V. Do women want FP?

Because such a thing as an FP programme exists, most women from the better-off sections, who also have access to sympathetic and competent medical advice, are more or less able to use birth control methods of their choice. The preceding chapters have shown that because of the ideology of population control and its objective of curbing the birth-rate of the poor, women from the disadvantaged sections are often not helped but exploited by the FP programme. To sum up briefly they don't have access to methods of their choice inspite of the policy statement that the Indian FP programme believes in the "cafeteria" approach. They are not given full information about the possible side-effects and long-term risks of the methods they accept. They fail to get sympathetic treatment when they experience side effects, and particularly no follow-up care. In the enthusiasm for achieving targets, basic safety norms are flouted and women's health is allowed to suffer. Abortion is often denied unless the women agree to sterilisation or IUD insertion. And sterilisation is promoted as being quick and easy without reckoning the adverse impact on women who have to resume heavy manual labour soon after the operation. Unsafe mass programmes with hormonal contraception are being contemplated although these will create further havoc in the lives and health of the target women. At the same time, the responsibility of men in family planning is totally ignored, thereby increasing the burdens on women. Women are FP targets whose felt needs regarding primary health care are not met and who still don't have access to safe child-birth or safe abortion.

Whenever women's groups protest against the directions in FP policy, they are often accused of being anti-birth-control. This is ridiculous. It is the demand of the women's movement that FP service providers should treat women as human beings without violating their dignity and their human rights. Besides, as stated at the outset, women want not only birth control, they also want equality, better status, the right to work and decent wages, and a transformation of the present oppressive patriarchal structure of society. To leave all these needs untouched, and to only offer family planning

as a universal panacea is to reject the very rationale of the women's movement.

In recent years, the population controllers have realised that education, employment, higher age at marriage, and a general enhanced female status have an impact on family size. Women's welfare programmes are drawn up *because* they may result in a drop in birth rate. On the other hand, the women's movement regards these indicators - education, employment etc. - as goals in themselves and access to birth control as one more goal in the larger campaign for equal status and control over our lives. It so happens that despite the widely disparate motives, the population control establishment may sometimes draw up policies and plans for women which are broadly in line with what women's groups are also demanding. Thus there exists a confusing dichotomy. It is vital for the movement to fully understand the women's perspective of FP in order to adopt appropriate action strategies. We should know clearly what to demand and what to reject; what to support and what to oppose.

For example, it is asked why do women's groups oppose the mass Pill programme and the injectables programme. After all, all contraceptive methods have side-effects, why oppose only injectables. The entire rationale of pushing hormonal contraception is based on a desire to control women without giving a thought to any consequences to their health. The lesson from Bangladesh is poised for repetition here. In the 70s, Bangladesh introduced a programme of "inundation" with the Pill. It was a failure and created havoc through irregular intake, especially by lactating mothers. Then an injectables programme was introduced, which has revealed that women are unable to tolerate the side-effects. Now trials are going on with the implant. This will "fix" the women effectively for two to three years. The same pattern is being repeated in India. Because of the failure to promote and encourage safe barrier methods, failure to reach safe abortion to all, failure to offer sterilisation backed by proper health care, and failure to provide IUD and Pill with adequate follow-up care, women have been *driven to* ask for an injectable, and the authorities are eager to oblige. Past failures in offering FP services are being made the rationale for promoting injectables and implants without correcting the fundamental reason for the past failure. This basic fault, which lies in the health service and the class bias of its personnel, remains unchanged and this same fault will render any programme with long-acting hormonal methods totally unsafe.

Women in the West have had to fight for birth control while here in India the FP programme began to offer contraception even before the women in this country thought of demanding it as a right. The MTP Act was passed not because abortion was considered a woman's right but because it was seen as a useful tool for population control. In fact the entire concept of birth control as a human right is submerged under an ideology of FP as a "national duty."

And yet, women do want contraception and they do want the right to safe abortion, both of which are theoretically in line with FP policy. Thus the FP progrmme and women's demands sometimes appear to converge and this is a fact we must use to our advantage and we can do this only if we clearly understand the difference in motivation. Women do want birth-control but on their own terms, as a means of controlling their lives. The women's movement rejects the use of FP as a means for government to control women's reproductive function, in isolation from other measures to improve the quality of women's lives. The movement also rejects the notion that FP is a cure for the country's many problems and demands that fundamental changes in the socio-economic structure accompany the provision of birth-control services.

A word about abortion: It was pointed out in the section on the "Population Problem" that the sense of powerlessness induced by poverty makes the very concept of "planning" unthinkable. As long as this situation is unchanged, abortion will remain the only acceptable option to many women who

want to have no more babies. Safe abortion for the masses is an urgent necessity even though the long-term goal of structural social change will hopefully, eventually, enable all people to feel confident of planning families through contraception. An activist paramedic friend working in a Bihar village writes to me: "Family planning is a virtually unknown thing for the women here. They may have some vague frightening ideas about an operation but that is about all. I doubt if the majority know it's possible to control the number of children you have. It's more common for women to ask for medicine to bring on a period than to ask for contraception. The death-rate from induced abortion is very high ideed."

Friends sometimes ask: why do women's groups emphasise abortion rights so much, though they oppose certain hormonal contraception policies. It is almost as though they consider abortion safer and better. It would be incorrect to say that the women's movement advocates abortion as the best contraceptive. But as long as basic conditions in women's lives remain unchanged, access to safe abortion would indeed be the most humane method of family limitation for many women whose lives are so deprived in so many respects.

A final point which needs to be made is the manner in which the FP programme has relentlessly succeeded in alienating large sections of the population. Examples have been given in the preceding chapters of the fear and distrust felt towards the entire health system as a result of FP policy. Because of this, even when there exists a potential for women, including poor women, to benefit from FP services, they may be unwilling to avail themselves of it. The Status of Women report had noted: "During our tours we found that wherever the medical personnel and the village level workers were mature and sympathetic in their approach and worked with a sense of social commitment, their persuasive power evoked a great deal of response. On the other hand there was considerable criticism of the 'motivators' most of whom are very young and inexperienced as well as purely untrained persons... An analysis of the tour reports reveals that the message of FP has reached almost everywhere, but access to health and FP services was most inadequate." To this, one may add that even when there is access, alienation may nullify it.

Because of past and continuing abuses, the sense of powerlessness is strengthened and so also the sense of resignation to one's "fate" regarding the number of children one might give birth to. To quote my activist friend again: "I would say the FP programme has not simply failed to make progress and create confidence, but has had precisely the opposite effect of frightening women. I had a discussion with some women here not long ago and asked whether they thought it was better to have a lot of children or a few. They answered it was best to have as many as God gave."

To explain away this attitude as arising from illiteracy or superstition or fatalism would be both simplistic and cynical. Nobody can blame these women for considering Fate to be a lesser evil than governmental FP.

By and for women: a US example

There are today some 200 women's health centres in the US providing information and in many cases direct health and FP services to women in a manner responsive to their needs and preferences and that involves them in the design and provision of services. This approach to delivering services was specifically recommended by the International Conference on FP in the 1980s, held in Indonesia in April 1981. In addressing the challenges facing FP programmes in the decade ahead, the conference noted that in many parts of the world, women often have little control over their decisions related to their own fertility. Furthermore, low levels of acceptance and use of FP, which are characteristic of many programmes, often reflect a failure to design and provide services in a manner that is responsive to the needs and perceptions of the users.

In a special report entitled "Women-Oriented Health Care", Judith Bruce of the Population Council describes how women-oriented services are designed and provided at the New Hampshire Feminist Health Centre.

The centre serves approximately 10,000 women and was started because the women organising and receiving these services have been dissatisfied with the established health care system. How does the women's health care movement provide services and how do these differ from conventional services? What services do they offer and how do women respond? What is the ideology of the women's health care movement and how does it influence service delivery? Are these services viable as a sustained option? The answers are of potential interest to service providers in both developed and developing countries.

The New Hampshire Centre is an important example of women designing, managing and directly providing health, contraceptive and abortion services to other women. The centre has 31 regular staff members plus one female and two male doctors hired on a continuous as-needed basis. The core members of the staff rotate responsibilities as much as possible so as to acquire diverse skills. The staff are trained in emergency medical techniques through a ten-week state sponsored course. Moderate fees are charged for abortion and gynaecological services and minimal or no fees for other health promotion activities.

Despite the Supreme Court ruling of 1973 making abortion legal in the USA, there is an unmet need and this the centre fulfils - especially of some groups of women - the poor and adolescents.

Vacuum aspiration is used and the centre has emergency back-up agreement with local hospitals. A low complication rate is seen of under 2 per cent, mostly post-abortion infections and treated with antibiotics. The rate is equal to or lower than the national average for first trimester legal abortion. Women are permitted to leave after 20 minutes if their blood pressure and pulse are normal. They leave with an instruction sheet and an appointment for follow-up care in two weeks.

The centre also provides gynaecological service and contraception information and counselling. Materials on these topics are published along with a quarterly journal on women's health and related issues with informative tips on self-care in health.

Perhaps the centre's most important research effort is the reintroduction of the cervical cap as a contraceptive device. The centre's interest in the cervical cap grew over time. Initially a New Hampshire nurse-practitioner obtained a supply of caps and fitted herself and a few of her friends. The method worked very well for them. She then incorporated the method into a college health service where she was working. The centre heard about cervical cap through her, discussed it and a number of the staff got fitted with caps to see how they felt about it. At that time caps were hardly avai-

lable in the US though they are as effective as diaphragms. Satisfied that it is safe and effective (their own experience proved it - a difference between them and conventional health service where service providers are not necessarily users), they decided to make it part of their gynaecological services. Demand became so high that prospective users are told they will be examined in groups of four and not individually. Not all women are good candidates for cap use: those with an active cervical infection, abnormal pap smears, a flat cervix or one that is hard to fit etc., are not appropriate users.

Women are fitted with one out of four sizes and are instructed that the cap should be half to two-thirds full of cream, should be left in place at least six to eight hours after intercourse and be removed at three-day intervals. A cap costs $7.50 and rarely needs to be refitted and can last as long as 40 years. Thus, the intial time spent in instructing the women in its use is very cost-efficient.

The work of this and other women's health centres has led to a revaluation of the cervical cap by the FDA. Currently it is classified as an experimental contraceptive though it was widely used until about 20 years ago.

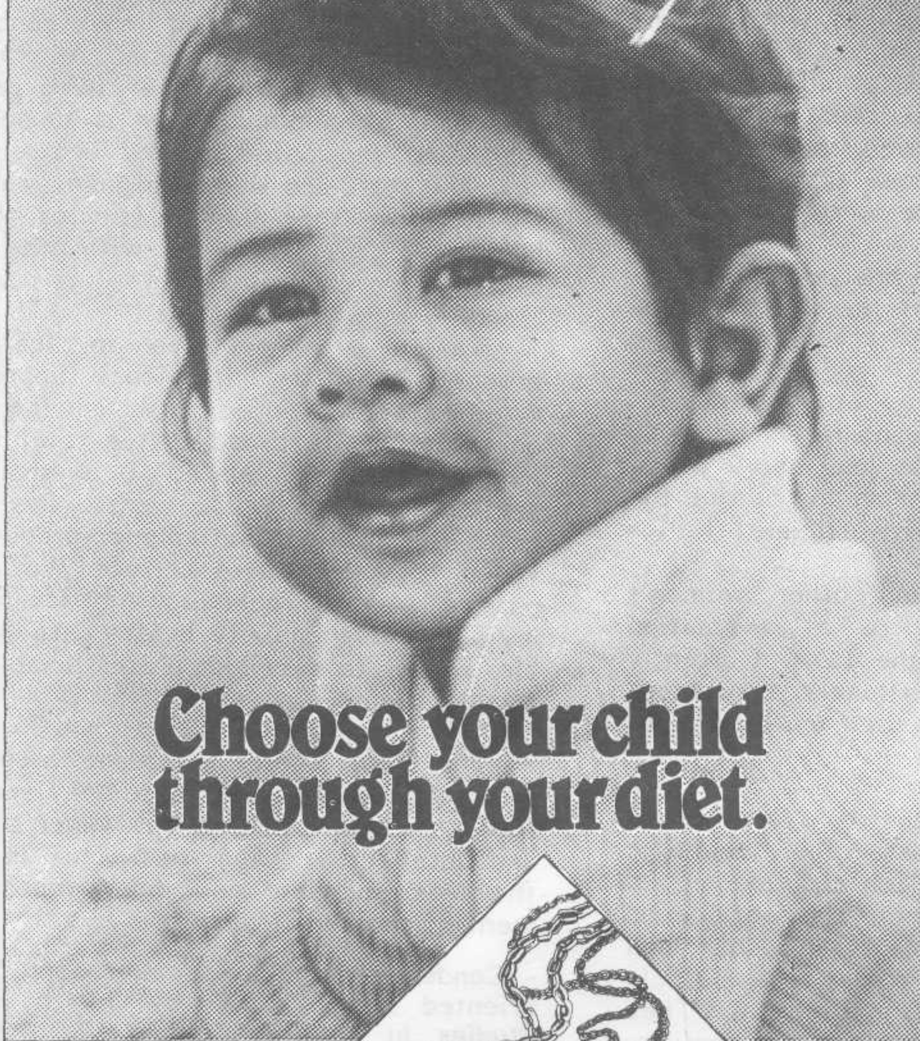
The New Hampshire centre is also involved in campaigns against rape, domestic violence and the struggle for abortion rights. The lesson offered from its services is that these are accessible, affordable and delivered with rapport. Women seeking help feel no 'social' distance from the staff. They have a choice of 16 models of fertility control including abortion. Sterilisation is available on referral. Enough information is given to make a self-determined choice. Questions and sharing of personal experiences are encouraged.

The word "patient" is not used when referring to a woman seeking a service. The service is built around the concept of a "Woman's culture". Women naturally seek out other women when they have problems. This kind of communication is supported rather than supplanted by the centre's services. The staff are women in many ways similar to those they serve. Many of the staff had their first contact with the centre as users.

Women are receptive to learning in groups. Also the individual approach is retained where needed. Although the focus is on health needs, broader aspects of women's lives not directly related to physical health are also discussed. The centre has tried to erase the artifical and counter-productive division between active service providers and passive service receivers and challenge the myth that high quality health care is available solely from male professionals serving female clients.

The role these providers assume and their attitude towards those they serve reinforce the value placed on women's physical and intellectual capacities. This is perhaps the least tangible and most important element of the centre's work.

- Condensed from a special report, "Women-oriented health care" by Judith Bruce in *Studies in Family Planning*, Vol. 12, No.10, Oct. 1981



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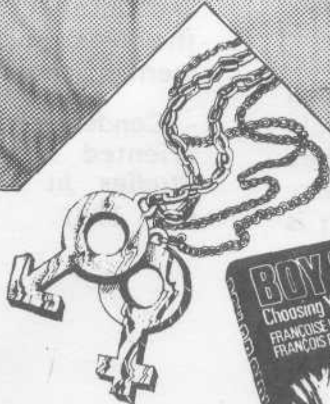

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