Canadian Policies and Practices in the Areas of Reproduction, Population, and Development

by the Canadian Women's Committee on Reproduction, Population and Development

Cet article est extrait d'un rapport qui présente une analyse féministe de quelques politiques et pratiques internes et externes sur les technologies de la reproduction, le contrôle des populations et le développement. Les auteures critiquent les politiques actuelles de contrôle des populations et elles préconisent certains changements aux politiques canadiennes.

While certain groups of women are encouraged to limit the number of births, technologies are being developed and used to encourage other groups of women to have more children.

In the Spring of 1993, women from across Canada and Quebec met in Ottawa to talk as feminists about population and development issues. Many of us had been part of dialogues on population issues with women internationally in the past decade and had expressed a desire to analyze the issues from a Canadian perspective, as well as to bring the debate to the attention of a larger Canadian public. As a group with a broad range of experiences working in Canada and internationally as activists and as researchers, we wanted to counter the assumption that rapid population growth is the major cause of poverty, hunger, and environmental degradation.

We discussed, among other things, the rapid development of reproductive technologies and their impact on the lives of women in Canada and the Third World. We talked about how we perceived population control[1] programs as an infringement of women's reproductive rights[2] and health. We also discussed the lack of access to appropriate and integrated health services for women, including birth control and family planning services.

We have continued to consult as we prepare for the UN Conference on Women in Beijing in 1995. The *Canadian Women's Report on Canadian Policies and Practices in the Areas of Reproduction, Population, and Development* aims to contribute a feminist perspective to discussions about these issues, rather than attempting to be "the last word." We are asking other groups and individuals to endorse and build on the *Canadian Women's Report* and use it in their educating, organizing, and advocacy work.

Canadian federal and provincial health policies

While Canada's population continues to grow, the overall fertility rate is dropping. Some predict that in the absence of interventions such as an increase in the number of immigrants, Canada will experience negative growth in about 20 years (Inter-Departmental Committee). At the same time, there are growing concerns about Canada's aging population, about the decrease in Canada's wage-earning population, and thus about the ability to ensure people's welfare in the future. Within this context, cutbacks have already been made to unemployment insurance, health, and education programs. As part of the cutbacks to health services, there is now less access to services for birth planning and abortion.

It is assumed by many that all services for birth planning and abortion are equally accessible to all women. However, there is considerable variation between provinces, as well as within provinces, where access to services often depends on age, race and class, and the attitudes of local governments and medical professionals.

Women in small towns and rural communities, in particular, have difficulty accessing abortion services and securing confidentiality. For example, in Prince Edward Island women cannot obtain abortions because there is no doctor who is willing to perform them. It is doctors who control the conditions under which women can have abortions. Some doctors use unnecessary invasive techniques such as general anaesthesia and routine antibiotics. These techniques may facilitate the doctor's job, but pose extra risks to women (FQPN).

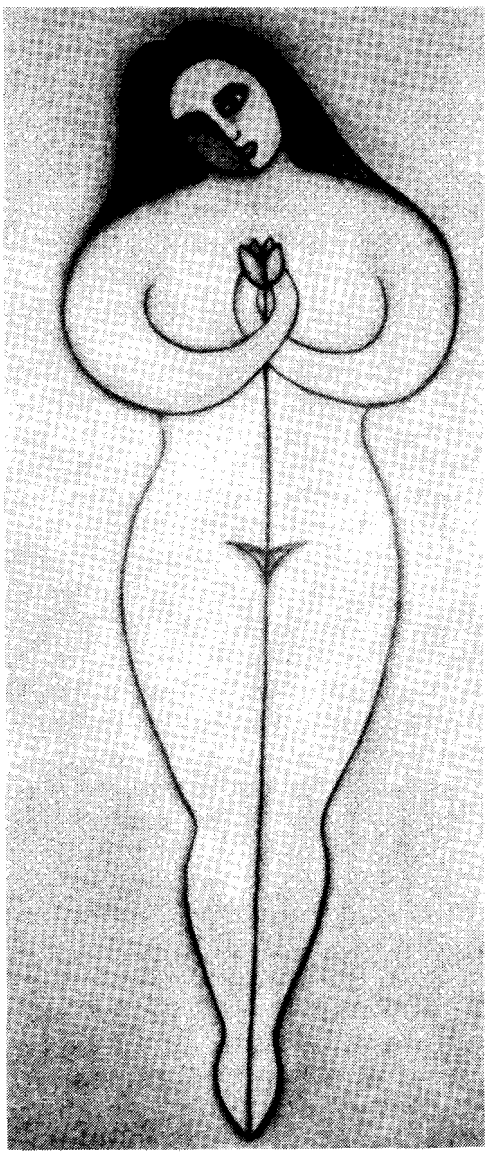
While certain groups of women are encouraged to limit the number of births, technologies are being developed and used to encourage other groups of women to have more children. Many of these fertility enhancing, "new" reproductive technologies (NRTs), are high-tech, invasive, and costly, and are still in an experimental stage. White, middle or upper-class couples have preferential access to nrts (Phillips). Although NRTs allow a small percentage of women to have babies, they do not address underlying causes of infertility such as the increasing prevalence of environmental contaminants.

Both high-tech, long-term contraceptives and nrts place the control over women's reproductive capacities in the hands of service providers. As well, little is known about the long-term effects of many of these technologies on women's health or on the health of the children they bear.

Prenatal testing as a means of screening out disability is a subtle form of population control and is part of a eugenics[3] agenda. These technologies can only verify some infant disabilities, and cannot determine the poten-

tial for a full, happy, and productive life. As well, the screening for genetic disability downplays the impact of environmental factors, and maternal nutrition and health (including addictions) on the health of the unborn fetus (Phillips 16).

In India and other countries, including the United States and Canada, amniocentesis has been used for the purpose of detecting (and aborting) female fetuses. This "sex selection" perpetuates the undervaluation of women which is prevalent in all societies, and serves as a means of population control by decreasing the number of females available to reproduce in future generations. While Indian feminists have been speaking out against this practice, attempts have been made in Canada to establish "sex selection" clinics, which target the South Asian community, on the pretext that this practice is "culturally acceptable" within their community (Peries and Phillips). South Asian women in Canada have successfully struggled against the opening of such clinics.



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Thus, NRTs overcome infertility and promote growth for particular populations, but they can be used as a means of limiting population growth in others. One of the greatest dangers of NRTs is that the search for "perfection" (as determined by race, class, gender, and ability) can subvert other values, including the acceptance of diversity. In a time when access to adequate and appropriate health services for all Canadian women has not been achieved, and when social and human needs are not being met, it is irresponsible to support the development and use of NRTs.

When discussing reproductive technologies, be they the "old" or "new", we must question whether women have control over the technology and are provided with sufficient information to make truly "informed" choices.

Recommendation: Policies must be put in place that support women of all races, class backgrounds, ages, and abilities in obtaining reproductive freedom, including access to appropriate primary health care services, food, housing, information, education, universal child care, as well as access to policy and decision-makers.

Recommendation: Canada must immediately address the development and use of "new" reproductive technologies in light of the outstanding questions about the impact of these technologies on the health of women and their children and on society as a whole.

Canadian immigration policies

Efforts to increase the birth rate through the provision of financial incentives have generally proven to be unsuccessful. Many demographers have recommended focusing on immigration as a way to maintain population levels. However, the Canadian government is under pressure to reduce its immigration rate from 250,000 to 150,000 per year and to rely more heavily on a point system for evaluating immigration requests.

At present, while actual numbers of immigrants are not diminishing, the number of lower income, and so-called unskilled and uneducated immigrants is. Along with this move to emphasize the immigration of a wealthier group of professionals, there has been a de-emphasis on the "family-class" group of immigrants. New regulations that define "family" along the western "nuclear family" model, have made it very difficult for grandparents, aunts, uncles, and others whom many people consider to be members of the immediate family to enter the country. Supporters of these changes argue that the practice of selecting immigrants on labour market criteria helps to ensure that not all newcomers are confined to the lowest strata of Canadian society (Parikh).

Increasingly, immigration and (over)population have been linked, based on a perception that immigration of poor people from the Third World threatens the quality of life of those already living in the receiving country. In Canada, this link has been made by prominent politicians and civil servants (External Affairs and International Trade). Many industrialized countries are tightening up immigration policies at home, while advocating and promoting population control policies for the Third World.

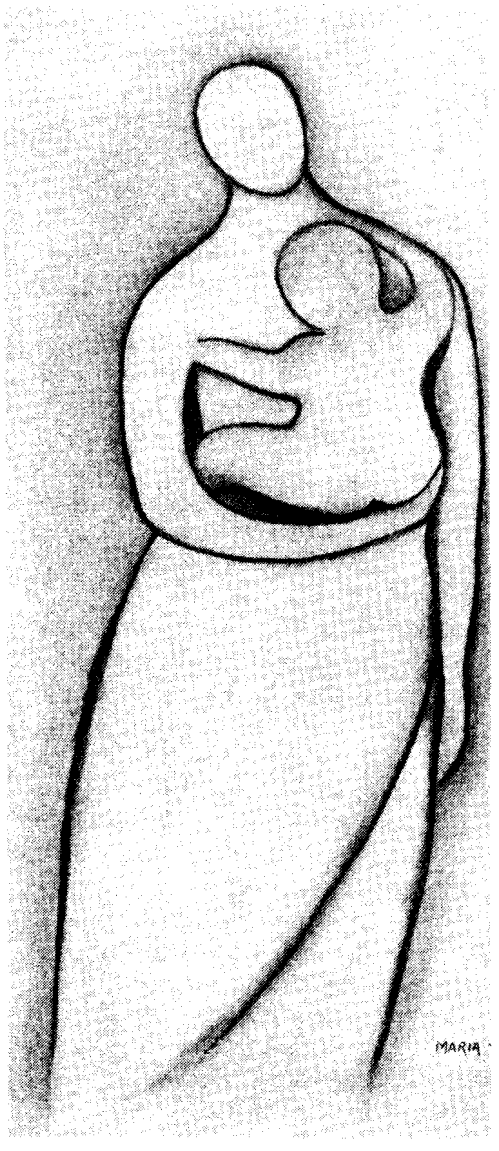
Recommendation: Immigration and refugee policies must be adopted that do not discriminate against people of the Third World. Migration and displacement of Third World people must not be used as a rationale for funding population control programs.

Quebec's efforts to increase its population

Within the context of the struggle of the Francophone majority in Quebec to maintain its cultural identity, the Quebec government has been alarmed by the decrease in the fertility rate, in particular among Francophones. A policy to encourage births and offer financial incentives has been adopted. A woman receives $500, $1,000, and $8,000 (Cdn) after the birth of a first, second, and third

child respectively (Gouvernement du Québec 18). The Quebec government is providing insufficient, but possibly attractive, payments, at the same time as it is cutting social programs which could provide more long-term support to women and families. This is an example of governments setting demographic targets which reinforce women's traditional reproductive roles and (in many cases) their poverty.

As in the rest of Canada, Quebec birth planning services are diminishing and le Ministère de la santé et des services sociaux no longer has a special budget for such services. At present, services are geared to women who are deemed "at risk" of having unwanted pregnancies: adolescent women and poor women. Women on welfare can obtain the contraceptive pill or the IUD for free (while they have to pay for barrier methods, like condoms). This situation illustrates how one sector of the population can be targeted to *increase* its birth rate while at the same time another is targeted to *reduce* it.



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In the 1960s, immigration in Quebec was seen as a threat to the Francophone community. Since then, the Quebec government has recognized that immigration is another way of preserving the French language and culture.

Disabled women's experiences

Disabled women have been a target group of population control. Canadians with disabilities have long been undervalued as participants in the economy, in society, and in our shared destiny. The exclusion and marginalization of persons with disabilities is largely due to a very *narrow* definition of the qualities and capabilities required to achieve certain standards. Rather than developing creative responses to suit the circumstances, the more common reaction is to reject disabled people as the source of the problem.

This rejection has had tragic repercussions for disabled women in Canada. Forced sterilization and contraceptive experimentation on disabled women has been carried out throughout the country, particularly in institutions. The province of Alberta provides one of the more blatant examples of these discriminatory practices. From the time of the adoption of the Alberta Sexual Sterilization Act in 1928 until its repeal in 1972, the Alberta Eugenics Board "used its authority to sterilize some 2,500 Albertans" (*Edmonton Bulletin*), mostly women who were labelled "mental defectives living in the various provincial institutions" (Christian and Barker 30).

It has been primarily due to the organization and lobbying of disabled Canadians and to the establishment of organizations like the Canadian Disability Rights Council (CDRC), the DisAbled Women's Network Canada (DAWN), and the Council of Canadians With Disabilities, that sterilization and drug testing of disabled persons is now considered a violation of human rights. Nonetheless, the rights of persons with disabilities continue to be disregarded in practice. For example, disabled women are given Depo Provera as a contraceptive, often without their consent, even though it is not approved for this use in Canada and has been shown to cause major side effects. At the same time, reproductive counselling and birth planning are often inaccessible to disabled women.

As articulated in the Final Recommendations to the Royal Commission on New Reproductive Technologies, submitted by the CDRC, NRTs have also provided avenues for discrimination. The CDRC is particularly concerned with the eugenic tendencies of reproductive counselling and testing:

> Eugenics is operating every time a woman with a disability is discouraged from considering motherhood, every time pressure is put on a woman with advisability to undergo screening during pregnancy, every time a woman, whether disabled or not, is expected to abort a fetus with a disabling condition.
>
> The presumption that a positive result will inevitably be followed by an abortion is particularly repugnant and disrespectful of people with disabilities...90 [per cent] of "positive" amniocentesis tests result in the termination of "wanted" pregnancies. (7)

Recommendation: Rather than investing millions of dollars in the development and use of sophisticated fertility and fetal monitoring technology, Canada should balance its use of technologies and financial resources to accommodate persons with disabilities and, in conjunction with disability rights organizations, to: 1) address the socio-economic and environmental causes of infertility and disability (such as poverty, war, toxic environments, and unsafe workplaces); 2) protect both disability equality rights and sex equality rights guaranteed under the *Canadian Charter of Rights and Freedoms* (CDRC 2); 3) educate all professionals and the Canadian public in order to replace the eugenic philosophy of "detection for the

purpose of elimination," with a philosophy which is respectful of the equality rights of persons with disabilities and the rights of all women to reproductive autonomy (CDRC 2, 10).

Depo Provera and Norplant

People who support the use of long-term, "provider-controlled" methods of birth control express a range of attitudes, from frustration that young girls have repeated pregnancies and abortions and that these methods can help "buy them time," to eugenic attitudes that women of colour, Aboriginal and Inuit women, and other women of marginalized groups have too many children. In Canada, as in Third World settings, these methods are used as "solutions" to much more complex social problems related to women's poverty and powerlessness.

Two examples of such long-acting methods are Depo Provera, a hormonal drug which is given by injection and has a contraceptive effect for at least three months; and Norplant, which is implanted under the skin and prevents pregnancy for five years. Both methods are dependent on care providers for injection or insertion and, in the case of Norplant, for removal. They are widely used internationally in population control programs.

Depo Provera is not approved for use as a contraceptive in Canada due to serious concerns about its long-term safety (Tudiver 1994). Yet, since Depo Provera is approved for use in the treatment of endometriosis and some forms of cancer, doctors may legally prescribe it for contraception where they feel the benefits outweigh the risks. Consequently, Depo Provera is used in Canada as a contraceptive. The women who most often receive Depo Provera include Aboriginal women, women with disabilities, teenagers, women of colour, women living in poverty, and substance abusers.

Many women request long-acting methods, but few feel they have all the information necessary to make a decision. There is no requirement that women be told Depo Provera is not approved for contraceptive use in Canada; indeed, many doctors and nurses do not know the current status of the drug (Tudiver 1994:1). Few appropriately conducted studies have been done to determine the health risks associated with Depo Provera, even though it may pose a potential increased risk of breast cancer. For women given Depo Provera, there is no registry so their health can be monitored in the long-term.

The recent approval of Norplant in Canada raises many similar issues. Women must have Norplant removed within five years of use, yet no tracking system has been established to keep track of Norplant users.

Recommendation: The Canadian government must adopt policies to end the use of Depo Provera as a contraceptive in Canada as well as in the Third World and to stop the unethical use of other long-acting "provider-controlled" contraceptives. The Canadian government must restrict the use of Norplant to recognized health centres where providers have been thoroughly trained in insertion and removal. The government must establish a registry to monitor women who have used Depo Provera or Norplant. The government must also fund ongoing research into the long-term health risks of these drugs on women and their children.

Oral contraceptives

While Canadian women are learning from women in the Third World of the adverse effects and health risks of contraceptives like Depo Provera and Norplant, there has been a lack of attention both at home and abroad to the risks of oral contraceptives. After many decades of use of "the pill," investigations of health risks associated with its use are still inadequate and women do not have access to complete information on the potential long-term risks. There is a "regrettable lack of information" (World Health Organization), particularly about the effects of the contraceptive pill on skeletal growth in adolescent women, on malnourished women, and on women with systemic diseases. In spite of warnings made more than two decades ago about these potential risks, this lack of information persists.

Contraceptive pill use is problematic in many areas of the Third World. Supplies of the pill are inconsistent in some areas. Moreover, women frequently are provided with this method without being properly screened. Women are also not monitored to detect potentially-dangerous conditions like hypertension, and do not have access to facilities for diagnosis or treatment if they develop complications.

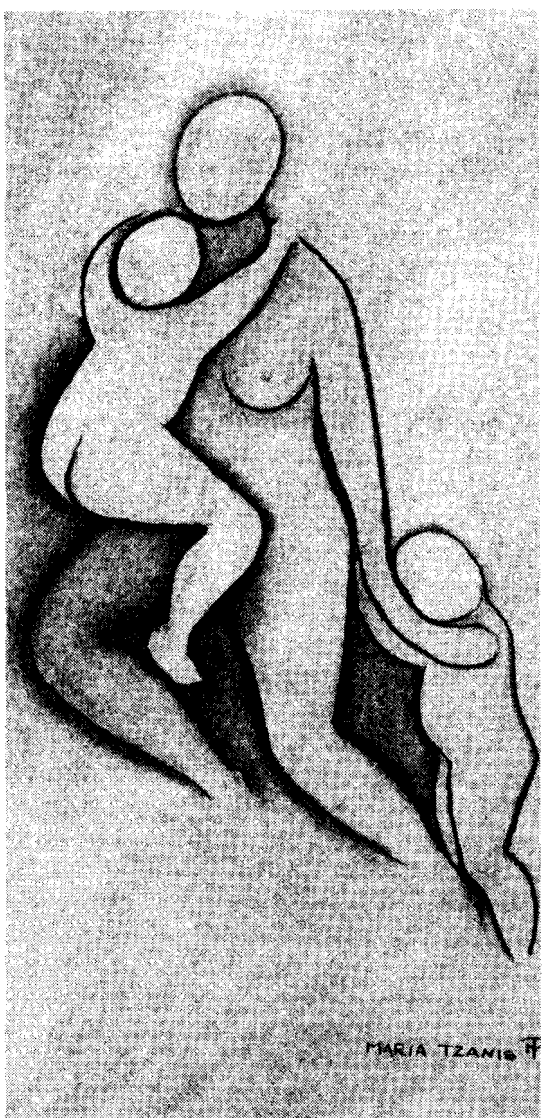
Concerns over health risks of oral contraceptive use, particularly risks of cancer, resulted in the use of pills with lower doses of synthetic estrogen in industrialized countries. High dose pills that were no longer considered safe for use in Canada were subsequently exported to Bangladesh by the Canadian International Development Agency (CIDA), as part of its development assistance program. To its credit, CIDA stopped this practice partly in response to concerns over the potential risks of these high-dose pills raised by Canadian and Bangladeshi women's and development groups. However, women are still concerned about CIDA's involvement in population control programs in Bangladesh and other countries.

Recommendation: Canada must take a leadership role in ensuring that the distribution of hormonal contraceptives takes place within an ethical framework, as part of integrated health services and with women's full and informed consent. For this to happen, full information about the potential risks of these agents must be gathered and made accessible to all current and potential users.

Recommendation: Appropriate government and health bodies, in consultation with women's organizations, must evaluate the safety, and use of hormonal contraceptives in Canada and in those Third World countries where cida provides development assistance.

Canada's involvement in contraceptive development

International agencies involved in population control programs have been the driving force behind the development of contraceptives. Contraceptives are being developed with "population" and not "people" in mind. Therefore the contraceptives that are being developed and promoted are long-lasting and increasingly controlled by the provider. With the exception of vasectomies, all of these methods target women. Canada's International Development Research Centre (IDRC) has made considerable financial contributions to two such contraceptives: Norplant, and an immunological contraceptive, also known as the anti-pregnancy vaccine. IDRC holds the patent on one such vaccine (Mulay).



Immunological contraceptives work by inducing an immune response to the egg, sperm, embryo, or pregnancy hormone (HCG), thus preventing pregnancy or implantation. Clinical trials are being performed in Sweden by the World Health Organization, and in India at the National Institute of Immunology (Richter). It is to the latter that IDRC is contributing $4 million (Cdn). There has been considerable criticism of the way in which the research has been conducted. Women recruited as subjects were not told about the experimental nature of the trial. There are problems with the subjective interpretation of the outcome of the trials. Both the immunological contraceptives and Norplant have a great potential for abuse in population control programs in the Third World, as well as among underprivileged groups in Canadian society (Mulay 7).

Recommendation: Canada and federally-funded institutions such as the International Development Research Centre, must put resources toward the development of safe and appropriate contraceptives that women control and that meet women's needs, and negotiate with women about the process for doing this. Canada should take a lead role in supporting the improvement of existing, and the development of new, barrier methods as well as in developing, educating, and promoting appropriate contraceptive use by men.

Canadian support for international population activities

CIDA's financial contributions to population activities are not high compared to the United States or Japan, but Canada remains a primary actor with considerable influence in this area. Canada's largest single financial contribution is to the Bangladesh Population and Health Program which is co-ordinated by the World Bank. Between 1986 and 1996 CIDA will have spent more than $100 million for population activities in Bangladesh. About $28 million of this amount is in the form of contraceptive pills. Bangladesh is the only country in which CIDA explicitly refers to the reduction of fertility as an objective of its program (1992).

The Bangladesh population program is the largest of its kind in the world. Even though a shift has been made in the program towards including health services, the majority of the funding is spent on fertility control measures. The World Bank population program continues to promote sterilization and Depo Provera and is now testing Norplant. CIDA funds facilitate Depo Provera use in Bangladesh, through the World Bank-coordinated population program, although this drug has not been approved for use as a contraceptive in Canada.

The Bangladesh Population and Health Program has a history of coercion. Women have been provided with cash incentives for sterilizations, and sterilizations have been a condition for access to food aid. As well, some agencies have denied participation in development projects to women who do not accept fertility control (Gillespie).

In addition to the bilateral funding in Bangladesh, Canada also funds multilateral agencies, such as the United Nations Fund for Population Activities (UNFPA). In 1992-93 Canada provided the UNFPA with more than $13 million. We do not know whether there are clear principles which guide UNFPA's use of Canadian funds. UNFPA has been involved with coercive and abusive population programs in India, Indonesia, and China.

Other recipients of Canadian funds are international non-governmental organizations. In 1992-93, Canada gave about $10 million to the International Planned Parenthood Federation. Canada also supports the Population Council, the International Council on Management of Population Programs, the International Federation for Family Life Promotion, and others. Funding contraceptive research through IDRC is another way that Canadian funds contribute to population control.

Recommendation: Policies and measures must be put

in place to ensure funds from the Canadian International Development Agency go to basic human development and integrated health services including reproductive health information and services, rather than to population control programs.

CIDA's population policy

Until recently, Canada did not have an explicit policy on international population issues. Despite the lack of a policy framework and guidelines, by 1986-87 CIDA had become the world's second largest bilateral (government to government) donor to the population sector, and the fourth largest donor overall for international population activities (CIDA 1987a).

In 1987, the first policy for CIDA's population activities was approved. It recommended that CIDA expand its activities in the population field, even though it recognized that research findings on the impact of these activities on population growth were contradictory. As well as recommending increased resources for population control programs, the policy touched on the importance of improving the status of women, the principles of free and informed consent, and the importance of mother and child health care as part of population control programs (CIDA 1987b).

In 1993, CIDA began to update its population policy. Although the new draft framework considers population issues in the larger context of human rights, health, and sustainable development,[4] it still names rapid population growth as the main barrier to sustainable development and improved quality of life. There is very little mention of the production and consumption patterns in the North as a cause of environmental problems and a barrier to sustainable development. The draft policy suggests that CIDA should support family planning even in situations where health services remain inadequate and poorly developed.

Recommendation: Canada should be a leading voice within the international community in promoting sustainable development as a priority rather than prioritizing a reduction of the population growth rate.

The way forward

Throughout the world, including Canada, women have organized reproductive health services as alternatives to population control programs. For example, in Bangladesh, the Philippines, Colombia, and Senegal, clinics provide pre-natal and postnatal care, and individualized counselling about birth control, sexuality, and sexually transmitted diseases. Most of these initiatives are small in scale, but provide a vision of alternatives to population control (Tudiver 1991). There are also examples of alternative approaches to development and population at a government level, such as in the state of Kerala, India, where investments in social and economic programs have had a significant impact on the birth rate (Hartman).

In contrast to those who argue that government population control programs should be the focus of and a precondition to development, we argue that to bring about improvements in health, the lead must come from the women whose lives are most directly affected. Studies show that birth rates only go down when people's social and economic conditions improve. Women must be allowed to determine their own needs and solutions in relation to fertility control, health and development. When women are asked, they rarely request contraceptives alone. They also want access to jobs, education and training, primary health care, better living conditions, and safety from violence.

Alternative strategies for people-centred development and creative approaches to reform are widely known. For the most part, they are ignored, dismissed, or actively undermined by those in government, industry, research institutions, and other sectors who see their interests threatened by such changes. It is no doubt true that if more women, especially poor women, had a say, funds for contraceptive research, social services, housing, and for military expenditures might be allocated quite differently.

Excerpted from the Canadian Women's Report on Canadian Policies and Practices in the Areas of Reproduction, Population and Development, *Carla Marcelis, ed., prepared for the International Conference on Population and Development, held in Cairo, Egypt in August 1994.*

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[1] Population control is the systematic control of a society's

birth rate. It is based on fertility targets set by national governments and international institutions like the World Bank. Rationales are based on the perceived need to combat poverty and social strife in the Third World, as well as among certain populations in the industrialized world (LaCheen; Mass), and on widespread concerns about environmental degradation and migration. Population control programs in the Third World generally aim to reduce the rate of population growth through potentially coercive incentives and disincentives to ensure that women will use birth control or accept sterilization so that national demographic targets are met.

[2]Reproductive health and rights (also referred to as "reproductive freedom") are an integral part of women's struggle for social justice and cannot be exercised without access to decision-making, to comprehensive health services, to education, to economic autonomy, and to bodily integrity. Reproductive health and rights imply that the conditions are in place for a woman to determine, in the absence of coercion, whether to bear children and how many children she wants. This includes having access to safe methods for birth planning and abortion.

[3]Eugenics is a social philosophy dedicated to "improving" the human race, either through selective breeding or by genetic manipulation. It is based on the assumption that social problems such as poverty and oppression may be eliminated by preventing the disabled, homosexuals, people of colour, the poor, and other "deviants" from reproducing.

[4]Sustainable development is global development based on the equitable redistribution of existing wealth, including the means of production. It aims to create to safe, secure, and lasting solutions to global poverty, injustice, and environmental degradation, at the same time as it supports the realization of the full potential of all members of society in a durable state of health and prosperity.

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