Sex Determination Tests

A Survey Report

THE practice of prenatal sex determination followed by selective female foetus abortion is one of the most striking examples of how advances in science and technology are employed for the furtherance of women's oppression. Although this inhuman practice has been in existence in India for many years, it is only last year that anything like an organised and sustained mass campaign against it became a reality. While Bombay has been a principal centre of the campaign, it has now also spread to other cities, including some small towns. A concrete manifestation of this positive change has been the formation of the Forum Against Sex Determination and Sex Pre Selection.

The collective efforts of several women's groups and other voluntary organisations, spearheaded to some extent by the Forum Against Sex Determination and Sex Pre-Selection, have yielded some notable results. Two private bills concerning this issue were introduced last year—one in Parliament and the other one in he Maharashtra legislature. This goes to prove that both the Union and the state governments were forced to take note of the issue because of the growing popular protest. The bill in Parliament is yet to come up for discussion. Nevertheless, the minister of state for health and family welfare did convene a meeting in New Delhi last December to discuss the issue. The Maharashtra government formed a committee in September last to study the problem and suggest a set of corrective measures. The private member's bill in the legislature came up for discussion in the 1986 winter session at Nagpur, but the same was withdrawn following an assurance from the government that the committee was still studying the problem and that, on the completion of the study, the government would itself initiate appropriate action in the matter.

As part of its activities, the state government-appointed committee commissioned me for the Foundation for Research in Community Health (FRCH), Bombay, to conduct a short study of the prenatal sex determination tests and female foeticide in Bombay city. The study was conducted in November 1986 with the objective

a) Determining the extent of the spread of sex determination tests and female foeticide in Bombay city;

b) Finding out other related aspects of this practice; and

c) Knowing the views and perceptions of the doctors involved in this practice.

Fifty private gynecologists, chosen randomly but with a view to covering the entire city and the suburbs, were interviewed in person during the course of the study. Some of the important findings of the study were:

1 Eighty-four per cent of the gynecologists perform amniocentesis for the purpose of sex determination. These doctors together perform on an average 270 aminocentesis tests per month.

2 Some doctors have been performing aminocentesis for the past 10-12 years. But a majority of the doctors (over 85 per cent) have started performing these tests in the last five years. On the one hand, this shows that Bombay is one of the first urban centres where SD tests and female foeticide started. On the other hand, it is evident that the debate that took place in the early 80s had a significant anti-publicity effect.

3 Only very few (upto 5 per cent) of the aminocentesis tests conducted are done for the detection of genetic defects.

4 Seventy-five per cent of the doctors interviewed said that over 50 per cent of the women who come for the tests belong to the middle class, whereas 85 per cent of the doctors said they do not get women from the lower classes for SD tests.

5 It is generally believed that it is only women with four or five daughters who go in for SD tests and female foeticide. But the study showed that the proportion of women going for SD tests when they have four or more daughters is quite small and that a majority of the women coming to the SD clinics are mothers of two or three daughters. Significantly enough, 24 per cent of the doctors said that 20 per cent of their patients had only one daughter. Thus, it appears to be a growing trend among the public to go in for SD tests in the second pregnancy itself, if the first issue happens to be a girl.

6 About 30 per cent of the doctors said that in nearly 10 per cent of their cases, the women already had one or more sons when they came for SD tests. This findings explodes one more myth that only those women go for SD tests who have no sons and only daughters. This trend moreover, appears to be on the ascendancy.

7 A majority of the doctors contacted in the study see SD tests and female foeticide as a humane service to women who do not want to have any more daughters. Some doctors also fee that SD tests and selective abortion of female foetuses are a good method of promoting family planning and controlling population growth in the country.

8 Six out of the 50 doctors said that they also perform chorion villus biopsy for sex determination.

—Sanjeev Kulkarni

Isolate Apartheid Health Care

THE Anti-Apartheid Movement in Britain has been campaigning for the isolation of the racist apartheid regime in all areas—political, economic, cultural and sporting for 27 years now. It has been realised that the policies of apartheid in segregating health care in South Africa and the inaction of the authorities in the face of rampant malnutrition and preventable disease amount to state-directed genocide against the country's black majority.

Recognising this and that health is an emotive issue which effects everyone and that everyone can therefore relate to, in 1979 health workers within the Anti-Apartheid Movement joined together to form a Health Committee. The mandate was to use health as an issue to educate people about apartheid and to mobilise health workers to support the international boycott. Since then Health Committee members have researched the health situation and produced campaigning leaflets, documents and a newsletter on health in South Africa. We have travelled up and down the country speaking at meetings and mobilising people in the struggle against apartheid.

Health and Liberation our newsletter is produced quarterly and covers the latest update on health in South Africa as well as news of our campaigns in Britain.

Exchange of medical skills in knowledge between Britain, South Africa has gone on for many years. British nurses are recruited to work in South Africa, lured by the prospects of sun, sea, sand and higher wages. The need for them lies in the racist ruling that black nurses may not care for white patients. Thus whilst black nurses, unemployed are relegated to the Bantustans, white British nurses are recruited to make up the shortfall of staff for the whites-only hospitals.

Many medical students go to South Africa for three months 'elective' period as part of their training and many doctors go to work there for short periods. These people are attracted by the regime's publicity that pathology can be seen in South Africa at a more advanced stage than elsewhere in the world. This is true, but it shows the true callousness of the regime that it can use the misery of the nation's black majority—created by their denial of facilities for the prevention and early detection of disease—as a way of attracting people to break the international boycott and make up the shortfall in doctors which has arisen through the denial of adequate places for training African people as doctors. To all these groups of health workers we have directed specific campaigns not to go to South Africa to work or on lecture tours.

Our international work to gain the expulsion of South Africa from international medical bodies began in 1981 when the Medical Association of South Africa (MASA) applied to be readmitted to the World Medical Association. A major international campaign was conducted with extensive briefing documents circulated covering the medical treatment of Steve biko and the inability of MASA to address itself to the collaboration of doctors with the security police and the inequalities in and fundamental issues behind health care in South Africa. International opinion was mobilised against MASA. The campaign culminated with MASA's readmission solely on the basis of the voting system which is loaded towards the United States. However all the African countries resigned, the WMA lost its consultative status with the WHO and in 1983 the British Medical Association withdrew. The WMA was thus left as an impotent and unrepresentative body.

A similar campaign was conducted at the International Planned Parenthood Federation which ended with South Africa's resignation in July 1986, and currently we are campaigning for South Africa's expulsion from the World Psychiatric Association and the International Dental Federation.

Another important facet of the struggle against apartheid is direct material solidarity with the liberation movements. With this in mind we established the Medical Aid Campaign for Southern Africa to collect money for medical supplies for the ANC and SWAPO. We have sent a large amounts of books and drugs to the ANC hospital in Tanzania at the Solomon Mahlangu Freedom College and to their clinics in Zambia and Angola.

Over the coming few years, the struggle in South Africa will be reaching its most crucial stage and with this comes an ever more urgent need for concerted international action to gain the total isolation of the apartheid regime and the final victory against the forces of racial and national oppression in South Africa. Health workers throughout the world must unite with this goal to contribute in a small way to the final victory.

Rachel Jewkes
Secretary AAM Health Committee

Towards Rational Therapy

THE Prescription Guidance and Information Services (PGIS) of LOCOST is an educational effort to promote awareness about the correct use of medicines. PGIS is therefore for the benefit of both prescribers as well as patients. Two main aspects of PGIS being proposed are:

(1) Information dissemination to doctors who write prescriptions and
(2) Guidance to the patients regarding the correctness and use of medicines prescribed in a particular condition.

The objective here, is to help the patient, the end user of medicines to know the correctness of the medicines prescribed. the PGIS will give comments on following aspects of prescription: correct medicine for a particular diagnosis, adequacy of the treatment, the uselessness or harmful effects of any medicine, the side-effects of the medicines required, the dosage, alternatives available both in terms of cost, quality and nature of medicines, etc. Wherever possible, other aspects of the therapy will also be explained. This will

help the patient by developing an understanding regarding the treatment given to him/her. This will also equip the patient and relatives or friends to question and to ask for more information from prescribers in future. Thus the ultimate aim is to build up consumer awareness and initiative to bring about a change towards more rational therapy.

LOCOST is aware of the limitations of PGIS: Personal examination of the patient may not be feasible, the scope of PGIS may not cover all diagnostic situations as also the fact that a large number of 'successful' treatments may not be touched, and so on and so forth. The service may not be useful for the patient as it will take at least 10-15 days to give a balanced view on the prescription. However, queries by doctors for information can be attended to faster. LOCOST is keen on not encouraging legal battles between the patient and the doctor. PGIS is a beginning, a collective effort to facilitate awareness, education and action. Action towards more rational therapy and towards conserving scarce resources of patients as well as that of the community.

LOCOST is also prepared to facilitate prescription medical audits of hospitals, dispensaries and community health projects, if so requested. You may be a like minded doctor, a patient or a person simply interested in social change. Contact: *Prescription Guidance and Information Service (PGIS)*LOCOST, Ist Floor, Premanand Sahitya Sabha Hall, Opp. Lakadi Pool, Dandia Bazar, Baroda 390 001.

Miracles and Profits in Sickness

A NURSE who focussed a small research project for a post-graduate university course on a private food allergy clinic managed to achieve a relatively high mark from the tutors involved, and it was also considered worthy of publication in a scholarly journal. To her amazement the doctor whose clinic had been studied objected to the publication, not because of any feared damage to his professional reputation, but because of certain implications seen behind the student's work—especially the open discussion of the sordid subject of money.

There are a number of diseases where medical science has not discovered or developed a method of entirely halting their progress and treatment is limited to controlling or alleviating the symptoms, but not the spread of the disease itself. These conditions typically attract imaginative mirage "cures" which are difficult to get, expensive, or both. The cure is often proclaimed as some commonplace naturally occurring substance—igonred by modern western technology—which, according to anecdotal claims, has been used for years in a remote part of the world. Sometimes the product or treatment method is a secret which cannot be disclosed to the general public, but you can always buy bits of the magic. Whatever the story, evaluation by independent scientific workers will prove fraught with snares and delusions.

If some unfortunate person whose name has publicity value falls ill, (s)he may be treated with the remedy and live happily ever after. Recently a former pop singer, hitherto not widely known but nonetheless of some public interest, fell ill; and her symptoms were attributed to multiple allergies. Personal friends and a sympathetic section of the public expended much good will, time and effort in what appeared to be a good cause. The patient was flown to Dallas, USA, to Dr Rea's Environmental Unit, but her luck did not continue; voluntary funds of sympathisers at home dried up and she was not shown returning home in triumph. She returned as she had left—on a stretcher with an oxygen mask attached to her face, as she inhaled the only unpolluted vapour she could tolerate.

It has been said that "A fool and his or her money are easily parted"; sadly many patients would seem to be fools, if judged by the large sums of money they seem willing to pay for treatment of very doubtful value. Maybe it doesn't matter what treatment patients have if their belief in it is enough to effect a cure, but the long-term consequences of 'miracles' have also to be considered.

What happens when the dream fades, when the symptoms return or new ones come in their place? The despair and frustration must be magnified, as the patient has once again to struggle with a handicapped identity. Having attended an unorthodox clinic the patient may not only be financially broke but, more difficult to repair, psychologically damaged by the disappointed dreams offered by modern medical messiahs.

It costs a lot of money to run private clinics, and to pay attractive salaries to people who remove themselves from incremental ladders in the NHS, and need financial incentives to get involved in work that is of doubtful validity within scientic medicine. It is not difficult to find private practitioners from various disciplines who will quite readily remove NHS equipment and surgical supplies to "get their clinic started." When they are challenged about this exploitation of the health service, one is reminded that the patients who attend the private clinic cannot be treated by orthodox methods and as they are paying their NHS contributions it is all OK. While a hospital porter may get taken to court for removing flowers from a tip outside the hospital, the consultant who sends a junior nurse down to surgical stores to collect an expensive piece of equipment is able with impunity to 'transfer' the hospital instruments to the private clinic and reap the benefits from the fee-paying customers.

Doctors and nurses who work in private clinics using untested methods which are either innocuous or dangerous, are prostituting themselves by capitalising on the dignity and prestige afforded by their medical or nursing qualifications. It is indefensible to take advantage of the trust patients place in health care practitioners, and to make financial gain out of their vulnerability.

—Virginia Scott

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