Family Planning and the Reproductive Rights of Women. Karkal, Malini. In: Understanding Women's Health Issues: A Reader Edited by Lakshmi Lingam. 1998. p.228.

Family Planning and the Reproductive Rights of Women

Malini Karkal

Change in the size of a population takes place due to births, deaths and migration. However, the programmes of population control have concentrated on births, and the 'undesirable' rate of growth of population in the developing countries is targeted to be reduced through the reduction of births in these, population. In this context the demand of feminists for establishing their reproductive rights and rights of controlling their fertility must be discussed as opposed to the population control policies promoted by the national governments, through the pressures of international bodies.

In the existing social structure, where motherhood is upheld, &the fundamental right to found a family can be, for women, a matter of life and death. Laws, social attitudes and traditional values that impair women's reproductive decisions reduce their right to protect their own lives and health, and those of their children' (International Planned Parenthood Federation, IIPF, 1990). The UN Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention) guarantees women the human right to plan the size and structure of their families by providing access to abortion and family planning knowledge and services, as well as equality in decisions regarding marriage and divorce, and in other areas of life that allow women to take effective decisions for themselves and within their families 5 and maternity protection that protects women's rights in their roles of production and reproduction. Ratification of the Convention by the member countries assures that the countries agree to eliminate discrimination against women in all civil, political, economic, social and cultural areas, including health care and family planning. (Ibid.)

The establishment of reproductive rights by law is a crucial starting point from which women may begin to exercise these rights. The Convention is an important touchstone of progress. It provides hope and a framework for action. By June 1990, 103 out of 159 UN member states had ratified the Convention. Seventeen countries had signed, but not ratified the Convention. Among others, the latter include India the Netherlands, Switzerland and the United States (IPPF, 1990).

In India, family planning services are available not only without cost, but financial incentives are provided for the acceptors of methods such as sterilization and IUDS. Besides individual medical practitioners and other lion-government and private centres, these services are provided through the government funded primary health centres (PHCS) and sub-centres in rural areas, and health posts and urban centres in urban areas. As on March 1990, the country had 23,097 PHCs and 138,692 subcentres, 939 health posts and 2,648 urban centres (Karkal, 1991b). These figures indicate the wide availability of the services for all population.

The law on abortion was liberalized in India by the Medical Termination of Pregnancy Act of 1971 and came into force from April 1972. The major concern of the Committee that was appointed to examine the abortion situation before the law was passed, was said to be the health hazards of illegal abortions to which women resorted. The Committee estimated 3.9 million abortions per year whereas the International Planned Parenthood Federation (IPPF) had estimated these to be 5 million. 'Deep compassion at the suffering involved and exasperation at the wastage that occurred were said to be at the root of demand for liberalization of the law on abortion' (Government of India, 1967: 39).

The law provides abortions virtually on all conditions, and is one of the most liberal laws. The figures March 1988 show that there were as many as 6,126 medical institutions approved for abortions. In addition, there are several private practitioners who provide abortion services (Karkal, 1991a).

The Question that remains is: does the provision of a large network of centres for family planning, as well as abortion services, assure women of the availability of services that protect their reproductive rights and the freedom to plan their own fertility? To answer this one can look at the, objectives of the population policy as laid down in official statements, such as the Five Year Plans, as well as the functioning of the family planning programme.

It should also be added that services for all health needs are said to be provided free through the wide network of health services previously mentioned. It therefore becomes necessary, accordingly, to see whether Indian women have safe deliveries and access to health services, which can be said to be an indication of the assertion of their reproductive roles.

Available data show that Indian women have one of the highest maternal mortality and morbidity rates. In 1990, the World Bank published a report on maternal mortality rates (MMR) of all the countries in the world. The lowest mortality rate of two was reported by Sweden. All the developed countries had rates that were lower than 10. Many developing countries (such as Sri Lanka and

Thailand) had rates around 20, whereas the rate for India was over 500. And this, in spite the fact that Indian doctors are qualified to manage the health of people in developed countries such as Britain and the US.

It is well documented that the mortality rates for Indian women are higher than those for the men. That the incidence of ill-health among women is high has been documented by several authors (Bang et al., 1990; Rao, 1992).

Women's Health and the Five Year Plans

During the pre-Independence period, organizations such as the National Congress and the All India Women's Conference did discuss, as early as the 1920s, the health problems faced by women and children. Services to regulate fertility were provided through a few clinics. It was, therefore, natural that in the First Five Year Plan (1951-56), drafted immediately following the independence of the country, provisions were made for fertility regulation services. The emphasis was on the health welfare of the family, and the services were aimed at the health and welfare of mothers and children. The programme was, therefore, named family planning. It is interesting to note that similar work that was being carried out by the IPPF in England, was known as birth control, since the objectives of the programme were the control of births and to liberate women from the continuous cycle of pregnancies and deliveries. This was a result of the suffragette movement that was aimed at the liberation of women (Karkal, 1986).

India was the first country to accept fertility regulation in its national programme. This is included in the Five Year Plans as a priority programme and is under the programme for maternal and child health (MCH).

The first two Plans (1951-56 and 1956-61) clearly stated that the objective of the family planning programme was to establish clinics to provide advice and services to couples wishing to space and limit births. Surveys had indicated that couples desired fewer children than they actually produced. It was also found that women desired less children than men (Berelson, 1976). It was, therefore, assumed that the provision of services for advice and the means to regulate fertility would have the desired impact on the health situation of women and children. The size and rate of population growth was also discussed, but there was no intention of making any special inroads in this direction.

At the request of the Government of India, Frank Notestein, a well-known demographer and Leona Baumgartner, then the New York Health Commissioner, visited India in 1955. They recommended an interdisciplinary programme, emphasising a public health approach, including the use of contraceptives, with strong demographic support from the centre (Karkal, 1986).

Since then, demographers have played an important role in planning by providing targets of achievement that, will have the desired demographic impact.

The number of family planning, clinics rose from 50 in 1951 to 165 in 1956 and to 4,134 by the end of the Second Plan. To ensure that the services were available to most of the couples, care was taken to see that the clinics were, spread through the rural areas well as the urban areas. The contraceptive methods advocated during this period were the diaphragm, jelly and rhythm methods. The first was chosen from the only available pattern (that of the clinics run by the IPPF), and the last with the belief that the culture in India was more favourable to natural methods than mechanical ones. Sterilization was added to the programme in 1959, after the visit of Notestein and Baumgartner. The involvement of demographers in guiding the programme before the introduction of terminal methods, such as sterilization, may not be a coincidence. By the end of the Second Plan, the number of sterilizations reported were 150,000.

Towards the end of the Second Plan, a survey to understand the functioning of the clinics was undertaken. The survey showed that the establishment of service points was not adequate enough to motivate couples to avail of the advice and the facilities. It also showed that the way the services were organized, couples did not get adequate information or motivation to understand the 'advantages' of using contraceptives. This resulted in barely 5 per cent of those visiting the clinics, who continued to adopt .the advice given to them (Chandrasekaran and Kuder, 1965). The way clinics functioned had to be modified as the approach was not influencing the birth rate satisfactorily.

The findings of the survey were in keeping with those of Stycos (1962), who reported that the clinic approach had a medical, feminine and middle-class bias. Since clinics were, headed by medical persons, fertility regulation was seen as a sterile, biomedical exercise which completely ignored the cultural setting which valued fertility. It could get practically no male participation and advising a feminine method (such as diaphragm or jelly) promoted this patriarchal attitude. It was also observed, that the use of methods such as the diaphragm and jelly required the clients to live in housing that had adequate privacy and facilities for water and storage space, which only middle and upper class income groups could afford.

In the 1960s, at the international level, there was concern about the size of the population of many developing countries. Several scientists pointed out that the increasing population of these countries, were likely to reduce the role of leadership that the developed countries were playing. They, therefore,

emphasized the need to control the population of these developing countries in the interests of the people of the developed regions (Karkal, 1989).

The approach to family planning in the Third Plan (1961-66) changed to extension education wherein the clinic staff were to work in the community and use an information-education communication (IEC) approach to (a) create a small family norm, (b) create acceptance of fertility regulations, (c) provide services within the reach of the people, and (d) spread knowledge about non-clinical methods, such as the rhythm. method and condoms, in the hope that people would influence each other and be given access to means to limit their family size.

The year 1965 saw famine in the country. There was a shortage of rain the following year, too. India experienced food shortages and the US government, in view of the food problem and the population situation, sent Dr, Jack Lippes to India to encourage both the use of intra-uterine devices (IUDS) that he had developed, and the contraceptive pill. Mass propaganda was undertaken to promote the IUD as a simple, effective and harmless method that freed women from the bother of being careful at each intercourse, as was the case with the diaphragm and jelly, or of reminding their husbands to use a condom. For the benefit of the government it was also propagated that the method was a one-time-motivation method and was inexpensive (Piotrow, 1973: 1227) which would result in fertility control while in situ.

At this time, the Ford Foundation also financed a nation-wide study to understand the experience of IUD users. This was one of the most carefully planned studies covering women from all geographic areas and all sections of the population. The results were positive but also indicated many side-effects, and it was obvious that the introduction of such a method had to be accompanied by careful medical check-ups of the acceptors. In the initial enthusiasm, a large number of women-both rural and urban-were fitted with IUD'S, but it was soon found that the women experienced problems. On the whole, this made for negative propaganda. Women either approached the service centres for removal or they pulled out the IUDs on their own. Continuation with the IUD was, at best, two years and with the pill were, even lower.

In spite of all these programmes, it was found that the birth rate at the end of the Third Plan was as high as 41 per 1,000 population. It is important to note that several studies that were conducted to find the level of knowledge, attitude to a small-sized family and the practice of family planning (KAP) had shown that there was an overwhelmingly favourable response to a small-sized family, but the practise of family planning did not give the results that were advocated by

the demographic interests of the government. The continuing high birth rates brought to light the fact that individual decisions for fertility behaviour and national interests in reducing the population were not directly related.

It must be re-emphasized here that the programme was started with the objective of improving the health and welfare of women and children. However, indices such as maternal and infant mortality showed very little change, and especially since interests were directed towards the demographic impact of the programme, there was continuous emphasis on lowering the birth rate. The KAP studies had shown that a smaller-sized family was desired, and that women desired fewer children than men (Berelson, 1976). In this context, the poor response to the services should have been seen as an indication of the fact that women had very little voice in matters affecting their own lives. The programme completely ignored the influence of the patriarchal nature of the society and the issues concerning the status of women and their helplessness in decision-making in family matters.

By the Fourth Five Year Plan (1966-71), the programme saw a clear shift from welfare to population control. The Plan stated: Population growth, presents a very serious challenge. It calls for a nation-wide appreciation of the urgency and the gravity of the population situation. A strong purposeful government policy, supported by effective programmes and adequate resources of finance, man and material, is an essential condition of success (Government of India, 1969: 310).

The Plan, therefore, had a target of reducing the birth rate to 25 per 1,000 in a stipulated period of 10 to 12 years. To coordinate activities, a special Department of Family Planning was also started at the centre.

Though the importance of IEC was accepted during the Third Plan Period, major interests in reducing population were indicated by an emphasis on selecting methods that would have a greater impact on the birth rate. One-time motivation methods were, therefore, emphasized in the programme. Two such methods available at that time were the IUD and sterilization. In 1962, the government introduced financial incentives that were billed as compensation for 'out-of-pocket-expenses, conveyance and loss of wages'. To obtain active cooperation of the staff, those participating in the programme were also paid financial incentives. These incentives continue to date, and it is observed that health staff gives much more time to family planning work while other health problems are virtually sidelined.

The programme gained momentum during 1966-67 by making it target-oriented, wherein the staff of the health services were given targets in terms of acceptors of contraceptives. The target for the Fourth Plan was 28 million couples. The

programmes were to be evaluated in terms of 'births averted'. The expected number of births to be averted during the Fourth Plan was 18 million (Government of India, 1969).

Till 1970, female sterilizations could be performed only during the post-partum period. But to decrease the number of childbirth's, a terminal method that ensured that the couple would have no more children was needed. This was vasectomy or the sterilization of the male. In patriarchal societies, it is never easy to get men to take the responsibility to ensure that the family is not burdened and the health of the women is not strained. Under these conditions, the only men who could be operated upon were the poor, especially those from the rural and tribal areas. It is known that the major achievements of the family planning programme are at the end of the financial year when the PHC staff as well as government officials pressurize people to accept family banning. It should also be noted here that the end of the financial year coincides with the lean period in agriculture, and the poor-in rural areas have no-money or grain, to feed the family. To get them to accepts family planning through financial incentives is, therefore, easy. It is known that in the 'welfare state', where most of the needs of the rural and the poor population are met through government agencies, it is easy for government officials to see to it that the people act as the officials desire. For instance, the agricultural needs (such as fertilizers, seeds and pesticides) of the people are met only on the condition that they accept family planning. Besides meeting the required achievement target, the government staff, are able to get the benefit of financial incentives that are available in the programme. Since the Indian family planning programme is said to be voluntary and cannot compel people, the approach is described as 'coercive persuasion' in common parlance.

In 1970, a vaginal tubectomy technique was developed and women could be operated in periods other than post-partum. Thereafter, tubectomy camps were organized, and since it was easier to get women to undergo sterilization, the numbers showed an increase.

To achieve quick results, services were brought closer to the people. In the urgency to get more contraceptor's, 1,000 mobile units staffed and equipped to provide services were included in the programme. A 'camp-approach' was also developed. Here, the staff of the local clinics motivated couples who gathered at a nearby place on an assigned date. The services of city doctors, who were perceived as professionals, were made available at these camps. The financial incentives at the camps were larger than the normal ones. Group pressure and mass motivation worked at these camps to bring in a large number of individuals. The success of the camp depended on the ability of the organizers to

collect people. The largest camp was organized in Ernakulam in Kerala in July 1971, where a total of 626,913 men underwent vasectomy (vaginal sterilization was not widely practised then) (Krishnakumar, 1974). After the vaginal tubectomy technique was developed, the camps were essentially for female sterilization.

The law on abortion was liberalized to further reduce the birth rate. However, in spite of the promotion of terminal methods such as, sterilization, and making abortions easily available, the birth rate at the beginning of the Fifth Plan (1974-79) was 33 per 1,000 population. It was, therefore, decided that the programme should be carried out more vigorously. The demographers who were responsible for estimating the number of couples that, had to be 'protected' (from pregnancy) decided that the target for achievement during the Plan Period should be 40 to 42 million couples. The number of couples who had been protected during the Fourth Plan was 15 million. Obviously, the pressure on the staff and other government officials to meet the targets, increased.

It was observed that the couples who accepted sterilization had, on average, four children. It was therefore decided to promote spacing methods, such as the IUD, the pill and the condom. Efforts were also made to get younger couples with fewer children to accept sterilization.

The Fifth Plan clearly stated that the objectives of the programme were demographic, the approach was target-oriented, and the target would be couples who were younger and who had fewer children. The Plan document also had an interesting statement: 'Increased available facilities for the medical termination of pregnancies (MTPS) may also have some effect on the birth rate' (Government of India, 1973: 241).

The Committee that was appointed to study the abortion situation in the country, before the law was liberalized, had clearly stated in its report that the abortion law was being liberalized as a health measure. It specifically denied that it intended to press for legislation for the sake of population control. It also accepted that 'there did not exist, or will not exist in the foreseeable future, either the doctors or the medical facilities to support the extensive abortion programme' (Government of India,.1967: 47). The report observed, therefore, that legalizing abortions with a view to obtaining demographic results is impractical and may even defeat the constructive and positive practice of family planning through contraception.

It is known that for every registered abortion, there are not less than three abortions in rural areas and four abortions in urban areas that are performed outside the provisions of the law. Abortion, the major cause of maternal-

mortality and, damage to women's health; is known to be widespread, though there have never been any, attempts to, assess the 'extent of this damage or prevent it. Easy access to abortions is seen from the free publicity to the services. Even a casual observation of their practice, is adequate proof of the fact that the prevention of births through any means, fair or foul, is the important objective. Also interesting is the observation that the official documentation of the Department of Family Welfare includes in its Annual Report the information on MTPs registered under the MTP Act:

Medical termination of pregnancy (MTP) is a health care measure, which helps to reduce maternal morbidity and mortality, which results from illegal abortions. Though this is mainly a health care measure, it can supplement family planning, as a large percentage of women undergoing MTP are wedded to the acceptance of small family norms and will, therefore, accept family welfare procedures (Government of India, 1989: 61).

It is clear that abortion is now openly advocated as a method of family planning. Seeing the unsatisfactory response to the family planning programme, Prime Minister Indira Gandhi, while addressing paediatricians, said: 'To bring down the birth rate speedily, to prevent the doubling of our population in a mere 28 years, we shall not hesitate to take steps which might be described as drastic'. (Government of India, 1976: 6).

The family planning programme in India went through a traumatic phase during 1976-77. With the declaration of a state of Emergency in the country, a national target of 4.3 million sterilizations for the period April 1976 to March 1977 was announced. The sterilization programme was implemented with coercion especially in the northern states where the, achieve merits in earlier years were relatively poor. The brunt of this was borne by the poor, illiterate lower castes, scheduled castes and Muslims. Since the programme had become target oriented, the staff were threatened with punishments such as stopping of their annual increment or cutting salaries if they did not meet the targets given to them. During the Emergency, the abuse of clients and implementers was widespread. The programme had strong positive incentives for achieving results, and stronger penalties for shortfalls. In this atmosphere, many leaders vied with each other to please Sanjay Gandhi, the architect of the programme. The quotas given by the government were 'improved' upon by several states. The quota for Uttar Pradesh was set at 400,000 sterilizations, but the Chief Minister raised it to 1.5 million (Banerjee, 1979). In 1976, the Rajasthan government decided to make sterilization compulsory after two or three children, if 'persuasion' failed. In Haryana and Punjab, government employees who had two children were denied facilities such as government accommodation and loans, unless they got sterilized (Statesman, 1977). In Bihar, the salaries of 50,000 government

employees were withheld fox three months and 600 or more lost their jobs for failing to bring 'volunteers or refusing to get sterilized (Time, 4 April 1977: 39). There were many such atrocities reported from several states.

In spite of these excesses, the target of reaching a birth rate of 30 by the end of the Fifth Plan was not achieved. The Sixth Plan (1980-85) document mentioned that, 'public enthusiasm and community participation in the programme which is necessary for the success has not been generated in adequate measure' (Government of India, 1980: 374). The objectives of the Sixth Plan were therefore directed towards other aspects of the population.

The Sixth Plan aimed to reduce the family size to 2.3 with net reproductive rate (NRR) of one, i.e. one mother was to have one daughter only. The underlying reason for this is that controlling the number of women in the population would lead to controlling the number of child bearers. This is like saying that to reduce poverty, reduce the poor. Interestingly, a recent publication by the United Nations Fund for Population Activities (UNFPA), New Delhi, on India's population programme, says that the UNFPA is supporting a long-term goal of NRR 0, reducing the birth rate of 33 (in 1978) to 21, the death rate from 14 (in 1978) to nine, and the infant mortality rate from 129 (in 1978) to 60 (UNFPM 1990). To achieve the targeted birth rate the couple protection was targeted at 60 per cent. Sterilization's were to be increased to 22 million, in addition to 7.0 million couples to be protected through IUD'S. There were targets for other/methods too.

The gravity of the size of the target's can be understood from the achievements of the programme during the period. Sterilization's performed, in million, were: 3.16 in 1980-81; 3.44 in 1981-82; 3.61 in 1982-83; 3.01 in 1983-84 and 2.48.in 198485. The number of IUDs inserted during the same period, in million, were: 0.97, 0.93 1.00, 1.42 and 1.56 respectively. In the Plan period, the number of sterilization's were therefore 15.70 million (against a target of 22.00 million) and IUD insertions were 5.88 million (against a target of 7.90 million).

The target of the programme, thus far, was the birth rate. Since the Sixth Plan, it became NRR one. Interpreted in terms of actual functioning, a couple that intended to be faithful to government instructions would have to make sure that they had only one daughter. If the couple had a daughter and the wife got pregnant, to follow government rules would mean that the couple would have to resort to amniocentesis and termination of the pregnancy if the foetus happened to be a female. Thus the government was indirectly advocating female foeticide (Karkal, 1986b).

All's Fair in the Interest of Population Control

As shown earlier, there is a widespread availability of the services for family planning and abortion that may seem to protect women's, reproductive rights; in reality, government policies and their functioning strengthen the patriarchal attitudes and traditions that oppress women. This is supported by the data that show that the burden of fertility regulation is essentially on women. Available data show that of the total acceptors of family planning methods 21.8 per cent had undergone sterilization (of these 85.0 per cent were tubectomies, which makes it 18.5 per cent of the total acceptors), 19.2 per cent were users of other' contraceptives such as condoms, or methods used by females such as diaphragms, vaginal jelly, cream and foam tablets (Government of India, 1989: 242). Thus, females not only constituted a larger proportion of the acceptors of family planning methods, but were using methods known to be used more consistently, in contrast to the use of 'other methods', especially condoms, whose extent of actual use is unknown.

In many countries that liberalized the laws on abortion, where reliable data are available (such as countries in eastern Europe and Japan), experience shows that immediately following the liberalization of the law, a large number of women had induced abortions. However, the number soon stabilized and showed a rapid decline, accompanied by an increase in the number of effective users of contraception. Finally, the number of abortions reduced to the relatively few who resorted to it only when contraceptives failed. In contrast, the experience with Indian women clearly shows that, apart from terminal methods such as sterilization (and there is every reason to believe that women are not accepting this method on their own), there has been very little change in the number of users of contraceptives, and this number has always been insignificant. This observation further supports the argument that abortion laws were liberalized in India as an additional means to reduce births to control the population.

Family planning has been provided by the government, and without cost, since 1952. It is, however, observed that the response to the programme has been limited. Women are known to have a large number of children, even when surveys repeatedly report that women want fewer children. That women conceive against their will is also borne by the fact that close to 600,000 abortions are performed under the provisions of the Act (Government of India, 1989: 233). It is further known that in spite of liberal laws and the provision of services, for one registered abortion, as many as three in rural areas and four or five in urban areas are performed outside the law (Karkal, 1991a). When liberalizing the law, it was claimed that the objective was to provide services to Women who were taking recourse to backstreet abortions, who faced several health hazards. Two decades after the MTP Act came in to force, the figures for abortions outside the

legal provisions prove that the provisions of legal abortion are not designed to protect the interests of women.

In India, the population policy of the government advocates the control of the size of the family to two. Larger families are unacceptable. Though there is no 'compulsion' for restricting the family size, there is enough evidence that the official family planning programme 'motivates' couples with a larger family size to undergo sterilization. It is obvious that the prevailing social attitudes that are supported by the government make it easier to pressurize women rather than men to accept family planning. It is further observed that other 'targets' of this government programme are the poor and the rural population.

The government's patriarchal attitude, which treats women as the targets of the policy of population control, is also indicated by the treatment meted out to women who go to the clinics to avail of their services. Studies investigating the services repeatedly point out that the women are treated with indifference and, often, even with disrespect. Regarding the quality of family planning services available through the clinics, (Khan et al. 1990: 75) say: 'The quality of counselling at the public clinics is very poor. Most of the respondents are neither informed about other family planning methods (other than sterilization and IUD'S) nor told about the possible temporary side-effects.'They further note: 'Cleanliness of the operation theatre and proper sterilization of instruments require special attention to ensure aseptic conditions, as, 16 out of 367 sterilization acceptors developed infections at the site of the operation, and complained about it in the interview' (ibid: 82).

It should therefore be obvious that the wide availability of the means of fertility regulation, including free access to abortion, is not an indication of the acceptance of the reproductive rights of women but an indication of the interest of the government in the policy of population control. This is also clear from the fact that the objectives of the population policy of the Government of India refer to the reduction of the birth rate and the number of contraceptor's that have to be 'reached' through the programme. It is also significant that the emphasis of the programme is on terminal methods (such as sterilisation), which assures the programme implementors success) the meeting the objective of the programme.

It is repeatedly reiterated that women are the instruments of the state. Their lives and futures are at stake and the restrictions on reproductive rights hit the vulnerable the young and the poor the most. However, it is the political vagaries that control freedom, by discriminating. It is in the prevailing patriarchal societies where men head the household and women serve them. Women derive their name, residence, nationality, sustenance and function from their husbands. Women are not equal partners in marriage and family life. Women who are not

married, separated, divorced or widowed are not given their rights as individuals and have no provisions for their health problems. Even the 'married' are only recognized in their role as mothers.

Biological differences between men and women are often considered a justification for setting the legal age of marriage lower for women than for men. However, this merely serves to stereotype women into child bearing and unskilled service roles at a lower age while permitting men extra years of education, preparation and experience to be breadwinner's, even when, in fact, female-headed households are on the rise.

Women have a much higher stake in reproductive rights than men do, and a much more direct and intimate concern with reproductive health. The politics of some countries have dominated international decisions on many of the issues affecting women. The Mexico conference of 1984 was not only silent on the issue of abortion but abortion itself became a defacto condition of the US restrictions on international funds for abortion related services. At the international UN World Summit for Children, while there was a call to reduce maternal mortality, no reference was made to abortion.

There is ample evidence that short-term national and international political interests take precedence over the health needs of women; family planning policies, in their formulation as well as in their implementation, completely ignore the issues of the reproductive health of women. Under these conditions access to services is determined by social, cultural, economic and political considerations. The status of women and their decision-making power play a crucial role in women's ability to receive adequate reproductive hearth care. When society is governed by patriarchal attitudes, the empowerment of women is a distant goal.

The right to maternity leave and job protection during maternity are important indicators of the extent to which a government is committed to protecting women in their productive and reproductive roles. There is ample evidence that, in India, 'women are forced to avail of maternity leave without pay, and maternal protection is denied to women in the unorganized sector, which forms a large portion of the women engaged in production. These are clear examples of the denial of reproductive rights to women.

The major focus of most human rights instituion's that deal with procreation and reproduction is on family planning, which is equated with limiting births. The broader issues of access to health care, economic resources and social security, to say nothing of freedom from sexual abuse and discrimination, remain unaddressed, though these conditions are directly related to women's lack of

reproductive self-determination. The policies that demand 'maternal and child health' have essentially emphasized the child; women remain the unspoken word. The starting point of reproductive rights has to be health, well-being and the empowerment of women. The needed approach to reproductive rights has to be 'women-centred' and social change oriented with an emphasis on health issues. It not only puts back the 'M' in MCH but modifies family planning and related programme's, making women's well-being and reproductive choice the central obectives. This means top priority to reducing women's morbidity and mortality related to reproduction and sex, as well as maximizing the conditions that make authentic choice-whether to have a child or not-possible. Under present conditions, such demands mean women walking the thin line between women's need for services and their need not to be controlled or coerced by them (IPPF, 1990). A woman's sexual self-determination is an intrinsic part of her dignity as a human being. Whether anti-natalist or pro-natalist, population policies tend to treat women's bodies as the instruments of male dominated populationist ends.

References

1. Banerjee Sumanta, 1979. Family Planning Communication: A Critique of the Indian Programme, New Delhi: Radiant Publishers.

2. Bang R.A. et al, 1990.'Hiah Prevalence of Gynaecological Diseases in Rural Women', Medico Friends Circle Bulletin 159, January.

3. Berelson, Bernard, 1976. 'Social Science Research on Population: A Review', Population and Development Review, Vol. 2, No. 2, June, pp. 219-66.

4. Chandrasekaran, C. and K. Kunder, 1965. Family Planning through Clinics, Bombay: Asia Publishing House.

5. Government of India, 1961. Third Five Year Plan, New Delhi: Planning Commission

6. 1967. Report of the Committee to Study the Question of Legislation of Abortion, New Delhi: Ministry of Health and Family Welfare.'

7. 1967. Fourth Five Year Plan, New Delhi: Planning Commission.

8. M1973. Fifth Five Year Plan, New Delhi: Planning, Commission.

9. 1976. Background to the News: Mrs Gandhi's Inaugural Address to the 31st Conference of the Association of Physicians of India, New Delhi: Ministry of Information and Broadcasting, 22 January.

10. 1980. Sixth Five Year Plan, New Delhi: Planning Commission.

11. 1989. Family Welfare Programme in India, Year Book, 1988-1989, New Delhi: Ministry of Health and Family Welfare.

12. IPPF (International Planned Parenthood Federation), 1990. The Wallchar on Reproductive Riahts, distributed by People Magazine, Vol. 17, No.4.

13. Karkal, Malini, 1986a. 'Family Planning in India: A Critical Appraisal', International Review of National Family Planning, Spring, pp. 23-42.

14. 1986b. 'Planning for Female Foeticide', Science Age, Vol. 4, No. 6, September, pp. 13-15.

15. 1989. Can Family Planning Solve the Population Problem? Bombay: Stree Uvach Publications.

16. 1991a. 'Abortion Laws and the Abortion Situation in India: Reproductive and Genetic Engineering', Journal of International Feminist Analysis, Vol. 4, No. 3.

17. 1991b. 'Health and Health Services in India', in C.A.K. Yesudian, (ed.), Primary Health Care, Bombay: Tata Institute of Social Sciences.

18. Khan M.E., Bella C. Patel and R. Chandrasekaran, 1990,'Contraceptive Use: Dynamics of Couples Availing of Services from Government Family Planning Clinics--A case study of Orissa', Journal of Family Welfare, Vol. 36, No. 3, September.

19. Krishnakumar S. 1974. 'Ernakulam's Third Vasectomy Camp Using the Camp Approach', Studies in Family Planning, Vol. 5, No.2, February, pp. 58-61:4.

20. Piotrow, Phyllis Tyson. 1973. World Population Crisis-The United States Response, New York: Prager.

21. Rao, Nagamani. 1992. 'Population Control and Women's Health', FRCH Newsletter, Vol. 6, No.1, January-February, pp. 8, 9, 12.

22. Stycos J. Mayonne. 1962. 'Experiments in Social Change: The Caribbean Fertility', Clyde V Kiser, (ed.), Studies in Research in Family Planning, Princeton: Princeton University Press, pp. 675-78.

23. World Bank, 1990. World Development Report 1990, Poverty-World Development Indicators, Oxford: Oxford University Press.

24. World Health Organization, 1992. 'Infertility-A Tabulation of Available Data on Prevalence of Primary and Secondary Infertility', Programme of Maternal and Child Health and Family Planning, Division of Family Health, Geneva: WHO.