bring this bill to the floor at this time. The bill would provide relief to Federal employees who through no fault of their own were placed in the wrong Federal retirement plan. Some Federal agencies mistakenly placed thousands of Federal employees into the Civil Service Retirement System, or CSRS, when the employees should have been placed in the Federal Employees Retirement System, FERS. Often this error has not been discovered until an employee is on the verge of retirement. Once discovered, the employee faces a severe erosion of his retirement security.

I am going to come back to the two employees that the gentleman from Florida mentioned who work at the Portsmouth Naval Shipyard in Kittery, Maine. They were very surprised to discover this error, and they face a serious deterioration of their retirement reserves unless Congress passes this bill. These two employees were placed in CSRS 14 years ago but only recently did they discover that they should have been placed in FERS. Once they learned that, they were then required involuntarily to switch from FERS to CSRS, and, since they had not been making their Social Security payments, all their CSRS resources were transferred to Social Security to make up for what they would otherwise have been paying in FICA taxes. For one of the men, his $30,000 CSRS investment was all used to pay so-called back FICA taxes. Furthermore, these employees will likely have to pay FICA tax not withheld for overtime, awards and other compensation for which they had legitimately not paid FICA tax because they were in CSRS which did not require it. This may total another $10,000 to $15,000.

Finally, the FERS plan consists of three components, Social Security, a small defined benefit plan, and a Thrift Savings Plan contribution plan. Consequently, these employees will need to make substantial catch-up contributions to the Thrift Savings Plan if they want any sort of nest egg for retirement. These heavy TSP contributions and FICA tax payments quickly consume the paychecks of these employees. As a result, one employee will delay his retirement by 3 years and the other may have trouble financing his child's college education.

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Mr. Speaker, H.R. 416 will offer vital relief to these employees by making the agency responsible for their mistakes. The agency made the mistakes; the agency should be responsible. The bill requires the agency to make up both the agency's and the employee's lost contributions to the TSP.

These hard-working employees do not deserve to have their retirement plans wiped out by a employer's mistake. H.R. 416 offers relief for a problem they did not cause.

I want to thank both the gentleman from Florida (Mr. SCARBOROUGH) and the gentleman from Maryland (Mr. CUMMINGS) for their work on this and leadership on this issue, and I urge my colleagues to support the bill.

Mr. CUMMINGS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, a little earlier I mentioned Mr. Garcia, and Mr. Garcia had been placed, of course, in the wrong retirement system, and like numerous other federal employees, he had been forced to rearrange his life and his financial plans to address this problem.

Many without financial means have had to work beyond their retirement dates to build a full annuity. The Federal Retirement System was created to prevent just that, employees working into what should be their golden years, the years they rest, the years they travel, the years they take time out to spend with their grandchildren. The Federal Retirement Coverage Corrections Act would essentially permit those who have been the victims of an enrollment error to remain in the retirement system they were mistakenly placed in or to be covered by the system they should have been in. It would also hold the government financially responsible for making whole an effected employee's thrift savings account. Together these provisions would end the harm now being done by the existing rules governing the correction of these errors. To address my concern that the unanticipated costs of making an employee whole might cause agencies to rif its employees, I included a provision in the bill requiring that offsetting savings be realized through attrition and limitations on hiring.

There has been much debate over the cost to the government of making effected employees whole. The IRS Code requires that private sector employers bear the cost of correcting retirement errors. The Senate bill leaves it to the victimized employee to come up with the money to make themselves whole. That simply is not right. Our approach mirrors the private sector and is the fairest way to handle these problems. The longer it takes to enact this legislation, the more it is going to cause all effected parties. Federal employees who are in the wrong retirement system should not have to spend another year worrying about a problem that their agency created for them.

Mr. Speaker, I am committed to working with the Senate to reach agreement on the legislation that addresses all parties' concerns. These employees are waiting for us to act. Let us do so today, and again I want to thank the gentleman from Florida (Mr. SCARBOROUGH) and all the members of our subcommittee, our chairman, the gentleman from Indiana (Mr. BURTON), our ranking member of our full committee, the gentleman from California (Mr. WAXMAN).

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mr. SCARBOROUGH. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, thousands of Federal employees, retirees and their families whose lives have been disrupted by bureaucratic errors are going to look again to this Congress to fix this problem. Many of them have suffered emotionally as well as financially, and I think it is time that we enact meaningful and fair relief during this Congress.

Mr. Speaker, H.R. 416 is strongly supported by the following employee organizations:

The American Federation of Government Employees,

The American Foreign Service Association,

The Federal Managers Association,

The Federally Employed Women,

The International Brotherhood of Boilermakers,

The National Association of Government Employees,

The National Federation of Federal Employees,

The Seniors Executives Association, and

The Social Security Managers' Association.

This is a bill that needs to pass in the best interests of every single Federal employee. It is the right thing to do, it is fair, and it is time that this House and, hopefully, this Senate, will step forward and do what is right.

The SPEAKER pro tempore (Mr. BASS). The question is on the motion offered by the gentleman from Florida (Mr. SCARBOROUGH) that the House suspend the rules and pass the bill, H.R. 416, as amended.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the bill, as amended, was passed.

A motion to reconsider was laid on the table.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 434

Mr. SHOWS. Mr. Speaker, I ask unanimous consent to remove my name as a cosponsor of H.R. 434.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Mississippi?

There was no objection.

SENSE OF HOUSE REGARDING FAMILY PLANNING PROGRAMS

Mr. CHABOT. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 118) reaffirming the principles of the Programme of Action of the International Conference on Population and Development with respect to the sovereign rights of countries and the right of voluntary and informed consent in family planning programs.

The Clerk read as follows:

H. RES. 118

Whereas the United Nations General Assembly has decided to convene a special session from June 30 to July 2, 1999, in order to review and appraise the implementation of

the Programme of Action of the International Conference on Population and Development;

Whereas chapter II of the Programme of Action, which sets forth the principles of that document, begins: ''The implementation of the recommendations contained in the Programme of Action is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights.'';

Whereas section 7.12 of the Programme of Action states: ''The principle of informed [consent] is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play.'';

Whereas section 7.12 of the Programme of Action further states: ''Government goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals . . . should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.''; and

Whereas section 7.17 of the Programme of Action states: ''[g]overnments should secure conformity to human rights and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision'': Now, therefore, be it

Resolved, That it is the sense of the House of Representatives that—

(1) no bilateral or multilateral assistance or benefit to any country should be conditioned upon or linked to that country's adoption or failure to adopt population programs, or to the relinquishment of that country's sovereign right to implement the Programme of Action of the International Conference on Population and Development consistent with its own national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights;

(2)(A) family planning service providers or referral agents should not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning;

(B) subparagraph (A) should not be construed to preclude the use of quantitative estimates or indicators for budgeting and planning purposes;

(3) no family planning project should include payment of incentives, bribes, gratuities, or financial reward to any person in exchange for becoming a family planning acceptor or to program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning;

(4) no project should deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any person's decision not to accept family planning services;

(5) every family planning project should provide family planning acceptors with comprehensible information on the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method;

(6) every family planning project should ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits; and

(7) the United States should reaffirm the principles described in paragraphs (1) through (6) in the special session of the United Nations General Assembly to be held between June 30 and July 2, 1999, and in all preparatory meetings for the special session.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Ohio (Mr. CHABOT) and the gentleman from Connecticut (Mr. GEJDENSON) each will control 20 minutes.

The Chair recognizes the gentleman from Ohio (Mr. CHABOT).

GENERAL LEAVE

Mr. CHABOT. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the resolution, H. Res. 118.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Ohio?

There was no objection.

Mr. CHABOT. Mr. Speaker, I yield myself such time as I may consume.

This bill reaffirms the principles of the program of action of the International Conference on Population and Development with respect to the sovereign rights of countries and the right of voluntary and informed consent in family planning programs. Mr. Speaker, I want to commend my good friend and colleague, the gentleman from Kansas (Mr. TIAHRT), for authoring this sense of the Congress resolution to affirm the voluntary family planning language that was adopted during House consideration of the fiscal year 1999 foreign operations appropriations legislation and later included as part of the Omnibus Appropriation Act of 1998.

As my colleagues know, the United Nations General Assembly will convene a special session from June 30 to July 2 of this year in order to review and appraise the implementation of the program of action of the International Conference on Population and Development. This resolution sends a message to that conference that it is the belief of the United States Congress that all family planning programs should be completely voluntary, avoid numerical targets and provide recipients complete information on methods and generally respect individual values and beliefs as well as national laws and development priorities.

Mr. Speaker, again I want to compliment my colleague from Kansas for offering this legislation. It is a timely resolution, it is well drafted, and it deserves the support of this House. I urge adoption of the resolution.

Mr. Speaker, I reserve the balance of my time.

Mr. GEJDENSON. Mr. Speaker, I yield myself such time as I may consume.

Over a year ago we had a debate on U.S. funding for family planning. Frankly, I was sad to see that a number of Members voted against that. About 17 of the original cosponsors of this resolution today, of the 23 Members who cosponsored this resolution, voted against the funding for AID to do family planning work. So I am happy to see them here today moving the abortion debate out of the family planning debate, and what is happening through the years all too often is people who oppose abortion end up opposing the funding for family planning, and it always confused me in the sense that, if we want to reduce the chances of abortion, make sure good family planning is available.

Mr. Speaker, there is nothing we can do for child survival, for the quality of life of especially some of the poorest countries, to make sure we maintain our leadership role in supporting family planning, and I am, frankly, hopeful by this resolution that we will see more cooperation on family planning and separate it from the debate on abortion. Some of us, like myself, are pro-choice and we think that that is obviously a woman has a right to decide with her doctor. We do not believe government ought to interfere with that. But if we can get an agreement on the family planning funds, we could certainly reduce the need for lots of abortions, and it is an area that we agree on.

Now, frankly, if I had written this resolution, I would have included other provisions than were included, but this resolution was written by the Republican majority. But for those of us on our side of the aisle, I think I speak for most of us that we want to make sure that child survival is increased and the space and number of children a mother has has a direct impact on child survival.

Mr. Speaker, voluntary family planning is at the heart of our program, and the folks at AID have done a great job historically in trying to lead that effort.

Mr. Speaker, I reserve the balance of my time.

Mr. CHABOT. Mr. Speaker, I yield 5 minutes to the gentleman from Kansas (Mr. TIAHRT).

Mr. TIAHRT. Mr. Speaker, I rise in support of House Resolution 118, and I want to thank the gentleman from Ohio (Mr. CHABOT) for yielding to me.

I have introduced this resolution in anticipation of the meetings being held at the United Nations this week to prepare for the 5-year review of the progress made since 1994 International Conference on Population and Development which was held in Cairo. The language of this resolution represents a compromise between myself and Population Action International. It is supported by Zero Population Growth, and it mirrors the language of the amendment I offered last year to the Fiscal Year 1999 Foreign Operations Appropriations Act. As my colleagues may recall, that language laid out the definition for ''voluntary'' in a context of U.S. funded family planning programs. That amendment was offered in the wake of disturbing news stories that spoke of women being forced to participate in family planning programs and

in some instances were sterilized against their will, as my chart indicates.

Here we have several stories that were covered by the New York Times, the Wall Street Journal, the Miami Herald and the Sacramento Bee talking about occurrences in Peru where women were forced into sterilization.

The voluntary family planning amendment I offered last year was adopted on a voice vote and later enacted into law as part of last year's Omnibus Appropriation Act. While the voluntary family planning amendment enacted into law last year prevents U.S. dollars from being spent in family programs that are not administered in a voluntary manner, many programs worldwide still employ these same methods of coercion, incentives, bribes and quotas. For example, in Indonesia family planning clinics rely on threats and intimidation to bring women into their clinics. In Mexico hundreds of forced sterilizations have been documented, and medical personnel have been fired for their refusal to perform sterilizations. In addition, women refusing sterilization have been denied medical treatment. In Peru, as we said earlier, family planning programs use coercion, misinformation, quotas and sterilization for food efforts.

These terrible violations of human rights are the reason I have introduced House Resolution 118. The resolution reaffirms the emphasis that the U.S. has taken on giving women a choice and stating that it is Congress' belief that all family planning programs should be completely voluntary, that they should avoid numerical targets and provide recipients with complete information on the methods, including telling recipients whether the methods are experimental, and I think we can all agree that we should respect individual values and beliefs as well as national laws and development priorities.

Mr. Speaker, it is my hope that the House will adopt this resolution and send a strong message to the United Nations that we believe every family planning program in the world should be carried out in a truly voluntary manner as described by the definition added to the Omnibus Appropriations Act last year. I would ask my colleagues to please support House Resolution 118.

[From the New York Times, Feb. 15, 1999]

USING GIFTS AS BAIT, PERU STERILIZES POOR WOMEN

(By Calvin Sims)

LIMA, PERU, FEB. 14—For Magna Morales and Bernadina Alva, peasant Andean women who could barely afford to feed their families, it was a troubling offer but one they found hard to refuse. Shortly before Chirstmas, Government health workers promised gifts of food and clothing if they underwent a sterilization procedure called tubal ligation.

The operation went well for Mrs. Alva, 26, who received two dresses for her daughter and a T-shirt for her son. But Mrs. Morales, 34, died of complications 10 days after the surgery, leaving three young children and a husband behind. She was never well enough to pick up the promised gifts, and the family was told it could not sue the Government over her death because she had agreed to the procedure.

''When you don't have anything and they offer you clothes and food for your kids, then finally you agree to do it,'' said Mrs. Alva, a neighbor of Mrs. Morales in the northern village of Tocache. ''Magna told them that her husband was against the idea, but they told her, 'Don't worry, we can do it right now, and tonight you will be back home cooking and your husband will never realize what happened.'''

Tales of poor women like Mrs. Morales and Mrs. Alva being pressed and even forced to submit to sterilization operations that have left at least two women dead and hundreds injured have emerged from small towns and villages across Peru in recent weeks in what women's groups, politicians and church leaders here say is an ambitious Government family planning program run amok.

Critics of the program, which was begun in 1995, charge that state health care workers, in a hurry to meet Government-imposed sterilization quotes that offer promotions and cash incentives, are taking advantage of poor rural women, many of whom are illiterate and speak only indigenous Indian languages.

The critics, who include many of the program's early supporters, say the health workers are not telling poor women about alternative methods of contraception or that tubal ligation is nearly always irreversible. They also charge that many state doctors are performing sloppy operations, at times in unsanitary conditions

''They always look for the poorest women, especially those who don't understand Spanish,'' said Gregoria Chuquihuancas, another Tocache resident. ''They make them put their fingerprint on a sterilization paper they don't understand because they can't read. If the women refuse, they threaten to cut off the food and milk programs.''

While it remains unclear whether such actions were sanctioned by the Government or were the work of overzealous health workers—the Government denies there are sterilization quotas, though it acknowledges goals for budgetary purposes—independent investigations by members of the Peruvian Congress, the Roman Catholic Church, local journalists and a United States Congressional committee have chronicled dozens of cases of abuse.

''The Government's program is morally corrupt because nurses and doctors are under pressure to find women to sterilize, and the women are not allowed to make an informed decision,'' said Luis Solari, a medical doctor who advises the Peruvian Episcopal Conference, which speaks for the country's Catholic bishops.

''No one has the right to intervene in people's life this way,'' Dr. Solari said. ''It's criminal.''

From its inception, Catholic church leaders have vigorously opposed the family planning campaign because it promotes artificial forms of birth control, which the church disavows. Augusto Cardinal Vargas Alzamora of Lima has warned Catholics that they will be committing a ''grave sin'' if they resort to sterilization. Tubal ligation is still only the third most practiced form of contraception in Peru, after abstinence and the I.U.D., family planning officials say. Abortion is illegal.

The Government has vehemently rejected charges that it is conducting a campaign to sterilize poor women and says that all its sterilization operations are done with the patient's consent, as required by law.

Health Ministry officials, who spoke on condition of anonymity, said that in the last year the program had suffered from ''lapses in judgment'' by individual health care workers and doctors, who had been reprimanded. But the officials said that such cases were isolated incidents that had been blown out of proportion.

Reached on his cellular telephone, Deputy Health Minister Alejandro Aguinaga, who oversees the program, said he did not wish to speak with The New York Times.

Three years ago, when President Alberto K. Fujimori announced plans to promote birth control as a way to reduce family size and widespread poverty in Peru, family planning experts, feminists and even many opposition politicians expressed broad support for the initiative. But the mounting criticism of the sterilization has tarnished the image of the family planning program, one of the most ambitious in the developing world.

In 1997, state doctors in Peru performed 110,000 sterilizations on women, up from 30,000 in 1996 and 10,000 in 1995. Last year they also performed 10,000 free vasectomies on men, a slight increase over 1996. However, women remain the main focus of the Government's program because men are less likely to agree to sterilization, on the mistaken ground that the procedure could impair their virility.

Health Ministry officials estimate that the 1997 sterilizations will result in 26,000 fewer births in 1998. This is good news, they say, in a country where the fertility rate—the average number of children born per woman—is 3.5, compared with 3.1 for Latin America in general and 2 for the United States.

The rate is 6.2 children for Peruvian women who have little or no education and 7 children for those who live in rural areas. That compares with a rate of 1.7 children for women who have at least some college education and 2.8 for urban residents of all educational levels.

Concern over reports of forced sterilization has led to an investigation by the United States Congressional Subcommittee on International and Human Rights Operations, which is seeking to determine if money from the United States Agency for International Development was used in the Peruvian Government's campaign.

Officials in Washington said in a telephone interview that the agency had no role in the Peruvian Government's family planning program. They said that money and training for family planning services went directly to nongovernmental agencies in Peru that have no connection with the Government's program.

The officials said that they had deliberately taken steps to disassociate the agency from the Peruvian Government's family planning program after it became clear that, while well intentioned, it was too hurried and ambitious to avoid the pitfalls that it has now encountered.

Joseph Rees, the subcommittee's chief council, said that after a recent fact-finding mission to Peru he was convinced that no United States money was directly used to finance the Peruvian Government's campaign.

But he expressed concern that some money may have trickled through in the form of infrastructure, management or training support. Because some United States-sponsored food programs are operated from the same Peruvian Government medical posts that administer family planning in rural areas, Mr. Rees said that it was possible that some of this food could have been used to bribe women to undergo sterilizations.

''The bottom line here is whether the Peruvian Government is more interested in doing family planning or population control and whether the United States wants to risk being associated with a program where that notion is so far unclear,'' Mr. Rees said.

Meanwhile, despite the reported abuses, the number of women undergoing sterilization in Peru has remained steady. Preliminary figures for January indicate that at least 10,000 women underwent free tubal ligations by state doctors.

The opposition Renovación Party, a conservative group that has always objected to the program, says it has collected more than 1,000 complaints from women who say they were either injured by Government sterilization or pressured into agreeing to the operation.

Arturo Salazar, a Renovación congressman, said the Fujimori Government had given no thought to the long-term effect of so many sterilizations, which if left unchecked, he said, will severely diminish Peru's rural population, deprive the nation of security on its frontiers and impede economic development in the countryside.

But those issues are of little concern to Martha Eras, also of Tocache, who is struggling to care for her new baby girl, who was born in August despite the Government-sponsored sterilization that Mrs. Eras voluntarily underwent eight months earlier. It appears that the doctor was in such a hurry that he did not check to see if Mrs. Eras was pregnant.

''My husband joked that it was immaculate conception,'' she said.

[Excepts from Population Research Institute Review]

PRI PETITIONS FOR NORPLANT WITHDRAWAL

(By David Morrison)

On 24 July 1994 Wyeth-Ayerst itself promulgated a revised and greatly expanded set of guidelines for doctors and clinics involved in the sale and insertion of Norplant. These new guidelines went far beyond those which had originally been issued, mentioning no fewer than 23 new, separate adverse health conditions related to Norplant, including pseudo tumor cerebri, stroke, arm pain and numbness. Unfortunately this new information on adverse health conditions is alleged not to have been provided to the hundreds of thousands of women currently using Norplant, nor, it is further alleged, were physicians or clinics required to inform prospective Norplant users of this new information.

STERILIZATION IN INDIA

Kathy Rennie, Bloomington, IL

Recently, I was able to spend seven weeks in India and was so surprised at what I learned. I was able to spend some time in a small village where the people were very poor and was appalled to learn that all the women had been sterilized. These were young women with one or two children. When I inquired further about this, I was told that the government had paid them a large sum of money to be sterilized.

These women felt they had no choice but to take the money because they were so poor and they felt as if they were doing their duty to lower the population.

NORPLANT ALLEGED TO CAUSE BLINDNESS—ABUSE OF WOMEN IN BANGLADESH AND HAITI DOCUMENTED

The side effects of having five-cylinders of synthetic progesterone implanted into one's arm were supposed to be minimal and to only occur in a few women. While Planned Parenthood Federation of America, in its fact sheet on Norplant, mentions ''irregular menstruation . . . headaches, and mood changes'' as ''possible side effects,'' another PPFA publication, Norplant and You, suggests that ''bleeding usually becomes more regular after nine to 12 months'' and ''[u]sually there is less blood loss with Norplant than with a normal period.''

NORPLANT LINKED TO BLINDNESS?

Nothing in the Population Council literature about Norplant describes the horrors Patsy Smith, a mother in Houston, Texas, experienced:

''Three months after having Norplant inserted I started getting horrible headaches . . . like somebody was just grabbing my head and just squeezing it together as tight as can be squeezed; like someone had put a bomb in there and it was going to go off. I'd noticed that [my vision] being kind of blurry and after the months it got a little bit more blurry and things started looking like they were on top of each other.''[1]

Although headaches are listed among the possible side effects for Norplant, the severity of the pain and the worrisome blurring of her vision led Patsy to visit noted neuro-opthalmologist Dr. Rosa Tang, who admitted her to a Texas hospital where she came to understand the seriousness of her condition

Patsy has a condition called pseudo-tumor cerebri, where increased fluid pressure in the brain crushes the optic nerve. The damage in Patsy's case is severe; blindness in one eye and partial blindness in the other. Another such episode could take away her sight entirely.

In reviewing Patsy's medical history Tang came to suspect that Patsy's condition was related to the use of Norplant. She wrote to all the other eye specialists in Texas to ask if any of their patients on Norplant had exhibited similar symptoms. Over 100 cases were brought to her attention, including 40 women with blurred vision and eight women with conditions identical to Patsy's. The numbers startled Dr. Tang:

''It was very surprising for me because I had not seen any reports in the literature at this time of such a link between Norplant and pseudo-tumor cerebri and I was surprised of the fact that there were so many patients that seemed to be having the condition related to Norplant. I think that there is enough out there that there is a possibility of a link between the two [and] that a larger-scale study should be done if Norplant is to be continued.''

If something as serious as pseudo-tumor cerebri was a possible side-effect of the implant, why weren't women being told? Why wasn't Wyeth-Ayerst, the company which produces Norplant for the Population Council, required to list this condition among the possible side-effects? Norplant is the result of almost 25 years of Population Council research. It has been tested on women in developing countries almost continuously since 1972. Surely something as serious as pseudo-tumor cerebri would have shown up during these lengthy and presumably rigorous trials. But how rigorous were the trials? Were they scientifically valid at all? Until recently no one was asking these questions. No one had heard of what had happened in trial sites such as Bangladesh and Haiti.

* * * * *

THE TRIAL OF THE POOR

The Norplant trial carried out in the slum areas near Dhaka, Bangladesh, according to recent reports, as anything but objective and rigorous. In fact, women were enrolled in the trial without their knowledge or consent. Dr. Nasreen Huq, a physician who works with several non-governmental organizations in the poorer areas of Bangladesh, states:

''Participation in a clinical trial requires that the person who is participating in that trial understand that it is a trial, that the drug they are testing out is still in experimental stages. This requires informed consent. This was categorically missing.''

Akhter reported that women who took Norplant ''. . . fainted quite often, you know, which was not the case before.'' Other women complained that ''[the family planners] were telling us we were supposed to be very happy after taking this Norplant, but why our life is like hell now?'' Not only were these adverse side-effects not noted, desperate cries from the women to have the implants removed were simply ignored according to several women:

''In 6 months [I went to the clinic] about 12 times. Yes, about 12 times, I went to the clinic and pleaded 'I'm having so many problems. I'm confined to bed most of the time. Please remove it.' My health broke down completely. I was reduced to skin and bone. I had milk and eggs when I could, but that did me no good.''

''I felt so bad, my body felt so weak, even my husband told me it was all very inconvenient . . . [My husband] says he'll get another wife tomorrow. I told the doctors. 'Please take it out, I'm having so many problems . . . I felt like throwing myself under the wheels of a car.''

Many women found their way out of the trial blocked for lack of funds:

''I went to the clinic as often as twice a week. But they said. 'This thing we put in you costs 5,000 takas. We'll not remove it unless you pay this money.' Of course I feel very angry. I went to several other doctors and offered them money to take those things out, but they all refused. I went to three or four of them and they said these can only be taken out by those who put them in. They said that if they tried they might go to jail.''

''One woman, when she begged to remove it, said 'I'm dying, please help me get it out.' They said 'OK, when you die you inform us, we'll get it out of your dead body,' so this is the way they were treated. In a slum area people are living in a very small, like 5 feet by 7 feet where at least five family members are living and these women are working outside. The most important resource they have is their own healthy condition.''

''We have . . . information where these women have told us that they have sold their cow or the goat which was the only asset they had for treatment because she had to get well, otherwise the family can't survive, so in order to save her, they had to, you know, sell the cow or if they didn't want to treat her then she suffered, so the family was suffering either way. In every sense these people were totally torn. Their economic condition was torn, their family happiness was totally gone.''

''I couldn't see. I couldn't look at things at a distance. I had trouble focusing. You know in the village we light oil lamps. I couldn't look at them. They looked like the sun, as red and large as the sun. If I looked into the distance, my eyes would water . . . If I went out of doors, my eyes became absolutely dark. I couldn't see anything at all as if my eyes had become affected by blindness.''

The 1993 report on the Bangladesh trial contained no hint of these problems. It blandly stated that: ''Norplant is a highly effective, safe and acceptable method among Bangladeshi women,'' claiming that less than 3 percent reported significant medical problems. The report did not mention women being denied removal of the implants or the problems with vision.

Haitian horror detailed similar problems were reported iN Haiti's Cit, Soleil (City of the Sun) by medical anthropologist Catherine Maternowska.

[1] All quotes in this story come from The Human Laboratory, a documentary produced by the British Broadcasting Corporation's Horizon series and aired in Britain on 8 November 1995.

GLOBAL MONITOR: POPULATION CONTROL'S QUESTIONABLE ETHICS

(By Ruth Enero)

But what exactly is all the fuss about? To begin with the so-called anti-pregnancy vaccine, Australia introduced this type of drug in 1986. The intent was to trigger a given woman's body into producing antibodies to hCG (human chorionic gonadotropin), a hormone essential to pregnancy. Because the drug affects the immune system, it poses health risks, including damage to pituitary and thyroid glands, inappropriate immune responses, possible infertility, and more. Women can't remove this vaccine or stop its effects once they've been given it. Violations of medical ethics regarding the use of this drug on Indian women were documented in 1993, including blatant disregard for informed consent. The 1992 Nov/Dec issue of Ms. relates that in 1951 India was the first country in the world to launch an official family planning program. India received a major component of its anticipated social change by testing contraceptives that were financed largely by the U.S. Indian women participated in the testing of (among other drugs) implants of (two rod) Norplant 2 and (five rod) Norplant. Most were not aware they were participating in an experiment. For these women, there were no cautions about Norplant's carcinogenicity and other side effects. Partly because drug studies seek long-term data, women who developed medical problems (hemorrhagic bleeding, dizziness, weight gain, heart problems) from their implants found that early removal was not part of their ''free'' care.

QUINACRINE IN INDIA

Dr. Biral Mullick has begun sterilizing women from Calcutta and surrounding villages with quinacrine, even though the World Health Organization and female health groups warn that the method is unapproved and risky. According to the Sunday Times of India, poor women in Calcutta are initially lured into trying the procedure because of its afforability—the paper quotes a price of 35 rupees—and relative ease of use. ''What these women do not know,'' the Times reports, ''is that they are guinea pigs being used to test the efficacy of the drug; that they have been subjected a method not approved by any drug regulatory agency in the world.''

According to Puneet Budim, an Indian gynecologist, none of these women in Mullick's and other clinics in the country are told they are part of a trial or what the risks might be. She alleges that they come into the clinics looking for a Copper T intrauterine device but walk out burned by the acid the tablets create when inserted into the womb. ''Scores of private doctors and NGO's across the country, including a prominent doctor politician from Delhi, are involved in this unethical practice,'' Budim said. ''It's a very disturbing development.'' (The Sunday Times of India, 16 March 1997.)

CUTTING THE POOR: PERUVIAN STERILIZATION PROGRAM TARGETS SOCIETY'S WEAKEST

(By David Morrison)

When the first sterilization campaign arrived in their little town of La Legua, Peru, Celia Durand and her husband Jaime were unsure they wanted to participate. Although they had discussed Celia's having the operation in the past, and had even researched its availability, they had begun to hear rumors about women damaged and even killed during the campaigns and Celia had decided she didn't want to be sterilized that way. Maybe sometime later she would do it; maybe in a hospital. Certainly not in the little medical post down one of La Legua's bare earth streets, with its windows opened wide to the dust, insects, and the smells from the pigs and other animals rooting and defecating the nearby streets and yards.

But then the campaign began and the Ministry of Health ''health promoters'' began to work her neighborhood. Going door to door, house to house, they repeatedly pressed the sterilization option. Interviewed later, her husband Jaime would recall the singular nature of the workers' advocacy. They wouldn't offer Celia any other contraceptive method, he reported. It was sterilization, nothing else. Many of the conversations centered around minimizing Celia's fears about having the procedure during the campaign. ''Do it now,'' they said. ''You may have to pay [to have it done] later.'' Other lines of argument included how ''easy,'' ''safe,'' and ''simple'' the procedure would be. And the workers persisted. Again and again they came to the family's home, refusing to accept 'no' for an answer, until finally Celia gave in and made an appointment. On the afternoon of July 3, 1997, she agreed, she would have the procedure.

Her mother, Balasura, worried and the two even quarreled about it. ''Don't go, daughter, there is always time later.'' Balasura remembers saying. But Celia wanted the daily visits to end and, besides, the health workers emphasized the procedure's easy nature. ''Don't worry, mama, I will be back in a couple of hours,'' she said as she left. That was the last time her mother saw her alive. Sometime during the procedure at the medical post, the surgeon caused enough damage to Celia that she slipped into a coma. Medical staff put off frantic visits from Celia's brother-in-law, mother and husband, finally moving her entirely out of the post and into a larger clinic in nearby Piura. It did no good. Celia died without every regaining consciousness.

Celia's story is just one of many which have resulted from a nationwide campaign which aggressively targets poor, working class and lower middle class women for surgical sterilization in often filthy circumstances and without adequately trained medical personnel. Although estimates of how many women may have been hurt in these campaigns are difficult to tabulate, a survey of reports about women who have suffered some injury, indignity, or coercion reveals a pattern stretching across Peru's length and breadth. Methods of coercion have included repeated harassing visits until women consent, verbal insults and threats, offers of food and other supplies made conditional upon accepting sterilization and making appointments for women to have the procedure before they have agreed to do so. Further, none of the Peruvian women interviewed by a PRI investigator reported having been adequately informed as to the nature, permanence, possible side-effects or risks of the procedure. ''All they told her was how easy it was,'' Jaime said later. ''No more.''

* * * * *

CAMPAIGN BACKGROUND

According to both high-and-low level Peruvian sources, the Ministry of Health's family planning program was a mostly quiet and somewhat moribund affair prior to 1995. ''It was just one of those things [the ministry] did,'' recalled one former high level official who served in the MOH when the sterilization campaign began. ''They would give their pills, maybe make some IUD's and give some shots and that was it.'' Everything changed, sources agree, when the Peruvian legislature changed the National Population Control Law to allow sterilization as a means of family planning.

According to Peruvian legislators, the Fujimori administration used a mixture of pressure and dirty tricks to change the law. Long-standing supporters of Fujimori, even if they did not want to vote in favor of a broad sterilization mandate, were told they had to support the administration or face political reprisal.

2. Using incentives to fill sterilization quotas

As with women in India, Bangladesh and Pakistan, Peruvian women also reported being offered food, clothing and other things for themselves or for their children as a condition or an inducement to sterilization. Ernestina Sandoval, poor and badly in need of assistance after a string of weather problems cost first her husband's livelihood and eventually her home, reported being offered food in a government hospital but then being told in order to qualify for the food she would have to accept a sterilization. ''They told me I had to bring a card from the hospital saying I had been ligated,'' she told a PRI investigator. ''If I didn't agree to do this they wouldn't give me anything.'' Maria Emilia Mulatillo, another woman, reported that her daughter's participation in a program that supported children of low birth weight was made conditional upon her acceptance of a sterilization procedure. Likewise, Peruvian papers like El Comercio and La Republica have published stories of how ''health promoters'' have been paid or rewarded with special prizes if they manage to bring more than their quota of women for the procedure.

3. Lack of informed consent

None of the over thirty sterilized Peruvian women whom a PRI investigator interviewed, which included a number of women who said they were happy they had the procedure, reported having given anything like informed consent. None of them were told of the procedure's possible side effects, particularly when performed under the time and other constraints that mark the campaigns. None were told of the risks. Universally what the women reported was being told over and over again about the procedure's eventual benefits, speediness and ease. But, as critics have pointed out, merely being told one set of facts about a potential medical procedure cannot be considered as having been adequately informed about the procedure.

4. Sterilization the only method offered

Although supposedly committed to offering Peruvian women a wide-range of family planning choices, including sterilization, PRI's investigation found that the government sterilization campaigns were single-minded. None of the women sterilized in the campaigns that we interviewed (as opposed to those sterilized, for example, in hospitals) reported being offered any options other than sterilization. Most were adamant on that point because, like Celia Durand, they were unsure if they wanted to be sterilized at all and would have welcomed a chance to take another option. Several women, particularly those who had already begun in other government family planning programs like those using Depo-Provera (which must be injected every three months), told of being instructed to have the sterilization procedure because their current program was being curtailed. Later, when asked directly about why women were pulled off Depo-Provera and pressured to accept sterilization, Dr. Eduardo Yong Motta, former Minister of Health and now President Fujimori's health advisor, replied that ''Depo costs too much,'' and that the Ministry had a problem with a method which a ''woman might forget'' or decide that she no longer wanted.

5. Medical histories not taken and post-operative care inadequate

None of the women sterilized in the campaigns that PRI interviewed reported having had any medical history taken prior to undergoing the sterilization procedure. This means that no one sat down with the women before the surgery to find out if any were experiencing medical conditions that might, in another circumstance, delay surgery. This is particularly important in light of the fact that the medical team was assembled and brought into a local area especially for the campaign. Familiar medical staff sterilized none of the women interviewed and thus, in some cases, no one was able to stop surgeries from proceeding in incidents where women were pregnant, menopausal or suffering from possibly complicating conditions. Post-operative care, particularly in cases leading to serious complications and even death, was sorely lacking. It was not uncommon for a woman to be rapidly sterilized in an unhygenic theatre in an afternoon and then sent home, feverish or still in pain, a few hours later.

THE OVRETTE PROGRAM IN HONDURAS: DID USAID ENDANGER HONDURAN CHILDREN WITH AN UNAPPROVED DRUG?

The Committee carried out an exhaustive investigation and discovered that the Health Ministry had issued a document entitled ''Strategy for Introducing Ovrette.'' This document stated: ''In order to avoid any misunderstandings which might jeopardize the distribution and harm family planning objectives, these instructions shall be implemented: 1) suppression of all literature from the boxes of medication at the central warehouse (prior to regional distribution) . . .''

In the Ovrette case in Honduras,USAID has been party to a flagrant violation of human rights through the imposition of a coercive and experimental population control program, has violated several Honduran laws and the constitutional rights of information, and has acted to the detriment of the health of Honduran mothers and children. The Ovrette incident should be thoroughly investigated in order to prevent such an imposition which can harm future generations not only in Honduras, but also in many other countries where such programs are implemented.

A DOCTOR SPEAKS OUT: WHAT HAPPENED TO MEDICINE WHEN THE CAMPAIGN BEGAN?

(Statement of Dr. Hector Chavez Chuchon)

My name is Hector Hugo Chavez Chuchon, and I am the president of the regional medical federation of Ayacucho, Andahuaylas, and Huancavelica in the Republic of Peru. This areas is the poorest in the country. I do not belong to any political group, and hope that the Peruvian government has as much success as possible in its enterprises. But, at the same time, I have the moral obligation to come forward and denounce wrongs there, where they are done.

I'd like to describe my work since the start of the tubal ligation and vasectomy sterilization campaign. There are approximately 200 doctors in my region. Some of them have come to declare and demand that the federation step forward to defend and to protest the ''inhumane,'' massive, and expanding sterilization campaign, a campaign which imposes quotas on medical personnel. As proof of these quotas, I have this document which is available in the information packet that you have. These doctors do not like the way in which people are brought in for these surgical procedures, where information is poor, incomplete, and generally deficient. Also, the places where these operations are performed are, for the most part, unsuitable, and the personnel often insufficiently trained.

The Ministry of Health denies that there are campaigns and quotas referring to sterilizations, and absolves itself of its responsibility, without taking into account, among other things, that the doctors work under their orders. Doctors work under pressure from their superiors, are given quotas and submitted to other more subtle forms of pressure. It is also true that doctors work under very unstable employment conditions, and could easily lose their posts.

I would like to have the people of the United States understand what their government is doing in Peru. My country is very large, and we do not have more than 25 million inhabitants, which in no way calls for a brutal birth control campaign, especially not one of sterilization. The facts show that prosperous countries like Japan have a high population density. Even though they are geographically much smaller, and lack the natural resources of my country, they live prosperously. So, we can see that the most important thing for a country is its human resources, which can generated wealth and well-being. Therefore, I would like especially to say that if you want to help my country, do so by investing in education and job creation, and not using these millions of dollars for population control programs.

''PRACTICALLY BY FORCE''

(Statement of Avelina Nolberto)

As a poor mother of five underage children and separated from my husband who also lives in the city of Andahuaylas, I wash clothes to support myself and the children. During my work activities I got to know an obstetrician who works in the Social Security hospital of Ayacucho. I confided in her about the problems I had run into with my husband. Then she spoke to me about tubal ligation and, of course, I was against it, but after so many demands she convinced me, adding that my husband could come back at any moment and would once gain fill me with children.

So on 16 October 1996 a worker, the sister of the obstetrician, arrived at my house telling me that it was free and I should take advantage of the opportunity since specialists from the Social Security hospital in Lima had arrived. I resisted, saying that I had to go to the market to cook lunch for my small children who were studying in school. I went to the market and stayed a long time. Upon my return I found her outside my house and she intercepted me saying that I was already scheduled for a ligation and that they would take me by taxi. That is how I arrived at the hospital practically against my will without any of my girls going in with me. This lady took charge of all the business in the hospital. This was the way I had the surgical intervention of a tubal ligation.

After the operation I was not able to recover. My stomach swelled and I had the sensation that all my intestines were burning. I could not expel intestinal gas. It was three in the afternoon on October 17, 1996. Then I began to worry because I entered the hospital totally healthy. When I went to the obstetrician to complain about my state of affairs, she became very insolent and said that she had nothing to do with this, and she had the audacity to tell me, ''Don't be bothering me, as if I had dragged you in.'' After that, my children came searching for me desperately when they did not find me home. They found me in the hospital and that is how I left still very sick.

In the night of October 17, 1996 I had terribly strong colic and my entire stomach swelled with a terrible burning sensation that I could not stand. So when I woke up, my oldest daughter took me back to the Social Security hospital where they intervened on me again on October 18, 1996. When my family started to inquire about my health status, what was the problem I really had, no one could tell them anything concrete. When I was supposed to be asleep I heard the nurses whispering among themselves that when they operated to do the ligation they had cut my intestines. I was not able to recuperate so they tried again on November 10, 1996, but my condition kept deteriorating so they decided to send me on November 15, 1996 to the Social Security hospital of Lima at my daughter's insistence. There they did a complete cleaning of my intestines because a greenish liquid had formed and the doctor told me that I had septicemia. I left there on December 12, 1996 returning to my city without medicines to continue my treatment.

The doctors treating me refused to give me medicines when I asked because I have no insurance.

From that time I have not been able to recover, and given my precarious financial situation, I had to return to my husband so that he could look after the children. I still cannot go back to work like before. Relapsing again, I went to the hospital Maria Auxiliadora de San Juan de Miraflores in Lima on November 4, 1997. I stayed there to be treated for what the doctor said was a perforated intestine. This was very expensive and I owe the hospital but do not have the ability to pay them back or to continue my treatment because of the expensive medicines needed. I am desperate from this situation. I cannot work to support my younger children. My oldest daughter, 20 years old, is studying and doing domestic work and is supporting me as much as she can. Now I am staying in the house where she works and the lady here has very kindly agreed to receive me with my young girls of 7 and 11 years old, and I have been given a great deal of help to recuperate.

FAMILY PLANNING BY THE NUMBERS: QUOTAS HAVEN'T GONE AWAY, THEY HAVE MERELY CHANGED THEIR NAME

(By David Morrison)

Although officials with the US Agency for International Development deny the practice, current documents and training programs indicate that the Agency still uses quotas to evaluate so-called ''family planning program.''

WHY ALL THIS MATTERS

This entire issue can seem like mere numbers on a page until a situation like that of Peru appears. Then it becomes clear what USAID's continuing reliance on quotas has wrought. Hundreds of thousands of women in Peru and elsewhere have had to confront workers from government and other organizations who view them not as human being but rather as numbers to be entered into a report or a means of filling a quota.

REFUGEE POP CONTROL ADVANCES: DESTRUCTIVE GUIDELINES REMAIN IN PLACE DESPITE ALTERATIONS

(By Kateryna Fedoryka)

As human rights activists and humanitarian aid workers contend against the tide, the United Nations moves closer to promulgating guidelines that would subject refugee women to clinically irresponsible and dangerous procedures of fertility regulation and abortion. Scheduled for completion in April, UNHCR guidelines for ''Reproductive Health in Refugee Situations'' has been the center of a protracted struggle between the UNHCR, concerned NGOs, and US Congressman Chris Smith.

Initial drafts of the guidelines called for the introduction of a specifically reproductive health component into the emergency

health care kits for refugee camps. Concern first arose among NGO participants in the preliminary drafting sessions when it became evident that the reproductive health kits were to include the so-called 'emergency contraceptive pill' (ECP), and a manual vacuum aspirator for use in early-term abortions. Objections centered on poor general hygiene, unskilled practitioners, and the lack of all but the crudest of operating facilities, which make safe and responsible administration and management of such procedures virtually impossible.

Following promulgation by the UNHCR, there will be a waiting period before the guidelines are submitted to the WHO, which has final oversight for medical operations in refugee camps. If signed into policy by the WHO, the regulations will go into effect immediately. Conditions in refugee camps will render impossible any attempt to prevent abuse. Population control will be imposed on poor refugees.

The aborting of refugee women under the euphemisms of ''emergency contraception'' and ''uterine evacuation,'' as well as the maternal deaths that are an inevitable result of carrying out these procedures in unsanitary and inadequate medical conditions, will undoubtedly reduce the numbers of ''vulnerable peoples'' suffering in refugee camps. If the present efforts to halt ratification of these guidelines do not succeed, there will in fact be no more place of refuge for those who have until now been able to turn to the international community in their moments of greatest need.

AIDING A HOLOCAUST: NEW UNFPA PROGRAM DESIGNED TO TIDY UP ONE-CHILD HORROR

(By Steven W. Mosher)

The United Nations Population Fund's (UNFPA) love affair with China's ruthless one-child policy continues. Despite overwhelming evidence of massive human rights violations stretching back two decades—and in violation of its own charter—the UNFPA has just quietly embarked upon a new $20 million program in China to assist its so-called ''family planning program.''

The program, which will be carried out in 32 Chinese counties, is being billed as an effort to replace direct coercion with the more subtle forms of pressure that the UNFPA commonly employs to stop Third World families from having children. Beijing has signed off on the four-year experiment. In the delicate phrasing of Kerstin Trone, UNFPA program director, ''The Government of China is keen to move away from its administrative approach to family planning to an integrated, client-centered reproductive health approach . . .''

As well it might. For except within the population control movement itself, which continues to celebrate China's forceful approach, the one-child policy has become a byword for female infanticide, coerced late-term abortions, forced sterilization/contraception, not to mention a host of other horrific abuses that rival in sheer barbarity the worst of Nazi Germany.

Recent examples of such abuses abound. In the August 1997 edition of Marie Claire magazine, for instance, we find a report that China has ''implemented [its] harsh birth control policy'' in Tibet, including ''forced abortions and sterilizations of Tibetan 'minority' women.'' Tibetan families are allowed one child in urban areas, two in rural areas. ''Excess births'' are illegal. As throughout China, it is legal to kill such ''illegal'' Tibetan babies in utero for the entire nine months of pregnancy, even as they descend in the birth canal. In sparsely populated Tibet, such a ''family planning'' program may properly be called genocidal.

Then, as reported in a previous issue of the Review, there is China's latest weapon in the war it is waging on its own people: Mobile abortion vans, each of which will be equipped with operating table, suction pumps, and . . . body clamp. According to Chinese officials, the government has plans to make 600 such vans to travel around the countryside doing abortions. Presumably such vehicles will be banned from the 32 counties in which the UNFPA will be responsible for keeping the birth rate down with its ''integrated approach,'' but who can be sure?

Nafis Sadik, the Executive Director of the UNFPA, has let it be known that the Chinese government has agreed to suspend the one-child policy in the 32 counties during the four-year experiment. In her words, ''In the project counties couples will be allowed to have as many children as they want, whenever they want, without requiring birth permits or being subject to quotas.''

Whatever the truth of this statement, it is by itself a remarkable admission. For it has been the steadfast position of the Chinese government—and the UNFPA itself—that the one-child policy does not rely upon birth quotas and targets, nor does it require parents to obtain birth permits prior to having children. Targets and quotas, it should be noted, were banned by the Cairo population conference because they always lead to abuses.

But lest the Chinese people living in these counties take their newfound freedom to have children seriously, the Chinese government has retained the right to use economic pressure. Sadik: ''[T]hey may still be subject to a ''social compensation fee'' if they decide to have more children that [sic] recommended by the policy.'' In other words, overly procreating parents will be fined into submission. That's hardly reproductive freedom.

And what of the ill-favored people in China's 2000 other counties? Counties where—we have it on the authority of Nafis Sadik herself—birth targets and quotas will continue to be imposed in defiance of world opinions. Counties where parents, on pain of abortion, must obtain birth permits for children prior to conceiving them. Counties where mobile abortion vans roll up and down rural roads, snuffing out the lives of wanted children while their mothers lie helpless in body clamps. And counties in oppressed Tibet, whose sparse populations of nomadic herdsmen are about to be further depleted by ''family planning.''

The Founding Charter of the UNFPA says ''couples have the right to decide the number and spacing of their children.'' The Executive Director of that organization has now admitted that China's population-control dictators deny that right. Until that changes, until China abandons the whole oppressive apparatus of targets, quotas, and birth permits, the UNFPA should get out—and stay out—of China.

FROM THE COUNTRIES: AGING JAPANESE; BIRTH-CONTROL TRAINS AND STERILIZATIONS EVERYWHERE—JAPANESE TO BE WORLD'S OLDEST

Meanwhile, more than 16,500 handicapped Japanese women were involuntarily sterilized with government approval during the period from 1949 to 1995, government officials now have admitted. However, unlike other nations whose own sterilization agendas have recently come to light, Japan does not plan to apologize, offer compensation to the victims, or conduct an investigation.

Japan legalized sterilization in 1948 (while under American occupation) as a means of improving the race through control of hereditary factors. The law, which was revoked only last year, allowed doctors to sterilize people with mental or physical handicaps without their consent, after obtaining the approval of local governments.

(Sources: ''Japan braces for life as world's oldest nation,'' Associated Press, 11 December and ''Japan acknowledges sterilizing women,'' The Washington Post, 18 September, A 26.)

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AUSTRALIAN STERILIZATIONS

Surgeons in Australia's public health system have illegally sterilized more than 1,000 retarded women and girls since 1992, a government-commissioned report said.

The chief justice of Australia's family court, Alastair Nicholson said, ''The research points to an irresistible conclusion that doctors are performing unlawful sterilizations on girls and young women with disabilities.''

In 1992, Australia's High Court made such sterilizations illegal if they were not medically required, unless a court or tribunal granted permission. Since then, such permission has been granted only 17 times, the report for the federal Human Rights and Equal Opportunity Commission said. However, at least 1,045 women and girls were sterilized during that period, the commission said. The government Health Ministry called the figure ''overstated,'' claiming that the true number of cases was only ''one-fourth or one-fifth that.''

(Source: The Washington Post, 16 December, A22.)

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AUSTRIAN STERILIZATIONS

The Austrian Ministry of Justice, following allegations by member of parliament Theresia Haidlmayr that thousands of women in mental institutions were being forcibly sterilized, promised on 28 August to curtail the rights of parents to authorize the sterilization of their handicapped children.

The judiciary's action was also in response to rumors in medical circles that Ernst Berger of the Rosenhugel Psychiatric Hospital for the Young in Vienna, was preparing a paper which would examine the questionable due process involved in the forced sterilization of young handicapped children in Austria. Berger's paper includes a case study of a 16-year-old mentally handicapped girl who was sterilized 4 years ago on the authority of her father, who was later found to have been sexually abusing her.

The administrative processing of such sterilizations, said Berger, ''had a professionally unsound cynical character differing only superfically from the forced measures legitimized by the the [Nazi] laws to prevent hereditarily ill future generations.

(Source: The Lancet, 6 September, 723.)

CHINESE UNVEIL ''MOBILE ABORTION CLINICS''

Delegates to the 23rd annual meeting of the International Union for the Scientific Study of Population (IUSSP) were treated to a macabre sight during their 11–17 meeting in Beijing. Chinese government officials drove one of the brand new ''mobile abortion clinics'' up to the parking lot of the building where the conference was being held. Delegates leaving their session were able to stop by the van's open rear doors and behold its small bed, suction pumps and body clamps up close.

''We plan to make 600 of these buses to travel around the countryside,'' said Zhou Zhengxiang,'' the ''vice general manager'' of the van's manufacturing company.

Human Rights advocates fear that the mobile clinics represent a further escalation in China's war against its own people's fertility, a war which has been characterized by

forced abortion, sterilization and IUD insertion.

''I think the need for body clamps in this thing speaks for itself,'' said Steven Mosher, President of the Population Research Institute. ''Women doing something voluntarily do not need to be held down with clamps.''

Chinese government officials, as usual, denied the practice of forced abortion in the countryside, but this time their denials flew in the face of more candid admissions by the Chinese government from only a few months ago.

The news of 600 mobile abortion clinics may indicate a split policy on population control in China.

THE DISASSEMBLY LINES, PART II: INDIAN WOMEN STERILIZED UNDER INDUSTRIAL CONDITIONS

(By James A. Miller)

AIR PUMPS AND ERRORS

The all-too-common primitive conditions at the camps were reported: air pumps for pneumoperitoneum, bricks to elevate the operating tables, gowns changed only at rest breaks, the lack of an anesthetist as part of the surgical team, the inadequate ''sterilization'' of instruments, the non-monitoring of patients' pulse and blood pressure during surgery, and the ignoring of regulations concerning the number of sterilizations to be performed per surgical team per day.

The report noted that the ''government sponsored campaign to meet [quota] targets set for each state by end of the fiscal year . . . [led to] a uniformly high risk of deaths in camps [during the] campaign season and a markedly reduced risk in the balance of the year.'' Another factor contributing to ''unsatisfactory outcomes'' was the ''speedy completion of the sterilizations . . . by the surgical teams who are anxious to return to their home base.''

Although one could go on and on in like vein, perhaps the best overall summation of what is really going on in India's sterilization camps was the devastating reply of two Indian physicians to a glowing Lancet editorial endorsing the camps.

The doctors noted that in some cases ''a bicycle pump [was] being used to create a pneumoperitoneum'' for laparoscopic sterilization—a grim symbol of how medical standards have been lowered in the zeal to meet national sterilization targets.''

They wrote of laparoscopes being ''reused after a quick wash,'' of ordinary, non-sterile ''air (not carbon dioxide)'' being used to create a pneumoperitoneum, of the ''high incidence of uterine perforations,'' of complications which ''are rife'' and a ''case fatality rate as high as 70 per 100,000.'' [See above] They condemned the system in which ''local authorities are under pressure to achieve set targets and the doctors are paid on a case basis,'' while ''inducements (cash or otherwise) are routinely sanctioned to candidates for sterilization and the motivator is similarly rewarded.''

Under such conditions, the doctors declared, ''informed consent is certainly not obtained.''

POST DOCUMENTS INDIAN HORROR

PRIZES

In the yard outside the sterilization center were ''tables of prizes for the government workers who had brought in the most women. Three patients won the worker a wall clock, 5 a transistor radio, 10 a bicycle and 25 a black-and-white television.''

At another camp in neighboring Saharanpur, the reporter noted that prior to the sterilization, blood samples were taken by a medical assistant who ''pricked each woman's finger—using the same needle on all the women. . . .''

But how voluntary have been the individual decisions made by these millions to submit to being sterilized? During the 1970s, several million Indian men were forcibly vasectimized. Now, critics of India's sterilization program say it is still ''inhuman because it relies on quotas, targets, bribes and frequently coercion. . . .''

These critics note that most of the women who are sterilized are poor and illiterate, and have been ''lured to the government sterilization clinics and camps with promises of houses, land or loans by government officials under intense pressure to meet sterilization quotas.''

V.M. Singh, a legislator from the State of Uttar Paradesh, declared that ''[e]very single thing in my district leads to one wretched thing: Will the woman be sterilized?'' Singh explained that ''[p]eople are told if they want electricity, they will have to be sterilized. If they want a loan, they have to be sterilized.''

Singh, who has complained about the situation to the state government, said that officials in his district and others along the border with Nepal, in order to meet their quotas, often ''resort to bribing Nepalese women to travel to India for sterilizations.''

The Post noted that the pressure for sterilization is especially acute in India's poor northern states, which ''impose sterilization quotas on virtually every government employee in the district, from tax collectors to schoolteachers. If they don't meet the quota, they don't get paid,'' explained V.M. Singh.

For most village women, months of negotiation precede the trip from their simple mud huts to the stained sheets of the makeshift operating table. The discussions do not begin with medical personnel, however. Rather, it usually begins with a local government bureaucrat, the ''motivator'' who will be paid for each woman he can deliver, telling the husband that ''if his wife undergoes a sterilization she will receive 145 rupees (about $4.60) and the family may qualify for materials for a new house, or a loan for a cow, or a small piece of land.'' And so another woman is off to a sterilization camp where she too can wind up on the ''recovery room'' floor.

THE DISASSEMBLY LINES; INDIAN WOMEN STERILIZED UNDER INDUSTRIAL CONDITIONS

(By James A. Miller)

Editor's note: Population control is literally and figuratively dehumanizing. In India, thousands of women are being herded into mass sterilization camps, where surgeons mutilate their reproductive organs in assembly line-fashion under unsanitary conditions, sometimes using bicycle pumps as medical instruments, and where mortality rates reach as high as 500 per 100,000 sterilizations. This article, the first of two parts, focuses on one such sterilization camp in Kerala, India.

Written consent was obtained at this time and the women were seen affixing their signatures to some printed forms. However, very little about the sterilization procedure was explained to them, nor were any alternative options offered.

On average, it took just four to five minutes for the completion of this three-stage procedure. Since three women were going through the different stages simultaneously, the total time taken for all 48 women was just 128 minutes—i.e., two hours and eight minutes. The surgeon thus spent an average of only two minutes and 40 seconds per sterilization.

The linen on the three makeshift operating beds was never changed during the course of the day's surgeries. Moreover, the surgeon never once changed his gloves during the course of the 48 surgical procedures he performed. Unfortunately, this disregard for aseptic conditions is quite common in the Indian sterilization camps and has been reported often through the years.

POST-OPERATIVE CARELESSNESS

All of women who were sterilized had to walk by themselves back to hall, which now served as the post-operative ward. They lay on the nine available cots, usually two per cot. The rest were accommodated on bed sheets spread out on the unswept floor, five women per sheet.

As each woman lay down on a cot or a sheet, a nurse sprayed the area around the abdominal incisions with an antiseptic and dressed the small wounds. The women were provided with an antibiotic and a pain killer and were instructed to contact the local JPHN in case of any problems. No doctor examined or counseled the women after surgery.

As the number of women of women who had been operated on increased, the available space in the hall begin to shrink. The last of the women had to lie on a bed sheet at the entrance to the bathroom, which was being used extensively by the women and their attendants. Extensive seepage from this overused bathroom barely missed the feet of the women lying on the bed sheet near it.

While the operations were proceeding, the District Medical Officer (DMO) came to inspect the hospital. He condemned certain items of equipment which were being used. The JPHNs and JHIs at the camp took the opportunity to inform the DMO about the problem of non-payment of incentive money to their clients during the previous months. (An incentive payment of 145 Rs is paid to sterilization acceptors.) The JPHNs and JIHIs knew that the people they served were upset that the incentive payments had not been immediately disbursed, and they were worried that as word spread in the community they would find it difficult to ''motivate'' future clients.

The surgeon and his team left the camp by 3:45 p.m., shortly after completion of the operations. Most of the JPHNs and JHIs also left the camp immediately, leaving the women and their attendants to fend for themselves. By 4:30 p.m., many of the women began leaving the premises, although they could barely walk; none of them were permitted to stay in the building beyond 5 p.m.

DARK AND DIRTY BUSINESS

As for the operating theatre, sometimes the ''flooring was dusty and unclean [and] the lighting . . . was very poor. . . .'' At many places the artificial light which was available was ''insufficient and uncertain because of drop[s] in voltage or power out[ages].'' Nonetheless, at some of the camps the surgeons operated ''round the clock through day and night with very scanty light—only one torch for two tables or so.''

Usually there was a shortage of linen required for the numbers of women to be operated on, and the sterilization of instruments and linen was inadequate. Often the local nursing staff who assisted the operations seemed to be ''assisting for the first time,'' which in fact was the case, as subsequent inquiry discovered. Moreover, the pre-operative preparation of the patients was so unsatisfactory that some of the women had apparently eaten recently and/or had not properly evacuated themselves, resulting in some even voiding on the operating table, causing a postponement in their sterilization.

Although the team of observers found the Kerala camp conditions ''appalling,'' they

were ''not as bad as elsewhere in the country.''

In many instances the sterilization camps were conducted in makeshift locations without even a thought to aseptic conditions. School classrooms have been used without any effort to disinfect them, and ''rusted, broken down tables draped with soiled rubber sheets have been used as operating tables.'' Surgeries have been performed with ''just one bucket of water for the surgeons to 'disinfect' their hands before operating.'' The same syringe has been used on all the clients.

WITH FRIENDS LIKE THESE: FERTILITY REDUCTION FAILS TO MAKE BANGLADESH RICH

(By Jacquelin Kasun)

The government does well to take very seriously what Messrs. Merrill and Piet say; according to US law, countries which receive US foreign aid must take steps to reduce their rate of population growth.

And the evidence suggests that the country is making a good faith effort in this regard. Fifty-three thousand family planning workers provide doorstep delivery of birth control services. Although the law restricts abortion to the saving of the mother's life, ''menstrual regulation''—removal of the womb's contents without a prior test for pregnancy—is widely available, often performed by person with only ''informal'' training. The press also reports that government doctors perform illegal abortions in clinics without anesthesia or sanitation.

The government pays women about $3 each, plus a new saree, to be sterilized. Men receive $4 plus a new lungi. The Sun reports that the numbers go up just before the rice harvest, probably because people are hungriest then. The Sun also reported that women's sterilizations were being performed with quinacrine, which severely burns the fallopian tubes. The women are unaware of the risks until they suffer the consequences.

An aid-dependent poor country whose people are mostly illiterate, Bangladesh is an ideal place to test birth control methods. Eager grant seekers in the United States can support their research and their professional advancement by doing experiments in Bangladesh. Local women's rights groups, such as UBINIG and its intrepid leader Fairda Akhter, give evidence that Norplant providers refuse to remove the implant even when the women suffer debilitating side effects. Losing subjects from the sample spoils the results of the research. Removing implants also uses resources that could be used to insert them and meet the quotas.

CHINESE ADMIT POLICY IS COERCIVE

Urban couples generally comply with the policy, the article reports, because they pay high fines and risk losing important benefits by having more than one child. In the countryside, where most Chinese live, enforcement is more difficult, the article maintains.

Rural officials are responsible for meeting family planning quotas. Some take bribes to neglect to report births. Some resort to terror and force to make sure the rules are followed. 'It would be better to have blood flow like a river than to increase the population by one' reads one rural slogan, according to a report by the Chinese newspaper International Trade News.

Women must get regular checkups and certificates to prove they are not pregnant. Those with unauthorized pregnancies are ordered to have abortions, the article reported.

The article declared that the highest birth rates are in China's poorest counties, where farmers still need their children's labor and rely on their support in old age. Those who have extra children are fined, but some are unable or unwilling to pay.

In many areas, the article declared, officials are turning to economics to help make their arguments. ''If you want to get rich have fewer kids and raise more pigs,'' says one sign painted on a wall.

FROM THE COUNTRIES: QUINACRINE IN INDIA, ESTONIANS DECLINE, MORE CONDOMS FOR UGANDA, QUINACRINE IN INDIA

Thousands of illiterate women in India and Bangladesh have been used as ''guinea-pigs'' without their knowledge in unauthorized trials of quinacrine, a derivative of quinine used to perform chemical sterilization by scaring and burning a women's fallopian tubes.

Although the ''Q method'' is illegal in India and has ''no medical sanction'' in Bangladesh, more than 10,000 women have been sterilized with quinacrine by a single medical practitioner in India's West Bengal state alone, with similar trials going on in Mumbai, Bangalore and Baroda; in Bangladesh's southeastern Chittagong district more than 5,000 women have been sterilized with quinacrine. In a documentary film on the ''Q Method,'' a doctor at Delhi's Lady Hardinge Medical College admitted using quinacrine on women in Delhi.

A group of doctors under the aegis of the Contraceptive and Health Innovations Project (CHIP) in Karnataka, South India, completed a quinacrine sterilization trial on 600 women in July 1996, and are currently involved in a 2-year project Ato sterilize 25,000 women.

Health activists claimed that the U.S. Agency for International Development has ''funded quinacrine supplies to India,'' along with a ''zealous population control at any cost'' international lobby. Since the quinacrine method requires no surgery or anesthetic, and no real follow-up, and costs only one dollar per case, it has become a favorite weapon for such groups.

TOO MANY PEOPLE? NOT BY A LONG SHOT

(By Steven W. Mosher)

The most notorious example is China, where for a decade and a half the government has mandated the insertion of intrauterine devices after one child, sterilization after two children, and abortion for those pregnant without permission.

Btu the use of force in family-planning programs is not limited to China. Doctors in Mexico's government hospitals are under orders to insert IUDs in women who have three or more children. This is often done immediately after childbirth, without the foreknowledge or consent of the women violated.

Perhaps the practice in Peru, where women are offered 50 pounds of food in return for submitting to a tubal ligation, cannot properly be called coercive. Still, there is something despicable about offering food to poor, hungry Indian women in return for permission to mutilate their bodies. And the potential for direct coercion is ever present, given that Peruvian government doctors mut meet a quota of six certified sterilizations a month or lose their jobs.

THIRD WORLD POPULATION GROWTH: FIRST WORLD BURDEN?

(By Steven W. Mosher)

At the time the NSC report was written, India was in the middle of its infamous ''compulsuasion'' campaign. Although this strange word was an amalgam of compulsion and persuasion, the emphasis was definitely on the former. No longer was our congenial Indian villager merely to be given boxes of contraceptives with which to build temples. Instead, he was to be sterilized. Governments officials were assigned vasectomy quotas, and denied raises, transfers and even salaries until they had sterilized the requisite number of men.

At the same time it was privately commending India's programs, the NSC strongly cautioned against public praise. ''We recommend that US officials refrain from public comment on forced-paced measures such as those currently under active consideration in India . . . [because that] might have an unfavorable impact on existing voluntary programs.''

STATEMENT OF M. GRACIELA HILIARIO DE RANGEL OF MEXICO

My name is Maria Graciela Hilario de Rangel. I am from the city of Morelia. I have had IUD's placed into me twice. The first time was ten years ago, when one was placed in me before I was released from the clinic. I later had it removed.

The second one was placed in me eight months ago after the birth of my baby. On this occasion, I repeatedly told the doctor that I did not want the device placed in me. He did not pay any attention to me and ignored my protests. He placed the device in me anyway.

Afterwards, the chief physician of the clinic told me he accepted responsibility for this act. I could place a complaint after I left the clinic, he said, but that his actions were protected by law. He did not tell me which law or when it was issued. I asked him for his name and he replied that he was Doctor Ildefornso Ramos Aguilar and that his office was in Morelia. He insisted that his doctors were authorized by law to place the devices and that the reason was to ''protect'' women.

I had the IUD removed 40 days later, but only after great difficulty. I went to the clinic several times, asking to have it removed, but each time I was sent away under the excuse that they did not thave the proper personnel to do it, or did not have the right instruments, or they had too many patients, or some other excuse. I finally told them I would not leave the clinic until they removed it. Only then did they remove it. I did not file a complaint against the clinic because the chief physician had told me that their actions were protected by law.

FAMILY PLANNING: POPULATION CONTROL IN DRAG

(By David Morrison)

Later that decade, according to the US Agency for International Development, the military government of Bangladesh employed soldiers to round up women for IUD insertions, besides threatening to withhold schoolteachers' wages unless they began using contraception.

In the eighties, according to a British Broadcasting Corporation documentary, another US-funded ''family planning'' organization used US tax dollars to mislead Bangladeshi and Haitian women about Norplant's side-effects prior to insertion. Then, when the women became seriously ill, removal was refused.

During the same decade targets became common. Twenty-five countries, ranging from the Philippines to El Salvador, set monthly quotas for numbers of sterilizations. As they invariably do, these quotas led to US women being sterilized without their consent or under false pretenses as workers scrambled to meet them. In Bangladesh, women whose families were driven from their homes by flooding were told they would not receive international humanitarian assistance until they submitted to sterilization.

During the nineties, right to the present day, some Mexican government hospitals, according to sworn depositions collected by

human rights activist Jorge Serrano, routinely sterilize or insert IUDs into women delivering their second or third child without their foreknowledge or consent, and (sometimes) even over their objections, immediately after giving birth. With the uterus expanded from childbirth, it is impossible to correctly size an IUD, which can embed in the uterine walls as the womb contracts. Then there is the well documented horror of forced abortion and sterilization promoted by the Chinese ''one-child'' policy, and supported by ''family planners'' like the United Nations Population Fund (UNFPA) and the International Planned Parenthood Federation (IPPF).

SRI LANKAN POPULATION ATROCITIES

In the Indian Ocean island state of Sri Lanka, female plant workers are being forced to undergo sterilization at government run clinics by health workers who are ''concerned only with meeting official [population] targets.''

Researcher Padma Kodituwakku of the Colombo-based ''Women and Media Collective,'' produced the study which discovered the ''dark side'' to the government's program to keep the country's birth rate in check. Each of the sterilized women was paid 500 Rupees—US $12.50—to undergo the surgery, ''ligation and resection of the [fallopian] tube.''

Kodituwakku's research revealed that the predominately Sinhalese speaking health workers used ''subtle coercions'' to force minority Tamil-speaking women to agree to the operation to foil the birth of their third child. In every case investigated the woman was made to feel guilt for having so many children; they were ''ignorant and irresponsible breeders'' whose reproduction needed to be curbed.

BAD BLOOD IN THE PHILIPPINES? POSSIBLY TAINTED VACCINE MAY BE TIP OF THE ICEBURG

(By David Morrison)

Philippine women may have been unwittingly vaccinated against their own children, a recent study conducted by the Philippine Medical Association (PMA) has indicated.

The study tested random samples of a tetanus vaccine for the presence of human chorionic gonadotropin (hCG), a hormone essential to the establishment and maintenance of pregnancy.

The PMA's positive test results indicate that just such an abortifacient may have been administered to Philippine women without their consent.

Individual women who have lost children to miscarriage after accepting the anti tetanus vaccine have already been found to have antibodies to hCG. Dr.Vilma Gonzales had two miscarriages after receiving the tetanus vaccine and became suspicious. She had her blood tested for anti-hCG antibodies and found, to her great sorrow, that these were present ''in high levels.'' As she later told a British Broadcasting reporter:

''Women should have been told that the injection would cause miscarriage and, in the end, infertility. The Department of Health should have asked beforehand, so that only those who didn't want to have children had the injection. I really hope and pray to God that I will still have a baby and get a normal pregnancy. And I am still hopeful that the Department of Health will find an antidote to the antibodies as well.''

The possibility that Philippine women were being covertly dosed with an abortifacient vaccine got widespread attention after Human Life International, an international pro-life group, reported on peculiar tetanus vaccination programs in the Philippines, Mexico and Nicaragua.

Current WHO-funded research in the United States, according to a leading researcher, has ''moved on'' from tetanus to diphtheria as the antigen link. For even greater efficiency and wider reach, the possibility of doing away with the antigen link altogether is also being explored.

But from the point of view of numerous Filipinas, the most disturbing allegation against Talwar is that he has, in the past, tested his abortifacient vaccines on women without first testing them on animals. Both Indian researchers and WHO officials are on record as declaring that such abuses have occurred. Their testimony has helped fire opposition to the vaccine, especially on the part of women's groups.

MEXICAN STERILIZATIONS

More than 300 Mexican women have documented their experiences with forced sterilization at the hands of Mexican population controllers, and an activist group claims to have gathered evidence of ''thousands'' more.

''Women are being trampled. Their rights are being trampled,'' said Jorge Serrano Limon, director of Pro-Vida, the Mexican group which has been investigating the issue.

''Sterilizing our population against its will is a complete violation of human rights,'' he said. ''We want to make an anguished appeal to the President to stop this genocide,'' he said. ''We can't let it happen that after these campaigns we are going to have a sterile Mexico.''

Pro-Vida held a press conference in Mexico City at which Rocio Garrido, a woman from the Puebla State, told of how she had been threatened with sterilization when she went to the hospital to deliver a baby.

Rocia reported that she later discovered an Intra-Uterine Device had been inserted into her womb without her consent. Hospital records back up her account. More than 40 other women from Puebla state sued the state health institute earlier this year for allegedly planting IUDs in them without their consent or knowledge. Some claimed to have been infected during the unauthorized procedures.

A spokesman for the Mexican Ministry of Health denied any government campaign to force women to be sterilized. (Mexico forcibly sterilizing, Reuters, 11 October 1996.)

BURN, BABY, BURN: QUINACRINE STERILIZATION CAMPAIGN PROCEEDS DESPITE RISKS

(By David Morrison)

This interpretation is supported by the coercion and dissembling that has surrounded quinacrine trials to date.

The largest clinical trial of the drug has taken place in Vietnam—a nation governed by a one-party dictatorship which is currently making a concerted push to lower the birth rate. Did Vietnamese women participate voluntarily in clinical trials, or were they coerced? There are allegations, made in a Vietnamese language publication called The Woman, that at least 100 of the participants in the Vietnamese study had quinacrine inserted without their knowledge during pelvic examinations. Faced with these and many other charges this study was suddenly halted in 1993.

There are also credible reports that ever-growing numbers of women are being sterilized without any standard drug trial protocol at all.

In Pakistan, for example, a Dr. Altaf Bashir of the Mother and Child Welfare Association in Faisalabad has reported sterilizing women with quinacrine at the rate of 100 a month. Most of the women were found in ''street camps'' or were otherwise tracked down and ''motivated'' by Bashir's staff.

Because so many women did not return to the clinics for the second insertion of the drug Bashir took up a single insertion approach, even though much of the available research so far argues against a single insertion being sufficient to cause complete sterility. An independent nurse practitioner who observed Bashir's work had this to say about it:

''Some patients are recruited at 'street camps' and given little information or time to fully understand and think about the implications of this type of procedure. Patients receiving treatment at regular clinic facilities receive a bit more information, but are not informed that this method has not been formally sanctioned for use in Pakistan. Insertions are primarily conducted by lady health workers (not doctors) with limited clinical skills necessary to rule out any underlying pathology. Essentially no follow up of these patients is conducted. The patient is told to 'return if she has any problems.' Those that don't return are assumed to have no problems, no pregnancies, etc. There is no mechanism established for follow up of these patients.''

THE CASE OF THE DALKON SHIELD

(By James A. Miller)

Government officials, A.H. Robins executives and Pathfinder Fund administrators (among others) conspired in the early 1970's to dump hundreds of thousands of dangerous unsterilized contraceptive devices—unmarketable in the United States—into the developing world, according to a recent analysis of government and other documents. These devices were Dalkon Shields.

Robins' international marketing director wrote to USAID to interest it in placing ''this fine product into population control programs and family planning clinics throughout the Third World.'' The deal was sweetened with a special discount: the company offered USAID the Shield in bulk packages, unsterilized, at 48 percent off the standard price!

One of the greatest hazards associated with the use of any IUD is the possibility of introducing bacteria into the uterus. Accordingly, all IUDs sold in the United States come in individual sterilized packages, with a sterile, disposable inserter for each device. The sale of non-sterile IUDs would be highly irregular in the United States, and would probably result in product liability suits.

Careful to preserve its image and to protect itself legally, Robins emphasized that USAID could not distribute the nonsterile Shields in the United States. A January 1973 Robins memo declared that the nonsterile form of Shields ''is for the purpose of reducing price . . . [and] is intended for restricted sale to family planning/support organizations who will limit their distribution to those countries commonly referred to as 'less developed.'

Robins expected practitioners in such countries to sterilize the Shields by the old-fashioned method of soaking them in a disinfectant solution, a procedure which, in the U.S., would border on malpractice. Moreover, Robins provided only one inserter for every 10 Shields, thus greatly increasing the possibility of infection.

Robins included only one set of instructions with every 1,000 Shields, and those were printed in just three languages, English, French and Spanish. Although the devices were destined for distribution in 42 countries, many of them Moslem and Asiatic, it is highly unlikely that they were read by more than a small number of people.

When USAID officials asked whether Dalkon Shields could be safely inserted by staff workers of remote family planning clinics, who would not have had the benefit of an American medical education, Robins replied

that was no problem. This was not what the company had argued in the U.S., where it customarily countered reports of adverse medical reactions by blaming unqualified personnel, such as the occasional general practitioner, for inserting the device.

Ravenholt approved the deal. Hundreds of shoe box-sized cardboard cartons, each filled with 1,000 unsterilized Dalkon Shields paid for by the U.S. Treasury, left the America's shores bound for clinics in Paraguay, El Salvador, Thailand, Israel and 38 other countries. The big Dalkon dump was on.

Altogether, USAID purchased and shipped more than 700,000 Dalkon Shields for use in the Third World. Slightly more than half of the Shields went to IPPF. The rest were provided to the Pathfinder Fund, the Population Council, and Family Planning International Assistance, all of whom were major grant recipients of USAID.

Although records are sparse and incomplete, Pathfinder's annual reports for fiscal years 1973 and 1974 disclose that it distributed at least 37,602 Dalkon Shield IUDs into the following countries: Indonesia (500), Kenya (5,000), Nigeria (1,000), Tunisia (5,200), Dominican Republic (4,000), El Salvador (2,000), Haiti (350), Jamaica (1,000), and Venezuela (5,000): Israel (500), Senegal (200), Indonesia (500), Tunisia (7,500), Mexico (1,152), Brazil (1,200), Chile (1,500), and Colombia (1,000).

Substantial but unknown quantities of Shields were also shipped by Pathfinder to India, Paraguay, Egypt, Singapore, and Thailand. Since the Dalkon dump of the early 1970's passed without notice, there is reason to be concerned that similar incidents could happen in the future, perhaps with Norplant.

''MARIA GARCIA'': I HAVE WITNESSED MANY ABUSES

I am a medical professional who has worked in Mexican hospitals for several years. I am here today to tell you about the devastating results of U.S. family planning funding sent to Mexico.

Here in the United States, family planning is voluntary. But in Mexico, it is often literally forced on vulnerable women. I have witnessed many abuses.

One common practice I have seen is coerced IUD insertion. This occurs when a woman is about to have a baby. When she comes to the hospital, she is separated from her husband. She is not allowed to see him from the time of the initial exam until she is discharged six hours after delivery.

At the time of her initial exam, doctors ask ''Que vas a hacer para que no te embarasas otra vez?'' ''What are you going to do so you don't become pregnant again?'' If she answers, ''I plan to have more children'' or ''I plan to use the Billings Ovulation Method,'' this is not acceptable. The doctors will continue to harass her throughout her labor and delivery until she says that she agrees to use contraception or have a tubal ligation.

If she says that she is willing to use contraception or have a tubal ligation, this is noted in her medical chart so that medical personnel can reinforce her statement throughout her stay.

If she says ''I don't know,'' she is offered two choices: an intrauterine device, known as an IUD, or sterilization. No other options are given.

None of the risks and complications of these two methods are explained to her. Therefore the patient who agrees cannot be said to have given her ''informed consent.''

The patient is also not asked her gynecological history. A history of repeated Population Research Institute Review 10 March/April 1997 vaginal infections, multiple sex partners, etc., are contraindications to the use of an IUD. But since there is no history taken these women are given IUDs regardless.

If a woman refuses to submit to either an IUD insertion or a tubal ligation, a steady stream of medical personnel, including doctors, nurses, and even social workers, pressures her to choose one of the two options. This pressure steadily increases as the time of the delivery approaches.

All this pressure occurs at a time when the woman is extremely vulnerable. The pain of labor she is experiencing weakens her resistance. I have seen women refuse to accept an IUD or sterilization four or five times during early stages of labor, only to give in when the pain and the pressure becomes too intense. In this way the woman is subjected to a form of torture, without actually having to torture her.

Any women in the audience who have gone through labor will agree that this practice is inhuman. Labor is not the time to be coerced into making possibly irreversible decisions about childbearing, especially when the husband cannot participate.

The more children a woman has, the more she will be pressured to submit to sterilization. After the third child, the pressure to accept tubal ligation is very intense.

Why are the IUD and sterilization the only options offered to women? Because these are once-and-done procedures. They do not require the continuing voluntary participation of the women in question. No further visits to the doctor are required.

The complaints of Mexican women suffering from IUD side effects are frequently ignored. Requests for removal are dismissed. Recently, a woman came to a clinic where I was working to ask that her IUD be removed. It had been inserted the previous month after the birth of her baby. The doctor in charge told her that the pain and abnormal bleeding that she was experiencing would disappear within several months. He refused to remove the IUD or even examine her. She came back the following week, begging to have it removed. I took it upon myself to remove it. Infection was already apparent. This woman is now faced with the possibility of further complications such as adhesions, pelvic inflammatory disease, or sterility serious side effects that may not be discovered until later, if ever.

Women have also been refused medical treatment unless they allow themselves to be sterilized. I recently saw a pregnant woman with a painful umbilical hernia. When she came to the hospital to deliver her baby, she wanted her hernia fixed at the time of delivery. The attending doctor refused to fix the hernia unless she agreed to have a tubal ligation. In other words, the threat of withholding medical attention was used to coerce her assent. The woman insisted that her husband did not want her to be sterilized. The doctor replied that her husband would never know. This conversation occurred in the delivery room just minutes before her baby was born. Can you imagine her dilemma? Despite her desire for more children, she agreed to be sterilized in order to receive much needed medical care.

What makes doctors and other medical personnel willing to violate women's rights and engage in substandard medical practices? Because they risk losing their jobs if they don't conform. Those who refuse to perform tubal ligations or involuntary IUD insertions are fired.

DR. STEPHEN KARANJA: HEALTH SYSTEM COLLAPSED

Our health sector is collapsed. Thousands of the Kenyan people will die of malaria whose treatment costs a few cents, in health facilities whose stores are stocked to the roof with millions of dollars worth of pills, IUDs, Norplant, Depoprovera, most of which are supplied with American money.

Special operating theatres fully serviced and not lacking in instruments are opened in hospitals for sterilization of women and some men. In the same hospitals, emergency surgery cannot be done for lack of basic operating instruments and supplies. Most of the women are sterilized without even knowing it is final. Some with only one child. Some are induced with financial assistance to accept sterilization. Horrified sterilized women now trot from hospital to hospital looking for reversal of the tubal ligation. This is breaking marriages especially when the single child or two succumb to the myriad tropical diseases with easy treatment that is not available.

Millions of dollars are used daily to deceive, manipulate and misinform the people through the media about the perceived good of a small family—while the infant mortality rate skyrockets. Some of this money is not used to educate people on basic hygiene, proper diet or good farming methods that would be useful development, but it appears that the aim of population controllers is to decimate the Kenyan people.

I am a practicing gynecologist in Kenya and I would like to share with you facts about some of the patients I see daily:

A mother brought a child to me with pneumonia, but I had not penicillin to give the child. What I have in the stores are cases of contraceptives.

Malaria is epidemic in Kenya. Mothers die from this disease every day because there is no chloroquine, when instead we have huge stockpiles of contraceptives. These mothers come to me and I am helpless.

I see women coming to my clinic daily with swollen legs—they cannot climb stairs. They have been injured by Depoprovera, birthcontrol pills, and Norplant. I look at them and I am filled with sadness. They have been coerced into using these drugs. Nobody tells them about the side effects, and there are no drugs to treat their complications. In Kenya if you injure the mother, you injure the whole family. Women are the center of the community. The wellbeing of the family depends on the wellbeing of the mother.

Why do you not stop this money being used for contraceptives and use it instead to provide clean water, good prenatal and postnatal care, good farming methods and rural electrification. Do the American people know that the millions of dollars spent for population control are used in the ways I have described? Why does your government not deal directly with our government but instead uses a third party like IPPF, which has no respect for the values of our people and our laws?

USAID is the single biggest supporter and promoter of population control in Kenya. The programs it funds are implemented with an aggressive and elitist ruthlessness. In Kenya the target are always the poor and the illiterate who are pressured and tricked into using dangerous drugs which are often banned in the west, or who are sterilized during childbirth without either their knowledge or consent.

If the funds you use to kill, maim, subjugate, dominate and break us to nothingness were used to cultivate our extraordinary resources, Kenya alone could feed more than half the African continent. Dear Americans, you cannot build your own security on the insecurity and degradation of others. You cannot build your own wealth on the poverty and destitution of people in the least developed nations.

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All this pressure occurs at a time when the woman is extremely vulnerable. The pain of labor she is experiencing weakens her resistance. I have seen women refuse to accept an IUD or sterilization four or five times during early stages of labor, only to give in when the pain and the pressure becomes too intense. In this way the woman is subjected to a form of torture, without actually having to torture her.

Any women in the audience who have gone through labor will agree that this practice is inhuman. Labor is not the time to be coerced into making possibly irreversible decisions about childbearing, especially when the husband cannot participate.

The more children a woman has, the more she will be pressured to submit to sterilization. After the third child, the pressure to accept tubal ligation is very intense.

Why are the IUD and sterilization the only options offered to women? Because these are once-and-done procedures. They do not require the continuing voluntary participation of the women in question. No further visits to the doctor are required.

The complaints of Mexican women suffering from IUD side effects are frequently ignored. Requests for removal are dismissed. Recently, a woman came to a clinic where I was working to ask that her IUD be removed. It had been inserted the previous month after the birth of her baby. The doctor in charge told her that the pain and abnormal bleeding that she was experiencing would disappear within several months. He refused to remove the IUD or even examine her. She came back the following week, begging to have it removed. I took it upon myself to remove it. Infection was already apparent. This woman is now faced with the possibility of further complications such as adhesions, pelvic inflammatory disease, or sterility serious side effects that may not be discovered until later, if ever.

Women have also been refused medical treatment unless they allow themselves to be sterilized. I recently saw a pregnant woman with a painful umbilical hernia. When she came to the hospital to deliver her baby, she wanted her hernia fixed at the time of delivery. The attending doctor refused to fix the hernia unless she agreed to have a tubal ligation. In other words, the threat of withholding medical attention was used to coerce her assent. The woman insisted that her husband did not want her to be sterilized. The doctor replied that her husband would never know. This conservation occurred in the delivery room just minutes before her baby was born. Can you imagine her dilemma? Despite her desire for more children, she agreed to be sterilized in order to receive much needed medical care.

What makes doctors and other medical personnel willing to violate women's rights and engage in substandard medical practices? Because they risk losing their jobs if they don't conform. Those who refuse to perform tubal ligations or involuntary IUD insertions are fired.

DR. STEPHEN KARANJA: HEALTH SYSTEM COLLAPSED

Our health sector is collapsed. Thousands of the Kenyan people will die of malaria whose treatment costs a few cents, in health facilities whose stores are stocked to the roof with millions of dollars worth of pills, IUDs, Norplant, Depoprovera, most of which are supplied with American money.

Special operating theatres fully serviced and not lacking in instruments are opened in hospitals for sterilization of women and some men. In the same hospitals, emergency surgery cannot be done for lack of basic operating instruments and supplies. Most of the women are sterilized without even knowing it is final. Some with only one child. Some are induced with financial assistance to accept sterilization. Horrified sterilized women now trot from hospital to hospital looking for reversal of the tubal ligation. This is breaking marriages especially when the single child or two succumb to the myriad tropical diseases with easy treatment that is not available.

Millions of dollars are used daily to deceive, manipulate and misinform the people through the media about the perceived good of a small family—while the infant mortality rate skyrockets. Some of this money is not used to educate people on basic hygiene, proper diet or good farming methods that would be useful development, but it appears that the aim of population controllers is to decimate the Kenyan people.

I am a practicing gynecologist in Kenya and I would like to share with you facts about some of the patients I see daily:

A mother brought a child to me with pneumonia, but I had no penicillin to give the child. What I have in the stores are cases of contraceptives.

Malaria is epidemic in Kenya. Mothers die from this disease every day because there is no chloroquine, when instead we have huge stockpiles of contraceptives. These mothers come to me and I am helpless.

I see women coming to my clinic daily with swollen legs—they cannot climb stairs. They have been injured by Depoprovera, birthcontrol pills, and Norplant. I look at them and I am filled with sadness. They have been coerced into using these drugs. Nobody tells them about the side effects, and there are no drugs to treat their complications. In Kenya if you injure the mother, you injure the whole family. Women are the center of the community. The wellbeing of the family depends on the wellbeing of the mother.

Why do you not stop this money being used for contraceptives and use it instead to provide clean water, good prenatal and postnatal care, good farming methods and rural electrification. Do the American people know that the millions of dollars spent for population control are used in the ways I have described? Why does your government not deal directly with our government but instead uses a third party like IPPF, which has no respect for the values of our people and our laws?

USAID is the single biggest supporter and promoter of population control in Kenya. The programs it funds are implemented with an aggressive and elitist ruthlessness. In Kenya the target are always the poor and the illiterate who are pressured and tricked into using dangerous drugs which are often banned in the west, or who are sterilized during childbirth without either their knowledge or consent.

If the funds you use to kill, maim, subjugate, dominate and break us to nothingness were used to cultivate our extraordinary resources, Kenya alone could feed more than half the African continent. Dear Americans, you cannot build your own security on the insecurity and degradation of others. You cannot build your own wealth on the poverty and destitution of people in the least developed nations.

[From the Wall Street Journal, Feb. 27, 1998]

IN PERU, WOMEN LOSE THE RIGHT TO CHOOSE MORE CHILDREN

(By Steven W. Mosher)

When a government team held a ''ligation festival'' to register women for sterilization in La Legua, Peru, Celia Durand resisted.

According to Mrs. Durand's now-widowed husband, Jaime, the 31-year-old mother of three was appalled at the pressure tactics government health workers used to induce women to have tubal ligations. Not only did they go house-to-house to round up candidates, but they paid repeated visits to those who refused to comply. Mr. Durand says they reassured his wife that the operation was ''simple and quick,'' adding that she could ''go dancing the same night.''

Even though Mrs. Durand knew that the local health station was equipped with little more than an examination table, pressure from government health workers finally wore her down. On July 4, 1997, she reluctantly underwent surgery. Two weeks later she died from complications.

Celia Durand was part of a massive sterilization campaign by the government of President Alberto Fujimori. It is a classic case of the conflicts of interest and potential for ethical violations inherent in a government sponsored ''family planning'' program. What was originally sold to Peruvians as an altruistic program aimed at helping poor Peruvian women has evolved into an orchestrated attempt to control reproduction and to meet a goal of fewer Indian children in the countryside.

In June 1995 Mr. Fujimori announced that his government would ''disseminate thoroughly the methods of family planning to everyone'' in order to make ''the women of

Peru . . . owners of their destiny.'' What has happened since belies Mr. Fujimori's feminist sentiments.

Until October 1995, even voluntary sterilization was illegal in Peru. With Mr. Fujimori's backing, the Peruvian Congress legalized it. Soon the Ministry of Health, then headed by Eduardo Yong Motta, made sterilization its main method of ''family planning.''

In a Jan. 29 interview with David Morrison of the Population Research Institute, Dr. Yong Motta, now President Fujimori's health adviser, defended the practice of sterilizing women even if they had previously been using other contraceptives such as the injectable Depo-Provera. ''Depo costs too much,'' Dr. Yong Motta said. ''In addition. . . . a women might forget to come in for her shot or might not want to.'' (emphasis added)

By spring 1996 the Ministry of Health had set national targets for sterilizations, and health workers were being given individual quotas. The ministry has been aggressively targeting poor women in rural areas—which in practice means those of Indian or mixed descent—for sterilization. The medical director of the Huancavelica region, for instance, ordered in a written communiqué that ''named personnel have to get 2 persons for voluntary surgical sterilization per month.'' According to this directive. ''At the end of the year thee will be rewards for the site that has . . . the greatest effort to bring in people.''

To meet these targets, mobile sterilization teams travel throughout the countryside, holding ''ligation festivals'' and practicing the kind of coercion that Celia Durand experienced. In many areas health workers receive a bonus for each additional procedure, while they can lose their jobs if they fail to meet their quotas. As the Huancavelica directive notes, ''At the end of the year each person will be evaluated by the numbers of patients captured.''

Dr. Yong Motta openly defends quotas. ''Of course the campaign has targets. . . . [Success is measured] through many methods, including numbers of acceptors verus nonacceptors.'' He admits the dangers of setting targets, but insists that ''the campaign has been a success.''

That Peruvian medical workers under heavy pressure to meet sterilization quotas should resort to coercion is hardly surprising. Knowing full well this danger, the 1994 Cairo Population Conference condemned the use of quotas or targets in birth control campaigns, an admonition Mr. Yong Motta and other Peruvian officials have now admitted ignoring.

Coercion takes various forms. First, there are repeated visits to the homes of holdouts. As one woman in La Quinta remarked, the workers came ''day and night, day and night, day and night to urge me to undergo the operation.''

Various bribes and threats are also employed. According to interviews in villages and press accounts in El Commercio, hungry women are offered the opportunity to participate in food programs, including programs supported by the U.S., if they agree to sterilization. Women already participating in food programs have been threatened with expulsion.

Rural women report that no mention is made of sterilization's health risks. Nor are they given the opportunity to choose alternative methods of family planning; indeed, women using contraceptives have been refused additional supplies. There have even been sterilizations performed on women without their consent, often during the course of other medical procedures. Victoria Espinoza of Piura has testified before a U.S. congressional committee that doctors at a government hospital told her she was sterilized—without warning or permission—during a Caesarean delivery. Her baby later died.

Dr. Yong Motta attempts to defend the pressure tactics. ''If the Ministry of Health did not do the campaign house-to-house, people would not come,'' he asserts. As far as the repeat visits are concerned, ''It was a doctor's responsibility to convince the patient into doing what was best and having [a tubal ligation]. Women in Peru have many children.''

The U.S. has some responsibility for all this. It has been pushing population control in Peru for three decades. As congressional staffer Joseph Rees remarks, ''We have enriched, encouraged, and thus emboldened the Ministry of Health to take decisive action where population growth was concerned.''

Dr. Yong Motta is more blunt, saying that the U.S. Agency for International Development ''is disqualified from objecting [to the sterilization campaign] because they have been helping in the family planning program from the first.''

To understand how oppressive and intrusive Peru's family-planning program is, imagine how you'd feel if someone from the Department of Health and Human Service showed up on your doorstep bearing contraceptives—let alone an order to report for sterilization. Not all government-sponsored family planning programs are this coercive. But there is an element of intrusiveness common to them all. Instead of making poor women in Peru ''owners of their destiny,'' Mr. Fujimori's birth control campaign paternalistically decides their reproductive destiny for all time.

STERILIZATION HORROR STORIES

Bangladesh—Women receiving sterilization and contraception were offered payment incentives of $3 each, plus a new saree. The government also pays incentives to providers for signing up women. Women consent to sterilization out of desperation for food. USAID endorses coercive incentives.

Honduras—USAID funds help implement coercive program for experiments with Ovrette, an unapproved contraceptive bill. Warnings about the experimental drug's side effects on nursing mothers were hidden from the women in the program.

India—Family planning programs depend on quotas, targets, bribes and coercion. USAID funds sterilizations using Quinacrine which is illegal in India and scars/burns the fallopian tubes. Conditions are miserable at the USAID funded sterilization camps, there are primitive, unsanitary conditions and appalling mortality rates.

Indonesia—Family planning clinics rely on threats and intimidation to bring women into the clinics. Studies have shown that IUDs are inserted at gunpoint. The programs employ life-threatening denials of treatment and follow up care and offer an informed consent.

Kenya—Women are coerced into Norplant implantation and sterilization. Sterilized women are denied health care for debilitating complications. USAID is the biggest supporter of population control in Kenya.

Mexico—Hundreds of forced sterilizations are documented. Medical personnel are fired for their refusal to perform sterilizations. Women refusing sterilization are denied medical treatment.

Peru—Family planning programs are coercion, misinformation and quotas and sterilization-for-food efforts. Medical personnel must meet sterilization quotas and surgical staff are insufficiently trained and work under poor conditions. USAID sponsors family planning billboards signaling to Peruvian women that the family planning methods employed are U.S. sanctioned.

Phillipines—USAID targets local governments with quotas as a condition for funding and encourages pharmaceutical companies to push contraceptives on unsuspecting Filipinos. Women are secretly injected with abortifacient while receiving tetanus vaccines.

TEXT FROM EMAILED ARTICLES AND OTHER TEXTUAL EXCERPTS

[From the Latin American Alliance for the Family—Press Release, Feb. 11, 1998]

U.S. GOVERNMENT ASKED TO WITHDRAW POPULATION CONTROL FUNDS FROM PERU FOLLOWING REPORTS OF MASSIVE HUMAN RIGHTS ABUSE

Amid ever-increasing evidence documenting coercive government population control efforts and sterilization campaigns in Peru, the Latin American Alliance for the Family (ALAFA) has called for the U.S. government to withdraw its financial support for Peru's population control efforts which have resulted in the deaths and injury of numbers of Peruvian women, mostly in very poor areas of the country.

Daniel Zeidler, director of the U.S. office of the Latin American Alliance for the Family, an international advocacy organization, following its own investigative efforts in Peru, said ''Peru's population program is seriously violating human rights by pressuring and coercing poor women to be sterilized. Reports and testimonies abound of women being offered food in exchange for agreeing to be sterilized, health workers being pressured to reach government sterilization goals, women being sterilized without their consent or without full knowledge of the implications.''

Numbers of women have died following sterilization procedures. Many women complain that after receiving a free sterilization they suffer serious medical complications and many times are not treated or are told by representatives of the same health system that gave them a free sterilization that the women must buy expensive medications that they cannot afford.

Medical experts have stated that the deaths and complications are due primarily to the poor sanitary and medical conditions under which these operations are performed.

Feminist and campesino leaders as well as Church and human rights leaders within Peru have denounced these campaigns.

Recently, a prestigious independent Peruvian human rights watchdog organization, the ''People's Defender'' recognized the validity of the human rights abuses and called upon the government to immediately reform the program.

The Peruvian government has denied the existence of a sterilization campaign and has minimized the complications, but has indicated it will make changes if necessary.

The involvement of US funds in Peru's population control programs is currently being investigated by Congress. The chief staff person of the U.S. House of Representtives subcommittee on International Operations and Human Rights, Joseph Rees, recently returned from Peru following a fact-finding mission in January. Rees met with feminist, human rights, religious and governemnt leaders as well as interviewing numbers of victims. His official report to the subcommittee, issued February 10, 1998, was critical of USAID's involvement in Peru's family planning programming and recommends that the U.S. ''discontinue all direct monetary assistance to the Government of Peru family planning programs until it is clear that the sterilization goals and related abuses have stopped and will not resume.''

The report also calls for the U.S. to ''discontinue in-kind assistance'' which might directly or indirectly facilitate the sterilization campaigns, and to ''publicly'' disassociate itself from the campaigns.

Zidler called on all those interested in human rights to contact both Congress and the President to urge them to publicly denounce these abuses to the government of Peru and to immediately suspend US populatin funds to Peru.

FACT SHEET NO. 1

SOME OF THE DEATHS RESULTING FROM STERILIZATIONS

Case of Juana Gutierrez Chero (La Quinta, Piura, Peru)—died at home approximately 10 hours after being sterilized; according to her husband she did not want to be sterilized, but the health workers kept coming to their house repeatedly to encourage her to be sterilized. Once she even hid from them. They came for her one day after her husband had left for work. They sent her home shortly after the operation. When her husband returned from work he found her very ill and in bed; he went off to the clinic to see if he could get help, but no one was there; Juana died that night at home about 2 am. (Testimony on video)

Case of Celia Ramos Durand (La Legua)—died about two weeks after undergoing a sterilization to which both she and her husband consented after being told it was a simple operation. According to the family, when she didn't return home from the clinic, the family went to look for her and were told she had been transferred to a hospital. They later found out she had gone into a coma as a result of the operation. (Testimony on video.)

Case of Magna Morales Canduelas (Tocache)—died 12 days after being sterilized. (El Comercio, Dec. 19, 1997)

Case of Alejandrina Tapia Cruz (Cajacay)—died one week after a sterilization operation. (La Republica, Dec. 7, 1997)

Case of Reynalda Betalleluz (Huamanga)—died day after sterilization (La Republica, Dec. 30, 1997)

Case of Josefina Vasquez Rivera (Paimas)—died day after sterilization (La Republica, Dec. 30, 1997)

STERILIZATION WITHOUT KNOWLEDGE OR CONSENT

Example: Case of Victoria Espinoza (Piura). Sterilized following a C-section. Baby also died. (Testimony on video)

FREE STERILIZATIONS, BUT PATIENT MUST PAY FOR COMPLICATIONS

Numbers of newspaper articles reported that women who suffered physical complications were required to pay for their medications. Many reported there was no follow-up by health workers.

FOOD IN EXCHANGE FOR STERILIZATIONS

Example: Case of Ernestina Sandoval (Sullana). She had been told by health workers that she could get free food by going to the local hospital. When she got there, she was told she had to be sterilized in order to receive the food. She refused. She was told she could get the food this month, but that next month she should not come back unless she was sterilized. (Testimony on video) Similar accounts of offering food in exchange for sterilizations have been reported in press accounts.

UNDERWEIGHT CHILD WITHDRAWN FROM GOVT. FOOD PROGRAM BECAUSE MOTHER REFUSED TO BE STERILIZED

Example: Case of Maria Emilia Mulatillo (Sullana). Her 2 year-old daughter was participating in a government food program, but after about two months, Maria was told she should be sterilized. She said she didn't want to be, yet the pressure on her continued, till finally she was told if she didn't get sterilized her child would be withdrawn from the program. She still refused to be sterilized and her child was then withdrawn from the program. (Testimony on video)

In order to get women to accept sterilization, health workers told women their contraceptive would no longer be available and they should get sterilized. (La Quinta)

YOU CAN'T LEAVE THE HOSPITAL UNLESS YOU'RE ON BIRTH CONTROL

Example: Case of Blanca Zapata Aguirre (Sullana). After giving birth she was told she had to have some type of birth control. She said she didn't want anything, but she was given a shot when she was sleeping. She was later told it was for birth control. (Testimony on video) Peru's government manual ''Reproductive Health and Family Planning 1996–2000'' calls for 100% birth control usage by women who have just given birth.

Charges of health workers go house to house, and then back, and back again pushing sterilization are common.

Health workers are reportedly pressured to meet their goals.

Some Health workers received 15–30 soles per sterilized woman (US $6–$12) according to Giulia Tamayo of Flora Tristan feminist organization. (La Republica, Dec. 30, 1997)

FACT SHEET NO. 2

LOTS OF NEWS COVERAGE IN PERU

16 major newspaper articles including numbers of investigative reports over a period of about one month (mid-Dec '97 to mid Jan '98) in the major newspaper EL COMERCIO. Other major newspapers also had significant coverage.) ALAFA has copies of many of these articles. It is impressive just to see the quantity of articles written.

SELECTED NEWSPAPER HEADLINES FROM EL COMERCIO, DEC., '97–JAN., '98

''Nurses Deceived Women in Order to Sterilize Them'' (El Comercio, Jan. 26, 1998).

''Widowers Were Paid Not to Denounce Deaths of Sterilized Wives'' (El Comercio, Jan. 24, 1998).

''Woman hospitalized for 3 months due to infection caused by sterilization'' (El Comercio, Dec. 24, 1997).

''They sterilized woman who was one month pregnant'' (El Comercio, Dec. 23, 1997).

''Woman received clothes for her children in exchange for sterilization'' (El Comercio, Dec. 23, 1997).

''Food Programs Used to Get Women to be Sterilized'' (El Comercio, Dec. 20, 1997).

''They Deceived Me'' (Nurse comes to woman's house after husband had left for work and told the woman that her husband had said she should be sterilized; woman refused to believe it, and refused to go; when her husband returned he denied he had told the nurse that.) (El Comercio, Dec. 20, 1997).

''Children of Woman Who Died Following a Tubal Ligation Are in Total Abandon'' (El Comercio, Dec. 19, 1997).

''Magna Morales Wasn't Sure, But the Donated Food Convinced Her'' (El Comercio, Dec. 19, 1997) (Magna Morales died 12 days later following her sterilization.)

SOME OF THE INTERNATIONAL COVERAGE

LeMonde.
Miami Herald,
Assoc. Press.
France Press(?).
Radio Nederland.
BBC.

[From World, Feb. 20, 1999]

IT TAKES MORE THAN A VILLAGE TO DEPOPULATE ONE

SPECIAL REPORT FROM INSIDE KENYA'S TWO-CHILD POLICY: CONTRACEPTIVE FAMILY PLANNING AND ABORTION ADVOCACY MARK THE KIND OF ''RELIEF'' INTERNATIONAL RELIEF ORGANIZATIONS ENERGETICALLY IMPORT TO EAST AFRICA

(By Mindy Belz)

A large, dusty sign hovering over the used-clothing stalls of Kenyatta Market reads, ''Marie Stopes International—family planning/laboratory services, maternal health, counseling services, curative services, gynecological consultation.'' Steps beckon to a second-floor clinic. It offers extended hours, six days a week, and the door is always open.

Inside, an American woman can inquire about receiving an abortion, if she will be discreet. ''Do you have all forms of family planning here, or do you refer patients to a hospital or somewhere else?''

''Yes, all forms,'' replies a friendly African receptionist.

''If a person were pregnant, but wasn't sure she could go through with it . . .''

''You have to just say what it is you want,'' the receptionist interjects, leaning into the counter and lowering her voice.

''Could a pregnancy be terminated or would that have to be done somewhere else?''

''It can be done here.''

Never mind that abortion in Kenya is illegal. Overseas charity organizations like the British organization Marie Stopes are the van-guard in changing Kenya's cultural reticence to killing unborn babies and limiting family size. They use enticing come-ons promoting ''maternal health'' and ''comprehensive family planning.'' In East Africa and other developing regions of the world, they receive outsized budgets from multilateral agencies in the name of empowering women, improving health conditions, and preserving the environment.

At the behest of the UN Family Planning Association (UNFPA) and international groups including Marie Stopes, the International Planned Parenthood Federation (IPPF), and others, Kenya is embarking on an aggressive family planning program. The UNFPA was denied funding by the United States from 1985 until 1993 for support of China's coercive one-child policy. Its allocation from Washington restored in 1993 by the Clinton administration, the UNFPA is in the middle of a five-year, $20 million program to control Kenya's population. Not content with the dramatic reduction in Kenya's birth rate—which modern contraceptives already have achieved (from 8 children per woman in 1979 to just over 4 children per woman today)—the UNFPA and others are looking to reduce fertility further, to 2 children per woman by 2010.

''We have a two-child policy except in law,'' said Margaret Ogola, a Nairobi physician. ''Practically the only kind of health care you get in this country centers on reproductive health and family planning.''

UNFPA papers refer to a ''decentralized'' national population policy driven by the Kenyan government's National Council for Population and Development. But local direction is not the case, according to Dr. Ogola, who, as a representative for Kenya's Catholic Secretariat, is involved in regular consultations with NCPD. Funding for the NCPD, as for all Kenya's population projects, begins with funding from UNFPA, the World Bank, the World Health Organization, and overseas developers like the State Department's U.S. Agency for International Development (USAID).

From those sources also flow grant and contract awards to groups like Marie Stopes

and to Kenya's IPPF affiliate, Family Planning Association of Kenya (FPAK). USAID does not list Marie Stopes as one of its beneficiaries, but FPAK received direct funding by USAID until 1997, according to FPAK director Stephen K. Mucheke. Mr. Mucheke told WORLD, ''We work in collaboration with other organizations, and sometimes we may be funded by the same donor that is funded by USAID. We share the same implicit plans.''

A little noticed amendment to last year's congressional budget bill should have put U.S. funding for UNFPA's quota-based program out of bounds. The Tiahrt amendment forbids U.S.-funded family planning programs from setting targets or quotas for number of births, sterilizations, or contraceptive prevalence.

Abortion, according to Mr. Mucheke, ''is happening down the street. . . . From an official point of view, I am not supposed to say that there are groups like Marie Stopes performing abortions. What I would say is, if you want to know about products and procedures, ask a consumer.''

In the UN lexicon, so-called private groups like FPAK are referred to as NGOs, or nongovernmental organizations. The NGO consensus holds that most of the problems in the developing world can be solved with more contraceptives. Private pharmaceutical companies also get a piece of the action by contracting with NGOs and government agencies to supply the contraceptives. Groups like IPPF, which cried foul when U.S. judges tried to force Norplant on convicted drug users and child abusers, don't have a problem when it is women in the developing world under not government coercion, but their persuasion.

Common among NGOs, particularly in controversial issues involving family planning, is a practice of ''stripping off'' portions of a large grant to other organizations, in effect subcontracting services in a way that makes following the money a challenge. More common, contraceptive programs reside in programs with blander names.

Thus, even when the Christian relief organization World Vision surveyed its health officers worldwide on family planning issues last year, it found: ''All responding NOs [national offices] are engaged in some type of family planning—related activity, either as a straightforward family planning or reproductive health project or buried within child survival, maternal health or women's health activities.''

As a result of the contraceptive campaign, Nairobi residents are streetwise about birth control. Women who wear Norplant are teased on city buses for the ''battery pack''; the six-capsule implant, just inside a women's upper arm, is revealed when a woman reaches for an overhead strap during crowded commutes.

Shoppers at Kenyatta, a busy nexus between the slum area of Kibera and lower-to-middle class neighborhoods near the downtown area, know where to go for an abortion. They know about the ''copper T'' and ''the loop,'' two different kinds of IUDs. And, like people everywhere, they dismiss much-touted condoms as impractical.

Even Christian women looking for inexpensive, safe, and acceptable contraceptives may be unknowingly referred to Marie Stopes, because it has been known to do some procedures, like tubal ligation, free of charge. The London-based organization gained a reputation for increasing the availability of both sterilization and abortion services in Bosnia and Croatia, countries that now report negative fertility rates.

In addition to performing actual abortions, Marie Stopes and other clinics, along with up to 90 percent of private OB-GYNs, peddle an abortifacient procedure called ''menstrual regulation.'' Similar to what is known in the United States as dilation and curettage (D&C), in Kenya menstrual regulation can be performed as an office or clinic procedure. It is done when a woman misses a menstrual period but without benefit of a pregnancy test. No one knows how many abortions result from menstrual regulation. Even without that tally, in Kenya, according to UN statistics, ''40 percent of all documented schoolgirl pregnancies terminate in abortion.''

But none of it means that women who need help are well informed, according to Stephen Karanja, a long-time Nairobi gynecologist. Dr. Karanja, a Roman Catholic, served as secretary of the Kenya Medical Association and has practiced obstetrics and gynecology at Kenyatta National Hospital, Nairobi's largest public facility, as well as at Mather Hospital, a smaller, private, and Catholic facility. Dr. Keranja helped organize the city's Family Life Counseling Center and has been an activist in upholding Kenya's law banning abortion. In 1992 he opened a clinic at Kenyatta Market—50 yards from the entrance to Marie Stopes. He named it St. Michael's, in honor of the patron saint that does battle with forces of evil.

Most of the women Dr. Karanja sees at St. Michael's have been given no information and little follow-up in connection with the methods of birth control they are using. Last year at the clinic, he removed approximately 200 IUDs.

''Word of mouth has spread, and when women begin to have problems with IUDs, someone tells them to go to 'that crazy man on the hill and he will remove it,'' he said.

He keeps a sampling of those reclamations in a screwtop jar, and when he wants to give a graphic depiction of how women are served by Nairobi birth control providers, he spills the jar's contents across his desk. To a trained medical eye, the devices are throwbacks, copper coiled or loop-shaped IUDs that were taken off the U.S. market at least five years ago. The T-shaped devices had an extremely high failure rate; another IUD, copper 385, contained enough copper wire to be deadly toxic to a developing, tiny unborn child.

Dr. Karanja's patients tell him, in most cases, that the birth-control clinics that inserted the devices are not willing to remove them. ''The services encouraged for poor women are those that are not repetitive,'' he said. ''They are not something the women can decide themselves to change.''

Catholics and evangelical Protestants disagree on where to draw the line on contraceptives. Both, however, see the pitfalls of a national family planning plan. ''In our culture, that is why the message and the messenger have to go together. The church is still custodian of morality in Africa. These are deep-seated issues, and people need to be able to trust the messenger,'' said Peter Okaalet, Africa director of MAP International, a Christian medical relief group based in Brunswick, Ga.

''NGO work has come into acceptance because the government has let us down,'' Mr. Okaalet told WORLD. ''We talk about Kenya as a country with 10 millionaires and 10 million beggars. With half the population living below the poverty line, NGOs are perceived as an answer.''

Dr. Ogola agrees: ''No individual, not even combined force of the churches—and it is a force to be reckoned with in this country—can compete with the massive propaganda and funding. The government has to wake up to the fact that its people are important and its policies have to be home-grown.

''We have to tell the government to resist. That is very hard when the government is broke and the donors are offering millions for family planning.''

□ 1330

Mr. CHABOT. Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. PITTS).

Mr. PITTS. Mr. Speaker, I rise today in support of House Resolution 118, a resolution to reaffirm that this Congress is committed to the principle that all family planning, both in the United States and, as we are addressing in this resolution, abroad should be voluntary.

It is critical that we affirm this commitment to voluntary family planning because even this week there is a gathering at the United Nations to discuss a 5-year review of family planning and population development progress since the same Cairo conference 5 years ago.

Since this conference 5 years ago, we have heard some disturbing accounts of women around the world becoming victims of coercion by agents of the United Nations. These women's choices are being limited against their will.

Is this what so-called population control advocates really want, to tell these women, many of whom are poor and scared, that they can never again bear more children? Well, we have seen the evidence, and that is why it is important for Congress to speak up about this today.

For instance, in Peru, what has population control come to mean? Education? Money to buy clean sanitary medical conditions? Even lessons about potential contraception?

No. Instead, population control and family planning has come to mean forced, mandatory and coerced sterilization of poor Peruvian women.

Have these women chosen such paths for their reproductive futures? Have they been able to discuss options with their husbands and families?

No. Without notification and without consent, the international community has strayed from voluntary family planning and is instead actively pursuing targets and quotas and deciding for poor women what is best for them.

In Peru, as in many other locations around the globe, this has resulted in sterilizations, sterilizations in filthy, primitive conditions, just to meet a mandated quota.

Similarly, in the BBC documentary ''The Human Laboratory,'' women told their stories about how U.S. taxpayer dollars were being used for family planning in Bangladesh, in Haiti. One woman begged to have a Norplant removed. She said, quote, ''I am having so many problems. I am confined to bed most of the time. Please remove it. My health broke down completely.'' She eventually resorted to pleading, ''I am dying, please help me get it out.''

Here was the response. The clinic worker told her, quote, okay, when you die, you inform us and we will get it out of your dead body, end quote.

Many other women have complained of severe bleeding, blindness, migraine

headaches. According to Farida Akhter, executive director of the Research for Development Alternatives in Bangladesh, quote, it is cheaper to use Third World women for such birth control experimental devices and methods than to use an animal in the laboratory in the West, end quote.

Through such grossly unjust experimentation, poor women have been robbed of the most important resource they have, their own healthy bodies. A woman's health is key to the survival of her entire family in many of these countries, and this must come to an end.

In the name of population control and under the guise of family planning, America and the United Nations have exported horror to women abroad. And our family planning advocates call this progress?

Mr. Speaker, we should be calling it by the most descriptive and accurate term that it is: Slavery.

I urge my colleagues to join in support of the Tiahrt resolution today. Reaffirm that all family planning programs should be completely voluntary. Help maintain the dignity of women around the world.

Mr. GEJDENSON. Mr. Speaker, I yield back the balance of my time.

Mr. CHABOT. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we would urge adoption of the resolution. I think it is a very good resolution. I want to again thank the gentleman from Kansas (Mr. TIAHRT) for proposing it.

Ms. JACKSON-LEE of Texas. Mr. Speaker, today I join my colleagues in support of House Resolution 118, which reaffirms the principles of the Programme of Action of the International Conference on Population and Development. This Programme of Action addresses the sovereign rights of countries and the rights of informed consent in family planning programs.

This resolution states that all family planning programs should be voluntary and completely informative on the various planning methods. Informed consent and voluntary participation are essential to the long-term success of any family planning program.

Family planning programs are an essential part of reproductive health care. Each year an estimated 600,000 women die as a result of pregnancy and childbirth most in developing countries, where pregnancy and giving birth are among leading causes of death for women of childbearing age.

With the current world population at over 5 billion and growing, we must support international family planning programs. Women in under-developed countries must have access to information that will allow them to make informed reproductive health decisions concerning contraception and the spacing of their children.

In supporting this Programme of Action, we support international reproductive health services and the sovereign right of other countries to make decisions concerning the well-being of their citizens.

Mrs. LOWEY. Mr. Speaker, I am pleased that the resolution we are debating today quotes from the Programme of Action of the International Conference on Population and Development. As many of my colleagues know, the ICPD met in 1994 and reached a consensus on a 20-year Programme of Action that makes an unprecedented commitment to women's rights and concerns in international population and development activities.

I applaud my colleagues for supporting the implementation of the Programme of Action. But since the authors of this resolution left out a good portion of the Programme. I'd like to fill in our colleagues about the rest of it, because it also deserves our strong support.

The Programme of Action calls for universal access to a full range of basic reproductive health services. It also calls for specific measures to foster human development, with particular attention to the social, economic, and health status of women. It supports integrating voluntary family planning activities with other efforts to improve maternal and child health to make the most effective use of our limited resources.

The resolution we are debating here today discusses the need to respect the religious and cultural realities of the countries in which we fund family planning activities. I agree. I also believed that we need to respect the rights of women around the world to make free and informed choices about their own reproductive health. And we need to help educate women and men to ensure that they have the information and resources they need to stay strong and healthy and to nurture healthy children.

In addition to supporting the portions of the Programme of Action included in the resolution we are debating today, the United States also must live up to the financial commitments it made at the ICPD.

To reach the Programme's year 2000 goal of providing $17 billion for international family programs worldwide—one-third of which would come from donor countries like the United States—the United States would have to triple its international family planning assistance.

Mr. Speaker, I am pleased that the authors of this resolution support the ICPD's Programme of Action. Now I look forward to working with them to implement all aspects of the Programme.

Mr. CHABOT. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. BASS). The question is on the motion offered by the gentleman from Ohio (Mr. CHABOT) that the House suspend the rules and agree to the resolution, House Resolution 118.

The question was taken; and (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

A motion to reconsider was laid on the table.

SENSE OF HOUSE REGARDING HUMAN RIGHTS IN CUBA

Ms. ROS-LEHTINEN. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 99) expressing the sense of the House of Representatives regarding the human rights situation in Cuba, as amended.

The Clerk read as follows:

H. RES. 99

Whereas the United Nations Commission on Human Rights in Geneva, Switzerland, is an international mechanism to express support for the protection and defense of the inherent natural rights of humankind and a forum for discussing the human rights situation throughout the world and condemning abuses and gross violations of these liberties;

Whereas the actions taken by the United Nations Commission on Human Rights establish precedents for further courses of action and send messages to the international community that the protection and promotion of human rights is a priority;

Whereas the Universal Declaration of Human Rights which guides global human rights policy asserts that all human beings are born free and live in dignity with rights;

Whereas international human rights organizations, the Inter-American Commission on Human Rights, and the Department of State all concur that the Government of Cuba continues to systematically violate the fundamental civil and political rights of its citizens;

Whereas it is carefully documented that the Government of Cuba propagates and encourages the routine harassment, intimidation, arbitrary arrest, detention, imprisonment, and defamation of those who voice their opposition against the government;

Whereas the Government of Cuba engages in torture and other cruel, inhumane, and degrading treatment or punishment against political prisoners including the use of electroshock, intense beatings, and extended periods of solitary confinement without nutrition or medical attention, to force them into submission;

Whereas the Government of Cuba suppresses the right to freedom of expression and freedom of association and recently enacted legislation which carries penalties of up to 30 years for dissidents and independent journalists;

Whereas religious freedom in Cuba is severely circumscribed and clergy and lay people suffer sustained persecution by the Cuban State Security apparatus;

Whereas the Government of Cuba routinely restricts workers' rights including the right to form independent unions;

Whereas the Government of Cuba denies its people equal protection under the law, enforcing a judicial system which infringes upon fundamental rights while denying recourse against the violation of human rights and civil liberties;

Whereas in recent weeks the Government of Cuba has carried out a brutal crackdown of the brave internal opposition and independent press, arresting scores of peaceful opponents without cause or justification;

Whereas the internal opposition in Cuba is working intensely and valiantly to draw international attention to Cuba's deplorable human rights situation and continues to strengthen and grow in its opposition to the Government of Cuba;

Whereas at this time of great repression, the internal opposition requires and deserves the firm and unwavering support and solidarity of the international community;

Whereas the Congress of the United States has stood, consistently, on the side of the Cuban people and supported their right to be free: Now therefore, be it

Resolved, That the House of Representatives—

(1) condemns in the strongest possible terms the repressive crackdown by the Government of Cuba against the brave internal opposition and the independent press;

(2) expresses its profound admiration and firm solidarity with the internal opposition and independent press of Cuba;

(3) demands that the Government of Cuba release all political prisoners, legalize all political parties, labor unions, and the press, and schedule free and fair elections;