Access to safe birth control methods and knowledge about their effectiveness and disadvantages are basic prerequisites for the liberation of women. But the propagation of contraceptive services in South Africa has often adversely affected black women’s health and has largely ignored their needs for education and personal choice. Focusing on interviews with a cross-section of the residents of Heideveld, a coloured township in Cape Town, this study isolates some of the patterns surrounding contraceptive facilities and methods. Most of the interviewees depend on state-run health services and have limited access to private health care. The study concentrates on women’s experiences and identifies some of the more insidious forms of violence against women.

In dealing with the politics of fertility control, it is necessary to distinguish between the concepts of ‘birth control’ and ‘contraception’.

Birth control refers to all methods (‘barriers’ like the diaphragm or condom as well as contraceptives) that control an individual’s fertility. Contraception refers to birth control methods that affect the body’s reproductive cycle internally, such as sterilisation, the injection and the pill.

Contraception & accessibility

It has served the state’s interests to limit the black population increase by using birth control as a weapon against the ‘Black Peril’, and researchers have dealt extensively with the sinister availability (compared with other health services) of contraceptive services for blacks in South Africa (see Brown, 1987 and Klugman, 1990). All the respondents who used birth control acknowledged the convenience and accessibility of the free public service in Heideveld. Of the 80 percent who felt that today’s parents have fewer children, 48 percent claimed that this was
The physical availability of general services obscures the inaccessibility of safe and effective birth control methods because of the increased accessibility and public awareness of contraceptive methods.

Yet the physical availability of general services obscures the inaccessibility of safe and effective birth control methods. This becomes clear in trends that reveal respondents' ambivalence and reservations about the methods offered to them. In interviews with 85 female birth control users, 55 percent of them had had unplanned children, although 64 percent felt that all the birth control methods known to them were effective. Asked whether and how birth control methods, especially contraceptives, could be harmful, only 55 percent felt that contraceptives were dangerous, yet 83 percent had experienced harmful side effects, and the incidence of similar complaints (migraine, hair loss, irregular or continuous menstrual bleeding) from injectable contraceptives is particularly high.

Syndromes of deference and awe towards technological and scientific knowledge lead to a belief that medical information is beyond reproach or question. For a user whose highest educational qualification is standard six, who has never held a job and who defines her occupation as 'housewife', it is intimidating to confront the epaulettes and starched white uniforms of clinic staff, the walls adorned with glossy scientific charts and the jargon-filled leaflets about the human anatomy. This situation explains why there are more women who simply discontinue usage of birth control than there are women who seek changes from their sources.

Contradictions

Significantly, responses often reveal a contradiction between respondents' actual and personal health perceptions on one hand, and their attitudes towards medical knowledge on the other. Many women commented on their own negative responses to certain methods, general unease with the methods they use, or knowledge of women who had experienced problems with specific methods. Yet far more women register total respect for medical knowledge and a belief in the infallibility of medical prescriptions and sources.

A woman who had used the pill for four years complained "It makes me feel tired, listless and sexless" yet described the pill as "the best contraceptive method". She also claimed that the clinic staff were
"efficient and helpful" even though they did not explain how the different methods worked or offer her any contraceptive choices. Some respondents said that contraceptives could not be harmful because the clinic provided them or doctors recommended them, while others transferred the problems associated with contraception entirely to users, maintaining that contraceptives could be dangerous only if used incorrectly.

**A reluctance to challenge**

Merely to argue that users are 'ignorant' or campaigning for 'more information' does not deal with the primary communication problem between service and user: users are not so much ignorant of the dangers of contraceptives, as reluctant to challenge the authoritative discourse of medical technology with their own self-knowledge.

Similar ambiguities emerge in the responses of contraceptive users towards public clinic staff. Although 75 percent claimed to have been given choices and explanations, 67 percent revealed a knowledge of less than half the birth control methods available from most public services, 65 percent had no understanding of how the methods they used worked; and most were unaware of the distinction between contraceptive and barrier methods as forms of birth control. Numerous respondents claimed that staff simply instructed them in the use of different methods, but failed to give any explanations of how the methods worked scientifically. The following response came from a 46 year old woman who had used five different methods: "Contraception is a substance that does harm to your body. I do not know how it works but I have to use it".

**Psychological accessibility**

Despite the unease about how their own bodies responded to contraception, 91 percent of the respondents felt that staff were helpful, had no recommendations for a better service and commended the affordability, helpfulness and convenience of the services offered. This must lead us to question the psychological accessibility of birth control services. The common feeling among both staff and users is that users should be grateful for the free public service provided. It is also often felt that the legitimate and sole role of staff is to prescribe pregnancy prevention methods and dispense them to passive, anonymous and uninformed users.

The high-handed attitude towards users of birth control is exacerbated by the South African medical profession's emphasis on a bio-medical rather than a holistic approach to health, with medical personnel concentrating only on patients' physical or bodily health as opposed to their general well-being. The present health crisis in the country also results in high patient-health worker ratios and overworked staff cannot provide the client with adequate care and
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attention. In the words of one woman, "(The staff) treat me like a piece of meat".

Because South Africa has a legacy of overtly repressive policies for the black population, birth control services are often seen as a privilege, rather than a right. Until the patronising image of the services change, and until a reciprocal relationship between staff and users is established, women will remain trapped in attitudes of self-disparagement, will be reluctant to demand their right to choice and education and will submit to endangering their health with inappropriate, ineffective or dangerous methods.

Birth control services are often seen as a privilege, rather than a right

Birth control or social control?

It would be futile to condemn individual staff members or to deplore the compliance of users. As this study has already suggested, what needs to be scrutinised is state intervention in birth control and the socio-political framework that has shaped the autocratic character of services and staff attitudes.

Before 1974, the largest birth control programme in South Africa was run by the state-independent Family Planning Association which, started in 1932, began to receive government subsidies only in the mid sixties. In the sixties, government policy on birth control was dictated largely by the Dutch Reformed Church (DRC) which opposed its use amongst both whites and blacks. A decade later the DRC was supporting birth control amongst blacks only. In 1974 the government, claiming that the rapidly growing black population was in urgent need of family-planning and modernisation, started its own birth control programme. A series of strikes and rising black unemployment in the seventies intersected with government-linked studies of population to prompt state attempts to control black population growth as systematically as possible. Once begun, the programme expanded rapidly, with government spending on birth control increasing by about R30 million between 1975 and 1985 (Brown, 1987).

Forced contraception

Extensive and accessible birth control facilities were accompanied by coercion: women factory workers have been threatened with losing their jobs until they submitted to contraceptive injections; Soweto school girls have been denied the right to sit for matric examinations unless they had contraceptive injections; and there have been many accounts of sterilisation and the fitting of intra-uterine devices (IUD's) for women without their knowledge (Brown, 1987; Klugman, 1990:265).

Efforts to restrict the black population were linked to campaigns to swell the white population. Tax policy favoured whites with large families, white immigration was encouraged and
whites were urged to have large families. In 1960, declared the Year of the Family, the Minister of Social Welfare and Pensions looked into the introduction of white family allowances "with a view to bringing about an increase in the white birth rate" (quoted in Brown, 1978:267). In the same year the Minister of Bantu Administration and Development called on every white woman to have a baby to celebrate the establishment of the Republic (Brown, 1987: 267). 'Family planning' has therefore acquired a dual meaning for the two main racial groups in South Africa: for blacks it has implied the control and reduction of families; for whites it has meant increased reproduction in the interests of white dominance. 

The Nationalist government's concern with overpopulation is not unique. In stratified societies, the anxiety about overpopulation usually stems from the dominant group's concern with protecting their privileges and the draining of 'their' resources by growing and needy dominated classes. It is noteworthy that 'foreign aid' actively promotes birth control programmes in the third world: the United Nations Family Planning Association, the World Bank, the Food and Agricultural Organisation and United States Aid for International Development pressurise loan recipients to institute family planning programmes with the covert threat that continued aid will be guaranteed only if birth rates (and the political threat that they pose) are lowered (Hartmann, 1978:212).

**Choices and education**

The injectable contraceptive, Depo Provera, has been banned in countries like England, the USA and Zimbabwe, although it is widely used in South Africa and by 58 percent of the users of birth control in our case study. Although the injection is reputed to cause fewer health problems than the pill, studies of women in numerous contexts have revealed severe problems. Women respondents in Heideveld are no exception, and their recurring ailments include very heavy periods or no periods, excessive weight gain or loss, decreased drive, hair loss and back-ache. An 18 year old woman who had had the Depo Provera injection recommended to her said "I have experienced bad hair loss..."
and headaches even though the nurse did not tell me about the side-effects”.

In the West, the debate about Depo Provera concerns the way its manufacturing and distributing company has promoted it as an ideal method in the third world, without a precise understanding of how it works or adequate research into its side effects. The assumption behind drug company’s sales pitch is that third world women lack the intelligence for responsible choice and that their long term health needs are unimportant.

Like Depo Provera, the pill (used by 30 percent of the women respondents using birth control) has become controversial because of its premature distribution and is now the target of campaigns by many women’s health activists. Although the pill remains popular in most countries and is considered highly effective in preventing pregnancy, its side effects include: circulatory disease, heart attacks, high blood pressure, cancer and diabetes. One woman who was on the pill claimed: “I used the pill and

I lost interest in sex. I also felt very sick afterwards. I became very thin. But the injection and the loop were even worse for me”.

Used by five percent of the interviewed women, the IUD (locally known as the ‘loop’) was also marketed after limited research, and reports of illnesses and sterility are common. Although considered highly effective, the numerous side effects of IUDs - confirmed by all respondents using the loop - include infections, infertility, ectopic pregnancy and embedding. Many interviewees testified that the insertion of IUDs at an early age and use over extended periods led to infertility.

**Sinister motives**

Yet few women are able to turn to free health care facilities for the treatment of infertility or the diagnosis and treatment of cervical cancer. South Africa has one of the highest incidence of cervical cancer in the world, yet the Department of Health stopped funding pap smear tests in 1980. If we consider the availability of extensive birth control schemes, the alarming incidence of cervical cancer among black women is extremely disturbing. It glaringly pinpoints the sinister political motives of state-funded health services for black women. As long as state-run birth control services emphasise pregnancy prevention to

South Africa has one of the highest incidence of cervical cancer in the world, yet the Department of Health stopped funding pap smear tests in 1980
the exclusion of the treatment of infertility and diagnosis of cervical cancer, they will not be serving women's general reproductive needs.

Manufacturers of contraceptives have capitalised on the powerlessness of women in the third world, while state-controlled services minimise expenditure by promoting contraceptive methods which are cheap and easy to administer. These economic and political objectives are revealed in the widespread availability of and use among respondents of contraceptives such as the injection, the pill, and the IUD, rather than barrier methods like the diaphragm and the cap. When we consider state policy or the operations of drug companies in South Africa then, it is clear that the needs of politically and economically dominant groups override those of black women.

Need for informed choices

Yet it would be presumptuous and counter-productive to prescribe an alternative or to dictate a national or regional policy on the basis of other women's findings and campaigns. Ideally, an effective birth control programme should allow all women to make informed choices. The principle of choice includes not only the avoidance of unwanted pregnancy, but the informed choice of a method most suited to the individual user or partnership. This means that the individual woman should be able to choose the birth control method most suited to her own social, economic, cultural, psychological and health status.

The following comments from respondents illustrate the extreme variability of users' needs and the importance of individual assessments in prescribing birth control:

"I use the injection - it makes me lose weight and my breasts increase in size. But I use it because I kept forgetting to take the pill" (an 18 year old single woman);

"I use the loop. I got a pelvic infection from it, but there are less hassles involved. I don't have to go to the clinic all the time" (a 46 year old factory worker with five children).

The balance between socio-economic, cultural, psychological and health factors is so delicate and variable that no ideal method can be prescribed or achieved. But the need to aspire to this balance is crucial, and this need is ignored when services confine their energies to mechanical, 'pregnancy prevention'.

Contraceptives have been shrouded in a mystique of scientific infallibility and economic disinterest. They are rarely defined as fallible commodities whose distribution is determined by the same market forces as those of all
other saleable products. Drug companies vigorously compete for consumer approval, and the consumer has a right to scrutinise, test and reject their commodities. Again, however, the medical mystique is so compelling that consumers do not monitor the use value of contraceptives to safeguard their own health and welfare.

**Sex education**

Another obstacle to informed birth control choices stems from a general avoidance of sex education. Anti-sex attitudes militate against the combination of birth control services with sex information and programmes aimed at users’ general sexual welfare and self-knowledge. Interviews with 139 women revealed that only 25 percent were introduced to sex information at school, and it is often only as adults, after they became sexually active, after pregnancies, or at antenatal clinics that women first learnt about birth control. Eighty five percent of the women interviewed first used birth control after becoming sexually active and the average age at which women learnt about contraception is 20.

The lack of sex education for adolescents and the infrequency of open discussion about sexuality and birth control in families reflect the prejudice that sex should be confined to the institution of marriage, to ‘responsible adults’, and should be aimed at reproduction. Some respondents felt there was an urgent need for special youth services which concentrated - particularly through schools - on consultation and sex education. The need for integrating comprehensive pregnancy prevention services with public sex information has become particularly important in relation to the demand for AIDS awareness.

**Gender roles/stereotypes**

The prescription of women’s roles determines responsibility for birth control. Sixty percent of men and 40 percent of women among all those interviewed felt that birth control is a woman’s responsibility, and 33 percent of women contraceptive users chose methods without consulting their partners. Sixty four percent of men (compared with 18 percent of women) were sexually active without using birth control methods, while 53 percent of sexually active men had never personally used birth control methods.

The status of birth control as a time-consuming, often health-endangering and disruptive activity is not acknowledged.

In a society where domestic labour is considered incidental and marginal, women are expected to harmonise domestic and sexual relations (as silently and discreetly as possible) while also taking responsibility for domestic labour and holding down full-time jobs. Responsibility for birth control is one of the many tasks that are automatically ascribed to women, and like other ‘domestic’ tasks, its status as a time-consuming, often health-endangering and disruptive activity is not acknowledged. Pressures on married women are greater, and it is revealing that
many male respondents felt that both partners should be responsible for birth control unless they were married, in which case the woman should assume responsibility. However, many women believe that they have more self-control if they are personally responsible and choose methods independently or without consulting partners to guarantee reproductive freedom and sexual independence. That sole responsibility for birth control is seen as a strategy of self-control should be of significance to staff and services who might urge women to involve unsupportive partners or parents.

Working women often struggle to co-ordinate domestic and other activities. Those women who used state-run facilities and did not have access to services at work frequently remarked that their jobs would be jeopardised or that their normal working routine was disturbed when using contraceptive services. For most women, long waits, inadequately staffed services, inadequately small clinics and inefficient or overworked staff seriously disrupt their lives and are not merely tiresome inconveniences. The masculinist biases of the workplace and trade unionism also warrant scrutiny. The ‘incidental’ labour of women is rarely the focus of employer or union concern, and by remedying this omission unions would go a long way towards ensuring that women do not compromise their health for the sake of job security.

A large number of women chose methods that may not agree with their physical health because they felt that they benefit in the long term: migraines and amenorrhoea or continuous menstrual bleeding might be regarded as less harmful than the anxiety of forgetting to take the pill because of endless domestic chores or losing one’s job to attend the clinic regularly or to have regular pap smear tests. The injectable, most frequently used amongst respondents, is often seen as a particularly convenient method. This, considering the controversy surrounding injectables in the West, reveals a complex and contradictory relation between women’s needs and struggles in a context like Heideveld and women’s campaigning in the first world. That many black, working-class and third world women have distinct perceptions and struggles should be of significance to feminists in the first world, who often prescribe to their ‘disadvantaged sisters’ and whose lobbying (ostensibly on behalf of an ‘international sisterhood’) is usually confined to their own needs and perceptions.
Reproductive rights

Because birth control in South Africa has had blatantly racist underpinnings, birth control debates have been constrained by a preoccupation with the needs of the apartheid state, and the perceptions and rights of women have been subordinated by other issues and emphases. In considering the role of a post-apartheid state, two agendas must be investigated. First, the Nationalist government's birth control programme has been a particularly brutal one. But how will a future government address perceived overpopulation and its attendant political controversies? This becomes especially important when we consider the coercive role of foreign aid (likely to increase in a post-apartheid context). State intervention in future programmes must be closely monitored to ensure that birth control schemes do not continue to reflect priorities that marginalise women's rights, health and general welfare.

Secondly, the primary function of birth control is to guarantee women's freedom in choosing or refusing maternity. When we consider the future of South African women and their reproductive rights, it is disturbing that earth mother motifs, slogans encouraging women to have babies for the revolution and a general coercion of motherhood have been at the centre of 'liberation' discourse and imagery. Women have been excluded from decision-making about maternity in the most basic ways. A meaningful birth control programme would be one in which women had the freedom to choose both the methods and aims of birth control. That this fundamental rule needs to be mentioned at all is an indication of the extent to which women are prevented from controlling areas which directly affect their lives.

We are indebted to the African Research Centre for facilitating this research

FOOTNOTES
1. For a detailed discussion of overpopulation theories in relation to the status of Heideveld women, see Salo, 1990. 'Perceptions and attitudes towards birth control among women in Heideveld'.
2. The Africa Research Centre is a Cape Town based black women's collective that funds research on human rights in South Africa.

REFERENCES

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