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CREATING COMMON GROUND IN ASIA

Women's Perspectives on the Selection and Introduction of Fertility Regulation Technologies

REPORT OF A MEETING BETWEEN WOMEN'S HEALTH ADVOCATES, RESEARCHERS, PROVIDERS AND POLICY MAKERS

The Special Programme of Research, Development and Research Training in Human Reproduction was established by the World Health Organization in 1972 to coordinate, promote, conduct and evaluate international research in human reproduction. The Special Programme brings together administrators, policy-makers, scientists, clinicians and the community to identify priorities for research and for the strengthening, in developing countries, of research institutions.

The current priorities of the Special Programme include research into new methods of fertility regulation for both women and men, the introduction of methods to family planning programmes, the long-term safety of already existing methods and other aspects of epidemiological research in reproductive health, social and behavioural aspects of reproductive health, and into methods of controlling the spread of sexually transmitted diseases which can cause infertility. The Special Programme also carries out activities to strengthen the research capabilities of developing countries to enable them to meet their own research needs and participate in the global effort in human reproduction research.

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CREATING COMMON GROUND IN ASIA

Women's Perspectives on the Selection and Introduction of Fertility Regulation Technologies

Report of a meeting between women's health advocates, researchers, providers and policy-makers
Manila, 5-8 October, 1992.

organized by

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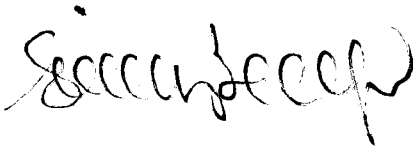
FOREWORD

In 1991 the Special Programme of Research, Development and Research Training in Human Reproduction sponsored with the International Women's Health Coalition a Conference to initiate a dialogue between the Scientific Community working in the field of fertility regulation and Women's Health Advocates, to give voice to women who are, by and large, the target of methods for family planning.

This dialogue has continued and expanded in scope and magnitude. We feel that this trend should continue especially because "population" is at present a focus of international attention, thanks to the preparatory work for the International Conference on Population and Development, scheduled in Cairo for September 1994.

It is vital that we bring our discussions and exchange of views to the regional and national level because, while considerable advances have been made over the past three decades in the domain of fertility regulation technologies, a number of major questions have also been raised. Groups concerned with women's reproductive health and rights worry about possible harmful effects of some of the new technologies, not so much because of their intrinsic lack of safely, but rather because of the less than optimal service delivery conditions unfortunately existing in some parts of the world. An additional source of great concern has been the coercive manner in which some family planning programmes seem to have operated. To address these issues, thereby helping to advance a field where not only women's health but the whole of humanity is at stake, the Programme continues to bring policy makers, researchers and field workers together with women's health advocates. in the words of my predecessor, Dr Mahmoud Fathalla, and Ms Joan Dunlop, President of the International Women's Health Coalition, "we want to create understanding and strategies that will enhance scientific exploration, improve the quality of technology and encourage advocacy on behalf of women's health and well-being".

The meeting reported here is the third in a series* which is part of this continuing dialogue. The process we have undertaken will, hopefully, promote a better understanding of the sometimes very different views and perspectives held by the players in this highly important domain. We welcome readers' responses and feedback, and look forward to a continuing and fruitful dialogue.



Giuseppe Benagiano
Director
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Development and Research Training
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* Creating Common Ground: women's perspectives on the introduction of fertility regulation technologies. WHO and IWHC, 1991.

Fertility Regulating Vaccines: report of a meeting between women's health advocates and scientists. WHO, 1993.

INTRODUCTION

In 1992, the Special Programme of Research, Development and Research Training in Human Reproduction celebrated its twentieth anniversary. The Programme was set up with two broad objectives: to coordinate, promote conduct and evaluate research in human reproduction with special reference to the needs of developing countries; and to strengthen reproductive health research capabilities in developing countries. The Programme is the main instrument within the United Nations system for research in human reproduction. Since 1988 it has been cosponsored by the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Bank and the World Health Organization (WHO).

Over the past 20 years, research on fertility regulation technologies been carried out by a number of public sector agencies, and the pharmaceutical industry. This research has contributed to some significant advances in the field, although few entirely new methods have appeared on the market. For the oldest modalities - barrier methods, intra-uterine devices (IUDs), tubal ligation and vasectomy - there have been significant improvements over time in the product or related procedures, but the methods themselves are not new. Hormonal contraception, introduced in the form of the oral contraceptive pill in the 1960s, has undergone considerable refinement, with the production of new synthetic hormones and the development of new ways of delivering the drugs, such as injections and implants, vaginal rings and hormone-releasing IUDs. Antiprogestins are still being tested for safety in use for early pregnancy termination, and as emergency post-coital contraceptives. One completely different technology - fertility regulating vaccines - has been the subject of research for many years, but is still 5-10 years away from becoming a marketable product. Within the Programme, research has also been undertaken on infertility and on technologies to help prevent one of the major causes of infertility - sexually transmitted diseases. Research on a vaccine against chlamydia, on virucides and on the female condom falls into this area.

At the same time, the Programme has supported the strengthening of research capacities in developing countries, with the aim of enabling these countries to meet their needs for research in reproductive health, and to participate in the global research effort to generate new technologies and information in reproductive health. The initial step is to encourage and assist countries in assessing the reproductive health status of their populations and to draw up a priority list of research needs. This process of defining national research agendas is clearly a key step in the improvement of reproductive health and one in which women's perspectives must be represented.

Women's health movement

During those same 20 years, an international women's movement emerged in varying forms and styles around the world. Economically, politically and socially, women's situations were and are quite different from one country and region to another, and even within one country. The basis for such a movement, though, was the quest for the

right to full personhood, the right to equal treatment in all spheres, and the right to dignity and self determination, which cut across such boundaries. Within the area of health, the primary concern has been with reproductive rights - the right of women everywhere to decide whether, when and how to have children. Women's health advocates have become active in many different ways to fight for this right. Some have set up women-oriented health services, some have concentrated on generating accessible information and creating information networks, and others have been working in the area of law and policy.

Dialogue

Until recently these two groups - researchers and women's health advocates - have been working in separate spheres. This lack of communication, despite certain areas of mutual concern, has led to major gaps in understanding. The Programme, recognizing the importance of involving women as consumers in its research and institution-strengthening activities, began to change this situation by organizing a meeting in February 1991 between women's health advocates and scientists working with the Programme. The recommendations from that meeting have given rise to a series of activities to help integrate women's perspectives into the work of the Programme*. For example, the regional committee which governs the Programme's activities in Asia has recently developed a strategic plan which emphasizes the importance of the incorporation of women's perspectives in decision making for essential national research. In support of this objective, the meeting reported here - **the Asian regional meeting on women's perspectives on the research and introduction of fertility regulation technologies** - is one of those activities, the first of its kind at the Asian regional level.

The Asian regional meeting

The objectives of the meeting were:

- to establish a dialogue between women's groups and researchers, policy-makers and family planning service providers;
- to define women's needs and perspectives on reproductive health and fertility regulating technologies; and
- to identify appropriate follow-up activities which would establish a basis for future regional networking activities.

Participants came from Bangladesh, India, Indonesia and the Philippines, countries with which the Programme collaborates, and in which women's health groups are active. Each of the national groups of about six people included a balance between women's health advocates on the one hand, and researchers and family planning programme managers on the other. In addition, representatives from a number of different international agencies were present, including staff from WHO. The meeting was held in the WHO Regional Office in Manila, Philippines.

* The report from the February 1991 meeting, **Creating Common Ground**, is published jointly by the Programme and the International Women's Health Coalition.

The meeting took the form of plenary sessions and group work. Two keynote presentations, one by Dr Haryono Suyono, Chairman of the National Family Planning Coordinating Board (BKKBN) in Indonesia, and one by Dr Sundari Ravindran, an advocate and reproductive health researcher from the Centre for Development Studies in India, set the scene of the meeting. Subsequent presentations were organized under four main headings: women's realities, policy considerations, research, and service provision. In smaller working groups, participants were asked to re-examine the criteria that should be used in the research and introduction of fertility regulation technologies. They then worked in national groups to define reproductive health and elaborate a plan for specific country-level activities that would foster continued collaboration on their return home.

The report

This report synthesizes the presentations, discussions and group work undertaken over the three-and-a-half days of the meeting. It must be said immediately that the process was not easy. Participants came from very different backgrounds, with different life experiences and values. The aim was to find common ground while recognizing diversity. The dialogue provided a forum for different groups to exchange views, experiences and information on an equal footing. This was a challenging undertaking, and one which needs a continuing effort to make it productive. As this report indicates, participants came away, for the most part, with new insights and a number of areas of agreement. This is a first step in the process of creating common ground in Asia.

WOMEN'S REALITIES

Women are the major users of contraceptive methods and health services. Yet historically there has been little attempt on the part of researchers, policy makers or service providers to seek out their point of view or to take account of their perspectives. This meeting was explicitly organized to enable women's perspectives to be put forward. This was done initially via three presentations by women's health advocates from Bangladesh, India and the Philippines. While the presentations highlighted some country differences in women's situations, there were a number of common threads running through all three presentations, which contributed to an understanding of the factors affecting the way women think and act in regard to fertility regulation. These include:

- the attitudes of the community towards having children and controlling fertility;
- the extent of women's autonomy;
- women's health status; and
- the quality of the family planning services available.

Community attitudes towards having children and controlling fertility

The first paper, presented by Dr Ravindran of the Centre for Development Studies in Trivandrum, India, provided the results of a participatory research project that involved 64 women in two communities in Tamil Nadu, South India. Dr Ravindran described the prevailing social and cultural attitudes towards fertility and fertility regulation that work against women adopting a contraceptive method. Based on discussions and interviews, the research identified three different stages in reproductive life: 'yet to begin', 'ongoing' and 'completed desired family size'.

During the 'yet to begin' stage, for example, contraceptive prevalence is nil because of cultural beliefs which place a high value on having children, particularly when young. The teenage girls interviewed saw having children as the reason for marrying and were therefore surprised at being asked about family planning. Women are often pressed to conceive immediately after marriage. One woman described seven years of marriage before the birth of her first child as "living hell". She said she was often told that "even a buffalo would have been a better investment".

The 'ongoing' and 'completed desired family size' stages are not clearly distinguishable. Women who said that they had completed their family sometimes found themselves reverting back to the 'ongoing' stage if they lost a child or if they decided they needed another child after all. In the 'ongoing' phase, few women use spacing methods. This is usually because they do not know about them or because they are reluctant to interfere with 'natural processes'.

In the 'completed desired family size', sterilization is the main option. However, women of 35 and over often choose to avoid this surgery if they feel it is unlikely that they are going to conceive. In interviews, they said that if they did become pregnant, they would have an abortion - which they saw as a

legitimate method of fertility regulation and then have a tubal ligation immediately afterwards.

Participants learned from Ms Nasreen Huq of Naripokkho, a women's organization in Bangladesh, that motherhood at a young age is also expected of women in her country. She said that the dominant image of 'women as nurturers' destines girls for early pregnancy. Most young women want to be 'blessed' by bearing sons and to avoid the curse of giving birth to daughters. Because cultural attitudes favour the seclusion of women, most are unlikely to be able to take full advantage of health and family planning services. Even if the services are available locally, it is often considered socially unacceptable to have any medical procedure that requires undressing in front of a stranger.

In the paper from the Philippines, Dr Sylvia Estrada-Claudio of the umbrella women's organization, Gabriela, described the influence of the Catholic Church in her country. She said that not only does the Church's influence affect attitudes towards modern contraceptive methods and abortion, it also affects the services available. A joint agreement between Church and State in 1989 limited family planning services to married couples. Gabriela, which has a national membership of 40,000 women, viewed such an agreement as a direct violation of women's right to adequate health services regardless of their civil status.

However, all three papers made it clear that, despite the fact that widely-held attitudes against fertility control and family planning exist, many women wish to control and regulate their fertility. Where women are in favour of family planning, evidence from the three presentations suggests that whether or not any particular woman is successful in achieving her desire depends on the extent of her autonomy, her health status and the quality of the family planning services available to her.

Women's autonomy

The lack of decision-making power among Asian women was reflected in all three papers. Dr Ravindran said that while some Indian women try to make decisions about whether to have another child, others could not even consider making such decisions. For many women, there are so many uncertainties in their lives, that making decisions is very difficult. Often women cannot believe that any life event is within their control. Few understand much about the workings of their own bodies, let alone using contraceptive technology to control their fertility. Even after several years of marriage and children, they understand little about conception except that it is related to sexual intercourse. On the other hand, most do know that it is possible to avoid pregnancy through abstinence and that it is possible to terminate pregnancy through abortion.

Among the best informed women, some of those interviewed stated explicitly that it is the fact that they cannot take their own decisions which prevents them from using family planning technology. When husbands disapprove of their wives practicing contraception, it is an exceptionally brave woman who defies the authority of her husband, Dr

Ravindran said. A few women have undergone sterilization against their husband's will or without his consent. These women face the risk that should their sons die, their husbands might desert them because there will be no son in the family.

In Bangladesh, seclusion prevents women having full control over their lives. Ms Huq described how any woman brave enough to venture into the outside world becomes an easy target for censure, harassment and violence. She said that restriction to the home begins at an early age. Once young girls reach menarche, parents begin to worry about protecting their daughters from any encounters with men. Some parents feel such pressure that they arrange for their daughters to marry before menarche. Even those who are willing to delay their daughter's marriage often feel that it is necessary to remove their daughters from school in order to ensure that they are kept out of harm's way.

The experience of Bangladeshi girls within the home exacerbates their powerlessness. Girls quickly realize that whatever their personal aspirations, their brother's education is always going to be considered more important than their own. They also know that they are expected to eat least and last at family meal times. Childhood malnutrition is more common among girls and they are less likely to be taken for medical care when they are ill than are their brothers. All these factors contribute to women's lack of self-esteem and this lack of autonomy.

For the small number of women in Bangladesh who might consider fighting for control over their own lives, the ultimate threat is that of prostitution. Ms Huq said that women who defy traditional attitudes towards the woman's place know that they could end up as prostitutes. Naripokkho, the organization that Ms Huq represents provides support to prostitutes in Bangladesh's largest brothel and has found that most of the women enter prostitution for social rather than economic reasons. She was critical of her society for the double standards it displays. She said that when young men transgress social mores by entering into sexual relationships, it is considered to be a folly of youth. Yet, when young women do the same thing, they face the possibility of being completely excluded from mainstream society.

Dr Estrada-Claudio suggested that the mere threat of violence towards women also constitutes a major constraint on the autonomy of Filipino women as well as being a threat to their health. She referred not only to violence in the home, such as incest and battering, but also to that taking place in schools, offices and factories. The National Bureau of Investigation had revealed that rape cases in Metro Manila had risen by 18% in just under a decade. Dr Estrada-Claudio also said that the lack of information and social support for women prevents the full enjoyment of their sexuality, and that this is a particular problem for young and unmarried women in the Philippines. On the basis of official figures, she estimated that between 720,000 and 1.32 million unmarried Filipino adolescents are cur-

rently sexually active and in urgent need of contraceptive advice and services.

The three women's health advocates who presented papers argued that men's lack of involvement and responsibility regarding issues of reproductive health also compromised women's autonomy. Their three papers all referred to the importance of encouraging male responsibility in fertility regulation and reproductive health as a means of supporting women's rights.

Health status

Dr Ravindran said that women's health status is frequently overlooked in family planning programmes even where women's health is generally very poor. This oversight is particularly serious in countries like India, where surgical sterilization is the most frequently available contraceptive option. Women are required to be in reasonable health to undergo sterilization, yet the services are most easily available immediately after delivery when women may have suffered complications and are therefore deemed unfit to undergo the sterilization procedure. More than one interviewee in her research said she was sent home without being given tubal ligation following a difficult delivery, and became pregnant again before she could return for sterilization. Even when women do manage to return, they are often turned down on the basis of gynaecological diseases, anaemia and chronic health problems such as tuberculosis. These conditions are very common and doctors frequently ask women to complete treatment and return at a later date for sterilization.

Conditions such as chronic fatigue, backache, gastric problems or worm infestation also make women hesitant about adopting a contraceptive method. They fear that using contraceptives might exacerbate their problems or create new ones. Dr Ravindran said that without a complete assurance that it is possible to stop contraceptive use should a problem occur, women's perceptions of the health risk of most contraceptive technologies often outweighed their perceived benefits.

The health of children within the community also affects both the desire and the possibilities of achieving fertility regulation. As is widely recognized, the greater the perceived risk of loosing a child, the more reluctant a woman is to accept sterilization. When a woman gives birth to a frail newborn, she is more likely to decide against surgery because she wants to look after the child. Furthermore, if her children are frequently ill, she has no time to seek contraceptive services.

Reproductive tract infections in women in Bangladesh commonly prevent women from taking immediate advantage of modern contraceptives, according to Ms Huq. Young women interviewed in an anthropological study on menstruation indicated that reproductive tract infections frequently begin to occur after menarche. This may, in part, be due to the fact that women hide the rags they use for protection during menstruation in a dark corner where they remain damp, attract mildew and become infested with insects.

Women's health and access to family planning in Bangladesh is seriously com-

Balancing act

Twenty-five year-old 'M' is the second wife of a wealthy fisherman who owns a mechanized boat. Both his and her families were opposed to the marriage because her husband's first wife is alive and well. 'M' lives in the thatched house her husband built for her, where he visits her from time to time. Since her family lives more than 50 kilometres away, she has no social support. When her first three children were daughters, she was ridiculed by the first wife who accused her of being incapable of bearing sons. To prove the first wife wrong, 'M' chose to become pregnant again soon after the birth of her third daughter. If the fourth child were a son, she had decided that she would have a tubectomy.

The delivery turned out to be complicated and she was rushed to hospital. She haemorrhaged heavily and was given a blood transfusion. The child was a son, so the doctors advised her to stay in hospital, have the sterilization a few weeks later and go home after that. Meanwhile, however, her one year-old daughter was taken ill with malaria. Having no-one to help her, she left hospital against medical advice to take care of the child. Despite these efforts, the daughter died.

Now, three months later, 'M' is in a dilemma. She wants to return to the hospital for sterilization. But what would she do with the newborn? What if he fell ill and died? All the same, she does not want another child and is afraid she may end up pregnant again. She says her husband is "very demanding".

Source: Paper presented on users' perspectives on the appropriateness of particular methods of fertility regulation for particular settings in Asia, by Dr T K Sundari Ravindran, Centre for Development Studies, Trivandrum, India.

promised by the fear of infertility, Ms Huq said. Girls and women adhere to the secrecy and eating restrictions surrounding menstruation because they believe that if they rebel, they will bleed heavily and experience severe cramps which they believe could lead to infertility. They also fear that contraceptives can cause infertility. For a woman in Bangladesh, infertility is "one of the worst fates", according to Ms Huq. It is grounds for her husband to desert her and remarry, often leaving her with no social support.

The risks to the mother's health involved in childbearing might be expected to encourage women to use contraception. In Bangladesh, six women die as a result of pregnancy and childbirth per 1,000 live births. Yet, according to Ms Huq, violence is a great threat to both the health and the autonomy of Bangladeshi women, and thus to their right to control their own fertility. She suggested that a survey of mortality and morbidity due to violence during pregnancy in Bangladesh is urgently needed.

The Philippines' presentation also indicated the links between women's health and her reproductive status. For instance, chronic dietary energy deficiency and anaemia are very prevalent in pregnant and lactating women and their children. Pregnancy and childbirth is one of the most common causes of death for women aged 15-29 years, according to government statistics.

Family planning services

The women's health advocates felt that the quality of services and the costs involved in gaining access to them are both key factors determining whether women who want to regulate their fertility will be able to do so.

In India, contraceptive services provided by the Government are free of charge. However, the main contraceptive option available through such services is sterilization which involves considerable costs to the woman in terms of her time and effort. For example, before going for sterilization, a woman must organize who will fetch the fuel and water, care for her children, and so on. Sometimes she also needs someone to accompany her to the hospital to feed and care for her. It is unlikely that friends or members of her family can afford to take this time off from their work at home.

Women's fears about side-effects might be related to the problem of abuse and misuse of modern contraceptives, said Dr Estrada-Claudio. She said that women's groups in her country have talked to women who have been coerced into using contraceptives by overzealous government workers. Some women have been prescribed contraceptive devices which are inappropriate for them, and others, wishing to change or stop using their current method, have found that family planning personnel are unwilling to help.

Reports of abuse within the national family planning programme were also included in the presentation from Bangladesh. Ms Huq said that incentives paid to clients for sterilization can have unfortunate consequences. For example, there have been reports that elderly men whose wives had passed the menopause have undergone vasectomy. Poor quality services have also been a concern, although recent government interventions have reduced unusually high death rates in the sterilization programme. Reports of women dying of tetanus after ligation and stories about perforations during IUD insertions, have been deterrents to use of these methods.

All three presenters were critical of the poor quality of health care services generally in the context of which family planning services are provided. Dr Ravindran said that in India, the emphasis given to family planning means that health care providers are unable to devote much attention to their responsibilities in pregnancy and delivery care.

Ms Huq said that in Bangladesh poor health is seen as a problem of high fertility and that most interventions appear to be focused on curbing fertility, to the detriment of other health interventions. In addition, family planning services are separated from other health services leading to situations where, for instance, anti-tetanus injections are not available to those undergoing sterilization because

such care is provided only by other health services.

Dr Estrada-Claudio said that despite the poor health of women in the Philippines, more attention is given to family planning than to the health problems that women themselves would like addressed. She said that women would like reproductive health services to give attention to such problems as reproductive tract infections, infertility, aging and menopause, occupational and environmental health risks.

These three presentations brought women to centre stage of the discussion. By providing an understanding of women's needs, concerns and perspectives regarding fertility control, the women's health advocates laid the basis for discussing with policy-makers, researchers and service providers how to approach reproductive health policy and services.

POLICY CONSIDERATIONS

Over the past two to three decades, all four Asian countries represented at the meeting have had officially-sponsored family planning services. Concern about the effects of unbridled population growth, and about high fertility rates and associated high rates of maternal mortality, have resulted in population policies to reduce the total fertility rate (TFR - the average number of children a woman will have during her life).

The TFR is closely related to contraceptive prevalence, and this is one important measure which policy-makers use to see if they are attaining their goal. In Bangladesh, for instance, the goal of the family planning programme is to reduce the TFR from 4.3 in 1990 to 3.4 by 1995. Dr Jahiruddin Ahmed from the Directorate of Family Planning in the Ministry of Health and Family Welfare said this would require an increase in contraceptive prevalence from 39% to 50% over the same period.

Experience has shown that achieving such contraceptive prevalence levels is not simply a matter of providing services and supplies. Although many programmes took this approach in the beginning, it rarely met with the success hoped for. Contraceptive prevalence has increased in all four countries over the past two decades, but the increase has generally been slower than expected. Current contraceptive prevalence is around 40% in Bangladesh, 30% in India and 35% in the Philippines. In Indonesia, however, the prevalence rose from 9% at the beginning of the programme in 1973, to 50% in 1991.

Policy-makers have had to confront the question of why family planning programmes were unable to achieve targets as rapidly as hoped for, especially when major demographic surveys have indicated that there remains an unmet need for family planning among a substantial proportion of Asian women. In the Philippines, for example, 23% of women aged 15-44 expressed a desire to limit or space pregnancies and were considered at high risk of another pregnancy, yet were not using contraception, according to a Government report in 1990.

Clearly, even women who want and need the services of national family planning programmes are not being reached. Many women know about modern contraceptive methods but do not use them. In Bangladesh and the Philippines, 84% and 94%, respectively, of women who were not using contraception but who said that they wanted no more children, knew of at least one modern method of contraception, according to figures in the 1990 World Development Report. One conclusion for policy-makers is that they need to find out why women are not using the services.

> *"The appropriate selection of fertility regulation technologies is important not only to women but to the success of the national programme. If contraceptive technology is to respond well to women's needs, policy makers and planners must be sufficiently aware of these needs."*
> -- Dr Haryono Suyono

Taking users into account

Awareness is growing among policy-makers that finding out what users think may be an important way of moving ahead in policy-making, service provision and research in reproductive health. Users' needs and preferences, and especially those of women, are being given more attention.

In the keynote address to the meeting, Dr Haryono Suyono, Chairman of the National Family Planning Coordinating Board of Indonesia (BKKBN), said that understanding the concerns of women and the family is important if policy-makers are to embark on strategies and policies that respond to them. Policy-makers, he said, must be sufficiently willing to listen to women's problems, particularly in societies where vast socio-economic disparities exist between men and women, where opportunities for women are yet to be improved, and where women's reproductive goals are sometimes unmet because policy-makers lack sufficient information and willingness to guide the development of policies appropriate to the needs of the clients.

In Bangladesh policy-makers acknowledge the need to move beyond simply providing family planning services, by giving more attention to maternal and child health care and women's status. Dr Ahmed told the meeting that, in Bangladesh, family planning service delivery alone would only increase contraceptive practice to a maximum of 50-55% of married couples. He said that in order to reach more women, the current need is to move towards improving the quality of people's lives through measures which go 'beyond family planning', including employment for women, delayed marriage and nutrition programmes.

It was reported that the Philippine Family Planning Program has failed to reach family size targets despite the fact that the Family Planning Program recommends the same number of children as women say they want, namely two or three. User dissatisfaction and logistical problems with the Program have been blamed for its lack of success. Recently, the Department of Health invited women's organizations to become involved in planning a national reproductive health strategy.

India has seen "three decades of lost opportunity", according to Dr Badri Saxena of the Indian Council for Medical Research. The spacing methods that women want are still not sufficiently widely available. The promotion of IUDs in the 1960s, and the sterilization programme in the 1970s, have had little effect on fertility rates, he said. By the time women opt for sterilization, they already have an average of 3 to 4 children. During the 1980s, attempts to introduce the two-monthly injectable norethisterone enanthate (NET-EN) and the contraceptive implant Norplant encountered problems arising in part from inadequate counselling information and follow-up given to women. This gave rise to doubts and misconceptions about the methods, and researchers concluded that there was a need to improve the counselling and motivational skills of both medical and paramedical health workers, since both methods could cause bleeding irregularities. In, addition, women's health advocates ques-

tioned the long-term safety of the methods. Dr Saxena believes that policy-makers and researchers are increasingly aware that the lack of communication between programme managers, scientists, women's health advocates and potential users might be the cause of many of the problems. Researchers and policy-makers are sympathetic to the view of the women's health advocates that reproductive health must be seen as a moral priority. They also consider that programmes are unlikely to progress further without expansion of the health services.

"There is a need to have intensive interactions between the programme managers, women's health advocates and scientists, to remove the areas of doubt, dispel misconceptions, and find ways and means to ensure continued mutually beneficial interaction."
-- Dr Badri Saxena

In Indonesia, where President Suharto won the United Nations Population Award for reducing the TFR from 5.6 in 1969 to 3.0 in 1990, there is now a growing recognition of the need to ensure the quality of health and family planning services. Following the results of a number of recent studies, it is now accepted in Indonesia that quality services will result in more satisfied users. Dr Haryono described the policy change as a transformation from a "supply based orientation" to "demand fulfilment strategies". He said that clients' needs and desires must be understood and also that the programme should stay as close to the clients as possible. As a policy-maker, he believes that in order to have a better understanding of women's needs it is necessary to initiate discussions with constituencies of women, to support surveillance studies, to develop strong advocacy on women's issues, and to offer a genuine determination to improve the Programme's responsiveness, not only to women's problems but also to those of the family as a whole.

The objectives of family planning programmes

The women's health advocates recognized the growing acceptance by policy-makers of the need to take user perspectives into account. However, they felt that there is also a need to challenge the underlying objectives of most family planning programmes. Their contention was that if family planning programmes' main objective is to curb population growth, the rights and health of women are unlikely to be safeguarded.

There was considerable discussion on this point, which was partly conceded by policy-makers. In the Philippines, for instance, recent statements from the Department of Health show that their objectives are changing, which women's health advocates find encouraging. The Philippine Family Planning Program 1990-1994 explicitly states that "...it is not run as a population control program ...it is not driven to reduce fertility as a goal."

Dr Haryono told participants that a woman's right to pursue her reproductive objectives, choice of method and rightful access to family planning information and quality services is now legally recognized and protected by law in

Indonesia. He said that family planning programmes should endeavour to support the basic human right of women and families to make independent voluntary reproductive choices.

Dr Saxena felt that it is impossible to ignore the fact that the population of his country has grown by 161 million in the decade 1981-1991, and that this has serious implications for government economic and social policy. He said that reducing the birth rate must therefore remain an objective of a reproductive health programme.

It was suggested that availability of resources is a key factor in shaping the way in which programmes are implemented by policy-makers. When resources are scarce, it is sometimes necessary to strike a balance between reproductive risks and the quality of service, said Dr Haryono. In the early days of the Indonesian programme, for example, the need to reduce population growth was so great that less emphasis was placed on developing client-oriented services.

The women's health advocates maintained that a woman's right to control her own sexuality and fertility has to be the cornerstone of any reproductive health programme, which would include family planning. Such programmes, therefore, should not be oriented towards increasing contraceptive prevalence and acceptor rates but towards women's health and rights. Further, it is necessary to ensure that this right be extended to women of all ages, regardless of marital status. It is also essential that men take responsibility for their own fertility and the health and well-being of their partners.

There was some discussion over what is meant by "women's right to control their own sexuality and fertility". Some participants felt that the word 'control' implied something negative, and that it might be interpreted as suggesting that women were being called upon to restrict their sexual behaviour.

Representatives from both Indonesia and the Philippines felt that their own languages offered expressions that are preferable to 'control'. For example, the bahasa Indonesia language offers the word 'Panghyatan' which means 'to manage and enjoy' one's own sexuality. Participants from the Philippines felt that the Tagalog word 'Panghawakan', meaning 'to take hold of' one's own sexuality, was what should be conveyed by 'control'.

Policy-makers and researchers challenged women's health advocates to provide a definition of reproductive health. As a result, there was considerable discussion resulting in the general acceptance of the definition of reproductive health set out by the International Women's Health Coalition (see box). However, it was suggested that each particular country would probably need to adapt the text, to reflect conditions involved in achieving reproductive health in a particular setting.

Both policy-makers and women's health advocates agreed that programmes based on boosting numbers of acceptors tend to ignore, or give less attention to, quality of care. When staff of family plan-

Defining women's reproductive health

Women should be able to:

- manage their own fertility safely and effectively by conceiving when they desire to, terminating unwanted pregnancies, and carrying wanted pregnancies to term;
- experience a healthy sexual life free of disease, disability, fear, pain or death associated with reproduction and sexuality; and,
- bear and raise healthy children as and when they desire to do so.

The conditions for achieving reproductive health include respect for women's individual rights in reproduction and sexuality within a broader commitment to increase women's opportunities and equity overall. The outcome is more caring, responsible and respectful sexual relations.

The above definition was provided by the International Women's Health Coalition. Ms Adrienne Germain, representing IWHC at the meeting, said that this definition had been evolving since 1987 and was useful for the Coalition's work at an international level. However, she said that no one definition of reproductive health could cover all situations and that every country needs to redefine, prioritize and examine the definition within its own context.

Reproductive health is not merely the absence of disease or disorders of the reproductive process, rather it is a condition in which the reproductive process is accomplished in a state of complete physical, mental, and social well-being. This implies that people have the ability to reproduce, that women can go through pregnancy and child-birth safely, and that reproduction is carried to a successful outcome, i.e., infants survive and grow up healthy. It implies further that people are able to regulate their fertility without risks to their health and that they are safe in having sex.

*From **Reproductive health: a key to a brighter future**, Special Programme of Research, Development and Research Training in Human Reproduction Biennial Report 1990-1991, World Health Organization.*

ning programmes treat women as numbers rather than clients, they are less likely to offer the women proper information or follow-up. Such an environment creates a negative image of the programme among its consumers and potential consumers, and probably does not contribute to women's overall health.

Participants of differing viewpoints agreed that target-oriented programmes restrict rather than advance the beneficial effects that family planning efforts can have. The use of incentives to encourage adoption of particular contraceptive methods has been a particular problem. Women's health advocates felt that even during clinical trials or when helping to defray costs of obtaining a contraceptive method, incentives could become coercive. In countries where many people are unemployed and hungry, they may have little choice but to accept any payment offered to them, according to Ms Alexandrina Marcelo, from Womenhealth in the Philippines.

"There are problems with incentives even when they are helping to defray the costs of accessing a (contraceptive) method. For in countries where chronic hunger and unemployment are rife, incentives may become coercive no matter the intent. The poor have no choice. They need to feed their children."
– Ms Alexandrina Marcelo

Women's health advocates proposed that a system for monitoring women's health should be developed. Contraceptive prevalence rates would be only one among many indicators such as maternal mortality and morbidity, miscarriage, secondary infertility, child spacing, and rates of reproductive tract infections and sexually-transmitted diseases.

It was also suggested that if family planning is to be a right, a range of contraceptive methods must be available. Some programmes have promoted provider-dependent long-acting contraceptive methods, such as IUDs or implants, because such methods lessen the burden on supplies and services. In Indonesia, for example, Norplant has been offered in mass outreach 'safaris' in which family planning teams provide on-site services in a health centre or from a mobile clinic at prearranged times. Women's health advocates felt that favouring provider-dependent methods compromised women's right to choose. If women are to be able to exercise this right, governments and providers should not promote certain methods over other methods.

Participation in decision-making

Participants agreed that women's involvement in all aspects of family planning programmes is important. Women's groups should be involved in determining the reproductive health needs and priorities in their countries. In both the Philippines and Indonesia, there are clear indications that this is beginning to happen. Acknowledging this development in Indonesia, Dr Haryono suggested that guidelines should be developed for the integration of women into all sectors of national development in an effort to improve the quality of life of women and their families. Although women's organizations are not yet represented in top-level pol-

icy-making committees in Bangladesh, all four participants from that country stated their conviction that family planning programmes require the full involvement and leadership of women.

"Progress cannot be made on health issues without the full involvement and leadership of women. We have demonstrated that once empowered, even the poorest, illiterate women can become leaders in the health field for their own families and their communities."
-- Dr Sadia Chowdhury

While welcoming support for greater involvement of women's organizations in policy-making, the Filipino women's health advocates sounded a word of warning. They said that the commitment must be genuine from both sides. If women are going to spend their time on government committees, there must be a real commitment to listen to them. Women in the Philippines have been working with government for a long time without very satisfactory results. It is difficult to influence policy when other non-governmental pressure groups, such as the Catholic Church, are pursuing policies, particularly on abortion, in the opposite direction. They suggested that the Government of the Philippines should take a stronger stand on this issue.

Increasing the proportion of women employed within family planning and reproductive health programmes is one means to achieve representation of women's views in policy development. Participants heard that more women are being involved in government family planning programmes in Bangladesh. Efforts have been made to employ women within the family planning programme and 10% of the programme managers at the sub-district (thana) level, which is the main unit of the programme, are now female. However, even more important is to ensure that women are represented in the top-level, national policy-making committees. The women's health advocates considered that for real change to take place, policy would have to address the gross inequalities in the distribution of wealth, resources and power. Women's rights need to be upheld through greater educational and employment opportunities, and through access to credit and political participation.

Men's responsibility

Finally, participants felt that much more attention has to be given to the roles and responsibilities of men with regard to fertility regulating technologies. The women's health advocates in particular said that there is a need to promote male reproductive health and responsibility and recommended greater investment in programmes promoting vasectomy and condoms. They noted the need to ensure that contraceptive pricing policies reflect government promotion of male contraceptive methods. At present, a month's supply of oral contraceptive pills in Bangladesh costs the same as a packet of three condoms.

The relatively large donor contributions for AIDS programmes in Asia provides an opportunity for the promotion of male responsibility in reproductive health as part of an effort to promote an integrated approach to health and human reproduction.

RESEARCH

The women's health advocates felt that priorities in reproductive technology research can not be adequately defined until women's perspectives are fully represented at all levels of decision-making. Only by including women's and users' perspectives in setting research priorities can the wide range of needs and preferences among different groups of women be adequately represented. For example, women want contraceptive methods they can safely use during breast-feeding and this may affect research priorities. It is also essential to take into account women's wider reproductive health concerns, such as reproductive tract infections.

Although participants agreed with the general principle of involving women's health advocates in the research process, there was disagreement over when and how they could be involved. Dr Kurus Coyaji, Director of the Department of Obstetrics and Gynaecology, K.E.M. Hospital, Pune, India, felt that women's health advocates should be involved in the later stages of contraceptive research (from Phase II - safety and efficacy trials -onwards), and that it was inappropriate for non-scientists generally to be involved in basic research. Chilean researcher, Dr Soledad Diaz, agreed. She said that it is often difficult to decide exactly where the first stage of a particular research process begins.

While recognizing the importance of autonomy for the creativity of any individual, the women's health advocates pointed out that those working in reproductive technology research have responsibilities not only in their laboratories but to society at large. Although their work is often constrained by the funding priorities set by governments and international agencies, they need to hear women's perspectives because the results of their research will have a major impact on the lives of millions of women. What better justification could there be for involving women in setting the research priorities?

Women's health advocates considered that their perspectives should be taken into account well before even Phase I (safety) trials take place, and that women should contribute to defining research priorities. Involvement in the bodies that decide what research is pursued is therefore crucial.

Ms Karen Beattie of The Population Council said that this consultative process is now beginning. For example, the Population Council involved women's groups from different countries in a meeting to discuss development of a virucide which would have the potential to protect women and men against sexually transmitted viral infections, including HIV. The meeting had been useful in stimulating a discussion on whether women want a virucide together with, or separately from, a contraceptive mechanism.

Many women's health advocates also felt they should be much more involved in introductory and pre-introductory trials. At present researchers tend not to take women's groups into their confidence when introducing new technologies. Dr Ravindran said that it should be possible to involve groups of both urban and rural women in workshops to discuss the details of new fertility regulation technologies before they are in-

troduced. She suggested that it would be better for government programmes to share any concerns about the contraceptive with women and to listen to their reactions to the potential risks, rather than attempting to 'sell' a new method.

Redefining safety and acceptability

The discussion about research priorities brought to the surface the fact that women's health advocates define 'safety' and 'acceptability' differently from scientists. Scientists define "safety" in reproductive technology as an absence of dangerous or permanent side-effects. Clinical evaluation of the safety and efficacy of a particular method therefore concentrates on medical rather than social and economic considerations. The scientists' definition of 'acceptability' is often linked to acceptance rates. These rates do not necessarily acknowledge the various factors involved in women's decision-making nor take account of the views of women on the advantages or disadvantages of the method.

The women's health advocates said that it is important to know the effects of the method on a woman's overall health and well-being. For example, although prolonged bleeding is not a life-threatening side-effect of a method, if it prevents a woman from earning subsistence wages and looking after her children, it could have serious consequences not only for her health but also for that of her family. Thus, for the woman, prolonged bleeding might represent a serious side-effect of a contraceptive method. The scientifically-proven 'safety' of a particular method might also be compromised, according to women's health advocates, by technical incompetence of health service providers, poor communication or the absence of objective, unbiased information.

> *"Adequate knowledge of contraceptives, particularly their indication, correct usage, and effects on the user, is essential if the clients are to make intelligent choices. To gain this knowledge, programme managers must be prepared to listen to clients' problems, incorporate findings from contraceptive introduction and clinical trials into policy decisions, support contraceptive surveillance and operations research studies and ensure that the findings from these studies are carefully considered in programme development."*
> -- Dr Haryono Suyono

As an example, the introductory trials of Norplant in Bangladesh and Indonesia were discussed. In both countries there were reports that women had complaints about the follow-up services. When women had problems which they associated with the implants, some had difficulties identifying health personnel willing to remove the implants. Similarly, during the clinical trials of Norplant 2 implants in India, it had proved difficult to follow up every woman involved in the studies. Women's health advocates there felt that if follow-up was difficult in the context of a clinical trial, it would be much more difficult in a normal service situation, and that this cast doubt on the appropriateness and safety of the method. Some women's groups had therefore publicly voiced opposition to the introduction of contraceptive implants.

Norplant implants had not yet arrived in the Philippines. However, the Filipino group, including women doctors and researchers, felt that poor health service infrastructure in many settings made it inappropriate to introduce this kind of method. They felt that, given the real health needs of women in the Philippines and elsewhere, far too much attention was given to Norplant implants, both in the meeting and in national family planning programmes. This detracted from the need for introducing barrier methods and promoting male involvement, for instance. They emphasized that technologies should be introduced only when (a) there is a national plan in which women are key participants, and (b) health infrastructures and facilities are in place.

"It is essential to involve women's health advocates in the planning, design and conduct of the introductory trial. They can be an additional source of strength to ensure the quality care and services necessary for a successful introductory study."
-- Dr Badri Saxena

Policy-makers pointed out that the high continuation rates achieved in clinical trials of Norplant indicated the popularity of this new contraceptive technology. However, the women's health advocates suggested that, in some countries, the difficulty that women face in having an implant removed - on the basis of complaints of menstrual irregularities, for example - created inflated continuation rates.

Discussions revealed that one of the recommendations from research on users' perspective of Norplant in Indonesia was that more training in removal was needed. In Bangladesh, where small-scale trials are being expanded gradually, a training programme to ensure that doctors are competent in removal is planned for 1993-4 when some Norplant users will have completed their five year period of use.

Women's health advocates were also concerned about the safety of other hormonal methods. Some felt that there is inadequate research to demonstrate that such methods do not have a more significant effect on the metabolism of malnourished, anaemic women in India, for example, than on the healthy women who are often the subjects of the safety studies. They were also concerned that controlled trials, by definition, provide no information on adverse side-effects that might occur in a general service setting if such methods are give to women who have serious illnesses, or who might be pregnant.

The scientists said that published data on hormonal methods such as oral contraceptives or injectables has established that there are no adverse effects on the metabolism of either well or undernourished women in India. Multi-centre studies, many of them supported by the WHO, are being carried out to examine hormonal contraceptives in relation to cardiovascular diseases, anaemia, liver disease and various cancers. Scientists noted that it is impossible to conduct exhaustive studies of safety in every country. In fact, relatively rare side effects can only be discovered through widespread, long-term, general use. If and when problems emerge, corrective action can be taken.

The women's health advocates pointed out that definitions of safety and acceptability are also affected by the lack of both human and reproductive rights in some countries. The risk of abuse of a particular method must therefore be taken into account when assessing safety and acceptability. Where women have few reproductive rights, they may find it difficult to have implants or IUDs removed. Provider-controlled methods can be more easily exploited by coercive family planning programmes than other methods.

Research on female barrier methods

Participants recognized the need for increasing women's access to a wide range of contraceptive options. Women's health advocates felt that currently emphasis seems to be placed on research into long-acting methods, and they questioned why coitus-related barrier methods, controlled by the user, are not given attention. The scientists expressed some skepticism about certain barrier methods, suggesting that women living in poor, overcrowded housing, without easy access to water and with little privacy, might face great difficulty in using methods like the diaphragm or vaginal foam.

Nevertheless, there was evidence that barrier methods might prove popular with Asian women. Experience with small-scale use of the diaphragm in the Philippines, for example, has been encouraging, according to Dr Estrada-Claudio. In Bangladesh, the non-governmental organization Bangladesh Rural Advancement Committee (BRAC) organized a low-cost, non-clinical family planning service, providing condoms, foam tablets and oral contraceptive pills to 220 families living in Sulla in 1978, in the context of an integrated development programme. The programme achieved the highest contraceptive continuation rate in the country at that time.

The women's health advocates had many reasons for arguing that more research funding should be invested in barrier methods. The first is that barrier methods, for both women and men, are non-invasive, and are under the user's control in a way that some hormonal methods, such as implants and injectables, are not.

The second reason is that, given the high rates of reproductive tract infections and sexually-transmitted diseases including AIDS, some users would prefer a contraceptive method which helps to prevent infection as well as pregnancy. Ms Adrienne Germain of the International Women's Health Coalition suggested that if reproductive health were to be made the priority of family planning programmes, a concentrated effort should be made to boost the use of barrier methods and to provide safe abortion services as a back-up for contraceptive failure.

Thirdly, despite the assurances of the scientific community, women's health advocates feel that there are risks involved in using hormonal methods - such as menstrual disturbances, the length of time needed to regain fertility after stopping the method, headaches, weight gain and nausea - which are potentially more serious than those in-

volved in using barrier methods. They argue, however, that until barrier methods are made more widely available, it will be impossible to assess the relative risks of the different contraceptive methods.

Finally, because of the interest in barrier methods, research on the introduction of barrier methods might provide a particularly good opportunity to involve women in the research process. Women's health advocates felt that the potential to involve women in research is often underestimated. It was suggested, for example, that women's organizations become involved in following women who discontinue with a particular method. Involving women's organizations in the introduction of methods could have an educative and empowering effect as well as producing more ample research findings.

Towards the end of the meeting, there was general acceptance of the need for research on the introduction or re-introduction of barrier methods. The participants urged the Programme to coordinate a working group to explore the possibility of conducting multi-centre trials on barrier methods of contraception. It was also suggested that research be done on whether privacy and a good water supply are necessary prerequisites for the use of barrier methods, and on why diaphragms, which had been available in some family planning programmes in Asia during the 1950s, are no longer available.

Women's health advocates were critical of the lack of investment in contraceptive methods for men. Researchers responded by saying that considerable investment had been made into different male methods. Several research projects were underway in India, for example. However, there was a general acceptance among those involved in reproductive technology research that no breakthrough in new male methods was expected in the near future, according to Dr Badri Saxena of the Indian Council of Medical Research.

Women's health advocates argued that with sufficient commitment and resources, more men could be encouraged to use condoms and to become involved in the responsibilities of reproductive health. One said she was tired of hearing that men did not like using condoms. Clever and careful promotion of condoms in an AIDS era should and could be made successful.

> *"Part of our advocacy of women's rights includes the advocacy of increasing men's participation in reproductive responsibility. We bewail the fact that it is still women who must bear much of the burden for contraception, unwanted pregnancies, safe sexual relations, childrearing and nurture."*
> -- Dr Sylvia Estrada-Claudio

The women's health advocates were also keen that the male barrier method, the condom, should receive greater emphasis in both research and family planning promotion. While the scientists pointed out that large sums had been invested in researching new male technologies, much less effort had been given to condom promotion as a means to promote a new, "non-macho" responsible male image.

SERVICES

Women's views of health and family planning services provided more evidence of why women are not using services even when they are accessible and even when women know about contraception and wanted to plan their families.

The women's health advocates said that a major complaint about family planning and maternal and child health programmes is that they are narrowly centred around women in their reproductive roles. As such, they reach out only to married women of reproductive age, and provide only for those aspects of women's health that are related to pregnancy and childbearing. The health advocates were also critical of the emphasis given to the provision of family planning in comparison to that given to mother and child care programmes. Despite high rates of anaemia, reproductive tract infections, maternal morbidity and mortality, and low birth weight in Asia, investment in family planning seems to exceed that available for the health of the woman and her child.

"Providers have a tendency to consider patients so ignorant that it is not helpful to provide information."
-- Dr Firman Lubis

Family planning programmes are also the least trusted of any of the government health services. Service providers at the community level are often looked upon with distrust because they are only interested in recruiting 'cases' for family planning. In the Indian participatory research study, village women were given no check-ups or counselling when visiting clinics for family planning, and faced a lack of concern when they came for help with a health problem. Even after sterilization, women were not told how to care for their wounds and there was almost no follow-up of their surgery. Some providers were inadequately trained to perform their work and others, while competent, treated their clients callously.

Two other urgent concerns are the lack of choice in contraceptive methods and the quality of the information about contraception available to women. Most women in the Indian study were only given propaganda on why they should have fewer children, and no information on either the range of methods available or the advantages and disadvantages of the different contraceptive technologies. An example from the Philippines is the availability over the counter of high-dose estrogen-progestin pills for women seeking abortifacients. No warnings are given to women on the dangers of these preparations during pregnancy.

Some positive examples

Nevertheless several examples of initiatives and pilot research programmes in service provision were presented that made it clear that attempts are being made to improve the quality of care.

The national family planning programme in Indonesia (BKKBN), has been giving increasing attention to user perspectives on quality of care. Since the introduction of Norplant, for example, studies have been conducted to provide information on the users' and providers' attitudes and on aspects such as the quality of training, counselling and

technical services. Dr Firman Lubis from the University of Indonesia explained that the results of these studies have prompted more training for medical workers in insertion and removal of Norplant implants, and information, education and counselling (IEC) materials have been developed for distribution in service sites. Efforts have also been made to strengthen supervision and monitoring of the programme by BKKBN, and surveillance studies on Norplant use in a number of provinces have been developed and implemented over the past 4-5 years. The value attached to the Norplant user perspective research is reflected in the decision to extend the work to other methods.

In the private sector, the Indonesian Planned Parenthood Association (IPPA), is involved in a project to provide "client-centred educational and motivational services". Established 35 years ago with a concern for women's health, welfare and personal control over family size rather than any demographic objective, IPPA is committed to client-centred services. It provides counselling and comprehensive reproductive health care in its network of Integrated Family Planning Homes, or Wisma Keluarga Berencana Terpadu (WKBT), across the Indonesian archipelago. However, the clients are primarily urban, middle or lower-middle class women, and IPPA wanted to demonstrate the applicability of the principles to the provision of family planning services everywhere. Thus the project is an experiment in bringing quality care to low-income communities in Jakarta and Lombok.

In a presentation of IPPA's work, Ms Ninuk Widyantoro, a family planning counsellor, explained the IPPA philosophy that women in Indonesia can only achieve real reproductive choice once they have the knowledge, the means and the power. The Jakarta-Lombok programme comprised a family planning and health training project for tutors selected from among disadvantaged women in the target communities. Once trained, the tutors shared their knowledge with other women in their own districts. Their trainers would provide back-up support and information materials for dissemination. Contrary to the generally held assumption that poor women lack the understanding and interest to benefit from training and to make rational decisions about birth control, the local women were successfully trained as tutors, said Ms Widyantoro.

These tutors then conducted small group meetings with women in their community to talk about reproductive health, sexuality and contraception, and to stimulate discussion. Women attending the meetings had a range of concerns and questions they wanted answered (see box). After the project in Lombok finished in February 1992, tutors were sufficiently motivated in their new roles to arrange meetings independently of IPPA for groups of women not previously covered by the project. They travelled from home at their own expense, arranged snacks and used left-over training booklets to interest new participants. Some of the original tutorial groups continued to meet of their own accord, either as a result of having formed rotat-

Concerns and curiosity

Despite two decades of "information" and encouragement to use family planning, we were surprised to hear the wide range of both simple and complex issues which continued to arise in the minds of the relatively poor women in Lombok. The following were among the hundreds of questions asked during the family planning training sessions held in late 1991:

"Can irregularities in menstruation affect your general health?"
"What type of contraception is best for a woman with varicose veins?"
"If a woman is experiencing white discharge (keputihan), can she still have intercourse if she uses a condom?"
"What are the causes of cancer of the uterus (or cervix)?"
"Does a man produce sperm each time he ejaculates?"
"What exactly is syphilis?"
"Can contraception cause any problems for a breast-feeding woman?"
"Does the pill cause freckles?"
"What are the side effects if a user of Depo Provera does not have her injections according to a regular schedule?"
"Is it true that contraceptive injections can cause your hair to fall out?"
"Does menstruation continue after female sterilization?"
"What is the 'female condom' people are talking about, and how does it work?"
"What is a 'molar' pregnancy (hamil anggur)?"

Such questions show a deep curiosity about a wide range of issues related to sex and contraception. They indicate that poor women in Lombok have a basic understanding which would make communication of further information both feasible and desirable. In fact, at times the supervisors associated with the project were hard-pressed to give satisfying answers to some of the women's questions. They had to promise to seek further clarification and send information back to the tutors to pass on to the women.

Source: Paper presented on service provision by Dr Ninuk Widyantoro, Wisma Pancawarga, and Dr Kartono Mohamad, Indonesian Planned Parenthood Association.

ing credit groups, or simply because they wanted to continue their discussion of health issues.

In both Indonesia and Bangladesh, efforts have been made to increase the number of women involved in national family planning programmes. In Bangladesh, the proportion of maternal and child health (MCH) and family planning workers who are female has reached almost 70%. At the same time, because of many women's reluctance to venture far from home, more family planning services are being made available on their doorsteps. The Bangladesh Government is also fostering relations with non-governmental organizations (NGOs) in an attempt to benefit from the complementary roles they play. This collaboration is intended to provide the national programme with an opportunity to replicate the positive aspects of some NGO experiences and to incorporate them into the family planning system in Bangladesh. Family planning in Bangladesh was first introduced in 1953 through the NGO initiative of the Family Planning Association of Bangladesh (then known as the East Pakistan Family Planning Association). Today, as many as two hundred NGOs provide family planning services to about 20 percent of the eligible couples.

An example was presented of an NGO which provides integrated health and development programmes. The Bangladesh Rural Advancement Committee (BRAC), one of the largest NGOs, has found that people will not necessarily restrict their family size until certain basic needs such as health services, employment, social and economic security are met, and that contraceptive supply alone cannot ensure an increase in contraceptive acceptance and subsequent child spacing. In this perspective, Dr Sadia Chowdhury from BRAC described how the organization recently undertook a combined education and health programme to provide successful health services and community-based family planning. Part of this programme established linkages with government workers to ensure supply.

The programme found that government Family Welfare Assistants (FWAs) often worked with erratic supplies of contraceptives and very little support. Taking a flexible approach to what might be needed to improve the services that the FWAs were providing, BRAC workers offered them any necessary assistance. They found that the important tasks were conducting baseline studies, helping to prepare action plans, providing training and helping managerial staff to develop supervisory checklists. Contraceptive prevalence rates in the various pilot programmes rose from 24% to at least 44%. BRAC now hopes that its findings will be built into the government programme, so that the impact of this NGO activity would not be confined to project communities but would benefit the whole country, said Dr Chowdhury.

There were also examples of women's organizations becoming involved in service provision. Gabriela in the Philippines, for example, launched five health projects open to women of all ages, married and unmarried. During counselling sessions with clients, health workers in the Gabriela clinics provided information to women on anatomy and physiology with the help of charts and

drawings. Gabriela also translated information materials about reproductive health into Tagalog, the official language of the Philippines.

Women-centred services

While information about these initiatives to improve the quality of family planning services was extremely welcome, the women's health advocates stressed the continued need for a greater sensitivity to women's needs on the part of policy-makers. They said that such awareness would make a significant contribution to building successful reproductive health programmes and pointed to some policy and programme changes which they felt would rapidly remove some of the barriers women face in getting access to contraceptive technologies.

• **A change in the attitude of some health and family planning workers** towards their clients would go a long way towards improving the image of the services. Services must become people-centred, catering to popular needs and responding to people's concerns. If women's health concerns about infertility and menopause were given as much attention as fertility control, women would recognize that their needs are being addressed. Good reproductive health care would allay many women's fears about the potential health risk posed by fertility regulation technologies.

• **Abortion and menstrual regulation facilities** must be included if services are to be women-centred. The consequences of unsafe abortion are a major cause of maternal death in Asia and elsewhere. Figures quoted during the meeting showed that as many as 750,000 abortions are estimated to take place in Bangladesh every year. In the Philippines, where abortion is illegal, studies have revealed that 13-37% of women have attempted abortion at least once. The maternal mortality rate among young girls, mostly as a result of unsafe abortion, is a matter of particular concern. Research in Indian villages revealed that women there see abortion as a legitimate method of birth control.

• **Quality of care** should be accorded priority, participants agree. Counselling, for example, should become an integral component of service provision. Women not only want a contraceptive that is safe, they also want a method that fits their life situation. Determining which contraceptive best meets a woman's needs requires good communication between the health care provider and the user. There has been a tendency for service providers to blame the women for their 'ignorance' rather than seek to communicate better.

• **Full and understandable information** about the contraceptive technologies available is needed by women. In the Indian study presented by Dr Ravindran, most women knew about family planning, yet less than 5% knew methods other than sterilization. Women need information about contraceptive methods that they are using, such as withdrawal and the rhythm method, or might like to use, such as the diaphragm or oral contraceptives. They need information about traditional birth spacing methods like prolonged breast-feeding which has enabled many women to

achieve a reasonable delay between childbirth and a subsequent pregnancy. However, the duration of breast-feeding is declining with increasing urbanization. In rural Bangladesh, for instance, it is estimated that 80-100% of rural women breast-feed their infants during the first year of life, but the duration of breast-feeding is much reduced among poor women living in the urban slums. Women need information on the range of methods, their contraindications, the advantages and disadvantages of each method, its proper usage, potential side-effects and on what to expect from service providers in terms of support, re-supply and related services. Better quality information must be accessible to women through the use of innovative dissemination techniques.

• **Expanding the range of contraceptive methods** is an important priority if services are geared to meeting women's needs not just demographic targets and goals. However, the extent to which the range of methods can be expanded depends on the capacity of the existing services; quality of care should not be jeopardized in favour of simply having more methods available. Unless providers can give them full information, counselling and follow-up care, availability of more methods will not improve women's well-being.

• **Reproductive health education and services for young and unmarried people** is also vital. Most participants felt that this is a priority, particularly given the fact that many young women are likely to risk an unsafe abortion, or even to commit suicide, as a result of an unplanned pregnancy. Providing such services, however, requires greater openness in discussing sexuality and contraception. Similarly, information and services must be made available to the hundreds of thousands of women in Asia working in commercial sex.

All participants recognized that there is tremendous hope for the future in offering young people education and services in reproductive health. The younger generation are known to be more open to new information and by changing the attitudes of today's young people, dividends can be reaped for the lives and reproductive health of future generations.

PROPOSALS FOR ACTION

During the course of the meeting participants met in country groups in order to develop country-specific action plans. Resource people were distributed evenly among the four groups. The idea of these group sessions was not only to identify proposals for action but also, by bringing together women's health advocates, policy-makers, researchers and service providers, to lay the groundwork for fruitful collaboration in the future. There was a need and a real intention, as the Bangladeshi group put it, to "listen and learn, and to learn to listen".

The country groups provided an opportunity for participants to establish areas of common interest to pursue. This was not always an easy process. In fact, there were voiced disagreements amongst the participants in all four national groups. Nevertheless, participants were able to discuss their different concerns and, in some cases, to make concrete proposals. The following statements are based on reports to the plenary.

Bangladesh

Women's health advocacy is rather recent in Bangladesh and collaboration with the Government has not yet occurred. Participants expressed a willingness to try to work together. Two important initiatives were suggested to achieve collaboration and to emphasize the importance of women's perspectives in reproductive technology research.

The first proposal for action was to ensure the participation of women's groups in the existing fora at national and district levels. As a first step in this process, the group suggested that a change in the constitution of the Family Planning Council of Voluntary Organizations (FPCVO) should be implemented to allow representation of women's health advocacy groups. FPCVO already includes representatives from governmental and non-governmental organizations, policy-makers, researchers and service providers.

The second proposal for action was for the participants to help involve women's groups in the process of identifying national research needs in reproductive health. To this end, the Family Planning Association of Bangladesh (FPAB) offered to host a meeting to disseminate the ideas discussed during the Manila meeting, and to identify and discuss research priorities. After the FPAB meeting the group suggested they meet to compile a report, including proposals for the February 1993 research needs assessment to be undertaken by the national authorities, with the support of the WHO.

At the time this report is being prepared for publication (August 1993), information from the Bangladeshi participants indicates that none of the suggested actions have yet taken place.

India

Women's health advocacy has a longer history in India than in Bangladesh and there has been confrontation rather than collaboration between women's health advocates and the government. In the 1980s, for instance, women's health advocates argued in the Supreme Court

that due to potential health risks and potential for misuse of injectable contraceptives in the national programme, ongoing introductory studies by the Indian Council of Medical Research (ICMR) be stopped. The Supreme Court overruled the request and the ICMR completed the introductory study of NET-EN. Similar criticisms have also been made regarding the Norplant II studies and the proposed introductory trials of Norplant. The group acknowledged this history and sought to determine whether and how to move forward.

There was agreement amongst the participants on the need to carry out research on the reintroduction of barrier methods such as the diaphragm, and on improving the quality of care of family planning services. There was considerable discussion about the possible involvement of women's organizations in helping to improve the quality of services both for existing and newer methods of contraception. However, there were deeply felt differences about the value of including some of the newer methods in the Indian programme, and about the nature and scope of potential collaboration between scientists and women's health advocates.

The women's health advocates from India remained seriously concerned about the safety of hormonal contraceptive methods for undernourished women living in communities where medical services are poor. In particular, they were anxious that hormonal methods could cause metabolic changes which would affect blood clotting and coagulation and therefore present greater risks of thrombosis. They argued that despite the evidence of high safety levels from other countries, the dose given to Indian women might be harmful, given their diet, body-weight or ethnicity. They felt that the collection of basic health information about different segments of the population is a vital first step before introducing hormonal contraceptives.

The scientists stated that most of the hormonal contraceptives such as combined oral contraceptive pills have also been studied in India in malnourished women and the published data does not seem to indicate that an undernourished woman is at greater risk of short-term or long-term side effects than a better nourished woman. They indicated that most hormonal contraceptives, including injectables and implants, have been studied in both developed and developing countries including South Asian countries where women have similar body weight, diet and other demographic characteristics, to Indian women. The scientists also felt that the need for a choice of effective contraceptives is imperative if Indian women are to control their fertility and reduce the burden on their health of too many pregnancies.

The group was not able to elaborate a common plan of action, but agreed that there was a need to find ways of pursuing dialogue at national and local levels.

Indonesia

One of the priorities proposed for action was a multi-sectoral meeting to continue the dialogue started by the participants at the Manila meeting. The expressed desire was to promote a new vision of reproductive health in Indonesia.

Another proposal from the group was to assess the data already available from qualitative research within the country. Where few data are available - especially in the area of male attitudes towards reproductive health and adolescent reproductive health - it was proposed that studies should be undertaken. It was also proposed that means to improve quality of care be demonstrated through an operational research project.

Several other proposals included the promotion of sex education and male involvement in reproductive health and the establishment of a women's health advocacy network in Indonesia.

As of August 1993, the participants have been meeting regularly with the full encouragement of Dr Haryono, and have been asked to give major input on "client perspectives" at both national and international forums. They are currently elaborating a strategy to pursue many of the proposals made at the Manila meeting.

Philippines

The group identified areas in which discussion between women's health advocates and policy-makers is needed, but realized that the close association of the Church and the State will be an obstacle, particularly with issues such as abortion and sex education for adolescents and the unmarried. Nevertheless, group collaboration was both strong and positive, and generated proposals in a number of policy and research areas. One major proposal was to hold seminars for policy-makers, programme managers and service providers to update participants on women's perspectives on reproductive health. They also proposed that guidelines for service delivery and training be modified along with mass media messages.

The group suggested that collaborative research be undertaken on the reintroduction of barrier methods, the introduction of new methods, the current abortion situation and services for all women of reproductive age. Women's health advocates also volunteered to compile information available from their own research in an effort to influence both policy and services.

RECOMMENDATIONS

The following recommendations are addressed to family planning programmes and international organizations wishing to strengthen reproductive health perspectives in the countries of Asia and elsewhere by **creating common ground** between women's health advocates and policymakers, researchers and service providers.

Consensus was reached on the principle that "women have the right to control (or manage) their own sexuality and fertility" (see discussion on page 19). There was also agreement on the objectives for achieving reproductive health outlined by the International Women's Health Coalition (see page 20). Participants worked in national groups to develop their own recommendations for achieving reproductive health. The essence of the recommendations from each of the four national groups has been preserved in the following abridged statement.

Policy

- Extend the scope of maternal and child health and family planning services beyond prenatal, delivery, postnatal and family planning care to cover all aspects of women's reproductive health, including infertility, reproductive tract infections and menopause.
- Provide education on reproductive health to everyone from an early age.
- Encourage men to take more responsibility for reproductive health, including the adoption of contraceptive and 'safe sex' practices.
- Involve women, particularly women's groups and organizations, in determining the reproductive health needs and priorities in their countries.
- Ensure that the selection and provision of fertility regulation technologies is placed within the overall context of national health and social services.

Research

- Introduce or reintroduce barrier methods, including male and female condoms, diaphragms, vaginal sponges and spermicides, into national programmes.
- Support research on users' perspectives of safety and acceptability in reproductive technology and on health services. The definition of acceptability should be expanded to incorporate issues such as affordability, accessibility and interaction with lifestyle.
- Ensure user involvement in the development of fertility regulation technologies.

Services

- Set standards for the achievement of quality care, including accountability for meeting those standards.

- Ensure that services respond to the changing needs and conditions of women's lives.
- Pay special attention to the needs of adolescent and unmarried people.
- Make fertility regulation methods available and accessible to men as well as women.
- Assess service facilities before introducing a method.

WHO

During the course of the meeting, two specific recommendations were made to the Programme.

- Coordinate with other agencies on the possibility of conducting multicentre trials of barrier methods.
- Help all four national groups in any follow-up activities they might carry out as a result of the commitment they made during the meeting to continuing dialogue and to creating common ground in Asia.

Participants also endorsed the Recommendations for Action from the meeting between women's health advocates and scientists held in Geneva, 20-22 February 1991. **(See page 44)**

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LIST OF PAPERS PRESENTED

Dr Jahiruddin Ahmed
Bangladesh: A Country in Demographic Transition and Women's Perspectives

Dr Sadia Chowdhury
A Community Based Rural Development Approach for Affecting Family Planning and Birth Spacing: The Brac Experience

Dr Sylvia Estrada-Claudio
Country Report for the Philippines - Women's Rights: Perspectives of Fertility Regulating Technologies

Ms Nasreen Huq
The Realities of Women's Lives in Bangladesh and Fertility Regulation Technologies

Dr Firman Lubis
The Experience of Norplant Use in Indonesia

Dr Sundari Ravindran
Users' Perspectives on the Appropriateness of Particular Methods of Fertility Regulation for Particular Settings in Asia

Dr Badri Saxena
Experience of Introducing two Long-Acting Contraceptive Methods (Norethisterone Oenanthate and Norplant-II) in India (A Summary Report)

Dr Haryono Suyono
Policy-Maker Perspective on the Selection and Introduction of Fertility Regulation Technologies into Family Planning Programmes in some Asian Contexts, and on the Participation of Women in those Efforts

Ms Ninuk Widyantoro and Dr Mohamed Kartono
Innovating Approaches to the Provision of Birth Control Technologies in Indonesia: Putting the Clients at the Centre

Recommendations from the February 1991* meeting between women's health advocates and scientists

Participation by women

- Ensure that women's health advocates are incorporated into policy and programmatic activities.
- Promote national and regional exchanges between scientists and women's groups, in order to help the scientific community, international agencies and national governments to incorporate women's perspectives into their health and family planning priorities.
- Convene special meetings for scientists and women's health advocates, along the lines of this meeting, to discuss key topics, including:
  - the development of new methods;
  - the development of contraceptive vaccines;
  - the use and further development of barrier methods;
  - induced abortion.
- Involve women, and include women's perspectives, in the identification of research needs and priorities and in the implementation of research on reproductive health at country and regional levels.

Research

- Revise technical, methodological, and ethical guidelines for research, in line with women's perspectives and experiences; promote widespread awareness of these guidelines; and foster their implementation at the country level.
- Promote the institutionalization of ethics committees at country level, with the participation of women's health advocates.
- Establish minimum standards for the quality of care in clinical and introductory trials, and mechanisms for promoting and monitoring quality of care.
- Discuss and revise, incorporating women's perspectives, the definitions of and relative weight to be assigned to safety, efficacy, affordability and acceptability in selecting and introducing fertility regulation methods.
- Encourage the formation of multidisciplinary research teams which include women's health advocates, and the use of participatory research methods at national, regional, and international levels.

Support research on:

- women's and men's views on and experiences with existing methods, and the attributes they most like or dislike;
- the comparative effects on women's health of fertility regulation methods, with attention to both pregnancy prevention and pregnancy termination;
- the safety and appropriateness of RU486 compared to surgical or vacuum aspiration abortion;
- the balance among safety, efficacy, affordability and acceptability for particular methods, in relation to other methods, in particular settings.

Training

- Promote training in reproductive health issues including family planning, in medical, midwifery and nursing schools and other key institutions. Such training should pay attention to women's perspectives and to the "human" as well as technical dimensions of fertility regulation and reproductive health.
- Increase the number of women scientists; incorporate women's perspectives into scientific curricula and programmes; and train women's health advocates to participate in research on fertility regulation.

Introduction of fertility regulation methods

- Encourage the introduction of safer, more user-controlled methods.
- Involve women's health advocates in all phases of introductory trials including design, provider training, management, implementation, monitoring and evaluation.
- Review approaches to method introduction to encourage use of integrated health services, other aspects of quality of care, and more participatory approaches.
- Develop criteria and methods to evaluate the settings into which particular fertility regulation methods might be introduced, including the characteristics of health care infrastructure, the recurring costs of providing the method on a national scale, the quality and quantity of existing family planning services, and the status and roles of women.
- Encourage governments to do everything possible to prevent and eliminate unsafe abortion.

Information dissemination

- Disseminate results of research as widely as possible, in particular to women's health advocates and women's groups worldwide, in appropriate languages.
- Support existing women's health advocacy networks and publications, and promote dissemination of their information widely among the scientific community.

* World Health Organization and The International Women's Health Coalition. Creating Common Ground: Women's Perspectives on the Selection and Introduction of Fertility Regulation Technologies. Report of a meeting between women's health advocates and scientists, Geneva, 20-22 February 1991. Document No. WHO/HRP/ITT/91, Geneva, 1991.