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Towards An Understanding

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The process

Those of us who spent four days together trying to enhance our own understanding about women's health and reproduction found ourselves grappling with various concepts. Each of the papers presented stimulated an animated discussion. Very often, we would find ourselves struggling to understand a complex issue. Some of us felt the need to "arrive at a position"; others felt that we were "in no position to do so." Our discussion proceeded at various tangential levels -some would try and steer it in a direction and link it up to the general issues, others wanted to carry on single-minded over a specific point until some consensus was reached. We often asked more questions than we received answers. The purpose of the discussions was not to find black and white solutions, but to work towards a greater clarity. If confusion is a step towards getting clear, then perhaps we are half-way there.

In all seriousness, however, we feel that it would be useful to share the discussion with others, highlighting the ideas which emerged, as well as expressing the conflicts/problem areas. Of course it is difficult to convey the sense of the discussions without some of the louder tonal affectations and banging on the table. We have tried to synthesize the main points, the salient features, the crucial issues of the workshop -some of these are obviously linked to one another, others may seem off the beaten track. Most of them are here, and the main purpose of including this section is to raise the issue, not because we feel it will be so simple to find the solutions, but because we are hoping that others are asking similar questions too. Through coordinating our efforts and our resources we hope were able to evolve our own feminist perspective and work towards gaining control (over our bodies).

We felt very strongly that the question of women's health must be linked to that of women's status in society. Therefore, it was essential to focus on the inherent ideology of women's role in society and it's implications on health, health programs and health education. The purpose was not merely to discuss the issue in abstract terms but to critique the conventional government health programs, even go into depth about a particular aspect, e.g. breast-feeding, and arrive at a feminist analysis about how women are perceived in these programs etc.

Among the government programs, we felt that the family planning issue ought to be discussed at length. There is a need for feminists to focus not only on criticizing the program, but also to initiate thoughts on what we want, and how we should go about getting this implemented. It was also essential to understand the current methods of contraceptive research and testing in the country and work towards influencing policy. Of late, new reproductive technologies have entered India and this raises a whole new set of questions about whether these liberate women or further subjugate and oppress us.

The issue of health care has always been women's domain, but there has been no appreciation of this fact. Even today, women health workers form one of the most significant work forces especially at the grass-root level. They are in direct contact with the people and, perhaps, have the best ideas about real health needs. The question therefore would be to understand the organizations working among women health workers, the problems faced by, them and whether the feminist movement can identify and support those.

There are broader issues which affect women's health, and one of these occupational health hazards of women health workers, was taken up. This was linked to the legal aspects, in order to press for our claims in court. There is a campaign towards establishing a rational drug policy and it is for us to consider the women's angle on this issue as well.

Finally, a major part of the last day was devoted to formulating action plans. We broke up into small groups to discuss what needs to be done in theory, research and action at the grassroots level. We will now present a summary about the discussions, using the, above frame work, and wherever possible, establish a link with the position papers.

Inherent Ideology: Who Controls our Choice?

The opening paper presented the viewpoint that in a patriarchal system, there was a distinction between control of women's reproductive ability and her sexuality. At the discussion, it was felt that sexuality could not be controlled by those in power. They have resorted to control of our reproduction against our will. There was some confusion about this: "Does not control of reproduction automatically create a control over sexuality?" What is the concept of sexuality?' Today sexuality is defined through male ideology: women are viewed as stereotypes, either good or bad; the wife or the prostitute. Sexuality is considered a man's pleasure, the woman is perceived only as having the reproductive function, of producing a child. Therefore the logic then becomes that control of a woman's reproductive function would in effect control her sexuality and in this analysis, women's sexuality is also controlled. It was felt however, that we women are not clear about our sexuality since we have not had the space to talk about this, therefore this should be further debated.

When the question of fertility control and control of sexuality was raised, this was linked of choice. There was a general agreement that concept of choice as it existed today was geared to the capitalist system. "Choice exists as an item in the consumer market, Here are the pills, go and have sex". It was felt that there is little understanding as to what determines the options in front of us. We felt that we had to probe into all our campaigns against new reproductive technologies (NRT), injectable contraceptives and other health campaigns, in order to establish a link between women's various roles in sexuality, reproduction, production, child-rearing and other duties based on the sexual division of labor.

What is our Stand on New Medical Technology?

The topic of pre-natal tests raised a valid question. "While we should protest against female foeticide, we should not forget to question the fact that prenatal tests also result in the abortion of deformed foetuses. How can the handicapped have any status in society as long as this discrimination exits?"

The discussion then moved to "the criteria underlying the quality of life" or, whether we were moving very close to "the right to the argument of the pro-life lobby". We agreed that we unconditionally supported abortion as a woman's right; what needed to be debated was the issue of selective foeticides. There were big question marks. "What position should we take when, for example, we know that after a disaster as In Chernobyl or Bhopal or after an iatrogenic (doctor or

drug created) problem, or in the case of a family history of genetic abnormality, a woman wants to abort 'selectively' to eliminate a deformed foetus"? Should we take a stand against the "abuse" of prenatal tests as in the case of female foeticide or should we categorically stale that elimination of deformed foetuses through the detection of genetic abnormalities is a bias against the handicapped?

The discussion then moved to the issue of 'neutrality' of science and technology. "Sometimes, technologists have no analysis about social problems and are therefore not even fully aware of the implications of their research and inventions." Therefore, they cannot be blamed. Some of the group clearly disagreed. There was however, a consensus regarding the fact that there is a disproportion of power in society and whether sexism is explicit or implicit in technology, it did affect large sections of society. For example "Reproductive technologies were developed in the Nazi era in concentration camps. It is full of sexist, racist and class biases".

It was felt that "many biases are overt and therefore difficult to pinpoint". Technologists belonging to the ruling classes may not deliberately wish to harm the working class, the blacks or women; however, by virtue of their very position they participate in women's oppression. "Take the case of research on rascally planning. Middle class males plan the strategy to be used on working class women". As individuals they maybe 'nice', however the collective harm which they inflict is tremendous.

Are we Rural, Urban or as One Voice?

Some of us raised the issue that "the feminist movement was a concern of the urban middle class. Do these technologies really affect women in the rural areas?" "If the movement is concerned about the issues of the rural working class women, they would have to be involved in the process of a broader social change." "Rural women do not even have information, so how can they take charge of their own lives?"

A point was raised that "Every-time the urban feminists raise an issue, they are confronted, with questions which make them feel guilty such as their alienation from the rural women." It was however agreed that raising demands in an urban environment is also a vital issue, e.g., an issue that did not remain urban. Like sex determination clinics being established in remote, rural areas. We therefore, have to be aware of the problem and raise it when relevant. "As urban-based women we should not feel apologetic".

After a lengthy discussion it was generally strong links with rural women, especially women health workers whose concerns have not been considered this feminist movement. It is important to network, certainly, and it will have to be two-way process.

Attitude Towards Women's Health: Focus of Health Programs

Women's primary role is seen as that of "reproducer" and therefore the focus of conventional health programs has been on maternal and child care. International agencies perpetuate "the point by point program" in the third world as a panacea for the survival of children. The paper on this has pointed out that the additional burden of child care through the target approach of "GOBIFF' the six-point program institutionalized by WHO/UNICEF, namely

- Growth monitoring
- ORT (Oral Rehydration Therapy)
- Breast feeding
- Immunization
- Family Planning
- Food supplements

Example of Breast-feeding

This type of approach to health care only increases the overworked mother's load. As feminists we believe that women's health needs must be viewed in its own right, and not as the right of a mother. No single method of child care can be a blanket stipulation for all women at all times and all places. For example, breast-feeding is recommended to women of all classes. But this is not what women want. We feel child care should be determined by the specific needs of women and children in their particular historical context although we understood the genesis of the breast-feeding campaign.

Breast-feeding was taken up as a topic for debate and campaign by WHO/UNICEF due to the 1978 INFACT/IBFAN campaign against "Nestle" for, its aggressive marketing of powdered baby-milk substituting mother's milk in third world countries. The campaign brought about public awareness regarding the high infant mortality rate which was seen as a direct impact of the proliferation of powdered babymilks. In 1981, WHO adopted the International Code on Marketing of Breast-milk Substitutes and later in 1983, the Indian National Code for Protection and Promotion of Breast feeding was adopted by the Indian Ministry of Social Welfare. The Code was legislated in 1986, thus prohibiting advertisements not only of breast-milk substitutes, but also feeding bottles and teats/nipples.

The campaign in India was taken up, and among us were those who had first-hand experience of the kinds of half-truths that were being perpetuated. For example myths that breast-feeding is the contraceptive; even malnourished women can effectively breast-feed; it makes the woman more beautiful and creates a bond between mother and child; women should demand paid leave if they are employed and so on. UNICEF printed a calendar in 1983, which depicted a new stereotype of women "12 pages of breasts in shades of white and brown, various shapes and angles, mothers holding the baby at different positions staring soulfully into their eyes." In rural India, the mother is probably making chapatis and breast-feeding simultaneously! Hence these sorts of campaigns have no relevance to our lives and reflect a bias against us.

When we analyze the conditions in India, in order to understand the constraints faced by women with respect to breast-feeding, we find:

Lactating women need more calories: the mother secretes 400-600 ml of milk per day, which gives 350 calories to the child. For this she needs high calories and protein/vitamin rich food, otherwise the milk is produced at the cost of the woman. The woman usually eats last, and that too the leftovers, hence her diet falls short. Moreover, the undernourished pregnant woman gives birth to an undernourished child, who starts life in a disadvantaged position.

Breast-feeding is a problem for the working mother, especially if she is far away from home. Yet bottle-feeding does not solve the problems of poor women, because of the unhygienic conditions, shortage of drinking water and cost of baby food. There are no creche facilities available, and which poor woman can avail of "paid leave to breast- feed"? Hence poor women in urban and rural areas

continue to breast-feed their children for $1^{1/4}$ to 2 years, and their own health continues to deteriorate.

Our Concerns

Therefore, if Intentional Agencies were genuinely concerned about woman's health, then a campaign would have to focus on educating the family about nutrition, improving the unhygienic conditions, providing safe drinking water for everybody. The emphasis on breast-feeding should be viewed in context and the focus should be on introduction of semi-solid food for infants in the fifth month - food which is nutritious and palatable, and within the means of people.

Moreover, the overall health of women must be looked at from infancy. Therefore, we raised significant questions about discrimination against the female child:

- Are girl babies fed fewer times and for shorter periods than boys? Are boys fed on demand?

- Are girls given inferior food? Less food than their brothers? Deprived of milk?

- If a girl child is ill, is she ignored and treatment postponed till to late? Are body children more cared for and taken to hospital when ill?

Lastly, the crucial question: in spite of negligence how do girls survive? Are girl babies stronger than boys? There is no concern or research which is looking into this, but should we not investigate further?

Terminal Methods are being Propogated

Family Planning was taken up as a separate issue, as it is a major program of the government, and of first world aid agencies. As feminists, it is essential for us to formulate a clear stand on the issue, since it directly affects women, who are the main targets of the program as it exists today.

A broad description of the various aspects have been outlined in the paper in Chapter 5. The discussion focussed on one of the major components of the program, namely laproscopic sterilization. The incentive-disincentive approach was criticized. This was then extended to a general analysis of the entire program. It has been proved that since the introduction of this technique, the number of female sterilization's in the country has gone up considerably.

The method of laproscopy as a technique for sterilization, is a superior one and very effective if conducted in a hospital within the operation theatre. However, there are several problems when laproscopy is conducted on mass scale - with doctors conducting 100 sterilization's per day under the most appalling condition.

Field Experiences Depict Reality

Statistics give one side of the story the other lies in field experiences. Intertwined with experiences of how laproscopic sterilization's work is the story of incentives - money which is given to those who undergo a family planning procedure: and of disincentives - the policy of penalizing those who do not perform and provide the targets fixed for them. The feminist position was clear and undebated - targets, incentives and disincentives have to go and the reason for this are brought out in stark detail by the stories of the field activists.

Incentives allow women to be exploited. There are many examples of how in times of scarcity, or starvation, the number of cases go up but often the money never reaches the women. The experience of the women speak for themselves; women working in tribal areas of Maharashtra related this to visitors:

"We visited many camps. In one, the doctor said, he did 180-200 surgeries in a day. Women were standing as though in an assembly line. They were taken to the operation theatre and we saw the doctor dipping his instruments in an antiseptic solution and taking it out - this was sterilization. After tribal women were sterilized, they were made to leave immediately. At that point I asked why the doctor was making the women walk? He replied, "You won't understand, you are a city woman. Tribal women have a higher threshold of pain."

Other Side of Male Sterilization's

In three villages we found that the number of vasectomies were much higher than laproscopies. We thought that this was a tribal area, and men may have taken the responsibility. The next day we talked to the villagers, in order to find out the reasons for this anomaly: During the emergency, the tribals were told that if they got themselves sterilized the land on which they were living, which was termed as 'encroachment', would be regularized, therefore 85 percent of men in one village and 93 percent in another got themselves sterilized. All were men whose wives were in the reproductive are group. This was not really a matter of choice because if a couple was in the reproductive age group, and if the men did not get operated on during the emergency they would have lost their land.

This is not so everywhere. A major problem is that if there were mass sterilization's of men in a village and women got pregnant the women were thrown out of the house. Hence women felt that it is better for them (women) to be sterilized.

The myths around male sterilization are greater - men cannot lift heavy weights, and have a fear of impotency. Hence women in these areas felt that laproscopy - a simple method, which does not require them to stay away from home for over a day, was preferable. So they went in for laproscopy sterilization.

Incentives Pose a Problem

From Gujarat we heard, "There is a dramatic increase in the choice of terminal methods because people are being given money for it. A lot of people are starving. The government does not think of alleviating this by providing food for work or some sort of relief programs: instead they give money for sterilization's. The government officials must be happy this year, Gujarat will surely get the prize for sterilization's because of droughts. They do not ask what can we do about the drought? But instead say: "Good, we can promote family planning. We are already surpassing our sterilization targets for three months." The lean months and the financial year coincide, so the family planning department is in a hurry to reach its targets by March and that is the time of drought and when they ran get people.

This can have a negative effect on people. This issue of incentives is a very touchy one. If, at the field level, we ask rural women, they say 'We really feel

there should be more money given." This is where those of us who work at the grass roots level are facing a lot of problems and contradictions.

Incentives are at two levels: for the 'target' and for the 'motivator'. Some-times this has a detrimental effect as an experience from an urban area shows. "In slums, women who have IUD's inserted get paid Rs. 20. It was discovered that local slum-lords (males) were rounding up women to have IUD's inserted in one hospital and removed in another; this was being done repeatedly. It is difficult for hospitals to keep track of the women since different names are used each time, and doctors do not usually recollect the faces of poor women."

Health Staff Pressurized

While discussing incentives we did not forget the issue of disincentives - disincentives for the entire health staff of a primary health center. "When we met the Auxiliary Nurse Midwives (ANMS) they said that they spend their own money to achieve the targets. We don't receive incentive money, but there are many disincentives which we face if we do not fulfill the targets -job harassment, sexual harassment, job transfers. We have not attended a single meeting in which ANMs do not cry. They are afraid."

A member of the nurses federation who was present talked about her experience, "There is a compulsion for nurses and ANMs to complete the targets set for them, otherwise their yearly increment will be cut. Therefore, the nurses go out and find cases, they send these to the doctor who then prepares the list. Even if 30-35 people actually come for the operation, the record states 50. Often the names on the list are false. These are the records sent to the state and central government." When asked whether the federation had taken up this matter with the government, we were told, "We do not have any proof on paper, how can it be possible?"

We felt depressed the nature of the discussion, yet we realized the above are glimpses - the experiences can ramble on. The family planning program is completely controlled by the state, and they recommend only those methods which are in their control. Why does the government distribute condoms for men along with adequate information about how to use it? Why is there no involvement of people - of women? Why are safer methods with abortion as a back-up service not being propogated?

We had wanted to discuss each of the contraceptive methods being propogated at greater length. However, we found that time was running short. Instead, we felt that it was more essential to fully understand the principles on which the FP program was run, so that we could formulate our own alternatives. So the discussion instead moved on to the controversial issue of abortion, which is also a method being used in the family planning program, whether stated or not.

Abortion: A Woman's Choice?

The discussion on abortion started on a controversial and heated note: It was suggested that safe and free abortion should be available at the lowest level of the government health care service. This trend argued that if women used some method of contraception and if this were found ineffective then an abortion should be made available to her, as her choice.

However, many cautionary remarks emerged:

1. The safety of repeated abortions

2. The present procedure of abort ions conducted in government hospitals

3. The problems of putting abortion in control of the State.

There was much discussion about whether the dangers of repeated abortions was not equivalent, or more, compared to the dangers of contraception and if so where should a woman's emphasis lie?

"In a study, under very controlled conditions, it has been shown that there are approximately 68 deaths per 1000 abortions whereas in other developed countries the rate is 5 per 1000. We agree, we do not wish to perpetuate a method which can kill women.

However, our statistics tell us that in India during the past 13 years only 4 million abortions are, on record, conducted 'legally' in hospitals. More than 50 million abortions are done outside. Don't we need to educate women? Don't we want to tell women that contraception has hazards, but abortion under

unhygienic conditions has still greater hazards. Why not educate our women? And help them get access to a method which gives them greater control.

The women from rural areas felt: "In the village where we work we find the women having an abortion once or twice in a year. If we take the girl to a government hospital the doctor asks if she has had an abortion in the last year. If the woman wants to go ahead, they say it is not good to have another abortion and suggest having the child."

In response to the situation in rural areas it was said, that it sounds like the women in the village are using abortion as birth control. If they are having two abortions a year, it is not really advisable, given their low nutritional status and the fact that many of them are anaemic. In Gujarat we have also recently found, in clinical practice, that a lot of women who have abortions in government hospitals have all lands of complications that develop later on. They are later told that they need to undergo a hysterectomy: they have erosion of the cervic and the possibility of cancer. So I think we have to be careful - abortion as a contraceptive method may not be advisable, when other things may be available. This is more significant given our situation where health facilities and follow-up procedures are poor - especially in rural areas."

Therefore, it was important to distinguish whether abortion was being advocated as a method of contraception or as a back-up service. The former is not to be recommended, yet it is covertly being used as a method the current family planning program. The feminist stand should be to demand a safe method, and in the event hat this is not effective, then abortion is the right of a woman, should be available, free and under safe conditions.

Lack of Facilities in Existing Health Systems

Despite legislations and rhetoric about abortions and existing government facilities, very few abortions occur in the legal framework. Why is this? Experience from the field shed some light:

"I will just talk about Ahmedabad. At the moment, in municipal hospitals an abortion costs Rs. 190; this is a lot of money for poor people and we were very surprised about this. It is probably the composite cost of medicine and after-care, but it is Rs. 190. Hence this is something which we should look into. Surely in our government hospitals abortions should be free and safe? But it is not so in

practice. When some of the women came to us we took them to a private clinic. If they have to pay for it anyway, they may as well be assured of the facilities." A poor comment on the public health system!

"In J.J. Hospital in Bombay, free abortion, is available, but it is linked to family planning. We know of this bad experience: a slum woman was deserted by her husband and she found herself pregnant. She went to J.J. to get an abortion, but they insisted that they would only do it free, if she agreed to have an IUD inserted. She tried to explain that she did not need it in her present circumstances. The doctors insisted on the IUD and finally, not knowing where to go, she agreed to the condition. The irony was that the IUD was inserted so badly that she bled continuously. Every time she returned to the hospital and told them that she was having a problem, they said she was psychologically disturbed because her husband had left her. It was only after a month and a half that it was realized that the IUD had moved into the fallopian tube, causing the bleeding and therefore had to be removed. After that, no other woman in that entire community, would approach that hospital for abortion or family planning information or even health care!! Can they be blamed?'

"In the tribal areas, we were in the Panchmapal district of Gujarat - the hill tribals, Bils, live there. They are mostly illiterate. In these places when the women get pregnant and they want to abort the child they have to travel 20-25 kms. to the nearest hospital. Once they reach there they are harassed by the doctors. If the tribals do not have money they are asked for food grains. So, these women do not approach the hospital - they get their abortions done by untrained dais or untrained traditional birth attendants. But then they end up in septic birth abortions and many women die due to septicemia." Therefore the existing services are hopelessly inadequate and do not fulfill the needs of women.

It was also pointed out that in India, legalized abortion was not a result of the woman's movement but was a response of the State as part of the population control program. It is certainly not seen as women's control over her own body. It was felt that if contraception, as part of the FP Program is coercive, so also is abortion.

Since we argue that contraception should be in our hands, child birth and delivery should also be in our hands. Yet we have no position against the State control of abortion today. Especially when the MTP Act has come, not through our demands, but through the whole family planning system. Is our current position about abortion, following our western sisters who raise the issue of

abortion in their situation? And are we following their position without sufficient analysis here?

Contraceptive Research and Testing in India

As feminists we are concerned about the contraceptive research and testing currently in progress in the country under the auspices of the Indian Council of Medical Research (ICMR) and the World Health Organizations. The concern about these current practices is at various levels: the present methods being tested are those which will ultimately be used on a mass scale in the national family planning program. Do we agree with the use of these? If we are against the current methods being tested (as we are) then how can we influence the government to test other more favorable methods? Moreover, the current methods are largely being tested on women, and ethical procedures are being violated. Can feminists act as vigilance teams to ensure that women are not unknowingly harmed in the process? Is it possible to evolve our own testing procedures and make recommendations to the government. These were the major questions in our mind, and we had several detailed discussions in an attempt to arrive at a position.

The real question in front of us was whether we would be able to keep pace with the scientists? The new methods being 'sneaked into our lives' are those which are taking control further and further away from us. First there was the pill, which had to be swallowed daily, then the injection (NET-EN) which was given monthly or even bi/tri-monthly, then the vaginal rings implant, etc., which remained in our body for six months to years. Today we know of these, tomorrow many more will be added to the repertoire. 'Basically they are the same steroids, in different combinations, which are introduced in different places in the body through different methods - an injection, insertion or an implantation.'

Do we understand how these methods have been 'discovered'? We are told that the are first tried on animals; when these are found to develop harmful side effects the trials are discarded as being 'not representative enough'. The studies show that scientists first used beagles as a model, the logic being that, 'beagles are the most sensitive animals and if it does not harm the beagles it will not harm anybody else". But unfortunately it did harm the beagles, therefore the argument now became, 'beagles are the most vulnerable animals, and if it harmed the beagles, it does not mean it will harm anybody else". So this becomes like the tale of the chicken and the egg.

Different animal models have been used - beagles, rats, monkeys, none of these have been found 'good enough'. Yet WHO has recommended that human trials be allowed to proceed. Does this mean that third world women are 'good enough'? For scientists studying leprosy, they have found an obscure creature such as the South American armadillo which suited their purpose. For the past twenty years in contraceptive research, why is it that scientists have not been able to find even one model in the animal kingdom that is representative enough?

Apart from the side-effects of these hormonal contraceptives there are other types of side-effects such as diabetes, hypertension, accumulation of fat, effect on the central nervous system, nausea, weight-gain, giddiness, to name a few. Hormones are very difficult to understand biochemically and we sometimes wonder whether the authorities understand their functioning at all. Until very recently one of our problems was that we did not know any concerned or sympathetic doctors who could help us interpret scientific literature and 'translate' it into English. However, now there is a technical committee which has come into existence to support the case against NET-EN which is pending in the Supreme Court. This is made up mostly of doctors, and we suggest that this committee take up all other forms of hormonal contraceptives and enhance our 'scientific understanding'.

We are aware that these contraceptives are being tested all over the country, but we have not monitored the extract locations and what is actually being tested. We know for example that implants are being tested in Ahmedabad; KEM hospital in Bombay is currently testing various methods which are in different 'phases of trial'. But it is difficult to gain information about women in the rural areas, "particularly since doctors are doing this without telling prospective patients. Hence an woman who has a gynecological problem may be used as a test case. It is very difficult to find out such information from rural women. How do we talk about it? The people don't even seem to be aware that such things exit."

However, this is not a uniform problem. For example in poor urban communities the word has spread that new types of contraceptive technologies are available. There is a lot of information and misinformation being spread. "The other day someone came and told us that they had heard there was an injection which when given, meant a woman will not get a baby for the next ten years. Is there such a thing'? Hence the issue of misinformation, lack of information and confusion may be taken up by those of us who are doing consciousness-raising

and awareness work with women. These are the types of areas we need to explore in order to explode the myths which are being perpetuated.

The crux of the matter is that testing is going on in the country, poor women are being exploited in the process, hence women's groups should form 'vigilant squads' to expose these practices. The example of NET-EN was cited: the way the testing is being done raises 'moral' issues. The argument the Supreme Court consists of conclusions arrived at during testing, especially about the side-effects. However, when some women went to the KEM hospital they found that the staff there did not have any information -they did not even have a record about the menstrual cycle of the women under trial! Considering that 'disruption and chaos in the menstrual cycle is one of the major side effects of NET-EN' we wonder how these are determined.

What do we want?

Often, when we expressed our view that we are against harmful contraceptives, we come up against the argument that 'even antibiotics are harmful, but one must be scientific enough to understand that antibiotics are required." However, this is irrelevant - antibiotics are used on an unhealthy population, whereas dangerous hormonal contraceptives are meant for healthy women. According to the 1981 census there are 11.6 crores of married women in the reproductive age in the Indian subcontinent. If hormonal contraceptives are to be used as a spacing method (which indeed is the recommendation) then all of these women will be potentially exposed to this at least once in their lifetime. Therefore, there is a tremendous market for the production and sale of these.

Our counter-arguments to the above should be:

1. Harmful contraceptives cannot be compared to harmful antibiotics.

2. In order to counter the side effects of these contraceptives we are given more drugs, which may be harmful in themselves.

Therefore, we now need to put our energies and resources together in order to articulate what it is that we want.

We went through the various contraceptives methods which we know of.

Barrier and Rhythm Methods

Women working with poor communities felt that this posed three major problem: storage in their small homes was difficult; often women were not 'prepared' as their husbands would come in drunk and demand sex; education about how these methods worked was of primary significance. An example was cited wherein a woman was using the diaphragm cream on her face after her children had played with the diaphragm thinking it to be a katori (a bowl). However, it was universally acknowledged that barrier methods were safe and effective, especially if used along with the rhythm method. There was a query as to whether creams, jellies and foams were harmful. Although it is said that they lower the incidence of sexually transmitted diseases (SID) it was still felt that introducing too many chemicals into our bodies could be avoided. Thus, in combination with the rhythm method, these creams would have to be used only during a couple of days a month. The other advantages of the rhythm method was that women would become more aware of their bodies, also, that it demanded male participation.

Various types of diaphragms which we discussed were said to be difficult to use since privacy is needed. However, there is another method called cervical cap, which does not seem to be available in this country at all. The information about this revealed that the woman could insert it herself, and remove it only after 21 days, for menstruation. There was some disagreement over this, as another opinion was that it was more difficult to insert as it had to fit exactly over the cervix and this was not as effective as the diaphragm. There was also the mention of a new method, a mushroom-shaped sponge which when inserted acted as a barrier method. However it also contained a spermicide. Moreover the sponge also absorbed the semen-making it have a three-way action. It is a disposable sponge, which is said to be very elective. But again, not available here.

There is no dearth of barrier methods available, but they are considered as ineffective because the "failure rate is higher". The role of education in ensuring that this is not so cannot be over-emphasized. Even in the case of male contraception such as the condom, if the method of using this is carefully explained, the success rate' is high. Nor does it have any harmful side-effects. But it is not advocated since it requires male co-operation. Should this not be more extensively thought about? We also stressed the need for developing more methods of male contraception. However, we did not think that men should be subjected to harmful methods either. There is an urgent need to focus attention on this.

We often find that when we campaign against harmful methods we are labeled as being anti-contraceptive. That we are not, for we believe that women should have the freedom to choose. Perhaps in theory the government has a cafeteria method, however in practice coercion and incentives are used in the government programs. Moreover, we do not agree with the present methods of research and testing. Is there another alternative?

How Can We Work Towards What We Want?

It was clear that we need to evolve a feminist methodology of testing contraceptives, but what is this? Since we had thought so carefully about what we wanted in terms of methods, it was essential to also think about how information about these methods could be disseminated in order to facilitate women's choice in the matter. That was one aspect in which it was unanimously agreed that education played an extremely important role. It was even suggested that the government be requested to stop spending vast sums of money on the incentive schemes in the family planning program and use this budget instead for education. It was also felt that if we acquired a clearer understanding of why we did not want harmful methods, we could recommend to the government which methods we wanted to be tested. But perhaps the government may not be willing. Besides, it was also felt that since we basically did not agree with the methodology of the government, could we not do this testing ourselves?

The essential principles we identified were that these methods should be made available in India; tested here on Indian women; the methods should be safe and reliable, and we should constantly try and develop other methods. These would be discussed at the field level to see how practical they were in the given environment. A group related their experience of research conducted using cervical caps. They had requested a women's group abroad to send them a supply and had given these caps to women in their area. If we can co-ordinate this type of 'feminist testing', then it would be possible to get official clearance.

Another opinion was that since most of the volunteers were picked out from the poorest sections - who had no awareness about these issues - perhaps we should do the testing on middle class women: "Why not ourselves"? In this case the women would be fully involved, and be able to give their 'informed consent'. However, this still did not resolve the larger issues-testing on middle class women would merely be focussing on a particular section of women - what about the masses? However, this sort of research among ourselves played a

significant role in developing and testing the efficacy of methods and ensuring their safety. Whether the same could be practical or poor women was to be seen.

Those of us who worked at the field level with poor women felt very strongly that they should be included as participants. Perhaps we were imposing our 'middle-class view' on them? We felt that poor women are eager to have access to contraception. At the moment the methods which are available are not relevant to their needs. Yet they are the victims of the coercive population control policy. In order to include these women in the decision-making process it is essential to understand their perceptions about their sexuality, and get them to articulate their specific needs related to contraceptive methods and the constraints which they face.

Thus research was required at two levels: research into the methods themselves, and field-level research into how these could be used effectively.

Even if we did not arrive at pat conclusions and chalk out neat little action plans, we felt good after the discussions. They had taken a positive note. Our emphasis certainly was on criticism of the government program, but a positive outlook also emerged. We felt that if we worked together in 'helping ourselves', then we are not bound to accept what is continuously being dumped on us and, we could walk hand-in-hand with our poorer sisters' towards gaining greater control over our own bodies.

New Reproductive Technologies: Our Fears

Unlike other discussions in which we have voiced our concerns, the issues raised regarding new reproductive technologies were scary. This is because the invasion of technology in women's lives was leading to a situation in which they would have less and less control. The fears expressed related to whether women would now become an endangered species. Can one class of women buy their reproductive freedom by hiring out another woman's body? Are we heading towards a commercialization leading to the most blatant slavery?

The two major aspects were: (a) Whether technology can be neutral. Who defines use and misuse of technology? (b) Women's capacity to bear children has been the root of her oppression. The current development of NRTs are not going to liberate women from this, but instead cause a greater oppression of women especially in the third world.

When we talk about being anti-amniocentesis, we are told that we are anti-science and anti-development. Therefore, we have to re-define what we mean by development in science, development of technology, what is use and misuse? Who controls technology? Is technology without control, ever neutral? Because of the kind of research being funded today and the values placed on it, it is difficult to project whether a technology, is going to be harmful or not. But it was felt that we can use some sort of guidelines about our reactions to technology. That guideline is not that nature can be controlled, but whether the development of a particular technology is in harmony with nature. Where it is not, there are problems. The whole issue of genetic engineering is horrific, because it is against the very forces of nature.

Imperfection of nature means somebody decides what is "imperfect," and therefore "perfection" can be achieved only within a genetic lab. Who controls this type of technology and for what purpose is it used? Whether it is used or misused are also terminologies defined by people. We might say that misuse of amniocentesis is when a female foetus is aborted but someone might say that amniocentesis is a misuse in itself, in the very act of aborting a deformed foetus. Therefore who defines use and who defines misuse?

There were some who felt that the basic assumption of a technology such as amniocentesis is that mentally retarded people have no plate in our world, anybody who is not normal has no place in our society. Efforts are not made for their existence. This was not there previously in rural areas. People would take care of the mentally retarded child. Today we are therefore, becoming more dehumanized.

What can happen to us is an extension of gene technology used in producing better varieties of hybrid plants and hybrid species. The danger is that these technologies can be used for selecting certain races, certain colors, certain eyes. The idea of controlling and exploiting nature is alien to us, and it can only lead to destruction. When we talk about a better breed of human being it is frightening to imagine the kind of effects it will have. As feminists we feel strongly that we must live in harmony with nature.

Can Technology Liberate Women?

It was felt among some of us that the root cause of women's oppression is her capacity to bear children. Can these technologies help our liberation? Take, for example, a sterile women. It may not be necessary that all women would like to

adopt a child; or may want to have the experience of actually producing the baby. This is a factor one must take into account when we take a position on medical technology. Otherwise we will be saying that we are against any kind of new technology.

The main issue to understand here was that these technologies are imposed upon sterile women, but they are not told about the painful nature of the tests they will have to undergo, nor the side-effects of the large scale of hormonal drugs which are introduced into their system. Hence it is really worthwhile to undergo this level of stress and physical/mental anguish? Is adoption not a saner alternative? Besides, given the present conditions of infant mortality and child survival in our country, can we justify the expenditure incurred on development of these technologies?

Another question related to these technologies was: "Biology is our destiny. It is because of our biology that these technologies are developed in the first place. Can't these technologies really relieve us of reproduction? And that freedom from reproduction can increase our status in society?"

A response to this was that when we looked at the issue of surrogate motherhood it was clear that a womb is required. That womb is going to belong to some other woman, just as there are prostitutes who are selling the lower part of the reproductive tract, now the upper parts are also going to be available. The bearer of the child is not going to produce the child that could be genetically hers, there is also the question of from where the reproductive material is going to come?

Reproductive material for a human being consists of sperm and an ovum. The ovum will either come from a surrogate mother in the third world, or from white middle-class women. The sperm is going to come from Einstein or some Nobel-prize winner. In this case one is giving up entire control of one's entire body. There is the possibility of more and more control… the sperm and the egg will come from a dominant class and other women will become bearers and reproducers.

Is this 'liberation'? Can we see these technologies as even having the potential to liberate women? There are going to be so many changes which are possible as scientists to conquer the imperfections of nature. Do we want this brave new world?

Do we want women to become endangered species because women are no longer needed for bearing a child? Every women has so many eggs, if some way of using this concept is found, only a very small number of women are needed. This could become a widespread policy, and women could be killed, or allowed to die, or not produced at all.

As feminists we can be clear about one thing, we may be the bearers of children, but we are not reproduction machines. This is our own body and we are capable of a particular biological function; these are our strengths. Do we have control over this? The next step should be to do away with the concept of a reproduction machine and therefore, any differences that exist between men and women are also done away with, leading to an equality of sexes. Is this what we are aiming for? For that is the logical end to such an argument.

When we discuss new reproductive technology we should not limit ourselves to just the economic classes -north/south/first world and third world discrimination. Patriarchy is not eliminated so easily, as experiences of all post-capitalist societies show women's sexuality is as controlled as in first world countries. For example in east European countries, where more population is needed, women are used as baby, machines and the state gives incentives for producing more babies. While in China, where there is a one-child norm the couples agree to have one child, but the child has to be a male. As per a World Bank report 45,000 female babies were killed in China. The World Bank still considers it a minor problem. The new reproductive technology have a very strong anti-women bias. Therefore, our fundamental concern should be survival of women when we discuss new reproductive technology.

Women Health Workers: How do we see them?

There were two questions that were bothering us so we put women health workers as one of the topics to be discussed. Firstly, have we as a 'woman-and-health movement', identified with any of the struggles of the female health professionals in our country? Should we do so? How can the feminist movement support what is one of our most crucial working forces? Not as a working force, but as deliverers of health care. The second issue which we needed to discuss was how we can interact more with the various female health-worker networks. What are the barriers? When we have our feminist ideas, perspectives, campaigns, we have not really interacted or drawn them into our concerns. How can we do so? What are the problems and what is the potential?

This was a difficult proposition, and we felt that this is the first time we have collectively discussed the issue at length. None of us had any direct experience with the health cadres in the country, hence we felt it would be useful to first understand what the existing situation is like.

The old story that doctors are not willing to go to the rural areas is not true any more. Today there are more people from rural areas who have access to medical education. These doctors are more comfortable in the rural set-up - they find the government services very helpful and therefore they return there. The result: these doctors displace the auxiliary nurse midwives, from their quarters. Because those quarters are occupied by doctors, they are not available for the women so she has to find a place in the village, where she is less protected. If she is not married, she may be called at any hour of the night, has to live in an environment where her security is very much at stake.

Her very existence is threatened not only by the rural people, but also by political workers who hold important positions. She is thoroughly exploited in every sense also by her own professional colleagues (apart from physical exploitation). She is liable to be transferred anywhere if she does not meet their demands. The demands go beyond just sexual demands.

The doctors who are supposed to provide free services charge money. They liberally give injections, (many of which are not good for the patient) and can earn upto Rs. 150 daily. Now a lot of work has been generated because of family planning and community health work. The ANM is expected to do whatever the doctor asks, therefore a lot of responsibility is passed on to the paramedical staff. These ANMs are not only over-burdened, but their training is insufficient. For example, they are required to give ante-natal care, but they do not have sufficient skills to do so.

It was strongly felt that we should try and see if we can align ourselves with these small movements of health workers. "Let us try to understand whether the" "women and health" and, the feminist movement, has really tried to identify and support the struggles of these workers. An example - six months ago the family planning health workers in Maharashtra had taken out quite a big demonstration, their basic demand was - the government had decided that IUD's can be put in by even ANMs - they were not going to do this because of insufficient training and their own fears regarding protection. They were also against the whole target approach.

The ANMs were struggling against this, saying, it was putting them under phenomenal pressure. There have been several issues and demands like this. So far the women's movement has rarely identified or, kept in contact with, these small struggling federation and unions which are developing, What can we do?

There have been cases of nurses who are raped and murdered. These go by unnotified. Therefore the crucial question ahead of us feminists is whether we can lobby with the government. Can we not take this up as a campaign, and struggle along with the nurses? We were wondering whether we could also get involved with the training of the women health workers. Some of us have experience of working with health groups. These were some of the ideas, however, we did not discuss at length. We feel that we have made a small beginning towards supporting these concerns.

Work and Ill health

The issues around occupational health were the following: One of the major causes of problems for women at the work place was the lack of legislation for women workers; hence experiences with the court were related. We discussed the types of problem which women faced, with examples of factory and agricultural workers. We also heard from the nurses present what their problems are. Finally, there was a question mark about the role of unions.

The lack of prevalent legislation could be seen as an issue which we could take up; a lawyer present pointed out that if we could prove that a particular health problem is linked to a specific occupation, then for formal sector workers, the Employment State Insurance (ESI) Scheme is applicable. We can work towards getting the ESI Act amended, so that all workers will be covered by the Act, and hence the ESI Scheme. One approach to this would be to ensure that those workers who are presently covered by the Unprotected Manual labor Act get included in the ESI Act. At the moment, the number of hazardous occupations and substances are listed as 23 under the Factories Act. Certainly our experience has shown us that this list needs to be expanded. Therefore it is up to us to examine the materials which women work with, and to document the hazards which they face. A comprehensive list would be useful for influencing legislative policy.

We heard about an experience of organizing asbestos workers for better working conditions. A writ petition against three asbestos companies has been filed in the Supreme Court. The harmful effects of X-rays was used as evidence of the

hazards of working with asbestos. When asked about protective clothing, the companies argued that the workers are not willing to wear protective clothing. However the workers pointed out that the kind of clothing supplied was imported directly from developing countries and therefore not suitable for our conditions. Their demand was that either the protective clothing be modified or else the entire, factory be air-conditioned. At the time of discussion the case was still pending in the Courts, it was heartening to hear that the Courts had considered the present protective clothing to be highly unsuitable.

There was interest in specific problems faded by women at their work place-were all these hazardous? Experience has shown that the persistent problems are less dramatic, but of a more chronic nature. For example, the conditions at work result in persistent headaches or backaches. Very little is known about the root cause of these ailments. Researchers and Health Personnel do not find these either acute enough or dramatic enough to examine at a medical level. Therefore agricultural workers continue to face low back pain.

We shared our knowledge about how these symptoms maybe partially alleviated. For example, special tools, for agricultural workers have been devised and can be used. We also heard about the experience in Ahmedabad, where it was found that the problems faced by beedi workers were linked directly to their posture. Therefore corrective measures could be found. These experiences need to be widely documented and shared, so that at least some of the health problems are avoided.

It was suggested that attention be focussed on agricultural workers-their exposure to the sun, chemicals, pesticides and hazardous work processes. The question of maternity benefits for women was raised. We heard about a pilot scheme conducted by SEWA in two of the villages where they work. Women received maternity benefits such as ghee, a safe delivery kit and enhanced ante-natal care. Based on these experiences, recommendations were made to the government, both at the State and the Central level.

In Gujarat, the Government has initiated a scheme through the labor ministry, where landless women workers receive, maternity benefits such as minimum wages upto six weeks for the first pregnancy and upto four weeks for the second. However, this had not been implemented because of bureaucratic delays. It was also felt that women were unable to demand implementation of the scheme since they were not yet organized to do so.

The nurses present described the work-related problems they faced: these included backache, varicose veins, risk of infection from various diseases including hepatitis B. Moreover the long hours of work and restricted sick leave exacerbate the problems. So far, there has been no move to resort to legal action in order to counter these problems because of lack of funds. The concept of 'suing' does not exist in our country.

Finally, an interesting point was raised regarding the importance that unions give to health issues. It was observed that wage issues always take precedence, because of the obvious economic pressures on workers, often at the expense of health and safety issues. At the same time, it was felt that by sharing our information, increasing our visibility and by empowerment through organizing, we can begin to tackle the numerous health issues that women face at their workplace.

Discussing Sexuality: How do we Raise the Issue?

When this workshop was being planned, it was mentioned that there would be some informal discussions on sexuality as well and some people felt that the organizers were opening 'a Pandora's box'.

The workshop was held, the discussions took place, no lethal fumes seem to have emanated, we are still all in one piece. In fact, having made a start to talk about 'these things' which remain otherwise highly 'tabooised' or subject to crude jokes, left us with a certain sense of relief.

Why, in the first place is it so extremely difficult to talk about sexuality and why is it necessary to do it all the same? It seems to be very difficult to find even approximate answers to the first part of this question. What precisely is the taboo which is attached to talking about sexuality, especially as far as women are concerned? How much of this taboo is `Indian', how much is `Victorian'? How much is `middle class'? Or is it, on the hand other hand, precisely very `middle class' and `westernised' to want to talk about sexuality? How much have we ourselves internalised the prevalent cultural stereotype that men are sexual beings who have a birth right on sex, but are basically exempt from cares about fertility? How much do we see ourselves primarily as child-bearers and sexless mother animals satisfying our need for physical contact through mothering and undergoing household chores?

In India, the need to discuss sexuality seems to emerge much more as a tailpiece to the discussion of fertility and fertility control. The compulsion to get and remain married is overwhelming. A single woman is supposed to fall prey to sexual harrassment. Thus, marriage often appears like a haven of freedom from sexual harrassment. What is being projected here?

Bearing children is as compulsory as marriage. An infertile woman remains an ill omen (and the assumption is always that it is the women who is infertile). Escaping into `motherhood' often appears as an escape into sex-lessness. This has to do with the over-all assumption that consent to marriage is an overall consent to have sex with one's husband at all times and of course with no one else at any time. The whole concept of marital rape appears extremely alien. At the same time, many women experience their first intercourse as highly traumatic.

The compulsion to have sex leads to the compulsion to use contraceptives. It is often only when the disastrous side-effects of contraceptives on women's health become visible that their total lack of control over their own body becomes apparent. Often this is the point where discussion on sexuality starts. It is usually a discussion on suffering. Sexual desire and fulfillment of desire remain peripheral. The sense of shame which becomes visible in these discussions is real and needs to be respected. Even speaking of sex, we make ourselves vulnerable. But only by conquering our own vulnerability, saying yes to it and transcending it, can we become capable of developing a new wholeness and sovereignity.

One of the aspects which surfaced during the discussions was the observation that sex is not a biological but a social event and that attitudes towards sexuality are shaped by caste/class factors, are highly culturally specific and gender-specific eg. it is often observed that among tribal communities sexuality is handled more liberally and somewhat less male-centred. Among low caste/working class women, sex is often described as a daily household chore, the sexual demand of the male being unquestioned and the role of women being expressed in terms of "beast of burden".

Another important factor is the fact that marriage is virtually compulsory and that begetting children is imperative. This means that sex is highly institutionalised and functionalised. Among middle classes as well as among working classes men see the need to get married when their mothers become too old to work for them.

The need for a wife has primarily to do with the need to have access to the facilities of survival: cooking, washing, cleaning, emotional support and sex are all part of a package deal of facilites to which a man has a birth-right. The other side of this coin is that women are brought up to provide all these services, including sex. What they are promised in return are `protection', `security', `respectability'.

It is obvious that this arrangement is upheld by the constant threat of violence. While a woman is trained in housekeeping to provide these services expected of her in the proper way, she is not told about sex, except that men `expect' it and that she has to `obey' her husband's wishes and to `adjust'. There are marriage vows in which a husband promises to `love' his wife, while the wife promises to `obey'. This has obvious implications for the physical side of the relationship as well. Sex is thus completely removed from her own subjectivity, her body is the `property' of the husband and decision-making about her own body, be it with respect to sexuality or fertility, is conceptually ruled out.

If quite a number of women start to assert their rights over their own body after years of marriage, this happens in defiance of the dominant ideology and social arrangements.

While all the activists present agreed that a woman has a right to control her own body and to enjoy sex, it was obvious that most of us have not really resolved this problem in our own lives. This has partly to do with the fact that consciousness grew during a married life which had been started under more traditional assumptions. Even feminists find acceptance to sexual rights of single women at time difficult. Another factor seemed to be that many of us did not give sex a very high priority in our lives. Our priorities are freedom of movement, equitable division of labour, getting our work done, advancing the women's movement, coping with children.

Most of us did not seem to have sex very frequently or be very dependent on it for emotional gratification. While there was a certain regret expressed on possible missing out on something beautiful and important, it was also acknowledged that perhaps one can't have `everything' in life. A person with whom one had enjoyable sex is not necessarily also a person who respects one's work and convictions and agrees to a fair division of labour. Likewise, a person with whom one agrees on priorities, lifestyles and division of labour, need not be sexually most attractive to us. Sexuality therefore can only be seen in the overall context of our life options and sexual gratification and freedom is only one

criterion among others to measure the content of relationships and the quality of life. Western lifestyles have often given such an over-emphasis to sexuality that it could not be understood in this over-all context.

Discussions on sexuality in a feminist perspective are not discussions about `free sex' but about power relationships and violation of human dignity. During the workshop, when we tried to define what we meant by control over our sexuality, we said: We want to be free to decide how we physically, emotionally and intellectually relate to others, men and women, and our whole social environment, and we want also to be free to determine how others relate to us, we do not want to be made objects or mindlessly follow prescribed roles.

The present pattern is that women are `property' and that men are not answerable for their sexual behaviour. We are striving for a situation where no human being is owned by another, but where everybody is answerable in mutual responsiblity and compassion. Intercourse requires consent, including in marriage, and violence has to be eliminated in every form inside and outside marriage. Sexual freedom cannot be the freedom of a consumer society which makes sex a commodity and human beings, objects. Being knowledgeable about our bodies and learning to love tenderly sounds simple enough to taks, but the barriers which prevent us and others from doing so are gigantic and need to be dismantled piece by piece.