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EDITORIAL NOTE

The Editorial Board regretfully records the retirement of our President, Sir Alexander Hadow. A new appointment will be made at the A.G.M.

In Part 7 of Volume 2, of the **Proceedings of the Medical Association for the Prevention of War** two papers based on addresses given at the Conference at the University of Sussex, in July 1972, are presented together with four book reviews.

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THE CHANGING FACE OF GENOCIDE—

BANGLADESH, 1971-2

An account of the problems met during the post-war IPPF Abortion Programme.

GEOFFREY DAVIS

Part of the overall plan for the subjugation of Bangladesh involved an order from Islamabad to the West Pakistan army to impregnate systemtically as many Bengali women (married or unmarried) as possible. The rationale was that this would disrupt the racial integrity of which Bengalis are so proud. Some reliance was also placed on the Muslim belief that a good son will fight anyone except his father.

After the cease-fire, Bangladesh authorities discovered, among their myriad problems, large numbers of pregnant girls in their early teens. International agencies were asked for assistance and a nation-wide abortion programme was hastily organized. During this it was discovered that the country's law remained natalist. Bangladesh, the country with the worst population problem in the world, retains Sections 312 and 313 of its Penal Code still in operation. These are Sections 58 and 59 of the English Offences Against the Person Act of 1861.

In spite of this, the only pamphlet describing a surgical technique (let alone one for abortion) was distributed by air-drop from the windows of light aircraft, producing rather a pretty effect, given a suitable breeze, though naturally, other more orthodox channels were also used.

BACKGROUND: East Bengal/East Pakistan/Bangladesh was involved throughout most of 1971 in a very bitter war of liberation/separation against West Pakistan with which country it had been politically linked after the Muslim/Hindu war of partition from India in 1947-8. Partition in 1948 resulted in the establishment of a separate Muslim state, Pakistan, consisting of two radically different countries separated by the whole of India and both loathing each other and India. In December 1970 the then East Pakistan voted 98% in favour of the then leader of the opposition Awami League, Sheikh Mujibur Rahman and the platform on which this election had been held made this a clear vote for independence. The political heavies of West Pakistan immediately made it clear that in no circumstances would they serve in a government with SMR (let alone under him). The military government of West Pakistan then, in the opening months of 1972, attempted (and it really did) to negotiate a politically face-saving compromise but these negotiations broke down due to the implacable anti-Bengali position adopted by Bhutto and the other West Pakistan political heavies.

Yahya Khan, by March 1971, was advised, by his military and political intelligence agencies, that a sudden limited show of force would quell the faction seeking independence for East Pakistan. On 25th March such a military operation started in Dacca and the West Pakistanis found themselves, to their astonishment and consternation, faced with relatively highly organised resistance – the last thing they had expected. Armed resistance quickly spread to the entire country. Guerrilla fighters of the hastily formed Mukhti Fouj (later called Mukhti Bahini) attacked Pak troops at Comilla, south of Dacca. On 13th April a provisional government of independent East Pakistan (Bangladesh) was formed with Chuadanga as its temporary capital. From this point the war developed into a full scale civil war with Bangladesh repeatedly calling for outside aid. The only country to respond was Russia.

By May there were strange political alignments. The Mukhti Fouj was fighting side by side with Indian and Burmese Maoist guerrillas. These have, since the armistice, become Naxalite and Meso terrorists and are being suppressed, where possible, by the Mukhti Bahini. Russia supported Bangladesh. The Americans were confused because of their previous commitment of aid to West Pakistan and waited hoping that they would win. Kissinger was using Islamabad as a starting point for exploratory talks with Peking. Peking sided with West Pakistan, their main anti-Indian ally and India gave unequivocal support to Bangladesh. This was established by May and was, at that stage, unofficial except on the part of the Russians. as can be confirmed from hotel registers, which reveal a substantial Russian presence throughout all of 1971 and 1972.

In April it was clear that the “West Pakistanis had more than purely military objectives in mind. In city after city, in fact, the soldiers were apparently determined to shatter the economic base of East Pakistan in order to crush the independence movement. On orders from the Islamabad (actually = Rawalpindi) high command, troops systematically gunned down students, engineers and doctors and any other persons with a potential for leadership, whether they were nationalists or not” (News-week April 26th 1971). “They want to make sure that no head will ever be raised against them again” (quoted from Mukhti Bahini who had fought in Sylhet and Comilla).

Now it starts to get interesting: *Time* 24th May 1971. “Perfect Order just about everywhere, Kraar found (Louis Kraar is utterly reliable as a journalist) the killing had followed a typical pattern: government troops would try to ‘liberate’ a rebel-held town in a deliberately provoking manner. The Bengali townspeople would wreak revenge on non-Bengalis (in the process killing perhaps 20,000 or about 10% of the total dead) and then the army would pounce with everything it had”.

This quotation is interesting because it was the first to mention Bengali killing Bengali and it bears out what I have been told often here, particularly by an elderly barrister, Shamsul Haq, president of his local bar association, a Muslim Leaguer for over 30 years and politically active for longer than that. The facts are that the Pak army hit the towns to put down resistance and hit the Hindu sections hardest but the Mukhti Bahini hit the towns' elite and did so because they regarded them as collaborators – definition: Anyone working in an official position is a collaborator during or prior to occupation whether avowedly nationalist or not and these should be shot if found

Immediately after “liberation” as many as possible of this group were liquidated and those of the remainder who had not fled to India and who could be traced were imprisoned. They are still in prison. In Noakhali prison there is accommodation for 250: on 1st May 1972, it contains 1,250 (I was there, counted them, talked to them). Some had been able to bribe their way out but 1,250 is the residual figure. They are in a dreadful condition.

It is essential to bear this in mind as it has an important bearing on the present running of the BWRP (see *Sunday Times* 20.6.71). Also in that issue there was the first mention of anything remotely relevant to this programme. “The Razakars have now extended their operations from murder and extortion to prostitution. In Agrabad in Chittagong they run a camp of young girls who are allocated nightly to officials. They have also kidnapped girls for their parties. Some have not returned”

Time, June 21: An account from a 16 year old girl in a refugee camp at Petrapole: “They killed my mother and father – battering to death with the butts of their rifles. They flung me on the floor and the three of them raped me”. “Other girls have reputedly been taken from their fleeing families to be sold as prostitutes to the soldiers particularly if their families could not pay a ransom for them.”

Newsweek, August 2, 1971: “With his two teenage daughters by his side, Chandra Mandal trudged through monsoon drenched swamplands and past burned villages. When he neared his scrap of land, soldiers stopped him. As he watched in helpless anguish, his daughters were raped again and again and again”.

New York Times, Oct. 11, 1971: “The army came to my village on the night of April 11. One patrol led me away from my house to identify something and when I got back I found my sister was missing. Another girl, the daughter of a neighbour, was gone and there was a Hindu whose daughter was missing. In the middle of May they released my sister and the neighbour's daughter but the Hindu girl is still missing. The two girls who came back are both pregnant and will have their babies. They had to wash clothing and make love to the soldiers two or three times daily”.

Newsweek, Nov. 15, 1971: "Army troops recently surrounded the village of Demora (where the Mukhti Bahini had never been), raped all the women between 12 and 35 and shot all the men older than 12".

About the end of January, it began to be realised that one of the more unusual of the country's post war problems was the enormous number of unwanted pregnancies resulting from what was reported in some circles (particularly in London) to have been a deliberate campaign of the Pakistan army. There is no evidence that this policy was dictated by the Islamabad political/military command but isolated reports from Punjabi officers suggest that it was policy handed down (e.g. von Schoultz' interview with a major at Dacca airport in June).

The first indications of the magnitude of this problem came from reports from Calcutta of the large numbers of women who had gone there seeking abortion. A doctor consulted there visited Dacca and, as a result, local enquiries confirmed that there were indeed large numbers. An organisation was hastily formed, The National Board of Bangladesh Women's Rehabilitation Programme, voted funds and was given high priority for dealing with the problems of the unwanted pregnancies, destitute widows with large families, women injured by the army (not necessarily raped or pregnant), women raped but not pregnant and cast out by their families.

The highest priority was intended for those with unwanted pregnancies and seeking termination. In mid-February a clinic was established in Dacca with overseas advisers and TOPs were carried out from about the end of February.

Attempts were made to estimate the number of women who had been raped. The official figure was 200,000 which was arrived at thus: approximately two girls were reported missing daily in each thana (area of local police station authority) during the occupation. There are about 480 thanas. The occupation lasted for 270 days. The calculation was made on $480 \times 270 \times 2 = 268,200$. The Board, allowing for exaggerations and for the fact that some women were missing for other reasons, rounded the figure to 200,000 and this is still given as the official figure. It is obviously an underestimate because

- (i) it takes into account only those reported as missing and ignores those taken from relatively orderly occupied areas (i.e. those in which missing girls were most likely to be reported) where the family knew well what had happened and felt it unsafe or useless to report the matter because those to whom one would make such a report were those who had the girl.

This group, as a general statement, comprised girls kept for repeated use until no longer serviceable (unserviceability, in general, means pregnant or with overt signs of VD or both) after which, if Bengali they were released and if Hindu killed. But many Bengali were killed, some committed suicide and precise figures for those murdered or committing suicide obviously cannot be given at any more than a guess. The number of suicides reported after liberation is 200 women (Jan. to April) and this is likely to be accurate because it is in the interests of the family to report a suicide and so avoid the possible murder investigation otherwise.

- (ii) The figure does not include the numbers of women raped in the course of the army's transient subjugation of a village. As about one third of the country's villages were molested, even though not destroyed, this army activity provides a huge number of cases of rape though the number of conceptions would not be enormous.
- (iii) Many women were separated from the refugee groups heading for India by elements of the army and Razakar (see quotation earlier concerning ransom). The total who sought sanctuary in India was roughly estimated at 10,000,000 of which, say, 1.5m. were women (based on family average of 4 children).

Bangladesh's population statistics are somewhat rough: the official figure for the population, in mid 1971 was 75 million (it could as easily be 90 million). Deduct 10 million refugees heading for or in India or otherwise out of villages and towns, 65 million remain of which roughly 1.1 million are women of reproductive age. If a third of these were raped, this makes 300,000. With a population growth rate of nearly 3% per annum it is safe to assume that about half these were pregnant, thus, if none conceived as the result of rape (clearly absurd), there will still be 150,000 pregnancies in this group.

Add the 200,000 from group (i) (it is safe to assume that all of these were pregnant as this was the prime reason for their being discarded) and remember that the girls were being changed regularly and discarded pregnant so that the estimate of 200,000 is a conservative one. About 10% of all conceptions should have delivered before liberation. Thus, at the end of December, there are 350,000 unwanted pregnancies. This is interesting in view of subsequent events.

In most of the districts I visited, the numbers of unwanted pregnancies were lower than this figure would suggest and, taking into account the number already delivered and the suicides, the number available, usually about 10 per village cluster is low.

In the districts where military activity was intensive and of long-standing (about half the major centres), wherever one could find a source of information with contact with villagers, a fascinating picture emerged.

The incidence of pregnancy at the end of December was about 1500 per district and, by the end of January most had been taken care of by the village dais, quacks, homoeopaths, etc., leaving only a small remainder. Taking rough figures of 1500 per thana for half the 480 thanas (those afflicted by a high concentration of military for a long time): when multiplied out this produces 360,000 which is in fair agreement with the figure reached by the other method.

In my opinion this is about right for the incidence of unwanted pregnancy at the time of liberation and, of these, the vast majority was dealt with locally using traditional indigenous methods.

The Indigenous Methods

In most villages this consists of the insertion of small sharpened stick (usually, at most, 5—6ins. x $\frac{1}{8}$ — $\frac{1}{4}$ in. diameter) through the cervix and pushed in until it reaches the uterine wall. In most areas the type of stick is unimportant. Married women, in general, do this themselves and the unmarried are taken to the local expert. (There is an incidence of unwanted pre-marital pregnancy here but how high it is cannot be ascertained). The stick is left in place until onset of regular pain results in its rejection followed by abortion. This method is reputedly almost 100% reliable but it is slow.

The process can be speeded up by use of one of other of the following means. There is a native plant (Corobi) of which the root contains a time-honoured abortifacient and which can be used as an aqueous infusion taken by mouth or the root can be inserted as the FB instead of a non-specific stick (Kabiraj or Ayurved system of medicine q.v.).

Those acquainted with allopathic medicine (and with some faith in it) have found that 9 G of Vitamin C (18 x 0.5 G tabs) in one dose the day after the insertion of the stick will usually produce abortion within 48 hours. This is said to be nearly infallible.

The other accelerator is to give the patient 4—5 oral contraceptives daily following insertion of the stick, i.e. for 5—7 days according to the pill used, and this produces abortion on the second or third day after completion of the course. It will doubtless comfort IPPF, the Swedish Government and others who supply the pill to know that it is being put to good use. It is also refreshing to know that family planning home visitors (from whom the majority of users obtain their pill) are not the fools they are taken for by the profession here. This could account for quite a lot of pills one way and another though I cannot say how widespread this practice is:

So, before any local authority, let alone any overseas agency, was even aware of the unwanted pregnancy problem in Bangladesh, the simple village doctors had virtually solved it but, though it is perhaps unkind to to say so, at the same time they created two new major problems:

- (i) the village families impoverished themselves in paying 150–300 taka;
- (ii) the young women of the villages now have a high incidence of short and long term gynaecological problems (as well as the VD they got from the army);
- (iii) the villagers become even more reticent than before.

My briefing in England was that approximately 200,000 unwanted pregnancies were thought to exist in Bangladesh (March 1972), that a clinic had started operation in Dacca, initially with outside help but currently with Bengali medical staff, that the law relating to abortion had been officially suspended with regard to this project. My role was to instruct all interested parties in practical methods for the termination of advanced pregnancy.

My chief impression during the first few days, was that cases were not coming forward in anything remotely like the expected numbers and that, in general, the explanation was that there had been too little publicity and what there had been was so ambiguous as to be incomprehensible. The Board, however, was convinced that the publicity had been clear and explicit, had reached those for whom it had be intended and that the small numbers seen was clearly due to the Muslim family's reluctance to produce its besmirched maidens and mothers. Among various reasons put forward to account for this attitude of mind were that a sexually assaulted female was a source of shame to the family, that by admitting the existence of such a member the family would lose face in the village and that (the most weighty one put forward), as female dependants were generally regarded as a burdensome family liability, the admission that one had been sullied would make her impossible to marry off. It was also thought that the "huge agricultural population in the far outlying districts" had perhaps not yet been reached by the propaganda and that, once reached, they would come forward in huge numbers. Consequently, it was generally thought, in Board circles, that special clinics should be started in all (about 20) major centres of the hinterland.

By the first week in April, 84 cases had passed through Dacca clinic and, by the second week in May, the number has risen to 130.

There was obviously something amiss so, somewhat bemused and not sure what to expect, I set out for Bogra, Rangpur and Dinajur armed with two complete kits of instruments and sufficient drugs to cope with about 200 ToPs.

I found, briefly, that Rangpur district had admitted patients to the local Sadar hospital in the care of their gynaecologist who was coping well even though short of equipment (no saline, no plasma, no pitocin, in fact, no oxytocic of any kind, and no antibiotics).

The first glint of light came, in Dinajpur, when the Civil Surgeon remarked that he was not sure of the legality of ToP at present and had seen nothing official to say that it was even allowable. He went on to say that some vague mention had been made in government circles that the meaning of the Top Priority circular was that districts were to seek out pregnant women and offer them ToP while everyone likely to cut any ice with the medical profession had said the opposite. The CMO pointed out that, as a ferang, it was extremely unlikely that I would hear anything like this on brief visits to districts because of the time-honoured custom of Bengali social etiquette which decrees, more or less, that it is extremely ill-mannered to contradict a ferang no matter how wild or mad one might consider what he was saying. They also said that the President of the local branch of the BMA (a very orthodox Muslim) had drawn their attention to the opinion of the Muslim IPPF conference, at Morocco in December (some forms of FP are in, abortion is out) and that, as he was President, they were stuck with it. I met the President on the following morning and found him, though polite and charming, absolutely unshakeable in his view and he had the personality to dominate totally all in his area and that was that.

The CS and his CMO also mentioned that they were unable to see why they should perform this operation for nothing when everyone else was getting something (note that anyone referring patients for ToP was on take 10 per head). This, clearly, had raised two interesting points and both were mentioned, with varying emphasis in every district I visited.

On my return to Dacca I raised both points with the Chairman of the Board who felt that, as the administration in the districts was so corrupt now, any offer of money would provoke disaster. Information on the vasectomy programme of a couple of years ago convinced me that he was absolutely right. On the question of legality, he was sure that the Secretary of Health had issued a statement clearly indicating that abortion for women pregnant due to rape by Pakistan troops could be terminated legally. He also felt that under sections 312 and 313 of the penal code as it stood provided that one placed the broadest Muslim interpretation of "to save the life of the mother" that this alone would be adequate cover in the circumstances.

In Mymensingh there was exactly the same problem. I lectured to about 120 staff and students at Mymensingh Medical College Hospital and noted that roughly 90% of the questions in the discussion concerned legality rather than technique.

In Dacca, I attempted to locate a copy of the letter said to have been sent to all DCs, all CSs and all CMOs by the Secretary of Health stating that abortion for the purposes of this programme was allowable (if not legal). No copy could be located nor could I find anyone who could remember having seen one. I contacted the Secretary himself who initially said he *had* sent it and, later on, that he had *not*. I then arranged a meeting

at the PM's Secretariat with its head, A. Rab Chowdhury, and the degree of ambivalence and political double thinking became very plain. He rang the Secretary of Health and was assured by him that the letter had been sent (I did not disclose my conversation of the previous day) after which we managed to convince him that many of those sent might not have reached their destination and we virtually dictated a letter for him to give me to carry into the districts. Fortunately, I was able to record this discussion and to play the cassette to the unconvinced in the districts, with some effect. It remained, however, somewhat disquieting to know that throughout this programme one was performing illegal operations in large numbers very publicly and usually with many interested professional and paramedical spectators.

The situation turned out to be something like this. The National Board in Dacca would instruct the local board in the district to obtain premises and convert them for use as a clinic similar to Saba Sadar, Dacca. Money would be sent to the chairman of the local board and the local board, supposing it received the money, would then contact Dacca to say that they

- (a) could not get equipment and
- (b) had no doctor or
- (c) had a doctor but the doctor had no idea of how to terminate advanced pregnancies;
- (d) there was no transport available to bring patients in from outlying areas and
- (e) most patients had either a relative with them (if unmarried) or (if married) children with them and where would they stay while the patient was in the clinic?

My contribution has been to enlist the hospitals as part of the programme and to separate the clinical from the rehabilitation programme. By proving to the satisfaction of the board that establishing a separate clinic was impossible in most areas, I was then able to get them to use the premises they had as rehabilitation centres.

Then, by taking members of the board to meet the hospital executive and clinical staffs, it was possible in all areas to get the hospital to agree to admit patients for ToP (after showing that this could be done without getting a live foetus) and, at the end of negotiations in each area, have a workable agreement whereby the board collected and housed patients in their premises, referred them to the hospital when beds were available and then took them back after their ToP to begin training them for some employment or other while they lived in the board's premises at the board's expense. Those areas without a suitable local hospital are now referring their patients to the nearest big hospital for ToP and then taking them back to their own rehabilitation centres. This seems to be working satisfactorily now throughout the country and the advantages are so obvious that they require no further elaboration.

METHODS for ToP in USE

1. Karman Supercoils: have two outstanding disadvantages. Live deliveries are the rule rather than the exception, especially where delivery is soon after insertion of multiple coils. It is noticeable that nearly all patients on whom they are used get temperatures. This, in my opinion, is due to the difficulty in sterilising the coils by methods available here. Secondly, there are none available outside Dacca and the supply here is limited.
2. Insertion of Catheter (Mullick's method): it has two drawbacks — there is always a live birth and it is notoriously slow and there is an occasional failure despite frequent replacement of the expelled catheter.

Both 1 and 2 have the additional disadvantage that, because of the need to expel a physically intact foetus, whether living or not, the labour is frequently troublesome and protracted and is, from some points of view, the actual event that the ToP is designed to avoid. This is the case particularly with unmarried primiparae.

3. Amniotic Replacement: I remain absolutely certain that there were sufficient fatal cases reported in 1962-9 to warrant abandonment of this procedure. Nevertheless, it is still in use and some of the time it works.
4. Hysterectomy: two have been performed to my knowledge but, as a general statement, this procedure is not warranted here because of waste of surgeon's time and material better used for other purposes.
5. Induction of premature labour following severance of the umbilical cord: this method is now in general use throughout the country (except in Dacca where Karman coils are the main method in use) and so far this appears to have gained wide acceptance because of its simplicity as a procedure, rapid patient throughput and lack of complications. It has several drawbacks, namely proper aseptic precautions are essential, some rudimentary surgical skill is needed, general anaesthesia is preferably (but cervical block adequate) and, in two situations both, fortunately, not very common, it cannot be done and an alternative procedure must be employed
6. Rupture of membranes and Omtocin infusion alone: this is in use in Naokhali and Chittagong with limited success. It is slow, tends to be unreliable and produces a living foetus.

Factors resulting in less than the Anticipated Number of Cases for ToP

- (i) The vast majority of pregnant women seeking ToP were accommodated by local unqualified village doctors long before there was any official recognition that the problem existed. There is still (8.5.72) one such working in Dacca not far from the Sava Sadar clinic. He has operated on some 8 to 9 hundred women but restricts his activities to early cases. While this is legally absolutely beyond the pale I think he should be encouraged to continue.
- (ii) There is still some confusion regarding the legality of abortion in this country and no government agency is prepared to give a clear unequivocal statement.
- (iii) There is *some* traditional religious opposition and this is being used by some inherently reluctant doctors, as is (ii).
- (iv) The organisation of local boards is such that there is an inbuilt lack of communication between board and medical service in each district. This is exacerbated by political unrest in the local administration. DCs are frequently absent from their areas and, as funds are sent to DCs, this makes for great difficulty for the board.
- (v) Political activity is accelerating in the districts and changes of personnel occur with great frequency. Posts, such as that of Civil Surgeon, are basically political and these men, are being moved from area to area. Consultant staff in hospitals are also moving from area to area at an astonishing rate so that having a trained and willing surgeon ready to treat patients one day does not necessarily mean that he will be there the next.
- (vi) There is a quite widespread feeling that doctors should be paid to perform operations. This is implacably opposed by the National Board. The Board is well aware of what happened in the vasectomy programme and is reluctant to organise a sequel.
- (vii) There is some difficulty in the districts about transport for intending patients but emphasis on this usually reflects inherent reluctance to cooperate in the programme as plenty of transport is available in all districts.
- (viii) Some districts have administration so corrupt as to make it impossible for anything useful to be done. The board sends money to the DC as chairman of the local board and the DC, who has never formed a board, keeps the money and sends a report on his board's activities giving imaginary details of the distribution of the money.

- (ix) There is some reluctance on the part of families to admit the existence of the “tortured woman” but the incidence is small. This factor loomed large in the National Board’s thinking but turns out to be a misapprehension due to lack of grasp of the social structure of villages. Nearly all small villages consist of groups of houses containing groups of related families. They are actually little communes and suggestion that an individual family is hiding women for fear of what the neighbours will say is quite wrong.
- (x) Emotionally based, reluctance to terminate pervades the profession here as in western Europe and, in many ways Bengali doctors, who have not been outside the country and have not had close contact with locally based consultants with overseas experience, show striking similarities in attitudes to ToP. Many overseas graduates picked up anti-abortion attitudes and have brought them back. In this connection, Her Britannic Majesty’s Royal College of Obstetrics and Gynaecology is perhaps the greatest liability this programme has to bear with and its anti-family-planning influence has to be seen to be believed.
- (xi) The employment of methods for mid-third trimester ToP which result in live deliveries has been discouraging in some areas and I sympathise with their distress.
- (xiii) Full term confinements in board clinics are a definite political mistake: this is illustrated by the “Mother Theresa Episode”. Three full term normal deliveries occurred in Savar Sadar, Dacca and the babies were handed over to Mother Theresa. These babies later died. There was an immediate outcry that the clinic had aborted three women, got live births, handed the babies over not knowing (or caring) what else to do and that they died because of the abortions. This did not do the clinic’s image any good. It is interesting to note that due to malnutrition and other factors, perinatal mortality has been very much higher even than usual in Bangladesh. Delivery at term produces astonishingly small babies. At 30 weeks, foetal size is approximately that seen at 20 weeks in the West a factor which made this programme more feasible than it might otherwise have been. Foetal size up to 20 weeks is comparable with that found in the West, after 20 weeks, very different.

The Immediate Future of this Programme

Basically, the NWRP consists of two phases: the *clinical* aimed at location and termination of all unwanted pregnancies resulting from the military occupation. It was agreed, after much negotiation, that, as it was impossible for doctors to distinguish between pregnancies resulting from Pakistan army activity and those attributable to the neighbours, it was not the responsibility of the individual doctor to determine which was due to

what and that any pregnancy conceived prior to 30th December 1971 could be terminated without much fear of reprisal. Despite this, no clear statement could be obtained from anyone in authority. A subsidiary part of the clinical phase was the location and treatment of women suffering from any physical injury or gynaecological disorder. Those with gross injury were treated by the district hospitals if possible. The other phase of the programme is *rehabilitation*.

I know of approximately 800 ToPs performed officially throughout the country, mainly mid and 3rd-trimester pregnancies and I know of two unavoidable deaths having occurred as a result. The first was a patient on whom amniotic replacement was attempted and the second was an afibrinogenaemia where no fibrogen (or even plasma) was available.

Investigations at village and town levels, have revealed that an alarming situation exists. Throughout the country, there is a huge number of young attractive women (the army had no need to rape the plain ones) who have had early abortions in the villages and who now have short or long term complications as a result. Those with major complications have, by now, died and the number involved is not known.

I would place the number of village abortions at between 300,000 and 400,000 (see earlier figures) and feel that this is a conservative estimate. Note that, in this connection, army units moved from area to area and that, in moving out, a unit would abandon its surviving women and the new unit would round up another lot, some of whom had already been through the mill. This introduces the next, and the most grave aspect of the whole affair, which is that a high, but as yet unknown, percentage of the women between 12 and 30–35 now have VD. This has been completely ignored to date.

In the only area outside Dacca where diagnostic facilities were available and used, 10 pregnant women were tested: 6 had gonorrhoea and 4 had gonorrhoea and a positive WR (I put it this way because there are other causes of a positive WR).

This really is serious because it represents nearly a whole generation of women who *probably* have VD and so far no attention has been paid to it. Figures for the prevalence of VD in Pakistani soldiers naturally are not available, but consideration of the way in which the army used these women and moved from district to district makes for a situation in which a low initial incidence in the army could result in incredibly large numbers being infected in a very short time. The social effects of this incidence of syphilis and gonorrhoea are and will remain disastrous. Paradoxically, some good might come of it because it will inevitably lower the fecundability of the country's infected women.

On the Number of Women Approaching Confinement at Term

With a population growth rate estimated officially at 2.7% p.a. (but it is probably closer to 5% p.a.), there are, at any given time, in this country, at least 500,000 pregnant women, otherwise, to achieve 2% growth rate per annum (1.5 million), then 125,000 are delivered every month. If the population growth rate is 3% per annum (assuming that the population really is 75 million) then 187,500 will be delivered monthly.

The population's use of obstetric facilities was reviewed during the last few years and it was found that about 2%, at the most, have hospital obstetric care, less than 20% have some village help (a local midwife = dai) and that, for the most part, a dai's help is sought only for primiparae and complications. The remaining, approximately 80%, have no care apart from their immediate family's women.

From this angle, making obstetrical provision for a population explosion due to women raped by the Pakistan army is not going to help. Also, supposing that some families really have hidden unmarried pregnant women awaiting confinement, the last thing they are likely to do now is to bring them in for obstetric care.

Further, assume that some women are hidden in villages and do come to term, there is much evidence to suggest that the village tradition of infanticide will be brought into play. It is not known how much of this there is but it does exist. The more practical villages might conceivably keep the males.

An interesting sidelight on this is that, at present, there are four adoption organisations working here with a view to international adoption. Even the largest is having trouble in locating newborn children: they are all beginning to concentrate on toddlers and older children.

Treatment of this Situation

- A. Those remaining with unwanted pregnancies: it has been assumed that the latest anyone could have conceived during the war of liberation is 30th December 1971. Most areas were pretty free of the army by 16th December, the date of the official cease fire. So all LMPs from 1st to 30th December come to term between 7th September and 7th October 1972.
- B. Those who were pregnant and had abortions in the villages: there is evidence to suggest that this number is really large, may be 3 to 4 hundred thousand. Many of these women have some form of VD. Those aborted by corobi all now have cervical erosions and leucorrhoea at least. Corobi contains a violent corrosive agent and since it is inserted through the cervix it affects it as well.

So there are large numbers of women about with smouldering pelvic infections, the bulk of them teenagers (the army did discriminate in their favour).

C. Those with as yet undiagnosed venereal disease: this is by far the largest group and includes groups A and B.

These women have to be found, screened and treated.

To do the vaginal swabs and collect the blood it would prove essential to use women, maybe the LFPVs could be taught to do this and the motivators used to flush the patients out of the villages. Recording the tests and being able later to relate them to patients is a horrifying task.

The vasectomy programme consisted of providing rewards for any who underwent vasectomy and those who brought them to the clinics. Clinics were only open during Western business hours. During these, the only men with nothing to do are, broadly speaking, the aged and indigent and so a substantial percentage of those undergoing vasectomy were well past reproductive age.

There is tremendous professional opposition to family planning in this country. This largely stems from resentment at having to sort out pill problems and, especially, IUD problems. They all remember the vasectomy programme and are also growing tired of fishing IUDs out of 65 year olds in whom they were fitted because of the 3 taka fee. If post-menopausal ladies must be provided with contraceptives, it has to be the pill.

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