

REPRODUCTIVE RIGHTS IN THE INDIAN CONTEXT : AN INTRODUCTION

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What are Reproductive Rights?

Do reproductive rights merely mean the right to reproduce? Or is the issue inextricably linked to the numerous questions that surround women's reproductive freedom?

The ability to reproduce seems to be what sets women apart from men. But do women have control over their own reproduction? Do women have the freedom to choose whether, when, and how many children to have? Do women have access to safe birth control methods? Do women have the right to safe abortion? Can sexuality be separated from reproduction? A big 'NO' in answer to many such questions led to the emergence of the women's health movement in different parts of the world in the early 1970's. It started as small 'consciousness raising' groups, which began by spreading awareness among women about the functioning of their bodies and gradually evolved into multi-faceted campaigns that have significantly influenced health policies in many countries.

Who Controls Women's Bodies? The Central Question Comes Into Focus

Control over women's bodies and sexuality is a crucial aspect of reproductive freedom. Hence, the women's movement articulated the range of situations in which patriarchal control over women's bodies expresses itself: from a husband forcing his wife to have sex to a government forcing a woman to undergo sterilisation. It critiqued the institutionalisation of patriarchal control over women's sexuality in the form of monoandrous (one husband only) hetero-sexual marriages. And challenged the predominant social norm of patrilineage (inheriting from the father's side) that only offers the stamp of legitimacy to the 'legitimate' heir, and severely punishes sexual expression or reproduction outside marriage.

When a woman does not have bodily integrity, when her body is invaded against her will, when her choices are determined by social norms rather than personal preference, it is unlikely that she can play an active role in decision making, be it at the micro household level or macro societal level. In an attempt to reclaim women's control over their own fertility, and open avenues for autonomy and decision making in other aspects of life, the women's health movement all over the world has defended women's right to voluntary maternity through access to safe contraception and abortion services. This struggle for women's 'reproductive rights' has resulted in the right to contraception being conceded in many parts of the world, although women still lack easy access to affordable contraceptives which are free from side-effects. Yet even today, these services are denied to women in many other parts of the world. Religious and cultural taboos prevent them from using contraception. In cultures such as India where motherhood is glorified and infertility viewed as a curse, the use of contraception is frowned upon. Nevertheless, thirty years after it began, the struggle for women's control over their own fertility has led to a separation between

sexuality and reproduction, where women are able to experience their sexuality without pregnancy being the inevitable result.

Reproductive Rights in the Third World: An Indian Perspective

The feminist analysis of patriarchal control over reproduction by the women's movement all over the world has spearheaded individual and collective attempts to fight against it at all levels. At the same time, women's groups in third world nations have asserted that the debate on women's reproductive rights must account for the fact that reproduction is only one aspect of women's physiology and lives, and cannot be viewed in isolation. They argue that the understanding of patriarchy must encompass far more complex realities, because we live in societies where political, economic, cultural and social factors come together to influence women's health and determine understandings of fertility and infertility, sexuality, reproduction and gender roles.

The Indian perspective on reproductive rights has had to additionally take account of several other inequalities and contradictions in society. On one hand, traditional feudal society has sought to regulate every aspect of women's lives. Religion, caste and cultural values have played important roles in defining and controlling women's fertility. And, sharp class contradictions have not only created, but also heightened inequalities with a direct adverse impact on women's health. On the other hand, the history of colonialism has compounded the situation further by contributing to the systematic destruction of indigenous structures of healing and health systems, and imposing allopathy or 'modern western medicine' as the norm. In the present scenario of economic liberalisation, this legacy has received a new lease of life, resulting in the exploitation of Indian markets and people by multinational pharmaceutical companies. Coupled together, these factors are causing rural-urban divides to sharpen further, creating ever-increasing gaps in development and planning, access to resources and opportunities. Overarching this scenario is the population control agenda of the first world that is dictated through international financial institutions and implemented through Indian population programmes and policies.

In a situation where women have no 'right' to clean drinking water, basic facilities, health care or education; where society decides where women will live, how they will live (and often, how they will die), who they will marry, whether they will study; where the State (and international development and aid agencies) believe they have the 'right' to determine how many children women will bear, when they will get sterilised and what form of contraception women must 'opt' for; it is apparent that the struggle for Indian women's reproductive rights needs to go further than reproductive freedom, and enter the arena of social, economic and political rights.

Population Control And Birth Control: What Is The Difference?

Women's groups have long campaigned for women's right over their bodies, and at the same time, they have argued severely against population control. Is that a contradiction in terms? It is crucial to understand that 'birth control', is an individual woman's right to control her fertility, and at most, a couple's attempt to determine family size, while 'family planning' or 'population control' is the government/States' attempt to limit the numbers of its citizens. This fundamental difference manifests itself as the difference between women's overall health and their reproductive role, individual life choices and national goals, personal empowerment and coercive government

programmes and policies that trample upon the individual's right to birth control in the national pursuit of limiting population.

Population growth and more significantly, population control has been one of the dominant areas of concern for the Indian state since soon after independence. But worldwide concern about numbers, especially of the poor, pre-dates this by almost 200 years when Malthus propounded his famous theory that population grows in a geometric progression, and will soon outstrip the earth's ability to provide food, which only progresses in an arithmetic progression. In fact, he also used this principle to explain the poverty of the masses and the inability of the rich to improve their circumstances.

Although history has proven Malthus wrong, and the earth continues to produce sufficient food for all its inhabitants, over the last two centuries, his theories have been modified, twisted and propagated to ease the conscience of the rich and consequently, the power of the nations of the first world. In fact, recent years have seen an increasing link being drawn between the argument of resource scarcity and the presentation of population growth as a security threat. The main proponent of the scarcity-conflict model, Canadian political scientist Thomas Homer-Dixon suggests that environmentally induced internal conflict in turn causes states to fragment or become more authoritarian, seriously disrupting international security. Internationally, the scarcity-conflict model largely dictates foreign policy and immigration laws, population and environmental policies today. This perspective ignores the other, more important factors of environmental degradation – forest policies which lay the ground for ravaging of forests by contractors and the government; uneven development plans, inequitable consumption patterns, and the widespread use of polluting technologies.

Is the scarcity argument really valid?

In the 1970s, Paul Ehrlich and John Holdren, scientists following the Malthusian perspective, put forth an algebraic equation, $I = PAT$ measuring the impact of humans on the environment (I) as the product of the number of people (P), affluence/the amount of goods consumed per person (A), and the pollution generated by technology per good consumed (T). This relationship between population, consumption and world resources has been widely used, but such a simplistic analysis fails to account for the complexities behind the *who* among the monolithic 'P' is responsible for *what*, and the *how* and *why* behind pollution. Is there any comparison between the 'A' and 'T' of the militaries of the world and an equal number of common people? Then, there are the issues of trade imbalances and debt. And factors like the subordination of women and other marginalised sections of society.

At a time when much is made of the fact that the global population has reached the 6 billion mark, it is worthwhile to remember that just under 25% of the world's population consumes about 75% of the world's resources and energy, and the same fraction generates most of the world's waste and global atmospheric pollution. The Pentagon, for instance, is the largest single consumer of energy in the US and generates one ton of toxic waste per minute. It is the 'luxury' emissions of the rich which generate almost 90% of ozone-depleting fluorocarbons (CFCs) and two thirds of carbon dioxide emissions, rather than the "survival" emissions of the poor. The 'consumption explosion', however, with its disastrous implications appears to engender less fear in the public consciousness.

Moreover, a perspective such as Ehrlich and Holdren's ignores the organic relationship with nature shared by many indigenous and rural communities. Human beings are not merely avaricious consumers of the earth's resources, but also protect and nurture the earth. Rural Indian women have spearheaded widespread ecological movements, questioned the dominant development paradigm, and campaigned for a more sustainable development model. If anything, the unsustainable depletion of natural resources is more characteristic of an urban, industrial society.

This is amply illustrated both within the country, and across international borders. In Latin America, for instance, vast tracts of valuable rainforest were cleared for cattle ranching. Due to favourable tariff treatment, most beef in Latin America is exported to the US, much of it for use in fast-food chains or for pet food. The average Central American eats less beef than the average house-cat in the US. At the same time, the consumption pattern of the elite in any Third World country is comparable to the relationship between that country and the 'developed' world. In India, the consumption by the highest income group (1.44% of the population), of electricity, petroleum products and machine-based household appliances – products that have global environmental impact – is about 75% of the total consumption for these commodities. For instance, the land diverted from food crop production to floriculture not only has an adverse impacts on nutritional levels, but degrades the environment with high pesticide and fertiliser use.

Global estimates have shown that every North American child consumes as much energy as 3 Japanese, 6 Mexicans, 12 Chinese, 33 Indians, 147 Bangladeshis, 281 Tanzanians or 422 Ethiopians! Yet, the truism that all people use resources and create waste, and large families use more resources and create more waste, gained currency among most international development agencies which put the 'population problem' high on their agenda. The 'T' component of the debate – the highest polluting industrial processes that provide consumer goods for the wealthiest fifth of humanity are controlled almost entirely by men in the most powerful, transnational corporations, governments and industrial giants who manufacture chemicals and weapons of mass destruction, with the main goal of maximising economic growth and profit. Yet, policies of 'population control' are targeted at the 'poorest of the poor' – women whose main goal is survival. Women targeted by these population control programmes are institutionally powerless, and have larger numbers of children for complex reasons that range from immediate survival and necessity, to high infant mortality, lack of access to health services and patriarchal control over reproduction. In Third World countries and poorer societies, the absence of social security means that children are not only a necessary security blanket in illness and old age, they are additional working hands crucial to the survival of the family, rather than additional consumers who drain the family, or in fact, global resources. Yet, the arguments of First World policy makers and elite from the Third World continue to hold sway.

It is clear that the 'population control perspective' only serves to reduce people to mere statistics, without a realistic foundation in social realities. Consequently, it limits the definition of women's health to reproduction alone, and bases all analysis and action on two fundamental fallacies: that the fastest and most cost effective way to reduce birth rates is to ensure the use of modern contraception; and that family planning should be a higher priority than basic health care.

Intervention of the Indian State: Limited to Women's Reproductive Role

Following independence, population growth was erroneously presented by policy makers as the biggest hindrance to India's development. Hence, although women's health has been a key area for state intervention since the early 1960s, the emphasis has largely remained on women's reproductive role. Even today, macro policy issues concerning health and population continue to be dictated by the over-riding objective of population control.

The last few decades have witnessed policy makers' pre-occupation with pregnancy and contraception-related services. Till date, this focus on reproductive health continues to address the symptoms, and leaves untouched the fundamental causes of women's ill-health. For instance, high maternal mortality rates are quoted as a reason to impose contraception. It is widely known that about 15% of all deaths occurring among women of child-bearing age are related to pregnancy, but what is rarely mentioned is that communicable diseases account for 30% of the mortality (deaths) within this age-group of women. Moreover, while the 'cause of death' may technically be maternity-related, the underlying conditions most often include fever, tuberculosis, malnutrition, anaemia and a range of undefined illnesses.

It is crucial that policy makers recognise that the root causes of ill health among women are social rather than biological. For instance, we all know that despite the quantum work that women do, most of it remains unpaid and unrecognised, and women are not viewed as 'producers' (of wealth) whose health has to be nurtured. Hence, they are often denied nutritious food in adequate quantities. It is not surprising, therefore, that malnutrition and under-nutrition among young girls and women accounts for high rates of morbidity (illness) among them. Added to this is the issue of access and utilisation of health services. A number of studies have shown that women tend to use health services much less than men, and continue to work and carry out their societal roles despite a high burden of ill-health. Yet, women's health in government policy has remained restricted to reproductive health i.e. contraception, abortion and maternity services.

With one of the oldest population programmes in the world, Indian women, especially from the poorer sections, have been subjected to a population reduction programme garbed in euphemisms ranging from 'family planning', to 'family welfare' and now to 'reproductive health'. Changing the terminology of the population control programme from "Family Planning" in the early 1950's to the present term "Reproductive and Child Health" has not changed the framework within which women's health is viewed. Today's family welfare programme is still replete with incentives and disincentives, and punitive measures like barring people with more than 2 children from contesting elections.

After the debacle of forced sterilisation of thousands of men by the Congress government in the mid-1970s, the onus of population regulation has shifted entirely onto women. And the focus has moved from safer, user-controlled methods like the diaphragm and the cervical cap to a range of dangerous contraceptives which are long-acting, invasive and beyond the control of the women using them. Another 'solution' that has been steadily gaining currency, is that of encouraging early sterilisation of women. Today, sterilisation accounts for 71% of contraceptive use in India. But since it is usually performed after a family size of 3-4 children is achieved, it is not considered to have 'a significant demographic impact' even though it is an effective option of birth control for the individual woman.

For the policy-maker in search of methods to 'reduce numbers', long-acting hormonal contraceptives like injectables (Net En and Depo Provera) and implants like Norplant are "ideal" because they are controlled by the provider (the government and/or medical establishment).

Women need not be 'relied upon' to remember to take the pill, or keep IUDs (intra uterine devices like the Copper-T) in place, and men need not be persuaded to use condoms. The shift to long-acting contraceptives which are hazardous is justified on the plea that birth rates have to be brought down in a hurry. The price that women pay with their health is not a relevant fact for policy planners. The nexus between the population control establishment and pharmaceutical companies promoting hormonal methods, also ensures that safer, cheaper and reusable barrier methods like the diaphragm and cervical caps are almost totally unavailable in India.

For many decades, it has been well known that birth rates are affected by the means of production, i.e. whether it is a subsistence economy or an industrialised economy; women's status and education, family structures, women's entry into the labour force etc. Though Indian representatives at the first World Congress on Population in Bucharest in 1975 popularised the slogan "Development is the best contraceptive", official policy has concentrated almost exclusively on provision of contraceptives. The International Conference on Population and Development in Cairo in 1994, to which India is a signatory, was followed by the much touted 'paradigm shift' in population policy from 'demographic imperative' language and accommodate women's perspectives. Yet, real changes have yet to be seen on the ground. The panic about population explosions overtakes concerns of empowering women and primary health care. The budget for 'family welfare' is still almost double the allocation for health – a clear indication of state priorities. Technological 'solutions' of developing more and more 'effective' contraceptives (even if they are more and more hazardous) are a politically 'safer' option for governments than genuine changes which could impact living standards, health conditions and birth rates, e.g. land reform, expansion of social services, and more even-handed distribution of resources. It is this paradigm which has to shift for birth rates to fall and equitable development to take place.

Twenty Years Of The Indian Women's Health Movement: Campaigns, Issues And Concerns

The women's health movement began in India in the early 1980s, with small groups of women discussing various aspects of being female. From experiencing menstruation, problems of contraception, awareness of bodies, and early discrimination which results in malnutrition. Cultural and religious taboos about menstruation, pregnancy and childbirth were thrown to the winds and issues brought out into the open. And the roots of women's oppression were analysed in the context of personal own lives, and the slogan 'personal is political' took on new meaning. Slowly, the discussions spread. Into colleges, among working women, into bastis and middle-class colonies. Charts, posters, phads (traditional pictorial representations on cloth), plays and songs became the medium to spread awareness about women's health issues. Simultaneously, what evolved was a scathing critique of the medical establishment, its dual role with respect to women, depending upon their class: its utter neglect of poorer women who had no access to medical care during pregnancy and its over-medicalisation of pregnancy and childbirth for higher classes of women, manifested by unnecessary caesarean sections, for instance.

A long battle against hazardous contraceptives

In the early 1980's, women's groups discovered unethical testing of hormonal contraceptives that were harmful to women's health. The Indian Council of Medical Research (ICMR), India's premier scientific institute, was trying to assess the acceptability of the injectable contraceptive, Net-En, prior to its introduction in the Family Welfare Programme. But instead of informing women (most

of them poor and illiterate) that they were subjects of a trial, and therefore, could be exposing themselves to both known and unknown health risks, injectable contraceptives were presented as the miracle solution to their problem of unwanted pregnancy. Such exploitation of women's individual need for birth control to meet national demographic goals was totally unacceptable on medical, ethical and social grounds.

Firstly, hormonal contraceptives like injectables can be extremely hazardous, causing irreversible and serious damage to women's bodies, influencing much more than just their reproductive system, by adversely affecting some functions of the brain.

Secondly, hormonal contraceptives require very close monitoring at every stage by trained personnel using sophisticated equipment. This should be done before use (to establish whether the method is suitable for the woman), during use (to determine any adverse reactions), and after use (to check for possible after-effects). The Indian health system being what it is, anyone can tell that it is close to impossible to make such facilities available either in primary health centres, or in fact, in many, especially small government hospitals, much less ensure that they are appropriately utilised.

Then, there is the crucial issue of insufficient knowledge on long-term harmful effects of hormonal contraceptives on human beings. Existing studies on animals have shown extremely disturbing evidence that these methods could cause diseases like cervical cancer, breast nodules and endometrial cancer (cancer of the lining of the uterus). Yet, the government continues to promote them as 'ideal contraceptives' for women.

Although hormonal contraception is meant for spacing children, return of fertility (the woman's ability to bear children) is also not certain. If a child is conceived either due to failure of the method, or immediately after the woman stops using the method, or if hormonal contraception is used on a pregnant woman the resultant child could have birth defects, that may show up as late as puberty. Neither the government nor the drug companies have conducted sufficient studies to determine what might happen.

Besides the pill, all hormonal contraceptives are long-acting e.g. injectables (such as Net En and Depo Provera), implants such as Norplant, nasal sprays, etc. They have an effect which ranges from 2-3 months (injectables) to 5-6 years (implants). Thus, even if a woman wishes to stop using the contraceptive, the effect of the hormone continues to linger in and affect her body for a substantial amount of time.

Lastly, the key 'advantages' of long-acting hormonal contraceptives, i.e. their effectiveness and their ease of administration have, in fact, proven to be key threats for women. They blind policy makers to their hazardous effects on women's health, they place the control of women's fertility in the hands of the health-service provider rather than in the hands of the woman, and expose them to potential for abuse inherent in these forms of delivering contraceptives. For instance, a woman may not know that the injection she is receiving is a contraceptive. Informed consent is a crucial issue which is often violated in clinical trials of contraceptives and their subsequent use. Often, women are not informed sufficiently about the nature of the drug or its possible side-effects. Which explains why women's organisations the world over, and India as well, have been opposing the introduction of long-acting hormonal contraceptives. In fact, over the last two decades, the campaign against hazardous hormonal contraceptives, which started with

injectables like Net En and Depo Provera, has broadened to include Anti Fertility Vaccines, hormonal implants like Norplant, and the Quinacrine method of chemical sterilisation of women.

Women's groups in India have consistently been campaigning for safe and effective contraceptives such as barrier methods like the condom, diaphragm and cervical cap. They have asserted that in order to increase women's control over their bodies, hazardous contraceptives, and contraceptives with potential for abuse should not be developed. Instead, the focus should be to develop contraceptive methods which promote women's health and well-being; be user-controlled (i.e. the woman or man using the contraceptive should have control over it), be reversible in the case of spacing methods, have no effects on children subsequently born, meet the needs of the women who will be using them at various times in their life cycle, and exhibit demonstrable advantages over existing contraceptives.

The women's movement has also campaigned towards increasing male responsibility for contraception. The condom is a cheap, reliable and easy to use barrier method with practically no side-effects, and it also provides necessary protection against sexually transmitted diseases and HIV/AIDs. Yet, male resistance to condom use has itself proved a barrier to popularising this method. Similarly, vasectomy (male sterilisation) is much simpler and with fewer complications than female sterilisation, but men's reluctance to undergo vasectomy leads to women having to take the major responsibility for sterilisation as well. Overall change in men-women relationships is essential, since it has been well established that women cannot gain control over their bodies in the context of unequal gender relationships.

The Abortion Debate

Abortion remains one of the most controversial issues of women's rights. In fact, it was the struggle for legalisation of abortion that sparked off the women's health movement in the U.K. and U.S.A. Yet, in many countries of the world, including industrialised countries of the West, abortion is still illegal, or conditional i.e. women can resort to abortion only in case of rape, or if the life of the mother is seriously threatened. Clandestine/illegal abortion is the cause of serious health complications and even death of women the world over.

The abortion debate stems from widely differing perspectives about when 'life' begins. 'Pro-life' advocates, i.e. those against women's right to abortion, say that 'life' begins at conception, and aborting a foetus is tantamount to murder. 'Pro-choice' advocates, i.e. those campaigning for women's right to abortion, say that 'life' begins only after the foetus is 'viable' i.e. it can survive outside the mother's body. Inherent in this controversy is the conflict of interests between the right of the woman to choose whether or not to go ahead with the pregnancy, and the interests of the foetus, which 'pro-lifers' claim, is an entity with a right to life. The pro-life position, advocated mostly by the Catholic Church, the Jewish orthodoxy and some sections of Islamic clergy, and newly emerging right-wing groups in the recent past, holds sway in many countries. In the United States, abortion became legal, albeit with restrictions, only as recently as 1973. However, anti-abortion forces began to mobilise, and the Hyde Amendment, enacted in 1976 banned state medical insurance for abortion, making it virtually inaccessible to the majority of women, especially the poor, black and Hispanic women who could not afford to have abortions outside the public health system. The anti-abortion movement, though it calls itself "pro-life", is in fact indifferent to fate of millions of women who die of unsafe abortion. Moreover, pro-lifers, in their

campaign to restrict the right to abortion have no hesitation in using violent tactics like harassment of medical practitioners performing abortions, and the bombing of abortion clinics.

In India, abortion was legalised by the Medical Termination of Pregnancy Act, 1972. Yet, even today, a majority of women do not have access to safe abortion services. Legal abortion services are not easily accessible, and women continue to resort to unsafe practices and self-induced abortions, making a mockery of the legalisation of abortion. Studies estimate that there are 2.2 illegal abortions for every legal abortion. Moreover, legalising abortion has, and continues to clearly be a tool for coercive population control. Women who approach government facilities for abortions are forced to 'accept' contraception/sterilisation after the abortion is performed.

Unsafe abortion is a major cause of death and health complications for women of child-bearing age. Although it is difficult to get data on illegal abortions, it is estimated that world-wide, one-third of all abortions are illegal. 20 million unsafe abortions are performed annually, and estimates of the number of women who die from unsafe abortions all over the world range from 70,000-200,000 each year. While fighting for the women's right to safe abortion, the women's movement has also cautioned women about the dangers of repeated abortions. Making safe and reliable contraceptives available to all women, including adolescents, would go a long way in reducing the need for abortion.

Struggles to re-orient scientific research

Beginning as it did with an exposé of the unethical nature of trials of contraceptives in India, the women's movement has highlighted women's right to information and protection against health hazards, in the pursuit of 'the perfect contraceptive'. Women's groups have protested vehemently against the fact that thousands of women in India and other Third World countries, being subjected to known and unknown hazards in the course of such research and trials, that too without their knowledge! They have exposed the blatant violation of internationally accepted norms of informed consent during clinical trials, pressed for more stringent regulation of studies and trials in both, the government and non-governmental sectors. They have also highlighted the inconsistencies of institutions such as the ICMR, World Health Organisation (WHO), United States' Federal Drugs Administration (USFDA), Drugs Controller General of India (DCI) which lay down such norms for 'ethical scientific research on human subjects' and yet have been known to violate them. In addition to bringing the debate of ethical scientific research into the public arena, these groups have raised fundamental questions regarding the direction of medical research, especially contraceptive research. Pressing for the pursuit of safer, non-invasive methods of contraception for both men and women, and a more women-oriented and pro-people perspective marked by a healthy balance of societal needs and individual rights.

Other attempts to regain control over health care

With a view to constructively countering the biases of government institutions and policy on one hand, and medical and scientific establishments on the other, the women's movement in India initiated attempts at self help and fertility awareness in order to regain control over their bodies. Today, groups all over the country are making multi-faceted attempts to evolve new and more sensitive approaches to women's health and health care. They are re-discovering traditional and indigenous treatments and cures, and redefining women's relationships with their bodies. And in

the process, taking significant steps to crucially impact the control that patriarchy in society, and the state has over their lives.

Strategies for awareness

The women's health movement in India has been sustained for the last two decades through a vibrant mix of strategies. The struggle against the coercive population control programmes of the government have been complemented by poster exhibitions, leaflets, street plays, songs and signature campaigns among the public. Debates with the scientific community and research establishment have been carried further through protests against the government and pharmaceutical companies. Lobbying with policy makers, submitting memoranda, critiquing official policy documents, direct action like sit-ins (dharnas) and other pressure tactics have effectively created a climate where the State is forced to heed the voices of women.

Analysis of scientific data, publishing of reports, mobilising the press, legal strategies and networking with other progressive groups have been part of other efforts to raise women's health issues at every level. In the matter of information dissemination, women's groups have also tried to gather, understand and share with others, women's experiences with various contraceptive technologies and the family planning programme. On the other hand, they have been working to demystify scientific jargon, and present it back to the people. At the same time, women's groups have continued to counter state propaganda of population control.

Consequently, they have won several battles. From the courtroom, they have managed to prevent the introduction of injectable contraceptives in the family planning programme. They have compelled pharmaceutical companies to take cognisance of their social responsibilities. They have created sufficient pressure for withdrawal of funding for some controversial research. They have compelled the establishment to change its perception of us from women who 'protest for the sake of doing so' to women who are a force to reckon with. Today, they wish to consult "women's groups" and "health advocates" on a range of issues from approval of new drugs to the formulation of Ethical Guidelines of Medical Research.

In the process of resisting harmful contraception, the Indian women's health movement has sharpened its critique of why the government promotes such methods and questioned the premise that "over" population is the cause of poverty, and that curbing the numbers of the poor is its "solution". Highlighting the gross inequalities in access to resources which is the real cause of poverty, they have resisted coercive population control policies that target women, especially the poor. Therefore, one more of significant area has been attempts to re-orient policies at both, the national and international levels.

Pressure to influence policy frameworks

The women's health movement in India has attempted to influence national policy related to health and population. Following the declaration of the International Year of Women in 1975 by the United Nations, national governments across the globe have experienced pressure to adhere to international norms of women's rights and human rights. The Convention on the Elimination of All Forms of Discrimination Against Women (1979) [CEDAW] which has been ratified by India, is a significant international treaty that protects the right of women to make their own decisions

about their fertility and sexuality. Under the CEDAW, governments are obliged to take appropriate measures to eliminate all forms of discrimination against women, including those forms that result from the lack of reproductive health services and education. The Convention stresses that policy makers, governments and service providers have to see fertility regulation and reproductive health services as a way to empower women, and not as a means to limit population growth, save the environment or speed economic development.

Yet, women's groups in India have had to consistently struggle against a national population control programme that remains coercive and anti-people. Despite several changes in terminology, 'target based approach' population control continues to be the norm, as do incentives and disincentives introduced by successive governments. Continuous pressure by women's groups has ensured the withdrawal of some of the more draconian measures recommended by an Expert Committee set up by the Government of India in 1993, like the use of paramilitary forces to enforce the use of contraception. Yet, several other challenges posed by the dominant population control mindset remain. Attempts to formally introduce a population policy at the Centre and in various states are constant, with states like Madhya Pradesh having succeeded in doing so. And in Haryana and Rajasthan, state governments have taken the unconstitutional step of disqualifying anyone with more than two children from contesting for Panchayati Raj institutions.

While resistance by the women's movement to such population policies has been unanimous, there has, at the same time, been some discussion and debate about the possibility and desirability of a 'feminist population policy'. Marge Berer, one of the proponents of this concept has outlined the dimensions of such a policy: the state would ensure that women have a free choice to decide the number of children they have; it would take care of poverty and assume responsibility for the sick, the old and children; it would change the role of women, provide them with jobs, etc and stop focussing on women only for contraception and population control. While agreeing in totality with the vision of such a policy, other women's groups have argued that this is a revolutionary redefinition of society itself and should not come under the term 'population policy' at all. A term that renders people invisible, and gives governments the sanction to intervene in matters like family size and individual contraceptive choices, without ensuring that it fulfil its responsibilities of dealing with the problems that cause inequalities in the first place.

The 1980s saw the emergence of a redefinition of reproductive rights. Vibrant women's health movements in many countries, as well as active international networking amongst them had a visible impact on national and international policy making on women's health. Following the International Conference on Population and Development (ICPD) (Cairo, 1994), the definition of reproductive health has moved out of the confines of the genitals. This wider perspective, adopted by both policy makers and non-government organisations (NGOs), has attempted to take a more holistic view of women's reproductive health. At the ICPD, the connection between sexual and reproductive health and human rights was explicitly acknowledged, as well as the links between population and human development, women's status, health, collective and individual well-being, and the respect for individual rights, especially reproductive rights. The all-encompassing Principle 4 of the Cairo document declares, "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility are cornerstones of population and development related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of human rights."

The Beijing Platform For Action from the Fourth World Conference on Women in Beijing in 1995 recognised women's right "to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence." (Beijing Platform For Action, Para 96). The Beijing Platform defines health in very broad terms as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Women's health involves their emotional, social and physical well-being and is determined by the social, economic and political context of their lives, as well as their biology."

Yet even by the turn of the century, all these international conventions have done little to change things on the ground.

Challenges Of New Technology

Pre-Natal Sex-Determination

New reproductive technologies have combined with patriarchal attitudes to take woman-hatred to new depths. Techniques like ultrasound, amniocentesis, and chorion villi biopsy developed to detect abnormalities in the foetus have, in India, been largely (mis)used to detect the sex of a foetus, and abort it if it is female. Pre-natal sex-determination tests have become enormously profitable, making full capital of the obsession for sons in our society. In addition to this grave violence against the female, the implications of sex-determination followed by abortion of female foetuses can already be seen at the macro level. Demographic imbalances have been heightened, affecting sex-ratios in the national population which has declined from 972 females per 1000 males in 1901 to 927 per 1000 males in 1991!

Women's groups all over the country have been protesting since the early 1980s when these tests first became available. They came out into the streets, demanding equal treatment for girl children, staged plays, sang songs, took exhibitions to street corners, distributed leaflets and raised the issue in local trains, in the media, schools, and forced the public to think about this issue. They challenged the myth that only sons take care of parents in their old age, by highlighting how much of that responsibility falls on the shoulders of daughters and daughters-in-law. They simultaneously held that state policies must be reoriented so that female children are not liabilities. Equal opportunities, and an adequate social security system would also go a long way in remedying the situation.

One of the major planks of the campaign was legislation to curb the proliferation and misuse of sex-determination tests. Maharashtra was the first state to enact a law in 1986. A country-wide campaign for a central law resulted in legislation finally being passed in 1997. Despite pressure from women's groups, the law remains full of loopholes, and is almost impossible to implement. The nexus of a strong lobby of commercial interests and the desultory functioning of the Vigilance Committees set up under the Act, and the fact that women undergoing these tests are also liable to punishment, has resulted in a situation where no one is willing to report violation of the law.

In the matter of sex selective abortion, it has been crucial for the women's movement to distinguish itself from the orthodox moral right which is anti-abortion per se. While fighting for women's right to abortion, we maintain that sex-selective abortion is an act of violence against the female gender. The proponents of these measures make no efforts to change the material conditions in society which result in females being an 'unwanted species'.

Sex-selective abortion has thrown up a challenge to the concept of reproductive rights itself. Proponents of sex-determination assert that women have a 'right' to undergo these tests and also abort an unwanted female foetus. Yet, in a society obsessed with the need to produce sons, with harsh consequences for women who 'fail' to do so, sex-determination followed by selective abortion can hardly be looked upon as a free 'choice' that women exercise. Loss of status within the family, traumatised by taunts, beating, and even being thrown out of the house are direct consequences of not producing a son. It is not surprising then, that women 'voluntarily' choose to undergo sex-determination tests.

Criminalising of sex-determination is not the sole step that will stop this form of violence against women. While making it illegal does remove social sanction from the practice, deeper changes are necessary to ensure that women are not devalued. Discriminatory inheritance laws, limited educational and job opportunities, family, community and caste structures that perpetuate the secondary status of women all have to change.

New Reproductive Technologies

In India, where womanhood and motherhood are so inextricably linked, infertility is looked upon as a serious disability. A 'barren' woman is the target of social disapproval, and is often outcast. Even though the male is often the infertile partner, it is the woman who bears the stigma of infertility, and made to feel worthless and inferior. In this context, the appeal of technological solutions to infertility are obvious. On one hand, some technologies of assisted reproduction (ARTs) help infertile couples to bear their own biological child. But research scientists and physicians the world over are constantly devising new technologies that range from in vitro fertilisation (IVF) and embryo transfer to genetic diagnosis of an embryo before implantation, and even cloning. All of which will certainly cause a drastic change in our relationship to child bearing, both individually and as a society.

The implications of such high tech and expensive medical interventions are serious and the ethical dilemmas posed by these technologies grim. In the first place, many of the new technologies involve a great degree of invasiveness and medical manipulation of women's body systems. They can pose grave risks to women's health, not to mention, the mental trauma and tension associated with such a venture. In addition, they also involve large monetary investments. Which leads us to crucial questions of who owns these technologies, and who profits from them? Do all 'needy persons' have equal access to them? And how proportionate is the amount of money spent on such research? There are those within the women's movement who vociferously argue that it would be wiser if such money was spent on researching preventive health measures that could avoid some of the causes of infertility such as sexually transmitted diseases, or even on cleaning up the polluted environment and toxic workplaces which are increasingly proving to cause infertility.

As these technologies proliferate, the ethical challenges that confront society also increase. The women's movement has been specifically concerned about issues of parenting and women's rights that are becoming more and more complex. For instance, surrogate motherhood (where a woman carries the foetus to the full term and then, in accordance with a prior arrangement, gives it up to the 'parents') poses a challenge to the notion of motherhood itself. Then there are questions such as what should be done with extra embryos that are not implanted? Can a woman use her

husband's frozen sperm after a divorce? Or how can we prevent the pre-selection of an embryo according to sex, or physical attributes?

The final goal of reproductive engineering appears to be the manufacture of a human being to suit exact specifications – of physical attributes, class, caste, colour and sex. Who will decide these specifications? We have already seen how sex-determination has resulted in the elimination of female fetuses. The powerless in any society will get more disempowered with the growth of such reproductive technologies.

It is also crucial for any society to understand infertility as a social problem and not merely as a biological one. Efforts must be made to make alternatives to having one's "own" children, such as foster parenting, adoption etc. more socially acceptable. A wider perspective, balancing societal needs and the individual "right" to bear a biological child at all costs has to be evolved.

In Conclusion

Reproductive Health has been defined as "a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and couples are able to have sexual relations free of the fear of pregnancy and of contracting disease." But in a world where a woman's rights are so severely curtailed; where her sexuality is not hers to have a say over; where she does not have access to equal opportunity or health care; where the state is determined to interfere in if, when and how many children she has; where privatisation, social sector cuts, shrinking work opportunities and wages and dwindling food security systems are hitting women hardest, it is clear that her reproductive rights cannot be discussed in isolation.

At the family and community level, the only way to tackle reproductive health issues is to locate them within the broader spectrum of needs as perceived by women. Similarly, at the policy level, this debate can only be meaningful if it recognises the interdependence of reproductive health, general health, and socio-economic conditions. The reproductive health concept, as advanced by both state and aid agencies, focuses on regulating women's fertility. In doing so, they have been merely 'women-centred', and not, it must be emphasised, 'pro-women'. They have failed to grasp the full complexity of the term 'reproductive health' and to put it in a public health perspective. Instead, they have repeatedly resorted to technocentric strategies of moving from one hazardous contraceptive to the other, one population control programme to the next, rather than opting for considered social and structural alternatives that have a development-led perspective. And in the process, they have systematically damaged women's health, and consequently, the health of the entire population.

For the women's movement, which for decades has been articulating the links between women's reproductive rights and their cultural status and socio-economic rights, the term 'reproductive rights' has come to be an ideal to work towards. A symbol as it were, of a society free from the ills of prejudice and malpractice, of coercion and compulsion. A vision of a world where the good health of all is as much a state of mind as a state of physical well-being, and consequently, the key to a healthier future for all.

* Saheli, New Delhi, is an autonomous women's group active in the campaign against hazardous contraceptives and coercive population control for more than sixteen years.

The group has also evolved a critique of unethical medical research and has been demanding a re-orientation in scientific research. This chapter is based on and reflects the group's work, experiences and concerns.

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