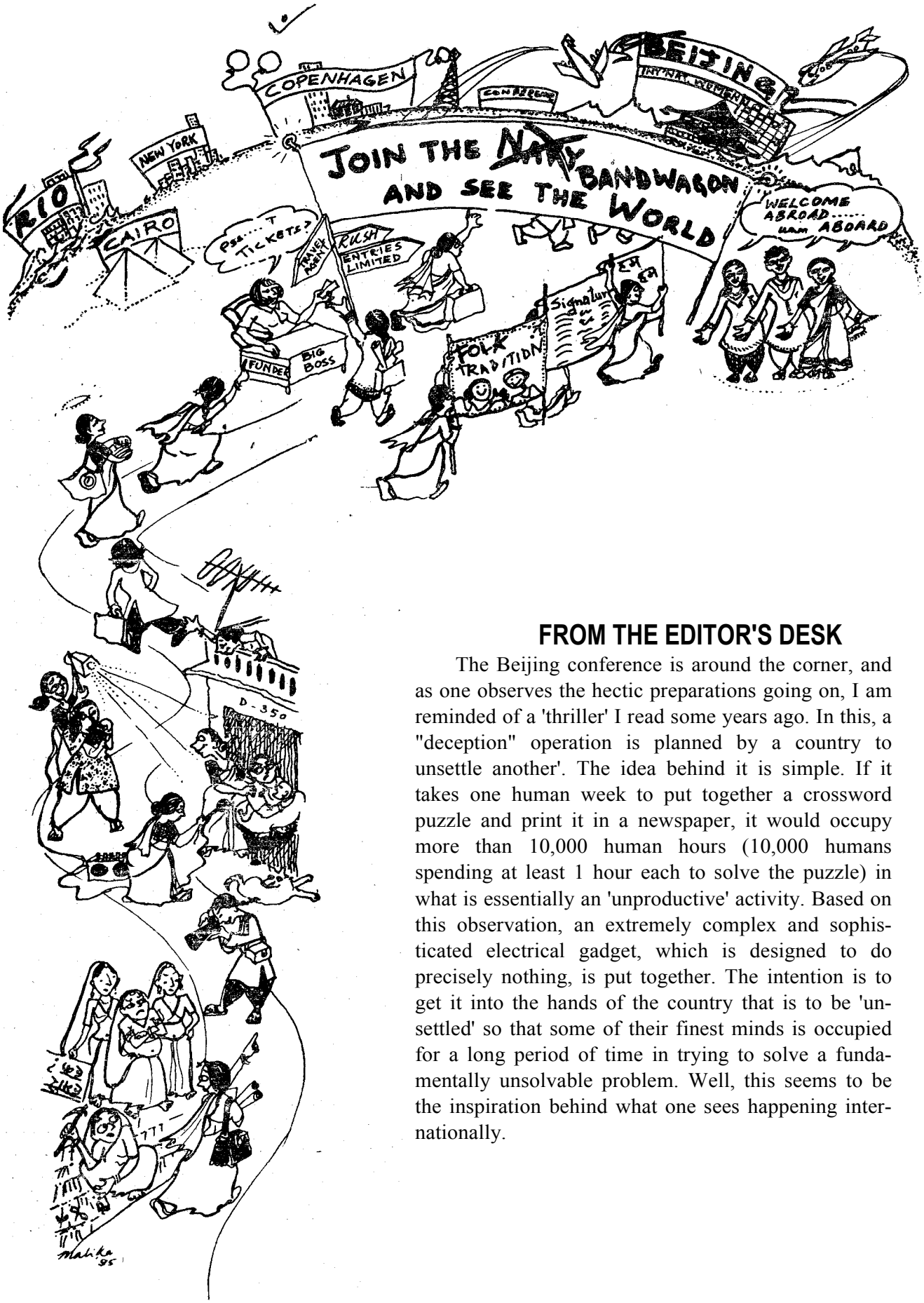

FROM THE EDITOR'S DESK

The Beijing conference is around the corner, and as one observes the hectic preparations going on, I am reminded of a 'thriller' I read some years ago. In this, a "deception" operation is planned by a country to unsettle another'. The idea behind it is simple. If it takes one human week to put together a crossword puzzle and print it in a newspaper, it would occupy more than 10,000 human hours (10,000 humans spending at least 1 hour each to solve the puzzle) in what is essentially an 'unproductive' activity. Based on this observation, an extremely complex and sophisticated electrical gadget, which is designed to do precisely nothing, is put together. The intention is to get it into the hands of the country that is to be 'unsettled' so that some of their finest minds is occupied for a long period of time in trying to solve a fundamentally unsolvable problem. Well, this seems to be the inspiration behind what one sees happening internationally.

Between 1975 and 1995, there have been eight international conferences preceded by innumerable preparatory meetings". For the Beijing conference, there has been, so far, 7 official Prepcom meetings and 7 Prep corns for the unofficial NGO forum. Jet loads of activists (both men and women) have flown from conference to conference and have been kept so busy that they have had little time to put their feet on the 'grassroots'. And attending the conferences is no better: trying out their lobbying and 'advocacy' tactics learnt essentially from sponsored trips to USA, trying to change a comma here and a full-stop there, (and if one is lucky, one may even get a bracket shifted") in country papers and the final documents. One fails to understand how these efforts will change and improve the conditions of the poor and oppressed people in Third World countries.

More than 36,000 NGOs are expected to attend the NGO forum at Beijing. While on the face of it, it may appear as though women's voices (albeit as articulated by the NGOs) are being heard at last in international fora, and that 'women' are emerging as a force to reckon with, the whole phenomenon needs a deeper reflection. If the intention is to create a diversion from building up local strength to collectively oppose fundamental issues of exploitation and poverty, the strategy seems to be succeeding very well. But this time the intention seems to be more than just that. For the Beijing NGO forum, special attempts are being made to send 'real' women, i.e., 'grassroots' level women workers. Whereas the objective is to create an illusion of participation from the working class, in reality, it is a clear attempt to expose them and tempt them with a certain life-style which would have been beyond their reach but for the largesse of funding agencies. Why this sudden generosity?

As the experiment in State sponsored Women's Development Programme has shown, women are permitted to become 'empowered' and express their 'empowerment' only 8.S long as they serve the interests of the State. The moment a threat is sensed, the 'empowered' women's organized strength is crushed ruthlessly. It is also not chance that functionaries of the same gender, who one presumes consider themselves gender 'sensitive'; are the ones who implement such ruthless measures. Patriarchy may cut across class lines, but class interests are also equally powerful. And while a woman from the upper classes maybe gender sensitive, when it comes to class, caste, and communal interests she may not be so sensitive. Including a woman from the working class in this complicity is the new strategy devised to induct her into the sanctum sanctorum of the inner privileged circle. This is what the Beijing NGO forum is all about.

I would like to end this with the words of a young woman *Sakhi* (equivalent to the *Sathin* post) from Saharanpur who died later of a non-pregnancy related cause for want of timely medical help[4]: *Behanji* (sister) when you talk of equality, are you talking of equality with my husband who is a landless labourer, or of equality with my landlord who owns 60 acres of land, or of equality with you who earns about fifty times my wages.

1. Bagley D, Running Blind, Fontana, 1971.
2. International conference on women and development, 197~, (Mexico); Mid-Decade conference on women, 1980, (Copenhagen); International conference on women and development, 1992, (Rio de Janeiro); World conference on human rights, 1993, (Vienna); International conference on population and development, 1994 (Cairo); World summit on social development, 1995 (Copenhagen); and Fourth world conference on women and development, 1995 (Beijing).
3. Portions of the draft that remain controversial are put in square brackets to be negotiated at the actual conference. In the draft for Beijing, the world 'gender' is still bracketed as there is no agreement on its usage in the document (Manorama R, *Uma Pracher,* March-May 1995).
4. Bhatti, Vikalp, Saharan pur, (personal communication).

Sathyamala

"The NGO forum helps in networking builds solidarity for the work to be done. Earlier, even in the 1985, Nairobi conference on Women and. Development, linkages between the NGO forum and official forum were few. The NGO forum was extremely active, intellectually stimulating, a fun place to .be. But it remained external to the official processes. Now the scenario is changing. With their growing strength and maturity, NGOs are playing a vital role in the official processes... NGOs have learnt a whole new set of skills for official negotiation and lobbying and its politics. What we have to guard against is people who are not knowledgeable and who are not skilled in lobbying going for the Prepcoms and conferences"

Gita Sen, a leading light of DAWN

Uma Prachar March-May, 1995

"During the New York Prepcom for Beijing, NGOs were not allowed to go in during major negotiations. The Indian Government refused to take up the issue of 'violence created by mega dams and projects and other kinds of development projects' that NGOs are opposed to."

Ruth Manorama & *Uma Prachar,* March-May, 1995.

(Contd. from p. 9 col. 1)

Ignoring macro level questions such as the need to tackle social and economic conflicts between classes and the politics of health rooted therein, leads to some serious consequences. Effectiveness of contraception becomes more desirable than its safety and drugs are seen more as a source of profit rather than the means of controlling suffering. The priorities of one class are taken care of *at* the cost of the priorities for others. Thus diabetes, heart diseases, cataract and cervical cancers are projected as the upcoming problems and Kala-Azar, malaria and diarrhoeas that are killing women, children and men are not mentioned.

In other words, broadly good intentions are not backed by sound analysis leading to biased prioritisation. The root causes of ill health as a social problem therefore remain untouched.

The same processes that are responsible for poverty are also responsible for feminisation of poverty. There can be no defeminisation of poverty without attacking poverty itself. Those who argue that women alone can be helped to break out of the trap they are caught in, are only attempting feminisation of the strategies of control. If women are to be targeted for social development in deteriorating economic conditions then, this can only be the means for stability in chaos's. It is expected that a woman strengthened will be a better "care taker" of an uncared house hold. She will do what the State is refusing to do: provide basic securities through her labour for love. This new kind of development and peace is too costly a myth and women must see through it. ●

(Contd. from p. 13 col. 2)

At the same time, the search for an adequately reliable and safe female contraceptive should continue. Such a female contraceptive would keep an additional option open to women. In no case, should any contraceptive be tried on humans without making certain that the contraceptive is potentially safe and reliable, i.e. after testing it in repetitive, extensive animal trials for sufficient duration. ●

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