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POLITICS OF POPULATION CONTROL

POPULATION CONTROL : FOR OR AGAINST PEOPLE ?

Whereas Malthus related population and population growth to consumption, Engels and Marx related them to production. By the Malthusian hypothesis, population could be checked by means of forcing down the wages which would in turn lead to a natural increase in death rates. Marx posed the question as to whether overpopulation was in relation to the natural resources or to the needs of the prevailing system. This debate, the first on the issue of overpopulation represents to date the crux of the ideology supporting the reasons for population growth and consequently the measures necessary to curb it.

The capitalist mode of production as a prerequisite demands a surplus population from which an everready supply of human material — surplus labour — is created for exploitation. Overpopulation has therefore to be seen in terms of this mode of production and not as a consequence of the 'Eternal Laws of Nature' (Meek, 1971). In capitalist society the actual producers are alienated from the means of production because the latter are owned by the capitalist. Production is geared to the market demand and not to the human needs of the population. Therefore, the Malthusian prediction that growing populations would be the main cause of world-wide starvation is a historical error. The truth is not 'how many people' but 'how many people who can afford to buy enough food just to stay alive.'

In his polemical writings against the Utopian thinkers of his time, Malthus expressed contempt for the poor. He claimed that the unemployed poor were a burden on Nature's reserves and therefore, had no right to live, leave alone to reproduce. Biased heavily in favour of the English aristocracy, his pseudo-analysis about the 'inferior ranks of people' offers a rescue even today to population control propagators when they have to explain 'undesirable' events, the rational and truthful explanation of which can result in 'undesirable' consequences such as the conscientisation of the oppressed masses (Bondestam, 1980).

The Real Facts About Poverty

Malthus' observation that a reduction in population size would release the otherwise limiting resources is only apparently true. When the entire family lives at a subhuman level of subsistence, having lesser children does not increase the standard of living perceptibly. They still live below the poverty line; often all of their life is spent only in combating death from hunger and starvation. Escape from death however does not mean any improvement in the standand of living. Malnourishment, unhygienic conditions and strenuous physical labour, all together increase body weakness and decrease body resistance to acute and chronic disease. Morbidity creates further poverty (due to inability to work, expenditure on disease) and eventually leads to death. Either way death seems inevitable. The reason for producing or wanting to produce more children is economic and its resultant is the surplus lives produced.

Among the poor, the cost benefit of having more children is greater than when they have less. At a very young age, the child becomes either a direct wage earner or helps enhance the family income indirectly (baby sitting, filling water) by relieving the adults of household chores. Having many children is thus not only beneficial but also necessary because not all children that are born would live beyond the age of five. It is only when a steady income flows in regularly that having more children becomes a liability. A small family norm is a middle class value and to force the poor into accepting this norm without improving their economic and social conditions is inhuman.

Release of resources through population control is possible only when resources are universally available and uniformly distributed. The inequalities in access even to basic services such as health care become apparent through the fact that though 80 per cent of the Indian population is rural, only 46.2 per cent of the total health budget is allocated for this population. Worse still, the public health personnel are so overburdened with family planning responsibility that primary health care has become synonymous with birth control for the rural population.

The poor live in deficits and debts, therefore a reduction in family size will not create any savings. Population control cannot ensure that the released

resources, however insignificant will be invested to benefit the poorer sections of society. A fair distribution of resources is possible only in a socialist society where the means of production are distributed fairly. The propaganda that population control will release available resources is just an eyewash (Quadeer 1976).

Neo-Malthusians and The Ideology of Population Control

The Malthusian theory of arithmetic increase in food production and the geometrical increase in population and the ensuing doom was belied by bourgeois development in Europe in the 19th century as also through the import of this development into colonial India. It was at this point that the capitalist forces in the form of neo-Malthusian arguments introduced the 'population bomb' hysteria. Neo-Malthusian ideology was part of the reactionary counterstrategy against rising socialist forces. They propagate the view that demographic factors are the main cause of economic and social difficulties experienced by developing countries and to control natality is the neo-Malthusian solution. This propaganda is furthered to divert public attention from the real facts about poverty and in order to disorganise and weaken struggles aimed at democratisation.

The propagators of family planning can be broadly classified into people who apolitically and genuinely believe that population control is the answer to the world's problems and neo-Malthusians who use family planning to propagate their own ideology. But the distinction is not sharp. For instance Margaret Sanger who did pioneering work in challenging religious orthodoxy regarding contraception considered that the American public was being too heavily taxed to maintain a 'growing stock of morons' (referring to the American poor) who 'threatened the very foundation of American civilisation'. Her statement was recollected with fervour by the neo-Malthusians whilst unleashing a population control programme among poor Puerto Ricans with lowered intelligence.

The neo-Malthusian ideology holds the distribution of existing resources as being inversely proportional to the growth of the 'teeming millions'. The truth is that the existing resources are concentrated in the hands of a few in a capitalist order. The underlying fear behind this gross misrepresentation of facts is the imminent possibility of socialism gaining terrain due to the rising unrest among the unemployed and the exploited working class. Capitalists even today form the major donors to the population control funds throughout the world, either through private agencies or through 'legitimate' government bodies.

The Population Control Policy

The 1974 World Population Conference at Bucharest gave a call (in fact Dr. Karan Singh, the then Health Minister of India, did) for 'development being the best contraceptive'. Ironically, one year later, India plunged into coercive and inhuman sterilisations under the Emergency regime of Mrs. Gandhi. Even on the global level, governments of developing countries and private population control agencies were planning family planning as the primary strategy for development policies. Programmes were made more accessible, more attractive and more efficient (Wolfson, 1978).

Though donor agencies recognise social problems, very few have been prepared to support these activities without population control being the frontal strategy of approach to solve problems of poverty and unemployment. Maternal and child health (MCH) is the classical example where donor agencies have diverted their funds to, since MCH is closely related to fertility. Family planning comes along as an indispensable part of the package. Donors make it quite plain that they consider development to be impossible without curbing the birth rate. Family planning is the unavoidable condition to be fulfilled when a developing country asks for international aid.

In post-independent India, most of the leadership belonged to the upper and privileged classes. They often had westernised values and were sharply different from the people they were supposed to represent. Independent India had proclaimed socialism from the roof-tops but in truth only the Indian bourgeoisie as a class had benefited with the elite becoming more privileged day by day. Due to technical incompetence and the quest for profits, there was an increasing dependence on western countries for technical and monetary assistance. A vicious circle emerged because this dependence created further incompetence and servility. Foreign experts virtually shaped India's policies and also acquired a great deal of influence on their implementation (Banerji, 1980). As the economic condition of India deteriorated under free enterprise and lopsided development, foreign aid acquired a crucial role in shaping Indian policies. In the field of population control, western capitalists were able to push in their anti-third world ideology along with aid for 'development.'

India was the first developing country to begin implementing a national programme on family planning as a state policy in 1951. In 1963, a revised and extended variant of the official family planning (FP) programme was put into action. Population control (PC) has become a priority increasingly, in fact with fanatic fervour it has been proclaimed that PC is so urgent that it cannot await improvements in the economic and social fields. It is like putting the cart before the horse. Though the Fifth Five Year Plan promised a "frontal attack on the citadels of poverty" what was actually implemented was an inhuman, anti-poor PC programme.

The role of the Indian government in unleashing all the repressive state machinery on the poor for forced sterilisation has been condemned the world over (Wolfson, 1978). Yet, even today the use of force, pressure, utilisation of the bureaucracy and panchayats at village and taluka levels as well as monetary incentives have become accepted as a form of motivating people to accept FP. If PC is seen independent of development, then motivation and incentives are seen independent of the individual's social existence. Target methods and coercion can also be understood when PC is treated as a substitute for development (Mamdani, 1972). Family planning is much easier to implement than major advances in the areas of education or the economy and though it has been repeatedly stated that FP is part of the package of development, it has been thrust as a substitute for development and structural change.

The Feminist Perspective

It cannot be denied that birth control has created more options for women. Knowledge and availability of birth control measures is a matter of women's rights because women should be allowed to govern their own fertility. Repeated pregnancies and the drudgery of constant child-rearing not being conducive to good health, it is of extreme importance that women have access to safe and effective methods of contraception.

The disturbing factor however is that the aggressive incentive based population control programme has not allowed this right to stay with the woman. Policy makers decide whether a woman should have children, if so how many or whether she should be allowed to abort her own foetus. Doctors and social workers in clinics for abortion and contraception tend to adopt moralistic attitudes. Pharmaceuticals decide that women should passively accept the contraceptives that fetch the largest profits to the manufacturers. Third world women are constantly used for the field testing of dangerous contraceptives. Primarily black and Spanish-speaking women are targets of sterilisation in the USA. Cultural biases in India naturally compel a woman more than her husband to accept the FP operation and poor as well as lower caste rural women have been targets of the mass sterilisation camps as well as those for Copper-T insertions. Powerful patriarchial institutions in fact have strengthened their hold over the woman's reproductive organs through birth control.

Even the bourgeois state fills in the gaps either at home or outside it through population control and birth control. A woman's leaving home for a job does seem as though she has a greater freedom of choice, but in truth it is the flexibility and compulsion of the changes in the labour market that have left her with no choice but to enter the production force as a wage earner. Even if a woman is a wage earner, her family labour always comes first. The birth control policy monitors her 'reproductive' and 'productive' duties. Abortion laws should also be seen in the same context. Population control has increased state and international control on a woman's intimate physiological function under the guise of 'making available a birth right'.

The alarming anti-woman trend in the new reproductive technology (NRT) needs to be studied carefully. Unichem and German Remedies will probably be given the licences to manufacture the injectable contraceptive NET-EN in India. Hormonal implants which render infertility for upto five years are being tested on Indian women inspite of dangerous side-effects. Amniocentesis for female foeticide has been covertly recommended by FP propagators since girl babies are the future 'breeders'. Research to develop a 'male child pill' is being recommended (Postgate, 1973). With the growing concept of surrogate motherhood, women could be converted into breeders in a reproductive brothel where the most powerful socio-political control over women's reproduction would be made possible (Dworkin, 1983). Here, the 'valuable' ova and sperms from white couples could be merely incubated in the wombs of brown or black poor women, sterilised for convenience (Corea, 1984).

We open this issue with Ramala Buxamusa's article based on her Ph.D. thesis which exposes the impact that foreign aid has had on the Indian population policy. International aid to the third world for development contains major funds for

population control in an attempt to prevent the developing countries from becoming socialist. She traces how the initial resistance of the Indian government broke under international pressures.

Sucha Singh Gill's article convincingly examines the ideological content and class bias of the birth control programme. According to him, the emphasis of the Indian planners on population control is an attempt to weaken the class struggle in India.

In the third article, Kusha relates her experiences in a contraceptive testing unit in a working class area of Bombay. During her association with this unit for many years she saw contraceptives ranging from diaphragms to hormonal implants being tested for field trial on working class women inspite of the unpleasant and dangerous side effects they created. Her first hand experiences are eloquent.

Ilina Sen focuses on the motivational aspect in the family planning programme. When the earlier subtle motivations failed to increase family planning acceptance, the government plunged into an aggressive disincentive based coercive birth control campaign. Ilina examines the social and psychological theories on which the motivational strategy was founded and highlights the fallacies that accompany the present family planning programme.

Vimal Balasubrahmanyan takes a critical look at the trend in the incentives and disincentives in family planning without making a single comment ! In a carefully prepared collage and not without a glint of humour, she traces the dangerous trend over a period of two years (1982-84).

The last article in this issue by Martha Giminez is reproduced from the Review of Radical Political Economics. She discusses the micro economic and the sociological theories that analyse reproductive behaviour and presents a marxist critique of the same. She argues that reproduction should be conceptualised in the context of a given mode of production.

—manisha gupte

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PHANTOM SUBSCRIBERS !

We have three subscriptions sent by M.O. in the last three months which have no addresses. The only information we have about our phantom subscribers is as follows : (i) From Anthya M, somewhere in Kerala (ii) From somewhere in Karnataka, and (iii) From somewhere in the Hindi-speaking region ! If any of you know of people who have not received our acknowledgements for their M.O. please ask them to write to us.

The Printed Word

newsclippings on health and medicine, july – september 1984

Health Policy and the Health System

Deccan Herald, 21 July : A 58-year old man was electrocuted at Ram Manohar Lohia Hospital, New Delhi when the metallic stand for hanging the glucose drip came into contact with the overhead light, which had been known to be giving 'shocks'.

Business Standard, 2 Aug. : USAID has offered to develop basic infrastructure (buildings for health institutions, residential complexes) and to improve the health delivery system, (including family planning and maternal and child health) in Bhiwani Mahendragarh and Sirsa district of Haryana. In phase I the USAID has released Rs. 7 crores.

The Daily, 15 Aug. : Yet another patient of the ESIS hospital at Kandivili in Bombay leapt to her death from the third floor. The patient had been considered 'rowdy' apparently because she was not able to bear the pain due to acute apendicitis, for which she had been admitted a month previously but had not been operated upon. The reasons for the delay in operating remain unclear.

The Hindu, 30 July: The Working Group of the Central Council of Health and Family Welfare has made the following recommendations : (1) The creation of mobile opthalmic units in all districts and stringent action against unauthorised persons conducting eye camps; (2) A whole-time trained TB officer with supporting staff at the directorate level for proper suppervision and monitoring of the national TB control programme (3) All hyperendemic districts to be covered with multi-drug regimen projects during the 7th plan period; and (8) All states to repeal the Leper's Act of 1888.

Financial Express, 18 Sept. : The government has sanctioned a budgetary allocation of Rs. 547.46 crores for the central sector health programmes for 1984-85 as against Rs. 482.02 crores in the previous year.

The Telegraph, 19 Sept. : In the WHO regional committee for southeast Asia, India has offered its 'vast reservoir of trained medical manpower' to neighbouring countries for meeting their immediate requirements and in organising training programmes for their medical personnel.

The Hindu, 25 Sept. : The Eighth Finance Commission has recommended a monthly allowance of Rs. 400 for doctors serving in rural areas.

Hindustan Times, 28 Sept. : A steering group appointed by the planning commission has proposed the allocation of Rs. 13936 crores for health and family welfare in the 7th Plan. It represents 8.3 per cent of the total public sector outlay of Rs. 180,000 crores envisaged for the period. The health sector's share in the 6th plan was just 3.3 percent. Out of this, Rs. 10457 crores (about three fourths) will go to the family welfare sector.

Medical technology and developments in medicel practice

The Hindu, 12 Aug : By the end of 1984-85 three medical colleges in Tamil Nadu, all district headquarter hospitals and 22 hospitals at the taluk level in the state would be equipped to deal with accident and emergency cases.

Financial Express, 20 Aug : A production of Rs. 350 crores is envisaged in the 7th plan for the manufacture of medical electronic equipment. The Department of Science and Technology has estimated that a tentative investment of Rs. 60 crores would have to be made during the plan. During 1982, the total production was of order of Rs. 13 crores but is expected to rise to Rs. 20 crores in 1984. But the demand is estimated to be Rs. 45 crores worth. In 1976-77 20 MEE products termed 'life saving equipment' had been exempt from customs import duty. The list has now risen to 47 items.

Protests, Strikes and Agitations

Times of India, 8 July: 7,000 medical personnel of the Government and municipal hospitals —4,000 resident doctors, 1,500 post graduates, and 1,500 interns will go on an indefinite strike to protest against the Maharashtra government's decision to start private medical colleges accepting capitation fee. *(Contd. on page 147)*

THE DISASTER

A reaction to the tragedy at Bhopal

The saddest fact about the Bhopal tragedy—quite apart from the horror of the numbers involved — is that it was man-made. And the people who were responsible were **Not** the ones who suffered. As one newspaper put it, "Man-made disasters, like natural ones seem to show a particular affinity for the poor." Why did it happen ? Who were the victims ? These questions have a bearing upon distinct social and political realities in India in particular and the world in general, that have been forged for us by our ruling classes.

Consider our perspective for industrialisation for instance. We have borrowed not only the capitalist framework of development but begged and borrowed the capital technology of the industrial nations. Third world countries which have historically been the plundergrounds of today's advanced nations, have been put into a peculiar dilemma — the workers and the poor still have to fight for a decent living and a decent wage in a labour surplus economy, sometimes to the exclusion of struggling and fighting against other destructive forms which industrial capitalism has unleashed. Moreover, workers are first taught to despise safety equipment and regulations, as mere obstructions in 'productive' efficiency and then when they suffer, they are told it is because of their carelessness. And to compound it, workers are forced to live with occupational hazards—they are undertrained, safety systems and procedures are substandard. Issues relating to health and safety are overwhelmed by wage negotiations or depoliticised.

In other words, it is built into capitalism that health of workers or of others may be affected is a low priority investment area that eats into profits 'unnecessarily' (See SHR 1:3). In advanced industrial countries, there are groups — workers and environmental lobbies — which fight this tendency tooth and nail. But here in India it takes a Bhopal to jerk us into a state of elementary environmental consciousness and that too at such a huge loss of life.

And yet the events that led up to the disaster form a familiar story in many third world countries. A multinational company with a lot of political clout works hand in glove with a corrupt, heavily bribed government to safeguard its profits despite the laws and regulations of the land. Hostile administrators are transferred, and factory inspectors bribed. And then there are other advantages such as what Union Carbide gained—cheap underpaid labour from slums and bastis around. Whatever happened to the industrial siting and zoning laws ?

There has been much written about the tragedy, and some issues have become controversial. But some facts are indisputable. Without a doubt there was insufficient safety design built into the plant. Proper foolproof safety means precisely the ability to take care of such emergencies. But in Bhopal the scrubber was meant for smaller amounts of gas, and the water sprinkler system was inadequate. Why were there no computerised warning systems here? In American and European facilities, even storage areas have elaborate arrangements of automated sprinklers, foam generators and so on. We are scapegoats and victims precisely because our ruling class wants us to be. And then there were operational lapses. If slip blinds were not inserted at the right points or if some crucial valves were left open, it is dominantly the ideology of carelessness as subtly cultivated by the management because it helps in two ways—one, disregard for 'cumbersome' safety apparatus or rules enhances the pace of 'productive' work and two, in an accident a concerete 'careless' act can be identified and the blame put on the worker responsible for it. And what of the process and plant design ? A textbook (David and Stanley, see box) says that out of the three methods for producing isocyanates, only the one using phosgene is 'economically viable'. Obviously, if regard for the environment and people's health were to be a major criteria, there would be far fewer hazardous processes. Union Carbide had changed over to the MIC route for manufacturing the pesticide from the less profitable 'chloroformate' route even though the latter did not have MIC as a storable intermediate and was therefore that much less hazardous. It is ultimately a question of choice and very often, of the many alternative routes available, the cheapest and hence the most profitable is termed 'economically viable'.

The Information Monopoly

There is not much information available in 'open' literature on MIC and its effects on biological systems. The one source which could have provided this information was Union Carbide which either maintained a stoic silence or issued deliberate misstatements

to the public. Unfortunately the confusion was further intensified by our 'experts' who issued absurd and incorrect statements. And those who could have provided relevant information were instructed to be silent. In fact, by dramatising operations like the 'neutralisation' of MIC, scientists further complicated the situation. Rather than providing information and assurances backed by facts, our scientist-politician combine preferred to dramatise the situation and mystify technology. A demand for information and public access to records and to data is an important component of the demands put forward by a number of people's groups working on environmental and health issues. We have to work to pursue and support these demands.

— anurag mehra

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Here is a brief list of references which might yield information.

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2. *Pocket guide to chemical hazards.* U. S. Department of Health (lists properties, symptoms, first aid etc.)
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1. *Bhopal City of Death.* Eklavya, E1/208, Arera Colony, Bhopal Rs. 3/- 62 pp
2. *Bhopal Gas Tragedy.* Delhi Science Forum, B—1, 2nd floor, J Block, Saket, 48 pp New Delhi 110 017 Rs. 5/-
3. *Human responses to isocyanate exposure* by R. V. S. V. Vadlamudi and V. A. Shenai of Department of Chemical Technology, University of Bombay in *Science Age*, January 1985. The same issue carries three other articles on Bhopal.

(Contd. from page 145)

The Telegraph, 18 Aug. : About 6,000 junior doctors in all the 7 medical colleges in U. P. are on indefinite strike in protest against the alleged police assault on doctors of the Swaroop Rani Hospital in Allahabad.

Professional bodies in health care

Times of India, 25 July : Should doctors working full-time as medical advisors to pharmaceutical companies be allowed to hold office in professional associations of physicians ? The issue is being hotly debated following attempts by two doctors from multinational companies to seek election as presidents of two such bodies. The issue is of particular relevance in view of the coming election of the Association of Physicians of India, the largest organisation of medical specialists with a membership of 4,000. The post of president is being contested by two professors of medicine from Bangalore and Bhopal respectively and by Dr. Paul Anand, a full-time director of medical research of Glaxo Laboratories. Six months ago Dr. A. S. Kochar from the same company had sought elections as president of the American College of Chest Physicians (ACCP), but the attempt had failed on procedural grounds.

Indian Express, 21 Aug : A complaint has been registered against an alleged quack who was operating as a qualified medical practitioner. His credentials were first suspected by the manager of a bank which had granted the 'doctor' a loan. The Maharashtra Medical Council sources say that for each such case detected many others may go unnoticed.

Free Press Bulletin, 7 Sept : A doctor who is a Congress (I) MLA and the chairperson of the Maharashtra Small Scale Industries development Corporation has had his name struck from the registers of the Maharashtra Medical Council for negligence and violation of medical ethics a year ago, continues to practice. The complaint had been registered by a patient whose left leg had been crippled following a wrongly administered injection in the knee cap.

Compilation : AJ, PP

The news items have been compiled from the files of the Centre for Education and Documentation, Bombay. We request readers to send us relevant items, especially from the regional press.

THE PRICE OF ASSISTANCE

The Family Planning Programme in India

ramala buxamusa

The evolution of the family planning programme has been greatly influenced by the foreign aid it has received. The author describes how (i) the nature and origin of 'aid' has changed and (ii) how and why the initial resistance of the Indian government to such aid crumbled. Not only the family planning policy but the methods of contraception promoted through the programme were determined by the aid, received directly from donor agencies or via international bodies such as the several UN agencies.

A commonplace assumption that goes virtually unquestioned these days is that the chief cause of every problem from the growth of slums to unemployment, famine, pollution, liberation, wars and strikes is overpopulation. Futurologists paint a pessimistic picture of the world in 2001 AD especially with regard to the third world and call for population control, that is family planning as the supreme panacea for all social evils. Similar views prevail amongst the Indian planners who accept the views that originated chiefly in the first world.

It is the hypothesis of this study that the present population policy is largely the outcome of factors other than mere socioeconomic and political changes in the country. The impact of external assistance as aid and loan received in cash as well as in kind has, over a long period of time, influenced the government's population policy. Although the government has shown ambivalence in implementing the population control programme, and although it is not officially accepted that the government's programmes rely largely on foreign aid, it can be proved that this external assistance has mainly been responsible for the population policy and programmes in this country. (1)

The Pre-Plan Period : 1947 to 1952

During World War II there was a lull in organised birth control activities. After the war statistical studies quickly gained momentum as valid science and "Asia's teeming millions" became a vital subject for investigation, particularly with the growth of political movements in India, China and south east Asia. The deepening food crisis in these areas frightened many American thinkers into the belief that they would turn communist (Borie, 1948).

As early as in 1946 the Swedish National Association, financed by some Americans tried to build up a liason between societies interested in population control but as the time was not ripe, efforts failed (FPAB 1948). Later in 1948, with the deepening food crisis all over the world the Family Planning Association of Great Britain and the Swedish National Association under the leadership of Margaret Sanger organised the 1st International Conference on Population of the World : Resources in Relation to Family in London. Here for the first time the 'dignified' term of family planning, actually a euphemism was used in place of 'birth-control'. The conference stressed the importance of human fertility research and an effort was made to involve the UN body but met with no response from the UN (FPAB 1948). In 1948 was born the Family Planning Association of India (FPAI) as a private body. This body was affiliated to the parent body, FPA Britain from which it received funds in cash and kind. During this period there was no direct government aid nor multilateral (eg. UN) aid to India.

In 1949 China turned communist and this shocked the imperialist world particularly the USA. It's reaction and attitude was to "save India atleast". Many thinkers expressed the view that it was essential to check India's population (Vogt,1949). Thus fertility control in India and the third world became a priority for the US monopoly organisations. One hears of birth-control only from the mouths of Americans, Swedish and British individuals and their organisations in the pre-independence period. Catholic opposition did not permit the first world governments nor the UN to get involved in birth control programmes. Private organisations previewing "danger" donated funds to Indian private organisations to open clinics and publish literature to favour birth control. A beginning was thus made by the private organisations in the family planning field in India.

The First Five Year Plan 1951-1956

The nations which the imperialists feared would be lost to communism became known as the

population powderkegs" of the "underdeveloped" world and population control programmes were designed for them. India was selected for special attention. The first in-roads into the population control programme in India were made by private organisations such as the Hugh Moore Fund, the Rockefeller Foundation, the Ford Foundation and Swedish and British businessmen (Mass,1978).

Politically the subject of birth-control was sensitive. In the West there was Catholic opposition to birth-control, forcing private organisations to move with caution. The first approach was to spread the ideology of "overpopulation" through seminars, conferences, publications and through statistics. In 1952 the UN, for the first time, was pursuaded to collect the demographic statistics of the third world countries (Mass, 1978).

Rockefeller, Moore and other private monopolies which had been supporting population studies earlier now made moves to start private international organisations. In 1952 under the sponsorship of the National Academy of Science, John D Rockefeller III convened a conference of demographic experts and population specialists in Williamsburg, Virginia to establish a non-profit organisation, the Population Council. This organisation was to provide a previously lacking "respectable base from which to influence professional and academic sectors to finance a more scientific approach to population". Between 1952-58 the budget of the council was quadrupled, rising from 4.5 million dollars to 18.3 million dollars. A large part of the 1958 budget, 8.4 million dollars was provided by Ford Foundation. It is said that over 500,000 dollars, nearly 80 percent of all the Ford's Fund for population control came to the Population Council. The Rockefeller Foundation also donated 3.4 million and the Mellon family 2.9 million dollars to Population Council (Mass, 1978).

With the creation of the Population Council in New York, British and Swedish businessmen were moved to organise the Third International Seminar in 1952 at Bombay. The Family Planning Association of India (FPAI) managed the show. Many foreign European dignitaries who attended expressed Malthusian views and an International Planned Parenthood Federation (IPPF) was founded, with headquarters in London. Swedish and British monopolies were not able to donate as much as American monopolies and in the 1950's IPPF's budget was comparatively less than that of Population Council. It supported all the affiliated Family Planning Associations of the world. India being the major target of attention, Lady Rama Rau was made the first joint secretary along with Margaret Sanger the pioneer of the birth control movement (FPAI, 1980-81). Margaret Sanger's views on birth control sound markedly racist today; she held that the growth in numbers of poor of the world was a burden and a threat to the peace of the "civilised" and needed to be checked.

India accepted the need for population control and incorporated a family planning programme in its health ministry. It officially opted for the clinical method and the opening of clinics. But in the first three years only the rhythm method was propagated. Private organisations such as IPPF and the International Red Cross donated in cash and kind to their clinics using diaphrams, foam tablets, condoms and conducted sterilisation operations in Bombay and Calcutta. These FPAI clinics were the first of their kind in the world (FPAI annual reports). Sanction for the use of contraceptives (mainly condoms, foam tablets and diaphrams) in the government's own clinics and the Rockefeller and the UN sponsored projects in Punjab and Bengal respectively was given only in 1955 (Ministry of Health Reports, 1952-1956). The Government's action in the first plan was negligible. This is confirmed by the fact that although the government sanctioned as much as Rs. 65 lakhs, no more than Rs. 31 lakhs was spent. This could not be due to mere moralist objections to artificial birth control programme alone. The need for birth control although accepted in principle by our planners, was not felt to be such a great necessity. Hence the difference between allocation and implementation persisted over many decades.

The Second Five Year Plan : 1956-1961 (March)

During this period, the liberation movements in the third world grew stronger. The economic condition of most of the third world deteriorated. For instance, India faced its direct major foreign exchange crisis in 1957 when the rupee was devalued. At this time, Coale and Hoover rejected the classical Malthusian theory but postulated that due to economic improvement death rates fall but not birth rate, and therefore, economic development is not possible. Thus the argument popular in the west was that investments in population control were more beneficial than investments in development programmes (Coale and Hoover, 1958).

Third world governments however, were not keen on finances from private donors. The Ford

Foundation and the Rockefeller Foundation finding that they instead were being cold shouldered helped in funding the UN. The UN also received funds from the Population Council. In 1956 the UN carried forth the recommendation of the International Social Science Council to collect demographic statistics (ECAFE, 70). It later moved two governments in the third world—one in Asia in 1957 and other in Latin America, to start demographic training centres catering to the people of neighbouring countries. In these institutes consultancy services were supplied by the UN. Most of the consultants were generally officials on leave from private population control bodies (for instance, Parker Mauldin, an Officer of the Population Council took leave from his office and came to the Bombay Demographic Training Centre as a UN Consultant on the subject) (Population Council Report, 1957). The idea was to train third world people in demography in order to spread the awareness of the need for population control. Thus ironically a member of the Population Council, (the ideology of which was not accepted by the third world), was allowed to help in training and advising Indians on the subject, as he came in the guise of a UN expert. **This trend of private organisations infiltrating the third world through international bodies like the UN and thus gaining acceptance is continuing even today.** It is in this way that their unacceptable ideas influence the population policy of the third world.

The WHO was in fact, severely critcised for organising such programmes for curbing population and controlling tropical diseases. This was interpreted as being not so much for the benefit of the third world, as for providing lucrative business for European and American drug cartels (Mass, 1978.) **An analysis of WHO's own reports reveals that the projects funded in the third world mostly relate to field and human trials of the drugs and chemicals being developed by first world firms** (Times of India, 1981) **Critics point out that but for these programmes, the firms would never have been able to develop the products or conduct such trials in the third word on their own.**

At the same time the Population Council, independently started aiding demographic teaching in Asian and African universities and began collecting demographic statistics as well so as to spread awareness for the need to control population growth. However, in the name of action research, they also carried out the testing of certain contraceptives which had not been tested or approved by their own government. The first world Drug Laws were too stringent and the lax laws of the third world on the other hand, offered wide opportunities for such testing.

The Ford Foundation, which had earlier showed interest in population control through other organisations now took a bold step. It independently started organising population control programmes in the third world, with its first programme being in India in 1959 (Ford Foundation, Report 60).

In 1956-57 the Indian government showed great resistance to private organisations aiding the family planning programme, although they accepted in principle the need for population control. But in 1958 faced with financial crisis the government's resistance broke down a little. India called for development aid from foreign countries which brought in aid first from the Ford Foundation that year and Bonnie Mass has stated that in 1959 India received 9 million dollars for publicity and campaigns for population control (Mass, 1978). Later others came with aid for agriculture and small industrial development. Along with development aid came assistance for population control. Various Universities departments of Economics were aided by the Population Council to start teaching demography.

One notices a strange situation here: the Indian government allowed the private organisations to directly carry out certain population programmes but did not itself get totally involved in the programme. However it began to show a keen interest in implementing population programmes. Several demographic training and research units were started by the government and plans were made to carry out empirical research on contraceptives previously tested by FPAI in their clinics. Oral pills and different methods of sterilisations were tested by the end of the plan.

The government expenditure in the second plan was ten times more than that in the first plan. This may have been a result of increases in foreign aid for FP after 1958. One also notices that after 1958 the private voluntary agencies were getting more funds from private organisations and increased their activities. For instance, FPAI started more programmes as its funding organisation the IPPF got 66600 dollars from the Population Council in 1959-60 (UN, 1968).

Third Five Year Plan : 1961-66

With the continuation of the cold war, came a tremendous investment in defence all over the world. Economic stagnation and inflation pressures hit the

first world. As a chain reaction third world countries were the most affected. The UN economic survey report of 1963 indicates the widening gap between the first and the third worlds. All this affected private organisations and they became more interested in selling the idea of population control. They attempted to involve the American government, but president Eisenhower rejected family planning (Wiessman, 1970). Many writers persisted in their argument that Vietnam and other liberation wars of Asia, Africa and Latin America were the result of overpopulation. Therefore population control activities were most essential in the third world. Still others stressed that the widening gap between the first and third worlds was due to third world overpopulation. (Berelson, 1964).

The growth of pessimistic thoughts about the overpopulation of the world caused some of the private organisations of USA for instance Draper, Moore, Harper & Row, Cass Canfield and Rockefeller to set up the Population Crisis Committee which was the political action arm of the Population Control movement. The US government officials served as representatives in the above committee (Wiessman, 1970). With the consent of President Kennedy, Richard Gardener was allowed to offer aid for the Population Control Programme of the UN marking the beginning of US government aid to population control (Chandrasekhar, 1969).

With a programme from J D. Rockefeller III, the White House gave a 'New Look', to foreign policy. USAID made birth control a part of foreign assistance and permitted President Johnson to judge a nation's "self help' in population planning as a criterion for giving Food for Freedom Aid. Developed rich nations thus directly pressurised underdeveloped poor nations through economic aids which the poorer nations could not refuse (Wiessman, 1970).

In India, by the end of the second five year plan it was realised that the economic plan targets were difficult to reach. secondly the policy resulted in widening the disparity in people's living standards. (Report 1960-61). In 1962 the Ford Foundation advised the government to take up the extensional approach ie to carry FP service to the door of the client through mobile units. camps and clinics. Besides Ford the other major donor to the Indian Voluntary agency FPAI was IPPF whose joint secretary was Dhanvanti Rama Rau. The Ford Foundation and FPAI experimented with mobile units and sterilisation camps and IUCD, initiating the period of bio-medical testing in India. (Ford Foundation, 1961-66).

India was the first country in the world to experiment with sterilisation and its result was utilised to formulate a sterilisation programme for the world (Population Report 1973). The government at the beginning of the plan paid no heed to the recommendations of the Ford Foundation but later in 1963 with the increased economic crisis, accepted 'the extensional approach' (UN India, 1966). Was the government's willingness to permit experiments by foreign institutions before its acceptance of the programme due to a fear of mass reaction, or was it due to foreign pressure ?

Thus we see that the private bodies gave up doing research in demography and moved directly to support action programmes. The money allocated in the third plan by the government was forty times greater than that in the first plan and foreign private agencies contributed more money to family planning. In this plan period, although the reports do not clearly indicate the relative proportions of foreign private aid and multilateral aid (Health Directorate Report, 1961-66).

The Three Annual Plans : 1966-69

The prolonged war in Vietnam continued to drain US wealth, while severe inflation hit many countries of the first world. The painfully slow rate of economic growth was noticed not only in India but in all the third world countries. Population control continued to siphon off funds from development. As a result of this, all the food shipments of USA "Food for Peace" programme under PL 480 aid to the third world had to be expended on Family Planning ie birth control programmes (Cleaver, 1973) USAID and many suspectedly private organisations moved to give population control a more international touch.

The Ford, Rockefeller, Moore and other foundations began to give larger donations to the international agencies resulting in larger budgets for the Population Council and IPPF. Among their many activities was especially encouraged the distribution and testing of contraceptives. In 1966 the Population Council went on to emphasise the use of Lippes' loops which had already been discarded in the west. They were either donated freely as aid to the third world countries or else loans were granted for their purchase or were manufactured in third world countries. In India, the Population Council funded the opening of the Lippes' loop factory at Kanpur, the

machinery for which was sold to the government by the Council (Population Council, 1966).

USAID donated assistance in cash and kind for population control along with development and food aid to India. In April 1966, the Population Council's bio-medical division continued to fund the testing of contraceptives and launched the International post-partum family planning programme. This was to start more direct FP assistance through a hospital base to all women who came for delivery or for Medical Termination of Pregnancy (MTP). (Mass, 1978). Although the acceptance of family planning appeared voluntary, the very fact that it was linked with delivery and abortion facilities detached it from the free will and volition of both the women as well as the hospitals that opted to receive the programme funds. But until 1969 funds for the post partum programme did not reach India (UN Report, 1970). Today this post partum programme has resulted in the acceptance of family planning measures being made a pre-requisite for obtaining medical treatment for deliveries or abortions. Thus a strange form of "compulsion" was created not overtly, but by skillfully narrowing down choices for women.

Faced with growing opposition from third world radicals and nationalists, private monopoly houses tried to move more cautiously. Through the UN a multilateral touch was given, by making family planning a human right in December 1966, adopted by 12 countries and later by all UN countries within a year. This resulted in the WHO, UNICEF, ILO, ECAFE and UNESCO directly donating funds for family planning and supplying contraceptives (UN Assistance 1968). In 1967 the United Nations Population Trust Fund (UNPTF) was formed whose major financial resources came from US donors and the USAID. In 1969 UNPTF became the UN Fund for Population Activity - UNFPA - and by the seventies, UNFPA dominated population control activities in the world (Mass,1978). With growing antagonism USAID routed its funds through small as well as better known organisations such as Pathfinders and the IPPF. Private voluntary agencies in the third world were also willing to use their good offices to put to test oral contraceptives and experiment with the effectiveness of various delivery systems of family planning in their respective countries (OFECD, 1975).

In India The Third Five Year Plan was greatly lagging behind in its targets in 1966. The country was faced with another great economic crisis resulting in a severe drain on it foreign exchange. During this period it is interesting to note that the "Development Aid" was bracketed with the family planning programme. The USA instead of signing annual or multiyear (food) sales agreements deliberately doled out food only for a few months at a time to ensure, through pressure, that family planning programmes were carried out. One notices that aid from USAID was the greatest to India during this period. It not only supplied money and PL 480 funds (such as oral pills in 1967-68 and then condoms for the Nirodh Marketing programme for testing as well) USAID in 1966-69 donated funds to start the "Intensive District Area Programme" providing nutrition programmes along with family planning. By 1968 SIDA, DANIDA and Japan signed the bilateral contracts with the Indian government and supplied contraceptives and equipment for family planning services (Ford Foundation, 69). Private organisations like the IPPF, Pathfinder and the Population Council which function through voluntary organisations tested IUCDs of different types and shapes oral pills were tested and sterilisation experiments were conducted in their voluntarily-run clinics, hospitals or dispensaries.

One notices that with each plan the priority accorded to the different methods of contraception has changed. In 1966-67 the government's stress was on IUCD; in 1967-68 sterilisation was officially emphasised and in 1968-69 it was Nirodh (Ministry of Health-Family Planning, 1966-69). Were these changes made by the government as a result of mass demand ? or were they the result of the supply of contraceptives as part of the external aid as India did not produce them indigeniously (UN,1970) ?

The government allocated in the first annual plan Rs. 149.30 million, in the Second annual plan Rs. 310 million and Rs. 370 million in the third plan for family planning. Incentive schemes were given emphasis in the second and third plans. One notices nearly a 100 percent rise from the sum allocated in the first annual plan. In this plan period almost 84 percent of the allocated funds were spent (Ministry of Health, 1966-69). This may have been a result of USAID compulsion to expand the FP activities and the PL 480 funds or it may be because the incentive schemes were offered to the acceptors and promotors of family planning. The most prominent trend in this period is the increase in direct involvement by the first world countries and the UN, instead of only private monopolies and their international organisations. With this the pressure for acceptance of family planning by the third world, especially by India, becomes greater and more rigid.

This desire for limiting population led to a marked increase in bio-medical testing to discover "the best contraceptive". In many cases women were not even aware that their bodies were being used for experimentation since they had approached the clinics for other medical treatment. Worse still others, because of financial incentives, sold their bodies to be used as "guinea-pigs" for experiments, the result of which could not be guaranteed; doctors themselves could not often predict possible reactions (Scheuer, 1972)

Family planning now became a goal to be reached, a tempting solution to the financial crisis and thus the human element was completely ignored. Protection of basic human rights, especially the rights of women, which the UN proposed as the aim of this programme, were completely ignored.

The Fourth Five Year Plan : 1969-74

The green revolution in certain parts of the world increased food production; but the Vietnam was continued to drain USA's public investments and world-wide inflationary conditions instead of improving had further hiked prices. Liberation wars and guerilla movements developed in the third world. All these conditions moved the private and government donors of the first world to loosen their purse strings for population control activities still further. During this period we see that the development aid increased in absolute terms but one can observe that the rate of growth for population control aid was much higher as compared to that in 1961. Development aid increased from 5200 million dollars to 7800 million dollars. Population assistance rose from 6 million dollars to 198 million dollars (UNFPA, 1974). In 1969 President Nixon in a revealing message to the committee of the White House stated that the UN, its specialised agencies and other international bodies should take the leadership in countering the problems of overpopulation in the third world and that the US should co-operate fully with such programmes (Singer 1971).

All this created a climate for symposia, conferences and debates on the population problem. The chief cause of every problem was seen as over population. Economists worked out the cost-benefit analysis of population control investment versus development investments insisting that the former was more beneficial than the latter. The World Ban received for the first time donations from the US and other first world countries for activities in population control. Under the leadership of Robert McNamara it frantically called for population control and assigned from its budget 27.0 million dollars in 1973 (World Bank) in India. The World Bank started population project in Rajasthan and Andhra Pradesh in 1974.

USAID, faced with objections from many third world countries rechanneled aid through multilateral and a few private international agencies. By 1973 100 million dollars of AID Funds entered the developing countries once again through private organisations for population control activities. By 1971 many new private organisations such as Family Planning International Assistance, Association for Voluntary Sterilisation, Asia Foundation and the International Confederation of Midwives had been founded, Pathfinder, a private organisation receiving funds from USAID had by 1973, 35 projects in 44 developing countries which were funded directly by private organisations and not by governments of the third world countries. IPPF in 1973 launched programmes to integrate family planning with rural development and when its activities expanded, it received increasing recognition by government. (USAID, 1973).

USAID was very keen on promoting bio-medical research and in developing new contraceptives. It donated 3 million dollars in 1970 to the Population Council to develop the "once a month-pill" and the Indian Council Medical Research Unit cooperated in testing in India (USAID, 1973).

In-mid-1971 when the New York Population Council started its International Committee for Contraceptive Research (ICCR), in India a Contraceptive Testing Unit (CTU) in Delhi with 14 centres in different cities of India was set up. This duplication was unnecessary as already there existed the Institute of Reproduction in Bombay which had its centres in major cities of India. The ICCR tested intra-uterine device on 50,000 women over a period of one year. The ICMR has conducted research on various intra-uterine devices and hormonial contraceptives. About 50,000 women are estimated to have taken part in these tests for the ICCR.

It is interesting to note that the population control activities which were started in 1952 by foreign powers with the sole emphasis on demographic research were transformed by the 70s into direct population control of the third world people. IPPF was the only international private organisation whose budget rose very fast as this organisation concentrated on family planning activities and worked on a voluntary basis in third world countries. But the budget of other private agencies like

Rockefeller, Ford Foundation did not increase and private organisations and USAID started donating more liberally to IPPF.

India, despite enjoying some fruits of the Green Revolution due to an increase in food production, could not check the growth of poverty and unemployment. The inflationary crisis continued to increase as well. World-wide inflation had further worsened her economic conditions. The Indo-Pak war for the liberation of Bangladesh further upset her economy and in 1971 the Indo-Russian pact strained her relations with USA triggering off other repurcussions.

The family planning programme was again given the highest priority and the population policy became in principle more ante-natal. Upto 1970-71 USAID and Ford Foundation had given major support for family planning. Their consultants advised the Planning Commission, the Health Ministry and the ICMR. When relations with the US were strained USAID and Ford Foundation were asked to wind up their population control units and their aid ceased to flow (Seal, 1974).

After a little lull in donations in 1971-72 funds from multilateral organisations and other governments were gradually stepped up. One sees SIDA, CIDA, UK and Norway donating large funds to support the building of the National Family Planning Institute in Delhi and some research on nutrition and health programmes in India. UNFPA, ILO, UNICEF and WHO, whose activities were limited in India gradually became the major donors. Both private and multilateral bodies were heavily supported by the USA. By the end of the plan an experimental area development scheme — India's first population project — was launched by the government with aid from the World Bank, IDA and SIDA. When USAID stopped functioning directly, many voluntary private organisations like IPPF, AUS, Pathfinder Fund, FP International Assistance, Christian Church Associations, and the International Red Cross started funding small voluntary organisations in India and thus many rural and urban clinics, hospitals and dispensaries were opened. The organisers were invited for seminars and conferences abroad and they were donated contraceptives and money. Many organisers came back and stressed sterilisation and offering incentives like radios, buckets, sarees, transistors.

In the Fourth Five year Plan Rs. 315 crores were allocated but government expenditure after 1972 reduced as USAID and Ford Foundation found themselves in disfavour at the government level as a result of the Indo-Russian pact. The USAID policy statement indicates 'AID recognised early that many instrumentalities would need in helping developing countries to attack their problems of population growth. Direct assistance could be helpful in those countries receptive to the bilateral approach. In some others however, assistance from multilateral agencies and from private organisations appeared to be more welcome — thus USAID shall help multilaterals and private organisations and they shall work independently".

The Fifth Five Year Plan : 1974-79

The decade of the Seventies began with a further upset of the already deteriorating world economy — the oil crisis hit the western world. At this crucial period in 1974, the World Population Year was celebrated and the activities of population control expanded. The first international conference on population sponsored by the UN was held at Bucharest. Various proposals and plans of action were put forward which would drastically reduce birth rates in the third world Planners of the conference were confident that they would be able to strike an agreement on 'plans of action' for family planning. Surprisingly third world countries formed a powerful block and opposed the US experts' 'plan of action' intended to stabilise the third world's population growth, treating birth-control as a factor which could be detached from the health and well-being of the women, family and society. Many of the socialist countries protested against what they considered the absurd theory of "population explosion." They felt instead that development would itself bring down the birth-rate. (Mass,1978) Experience had shown that poverty was the main factor responsible for over-population. Hence they argued that to insist that family planning was more important than development was to see the problem from the wrong end.

The social and political consciousness of the third world made it necessary that population programmes of the future would have to be couched in more subtle terminology. In order to make it palatable to the third-world recipients John D Rockefeller II was the first to put population planning in a developmentalist framework. He argued that population programmes and overall development programmes should indeed go hand in-hand. "We recognised that reducing population growth is not an alternative to development, but an essential part of it for most countries" (Mass, 1978).

Though there was a protest and an apparent setback for imperialists at Bucharest, the working group of the conference comprised representatives from many countries who chose to make the final draft. They voted to retain neo-Malthusian 'target' figures which proposed that the birth rate of the underdeveloped nations be reduced to an average of 30 per thousand by 1985. Despite the vehement protests of the third world, the end results of the report of the conference were heavily influenced by the opinion of the first world.

The Population Council concentrated on its bio-medical testing even after 1975. Till 1975 the International Committee for Contraceptive Research carried out tests on 12 new potential fertility control methods. However, faced with objection in the third world the Population Council handed over the post partum projects to UNFPA and donated large funds to it (Mass, 1978).

The Pathfinder Fund with a budget in 1965 of 100,000 dollars expanded in 1975 to 3.5 million dollars and supported approximately 150 studies in more than 40 countries. Its office in New Delhi which was set up in 1964 was later closed down (Mass, 1978).

By 1975 the Family Planning International Association funded by the Planned Parenthood Federation of the American IPPF and other voluntary world church organisations, services aided by USAID became the single largest source of contraceptives and other family planning supplies to the third world. Nearly 1000 church related hospitals, clinics, dispensaries and private groups were supported.

The Co-operative for American Relief Everywhere (CARE) began by 1970 to support birth control and by 1975 gave birth control the highest priority. Many other private organisations like OXFAM (England, Canada), Christian Aid (England), Asia Foundation, American Voluntary Association for sterilisation supported family planning ie birth control as their highest priority projects (UN, 1979).

UNFPA whose activities expanded in 1974 and which was in charge of the world conference split up its global role of population assistance into three phases by mid-1976 : (1) Traditional technical assistance-transfer of technical know-how (2) Financial support to assist government and non-government bodies to expand activities. (3) Phasing out of assistance or foreign experts at the country level which will expand the programme.

India's economy suffered grave setbacks due to world inflation. In response to the Bucharest conference, assistance from the UN, as well as voluntary organisations took a more subtle form and was linked with rural development, child care and nutrition. For example, families accepting birth control were given free tube wells, free meals, or free maternity and child health benefits. The government too accepted this approach and integrated family planning with nutrition. This can be seen as a method of making family planning a prerequisite for nutrition benefits from the government.

Meanwhile, after the 1971 war, political consciousness was reaching a new peak with mass peasant uprisings throughout India. The movement by Jay Prakash Narayan was to have important consequences for the future. The political overtones of this and other movements and the insensitivities of the ruling party led to the declaration of the emergency and the upsetting of the five year plan.

In 1976 the central goverment in an important move to make state governments accept the family planning decided to freeze the population based at the 1971 level for the next 25 years for determination of representatives in the Lok Sabha and state legislatures. This compelled the leadership of many of the states to accept compulsory sterilisation and offer incentives viz. Rs. 150/- if performed with two living children, Rs. 100/- if with three living children and Rs. 70/- if performed with four and more (Times of India, 1976). Maharashtra declared that government servants who were not sterilised and had more than two children would not be given ration, housing facilities, or free hospital services (Times of India, 1976). To add to these frightening and unjust disincentives, in the Pune Municipal Hospital a sick person was not admitted unless and until one family member was sterilised and produced a certificate. All these measures led to great opposition to family planning among the public and to the Congress regime and the Congress was voted out of power. With the advent of the Janata Party, Raj Narayan, the Health Minister modified the Population Policy. He eliminated all forms of compulsion and gave family planning a new dignified name — family welfare programme, which in substance remained the same.

In this plan as compared to the earlier one, Rs. 497 Crores were allocated. The major donors during the Fifth Plan were UNFPA — 40 million dollars; World Bank — 21.2 million dollars, and SIDA — 10.6 million dollars.

With more funds coming in, the expenditure rose in each successive year. For e.g. in 1976-77 it increased almost to Rs. 16793.89 lakhs mainly due to the so-called incentives for sterilisation and IUCD programmes. Although it increased during Janata regime there was a fall in the expenditure and surprisingly enough, the external aid received during those last two years of the plan exceeded earlier donation. This was because during the Janata regime, "family welfare" (nutrition, child welfare, post-partum programmes) were used as a bait. Before the sixth plan began in 1980 a year passed without a five year plan but activities on Family welfare increased during this year.

The Sixth Plan : 1980-85

With the world situation remaining practically the same, with increasing recession, the emphasis on the need for population-control continued. Bilateral aid, earlier rebuffed, was now welcomed by the Indian Government. Permission for adoption of villages in the third world by the UN and by the World Bank was now extended to bilateral organisations like USAID, CARE, SIDA and others. In India too this became a common feature. Monetary crisis has made India sign a development pact with many First World countries. Although the total figures of external aid was not available, the Indian government allocated Rs. 1010 crores for family welfare of which Intensive District Development (ie development of primary health centres and family planning in districts by multilaterals and bilateral units) accounted for nearly Rs. 225 crores (UN, 1980-81). The India Population- II programme of Intensive District Development based on the experience of Population-I programme was extended. Their aim was "to promote family welfare to lower the fertility rate through the creation of facilities for integrated delivery of services for health, nutrition, MCH, contraceptives and medical termination of pregnancy, closer to the homes of people particularly in rural areas" (USAID, 1980-81).

The external aid for India Population Project-II has involved many donors. The multilaterals UNFPA and the World Bank consented to support projects in 18 districts with 95 million dollars. Performance Budget, 1980-81). On examining bilateral involvement one finds that USAID which had stopped donating for the family planning programme since the Indo-Soviet pact of 1971, agreed to donate 40 million dollars supporting 12 districts and the above project is still being implemented (USAID paper, annexure). Further UK and DANIDA who had earlier supported the sterilisation programme and National Health and Family Welfare Centre building funds, donated 63 million dollars to carry out family welfare and health programmes in 15 districts (Performance Budget, 1980-81).

It is not easy to get statistics on the foreign contribution to family welfare but one is aware that a good quantity of Copper T manufactured by the Population Council has reached India, and today besides sterilisation, this is the foremost method of family welfare adopted by the government for which substantial incentives are being given.

The state of Maharashtra which was declared as the foremost in the use of Copper T for three consecutive years was exposed in a racket uncovered by the Indian Express (1984). The number of eligible couples in Maharashtra, were found to be much less in number than the acceptors of Copper T ! When the government field surveys for inspection were conducted, it was found that nearly 25 percent of the copper Ts inserted ie 726 lakh Copper T inserted, worth four crores were fictitious cases.

The annual reports of ICMR indicated that the Population Council, Ford Foundation, and WHO continued to give funds for bio-medical contraceptives research. The FPAI received laproscopes from IPPF in 1979-80 and organised camps in rural areas. For example a welfare organisation in the village of Tara, used laproscopes in Raighad District while the taluka hospital had none. A demand for laproscopes was made. Thus by 1984 almost all districts of India, especially in Maharashtra, got laproscopes.

In 1970 the direct involvement of Ford Foundation which had started since 1959 was stopped. In 1971 JRD Tata founded the Family Planning Foundation of India (FPFI) and the Ford Foundation stepped in as one of its major donors. (Ford Foundation, 1980).

The FPFI by 1972 took up action-cum-research projects, demographic research and later biomedical testing of contraceptives. The activities which were initially directly handled by the Ford Foundation were now aided by it. Its role thus remains important even today, and its philosophy continues to influence the Indian population policy. In 1979 the Ford Foundation donated 700 000 dollars ie almost 50 percent of the FPFI's total budget (Ford Foundation, 1980). Though the acitivities of the Family Planning Foundation began during the Fifth Plan period, it was only during the sixth plan period that it took on a more prominent role to carry forward the philosophy of the Ford Foundation by organising and founding seminars, conferences, action research, etc.

Table 1

Nature of Assistance of Imperialist Powers to private voluntary organisations and the government for Family Planning Programmes and central government plan allocations :

The following data has been tabulated to (a) understand why the population policy has undergone changes and (b) to find out what the impact of the external assistance ie. private, government and multi. lateral (2) has been, and (c) how and in what way it has affected Indian programmes.

Phase	Plan Period	Donor Agency to India	Recipient Agency in India	Central govt. allocation for FP
I	Pre Plan 1947-1952	Private	Private	British government had no programme
II	First Five Year Plan 1952-1957 March	Private Multilateral	Private Government	Rs. 65.00 Lakhs
III	Second Five year plan 1957-61 March	Private Multilateral Private	Private Government Government	Rs. 479.00 Lakhs
IV	Third Five year plan 1961-66 March	Private Multilateral Private Government	Private Government Government Government	Rs. 269.70 Lakhs with provision for Rs. 500.00 lakhs
V	Three Annual Plan 1966 to 1969 March	Government Private Multilateral Private	Government Government Government Private	Rs. 750.01 Lakhs
VI	Fourth Five Year Plan 1969 to 1974 March	Governments Multilateral Private Private	Government Government Private Government	Rs. 3150.01 lakhs
VII	Fifth Five Year Plan 1974 to 1979 March	Private Multilateral Private	Private Government Government	Rs. 4970.00 lakhs
VIII	1979-1980	—	—	Rs. 1180.00 lakhs
IX	Sixth Five Year Plan 1980 to 85 March	Multilateral Private Private	Government Private Government	Rs. 10100.00 lakhs

Note :- Figures of Donation received not indicated as assistance is in cash and kind.

Source :- Data collected from various yearly reports of :

1) Population Programme Assistance United States Aid to Developing Countries; 2) Reports of the Ministry of Health; 3) Annual Reports of the Directorate General of Health; 4) Annual Reports of the Ford foundation; 5) Annual Reports of the Rockfeller Foundation; 6) Annual Reports of the Population Council; 7) Annual Reports of the International Planned Parenthood Federation; 8) United Nation Funds fo Population Activities; 9) Aid for Family Planning pamphlet by Emerging Population Alternative. (Mimeograph)

Summary and Conclusion

In the pre-independence period the efforts of birth control were carried out by a few concerned individuals in India. A couple of foreign organisations funded Indian birth control clinics. There was no state level movement.

In the First Five Year Plan the Government accepted family planning as a programme. The major emphasis particularly in the early years lay on the rhythm method, due to the diffidence of the government. Private organisations funded generally by private organisations were free to propagate other methods.

In the 60s the increased economic crisis, the shortage of food, the growth of liberation movements brought first world governments to focus their attention on the importance of population control to avoid major social and political upheavals. Development aid was increasingly linked to population programmes and there were an increased aid flow from governments of the First World to the governments of the third world.

In India, the programmes of voluntary organisations served as important pointers as to what direction the government policy would take. It was also their advice and donation which compelled the government to change prescribed contraceptives during each plan period. It gave or promoted what it received and tested what it was asked to as the economic crisis made them helpless and forced them to accept assistance which led often to indebtedness.

After the World Population Year, 1974, the approach has again changed. It is now recognised that development is essential for birth control programmes to make a headway. Thus increasingly the trend is to support 'integrated' projects which include health, nutrition, and development. Multilateral and governmental aid have become the major source of finance for the Indian govenment though it still remains to be analysed whether these programmes are development oriented or whether they are basically family planning programmes with merely an acceptable cover.

The point of this article, is not merely to criticise the idea of birth-control itself which should be available to women as their basic right. This paper is also aimed at examining the history of the fallacy that family plannining is a solution to the problems of poverty, underdevelopment and unemployment. Has the bogey of overpopulation been created by the leaders of the first and third world countries and exaggerated merely to divert attention from the real problems facing them ? More important have the woman's basic needs been forgotten in the quest for ever-higher targets of achievement in family planning measures? Do we in the Third World want a reduction in the birth rate, at any cost ?

NOTES

1. *Performance Budget* 1977-78 Ministry of Healh and Welfare Government of India P. 184 "The expenditure on the family welfare programme is basically met out of the national exchequer. Some assistance which forms a small proportion of the total expenditure on the programme is received by way of international cooperation from some of the international agencies".

2. *Private Donors* to India are most often the monopoly houses or its funded voluntary organisation. Many of these voluntary organisations are also funded by government aid agencies eg. The Ford Foundation, the Rockefeller Foundation, Hugh Moore Foundation, International Planned Parenthood Federation, Population Council, Pathfinder Funds,Medical Christian Association, International Red Cross, Peace-Corps, OXFAM, Population Crisis, Voluntary Sterilization Association and other private receiving agencies, Family Planning Association of India, The Family Planning Foundation, Indian Red Cross, various Rural & Slum Developmental Agencies, Gandhigram Institute etc.

3. *Multilateral Donors* are the agencies funded by more than one monopolies and governments such as bodies of United Nation and recently the World Bank eg. WHO, ECAFE, UNICEF, UNFPA, IDA and others.

4. *Bilateral-Government* - First it was USAID United State Aid to Developing Countries, NORAD Norwegian Agency for International Development, BODA British Overseas Development Assistance, SIDA Swedish International Development Authority, DANIDA Danish International Development Agency, CIDA Candian International Development Authority, France, Japan, Korea, Finland, Representative of Germany, Australia.

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OUR FORTHCOMING ISSUES

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POLITICS OF THE BIRTH CONTROL PROGRAMME IN INDIA

sucha singh gill

The myth that projects population control to be the cure-all for all social and economic problems has a class bias. According to the author the emphasis of our planners on population control is an attempt to weaken the class struggle in India by absolving the exploiters of the responsibility for perpetuating inequalities and shifting the blame from the capitalist order to the people. The article deals with two major issues in the family planning programme (i) that overpopulation is a major cause of poverty and (ii) that persuading people to accept the small family norm is the only way that population growth may be controlled. It examines the socio-political content of these issues and emphatically suggests that eardication of poverty and unemployment, and guarantees against insecurity, sickness and the death of children must be demanded as a prerequsite for accepting the small family norm.

For the last many years the family planning programme has overshadowed all aspects of our social life including the development of health services. In fact health services have been oriented drastically to suit the needs of this programme. All activities of the health institutions and their staff are subordinated to the fulfilment of family planning targets. While assessing the work of the health staff including the doctors, the only criteria has been performance in family planning work. Their annual confidential reports, efficiency bars, transfers, rewards and punishments are all based on the achievements of this programme.

The family planning programme is getting nearly as much budget as the entire health sector which contain programmes of equal or even more importance. During the 1974-79 period the health sector was allotted Rs. 681.66 crores and the family planning programme received 645.00 crores. In the sixth plan the health sector and family planning programme got Rs. 1821.05 crores and 1010.00 crores respectively[1]. Later on during the time of mid-term appraisal Rs. 68.00 crores were shifted from the general side to the family planning programme. (Planning Commission, 1983). A population Advisory Council was also set up under the chairmanship of Health Minister to keep population control under close watch and advise the government on policy matters. The 13th item of the new 20-Point Programme is specifically related to popularisation of family planning programme with the people. (Planning Commission, 1983). This renewed emphasis on the population control programme intends to achieve the long term goal of planning to reduce birth rate from 33 in 1980 to 21 per thousand in 1995 and increase the couple protection rate from 22.5 percent in 1980 to 36.6 percent in 1984-85 and 60 percent in 1995.

Although the programme is given the name of family planning and lately, family welfare, in essence it remains primarily a birth control programme. This is evident from the fact that as compared to Rs. 1078 crores allocated for family welfare programme in the Sixth Plan only Rs. 250 crores were for nutrition programmes (Planning Commission, 1980). The programme is not linked up with important aspects of future plans necessary for the welfare of each family such as education of children, their employment, security of family against sickness and old age or rehabilitation of the destitutes. There is no provision in the programme to protect the family against economic, social and psychological insecurities being increasingly generated by the socio-economic dynamism of Indian society on the capitalist path. In this situation the family planning programme remains as an intervention by the government only to limit the number of children through birth control measures.

However what matters most for individuals who plan their families is a better future. They want to improve the economic and social status of their family through education and employment of their children and accumulation of non-human assets. Both these assets human and non-human, are a guarantee against sickness, old age and destitution in addition to the psychological satisfaction. Obviously, they need a minimum number of children particularly male ones for this purpose. Nothing is done where actual planning is required and couples are left on their own, unprotected against various types of insecurities. Thus family planning or welfare programme is a misnomer and emerges prominently as a birth control programme.

The Poverty-Overpopulation Myth

The Population control programme is one of the key programmes in India. Indian planners view the

limiting the growth of population as one of the main objectives of planning. In the words of the planning commission, " it is almost axiomatic that economic development can, in the long run, bring about a fall in fertility rate. However developing countries with large population cannot afford to wait for development to bring about a change in attitude of couples to limit the size of families as the process of development itself is stifled by population growth". (Planning Commission, 1980). During the emergency (1975 77), a naked expression of this hidden message of the Planning Commission was seen. The poor people were forcibly sterilised in huge numbers and in a manner worse than animals because the government and the Planning Commission could not wait for a change in their attitude.

The success of development planning and particularly solution of major economic problems such as poverty and unemployment have been linked up with the success of population control programme. Planning Commission states, "All plan projections of reduction of poverty and unemployment will go wrong if success is not achieved in containing the growth of population". (Planning Commission, 1980)

This policy of the government to control population has a class bias (Banerji, 1971). Indian society is a class divided society. Rural and urban poor belong to oppressed classes — poor peasants, tenants, artisans, agricultural/industrial proletariat and others engaged in a number of odd jobs. These poor people have a very weak material base and are deprived of the means of production. They live on their family labour. Their greatest asset is their labour power. It is the sole source of their income, prosperity and security against old-age, sickness and other adverse circumstances. The poor people without children generally become beggars and destitutes in their old age as there is no institutional arrangement in our society to look after them. The material need of the poor to have more children is more acute as compared to the rich.

A number of studies in India show that among the poor households poverty is not caused by the large family but rather, it provides some relief against it (Mamdani 1972, Mamdani 1976, Nadkarni 1978). The poverty of the poor households originates from their poor command over the productive resources such as land and capital assets. According to agricultural census 50.62 per cent holding with less than 2.5 acres of land operated only 8.97 percent of total cultivated area. On the other hand, the top 15.17 per cent of the holdings with more than 10 acres of land operated 60.63 percent of the area in 1970-71. Almost the same trend is observed from data about 1971-72 from the 26th round of National Sample Survey (Laxminarayan and Tyagi, 1976) Land is the most prominent asset in the rural areas and it accounted for 66 per cent of the total assets in rural India in June 1971. According to the Reserve Bank's All India Debt and Investment Survey (RBI, 1971-72) 9.34 percent of rural households were landless and 27.63 per cent of the household owned less than 0.50 acre of land. According to this survey the top ten per cent of the rural households accounted for 50.56 per cent of the total rural assets (Basu 1976). The distribution for assets in urban areas is even more skewed with major part of the private corporate industrial structure being under dominant control of top monopoly houses (both Indian and foreign). Thus the poverty of the poor families emanate from their weak material base rather than family size.

In the same way unemployment in society cannot be explained in terms of population growth. It can be explained only in terms of management and development of the economy on capitalist lines. The dynamism of capitalist development produces large scale unemployment. Marx points out, "the labouring population therefore produces, alongwith the accumulation of capital produced by it, the means by which it itself is made relatively superfluous, is turned into a relative surplus population; and it does this to an always increasing extent. This is a law of population peculiar to the capitalist mode of production; and in fact every special historic mode of production has its own special laws of population, historically valid within its limits alone". Even in professional jobs like that of teachers, doctors and engineers there exists unemployment, though there are a number of illiterate persons needing teachers, sick people in need of doctors and a large number of projects needing engineers. In a capitalist economy resources are directed towards profit maximisation rather than towards social usefulness. Many resources including an unemployed labour force can be socially useful but remain unutilised for want of profitability. Unemployment is a typical characteristic of capitalist development. It is not due to high population growth. In capitalist economies there is a fundamental right to property but no such right to work.

The emphasis of Indian planners and policy-makers on control of population through birth control measures as a precondition for the success

of plan to eradicate poverty and unemployment is an attempt to conceal the basic causes of these problems. It is an attempt to project population growth as the villain of every problem in society. This tries to conceal the root cause of such problems that is unjust socio-economic systems. It helps in diverting attention from the exploitation of society being carried out by multinationals in collaboration with local monopoly (and non-monopoly) capital, exploitation of labour by capital (both in industry and agriculture), and exploitation of tenants and peasants by landlords, moneylenders and traders. It is this system of exploitation which is responsible for a shift of resources (income and wealth) from the poor to the rich and is the basic cause of poverty. The control of the exploiting classes over state power to maintain the existing system of socio-economic organisation of society on capitalist lines is the basic cause of unemployment and other problems of Indian society today.

Poverty and Family Size

Family size is the only asset which the poor possess and it provides them income and security of various types. Since the family size and from it the family labour is the mainstay of the poor, they have a greater need for children. Added to this is the fact that the survival rate of children in India particularly in poor families is low. In 1971 infant mortality rate was 129 per 1000, 138 for rural and 82 for urban areas. In 1978 Infant mortality rate was 126-136 for rural and 71 for urban areas. Inspite of the wide claims of improvements in the health services the infant mortality rate has not gone down, particularly for the rural areas, where three fourths of India's population resides. The infant mortality rate though slightly low for male as compared to female is quite high in India. In 1978 it was 120 for male and 131 for female. Data on the infant mortality rate of different income groups/classes is not available. In their absence, let's look at the data of scheduled caste/tribe. Infant mortality rate in case of these two categories is higher than the average. In 1978, it was 152 for scheduled castes as compared to all India rate of 126. Similarly infant mortality rate in the women workers is high. It was 143 for farmers, fishermen, hunters, loggers and related workers; 150 for production and related workers, transport equipment operators and labourers. (Registrar General of India 1983). The magnitude of the problem can be judged from the fact that a fourth of the children in India die before attaining adulthood. Thus the survival rate of children is low particularly among the weaker sections and oppressed classes in India.

The socio-economic dynamism of society on the capitalist path levies very meagre resources with these sections. So they cannot afford medical facilities of their own. They are denied even the shabby public health facilities available in our country. That is the reason that most infant deaths below one year take place unattended by trained medical practitioners. Percentage of such deaths was 58.3 in 1978. The state of other necessities of life needed for good health is also deplorable. In India most of the people do not have facility of hygienic and clean drinking water. Even now 57.70 percent of the people are drinking water from wells and 5.31 percent from pond/tank and rivers. Only 34.35 per cent of population drinks water from taps and handpumps. (Registrar General of India, 1983) Average calorie intake in our country is 1880 which is even less than the minimum calories needed i. e. 2250. Inspite of three-fold increase in the food grain production our per capita consumption is stagnant since 1956. The poor do not get reasonable good diet, clean water and secure shelter in life. These factors are responsible for high motality rate in the children, thus the need of the poor to produce more, in order to get a minimum number of surviving children. Even in a prosperous state like Punjab, on the average 1.10 children per family had already died when a survery of the sterilised couples was conducted (People's Health Group,)

Childern are also source of income before their adulthood. Though child labour is legally banned yet a large number of children from poor families are labourers. Both in urban as well as in the rural areas children can be seen doing all types of odd jobs to earn wages or help in family work in productive activities. According to the Government of India survey 3.7 percent of the Children were full-fledged workers in 1978 — 4.2 percent in the rural areas and 1.5 percent in the urban areas. In the rural areas 4.8 percent of male children and 3.5 percent of female children were workers. About 80 percent of child labour were children of farmers, fishermen, hunters, loggers and related workers and 11.64 percent of production and related workers, transport equipment operators and labourers. Thus children belonging to the poorest families do not attend the school - but contribute to the family income. On paper children may be shown in schools but a large number of them from poor families drop out and

join the labour market at a very early age. In addition to being full-fledged workers a majority of the children, particularly in the rural areas, contribute significantly to the family labour. It is obvious that child labour can not be stopped by implementation of legislation but through material upliftment of the poor families in the society.

Apart from these economic factors, there are a number of social reasons why people need to have more children, particularly male ones — emotional security, social status and continuity of family, are some of them. For these reasons common people have an urge to have more than one surviving male child in the family .Even in a relatively prosperous state like Punjab where a lot of people from the villages are employed in government and semi-government jobs, the average number of children after which the couple accepted sterilisation was 4.47 with 2.48 boys. The figures for the agricultural workers was a little higher i. e. 4.54 and 2.58 respectively (The detailed break up is shown in Tables I & II.)

Only four percent of the couples accepted sterilisation after two children — the norm recommended and propagated by the government. None of the agricultural worker's families accepted to stop after two children.

Table I

No. of Children per Family in rural Punjab (percent of couples already sterilised).

Category	No. of children/family					
	1	2	3	4	5	More than 5
In general	Nil	4	22	30	22	3
Agricultural workers	Nil	Nil	14	37	30	19

Table II

No. of boys per family in rural Punjab (percent of couples already sterilised)

Category	No. of boys/family				
	1	2	3	4	5
In general	7	48	38	4	3
Agricultural workers	7	42	40	9	2

Table III

Minimum no. of children they could imagine (Boys + Girls)

Boys Girls	1+0	1+1	2+0	2+1	2+2	3+0	3+1	3+2
No. of couples (percent)	Nil	2	4	66	21	2	4	1

In this survey which was carried out in the rural areas of Punjab, 98 per cent of the couples could not imagine less than two boys for a family. This survey was conducted by the family planning staff whom the villagers always want to please by mentioning the least number of children there should be in a good family. Taking into account the average loss of 1.10 children per family, one can imagine that their desire to produce 4 to 6 children or 2 to 3 boys is not unnatural.

A family without a male child is still looked down upon and parents with one male child are still considered as blind in one eye. The two children norm propagated by the government is not acceptable to people at large. These are in fact, family norms of educated middle class. It is for this class that children remain a burden to be borne by families for a considerable period in India. They have to be reared, well-looked after, educated and even helped to get a middle-class job. In this way they have to be supported for 20-25 years before they can be of economic use to the families. That is the reason most of the middle class people have been following small family norms and not primarily because of family planning propaganda. It is worth mentioning that many of the countries have never propagated family planning and still their growth rate is almost nil. For example USSR had never launched a family planning programme of the type we see here in our country. Although that government always encourages its citizens to produce a number of children, half of the couples produce only one or two children.

It needs to be reasserted that poverty is not explained by big family size but by the weak material base or by lack of productive resources at people's command. The link between eradication of poverty, population control and the idea subscribed to by Indian planners, that the success of the former is linked to the success of the latter, is ideological. It is not based on a scientific analysis of our socio-economic reality but rather, it amounts to consciously making the whole thing stand on its head.

The idea of projecting population growth and large family size as the basic problem of society is an attempt to hold people responsible for their problems and exonerate the ruling classes from this responsibility. It is an ideology of the ruling classes to shift the blame of existing social and economic mess to the people in general. This 'ideology of victim blaming' is being widely used by the ruling classes in all fields of life to blur the rising consciousness of people. This fact, that the poor do not find the two child norm suited to them and therefore do not accept it is used by the rulers to attack the poor, an attempt to pre-empt the attack by the poor on rich.

Birth Control Programmes : A Subtler Form of Class Oppression

The rigorous implementation of small family norm and population control on the unwilling poor leads to the use of some form of open or tacit compulsion. The officials entrusted with the task of fulfilling the targets, compel the field staff to bring enough number of cases for sterilisation. The field staff uses various means ranging from incentives of financial help to the threat of officials and local influential persons to complete sterilisation targets. Given the unjust socio-economic system, such threats work only on the unorganised poor in the country. This take the form of direct class oppression of the poor, the worst form of which was faced during emergency period of 1975-77.

Sterilisation particularly of the women has mainly become the birth control method of the poor. The side effects are multiple. One is the development of complications arising out of sterilisations and even deaths of some women. Back-ache, pelvic pain and other problems make the women chronically ill. In a survey conducted in Punjab more than 80 percent of women complained of one or more problems after the operation. (People's Health Group). This adversely affects their capacity to work and consequently the earnings of the working class families. "For women of labouring class . . . tubectomies may be a dangerous intervention, productive of family conflict and tragedy: if it decreased the women's output then children are made to do her work, while if she is forced to keep her economic activity at the same level, children then have no protection against either the hopelessness or savagery of her feelings". (Pettigrew, 1984). Therefore, tubectomy operations are not only inappropriate but harmful to working class families. For obvious reasons, doctors, engineers, lawyers, college/university teachers or bureaucrats hardly use this method. Nobody has ever asked those recommending tubectomy to poor women as to why they do not get their own women sterilised.

In this context birth control programmes not only becomes a political enterprise but a subtler form of class oppression. It hits them hardest but conceals the identity of the attacker. It directly transmits the class conflict into family conflict among the

poor. It is an attempt to blur the class conflict and hits the poor through control of their reproductive system. By thrusting upon the unwilling poor sterlisation and particularly the tubectomy operations make the poor economically weak and psychologically shattered. This reduces further their capacity to organise and fight against their oppression and exploitation. It is a way to dominate economically, politically, culturally and socially to perpetuate the system of exploitation. This leaves them ideologically confused, socially shattered, politically weak and psychologically perplexed. This is an offensive of the exploiters against the exploited to weaken them to avert the offensive. It is a serious attempt by the rulers to reduce the number of their enemies in order to reduce the risk to their oppressive regime. It must be emphasised and re-emphasised that too small a family among the poor is economically, socially and politically a weak family and is bound to affect their class strength. Therefore, pro-people elements in the society must understand that birth control programmes are a part of the ruling class strategy of repression of the poor in general. But this is presented as a programme of welfare of the people. This needs to be exposed as a thoroughly anti-people programme which affects the very vitals of the people. It operates at a very subtle level and intends to control the most senstive part of life that is, reproductive system.

The political nature of this programme must be made clear to the people. The failure of the ruling classes must not be allowed to be projected as failure of the people. The un-willingness of the poor to accept the two child norm of the ruling classes must not be allowed to be used as a pretext to use frank and hidden compulsions against the poor. The eradication of poverty and unemployment and guarantees against insecurity of old age, sickness and death of children must be demanded as a pre-requisite for accepting the small family norm. The impatience of ruling classes to thrust birth control programmes on the poor even with coercive methods before even attempting to solve the socio-economic situation which make a large family desirous needs to be understood and opposed. The only check against this on-slaught is through the conscious organised force of the poor.

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CONTRACEPTIVE RESEARCH IN INDIA

Testing on Women

kusha

Field trials to determine the efficacy and safety of a particular contraceptive are very often carried out in a dubious manner in the third world on woman from the deprived sections of society. Research institutes are either coerced or tempted by international funding agencies (sometimes through the government) and are used as laboratories to test out potentially dangerous contraceptives The author relates her experiences in a contraceptive testing unit (CTU) located in the working class area of central Bombay. Inspite of visible side effects, contraceptives ranging from diaphragms to hormonal implants to injectable contraceptives as well as new drugs to induce abortion (MTP) were tested on women in exchange for a modest monetary incentive.

Introduction

Family welfare programmes have to be committed to the emanicipation of women and their being accepted as equal partners in decision making in all spheres of developmental activities. International women's year has created a widespread awareness of the inequalities between men and women. It threw light on the steady decline of women in the labour force, and on the poor participation of women in socio-economic and political activities. The report on the status of women brought out the urgeney of providing facilities for training women and to provide an opportunity for their access to sources including tools and skills so that they could enhance their contribution to their family and to society.

In the field of family planning, it is important to understand the acceptability of a particular contraceptive, reasons for choosing one method over the other and assess what makes women and men continue or discontinue using a method of their choice. It is also important that family planning education is given to both men and women emphasising the inter-relationship between family planning and the status of women, since it is a recognised fact that the status of women directly influences the acceptance of family planning. At the same time the availability of family planning education directly contributes to the status of women by conferring on her a basic human right to choose.

The term 'family planning' was changed to 'family welfare' on this basis and entirely on the premise that when an eligible couple is contacted for family planning, it is the 'couple' who equally share the responsibility of deciding the type of contraceptive they will use, the number of children they will have and when to have them. What is generally happening in reality in the field of family welfare is just the opposite. The ideal contraceptive, acceptable to all people from different strata of society, at the same time being harmless, effective, easy to use, easily available and cheap simply does not exist, at present. What is more disturbing is that research towards attaining this ideal is also not given priority.

Goverment Policies

The initial approach of setting up clinics in different parts of the country and waiting for people to accept fertility regulating methods (FRM) was based on the several so-called (KAP) studies which indicated family planning acceptance. However, the policies of the government changed from time to time due to pressures from foreign government and non-government agencies mostly from the west since these agencies provided money and aid in kind. Later, the approach was changed to family planning extension programmes wherein family planning workers moved in the community and set up depots to distribute condoms. However targets were not fulfilled and once again the approach was changed. Family planning was then integrated with maternal and child welfare programmes and in 1966 post-partum programmes were launched.

These changes of approach were only made on the basis of whether targets were being met or not. For instance at first the number of conventional contraceptive users was considered; the number of IUD users was counted without any consideration of the removal rate after IUD, insertion and so on. The same was true with pill users and the extent of bogus sterilisation is only too well known. The KAP studies were mostly useless because the ethos, needs or priorities of the people was not considered.

Added to this in several states the government in its enthusiasm to achieve targets bungled their programmes by coercing people to accept IUDs or sterilisation operations.

The state governments got away with this callous approach to meet targets as far as women were concerned. Women were made to suffer humiliations, indignities and often serious physical side-effects, but the strategy boomeranged on the government when men were forcibly sterilised. A government was toppled! Even then this patriarchial male-dominated society did not care to understand what suffering women had been made to undergo for so many years. If women complained they we e told to bear the side-effects. Now during the past few years, probably to pacify the male ego and to stay in power, the government's stress is once again on women—catch them anywhere, in hospitals after delivery or in abortion and child welfare clinics. Women have to accept any contraceptive that suits the authorities.

Review of literature

Dr. D. N. Kakar has done a study of women using either the pill, IUD, or injectables Kakar, 1984). The study throws light on several factors responsible for a method being continued or discontinued. It is strange why a similar study was not done on the use of condoms. It is because men cannot be bothered to accept the responsibility of using this method ? Though Dr. Kakar's book deals only with women's contraceptives, it sheds light on several important factors which are directly connected with physical problems faced by women due to contraceptive usage and male attitudes to contraception. In several case studies it was pointed out that women discontinued contraceptives because of side-effects such as spotting or intermenstrual bleeding. Several women said that they needed much greater medical attention when these side effects took place. They needed reassurance and understanding from their husbands but were instead treated with a certain coldness Dr. Kakar asks, "how many husbands would be genuinely concerned about providing comfort to their wives without being able to derive sexual gratification ? " It is usually the woman who bears the brunt of physical discomfort and at the same time takes the responsibility of avoiding a pregnancy.

Annual reports of the Indian government and many of the western offices of population have shed light on the amount of foreign aid in the nature of cash and kind. The main contributor to the population control fund and even to the concerned UN body is the USA. The UN has set up a special division on biomedical research and over 100 million had been spent by 1972. The division has clinically tested 45 different drugs and six different devices on 45,000 persons — mainly women of the third world. Among those who have been funding the population activities in the third world countries in cash or kind either through the government or through private agencies are US, UK, Netherlands, Japan, Germany, Canada, Norway and Denmark. In India, WHO and Ford Foundation are the major contributors for research in contraceptives. IPPF, Pathfinders and Population Councils are other important donors. By 1980 over 7,500 subjects, mainly women in Bombay alone were involved in some of the trials in contraceptive testing.

Historical background of a contracptive unit

The family planning unit of the government of India was started in 1954. It had three main objectives - (i) testing of contraceptives for their efficacy, safety and acceptibility; (ii) conducting research in reproduction and fertility control; and (iii) developing newer contraceptives. In 19.6, the FP unit was reorganised as a contraceptive testing unit (CTU). The first clinic was set up in the industrial area of central Bombay. Located in the premises of the mother and children welfare society, the health of mothers and children formed an integral part of its work from its very inception. The social workers' attitude then was to educate women and men of the community in every facet of health. Stress was laid on the overall education of people through organising the community around the clinic. Men, women and children came to the clinic not only for FP methods but for all their socio-economic and other personal problems. Some of the activities started at the clinic were (1) Education of men and women and children through exhibitions, group talks not only on FP but also in health care, antenatal care, post natal care, women's movement and nutrition education. Women and girls were given sex education. (2) The entire community was screened for TB by taking mini x-rays and treated or referred for admission to a hospital. (3) To get the entire community involved in the welfare activities, health day, 'makar-shankranth' day, children's day, women's day and so on were celebrated. (4) Women were encouraged to speak in meetings and debates, their mahila mandal was set up and skits and songs were staged by the women themselves. Competitions in essay writing, painting, were held. Classes in first aid, nutrition and adult education were conducted. (5) Efforts were made to help women continue education and to

secure jobs. (6) Even separate clinics were conducted for ANC and PNC as well as for babies. Sterility being a major problem of the community, sterility clinics were also conducted.

Research activities

Between 1958 and 1962 it was found that older women with large families were the only ones who were attracted to the clinics. As welfare activities increased and as more welfare clinics were set up in different parts of the industrial area in central Bombay a larger number of younger women began to attend the clinics. Foam tablets, spermicide jellies and diaphragms were the conventional contraceptives available at that time. Each woman attending the clinic had to undergo a test for PAP smear and colposcopy examination to rule out cancer and other gynaecological complaints before contraceptives were given to her. Field trials on foam tablets were conducted. Several foam tablets like Contab and Planitab, were tested. The CTU developed a "24-hour CAP test", to assess the harmlessness of foam tablets and contraceptive jellies Several batches of foam tablets and contraceptive jellies received under a code number were tested by this method which was standardised and recognised internationally. When several jellies were disqualified, there was a hue and cry by the pharmaceutical companies manufacturing these jellies. They pressurised the CTU to abandon the test but the CTU was firm and this rigid stand taken by the unit prevented the release of these sub-standard contraceptive jellies into the Indian market.

By now there were six clinics, three being in industrial areas, two attached to hospitals in Bombay and one in a rural area attached to a PHC In the first year of their existence the community had accepted these clinics truly as family welfare centres. There was an excellent rapport between the research staff and the family members. Those who participated in research trials knew fully well the implications involved. With the arrival of IUDs and later the hormonal pills welfare activities were curtailed. The government started thinking in terms of cost benefit for the entire FP issue. No funds were released for activities which were meant for the welfare and education of the people.

Women were offered money for participating in research. The health of women did not remain the prime consideration of these centres. Several types of IUDs were tried. Now with education, younger women had started attending FP clinics for spacing their children. Eminent gynaecologists based in Bombay made some modifications in these IUDs. Comparative studies with different types and sizes of IUDs were conducted to find out the ones that had minimal side-effects and low failure rates. Copper T and Lippes loop are the outcome of this research and both are now extensively used by women all over the world.

In 1958 and 1959 Dr. Gregory Pincus introduced hormonal contraceptives. The CTU at that time was asked to introduce in their field trials 10 milligram doses of this hormonal contraceptive. This move was resisted by the social workers as they did not want to endanger the health of Indian women. During the sixties and seventies, the government accepted lower doses of hormonal contraceptives for trials in our country. Then began the exploitation of women in contraceptive research.

In the field of research, the funding authorities selected their own research scientists, institutes and private agencies to carry out the research in what they believed was the important area. Policy decisions were also in their hands. What we see today, therefore, is that contraceptive research is being conducted in the area of "someone else's" choice. No research is being done to evolve safer mechanical barrier methods, neither to improve the efficacy of the older methods nor to evolve indigenous safe methods The mode of administration of hormonal drugs, the dose and the content have varied. But they still remain the dreadful hormones tampering with the woman's body. Listed below are some of the contraceptives, in which research trials were conducted :

Foam tablets : These are used by women just prior to coitus A wet tablet is inserted in the vagina releasing foam which acts as a screen against penetration of sperms which are killed by the chemical action. The women's cervix and vaginal walls could be affected, resulting in irritation, burning and white discharge for many. Efficacy is around 40 per cent.

Diaphragm and jellies - or jelly alone : Spermicidal jelly is applied to the diaphragm and inserted in the vagina within an hour before coitus. The diaphragm acts as a mechanical barrier and the jelly destroys the sperms. Efficacy is good, but this method requires privacy and facility for washing. As above, the cervical canal and the vaginal walls are affected and may cause irritation, burning and white discharge.

Intra-uterine devices (IUD) : There are several types and sizes of these devices— the

important ones being the Lippes' loop, maxguli coil, CuT, CuY, Sonawala and Merchant's devices, and others. All these are inserted within four to seven days of menstrual flow. Being a foreign body inside the uterus, changes in endometrium and release of chemicals occurs resulting in cramps, irregular bleeding, perforations, white discharge and abdominal pains. Some women also complained of headache due to copper devices (Interestingly when a Lippes loop was inserted headaches disappeared) Unnoticed expulsion is another problem. Perforation with IUDs are well known and the whole of the abdominal cavity could be affected.

Oral pills : Hormal steroids are the basis of each pill. The woman has to swallow one pill a day for each day of the month (with a gap of seven days or otherwise depending on the type of steroids). There have been three-a-month pills too. These gave woman a severe bout of vomitting, giddiness and headaches. Women complained of headaches, nausea, giddiness, dizziness, weight gain, weight loss, rise in blood pressure, continuous bleeding or intermenstrual spotting. Pills have adverse effects on liver function, immune response of the body and cause vitamin B complex deficiency. The oral pills either inhibit ovulation or bring about changes in cervical mucous prevailing pregnancy. Drop out rates are very high.

Injectables : There are two types of injectables, injection Depoprovera and injection NET-EN. Both are known for their adverse effects. These are given to women either once a month, once in three months or once in six months depending on the dose of steroids. Those women who were given 300 mgs (once in six months) after delivery continued to have bleeding severe or moderate to spotting daily for over four to five months. Woman developed prolonged ammenorrhea (absence of menstrual flow). The drop-out rate was very high. Although injection Depoprovera was withdrawn by the government on hearing of the dangerous effects private agencies even today are promoting these through their outlets in India as well as in many other third world countries. Once the injection is given it cannot be withdrawn and the woman has to suffer as long as the effects of the injection persist in her body.

Implants : These are silastic subcutenous implants introduced in women's thighs. The hormones are slowly released into the blood stream and act to prevent conception. Those tried in the CTU clinics were supposed to protect women from pregnancy for eight months but the majority of subjects become pregnant within six months. Side-effects are same as those of hormones. Women had to undergo minor surgery for removal of empty implants which would get embedded in the muscles.

Vaginal rings : These are inserted in the vagina on the fifth day of the menstrual period. It is removed only at the next menstrual period. The vaginal rings are absolutely useless for the majority of women who have no proper toilet facilities. But they were being tried for the prestige of an individual scientist. The vaginal ring caused irritation, burning in the vagina and white discharge. It would also slip off and get lost.

Nasal spray : This drug is dangerous and useless for the majority of our women. It could affect the nasal cavity, thalamus, brain and even the heart as the woman is expceted to spray the drug daily through her nose in definite quantities. Poor malnourished women were cajoled into participating in this trial.

In all the hormonal drug trials women were required to give blood samples at definite intervals to assess the release of hormones in the blood stream. As many as 80 blood samples were collected in some of the trials. At least 10 to 15 blood samples required to be given by each woman participting in each of these trials. Not one lady medical officer has ever raised her voice in protest against this exploitation of poor women. Medical officers are more aware of the hazards a malnourished woman on these trials had to undergo. Yes, women were paid for participating in these trials. But that did not mean that these women had been bought that they could be used as guinea pigs. Are the women doctors so inhuman as not to understand the gravity of the situation ? The health of poor woman is being sacrificed for others — mainly for those funding nations and agencies and in order that the elite may know if a contraceptive might be dangerous or not. Few middle class or upper class women will agree to participate in such trials.

Research in male contraceptives

Mention has to be made of Dr. Padma Vasudevan who has used her knowledge in polymers for evolving a new method of contraception for use by men. Condoms and vasectomy operations are so far the only two methods for men, condoms being the most harmless and the easiest to use.

Dr. Kothari of the KEM Hospital has also conducted some research on developing intravas device (IVCD). But Nothing has been heard of this research for some time now. Nasal sprays were also to have been tried out on men. It is reliably learnt that although men were being approached for trials, not a single man could be enrolled for this trial inspite of being offered VIP treatment. Men apparently could never be bothered with any such trivial contraceptive research trials !

Birth control methods under trial

(a) Morning after pills : Trials with 'Morning After' pills are in progress. These are hormonal pills to be swallowed by women the day after coitus. It is too early to say what the side-effects it may have. Women on this trial are also required to give a number of blood samples.

(b) Pellets : These are expected to arrive soon for trials on Indian woman. It is not yet known as to which part of the woman's body will be tampered with this time.

(c) Vaccines : These are also expected to make their way into India. These vaccines will affect the outer covering of the ovum making it impossible for sperms to penetrate and for fertilisation to occur.

(d) Prostaglandins for abortion: When a woman desiring abortion (MTP) goes to a hospital she cannot choose the method by which she will be aborted. Even though there are safe methods which could be improved by research, a drug prostaglandin is being tested. This drug not only gives the women severe camps, abdominal pain, vomitting and diarrhoea but in some cases was the cause of incomplete abortion. Women under the trial programme suffered tremendously. This is another case where advances in science are also being used against women. Amniocentesis was a method developed to help detect an abnormal foetus yet it is now being used extensively for sex determination of the foetus which has in turn led to sex selective abortions.

From the CTO Records

Women of India, mainly from the weaker section of society, are being subjected to all kinds of inhuman treatments at home and even in places where they expect help and service. The following are a few instances recorded in the clinic which illustrate the attitude of husbands towards the wife vis a-vis her reproductive responsibilities.

Case 1 : During the late 1950s, the early years of the FP programmes, foam tablets as contraceptives were being offered to women. A mother of five children accepted this method after consulting her husband. A packet of 12 tables used to be issued whenever she wanted the stock. Once, a clinic staff removed one tablet from the pack to test the foaming capacity of the tablet and issued 11

(Contd. on page 178)

Campaign Against Long Acting Contraceptives

The government has decided to allow family planning institutions and private gynaecologists and obstetricians to import the injectable contraceptive, Norethisterone enantale (or NET-EN). The ICMR has been conducting studies on the drug for some time now under the WHO multicentric trial programme. The report of the study has not yet been made public and components of the study have not been completed as yet. NET-EN is a synthetic progestogen, similar to Depo Provera which has been the centre of a raging controversy among experts regarding its safety and suitability for women. Several women's groups, people's science groups and people's health groups have come together to protest against the introduction of NET-EN or any other long-acting contraceptive, such as Depo-Provera or contraceptive implants. The demands of the campaign are : Ban NET-EN; Ban all injectable contraceptives; All exports of the ICMR and other studies should be made available to the public; A public inquiry and debate must be instituted before such controversial contraceptives and drugs are introduced into the country. The campaign group's first action was a demonstration at the closed-door experts' meet convened by the Family Planning Association of India ostensibly to help make the decision on whether or not to use NET-EN and/or Depo Provera. The demonstrators distributed pamphlets and stated their demands to the assembly. Sympathetic participants later disclosed that discussions had centred around how best to use the injectables and not whether or not.

For further information on the campaign, please write to Women's Centre, Yasmeen Apartments, Yeshwant Nagar, Santacruz (E), Bombay. So far the following groups have decided to participate in the campaign—Women's Centre, Forum Against Oppression of Women, Medico Friend Circle, Committee for Protection of Democratic Rights, Shramik Mukti Morcha, Kashtakari Sanghatana, Yuva Sangharsh Vahini and others.

— p. p.

Response

Dear Editors : I would like to begin by congratulating Ilina Sen on a principled stand from which many women withdraw feeling that it is not worthwhile raking up a lot of muck. With the result that we continue to be invisible and inaudible. It is important that women emphasise their contribution and insist on recognition if certain deeply ingrained attitudes and assumptions are to be rooted out.

As for Dhruv Mankad's reply - if it had ended with the first paragraph it would have been excusable. Even there - there is the implication that among all the people listed to who contributed to discussion there was no one else who chose to make such a fuss over nothing. It is also astonishing that an editorial perspective is produced without actually reading the articles referred to. I will not raise questions of thoroughness (marxist or male) for fear of being labelled ignorant and presumptuous. Let us just look at the rest of the reply. It is so typical that it merits some examination. A perfectly legitimate protest is called "petty" and "unprincipled", *because the misunderstanding is not sorted out in private*. When such attempts are made in private, our experience is that the jokes which are the normal response deprive it of all seriousness. Secondly the "allegations" are called "wild", the reasoning "immature" and the presumptions "incorrect". This leads to "bickering and quarrels". All this is old hat. Whenever a woman protests about such omissions - the assumption is always that the basis is emotion, hysteria, imbalance and irrationality. The old myths about what the ovaries can do ! Finally after all this heavy-handed, high school masterish chastising of such infantile behaviour Dhruv Mankad actually says he is restraining himself. This is admirable. I for one am really curious to see what his less restrained public behaviour is like. Finally of course the accusation that such reactions are not "responsible' . I think it is time we began to examine our own reactions a little more responsibly and critically. It is ironic that in an issue on **Women and Health** such stereotypical reactions should be produced. When I mentioned my own angry reaction to a friend the response was that such debates would not do the magazine much good. On the contrary many of us feel it is far better to discuss these things frankly and openly and expose our own weaknesses, so that we can make a beginning towards recognising and dealing with them. For too long now, the questions raised by women have been subsumed to a larger good, be it the Family or the Cause. Perhaps it is time at least when we are talking about how medicine has rationalised Society's and Men's notions about women we begin to question our own.

May I say how much many of us have looked forward to and enjoyed both the issues of Socialist Health Review ?

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Hyderguda, Hyderabad 500 029
Vasantha Kannabiran

Dhruv Mankad replies

I agree with Vasantha and Ilina that generally a woman's contribution is, consciously, or unconsciously ignored and that whenever she protests against this, it is rejected as hysterical. I also accept that, generally men, including myself, do have conscious or unconscious patriarchal prejudices, having been under their influence for many generations. But in this particular instance, neither in the 'lapse' nor in the response to the 'protest', were these prejudices at work.

I do not call the protest 'petty and unprincipled' because the misunderstanding was not sorted out in private, as Vasantha seems to have assumed. Nor do I call it unprincipled because the protest was not based in principles (which of course, it was). I call it that, because it was not carried out in a principled manner. To me, a principled way of protesting when a lapse occurs on the part of a comrade (I hope Ilina grants me that status), is for the purpose of correcting this error, not just to denounce his/her weakness in strong terms. If that is so, then one does not proceed to accuse the comrade of anything without **first** giving him/her a chance to explain whether it was an error at all, and if it was, under what circumstances it was committed. I think I have tried to point to this in my response. I felt that Ilina should have given me a chance to explain -in PRINT, not in private.

Regarding Vasantha's objections to the terms that I have used in my response viz., 'wild allegations', 'immature reasoning', 'incorrect presumptions', I can only say that I do now realise that these are the very terms about which women are— and ought to be — sensitive about. I did allow my own sensitivity to be blurred by anger.

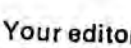
By all this, I do not claim that I am completely free of patriarchal prejudices. But I am unable to accept any trace of 'stereotypicity' in this particular instance, where in the first place I was not directly responsible for the original lapse.

Finally I do wish to ask Vasantha as to how she came to the conclusion that I have implied that

no one among those with whom the article was discussed has made "such a fuss over nothing". The line in question (of my response) merely states a fact regarding how I came about the content of the article by Binayak and Ilina and that's just what it is supposed to mean.

1877 Joshi Galli, Nipani
Belgaum District Karnataka 56
Dhruv Mankad

Working Editors Reply : We believe that much of this debate would have been avoided if, in the first instance, we had explained how exactly we produce each issue. We do so now especially in reply to Vasantha's query about how an editorial perspective can be produced without actually reading the articles referred to. The editorial perspective for each issue is written and circulated among the editorial collective months in advance (for instance, the editorial perspective for the June 1985 issue was circulated sometime in November, 1984). Articles are 'commissioned' with the perspective in view and in consultation with the author of the perspective. The collective is supposed to send their comments to the author, who incorporates them as s/he sees fit and sends us a final draft for printing. Given the geographical distances, it is not possible for the author of the perspective to read all the articles to be published in the issue, although the contents of each are generally known. The Working Editors in Bombay then add to the perspective, an introduction to the issue containing short synopses of the articles. This is how we worked in producing the first issue as well. Unfortunately, given the fact that we were, at that time trying to accomplish unfamiliar tasks and had to face an array of 'teething troubles' in producing that first issue, we did not check either the copy or the proofs as accurately as we ought to have. Hence the ommission of Ilina's name in the perspective. (with which Dhruv had nothing to do). After having produced four issues, we are now a little more confident and better organised and are careful about checking everything closely. But if there are ever such lapses, please bear with us. Please be assured that we will endeavour to see that prejudicial bias, of any kind, conscious or unconscious, is not projected through SHR.



Dear Friends: Your editorial (SHR I:2) speaks of health organisation as some sort of minimal structure for the poor (working classes), just to keep them from being unproductive to capital. Perhaps your analysis is correct for India (but even there you should think more on the social role of the hospital and the whole gigantic structure of the health institution), but it is not correct and could be misleading for 'capital' as such (which would include industrialised countries as well). I think in our countries (in particular Switzerland) the health institution has been growing to gigantic proportions -- providing a well-defined and reductive sort of 'health', but providing it all the same --- because of the powerful interests that are gravitating around it. It would be the same for a television production capital, an eterfainments producing capital, and so on. All these, health included, are capitalistic commodites and lead to profit and accumulation. In the same way as you make money forcing people to go in for colour television (the advertisements are increasingly directed at the working classes) and for personal computers (Spanish and Italian immigrant parents here seriously think of investing 4,000 to buy one for their 14-year old boy), they make money by sending people to ever-growing numbers of hospitals and giving them an increasing number of drugs. Thus the model presented should be more elastic and realistic and try to rouse people about the lack of medical care as well as the profit aspect of this care.

I dislike very much the statement that "women can relate only to other women when it comes to health and their bodies because only women can truly unlerstand one another's problems ' (SHR I:2, 66). It is unmotivated, purely sentimental, imported from liberal (or radical) not marxist feminism. Should a worker in the industry were to say that he cannot 'truly understand' the exploitation of a poor peasant, what would you say ? It would be a pity to give emahasis to a thinking that separates what should be united (working class) and unites what should be separated (rich, middle class from poor women).

The paper on amniocentesis is vague and uncertain (at least in its wording which is often ambiguous). Sometimes it seems to say that the reasons were medical (deformations, and so on) but that the social context made it a real danger to female embryos; and sometimes it seems to say that it was introduced to help the massacre of female embryos. A more careful wording (and perhaps thinking) could help the reader find a way to action without being misled

We found the paper on the Bhutali phenomenon very important and well-written But we lack the background for understanding what 'adivasi' means for instance, The paper does not help in understanding the relevance of the phenomenon (are there a few villages or some thousands in this situation Does the phenomenon occur a few times a year or several thousand times a year ?) If you would like your journal to be read in the world could you please define terms such as adivasi, lakhs and so on?

8, Bugnons
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Dr. Bruno Vitale

Adivasi : aborigines; lakh : one hundred thousand. —W. E.

MOTIVATION FOR FAMILY PLANNING : A Short Critical Review

ilina sen

An important component of the family planning programme of the sixties and the seventies was motivation which meant planned efforts to persuade the public accept the small family norm as well as the particular method of birth control. This concept of motivation became important particularly in the mid-sixties and several strategies were evolved and implemented over the years – mass education about family planning, mass mailing schemes and the use of incentives and disincentives. The article takes a critical look at these strategies, the social political background which gave rise to them, their implementation and effectiveness. The author further examines the assumptions on which the entire motivational strategy was founded and finds them inadequate and full of deeper fallacies.

Among social development plans of the government in the years since independence, thefamily planning programme has perhaps received greater funds and attention than any other single programme. A central element of the family planning programme. as it evolved in the sixties and seventies, was its attention to motivation. By this was meant conscious and planned efforts to influence the public to accept (a) the small family norm, and (b) a particular method of birth control among the many available. In this paper we will attempt to understand this phenomenon of motivation for family planning in greater detail. We shall do this with reference both to actual strategies adopted for motivation in the period before 1977, (a year which marks a watershed of sorts in the history of the Indian family planning programme), and with reference to the theoretical and intellectual basis on which these strategies were founded.

Motivational Strategy — What It Consisted of

The Indian family planning programme was developed in response to what the planners perceived as the 'population problem'. Briefly stated this meant that they saw a high rate of population growth as a major road block on the path to planned development and had visions of the gains of industrial agricultural growth being swallowed up and reduced to nothing by the growing number of hungry people. Family planning was always an euphemism for a policy of population control and a euphemism based on the faith that the surest way to control the rate of population growth was to get individual families to 'plan' their (small) size, which in any case was in their own interests. In the first decade of independence, the approach to family planning, as to much else, was relatively relaxed. While family planning was designated as a key sector in policy/plan documents, the adoption of specific family planning practices was left for the individual couples to decide upon. The state made available at health care centres, a variety of alternatives in birth control under a cafeteria approach.

The result of the 1961 census showing a decennial growth rate of population that was markedly higher than that of earlier decades (population growth rate was 14.23 percent in the period 1931-41, 13.31 per cent in the period 1941-51 and 21.64 per cent in the period 1951-61) brought on the first signs of panic. The FP bureaucracy felt the need to be radical, and the strategy of community motivation was among its most radical innovations.

The concept of motivation gained importance in the family planning programme in the years following the 1962-1963 report of the Director of Family Planning. This report, known popularly as the Raina Report (1963) seriously questioned the clinic type of family planning services that were then available, and under the broad heading of 'extension approach' laid down the basis for a new strategy, relying on community motivation. It recommended the positioning of an extension educator at each block who would educate and motivate people to become FP acceptors. Hard on the heels of this report, in 1965, came the the IUD breakthrough. All, it seemed that was needed to curb the population growth rate was to (a) motivate the people to have fewer children, and (b) insert IUDs. In 1965 also occurred the first evaluation study of the FP programme by the Programmes Evaluation Organisation (PEO) of the Planning Commission (1965). Following this spate of activity, PF was separated completely from health and established as a separate department. United Nations team that evaluated the programme at the request of the government (UN, 1966) in the

same year spoke optimistically of the education of the public, through opinion leaders, satisfied customers and all available types of mass media. The Mukherjee Committee on IUCD (1965) urged for a mass publicity and communications wing for the new department in addition to the army of staff recommeded by the Raina Report. One of the first results of this decision to go in for mass motivation was thus, a fantastic expansion of the Department of Family Planning. The staffing pattern recommended visualised a Block Extension Educator (BEE) at each of the over 5000 Primary Health Centres, assisted by male FP workers, and female ANMs covering 20,000 and 10,000 population respectively. Full and part-time paid voluntary workers were also employed (numbering over 75,000), in addition to extension staff for the urban clinics. However, in later years, the Kartar Singh Committee was to acknowledge that the actual coverage of extension educators had remained much lower.

The motivational strategy consisted of a massive educational programme supplemented by the field work of the extension educators who directly motivated eligible couples. The strategy for mass education was to flash continuously a few "meaningful and understandable" messages to the public such as "Do ya teen bachhe bas". The country was simultaneously plastered with the red triangle of family planning. This simplistic approach often had no real relevance to the life situation of the public that was being educated; for instance, the slogan "do ya teen bachhe bas" ; was cut down to its present size from "do ya teen bache bas; doctor ki salah maniye", when it was discovered that the average Indian villager had no doctor to consult. Films, radio "traditional media," were all used for educational purposes, and although the degree or support to the programme from the mass media unit of the Ministry of Information and Broadcasting, was impressive, the contents of these media products, were unimaginative and often reflected the upper class bias of the producers and of the programme. A lot of the propaganda was centered around a stereotype of two families, the large family is always shown to be poor, unhappy, rural, dark and desi. The other familly, urban, middle-class and westernised is, needless to say, the small and happy one (Banerji, 1971). Songs were written and sung about FP by famous playback singers. FP fortnights, contests and exhibitions were organised in remote small towns and magazines were encouraged to bring out special FP supplements.

In 1969, was started the Mass Mailing Scheme. This mailed suitable informative literature directly to opinion leaders from all walks of life. Even though research found a "good" response to mass mailing, no precise indications regarding the outcome of this expensive exercise are available.

These remained the main prongs of the motivational strategy throughout the sixties. However, from the late 1960's, two parallel but conflicting trends are visible in the programme and its strategy for motivation. The painful realisation around 1968, that the IUCD had failed to deliver the goods, intensified the reliance on sterilisation, if necessary by coercion At the same time some rethinking took place on the whole issue of community motivation. In practice a "hard" and a "soft" line of action are discernable, and these can be followed up separately for convenience.

The 'hard' line :

IUCD insertion figures came down from 909, 726 insertions in 1966-67 to 478,73 in 1968-69. In hindsight, it appears that there could have been many reasons for this perhaps the natural limits of demand had been reached. However, the interpretation put on this trend by the planners, was that there were shortcomings in the motivational efforts. Community motivation being carried out at great expenses, was not having the desired results. This realisation led to the adoption of cruder measures.

Incentive for sterilisation or IUCD insertions have always been spoken of in official family planning circles as "compensation for wages lost." The 1965 Mukherjee Committee report, had spoken of paying compensation to IUCD acceptors (Mukherjee Committee, 1965). While perceiving tne danger of malpractices that may result, this was thought to be less than the danger that would threaten the programme if compensations were not paid. Compensation was tried on a small scale in some states, for instance Madras, in the 1950s, and was started on a national scale in 1964. The motivator's fees that went along with compensation was admissible not only to private citizens but also to Government Servants including FP workers. Rates of compensation were graded as being higher for sterilisations, and lower for IUCD insertions The rates were revised in 1965, and again in 1966. Incentives and target orientation of the programme led, in the late 1960s, to an increasingly greater emphasis on sterilisation with growing tendency to using coercive methods, in addition to widespread malpractices because of the system of the incentives. Any attempt at cutting down on compensation / incentives was however, strongly resented by the medical FP staff,

The idea of using disincentives finds expression in the 1970 document entitled "Master Plan for total Health Care in rural areas" (GOI, 1970) which fortunately, was never implemented. This advocates the professional access of the FP acceptors to all health services The first non-birth incentive scheme was begun by the United Planters Association of South India (Upasi) in selected tea estates in the Nilgiris under the consultancy of Doctor Ridker of USAID. Female tea pickers who had enrolled had a monthly deposit of Rs. 5/- made into their retirement benefit plan by Upasi as long as they did not get pregnant. Specific amounts of the total sum were forefeited in case of pregnancy.

The first mass vasectomy camp was held in the Ernakulam district of Kerala in 1971 (Kumar, 1972). A very large number of sterlisations were performed during the camp duration. The camp and the district collector who had organised it were hailed in FP circles in India and abroad Such camps were held in subsequent months in several other states, and they were all marked by certain special features. Higher than usual rates of compensation were given in cash in addition to gifts in kind during the duration of the camp and the entire administrative machinery of the government of the area was mobilised for publicity and organisation work during the camp. The Kerala camp also happened to coincide with the leanest agriculture season, when special incentives such as a week's extra ration took on a special significance. The demographic quality of those sterilised in the camps was never properly established by independent authorities and in any case the attendance at such camps fell off after the 1972 Gorakhpur incident in which 11 persons died of tetanus, following vasectomy. The camps were discontinued shortly thereafter.

The declaration of the Emergency in June 1975, brought the family planning programme to the forefront of Indian politics The subtle coercion used earlier was now exercised openly to promote sterilisation. Perhaps the turning points was the announcement of Sanjay Gandhi's 4- Point Programme later in 1975, in which FP played an important part. (FP had not been mentioned in the 20-Point Programme.) Sterilisation figures picked up massively—2.5 million operations were performed in 1975-76 as against 1.35 million in 1974-75 and only 0.9 million In 1973-74.

The growing panic at non-performance in a topheavy programme finds its culmination in the National Population Policy of 1976 (Singh, 1976). Though this document did have some developmental content, for instance, stress on female education, only its most coercive aspects were put into effect. The policy graded incentives according to the parity of acceptors, and advocated disincentives for government servants not practising FP. Compulsory sterilisation was left to the discretion of individual states as the centre lacked the infrastructure to put such a policy into effect. However, to prod the states into activity in this regard it was stipulated that in all matters of aid allocation to the states, the 1971 population figures would be followed till the year 2001, and that eight percent of the total central aid would be specifically linked to performance in family planning In the prevailing political climate this was interpreted by most of the states as a clear directive, and the states vied with one another to fulfil targets, and to give an impression of success. In many states, departments such as police and education were used to mop up people for sterilistation, and states like MP and Bihar, fulfilled the annual target for sterilisation in less than six months of the year 1976-77. One state, Maharashtra, actually passed the bill on compulsory sterilisation, and this was only prevented from becoming a law by the grace of the President. The political consequences of these events are only too well known

The soft line :

The "softer" trend in the programmes of motivational efforts, the carrot that accompanied the stick, remained much less effective, often amounting to a lip service only to liberalism and can be traced from the same period as the beginning of the "hard" line. Like the hard line, the 'soft' line was prompted by the realisation of failure.

Doubts began to be cast on efforts to motivate from about 1970. In that year the, second PEO report found the contacts of the FP staff with the local community to be limited and felt that "carrying the messages of FP to the village people required a knowedge . . . of their . . . norms, values, and experiences." (PEO, 1970 , Some of the pioneering writings on population, for instance that by Mamdani, had already pointed out that a large number of children may be an asset in certain class/production situations, and that in these situations it was unrealistic to expect that people would adopt the small family norm merely because a well intentioned department advised them to do so (Mamdani, 1972). It was also perceived that high fertility had a close

relationship with high levels of infant mortality, and in general, with low levels of development. The PEO report briefly acknowledges these trends when it says that "the desire for a small family is more due to economic reasons rather than due to changes in social norms." (PEO, 1970). No concrete approaches in this direction are however, suggested. Similarly, in 1969, the UN evaluation of the programme complained of "gap in our knowledge of the motivational process" (UN 1969). All the soul searching led to a few "changes and departures" in the programme's strategy to motivate the people, and these can now be taken up.

The fallacy of developing FP in isolation from health was realised, and in 1968, maternal and child health services were integrated with immunisations to children and the theme of reduced infant mortality used to establish contact with eligible couples and to motivate them to accept FP. Since however, this was also the period of targets and incentives it is doubtful if this led to any real changes in the approach or not. Possibly it only meant that the already harassed staff were overburdened with finding time for MCH and that these services actually suffered in consequences. The post-partum programme was launched in 1969 in selected hospitals in the country on the basis of the following philosophy: "the months following delivery or abortion... are significant periods of high motivation during which women can be approached concerning future child bearing". Since however, the actual number of hospital deliveries in India form so insignificant a part of the total, the demographic impact of this programme could not have been very high at the best of times. The Country Statement for India at the 1974 World Population Conference in Bucharest with its slogans "Development is the best contraceptive", is also an acknowledgement that more fundamental changes are necessary before the small family norm can be internalised. (World Population Conference, 1974). The approach document to the Fifth Five Year Plan saw FP as part of the integrated package with health and nutrition in the Minimum Needs Programme (Planning Commission, 1977). However, these pious intentions remained unredeemed and from 1975 onwards, in the holocaust of the Emergency, all voices of reason were drowned.

The year 1977 saw a change in government, a change that had taken place at least to some extent as a direct reaction to an unpopular FP programme. The new government redesignated the department as that of Family Welfare and seemed anxious not to repeat the zeal for birth control through sterilisation The Policy statement of the department of June 1977, stressed the voluntary nature of the programme, emphasised the cafeterial approach (allowing the acceptor to choose from a wide variety of methods) and recognised the need of linking FP with other welfare programmes. (GOI, 1977). However, it also expressed concern with the high population growth rate. and fixed birth rate targets of 30 and 25 per thousand to be achieved by the end of the fifth and sixth Plan periods respectively, (as against the then current 34.6. in 1973 as per Sample Registration estimates). It was also stated that the policy of linking eight percent central aid to the states to their FW performance was to continue. In a separate publication " guidelines for media and extensions personne" humility of approach and the pro-mother and pro-child nature of the programme were stressed (FWP, 1977). But the Minister for Health and F.W. made it clear in numerous press statements that incentives for sterilisation would continue. In effect, while some lifting of pressure certainly took place, no real change occured, and certainly no basic assumptions were challenged either by the Janata Party government, or by the Congress government that followed.

The Assumptions Behind The Strategy of Motivation: The 'Relevance' of Theory.

We shall now examine the theoretical assumptions on which the entire motivational strategy was founded. Intellectual support for motivational attempts in the family planning programme, were imported mainly from American agricultural extensions and industrial psychology experience. Continued support was provided, once motivation did become the accepted strategy, from KAP (Knowledge, Attitude and Practice) studies in family planning and from 'communications' theory. The periodic evalutions of the programme (twice by the Planning Commission, and twice by the United Nations) also dealt with the theoretical issues.

The classical "diffusion model" that theorised on how and why innovations were adopted was an American agricultural extension creation. It demarcated the following stages in the diffusion of an invention — awareness, interest, evaluation, trial, adoption — and classified the target population into innovators early adopters, non-adopters and so on. Informal sources of information were held to be the most important at the awareness and interest stages, and neighbours and friends were named as

the most important motivators at the evaluation, trial and adoption stages. This theoretical framework was held to have usefulness for "people who are faced with the problem of diffusing new ideas and practices". (Bohlen, 1957).

Of the social and industrial psychology theories that lent support to motivational experiments in India, the following deserve mention :

(a) Maslow's theory of the Heirarchy of Needs that graded human emotional needs as "basic psychological safety, belongingness and love, esteem, and self-fulfilment needs", in that order (Maslow, 1954). Satisfaction of needs at one level motivates the individual to seek satisfaction of needs at the next level, and so on. The most important applications of Maslow's ideas, have been in the labour management and advertisement fields.

(b) McClelland's theory of Need Achievements that stated as a first premise that an individual's success in economic activities was due to his need for achievement or "N-Ach" (McClelland and Winter, 1969). Further premises, developed over several years, were that a society's levels of economic achievement depended on prevalent levels of N. - Ach and that it was possible to teach N-Ach. The last belief had important implications for the Indian FP programme, where much of the motivational strategy was based on the belief that the extension educators could teach the small family norm.

(c) Herzberg's Motivation Hygiene theory which opined that in a work situation, achievement was affected more by the workers' inner urge to succeed than by environmental factors (Herzberg, 1966). The latter had more importance as sources of dissatisfaction.

All these theories had an element of psychological determinism about them. Their view of the individual was that of a 'blank field' that would produce predetermined responses to given stimuli. Developed in the context of early and aggresive capitalist growth, they had a totally atomised concept of a human being who could be egged on through this or that process to have more "N-Ach" or more "inherent urge to succeed". Instead of viewing the individual as a product of a set of social circumstances, they viewed society as the product of differential drive/or N. Ach of its individual components. Only this totally top-sided view of history and society could produce the delusion that 'small family norm' could be taught regardless of its relevance to the life situation of a particular couple.

The other important source of intellectual support came from theories on communications research, developed orginally in the advertising and broadcasting fields, but later studied with particular reference to family planning. Communications research developed an impressive vocabulary of its own. Communication was broken up into its "main elements"- source, message, channel, receiver, bottlenecks, networks and so on. Great importance was attached to identifying particular areas of communication "breakdown" and removing the particular source of a problem. A certain amount of communications research also went into special areas of FP motivation like the whole question of incentives. Incentives were formally classified into positive/negative, acceptor/diffusor, individual/group, immediate/delayed Rogers, a prolific writer on communications, worte regarding incentives, that while they do result in an increase in the "quantity of FP acceptance", they are likely to affect "quality" adversely. Rogers, (1973). However such cautions were seldom heeded by those on the programme bandwagon, and more encouraging findings of communications research have continued to enrich motivation vocabulary.

Once the programme was properly launched in India, KAP studies conducted by the department itself, as well as by obliging university faculties, became the main prop of the programme against which motivational strategies were planned and evaluated. Rao and Mullick have reviewed over 200 of these studies, and their main theme is that of a KAP gap in India. (Rao and Mullick, 1974). Awareness of FP methods is high, attitudes towards FP are favourable, but the actual practice of family planning by eligible couples is low. The model is obviously based on the classical diffusion theory outlined above. The methodology of the KAP studies has come under increasing attack in recent years. It is to be doubted if a simple linear relationship between K, A, and P exists in as complex an area as this. The measurement of attitudes through surveys or ordinal scales is again of questionable validity. There is, in any case, a vast difference between an attitude, which is a complex socio-psychological entity and an opinion, which is what the questionaires used in the KAP studies elicited.

Some of the inadequacies of the theoretical bases of the motivational strategy are pointed out above. Certain other and deeper fallacies however, have affected the entire programme and we can now turn to these.

The FP programme was prompted in the main by a fear of population size, that is, by (correct or incorrect) considerations of macro population policy. It being unrealistic to expect that family planning decisions should reflect population policy norms rather than individual life experiences, people were quite dishonestly sought to be converted with the message that the small family norm was good for them; proposition that was simply not correct. Considerable evidence was available even in the late sixties that a large family norm may be more suitable in certain situations (for instance in poor, labour intensive agrarian economies and where poorer classes are subject to heavy depletion in children ever born). Some of this sort of understanding did creep into the programme rhetoric from time to time, but made no real difference, as the real moving force behind the programme was never the happiness of individul families

As far as the macro understanding goes, it is not difficult to see through it at all. The argument that over population eats up the gains of developments is not a new one. Not only does it divert attention from more fundamental questions like models of development or distribution of resources; one also senses behind it a fear of people, people of certain nations, certain races and certain classes. It is another manifestation of the old Malthusian bogey that the poor are responsible for their own poverty because of their large numbers.

Birth control, which was all that family planning ever meant in India, can be advocated on many grounds. But certainly it cannot be advocated as a uniform prescription for all, without any regard for human dignity or individual liberty. The events of 1977 amply illustrated that the people would not buy an irrelevant product, however sophisticated the packaging. The tragedy is that no real lessons appear to have been learnt.

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tablets. That night the wife received severe beating from the husband. He suspected that his wife had used one foam tablet with another man.

Case 2 : Having got fed up with her husband forcing her to undergo repeated abortions a woman quietly got an IUD inserted. The husband got suspicious and forced his wife to get it removed. Inspite of removing the device, she was thereafter maltreated and beaten up often. After a few months inspite of her being pregnant she was thrown out of the house in the middle of the night, the reason being that she had not taken her husband's permission to get the IUD inserted.

Case 3 : There was a case of a doctor's wife who had to undergo repeated abortions each time after a 'sex determination test' revealed a female foetus.

Case 4 : Women have to bear the burden of looking after the family and also take the responsibility of contraception. There were several instances when a woman could not be offered any method immediately as she required treatment for some gynaecological complaint. The period of treatment was always short — a month or two in each case. Her husband would be asked to use a condom or refrain himself till she was alright. But in most cases the women would conceive during this period and either continue with an unwanted pregnancy or be forced to undergo an abortion.

Any one who has worked in FP clinics has come across women belonging to various religious groups who demand oral pills to postpone their menstrual periods so that they could participate fully in religious and social functions or even go for an outing. If given a chance, women can decide how they would like to utilise scientific discoveries.

Conclusion

In conclusion, the poor women of the third world countries like India get exploited not only by the government, the research institutes, private individuals in the field of contraceptive research but also by men who care very little about their health and their comforts. Research on birth control measures which could be used by men has not been undertaken with any degree of seriousness.

For instance although the condom is really a harmless and effective method for men, no serious studies have been conducted on its being accepted or rejected by men. Women just leave condoms behind at the hospitals if they are distributed knowing fully well that husbands will not use them. The statistics on condoms are based not on the numbers used but on the total number issued. There is no proper follow-up nor any serious effort to promote this harmless contraceptive. Is it because it is to be used by men ?

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A BIZARRE MEDLEY OF CARROTS

vimal balasubrahmanyan

In the last two years the government in achieving its aims of population control has proposed a number of incentives and disincentives. The author has compiled reports from newspapers in Hyderabad, which tell eloquent story about the government's priorities with regard to the family planning programme.

The following collection of news items over the period 1982-84 presents a picture of the Establishment's preoccupation over incentives and disincentives to achieve population control. They are arranged in a roughly chronological order and a number of the items happen to be from Andhra Pradesh because they were reported in newspapers in Hyderabad where I live. If the readers were to go through newspapers pulished from other cities the picture from other states would be much the same. I've left out a large number of items which tend to be repetitive and which are only too familiar today to the average newspaper reader in this country ie, announcement of a 'camp' with date and venue, total number of operations proposed to be performed and quantum of incentive money offered. I've included a few oddities which are not strictly about incentives but which add further piquancy to the total mosaic. I refrain from making any comment as the collage speaks eloquently for itself.

1982

⚙ The Bihar cabinet sub-committee on family welfare announces 33 cash prizes of Rs. 10,00 each for gram panchayats achieving the "highest target" of sterilisations in the current year. As second and third prizes 66 cash awards would be given to gram panchayats at the rate of Rs. 5,000 and Rs. 3,000 each respectively.

⚙ Extract from a panel discussion on Calcutta Doordarshan's family welfare programme One doctor comments on the uneven performance of different states in curbing the birth rate and another responds : "I suggest, but you may not like the idea, that birth control should be made compulsory by law."

⚙ A new scheme is introduced on an experimental basis by the union ministry of health to enlist the help of private practitioners to achieve tubectomy targets. A private practitioner will be entitled to receive Rs. 50 for each case of tubectomy out of the admissible compensation amount of Rs. 170 to the acceptor, irrespective of whether or not the doctor charges his own fee from the acceptor.

⚙ Industrialists led by J.R.D. Tata announce a contribution of Rs. 10 lakhs to the Family Planning Foundation of India and Rs. 5 lakhs every year hence forth. Mr. Tata tells newsmen that the allocation of Rs. 1,000 crores for FP in the Sixth plan is barely one per cent of the total outlay and is inadequate to check population growth.

⚙ Mr. Sat Pal Mittal, MP and chairman of the Indian Association of Parliamentarians on Population and Development. suggests incentives for FP acceptors like : cash awards, additional bonus, allotment of houses, plots, commercial shops or booths, rebate in income-tax and exemptions from import duty. Other suggestions : three increments for an employee opting for a terminal method after one child and two increments for an employee opting for terminal method after two children. However, an employee having a third child should have his increment deferred by six months, and by one year for any subsequent birth.

⚙ Package of disincentives suggested to the health ministry by the Asian Parliamentary Forum for families with more than two children : higher rate of interest on loans, low priority in housing, higher rate of income tax. leave travel expenses only for two children; free medical treatment or reimbursement for only two children, no paid maternity leave for women after two children, public officials who exceed the limit of two children during their tenure of office be made to resign from office.

1983

⚙ Union government announces that green cards will be issued to individual acceptors of terminal methods after two children. Such green card holders will be accorded recognition, priority attention and preferential treatment.

⚙ During 1982-83, East Godavari district performed 27,937 sterilisations against the target of 27,900 thus giving 100.13% achievement for the district.

⚙ At special sterilisation camps organised in three AP towns, State Bank of India provided incentive

money at the rate of Rs. 115 per woman and Rs. 95 per man in addition to gifts for motivators.

۞ A laparascopic 'mela' took place in Kumbakonam, the city of festivals in June 1983 when as many as 1,225 women were operated upon. The district collector who organised the camp said it was a world record for a single day. So great was the response that the camp was extended for a second day. The highlight is described as the fact that as many as 263 women were below 25.

۞ Maharashtra having won a Rs. 2.5 crore award for outstanding FP performance in 1982-83, announces an ambitious target of 687,000 sterilisations in 1983-84, though the target fixed for this state by the centre is only 601,000 sterilisations.

۞ The Gujarat goverment announces a 20-day foreign trip for district panchayat officers and employees with best performance in family welfare programme. The new scheme is introduced to maintain 'round-the-year' tempo of the programme. District officials with best performance would be sent on study tours to foreign countries at state government expense while the staff of taluka and village panchayats would be sent on a 20-day tour within the country.

۞ The Kerala government offers incentives of a would tour at government expense to the collector of the district which registers the maximum number of FP operations in a two-month campaign. During the programme incentives to acceptors would be enhanced from Rs. 145 to Rs 170 for women. Men undergoing vasectomy would get Rs. 155 while promoters would receive Rs. 20 for each vasectomy case and Rs. 15 for each tubectomy against the earlier Rs.10. The state health minister expresses the hope that Kerala would win the Rs 2.5 crore cash award given every year by the Union government to that state which performs the maximum number of sterilisations.

۞ The Delhi Administration announces 'attractive' prizes like wrist watches and cash awards for motivators and acceptors as part of a family welfare programme.

۞ After the announcement of an enhanced incentive of Rs. 200 for acceptors of sterilisation, there was an unprecedented turn-out at FP camps in Madras --posing problems for the organisers who ran out of funds.

۞ A health ministry working group on incentives and disincentives suggests that any violation of the small family norm should disqualify a person from standing for an election. Such violation should also disqualify a person from appointment to university senates, directorship of a bank, vice-chancellorship and gybernatorial posts.

۞ An expert group appointed by the Family planning Foundation of India, chaired by Justice G. D. Khosla, reiterates the disincentives recommended earlier by bodies like the Asian Parliamentary Forum and other working groups (listed in the earlier news items), In addition the Khosla committee suggests low priority for admission into educational institutions for third and subsequent children.

۞ A DAVP ad issued by the Delhi Administration announces special attractions by lucky draw during a family welfare campaign : **Male sterilisation** : (apart from normal incentives) : Rajdoot motorcycle, TV, Phillips transistor radio, and HMT watches. **Copper T** (apart from normal incentives) : Colour TV, black and white TV, pressure cookers and HMT ladies watches. The ad urges readers to 'avail opportunity' and says : "Do not wait for tomorrow".

1984

۞ TISCO of Jamshedpur wins the 1983 award from FICCI (Federation of Indian Chambers of Commerce and Industry) for promotion of FP among workers. TISCO's FP programme achieved 7,249 sterilisations during 1982-83.

۞ Health ministry's advice to state governments on wooing the public to take to sterilisation : issue green cards entitling acceptors to jump the queue for certain facilities and to provide five state lottery tickets of the next draw to acceptors.

۞ The Andhra Pradesh state government gears itself to achieve the FP target for 1984-85 through a larger number of camps and more incentive schemes. Acceptors' awards to carry prizes of Rs. 400, 200 and 100 through a lottery system in sterilisation camps where over 100 operations are conducted.

۞ A DAVP ad for a special FP drive in Delhi announces a target of 7,000 sterilisations and 10,000 IUD insertions. To achieve this an 'additional' amount of Rs. 25 and Rs. 5 respectively would be given to the motivator for each case of sterilisation and IUD.

۞ The Sadhana Samiti in collaboration with the AP government organises a cartoon competition with cash prizes on the theme of family welfare, the

topics being : small family, spacing, sterilisation, MTP, late marriage and maternal and child services.

⚙ The Kerala government announces a lottery exclusively for sterilisation acceptors. Men and women undergoing the operation would receive free lottery tickets and there would be a draw once every three months.

⚙ The Population Advisory Council has before it a proposal by which a public servent will be sacked if a child is born to him besides the two or more existing children after one year from the prescribed date. Other proposals : Security bond of Rs. one lakh maturing after 20 years for those undergoing sterilisation after one or two daughters; a bond of Rs. 60,000 for those undergoing sterilisation after one son and one daughter or after one or two sons; income tax rebate for persons not having more than two children; to promote late marriage employers should pay Rs. 25 per moth to unmarried working girls over 20 years with a matching contribution by the government for three years. The amount will be credited to their account and will be available after three years. To postpone the birth of the first and second child a small monthly allowance may be paid to newly married employees.

⚙ The AP health minister. Rammuni Reddy, calls for a hike in incentives for FP acceptors, citing the example of Maharashtra where such a hike enabled that state to bag the cash award of Rs. 2.5 crores. He feels that if the state fixes a target of five lakh sterilisations, the extra expenditure involved would be offset by the bagging of the national cash award.

⚙ The Madhya Pradesh government introduces a 'green card' system for those undergoing sterilisation after two children : each green card holder will get preference in employment, health cover and financial assistance under various schemes; two years relaxation in age for employment and 5% extra marks in interviews; also free medicine and medical care in government hospitals; children need not pay fees in professional courses. In rural areas, landless card holders will get priority in land allotment and house plots, as well as 20 bamboos and ten wooden poles free of cost from the nearest forest depot, licences to open retail shops for fuel and kerosene, priority in allotment of cement, priority in getting loans for milk cattle, grants for setting up wells, pumps and bio-gas plants.

⚙ The *Indian Express* reports a 'massive fraud' and "statistisal acrobatics" in Copper T figures by the Maharashtra government in its efforts to ensure that it again wins the Rs. 2.5 crore annual cash prize awarded by the Union government.

⚙ The Rotary Club announces a two-day 'mini' camp at Nellore in AP with a target of 300 sterilisations. An incentive of Rs. 145 for women and Rs. 125 for men will be given, plus free food to attendants and milk to children accompanying the parents.

⚙ The Punjab health secretary announces a plan to introduce a raffle scheme to attract acceptors of sterilisation. Apart from prize Rs. 1,000 each at monthly draws, a quarterly state-level draw would have a first prize of Rs. one lakh. The scheme would not be a burden on the exchequer as the funds would be drawn from the prize money earlier won by the state from the centre for its FP performance. Approval from the centre is awaited.

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THEORIES OF REPRODUCTIVE BEHAVIOR

A Marxist Critique

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This article is reproduced from the Review of Radical Political Economics. Micro-economic theories that view children as consumer goods or home produced goods which parents either purchase or produce subject to income, price, and taste constraints, are essentially voluntaristic. Sociological theories, on the other hand, stress the socially determined and coercive nature of reproductive behavior. From the standpoint of historical materialism, both theories are open to criticism. It is argued that a scientific analysis of reproduction should transcend the voluntaristic and deterministic alernatives which are the hallmark of bourgeois thought. Instead, using the method of historical materialism, reproduction should be conceptualized in structural, concrete, and historical terms; i.e., as the reflection of the reproductive strategies of classes in the context of a given mode of production This article is reproduced from the Review of Radical Political Economics.

Economics is all about how people make choices. Sociology is all about why they don't have any choices to make. Historical Materialism is all about how and why people make historically specific choices.[1]

Current theories of fertility fall within voluntaristic or deterministic frameworks. Microeconomic theories are voluntaristic: they rest on the assumption that individuals are free to decide whether they want to have children and how many, and that such decisions are based upon a comparsion between the utilities to be expected from children and those expected from allocating resources to other goods.[3] Sociological theories, on the other hand, are deterministic. Sociologically, reproductive behavior[4] is socially determined; it is rooted in the social and economic structure which determine the set of role alternatives, rewards, and punishments confronting individuals at a given time and, consequently, it cannot be adequately investigated if viewed in purely voluntaristic terms.[5]

The shortcomings of microeconomic and sociological theories of reproductive behavior may be traced to their ahistorical approach to the study of social reality and their conceptualization of reproduction in terms of individual behavior and its determinants. Historical materialism[6] transcends the opposition between voluntaristic and deterministic viewpoints and offers a historical and structural approach to the study of reproduction which shifts the focus of theoretical concern to the reproductive strategies of classes and sectors of classes in historically specific contexts.

The epigraph above sums up the content of this essay. The methodological assumptions underlying microeconomic and sociological theories will be outlined and critically examined. Rather than exploring specific applications of these theories, I develop a critique of their theoretical foundations which is based on my interpretation of historical materialism. Several conditions for a scientific Marxist analysis of fertility are delineated.

The Economic Theory of Fertility

The dominant contemporary theoretical efforts at explaining fertility behavior stem from the use of microeconomic theory. Children are viewed as consumer durables[7] or, in the most recent developments, as household produced goods[8]. The main assumptions common to both types of analyses is that households (like firms) behave rationally, maximizing their utility in a context of scarcity: households characterized by given tastes or preferences can choose to consume/produce children and/or commodities. The theory of fertility as consumer behavior also emphasizes income and price constraints: households with given tastes"... are viewed as maximizing utility subject to the constraints of income and prices Thus three factors—income, tastes, and prices—are the basic building blocks of fertility behavior.[9] The theory of fertility as productive behavior adds a fourth relevant constraint: time. The quantity and quality of children and other household goods will be thus a function of the time and resources allocated to their production.

The essence of this approach to fertility behavior lies in the importance given to choice. It is assumed that children and commodities can be described by an indifference curve whose points represent combinations of children and commodities providing the same amount of utility to the household. Households are, consequently, indifferent when confronting the

options offered by an indifference curve and, when facing a set of indifference curves they will choose that which — given their income and price limitations — maximizes their utility.

The Sociological Criticism

Sociologists emphasize social constraints on individual choice. Sociologically, reproductive behavior is socially constrained behavior; it is a key dimension of adult sex roles and, as such, it is supported by a network of social, economic, and psychological rewards and punishments that rule out the desirability of alternatives to the performance of family roles.[10]

Sociologists have convincingly argued that children cannot be appropriately considered as equivalent to consumer goods or home produced goods because the social context of reproduction introduces elements in their process of "consumption/production" that render untenable the main assumptions upon which the economic model rests. Essentially, this means that parents are not free to choose the quality and quantity of children. With respect to quantity, societies vary in their normatively sanctioned desired family size; advanced Western societies seem to have settled upon two as the minimum. Quantity interacts with quality as it is assumed that an only child is likely to have "problems" that could be avoided by having at least two.[11] With respect to quality, parents cannot raise their children at a level separate from their own or that of other siblings; i.e., they are not free to choose between possible combinations of high and low quality children.

Furthermore, parents cannot raise children according to arbitrary rules : there are general socially established minimum standards of child quality as well as specific standards linked to class, socioeconomic status, ethnicity, religion, culture, etc. Finally, parents lack control over the initial quality of their children so that they lack a basis for balancing their potential utility with that of other goods; they cannot reject them if they do not conform to expectations nor can they exchange them or abuse them as they could any other good at their disposal.[12]

The substance of the sociological approach to productive behavior is the following:

People make their "voluntary" reproductive choices in an institutional context that severely constrains them not to choose non-marriage, not to choose childlessness, not to choose only one child, and even not to limit themselves solely to two children.[13]

Like economists, sociologists begin "post festum" with the results of the process of historical development (e.g., norms, sex roles, desired family size, parental roles, etc.) having acquired the stability of coercive and constraining "social facts." Neither economists nor sociologists deal with the historical specificity of the fetished facts they study and this is why, from the standpoint of historical materialism, their scientific contributions are inherently ideological.

The Marxist Critique

The ideological nature of economic and sociological theories does not stem from deliberate distortions nor from errors that could be eventually corrected. Under capitalist conditions, ideology becomes an inextricable aspect of the social sciences to the extent that those sciences are limited to the partial investigation of social reality thus overlooking aspects of it which while less obvious and apparent are just as important and as real. The material basis of this phenomenon is rooted in the peculiar nature of the social reality treated by capitalist production whose defining feature is the "fetishism of commodities".[14]

Capitalism, as a mode of production presuppose the universalization of commodity production; i.e. the transformation of labour-power into a commodity and the satisfaction of all needs through market exchanges. It presupposes, therefore, the existence of two classes; the capitalist class which owns the means of production and the working class which owns nothing but its labor-power and must sell it in the market for wages which it must subsequently exchange for goods and services needed for survival. The reality of the market is only one aspect of the totality of capitalist relations. This is the sphere of exchange and circulation of commodities which Marx describes as follows:

> ... (it) is ... a very Eden of the innate rights of man. There alone rule Freedom, Equality, Property, and Bentham, because both buyer and seller of a commodity, say of labor-power, are constrained only by their own free will . . . Equality because each enters into relation with the other as with a simple owner of commodities, and they exchange equivalent for equivalent. Property, because each disposes only of what is his own. And Bentham, because each looks only to himself. The only force that brings them together and puts them in relation with each other, is the selfishness, the gain, and the private interests of each.[15]

At the level of production there is neither freedom nor equality. Property relations assert themselves as

relations of domination : workers are actually ' free" to choose between starving or working under the sway of capital and the contradiction between their interests and those of the capitalist class results in protracted class struggles whose outcome determine the working conditions found at a given time.

In the capitalist mode of production, the market mystifies the appropriation of unpaid surplus-value by the capitalist class because, at the level of market exchange it appears as if capitalists and workers exchanged equivalent for equivalent; as if the wage were equivalent to the workers' output. Actually. the value of wages is equivalent only to the value of the goods and services needed to reproduce the labor force on a daily and generational basis.[16] The value of the workers' total output, on the other hand, is greater than the value of wages in a proportion determined, ultimately, by the class struggle; the difference is surplus-value, the product of surplus labor time, which capitalists appropriate at the level of production and realize at the level of market exchange.

The market exchange of commodities, through the tyranny of the laws of supply and demand, obscures not only the relations of production between capitalists and workers but also the relations among capitalists themselves which, in their eyes appear as relations among things — their products — which they are unable to control. This is the fetishism of commodities which results in the perception of things and relations among things while class relations and relations of production remain outside the purview of the members of capitalist societies, including social scientists.

The universalization of commodity production ensures the pervasiveness of commodity fetishism which is, from the standpoint of historical materialism, the material basis for determining the boundaries between science and ideology[17] as well as their inextricable combination to the extent that scientific practice remains limited to investigating the level of exchange and circulation of commodities while overlooking the level of production. Marx states the point as follows:

> Man's reflections on the forms of social life and, consequently, also his scientific analysis of those forms, take a course directly opposite to that of their actual historical development. He begins, post festum, with the results of the process of development ready to hand before him. The characters that stamp products as commodities, and whose establishment is a necessary preliminary to the circulation of commodities, have already acquired the stability of natural, self-understood forms of social life, before man seeks to decipher, not their historical character, for in his eyes they are immutable, but their meaning.. The categories of bourgeois economy consists of such like forms. They are forms of thought expressing with social validity the conditions and relations of a definite, historically determined mode of production.[18]

The economic theory of fertility is an object lesson on the meaning of commodity fetishism and, as such, it shares the basic ideological flaws of economic theory in particular and social science in general criticized by Godelier.[19] An application of Godelier's major critical insights to current theorizing about fertility can be summarized in four major points.

1. The microeconomic approach to fertility takes as a point of departure the obvious and visible maximizing behavior of individuals and overlooks the structures that render possible such forms of individual reproductive behavior. It bypasses structures which are "... part of reality but not of visible relationships"[20] and limits the scientific analysis of fertility to its fetishized dimensions. It does not inquire, in other words, into the historically specific conditions under which it becomes possible for scientists to conceptualize fertility behavior in those terms and for people to ask themselves whether they can "afford" a child; instead, it justifies its analysis on the basis of a formal theory of rational choice.[21]

2. It defines fertility behavior in terms of a formal theory of rational action as optimizing behavior in a context of scarcity. Such a formal theory of rationality is a poor basis for a scientific analysis of reproductive behavior because it explains nothing about its content, its origin, and its change. The use of formal rationality is ideological. Whether it is conceived as a universal feature of human nature or as a product of capitalist development, formal rationality functions as an apologia of capitalism. In its light capitalism can be pseudo-deduced from human nature (and consequently endowed with ahistorical immutability) or it can be considered as the source of rationality thus relegating everything else to the realm of tradition, religion, custom, and other substitutes for reasoned analysis.[22]

3. The reliance on formal rationality and individual behavior necessarily leads to neglect of the social nature of the criteria by which individuals

maximize their utility. The subjective utility of children for individuals or households is taken as the basis for explaining how reproductive behavior operates. It is assumed that those utilities, as well as their hierarchical ordering in a map of indifference curves responds solely to individual subjective preferences which can be collected and statistically analyzed, thus providing a pseudoscientific analysis of social needs. It is obvious that such statistical analyses are insufficient to scientifically explain not only the needs and hierarchy of needs dominant in a given social formation at a given time but also, what is more important, the reason why the satisfaction of some needs as well as the form in which such needs are satisfied are deemed more "rational" than others.

4. The theory of choice is based upon a conceptualization of income as an individual attribute. Income is viewed in purely quantitative terms : the amount of income accruing to individuals thus determines, given tastes and market prices, the combination of goods and children that best maximizes their utility. The exclusive concern with the quantity of income reflects the narrow basis of the analysis which remains at the level of market relations and unavoidably overlooks the relevance, for the explanation of fertility behavior, of the relations of production and class relations in which all individuals participate. It obscures the existence of qualitative differences in the sources of individuals' income, differences that stem from their specific location in the mode of production.

The scientific kernel of the economic theory of fertility lies in the identification of the economic constraints that shape fertility behavior under capitalist conditions, and the articulation of those constraints with individuals' tastes into a theory potentially useful for the study of reproductive behavior. The universalization of commodity production, which implies the satisfaction of all needs through the market, does incorporate child-bearing and rearing into market relations both symbolically and practically to the extent that such activities presuppose monetary outlays. Market considerations and relations do invade the household forcing its individual members to behave in an optimizing manner in order to maintain or improve their standard of living and that optimizing behavior necessarily affects reproduction.

On the other hand, the economists' insights on the nature of fertility behavior are scientific for they express "...with social validity the conditions and relations of a definite historically determined mode of production;"[23] but they are also ideological because they do not acknowledge the historical nature of those conditions: i.e., their basis on the capitalist mode of production which not only makes possible the theory and the practice of fertility behavior as consumer/producer behavior but also gives it a historically specific content. Their analysis is limited to the subjective, individual, and formal aspects of fertility behavior; i.e. to its fetishized form.

The Marxist Alternative

These critcisms suggest three specific conditions for a scientific Marxist analysis of reproductive decisions.

1. It should define reproduction in structural rather than individual terms.

Instead of investigating reproductive behavior primarily as the behavior of individuals who, given certain individual attributes (income and tastes) and market prices, choose to consume/produce children, Marxist analysis would investigate the reproductive structures characterizing a given social formation at a given time. As Engels pointed out,

> ... according to the materialistic conception, the determining factor in history is, in the final instance, the production and reproduction of immediate life. This, again, is of a twofold character : on the one side, the production of the means of existence ... on the other side, the production of human beings themselves, the propagation of the species.[24]

Under capitalist conditions, given the twofold nature of production, it becomes necessary to investigate the relationship between the capitalist mode of production and the capitalist mode of reproduction (in the biological and social sense) it presupposes. The capitalist mode of reproduction is the complex structured totality formed by the combination of the material and social elements that enter into the biological and social reproduction of human beings through historically specific (i.e., capitalist) relations of reproduction (relations between the sexes, independent from their will, mediated through their relationship to the material and social conditions of production and reproduction).[25] Consequently, the study of the relationship between capitalist modes of production and reproduction is not equivalent to studying the "interaction" between "family" and the "economy". At the market level, economy and family appear as things in themselves that "interact" with each other in ways that reproduce market relations thus obscuring the relations of production

and the relations of reproduction which underlie market behavior. Under capitalist conditions (as well as in all modes of production based on the private ownership of the means of production) the social relations of reproduction are sexist relations. A structural and historical analysis of the relationship between the capitalist modes of production and reproduction entails, therefore, the investigation of the relationship between capitalist contradictions and sexism both at the levels of public production and at the level of the modes of reproduction that characterize specific classes and sectors of classes. From the standpoint of historical materialism, this investigation is a nececssary preliminary step for the sound study of reproductive patterns for it would disclose the historically specific constraints determining individual reproductive behavior at the market level.

2. It should define reproduction in real, concrete terms, rather than formal terms.[26]

In the *Grundrisse*, in the section on "The Method of Political Economy,"[27] Marx makes an important distinction between three kinds of concepts: imaginary concretes, abstractions of simple definitions, and concrete concepts. The substance of his argument is the following:

> it seems correct to begin with the real and the concrete, with the real precondition, thus to begin, in Economics, with e.g., the population, which is the foundation and the subject of the entire social act of production. However, on closer examination this proves false. The population is an abstraction if I leave out, for example, the classes of which it is composed. These classes in turn are an empty phrase if I am not familiar with the elements on which they rest ..... If I were to begin with the population, this would be a chaotic conception (Vorstellung) of the whole, and would then by means of further determination, move analytically towards ever more simple concepts (bhegriff), from the imagined concrete towards ever thinner abstractions until I have arrived at the simplest determinations. From there the journey would have to be retraced until I had finally arrived at population again but this time not as the chaotic conception of the whole, but as a rich totality of many determinations and relations. The concrete is concrete because it is the concentration of many determinations, hence the unity of the diverse.[28]

The economic theory of fertility is a "thin abstraction" a formal analytical construct that distills the essence of the reproductive experience of the vast majority of the people living under capitalist conditions and reifies it into an ahistorical, formal theory of rational choice. The development of a real and concrete concept of reproduction as a "totality of many determinations and relations" involves "retracing the journey" in order to elucidate its historically specific structural foundations. This calls for the investigation of the content given to formally rational individual behavior by the location of individuals and households in the mode of production. In the context of capitalist social formations, the apparently homogeneous population of individuals who, at the market level of analysis appear engaged in formally similar optimizing behavior as consumers/producers of children, disappears at the level of production where it is replaced by a heterogeneous population divided in classes whose rational behavior has qualitatively different contents.

At the level of production, the rational behavior of the capitalist class is dominated by the problem of investments; how to invest to maximize profits. The rationality of the working class, on the other hand, is dominated by the problem of survival: to sell labor-power for the highest possible wages. Survival is ensured by compliance with the goals of the capitalist class and, in that sense, the rationality of the working class is " ... complementary, derivative, and dependent" upon the rationality of the capitalist class.[29]

The relationship between these classes is contradictory and complementary at the same time. The contradiction between capital and labor is obvious: the higher the wages, the lower the profits and vice versa; hence the presence of class struggles as a permanent feature of capitalism. They are complementary in terms of their role in the production process: the ongoing smooth functioning of capitalism depends both on the rational behavior of the capitalist class (e.g., making adequate investment decisions, and the rational behavior of the working class (e.g., adapting its needs and work patterns of the conditions set by the capitalist organization of production). The rational behavior of the capitalist class can be fully effective to the extent it counts with a subordinate, malleable, and controllable labor force. It follows that, while the rationality of the capitalist class is unitary (i.e., its class interests and its goals as defined in the production process coincide), the rationality of the working class has contradictory dimensions rooted in the context from which it is defined. From the standpoint of the working class, the rational pursuit of its class interests is in the contradiction with capitalist interests both in the short (e.g., struggle for higher

wages/salaries) and the long run (e.g., struggle to abolish capitalism). On the other hand, from the standpoint of the capitalist class, the working class behaves rationally to the extent it overlooks its own interests and, instead, conforms and adapts its behavior to capitalist demands inside and outside the production process.

At the level of reproduction, it becomes necessary to investigate the ways in which capitalist and working class rationality (i.e., the pursuit of their class interests) affect the reproductive behavior of both classes. To define reproduction in real, concrete terms means, therefore, to inquire into the conditions surrounding the reproduction of classes rather than merely the reproduction of "individuals" or the "human species."

With respect to the reproduction of the rational pursuit of class interest, rational profit-seeking behavior and reproductive patterns are, in principle, functionally related. Reproduction is an integral part of the overall rational behavior of the capitalist class aimed at preserving its economic and political power. Capitalist class families seek to ensure that their children will also be members of the capitalist class, and this inevitably affects their family-size decisions.

The analysis of the reproductive patterns of the working class is more complex because the rational pursuit of class interest and the content of formally rational reproductive behavior are relatively independent. Workers cannot directly affect the outcome of the class struggle, nor further their class interests through changes in their reproductive patterns. This assessment of the relationship between reproduction and working-class interests rests upon the crucial distinction between *labour-power*, the capacity for physical and intellectual activity, and *laborers* or workers, the owners of labor-power. While the production of labor-power presupposes the existence and reproduction of the workers, the demand for labor and the level of wages are determined not by the existent number of workers, but by economic and political considerations establishing the quantity and quality of labor-power needed at a given time. Under capitalist conditions, whatever their rate of natural increase might be, workers are constantly in excess of the demand for labor-power. Reproductive decisions in other words, do not affect, directly, the size of the reserve army of labor.

Workers do, however, respond to the uncertainties of the labor market by attempting to improve their own individual situation and this has important implications for their reproductive behavior. They may attempt to improve their children's "life chances" in the market by restricting their family size so that each child has larger claim on the family's scarce resources. On the other hand, they may find that a large family is beneficial because it increases the size of a family network which affords protection against the insecurities of the labor market. The specific ways in which different sectors of the working class adapt to changing demands for labor power and the relationship between those adaptive patterns and changes in the status of women in the context of unchanging sexist relations of reproduction are, consequently, of key importance for understanding their reproductive behavior. Rational working-class reproductive behavior is, therefore, another maniestation of the dependent, complementary, derivative rationality that suits the needs of the capitalist class. What appears at the level of the market as the rational optimizing behavior of individuals is a structural effect of the processes through which different sectors of the working class adapt their behavior to the productive and reproductive demands of the capitalist class. The changing content of that formally rational reproductive behavior reflects those changing demands and this topic will be considered in the section that follows.

3. It should analyze "taste" on an objective rather than subjective basis.

It is important to investigate the relationship between the requirements of the capitalist mode of production and the historically specific hierarchy of socially structured alternative and needs confronting different classes at a given time. Marx's analysis of the needs of the working class is pertinent at this point and applicable to all classes:

> the number and extent of . . . necessary wants, as also the modes of satisfying them, are themselves the products of historical development, and depend, therefore to a great extent on the degree of civilization of a country, more particularly on the conditions under which, and consequently on the habits and degree of comfort in which, the class of free laborers has been formed. In contradistinction, therefore to the case of other commodities, there enters into the determination of the value of labor-power a historical and moral element.[10]

A given number of children can thus be viewed as an integral part of the "historical and moral elements" that enter in the determination of the value of labor-power which includes the means of

subsistence necessary for the reproduction of the labor-power of the workers and their future substitutes : their children.[31] Different kinds of labor-power have different values and are reproduced in contexts requiring a variable number of children. This is a matter that can be empirically determined for different classes and sectors of classes. While that number is subject to a variety of historically specific social constraints (e.g., pronatalist sex roles, norms about family size, tax advantages for families, etc.) and fluctuates in tune to changes in wage levels and market prices, there is at any given time a family size which appears rational within a framework defined by the power of the capitalist class. The extent to which that family size is overtly or tacitly used by social scientists to evaluate the rationality of the fertility behavior characterizing specific countries and/or sectors within a given country is a matter to be empirically established.

In so far as economic theories of fertility overlook the three conditions discussed above, they will retain ideological and apologetic implications for they will conceptualize capitalist reproductive behavior either ahistorically (i.e., as rooted in an utilitarian "human nature") or as the abstract result of "modernization" and "rationalization" processes. The concrete consequences of such approaches are : a) the misunderstanding of reproductive behavior and its determinants; b) the tacit acceptance of capitalist structures, processes, and contradictions which remain outside the scope of scientific concern; and c) the use of the empirical effects of capitalism as a variety of "factors" (e.g., cultural, technological, educational, etc.) that could "explain" variations in reproductive behavior.

Conclusion

As Marx pointed out in this famous passage :

> Men make their own history, but they do not make it just as they please; they do not make it under circumstances chosen by themselves, but under circumstances directly encountered, given, and transmitted from the past.[32]

The deterministic and voluntaristic theoretical assumptions underlying sociology and economics respectively are transcended by historical materialism which, while allowing for the importance of individuals active intervention in social life, it also acknowledges the historical boundaries that give meaning to that intervention and make it possible. From the standpoint of historical materialism it is as abstract and one-sided to argue that individuals are free to choose their family size given income and price limitations as it is to argue that they have no choice whatsoever because their behavior is socially determined. The economists' individualistic/utilitarian assumptions are as misleading as a basis for developing a scientific analysis of reproduction as the sociologists' oversocialized conception of man. Both capture partial or fetishized aspects of social behavior without dealing at the same time with the structures that produce and reproduce those "social facts" on an ever expanding scale. A scientific analysis of fertility cannot be limited to mapping the reified consciousness emergent in the context or universalized commodity production nor to describing the various forms in which coercive "social facts", impinge upon reproductive behavior. A scientific analysis must specify the structural mechanisms that make possible those forms of objectivity and consciousness at a given time. The identification of those mechanisms rests upon a structural concrete, and objective definition of reproduction as the reproduction of classses and relations of production in the context of a historically specific mode of production.

Notes and References

2. J. Duesenberry in *Demographic and Economic change in Developed Countries.* Universities — National Bureau Conferences Series No.11 (Princeton: Princeton University Press 1960), p. 233. I have added the statement about historical materialism.

3. See: Gary S. Becker. "An Economic Analysis of Fertility," in *Demographic and Economic Change in Developed Countries, op. citl.,* p. 209.231; R.A. Easterlin, "Toward a Theory of Fertility," in S. J. Behrman *et. al.*, eds. *Fertility and Family Planning : A World View* (Aun Arbor: U. of Michigan Press, 1969), pp. 127-155: and T.W. Schultz, (ed), *Economics of the Family* (Chicago: University of Chicago Press, 1974).

4. The concept of reproduction can be used to indicate three different levels of analysis : human reproduction, reproduction of the labor force, and social reproduction (Edholm, et, at. 1977). This essay has methodological critique of the economic and sociological approaches to the study of human reproduction. By theories of reproduction it is meant, consequently, theories of fertility and reproductive behavior will be used as interchangable terms. On the other hand, the critique suggests that human reproduction cannot be adequately studied in isolation from social reproduction and the reproduction of the agents of production. Such shifts in levels of analysis will be made explicit in the text and should not pose difficulties for the reader.

5. See, for example, K Davis. "Population Policy Will Current Programs Succeed?" *Science* 158 (1976), PP. 730-739; J. Blake, "Are Babies Consumer Durables?," *Population Studies* 22 (1968). PP. 5 25; Coercive Pronatalism and American Population Policy," in Ellen Peck and J. Senderowitz, eds., Pronatalism: The Myth of Mom and Apple Pie (New York; T. Y, Crowell. 1974). PP, 29-67.

6. Historical materialism is the science of history originally developed by Karl Marx and F. Engels. For a historical analysis of its emergence and an enlightening and systematic discussion of its main concepts see Goran Therborn, *Science, Class and Society* (Atlantic Highlands: Humanities Press, 1976, especially ch. 8. "Working-class Struggles and Theoretical Breaks. The Social and Theoretical Formation of Historical Materialism"). Marxist theory is a more general concept which has been used to indicate a wide range of theoretical standpoint, from idealist to mechanical materialist reading of historical materialism. Throughout the essay and for reasons of style, both terms will be used as if they were synonymous.

7. *Op. cit* in footnote 3; also Easterlin, *loc cit*, in footnote 3.

8. Schultz, *op, cit* In footnote 3.

9. Easterlin, *op. cit*, in footnote 3, p. 128.

10. Davis, *op. cit*. in footnote 4; Blake, *op, cit*, in footnote 5.

11. For recent research and discussion of the advantages and disadvantages of the one child family in comparison to the family sizes see Sharryl Hawke and David Knox, *One Child by Choice* (Englewood Cliffs N.J. Prentice Hall, 1977).

12. Blake (1968), *op cit* in footnote 5, pp. 15-19

13. Blake (1974), *op. cit*. in footnote 5, p. 30.

14. Karl Marx. *Capital* Vol. I (New York International Publishers 1907). pp 71-83.

15. *Ibid* p. 176.

16. *Ibid* pp. 170-172.

17. For further elaboration of this perspective, see: Therborn, *Science. Class and Societry op. cit*. in footnote 6. pp. 367-8 and Alfred Sohn-Rethel, *Intellectual and Manual Labor* (Atlantic Highlands: Humanities Press, 1978).

18. Marx, *op. cit*. in footnote 14, pp. 75-76.

19. Maurice Godelier, *Rationality and Irrationality in Economics* (New York: Monthly Review Press) 1973, p. 7-49.

20. Maurice Godelier, "Structure and Contradiction in Das Kapital" in Michael Lane ed,. *Introduction to Structuralism* (Boston: Basic Books, 1970). p. 347.

21. Economic rationality is equivalent to formally defined rational behavior (i.e. optimizing behavior or selection of means and ends in terms of marginal utility) and, as such, it can be understood in terms of the formal theory of rational choice which underlies much of the theoretical development of modern social science, including economics. For a detalied analysis of this point see M Godelier, *Rationality and Irrationality in Economics* (New York: Monthly Review Press. 1972) and Anthony Heath. *Rational Choice and Social Exchange*, a Critique of Exchange Theory (New York: Cambridge University Press. 1976).

22. Godelier, *op cit*. in footnote 1 . pp. 15-21.

23. Marx. *op. cit*. foot note 14, p. 76.

24. F. Engels, *The origin of the family, Private Property and the State* (New York : Internatianal Publishers, 1972) p. 71.

25 The methodological argument developed in this essay presupposes knowledge of concepts such as mode of production, social formations, relations of production mode of reproduction, relations of reproductions, and so on. It is true that the theoretical elaboration of historically specific modes of reproduction (biological and social) is still in its early stages and widespread knowledge. let alone agreement, about their adequacy cannot be expected. On the other hand, a detailed presentation of my own understanding of these issues, which I have stated in a recent article (see M. E. Gimenez, " Structuralist Marxism on 'The Woman Question,' " *Science & Society*, Fall, 1978, pp. 301-323), would necessarily break the continuity of the argument. I think, though, that readers familiar with Marxist and feminist theories should have no difficulties in understanding my usage of the concepts mode of reproduction and relation of reproduction.

26. Marx's distinction between imaginary concrete, formal, and concrete or real concepts is one of his most important, albeit cryptically stated methodological insights. The significance of these distinctions is the following : unlike empiricist and idealist epistemologics which seek an understanding of social reality through the discovery of universally valid categories of analysis, Marx's methodology shows that such categories are themselves the product of specific historical relations ; they are valid in all modes of production but on the other hand, they possess their "full validity" only for and within the historic relations that produced them (K. Marx, *Grundrise* London: Penguin, 1973), p, 105.

27. *Ibid*., pp. 107-8.

28. *Ibid*., pp., 100-1,

29. Godelier, *op. cit*. in footnote 19. p. 37.

30. Marx. *op. cit*. in footnote 14. p. 171.

31. Marx, *op. cit*. in footnote 14, p. 172.

32. Karl Marx, *The Eighteenth Brumaire of Louis Bonaparte* (New York; International Publishers, 1969), p. 15.

Rural Energy Situation : Consequences for Women's Health - A Comment

Shobha Rao

In recent years there has been a growing awareness among nutritionists and other scientists regarding the problem of undernutrition in our country. Despite the fact that several studies reported in literature come out with diverging opinions and findings, their importance cannot be overlooked since they are likely to influence national nutritional planning. One of the recent studies by Batliwala (SHR I, 2) is of interest in this context and needs to be critically studied.

The scrutiny is of importance for two reasons. First, while many studies deal with the problem of undernutrition in general, very few have discussed its nature in the case of women. Secondly, the study claims to offer an alternative facet of improving women's nutrition and health which is rather interesting and might have consequences for policy implications.

The main conclusions of the study are given as (i) women contribute the greatest share in human energy expended, but in comparison to this energy output, women get a lower share of food intake and face a nutritional deficit. (ii) In addition to nutritional deficit, women face health hazards due to the village energy system (iii) Redusing energy expenditure..... energy saving-is recommended as an additional facet of improving women's nutrition and health.

Let us start with the central issue i.e. women contribute the greatest in human energy expended. The relevant figures are given in Table 2 (1:2,). tI should be noted that not only the difference in energy expenditure of men and women is negligible, but the way these estimates are obtained is also questionable. For example, one of the assumptions is that the ratio of caloric costs for any activity for female to that for male is equal to the ratio of female BMR. The author appears to be unaware of the fact that in recent years the notion that the BMR in an individual is constant, has been questioned and evidence is coming up to show that it is not. Therefore, although we doubt very much that this could be so, it would have been better if the author had cited appropriate references. The reason why the author suspects this negligible difference is due to the fact that men on average work for 4 hours a day, whereas women work for 6 hours. However, it cannot be neglected that men are engaged in heavy activities whereas most of the activities of women are of a sedentary and moderate nature. Considering that the caloric costs of moderate and heavy activities differ significantly, the observation that the difference in energy expenditure is marginal could be well so. In short, the methodology of obtaining the estimate of energy expenditure appears to have a weak basis.

Coming to her estimate of the intake of men, women and children, the situation is even worse. She uses crude ratios such as 2:1.5:1 (balls) based on responses to oral questions put to the local women and applies this ratio to the overall cereal consumption of the family for the day thus obtainingi ntake estimates. The author gives no information whatsoever on whether this ratio is based on the responses of a sufficiently large sample of women, nor on how the figure 4.24 kg of overall cereal consumption has been arrived at. The conclusion therefore that a man has an intake surplus of 800 calories whereas a woman has an intake deficit of about 100 calcries is unacceptable in the light of the weakness of her methodology.

Further, she goes on to claim that this 'calorie gap' suffered by women is not of equal concern to all and brings in Sukhatme's theory. Her criticism of Sukhatme's theory only reveals that she is missing the essence of this theory. It is necessary to understand that it is the nutrition science itself that offers body weight and level of activity as indicators while defining calorie requirements. Thus, accerding to the current concepts, individuals similar in age-sex, body size, doing similar activities are assumed to have the same energy needs. Alternatively, if an indiviqual maintains his body weight and activity over time, his requirement is assumed to be constant.

Sukhatme is bringing out the fact that these assumptions are not supported by experimental data. For, if the above assumptions were true, we would not witness the large variation in intake (coefficient of variation of the order of 16 percent) of individuals similar in age-sex weight and doing similar activities (Widdowson 1962, Harris 1962). Nor would we observe the coefficient of variation in weekly mean

intakes of the same individual to be as high as 13 to 15 percent. Sukhatme thus brings out the fact that the current definition fails to explain the large variation observed in intake or balance.

His theory on the other hand explains the nature of this variation with the help of the concept of intra-individual variation. Just as the blood glucose concentration in a healthy active man in fasting condition varies between 60 mg and 120 mg per 100 ml of blood, there is evidence to show that a man can do a given amount of work on a range of intakes. Thus, intra-individual variation is the fundamental source of variation and therefore it is hard to obtain a one-to-one relationship in daily intakes and expenditure. Finally, it is worth mentioning here that intra-individual variation is related to short-term fluctuations such as observed over few weeks or months, but cannot be taken when considering long term periods (of several years or a life long period) as the author seems to consider. It would in fact be wrong to visualise this hypothesis in such a way and comment on long term adaptations and so on. Nutrition science has yet to go a long way to study the phenomenon of 'adaptation' which the author is speaking about.

The author seems to assume that undernutrition is the sole cause for the several facts mentioned such as more female deaths, high maternal mortality rates, low birth weight and so on. It is well known that a number of social and environmental factors also contribute to this and it is difficult to show a causal relationship between undernutrition and these facts. Just the same way, it has been shown that although low birth weight could be one of the factors responsible for high infant mortalityr ate, most infant deaths in developing countries are due to past neonatal causes and diarrhoea is observed to be one of the main causes, thus indicating the influence of poor environment.

Although her concern about women's health is well understood, isn't it a fact that the issue has its roots in the law status of women, both social and economical in our society. There is therefore, no dispute that every effort should be made for proper implementation of current health services to ensure that they reach needy women.

To summarise, the lack of sound methodology in obtaining estimates of intake and expenditure seriously questions the finding that women face greater nutritional deficit. Therefore, her suggestion for reducing energy expenditure or for energy saving are not appealing. Further, there is no reason to consider that physiological responses of the body for increased intake or reduced expenditure could be same. Today in developed countries individuals find ways to spend there energy by means of jogging, bicycling etc. in order to keep their muscles active and to maintain proper body stature. Therefore it is necessary to give a thought for the possible consequences, good or bad, of energy saving.

Finally, it is clear that energy saving in practice will not be achieved without enough technological and economic resources. This is not to deny the role of technology, but at the same time it is important that changes introduced for saving women's energy should fit in the culture of our rural life. For example, replacing traditional chulas by gas stoves to reduce health hazards may not be a wise step. But instead it is necessary to convince villagers that there should be a proper outlet for the smoke to go out and see that every house in fact, has one such outlet. It is our experience that in the past few years, bore-wells have been installed in almost every village but the fact is that women still go for fetching water to the old village well, without realising that that this water is unsafe for drinking. It is therefore a basic minimum education for the women for their own wellbeing that should precede such technological and other advances.

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Witch Hunting Among The Bhil Meenas of Rajasthan

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The problem of witch hunting as reported by Kashtakari Sanghtana SHRI (1:2, 1984) is prevalent among all adivasi and primitive societies in varying forms. The problem as envisaged in the report has no ready solution because the tradition is very old and deeply rooted within the culture. The practice of witchcraft evolved as a system of beliefs to face the unknown supernatural world and its adverse

manifestations in day-to-day life. To find any resolution of this problem would require a greater insight into adivasi culture, environment, social and religious institutions.

Southern Rajasthan where we work, is mostly inhabitated by Bhil Meena adivasis. Here the incidence of witch-hunting has decreased considerably in the past few decades. It is now present in a different and milder form. Among the Bhil Meenas, witchcraft forms a part of magical rites and can be performed by magicians who are called as "Zangars" in the local dialect. These zangars are not medicinemen and they are approached when all other measures of resolving the crisis have failed. The first agency in any sort of crisis is the bhopa who is a faith-healer, an adivasi with powers to call supernatural spirits into his body. At a sanctified place he goes into a trance when the spirit enters him. The problem is explained to this spirit and it suggests remedies. If all such remedies fail then the possibility of a witch is considered. A magician is approached to ascertain the involvement of a witch. (There are very few magicians in this area.) These magicians by performing magical rites through the night will confirm the presence of a witch and provide either the description of witch or her exact name or address. Through another set of magical rites the magician will invoke the witch and ask about her presence in the family facing crisis and what she requires to leave the diseased person or the family. She is never however offered any of the things she wants but tortured and forced to leave by magical charms. In some cases the woman who is believed to be a witch is brought to the magician and put in his control. There have been some instances when a woman identified as a witch was killed but not in an open trial. These women were killed secretly by the family members facing crisis. Generally witches are considered to be females in this area however there are also male witches. They are thought to be stronger than women witches.

Who is this witch? Why did such a concept and practice evolve? Some of the explorations and causes mentioned in the report in SHR seem logical but only in the present-day context. However, we need more definitive knowledge. Adivasis are a brave and courageous people. At the same time they have a carefree attitude towards life and believe in enjoying it. Therefore, poverty has a very marginal effect on them. It is only recently that they have turned agrarian and have started taking up jobs out side their homeland. The concept of storing things for the future is also very new to them. Hence any sort of condition leading to material hardship, lowered resistance to disease cannot be a sufficient reason for the continuing practice of witch hunting, which has become institutionalised in this society for centuries. Similarly, inaccessibility to health care facilities, disruption of communications and shortage of money are very new occurrencs which are not even well perceived by adivasis and cannot be the cause of frustation leading to witch hunting.

To the Bhil Meena adivasis, death is an integral part of life and is not seen as something ghastly. Death even in action (hunting, war, orb of snake bite) does not inspire awe or horror. It is also believed among them that the soul, the divine force in the living body, after death goes to the land of dead to rest with ancestors who are believed to have influenced their every day affairs, when alive. According to them this soul may also take the form of an evil spirit and return to this earth to finish its unsatisfied desires. This evil spirit on earth makes its home in the body of a human being, (mostly woman) as it is the woman who can beget. Such a woman will change into a witch. There are lots of descriptions of witches which vary from place to place.

One more possible reason for the practice of witch hunting among adivasis could be their cultural configuration which is close to nature and the core of their own cult practices. Although primitive, it is representative of their beliefs and religion. During the course of their day-to-day life they have to encounter the wildness of this configuration. Wildness provokes wildness, and it is this animistic behaviour of adivasis which finds its expression in the form of witch hunting. The reason for diminished incidence of witch hunting in this area can also be attributed to the influence on adivasis of Hindu religion. Adivasis in this area have made many adjustments to fit in with this new influence and it is always considered superior. This constant interaction with new patterns of culture has resulted in a diversity of cultural practices and traits which are less animistic.

A practice like this is barbarous and should stop, but the people who practice it, do it within a set of concepts and unless these concepts are changed, it is very difficult for people to get away from it.