WOMEN IN ASIA NEWSLETTER

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POPULATION AND FERTILITY CONTROL IN ASIA

INSIDE THIS ISSUE

EDITORIAL TEAM NOTES

This second Queensland issue focuses on the thorny debates on Population Planning and Reproductive Rights. The range of Australian research on this topic is reflected in the contributions published in this issue—Andrea Whittaker writes on abortion in Thailand, Cynthia Hunter discusses *posyandu* in Indonesia, Nicole Woelz debates China's One Child Policy and Sheree Smith discusses the importance of gender sensitivity in policy planning. Complementing this Australian research are the press releases from "The International Public Hearings on Crimes Against Women Related to Population Policies" convened in conjunction with the UN's Cairo Conference on Population and Development (ICPD). Taken together, the Australian and the international perspectives highlight the degree to which population planning remains highly controversial. Moreover, it is clear from these discussions that there is a desperate need for policy that addresses the real concerns of real women and is not simply driven by statistics on fertility rates.

A word of thanks is due to all those people who have supported the newsletter with their news, articles and email messages. We do however, need financial support through subscriptions as well! Please renew your subscription NOW while you think of it. The back page of the newsletter has details on how to subscribe/update.

Louise Edwards (ACU-Qld)
Anne Cullen (Griffith)

NEXT ISSUE

The theme for the next issue of the *Women in Asia Newsletter* will be Women and Migration.

Please feel free to contribute a short piece to the newsletter on this or any theme—either work in progress, miscellaneous jottings, cartoons, notes etc.—along with the usual news.

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WOMEN'S CAUCUS EMAIL NETWORK

To make it easier for women's caucus members to contact each other we are compiling a list of email numbers to be included in forthcoming issues of the Newsletter. If you have email facilities and want to be on the list please send a message to Dr Mina Roces at Central Queensland University or Louise Edwards at ACU.

Send a message *now* while you remember!

m.roces@janus.ucq.edu.au
or
L.Edwards@mcauley.acu.edu.au

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GUEST COLUMNIST

"State Control and Personal Control: Abortion, Thailand and the ICPD"

ANDREA WHITTAKER

> I wanted to have the abortion because my husband wasn't here and I didn't think that I could look after the baby. When I was four months pregnant I had an injection from the *mor phu'n baan* (untrained local doctor). I was very sick and thin and couldn't eat any food. After it was out it was very painful from 3pm to 8pm...I did the abortion at home because at the hospital they ask lots of questions and you have to have enough reasons not to keep your baby. If you're in the city [having the baby] will cause lots of problems for you and the doctor might do it [an abortion] for you, but for villagers they try to force you to keep the baby even though you don't have lots of money. The pain was worse than when you give birth, not the same at all...(Aunt Uay)

The question of abortion in Thailand highlights many of the issues fundamental to state attempts to control population and fertility. Abortion is illegal in Thailand unless performed by a medical practitioner for the sake of a woman's health or if the pregnancy is the result of rape, incest or unlawful sexual contact (Population Council 1981: 101-102). The state prohibition of abortion is derived from Buddhist beliefs, as it is considered a sin to kill a sentient being. For women with appropriate knowledge and resources however, abortions are readily available from sympathetic registered physicians. However, the majority of poor village women with only basic education are unaware of the actual availability of abortion options and many women attempt to induce abortions or consult untrained abortionists.

Field and hospital-based studies suggest that despite the illegalities, induced abortions in Thailand are common, with over 200,000 to 300,000 performed each year by a variety of methods, including massage, the insertion of abortifacients, uterine injections and consumption of traditional emmenagogues (Population Council 1981). A high number of these procedures result in complications including injury, infection, infertility and maternal death (Thailand, Ministry of Public Health 1990). As Germain (1989:1) writes, the question of access to safe abortions services is important to women's health status throughout the world:

> an estimated 200,000 or more Third World women die needlessly every year due to botched abortions. Additional uncounted thousands suffer sever morbidity, including infertility and chronic health problems due to unsafe clandestine abortions...

The difficulty in obtaining an abortion through government hospitals was described by Aunty Uay above, whose story highlights the linkages between class and wealth and access to safe abortion. In Thailand as in many countries, money makes the difference between painful and dangerous abortions by untrained practitioners, and safe, quick and less painful abortions in a clinic.

The number of women seeking abortions indicate that the state morality, as codified in Thai law, is inconsistent with the realities women face in controlling their fertility. As long as governments in Thailand and elsewhere fail to publicly acknowledge the need for safe therapeutic pregnancy terminations on demand, women will continue to utilise unsafe abortifacients and untrained abortionists.

Thailand has an extensive and successful family planning program which has insitutionalised the motto "two children are enough" in the minds of its citizens and has been responsible for a large reduction in the average birth rate in the last two deades. A range of contraceptive technologies are widely available through village health centres and social marketing. Family planning programs have enabled women to control their fertility and release them from the pattern of high parity and high maternal mortality which their mothers experienced. In this respect the objectives of the state programs coincide with

the desires of women to control their fertility. Yet at the same time, despite the state rhetoric of women's empowerment and development through family planning, access to legal abortion is denied. In inducing abortions, women are actively resisting state regulation and asserting control over their reproductive bodies, but in that same act they also risk their lives.

The issue of abortion dominated the International Conference on Population and Development (ICPD) in Cairo last September, The Programme for Action signed by 180 countries set as a standard women's decision-making about reproductive health issues, policies and programs. Despite debates on conflicting religious and cultural ethics, the following paragraph 8.25 was finally accepted in the draft Programme for Action:

> In no case should abortion be promoted as a method of family planning. All government and relevant inter-governmental and non-governmental organisations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and all attempts should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances in which abortion is not against the law such abortions should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly which will also help to avoid repeat abortions (ICPD Programme of Action cited in World Bank 1994).

This statement reiterates the need for family planning programs to be implemented within quality reproductive health services. It places these issues squarely in the public realm of the state. Whilst falling short of advocating a women's right to choose it recognises unsafe abortion as a major public health priority that needs to be addressed by all governments within their own cultural context. The challenge remains to see whether the rhetoric of quality services and women's participation and empowerment in the policy dialogue are made into realities. Meanwhile despite the ICPD conference and despite the Thai state, women such as Aunty Uay will continue to make personal decisions about reproduction.

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RESEARCH COMMENTARY

Posyandu: Disjunctions Between Policy and Practice in Lombok

Cynthia L. Hunter

In an effort to reduce infant mortality and improve women's reproductive health, the Indonesian government, embracing the rhetoric of the WHO's notion of Primary Health Care, has focussed on improving Maternal Child Health (MCH), by extending health services to urban and rural communities through the organisation of volunteer-staffed Integrated Health Posts (*posyandu*). *Posyandu* sessions are organised monthly in each village ward where pregnant women and mothers and their children under five years come for all aspects of child and maternal health. In 1990 there were 220,000 village *posyandu* in Indonesia.

The implementation of *posyandu* requires an intersectoral approach between the Departments of Home Affairs and Health at the subdistrict level. The success and operation of *posyandu* relies on the participation of voluntary health workers (*kader*) from each village ward, who recruit mothers to benefit from the technical expertise of the subdistrict health centre (*puskesmas*) personnel. The recruitment of *kader*, the provision of suitable venues and the preparatory tasks for each monthly session is the responsibility of the local Village Community Development Committee (LKMD), the Family Welfare Organisation (PKK), the village head and the heads of each administrative ward. Ideally, *kader* recruits are married women and members of PKK, with the time and motivation to improve community health.

The programming and timetabling of sessions are coordinated by the *puskemas* staff and the subdistrict local government head (*camat*). Health personnel coordinate their services with *posyandu* sessions, and are responsible for the training of *kader*. A Department of Health booklet contains a sequential list of activities and roles for mothers, *kader*, nurses and midwives. Popularly known as the "5 tables system", women move from one table to another staffed by *kader* performing a particular task, having their infants and children registered, weighed being recorded on child health *Kartu Mengenah Sehat* (KMS) cards, receiving information about immunisation, nutrition and hygiene, and finally having their child immunised. Pregnant mothers, nursing mothers and prospective marriage candidates can obtain services ranging from physical examinations, family planning information to tetanus toxoid immunisations.

In practice, the *posyandu* process is something quite different. My information from one health centre with jurisdiction and responsibility for eight villages in East Lombok indicates the most frequent problem is the spasmodic and unreliable operation of *posyandu* sessions. During a three month period of observation in which 150 *posyandu* sessions were scheduled, 42 or about one third did not eventuate. A number of problems were identified: the shortage of trained and suitable *kader* often leads to the breakdown of *posyandu* sessions; the difficulty of finding suitable recruits forces village officials to coerce women into taking on the *kader* role. In contrast to the ideal envisaged by State planners, most *kader* are young and unmarried, lack motivation, respect and trust from the community and leave once married.

Furthermore, preparatory tasks by the village officials are often neglected in favour of other projects and/or customary social and ritual activities involving the community which are given higher priority. The health centre personnel explain their difficulties in terms of poor coordination of the *posyandu* timetable, a shortage of medical supplies, transportation and difficult road access. They complain that specific projects generate more work pressure at the health centre and holidays at the end of Ramadan interfere with the smooth running of the programme.

The recipients of health care, the rural women, say they enjoy the social aspects *posyandu* and the opportunities to monitor and compare their baby's weight gain. But the business of everyday living, organising the household and working the rice fields does not leave time to stand around after a weighing session waiting for the health centre personnel to arrive for the immunisations. In some villages women come to the weighing sessions

only, not waiting for immunisations because of the fear of injections causing fevers in children. Women say they would like to be better informed and more involved but they are not encouraged to ask questions of health personnel, nor motivated to learn how to read their health (KMS) cards, which are often kept by the head *kader*. *Kader* have no or insufficient training for their tasks which prevents them from being able to relate information to mothers about the relationship between health, childhood diseases and immunisation.

Moreover, health centre personnel practices such as immunisation recording, sterilisation of equipment, diagnostic methods, and resource management are incomplete and sometimes but not always incompetent. They are focussed on the execution of the task rather than quality control, or the provision of health education. In theory, the health care system requires supervision of *kader* by nurses, whose practices in turn should be supervised by district health personnel or the doctor, but this rarely occurs. The result is that the "5 tables system" does not exist in practice and there is a lack lustre motivation for individual task and a poor perception of the real purpose of *posyandu*.

Within the social dynamics at a *posyandu* session status differences are apparent. Health centre personnel are educated, have permanent jobs and salaries, wear a uniform and interact with the villagers in what appears to a Westerner to be an authoritarian and didactic manner. *Kader* are poorer, less educated and have no uniforms or salaries. Health centre personnel consider rural villagers "*masih bodoh*" (still dumb/ignorant), the women recipients consider them "*sombong*" (arrogant). Thus, there are different perceptions of *posyandu* by health centre personnel and the community. Villagers consider *posyandu* to be the responsibility of the subdistrict health centre. Health centre staff perceive *kader* as working for the health centre rather than for the community.

There are different motivations for involvement in *posyandu* within these groups. Village women are intent on raising healthy children as part of parental love and as an emotional and economic investment for the future. In contrast , village officials and health personnel are bureaucrats of the State and in accordance with the State ideology of *pembangunan* (development) they relate to villagers as officials who need to get a task done, whether by coercion or cooperation. But there are times when village officials and health personnel will join ranks against the community for the purposes of maintaining or elevating their own status within the government bureaucracy. Health personnel are pressured by the State system to raise the level of health statistics and curative care through a task oriented approach.

These observations from East Lombok suggest that there are a number of differing discourses engaged at *posyandu*. Moreover, few changes or improvements occur at this level because directives are only implemented from the top down. Community participation therefore, is more rhetoric than reality. The central government's principle of intersectoral cooperation and policy of "Health for All" to be implemented by the local administrative apparatus doesn't take account of the customary principles of social organisation among the rural population throughout the archipelago.

[Cynthia Hunter is a Research Scholar in the Department of Sociology and Anthropology at the University if Newcastle, NSW]

RESEARCH COMMENTARY

Social Policy and Program Planning: Health
A Brief Review of Gender Sensitive Approaches to Health

Sheree Smith

With the national and international press highlighting issues of concern with Care Australia, it is timely to review gender sensitive approaches to health care in developing countries and conceptual shifts in primary health care and aid to these nations. The situation of women in relation to the health care system in developing countries appears dependent upon variables sch as women's status in the specific culture and society to which they belong, their socio-economic situation, the control of decision making, and their position in the labour force (Puentes-Markides, 1992). For most developing countries the way in which these variables interact with others relates particularly to the structure of the health services and the behaviours of the providers, and is also influenced by economic policies. Ideally, a social model of health incorporates the belief that health and economic policies are interdependent with social policy and planning, although policy that promotes health requires recognition that political and economic barriers may exist (Hurowitz, 1993). Health opportunities and health hazards are not the same for women and men. Health care permeates all aspects of daily life and includes social elements such as housing, sanitation, work environments, employment, education and interpersonal relationships (Hurowitz, 1993).

Ostergaard in *Gender and Development: A Practical Guide* (1992) explores the concepts of disease, development, gender and health. The concept of health as defined by WHO 1978, is concerned with the absence of disease, with social and physical wellbeing. The concept of development is couched in terms of health and development being closely linked.

> Health is an integral part of development because people are both the means and the ends of development. The human energy generated by improved health should be channelled into sustainable economic and social development and inturn be harnessed to improve the health of people. Measuring development can be viewed in terms of access to basic services such as health care, food security, safe water and primary education. (Ostergaard, 1992, p. 111)

The concept of gender with health and development recognises that health opportunites and health hazards are not the same fore men and women, although what is commonly accepted as the typical attributes of men and women differ amongst cultures, societies, classes and throughout time. This raises the issues of resources which many groups may lack access to which in turn affect health. These issues include poverty, food security, water and sanitation, workload, and industrial injuries and education. There are also differential practices and health such as son preference and daughter neglect. (Ostergaad, 1992, pp.111-13)

MacCormack (1986) argues the relationship between women's social status and the survivial chances of their children can be explored in the paradigm of health and the social power of women. When women have low status, relatively little social investment is made in them, and this is reflected in the different mortality rates of girls compared to boys. It has been suggested the cultural propensity to invest in girls (nutrition, education etc.) and their resultatnt survivial chances are explaimed by ecology which in the past has been largely determined by agricultural economies that either had a high demand for labour or did not. In the high demand for labour agricultural economies, the women were more likely to control the wealth they produced threfore policy implications for planning and implementing primary health care may be different in this society (MacCormack, 1986, pp. 677-78).

Colonization and its associated social and political systems has also had an effect on health. The political economy of health care services in Colonial Namibia closely reflect the extreme racial and class imbalance of power. The colonial power allocated to the indigenous people, who are 90% of the population and the

poorest, an average of only 43% of the health care budget. External forces such as the League of Nations mandate proved toothless in pressuring the mandatory power to rectify this and other inequalities (Gottschalk, 1988, p. 577).

In the arena of technology, health and development, social scientists have asked how technology transfers from industrial to developing countries has affected women's lives, sexual divisions of labour and gender relationships at work and at home (Bourque & Warren, 1990, p.93). Social scientists have also questioned whether technology has improved the lives of women, lessened their workload and increased their employment opportunities. The article by Bourque and Warren (1990, p. 83-100) explores these questions and raises the issue of four alternative perspectives on technology—the feminisation of technology, appropriate technology, global economy perspective and cultural political integration.

Whereas Bourque and Warren's work concentrated on technology and education, MacCormack's article "Technology and Women's Health in Developing Countries (1989, p. 681) explores the relationships between health, technology and gender. MacCormack reviewd the documented process of medical professionalisation in which women as healers lost social status and income to men as modern technologies developed. Forceps, for example, have become male technology and most medical instruments are named after men such as Kocker's clamps, Lanaghan's artery forceps and Edward's chest spreader. It is suggested there is some evidence that substantial numbers of third world women perceive the development process as leaving them relatively impoverished in terms of wealth, social and health status (Huston 1979, Keyfitz, 1985).

The technological component of primary health care (nutrition, water and santitation) are traditionally women's activities although most of the literature on primary health care defines women as childbearers, mothers, consumers of health serivces. Their contribution to production of goods and services is largely unacknowledged in official statistics. The literature supports the belief of a relationshp between household income and children's nutritional status and between women's control of wealth and child health (MacCormack, 1989). It is also recognised that women appear to be the only financial support of as many as one third of families in the world. Technologies for child survival have been available for many years but are reported to be underutilised by women who are poor and have little free time (MacCormack, 1989, p. 681-92).

Primary healthcare concepts encompassed in the WHO/UNICEF international programme list eight essential elements—education concerning the prevailing health problems and methods of preventing and controlling them, promotion of food supply and proper nutrition, adequate supply of safe water and basic sanitation, maternal and child health, including family planning, immunisation against major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and the provision of essential drugs (Ostergaard, 1992, p. 130). Primary health care is now being encumbered with a 'cost revival' ethos. Increasingly, donor agencies are requiring some cost recovery in primary health care programs (MacCormack, 1989). Essential drugs cannot be bartered or paid in kind at a healthcare centre, but require purchase with cash. Women historically spend a larger proportion of household income on medicine and immunisation than do men. In most societies women control less cash than men. Donor agencies are increasingly tying health sector aid to fees for health services. It is suggested there is a need to document the extent to which this policy may exacerbate women's access to health technologies, especially if women's earning capacity is not enhanced by placing them in the mainstream of development programs with access to skills training, land and credit (MacCormack, 1989, p. 683).

A second related conceptual shift in primary health care is toward 'selective' primary care. Effective and economic technologies to reduce disease are identified and transferred to poor countries as quickly as possible. The emphasis is on medical interventions at low cost without 'wasting time' in social research on who controls the inputs, or who experiences health improvements. These 'supply-oriented' programs define research narrowly in terms of epidemeology of specific interventions and research on management systems. This technology-driven approach, it is suggested, is in contrast with the original primary healthcare declaration from WHO/UNICEF which acknowledges the broader definition of social development (MacCormack, 1989, p. 683).

An urgent call for collection of statistics on trained health workers by grade and sex continually goes unheard. Stinson (1986) argues that in most countries women are being trained for only the lower grades of community health work, while men for longer

periods learn curative skills as well as preventative skills, have control of drugs and receive salaries. Even when women have been traditional providers of healthcare there is a bias toward training men (Stinson, 1986). A review of 52 agencies for international development who sponsored primary health care projects found that men had difficulty in working for women in all countries reviewed except Thailand (Parlato & Favin, p. 50).

It is suggested rural development programs often marginalise women by being directed only at men while eliminating traditional specialised roles for women or over working women in production situations where machines only compensate for the male labour process (Boserup, 1970). In agriculture, women are exposed to dangerous pesticides and in non-agricultural work women are exposed to stress, toxins, radiation and other hazards. Women in developing countries are more vulnerable than men to these technological health risks because health and safety regulations are usually only enforced in large formal sector businesses and women tend to work in small informal sector businesses or ar home (Stinson, 1986).

Various approaches to defining variables affecting access to health care appear in the literature reviewed. While some of them indicate that ability to pay for services acts as a major health determinant of access to health care, others point to behavioural issues related to motivation, health seeking behaviour or perceptions of illnesses deterrant to women of low socio-economic strata, while others indicate that sociocultural issues, such as values, education, religion or demographic variables related to age, influence access to health care (Puentes-Markides, 1992, p. 619).

In conclusion, policies and strategies for securing access to health and healthcare, need to move away from traditional solutions including framing gender-based health differences in status and access adequately, promoting and strengthening social participation of women in policy making. Health policy should emanate from the target countries and communities themselves and participatory planning is one method that attempts to ensure all segments of society participate (Puentes-Markides, 1992, p. 626). It is based on decentralised administrative systems and allows for the local control and assignment of resources to specific health activities. Finally it is suggested that gender sensitive health information should be available for policy makers in developing countries to facilitate appropriate health policy with a vision of primary health care for all.

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Nicole Woelz

Xiao kang shenghou! roughly translated as "The Good Life For All" is a phrase borrowed from an ancient Chinese poet to express the goal of China's population policy. This goal has been implemented by planners and embodied in a target to substantially decrease population growth through the creation of the "One Child Policy" implemented in 1979. This policy has been seen as imperative by many throughout the world because China, the country with the world's largest population (22%), contains only 7% arable land. This means that each person has 0.086 hectares compared to the world average of 0.3 hectares (Wei 1993:17). Many view China's "One Child Policy" as highly successful and hold it up as a model for developing countries but these same people do not look further to examine the methods by which these remarkable statistical results were achieved.

The successes of the policy are in fact outweighed by the failures and weaknesses of the program. It is a myth that China's "One Child Policy" is successful because it is broadly supported by the masses. There is an exceptionally high level of coercion used by the central government and local cadres to achieve the policy's aims. The accumulated affects of abortion and sterilisation, the high rates of female infanticide and the detrimental effects on the structure of families have caused many Chinese, especially in the rural provinces, to resist the policy both covertly and overtly. Aird states "China's birth control program has earned a worldwide reputation as the most draconian since King Herod's slaughter of the innocents" (Aird 1990:1). China's birth control program continues to remain highly coercive through policies of indoctrination, incentives and other such pressures forced onto Chinese families. These policies are embedded in an unique system of government control. Qing reported in the *Chinese Daily* April 20 1989 (p.4), that human rights in the "One Child Policy" are a luxury that China could not afford (Qing in Aird 1990:3).

It has been extensively documented that the practice of forced abortions has occurred on a large scale in China. Among the policy initiatives issued by central authorities regarding the "One Child Policy" are the mass "mobilisations" for sterilisation and abortion, from which many women try to escape and go into hiding. Another is the policy of "study classes" where pregnant women are pressured and threatened by cadres and not allowed to return to their homes until they have agreed to an abortion. A third tactic of coercion is "heart-to-heart talks" with cadres who repeatedly visit the homes of "disobedient" women until they agree to have an abortion, sterilisation or an IUD insertion (Mosher 1989:33-35).

The unpopularity of the "One Child Policy" can be further seen by the dramatic increase in the practice of female infanticide. Female infanticide has been practiced throughout China's history, but never on such a large scale. Hull reports that in 1986 there were roughly 491 000 missing female babies—as revealed in the 1986 recorded sex ratio of 110.94 male births per 100 female births (the regular level being 106). Hull states that, assuming there has been no major change in the biological sex ratio—and there is no evidence to suggest such a change has occurred—the most probable cause is that a high proportion of female babies have been born and then killed. This is confirmed by the constant current reports of female infanticide in many regions of China and reflected in the light of traditional practices (Hull 1991:2-5).

There have also been immense microsocial consequences affecting the family structure as a result of the "One Child Policy". Virtually every policy goal in the program has severely changed the structure of the Chinese family, from restricting the number and sex of children, delaying the formation of a family and lengthening birth intervals. These policy outcomes all differ sharply from traditional family values and with the Chinese philosophy that large numbers of children ensure the family's prosperity. Greenhalgh predicts that there will be a "personality configuration" in the next generation as a result of children being spoilt, selfish and non caring. For many, as a result of the "One Child Policy", sibling relationships have disappeared (Greenalgh 1990: 193). As mentioned previously, the sex ratio has also been severely distorted, with male births, far outweighing female births. These factors will have serious repercussions for future generations.

Furthermore it can be seen that instead of the "One Child Policy's" obtaining a high

degree of support from the party, a high proportion of rural and some urban cadres do not enforce the policy and many openly violate it. There is a low level of support from the local cadres in the rural provinces of China because of the economic improvements in the rural sector. Through the economic upsurge in the late 1980s to the present, a large proportion of rural cadres became part-time peasants with little desire to enforce the "One Child Policy" among fellow villagers (Greenhalgh 1990: 204).

Clearly the Chinese government is still facing a difficult problem in the fight to decrease fertility rates. However it can be seen from this study that a family planning program based on coercion yields detrimental and irreversible effects not only on family structure, but causes the violation of human rights of women in China, without achieving sustainable long-term fertility decline. It seems that in order to produce a sustained fertility decline that does not do extensive damage to the social and political fabric of the nation, fertility must be lowered through informed choices and greater levels of education, especially for rural Chinese women.

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SIR EDWARD "WEARY" DUNLOP ASIA FELLOWSHIPS

Administered by the University of Melbourne's Dunlop Asia Awards Trust, fellowships of $15 000-$25 000 for Australians between the ages of 18-40 to carry out work or study programs in Asia for up to twelve months.
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For more information
Ms Helen Durham
The Asialink Centre 107 Barry Street, Carlton Vic 3053
Tel (03) 349 1899 Fax (03) 347 1768
Closing date 28 April 1995

GENDER, CULTURE AND SOCIETY: AN INTERNATIONAL JOURNAL

This journal wishes to raise to the foreground the issue of boundaries of modernity which has been unwittingly identified with progress within a Western tradition.
Contributions max. of 4000 words.
Deadline **31 March 1995**.
Inquiries to
Dr Renuka Sharma
tel (03) 889 2161 : fax (03) 629 1001
e-mail rsharma@ariel.its.unimelb.edu.au

NEWS FROM THE STATES

NEW SOUTH WALES

- Dr Kathryn Robinson of Newcastle Uni has been appointed as senior research fellow at ANU's Research School of Pacfic and Asian Studies.

ACT

- Dr Rosemary Haddon Research fellow with the Contemporary China Centre has just taken up a position in Massey University, Palmerston North, New Zealand.
- ANU's Research School of Pacific and Asian Studies has appointed Tessa Morris-Suzuki to a personal professorship and Dr Margaret Jolly as senior research fellow.

WESTERN AUSTRALIA

- Beverly Hooper (Director, Centre for Asian Studies, UWA) has been appointed to the Board of the Australia-China Council. She recently received an ARC large grant of $94,400 for her project on Women, Consumerism and the State in Contemporary China. She has also just been elected as the new president of the ASAA replacing outgoing President Colin Mackerras.
- The Centre for Asian Studies at UWA continues to grow and this year will introduce its third year Asian Studies Program with the help of CAUT, the National Priority Reserve Fund) and UMAP. Director, Beverely Hooper hopes to advertise two positions in the middle of the year. One in Indonesian Studies (including some language teaching) and the other in Asian Studies (possibly some expertise in Chinese but expected to be able to teach general Asian Studies courses as well).
- Tamara Jacka of Murdoch University is organizing a course on Approaches to Women and Development Studies as part of the Masters in Development Studies. It will be taught externally begining next year. Anyone interested can obtain a course outline from Tamara at Humanities, Murdoch University.

CAIRO CONFERENCE ALTERNATIVES

The following few pages include excerpts from the NGO forum "Crimes Against Women Related to Population Policies" held in conjunction with the UN sponsored International Conference on Population and Development. This forum was co-ordinated by Nelia Sancho, Asian Women's Human Rights Council (AWHRC), and Farida Akhter UBINIG (Policy Research for Development Alternative). Sponsoring Organisations: People's Health Network (India), Arab Women's Organisation, Women in Development (Europe) and Terra Femina.
The hearing included personal testimonies from women of each region in the globe, papers by activists and prominent academics—examples of each are included below.

The press release concluded
"In spite of very different personal circumstances and that the testifying women came from countries with very different policies towards Population Control (both pro and anti-natalist) the message they were getting was very similar.

1. Population policies worldwide discriminate against the poor, the disabled, Indigenous peoples, those from the South as well as those marginalised in the North. Population Control policies remain racist and eugenicist.
2. Bribery, inducements, misinformation on adverse effects of drugs as well as outright violence through forced sterilisation used of long-term drugs and other means are crimes against women
3. Women must have control over their own decision-making about how many children they will have and the means they will use to control their own fertility. Outside forced control over this decision making constitutes a crime against women.

In this context the Public Hearing reminded everyone that crimes committed against women by the population agencies, donors, states, medical/pharmaceutical interests for decades wihout even recognising the horrendous experiences women went through in their lives. It is time that the crimes that have been committed are recognised, the criminals are identified and that justice be delivered. Otherwise the ICPD 94 is going to contribute to the perpetuation of these unforgiveable crimes against women.

OPENING STATEMENT AT THE INTERNATIONAL PUBLIC HEARING ON CRIMES AGAINST WOMEN RELATED TO POPULATION POLICIES (SEPTEMBER 7 1994, CAIRO, EGYPT)

FARIDA AKHTER (UBINIG)

The International Public Hearing on Crimes Against Women related to Population Policies is an event that challenges the basic premises of the population policies. A major claim of the International Conference on Population and Development (ICPD), 1994 is population policies are beneficial to women. Therefore, Women should be central in planning and execution of the global depopulation strategy despite its racist, eugenicist, anti-poor and women content. In this context The Public Hearing is to remind everyone the crimes committed against women by the population agencies, donors, states, medical pharmaceutical interests for decades without even recognizing the horrendous experiences women went through in their lives to make population programmes "successful". It is time that crimes that have been committed must be recognised, the criminals are identified and the justice delivered. Otherwise the ICPD 94 is going to contribute to the perpetuation of the unforgivable crimes against women.

The public hearing is indeed very crucial where women who are victims of the population policies implemented in their own countries in a particular context are going to share their experiences and crimes committed against them. These reflect the different ways, population policies affect women, be it in a poor developing country or in a developed country. It is very clear that population policies are not directed against particular countries, it is against particular people, those who are poor, black and indigenous. So each country can have their own population policy based on the kind of people they have. Therefore, the solidarity of the victims transcend national and geographic boundaries. It is not merely a North-South issue. The Public Hearing is therefore a cry for justice of the people of the world against the elites who turn people into "population" to dehumanize

TESTIMONY OF UBINIG (POLICY RESEARCH FOR DEVELOPMENT ALTERNATIVE—BANGLADESH)

AN ORGANISATION FIGHTING AGAINST POPULATION CONTROL POLICIES AND PRACTICES

UBINIG (Policy Research for Development Alternative) is a research and campaign organsiation. As a group we organised ourselves in 1984 around a fundamental question—"Why are we poor? Is it because we have too many people?" We noticed that the dominant developmental paradigm blames people who are themselves victims of a global order that perpetuates poverty and underdevelopment. World elites, who are controlling the world resources, are engaged in a desperate campaign to terminate the poor and the people of colour. it is not only a quesion of power and equality, it is a question of justice as well.

We started to challenge the ideology of population control as being racist, anti-poor and anti-women. On the other hand we also started monitoring the population programme which is primarily based on contraceptive distribution and dumping of unsafe and harmful methods on our women.

Sterilization:
The main method of contraception used in Bangladesh are sterilisation as a permanent method; IUD, injectables, pills etc as temporary methods. In the early 1980s sterilisation was made the number one method. Cash monetary incentives were declared for clients and for people to bring clients. Poor people responded to those incentives. Lots of abuses were reported in the newspapers and through other sources. We went to the villages to talk to people. We found different forms of coercion experienced by women. Women were suffering from various side-effects such as lower abdominal pain, menstrual disorders and other health problems. We talked to the family planning workers and doctors. They advised us not to believe the "illiterate and ignorant women", because they make up "stories". We could not help these women directly, but documented all the cases to report at the policy level. Some of these reports created some sensation among liberal donors who put pressure on the government of Bangladesh.

Depo-provera:
Depo-provera, an injectable contraceptive produced by a US company Upjohn was being promoted on a national scale, despite the fact that it was not an approved drug in the USA. It was one of the cases of dumping, which the US was carrying out. It was in the early 1980s when we protested against the use of Depo-provera in the national family planning programme of Bangladesh. We raised the question that when the National Drug Policy was announced in 1982, why drugs like Depo-provera were not banned? We went out in the villages and met women in the family planning centres. We a least wanted to warn these women who were being "motivated" to accept the method. In doing this, we also found out that another brand of injectables Net-en (trade name Noristeret) produced by Schering AG of Germany was also being used in the family planning programme. For the family planning workers both were injectables. So they used these on the same women interchangeably at different times according to the availability of the drug. The users did not know the difference. They were also not aware of the potential side-effects. Women with infants who were breastfeeding their children were given injectables. Some women who were in early pregnancy were on injectables till the later stage of pregnancy. We reported these to the family planning department, but they would not listen.

Dalkon Shield:
In 1987, we came to know about the compensation claim against A.H. Robins in the USA which has produced and marketed Dalkon Shield. Women in the developed countries and later in the countries like Bangladesh had this method and suffered serious health hazards. Dalkon Shield was an example of the dumping of the harmful contraceptives which were banned for use in its country of origin, while allowed for use in developing countries. A compensation claim filed on behalf of a group of 300 women of Bangladesh who used Dalkon-Shield, has been submitted by UBINIG through a law

firm in the USA. Fifty women were selected for compensation payment but never received a penny. The company declared itself bankrupt.

The women of Bangladesh who suffered from the use of the Dalkon Shield did not get justice despite the fact that the company and the population controllers are to be blamed for the damage of their bodies and lives.

In order to find out the Dalkon Shield clients in Bangladesh we put up an advertisement in the newspaper. USAID reacted to it and pressured the government to stop UBINIG from filing claims. It was a struggle to send the names of the women to the US court, yet we managed to do it.

Biomedical research:

Countries like Bangladesh are "excellent" places for the west to conduct biomedical research on human subjects, especially on women and children. Historically, research on tropical diseases like cholera and malaria were linked with military research. In Bangladesh research on cholera was first initiated during the pre-liberation Pakistan period under the Pakistan-SEATO agreement. SEATO stands for South East Asian Treaty Organisiation; it was a military alliance to maintain the domination of wester power. The centre for cholera research is presently called International Centre for Dairrhoeal Disease Research, Bangladesh (ICDDR,B), which is conducting various bio-medical military research including research on contraceptive methods involving human subjects, especially on women and children in Bangladesh.

We have unfolded violations of the international ethics of informed consent and the principles of declaration of Helsinki in the bio-medical research. UBINIG uncovered unethical practices and undertook a campaign to stop this practice.

Norplant:

In 1981 we protested against an unethical advertisement in Norplant claiming it was a "wonderful Innovation of Science". While Norplant is still in the Trial Status, it was being promoted as a solution for women, claiming it safe and effective. Since then we have been watching the introduction of Norplant in Bangladesh. In 1985 we found that the trial was being conducted on poor slum women. We found out a few of these women in the slums and in villages were women given without their knowledge of being under trial. We carried out a campaign against unethical practices and also highlighted the sufferings caused to women. Till now the struggle is continuing. The government has reacted several times to our concerns. The Population Council, which is supporting the trial has reacted several times to our concerns. The Population Council, which is supporting the trial has been very aggressive and continued their activities. The government in this respect has no voice. Several demonstrations were organised and press conferences were held to protest against the trial of Norplant. the positive impact is that many activist organisations, the journalists and the public in general have become aware of the issue and have started to look into issues more critically than before.

Awareness at the village level—Since last year we have started holding big meetings at the village level with women who are using contraceptives. After we have given them all the information, they became very open about expressing their experiences and articulated clearly about their problems. These meetings are held regularly and more information is coming out. Women have started resisting impositions of contraceptives which they think are harmful.

Population Control and Family Planning

We expose the ideological character of the depopulating strategy and the violence done against women in promoting unsafe modern contraceptive methods that benefit the multi-national corporations and vested interests. The coercive sterilisation programme is an assault on the human person and a violation of human rights. We also fight against the ideological notion by which depopulating strategies equate population control with family planning.

We want to ensure the informed decision of the couples about family planning. The right of a women to take a decision in this respect is an objective we want to establish to protect her from patriarchal oppression. Health of women is another most important concern of ours. We are working to develop a strong MCH programme with a component of SAFE family planning methods.

—Presented at the International Public Hearing on Crimes Against Women Related to Popluation Policies, held in Cairo, Egypt at NGO forum '94 (7th September 1994)

PUBLIC HEARINGS ON CRIMES AGAINST WOMEN

GAYATRI CHAKRAVORTY SPIVAK

COLUMBIA UNIVERSITY

I am a South Asian who lives and works in the UnitedStates as well as South Asia. I will relate the testimonies I have heard this morning to this experience. Because of the peculiarity of this experience, my argument might seem too polarised between North and South. However, as France Tardif's (Quebec Federation for Family Planning) testimony made clear, my works apply also to the South in the North— "Native American women, women of color, migrant women, disabled women, women of little education and poor women." Whenever I say "South" please also hear "South in the North."

A large part of Northern women's energy at this conference is devoted to the wording of the UN document regarding reproductive rights. I have no doubt that the language of the declaration is of utmost importance. Yet I am also absolutely convinced, and so should you be after our testimonies, that at the grassroots level, where doctors and health workers coerce helpless women at the behest of governments that are obliged to accept population control as part of a so called "aid" package, the delicate nuances of the wording of a United Nations declaration don't make much difference. Do not for a moment think that I am asking you to relax your interest in wording. But, as the statements of the testifiers should make clear, we have to look at what is taken for granted in the debate over wording. It is my view that unless some of its assumptions are changed, this conference cannot be considered international. To demonstrate this I will focus upon the most controversial issue at the 1994 ICPD—abortion. This is the issue around which the news media the world over is dramatizing at this conference.

In the debate over wording, it is taken for granted by both sides that the issue of reproductive rights can be reduced to abortion. Farida Akhter has already stated forcefully that we are not against abortion. Let me quote from the *People's Perspectives*, the journal she edits, to assure you through our published statement: "We are against criminalizing women for seeking abortion by the state or any religious institutions in any country of the world. Safe and reliable methods of abortion must be available for women who do not want to carry out the pregnancy. At the same time, we are against commercialising the need of women for abortion services by making it a profit making venture." (*People's Perspectives* No. I, August 1993, p.1)

Speaking from this position, I urge that to reduce reproductive rights to the issue of abortion is to forget the poor women of the South. Let me clarify with a simple example.

Let us assume two women losing weight. One is dieting and the other starving. We decide to do a comparative study of the two from the point of view of weight loss alone and we claim weight loss as the most crucial right. To reduce reproductive rights to abortion seems to us to be similarly North-centred and decontexualized. Remember we are not against access to legal and safe abortion. But we feel that to focus as much of the energy of a conference as large as this upon the right to abortion provides the North with a huge alibi.

In a situation where extreme poverty makes children mean social security, the right to abortion is immaterial. In a situation where coercive contraception lays waste a woman's reproductive and general health, the right to abortion is immaterial. In a situation where the absense of resources makes it impossible to think of male and female children becoming equally competitive in the future, the right to abortion may facilitate the removal of female foetuses, where internalised gendering is misrepresented as women's choice.

Even the most patriarchal systems now allow abortion in the case of rape. It is interesting that the question: why do men rape? is left as much out of this provision as is the question: why should a poor woman of the South or a disabled woman anywhere want an abortion?

Focussing reproductive rights so intensely on abortion assumes that the able woman of the North is a person endowed with subjectivity and that the poor woman of the South should of course want what she herself wants.

In the service of ethnocentricism, a profound silencing mechanism is at work. Any position critical of the construction of abortion as the master symbol of reproductive rights is immediately read as a sign of extreme cultural and religious conservatism. In addition, the Holy See has appropriated the language of women's choice and women's education. We hold no position against religion as a bearer of culture. But when the great patriarchal religions offer education as an excuse, they mean the internalization of patriarchal constraints masquerading as choice; just as women's education in the context of socalled Development means, either, preparation to enter a workforce devoted to mortgaging the future of a developing nation in the interest of export-based investment and resource-intensive technology; or the education of the elite into consumerism (or into sponsorship of population and development policies), so that they too, like former President George Bush, can say: "Our lifestyle is not negotiable."

(Consider in this perspective the following statement by the US State Department:

> One key aspect of the US belief in strong South-North partnership is reflected in our position on comsumption issues. The United States, and all nations, have an obligation to address unsustainable consumption patterns. In the U.S. we have developed a variety of policies and programmes to improve the efficiency with which we use out resources. And thus to lower our national consumption consistent with our Rio treaty commitments we will work for strong langauge in the Cairo document that recognises, within the context of sustainable development, that consumption patterns in the North must be addressed along with rapid population growth in the South."

[Department of State Outgoing Telegram #SHC7112, March, 1994, item #15].)

What we have heard today tells us that the bodies of poor women in the South are being used as dumping grounds for surplus contraceptives produced by transnational pharmaceuticals. We have seen that dangerous permanent methods and longterm contraceptives are preferred because these women are considered objects, incapable of choice. If we focussed on these issues rather than abortion, which, for this larger part of the world, is not unimportant but secondary, we would be looking at the increasing poverty that leads to excessive childbearing as social security. This conference is about Population and Development. By keeping our eyes focussed on abortion as the central controversy we contribute to the objectification of the women of the South and allow Development to be an alibi for exploitation. It is a hopeful sign that the International Steering Committee of the NGO Forum took a strong stand against the World Bank, IMF, and GATT. It remains for us all to emphasise that population control is part of the socalled aid package that devastates the South. I quote from the same State Department document: "The United States is committed to working in the Cario process to stengthen the partnership between the developed and the developing world"—Dr Mira Shiva's comments prepare us to ask "what partnership?"— "on population issues. We have common interest in promoting sustainable economic development,"—for whom?— "stabilizing population growth"—what does the code word "stabilization" mean?— "and protecting our shared global environment." (ibid, iten #13).

If you are interested in language, consider that the World Bank has chosen the phrase "fertility decline in Bangladesh" as a "Success In A Challenging Environment" (Title, booklet for the Population Reference Bureau, Washington, 1993). If you are interested in images, consider the picture on the cover of its brochure on the Middle East and North Africa: the hard-hatted white woman pondering leadership as the modern Arab woman in culturally approved garb points the way to go ("A Population Perspective on Development: The Middle East and North Africa", Washington: The World Bank, August 1994).

Whatever the outcome of this conference, we call upon our Northern sisters—not many of who are present here—to situate abortion as an important but society-specific issue and to examine the political economy of reproductive rights redefined with a global focus. Do not silence, or worse, ghettoize—as you have done today by your absence—the critical voice of the South between fundamentalism and racism.

WHAT IS AUSTRALIA DOING ABOUT TRAFFICKING IN WOMEN?

HOW YOU CAN ASSIST IN THIS NON GOVERNMENT INQUIRY

The Global Alliance Against the Traffic in Women was launched on the last day of the International Workshop on Migration and Trafficking in Women 17-21 October 1994. The Conference brought together 75 representatives from 22 countries; mostly women who are working directly on this issue. The Conference called for a Global Partnership amongst individuals and organisations to raise international awareness and lobby for political change.

OBJECTIVES

The objectives of the alliance which are contained in the International Action Plan are:

1. Exchange of information and experiences and cooperation among members in order to improve practical support and advocacy work
2. Link up with other international organisations which have action against trafficking in women in their programme e.g. development, human rights, legal, labour, Interpol, governmental and non governmental organisations
3. Develop the content and lobby stratgey for the adoption of a new UN Convention to replace the present (1949) Convention on the Suppression of Traffic in Women and the Suppression of the Prostitution of Others to include a broader and more precise definition.
4. Work for the appointment of a Special Rapporteur on Traffic in Women by the UN Commission On Human Rights.
5. Prepare and organise for participation of members in relevant international meetings in order to address the issue of trafficking in women. In 1994/5 these are:

a) the international experts meeting Utrecht, Netherlands

b) the World Summit on Social Development in Copenhagen, Denmark

c) the Commission on the Status of Women in Beijing, China

6. To Study and develop the use of other relevant UN instruments for campaigning and advocacy work on this issue
7. To facilitate advocacy and campaign work at all levels. e.g. to design and produce a lobby manual, to organise training seminars on practical and substantial matters.

As a result of our participation in the Conference we have formed a working group with interested others with the aim of producing a country profile through collecting information on the Women and Trafficking in relation to Australia's role as a receiving and sending country.

The working definition we are using for trafficking is one developed at the International Conference which involved forced prostitution and other forms of forced labour where people are lured or deceived into forms of contemporary slavery.

Are you aware of any agencies, individuals, or govt. departs. working on the issue?

Do you have any relevant information that would assist us e.g. media clippings, research, references, statistics?

We are interested in making contact with individuals/agencies who are working on this or related issues and/or interested in pursuing this issue within the Australian context as part of the Global Alliance. We are particularly interested in learning more about:

the nature and extent of the trafficking of women into Australia;

#the conditions and lack of rights that the women find themselves in Australia especially those women who are working in the sex industry;

Policies/practices of Australian authorities;

Issues related to the welfare of the women once they are deported/expatriated to their home country;

#Migration policies/issues which allows known brothel owners/brokers to travel overseas and bring back Thai/Filipina's etc. on tourist visas.

It would be appreciated that replies to this request are sent as soon as possible. **All information will be in the strictest of confidence.**

Please send all replies to
ATTN. SUE GRANT c/o PCV,
10 Inkerman St.
St Kilda
Victoria 3182
Australia

As soon as we have correlated the material we will be calling a meeting to discuss the findings. Please let us know if you are interested in attending.

- Sue Grant/ Heather Noske

Prostitutes Collective of Victoria (PCV)
10 Inkerman St. St Kilda Vic 3182
(03) 534 8166

- Bernadette McMenamin

End Child Prostitution in Asian Tourism ECPAT
GPO Box 2593 W, Melbourne, Vic 3001
(03) 650 3295

- Denise Nichols

Community Aid Abroad (CAA)
156 George St., Fitzroy, Vic 3065
(03) 289 9444

CONFERENCE REPORTS

◊ SEX AND POWER IN AFFLUENT ASIA
—Krishna Sen—

This workshop was organised by the Asian Research Center on the 13 February 1995. The Workshop discussed 8 papers which were written as draft chapters for a book to be published as part of the "new rich" series of Routledge (with Asia Research Centre).

The book is being edited by Krishna Sen (Murdoch Uni) and Maila Stivens (Melbourne Uni). Other participants in the project are Nerida Cook (Uni of Tasmania), Stephanie Fahey (VUT), Bev Hooper (UWA), Ann McLaren (LaTrobe Uni), Nirmala PuruShotam (Nat. Uni of Singapore), Kathy Robinson (Newcastle Uni) and Mina Roces (CQU).

The papers attempted to analyse the ways in which the current phase of globalisation is affecting the relations between sexes in particular Asian national and local contexts. Those who wish to comment of the draft papers should contact Krishna Sen (Humanities, Murdoch Uni). The manuscript will go to the publisher in July.

FORTHCOMING CONFERENCES

- ASEAN Inter-University Seminars on Social Development II—Issues in Social Development in Mid 1990s Southeast Asia. Cebu, The Philippines. 17-19 May 1995.
  Contact: ASEAN Inter-university Seminars, Dept. of Sociology, National University of Singapore, 10 Kent Ridge Crescent, Singapore 0511.
  Tel : (65) 772 6110
  Fax: (65) 777 9579
  email: sochakh@nusvm.bitnet

- "4th Biennial Conference of the Chinese Studies Association of Australia."
  Macquarie University, Sydney, 5-7 July 1995.
  Contact: Conference Convenor
  Centre for Chinese Political Economy
  Macquarie University
  Sydney, NSW 2109
  tel: (02) 850 7898
  fax: (02) 850 7821
  email: ccpe@efs.mq.edu.au

- "Eleventh New Zealand Asian Studies Conference" Auckland University, Auckland, New Zealand. 1-4 July 1995.
  Contact: Conference Secretary, Professor Paul Clark, Dept of Asian Languages and Literatures, University of Auckland, Private Bag 92019, Auckland, New Zealand.
  Fax: (64 9) 373 7411

- "The Seventh International Congress on Women's Health Issues" Khon Kaen University, Khon Kaen, Thailand. 5-8 November 1996.
  Contact: Associate Professor Earmporn Thongkrajai, Faculty of Nursing, Khon Kaen University, Khon Kaen 40002, Thailand. FAX: 043-237606 / 043-242106

  The theme of this conference is Women in Development and proposed topics include Reproductive health, women in work, Women and AIDS/HIV, Women as Health Advocates, Women in the developing world and gender issues in general.
  Deadline for abstracts December 1 1995. These should be 250-300 words, typed single space. Submit 3 copies and one cover page with name, position and address to Earmporn Thongkrajai at above address.

- Japanese Studies Association of Australia. University of Queensland, Dept. of Asian Languages and Studies.
  July 5-8 1995. Contact: (07) 365 6311

GRANTS AND AWARDS

Asian Studies Library Awards (ASLA) 1995
Postgraduate students and junior university staff members are eligible to apply for support to undertake library research in Canberra and other centres well-endowed with Asian Studies collections. [Funded by DEET, administered by ASAA and RSPAC at ANU]
Benefits: Contributions to cost of travel and accommodation
—up to $800 to scholars from WA, NT and Nth Qld
—up to $500 to scholars from SA, Sth Qld, Tasmania and Victoria
—up to $250 to scholars from NSW
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Applications close 30 June 1995
Contact: ASAA Asian Studies Library Awards
Collection Management Division
ANU Library Canberra ACT 0200

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