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Population Control: State Sponsored Violence Against Women

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The planet is getting polarized in demographic and economic terms. Developing countries experience problems with their population growth along with pervasive poverty. Demographic projection of population raise questions on the ability of the earth's carrying capacity to maintain people at adequate standard of living. Inspite of the overall improvement there are wide variations in the quality of life of people. High rates of growth of population therefore certainly need to be contained. Thomas Malthus in 1798, exactly two centuries ago, had warned about maintaining.the balance between population and flood-supply unless population size was controlled. The population in these two centuries has grown six fold from one billion to six billion. Food available in the market is enough to feed all, and on this count Malthus is proved wrong. If people still go hungry it is because of absence of distributive justice in the prevailing social system. Similar situation prevails with respect to other resources.

The problem of having adequate resources is not necessarily a problem of the future. Many non-renewable and renewable resources are already being used in an sustainable manner and consumption is more than the earth can regenerate. Available information indicates that the economic inequity among people is very rapidly growing. A fraction of the world's people consume disproportionate amount of natural resources.

During the pre-independence period, national leaders active in movements for improving the life of the people in general and those working for the welfare of women, such as the All India Women's Conference, had discussed the health problems faced by the women and the children. Some of the elite, who were exposed to Malthusian thesis on population set UP Neo-Malthusian Leagues on the lines of those functioning in England and Europe to warn people on the dangers of large size of population. First such League was established in 1929, in Madras City. Similar Leagues were established in Pune and Bombay. However the data available from the -censuses had shown that the rate of growth of population.was low. During 1911 and 1921 the population had actually declined from 252.1 million to 251.3 million because of high mortality. Health of the people was a major problem.

Professor R. D. Karve, who was the main motivator for the work of the League in Pune, was convmced that to improve the health conditions of the people the conditions of women needed to be improved. He also realised that the poor conditions of women were both products of their neglect and results of the problems such as high morbidity-mortality in the society. To improve, the conditions of women, among the issues he dealt with were, child marriages, widow remarriages, access to knowledge on sexual health and availability of contraceptives to regulate child bearing. Dr. Karve started a magazine named Samaj Swasthya that discussed issues of social well being. It advised men and women to use contraceptives so as to make men see reason in taking their share of responsibilities in parenting a child and prevent unwanted pregnancies thereby reducing incidence of induced abortions.

The Bhore Committee set up in 1943 to asses the health situation in the country, submitted its report in 1946. The Committee recommended setting up of the health infrastructure that would promote preventive health through primary Health Centres (PHCS) spread to cover entire population. Incidently, the WHO Assembly held in Alma Ata in Russia, which suggested Health for All, had the same principles for designing health services. Bhore Committee had also suggested the need to control population. In the First Five Year Plan (1951-56) of the independent India, provision was therefore made for a Family Planning Programme. It is to be noted that similar work of guiding couples to regulate fertility, so as to liberate women from the cycle of pregnancies and deliveries, carried out in England by the Planned Parenthood Federation, was called Birth Control. Indian programme which had the aim of health of mothers and their children was named Family Planning.

The programme came in operation in 1952. India became the first country to accept fertility regulation in the national programme. A sum of Rs.6.5 million was provided in the First Plan. The Programme was to provide services for care during pregnancies and during the post-natal period, and motivate couples for regulating fertility in the interest of the health of the mothers and their children. Advise and services for contraceptives as well as research was also included in the programme,. Since family planning was a part of health programme a cell was created in the office of the Director General of Health Services.

The number of family planning clinics rose from 50 in 1951 to 156 in 1956 at the end of First Plan and to 4,134 by the end of Second Plan (1956-61). To assure that services were available to all the couples the clinics were spread through the rural as well as the urban areas.

"Based on a mathenmtical model, Coale and Hoover showed that, with the rate of growth of population experienced by India, in 30 years the per capita income would be lower by 40%. Coale and Hoover's work stimulated interest in economic-demographic relationships of populations. A large number of Western writers highlighted the public sector costs in Third World countries of supporting rapidly multiplying numbers of people. Among the areas that were to be affected were: education, health, job opportunities, income distribution, food, other resources and effects on environment. Leff analysed data from 74 developed and developing countries and concluded that higher fertility increases, dependency burden and adversely affects saving rates." (Karkal Malini, 1989, Can Family Planning Solve Population Problem? Stree Uvach Publication, pp.24-25)

"In the light of the growing concern about the growth rates bf populations, the General Assembly of the United Nations carried a resolution in December 1962 asserting the relationship between population growth and economic development. The Assembly authorised United Nations to take steps designed to provide assistance in population problem. Simultaneously the Government of the United States of America issued a Statement of United States Policy. The Statement expressed concern about the population trends and offered to help other nations." (Karkal, 1989, ibid, p.25)

The year 1965 saw famine in the country. There was shortage of rain the following year too. India experienced a food crisis, and the United States government discussed the food shortage and population situation in India. The U.S government sent Dr. Jack Lippes with the new method - Intra Uterine Device (IUD) - a female method that he had developed. The method was promoted saying that it was simple, inexpensive, easy to use and 'one-time-motivation' method that can remain in situation for a long time.

In 1962 Indian family planning programme set for itself a demographic goal. To achieve the goal, for the first time target for the programme was set at achieving a birth rate of 25 by 1972.

K. Srinivasan says, "With the setting of the Demographic goals for the programme and achievements of these goals being made the responsibility of the health department the programme became entranched in a HITTS model: i.e Health department operated, Incentive based, Target-oriented, Time-bound and Sterilisation-focused programme" In my view 1962 was the beginning of HITTS approach which lasted until 1972 with varying degrees of emphasis on each of its components of involvement of health functionaries, change of incentives, targets and the time-frame for the achievement of targets, leading to the coercive approach' during 1976-77". (K. Srinivasan, "Population Policies and Programmes

since Independence: A Saga of Great Expectations and Poor Performance", Demography India, Vol-27, Number 1, January to June, 1998, p.6)

"During the Third Plan (1961-66) the programme expenditure increased to Rs.248.6 million, 11 times more than the Second Plan. it was again raised to Rs.704.6 million, almost three times the expenditure during the five years of the Third Plan. Expansion of personnel at the PHCs and Urban Family Planning Centres occurred rapidly to pursue the HITTS model. (Srinivasan, 1998, ibid, P.6) The budget Provision for family planning during the Fourth Plan was Rs.3150 million. "The infrastructure was considerably expanded and there was a strong desire on the Part of Government of India to resolve the population problem once and for and for all by intensifying on the HITTS model by organizing vasectomy camps on a mass scale." (Srinivasan, 1998, ibid, p.6)

In the camp-approach the staff of the local clinic motivated couples who gathered at a nearby place on an assigned date. The services of city doctors, who were Perceived as professionals were made available at these camps. The financial incentives at the camps were larger than the normal ones. Group Pressure and mass Motivation worked at these camps to bring in a large number of individuals. The success of the camp depended on the ability of the organisers to collect people. The largest camp was organised in Emakulam in Kerala in July 1971, where a total of 6,26,913 men underwent vasectomy. (Krishnakumar S., 1974, Ernakulam's Third Vasectomy Camp Using the Camp Approach, Studes in Family Planning, Vol. 5, No.2, February, pp 58-61)

The law on abortion was liberalized to further reduce the birth rate. However, in spite of the promotion of terminal methods such as sterilisation, and making abortions easily available, the birth rate at the beginning of the Fifth Plan (1974-79) was 33 per 1000 population. It was therefore decided that the Programme should be carried out more vigorously. The demographers who were responsible for estimating the number of couples that had to be 'Protected' (from pregnancy), decided that the target for achievement during the Plan period should be 40 to 42 million couples. The number of couples who had been 'protected' during the Fourth Plan was 15 million. Obviously the pressure on the staff and other government officials to meet the targets, increased." (Karkal Malini, 1998, Family Planning and the Reproductive Rights of Women, Understanding Women's Health Issues, a Reader edited by Lakshmi Lingam, Published by Kali for Women, p. 169-70)

"Till 1970, female sterilisation could be performed only during the post-partum period. But to decrease the number of childbirths, a terminal method that ensured that the couple would have no more children was needed. This was vasectomy or the sterilisation of the male. In patriarchal societies it is never easy

to get men to take the responsibility to ensure that family is not burdened and the health of women is not strained. Under these conditions, the men who could be Operated upon were poor, especially from the rural and tribal areas". (Karkal Malini 1998, ibid, p. 168)

The then Prime Minister, Indira Gandhi, believed that there was a desperate need to control the size of the population. In her address to paediatricians, she said, "To bring down the birth rate speedily, to prevent the doubling of our population in mere 28 years, we shall not hesitate to take steps which might be described as drastic." (Government of India, 1976, Background to the News. Mrs. Gandhi's inaugural address to the 31 st Conference of the Association of Paediatricians of India, New Delhi, Ministry of Information and Broadcasting, 22 January)

The family planning programme in India went through a traumatic phase during 1976-77. With the declaration of a state of Emergency in the country, a national target of 4.3 million sterilisation for the period April 1976 to March 1977, was announced. The sterilisation programme was implemented with coercion, especially in the northern states where the achievements in earlier years were relatively poor. The brunt of this was borne by the poor, illiterate, lower castes, scheduled castes, and Muslims. Since the programme had become target-oriented, the staff was threatened with punishments such as stopping of their increment or cutting salaries if they did not meet the targets given to them. During the Emergency, the abuse of clients and the implementers, was widespread.' (Karkal Malini, 1998, ibid, p. 170) The number of sterilisation done during April 1976 and March 1977 was 8.26 million, more than the number done in previous five years and more than the number done at any time in any other country in the world. Inspite of the excesses, the target of reaching the birth rate of 30 by the end of the Fifth Plan, was not achieved.

Demographers, supported the achievements of sterilisation programme conducted during the Emergency. Means used to achieve the targets for reducing birth rate, and the impact on the lives of common people, was none of their concerns. Inspite of strong evidence that mere reductions in birth rate cannot assure better life for substantial proportions of the population, demographers argue for demographic transition as an objective to be achieved at any cost. K. Srinivasan, a well known demographer and ex-director of a World Bank project, ex-Director of UN-GOI Institute for Population and now Executive Director of Population Foundation of India, praises the achievements of the coercive progranirne during the Emergency. Commenting on the slowing down of that programme due to strong national and international criticism, he says, "From a retrospective analysis - it seems that India made a sacrifice in terms of delayed demographic transition, and possibly socioeconomic development to safeguard

her people's democratic rights. It is doubtful whether a compulsion in family planning programme can ever be implemented in India within the present political structure or that centrally specified demographic goals can be imposed on the States." (Srinivasan K., 1995, Regulating Reproduction in India's Population: Efforts, Results and Recommendations. Sage Publication, New Delhi.

Srinivasan is not alone in providing moral support to coercive family planning programmes. There are other demographers who hold similar views. Among them is Ashis Bose, Founder Member of the Indian Association for the Study of Population. Bose says, "The main reason for the success of the Indonesian model is the excellent military style logistic in naming the programme. In India we have an overdose of democracy. (Bose Ashis, 1994, Tamil Nadu's Successful Demographic Transition, Financial Express, January 4.) It is therefore not surprising that the population policy drafted by the committee chaired by the agricultural scientist, M. S. Swaminathan, and of which Bose was a member, had suggested use of army for 'implementing the Indian family planning programme.

The target of the programme so far was the birth rate. Seeing that in-spite of implementing the HI'TTS model under the guidance of the demographers, birth rate had not shown a reduction to the desired level. The Sixth Plan aimed to reduce the family size to 2.3 with net reproductive rate (NRR) of one, i.e. limitations on the number of daughters a mother was to have, to be achieved by 1996. Obviously the underlying logic of the goal of the Plan was to reduce the number of women - the child-bearers - in the population. The Plan aimed at CPR (Couple Protection Rate) of 60% sterilisation during the plan period was to be increased to 22 million. In addition 7.9 million couples were to be protected through IUDS. During the Sixth Plan (1980-85) an allocation of Rs. 10,780 million was made in the sector of family welfare while actual expenditure was Rs. 14,480 million.

Since the voluntary response to the programme was poor, and infant and child mortality continued being high, and it was believed that acceptance of family planning depended on survival of children, a programme of Child Survival and Safe Motherhood (CSSM) was started with funding from the UNICEF. All along mothers and their children were considered together under the Mother and Child Health (MCH) programme in operation as a part of the normally provided health services. The new programme separated the mothers from their children when the fact is that the health and the well-being of the children was dependent on the health and the well-being of the mothers.

Thus the progranune that was started with the objective of welfare of the women and children became a population control programme with demographic goals

and its targets became women. Mainstay of family planning now is sterilisation and largely of women. And to have larger impact on the birth rate, interests are to sterilise women at young ages. National Family Health Survey (NFHS), (International Institute for Population Sciences, 1995, National Family Health Survey 1992-93) which collected data from 99% Indian population, reports that the TFR (average number of children a woman is estimated to bear) has declined from 5.1 in 1971 to 3.39 in 1992-93. This has been achieved by increasing the proportion of couples using contraceptives from 10% in 1971 to 44% in 1992. More significant is the fact that 84% of the total users are using terminal method such as sterilisation and 88% of the sterilised are females. The average age of the women among the sterilised is 26 years and in the States, of Andhra Pradesh, Maharashtra and Kamataka, it is as low as 24 years. h is also important to note that majority of the sterilised have never used any temporary method before going for a terminal method such as sterilisation. Thus raising doubts about the women's role in the decision to accept the terminal method and the methods used to promote population control.

States of Bihar, Madhya Pradesh, Rajasthan and Uttar pradesh are known as BIMARU States because of their lower acceptance of family planning and higher TFR. NFHS however shows that irrespective of differences in TFRs, the number of children age five is about 2.6 in all the states including the BIMARU states. Further, the Registrar General (RG) of India reports 37.3% of total deaths are to children under age 15 years. This percentage for Bihar is 41.5, for Madhya Pradesh it is 45.3, for Rajasthan it is 45.4 and for Uttar Pradesh it is 47.7. There is evidence that high mortality among the young is closely linked with the health of the mother and their status in the society.

NFHS also shows that every third child born in India is handicapped at birth as it is born with weight 2500 grams or less and has not had opportunities for the full expression of the innate genetic potential for mental and physical development. The data also shows that order birth does not make much difference to being born low-birth-weight, indicating that limiting number of births is not a solution to the problem of quality of the health of the children born. Such inequality is the cruellest form of social inequity.

Among the reasons for the high incidence of low-birth-weight babies, high infant and child mortality as well as high maternal mortality is the child bearing at young ages. Though there is a law prohibiting marriage of girls till age 18, NFHS data show that, about 5% of the girls in ages 10 to 14 are married. This percentage for the age-group 15 to 19 is 36 (rural areas it is 41%). (The data provided by C.P.Prakasam of IIPS)

Maternal mortality rate (MMR) in India is one of the highest compared to several other countries. NFHS reports 437 deaths for rural and 397 deaths for urban areas per 100,000 mothers. This implies that 100,000 women die each year for causes related to pregnancy and childbirth. Other studies show that per loss of a mother due to death there are about 16 who suffer serious damage to their health. Post-mortems of mothers, in a hospital in Bombay, had shown that even when the death certificates showed that the mothers had died due to direct obstetric causes, majority of them were diseased and had poor health. It is to be noted that 73% of the deliveries take place at home and are conducted by traditional birth attendants (35.2%) and by relatives or friends (29.5%), and counting even the minimum ante-natal care 68% of the mothers received ante-natal care. (IIPS, 1995, India Report, pp.239-240)

Analysing NFHS data, Raju (Maternal and Child Health-Services, 1997, The Indian Journal of Social Work, Volume 58, Issue 3, July, p.417) reports, "The analysis indicates that MCH services are probably reaching often to mothers who are potential cases for sterilisation. The reason seems to be that there is a lot more emphasis on achieving family planning targets, and MCH services have become a means to achieve the targets as these services form a part of overall family planning programme."

Despite cuts in most areas of public expenditure, including health, the government's budget for family planning has increased from Rs.3,200 crore for the five-year period 1985-1990 to Rs 1,000 crore for the one-year period 1992-1993. The UNFPA has increased its assistance from US $52 million for 1985-90 to $90 million for 1991-95. By 1995, the population growth rate is to be reduced from 2.1 percent to 1.76 percent and the crude birth rates from 30.5 to 26.7 per 1,000 population. The use of contraceptives is to be increased from 43.3 per cent to 53 per cent. USAID has given financial assistance of US $325 million for decreasing the total fertility and mortality levels, from 5.4 to less than 4 and increasing couple protection rates from about 35 per cent to 50 per cent by the year 2000. This is largest programme of foreign assistance for reducing population growth rates that the country has ever embarked upon.

Women's movement has gained considerable clout. United Nations has now accepted an NGO Forum as a part of its major conferences. At the conference on environment held in Rio in 1992, and at the human rights conference held 1993 in Vienna, women vehemently opposed the move to blame the problems on rate of population growth. Before the International Conference on Population and Development (ICPD), scheduled for 1994, women organised strong international networks that argued that the population control programmes were anti-poor, and anti-women. They pointed out that the consumerist life-style of the 20%

minority of the worlds people was not only creating shortages of resources but was causing irreparable damage to the environment.

The Program of Action (POA) of the International Conference on Population and Development (ICPD) officially condemned the practice of quotas and targets and other ways of measuring the success of family planning programmes by the number of users of so-called 'modem' contraceptive methods. POA stated, "Government goals for family planning should be defined in tenns of unmet needs of infomiation and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment. of clients." India is a party to the decision. But the condemnation on paper has not meant a change in the behaviour.

There is a growing feminisation of Poverty in India. Gender equity and free and informed choice for women are critical for empowerment of women. There is a need to shift the burden of family Planning from women and aim to foster a "culture of joint responsibility of the couple.' There is also a need to emphasize the problem of women's status as such in the family, the dynamics of control, domination and violence against women that characterise the working of the family and the lack of access to an independent income, the most women suffer. Coercion and consent, of economic Power, and cultural authority within the family are used to secure and perpetuate the subordination of women. It is clear that unless a working model of the various types of families and their dynamics is posited, notions of 'joint responsibility' cannot simply be realised in practice, nor can policies and programmes be sufficiently sensitive to the needs and rights of women and children.

The major focus of most human rights institutions that deal with procreation and reproduction is on family planning, which is equated to limiting briths. The broader issues of health care, economic resources and social security, to say nothing of freedom from sexual abuse and discrimination, remain unaddressed, though these conditions are directly related to women's lack of reproductive self-determination. The policies that demand maternal and child health have essentially emphasized the child, women remain unspoken word. The starting point of reproductive rights has to be health, well-being and empowerment of women. The needed approach to reproductive rights has to be women-centred and social change oriented with an emphasis on health issues. This memis top prionty to reducing women's morbidity and mortility related to reproduction and sex, as well as maximising the condition that make authentic choice - wheffier to have a child or not - possible. Under the present situation such demands mean women walking a thin line between women's need for services and their need not to be controlled or coerced by them. A women's self-

determination is an intrinsic part of her dignity as a human being. Whether anti-natalist or pro-natalist population policies tend to treat women's bodies as the instrument of male-dominated population ends." (Karkal, 1998, ibid, p. 177)