WHO ROCK THE CRADLE? WOMEN, FERTILITY CONTROL AND TECHNOLOGY IN INDIA

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Voicing deep concern against pervading gender bias against women, particularly, and also the general bias against poorer people in family planning programmes, ignoring the criticality of their inputs, the authors raise a number of related issues duly backed up with empirical evidence. Underscoring the need to resist forcing of FP methods and technology on them without securing their informed consent permitting option from a range of safe methods, the authors are highly critical of persistence in forcing of such methods which, based on research findings, are known to have serious side-effects.

"WOMEN ARE at the centre of the development process. The improvement of their status and the extent to which they are free to make decisions affecting their lives and that of their families is crucial in determining future population growth rates."[1]

However, even a cursory scan of the demographic literature ranging from statistical accounts of fertility levels, target achievements and performance evaluation, including use of contraception to the surveys of knowledge, attitudes towards family planning (FP) brings out clearly that though fertility has been treated as an almost exclusively female attribute, the decision-making in terms of not only FP, but also who would practice it almost always lies beyond female domain.* Just one example would suffice: vasectomy—voluntary male

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[1]R. Ahmed, *Population Headliners*, No. 207, June 1992, p. 1.

*It often happens that despite unwillingness to bear more children, women do not use any preventive measure because their husbands do not approve the practice, *see*, S. Bhatia, "Traditional Practices Affecting Female Health and Survival : Evidence from Countries in South Asia", in A.D. Lopez and L.T. Ruzicka (eds.), *Sex Differentials in Mortality*, Canberra, Australian National University, 1983. Another study about family planning knowledge, attitudes and practices among males in Nigeria is noteworthy in revealing differences in the relative authority and responsibility of men and women where men expressed a desire to have a major role in the decision to limit fertility but they felt that the responsibility for actual use of contraceptive lies predominantly with women. *See*, G.A. Oni and J. McCarthy, "Family Planning Knowledge, Attitudes and Practices of Males in Ilorin, Nigeria", *International Family Planning Perspectives*, Vol. 17, No. 2, 1991, pp. 50-4.

sterilisation—offers "effectiveness, a quick and simple procedure, permanent protection, convenience, little risk of complications, no long-term effect on his own health or sexual performance, and no health risks for his wife" yet it is the least known and least used method. Worldwide, about 42 million couples rely on vasectomy as opposed to nearly 140 million who rely on female sterilisation.*

THE IDEOLOGICAL BASE AND FERTILITY CONTROL

India has the distinction of being the first country in the world to formulate its National Population Policy in 1951. In early years of its inception, welfare aspects of FP in the context of overall medical and public health services, including maternal and child health programmes, were highlighted. A decade later, concurrent social and economic development, as an important component of population control, was included. Health, nutrition and family planning were envisaged as a single package which was, in fact, seen as a part of still bigger package of the Minimum Needs Programme of the Fifth Five-Year Plan. But, as pointed out by Banerji, despite repeated concern to link FP to the wider development processes, in practice its implementation throughout the three decades has remained coercive, motivationally manipulated and bureaucratised.[2] Over the decades, the attention has increasingly been almost entirely directed towards women as the target group which is attributed by some to the past experience of coercive male sterilisation during the period of emergency, which ultimately resulted in the tumbling of the then government.[3]

Although India is one of the three developing countries where vasectomy is a major FP device[4], it may be seen that over the last three decades, *i.e.*, from 1956 (the year of inception) to 1989, tubectomies accounted for 61 per cent of total sterilisations. What is more, over the last one decade, not only tubectomies are on rise, but their proportion as percentage of total sterilisations was also as high as 73 to 87[5] per cent. According to 1990-91 figures, in addition to other FP devices, women formed 94 per cent of the acceptors in sterilisation cases[6]. Service statistics suggest that in India, 21 per cent of the married women in the reproductive age have been sterilised and that 60 per cent of Indian couples

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*The same study reports that men were more willing to support their wives in using contraceptives than they were to consider using them themselves.

[2]D. Banerji, "Technology of Reproduction Control and Population Policy" in V. Gowarikar (ed.), *Science, Population and Developemt*, New Delhi, Umesh Communication, 1992.

[3]N.H. Antia, "Science, Population, Development and Health Care" in V. Gowarikar, (ed.), *op. cit.*, p. 27.

[4]*Population Reports*, 1992, Series D, No. 5, pp. 1-2, and *Population Reports*, 1992, Series C, No. 10, pp. 1-5.

[5]Government of India, *Family Welfare Programme Year Book 1979-80 and 1989-90*, New Delhi, GOI, 1990, p. 172.

[6]V. Gowarikar (ed.), *op. cit.*, p. 439.

using contraception are protected by female sterilisation alone.[7] Since sterilisation-based FP is essentially adopted by the families who have already achieved their desired family size, in India, greater use of birth spacing through intervening methods have been propagated. These methods include pills, IUDs, condoms, implants, injectables and so on. It is clear that given the nature of options available, users aiming at family planning would still be largely women. Thus, not only the technology itself is not gender neutral, it reduces women from productive persons to reproductive machines constantly undergoing technocentric experimentations. In an extremely sensitive and investigative analysis, Greer notes aptly how, in the course of governmental interventions, individual's right to control own reproductive destiny—an extremely private matter—has been invaded and how reproductive behaviour has been made a public matter in the hands of medical and pharmaceutical establishments.[8]

It may be noted that although Margaret Sanger has been hailed as a pioneering figure in advocating birth-control, from the outset, her interest was to limit the excess fertility of the poor.[9] At an international conference on birth control in Bombay in 1956 under her leadership, the rhetoric of her purpose remained unchanged even though the target audience was foreign:

> Nor did we question that a husband and wife living in squalor and ignorance who already have a number of children not being reared properly, might well be considered unfit to have additional children. Yet many parents of these various unfit types keep producing unduly large numbers of children, chiefly because through ignorance or indifference—and often against their will—they let Nature take its course.[10]

Over years, a somewhat similar situation has prevailed in India. Referring to 1971-73 period, Mitra observes:

> The sterilisation campaigns in the past had assumed* . . . the character of aggression by the strong on the weak, reflecting the fear that the poor and less endowed, by the strength of their numbers, were going to swamp the rich and better endowed. A similar fear has been in evidence among rich and numerically small nations who feel threatened by poor but large

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[7] *Population Reports*, 1990, p. 4.
[8] G. Greer, *Sex and Destiny: The Politics of Human Fertility*, London, Picador, 1984.
[9] *Ibid.*, p. 303.
[10] *Ibid.*, p. 341.
* In this context, it is revealing to note that a research on a possible chemical for a male pill was terminated when it was found to react unfavourably with alcohol consumption. *See* H. Jackson, "Antispermatogenic Agents", *British Medical Bulletin*, Vol. 26, 1970, pp. 79-8.

nations and have relentlessly advocated population control as the panacea....[11]

It is ironical that in recent past despite perceptible change in attitudes and objectives of FP, much of the malady continue to plague a substantial population of the country in that the poor still form a distinct section of the 'target' group for population control. The reason for such a state of affairs is ideological. In case poverty were to be seen and explained not so much as an outcome of exploding population alone, but as a consequence of misappropriation of wealth, of lopsided approaches to planning and of inadequate political will, the centres of gravity of the population problem would have shifted from the masses to the 'powers-that-be'. This, in turn, would have involved a revolutionary change in the existing power structure, a major revamping of political machinery and a fresh look at the various components of population management, including issues pertaining to education, literacy, maternal and child care, women's employment, land reforms, etc. Given the nature of massive efforts, will and the ensuing discomfort, this would mean to some sections of the society, it was much easier to shift the responsibility of saving India from the Malthusian doom to well-equipped sleek laboratories in affluent countries and seek foreign assistance essentially in the field of developing devices for birth control.[12]

There are enough documented evidences to suggest that ever since the setting of a new Family Planning Department in 1966, our efforts to hasten the demographic transition have been largely technocentric without taking into consideration the basic developmental issues which are crucial in generating demand for contraceptives.

Without going into details at this point about the problems of technologies which were imported, the three isolates of the politics of fertility control as reflected through our population efforts so far are as follows: (*a*) female sexuality under male control, (*b*) fertility control of the poor by the rich, and (*c*) control of developed countries in terms of technological transfer.

These relations can be understood within the framework of patriarchy. But instead of defining it as a structure in which men as a group dominate women as a group, patriarchy has to be redefined as a system of social structures which needs to be conceptualised at different levels of abstraction consisting of: (a) the patriarchal mode of production, (b) patriarchal relations in the paid work, (c) patriarchal relations in the state, (d) patriarchal relations in sexuality, and (e) patriarchal relations in cultural institutions.*

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[11]K. Sharma, "Women, Population and Development : Some Reflections"; in V. Gowarikar, *op. cit.*, p. 352.

[12]Banerji, *op. cit.*, pp. 49-50.

*This section draws heavily from Walby. *See*, S. Walby, *Theorizing Patriarchy*, London, Basil Blackwell, 1990.

Areas where affordability of public health is a major policy issue, the state is supposed to play a far greater role in enforcing legislations and interventions affecting the right of citizens, in general, and that of women, in particular, as far as fertility control is concerned. However, the state, in its very origin, is patriarchal as well as capitalist and racist although the latter aspect has not been touched upon in the present analysis. It is, therefore, not surprising that most of the state operated interventions in fertility control are gender biased and operate within the existing notion of male supremacy in which women are always made to fit into controlled categories defined by males. That FP as an approach was identified with birth control and contraception rather than family welfare with the women at the centre except as human guinea-pigs for carrying out various experiments is enough to understand the prevailing thinking.

At the outset, fertility control of the poor by the rich involves the notion of class and the capitalistic mode of production. In such a context, there exists a distinct cleavage between producers and expropriating class: the 'haves' and the 'have nots'. As has already been pointed out, the redistribution of wealth in such situations is a rather tricky matter and it remains in the interest of the rich to control the fertility of the poor.

At this juncture, it is appropriate to ask what is the relationship between class and gender. A complete analysis of this aspect is outside the scope of this article, but it may be noted that gendered economic cleavages may co-exist class cleavages within capitalism and women can be "the poorest of the poor". Thus, there are two class systems, one centred around patriarchy and the other around capitalism.[13] Access to information and control over construction of knowledge by males as well as the rich countries can also be viewed within this dual system. In this context, the gradual professionalisation of obstetric and gynaecological services and commercialisation of fertility control at the expense of traditional/indigenous methods as well as import of obsolete technologies are not without meanings.[†] Some of these aspects are highlighted in the following section of the article.

FERTILITY CONTROL AND POLITICS OF TECHNOLOGY

As pointed out earlier, women operate within structures which are unrelated to them. In the field of FP, institutions which control contraception from production to access are areas where they have no say.

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[13]S. Walby, *Theorizing Patriarchy*, London, Basil Black-well, 1990.

[†]The general aversion towards condoms by the Indian men has been attributed in some way to a fear in the Indian sub-continent that western rejects are commonly dumped there. *See*, J. Rakusen, "Depo-Provera, the Extent of the Problem : A Case Study in the Politics of Birth Control" in H. Roberts (ed.), *Women, Health and Reproduction*, London, Routledge and Kegan Paul, 1981.

Out of a wide range of available contraceptives, one may opt for: (*a*) the regulative methods of FP, *e.g*, pills or (*b*) invasive methods, *e.g*., intrauterine devices. Both the methods entail a certain degree of difficulty in usage because they are not entirely harmless for general health of the acceptor. Some of these side effects are too well known to obviate a detailed discussion. However, the following section outlines some of the problems associated with a few methods—some the latest, some not so latest—in fertility control.

CASE OF DEPO-PROVERA: THE INJECTIBLE MIRACLE

The contraceptive 'pill' of the 60s came to be known as a wonder pill which would help to accelerate the FP programmes. However, in the early 1970s, the possible side-effects of the 'pill' began to filter in reducing the general efficacy of the pill.

The Depo-provera (DP), an injectible contraceptive consisting of progestogen (a synthetic female hormone) was pushed into the market as the most dependent and useful method of FP. The propagation of this contraceptive as an outstanding device was based on the virtue of "it being an injectible, so that its control need not lie in the woman's hands"[14]. This was the 'wonder drug' which was seen as particularly useful for the Third World where women were not sufficiently informed, nor motivated to take the pill or use the IUD or condom and diaphragm or for those who were unable or unwilling to use alternatives[15] or for those who were illiterate, unreliable and irresponsible[16].

The very fact that the biggest threat of population explosion came from the Third World, where mass illiteracy, poverty, ignorance and health awareness were beyond comprehension and where population programme was essentially geared towards reduction in fertility as well as birth rates provided an ideal market for aggressive publicity campaigns by multinational big business houses for a drug which could be administered by external agencies outside the control of the users.

DP since been banned in the West. The reasons were that breast tumors became prevalent reaching cancerous proportions. There are also incidences showing that it induces cervical cancer.[17] DP also tends to delay the return of fertility, perhaps causing permanent damage to pituitary gland and infertility. The manufacturers also duly acknowledge that birth defect may be induced in

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[14]J. Rakusen, *op. cit.*, p. 78.

[15]M. Smith, "Depo-Provera—A Review", *Scottish Medical Journal*, Vol. 23, July 1978, p. 3; and H. Roberts, *op. cit.*

[16]Girotti and Hauser, *Therapeutische Umschau and Medizinisehe Bibliographie*, Band 27, Bern, 1970, p. 671; and J. Rakusen, *op. cit.*

[17]L. C. Powell and R. J. Seymour, *American Journal of Obstetrics and Gynaecology*, Vol. 2, 1971, pp. 946-8.

children of women who were administered with the drug during pregnancy. It has been observed that during lactation, children tend to absorb considerable amount of DP via their mothers' milk.[18] The drug has also been associated with liver tumors.

NORPLANT CONTRACEPTIVE-SUB-DERMAL IMPLANTS

Norplant, a long acting, reversible hormonal contraceptive that provides protection for five years has become another wonder implant of the 90s. However, it is a provider-dependent method. That is, its use depends on the service delivery system to provide women not only with access to personnel who can insert and remove it, but who can also closely monitor their health during all phases of implementation.* Secondly, the most important guideline for the implant is regarding informed consent.†

While the technology *per se* is not to be undermined and "the introduction of any new product or service into the Family Planning System of a country is, to a large extent, a process specific to that country; certain principles and responsibilities of the services provided should be stressed to assure the appropriate use of the new method".[19] Women's satisfaction with Norplant, therefore, depends not only on the features of the method (its high level of effectiveness, long acting duration and convenience) but also on the quality of the FP services.

However, its potency for the Third World population is still a suspect. While the effectiveness, long-acting duration and convenience is emphasised, as is clear, there is total apathy so far as the women's health is concerned. The question remains: are FP services envisaged merely to assist in the control of 'bleeding' by providing a couple of pills to check 'dizziness'? What happens to 'choices' and the concept of 'informed consent' both consequent upon extremely detailed divulgence of information to the women

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[18]B.N. Saxena, K. Shrimanker and J. G. Grudziwskas, *Contraception*, Vol. 16, No. 6, 1977, p. 605.

*Even the Indian Council of Medical Research has admitted that 10 per cent of the women who were on trial for Norplant have been lost to follow up. For a detailed discussion, *see* P. Mehra, "Of Human Guinea Pigs", *The Illustrated Weekly*, May 2-8, 1992.

†The superficial way in which information is imparted to the users has been brought out in a documentary made by Deepa Dhanraj on family planning. She has also interviewed two volunteers for Norplant who categorically admitted that they were not told about the Norplant trial being conducted on them. Similar incidents of misinformation or no information abound in case of other means of family planning. *See*, P. Mehra, *op. cit.*, 1992.

[19]WHO, Norplant Contraceptive Sub-demal Implants, *Managerial and Technical Guidelines*, Provisional Version, 1970.

under question*? Related are the questions of available expertise and handling and storage of material.†

Based on 20 years of exclusive research and testing, both in the developing and developed countries, it is estimated that by 1989 approximately 55,000 women in 41 countries had used Norplant in clinical trials and pre-introduction evaluations. An additional 300,000 women had used the method in countries where Norplant is approved for general distribution.[20] However, it may not be out of place here to mention that the same Norplant 2 has been withdrawn from the US market because of economic inviability of conducting additional studies following doubts about "the teratogenic and carcinogenic potential of the synthetic material, Elastomer 385, that Norplant contains".[21]

That even the WHO manual on the Norplant is not explicit about the effects of the Norplant is a matter of great concern. Further, cases where Norplants have been abused have come to light in the USA. Women criminals accused of drug usages (whose children were found to be addicted since birth) have been forced to implant Norplants whereby their pregnancy can be totally controlled for at least five years. Earlier, two days after the formal approval of Norplant in USA, the technology was projected as a tool to control the spread of black population.[22] Technology apart, it is necessary to question ethics involved as

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*There is still on obsessive adherence to traditional attitudes about female sexuality. A phenomenon common to all the professions is the tendency to withhold information from potential consumers and then to accuse those consumers of ignorance. Nowhere is this more evident than in the medical profession. (*See*, P. Roberts, *op. cit.* Citizens, particularly women, who are demanding to be more informed about particular contraceptives, therefore, pose a challenge to medical authority.

†There are very specific guidelines for the users of Norplant as well as for those who cannot use it. The latter category includes women, who are suffering from: (*a*) acute and chronic liver disease, (*b*) jaundice, (*c*) unexplained vaginal bleeding, (*d*) those having blood clots in the legs or eyes, (*e*) having a history of heart attack, chest pain due to diagnosed heart disease, (*f*) smokers, and (*g*) those who are pregnant. Those who can use Norplant with special precautions and follow-ups are the ones with: (*a*) diabetes, (*b*) disease of the breast, (*c*) elevated cholesterol, (*d*) high blood pressure, (*e*) migraine or other headaches or epilepsy, (*f*) gall bladders, kidney and heart disease, (*g*) mental depression, and (*h*) severe anemia.

Similarly, there are elaborate guidelines as to who can perform the insertion and removal of Norplant. Removal can be sought on the bases of: (*a*) dissatisfaction with the method due to side-effects and other complaints, (*b*) personal reasons, such as desired pregnancy, (*c*) change in the marital status, (*d*) religious consideration, (*e*) accidental pregnancy, and (*f*) severe hypertension or anemia. All this presupposes an excellent health infrastructure.

It has been pointed out that "the fact that implant removal is more difficult for clinic staff than is the discontinuation of other methods should not influence the decision to discontinue the Norplant. Storage requirements are stringent and has to be protected from excessive heat, excessive moisture". *See*, WHO, "Norplant Contraceptive Sub-derival Implants", *Managerial and Technical Guidelines*, Provisional Version, 1990.

[20]WHO, *op. cit.*

[21]P. Mehra, *op. cit.*

[22]K.R. Srinivas and K. Kanakmala, "Introducing Norplant Politics of Coercion", *Economic and Political Weekly*, July 18, 1992, pp. 1531-3.

well as the underlying patriarchal ideology in such value judgments. Can a male judge in the state court take such a decision? What about a male HIV carrier? Can he be forced to undergo vasectomy or even castration to 'control' his libido?

In all such cases, much is at stake as far as the nexus between developed and the developing countries, between patriarchal power relations, between control of male *vs* female sexuality and its consequences for fertility is concerned. Our contention is that while limits to population growth is a must, the unqualified acceptance and adoption of contraception in a situation where the targets are predominantly women, used as "guinea-pigs on a conveyer belt" is unethical.

IMPLICATIONS FOR THE THIRD WORLD WOMEN

It is generally difficult to achieve adequate monitoring and follow up because services are inadequate. Moreover, few women would freely accept public examination and cervical smears to assess the effect of a contraception. Fewer still have complete knowledge and confidence about their own anatomy.

The service delivery systems are usefully inadequate in the developing countries. Potential users may be deterred by distance of the service unit or waiting time or the unsympathetic behaviour of the staff. Invariably, it is noted that women get first exposure of FP and welfare services when they receive ante-natal and delivery services and their experience during this exposure becomes the basis of the attitude toward the service delivery system.[23] It is quite clear that if proper scanning and follow-ups were practised, fewer women could end up being forced to a particular form of contraception such as DP and Norplant. Consequently, the speed with which most FP methods are forced on to the women would be slackened. This would definitely check the 'conveyer belt' approach to contraception.

It has been observed that "those in charge of giving out contraception largely dictate the contraceptives that women will 'choose', since their own prejudices govern the information put across as well as the contraceptives available".[24] 'Clinical judgment' in the use of contraception may not always be in the best interest of the woman. For instance, a drug licensed for short-term use in very limited circumstances (*e.g.*, Norplant) has its shortcomings. The very availability enables the doctors to prescribe a particular drug, in whatever way they like, based on their 'clinical judgment'. Some doctors discourage the use of 'diaphragms' mainly because of the tedious procedure and the time involved

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[23]Indian Council for Medical Research (ICMR), *Socio-Cultural Determinants of Fertility*, New Delhi, 1983, pp. 57-68.

[24]Rakusen, *op. cit.*, pp. 75-108; M.E. Lane, R. Arceo and A. J. Sobero, "Successful Use of the Diaphragm and Jelly", *Family Planning Perspectives*, Vol. 8, No. 2, 1976, pp. 81-6; and T.J. Trussell, R. Faden and R.A. Hatcher, "Efficacy Information in Contraceptive Counselling : Those Little White Lies", *American Journal of Public Health*, Vol. 66, No. 8, 1976, p. 76.

(wasted?) in their proper fitting. Many abuses, therefore, relate to the question of choices and of 'informed consent'. Even the distributors of the technology manipulate the choices. There have been cases, *e.g.*, DP where consents were sought under duress and the contraceptive was given under the guise of glucose injections. Such abuses are common in mental hospitals, asylums and even in the 'homes' for women criminals under probation.*

IN SUM

In a country like India, "even verbal expression of the couple that they want no more children is normally understood as synonymous of desire of adopting terminal method of birth control (*e.g*, tubectomy or vasectomy)".[25] It is fairly well established, therefore, that any initiation of birth control practice is not a simple act. Acceptance of particular FP technology comes through a complex process of mental preparedness. Thus, the adoption of a particular contraceptive is not the result of a single decision.[26] The entire question hinges upon a delicate balance of power. The point remains as to who controls the body of knowledge and information on contraceptive technology? Who controls the female sexuality and who is at the helm of the affairs? Invariably acceptors' questions go unanswered; at times questions are never asked because of the experience of being intimidated. In the ultimate analysis, not only any attempt at coercion through a technology which aims only at the control of population has to be resisted, but an uncontrolled distribution of the contraceptive technology in the Third World coupled with inadequate information women tend to receive in this regard has to be resisted as well. What is far more valuable is the concern for an overall improvement in the quality of life in which women's health assumes paramount importance and where women are treated as human beings rather than a mere medium for reproduction.

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*A case of a 14 year old girl from London is revealing who decided on the pill, having changed her mind from the IUD, only to find that she had been given Depo-provera without her knowledge while under general anesthesia during an abortion. *See*, Rakusen, *op. cit.*

[25]A. Kumar, "Understanding of Hindrances to use of Family Planning Methods with Special References to Uttar Pradesh" in ICMR, *op. cit.*

[26]ICMR, *op. cit.*, p. 64.

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