The issue of reproductive rights is complex and sensitive. Many different ethical and religious views exist on these matters. Oxfam respects the diversity of culture and tradition among the people with whom it works, and the different viewpoints of its supporters. As with all issues of Focus on Gender, Oxfam wishes to emphasise that the views expressed in this publication are those of the individual authors and not necessarily those of Oxfam.

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This edition of Focus on Gender was edited by Caroline Sweetman with Kate de Selincourt.
Editorial

In this issue, *Focus on Gender* considers the debate on population, as final preparations continue for the forthcoming United Nations Conference on Population and Development in Cairo in September this year. Contributors explore the complexity of the links between population, environment, and the ideal of sustainable livelihoods for current and future generations.

The new point of entry to discussions about population has been the growing global concern about the environment. In 1992, at the Earth Summit in Rio, a direct link between population and environment was recognised in the Conference’s Agenda 21. There is a common perception, especially in the North, that ‘too many mouths’ represents one of the greatest threats to the global environment.

There are three main theories regarding the possible existence of the link between population and environment. First, the neo-Malthusian view argues in terms of finite resources and limits of the earth’s capacity to support its inhabitants. The ‘carrying capacity’ of regions is used as the tool to measure whether populations can continue to be sustained by the resources within a region without deterioration of those resources. Environmental degradation is seen to stem in major measure from population growth, with the focus being on numbers of people rather than the nature of their activities.

Emphasis is placed heavily on the control of populations in Asia, Latin America and Africa.

The second theory, put forward by neoclassical economists, asserts that resources are not finite in any economic sense. When natural resources are under threat, population growth acts as a stimulus to induce technological innovation and/or new methods of resource management in order to conserve or create substitute resources. This analysis does not, therefore, require any controls to be placed on human fertility.

A third theory fuses political and economic perspectives and sees poverty and unequal distribution of resources to be the main cause of both environmental degradation and population growth. It is therefore quite feasible that poverty, inducing natural resource degradation, can in turn induce responses leading to increased fertility. Population growth is seen as a symptom of poverty. This analysis emphasises the importance of an integrated approach in understanding environmental and population concerns, advocating a solution of poverty alleviation via a broad programme of social, political and economic change, rather than through narrowly focused programmes of resource management or fertility control.

All three theories are open to debate and criticism and all three lack conclusive empirical evidence to prove their hypo-
theories. Jolly (1993) argues that these very different theories need not be mutually exclusive, suggesting that each one contributes a partial understanding of why environmental degradation occurs. Even allowing for the lack of academic consensus on the possible linkage between population and environment, the relationship between population growth and environmental degradation is much more complex than allowed-for in UNCED’s ‘general recognition’ that high population growth rates adversely affect the environment. Susan Joekes unpacks the perceived and real links between population and environment in her article.

There is a real danger that, because this ‘general recognition’ has been written into a document as influential as Agenda 21, it will in the future be accepted without question by policy makers and co-opted by the population establishment. Already the United Kingdom delegation to the preparatory meetings for the 1994 International Conference on Population and Development in Cairo has stressed the importance of raising environment and development as an issue. The delegation calls for more specific references to the relevant part of Agenda 21, requesting that questions covered at the Rio Summit should not be re-examined (UK Statement, 1993).

The UNCED support for a general recognition that high population growth rates have a universally adverse effect on the environment may be a reflection of an ideology whose roots lie in population control within less developed countries. It may also reflect a preference for the pursuance of a clear-cut, relatively simple policy of family planning (in which women’s rights to choice and information are expedient), rather than a programme which takes into account the complexity of the variables contributing to the current crisis which affects the world’s resources.

It is generally accepted that structural adjustment has aggravated the poverty felt throughout the Southern countries dependent on the goodwill of the IMF. Poverty often increases the economic rationale for a larger number of births (The Ecologist, 1992), which might logically lead to the prediction that if structural adjustment does impact on the birth rate, it is likely that it would raise it. In her introduction to the statement from Development Alternatives for Women in a New Era, which was issued at the New York Preparatory Conference for Cairo this year, Peggy Antrobus calls for analyses of population issues to take into account economic poverty and women’s empowerment.

Population control policies have had a history of negative effects on women’s health and rights. Male methods of contraception have been scarcely promoted,
in comparison with efforts to find acceptors of female-used contraceptive technology. This places both responsibility for and risks of contraception squarely upon the shoulders of women. The modern range of contraceptives promoted by planners and donors is predicated on concerns for efficacy and cost-benefit (Hartmann, 1987). The many side effects of these technologies are played down, and research into the effectiveness of new drugs such as Norplant have been undertaken in trials which may be inadequate and unethical. As Anita Hardon warns, feminists need to keep a close critical eye on the services, drugs, and devices that are being delivered to women in the name of contraceptive choice.

Weaknesses in the delivery of family-planning services include insufficient knowledge by deliverers and users about side-effects and alternatives, inadequate screening and monitoring of users to ensure their health and safety, lack of concern and provision for women's general state of health, and finally the high cost and poor accessibility of contraceptive technology. Ines Smyth explores the World-Bank-sponsored Safe Motherhood initiative in Indonesia in the light of this: as she states, a holistic health service for women which recognises the links between poverty, women's empowerment, maternal mortality and contraceptive uptake is more likely to achieve a positive outcome for women, health service providers, and development agencies, in terms of reduced maternal mortality and morbidity as well as lower fertility.

As Ines Smyth asserts, a proper reproductive health service should be more than just a renamed family-planning clinic. Reproductive health services are misnomers until the day they offer not only contraception, but include the diagnosis and treatment of sexually transmitted diseases (STDs) and other reproductive tract complaints and, crucially, address one of the biggest and least discussed reproductive needs of women worldwide — help with infertility. Availability of this desperately-desired service would truly demonstrate whether a programme was genuinely intended to promote reproductive health in all its aspects.

Beyond the issues of poverty and equity, the provision of family-planning information and services has seemed an obvious and desirable measure to many Western feminists who are committed to an ideal of a freely determined sexual life for women separated, by means of the technology of their choice, from the risk of conception. However, as Renu Khanna and Janet Price discuss, notions of female sexuality are dynamic and alter with time, geography, and the need of society's rulers. Pleasurable sexual relations and planned childbearing is irrelevant to many women in both Southern and Northern communities. Sue Armstrong shows in her article on rape in South Africa that many women experience sexuality as an assertion of male power and female submission.

In line with this, fertility decisions, whilst being personal, are also determined by culture. Abortion, which is the main or a significant cause of death among women of child-bearing age, is yet to be legalised and made safe by most national governments (Hartmann and Standing, 1989). Women cannot individually, freely or unproblematically take the decision to use family-planning services, even when service delivery and access is improved; in addition, no contraceptive method can guarantee 100 per cent efficacy. Thus, biology, conjugal relations, and kinship obligations can override women's freedom to decide their own fertility. Ruth Pearson and Caroline Sweetman highlight the need to address abortion on grounds of human rights and in order to address the problem of maternal mortality associated with abortion. They make the case for provision of legal, safe abortion as an essential element of reproductive health services.

Two very different publications are
reviewed in this issue: first, Kali for Women’s book, *Know your Body*, shows how vital information on reproductive health can be distributed through the medium of pictures. Secondly, Rayah Feldman reviews a recent work on female genital mutilation, emphasising the complexity of the issue in relation to human rights, cultural identity and social conformity, and fundamentalism.

Despite the areas of controversy discussed above, there are broad areas of agreement over the outcomes feminists would wish to see from Cairo this year. Julia Cleves Mosse’s survey of the evolution of reproductive choice policies, which begins this issue, demonstrates that the current population policies and programmes, however much or little they have altered over the past 20 years, still fall short of meeting women’s needs. What we seek is a recognition of the complexity of the issues surrounding poverty, population, environmental degradation, and women’s rights, and an assertion that women will no longer be viewed as passive receptors of contraceptive technologies in the absence of information which would allow them to make a free choice.

**References**


*Monitoring nutritional status at a clinic in Sudan. A reproductive rights approach means women being able to take decisions about the size and spacing of their families.*  

Jeremy Hartley/Oxfam
From family planning and maternal and child health to reproductive health

Julia Cleves Mosse

This paper looks at the transition that is taking place in the provision of women's health care, within the context of development projects and programmes funded and implemented by the 'development' community (national and international NGOs, bilateral and multilateral organisations). While a women's health movement has been identifiable since the 1970s, with a growing internationalism, it is only in the last five years that the transition from programmes in which women's health needs were primarily addressed through family planning (FP) and maternal and child health programmes (MCH), to reproductive health care programmes, has begun to take place within official and NGO development assistance. There can be no doubt that this transition is taking place, though the extent to which the terminology and rhetoric of donors is matched by changes experienced by the clients of these programmes is open to question.

Reproductive health: a new focus for donors

The indicators of a major transition in women's (and to a lesser extent, men's) health care, are not difficult to locate. For example, the World Health Organisation (WHO) has now defined reproductive health as 'a condition in which reproduction is accomplished in a state of complete physical, mental and social well-being, and not merely in the absence of disease or disorders of the reproductive process. The ability, particularly of women, to regulate and control fertility is an integral component of the reproductive health care package.' Reproductive health now has its own journal, Reproductive Health Matters, launched in 1993, which states in its Editorial Policy that 'it offers in-depth analysis of reproductive health matters from a women-centred perspective, written by and for women's health advocates...Its aim is to promote laws, policies, research and services that meet women's reproductive health needs and support women's right to decide whether, when and how to have children' (Reproductive Health Matters 1993).

Bilateral donors such as the British Overseas Development Administration (ODA) have adopted a 'children by choice' policy, in which improving coverage and quality of reproductive health services is a priority. The policy endorses project activities such as improving the standard and range of services; offering more effective prevention and treatment of both sexually transmitted diseases — including HIV — and infertility; and providing better antenatal, natal, and post-natal care (ODA 1991). Similarly, the multilateral donor, UNFPA, has developed a policy note on reproductive health, which endorses the
WHO definition, and outlines specific components of a reproductive health care service. To work in the health sector in development, and not to have a perspective on reproductive health is to be very much out of line with current thinking.

The reproductive health approach: a history

It is fruitful to trace the linkages between the emergence of a reproductive health approach and the steady growth of a gender and development literature and practice. The development of population literature, policy, and programmes has clearly been significantly influenced in the last 20 years by changing ideas about the appropriate role of women in development. The very brief sketch that follows indicates these influences. In this analysis, Moser’s terminology of welfare, equity, anti-poverty, and empowerment (Moser 1989) is used, not to suggest discrete, or chronological approaches, but as a familiar form of shorthand to describe approaches to women in development.

The so-called ‘welfare’ approach, in which women are targeted primarily in their reproductive role as mother and child-carer, appears to have a natural affinity with family-planning programmes. Welfare programmes are family-centred in orientation, and women in their mothering roles have been the targets for welfare initiatives, particularly MCH. In the mid-1960s, the United States Agency for International Development (USAID) abandoned its commitment to orthodox demographic transition theory and pursued a policy of contraceptive promotion, in the belief that family-planning programmes could lower fertility prior to, or in the absence of, other developments (Hodgson 1988). Welfare

Queueing up for immunisation, El Salvador. Women in their role as mothers have been the target for welfare initiatives for many years. JENNY MATTHEWS/OXFAM
programmes thus became the obvious channel for distributing contra-ceptives. Hartmann provides a good example of a family-planning programme administered along welfarist lines, in an IPPF-funded Women’s Development Project in Guayanquil, Ecuador, which combined ‘cooking and sewing classes for women and dance classes for their children, along with family planning and health services’ (Siquerira, Wiarda and Helzner 1981, cited Hartmann 1987).

Throughout the South, programmes with clear demographic objectives were, and still are, introduced to ‘target’ populations via sweeteners in the form of MCH initiatives, curative health services, and other programmes in which the women concerned are the passive recipients of the services, and which in no way attempt to tackle other pressing concerns, such as poverty, environmental degradation, and violence, which impact directly on women’s reproductive health.

The UN Women’s Decade (1975-1985) was a major spur to all aspects of research into women’s role in society. It was during this period that demographic research began to focus extensively on the links between women’s status and fertility. High fertility was linked to low status, in an association derived from various positive correlations of factors such as female education, literacy and labour force participation, with smaller families, later marriage, and contraceptive use. In what Hartmann refers to as an ‘isolation exercise’, population researchers attempted to isolate the indicators most conducive to fertility decline (Hartmann 1987:284). In its concern with status, this approach can be seen as a co-option of the concern for ‘equity’ (defined as an approach to women in development by Moser).

The theme of equality that shaped the UN Women’s Decade was translated in the population literature into a concern with increasing the level of women’s participation in education, social, economic, and political spheres in order to create ‘favourable conditions for the pursuit of population...goals’ (UNESCO 1991:29). The over-riding impression from literature of this period is the subordination of women’s development for its own sake, to its role in meeting demographic objectives. Hence statements from the World Bank in 1986, for example, that ‘enhancing the status of women is of critical importance in strengthening the demand for smaller families’ (World Bank 1986:39).

At the same time as the UN Women’s Decade was being initiated, mainstream development thinking was turning to the concept of alleviating poverty as an essential prerequisite for development. The ‘anti-poverty’ approach to women and development took as its starting point poverty rather than subordination, and set out to improve the incomes of poor women. Population programmes were quick to adopt an anti-poverty approach themselves, and family-planning programmes with income-generating projects attached, rapidly followed. The logic was that, if women are given greater power to earn cash incomes, often in women’s cooperatives and clubs, they will gain greater decision-making power within the family, have less need to depend on children, and their views on the number of children they need will change. ‘When a woman feels the touch of the first taka she has earned with her own labour, she feels liberated, and fertility behaviour changes to a great extent’ (cited in Hartmann 1987:130). Income-generating schemes linked to family-planning programmes were particularly promoted in Bangladesh, where the monopolisation of clubs and cooperatives by more prosperous women keen to learn new skills, earn a little extra income, and receive family-planning services, has meant that these projects can do little in pursuit of structural or strategic change for the poorest women.

There is now a considerable body of literature on the relationship between women’s education and work, and fertility; and women’s status and family planning, a
From family planning and maternal and child health to reproductive health

review of which is outside the scope of this paper. As more research has accumulated, the complexity of the relationship between education, work, fertility, and family planning has been revealed. It has become evident that a correlation is not the same as a causal relationship; for example, among the determinants of fertility the inverse relationship between education and fertility seems to be 'one of the strongest, best researched and most stable relationships in the demographic literature...[but] the relationship...is far more elusive than these observations would suggest. It has been found that education does not affect fertility directly, but that it acts through many variables' (UNESCO 1991:61).

Similarly, far from the first self-earned taka profoundly changing fertility, there is evidence that, in the short term, recent work appears to be associated with higher fertility (UNESCO 1991:79). The more research that is done on the subject, the more complex the relationship between women, fertility, and development appears to be. Simplistic attempts to upgrade the 'status of women' through project initiatives which do nothing to challenge the underlying structural causes of women's subordination, appear to be misguided. Moreover, the fact that a 'women-in-development' (WID) discourse — translated into upgrading the status of women — can be co-opted, however ineffectively, for the purposes of meeting demographic targets, highlights the shortcomings in the discourse itself. Only an analysis which takes into account gender relations, can shift the focus of 'women-and-population' programmes from fertility reduction to reproductive choice.

Empowerment, as a development strategy for working with women, grows out of a gender and development analysis that takes full cognisance of gender relations and the social construction of gender within households and communities. As such it must begin with a clear understanding of the socio-economic positioning of any group of women, and of internal stratifications within the group. It must look at relations within the household; at the way in which decision making is determined by gender, age, and other hierarchies; at reproductive and productive work and the organisation of this within the household and wider social group; at the impact of modernisation on family structure and migration patterns; and at how the specific oppression faced by women as a gender is created and recreated by kinship patterns, marriage, son-preference, education, legal systems, property rights, violence, labour laws, religion, and ritual and cultural taboos.

If a gender and development approach offers a theoretical framework, empowerment (Moser 1989) is the strategy that both grows out of, and informs that framework. Empowerment is the process in which women become aware of and challenge the socio-economic and cultural factors that determine their choices. As far as fertility is concerned, this would involve an increase in understanding of the factors that determine fertility. These include the existing number of children, the conditions under which they are borne, pregnancy outcomes, health and well-being during pregnancy, birth and lactation, control or lack of control over conception, infections brought about by sexual contact, the incidence of marital violence, and infertility. Empowerment in this context would be the ability to gain control socially and technically of reproductive health (Hartmann 1987).

A reproductive health approach is therefore the necessary outworking of a gender analysis of women's reproductive role. When reproductive health is understood in this context, several important things follow. Firstly, it cannot so easily be co-opted by the 'population establishment' for meeting demographic objectives. As Locke expresses it: 'The notion that women who are in control of their fertility are those who are actually limiting fertility, must be questioned. Women who are in
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control of their fertility have the choice of whether to limit their fertility or not. The
meeting of women’s strategic needs is not commensurate with lowering fertility but
with empowering women to take control of their fertility, both socially and technically’
(Locke, 1989:8).

Secondly, programmes must look at the whole of women’s (and men’s) reproductive
health, not only at the number of children they have. The discreet MCH/FP approach
adopted to provide services to women misses a crucial aspect of the determinants of
women’s health. To quote a key paper by Sai and Nassim: ‘it is very difficult to define
where maternal health begins; in dealing with maternal health problems, one should
recognise that health problems in early childhood and adolescence contribute to
conditions that may interfere with safe sexuality, pregnancy and delivery in later
life. Because the foundations of health are laid during childhood and adolescence, a
reproductive health approach encompasses nutrition, development, education, and the
socioeconomic environment girls and women experience...A reproductive health
approach also recognises that maternal mortality, currently the main indicator of
women’s health, is just the tip of the iceberg of the problems caused by sexuality and

Advocates of a reproductive health approach insist that population policy must
encompass more than family planning services, if reproductive health is to improve. It is clear that empowerment in the
context of fertility cannot be confined to fertility alone, but would impinge on the
broader social, economic, and political framework in which fertility decisions taken: ‘empowerment strategies would have
to go beyond the narrow confines of most fertility education programmes: they would
require interventions at the broader social level’ (Kabeer, 1992:9). A reproductive
health approach to women’s health care necessarily carries with it a strategic
dimension — seeking not just to meet women’s and men’s practical needs for
health care, but rooting its analysis of the causes of the reproductive health
mORBIdities in the gender relations which determine women’s access to both
behaviours and resources that will either ensure good reproductive health, or a life-
time of chronic reproductive ill-health.

Plus ça change...?

In practice, the design and implementation of reproductive health programmes
presents enormous challenges, and the practical difficulties must be understood if
women’s and men’s reproductive health is to improve. The most obvious difficulty is a
failure to link the analysis of the causes of reproductive morbidity with the activities of
a reproductive health programme. Consequently, a reproductive health approach is
frequently translated into a series of activities, which, while broader than the
services offered under traditional MCH/FP, represent practical solutions to a wider range
of reproductive morbidities, rather than attempts to address the underlying causes of
such morbidities, through a strategic analysis.

Reproductive health programmes are
now often defined as those that offer women
(and men) an expanded range of services:
contraceptive information and services,
including, where legal, abortion; ante-natal,
natal and post-natal care; screening and
counselling for STI (including HIV/AIDS);
infertility treatment; screening and
treatment of reproductive cancers; advice on
breast health; and so on. The actors in the
programmes are the same actors, who may
have undergone additional training,
particularly in implementing ‘quality of
care’ in their programmes; and the clinics
are, often, the same clinics.

The changes in service delivery which are
taking place are certainly significant. Tradi-
tional providers of family-planning services,
for example, IPPF, UNFPA, population NGO's such as Population Concern, Marie Stopes International, and the bi-lateral donor, (supporting increasingly impoverished MCH programmes) have, as we saw at the opening of this paper, rapidly changed not only their vocabulary, but the range of the programme activities that they wish to support. For example, the growth in understanding of both the prevalence and impact of STI on pregnancy outcome, vulnerability to HIV, and long-term reproductive health, is being rapidly understood and assimilated. Programmes are being designed to make the best use of scarce resources in addressing the linkages between HIV/AIDS and family planning.

Linkages between government, private-for-profit and non-profit organisations are being developed, for example, to improve the number of outlets providing contraception, so that the needs of adolescents, and those without access to conventional clinics, can be met. At village level traditional birth attendants are being trained not only in improved birthing practices but also to distribute condoms and oral contraceptive pills, and in some programmes to recognise the symptoms of reproductive tract infection so that they can refer clients to appropriate sources of care.

These are important and necessary developments but remain at the level of practical solutions to immediate reproductive health needs. As long as the key actors in the provision of reproductive services remain the traditional specialists within the population sector, it is unlikely that they will go much beyond these improvements in service delivery, however welcome such improvements might be.

Taking it further...

How can longer-term changes in the reproductive health of women and men be
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brought about? Some of the documents produced in preparation for Cairo provide important indications of the thinking of the international women's movement. For example, in January 1994, 227 women from 79 countries participated in 'Reproductive Health and Justice: International Women's Health Conference for Cairo'94' held in Rio de Janeiro. Much of the agreement reached focused on the need to see reproductive health within the context of inequitable development models and strategies, which constitute the underlying basis of growing poverty of women, environmental degradation, growing numbers of migrants and refugees, and the rise of fundamentalism. Profound changes at a policy level are essential to address issues of this magnitude, but, even within population policy per se, changes need to be made that will bring about longer-term changes. The Cairo conference is likely to produce important recommendations that will address gender equity and reproductive rights within a broader development context, and which take a gender analysis within reproductive health further than ever before in an international agreement.

Within the changing policy framework, there are also encouraging indications that NGOs who have traditionally been unwilling to engage in family planning programmes are switching their analysis, in recognition that high fertility may be a problem for individual women, and that freedom to choose how many children you have is an important human right. 'Childbirth by choice' is being seen in the context of wider reproductive health needs. Moreover, by locating reproductive health programmes within the context of broader development work, such programmes have the opportunity to work both strategically and practically to improve the reproductive health of women and men. A growing number of NGOs are beginning to integrate reproductive health into rural development programmes in recognition that reproductive roles as well as productive roles are an important determinant of well-being, and that unless gender inequities are challenged in a reproductive context, lasting changes in gender relations are unlikely to come about.

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Children as a resource: environmental degradation and fertility

Susan Joekes

The nature of the relationship between population and environment is complex and contentious, attracting enormous attention from development agencies and academics, and in international fora such as the 1993 UN Conference on Environment and Development in Rio de Janeiro. However, there has been very little attention given to the gender aspects of population growth and density in relation to pressure on environmental resources, despite women's vital contribution to local environmental resource management, and the manifold importance to women of access to those resources.  

There are many factors influencing people's decisions to have children. In almost all societies, parenthood is viewed as the fulfilment of the individual's gender destiny, and in many situations it is, for women especially, crucial to their social status. Often only the production of male children is considered reproductive success.

An economic analysis would thus seem to have little to offer in helping to understand why people want a certain number of children. The tendency to reduce everything to money terms, and to deal in crude costs and benefits, seems almost absurd in this context. But it can help to explain the variation across countries in the average number of children per family. An economic analysis of fertility desires is quite convincing in this connection, where the value and costs of children to parents are considered and where the term 'cost' is broadly defined to include opportunity costs to women or children, i.e. the value of the alternative activities that a woman foregoes by having children, and the labour which children are unable to perform because of school attendance.

Environmental pressures are just one of several economic factors that may influence reproductive decisions. They may have no effect on women's reproductive decisions; they may lead women to want to have more children; or they may lead women to want to have fewer children. The outcome in a particular locality depends on the specific environmental pressures involved. The relation of environment to fertility decisions is essentially indirect: in none of the study areas did the respondents declare that poor environmental conditions would cause them to consider limiting the size of their family. However, the link that exists derives from the fact that children constitute an important element in the set of options out of which individuals forge a 'coping strategy'.

It is important to determine how environmental pressures affect women's workload, and how resource use is organised in the community, and to examine other factors which affect income generation, especially the provision of education. Sometimes the counteracting facts which lead women on the one hand to desire more children and on
the other to desire fewer, are so balanced as to cancel each other out, and result in no actual influence on desired fertility levels.

This paper explores just a small part of the subject, looking into the gender aspects of environmental pressures on community livelihoods, discussing why environmental degradation might have an influence on women’s childbearing decisions, the mechanisms through which the influence might take effect, and the possible and actual consequences. The studies show that environmental pressures will only lead women to want more children where there is a very pronounced gender division of labour, women have a very low social status, and the priority given to education is low. Such situations are not the norm.

The case studies

These ideas grow out of a set of case studies in Kenya, Malaysia, Mexico (Mexico City), and Morocco, based on material collected by local researchers. The areas studied represent widely differing environments, all undergoing change.

**Kenya:** The Kenyan research studied conditions in villages in different agro-ecological zones in Embu, on the slopes of Mt Kenya, where many of the population, newly settled in the lowest potential zones, have to cope with poor soils and very low and variable rainfall.

**Malaysia:** In Malaysia, the research was conducted in the rain forest in the Limbang river basin in Sarawak. It investigated how living conditions for populations settled by the river were affected by commercial logging by outsiders and the resulting government restrictions placed on the right of tribal people to cultivation and use rights in forest land.

**Morocco:** The Moroccan study focused on the northern mountainous provinces of Tetouan and Al Hoceilmain, where there

*Erosion of land into gullies, near Mt Kenya.*

*JEREMY HARTLEY/OXFAM*
have recently been abnormally low rainfall levels, and where the population is extremely poorly provided with social services, especially health and education.

The main types of environmental pressure in the study areas are deforestation; decline in water quantity and/or quality; and loss of soil stability and fertility.

In the areas studied in Kenya and Morocco, population growth has been very rapid, in contrast to a recent fall at national level. Family size in the study areas is large: in Kenya, the average number of children per woman is eight, and in Morocco six.

**Population and livelihoods strategies**

The process of environmental degradation intensifies the need for people to search for alternative ways of supporting their livelihoods, as well as enhancing the value of children's contribution to livelihoods. This is because pressures are likely to lead to a fall in income earned from resources, whether communities operate at subsistence level, as in the Kenyan and Moroccan study areas, or at higher standards of living, as in Sarawak, unless additional labour can be found to augment that of women. This may induce a decision either to increase or to limit fertility. The crucial issue as regards changes in desired fertility levels is whether environmental changes lead women to emphasise their children's *future* or *current* contribution.

Current contribution may involve helping with the drawing of water and collection of fuelwood, fodder and wild food, which tends to be regarded as women's work. Unless men take some of the additional workload from women, if the environment deteriorates, women's expenditure of time and energy on resource collection will increase as supply diminishes. The more this happens, the more value women will put on having more children whose labour they can mobilise.

If the emphasis falls on children's likely future contribution, which is normally heavily influenced by the educational investment made in them, this will tend to reduce desired family size. Education raises the cost of children in two ways: first, through the actual fees incurred, including books, uniforms and transport, and indirectly, since the child is not available to work. Education has a powerful, independent and universal fertility-reducing effect, leading parents to invest in the 'quality' rather than 'quantity' of their children. Its effect seems normally to outweigh the idea that parents may have more children to diversify their future sources of income. In this perspective, environmental problems highlight the possibility of investing in children's education as a major element in a coping strategy.

In the case-study areas, there are great differences in the level of educational provision. Malaysia and Morocco are at opposite ends of the spectrum. In Sarawak, education is virtually universal at primary level, and the secondary level is being widely expanded. In Morocco, by contrast, educational provision is very poor in most rural areas throughout the country. For children in the villages in the study area, school attendance is virtually impossible, since there are none within reach (although about three-quarters of parents declare that they would enrol their children if possible). There are some local Quranic schools, for boys only, run by village-based instructors. This form of schooling has some vocational value, in that attendance is a necessary first step for a boy to become an instructor in turn (and gain a small income thereby). But it opens no doors to other kinds of job. In fact, lack of education is not a hindrance to a man seeking paid work. Quranic instruction not only has little effect on future income prospects, but does not have the usual fertility-reducing consequences of education. This is partly because it reinforces local unprogressive attitudes of gender segre-
Helping with agricultural work can be a valuable contribution; but many parents in Kenya would prefer their children to attend school.

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gation and hostility to contraception (despite pronouncements in its favour from high-level religious authorities and the state adoption of a nationwide family-planning service).

The situation in Kenya falls between that in the two other countries. Schools for both boys and girls are accessible for the population in the study area, but not all children attend. Although parents express a general wish to send their children to school, the fees are not affordable for all; most declare that, in the face of financial constraints, they would attempt to put the eldest child through school (or sometimes the most able), regardless of the sex of the child.

Finally, environmental degradation may have gender-differentiated effects as regards child preferences. Emphasis on children’s future earning capacity probably leads to son preference, for two reasons: first, males have privileged access to paid employment to a greater or lesser degree in all situations; in the case-study areas, it is only in Kenya that women have any access at all to paid employment, and very limited access to income-earning activity of any kind. Second, the common pattern is for claims on support from a woman’s income-earning capacity to pass from her own to her husband’s family on marriage.

On the other hand, emphasis on the immediate labour contribution of children may well make women desire female children, because they work alongside the mother to assist her in environmentally
related tasks, which, as suggested above, become more burdensome in conditions of environmental resource decline. Some Moroccan respondents were explicit, most unusually, in their wishes for more girls among their children, for this reason. Either bias serves to drive up total family size, however; so there will be no net effect on desired fertility levels.

**Conclusion**

In summary, the apparent consequences of environmental pressures on women’s desired fertility levels are as follows:

**Malaysia:** Several factors work together to minimise a link between environmental change and desired fertility level. Women (especially among shifting cultivators) declare that they miss the labour input of children while they are at school; but since their main contribution is the care of younger siblings, this merely reinforces the incentives to limit family size. National population policies have emphasised reductions in fertility, and more than half of women interviewed for the study had used contraception.

The balance of income sources in community livelihoods is moving rapidly away from resource-based activities because of very rapid macro-economic growth in Malaysia, and the upsurge in relatively well-paid employment opportunities. A polarisation of men’s and women’s spheres of activity is taking place, with traditional environmental exploitation tasks left increasingly to women. This might lead one to expect an increase in women’s desired family size. But the relative importance of these environmentally-related activities is fast diminishing within the total livelihood pattern. The fundamental incentive is clearly to invest in children’s education to the fullest extent, to take advantage of the new possibilities. Moreover, the easiest way for women of alleviating the specific and burdensome costs of environmental deterioration (e.g. in treating polluted water and compensating for falls in the fish catch) lies in cash expenditure on filters and purchases of other foods. These adaptations will further reduce community dependence on environmental resources.

**Kenya:** In the community in Kenya, the influence on fertility levels of environmental pressures is mixed. First, pressures affect the general productivity of a resource-dependent livelihood system. This has an impact on women, as it increases the burden of wood gathering and water collection. However, the extra work is redistributed to give men part responsibility, so that women’s extra labour load is less than it might have been. Thus the prevailing change in perception of the value of children is towards appreciation of their future income-contribution, which entails giving them an education, where possible. In the Kenyan case, therefore, environmental pressures have the indirect effect of influencing women and men to desire a smaller family size. The respondents stated that their desired family size is, at 3.5 children on average, only half the actual current level.

**Morocco:** Morocco is the exceptional case in the three studies with respect to community adaptation to environmental pressures, because of the virtual non-existence of educational provision by the state in the study areas. Combined with an unbending gender division of labour, which throws many of the specific impacts of environmental change onto women, who may call only upon children to help them, the net result is that there is no desire among women to limit the size of their families.

We can draw two different policy messages from this analysis. First, increased family-planning services will be welcomed and accepted in certain situations which fulfil two conditions. These are:

- That the gender division of labour is responsive to the labour implications of specific environmental changes so that women do not have exclusively to manage
the additional labour demands which are linked to environmental degradation.

- That the undermining of the general resource base of a community’s livelihood leads to an increased valuation of children’s future income-contribution to their household.

There is another proviso — that schools are accessible. If these conditions are met, as in the Kenyan case study, they will tend to produce a desire among women to limit family size.

The second policy message is more problematic and challenging for family-planning service providers. If there is a rigid gender division of labour, which does not allow a redistribution of tasks when environmental changes add to women’s workloads, children’s labour (probably especially that of girls) is increasingly necessary for women if they are to provide for the household. This is the case in Morocco, where the gender segregation of responsibilities is so marked that men would seldom consider investing some of their income in time- and labour-saving technologies to ease women’s workloads.

Development practitioners must understand that children are a crucial resource for women in this situation. If attempts are made to introduce family planning services in such areas, there needs to be accompanying provision of alternative resources to address the adverse impacts of environmental pressures on women. If environmental problems are disregarded, women acceptors would risk decreasing their resource base and damaging their livelihoods in the short term. It is an indication of the limitations on women’s life-options that they feel they must have several children. Family-planning services will meet resistance from women and lose credibility in such situations — especially if they themselves are seen as a panacea for environmental problems.

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Notes


2 The term ‘environmental degradation’ is one to be avoided, since the notion of irreversible decline, also contained in the concept, is only verifiable in rather few cases.

3 The project was carried out under the auspices of the UN Research Institute for Social Development, Geneva, with funding from the UN Fund for Population Activities. The population aspect was only a part of the project, whose general objective was to gather evidence and analyse, with special reference to gender considerations, the impact of environmental change on community livelihoods in different settings. The preliminary results of the project as a whole (except Morocco, where the research was done later than in the other countries) are reported elsewhere. S Joekes et al, (1994) ‘Gender, Environment and Population’ in Development and Change, 25: 1, January, Special Issue on Development and Environment Sustaining People and Nature, edited by Dharam Ghai.

Please note that responsibility for the interpretation given here of significance of the data from field studies regarding the population-environment linkage is my own, and not necessarily shared by the in-country researchers, who are: Ruth Oniang’o (Kenya), Noeleen Heyzer (Malaysia) and Cherifa Alaoui (Morocco).
‘Safe Motherhood’, family planning and maternal mortality: an Indonesian case study

Ines Smyth

The notion that family planning can directly reduce maternal mortality has been challenged on several counts (Winikoff and Sullivan 1987), including the ‘high-risk’ approach which aims to concentrate births to the safest groups of women in terms of age and parity (Graham and Airey 1987). Nonetheless, the use of family planning for the purpose of tackling the problem of maternal deaths in developing countries is still strongly advocated.

This paper joins in some of the criticisms and looks at the relationship between maternal mortality and family planning in Indonesia. Indonesia is chosen since, while it is considered to have achieved much in economic development, attracting international praise for reducing poverty and improving the standard of living of its population (Cheetham 1991), available information on maternal mortality suggests that women’s reproductive health is more at risk here than in countries where the level of economic development is much lower. Another reason for using the case of Indonesia is its demographic situation as having one of the world’s largest populations, totalling 179,321,641 in 1990 (BPS 1991). Since the early 1970s abundant resources have been devoted by the government to curb population growth: the national family-planning programme has a very high profile nationally, and is internationally recognised as being one of the most effective in reducing fertility rates. Finally, the ‘Safe Motherhood’ campaign in Indonesia has had an early start. Its results will be important in their own right and in the lessons other countries can learn in the fight against high levels of maternal mortality and morbidity.

Maternal mortality in Indonesia

There is a serious problem in discussing maternal mortality: the lack of accurate information (Ravindran and Berer 1989), due to the scarcity of actual studies, and to the ways in which available statistics are presented. This lack of information on maternal mortality is both cause and effect of the neglect of women’s health (Graham and Campbell 1991).

Though Indonesia shares these problems (Agoestina and Soejonoes 1988), it is clear that maternal mortality is high in comparison with other countries in the region, and given the level of socio-economic development of the country. There is no official estimate for the national maternal mortality rate, as 80 per cent of births are attended by TBAs (traditional birth attendants) who do not report deaths systematically (Utomo and Iskandar 1986). The most recent accepted estimate is 450 per 100,000 live births. Given the difficulties with statistical information, it is almost impossible to have an idea of trends (Budiarso et al 1989). A study carried out in
12 teaching hospitals nationwide in 1982 (Agoestina and Soejoenoes 1988) reports a rate of 390 per 100,000 live births. Given the present rate, this would indicate that maternal mortality is on the increase. Other studies confirm this (Moeloek 1988:23), though again great care should be taken in accepting this conclusion unconditionally. Finally, these data exclude maternal morbidity.

Deep concern among observers and policy makers about this situation led to Indonesia joining the international ‘Safe Motherhood’ campaign in 1988. It was agreed to employ a ‘high-risk’ approach (World Bank 1990), and the commitment was made to reduce maternal mortality by 50 per cent by 2000, through the National Initiative for Maternal Welfare. This aim has since been incorporated at the highest level of policy making in the country, such as the guidelines for the new five-year development plan, Repelita V.

**Does family planning lower maternal mortality?**

Strategies advocated to reduce maternal mortality in developing countries include programmes which attack poverty and other social causes of the poor health of women; improvements in the provisions for reproductive and general health; and family-planning services. However, though the approaches are not considered mutually exclusive, the importance of family planning is often emphasised over that of other strategies.

Indonesia’s Safe Motherhood initiative has been criticised for relying too heavily on the top-down delivery of professional services while ignoring local health-enhancing practices, and the role played by fathers, families, and communities as health providers (Hull 1988; 1990). In addition, it is dominated by family-planning activities, though it encompasses other measures, in health care, education, and expansion of facilities (Safe Motherhood 1991; Gunawan et al 1992).

The advantages of family planning as an instrument for the reduction of maternal mortality are said to be many, including the ability to ‘save women’s lives’ directly, by averting births; preventing high-risk pregnancies and reducing the need for unsafe abortion; and indirectly, by allowing the family and society to set aside more resources for health care (Measham and Rochart 1987). Family-planning services are considered to be more cost-effective than other types of interventions (Measham and Rochart 1987). Internationally, this conviction is reflected by the trends in aid to developing countries. In Indonesia the financial advantages of family planning are stressed also for the savings that declines in population growth will bring to government expenditures, especially in health and in education (Chao et al 1985).

**Lessons learnt**

Winikoff and Sullivan (1987) state that the potential effectiveness of family planning to reduce maternal mortality, summarised by the views given above, cannot be easily realised, though appealing in abstract. There is so far no indication that the widespread availability of family-planning services in Indonesia has resulted in a lowering of maternal mortality.

It is undeniable that in the last 30 years the family-planning programme has achieved remarkable results. Contraceptive prevalence during the 1960s — before the advent of the official national family-planning programme — was 10 per cent. By 1988 it was estimated at 44 per cent (World Bank 1990:ii). Total fertility rates have also dropped, though it is disputed whether this has been solely a consequence of the activities of the family-planning programme (Titus, 1989; Warwick, 1986; Edmondson n.d.). Since the late 1960s total fertility rates have decreased from 5.6 children per
woman, to slightly more than 3 in 1990: a decline of 44 per cent nationally, with marked regional variations.

Appearing to disprove the notion that widespread use of family planning per se can reduce maternal mortality, Bali is among the provinces which have very high contraceptive prevalence rates, yet also higher than average maternal mortality: 780 per 100,000 live births (GOI-UNICEF 1989). While a recent study states that ‘the birth rate in East Java (and almost certainly in Bali) has been almost halved since the development of the national family planning programme...’, and this fact alone has contributed enormously to the reduction in maternal morality’ (Fortney et al 1986:137), this statement is not backed by maternal mortality data (rates or total numbers) for any period prior to the study. Fortney et al actually deduce a decrease in maternal death from the reduction in birth rates.

While this reasoning may be correct, it offers no proof that family planning reduces mortality rates, for two reasons. The first is that the reduction in fertility cannot be unquestionably attributed to the family-planning programme. Additionally, lower birth rates may mean that there are fewer maternal deaths but it does not mean that the pregnancies and births which do take place are less risky. Further, the study reveals that some maternal mortality is actually due to contraceptive use. While the incidence is very small (8 out of 558 maternal deaths), it leads the authors to conclude that ‘...contraception itself also carries a small but measurable risk’. This is a fact which is seldom mentioned when family planning is advocated as a tool for maternal mortality reduction.

Integrating family-planning and health services

Family planning is considered particularly effective when integrated with other health services (Taylor 1989; Mosley and Sirageldin 1987). The justifications for integration of reproductive health services with family planning, as in Safe Motherhood initiatives, are many, but those most often stressed are that integration increases access to services, simplifies organisation, allows for more efficient use of infrastructures, and reduces costs (Mosley and Sirageldin 1987). However, as advised by Winikoff and Sullivan, the effectiveness of such integrated services to reduce maternal mortality can only be assessed through examining the reality of individual situations, since ‘the content of this [health] care and its integration with family planning services need to be clarified in order to increase the safety of reproduction’ (1987:141).

In Indonesia, the main systems for providing the population with health services are the Health Centre (Puskesmas), providing basic health services, and, since 1985, the Village Integrated Service Posts (Posyandu), specialising in nutrition, immunisation, control of diarrhoeal diseases, mother and child care, and family planning (MenUPW 1990).

The family-planning programme is managed by the BKKBN, and its services are delivered through the health infrastructures. Thus it can be said that health and family-planning services are integrated. But is this true integration, namely the ‘...consolidation and linkage of activities from two programs that are mutually supportive in reaching a common target to achieve a similar goal’ (NFPCB 1987:25)? Kartono Mohamad, chairman of the Indonesian Planned Parenthood Association and President of the Indonesian Medical Association, admits a certain lack of common interests and the presence of ‘dichotomous thinking’ in the system (Mohamad 1991).

In terms of the ability of family planning to reduce maternal mortality, there are serious conflicts between health and family-planning services. First, the many tasks performed by the integrated health centres can lead to overload and poor quality of
services (Heering 1988). Also, women’s health care may suffer from falling between two stools. On the one side, the family-planning system is mainly preoccupied with recruiting and retaining large numbers of acceptors (Smyth 1991). Health care offered to women by the family-planning service is virtually non-existent. Counselling and follow-up checks of acceptors are not carried out (Widyantoro 1989, Hull and Hull 1986), and negative side-effects or other complaints are treated in the most perfunctory manner (Hafidz et al 1991; Tacoma 1991).

On the other side, the health system’s brief is to offer maternal care. In fact, though in many parts of the country health clinics are easily accessible, women’s reproductive health receives little or no attention. In addition to problems related to the poverty of infrastructures and to the attitudes of medical personnel (Poerwanto and Imam 1991), one reason is that the work of the health personnel is often disrupted by the demands of the family-planning workers, and resources are unequally appropriated for family-planning purposes (Sciortino 1991). Integration of services can also have the effect of actually deterring women from attending the Posyandu, in the fear that their visits for child or maternal care purposes will be used by family-planning workers to check on them or to ‘motivate’ them. Even though cultural acceptance of family planning is one of the key achievements of the national programme, (Suyono 1991), individual women often perceive the efforts of family-planning workers as intrusive.

These problems exist against the specific socio-cultural background: in Indonesia, as in other countries, traditional beliefs and practices related to birth can be beneficial to women’s health (Hart et al 1990), while others are detrimental to it (Poerwanto and Imam 1991). The integration of family planning with other health services does not seem,
therefore, to offer much to women’s reproductive health needs. This confirms Winikoff and Sullivan’s assertion that, while on paper family planning together with improved health services should reduce maternal mortality, in practice the nature of the services and the relation between the two determine their impact on maternal deaths.

The high-risk approach

The Safe Motherhood campaign concentrates on women who are considered high risk (Mashjur 1988). This category includes women younger than 17 and older than 35, those who have had five or more pregnancies, those suffering from specific diseases, and those with difficulties in former deliveries (Gunawan et al 1992). The adoption of the high-risk approach in Indonesia seems to stem mainly from financial considerations: the World Bank, the main sponsor of the Safe Motherhood initiative worldwide, states that ‘given the limited resources available in Indonesia...it will be important to employ a “high risk” approach to improving maternal health’ (World Bank 1990:43).

There are many doubts about the effectiveness of the high-risk approach. Hull (1991) questions it in the Indonesian context, on several counts. First, it assists women only during ante- and post-natal periods, while the causes which put them at risk emerge through long-term processes. Secondly, it is difficult to identify risk factors which are sufficiently accurate to include all ‘needy’ mothers. The use of family planning to combat maternal mortality is advocated as a preventive approach for women in the high-risk category. This is believed to be equivalent to primary prevention in public health (Rosenfield and Maine 1987). The comparison seems out of place, since exposure to the risk of illness and disease is different from exposure to pregnancy and childbirth.11 The latter represent a threat to women’s life and health not in themselves, but rather because of the conditions under which they take place, both in terms of the health of women and the environment in which childbirth occurs. The truly preventive approach is that which advocates improvements in all relevant conditions.

The use of family planning in the high-risk approach context has been challenged, first in that it cannot prevent between half and three-quarters of all maternal deaths, these being the proportions of women who, in different demographic regimes, are in the non-high-risk category but contribute most to both deaths and births. The second challenge is on the ground of efficiency, since a very high number of births must be avoided for each maternal death averted (Graham and Airey 1987). Here, the tensions between family-planning and health services create a situation where the reproductive health of women is largely neglected, making it unlikely that women at risk can be identified, let alone provided for.

The role of family planning is questioned further in relation to young women. Mortality rates for the 15-19 age group are as high as 1100 per 100,000 live births (Women’s Global Network for Reproductive Rights 1989). Recent research in Central Java has confirmed this, showing the highest maternal mortality to be among women aged less than 20 years (Agoestina and Soejoenoes 1988). However, the capacity of family planning to reduce maternal mortality among younger women is limited, firstly because the current low contraceptive rates (Central Bureau of Statistics 1991: Table 7) displayed by this group (the lowest of all age groups across regions) are unlikely to increase, given the cultural resistance to delaying first births.

Another reason for the limited potential of family planning to reduce the mortality rates of younger women is linked to abortion. Illegal and unsafe abortions are responsible for the death and maiming of hundreds of thousands of women every year, worldwide. Information on abortions
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in Indonesia is scarce, since abortion is illegal. One recent estimate puts the total of annual abortions in the country at 1,152,000, with 6,900 related deaths (WHO 1990). Despite the lack of data, it is justifiable to think that many of these abortions are performed on young, unmarried women. For example, a study of clinics in Java and Bali found that, of the women seeking menstrual regulation to terminate unwanted pregnancies, about 50 per cent were between 15 and 20 years of age (Kelompok Studi Wanita 1991). It is often repeated that family planning can reduce maternal mortality through limiting unwanted pregnancies and thus unsafe abortions (Harrison 1987). But in Indonesia, as in so many other countries, family-planning services are reserved for married women. The limitation has been imposed as a trade-off for the religious and popular acceptance of the programme. It also reflects the naive idea that in Indonesia 'child-bearing takes place almost exclusively within marriage' (World Bank 1990:13). Clearly, this ignores the fact that young, unmarried women are often sexually active (Royston and Armstrong 1989) and that marriage sometimes follows pregnancy rather than the other way round. By excluding unmarried women, the family-planning programme could be contributing to the high mortality which is the inevitable outcome of clandestine, unsafe abortion.

Thirdly, the high-risk approach leads to the neglect of certain categories of women, such as prostitutes, and women workers (Katoppo 1988), all exposed to considerable health risks. Here women workers are treated as a separate category, though most women in Indonesia work, because of their frequent exposure to specific health risks.

Mother-and-child clinic, Indonesia. Family-planning services are often reserved for married women, ignoring the fact that unmarried women may become pregnant. JEREMY HARTLEY/OXFAM
Research shows that conditions of work, and health and safety provisions, are very poor in Indonesian industries, both modern and 'traditional' (Grijns et al 1994). Employers in this sector consistently disregard existing regulations on menstrual and maternity leave, and other similar benefits.

A final problem of the high-risk approach is the concentration on mortality — and its prevention — to the exclusion of morbidity and infertility. Concern for reproductive health should include infertility, problems with menstruation, and all other aspects of women's reproduction. The narrow focus of the Safe Motherhood initiative means these receive very little attention. The problems associated with infertility and with illnesses related to reproductive functions must be considerable. While infertility is still one of the main reasons which lead men to divorce or abandon their wives (Nakamura 1983), illnesses may seriously impair a woman's ability to work, thus affecting her welfare as well as that of her family.

**Conclusion**

This paper has looked at three aspects of the current concern with maternal mortality in Indonesia. It has noted that there is no past evidence to support that an increase in family-planning services leads to a decrease in maternal mortality rates. It has expressed doubts that this may happen in the future, mainly because of the nature of the relations between family planning and health services. Finally, it has concluded that the high-risk approach to the problem of maternal mortality is too narrow.

It can be concluded that Safe Motherhood initiatives give too much importance to family planning as a strategy to reduce maternal mortality: family planning has limited potential in this direction since, rather than eliminating the factors which endanger women's lives, it merely prevents some women from exposing themselves to risk. Taking the family-planning solution to extremes would suggest that maternal mortality can be eliminated when women stop becoming pregnant and giving birth!

There is insufficient evidence to suggest that there is a sinister explanation for the stress that Safe Motherhood initiatives give to family planning. However, it is common to consider reproductive health primarily from a demographic perspective and to link it to family planning. The cost-saving benefits of family planning over the more radical measures necessary to improve women's general and reproductive health are perhaps a more realistic explanation of this emphasis. Though realistic, these justifications are felt to be counter to the basic idea that 'In the battle against high levels of maternal mortality, family planning should never be seen as a substitute for obstetric care' (Royston and Armstrong 1988:215).

This does not mean that family planning has no role in reducing maternal mortality, or that it does not offer other benefits to women. However, it should be considered as a component of a much more comprehensive set of measures, which should be designed for women at all stages in their life cycle, and provide generalised as well as reproductive care, including medical care for women who are exposed to risks other than those of pregnancy, for example, as family planning acceptors. These measures should enhance the health of women as citizens and workers, not only mothers, and address patterns of nutrition, work, and access to resources which affect women's health from a very early age, rather than concentrating on technical interventions surrounding childbirth. Such comprehensive measures should go hand in hand with generalised growth in the economic, educational, and health fields (Harrison 1989).

The Safe Motherhood initiative has taken surprisingly long to emerge. Indonesia is to be praised for being one of a few countries where a programme is either in existence or is being planned (Safe Motherhood 1991).
This is an important programme, with the potential of saving women’s lives, and enhancing their health and general welfare. This potential can be realised only if the circumstances under which the programme is implemented, and the approach which prioritises family planning over everything else, are reviewed.

Notes

1 Such recognition was made tangible in 1989 by the award to the President of the UNFPA prize for achievements in the field of population.

2 There are three main information sources for maternal mortality in developing countries: vital registrations, health services statistics and community-based surveys (Graham and Airey 1987). None of these reveal the full scope of maternal mortality and morbidity.

3 This accounts for about 20,300 maternal deaths per year, far above the rates for other countries in the region: Singapore 45, Thailand 100, Philippines 162 and Malaysia 69 (Soekirman 1988). It is also higher than the average for Asia, 420, and for the world as a whole, 390 (WHO 1986). The average rate hides enormous regional differences. The 1986 Household Health Survey gives 450 as the national rate, 150 the rate for Java, 450 for 7 provinces outside Java and 780 for Bali (GOI-UNICEF 1988:48).

4 The Indonesian initiative is managed by a committee composed of the BKKBN, the Ministry of Health, the Ministry of Women’s Roles and the Indonesian Society of Obstetricians and Gynaecologists (POGI).

5 In 1988 the 17 major bilateral sources of aid to developing countries gave Safe Motherhood programmes $818.8 million. Of this, about half were earmarked for programmes with direct benefits to maternal health, while the rest was for those with indirect benefits. However, of this amount (about $400 million), $300 went to family planning and only $100 to maternal health programmes.

6 In fact, other sources claim that it is due either to changes in socio-economic conditions or to a combination of the two factors (Edmondson n.d.).

7 These exclude the ‘safari’ and other recruitment campaigns, where health considerations have very low priority.

8 These comments do not reflect on the personal commitment of individual workers either of the health or of the family planning programme, but refer to problems which result from institutional pressures.

9 Motivation work comprises much of the activities of field workers of the family-planning programme.

10 For example, in West Java a woman is considered pregnant only after three missed menstrual cycles, thus only after that time she will seek medical attention. This contributes to the poor attendance at antenatal clinics. The importance for maternal health of pre- and post-natal care cannot be overestimated, especially in situations where the health conditions of the majority of women are poor and sanitary standards in the domestic environment are inadequate. In Indonesia as a whole 80 per cent of the children born in the last five years are said to have received some ante-natal care (Central Bureau of Statistics 1991:10). However, this figure varies enormously from province to province, and does not explain the type and quality of the ‘care’ received. Information on post-natal care is not available, but can be deduced from the fact that the great majority of women are assisted at birth by Traditional Birth Attendants, 26 per cent by a midwife and only 2 per cent by a doctor (Central Bureau of Statistics 1991:10).

11 The implications of the frequency with which reproduction and its functions are seen as pathological are discussed in Graham and Campbell (1991).

12 There is virtually no information on the sexuality and sexual behaviour of women in Indonesia. This is clearly an area where research is much needed.

13 For example, the results of the Health and Fertility Surveys for Indonesia give extensive information on fertility and contraception but little on women’s reproductive health.
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Female sexuality, regulation and resistance

Renu Khanna and Janet Price

A woman in rural Maharashtra, India, had not conceived after being married for several years. Labelled baanj (barren), she was the butt of ridicule and scorn in the village. One day she was raped by the village headman, who threatened her with dire consequences for her family if she revealed this. The woman suffered in silence. Within a few weeks she realised that she was pregnant. She was in an awful situation: barren within marriage and pregnant from a brutal incident outside marriage. She could not cope with the conflict between her deep desire to be a mother and her revulsion at carrying a child which was the result of rape. She committed suicide (Gupte 1994).

This recent incident illustrates some of the rigid local norms of female sexuality, including limits on sexual expression within marriage, the expectation of childbearing within and the intolerance of sexuality outside of marriage, and the stigma attached to women who are raped. It shows how such norms can make women's lives unbearable.

In this article we will discuss the emergence of ideas about female sexuality and illustrate the discussion by looking both historically at the Indian-British colonial period and to the present-day work of women's groups in India. Our reasons for focusing on India is firstly, to provide a coherent context for discussion and secondly, because India is where we first met and worked together, and developed some of the ideas presented here.

Models of sexuality

One view of sexuality, derived from Western thought, sees it as determined by our sex and reproductive physiology. The acceptable and ‘natural’ face of sexuality is represented by the adult, preferably married, able-bodied, heterosexual couple, in which man and woman have different roles and modes of behaviour which are predetermined by their biological sex. In this analysis, women are viewed as inferior, but are held responsible for male sexuality, which is thought to be more aggressive and often uncontrollable.

This inflexible biological view of human sexuality takes no account of socio-cultural and historical influences. Forms of sexuality that do not fit the norm (male homosexuality, lesbianism, and assertive female sexuality) are viewed as deviant. Normative views of sexuality may be used to reinforce oppressive ideologies, including patriarchy and colonialism.

As this article will show, women have developed a range of strategies for resistance. New ways of talking about sexuality are constantly emerging, and new sets of rules have been established, to manage sexual behaviour. These differing views do not represent an absolute truth about the
sexuality of Indian or British women (for no such truth exists); but are specific to a particular historical time and place, and to particular groups of women. The article considers the ways in which the management and control of female sexuality has been influenced by factors such as class, religion, caste, and ethnicity. In drawing on historical records, it is important to note that these ‘disproportionately represent the interests and concerns of the dominant classes’ and specifically of their men (Nair 1992).

The evolution of female sexuality in colonial India

During the first half of the nineteenth century, the sexuality of Hindu women, predominantly of the higher castes, was debated by missionaries, nationalist Hindus, Indian social reformers, and colonial officials. Hindu women were seen as the victims of ‘traditional’ Hindu practices, such as child marriage and early widowhood, the restrictions on widow remarriage, and the ritual of sati (the burning of widows on the funeral pyres of their husbands). Missionaries argued that such atrocities showed the need for Christian social reform, and saw women as victims of the Indian male and Hindu culture (Price and Shildrick 1992).

Recent historical research suggests that the sati-abolition movement might have created the myth of a practice which was virtually non-existent (Kumar 1993). The theory of passive female sexuality, with women as victims, was concerned less about women themselves (many of whom resisted such practices, and the categorisation of themselves as victims) than with ‘tradition’ and the moral basis for colonial rule (Mani 1985). Laws to control and abolish the practice of sati were duly imposed by the British, initially locally (for example, in Bengal), but then further afield, as a means of extending colonial rule into regions formerly outside British control, on the basis of abolishing practices such as sati.

Categorisation and control of prostitution

At the same time, a second ideology of female sexuality emerged to suit a different set of circumstances. Again, the aim was to regulate female rather than male sexuality, this time in order to maintain the health of the British army in India. Attempts to regulate prostitution around British army bases, begun in the late eighteenth century, were regularised in the Contagious Diseases Act XXII of 1864.

Prostitutes were identified as a sexual danger, responsible for the massive increase in sexually-transmitted diseases (STDs) in the army (Ballhatchet 1980). Under the new Act, women wishing to be army prostitutes were compulsorily registered, examined, and committed for treatment in secure hospitals if they were found to be suffering from STDs. This in effect established legalised prostitution, managed by the army. The women concerned resisted on a large scale, and the numerous attempts to implement the law were disrupted by their refusal to be examined, certified and treated.

Myths of motherhood

A third ideology of female sexuality came into focus in India towards the turn of the century, when a new image came to the fore, linked to notions of family, race, and nation — that of woman as the responsible (or irresponsible) reproducer of her family. The missionaries, who had been expanding their work in health and childcare, began to express concern about the condition of the Indian family. Mothers were held responsible for perpetuating ‘through that mighty force of maternal influence ... all the foolish and base institutions and degrading tenets of Hinduism or Islam’ (Weitbrecht 1880).

Mothers were seen as irresponsible; unable or unwilling to care properly for their children and ready, in some instances, to
give them up for adoption or even sell them (Price and Shildrick 1992). Middle-class Hindu and Moslem women were given training in Western-style health and hygiene, encouraged to abandon traditional child-rearing practices, and invited to attend ‘Mother and Baby’ shows, where prizes were given for the healthiest baby (Homes of the East 1924). Working-class and poor rural women were more likely to be either ignored, or pressured to attend classes at which their clothes, language, and living habits came in for severe criticism (Marriage Hygiene 1935).

Motherhood was evoked in quite another context by the nationalists, particularly in Bengal, who turned to the mother goddesses as symbols of the struggle for liberation. Female sexuality was invoked in its various forms — Durga as mother and protector, Kali as erotically destructive — and these spiritual and sexual aspects combined in a powerful representation of India as Mother, which spurred young nationalists on the path to martyrdom. These images of motherhood as central to the independence movement were taken up by nationalist women, involved in women’s education. They ‘asserted the power and strength of Indian mothers’, and saw education as the way to strengthen the maternal role (Kumar 1993).

The notion of women as mother of the race was strengthened by the growing eugenics and population control movement coming out of Britain and the US, whose ideas were exported to India by activists such as Marie Stopes and Margaret Sanger. Positive eugenics, aimed at improving the ‘quality of the race’, had a strong imperial emphasis, being concerned with producing British men and upper-class Indians who would be able to rule the Empire. In comparison, negative eugenics focused on the reduction of groups such as the mentally insane, the poor, and those suffering from alcoholism. Eugenicist Dr Pillay opened India’s first clinics for women’s sexual and marital health, in Bombay. These were intended for the wives and families of mill workers, with a major aim being to reduce the birthrate amongst the poor (Marriage Hygiene 1936). Marie Stopes, in her writings, focused particularly on controlling the birthrate of ‘the poor women of India, the vast majority, for whom special methods must be devised’. She suggested women use cotton waste, soaked in bland cooking oil, ‘inserted high in the vagina just before she goes to bed’, as a barrier method of contraception (Stopes 1934).

The regulation of female sexuality

The above examples show female sexuality as the focus of varying strategies of control. The sexuality of middle-class, higher-caste Indian women had to be protected from the dangers of child marriage, managed
eugenically to ensure the birth of sound children, and the continuation of a race 'fit to govern', and medicalised to take control of female reproduction. For working-class and poorer women, sexuality had to be regulated to protect against the negative consequences of promiscuity, prostitution, and overpopulation. Women were marginal in the debates, which revolved around the needs of and resistance to the colonial process.

**Sexual norms in post-colonial India**

Rather than returning to a pre-colonial, 'traditional' state, post-colonial ideas of female sexuality show a combination of local, national and international influences. International organisations such as the World Health Organisation (WHO), UNICEF, International Planned Parenthood Federation (IPPF), and bilateral donor agencies such as USAID and British ODA, have instituted a wide range of programmes, including the Safe Motherhood Initiative, HIV/AIDS and STD prevention, and population control programmes, which directly relate to sexuality.

The notion of sexuality held by workers in health in India has shifted with the advent of HIV/AIDS. Sexuality is viewed as pleasurable yet also dangerous, with elements of desire and sexual satisfaction which are intertwined with the possibility of infection, sickness, risk, and death (Gordon and Kanstrup 1992). While it is argued that no specific sexual practices should be ignored or denied, in reality health-education programmes focus on a range of 'normative' sexual and reproductive behaviour, and reinforce the ideology of a stable, heterosexual family unit. Those whose sexual practices fall outside these norms have been the targets of programmes — women who are perceived to bear too many children, men who have sex with men, women who work as prostitutes.

Post-independence, and in growing strength since the 1970s, women in India have been involved in a wide variety of activities concerned with challenging culturally-imposed notions of female sexuality. Campaigns against rape, and antidowry protests; protests against violence against women (in many cases linked to anti-liquor movements); campaigns against international and government population policies and the introduction of contraceptive hormones such as Net-en, have all been waged (Kumar 1993). Women have also set up extensive networks and support groups.

The perspective of international agencies on population policy has moved from advocating population control to describing their objective as promoting 'women's choice'; and a similar argument for choice has been put forward by some reproductive rights groups in the West. However, women from India and other developing countries are rejecting the reduction of women's issues to the narrow range of 'reproductive choice and reproductive rights', and have not felt fully able to respond to the efforts of reproductive rights groups in the West aimed at the creation of global solidarity around 'women's choice' issues. For example, Southern women who met at a conference in Uganda in 1993 felt that the most urgent question in the 1990s was of survival, due to phenomena such as the Structural Adjustment Programmes (SAPs) of the IMF and World Bank, which severely affect the lives of poor women (personal communication). Women in the Third World are demanding that their counterparts in the First World widen their definition of what constitutes women's issues, and take action against continued Northern exploitation of the South.

**Sexuality and spirituality**

Indian women activists, and women's health and self-help groups have, at a local level, been developing ways of providing
women with the opportunity to explore their bodies, and question their own views of themselves and their sexuality. They have challenged beliefs about the polluting aspect of female sexuality, and attempted to strengthen the links between sexuality and spirituality, encouraging women to acknowledge their needs and desires.

In Himachal Pradesh, Society for Social Uplift Through Rural Action, (SUTRA), a voluntary agency supported by Oxfam, has as its main objective the empowerment of local women. In its workshops, images of goddesses are used as tools to promote awareness of the inherent power of women. These images evoke both women's strength and their potential for feelings of abandon, neither of which form a part of 'traditional' female sexuality.

Women identify themselves with the different images according to their own moods, working through drama or dance. Women have found these experiences energising, allowing them to perceive aspects of their physical, mental, and spiritual lives as an integrated whole. Workshops like this can challenge the passive view of female sexuality by working with traditional mythology and folklore.

Self-help health and sexuality workshops

In 1989, a network was formed of women working at the grassroots in organising local women in India. The aim of the network, Shodhini, was to create empowering alternatives in women's health through an action research programme on local health traditions and alternative medicines used by women. A central part of this process was a series of self-help workshops, 'learning on and through one's self', to train women in simple gynaecology. Social Action for Rural and Tribal Inhabitants of India (SARTHI) is one of the voluntary organisations with which Shodhini members work, and a group of Women Health Workers (WHWs) who had been working in SARTHI's women's help programme for about two years came together for the self-help workshops.

Although the WHWs had wanted to learn about gynaecology in theory, they were very resistant at first to taking part in the practical sessions. Most of the resistance stemmed from feelings of shame: "How can I open myself up before everybody?". Women also felt that 'genitals are dirty', 'the smell is awful and I will vomit'. They were afraid that some serious disease might be discovered as a result of examination. They were also afraid of what their own family and community members would say if they found out that SARTHI had arranged such a training for them. Such anxieties are a consequence of the way people are socialised to believe that the sexual organs are shameful and dirty.

After the first participants' self-examination, feelings had changed. 'It was very good because I discovered part of myself that I had never known before and realised how beautifully I am made.' And as participants discovered that the traditional remedies they were using were working, a new energy infused the self-help sessions, and greater keenness to learn.

In their villages, the WHWs started talking about the training they were undergoing, and their increasing skills. They began to be sought after by women in their communities. Now the WHWs' expertise has been recognised, and some of the older ones are sought out by men to provide treatment for STDs; other women in the community say they want similar training; WHWs are approached for abortions; and people are willing to pay for their services.

More than just barefoot gynaecologists, the WHWs have become the supporters of women in the community. They intervene frequently in domestic crises and they have begun to organise women to demand better health services from the government. Looking after not only the physical health of women, they take a holistic view of health.
The self-help group was instrumental in changing radically the participants' perceptions of themselves and their relationships to their bodies. The women stated that the self-help workshops enabled them to share and release the tensions of family life, and made them self-confident and aware. The practical self-examination sessions demystified their bodies and put their minds at ease about fear of disease (Shodhini 1994, examples of work with SARTHI taken from Khanna 1992).

**Conclusion**

Sexuality has often been regarded as a source of male power and female oppression. We have tried to show how views of sexuality are not fixed but constantly changing, part of a network of power that affects our lives on an intimate level. While theories of sexuality have often served the interests of the powerful, our examples, both from history and the present day, show how women have resisted, and have struggled to redefine sexuality, 'to exert control over their bodies and recognise their intrinsic strengths, both individually and collectively' (Khanna and Price 1988).

Renu Khanna has worked for 17 years on women's health issues. Her current interests are reproductive medicine and the use of traditional Indian medicines for women's health. She is vice-president of SARTHI.

Janet Price underwent medical training in the early 1980s and has spent the time since unlearning much of what she was taught about women's health and sexuality. She worked in India with local NGOs involved in women's development. She is currently working on feminist approaches to women's health within the post-colonial context.

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Rape in South Africa: an invisible part of apartheid's legacy

Sue Armstrong

Contraceptive technology, information, and education may combine to offer women a degree of choice over their reproductive role, but none of these can afford any protection for girls and women from the experience and consequences of coerced sex. Rape is often reported by the media in a way which sensationalises the sexual aspect, while playing down the fact that, in essence, rape is a form of violence used by men to assert their authority and power over women's bodies and minds. For many men, female consent to intercourse is simply not considered an important issue. Where this attitude is the prevailing one, women are less likely to demand the right to say no.

This article investigates rape in South Africa, where, during the years of apartheid, a culture of aggression and domination has caused both black and white cultures to intensify their specific male-dominated power systems, as the national liberation struggle has been fought. This heavily militarised society has marginalised qualities which are traditionally thought of as female, such as trust, compassion and gentleness (Cock, 1989). In situations of conflict, rape as a means of asserting male power over women tends to increase in incidence and intensity (El Bushra and Piza Lopez, 1994). This has certainly been the case in South Africa, where the incidence of rape and other forms of gender violence, has soared (Segel and Labe, 1990).

Rape and apartheid

Heather Reganass became concerned about the prevalence of rape in South Africa during the course of her work as director of South Africa's National Institute for Crime Prevention and Rehabilitation of Offenders. During the apartheid years, it became obvious to activists concerned with gender issues that rape statistics were escalating and no one was commenting on it. It was unquestionable that rape was intertwined with the racial injustice of the apartheid system. As Heather points out, 'right up to the moratorium on the death penalty, no white man had ever been executed for rape, whereas the majority of people who were hanged in this country were actually hanged for raping white women. If a rape victim was black it wasn't really seen as quite as serious as if she had been a white woman.'

However, instead of being perceived as an abuse of human rights around which anti-apartheid protesters could mobilise, Heather believes that rape 'was seen as being just part of life', particularly for poor black women, who have experienced the triple oppression of race, class and gender. Discriminated against economically, politically, and culturally, they have suffered abuse at the hands of both black and white men.

The problem of fighting the widespread violence against women as an anti-apartheid issue can be seen to be twofold. First, while

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racism may aggravate gender violence, it is not its only cause. Second, gender violence exists as part of all cultures in South Africa, and is indeed a feature of most societies worldwide (Levinson, 1989). Gender violence and rape have thus been perceived as marginal issues, which at best could divert attention from the struggle against racism, and at worst could divide black South Africans against themselves.

‘When we started investigating, we discovered that rape, particularly of black women, was so prolific in South Africa that it was just accepted by everybody: social workers, doctors, policemen, and even the victim herself. A black woman's life was considered valueless, and what had happened to her unimportant. We wanted to question that assumption: rape is abhorrent and cannot be condoned, whoever the victim is.’

The unreliability of statistics

In common with many countries, South Africa’s rape statistics come from the police. It is likely that only a small percentage of the rapes which occur are reported to the police. In particular, rape statistics in the 1980s were completely inadequate, because, as Heather says, ‘no black woman would go to a police station. In those days, just to be seen near a police station might mean you were perceived as an informer, your home would be burnt down and you would be killed.’

As well as being unwilling to approach the police, many women are embarrassed to admit marital abuse, including rape, to medical practitioners (Geldermalsen and Van Der Stuyft, 1993, in the context of Lesotho), since in some communities marital violence is traditionally associated with a failure on the wife’s part to perform her duties (Germoind, 1967). Other women may be frightened to visit a clinic to get help for gynaecological injuries; as Heather says, ‘you interview women who have been raped and hear how they’re treated by district surgeons (police doctors) — sometimes they’re kept waiting days, and then the surgeons can be very rough.’

While official statistics were of limited use in her research into rape, Heather found out much more when she approached women themselves. ‘We had to talk directly to representative groups of women. In Soweto, we discovered that one in four women had been raped, perhaps even one in two; and then we started looking at different age groups. Girls were being raped for the first time at a very young age, on average, at about the age of 14. The final estimate is that one in four women has been raped, and there is one rape in South Africa every 83 seconds. Please God, there are women out there who will never be raped. That means that some women will be raped more than once.’

Who is involved?

Who are the rapists? ‘It’s more often than not people that the women know. Women are made vulnerable by poverty, the distorted South African justice system, prejudice, alcohol abuse, and other sorts of abuses that you see in desperate, impoverished communities.’ Among married women, the rapist may be her husband. Marital rape is not recognised as a crime in South Africa, despite a test case ruling which recognised it in the former homeland, Ciskei, in 1991 (Shoeshoe, 1991).

The rapists of young girls may be schoolfellows or the ‘comrades’, young street fighters supporting one or other of the political movements. Heather points out: ‘rape may happen when girls leave their close family homes — which aren’t close family homes any more — and often happens at school. At one point we began to believe that every black Sowetan teenager who lost her virginity was losing it in a violent way, rather than in a normal way which one would hope included affection. I think this is more or less what is happening.’

Coercion plays a major role worldwide in
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School at Roosboom, South Africa. Young girls may be raped by their schoolfellows; they may even be abducted from their classrooms.

initiating young women into sexual activity; in South Africa, the practice of ‘jackrolling’ (abduction and forced sex) has legitimised rape for a generation of young men in the townships. Heather points out that there are myths in the black teenage community that not having sex is bad for your mental health: ‘these myths are perpetuated and they make these young guys more powerful. There’s a belief that you go totally crazy if you don’t have sex. So if you can’t get it legitimately then you go out and get it illegitimately.’

It seems likely that such rapes, where girls may literally be abducted from the classroom, are in part motivated by the desire to intimidate girls from attending school, as a way of asserting male authority: education plays a key role in allowing an individual to gain access to and control of assets and resources, and may thus pose a potential threat to gender power relations.

Sadly, since rape is condoned within their peer group, girls may collude with young rapists rather than putting up a united front against them: ‘the popular girls certainly colluded with the boys. I remember one particular girl who had been raped was fat and quite unattractive, and the attractive girls thought that was hilarious. One of them actually said “well, what are you bitching about? You were quite lucky because if you hadn’t got it that way, you wouldn’t have got it any other way”.’

Heather was involved in making a film about rape in the townships and found that some young victims of rape were willing to speak about it and denounce their attackers. ‘We found victims who spoke up in the film we made. They spoke up in front of the boys in their class, but the boys mocked them. And one of the girls — I feel very guilty about this — actually dropped out of school after we made the film.’

Ironically, despite the widespread incidence and acceptance of rape among adolescents, schoolgirls who become pregnant are often forced to leave school. Prostitution is linked to early experiences of rape, as
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uneducated young mothers, often rejected by their families, struggle to survive (El Bushra and Piza Lopez, 1994).

In this analysis, rape may be perceived as the ultimate means of forcible prevention of women’s participation in the public sphere beyond the household. In support of this, Heather confirms that her research showed that rape using bottles, tins or other objects, happened especially to older women. ‘Rape of this sort is quite common in Soweto.’ The nature of these rapes makes it clearer than ever that rapists are not interested in sexual gratification but in the infliction of injury and intimidation.

The law of South Africa only recognises rape if the perpetrator uses his penis for penetration: the horrific rapes cited above are defined as the lesser offence of assault. This is just one example of the way in which women and girls who do speak out against rape, and attempt prosecution, are let down by the authorities. As Heather says, ‘the law is not there to protect black people — we’ve got a very long way to go — and women have always been second-class citizens in South Africa. Of all the victims of crime, the least protected are women and children. And women and children who have been sexually abused are really marginalised.’

Added to the physical and mental trauma of rape and the risk of pregnancy, women today also are at risk of contracting HIV. International campaigns on reproductive rights and against AIDS have yet to acknowledge the significance of the widespread violence against women. According to projections based on data from other African countries, it is possible that in 1995 there will be 970,000 HIV positive people in South Africa (Whiteside, 1994). While a single act of unprotected intercourse with a male HIV carrier may normally mean a one in 250 chance of infection for a women, rape shortens the odds. In sex against a woman’s will, there is likely to be no lubrication, more friction than usual and possibly bleeding, all of which adds to the risk of infection. In addition, in the case of a young girl, the surface cells in the immature genital tract are less efficient as a barrier to HIV than the mature genital tract of older women.

For too many women and girls, rape and forced sex are a daily fact of life. However carefully designed or successfully implemented, programmes offering safe-sex advice or assistance with reproductive health and family planning are irrelevant to those forced to have sex against their will.

Now that the apartheid era is finally at an end, there is an opportunity to address rape — including homosexual rape — and gender-based violence, along with many other issues in South Africa which need urgent change. Preventing rape must start from changing social attitudes, towards women’s status; men must no longer view women as their inferiors, and violence as an appropriate means of enforcing male superiority. The African National Congress (ANC) is committed to striving for gender equity, but time will tell whether, as in many other national liberation struggles, women’s concerns are actually deprioritised after the movement reaches government (see for example Urdang, 1989, in the context of Mozambique, and Molyneaux 1985, in the context of Nicaragua).

Changing cultural attitudes

Meanwhile, in Heather’s view, efforts to make rape socially and culturally unacceptable start within the household and local community. ‘At the start of our research, girls and women were amazed that anyone had the time or interest to discuss this thing with them. Nobody had ever done so before. Then the media climbed on the bandwagon and, as more and more was written, so more women were coming out and saying, “this has happened to me”. However, urban and rural South Africa differ. In the urban areas women are very much aware of rape. For instance, there is a trauma section at Baragwanath Hospital in Soweto and rape
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Recently, there have been small but significant improvements in the way raped women are treated and in the likelihood of their receiving justice. For example, Heather says that the process of reporting a rape has changed: ‘the very first police station in South Africa to have a one-way mirror was in Soweto, and a lot of the experimentation of treating victims with a little more care started in this one police station, way before the others. The station was headed by a very enlightened commander.’ But improvements in Soweto cannot influence the treatment of rape victims in the rural areas: ‘probably one in 50 rapes in the former homelands are reported, because you have to walk a very long way to a police station. And the tribal court doesn’t seem to deal with these cases at all. Things are still very bad in much of the country.

‘The best protection against violence and abuse of power — which is what rape is — is healthy family and community life. Family life has disintegrated here. The erosion was engineered by the authorities when they broke down communities and moved people, and tore them away from their roots. We are harvesting today the apples of the trees planted by Verwoerd in 1948, when he created the apartheid system. You’ve got to start with young children, teaching them to respect women, teaching them to respect people, talking to them about violence. None of us are unpolluted.’

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References


The development of contraceptive technologies: a feminist critique

Anita Hardon

Over the past two decades, contraceptive technologies have been the subject of increasing criticisms from women's health advocates. Critics have said that the way contraceptives are designed, developed and distributed has had the effect of controlling women's fertility and harming their health, rather than meeting their reproductive needs. A specific criticism is that too many of the technologies depend on medical professionals for administration and removal. This means that women are not in control of their contraception, with a resulting potential for abuse.

Voicing misgivings about the testing of contraceptives is not the same as criticising all contraceptive technology. A major problem confronting women worldwide is the inaccessibility of appropriate contraceptive techniques, as reflected in the estimated 40 million abortions performed on Third World women each year; many of these are illegal (Germain 1989). It is, rather, a call for technology which is appropriate, safe, and under the user's control.

The testing process

To understand how this situation comes about, one needs to look first at the process by which these technologies tend to be developed and evaluated. This process follows a fairly standard format established to meet the requirements of drug-regulatory and licensing bodies. The evaluation is performed in the context of a formal scientific trial.

Although the format ensures a degree of objectivity in assessment of technologies before they reach the market, it also has shortcomings. The scientific trial will probably be carried out at a university hospital or large urban family-planning clinic. Patients will be carefully selected to exclude women who might be especially vulnerable to the effects of an as-yet unfamiliar compound: adolescents, anaemic women, women with liver disease, pregnant or breastfeeding women will all, as a rule, be carefully excluded.

This carefully controlled choice of testers is obviously very different from the circumstances under which a 'proven' contraceptive technology will generally be used. There are further differences: in trials, both providers and clients may be reasonably well-informed; the clients are expected to be healthy; the clinic is likely to be well-equipped to screen subjects for pregnancy, health problems and so on; and able to follow clients up to check on their health.

In normal family-planning practice, providers may be poorly trained and under-resourced. Users are more likely to be in poor health, less likely to be literate, and less likely to be able to return to the clinic for follow-up health checks. In other words, the
results of clinical trials cannot be applied to women who were not included in the trial; the effect of the technology on these women may well be different.

The standard trial design has other important limitations. Trials rarely last longer than five years, so there is no possibility that any long-term consequences of taking the new contraceptive, such as cancer, would be detected. In addition, the sample number of women testers may often be too small to detect rare but serious side-effects. Side-effects may also be missed because researchers tend to decide in advance what to look and test for in the women they follow up. Something they had not thought of in advance of the trial may be missed.

**Testing acceptability**

Further trials are usually carried out to determine the 'acceptability' of the technologies. The trials for acceptability have similar limitations to the trials for safety. It is the researchers who decide what 'acceptable' means; quite often, they do not even state their own definition of 'acceptable' before drawing their conclusion. For example, none of the ten 'acceptability' trials of Norplant published in the 1980s makes explicit what criteria and indicators were used to assess what makes a method acceptable or not (Hardon 1992).

The main criterion of acceptability seems to be the proportion of women at the end of the trial who are still using the method. However, because the women in trials are not representative of the general population, as discussed above, the continuation rate in trials may be higher than in ordinary use. Thus only 6 to 30 per cent of users of Depo Provera (DPMA, three-month contraceptive injection) had discontinued use at the end of one year of trials, whereas in family-planning programmes, anything between 30 and 50 per cent of users discontinue by the end of one year (Liskin 1987).

In the acceptability trials for the five-year contraceptive implant Norplant, clinic staff in Ecuador were reported as being 'initially over-selective' in choosing users because they were worried about patient reaction to the bleeding disturbances caused by Norplant. In China, staff had 'latitude to exclude women' at their own discretion (Marangoni et al., 1983).

Despite the fact that the women subjects of such trials are unlikely to be representative of the general population, researchers tend to draw conclusions about the safety and acceptability of a method for a population as a whole — for example, 'Norplant implants are an effective, acceptable method of contraception with minimal side-effects and definitely deserve wider use in Egypt', or '... this high rate also indicates that Norplant is acceptable to Chinese women' (ibid., 1983).

**Different goals of users and researchers**

While some of these deficiencies flow directly from the standard format for clinical trials, other shortcomings in the process of contraceptive development arise from the differing goals and desires of users and researchers. It is the 'population establishment' — international agencies and national governments interested in population control and family planning — which employs most of the researchers and provides the settings and users for trials. Researchers might be expected to share some of their employers' goals. Criteria for what constitutes a desirable contraceptive technology are all to do with how many pregnancies can be prevented. These views are reflected in the kinds of technology developed and distributed.

Once again, the user definition of a 'good' contraceptive, which is likely to be different, is not heard. Safety and acceptability, which are likely to be equally as important as effectiveness to women, do not appear to be given so much weight. Thus agencies
involved in family-planning programmes in developing countries have argued in favour of the use of Depo Provera by pointing to the fact that it is easily administered, and especially useful for women who have difficulty in remembering to take oral contraceptives each day. The 'non-visible' nature of the method is also seen as an advantage to women whose husbands do not agree with their decision to practise birth control.

There are concerns about the effects of Depo Provera, because the active ingredient has been found to cause cancer in animals, and causes menstrual disturbances and a delay in return to fertility when the method is discontinued. Depo Provera is rated as 'second-choice only' by several drug-regulatory authorities in the industrialised world because of these worries. Agencies promoting family planning in the South counter this by saying the risks of the method should be weighed against the risk of an unwanted pregnancy, pointing out that childbirth is riskier in developing countries than in the industrialised world (SCF 1985, IPPF 1980). Women's groups are very critical of this comparison of Depo-Provera with pregnancy, rather than with other, safer methods of contraception.

In safety and acceptability studies, value-judgements are made by researchers about what is and is not important to women. Menstrual disturbances, mood changes, weight gain, headaches or dizziness are dismissed as 'minor' — even when they make the woman feel so ill she is admitted to hospital. A similar value-judgement is used when users voice fears which scientific trials have yet to prove unfounded. Worries about the effects on breastmilk or a foetus, or long-term health effects, are dismissed as 'rumours' by researchers.

The difference in perceptions of a method by user and researchers is particularly striking when menstrual disturbances, common to most long-acting hormonal contraceptives, are considered. Anthropological research suggests that the consequences of disturbed menstruation can be far-reaching. The meaning attached to menstrual bleeding varies in different cultures; it can affect food preparation, sexual contact and religious practice. For instance, among the Enga people of New Guinea, contact with menstrual blood, in the absence of appropriate counter-magic, can 'sicken a man, kill his blood, corrupt his vital juices, waste his flesh and dull his wits, and eventually lead to slow decline and death' (Douglas, 1988).

In many societies, delay in menstruation, and scantiness of menstrual blood, is considered unclean or bad for a woman's health, and women are encouraged to take remedies to restore regular flow. Yet researchers and contraceptive providers generally recommend that women need only be counselled about menstrual irregularities, and told they are not serious in medical terms, because haemoglobin levels do not usually fall even when bleeding is prolonged.

Similarly, summarising the results of 'pregnancy vaccine' trials, on very small research samples, Indian researcher Pran Talwar reports there were 'no notable adverse effects' (Talwar et al., 1989). Yet he had reported that 28 per cent of the women in his trial had 'minor complaints' such as redness or pain at the injection site, fever, swelling, all-over rashes, temporary joint pain, nausea, muscle pain and giddiness.

Pran Talwar has been reported in the Indian press as 'seeing population as an epidemic, not unlike the tetanus, diphtheria and smallpox epidemics which once ravaged mankind. And it can be defeated, he declares, in the same way by a vaccine'. Researchers working on the contraceptive vaccine justify their research by discussing population growth and stating that to overcome this problem it is pertinent to evolve new safe and effective contraceptive agents.

It can be seen from the above that contra-
The development of contraceptive technologies: a feminist perspective

Contraceptive researchers appear to consider diverse factors. But they do not explain on what they base these lists of requirements, seeming to think it is generally agreed that the model they suggest — including long-lasting action — is generally agreed to be the appropriate model for a contraceptive technology. But do they back up these objectives with evidence of the demand? Is there any evidence that people really want an injectable contraceptive that is longer-lasting than the current alternatives? In fact, nowhere do the scientists refer to research on what users and providers themselves say they need.

The clinical trials and acceptability studies that have been done do not consider the effects of the technology on the relationship between users and providers, nor does it pay attention to the deficiencies in health care infrastructure in places where the contraceptive will be used, including the frequent occurrence of uncontrolled distribution of contraceptives by unlicensed village stores and travelling peddlers.

Worse still, there is the potential with many contraceptive technologies for abuse and coercion. There are reports that Norplant users sometimes experience great difficulties in having the implant removed. A contraceptive vaccine could be used without the user understanding, or fully understanding, what the injection was — especially as the term ‘vaccine’ has potentially misleading connotations about protection from infectious illness. The use of quinacrine pellets for female sterilisation also has the potential for abuse.

Recognising women’s needs

It seems clear, therefore, that the current process of development and evaluation of contraceptive technologies is not sufficiently oriented towards women’s reproductive needs, their experiences in using the methods, and the effect of the method on their daily lives and their relationships with men.

What appears to be needed is a more comprehensive analysis of ‘context-related’
effects of the methods, and user perspectives on appropriateness and safety, in an early stage of contraceptive development. Marshall's comments in 1977 that 'family planning studies tend to be reactive, accepting without question whatever contraceptive technology emerges from the laboratory', with social scientists being involved in trials rather to fit the people to the technology than vice versa, seems still to be the case (Marshall, 1977).

Activists point out that family-planning programmes should take women's needs as a starting point, be firmly based on principles of justice and equity, and offer the widest available choice of methods.

In the 1990s, in response to the criticisms of women's health advocates on the way in which new contraceptives are developed and introduced, international agencies such as the Population Council and the World Health Organisation have initiated discussions about the differences in perspective on contraceptive safety, efficacy, and acceptability. One of the resulting recommendations, entitled 'Women's perspectives on the selection and introduction of fertility regulation technologies', was to convene special meetings for scientists and women's health advocates to discuss the development of new methods. The Population Council is currently putting this recommendation into practice by involving a group of around eight women's health advocates in the process of developing female-controlled vaginal microbicides, which could possibly prevent HIV transmission as well as pregnancy (WHO 1991).

Such initiatives signal an increasing awareness among scientists that user-perspectives are relevant even in the early stages of developing new technologies. Development of new contraceptive technology must be firmly linked to woman's reproductive needs: a formidable challenge, as at the end of the day it will always be the end-users of the methods who have least power to influence the processes.

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Abortion, reproductive rights and maternal mortality

Ruth Pearson and Caroline Sweetman

In considering reproductive health, it is essential to address the issue of abortion, despite the dilemmas and distress uncovered in such a debate. As Marge Berer puts it, 'ambivalence about abortion, which I believe all of us feel in some way, is expressed both at personal and at institutional and political levels' (Berer, 1993). Gender and development practitioners tread a tightrope of addressing the reality of high maternal mortality and unnecessary suffering associated with unsafe abortion, while recognising the cultural and religious sensitivities of the abortion debate, which women themselves may share. However safe abortion is made, 'hardly any woman “prefers” abortion. If they have the choice, they prefer to prevent unwanted pregnancies. They do not have to be told that contraception should be the first option. It is self-evident to almost every woman...' (Ketting, 1993, 6).

In 1991, the World Health Organisation (WHO) recommended action to ‘encourage governments to do everything possible to prevent and eliminate the severe health consequences of unsafe abortion’ (WHO 1991). Unsafe, usually illegal, abortion is among the greatest single causes of mortality for women today and causes 40 per cent of maternal deaths worldwide (IPPF, 1993). The United Nations Population Fund estimates that the death toll associated with abortion-related complications is 200,000 per year (UNFPA, 1993). Of the 35-55 million induced abortions which take place annually throughout the world, more than half are performed by unskilled persons (IPPF, 1993). The tragedy is that abortion itself should be a safe procedure: in the US, legal abortion is 11 times safer than childbirth (Coeytaux et al., 1993). 'In short, mortality and morbidity due to abortion is almost entirely preventable' (ibid.).

It is likely that the figures given above are an underestimate, due to the under-registration of maternal deaths, and to the fact that abortions are often carried out illegally and secretly, so that deaths resulting from them are not identified as abortion-related. In addition to this huge number of deaths, women who have undergone unsafe abortion may suffer serious and permanent damage, including chronic morbidity, infertility, or psychological problems.

Abortion’s cost to society

However desirable it would be to rid women of the need to face the risks of abortion by succeeding in preventing all unwanted conceptions, in fact the provision of existing contraceptive technologies cannot be relied upon to prevent pregnancy: it has been estimated that reducing fertility to an average of two births per woman would still mean that seven out of every ten women
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would have an unwanted pregnancy during their reproductive years (Tietze and Bongaarts 1975). Thus, abortion will continue to be needed and sought by women.

The failure to provide the option of safe abortion carries costs beyond the death, pain, and suffering of women themselves, into the family and wider community. Douwe Verkuyl, a gynaecologist working in Zimbabwe, describes the death of a 42-year-old woman: ‘when I met her for the first time she was very ill. I had to ... remove the womb which had a large hole and was severely infected ... she died a few hours after the operation from septic shock. She left behind a husband and eight children, the youngest of whom is one year and three months old...’ (IPPF, 1993).

Abortion carried out in illegal and unsafe conditions also carries a cost to health services, currently struggling in many developing countries to operate under the cutbacks resulting from Structural Adjustment programmes imposed by the International Monetary Fund (IMF). In developing countries, where the ratio of health service providers to population is very low, already overstrained services struggle to care for women suffering the effects of botched abortions. Ironically, the cost of this after-care may be more expensive than the provision of safe abortions: when abortion was legalised for a short period in Chile in the 1970s, there were considerable savings in the public health bill (Potts et al., 1977, quoted in Coeytaux et al., 1993).

Approaches to abortion

According to the International Planned Parenthood Federation (IPPF), ‘abortion rates are highest in those countries where information and services in family planning are weakest and where the greatest restraints on the autonomy of women exist’ (IPPF, 1993). A reproductive rights approach to women’s health care emphasises the importance of women being empowered to make decisions on family size and spacing. Such health care, premised on free access to information and the widest possible choice of contraceptive technologies which are free from harmful and distressing side-effects, remains an unrealised ideal for the majority of the world’s women. Allied to this, most women do not have the autonomy or the economic means to decide to use existing technologies, so that seeking abortion represents their last chance to take control of their lives. Thus, from a perspective of basic human rights, abortion can be seen as an essential back-up option to allow a woman control over her body and destiny.

A determinist view of human sexuality, predominant in male-dominated cultures throughout the world, sees procreation as the central purpose of sexuality, and women’s prime role to be motherhood. Family planning and abortion both run counter to this view and are thus condemned. The new Papal Encyclical, Veritatis Splendor, confirms this in the context of the Roman Catholic Christian church (Ketting, 1993).

A gender analysis of the reality of women’s lives takes into consideration a multiplicity of roles: in addition to biological motherhood, women are producers in their own right, and reproduce the workforce through their role as carers and community activists. While the cultural and religious taboos surrounding abortion in most societies are strong, these are in marked conflict with women’s desperate need for control over the reproductive function of their bodies.

Abortion and sexuality

Coeytaux et al. point out that no society has been able to eliminate induced abortion as an element of fertility control (Coeytaux et al, 1993). Sexual relations leading to conception cannot be assumed to take place within the boundaries of societally-sanctioned norms. Thus, development initiatives seeking to
provide family planning, for whatever motive, must address the issues of female sexuality and women's reproductive lives, stripping away gender ideology to arrive at what really goes on. Until this happens, unwanted pregnancies and maternal mortality arising from unsafe abortion will continue.

For example, the current trend towards internationally-sponsored 'Safe Motherhood' initiatives, which set out to integrate family-planning provision with primary health care, education, and expansion of facilities, has been criticised for its emphasis on family planning directed at so-called 'high-risk' groups of women as a primary means of reducing maternal mortality, while ignoring the reality of abortion-related deaths. In many contexts the provision of family planning in Safe Motherhood initiatives is confined to married women, with the result that the maternal mortality rate of young, single women who seek abortion remains high (see Smyth 1994, this issue, in the context of Indonesia). The separation of family-planning services from abortion can be seen here to be artificial, and the family-planning movement should recognise the fact that the prevention and termination of unwanted pregnancy are equally important in controlling fertility (Berer 1993).

Abortion as 'contraception'

Instead of being viewed as an essential back-up service against contraceptive failure, abortion has in some contexts been seen as a form of fertility control in itself. This was the case in many parts of the former Communist bloc. State approval of abortion, together with an almost total lack of effective contraceptive provision, cut across cultural and religious sensitivities to make abortion a regular and repeated experience for many women throughout their reproductive years. The effect of having perhaps 12 or 15 abortions in a woman's lifetime, conducted with varying skill and after-care, is obviously detrimental to her physical and emotional health.

The outcomes for women's reproductive rights since the break-up of the Communist bloc vary across different countries; and are dynamic, changing rapidly. Poland's return to liberal democracy has been accompanied by the renewed strength of Roman Catholicism, with a resulting erosion of women's right to abortion (Nowicka, 1994); in comparison, in Albania, whose government under Communism was strongly pro-natalist, abortion is only now becoming a possibility, together with contraceptive technologies (Sahatcl, 1993); although access to contraceptive advice and technology is largely limited to the urban areas, whereas two-thirds of Albania's population is rural (personal communication, 1994).

Access to abortion

Women's experience of, and access to, abortion is closely connected to poverty and social status. The link between poverty and unsafe abortion includes lack of access to contraceptive advice and appropriate, safe contraceptive technology (Hartmann, 1987, in the context of Bangladesh). In addition, poor women are more likely to seek unsafe abortion because they cannot afford a safe procedure, the cost of which will be related to the illegality and societal condemnation associated with abortion. Even when abortion is illegal and publicly condemned, it is possible for a safe, tacitly-condoned procedure to be procured for those who can afford to pay for it, either in-country or further afield.

In countries where abortion is legal the decision as to whether or not to perform an abortion is ultimately in the hands of the health services. Society is, in many countries, prepared to countenance abortion in certain circumstances. Two of these — rape and incest — run against prevailing societal norms on sexuality in many countries.
However, not all rape victims can obtain abortions. For example, the Kuwaiti women raped by Iraqi invaders during the Gulf War in 1991 were in the main obliged to carry their pregnancies to term, and received a mixed reaction from the authorities (El Bushra and Piza Lopez, 1994).

In contexts where abortion is permissible, if there is likely to be medical cost to the mother the law may be liberally interpreted, but the lack of explicit legislation on a woman’s right to abortion on demand means there is no statutory entitlement. In Britain, cuts to health funding mean the National Health Service is no longer obliged to provide abortion, and women who do not exhibit signs of severe mental or physical strain have in some regions been denied a state-funded abortion (Guardian, 1994).

In the case of developing countries whose health services receive international funding, political considerations in the North may affect women’s chances of securing the right to safe abortion, as in the January 1993 decision by President Clinton’s Administration to reverse the restrictive Mexico City Policy, imposed by the Bush Administration, which banned the funding of development agencies involved in abortion as an issue (Thoss, 1993). This recent development may open the way for a liberalisation of international policy on funding bodies who see abortion as part of reproductive rights-oriented health care provision.

**Safe abortion**

The recognition that induced abortion is almost certain to continue to be a part of human existence — barring a great change in contraceptive technologies, gender power relations, and access to contraceptives — places an onus on societies around the world to choose whether or not to provide safe abortion. To decrease the appalling toll that abortion takes on women, legalisation needs to be accompanied by making abortion safe, accessible, and affordable. Since the liberalisation of India’s abortion law in 1972, the number of legal abortions carried out has remained a small proportion of the whole: it has become clear that changing the law alone cannot combat the continuation of illegal, unsafe abortion (IPPF, 1993).

As stated above, if abortion is performed properly, in conditions suitable for a surgical
procedure, there is little risk and lower cost to the health service. Vacuum aspiration (VA), used for many abortions in developed countries, is a safer and simpler option than dilation and curettage (D and C), which, due to lack of VA technology, continues to be the standard in many Southern hospitals. D and C is expensive, requiring general anaesthesia and may require an overnight hospital stay.

Manual vacuum aspiration has been put forward as a useful option for developing countries, costing less than VA, needing no electricity, and able to be administered by trained paramedics, thus allowing decentralisation of abortion facilities (Coeytaux et al., 1993). The abortion pill, RU486, was authorised for US testing in 1993 but is currently only distributed in France and the UK. Coeytaux et al. call urgently for studies on the acceptability and feasibility of providing RU486 ‘in a variety of countries and cultural settings’ (Coeytaux et al., 1993).

Conclusion

In addition to abortion’s claim to inclusion on the development agenda on grounds of women’s health and maternal mortality, it is also seen as an issue of basic rights and women’s empowerment by women’s groups throughout the South. In the Philippines, Woman Health focuses on abortion to emphasise the links between women’s health and human rights (Camiwet, 1994). In Mexico, the Coalition of Feminist Women campaigns for the decriminalisation of abortion, supported by political groups (del Carmen Elu, 1993). Abortion should be understood, and addressed, as an issue which encompasses both health and human rights considerations.

Gender analysis shows that no technocratic intervention can succeed in isolation from its cultural setting. While women continue to become pregnant against their will, they will continue to risk death or sickness...
themselves in their desperation to rid themselves of the pregnancy.

The appalling rate of maternal mortality associated with illegal, unsafe abortion is an issue which must be addressed as part of the health policy of development agencies. One way to do this is to assert women's ultimate right to decide the functions of their own bodies, and their right to life outside wife-and-motherhood. Men's power over women to coerce and force them into unwanted pregnancy should be addressed through initiatives to facilitate the empowerment of women. The provision of safe, legal, accessible and affordable abortion needs to be linked to the provision of a holistic reproductive rights-oriented health service, which provides full information on available contraceptive technologies. By many, the decriminalisation of abortion — in our hearts and minds, as well as in law — is considered as a fundamental human rights issue.

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Women’s health and feminist politics

Denise Faure

Since 1963, Sempreviva Organizacao Feminista (SOF) has been working on women’s health in low-income communities in south-eastern Brazil. Through successive changes in policy and emphasis, SOF is now a feminist NGO.

Women’s health and reproductive rights are a constant concern for the women’s movement in Brazil, due to the almost total lack of adequate social and health services accessible to low-income communities, and also due to the feminist movement’s understanding of the body as a focal point for domination, and a source of freedom.

Looking at the status quo of health services in Brazil today, one sees that health care for women is insufficient in both quality and quantity. Reproductive rights are ignored in the pursuit of population control; information on patients is not shared with them but controlled by health professionals, who adopt an authoritarian attitude which disempowers women.

The aim of organisations addressing the issue of women's health is to obtain full health services, geared to all phases of a woman's life (childhood, adolescence, maturity, and menopause), taking into consideration the specific needs of each stage. Today, concern over women’s health has begun to enter the agendas of mixed social movements thanks to the actions of the women’s movement, and of organisations such as SOF, which emphasise the links between gender, health and poverty.

Urbanisation and poverty: SOF’s constituency

SOF has been developing its activities in the context of the irreversible, uncontrolled, and explosive growth of the city of Sao Paulo. The infant mortality rate in the periphery of Sao Paulo is seven to eight times higher than that of Sweden or Japan. In the dormitory suburb of Sao Miguel, one of several areas where SOF works, demographic growth has been rapid over the last 25 years, as migrant workers from the north-east pour in to find work in the commercial and service sectors. Public health facilities, education, transport and childcare provision are woefully inadequate.

Sao Miguel has a recent history of considerable community mobilisation, and there are organisations for the landless, the health movement, cultural and educational groups, street children’s movement, church groups, and women’s associations. SOF works with the health movement, the women’s coordination, and the women’s movement, providing gender consultancy to community groups, trade unions, and professional bodies.
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‘Man’s pleasure, woman’s duty’

Ninety per cent of women involved with SOF are between the ages of 20 and 40, with families of two to five children, and little or no schooling. Seventy per cent of them stay at home, devoting their time to domestic tasks. Some participate in community projects (such as health commissions, creches, and mothers’ clubs). A few are factory workers, and 25 per cent are employed, formally or informally, in the service sector. SOF’s clients are likely to have a high fertility rate, a high failed pregnancy rate (still-births, spontaneous or provoked abortions) and the desire to limit the number of children they have.

The families living in the area have an average of five people living in two rooms per house and sharing an income of one to three minimum salaries per month (US$ 66-200). Eighty per cent of couples do not have a room to themselves; 85 per cent of the women have never talked about sex with their parents, and are ill-informed about the anatomy and physiology of their own body, public health, gynaecological disease, and contraception. They experience sexual relations as an obligation, a duty. Eighty-five per cent of women aged 15-54 who use contraception are either sterilised or on the pill.

Within the women’s movement in Brazil, there are attempts to move away from the view of women as ‘objects’ of health care, and develop a new participative approach, through activities such as workshops and self-examinations. Workshops facilitate the sharing of experiences and the development of a critical view of social structures and established social relations.

From family planning to feminism: SOF’s evolution

SOF was first set up by a group of professionals as a non-profit association offering health services to the needy in a suburb of Sao Paulo. SOF was a pioneer in Brazil, providing family planning for underprivileged groups with a non-authoritarian approach, and raising social awareness of the issues surrounding gender, feminism and health.

From the early days, SOF’s Directorate was made up of volunteers, and medical staff were paid, with everyone working together in an open team. For the health professionals, SOF gave them an opportunity to work in a way which was consistent with their political beliefs. 12,000 families registered in SOF’s Santo Amaro clinic.

Initially funded by the International Planned Parenthood Federation (IPPF), SOF cut ties with them in 1967, because of the demand that its clinic should promote female sterilisation. A grant from the World Council of Churches, among other donors, guaranteed the continuity of SOF’s work in family planning and education. Later, the Episcopal Church opened three other clinics where SOF provided training and supervision with the intention of not only offering services but also pressing for better state services. SOF also publicised the issue of family planning through talks and articles in the press.

The 1970s saw the growth of the feminist movement in Brazil. By this time SOF had already defined itself as a feminist organisation. The concept of gender, which shows how relations between men and women permeate and structure social relations, overlapping with race and class, provided the rationale behind SOF’s attempts to ‘connect the specific with the general’. Struggling for equal opportunities for women is linked to combating racism and social exclusion.

SOF invested more in training and raising awareness of health and education problems, and created a system of ‘active members’ whereby, after a basic course, clients became members of SOF, accepting the organisation’s objectives. The aim was to offer a forum where women could talk about
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their role in society. By 1971 SOF had 7,600 active members.

By 1983, a heated discussion on the future involved all members for a year, and the decision was taken to focus on the issue of women’s health in the public services, which would benefit a greater proportion of the female population. Out-patient attendance at clinics ended and SOF devoted itself to training, establishing contacts and links with community leaders, the trade union movement and NGOs, and participating in campaigns and in the setting up of services and Community Councils by the Sao Paulo City Council.

The present

Currently, SOF is consolidating its work with different target groups in the urban community, strengthening its identity as a feminist development organisation, and working on a gender-aware approach to women’s health and reproductive rights.

Since 1985, SOF has been organising workshops, drawing upon the women participants’ shared experiences, using methods such as group dynamics, drama, games, drawing, collage, modelling, and body expression.

Currently, SOF’s objectives are:
• to strengthen the women’s movement;
• to develop feminist approaches to health issues;
• to implement a women’s health programme;
• to incorporate gender concerns into mixed movements.

The state, NGOs and women’s health rights

Eleven years ago, the Programa de Assistência Integral A Sarnde da Mulher (PAISM), a joint proposal for an integrated women’s health programme, was drawn up by the government as a result of pressure from the women’s movement and feminist health professionals in the public sector. Before PAISM, health care for women was limited to mother-and-child health care, treating women merely in their reproductive role.

The government invested minimally in the implementation of PAISM, neither altering health service structures nor allocating sufficient resources for the Programme to function. There was no attempt to change the relation of the State to the pharmaceutical industries, or to modify the training of health professionals to provide an integrated form of health care.

Nationally, the main integrating mechanism for NGOs opposed to such piecemeal measures is the feminist meeting held every two years, which has involved a growing number of women from grassroots organisations. The National Feminist Network for

Teaching about reproductive functions, Brazil. Many women are ill-informed about the anatomy and physiology of their own body.

JENNY MATTHEWS/OXFAM
Health and Reproductive Rights (RNFSDR) facilitates networking between individuals and groups, and gives guidelines to the whole movement on strategies. The number of feminist NGOs that address issues of reproductive rights, sexuality, and violence is fast growing. They have been responsible for promoting campaigns and discussing women's demands with the authorities.

Changes for women require social changes that address the needs of the majority of the population and eliminate discrimination and oppression of women. Women's freedom is a vital step towards building a society free from oppression.

In a letter sent to the Minister of Health in 1993, RNFSDR presented the Minister with a list of priority concerns: the rapid growth in the number of HIV/AIDS cases; the high level of sterilisations and abusive caesareans; the alarming figures for maternal mortality and gynaecological cancer deaths; the lack of information and access to contraceptive methods; and the lack of provision of care for menopausal women.

**Looking to the future**

SOF has become a support organisation for grassroots organisations, and is, therefore, closely aware of the realities of life for poor people in Brazil. This is largely due to the basic guideline that the organisation has always followed: to communicate effectively with people — particularly at the grassroots — on the basis of their experience.

Ever since it was set up in the context of an authoritarian regime, SOF has provided an alternative organisation for health professionals concerned with public health. The combination of social activism and professional work offered by SOF provided a broad, complex, and innovative experience, involving an immense variety of contributions, and characterised by a collective way of working.

The impact of SOF's work can be measured by the transformations which have occurred in terms of health infrastructure, and by the changes in the region's health policies. SOF participated in the 1983 Parliamentary Commission of Inquiry, where public health policy guidelines for the Sao Paulo City council were adopted. SOF has also encouraged the participation of women in the region's social movements, trade unions, and political parties. The vigour of the Health Movement shows SOF's input: people living in the south and west of the city have become more and more organised, and made demands which range from the extension of the water supply and sewage disposal, to price freezes on basic items.

At the moment, SOF is taking part in the formation of a coalition that incorporates sectors of grassroots movements, rural Trade Unions, and independent groups. SOF maintains its original aim of contributing to improvements in the living conditions of its target population. Its particular form of participating is by helping the social movements in the identification and incorporation of gender as an integral part of the construction of democratic citizenship, and in the implementation of gender policies in local government policies. SOF concentrates on partnership with women's organisations, groups of women from the Trade Union, and black women's movements.

One of the reasons for SOF's credibility seems to be the organisation's capacity to connect specific subjective and gender issues with broader political questions. Maintaining the link between the specific and the macro, SOF aims for progress in its analysis and practice at both ends of this spectrum.

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The road to Cairo

Peggy Antrobus

Peggy Antrobus introduces the statement she made on behalf of the DAWN network to the third and final preparatory committee to the UN conference on Population to be held in Cairo in September. An abbreviated version of the statement follows her introduction.

'This is the last prepcom before Cairo, and we have made a lot of gains since Prepcom II, with recognition in many quarters of the need to consider population in a wider context of women's reproductive health. However, there is still a tendency for population to be separated from other issues of development: to be considered merely in terms of demographics and population control, rather than in the context of sustainability and equity.

'DAWN asserts that population is absolutely inseparable from issues of women's rights, women's empowerment, and the provision of comprehensive health services — and all of these are integral to development. DAWN does not consider it is possible to talk about 'development' without addressing the fundamental equity issue of women's empowerment, which itself is central to all discussions on population.

'It is also not possible to consider issues of women's reproductive rights and reproductive health without considering the crucial impact which different development models have on women. For instance, structural adjustment policies have devastated the very health services without which women cannot attain reproductive health or gain access to their reproductive rights.

'However, in our address to the second day of Prepcom III, we focused on women's rights, because, on the one hand, the dichotomisation which dominates events like the Cairo Conference on Population and Development means there is no chance to challenge development models. On the other hand, the issue of women's rights has become very much the battleground at this conference.

'It is our opinion that the Vatican is using its moral authority and its position at the UN for political purposes. Because, although population may be talked about in religious or moral terms, it is very much a political issue. The Vatican seems to be attempting to use the prepcom to reverse some of the gains made by women — and any reference to women's rights or reproductive rights is being challenged, as is any reference to contraception. There is to some extent a North/South split on these issues, with governments of the North more open to considering reproductive health and rights issues.

'There has been a lot of resourceful and energetic lobbying by women's groups, not only here in New York but also in the capitals of voting countries. I think the women's movement is likely to prevail and

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win the inclusion of a broader framework of women’s rights within the document, but we remain concerned that the actual services delivered might not improve very much in the future, despite this lip service. This is why the issues of accountability and empowerment are so crucial.

‘In order to end the abuses of the past and ensure a proper service to women, which really does respect their reproductive rights and safeguard their reproductive health, women’s organisations need to be involved in monitoring policies and their implementation. Women’s organisations must be empowered to make governments, donors, and service providers accountable.’

Statement to the International Conference on Population and Development PrepCom III, New York, 5 April 1994, on behalf of DAWN

Mr Chairman, the DAWN network represents women. These are our recommendations:

1. Macroeconomic policies of structural adjustment need to be reviewed in order to ensure that they do not continue to reduce investments in basic social services, especially those in health, education, and welfare.

2. Governments should promote a model of sustainable human development which addresses issues of equity and prioritises poverty alleviation and job creation.

3. Within this approach to development, population policies must focus on promoting the well-being of people, and especially in ensuring reproductive health and rights for women.

4. Comprehensive and high-quality health services for women, including those for reproductive health, are a primary responsibility of governments.

5. Governments must recognise that women’s rights are human rights, and that reproductive rights are a central aspect of women’s rights, and take steps to adopt and implement the resolutions from the recent UN conference on human rights.

6. Health services must be reorganised to bring together a constellation of programmes which fall within the concept of comprehensive reproductive health services, including not only safe contraception but also safe abortion, and prevention, early diagnosis and treatment of sexually transmitted diseases including HIV/AIDS, and of infertility.

7. The UN, governments, and other agencies should recognise the right to safe legal abortion as an intrinsic part of women’s rights, and governments should change legislation and implement policies to reflect such a recognition.

8. Programmes to address gender issues and women’s empowerment, including the programmes of women’s organisations, must be recognised as making an important contribution to achieving the goals of reproductive health, and given the necessary support.

9. The diversity of family patterns must be recognised — especially models which are non-patriarchal — in the design and provision of reproductive health services.

10. Special attention must be paid to the reproductive health and rights of migrant women, refugees and disabled women.

7. Mechanisms of accountability must be instituted, and must provide for the participation of representatives of women’s organisations that are committed to women’s reproductive health and rights and linked to the women to be served.

10. Resources must be allocated to the restructuring of population programmes to reflect the above recommendations.
A valuable lesson

Uravashi Butalia and Ritu Menon

A few weeks ago we were asked by a journalist if we would show her our best-selling title. 'Best-selling' is a relative term, usually understood in money terms. Yet we had no hesitation in pointing her in the direction of our favourite book, Shareer ki Jaankari ('Know your body'); an illustrated book produced by village women from Rajasthan.

When activists of Mahila Samuh, a group in Ajmer district in Rajasthan, north India, brought a handmade copy of this book to us more than five years ago, we were just a fledgling publishing company. Being politically committed to the women's movement, we knew, when we saw this book, that this was the kind of thing we wanted to publish. But could we produce it? Would it make us any money? Would we still do it even if there was no money in it?

In many ways, a book like this is a publisher's dream: it came to us from grassroots, largely illiterate, women, with a guarantee that if we could produce it, they would undertake to distribute it among other such women. Every publisher wants to reach beyond the literati — here we were actually being offered an opportunity to do so. We decided to take our courage in our hands and jump in. And we were not wrong.

Shareer ki Jaankari is a book produced by a hundred village women. A series of workshops on health was the starting point. In the workshops the discussion focused on women's health issues: how does the woman's body change from girlhood through adolescence to old age? What is menstruation? How do you know when you are pregnant? Who is responsible for the sex of the child? In the course of the workshops it became clear that mere talk was not enough: something was needed to spread the message further. With the help of the workshop facilitators, the women got together and produced two copies of an illustrated book on women's bodies.

The next step was to test this book in the villages. When they did, they came up against a problem: how could naked women be portrayed? Women are not seen like this in villages. True enough. So the women went back to the 'work table' (more accurately the work floor) and, after much thought, came up with an ingenious method to illustrate everything they needed to say. Women — and men — were drawn fully clothed, and then little flaps were put on in strategic places. If you lifted these you could see how the body was made, from the inside; a little window showed a different dimension. For example, a series of flaps showed the course of menstruation: 'modest, and explicit' was how the book was described.

Two copies of the book, however, were clearly not enough, and it was at this stage that we were approached. Mahila Samuh was then part of a major development project called the Women's Development
Programme, but the activists felt the project was not sympathetic to their kind of work, so they came to us.

For us, too, this was a first in several ways. The first book meant for rural women; the first time we had a book with at least a hundred authors; the first time we had a book on women’s bodies. So we settled on an initial print run of 2000 copies, priced practically at cost so that activists, both urban and rural, could afford to buy it. Before we had gone to press the group had pre-sold almost the entire print run.

But the printing was not without adventure: while our printers were happy to do the book, our binders had some hesitations. ‘The little flaps made things a bit obscene’, they said, and they were worried about how this would affect their workers, mostly young men. In the end, they refused to handle it, and we had to start hunting for other binders. As luck would have it, we came across a group of women binders who agreed to do the work, and since then, every time we have reprinted the book (and thousands of copies have sold) these women have taken on the task of binding it.

For us, what has been important is not only the book itself, but the entire process of making it, first in the villages and then in the city. Today we have many more ‘activist’ books, but *Shareer* will always remain our very first, and our favourite. This book on women’s bodies, made by rural women, has also pointed to the need for a similar work for urban women. We are not the only ones aware of the need: the other day we had a phone call from the World Health Organisation asking if we had such a book in English.

Feminist publishing is full of such adventures. You can step in where the mainstream publisher fears to tread, principally because you believe in what you are doing. Books like *Shareer* also prove the importance of books — and indeed the need for them — beyond just those who have money to buy them. For us, *Shareer* has also proved that it is possible, in this trade, to do what we believe in, what we want to do, and what we know is important. I think we can say without hesitation that this is one of the most valuable things we have learnt in the first decade of our life.
Resources

Book review

Every so often an issue becomes a focus for political attention which does not permit a comfortable reiteration of stock positions. This may be because political goals seem to be in conflict, where we are used to thinking of them as complementary; sometimes it is because new ideas have to be formulated about strategy and tactics; it may also be because the issue deals with deeply held feelings. Female genital mutilation (FGM) is one such issue. It is a practice which may be considered an ultimate form of women’s oppression, yet it is mainly carried out by women. It is a traditional practice which can be the focus of racist hostility and condescension, but which is seen as a cultural defence by some of the world’s poorest people. As a sexual violation, it also touches on public taboos that obscure some of our deepest fears and sentiments.

It is to the credit of the authors of Female Genital Mutilation: Proposals for Change, that all these and other contradictions are explicitly addressed and confronted. The booklet is a model of calm, clear, and coherent writing, which at no point turns to polemic or invective, and yet is underpinned by a passionate concern and commitment to action. The booklet explains what FGM is, how many women are affected by it, and what its effects are. It looks at the global distribution of the practice, why it continues, and how it is changing, and then explores proposals for international and national action both in Africa and in the West.

The authors describe the different types of genital mutilation (a term preferred to circumcision as it has a wider reference) which include circumcision, in which the hood of the clitoris is cut, excision, where the clitoris and all or part of the labia minora are removed, and infibulation, in which the clitoris, labia minora and much of the labia majora are also removed. It is estimated that 74 million women have been genitally mutilated in a belt from west to east Africa, and northwards up the Nile. The age at which the operation is done varies according to place — from young babies right up to adolescence or even adulthood — and is associated with virginity and sexual control. In some places it has been connected with adult initiation rites, though this appears to be less and less the case.

Both the operation itself, which is usually carried out without anaesthetic, and its consequences, are horrific for the girls and young women involved. Complications include haemorrhage, post-operative shock, and septicaemia, sometimes resulting in death. Long-term health complications include chronic vaginal and uterine infections, sterility, and painful sexual intercourse and childbirth.

Yet however shocking the operation may seem to those unfamiliar with the practice,
the book demonstrates the contradictory psychological effect of FGM. On the one hand, anxiety, fear, and trauma characterise the operation itself and the preparation for it. On the other hand, girls may participate willingly, as it is a culturally required practice, essential for the only available womanly role of marriage and childbearing. ‘To those from other cultures unfamiliar with the force of this particular community identity, the amputation of the genitals carries a shock value which does not exist for most women in the areas concerned. For them not to amputate would be shocking.’

While many of the populations which practise FGM are Muslim, not all are. The practice is known to long pre-date Islam and to involve Christians, Jews (Ethiopian ‘Falashas’), and animists. Not only is FGM not required by Islam, some Islamic authorities have spoken out against it, and in many Muslim countries it is not practised. In spite of this, FGM is an example of a custom that for many people has become absorbed into religious tradition and is seen as having a religious basis by means of a ‘correct’ reading of the scriptures. It is important that opponents of the practice be aware of its non-religious foundations, and its contested place within Islam.

Perhaps the role of women in FGM is the most challenging issue to Western feminists. Women are involved in FGM as mothers and grandmothers, and as paid operators. Mothers are concerned that their daughters be marriageable since marriage is a girl’s only route to security and prosperity. Thus good mothers see it as their obligation to enforce the operation on their daughters. On the other hand the booklet reports research suggesting that many women also continue the practice as a vindictive compensation for the suffering which it imposed on them. In some areas older women operators also have economic motives for continuing the custom, as there are few alternative opportunities to earn an income. The authors make clear that economic underdevelopment is itself a powerful force sustaining the practice, by preventing women from getting access to education, power or resources outside marriage. Moreover, to take refuge in ‘tradition’ is a common response to poverty and oppression.

However, the contemporary world also involves social changes that may facilitate challenges to FGM, though in some cases they may serve to entrench it more deeply. Urbanisation has created an elite of women who are opposed to the practice and it may also have made it easier for girls to run away from home to escape it. Some governments have legislated or made declarations against FGM, though no African government has so far taken strict steps to enforce a ban.

Political turmoil in Africa has had contradictory effects. The Eritrean People’s Liberation Front successfully banned FGM and forced marriage, in the areas it controlled. It has been suggested that this attracted many young women to its army because they were running away from home to escape these forms of control.

At the same time, however, the exodus of people from the Horn of Africa as refugees, and from other places as economic migrants, has spread the practice around the world. While refugees may be concerned to cling to traditions, they are also subject to new pressures and opportunities for change. However, increasing pressure on asylum seekers in Europe will result in refugee organisations prioritising many issues before FGM.

In many other ways the consequence for this practice of contemporary changes is still uncertain. Population growth means that in absolute terms more women are likely to come under the knife. The debt crisis and structural adjustment policies in Africa, leading to cuts in social expenditure, are keeping more women without access to education and health care, and are generally having a negative impact on social policies. Given FGM’s ambiguous relationship to Islam, it is not clear what direction pro-
Beja woman consulting a doctor in an emergency clinic, Sudan. The Beja is an ethnic group which practices female genital mutilation.

fundamentalist regimes like that in the Sudan will take.

It is certain, though, that repressive regimes which prevent the development of autonomous and oppositional groupings will silence voices which might have spoken out to end the practice. Political conditions in Africa and globally suggest that the elimination of FGM will take a long time.

Meanwhile the booklet surveys forms of legislative action, international declarations, developments in health care and training, education, and international resistance, particularly by women, that are being developed to oppose FGM. It draws attention to UN declarations on the elimination of discrimination against women, on protection from torture, and on the right to development, as all relevant to FGM.

The authors emphasise that Western feminist participation in this enterprise must involve supporting activities in the countries concerned, on the terms of the people engaged in them. Depending on the country, different types of approach have been prioritised. For instance legislation supported by a medical and education action campaign was promoted in Somalia by the Somali Women Democratic Organisation before 1991; while in Nigeria the emphasis has been on education via schools, colleges, and hospitals, without any legislative back-up, on the grounds that enforcement would be impossible. The spread of FGM to Europe and the USA has produced a new context for challenging it. In the UK, the Foundation for Women’s Health and Development (FORWARD), of which Efua Dorkenoo is the Director, has a ‘multi-pronged’ approach of grassroots public health and gender-awareness education, law enforcement on child protection, combined with practical support for resisters and survivors of genital mutilation.

The authors describe FGM as one more in a long line of historical practices which have
been repressive of female sexuality and of women generally. But by their careful review of the context of this particular practice and the efforts to challenge it, they raise, either explicitly or implicitly, a large number of issues that have a relevance beyond FGM.

Firstly, FGM poses questions for feminism, since it is women, and not men, who are the chief perpetuators of this oppressive practice. Moreover, FGM also constitutes the abuse of children by women, thus calling attention to another set of power relations in which women are engaged.

Secondly, FGM requires a challenge to multiculturalism. It cannot be justified or defended as an ethnic minority tradition. At the same time, the fact that it is practised by oppressed minorities in the West, must, for anti-racists, inform the methods of combating it.

Thirdly, FGM is linked to imperialism as a factor in perpetuating it. Imperialism’s ‘civilising mission’ in Africa provoked not the elimination of the custom, but its defence on the grounds of resistance to colonialism. African indebtedness to Western governments and the IMF continues to lock the mass of its population into continuing poverty, in which the expansion of women’s rights and attention to women’s health are likely to get very little attention.

Fourthly, FGM, like other kinds of violence against women, raises the question of how we should use the state to control the practice. In Britain FORWARD has succeeded in putting FGM on the mainstream child-protection agenda by getting it defined as child physical abuse. It has proposed that FGM be a sixth risk category to merit registration of a child on the at-risk register. Given the history of state racism and of social control of the poor through health and social work interventions, this is clearly an issue which requires a clear understanding of the limitations and implications of state involvement.

Fifthly, FGM has been shown not to be fundamentally an issue of religion. Yet many people believe that it is a religious requirement. Paradoxically, as some women discover it is not, as seems to be happening in Sudan, religion may provide a forum from which to resist the practice. On the other hand, some fundamentalists may use it as a further means of repressing women. Clearly, this issue, as others, shows that we need to draw distinctions between different genres of institutionalised religion, and engage in dialogues with religious opponents of FGM.

What Female Genital Mutilation: Proposals for change teaches is that such solidarity with activists campaigning for the end of FGM cannot be given cheaply, as a knee-jerk reaction to the strong arm of fundamentalist men, but requires a close political analysis of the issues it raises.

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Review by Rayah Feldman, who lectures in social science at South Bank University, Britain, and is a member of Women Against Fundamentalism.

Female Genital Mutilation: Proposals for Change is written by Efua Dorkenoo and ScillaElworthy, and published in 1992 by Minority Rights Group, London.

Further Reading


London: Pandora Press: information, action and resources on women and HIV/AIDS, reproductive health and sexual relationships.

Hartmann, B (1987) Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice, Harper and Row, New York: encompassing a wide view of the policies and practices which have affected women's reproductive rights, this invaluable publication provides a compelling and urgently needed critique of the economic, political, health and human rights consequences of population control as practised by national and international agencies.


Khattab, H (1992) The Silent Endurance: Social Conditions of Women’s Reproductive Health in Rural Egypt, New York, UNICEF: original research into the widespread reproductive morbidity experienced by women, and their reaction to it. Women generally are taught to put up with pain and discomfort as part of their condition. Information, education and the communications of health messages are seen as an essential part of initiatives to combat women's ill-health.


Reproductive Health Matters, ed. Berer, M and Ravindran, S — twice-yearly journal published in English, offering in-depth analysis of reproductive health matters from a women-centred perspective; 1, London Bridge Street, London SE1 9SG Tel (44-71) 357 0136.


Too Many for Whom? People or 'Population', forthcoming in 1994, London: The Ecologist/Earthscan: a look at the way the 'population problem' has been constructed, looking at the broad framework of interrelated factors such as food distribution, gender, land use, lifestyle and consumption patterns within which the debate must be understood, and elicits the roles and motivations of key players such as Northern donors, pharmaceutical companies, economists and environmentalists.

Turshen, M (ed) (1991) Women and Health in Africa, New Jersey: Africa World Press: this collection of articles covers sensitive and complex issues of family planning and reproductive health, such as how women of Algeria strive to take control over their fertility and how dangerous anti-fertility programmes have been undertaken in Namibia.

Film: Antibodies Against Pregnancy — documentary film made in India by Ulrike Shaz
Focus on Gender

with I. Scheider, showing recruitment to clinical trials and interviews with researchers. Available from U.Schaz, Bleicherstrasse 2, D-22767 Hamburg, Germany.

Organisations working in the fields of population and women’s health

Association for Voluntary Surgical Contraception 79 Madison Ave New York, NY 10016 tel (1) 212 8000, fax 779 9439.
BUKO Pharma-Campagne — network of German groups campaigning against malpractice by the pharmaceutical industry, and promoting rational use of drugs. August Bebel Strasse 62, D-33602 Bielefeld, Germany tel (49 521) 60550, fax 63789.
Catholics for a Free Choice: supports the right to legal reproductive health care especially family planning and abortion. Publishes quarterly magazine, Conscience; 1436 U St NW, Washington DC 20009-3997 Tel (1 202) 986 6093
Health Action International — network campaigning internationally for more rational use of drugs. Three offices: HAI Clearinghouse c/o International Organisation of Consumers’ Unions, PO Box 1045, Penang, Malaysia, tel (604) 371396, fax 366506; AIS Latin America, c/o Accion para la Salud, Avda Palermo 531, Dpto 104, Lima, Peru, tel./fax (51 14) 712 3202; HAI-Europe Jakob van Lennepkade 334-T. NL-1053 NJ Amsterdam, The Netherlands tel. (31 20) 683 3684, fax 685 5002.
International Planned Parenthood Federation — works worldwide on reproductive health issues, publishes regionally-based journals, including Planned Parenthood in Europe; Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS Tel (44-71) 486 0741.
Latin American and Caribbean Women’s Health Network/Isis International. Networks, organises meetings, publishes news-letter. Casilla 2667, Correa Central, Santiago, Chile, tel (56 2) 633 4582, fax 638 3142
UBINIG: Bangladesh-based reproductive rights and development research group, critical of mainstream policies; 5/3, Barabo Mahanpur, Ring Road, Shaymoli, Dhaka, Bangladesh Tel (880 2) 811465, fax 813065.
Women Against Fundamentalism: campaigns against oppression under fundamentalist regimes, publishes newsletter;c/o Red Rose Club, 129 Seven Sisters Road, London N7 7QG Tel (071) 272 6563.
Women’s Global Network for Reproductive Rights; NW Voorburgwal 32, 1012 RZ Amsterdam, The Netherlands Tel (31 20) 620 9672 fax 622 4250.
Women Living Under Muslim Laws International Solidarity Network Boite Postale 23 34790 Grabels, France Tel (33 67) 454329 fax 452 547.
Also Shirkat Gah, network member in Pakistan, producing informative newsletter and other bulletins and booklets, campaigning etc. 14/300 (27-A) Nisar Rd, Lahore Cantt., Pakistan Tel (92 42) 372414.
Women’s Voices ’94: Women’s declaration on population policies — this ‘strong, positive statement from women around the world’ is designed to reshape the population agenda better to ensure reproductive health and rights. It is being circulated to women’s groups for signature, before going forward to Cairo. The circulation is being organised by the International Woman’s Health Coalition 24 East 21st Street, New York, NY 10010, fax 1 212 979 9009.