

**Empowering Women? Family Planning and Development in
Post-Colonial Fiji**

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Fleur Dewar

University of Canterbury

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ABSTRACT

Family planning initiatives have been critical to development strategies since the 1950s. Family planning has been justified on various grounds including its contribution to poverty alleviation, improved maternal and infant health and the advancement of women's rights and choices. More recently, the discourse of 'women's empowerment' has been used in the advocacy of family planning. This discourse integrates a number of earlier justifications for fertility control promoting family planning as a strategy to enhance women's access to higher standards of living and improved health. It associates family planning with advances in women's rights as individual citizens in 'modern' economies and their greater involvement in paid work. This thesis investigates whether this empowerment discourse is evident in family planning programmes in Fiji and its relationship to the socio-economic development of that country.

Critical analyses of the operation of power, development strategies and western assumptions about family size, human rights and economic wellbeing inform this research. In particular, Foucault's concept of 'biopower' is used to analyse narratives about family planning articulated by health practitioners, women's rights activists and officials in the Ministry of Health. The analysis of key informants' statements is complemented by consideration of official statistics, and existing empirical data such as documents and pamphlets.

The thesis argues that an empowerment discourse is strongly evident in Fiji with respect to the statements made by key informants and available written sources. It looks critically at the narratives that construct family planning as empowering for women, particularly the tropes of choice, health and full citizenship. Close analysis of these narratives demonstrate that the 'stories' uniformly position women as potentially empowered 'modern' subjects. However, critical analysis of these stories about choice, health and citizenship found that family planning strategies were

sometimes disempowering. The generic stories embodied by the empowerment discourse did not allow for the diversity of women's needs; this finding supported critiques of one-size-fits-all development strategies. I demonstrate that while the empowerment discourse provided women with the opportunity to control their fertility, engage in paid work and be empowered, it simultaneously created new challenges and different forms of subordination. This thesis found that the empowerment discourse was an unmistakable example of biopower at work

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ABBREVIATIONS

ARH	Adolescent Reproductive Health programme
CPR	Contraceptive Prevalence Rate
DAWN	Development Alternatives with Women for a New Era
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
FBS	Fijian Bureau of Statistics
FPANZ	Family Planning Association of New Zealand
FWCC	Fiji Women's Crisis Centre
FWRM	Fiji Women's Rights Movement
GAD	Gender and Development
GDP	Gross Domestic Product
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Inter-Uterine Device
MCH	Maternal and Child Health service
MDGs	Millennium Development Goals
SAP	Structural Adjustment Policies UN United Nations
SPC	Secretariat of the Pacific Community
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organisation

CHAPTER ONE

Introduction

Family Planning, Development and Empowerment

Over the past sixty years, international development agencies have invested considerable resources in the promotion of fertility control programmes in ‘the South’.¹ Family planning services have been critical to these initiatives (Gupta 2000; Seltzer 2002). Those advocating these services have argued that the social and economic benefits associated with restricting women’s fertility are significant, including poverty alleviation, better infant and maternal health, improved rights (Seltzer 2002), and, more recently, women’s empowerment. International fertility control strategies were first introduced in the 1950s as a measure to combat ‘overpopulation’, which was identified as being the cause of poverty in the ‘third world’(Hodgson 1983; Harkavy 1995; Gupta 2000; Seltzer 2002).² Development specialists held high birth rates responsible for poor living conditions (Seltzer 2002). They argued that high birth rates diminished access to already scarce resources and prevented the appropriation of material goods. ‘Overpopulation’ consequently was the first rationale for introducing international family planning programmes.

In the 1960s, and again in the 1980s, development programmes shifted their attention towards the health benefits of fertility control as a rationale for family planning (Gillespie 1987; Sadik 1990; Grant 1990; Seltzer 2002). High rates of maternal and infant death in developing countries were used to highlight the importance of family

¹ I have reservations about using the term ‘the South’ as it uniformly categorizes many diverse countries. I use the term in this context, however, to highlight the way in which ‘poor’ countries, such as those in Asia, Africa and South America, have been homogenized in development discourses over the past six decades.

² I have similar reservations about the term ‘third world’ as I do for ‘the South’. The ‘third world’ defines countries by their economic status and homogenizes many poor countries failing to recognize their diversity. However, when talking about the ‘overpopulation’ discourse as it was constructed in the 1950s it is useful to use this term as it provides insight into the ideologies of development agencies during this period.

planning and fertility control initiatives. Fertility control was identified as pertinent to the wellbeing of infants and mothers (Seltzer 2002; Allen 2004). Talk about ‘rights’ emerged within development literature in the 1990s and family planning was promoted as being essential for the enhancement of women’s and human rights (Alberty 1999; Gupta 2000; Seltzer 2002).³ Most recently, family planning has been advanced as a means of addressing women’s disempowerment.⁴ This thesis examines the use of the language of empowerment by development agencies such as the United Nations (UN) and the World Bank (WB). It investigates whether this discourse is used to encourage women’s fertility control in a specific context – Fiji. Having documented the presence of this discourse in accounts of family planning among key informants in Fiji, it also explores how this discourse plays out in practice. The goal is to assess the value of an international family planning strategy through consideration of its implications in a particular local context – in this case Fiji.

I have identified the use of discussions about empowerment within the current development literature as a *discourse*. I understand discourse to be the institutionalisation of a series of statements and their associated meanings. A discourse carries with it a set of pre-formulated ideas that are reproduced by repeated forms of public communication. Talking about an empowerment discourse also acknowledges the role powerful groups have in shaping discourses and the impact these have on individuals’ understandings of their surrounding world (Hollway 1983; Weedon 1987; Gavey 1989). I will illustrate the ways in which women’s empowerment constitutes a discourse within the field of family planning, internationally and locally within Fiji.⁵ In other words, I am concerned with the empowerment discourse produced by international development agencies in regard to family planning and whether that empowerment discourse is constructed and used by family planning experts in Fiji.

³ Further evidence of the adoption of ‘rights’ by development agencies in the 1990s is the International Conference for Population and Development (ICPD) and its Programme of Action. This conference strongly urged the promotion of family planning in the advancement of women’s and human rights. For evidence of this and details about the Programme see UNFPAa (2005).

⁴ To find the website that explores the ICPD Programme of Action see UNFPAa (2005). It provides an example of how family planning is presented as being a critical tool to women’s empowerment and the Millennium Development Goals (MDGs) also illustrate this point. The significance of empowerment to the MDGs can be found by looking on the website by the United Nations (2005). Alternatively Sweetman (2005) provides a discussion of these goals.

⁵ Notably, there is no universal empowerment discourse; there are many empowerment discourses, within and outside of the development context.

I have identified three key pre-formulated ideas that principally inform the international empowerment discourse: ‘overpopulation’, ‘health’ and ‘rights’. Narratives on these themes have been evident in family planning programmes since the 1950s. I use the term *narrative* to describe how these themes are used within the empowerment discourse. Narratives have a ‘logical’ plot and are an effective way of communicating particular arguments and sets of interrelated ideas. They are useful because they present information in a succinct manner and are ‘told’ in a uniform way, making them easy to replicate. They have a specific narrator, are designed for a specific audience and are usually used to legitimate actions and create social order and meaning (Gergen & Gergen 1984; Hinchman & Hinchman 1997). Information in these narratives is presented selectively. The information is rearranged to fit the narrative and is often simplified (Mink 1970; Bennet 1978; Bruner 1986; Fisher 1992; Hinchman & Hinchman 1997). This thesis will illustrate that accounts of overpopulation, health and rights associated with family planning advocacy constitute narratives and show how significant these narratives are for creating social order and potentially disciplining women in developing countries.

Protagonists of family planning programmes highlight the perceived social benefits associated with fertility control and espouse family planning as a strategy for fostering wellbeing in developing countries. Critics of these programmes alternatively argue that political and economic agendas drive many fertility control initiatives and highlight the negative impacts of the programmes and technologies on women (Hartmann 1987; Mies & Shiva 1993; Gupta 2000). The decision to embark on this thesis was informed by an analysis of documents about family planning that adopt the empowerment model and the critical assessments that have been made about past family planning strategies. The thesis documents the ways in which advocacy of family planning as ‘empowerment’ is evident in the ‘talk’ of key informants within Fiji and some of the resource material distributed through family planning networks. This chapter provides a brief history of the use of the concept of empowerment in the context of fertility control and development. I also explain why Fiji was selected for this investigation. I outline the research objectives for this inquiry, the theoretical framings that inform the analysis and outline the overall structure of the thesis.

Family Planning as Empowerment

While the control of women's fertility has been targeted by development agencies since the 1950s, it has only recently been associated with 'empowerment'. Historically, birth control activists (Gupta 2000) first articulated concerns about women's empowerment and fertility control in the United States in the period between 1910 and 1920. Members of this movement advocated birth control "not only for women's autonomy, but [also] for the revolutionising of society and empowering the powerless – the working class and the female sex primarily" (Gordon 1976 : vi). However, the birth control movement lacked the support of the wider public. To effectively promote birth control, it needed the backing of conservative community organisations. For this reason, ideas about women's empowerment and sexual freedom were removed from the birth control movement's agenda. Instead, the perceived social benefits of birth control, such as a way of strengthening marriages and reducing poverty were promoted; in the 1940s, birth control was reframed as 'family planning' (Gupta 2000).

Issues around women's autonomy and empowerment were readdressed in the early second-wave feminist movement (Freedman 2001). Within the feminist-oriented women's health movement of the 1970s, empowerment, autonomy and women's control over their own bodies were critical and reproductive control was again advocated to liberate and empower women (Kaler 2004). As Freedman (2001) argues, for some feminists, reproduction and mothering are oppressive forces. These feminists often saw new fertility control technologies as a way of relieving the burden of motherhood and associate reproductive control as being fundamental to women's liberation.⁶ Firestone (1979) was a strong advocate of this position. She argues the only way to liberate and empower women is to free them from the burden of reproduction through contraceptive technologies. This position is supported by Sacks (1979) and Lerner (1986), who argue that motherhood is one of the key institutions

⁶ It is important to note that for other feminists in this period motherhood is associated with empowerment and great pleasure. While this is important to acknowledge the intention of this discussion is to highlight the connections that were made between birth control and women's empowerment in the 1960s and 1970s. This is important because as will later be shown, development agencies have used ideas in this period to advocate the uptake of family planning services in developing countries. It is also important to note that later feminists in this period argued against the provision of contraceptives. Arguing that they were used by men to control women's bodies and their reproductive capacities. They also highlighted the medicalisation of women's bodies that occurred through this process and the male manufactures of contraceptives.

and mechanisms that create and maintain gender inequality and the powerlessness of women. As stated by Gupta (2000: 79), motherhood has been “seen by many feminists as one of the key institutions and mechanisms that creates and maintains gender inequality and the powerlessness of women”.

Firestone (1971) proposes that control over women’s reproduction and sexuality would lead to advancements in other areas of women’s lives. For example, pregnancy and motherhood were identified as being responsible for confining women to the domestic context inhibiting them from entering paid work, preventing women from personal development and accessing financial autonomy. Beneria (1979), Meillassoux (1981) and Gupta (2000) argue that motherhood contributed to the low status of women, as unpaid work was less valued than paid work outside the home. Equality within politics, family and work were all critical to feminist movements in the 1960s and 1970s (Gordon 1976) and birth control was identified as being an important tool in achieving this equality. Reproductive control came to be closely associated with women’s empowerment.

The issue of women’s empowerment first emerged in western industrialised economies and was closely linked to claims for human rights and individual freedoms. ‘Empowerment’ in non-western countries became relevant in the 1980s and was associated with different agendas. In this context, understandings of empowerment were derived less from feminist movements in the West and more from grassroots feminist groups in developing countries (Moser 1993; Kabeer 1994). Discussions about empowerment stemmed from dissatisfaction with mainstream development strategies for women. There were some similarities between western women’s rights concerns about empowerment and the non-western context. Both addressed the inequalities between men and women and acknowledged ‘the family’ as an institution significantly contributing to their powerlessness (Moser 1993). However, empowerment as an alternative development initiative emphasised the impact of “race, class, colonial history and current position in the international economic order” (Moser 1993: 74) on women’s experiences of oppression. It encouraged women to challenge subordination at all levels, including the sphere of reproduction and sexuality.

Development Alternatives with Women for a New Era (DAWN) popularised the empowerment approach to development (Sen & Grown 1987). DAWN offered a theory of development that was the creation of third world women. This approach challenged generic development strategies, and used the language of ‘empowerment’ to share the collective experiences and visions of third world feminists and their aspirations for change (Sen & Grown 1987). Autonomy was paramount to achieving women’s empowerment, and the role of external influences such as colonial and neo-colonial forces was identified as perpetuating women’s subordination (Moser 1993: 74-75). The augmentation of women’s power was important to their understanding of empowerment, but this approach emphasises the importance of internal strength and the re-distribution of existing power between men and women. This was the first development strategy to challenge the presumption that all men benefit from development and furthermore, it strongly asserted women’s rights to be included in the mainstream development process (Moser 1993: 74-75).

Dominant development agencies were threatened by this strategy and rejected it for some years (Moser 1993: 78). Whilst development agencies initially rejected this approach (Moser 1993), empowerment is currently the buzzword of mainstream development policies. An empowerment discourse is evident within contemporary family planning and development literature.⁷ The empowerment discourse, as constructed by development agencies such as the UN and WB, differs from the approach outlined by DAWN and other grassroots development organisations. As this research will illustrate, contemporary mainstream development agencies’ empowerment discourse tends to universalise the experiences and needs of women in developing countries. Furthermore, this discourse is more akin to the western women’s rights construction of empowerment. The focus in these documents is primarily on fertility control and the participation of women in the formal economy.

⁷ The term ‘empowerment’ is popular with a variety of development institutions as is illustrated in the list of resources below. However, it is particularly evident in programmes and literature published by the United Nations (UN). To see the widespread use of the term ‘empowerment’ in current development literature see these resources: UNFPA (2004); ISSD (2005); UNFPAa (2005); Interactive Population Centre (2006) and UNFPA (no date). These websites and information booklets discuss the ICPD and MDGs and illustrate the centrality of ‘empowerment’ to current development programmes. For more examples of how the term ‘empowerment’ is used within current development initiatives see also: IANWGE (2005); IWDA (2006); UNDP (2006); Genfinance (2005) and Organisation for Economic Co-operation and Development (2006).

They do not address the influence of colonial and neo-colonial powers on the position of women.⁸

The empowerment discourse was first mainstreamed in 1994 at the United Nations International Conference on Population and Development (ICPD) in Cairo. The ICPD Programme of Action stated that the conference sought to address “the growing recognition of global population, development and environmental interdependence” and create “policies to promote sustained economic growth in the context of sustainable development in all countries.”⁹ Empowering women was one of the strategies identified as critical to addressing the population and development problems identified and achieving the goals proposed by the ICPD. It states that, “[t]he empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. In addition, it is essential for the achievement of sustainable development.”¹⁰ In this discourse, addressing the reproductive health ‘needs’ of women and the provision of family planning was critical to women’s empowerment.

Since 1994, development institutions have created new programmes of action to combat underdevelopment. The Millennium Development Goals (MDGs),¹¹ set by the UN, are the most recent guide to development programmes. These goals are an extension of the ICPD Programme of Action and the focus of empowerment remains important. Family planning programmes are employed as critical strategies in achieving the eight principal goals (UNFPA no date; Sweetman 2005),¹² one of which is the empowerment of women. Family planning and empowerment are integral to contemporary development policies. Having encountered versions of the international discourse I wanted to investigate whether this discourse was present in a local context and whether the representations of empowerment were specific in this context. I was interested in finding out whether key actors in this environment offered statements

⁸ As this research will illustrate and as an analysis of the ICPD Programme of Action or the MDGs show one generic strategy to empower women is prescribed, critical to which is the adoption of family planning and modernity. There is no mention of colonialism or neo-colonialism on the subjugation or disempowerment of women. More detailed information on these programmes can be gathered from these websites: Interactive Population Centre (2006); UNFPAa (2005) and ISSD (2005).

⁹ ISSD (2005).

¹⁰ ISSD (2005).

¹¹ UNFPAa (2005).

¹² These goals are outlined on page 32.

about family planning that resisted the mainstream empowerment discourse as well as whether their statements were modelled on the international discourse. This thesis presents evidence for the use of this discourse to promote fertility control in Fiji and looks critically at the relationship between empowerment claims and women's experiences of family planning and 'development' in this Pacific state.

Localising the Empowerment Discourse: The Case of Fiji

Fiji presented itself as a particularly interesting country in which to investigate how the international approaches to fertility control might affect local family practices and how an empowerment discourse plays out in practice. Reasons for choosing to focus on Fiji include: the absence of detailed information in the literature, the commitment of successive Fijian governments to promote and implement family planning services and the prevalence of two dominant ethnic groups who have had different experiences of population policies and family planning.

Initial attempts to identify information about family planning in Fiji illustrated that there was an absence of critical literature about family planning and what have been referred to as 'empowerment strategies'. I was interested in analyzing issues around generic development programmes and the value of family planning and finding out whether the empowerment discourse was used in non-western countries. Literature by Mehmet (1995), for example, condemns development policies for their one-size-fits-all strategies, as he argues that the universal programmes promote western values and negatively affect non-western cultures. Similarly, Sen and Grown (1987), Abu-Lughod (1993), Parpart (1993), Kabeer (1994) and caution against homogenising women's experiences and argue against the effectiveness of generic development policies. Similarly, literature by critics such as Hartmann (1987), Correa and Reichmann (1994), Bandorage (1997), Gupta (2000), and Allen (2004) question the value of western initiatives such as family planning and empowerment in non-western countries. The limited research on Fiji in the field of family planning attending to these critical perspectives prompted me to address this void. Was the empowerment discourse articulated by Fijian practitioners of family planning? If so, how was it manifest, and how did empowerment claims relate to information available about

women's experiences as users of family planning technologies, as family members and as those involved in the formal and informal economy?

The position of Fijian governments, since the 1950s, has been to advocate family planning services and programmes (Hull & Hull 1973). It remains an integral component of their health and development policies today.¹³ Family planning programmes are well established in Fiji and had a reputation for being particularly successful in the 1960s (Lucas & Ware 1981). Successive governments have been praised by the international community for their commitment to advocating fertility control, and their 'success' in implementing, family planning programmes. In comparison to many Pacific nations, family planning is well entrenched in Fiji (Lucas & Ware 1981). I was interested in exploring the discursive practices of those involved in promoting family planning in order to investigate whether and how an empowerment discourse was used to encourage the use of family planning services. Accordingly, it was useful to choose as a case study a country that had a substantial history of implementing family planning initiatives and one that remains officially committed to such programmes.

The initial success of family planning in Fiji can be attributed to early conflicts between the Indo-Fijian and Fijian populations around birth rates and population size. In the late nineteenth century, the British transported Indians to the Colony as indentured labourers in sugar plantations to promote economic development (Sutherland 1992). At this time, the indigenous Fijian population was in a rapid decline and pro-natal policies were implemented to encourage growth of the Fijian population and remedy 'under population'. Whilst the Indian community was initially small, Indo-Fijians grew as a percentage of the total population and eventually surpassed the number of Fijians. In the context of a declining indigenous Fijian population, the high fecundity of the Indian population contributed to Fijians being apprehensive about becoming an extinct indigenous people (Hull & Hull 1973).

Concern that the Fijian population was being overwhelmed socially and politically by Indians continued throughout the early to mid twentieth century. The Fijian and

¹³ Evidence of this is available from UNESCAP (2005) and Ministry of Health (2006).

European communities were anxious about the political power of a growing Indian population. Controlling the growth of the Indian population was thus a priority (Hull & Hull 1973). Fertility control promised with the advent of family planning in the early 1950s was thus warmly received and advocated by the Fiji government (Chung 1999) as a way of curbing Indo-Fijian population growth. Consequently, family planning provoked little resistance, even from the most conservative sectors of indigenous Fijians (Chung 1999).

As the political climate, both in Fiji and in the international community, changed so too did the family planning and population control policies in Fiji. While initially population control had been directed at the Indian community, in the mid 1960s both ethnic groups were targeted by family planning practitioners (Hull & Hull 1973). Discussions about population control changed from being race-centred to reflect the international discourse about 'overpopulation' and the impact of high birth rates on poverty, resources and the economy (Hull & Hull 1973). The shift to include the Fijian population was particularly significant. Within a couple of decades, the colonial government moved from pro-natal policies to family planning programmes for indigenous Fijians. The rapidly changing needs of Fiji highlight the political nature of family planning programmes. This will be explored in later chapters of this thesis.

Over the decades, Fijian and Indo-Fijian citizens have experienced different population policies and thus have been exposed to different family planning services. For many years, Fijian populations were protected as pro-natal policies were formulated to preserve the Fijian population (Hull & Hull 1973; Jolly 1998). In contrast, the Indo-Fijian population were the targets of population control policies (Hull & Hull 1973) making Fiji a particularly interesting case study with respect to family planning and development.

Family planning data shows that Fijian and Indo-Fijian populations have engaged with family planning in quite different ways (Roizen, Gyaneshwar & Roizen 1992; Chung 1999). For example, their preferred methods of contraception have differed. Also, Indo-Fijians have been consistently more accepting of family planning than indigenous Fijians. The differing relationships Fijian and Indo-Fijian groups have with family planning provide an interesting case for questioning and problematising

the ‘one-size-fits-all’ approach to both family planning and development which has been the object of critical attention. Women in both major ethnic groups in Fiji could be categorised as ‘third world woman’, yet their engagement with family planning and development differ. Fiji is thus a unique and interesting case study to highlight and engage with international debates around family planning, women’s empowerment and development.

Research Objectives

Within the international development community, an empowerment discourse provides a significant rationale for implementing family planning. The focus on Fiji in this research provided an opportunity to explore whether this international discourse was manifest in a local context and to make some assessments about the value of the associated strategies. While my objective was not to investigate whether women did experience empowerment in Fiji, I did want to tease out what family planning was said to offer women and whether ‘empowerment’ was a significant goal. This required a multifaceted research strategy. It involved the collection and analysis of official statistics, documentary resources and email interviews with people involved in promoting family planning at both the strategic and community level.

Theoretical Framings

Throughout the process of researching this thesis, I found that international family planning and development literature has used three main narratives to justify the implementation of family planning programmes in developing countries since the 1950s: over-population, health and rights. These narratives have also been pertinent to the construction of the empowerment discourse. Critical assessments of these narratives and the adoption of ‘empowerment’ by international development agencies informed the research I conducted. Investigations into these narratives raised critical questions about the value of family planning and its ability to empower women in Fiji. The overpopulation narrative advocates implementing family planning to prevent poverty and increase the resources available to women in developing countries. Critics of this solution to poverty, such as Mies and Shiva (1993), Under-Hill Sem (1994), Bandorage (1997), Gupta (2000) and Seltzer (2002) contest the existence of a

‘population problem’ and the relationship between high birth rates and underdevelopment. They argue that forces such as industrialisation, consumerism and colonialism are the cause of poverty and highlight the political and economic motivations that have shaped the ‘over-population’ discourse and the consequent administration of family planning.

Opponents of the health narrative argue that shifts in discussions about population control used health as a strategic move to enrol family planning users in response to objections to the ‘overpopulation’ discourse (see Hull and Hull 1973; Seltzer 2002). Others challenge the health narrative on the basis that health is culturally defined and highlight studies which show that some women experience negative side effects from the very technologies aimed at improving their health and wellbeing (Allen 2004; Hartmann 1987; Gupta 2000). They draw attention to the western genesis of contraceptives and contend that some negative side effects are a result of this factor. The health narrative draws on ‘modern’ western values that associate ‘control’ ‘predictability’ and ‘good’ health with modern scientific technologies and women’s empowerment. The ‘rights’ narrative constructs family planning as pertinent to women’s rights and their consequent wellbeing. Paid work and small families are constructed as being critical to women’s empowerment. Gupta (2000), Albury (1999) and Correa and Reichmann (1994) claim that ideas about ‘rights’ are politically and economically driven and are based on western values about individualism and choice. This narrative fails to consider the value of large families and unpaid work. These narratives position an empowered woman as a modern subject.

Literature that evaluated the contributing narratives of the empowerment discourse and the universalism and one-size-fits-all approach to many development programmes directed the analysis of this thesis and was particularly useful when exploring cross-cultural meanings and understandings of empowerment. Arguments that challenge the prioritisation of ‘modern’ mothers and ‘modern’ values (for example control, individualism, rights and capitalist relations of production) also inform this research. Additionally I draw on Foucault’s theory of ‘biopower’ (Sawicki 1991; Ransom 1997) to critically analyse family planning, empowerment and development. Biopower explores the importance of population to political and economic power. It provides a framework for analysing how governing bodies might insight desires as a measure to

control a population without coercive measures. By creating desires, it persuades people govern and discipline themselves, arguable the most effective form of social control. Biopower is useful to explore how the promise of empowerment might be used by family planning associations, development agencies and governments to enrol family planning users and encourage women to reduce their fertility.

Thesis Structure

This research looks critically at the construction of family planning as a source of empowerment for women in post-colonial Fiji. Arguments and evidence are distributed over seven chapters; a summary of each of the chapters is outlined below. The following chapter explores literature that critically investigates the multiple arguments and theories that both construct and deconstruct the empowerment discourse and its associated narratives in the field of family planning and development. It is broken into five sections, ‘overpopulation’, ‘health’, ‘rights’, ‘empowerment’ and ‘biopower’. These ways of framing discussions of family planning are important since they shape the analysis of the specific research findings relating to family planning and women’s position in contemporary Fiji offered in the subsequent chapters.

The history of family planning in Fiji is explored in Chapter Three. It provides an overview of the colonisation process and the impact of white settlers on the social, economic and political structures of Fiji. It explores early Eurocentric colonial policies and programmes aimed at improving existing pregnancy, childbirth, childcare and family practices. It investigates later family planning initiatives and discourses implemented by Fijian governments and non-governmental organisations (NGOs) and draws parallels between the intervention of the early colonial period and recent family planning programmes. It highlights the political nature of family planning programmes in Fiji and demonstrates that the discourses used to rationalise and advocate family planning, have been shaped by broader political and economic agendas. Understanding past family planning programmes and the impact of these initiatives on Fiji is important for providing a critique of current family planning programmes and empowerment strategies.

Chapter Four describes the research process. It summarises my research questions and also argues that pursuing the answers to these questions required a range research strategies. These included collecting and analysing official statistics and documentary sources, as well as key informant interviews. I looked at narrative-based data about women's experiences of family planning and the labour market; contraceptive information pamphlets used by family planning practitioners in Fiji; and information booklets from the UNFPA about family planning strategies and objectives. I also completed a series of email interviews with key informants who worked with issues around family planning and/or women's empowerment. Participants include representatives from the Fiji Ministry of Health, the Pacific Office of the UNFPA, a prominent women's rights activist and a family planning practitioner.

The analysis of the outcomes of that research are presented in Chapters Five and Six. They present evidence for an empowerment discourse in the words of those involved in family planning, both at the strategic and practical levels, and within documentary sources. I argue that three narratives relating to choice, health and full-citizenship inform the empowerment discourse in Fiji. These chapters critically analyse these narratives and show that many of the international constructions of empowerment are reflected in this local context. Chapter Five explores the choice and health narratives, while Chapter Six investigates the full citizenship narrative. In these chapters I question how assertions associated with the empowerment discourse empower women. I argue that political and economic agendas associated with neo-liberalism are consistent with the empowerment discourse and strategies to achieve fertility control. The use of universal strategies and initiatives is problematised, which challenges the success of the strategies in empowering women in Fiji.

In Chapter Seven, I review my key findings and use Foucault's biopower and critiques of universal development policies to draw conclusions about the manifestation of the empowerment discourse in Fiji. I find that the empowerment discourse is used to promote family planning services and find stories about the relationship between fertility control, choice, improved health and enhanced rights critical to its construction. The discourse, and its associated narratives, defines an empowered woman as a modern subject, advocating modern methods of fertility control, small families and participation in formal paid labour. Indeed these are the

very goals development agencies have been promoting for decades. I conclude that these narratives and the empowerment discourse are a clear example of biopower at work. I find that the generic strategies articulated by the empowerment discourse are ineffective in empowering the diverse needs of women in Fiji and in the process in fact create new challenges and different forms of subordination.

CHAPTER TWO

Literature Review and Theoretical Framings

Introduction

Family planning has been an integral component of development programmes. Over the past six decades, three narratives, overpopulation/poverty¹⁴, health and rights have primarily rationalised the implementation of family planning within international development literature (Seltzer 2002). More recently, talks about improving women's empowerment have emerged to validate development programmes and, more specifically, family planning initiatives. As this chapter will illustrate, the current empowerment discourse is largely informed by the narratives that preceded the empowerment discourse. This chapter explores the literature that both contributes to and contests these narratives and the empowerment discourse. Critical insights from this literature inform analyses of the empirical material gathered in this research to investigate the manifestation of the empowerment discourse in Fiji.

Literature on overpopulation/poverty commences this exploration. It describes what constitutes the overpopulation narrative and questions the application of family planning as a strategy to remedy what have been defined as population 'problems'. It critically explores the way in which ideas about population control have been used to advance claims about how to enhance women's wellbeing in developing countries. An analysis of the health narrative, which dictates that family planning is essential for the welfare of women and children in developing countries, follows. Improved 'rights' is an additional rationale for the implementation of family planning in development literature. However, antagonists dispute its validity which is based upon western

¹⁴ Poverty' in 'third world' countries was first 'discovered' in the post-World War II period. Development agencies sought to address this finding (Escobar 2002). While overpopulation was an early intervention it was poverty that they sought to address. The emergence of the overpopulation discourse and the implementation of family planning and population control policies was to remedy 'third world' poverty.

values. Concerns about the motivations behind this discourse of empowerment are also highlighted. Foucault's concept of biopower is considered as a way to understand the links between family planning, empowerment and development.

Family Planning: A Means to Combat Overpopulation?

Family planning was first implemented in the 1950s and 1960s as a development initiative in response to concerns of development agencies about the relationship between poverty and high birth rates. Three organisations from the United States, the Ford and Rockefeller Foundations and the Population Council, were the first to initiate international conversations on the effects of high birth rates (Seltzer 2002).¹⁵ They argued that population growth would exceed the ability of 'Third World' countries to feed their populations, have a ruinous impact on natural resources and the environment, hinder economic development and consequently perpetuate poverty. Since this time, poverty, insufficient resources and environmental degradation have all been nominated as consequences of 'over-population' (see also Hodgson 1983; Harkavy 1995). Calls to develop population control policies and programmes consequently ensued. Family planning services and contraception thus became a critical tool (Seltzer 2002).

Family planning initiatives were implemented in a number of countries. These included Chile, Colombia, Fiji, regions like Sub-Saharan Africa and other developing countries (Seltzer 2002).¹⁶ Development agencies maintained that reduced fertility and slower population growth would facilitate economic development and subsequently remedy poverty. Accordingly, family planning and modern methods of contraception have been identified by development agencies as critical in developing 'third world' countries and eradicating poverty (Moser 1993; Leftwich 2000; Seltzer

¹⁵ "Two international conferences are examples of these early consensus-building efforts. The International Conference on Family Planning Programs, held in Geneva, Switzerland, in 1965, included participants from 36 countries with representatives from government health ministries and representatives from private family planning organizations, bilateral assistance agencies, international organizations, and private foundations. The First Pan-American Assembly on Population, held in Cali, Colombia, also in 1965, had 80 participants from many countries and called for responsible parenthood..."(Seltzer 2002: 9).

¹⁶ Family planning programs exist in most countries and in all world regions. Since 1998, 179 governments have supported the provision of contraception. International donors have provided extensive support for many of the family planning programs in developing countries (Seltzer 2002).

2002). Significantly, this was not a theory that was constructed by people in ‘third world’ countries from their personal experiences; the United States were responsible for defining the apparent population problem (Seltzer 2002). This is interesting because, in identifying the ‘population problem’, the United States became privileged. Identifying this ‘problem’ situated the United States as knowledge providers and the benefactors, consequently putting them in a position of power. Contemporary rationales for implementing family planning continue to identify problems in the lifestyles and practices of developing countries. Often, external groups such as the (WB), the World Health Organisation (WHO) and the United Nations Population Fund (UNFPA), identify the problems. This continues to locate developing countries in the disadvantaged position of beneficiaries and perpetuates existing unequal power relations.

Seltzer (2002) illustrates that while family planning initiatives have been popular, they have also received extensive criticism. Whilst the rhetoric at the time was to alleviate poverty, Seltzer (2002) argues that some proponents of family planning initiatives were politically motivated by such factors as Cold War considerations and eugenic agendas. These political agendas resulted in some coercive population control programmes. Aversion to the term ‘population control’ consequently emerged, leading to discursive practices around international family planning initiatives being modified. As is explored later in this review, health predominantly overtook the rationale for implementing family planning (Seltzer 2002) as is clearly evident in the Fijian context.¹⁷ Whilst the narratives surrounding fertility control have changed, the political motivations have not necessarily disappeared. As I explore in the following chapters of this thesis, using an empowerment discourse to encourage fertility control is a politically useful tool.

Despite some negative connotations associated with population control, theories about overpopulation remain in contemporary development policies. The centrality of population and fertility control as a means of remedying poverty, promoting development and sustaining resources is evident in statements associated with the 1994 ICPD and the MDGs. The 1994 ICPD Programme of Actions stated that:

¹⁷ See page 54

The objective is to raise the quality of life for all people through appropriate population and development policies and programmes, aimed at achieving poverty eradication, sustained economic growth in the context of sustainable development and sustainable patterns of consumption and production, human resource development and the guarantee of all human rights, including the right to development as a universal and inalienable right and an integral part of fundamental human rights (UNFPA no date: 9).

Whilst the theories about population in this passage are less control centred and more human rights focused, the underlying ideas essentially embody the very narrative that existed in the 1950s. This passage presents ‘population’ at the centre of social and economic problems.

Kofi Annan reinforces the position of the ICPD Programme of Action when he states:

The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women’s rights, and greater investment in education and health, including reproductive health and family planning (UNFPA, c2000: 1).

Population control narratives and family planning as a means of preventing ‘over-population’ and its associated negative effects remain critical to contemporary development programmes.

The position that locates high birth rates at the centre of global issues, however, has received significant criticism. Under-Hill Sem (1994) is among those who analyse the ‘overpopulation’ theory specifically in regards to the Pacific context. She argues that population is not the primary concern in the Pacific and that population growth comes second to other more pressing issues such as the impact of consumption, technology and resource distribution in creating underdevelopment. She affirms:

The problem for the Pacific of not exploring this issue more fully and empirically is that population alone becomes the focus of analysis, to the exclusion of all other factors in resource use and degradation. In particular, more attention should be given to changing technologies, changing patterns of consumption, inefficient bureaucracies, the inequitable distribution of wealth, and unequal access to resources (1994: 11).

She also finds little evidence to confirm the common assumption that population growth negatively affects economic development in the Pacific. Others such as Griffen (1994) and Slatter (1994) also comment on, and critique, the continued focus of development agencies and the Fijian government on population and its relation to economic development and poverty.

Early development agencies were not the first to articulate the connections between high birth rates and poverty. Gupta (2000) argues that the strategy to implement family planning and control population growth to eradicate poverty and develop the 'third world' is closely aligned to a Malthusian worldview. She expounds that the close ideological views on population between Malthusianism and development is evidenced by the manner in which developmentalists hold women's fertility and people with 'excessively' large families responsible for their poverty and for global ills, such as environmental degradation and the dearth of resources. In 1798 when Thomas Malthus first articulated his theory, he argued that while population grows geometrically, food production and natural resources grow arithmetically, meaning eventually the globe will lack the space and food for its inhabitants. Bandorag (1997) states that Malthusianism attributes all social problems to population growth. The theory argues that insufficient resources are the result of population growth and that consequently, poverty could be remedied by population control¹⁸.

Bandorag (1997) fundamentally opposes the principle of Malthusianism. She does not believe that a reduction in population will alleviate the globe's ills. She maintains that population control, without simultaneously working to confront issues around poverty, the environment, political instability and other social tribulations, will conversely aggravate existing problems and result in the persecution of women. Mies and Shiva (1993) also refute Malthusian logic. They argue that the theory implies uncontrolled fertility that is purely unconscious, and maintain that women have always controlled their fertility to suit their needs and that of their surrounding environment.

Gupta (2000) contests the value of the contemporary population control narratives. She claims that some groups in developing countries align population control with western hegemonic power. This perspective contends that western countries take this opportunity to manage reproduction as a way to dominate developing countries and control their resources. This viewpoint implies that support for the control of

¹⁸ Whilst original Malthusian thought opposed abortion and birth control, as modern technologies emerged, neo-Malthusians began to advocate artificial methods of birth control as a means to control growing populations (Bandorag, 1997). Neo-Malthusian ideologies are similar to Malthusian philosophies. They attribute environmental damage, poverty, political instability on the vast burgeoning of populations (Bandorag, 1997).

developing countries' population has eugenic motives. They argue that population control seeks to minimise the growth and prevalence of non-white demographics.

Other criticisms of the population control narrative are outlined by Seltzer (2002) who maintains they have been controversial from their debut. In the post-war period, many developing countries suspected the motives of those implementing emergent population control policies prompting debates about cultural intrusion and the influence of outside countries on national policies. Additional criticisms came from women's rights and health advocates who addressed both the prospective and actual conflicts between human rights and national demographic goals fearing individual human rights might be jeopardised. Thus, they maintained that national demographic targets should not inhibit the right for women to conceive.

Whilst population narratives emerged in the 1950s and were subject to extensive criticism, their popularity was significantly augmented in the 1970s with the advent of two key contributions to this field: Donella Meadows' *Limits to Growth* and Paul Erlich and John Holdren's IPAT equation (Mies & Shiva 1993). *Limits to Growth* highlighted population increases as the main cause of global environmental deterioration (Mies & Shiva 1993). Erlich and Holdren's IPAT equation estimates that environmental impact can be measured where "(I) is a product of the number of people (P), the amount of goods consumed per person (A) and the pollution generated by technology per good consumed (T)" (Hynes 1999:39). Accordingly, environmental degradation is dependent on the number of people, the number of goods people consume and the pollution caused by the products. Erlich and Holdren argue that fewer people consume less goods and consequently minimise pollution and environmental degradation. Both these publications position population growth and high birth rates at the centre of many of the globe's most pressing issues. This locates family planning initiatives as being critical to the wellbeing and to the development of countries with high birth rates.

Ideas popularised in *Limits to Growth*, and the IPAT equation are evident in contemporary development literature. The State of World Population 1990 (published by the United Nations Population Fund (UNFPA)) states:

For any given type of technology, for any given level of consumption or waste, for any given level of poverty or inequality, the more people there are the greater the impact on the environment (as cited in Mies & Shiva 1999: 277).

Like the IPAT equation, the UNFPA acknowledges the role of consumerism in environmental degradation. However, it continues to single out population as both the primary cause of, and only solution to, global poverty. Mies and Shiva (1993), however, refute this position, arguing that degradation of land, deforestation, climate change, and global warming are the primary threats to the globe's welfare. They dismiss the thesis that an over-populated globe is principally responsible for this ruin. Instead, they hold industrialisation, consumerism and indulgent lifestyles of the West accountable for such demise.

The continued focus by development institutions on population control renders women in developing countries responsible for under development and pollution which diminishes attention to the role of colonialism and capitalism and fails to acknowledge the important economic advantages of high birth rates in particular systems of production. This Eurocentric model does not allow for the benefits of large families organised around subsistence-based living in which children are required for production and to act as social security for the parents' future (Mies & Shiva 1993). To assume that large families result in poverty and economic strife is to privilege western methods of production over subsistence economies and denies the heterogeneity of the world's cultures.

A Shift in Rhetoric: From Overpopulation to Health

While population control narratives continue to exist in contemporary development strategies, additional narratives advocating the integral role of family planning in improving the quality of life, particularly for women in developing countries, have since emerged. Seltzer (2002) maintains that following critiques of 'overpopulation' development agencies focused on maternal and infant health to promote, implement and rationalise the use of family planning in advancing, modernising and improving the quality of life for people in developing countries. This shift is overtly evident in the Fijian context and is explored in more detail in the following chapter (Hull & Hull 1973).

Seltzer (2002) contends family planning was linked to improved maternal and child health because family planning gave women access to safe and effective contraception and reduced maternal mortality by reducing the number of births and high-risk pregnancies. Whilst this argument began to emerge in the 1960s, it is most evident during the 1980s. Seltzer (2002) claims that using 'health' to encourage family planning was a strategy of development agencies to combat the negative connotations population control narratives brought to family planning initiatives. She maintains family planning, when represented as 'health', was better accepted by policy makers in developing countries than when linked to ideas about the negative economic consequences of large families.

Allen (2004) also discusses the emergence of a concern by the international development community in the mid 1980s around maternal mortality, the implementation of family planning programmes and the promotion of socio-economic development to remedy high death rates (see also Gillespie, 1987; Grant 1990; Sadik 1990). The diagram below (Figure 1) which was produced by the World Health Organisation, and reprinted by Allen (2004), illustrates the association development agencies made between pregnancy and ill health.

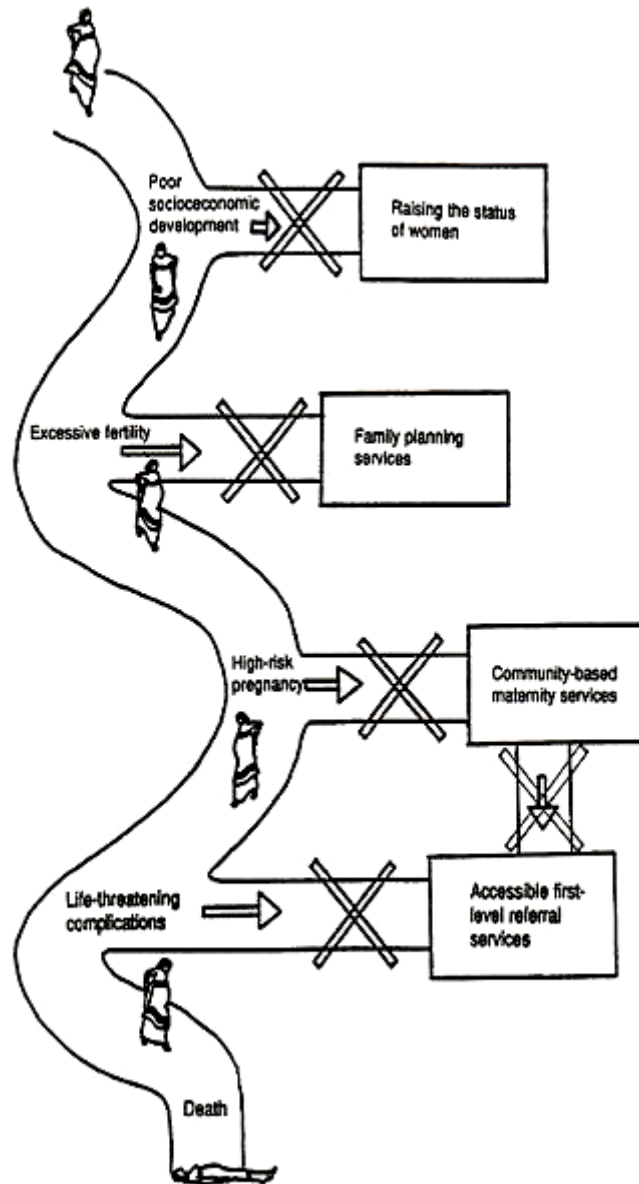


Figure 1: The Road to Maternal Death (Allen 2004:4)

The diagram explicitly links pregnancy with ill health and advocates family planning and economic development as critical strategies in improving the life chances of women in developing countries. It is a simplistic model, which implies that women in developing countries who have large or ‘excessive’ families are on a trajectory to death.

Allen (2004) discusses the concern international development agencies had about maternal mortality in relation to a development programme in Tanzania. This programme was the “Safe Motherhood Initiative”. This Initiative came out of a

conference in 1985, hosted by WHO in Geneva, Switzerland, which brought together a range of policy-makers, researchers and health specialists to discuss the causes of maternal mortality in developing countries. The issues that were raised from these discussions saw the UNFPA and WB join with WHO to develop and internationally promote the “Safe Motherhood Initiative” in 1987. The rhetoric around the strategies was that they were designed to create measures that would make motherhood safe for women in developing countries. The aim was to halve the number of maternal deaths by 2000. Allen states that:

a standard set of preventive and curative interventions were seen as key to achieving this goal.... These included, but were not limited to, the establishment of emergency obstetric and community maternal health services, the promotion of family planning, and the implementation of social policies to raise the status of women (2004: 8).

This international initiative implemented a generic formula for reducing maternal death in a myriad of developing countries. The impact and failure of these universal policies is explored in regards to Tanzania below. Looking critically at the universality of family planning services and programmes is an important component of this analysis, as findings in this research suggest that generic family planning services are also ineffective in the Fijian context.¹⁹

Whilst Allen (2004) discusses the Safe Motherhood Initiative in regard to Tanzania, the critical nature of her research renders it useful for analysing family planning in other national contexts. Allen highlighted the different perceptions of those involved in implementing the Safe Motherhood Initiative and the perspective of many of the women she spoke to about the danger of women’s fertility. The principal agenda of those executing the Safe Motherhood Initiative was addressing the effect of “excessive fertility” on women. However, most women in Tanzania were primarily concerned with the risk of “unsuccessful fertility” and the impact of this on their identities as women and mothers (2004:10). Great measures, including spiritual and herbal remedies, were undertaken to ensure that they became pregnant and that the pregnancies went to full term.

In this regard, the risk associated with pregnancy manifested in quite different ways and is significant because it suggests the initiative was creating strategies that did not address the needs or desires expressed by the women in Tanzania. Measurements of

¹⁹ This is discussed in Chapters Five and Six. See specifically Chapter Six, pages 107-111.

what was deemed most important to women in Tanzania differed from what the development strategy understood to be necessary. This raises issues that extend beyond the realm of health to development policies in general. It suggests that some development policies do not adequately shape their programmes to the cultural context in which they are being implemented. This problematises the value of one-size-fits-all development programmes and highlights their Eurocentric nature. Similar assessments can be made with respect to family planning initiatives in Fiji. When family planning is promoted for improving women's health or empowering women, it is difficult to be critical of the programmes. However, as the Tanzanian case has illustrated and as the Fijian case will also show, generic programmes often do not have the desired positive effect.

Also significant about Allen's (2004) work was the presentation of the side effects many Tanzanian women expressed about family planning. Many did not subscribe to family planning because of the harmful side effects associated with fertility control technologies. Irregular periods, cancer, infertility and risks to women's spirituality were all provided as reasons for not using family planning. Similar findings are evident in the Fijian context.²⁰ A dominant rhetoric of family planning programmes is to promote good health and foster wellbeing; however, the negative side effects of the contraceptives experienced by the women in Tanzania challenge the benefits of such narratives and programmes.

It is probable that the experiences of women in Tanzania will differ from how women from other parts of the world engage with family planning. Literature by Hartmann (1987) is useful for explaining this. She argues that "technological innovations are not 'neutral', instead they embody the values of their creators" (161). Birth control is a product of modernity, developed in the West. To assume that birth control technologies developed in the West will affect a population that is not embedded in modernity and its associated values is to ignore the cultural values attached to technological innovations.

²⁰ See pages 85-88 in Chapter Five.

Whilst many of the side effects outlined by Allen (2004) as affecting women in Tanzania are consistent with experiences in the West, such as irregular periods, some of the spiritual experiences are specific to the local belief systems and expectations of Tanzania. The inattention of some development agencies to the incompatibility of modern fertility control with some groups may, in part, be explained by what Ong describes as “a kind of magical thinking about modernity” (as cited in Allen 2004: 16). Modernity has historically claimed to be superior to other worldviews and is often valued over traditional customs and practices.

The privileging of modernity in the field of health and family planning is further evident in writings by Jolly (1998). Jolly explores the notion of modernity in relation to motherhood in the early colonial era in Fiji and Vanuatu, with a particularly relevant discussion of Fiji. She details the prioritising of modern understandings of pregnancy and motherhood by colonials and missionaries, in Fiji, over traditional methods. Strategies to implement modern practices in regard to health, hygiene and childcare were born from ‘understanding’ the ‘superiority’ of European health and family practices. Interestingly, Jolly (1998) draws parallels between early colonial practices and contemporary development policies which maintain the possession of knowledge and skills to dictate what constitutes good health, good mothering and appropriate familial structures. This is addressed in more detail in the following chapter.

Literature by Albury (1999) also contributes to a critique of the health narrative. She argues that women’s bodies and their reproductive capacities have been medicalised as part of the modernity discourse. She argues that the medicalisation of fertility depicts women’s bodies as being in need of control, discipline and medical treatment. This constructs women’s bodies as sick and places the western medical technology and philosophies in a position of power. She also argues that “pregnancy is often regarded as a moral failure of control and personal responsibility rather than as a failure of the contraceptive method or plain bad luck (38).”

The health narrative is evident in the ICPD Programme of Action and the MDGs. It is asserted that:

The highest proportion of women's ill health burden is related to their reproductive roles. Universal access to reproductive health care – including family planning; care in pregnancy; during and after child birth; and emergency obstetric care – would reduce unwanted pregnancy, unsafe abortion and maternal death, saving women's lives and the lives of their children (UNFPA no date: 20)

This illustrates the extent to which the health and medicalisation narratives shape contemporary development strategies. It fuels the implementation of family planning programmes and attempts to convince women that their bodies require medical assistance for the everyday 'control' of their fertility.

Whilst development strategies advocate that modern methods of contraception are critical to women achieving good health, Hartmann (1987) challenges this assumption. She claims that modern contraceptives have negatively affected the health of women living in developing countries. Both Hartmann (1987) and Gupta (2000) discuss the use of poor women in developing countries for contraceptive trials and the use of unsafe contraceptives. Similarly, Tagicakibau²¹ highlights the need to address this in Fiji.²² Gupta (2000) calls attention to double standards in the implementation of contraceptives in developing countries, claiming there are a number of products available and used in developing countries that have been restricted or prohibited in developed countries. Additionally, she points to the lack of information supplied to the health providers and clients on contraception in developing countries. Findings outlined in Chapter Five suggest that this issue is very relevant in the Fijian context.

Family Planning: From Health to Human Rights

The question of human rights is an additional narrative used by development agencies to enrol users (Seltzer 2002). Conversations connecting family planning and human rights first emerged in the late 1960s when the United Nations announced:

That lasting and meaningful peace will depend to a considerable measure upon how the challenge of population growth is met. That the objective of family planning is the enrichment of human life, not its restriction; that family planning, by assuring greater opportunity to each person, frees man to attain his individual dignity and reach his full potential (Berelson 1969b as cited in Seltzer 2002: 7–8).

²¹ A key informant interviewed for this research. She is a women's rights activist in Fiji. This is detailed on page 69.

²² See page 84.

Emerging in the 1960s, this narrative became predominant in the 1990s and was particularly visible during the ICPD when women's reproductive control was constructed as being intrinsic to both human rights and development (Seltzer 2002).

Gupta (2000), however, is critical about the use of 'human rights' in the context of family planning and development. She maintains that the narrative has been pilfered from women's right movements in the 1960s, as a way of covering the agendas of population control strategies. As the earlier section on overpopulation illustrated, population control strategies have many negative associations. She claims the goals of early population control programmes remain the primary objective of implementing family planning, despite a shift towards talking about fertility control in relation to rights (Gupta 2000). Bandorage (1997) supports this position. She is also sceptical of the human rights narrative in this context. She asserts that the promotion and availability of family planning services have not improved women's rights but instead have altered the appearance of their oppression.

Albury (1999) similarly explores the promotion of 'rights' with particular reference to reproductive control. She argues that this is a political issue which is over-shadowed by the narrative of individual rights. She asserts that a narrative which appeals to individual liberties hides the underlying power relations that exist within reproductive control programmes. She claims that a narrative that centres on reproductive control as being a human right fails to discuss the political and economic advantages that come from a reduced population and small families, which benefit a few elite. For example, part of the rights narrative encourages the participation of women in paid work. This clearly supports neo-liberalism and promotes capitalist growth.

Correa and Reichmann (1994) challenge the place of human rights' narratives in developing countries. They argue that current family planning and development programmes and their focus on individual autonomy is a western construct. They contend that many Southern activists assert that:

the related concept of bodily integrity is contested as founded in Western capitalist assumptions of self-ownership that imply a patriarchal, bourgeois concept of a discrete 'self' that maybe subjugated by medical science, population control or patriarchal kinship systems. The individualism and possession of the body, as well the power dimension implied in a concept of autonomous control (and, therefore, individual choice) are criticized as culturally

biased notions inappropriate for many Southern women, particularly in Asia and Africa (1994: 77).

This suggests that the very attempt to discuss women's rights and implement reproductive control is not universally approved challenging the implementation of the western family planning technologies in Fiji and the understanding it is essential to women's rights and wellbeing.

'Rights' are espoused as being critical to family planning in which ideas about 'choice' are often promoted. Albury (1999) problematises the rhetoric of choice, arguing it is not an expression of personal freedom but is rather limited to making decisions within certain parameters. This is certainly evident in the Fijian context.²³

Participants in the Women's Global Network for Reproductive Rights 1993 India meeting also challenged ideas about choice. They argued that:

Putting free choice central to reproductive rights leaves too much room to interpret it at an individual level and thus completely bypasses the level of society as a whole. As such, 'choice' reflects the dominant view of individualism in the West, more than anything else. Choice on its own, without much attention to the context, has no value. (Correa and Reichmann 1994: 77)

This troubles the discourse that depicts birth control as synonymous with women's liberty, freedom and empowerment.

Family Planning as Empowerment

Whilst empowerment has been associated with women's rights issues for many decades, the relevance of empowerment in mainstream contemporary development initiatives is relatively new. Empowerment is the buzzword of current development programmes.²⁴ It is used not only in association with family planning, but in other development programmes such as micro-credit initiatives.²⁵ Implementing strategies to advance the quality of life for people in developing countries has been the rhetoric of development agencies from their debut. An empowerment discourse is consistent with this trend. This section explores the empowerment discourse and literature that analyses this as a means to justifying family planning intervention. Critical literature highlights the emphasis development institutions place on the economic participation

²³ See Chapter Five.

²⁴ This was detailed in Chapter One: Introduction of this thesis.

²⁵ See for example Genfinance (2005); Grameen (2005).

of women in determining their empowerment and claim that the discourse is a new face to old strategies.

The promotion of women's empowerment as a development agenda suggests a change in developmentalists' motivations and the way in which they attend to women's needs. In early development initiatives, women were primarily passive recipients of aid, they were given little consideration and no attempt was made to include women in the development process (Moser 1993). During the 1980s, this changed and developmentalists sought to make women active participants in the development process. However, this primarily involved encouraging women to enter paid work (Moser 1993). Critics of this era refer to it the lost decade in development (Kabeer 1994). Poverty grew and antagonists of this approach argue that encouraging women to participate in paid work was more about supporting international capitalist growth than improving the living conditions for women in developing countries. An empowerment discourse presents a particularly humanitarian rhetoric to development and suggests a move away from purely economic centred development. However, closer attention to empowerment strategies within development literature suggests that economic and political motivations continue to lie behind the benevolent exterior of development programmes.

The empowerment discourse is evident in statements made during the 1994 ICPD. This Conference marks the introduction of the empowerment discourse to conventional development initiatives. Thoraya Ahmed Obaid comments that:

The ICPD consensus on population and development starts with respect for national sovereignty and for human rights. Its goals include universal access to education and health care, including reproductive health – family planning services; safe motherhood; treatment and prevention of sexually transmitted infections including HIV/AIDS, and protection from violence. ICPD goals also include empowering women and guaranteeing their access to education, healthcare, and work outside the home. Empowering women is an end to itself. It also translates into stronger families and communities and gives them the power to fight poverty together (UNFPA no date: 3).

This quote illustrates how the empowerment discourse plays out within this context. It shows how this discourse reuses key ideas already explored within the overpopulation, health and rights narratives. The empowerment discourse envelops many of the critical discourses that have surrounded family planning initiatives for many decades. The Fiji context reinforces this position.

Since the ICPD, the empowerment discourse has continued to shape development programmes. This is evident in the MDGs. In 2000, 189 countries signed the Millennium Declaration. This Declaration promised to combat global poverty and implemented strategies to achieve this goal. These included: eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/Aids, malaria, and other diseases; ensuring environmental sustainability; and developing a global partnership for development (Sweetman 2005). Significantly, the provision of family planning was critical to the achievement of all the mentioned goals. Of particular significance to this research is the third goal, which seeks gender equity and the empowerment of women.

According to Karl (1995), development agencies have two primary approaches to implementing empowerment strategies. The first is through economic empowerment; this is achieved through increasing women's economic status and prioritising tools which aid this goal, such as: education and access to credit. The second approach empowers women through "education, literacy, the provision of basic needs and services and fertility control" (1995: 109). These are all strategies which describe women as passive recipients of development. The empowerment discourse evident in the MDGs guide current development initiatives by institutions such as the UN. The promotion of gender equality and the empowerment of women, as an objective of dominant development programmes, is viewed by many as an acknowledgement of the success of the international feminist movement (Sweetman 2005). According to Sweetman, this perspective endorses the mainstreaming and internationalising of this agenda.

Kabeer (1994), however, rejects development initiatives that endorse strategies to empower women. Kabeer argues that the view of empowerment, encompassed in these goals, is narrow and finds the implementation of empowerment by development agencies ironic. This is because "the vision and values of women's groups and organisations across the world have been translated into a series of technical goals to be largely implemented by the very actors and institutions that have blocked their realisation in the past" (1994 as cited in Sweetman 2005:4). Lairap-Fonderson, is also critical of the way empowerment is used within development programmes. She

maintains that “[t]he attractiveness of the concept of empowerment lies mainly in the fact that it legitimises various policies and practices. Empowerment is economically, politically and socially useful” (2002 as cited in Sweetman 2005: 4). These opinions suggest that the empowerment discourse is complex and requires a critical reading attending to the specificity of context and the problem at hand.

Another critical perspective is presented by Young who states that development institutions primarily use empowerment to refer to “entrepreneurial self-reliance”. She states:

The term echoes the general emphasis within the mainstream on unleashing the capacity of individuals to be more entrepreneurial, more self-reliant. It is closely allied to the current emphasis on individualistic values: people ‘empowering themselves’ by pulling themselves up by their bootstraps (1993 as cited by Karl 1995: 108).

This suggests that empowerment is fundamentally about economic autonomy. In conventional development initiatives, individuals are responsible for their own empowerment. It is about personal action and choice and does not consider the impact of external forces on individuals’ situations.

Rowlands (1998) also attends to the individualistic nature of the empowerment discourse. She problematises the notion of empowerment in this context, arguing that empowerment is “rooted in the ‘dominant culture’ of Western capitalism and [has] arisen alongside ‘individualism, consumerism and personal achievement as cultural and economic goals” (1998:11). She claims that ‘empowerment’ is a development tool that serves to validate and authorise development *over* women. By creating development policies in the name of empowerment, the economic and political agendas that shape many development initiatives are hidden.

Rowlands (1998) argues that the empowerment discourse first emerged in the 1980s becoming popularised in the 1990s during development initiatives known as GAD (Gender and Development) which sought to make women active participants in the development process. For many years, women had been recipients, but not agents of development. However, change was effected during this period. The act of bringing women into the development process was supposed to empower women to contribute to their countries’ economic and political configurations. Accordingly, Rowlands understands empowerment to be fabricated and developed as a tool to encourage

women's active participation in the economy. This serves to fulfil the primary objectives of development institutions – economic growth.

An additional reason for Rowlands' (1998) critical perspective of the empowerment discourse comes from her understanding of empowerment. Rowlands maintains the very meaning of empowerment requires that it be a process emerging from within. This problematises the empowerment discourse, which relies on the implementation of strategies created by development institutions to empower women. Many 'empowerment' strategies are implemented through forced Structural Adjustment Policies (SAPs) and neo-liberal reforms; contradicting the very sentiment upon which empowerment is built.

To better comprehend empowerment, Rowlands (1998) explores the root of the word, power. She argues that power carries multiple meanings. Considering the different constructions of power opens up the opportunity to have different understandings of empowerment. She states that in the social sciences, the most dominant definition of power, is 'power over'. Understanding power in this way has implications for conceptualising empowerment, for it suggests that the process of empowering a group using this definition requires a subordinate or dominated group. According to Rowlands, development policies construct empowerment relative to the common understanding of power, which is 'power-over'.

To seek an alternative to the empowerment discourse, as it stands within contemporary development programmes, Rowlands (1998) explores other definitions of power. Particularly significant are feminist definitions. Power, from this perspective is defined as 'power with' or 'power from within'. This eliminates the hegemony commonly attributed to the concept. Comprehending power in this way gives empowerment a different meaning. This has implications for how strategies to empower women could manifest. It suggests that empowerment should not be 'done' to women, but that strategies should either come from women themselves, or be constructed with women. This supports Rowlands early scepticism about the effectiveness of empowerment strategies that are imposed on women

Clearly, empowerment, in the context of development, has evoked much discussion. Rowlands (1998) summarises the two debates nicely. She argues that the principal problem associated with the empowerment model is finding a balance between combating internal subordination and preventing development institutions from imposing strategies that may not be desirable or compatible with the countries in which they are implemented. Empowerment becomes a highly political issue; it is about power and thus, potentially, an authoritative and dominant phenomenon that requires close attention.

As it stands, development strategies to empower women in Fiji are problematic. The formula for women's empowerment is largely constructed around family planning and the ability of its technologies to improve material wellbeing, health and human rights'. However, as this section has illustrated, 'empowerment' has varied definitions and understandings. This suggests that for women in Fiji, 'empowerment' is more complex and complicated than the development strategies propose. The workshop *Women, Development and Empowerment: A Pacific Feminist Perspective* (Griffen 1989) is useful for gauging a Pacific understanding of empowerment.

One of the critical points to arise from the workshop was the women's desire for a definition of empowerment to be created by women themselves in the Pacific (Griffen 1989). This suggests that universal understandings of and strategies to achieve empowerment are problematic. This questions the validity and place of universal development strategies to empower women in Fiji. Critical to empowerment is the root word, power. This is also reflected in Griffen's understanding of empowerment. She argues empowerment in the context of women in the Pacific simply means, "adding to women's power" (1989: 118), where power means,

having control, or gaining greater control; having a say and being listened to; being able to define and create from a woman's perspective; being able to influence social choices and decisions affecting the whole society (not just areas of a society accepted as women's place); being recognised and respected as equal citizens and human beings with a contribution to make (1989:118-119).

Understanding empowerment in this way is useful for critically exploring current initiatives and outcomes of empowerment strategies in Fiji.

Biopower and the Empowerment Discourse

Foucault explores the interest political authorities have in surveying and regulating populations through a discussion of ‘biopolitics’. I explore writings about biopower to consider how it might be useful in the context of family planning practices and the empowerment discourse. Biopolitics acknowledges the importance of population to economic and political agendas (Ransom 1997). The centrality of population to family planning and the empowerment discourse renders his theory useful for investigating how the empowerment discourse might affect people who embrace the discourse and how it might persuade women to use family planning practices.

Biopolitics draw on the idea of biopower. Foucault’s ‘biopower’ is composed of two basic and interwoven forms: disciplinary power and regulatory power. Disciplinary power is an understanding of and control over the individual body. Disciplinary practices are the actions that control people’s bodies. Disciplinary practices depict the body as akin to a machine (Sawicki 1991) and aim to “render the individual both more powerful, productive, useful *and* docile” (67) and in doing so achieve control. In this case, birth control technologies might represent a form of disciplinary practice, as they are the measures individuals take to control their bodies. Birth control technologies make women’s reproductive capacities ‘docile’ in an attempt to become more powerful, productive and useful to themselves and the society at large, for it allows them to participate in paid work and engage in activities outside of the home. Also significant to biopower is regulatory power which regulates populations by creating governing policies and interventions (Sawicki 1991: 68). Population control policies, health initiatives and the empowerment discourse might be examples of regulatory power.

Foucault argues that biopower and the use of disciplinary and regulatory power, as a way of controlling populations, is unlike many other forms of power. It is different from forms such as violent power, as it is seemingly benevolent and difficult to detect. According to Foucault, this makes biopower a peculiarly insidious and effectual form of social control. Compliance is achieved “not through the threat of violence or force, but rather by creating desires, attaching individuals to specific identities, and establishing norms against which individuals and their behaviours and bodies are

judged and against which they police themselves” (Sawicki 1991: 68). The empowerment discourse is a particularly emotive discourse. It makes great guarantees that the strategies advocated by family planning and development programmes will reduce poverty, improve health and improve the status and rights of women. Biopower offers the opportunity to explore how the empowerment discourse might create desires in individuals to control their fertility and participate in paid work without strict population control policies or forced labour.

Critical Reflections

This review has opened up a number of debates in relation to the empowerment discourse in the field of family planning and development. Critical examination of the debates that surround the empowerment discourse is pertinent to providing an in-depth and critical investigation into the case study of Fiji. This literature is pertinent to informing the analysis of my empirical data and significantly contributes to evaluating family planning and the empowerment discourse in Fiji. The following chapter seeks to contextualise this discourse in Fiji. What follows is an exploration into the history of population and family planning in Fiji.

CHAPTER THREE

Population and Family Planning in Fiji- Historical Overview and Analysis

Introduction

Investigating how the empowerment discourse is manifest in Fiji, in the field of family planning, requires attention to specific elements of Fiji's history. In particular, it requires an investigation into how family planning came to Fiji and the discourses that have shaped the birth control programmes. The arrival of Europeans has been a significant part of Fiji's history and critical to family planning services. To commence, this chapter discusses the advent of Europeans to Fiji and the way in which they exploited the people and natural resources for profit-making endeavours (Sutherland 1984). It also investigates the effects of Eurocentric ideas about family life that missionaries brought to Fiji in the early to mid 1800s. One of the primary goals of the missionaries was to 'educate' the Fijians on their 'uncivilised' familial structures and practices with which they were confronted. This intervention and privileging of European knowledge foreshadows later family planning initiatives (Jolly 1998).

This chapter addresses dramatic decline in the Fijian population parallel to European contact (Hull & Hull 1973) and explores pro-natal policies implemented by the colonial government as a consequent strategy in the later nineteenth century. These policies were designed to remedy the customs that the European community identified as causing the decline, which in the process implicated local practices and positioned indigenous Fijians as unknowing subjects in need advice and education (Hull & Hull 1973). The pro-natal period is contrasted with the overpopulation discourse that emerged in the early part of the twentieth century. Concerns about population growth first emerged as the Indian population, who arrived as indentured labourers, threatened to outnumber the Fijian and European communities (Hull & Hull 1973). To

control the growth of the Indian population birth control technologies were promoted in the 1950s within Indian communities. This is the genesis of family planning in Fiji.

The overpopulation discourse continued to provide rationale for the place of family planning in Fiji throughout the 1950s; however, in the late 1950s and the early 1960s, discussions shifted from racial issues to resources (Hull & Hull 1973), reflecting the international overpopulation discourse at the time. The colonial government argued that high birth rates would negatively affect natural resources and inhibit economic development. The change from pro-natal policies and concerns about 'under population' to the adoption of the overpopulation discourse and its consequent shift, suggests that population management in Fiji has been politically and economically motivated. Discussions about family planning in relation to population diminished in the 1960s to be replaced with a discourse about health (Hull & Hull 1973). A review of the historical climate in which family planning has been implemented in Fiji is critical to understanding current population (or fertility) control strategies articulated in a discourse of empowerment.

Colonisation of Fiji

A critical phase in the history of Fiji was the coming of Europeans in the early nineteenth century. Early Europeans, and their continued presence, brought new ideas to the Fiji islands and significantly affected their existing social, economic and political structures (Hull & Hull 1973; Sutherland 1984; Chung 1991). Early Europeans were primarily attracted by the profit-making opportunities the Islands presented (Sutherland 1992). Whilst the commercial incentives for the place of Europeans in Fiji have become less explicit, profit-making opportunities have continued to drive colonial and neo-colonial initiatives (Jolly 1998). Family planning is one such initiative. This becomes evident throughout this and subsequent chapters that explore the empowerment discourse in Fiji and the role of family planning within development programmes.

The first Europeans believed to have arrived in Fiji in 1800 were men shipwrecked on the trading boat *Argo* on its way from Australia to China. *Argo* survivor *Oliver Slater*, noting Fiji hosted sandalwood and knowing China's demand took the news to New

South Wales (Derrick 1946). A resultant throng of Europeans came to Fiji to seek their fortunes and soon Fiji became incorporated into trading with China, the Pacific and the North West coast of America (Sutherland 1984). After a decade of lucrative commerce for the Europeans in Fiji, trade in sandalwood began to decline. However, the lines of trade were open and a much larger trade in *beche-de-mer* ensued. Further, profit-making initiatives followed. The sea slug was in great demand within the affluent classes in China which saw the trade in *beche-de-mer* extend to unprecedented levels by 1829 (Sutherland 1984; Ward 1972). The Fijians played a critical role in this process providing cheap labour required to fell trees, transport goods or procure and cure *beche-de-mer*. This presented Fijians with an alternative production system and took Fijian men away from their families in the villages. Both the exposure to capitalism and the absence of many Fijian men from their villages put pressure on the subsistence-based lifestyles they were accustomed to living (Sutherland 1984).²⁶

Whaling on the coast of Fiji also emerged during this period bringing mostly American whalers to the region (Ward 1972; Sutherland 1984) and proving a lucrative activity. By 1840, the whaling and trading of *beche-de-mer* had largely subsided but Fiji had been exposed to global trade and capitalist relations were well established. Fijians had been shown the worth of resources beyond their 'use' value and introduced to the 'trade' value of local materials (Sutherland 1984). Trading was one of the first disruptions to Fijian practices and ideologies²⁷ marking the beginning of a trend that saw Europeans use resources in Fiji for economic imperatives that gave little return to the indigenous population.²⁸ Commercial imperatives continue to be reflected in later projects implemented by Europeans and the colonial government. These include the advent of a cotton industry²⁹ and sugar plantations, which involved

²⁶ This period was critical for introducing capitalist ideologies to Fiji. Capitalist production requires small families. The link between capitalism and the need for fertility control technologies is important.

²⁷ Detailed knowledge about the structure of Fiji, before European contact, is vague. However, it is generally understood that prior to capitalism, production in Fiji was primarily subsistence-based and organised by small semi-independent social groups ruled by independent chiefs. The structure of pre-European Fiji, however, differed from most subsistence production in that commoners worked the land and gave surplus produce to the chiefs. The reverence and material goods awarded to the chiefs was in exchange for ensuring the safety, welfare, harmony and cohesion of the group (Sutherland 1992).

²⁸ For information on the unscrupulous practices of the visiting traders see Williams (1858); Derrick (1946); France (1969).

²⁹ European profit-making schemes continued to prompt change in Fiji throughout the nineteenth century. In the mid-eighteen hundreds, the American Civil War severely declined, which gave rise to a global

contracting Indian indentured labourers.³⁰ Current family planning initiatives and the strategies advanced within the empowerment discourse also favour capitalism and promote the benefits of formal production over traditional systems.

Wesleyan missionaries arrived in 1835, shortly after the first traders and fortune hunters, and continued to come throughout the 1840s (Sutherland 1984). Whilst the missionaries' imperatives were not economic centred, their impact on the local culture was also significant (Chung 1991; Jolly 1998). Their primary aim was to enlighten the indigenous population about the 'Christian way of life' and to 'civilise' the 'savage' local people. Accordingly, they attempted to 'educate' Fijians about the 'better' European way of life. They attempted to remedy family structures that did not fit the nuclear family model and practices surrounding marriage, pregnancy, childbirth and motherhood that the European missionaries deemed uncivilised, inappropriate, unsafe or unhygienic (Jolly 1998). This process assumed a superiority of European culture. It suggested that local Fijians were unable to care for themselves and that they required help and education from Europeans. In many ways, this process foreshadows later pro-natal policies that were implemented by the colonial government in an attempt to remedy high death rates in the Fijian community that were prevalent around the time of colonisation and associated with 'inferior' indigenous practices.

shortage in cotton. Fiji filled this shortage (Sutherland 1984). Hopeful merchants from Australia and New Zealand arrived in Fiji to buy land and try their fortune. The arrival of Europeans to Fiji to secure their fortune had implications for the indigenous population. Capitalist production had a significant impact on both the land and people of Fiji. For example, Fijians primarily functioned on a subsistence-based lifestyle. The setting up and expansion of the cotton fields meant that land once belonging to some Fijians was taken away from the local people for European cotton production. This disrupted the subsistence-based economy of some indigenous people, dislocated people from their homes and resulted in conflict between the European cotton producers and the Fijians (Ward 2002). The European settlers treated the Fijians poorly, were abusive and engaged in acts of gross misconduct and 'tyranny' (Sutherland 1992:18). During this period, the country was in a state of disarray. Aside from the social implications of the chaos that emerged at this time, it became evident that the instability present was inhibiting production. Capitalist modes of production necessitated stability and order. Accordingly, measures to establish law enforcement and a legal system ensued (Sutherland 1992). By 1873, the once affluent trade was in serious decline and the country was fast approaching bankruptcy. Discontent had reached its summit and a final call to Britain to colonise the Islands resulted in the annexation of Fiji on 10 October 1874 (Sutherland 1992). The colonial government brought further changes to the structure and social life of Fiji. As becomes apparent throughout this chapter, many of the changes were further centred on economic development.

³⁰ Discussed on page 45 of this chapter.

Population Decline After Colonisation

As previously illustrated, Europeans had a major impact on the land, people and culture of Fiji. However, one of the major impacts of the European community on the indigenous population that has not yet been discussed was the high death rate caused by the introduction of European diseases. The high death rate was one of the first issues to confront the colonial government. The most likely estimate of the size of the Fijian population at colonisation in 1874, was 140,500 (McArthur 1968). By 1901, the population had fallen to 94,397 and in the 1921 census the population recorded was 84,475 (Hull & Hull, 1973: 169). This decline was a source of considerable concern for both the Fijian leaders and British officials who sought to understand the decline and implement remedies to prevent the extinction of the indigenous population. At this time, foreign diseases, acknowledged as potentially contributing to the falling population, were generally given a low priority. Instead of looking at the contribution of the European community to the high death rates, Europeans immediately set to blame the indigenous population (Hull & Hull 1973). Little consideration was given to the fact that the Fijian population had been more than capable of caring for their communities for centuries before the arrival of Europeans. Eurocentricity did not allow for explanations that might implicate the European settlers.

Discussions about the cause of population decline identified a number of factors responsible. These included “insufficient care and nutrition of infants, the sick and aged; the disruption of the traditional Fijian custom of a post-partum taboo on intercourse; women inducing abortions and causing barrenness; and high fees for marriage acting as a deterrent to unions” (Hull & Hull 1973: 169). It was also suggested that, “the practice of women working while pregnant and soon after childbirth, [and] the poor [quality of] food and water supplies of unsanitary dwellings of the Fijians” were factors which contributed to the high death rates and declining population (Hull & Hull 1973:179). Chiefs and British administrators recommended that the government implement strategies to prevent further decline. From this emerged a number of regulations. These included the prohibition of abortion, penalties for women who “attempted to cause barrenness” and rewards for large families (Hull & Hull 1973: 170). Fijian families, women in particular, were effectively punished or rewarded according to the size of their family, which was

largely beyond their control. They were forced to change their behaviour to compensate for what was the result of diseases brought to Fiji by the European community.

Further attempts to remedy the population decline emerged in 1891 when the colonial government commissioned an inquiry into the causes of the high death rate. The colonial secretary distributed a circular to a significant proportion of the European community (Hull & Hull 1973) requesting opinions on the causes of, and remedies for, the population decline. This presented the European community as having a greater perspective and understanding of the problems facing the Fijians than the indigenous population who were living the experiences. New explanations that emerged from the circulars were that children received insufficiently nutritious food and that Fijian women had “a weakness of maternal instinct” (Hull & Hull 1973: 172; see also Jolly 1998). The remedies suggested included, “training village midwives, raising the status of women, creating incentives to ‘industry’ and ‘thrift’, and employing European officers to serve as examples of ‘civilised behaviour which the Fijians could copy’” (Hull & Hull 1973: 172; see also Jolly 1998; Thomas 1990). Despite the disruption European settlers had brought to Fiji, the European community continued to ‘other’ the indigenous population and primarily held indigenous practices responsible for their decline.

The outcome of these opinions saw the introduction of pro-natal policies essentially putting Fijian women under surveillance and seeking to change local practices deemed responsible for the high mortality rates (Jolly 1998). Policies managing the physical labour of pregnant women were one example of a strategy that emerged from the inquiry. Whilst restrictions prohibiting women from fishing at night were already in place, further limitations forbidding women to fish all together, were imposed (Jolly 1998). Digging and carrying firewood also became illegal for women while they were pregnant and for the six months following childbirth. These were activities that prior to the pro-natal policies had been part of everyday activities for women. A few of them monitored men; however, the policies were disproportionately aimed at women (Jolly 1998). The rhetoric of the colonial government was that they had a particularly protective attitude towards the Fijian people (Hull & Hull 1973). The policies were designed to improve the status of women and to encourage population

growth. However, the reality suggests something different. They subjected women to increased surveillance, restricted movements and behaviour and control by the colonial government. The policies assumed that the colonial government was more knowledgeable than the Fijian population. This intervention foreshadows later family planning initiatives. Whilst family planning programmes have a different goal: to promote the adoption of modern contraceptives and reduce fertility rates, the privileging of Eurocentric ideas about 'the family' prevail in both contexts.

There is a common assumption that women in the Pacific in the pre-colonial era were victims of patriarchy. Jalal (1997), however, argues that women's lack of power in Fiji in pre-colonial times, was perpetuated, rather than alleviated, by colonisation and modernising processes. Although it is important not to romanticise the position of Fijian women prior to colonisation and the pro-natal policies, the policies undermined the knowledge and skills of local women. The strategies executed were often put into practice without understanding the broader context in which family structures and practices worked. For example, while motherhood was pertinent to the identity of Fijian women, they were not ascribed the role of primary caregiver (Jolly 1998). In pre-colonial Fiji, childcare was shared equally amongst all members of the family. What the European community identified as maternal incompetency or insufficient childcare, was instead often the result of differing cultural practices.

Many other cultural differences existed between the Fijian and European communities, during this period, around family structures and childcare. One practice that horrified and shocked many Europeans was polygamy (Chung 1991). It is argued by some, however, that polygamy was a traditional practice used to heighten the chance of survival of infants, young children, pregnant women and mothers. Multiple wives spread the workload. This was particularly important for pregnant women and new mothers. It also ensured that women received better care and more help throughout their pregnancies. Additionally, following the birth of their child, polygamy allowed women to spend more time with their children, to ensure their survival. Polygamy also diminished a woman's sexual exposure to her husband. This helped women to space their children and again, ensured that the women were in a position to be able to care for a new child (Chung 1991).

Another tradition that challenged European understandings of ‘family’ was the custom, which saw the father separated from his wife when a child was born. This separation could last for up to two years (Chung 1991). The practice was designed to allow the mother time to nurse the children and wean them only when they were strong. Furthermore, this moderated the sexual exposure of women to men and prevented women from having children too close together. Children born before the previous child was weaned were called *dabe* or *save*, “prone to illness and early death” or “a weakling and late developer” (Chung 1991: 28). This custom was abandoned in the 1890s as pressure to conform to a ‘Christian family life’ and the nuclear family prevailed (Chung 1991). Interestingly, while Europeans identified this custom with the high death rates, chiefs were concerned that the cohabitation of husband and wife after childbirth was a significant contributor to the declining population (Hull & Hull 1973).

Population was a concern of the early colonial government. High death rates and a rapidly declining population saw them anxious for the survival of the indigenous population. An inquiry into the deaths largely attributed the decline to an inferiority of local practices. These included poor health and hygiene management, ‘inattentive’ and ‘unloving’ mothering, and familial structures that failed to adequately provide care and support for vulnerable members of the family, such as young children pregnant women and the elderly. This resulted in the government implementing pro-natal policies to promote population growth and to ‘protect’ the Fijian population (Hull & Hull 1973; Jolly 1998). Exploring how the European community interpreted Fijian practices and the implementation of strategies by the colonial government to remedy the high mortality rates exposes the Eurocentricity of early colonial initiatives and highlights the disregard Europeans had for Fijian methods of childcare and motherhood. European knowledge about health, hygiene and pregnancy took precedence over Fijian knowledge.

The Indentured Labour Contracts: Indians in Fiji

Population first became an issue in the early colonial period when the Fijian population experienced a dramatic decline at the end of the nineteenth and beginning of the twentieth century (Hull & Hull 1973; Chung 1999). In 1879, not long after Fiji

was colonised, the government brought Indians to Fiji to work as indentured labourers on sugar plantations. Relative to the indigenous population, the initial Indian population was small, however, the number of Indians rapidly and dramatically increased (Chung 1999; Hull & Hull 1973). This put pressure on relations between the Indian population and the Fijian and European communities. As the Fijian population continued to decline, European and Fijian communities were fearful that the Indian population would overtake and drown out the indigenous population. Accordingly, talks turned to the negative effects of rapid population growths on Fiji (Mayer 1963; Hull & Hull 1973; Chung 1999). This 'problem' was largely constructed around racial issues. It was highly political and in many ways related to power conflicts. The emergence of an overpopulation discourse dramatically contrasts with the earlier under population discourse.

Racial issues continued to define the overpopulation debate in Fiji until the 1950s when the overpopulation discourse shifted. New discussions were less centred on race and more on the perceived impact of growing populations on the resources and economic development of Fiji (Hull & Hull 1973). Unlike previous conversations about population growth in Fiji, shifts in discussions about overpopulation in this period reflected the arguments and concerns about the impact of high birth rates on resources which emerged in post World War II, within a context of economic development and modernisation. In response to this shift in the overpopulation discourse the government introduced and promoted family planning services and birth control devices to combat overpopulation and its professed associated problems. Initially these were directed at the Indian population who were deemed strong enough to survive population restrictions. However, shortly after, the Fijian population was also encouraged to control their fertility for the 'well-being' of the nation (Hull & Hull 1973).

The perceived problems associated with high birth rates against economic development and the wellbeing of Fiji were critical to the implementation of family planning and population control discourses. The goal to modernise and economically develop Fiji, surpassed previous desires which, only decades before, had been to promote the growth of the indigenous Fijians. The changing discourses about population and the changing 'needs' of the indigenous community highlight the

political nature of population in Fiji. Family planning became a critical tool to service the changing ideas and agendas of the ruling elite. This is a trend that has continued throughout family planning practices in Fiji. Discourses have changed, but it remains evident that family planning and population control, be it in the name of poverty alleviation, health, or empowerment, facilitate the growth of the international neo-liberal economy. I will demonstrate this throughout this chapter and the two findings chapters that explore the empowerment discourse in Fiji.

Following colonisation, one of the primary aims of the government was to develop the nation's economy (Hull & Hull 1972; Chung 1991; Sutherland 1992). While early traders and fortune hunters initiated the formation of industry, the government sought to formalise initiatives, stabilise production and promote economic development. Accordingly, the government decided to create sugar plantations and export their produce. This profit-making venture, however, required a considerable but inexpensive labour force. Fijians resisted this work (Sutherland 1992). Seeking a working population for the plantations, the colonial government sent a request to India. From India, sub-agents of the colonial government were appointed to recruit workers (Mayer 1963). The agents were employed to explain the indenture contract and have recruits sign the contract under their free will. The recruiter received commission for each emigrant they enlisted. The process of conscripting labourers to work on the sugar plantations, however, was not as simple as the government had anticipated (Mayer 1963). Most Indian villagers were attached to the land and associated travel with religious pilgrimages rather than emigration. Furthermore, travel stripped people of their caste membership. Moving to Fiji was thus not particularly appealing to many Indians (Mayer 1963). Accordingly, officials in India recruiting workers began to attract migrants by misinforming prospective workers about the location of Fiji, the wages and the punitive clauses that underlay the indenture contract (Mayer 1963).

In 1879, the first Indians were brought to Fiji. The migrants were generally young, between the ages of 20 and 30 (Mayer 1963). They primarily arrived as individuals or couples and there was little group migration. The lack of group immigration hindered community development. The migrants came from a range of castes and spoke various dialects. Whilst a debased Hindu dialect did evolve, communication was

difficult and further inhibited the evolution of 'community'. Accordingly, the Indian population remained dislocated for many years, creating a disjointed community with a greater sense of individualism (Mayer 1963). Another issue that inhibited community development was the small percentage of female migrants. It was stipulated by the Indian government at the time migrants were being recruited that forty percent of the migrants were to be women. This was a regulation imposed by the Indian Government to ensure that the migrants were given the opportunity to have a family in Fiji. This proportion, however, was scarcely maintained (Mayer 1963). The small number of women caused tension within the Indian population and they were forced to sexually service multiple men (Mayer 1963). The migration process was an extremely arduous and disruptive process for the Indian population.

The Fijian and Indian communities had quite distinct histories. Their lifestyles and experiences continued to be differentiated throughout the twentieth century. The indentured labourers' scheme concluded in 1916 following mounting resistance from Indian labourers. In response to this resistance, the plantation was divided into 10-acre plots and rented out to Indian farmers who produced cane independently for the company (Sutherland 1984). This new structure provided Indian farmers greater autonomy and eventually gave rise to the commercial and merchant sectors evident in the Indian community today. While the Indians worked on the sugar plantations, the Fijians remained involved in subsistence-based production. The different forms of production required of the two ethnic groups kept the communities divided for many decades (Chung 1999). This divide remains in contemporary Fiji. Today Indians dominate the commercial sector and Fijians largely remain involved in agricultural and rural production (Chung 1999). This history has affected how the two communities engage with family planning services. This can largely be attributed to the differing needs of particular modes of production. Generally, rural/subsistence workers require large families to maintain production, while large families are costly to those engaged in capitalist economies. The distinct histories and unique ways in which the two ethnic groups, Fijians and Indians, negotiate fertility control present Fiji as a particularly interesting case study with which to explore how family planning policies and practices are being played out in the two communities.

Population Politics

As has already been illustrated, at the end of the twentieth century, Fijian mortality rates were high and numbers were in serious decline. This contrasts with the Indian population which in 1881 was 588. By 1946, however, Indians had reached 120 414 and had surpassed the Fijian population (Hull & Hull 1973: 177). This rapid growth, parallel to a declining Fijian population further ignited existing fears for an extinct indigenous people. This caused extensive concern within the European and indigenous communities who were primarily apprehensive that Indians would 'overtake'. One article printed in the 1930s stated that "...if there is to be any future European expansion in Fiji there must be some limitation of Indian activity and enterprise" (Hull & Hull 1973: 175). This comment suggests that concerns about population were in many regards centred on economics and the maintenance of control and resources. These fears prompted widespread criticism of the Indian community. A letter written to the widely read *Pacific Islands Monthly* magazine expresses common sentiments about the Indian population. It stated that, "the Indians in Fiji are a problem and a curse ... they breed like rabbits ..." (Hull & Hull 1973: 175). This marks the beginning of an over-population discourse in Fiji and contrasts with early discussions about population, which were decidedly pro-natal.

The indigenous Fijian population began to increase in size around the 1930s, but concerns about the growing Indian population continued for some years. The idea of a 'race' between the two dominant ethnic groups was well entrenched. The growing number of Indians remained an issue in Fiji until the mid-twentieth century. Eventually, fears of extinction subsided, but the issue of Indian growth continued to define public debate throughout the 1950s. Although there was no longer a concern about the extinction of the indigenous people, the overpopulation discourse remained (Hull & Hull 1973).

Around the 1950s the overpopulation discourse, shifted from being about a population race to centring on the perceived impact of high birth rates on local resources, economic development and the wellbeing of Fiji's inhabitants (Hull & Hull 1973). In particular, there was anxiety about the availability of land and how a large population could be sustained in Fiji with current birth rates. Accordingly, the government

announced that Fiji had a problem with overpopulation and that reductions were necessary to ensure the future of Fiji (Hull & Hull 1973). Initially this was directed specifically at the Indian population, although this was later amended when fertility control was also requested of the Fijians. Numerically, the Indians were deemed strong in comparison to the Fijian population which had only just recovered from a disastrous decline (Hull & Hull 1973). In 1949, the Governor, Sir Brian Freeston, suggested to Indian leaders they voluntarily limit the growth of their community. To achieve this, birth control technologies were promoted within the Indian community. In 1952, Mr Jannif, an Indian leader, advocated the widespread application of birth control to limit the growth of the Indian community. The Indian leaders were in a difficult position. There had been government inquiries into the state of the Indian population and talks about the possibility of deportation. With the idea of deportation rejected, talks turned to population control and the use of birth control (Hull & Hull 1973). In many ways, the Indian leaders had no choice but to advocate the fertility control of their community. This marks the beginning of family planning initiatives in Fiji.

Family planning and modern methods of birth control have since been deemed critical to the development of Fiji and advocated as a necessary tool in ensuring the sustainability and wellbeing of the nation's future. However, as this chapter has illustrated, population, and family planning as a tool to control population, has been highly political. Since the pro-natal policies to the introduction of modern contraceptives, ideas and practices managing population have shifted and changed. However as this research will indicate, they remain politically useful tools. It is with this in mind that the advocating of family planning for women requires investigation. Before further exploring changes to family planning since its introduction in the 1950s, it is first necessary to provide a brief history of family planning more generally. Family planning has a long history that precedes its formal introduction into Fiji and a history that has implications for how family planning initiatives might be investigated today.

The Advent of Family Planning

Family Planning: The International Context

Contemporary family planning has emerged out of a series of reproductive control movements in both the United States and England in the nineteenth and early twentieth century (Gupta 2000). These were the voluntary motherhood campaign, the neo-Malthusian league and the eugenics movement. Whilst their philosophies varied in a number of ways, all generally advocated controlling the birth rates of the working class. The voluntary motherhood campaign in the United States was shaped by some feminist influences (Gordon 1976) who argued women had a right to control the number of children for whom they could adequately care. However, the campaign remained centred around poverty alleviation and promoting a better quality of life for the poor sectors of society. The primary aim of the neo-Malthusian birth control campaign in England in the 1820s and 1830s was also to educate and inform the 'poor masses' on birth control. It was a movement led by socialists who believed that the working class would benefit from limited fertility (Rowbothan 1974, 1978; McLaren 1978; Gupta 2000).

Around 1910-1920 the term 'birth control' emerged bringing a new social movement (Gorden 1976) promoting birth control to improve women's autonomy and self-ownership. However, this movement was also directed at the poor sectors of society. Even socialist Margaret Sanger, one of the most renowned birth control activists, advocated sex education and birth control in the working class to alleviate the suffering of the poor (Gupta 2000). From this movement came a greater interest in birth control technologies and Sanger soon came to focus on promoting and distributing contraceptives. However, to obtain support of the conservative sectors of society, discussions about women's autonomy and empowerment were removed from the birth control agenda. Instead, the movement focused on the social benefits of birth control on the wider community. These included poverty reduction and the strengthening of marriages and the family unit. In keeping with this shift, in 1942, the Birth Control Federation was renamed the Planned Parenthood Federation of America. The Federation was the combination of a variety of different reproductive control organisations, including the American Birth Control Federation and the

American Eugenic Society (Gupta 2000). It is from this group that there emerged the Family Planning Association evident today.

In 1952, Sanger formed the International Planned Parenthood Federation (IPPF) which worked to implement birth control in countries outside the United States, with a particular focus on poor nations (Gupta 2000). Government implementation of birth control was assisted by the IPPF in Fiji (Hull & Hull 1973). In the 1950s and 1960s development agencies also began to emerge and become concerned about population growth and high fertility rates in developing countries (Seltzer 2002). Three development agencies in the United States were the first to begin international discussions on the implications of high fertility on developing countries and the role of family planning for sustainability: the Ford and Rockefeller Foundations and the Population Council (Seltzer 2002).

Significantly, family planning is a western concept. Emerging in the United States and England, it was primarily concerned with controlling the birth rates of poor people. It was constructed out of a desire to alleviate poverty, promote strong marital relations and prevent 'unfit mothers'(Gupta 2000). Similarly to the aims of the missionaries and early colonial officials in Fiji, family planning groups attempted to improve the quality of life of the poor and remedy their 'problems'(Jolly 1998). It was assumed that the 'poor' were unable to adequately care for themselves, suggesting that poverty was a result of individual choices that could be remedied with family planning, rather than the result of structural inequalities.

Family Planning In Fiji: A Measure to Promote Economic Growth and Sustain Fiji's Future

Overpopulation continued to promote family planning in Fiji throughout the 1950s and early 1960s. The early focus was on the reduction of the Indian population. As national population rates continued to grow, and fears for the impact of 'overpopulation' on the economic development of Fiji increased, the government also requested that the Fijian community control their fertility. Family planning was advocated as a tool with which to achieve this goal illustrating how the pursuit of economic development influenced family planning initiatives. As will become

apparent throughout this thesis, capitalism continues to shape and rationalise the implementation of family planning and birth control initiatives.

A call by the Fijian Government, for the reduction in birth rates of both ethnic groups in pursuit of economic development, is evident in a statement made by the Governor of Fiji in 1962. He asserted that:

The economic well-being of the population requires a considerable reduction in the birth-rate of all races. It is therefore Government's policy to disseminate information about family planning as widely as possible. The facilities which are now provided at twelve clinics will now be extended next year to all fifty-one government dispensaries (Hull & Hull 1973: 187-188).

Arguments about the impact of high birth rates on economic development and the sustainability of resources have since been critical to the promotion of family planning to Fiji. The shift in talking about population in Fiji had dramatically changed since 1900 when discussions were decidedly pro-natal. It is interesting to contextualise this change in discourse within the wider international community. It was during this period that international development agencies first emerged alongside international conversations about the impact of high birth rates on the development of 'third world' countries began (Seltzer 2002). The 1950s also marks the emergence of the IPPF (Seltzer 2002). Both the international development agencies and the IPPF had concerns about high birth rates on poor nations.

The notion that high birth rates would negatively affect economic development and people's wellbeing is a theory that is still used to explain underdevelopment in Fiji today. Accordingly, this argument significantly contributes to rationales for implementing family planning in contemporary Fiji. The popular belief that Fiji has a population problem has recently received some challenges. In the 1950s, when ideas about overpopulation began to surface, one Indian leader argued that "nobody in Fiji starves"(Hull & Hull 1973: 181). In exploring the population debate, with particular reference to the Pacific, Under-Hill Sem (1994) maintains that the argument is simplistic and that underdevelopment requires a more complex consideration of the factors that contribute to poverty and economic stagnation in the Pacific.³¹

³¹ See page 19.

Family planning in Fiji was primarily introduced as a tool to control populations. It began to be widely promoted in 1962; however, it was first introduced to Fiji in the mid 1950s (Hull & Hull 1973). It began as a small-scale venture, which was set up with the help of the IPPF. Initially, family planning services were limited and publicity was minimal as it was unclear how the public would react to the facilities. As one doctor stated, “we just didn’t know how the idea of family planning would be accepted by the various religions and races involved” (Hull & Hull 1973:187). Because population control was seen as necessary for economic wellbeing, the programme was expanded. This was largely prompted in 1961 by a new medical director who advised the governor that to effectively promote economic development, populations needed to be controlled and family planning had to be widespread (Hull & Hull 1973). It is ironic that the same population which was encouraged to have more children in the late nineteenth century was being encouraged to have few children in the mid twentieth century. To achieve this, the director recommended integrating family planning into official government policy. Taking this advice, the governor extended family planning clinics and, with increased publicity, family planning became integrated into the Maternal and Child Health service (MCH) (Hull & Hull 1973).

The Adoption of a Health Narrative

Prior to the integration of family planning into the MCH, the MCH was already involved in delivering a significant number of births in Fiji. This was advantageous to the promotion of family planning as the integration of the two services meant that as women used the MCH, they could be educated on family planning services (Hull & Hull 1973). By marrying the services, the government was assured widespread dissemination of family planning and knowledge of their services. This shift was highly strategic (Hull & Hull 1973). It provided the department access to women at a time when suggestions of family planning and birth control were most likely to be adopted (Hull & Hull 1973: 189). In addition to promoting family planning through the MCH, the government also advertised the benefits and services of family planning via the radio, cinema, posters, leaflets and newspaper advertisements (Hull & Hull 1973).

Integrating family planning into the MCH was significant, because it marked a shift in the family planning narrative. Hull and Hull (1973) argue that the focus of the MCH on health enabled family planning to move from being talked about in relation to population to being promoted as a tool to foster the wellbeing of mothers and children. The government was keen to move away from narratives that were associated with a 'population race' and population control, as they had negative connotations and were believed to inhibit the uptake of family planning (Hull & Hull 1973). Despite concerns for the impact of population discourses on the adoption of family planning in Fiji, it is often argued that the political nature of population in Fiji contributed to the acceptance of family planning (Chung 1991; Chung 1999). The competition that existed between the indigenous Fijians and the Indian population meant that the Fijians in particular were keen to see a measure of control over relatively high birth rates of Indians. Because of this, resistance from even the most conservative sectors of the indigenous Fijian population were minimal in the hope that the Indo-Fijian population would take to the idea of fertility control (Chung 1999). Low levels of active resistance remain in contemporary Fiji, despite large Christian community which has resisted family planning in other countries.

In the early period, family planning initiatives were hailed as a great success. In its first decade, birth rates dropped from 40 to 30 per thousand (Lucas & Ware 1981). In March 1969 Pathfinder Fund declared that, "they knew of no other country 'where better co-operation had been worked out between public authority and private agency in furthering the family planning programme ... or where steps to inform and motivate the people are as far advanced'" (Hull & Hull 1973: 169). Whilst birth rates did dramatically decline during this period, subsequent research suggests that the role of family planning in achieving these declines was overstated. Other factors contributed to this decline. Chung (1999) asserts that more pervasive agents than the availability of family planning have influenced declining fertility rates. She argues that social and economic changes in Fiji have transformed the life experiences of women and forced them to reconsider how large families might affect their lives. The ever-increasing pressure to engage in capitalist production changes how women think about child-bearing.

Despite the tendency to overstate the role of family planning in reducing birth rates, many Fijian women adopted family planning. Fertility control has largely been the responsibility of women in Fiji (Chung 1999). This included both indigenous Fijian and Indo-Fijian women and had some effect on declining birth rates. However, indigenous Fijians and Indo-Fijians engaged with family planning quite differently (Lucas & Ware 1981; Chung 1999). The Indo-Fijian women were more accepting of family planning and fertility rates dropped more dramatically than Fijian rates. Fijians showed less interest in family planning services (Roizen et al.1992). IUDs and the pill were the most popular methods during the 1960s, followed by sterilisation and then lastly condoms. In the 1970s, there were significant drops in the use of the IUD and the pill, however, sterilisation rates increased dramatically. The 1980s saw this trend continue. Sterilisation has remained the most widely used method of contraception in Fiji (Chung 1999). Condoms were more popular within indo-Fijian couples (Chung 1999) while natural methods such as rhythm and withdrawal were most common with indigenous Fijian couples.

The differing rates of acceptance could be attributed to the different modes of production in which the ethnic groups were primarily engaged. In 1966, the secretary for Fijian Affairs and Local Government said, “Folk who live in the country, with ample land ... are often not greatly interested in family planning, for they regard an added member of their family to be an added helper in field work, and an added security for parents when they get old” (Hull & Hull: 1973: 212).

The indigenous population was principally involved in rural production in which large families were beneficial. Understanding the different histories, also helps to explain why the Indo-Fijian population was more accepting of family planning than the indigenous Fijians. Through the migration process, the Indian community lost an older generation to enforce traditional social relations and mores. This disruption of culture is particularly significant to the adoption of family planning services as, unlike the indigenous young Fijian women, Indo-Fijians lacked the support and knowledge of their mothers and grandmothers. Social regulations depicting the appropriate constitution of families, and traditional knowledge on how to control fertility were arguably lost through the migration process.

Critical Reflections

Economic development and improving maternal and infant health have been central in advocating family planning in Fiji. Both economic development and health remain critical rationales within contemporary family planning initiatives. However, as indicated in the introduction of this thesis, the latest discourse to surround family planning and socio-economic development policies is empowerment. Empowerment as a solution to underdevelopment is the dominant discourse advocating the implementing of family planning in international development policies. Seeing how different population strategies have emerged in Fiji, and the decidedly political nature of these narratives, prompted a consideration of how power and politics might also manifest within the empowerment discourse to suit the ruling political elite. An investigation into the manifestation and construction of this discourse in relation to Fiji is presented in Chapter Five and Chapter Six. First, however, the following chapter outlines the research strategies used in this thesis to collect data and analyse the manifestation of the empowerment discourse in Fiji.

CHAPTER FOUR

Research Process

Introduction

The principal aim of this research was to investigate whether an empowerment discourse was manifest within family planning and development programmes in Fiji and to provide a critical analysis of the discourse used in the context of that Pacific nation. To achieve this, I accessed as much information as possible about family planning services and their impacts to explore the discursive practices of those implementing and advocating family planning and to develop an understanding of how the empowerment discourse was constructed in Fiji. Gathering this information required a multifaceted research strategy. This included access to relevant statistics, and collecting existing documentary material relevant to family planning and development in Fiji. Such material included reports relating to women's experiences of family planning and their positioning within the Fijian labour market. It also involved a discourse analysis of significant family planning documents (both local and international) and interviews with key informants who occupied different positions in the development of policy and the delivery of family planning initiatives. The primary challenge of this research was conducting research on Fiji, while located in New Zealand.

This chapter outlines the development of my research strategy and gives an account of the complexity of the research processes through which I acquired the information that is the source of the analysis offered in the following two chapters. It begins with a brief summary of the research objectives and an introduction to the overall research design. This is followed by a discussion of the use of statistical information in pursuing my research objectives. The next section outlines my pursuit of documentary sources of information and considers how the reports, pamphlets and papers I was able to access contributed to my investigation. Interviews with key informants were

critical to the research strategy. A section discusses the challenges of accessing participants and the process of conducting email interviews with a small number of the informants in Fiji. The chapter concludes with some reflections on the strengths and weaknesses of the overall research strategies used in this thesis.

Research Design

Developing Research Objectives

This research was shaped by an interest in the recent use of an ‘empowerment’ discourse in family planning in light of international development policies.³² The adoption of an empowerment discourse by mainstream developmentalists marks a shift in the political environment with which it has traditionally been associated.³³ Interestingly, ‘empowerment’ has also been associated with women’s rights and women’s liberation movements in the 1960s and 1970s, as well as with alternative development movements in the ‘South’.³⁴ The adoption of an empowerment discourse by development agencies to promote and justify family planning was of interest for two main reasons. Firstly, because early western feminist movements espoused family planning for women’s empowerment (Gupta 2000), and secondly, because implementing family planning programmes has been a longstanding objective of developmentalists (Seltzer 2002). I was interested in the connections made by international development agencies between family planning and women’s empowerment and how western feminist movements and past family planning initiatives might influence the construction of the empowerment discourse.

The international empowerment discourse, as espoused by mainstream developmentalists, occurs at a highly theoretical level. It is difficult to explore the value of this discourse without paying closer attention to how it is manifest in particular contexts. Accordingly, I was interested in investigating whether

³² See for example Interactive Population Centre (2006); UNFPA (2005); ISSD (2005); Sweetman 2005; UNFPA (no date) and UNFPA (2004).

³³ An empowerment discourse is not only used by development agencies in the field of family planning. There are other empowerment discourses in the context of development, such as within micro-credit schemes. However, this research is concerned with the empowerment discourse that specifically relates to family planning.

³⁴ A brief history the use of an empowerment discourse within the context of family planning and development was outlined in Chapter One: Introduction. See pages 4-7 or Gupta (2000); Gordon (1976); Moser (1993); Kabeer (1994); Sen & Grown (1987).

‘empowerment’ contributed to the discursive practices of those implementing and advocating family planning initiatives in a contemporary local context, in this case, Fiji. If indeed, an empowerment discourse contributed to the rationale and promotion of family planning initiatives within the Fijian context, I sought to analyse how the ‘empowerment’ discourse was constructed and if it connected to the international discourse. In particular, I was interested in exploring what was asserted about women being able to control the number of children and the timing of their pregnancies that made family planning empowering to women in Fiji.

Because of the environment in which the empowerment discourse was being promoted, I had questions about the value of this discourse in Fiji. My primary concern is to examine the ‘universal’³⁵ nature of the empowerment discourse and the political and economic imperatives that shaped past family planning initiatives in Fiji.³⁶ Accordingly, I sought to explore how the empowerment discourse is played out in the field of family planning and how it might affect women using this service.

Researching the discourse of empowerment is different from research whose aim is to measure empowerment. This clarification is essential as making assessments about whether women in Fiji are ‘empowered’ through family planning programmes would require a different research strategy. Talking specifically to women about what constituted ‘empowerment’ for them (if in fact the concept is relevant) would be one such requirement. The aim of this research was not to arrive at an assessment of whether or not women, or particular sets of women in Fiji, are empowered, but to critically examine family planning as an empowerment strategy. To measure women’s empowerment would require constructing a definition of empowerment and a relevant set of indicators. This lies at the very centre of what this research seeks to problematize. To critique one empowerment discourse and replace it with another with its own set of indicators, was not the purpose of this inquiry. I did not see the value of setting up alternative definitions and a new set of rigid indicators. Given the dominance of the empowerment discourse in the literature on family planning and

³⁵ It is important to note that the ‘universal’ has come to be primarily associated with western strategies and modern ideologies. This was discussed in Chapter Two: Literature Review and Theoretical Framings.

³⁶ Literature by the likes of Mehmet (1995) Abu-Lughod (1993), Kabeer (1994), Parpart (1993) and Sen and Grown (1987) suggest that attention to these factors are important when investigating development programmes.

development, my interest was in problematizing this discourse in the specific context of Fiji. The literature review has shown that contemporary definitions of empowerment are problematic (see Kabeer 1994; Rowlands 1998; Sweetman 2005). Their definitions are narrow and embody the agendas of their creators. This is unavoidable; any definition of empowerment is likely to reflect the position of the creator and develop a measurement that fails to encompass the meaning of empowerment for one group or another. I consider that this critical discussion might also benefit other investigations that explore the use of the empowerment discourse in other settings. However, any consideration of its relevance will need to attend to specific information about other cultural, economic and political environments.

The Use of Statistics:

Providing Background Information

I started my investigation of family planning practices and discourses in Fiji by searching the internet. As I was located in New Zealand and conducting research about Fiji, this was a useful scoping exercise. I looked for websites and organisations that discussed family planning in Fiji. The search produced links to many international development organisations that had small amounts of information about Fiji.³⁷ This was interesting, because it immediately drew my attention to the international nature of family planning services and influence of international development agencies in the Fijian context. Much of the data made available on these websites was statistically informed and part of a wider database that provided broad information about family planning and development in a number of different countries. The websites presented statistics on a variety of indicators such as the size of the population in Fiji, crude birth rates, fertility rates, contraceptive prevalence rates, infant and maternal mortality rates and measurements of what was defined as the ‘unmet need’ for family planning. They also provided statistics about literacy rates, life expectancy and Gross Domestic Product (GDP). The function of many of these websites was to assess the development of Fiji, the level to which Fiji was engaged with family planning and to promote a variety of development initiatives.

³⁷ Marie Stopes International (2006); UNFPA (2005); UNESCAP (2005); UNICEFa (2006); UNICEFb (2006); UNICEFc (2006); UNICEFd (2006); UNICEFe (2006); UNICEFf (2006); WHO (2006)

This search provided background information about the status of development and family planning in Fiji (Brown 1999).

Statistics as a Critique of the Empowerment Discourse

As I conducted more research, however, I saw the potential for statistics to play a more prominent role in my research strategy. While they provided me with critical background information about family planning and development, they were also useful for investigating claims about the importance of family planning in empowering women. For example, the empowerment discourse associates women's empowerment with family planning and a reduction in birth rates. It is assumed in this discourse that modern methods of family planning are the only effective way of managing fertility. By comparing contraceptive prevalence rates from 1963 until 2004 with birth rates from 1960 until 2004, I was able to analyse the extent to which family planning contributed or failed to contribute to reducing birth rates and its critical relevance to the empowerment discourse.

Exploring data outlining contraceptive methods used in Fiji was also a valuable way of analysing the empowerment discourse. Investigating contraception and their impacts was especially relevant. Any ethnic differences were also of great importance. These differences helped to describe how family planning practices manifest in Fiji and provided the opportunity to critically explore the validity of the universal make-up of the discourse. Clear differences in how the Indo-Fijian and Fijian populations engaged with family planning, would indicate that the application of one-size-fits-all strategies do not attend to the specific needs of individual groups and people, questioning the validity of the empowerment discourse.

Statistics comparing crude birth rates and national economic growth were also important for analysing the empowerment discourse. The economic benefits that reduced fertility is said to have on the nation, and consequently, local families, were a significant component of the discourse. Consequently, assessing the relationship between birth rates and economic growth was advantageous to this investigation. Analysing national economic growth against local poverty rates was also a

worthwhile strategy as poverty alleviation and economic growth are significant contributors to the construction of the empowerment discourse.

Accessing the statistics that I needed to critically evaluate the impact of family planning services in Fiji and the empowerment discourse associated with family planning, however, proved more challenging than I had initially anticipated. The first place I looked for statistical information was the Fijian Bureau of Statistics' (FBS) website.³⁸ Whilst this website gave me access to relevant material such as crude birth rates, fertility rates and national income, the information was limited. For example, this website provided data about crude birth and fertility rates for 2000 and 2001 and was useful to some degree. However, I was interested in gaining this kind of information from 1960s to 2005 (or as close to that date as possible). A similar situation occurred with statistics on the Fiji GDP. The FBSs' website presented statistics on the GDP for 2001 and 2002, but I also required this information from the 1960s onwards.³⁹

To access a greater range of data on these indicators, I emailed the FBS and various government departments requesting more detailed information. However, these requests were not responded to. Accordingly, I searched for data elsewhere. While the Ministry of Health did not respond to my requests for information about the types of contraception used in contemporary Fiji, I was able to access statistics produced by the Ministry of Health published in research by Chandra (2000). Hull and Hull (1973), and Lucas and Ware (1981) published early statistics on contraceptive prevalence rates, however, to gather information from the 1980s until 2004 I was required to use information published on the UNFPA and United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP⁴⁰) websites.⁴¹ Similarly, Lucas and Ware (1981) published early statistics on birth rates, but for information from the 1980s until 2004, I used information produced by UNESCAP. The UN System-Wide Earthwatch provided information on the GDP of Fiji from 1960 to 2004.⁴²

³⁸ Fiji Islands Bureau of Statistics (2005); Fiji Islands Bureau of Statistics (2006).

³⁹ Fijian Bureau of Statistics (2006).

⁴⁰ Sometime abbreviated to ESCAP.

⁴¹ UNFPA (2006); UNESCAP Statistics (2005).

⁴² UN System Wide Earth Watch (2006).

The process of collecting statistics involved negotiation and was conducted throughout the period of this research. It preceded the use of other strategies and was also a source of information, as I analysed documents, conducted interviews and analysed interview transcripts. It required examining assertions made in the interviews, the documents and pamphlets and then searching for statistics that applied to the claims made about family planning and women's empowerment. For example, a common claim was that access to fertility control improves national economic growth and reduces poverty. Having identified this narrative about fertility control and national economic growth in pamphlets, policy documents and interview transcripts, I searched for statistics on the birth rates, economic development and poverty. I repeated this process with respect to other such claims.

This was sometimes very time consuming, as it involved searching the internet, reading existing literature and telephoning groups such as the UNFPA and the Fijian Ministry of Health to access the material. One of the impacts of not having access to significant data sources from the FBS or other government departments was that I often had to rely on reports from development organisations, the very organisations whose construction of empowerment I was interested in critically examining. Despite this, statistics were a valuable tool and were vital for bringing a critical edge to the investigation. The multifaceted approach to my research strategy meant that the source of the statistics I used was not too problematic, as I had a variety of resources with which to support my arguments.

Research on the Pacific remains relatively minimal, thus, there was not a plethora of relevant up-to-date statistics from which to choose. This indicated that additional material would be necessary to complete an in-depth and meaningful investigation of the empowerment discourse I had encountered in the development literature. This indicates a need for more qualitative and quantitative research on Fiji generally and on women's use of family planning strategies in particular. The lack of recent independent statistics questions how policy advisors and practitioners assess the effectiveness of current family planning programmes and empowerment initiatives in Fiji if independent data to contribute to these decisions is unavailable.

Analysis of Documents: Reports, Information Booklets and Pamphlets

To thoroughly explore the empowerment discourse in the context of family planning in Fiji, I required additional material. Statistical analyses were beneficial, but they could not describe the international empowerment discourse or effectively express people's experiences of family planning or the labour market. Accordingly, I sought documentary material to access this data.⁴³ To investigate the international empowerment discourse, I collected relevant documents about women, family planning and Fiji from talking to a variety of people throughout the research process. I began by telephoning the Family Planning Association of New Zealand (FPANZ) and spoke to Joanna Spratt, the Pacific Programme Manager. She sent me a selection of documents about family planning programmes and empowerment. They consisted of information booklets published primarily by the UNFPA outlining the statements of goals and objectives in regards to the ICPD and MDGs. Common topics addressed in these publications were problems associated with overpopulation, reproductive rights, reproductive health and the benefits of family planning. I chose to closely analyse two of these documents. These were "Population, Reproductive Health and the Millennium Development Goals" (UNFPA no date) and "State of the World Population 2004" (UNFPA 2004). These were chosen because they were the most comprehensive of the documents, summarising much of what the other documents presented.

I read each of these documents in turn to gather what was articulated about empowerment and the assertions being made about family planning. This process involved searching for the key words 'empowerment', 'family planning' and other common phrases associated with family planning such as 'fertility control', 'birth control' and 'contraception'. My attention was especially drawn to passages where both empowerment and family planning were prevalent. As I proceeded, a series of other words emerged as being commonly associated with family planning and/or empowerment. These were health, human and women's rights, control, choice, overpopulation and economic development. These words also became critical. Having identified the themes that commonly emerged through the documents, I examined how these additional key words manifested. Viewing other contexts in which the key

⁴³ Documentary resources are a useful research strategy. Extensive valuable information are available in documents and existing written sources (see Finnegan 2006; Kelsey 2003).

words emerged afforded a way of further understanding and deconstructing the empowerment discourse.

Also of value were pamphlets sent on contraception and family planning in Fiji supplied by the Oxfam Clinic in Suva which were made available by Dr Garimella, the Principal Medical Officer at this clinic and one of the research participants. These pamphlets were a source of information about how women in Fiji were informed about family planning and the extent to which the empowerment discourse was used in the presentation of contraceptive strategies. The content of some of these pamphlets will be discussed in some detail in Chapter Six.⁴⁴

These documents outlined the empowerment discourse at the international level and provided some insight into how family planning practices are informed in Fiji. However, having some understanding of women's experiences of family planning or the labour market was still required. Neither statistics nor the information booklets and pamphlets provided this insight. Accordingly, I sought to gather descriptive material about women's experiences of family planning to contribute to this critical investigation. Descriptions of women's working conditions, reports about how women negotiate work and home life, as well as their experiences of family planning and their understandings of contraception and health were also pertinent. Exploring these factors was in response to constructions of empowerment found, both in the international literature and in my investigation into the empowerment discourse in Fiji. To access this kind of information, I sought existing reports.

Research by Chandra (2000) provided empirical information about women's experiences and opinions about family planning, contraception and health. Similarly, narratives relayed by Leckie (1997) about the reality for women in Fiji, negotiating paid work with home life were additional sources. Other research about the working conditions of women in Fiji by SPC International (2006) and Bargh (2001) presented critical contributions to the deconstruction of the empowerment discourse. Research providing insights into women's experiences of the strategies suggested by the

⁴⁴ See pages 105-107.

empowerment discourse was essential as it allowed an in-depth investigation into the value of the discourse, while being in New Zealand.

The research strategies employed thus far gathered material about the international empowerment discourse, as well as data with which to critique this discourse. These sources were integral to this investigation. However, they did not explore how those involved in advocating or delivering family planning programmes in Fiji talk about these programmes and the extent to which the empowerment discourse inform that talk. Accessing this information was fundamental to the research. I decided that an analysis of any promotional material about family planning in Fiji would be one way of accessing this information. The documents that I gathered were helpful, however, the material was predominantly general information about international family planning goals and strategies, not specific to Fiji. While this was interesting because it indicated that family planning in Fiji and the information supplied to family planning clients was significantly connected to international programmes, I needed more information specific to Fiji.

Interviews with Key Informants

The Search for Participants

To gain insight into the construction and delivery of the empowerment discourse in Fiji I decided to conduct interviews. I sought to speak to people in different positions with respect to the development of policy and delivery of family planning and well as those representing women's organisations who could offer an analysis of these services. I needed information specific to Fiji about family planning practices, services and ideologies. Interviews allowed me to access this kind of information. As my research was focused on exploring the discourse of empowerment and the institutionalisation of family planning, I located people who implemented and promoted family planning, as well as people and groups who advocated women's empowerment and material wellbeing.

My search for participants began at the UNFPA Pacific Office in Fiji. The UNFPA provide funding, technical assistance and implement programmes and policies around

population control, gender and development in Fiji. They are integral to family planning programmes in Fiji, making them an essential participant. I spoke by telephone to Annette Robertson, the Adviser on Reproductive Health Programme Assessment and Operations Research. I spoke also to Rufina Latu, an Adolescent Reproductive Health Project Advisor which is a programme run by the UNFPA. I was interested in hearing about younger women's use of family planning services and thought that she also would be able to offer some interesting reflections on family planning for those outside of the adolescent domain.

Having spoken with Robertson and Latu, I concurred that interviewing a member of the Fijian Ministry of Health, with expertise in family planning, would offer a vital perspective. The Ministry of Health works closely with the UNFPA to develop family planning policies. I telephoned Timaima Tuiketai, the Director of Public Health in the Fijian Ministry of Health. With jurisdiction for family planning within the Public Health Division of the Ministry, the division is responsible for developing family planning policies and setting the direction of family planning programmes in Fiji.

Talking with representatives of the UNFPA and the Ministry of Health provided critical insights into family planning discourses at the strategic level. In addition, I sought the perspective of a family planning practitioner. Practitioners are critical in implementing family planning programmes and are directly responsible for imparting knowledge about their services to women. I spoke to Dr Garimella over the telephone, who is the Principal Medical Officer at the Oxfam Clinic in Suva. This clinic implements family planning services. Dr Garimella was a key participant in this research. She demonstrated how information about family planning might be communicated to women in Fiji and how women engage with the services provided by her clinic. All three women agreed to participate in telephone interviews, which were to be arranged at a future date when I had formulated more specific questions.

The centrality of women to my thesis prompted me to speak to women's rights advocates in Fiji. I initially contacted two women's groups, the Fiji Women's Crisis Centre (FWCC) and the Fiji Women's Rights Movement (FWRM). I telephoned both of the organisations to explain my thesis agendas, gain a greater understanding of the group's activities and sound out the possibility of their participation in this research.

Both groups agreed to participate in telephone interviews, however, over time their interest diminished. Despite frequent attempts to talk to individuals within these groups, I was not able to arrange a time for detailed interviews, nor was it possible for me to receive information from them via email in response to the questions I sent them.

Although I was not able to include these potential participants in this research, my desire to talk with an expert in the area of women's rights activism in Fiji was sustained. I maintained that this perspective was essential to this investigation. A colleague with personal contacts in Fiji put me in contact with Ema Tagicakibau. She has worked for both the FWCC and FWRM and has a long history in women's activism in Fiji. Whilst she is currently involved in work surrounding conflict and the securing of a peaceful Pacific, her longstanding involvement and interest in women's activism and women's rights made Ema Tagicakibau a useful person to talk to about the agendas pursued in this thesis research.

The Interview Process – the Use of Email Interviews

Contact with Robertson, Latu, Tuiketai, Garimella, the FWRM and the FWCC was first initiated in May/June 2005. I approached Tagicakibau later in September, when it was apparent that the FWRM and the FWCC would not be participating. I felt confident in the ability of these informants to aid my understandings of the discursive practices of family planning and constructions of women's empowerment in Fiji. As I negotiated with the participants about the most appropriate time to conduct the interviews, several of them commented on the fluid nature of their working week. They were extremely busy and were often at work, or available to speak at irregular times due to meetings, clients, research and both domestic and international travel. Whilst they were willing to participate, they were concerned about the disruption of telephone interviews to their working day and the logistics of organising these international phone calls. As it became apparent that it would be difficult to coordinate telephone interviews, a couple of them requested that, as an alternative, I send them a series of questions via email. This would enable them to answer the questions in their own time and to better negotiate their tight schedules. Unsure about

how this would affect the responses to my questions, I set about exploring how email interviews would play out.

I had initially envisaged the telephone interviews to be semi or un-structured. This new research strategy caused me to re-assess the structure of the email interviews and how they would play out. The questions would need to be prepared in advance, which suggested that the interviews would be formatted like a structured interview. However, structured interviews involve asking participants the same series of pre-formulated questions (Opie 2003; Wilson & Sapsford 2006). This was not a strategy that I valued for this research. Each participant had different knowledge about family planning and empowerment, to make the most of this knowledge I would be required to ask specific questions tailored to their expertise. I concluded that the email interviews would be a mix between a structured and un-structured interview.⁴⁵ Ultimately, all of the interviews adopted this email interview methodology.

The use of email interviews is a relatively new research tool. Accordingly, there is limited research assessing this research strategy. However, Selwyn and Robson (1998) find that email interviews have many advantages. One of the benefits of email interviews is that interviews are not limited by geography making time and space irrelevant. This was particularly appropriate for this thesis as I was conducting research about Fiji while in New Zealand. An additional benefit, as argued by Boshier is that they provide “a context for the kind of non-coercive and anti-hierarchical dialogue that ... constitutes an 'ideal speech situation', free of internal or external coercion, and characterised by equality of opportunity and reciprocity in roles assumed by participants (Boshier 1990, p. 51)” (as cited in Selwyn & Robson 1998). The affect of race, gender, age and sexuality on interview relations are less prominent in email-based interviews. Issues around the sometimes-problematic power relations between the interviewer and participant are minimised in email interviews which are also advantageous because they do not require transcription. This avoids potential errors throughout the transcription process; errors here could change the meaning of the information that I process. This is imperative because language is critical to

⁴⁵ Unlike structured interviews, un-structured interviews allow for variance in the questions asked to different participants (Opie 2003; Wilson & Sapsford 2006).

discourse (Gavey 1989). The primary disadvantages with email interviews are the lack of non-verbal communication that occurs throughout a face-to-face interview.

Pursuing the email-based methodology made the interview-based research a challenge. Semi/unstructured interviews allow the researcher to design questions throughout the interview as they learn, process and gather information from the participant. Email interviews, however, did not allow for the same spontaneity and responsiveness to the ways in which participants answer questions. I was required to predict to some extent how they would respond to the questions. Furthermore, unlike structured interviews, each interview had to be hand-crafted for each participant. I needed to design questions that covered similar ground, while simultaneously being specific to what I thought would be their specific knowledge and fields of expertise. Designing these questions was challenging and I produced a number of drafts.

I conducted the email interviews to gain insight into family planning practices in Fiji and to identify the manner in which people talked about family planning in this context. To access this data, I first identified areas of interest and used these as a base upon which to develop questions. These were 'your position/role', 'population control', 'family planning', 'clients', 'context' and 'families and culture'. Within each of these categories, I formulated questions - some were asked of more than one participant, and others were specific to the participant. No two sets of interview questions were the same.⁴⁶ In 'Your Position/Role', I posed questions to ascertain the relationship between the informant and family planning and to contextualise the participant within the wider family planning context. 'Population control' was aimed at investigating the extent to which ideas about over-population might inform family planning programmes.

The 'family planning' section sought details about family planning initiatives and the services that were offered in Fiji. It also included questions about what the informants identified as the principal goals and the benefits of family planning. The section on 'clients' investigated who was using the family planning services. I was interested to find out if ethnicity, occupation, education, age or marital status affected who

⁴⁶ The interview questions are provided in Appendix A.

accepted family planning. The questions in the ‘context’ section sought the informants’ opinions about the advantages and disadvantages of family planning and what the goals of family planning were beyond fertility control. Questions in ‘families and culture’ were designed to investigate if and how family planning has affected familial structures and the wider community. These last two sections were particularly useful for exploring the discourses that surround family planning and empowerment in Fiji.

Having constructed the interviews, I emailed the participants their questions. With this, I also attached an information sheet.⁴⁷ This outlined who I was, my research institution, the aims of the research, how the information would be used, their rights to pseudonyms and their right to withdraw from the research at any stage. As the informants were participating in their employed capacity, I did not attach a consent form. Furthermore, their role in the research and how the information they provided would be used was clearly set out in the information sheet I provided. I took their responses to the questions as informed consent. Having sent the interviews, I was now required to wait for their responses.

Assessment of Email Interviews

Email interviews with key informants proved to be a useful strategy allowing me to explore a broad range of topics and gather information that the statistics and documents did not. Particularly, they explored the orientation and discursive practices of those involved in delivering and assessing family planning in Fiji. This approach was worthwhile because pre-established questions gave the participants time to reflect on the questions and research areas that required further investigation. This methodology worked well in the context of this research as efficiency was required, due to the busy nature of the participants’ work schedules. Additionally, this process allowed me to maximise their time and knowledge as they were able to answer the questions at a time that best suited them. On the other hand, my questions had to compete for their time and attention with very immediate questions and face to face demands on their time.

⁴⁷ A copy of the information sheet can be found in Appendix B.

Waiting for the interviews to be returned was a process that required some patience and tact. Whilst a couple of the participants responded to my questions promptly, others, having promised to complete the interviews failed to reply. I had anticipated this delay and had accordingly allowed plenty of time for the responses. However, as time continued to pass I was forced to email and telephone the participants to enquire as to when I could expect their interviews to be complete. I found this a difficult task, as all the participants were extremely friendly but also extremely busy. Eventually, all the participants responded to my email questions. The delay was very much a problem associated with the email interview methodology. Whilst, many had initially thought that email interviews were preferable to telephone interviews, it proved to be a task that was easy to postpone and in many ways, required more effort from them than a telephone conversation.

Critical Reflection

As I have indicated, exploring the discourse of empowerment, family planning and development in Fiji from New Zealand required a multifaceted research strategy. It involved gathering existing data such as statistics and the examination of documents relating specifically to family planning and women's position in the Fijian labour market. Available statistics drawn from a variety of sources, reports, policy documents, family planning pamphlets and email interviews with key informants were all critical components of the research strategy. The overall research strategy involved some forms of triangulation – I was attempting to access information about family planning and development in Fiji from a variety of different sources (Fetterman 1989; Davidson & Tolich 2003). This research is an excellent source of complexity and depth with respect to research material and uses information from different sources to evaluate other sources of information. However, as I have indicated above in my discussion of the research processes associated with each of these sources of information, each of these data collection strategies had its own challenges.

This research has been a useful starting point for exploring many of the international debates that surround the implementation of family planning and also for critically examining the use of the empowerment discourse by contemporary development institutions. This research has been appropriate for a masters thesis; however, in this

regard, it has had time and resource limitations. I see ways in which the agendas pursued in this research could be attended to in more detail. Future research would benefit from conducting a series of in-depth one-on-one and group interviews with women in Fiji about their personal experiences of family planning. It would also be interesting to do a comparative study relating to the implementation of family planning in another Pacific Island nation. Such study would provide a deeper and more comprehensive understanding of how women in the Pacific engage with family planning policies and technologies and the empowerment discourse. In the next two chapters, I examine what I learnt about the use of the empowerment discourse in the development and implementation of family planning in Fiji as a result of analyzing the material generated through the research processes described in this chapter.

CHAPTER FIVE

An Empowerment Discourse? An Exploration of the Health and Choice Narratives

Introduction

The following two chapters present a critical analysis of the ways in which the empowerment discourse operates in family planning in the context of the socio-economic development of Fiji. The analysis draws on data gathered from a variety of sources including key informant interviews, official statistics and textual analysis of documentary resources.⁴⁸ The chapters explore whether the empowerment discourse is used by those implementing and advocating family planning initiatives in Fiji. I argue that an empowerment discourse is evident within relevant documents and in the ‘voices’ of key actors interviewed for this investigation. These actors include the Pacific branch of the UNFPA, a family planning practitioner, a member of the Fijian Ministry of Health and a prominent women’s rights activist. This chapter, followed by Chapter Six, illustrates how an empowerment discourse is articulated in Fiji and discusses how empowerment through family planning is constructed in this context. Discourse in this context refers to the meanings and values that are repetitively attached to statements articulated by powerful groups and reproduced by broader society.⁴⁹

This investigation found that an empowerment discourse with respect to family planning was primarily constructed around three key narratives about choice, health and full-citizenship. Interestingly, these three contributing narratives⁵⁰ that discuss the advantages of family planning to women draw on earlier development discourses and

⁴⁸ For more specific information on the resources used in this analysis see Chapter Four: Research Methods.

⁴⁹ See Chapter One: Introduction for an explanation of my use of the term discourse. Or see Hollway (1983); Weedon (1987) or Gavey (1989).

⁵⁰ See Chapter One: Introduction for a discussion of the use of ‘narrative’ or see Mink (1970); Bennet (1978); Bruner (1986); Gergen and Gergen (1984); Fisher (1992); Hinchman and Hinchman (1997).

previous family planning initiatives that were driven by goals other than women's empowerment.⁵¹ Accordingly, these chapters raise critical questions about the agendas that lie behind the empowerment discourse identified in this study and the extent to which pre-existing political and economic imperatives shape current family planning initiatives. This chapter focuses on the construction of choice and health narratives. It illustrates that key informants consider women's ability to access family planning and choose the number and spacing of their pregnancies to be critical to women's empowerment. It finds that having a choice in the kinds of contraceptives women use is also a critical component of this narrative, and of the empowerment discourse informants espouse. I examined these statements about choice in the light of available evidence about the way family planning practices were implemented in Fiji and found the level of choice available to women questionable.

This discussion of the choice narrative is followed by an exploration of how the health narrative is constructed and the way in which the health narrative contributes to the empowerment discourse. This discussion explores the practices most often used in Fiji and finds that women using modern contraceptive interventions experience a number of negative side effects. It also highlights the cultural incompatibility of modern family planning methods implemented in Fiji. The final section of this chapter highlights the centrality of 'control' to family planning practices and the empowerment discourse. It questions the extent to which modern methods are effective in achieving the desired level of control by women over their lives and the expense to which fertility control is privileged over health, culture and 'free choice'.

The Question of Choice

A significant component of the empowerment discourse, as presented within the 'talk' of key informant interviews, was the choice narrative. Choice was commonly advocated as being essential to women's empowerment. This narrative was evident in a number of statements made during key informant interviews. Choice in this context is constructed as both about being able to plan pregnancies and the 'right' to a broad

⁵¹ Chapter Two: Literature Review and Theoretical Framings outlines the various development initiatives that have used family planning programmes. It critiques the rhetoric of programmes which claim that family planning is necessary for fostering wellbeing in developing countries. Instead it highlights some of the political and economic agendas that have prompted developmentalists to implement family planning in developing countries. See Chapter Two for more details.

range of family planning practices from which to choose. For example, Tuiketai⁵² stated that family planning “helps them [women] to make the decision on the right number of children they want, when do they want to have it and at what age and time”. In addition, Robertson⁵³ highlighted the importance of offering a wide selection of safe and culturally appropriate methods of contraception from which women can choose.⁵⁴ The narrative asserted that fertility control gave women the choice to make decisions for **themselves**. In other words, family planning empowers women to make autonomous decisions. This is a narrative that is very much based on western individualistic values (Albury 1999).

Comments by Tagicakibau captured the empowerment discourse and role of the choice narrative in its construction. She stated, “choice is empowering so there is a higher self esteem for those who have access to family planning resources, and could control their own situations compared to those who do not have access...” She continued, “family planning is about empowerment, having a choice, making decision(s), health and a more quality life for the woman, her children and her family, in turn the community benefits [sic].” The choice narrative suggests that women are empowered because they have choice, especially choice about the spacing and number of their children and in the method of contraception they use. The choice narrative strongly reflects the contemporary international development discourse, which focuses on promoting the individual rights of women in developing countries.⁵⁵ Identifying the choice narrative was significant, as it informs and shapes the construction of the empowerment discourse. I was interested in finding out more about family planning practices in Fiji as well as accessing the language of family planning advocates and Planned Parenthood pamphlets to deconstruct how ‘choice’ is manifested within the field of family planning for women in Fiji.

⁵² Key informant: Ministry of Health.

⁵³ Key informant: UNFPA.

⁵⁴ Chung argues that offering a wide selection of methods with which women can manage their fertility has been the rhetoric of family planning providers in Fiji (Chung, 1999), but she questions the reality of this rhetoric. Instead she claims that long-term methods are strongly promoted in Fiji.

⁵⁵ See Chapter Two: Literature Review and Theoretical Framings for more detailed information about the use of ‘rights’ in contemporary development discourses. Literature by Seltzer (2002) and information from the ICPD Programme of Action are particularly useful for highlighting the current focus on rights and its association with family planning in the international context.

Choice? Family Planning Talk and Practices

An analysis of the language used by the key participants found that choice was rarely articulated as being ‘free choice’. The phrases “better choices”, “informed choice”, the “right [to] informed choices and informed decisions” were common throughout the interviews.⁵⁶ This was interesting because it raised questions about what it means to choose. These comments caused me to question how choice was constructed within family planning initiatives as this language implies that those involved with family planning services had preconceived ideas about the ‘correct’ family size and the ‘best’ methods of contraception. The comments articulated also suggest that women’s choices are shaped by, and limited to, particular discourses and understandings that dictate how to ‘choose correctly’. As outlined in Chapter 2 of this thesis, some early family planning initiatives in developing countries were coercive (Gupta 2000; Seltzer 2002). This further propelled my interest in exploring how ‘choice’ was enabled in Fiji. I was interested in finding out what ‘choices’ were available to women and how these ‘choices’ affected women. The international literature suggests, “small families are happy families”. The key informant interviews reinforce this position.⁵⁷ This raises questions as to how women who choose to have large families or to use ‘natural’ methods of contraception are constructed within this narrative.

Comments by Tuiketai and Garimella,⁵⁸ who listed multiple fertility control methods were available to women in Fiji, suggested that family planning practices were in line with the choice narrative and the empowerment discourse. As Garimella put it “Hormonal contraceptives which include oral, injectable and implants, Intrauterine device (Cu 380A), Condoms mainly male condoms and last year female condoms were made available ...Natural family planning methods are explained for interested clients, Tubal ligation and Vasectomy are offered.” Interestingly, the majority of fertility control methods mentioned here were modern ones, as opposed to traditional practices. The prioritisation of modern over traditional or natural practices is further evident in one of the pamphlets I received from Dr Garimella. The options for fertility

⁵⁶ Tuiketai for example stated that one of main goals of family planning, “[t]o provide the right size and number of children for that couple to have them when they want it, how they want it and the number they want through an informed choice decision making process”.

⁵⁷ For example Dr. Garimella stated that “The women see small families as healthy and happy families”.

⁵⁸ Key informant: family planning practitioner.

control included: condoms, spermicides, intra uterine devices, vasectomy, tubal ligation, combined pill, progestogen only pill, Depo Provera, contraceptive implants and fertility awareness. The fertility awareness approach, which does not require modern intervention, was presented by the pamphlet as the most unreliable of all methods. This was because this method was rated the highest under the “chance of getting pregnant” category. When ‘control’ is constructed as being critical to improving choice, it suggests that methods that provide less control over women’s bodies do not provide women with the same access to empowerment as other methods. In this regard, ‘natural’ methods of contraception are not associated with the empowerment of women, families or nation states. Thus, significantly, it is modern contraceptives which are critical to the empowerment discourse.

Despite the variety offered, the women in Fiji seemed to have a preference for long-term methods of fertility control. As Tuiketai stated, “most couples now want permanent methods when they have completed their families”. Dr Garimella in turn clarifies that, “TL [Tubal Ligation] is the most popular choice for those who completed their families.... Injectables as they are convenient (sometimes the partner may not be agreeing for FP [family planning]) IUD is the other popular choice Pills and Condoms are the other important methods. Pills are used more than the IUD.” I sought additional information about how women in Fiji ‘preferred’ long-term methods of fertility control over short-term options. Using Statistics from the Ministry of Health in Fiji, Chandra (2000) stated that in 1998,

[a]mong the clients of family planning services, tubal ligation (female sterilization), used by 32 per cent of clients, was by far the most preferred method Injections (18%) and pills (16%) followed by IUD and condoms (both 13%) were also important methods. It is apparent that there was limited use of male methods – condoms (13%) and vasectomy (0.2%). Norplant (0.2%) is a relatively new method which has not yet won client acceptance. Many of the clients using natural methods (6%) do so for religious and other personal reasons (Chandra 2000: 36).

These statistics indicate a particularly high rate of long-term solutions to fertility control and reinforce the proposal that women in Fiji are choosing long-term solutions to birth control. The particularly high rate of long-term methods caused me to query how information about contraception was presented to women. It also reaffirms my earlier concerns about what choices are being advocated as being superior by family planning advocates to women in Fiji. A comparison with New Zealand statistics on

methods used is useful for contextualising and highlighting the extremely high rates of permanent methods of contraception used in Fiji.

In New Zealand, rates of long-term fertility control solutions for women were much lower. Only 14.4 percent of women were sterilised, 1.8 percent used injections and 3.3 percent used an IUD. Short-term methods were more popular; 20.5 percent used the pill, while 11.3 percent used condoms. Significantly, 19.3 percent used male sterilisation.⁵⁹ This means that 63.2 percent of women in Fiji were using long-term solutions to control their fertility as opposed to just 19.5 percent in New Zealand.⁶⁰ If vasectomies are included, as they too are a long-term method of contraception, the difference remains significant. In this case, 63.40 percent of couples were using long-term solutions to fertility control in Fiji and 38.8 percent in New Zealand.⁶¹

Chung (1999) argues that whilst a “cafeteria” approach to contraception has been the rhetoric of family planning providers in Fiji for many years, in reality only a few ‘choices’ are promoted. She maintains that in Fiji, priorities have been given to long acting methods of contraception. She claims that this is because long-term methods better ensure fertility control, while short-term methods such as the pill and condoms require more regular attention. In this regard, there is a higher possibility that the method will fail. Long-term methods, in addition, are easier to apply and quantitatively provide better results than less permanent methods of fertility control. Ensuring that women’s fertility is ‘adequately’ controlled supports the desires of the national and international political bodies (Gupta 2000; Seltzer 2002)

Understanding the different fertility rates between New Zealand and Fiji helps to explain why different methods may be encouraged in different countries. The fertility rate of New Zealand in 2000 was 1.97 (Globalis 2006) in comparison to the fertility rate in Fiji which was 2.70 in 2000 (Fiji Island Bureau of Statistics 2005). The family

⁵⁹ Population Reference Bureau (2006).

⁶⁰ I define long-term solutions to include tubal ligation, injectables, implants and IUDs.

⁶¹ Besides the significant difference in long-term over short-term solutions to fertility control, it is interesting to briefly explore the differing rates of condom use between Fiji and New Zealand. More couples in Fiji use condoms than in New Zealand. While the difference is not great, what is interesting is that condoms require a greater negotiation between couples. In Fiji, where family planning is less accepted than in New Zealand, and where typically men are less supportive of modern contraceptive methods, a lower acceptance rate of condoms would be expected. However, the rate in Fiji is slightly higher than in New Zealand.

planning in Fiji exists in the context of wider global discourses that suggests that high fertility rates inhibit development and thus perpetuate poverty (Gupta 2000; Seltzer 2002; UNFPA no date; UNFPA 2004). Consequently, developmentalists advocate that women in developing countries should reduce and control their fertility. The application of long-term or permanent methods is more likely to achieve these results (Chung 1999).

Fertility control is seen as critical to family planning and development goals in Fiji. The long-term contraceptives are better able to achieve this goal; particularly in countries which 'struggle' to reduce their national birth rates (Chung 1999). However, whilst long-acting methods of contraception may reduce fertility rates and therefore provide 'better' results, the promotion of selective long-term methods to women in Fiji disrupts the 'cafeteria' rhetoric (Chung 1999). Furthermore, the imposition of such methods obstructs the 'choice' narrative that has come to be closely associated with family planning technologies and women's empowerment.

The Health Narrative

The choice narrative significantly contributed to the construction of the empowerment discourse in relation to family planning. Another narrative or story about potential empowerment that commonly emerged within the key informant interviews was an account of how women's health was improved through the use of fertility controls. The use of a health narrative within development strategies is not new and is evident in documents relating to many earlier family planning and development initiatives. It was implemented by colonial officials in the early twentieth century and later in the 1960s as part of the promotion of family planning services.⁶² A health narrative is now a critical component of the empowerment discourse. It focuses on achieving the wellbeing of women and children through fertility control. It is concerned with the impact on women's bodies of bearing too many children, high-risk pregnancies, and infant and maternal death. The narrative suggests that the control family planning gives women over their bodies improves women's health and in this way contributes to their empowerment.

⁶² See Chapter Three: History: Family Planning and Empowerment in Fiji; or Hull & Hull 1973; Jolly 1998.

Garimella argues that family planning is important for fostering the health and wellbeing of people in Fiji. She comments that the primary aim of family planning is, “[t]o have healthy mothers and healthy children.” Robertson also identifies the role of family planning in improving the health of women and children in Fiji. She states that:

[f]amily planning allows women to have the number and spacing of children that they wish. In women for whom pregnancies or deliveries may pose health problems e.g. too young, too old, too many previous children and too close together, family planning prevents at risk pregnancies and therefore contributes to the aversion of possible maternal and infant deaths.

She continues:

Reproductive health is a means to sustainable development as well as a human right Investments in reproductive health save and improve lives, slow the spread of HIV and encourage gender equality. These benefits in turn help to stabilize population growth and reduce poverty.

Health is constructed as a human right that has positive collective consequences – a means of achieving sustainable development.⁶³ This passage uses the health narrative to support strategies aimed at relieving concerns about population growth that are informed by Malthusian ideologies. The use of Malthusian philosophies reflects the rhetoric of early population control discourses that promoted family planning based on Malthusian ideologies. This comment illustrates that the rationale for implementing early family planning initiatives continues to exist in contemporary family planning and development initiatives.⁶⁴ Literature by Mies and Shiva (1993), Bandorag (1997), and Gupta (2000) contest the value of Malthusian worldviews and argue that it oversimplifies global issues and because of this perpetuates poverty and inequality.⁶⁵

The following statement by Tagicakibau explicitly illustrates the connections between family planning, health, and women’s empowerment. She states that:

[w]omen taking a more active decision making role in the spacing and timing of child birth and rearing for their own health and that of their children, with support and understanding

⁶³ One of the most common definitions of sustainable development was coined according to the United Nations Brundtland Report in 1987. Sustainable development was defined as development that “*meets the needs of the present without compromising the ability of future generations to meet their own needs*”. This includes attention to environmental degradation, but it must not be at the expense of economic development, social equality and justice United Nations Division for Economic and Social Affairs (2005).

⁶⁴ See Chapter Two: Literature Review and Theoretical Framings for more information on the early international population control discourse and Chapter Three: History: Family Planning and Empowerment in Fiji to see how this discourse manifested in the Fiji context.

⁶⁵ See Chapter Two: Literature Review and Theoretical Framings for more information on Malthusiansim.

from their male partners will contribute to a healthy and empowered mother, healthy children and a healthy family

She also comments that

women need information, to be empowered to make decisions about their bodies and their health... Family planning is therefore a health issue, an empowerment (power, control, decision-making) issue, a human rights issue.

Family planning is advocated as a way of improving women's health. It is interesting that Tagicakibau simultaneously advocates women's empowerment and reinforces traditional assumptions about gender roles and motherhood. This discourse identifies 'good' mothers as those who use family planning and positions women as the primary health care providers and nurturers whose families' wellbeing is dependent on them actively controlling their fertility.

Comments made by Tagicakibau further illustrate the link between choice, health and family planning. She comments that, "where they [women] have been able to access advice and resources in confidence and with support from male partners, it [family planning] has led to improved health and better choices." This statement is interesting because it is one of the few comments in the interviews which suggests that there are instances when family planning services might not be empowering. It draws attention to the important fact that family planning does not occur in a vacuum and that in particular circumstances family planning might not have the desired positive effect. Family planning in itself is not empowering. The other participants did not clearly articulate similar concerns. In the case of Tagicakibau, she was particularly interested in ensuring that women had adequate information about family planning. Research by Chandra (2000) showed that women's understandings of contraception in Fiji was very limited and argued that practitioners did not give women adequate information about the side effects of contraceptives (Chandra 2000:75). This suggests that the current practices in Fiji do not always improve women's health or their choices or consequently, ensure that women are 'empowered'.

Tagicakibau also notes that, whilst family planning has the potential to be empowering to women, they "... also need to be fully informed of the consequences of the family planning strategies they are using e.g. tablets, etc. In some cases, some of the pills used could be dumped in third world countries so women need to be fully informed of the consequences and side effects of the types of family planning

strategies used.” This suggests that family planning may undermine people’s rights to quality health care. Gupta (2000) and Hartmann (1987) have directed attention at the ‘dumping’ of unsafe contraceptives in developing countries. This indicates that family planning practices need to be scrutinised and that, while family planning might be an empowering tool, it can simultaneously be disempowering and insensitive to cultural differences.

Deconstructing Definitions of Health

Before examining family planning practices, it is necessary to unpack the health discourse and understand what it means to be healthy within the context of family planning and development. The comments above by Robertson and Tagicakibau construct health primarily around the absence of infant and maternal death. An analysis of the UNFPA’s development goals suggests a similar understanding. The UNFPA strategies to improve the health of women include the universal provision and access to reproductive health services, a reduction in maternal and infant mortality, increased life expectancy and reduced HIV infection rates (UNFPA no date; UNFPA 2004). These strategies construct health as the absence of disease and death. They are a particularly biomedical interpretation and fail to explore expressions of health that exist beyond the physical. It is a primarily western construction of health and does not take into consideration non-western culture’s interpretation of health. This is despite the ICPD Programme of Action promoting reproductive health as “a state of complete, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes” (UNFPA 2004). The western nature of this definition of health is further highlighted in the following section, which draws attention to the different understandings that many women in Fiji have about health, compared with family planning advocates and implementers. Literature by Allen (2004) is also useful for addressing these differences.⁶⁶

Health: Side-Effects of Family Planning

The promotion of long-term methods has serious implications for women’s bodies and their health. Their effects are long-lasting and can be serious. Tubal ligation, for

⁶⁶ See pages 23-27.

example, the most popular ‘choice’ for women in Fiji, is a permanent method of fertility control that cannot be reversed. It requires a local or general anaesthetic and surgery in which fallopian tubes are cut, burned, or blocked with rings, bands or clips⁶⁷. Furthermore, injectables and implants are also long-term solutions to birth control which work by interfering with the hormones that regulate women’s reproductive cycle (Gupta 2000). Injectables, the most common form being Depo Provera, last between 1-3 months and the 6-capsule implant Norplant⁶⁸ can last up to 5 years. Injectables work by inhibiting the production of gonadotropin, which in turn prevents ovulation (Gupta 2000). Consistent with the high use of injectables in Fiji is the fact that injectables are most common in developing countries (Gupta 2000). The high rate of injectables in Fiji is worrying, as many adverse side effects have been associated with the technologies. These side effects include: “severe headaches, nausea, weight gain or loss, possible carcinogenicity, disturbed menstrual cycles, long and heavy periods of bleeding, spotting and amenorrhoea” (Gupta 2000: 248). Gupta also notes that there are concerns about the negative effects of injectables on future reproduction, metabolism and foetuses. A loss of sex-drive has also been documented as a side effect of Depo Provera.

Norplant is the most common implant. While only low levels of Norplant use were recorded by the Ministry of Health in Fiji (Chandra 2000), Dr Garimella noted that now, “many women are opting for Norplant”. Norplant prevents conception by repressing ovulation; this reduces the number of eggs produced. It also works by making the cervical mucus thicken which makes it impermeable to sperm (Gupta 2000). The principal side effects of Norplant are “cardiovascular disorders, abnormal vagina bleeding without a known cause, benign or malignant live tumours, and known or suspected breast cancer” (Gupta 2000: 254). Norplant requires significant assistance from health providers as women are dependant on assistance for both the insertion and removal of Norplant.

An additional method used by a substantial sector of women in Fiji was the IUD advocated for those seeking long-term protection against pregnancy. Risks include:

⁶⁷ Feminist Women’s Health Centre (2006).

⁶⁸ Whilst the Ministry of Health statistics indicate that Norplant is not a popular method, Norplant was introduced in 1996 and Dr Garimella noted that since that time ‘many women are opting for Norplant’.

perforation of the uterus, infection of various organs in the pelvic area and ectopic pregnancy. Other problems include pain at the time of insertion, expulsion, longer duration of menstrual bleeding, and if the method fails, the possibility of spontaneous abortion with or without infection (Gupta 2000: 265).

The IUD can be removed before the five years is complete but is not advocated as a short-term strategy for birth control. Long-term use is encouraged (Gupta 2000). In a discursive environment that advocates family planning and contraceptives to improve the health and wellbeing of women, these side effects call into question the validity of this narrative.

Research by Chandra (2000) indicates that negative side effects are a real problem for women using modern methods of contraception in Fiji. According to Chandra, the side effects include:

method failures and the link of some methods such as pills and injection to increased appetite, swelling of body, and weight gain and IUDs to bleeding. It is of much concern that women associated pills with cancer. In the case of some younger women, older women relatives told them about pills and their link with cancer (2000: 75).

This is supported by Dr Garimella who states that:

The women see small families as healthy and happy families. [However] [a]t times they talk about disadvantages like weight gain, delay in fertility after injectable contraceptives and also the rumours due to lack of proper knowledge cause some problems.

This disrupts the health narrative that presents family planning as a key ingredient to improvements in the health and welfare of women in developing countries and also questions the ability of contraceptives to empower women. Debilitating side effects are inconsistent with good health and women's empowerment.

Whilst side effects are acknowledged as affecting women in Fiji, women's concerns are not always considered authentic. When asked why women in Fiji might not use modern methods of family planning, Dr Garimella replied, "Due to some rumours and misconceptions like using FP [family planning] can cause infertility, cancers and other sicknesses". Chung elaborates on this point. She states, "In particular, experiences of side effects have been generally dismissed by medical personnel as evidence of women's irrational acceptance of rumours (Cleland 1975: 90). Yet, side-effects are commonly experienced where hormonal methods or intra-uterine devices (IUDs) are poorly administered" (Chung 1999: 132-133). Because the side effects are

rarely acknowledged, contraceptives continue to cause ill-health and uncomfortable side effects for some women.

Whilst health and wellbeing are elementary to life, understandings of health are varied and dependent on epistemological viewpoints, cultural influences and personal opinion. Chung (1999) argues that culturally defined understandings of ‘good’ and ‘bad’ health are not given enough emphasis. She states that:

the extent to which “good” health or “bad” health is culturally (rather than physiologically) defined, has been given too little attention. Among some Fijian women, for example, the absence of regular menstruation is interpreted as a serious sign of ill-health, and the connection they see between the use of some contraceptives and a woman’s “stomach poking out”—heralding the early onset of ageing and a woman having “lost her strength”—mean to them that the use of contraception is a trade off between the worry of becoming pregnant and the risk to one’s health (Chung 1999: 132-133).

The strategies adopted by the UNFPA and family planning services in Fiji to improve the health of women in Fiji and to consequently empower women can result in symptoms that are associated with bad health for some Fijian women. These findings are supported by Allen’s (2004) research on the Safe Motherhood Initiative in Tanzania, which also found that the family planning services implemented were incompatible with the needs of the local women.⁶⁹

Interview material cited by Chandra (2000) indicates why the experiences of women in Fiji with modern methods of family planning may not be taken seriously. One woman in Fiji said that “The belief among women is that when a woman takes pills her menstruation stops, when this happens the flow of blood gets concentrated and it blocks the passage and hence it leads to cancer of the baby bag” (2000: 76). To a biomedical ontology, this construction of events is ‘irrational’. However, as the side effects of contraceptives outlined above indicate, some fertility control technologies are linked to cancer. Whilst the manner in which the women express their concerns may differ from medical understandings of side effects, it does not mean that their concerns should be disregarded. Furthermore, regardless of the frequency of these side effects, the concerns themselves are prompted by technologies that are advocated as a source of health and empowerment for women.

⁶⁹ Refer to pages 23-27.

Exploring family planning and the effects that may have on women's bodies problematises the often enthusiastic health narrative that is closely associated with family planning. These concerns contribute to a questioning of the ability of family planning to give women control over their bodies, or provide them with safe and effective choices. This consequently raises doubt about the role of family planning in empowering women in Fiji.

Family planning and the Issue of Control

This investigation has illustrated that 'control' is seen as critical to women's empowerment. This is evident in the emphasis that the key informants placed on the importance of women spacing and limiting the number of children they conceive. The value of control is also manifest in the methods of contraception that are prioritised in Fiji. The administration of long-term methods of contraception supports a narrative that values the maximisation of control over fertility relative to possible outcomes such as potentially harmful side effects. Albury (1999) argues that control is becoming an increasingly valued attribute in contemporary society, and argues that fear of losing control has resulted in people voluntarily disciplining their bodies. Birth control is an example of the imposition of such discipline. Despite the negative side effects and some cross-cultural differences associated with modern methods of family planning, the associated benefits articulated by family planning advocates, over-ride the negative effects of the practices that are associated with fertility control. A Foucauldian analysis of biopower draws attention to the use of health and choice narratives in creating desires in women that supersede the negative impacts of fertility control practices (Sawacki 1991). The health and choice narratives embodied in the empowerment discourse can generate desires among women to control their fertility. This is one way in which hegemony is evident in the operation of institutions, such as development agencies.

What is interesting about the importance of control within the family planning discourse is that it is uniquely constructed around controlling fertility and little attention is paid to additional ways in which people have control over contraceptive choices and their impact on their bodies. While contraceptive technologies may control women's fertility, they simultaneously expose women to different forms of

power that affect the control women have over their lives. Women in Fiji appear to lack choice in deciding their preferred method of contraception and, as a result, significant numbers of women suffer from the negative side effects explored above. These factors suggest that, in seeking to control fertility, many women lose control over aspects of their body functions. Through using modern methods of fertility control, women transfer the power they have over their bodies to the medical and pharmaceutical professionals (Albury 1999). They become dependent on medical professionals for providing and administering fertility control technologies and the professionals may have an interest in how certain technologies are presented. The pharmaceutical business is a multi-billion dollar industry of which the contraceptive industry is a part (Gupta 2000). Developing countries constitute a large percentage of the globe and represent a huge market for pharmaceutical corporations; spreading and encouraging modern methods of family planning is to their benefit (Gupta 2000).

While women who use modern methods of fertility control may no longer be controlled by their fertility, they do not necessarily have more control over their bodies or lives generally. While control is critical to family planning and constructions of empowerment, it is important to look critically at the current use of birth control to empower women in different cultural and economic contexts and the different forms of empowerment and control associated with contraceptive technologies.

Control: Questioning modern methods of family planning

Developmentalists and family planning advocates promote modern methods of family planning to control women's fertility, based on the belief that modern fertility control technologies are the only way to effectively manage women's fertility. However, a critical analysis of family planning in Fiji suggests that the correlation between modern methods of birth control and declining birth rates is not as strong as development agencies proclaim. It also suggests that alternative methods of family planning remain in Fiji casting doubts on the necessity of uniquely modern methods of family planning as effective measures to control women's fertility.

Following the introduction of family planning to Fiji, between 1960 and 1968, the crude birth rate of Fiji fell from 40 per thousand to 30 per thousand ⁷⁰ (Lucas & Ware 1981). The crude birth rate has continued to decline since this time, until the 2002 when a slight increase occurred. In 1980, the crude birth rate was 29.7; in 1990 it was 24.8; and in 2000 it was 21.2 (UNESCAP 2004). The crude birth rate for 2004, as calculated by ESCAP (2004) measured the birth rate to be 23.0 per thousand. Family planning and modern methods of contraception have largely been held responsible for the decline in women's fertility (Chung 1999). However, an analysis of family planning clinic attendances shows that family planning technologies may not be as significant in achieving this decline as was originally thought.

Attendances at family planning clinics rose more or less periodically from 1963 to 1971, with just 2 732 women attending in 1963 and 77 372 in 1971 (Hull & Hull 1973)⁷¹. Since this time, contraceptive prevalence rates have continued to rise. In 1979, 29 percent of women between the ages of 15 and 44 were using modern methods of contraception (Lucas & Ware 1981). In 1990, the rate increased to 35.1 (UNFPA 2006). Since this time, contraceptive rates have plateaued. The most recent statistics indicated that the contraceptive prevalence rate (CPR) in Fiji for 2004 remains at 35.1 percent (41 percent if natural methods are included) (ESCAP 2004). Comparing the crude birth rates of women in Fiji with contraceptive prevalence rates challenges the assumption that family planning is responsible for declining birth rates.

Whilst there is a correlation between the introduction of family planning and declining fertility rates, the most significant decline in fertility and birth rates occurred

⁷⁰ Investigating the changing rates of fertility for women in Fiji provides an alternative means of assessing the 'effectiveness' of family planning. Lucas and Ware (1981) provide statistics for the rates of fertility for women in Fiji during the early stages of family planning. Fertility rates, like the rate of crude births during this early period, saw dramatic declines. Whilst the statistics they provide are somewhat vague, they serve to illustrate the overall trend of fertility during this period: Total fertility rates (per woman) in Fiji around 1966 were 4.8, the rates for 1970 were 3.8 or 3.2 and 1978 measured a rate of 3.6 or 2.6. Following this initial decline, rates have not changed significantly. Measurements available for the Fijian Bureau of Statistics indicate a fertility rate of 2.70 in 2000 and 2.19 in 2001. What is evident is how dramatically the rate of decline has slowed since the government first became involved in family planning and the subsequent decades.

⁷¹ Whilst figures measuring the attendance of women at family planning clinics were collected during the early period, the reliability of this collection has since been reviewed. It is now acknowledged that the records are, 'only a guide to the number of women displaying an interest and do not indicate the total number of women protected' (Hull & Hull 1973: 192). However, they are still useful for looking at general trends.

at a time when the fewest women in Fiji were attending family planning clinics and presumably accessing modern methods of family planning. Furthermore, a decline in crude birth rates occurred between 1990 and 2000, despite a consistent level of contraceptive prevalence rates. This suggests the role family planning has played in Fiji in reducing birth rates has been over-emphasised. Furthermore, it suggests that fertility control can be achieved without modern fertility control technologies.

What is also significant about the use of contraception in Fiji is that, despite 40 years of publicity and near universal knowledge of family planning services, over 60 percent of the female population do not use family planning (Hull & Hull 1973; Lucas & Ware 1981). Even though the highest rate of contraceptive prevalence measured in Fiji was 41 percent, there remains 59 percent of the population disengaged from family planning, despite declining birth rates. This further suggests that women are using fertility control methods that fall outside methods approved by family planning agencies. Chandra noted that “traditional medicines (leafy concoctions) were still perceived as one of the fertility control devices among some Fijian women in rural areas. Older rural women provided the information on traditional herbal methods but the extent to which these methods were still used was uncertain” (2000: 75). This illustrates that women in Fiji do engage with fertility control technologies that extend beyond western understandings of modern and natural methods of family planning. It also questions family planning discourses which advocate modern methods of fertility control as being the only way to reduce fertility rates and access the consequent benefits.

The stagnant CPRs, despite wide access to family planning services, also suggest that women in Fiji are resisting modern methods of family planning. The 2004 CPR for modern methods in Fiji was 35.1%. As a means of contextualising this figure, New Zealand’s 2003 CPR for modern methods was 72% (Globlis 2006). This resistance, in conjunction with the negative side effects noted by many women in Fiji, suggests that a large sector of women in Fiji are not interested in using modern methods of contraception.

Further evidence of resistance to modern medicine in the Pacific is the Pasifica Declaration on Traditional Medicine made in 1993 which emerged out of concerns to,

encourage the conservation of traditional medicine knowledge, encourage the documentation and dissemination of traditional medicine knowledge, encourage the protection of traditional medicine plants, [and]encourage Pacific Island governments to recognize the important role that traditional medicine can play in national health services (Strathy 2006).

The authors of this Declaration were also concerned about

the unacceptable loss of medicinal plants due to habitat destruction, the need to encourage research on the availability, safety and efficacy of traditional medicine plants, the need for Pacific Island governments to recognize the important role that traditional medicine can play in national health services, the significant economic value of medicinal plants used today, the need to ensure that indigenous knowledge and practice of traditional medicine are respected and protected, the need to ensure that researchers respect traditional land ownership and rights, and compensate indigenous people for their use (Strathy 2006).

Whilst family planning is not explicitly mentioned in this declaration, the resistance to modern understandings of health, medicine and wellbeing is evident. Modernity is often hailed as the only way of advancing or changing a population. However, the resistance to modern methods of family planning, and modern medicine more generally suggests that the western modernity discourse may not be the vehicle for change that some women in Fiji are seeking.

Exploring traditional knowledge and natural methods of family planning opens up the opportunity to think about controlling/disciplining and empowering women's bodies in ways that modern medicine does not. Discourses of modernity have constructed family planning as the only way in which women in Fiji can effectively control their fertility and consequently improve their lives. However, this exploration of Fiji suggests that there are successful worldviews beyond western modernity that enable women to effectively control their fertility, improve their lives and become empowered.

Critical Reflections

This exploration of the choice and health narratives gained from key informants and documentary material has shown that these narratives are critical components of the empowerment discourse. Interestingly, the narratives closely relate to the international empowerment discourse in the field of family planning and development. I found that what is articulated about choice and health by key informants and documents, in practice is not always empowering for women in Fiji. This prompted me to raise questions about whether the empowerment discourse does contribute to improvements

in the quality of life for women living in Fiji or whether it predominantly supports the agendas of international development agencies. The choice and health narratives are integral to the empowerment discourse; but do not entirely account for how the empowerment discourse is constructed. Therefore, further exploration into this discourse is required. An exploration into the full citizenship narrative consequently follows in Chapter Six. Here again a generic story is told about how women might achieve empowerment through exercising control over their fertility.

CHAPTER SIX

The Full Citizenship Narrative: A Critical Analysis of the Empowerment Discourse in Contemporary Fiji

Introduction

Choice and health narratives have emerged as critical components of the empowerment discourse in Fiji. The previous chapter illustrated the use of these narratives in the construction of the empowerment discourse in Fiji. The ideal of women achieving 'full citizenship' in a contemporary capitalist state informs this empowerment discourse. The full citizenship narrative is predominantly about encouraging women to engage in activities outside the home. This narrative rests on the assertion that motherhood and 'excessive' pregnancies prevent women from achieving their full potential. In response to that scenario family planning and fertility control are constructed as important components in the pursuit of 'modern' citizenship through freedom from endless pregnancies and participation in the formal economy. The full citizenship narrative, and its association with empowerment, is based on three rationales. These are: rights, resources, and national economic growth, all of which promote the participation of women in formal work. Both western feminist movements of the 1960s and 1970s, and the neo-liberal market approach to development inform these ideas. The 'rights' component of this narrative suggests that large families restrict the activities of women. The narrative argues that large families tie women to the home and prevent them from entering paid work inhibiting women's independence, financial autonomy and restricts their personal development. Family planning is advocated as a remedy. Women's rights and ideas about self-determination, autonomy and individualism inform this component of the full-citizenship narrative.

Another element of the full-citizenship narrative is resources. The narrative suggests that family planning will enable women to have better access to resources and will

alleviate poverty through facilitating their involvement in the formal economy. There are two strands to this argument: one is that having fewer children enables women to participate more in paid employment and to contribute financially to the running of their households. The rhetoric asserts that having fewer children is useful for both women's self-determination and because of the greater access to resources paid work is said to bring. The other is based on Malthusian ideologies, which assert that fewer children require fewer resources. Proponents of this rationale do not consider the effects of external forces and structural inequalities in understanding poverty. The final component of this narrative is the contribution of women in paid work to the economic development of the nation. This narrative reflects neo-liberal ideologies which began in the 1980s and 1990s. Development agencies espousing these ideologies emphasise the importance of productivity, for men and women alike, in promoting wellbeing and development (Moser 1993). Similar to the individual benefits associated with the engagement of women in paid work, this component suggests that the participation of women in the labour force and small families will promote national economic growth, which is believed to be critical for alleviating poverty. Family planning and the full-citizenship narrative are integral to the empowerment discourse.

The narrative of full-citizenship in Fiji may be deconstructed by exploring the position of women in paid employment. The common assumptions that economic growth requires low birth rates and that national economic growth translates into reduced poverty for local people may be questioned. Exploration of visual material presented in documentary sources about family planning provides further understandings of the messages and narratives that are being promoted to women in Fiji about family planning and empowerment. It is clear that there are ethnic, economic, age and marital status differences in the use and acceptance of family planning in Fiji. The relevance of generic family planning programmes and universal strategies to empower women are consequently called into question. A Foucauldian analysis of family planning and the empowerment discourse in Fiji draws on ideas about biopower⁷² and suggests that political elites use the empowerment discourse to control women in Fiji, and to promote longstanding political and economic agendas.

⁷² See Chapter Two for discussion of Foucault or see Sawacki (1991) or Ransom (1997).

The Role of ‘Rights’ in Promoting Family Planning

Comments by Tagicakibau illustrate how ideas about rights and full-citizenship are manifested within discussions about family planning in Fiji. Tagicakibau argues that women who do not use family planning or have no control over their reproduction, “become burdened with child bearing/rearing [one] after another, and have little time or energy to develop their own empowerment.” She states “I see the issue of a woman’s absolute control over her own body and reproductive organs as a critical human rights issue of self determination”. She further argued that family planning improves women’s self-esteem and enables women to participate as “full citizens.” Talk about ‘rights’ and fertility control is consistent with Seltzer’s (2002) analysis which focuses on the use of ‘rights’ in recent development discourses to promote family planning initiatives. The promotion of women in formal work connects to development programmes in the 1980s and 1990s which used ideas about women’s rights to encourage capitalist growth. This period was known as the Gender and Development (GAD) approach (Moser 1993).

Latu⁷³ talks about family planning in a similar fashion to Tagicakibau. Latu asserts that family planning is beneficial, because having fewer children allows a woman “more time for herself and to attend to other activities outside the home.” She comments “those who don’t use FP [family planning] are stuck in the home busy attending to children, repeated pregnancy and childbirth and really does not have quality time for herself [sic].” Similarly, Dr Garimella comments that “[w]omen who follow FP [family planning] have more time to pursue their studies, career and other activities.”

This narrative suggests that family planning and participation in paid work are necessary for women to be more “complete”. This is interesting because, within a neo-liberal development approach, people participating in formal productive employment are more “valuable” than unpaid workers (Bargh 2001; Moser 1993).” Whilst providing women with the opportunity to engage in activities outside the home may be empowering for some women, to suggest that women whose primary occupation is motherhood are disempowered undermines the value and role of

⁷³ Key informant: ARH Advisor

motherhood. It suggests that motherhood does not constitute “work” and presents full-time mothers as less valuable than paid workers. This suggests that the full-citizenship narrative is strongly connected to development strategies based on neo-liberal agendas.

The comments by Tagicakibau, Latu and Garimella reflect ideas about women’s autonomy and personal ownership. They associate women’s empowerment with paid work and associate subordination with domestic duties, an argument that first emerged in the 1960s and 1970s women’s rights movements.⁷⁴ These passages illustrate the western and individualistic nature of the full-citizenship narrative and the empowerment discourse. Recently, Nanise Nagusuca, the Assistant Minister for Culture and Heritage in Fiji, questioned the western discourse of human rights in Fiji. She told a meeting of an indigenous women’s organisation that “human, women’s, children’s and individual rights are eroding the indigenous national identity” (Radio New Zealand, 2005). As previously noted, Correa and Reichmann (1994) also asserted that human rights are founded on western capitalist ideas about individualism.⁷⁵ Accordingly, they questioned the place of this narrative in ‘the South’. This discussion problematises the Eurocentric nature of the empowerment discourse and brings into question the validity of ‘one-size-fits-all’ approaches to development. Critics of this approach to development, such as Mehmet (1995), argue that the universal strategies are Eurocentric and are a way of promoting western ideologies and agendas. They do not attend to the specific needs of local cultures and cause problems for non-western cultures.

Opponents of this position highlight the use of ‘culture’ and ‘tradition’ to prevent change and maintain the subordination of women. Siwatibau from Fiji argues, “Culture has often been used as an excuse to ensure the continued domination of men over the women of their societies” (as cited in De Ishtar, 1994: 218). Similarly, Griffen states:

Culture or custom, is the commonest argument used against any call for a new image of women in the Pacific. Even aware women are confused about this question because in the postcolonial period, cultural identity is an important part of national rehabilitation and pride.

⁷⁴ This is explored in Chapter One: Introduction. See pages 4-7.

⁷⁵ See Chapter Two: Literature Review and Theoretical Framings.

We as women need to deal with this question and present a clear statement of custom and tradition in relation to the liberation of women (Griffen as cited in De Ishtar, 1994: 218-219).

These arguments highlight the complicated and complex nature of the empowerment discourse. Rights and empowerment are rooted in modernity and western culture. The disruption this can cause to local cultures is used by some, such as Nagusuca, as an argument against implementing universal discourses and strategies in countries in 'the South'. However, as Griffen (as cited in De Ishtar 1994) and Siwatibau (as cited in De Ishtar 1994) argue, many women in Fiji are dissatisfied with their current position and accordingly seek change. Ideas about rights, the full citizenship narrative and the empowerment discourse are based on western ideas about individualism. The comments by Griffen and Siwatibau, however, suggest that the empowerment discourse, and its associated narratives, might be a useful tool with which to promote change and elevate the position of women in non-western countries. Deconstructing the empowerment discourse requires attention to both the western and Eurocentric nature of the discourse, but also an awareness that some women in Fiji do find western ideas about rights and self-determination empowering.

Family Planning: A Tool to Alleviate Poverty and Promote Women's Self-Determination?

In discussions about family planning in Fiji, the participants often talked about the ability of family planning to provide women and their families with greater access to resources and financial security. This argument is built on Malthusian theories (see Bandorage 1997; Gupta 2000), which consider high birth rates to be responsible for poverty and underdevelopment. The narrative suggests that family planning improves the lives of women in this regard. It argues that contraceptives are also important for alleviating poverty because smaller families better enable women to engage in paid work outside the home. Accordingly, the discourse espouses family planning for empowering women in regards to the provision of self-determination, but also in terms of their access to resources through participation in the formal economy.

Economic Autonomy and Women's Empowerment

Latu argues that family planning allows women "to contribute more economically to the running of the home by going to work" and puts women in a position where they

have the opportunity to 'choose' to work. She asserts women who do not use family planning are socially and economically disadvantaged because they are likely to bear more children than is desirable and affordable. Women are empowered because of the personal benefits, such as autonomy and also by financial rewards. An investigation into the position of women in the Fiji labour market, however, encourages scepticism about the argument that paid work contributes to their personal growth, self-determination and financial autonomy.

A story told by Leckie (1997: 128) is useful for exploring how paid labour changes the lives of women. This narration challenges the extent to which paid work improves the quality of life for women in Fiji. In particular, it enables an exploration of how being a 'full citizen' and participating in paid labour creates new problems for women. She recounts the experiences of a woman, Asena, who was forced to move from subsistence gardening and fishing in a rural village to paid employment in Suva. This was largely in response to the 1987 military coup and the SAPs that followed. These changes made earning a living in her village, Rewa, difficult. The coup and the SAPs were supposed to improve living conditions; however, the economic restructuring caused rising unemployment and therefore her husband was unable to find work. Asena and her family experienced great economic adversity and, as a result, Asena was forced to leave her children with her husband's parents and find formal employment.

This story is consistent with Chung's (1999) claims that women have increasingly reduced the size of their families and entered formal labour, not because of the personal rewards that paid work brings, but rather because changes to Fiji's structure and economy since the 1960s have forced women to reconsider family formation and enter paid work. These changes include the increased promotion of capitalism, the adoption of SAPs and the opening of the Fijian economy in the 1980s. She maintains that following economic changes in Fiji, women have been forced to participate in the formal economy and can no longer afford to finance the large families that they were once able to sustain through agricultural production. She argues that economic growth within the Fijian economy has pressured women into reducing their birth rates. This challenges the argument that women are voluntarily reducing their fertility so that

they have the opportunity to participate in the formal economy and improve their status and wellbeing.

The argument that the participation of women in paid labour usually contributes to women's empowerment is further challenged by evidence reported by Leckie (1997), the SPC International (2006) and Bargh (2001). This research illustrates that many women in Fiji have poor working conditions. Leckie (1997: 128) describes the working experiences of Asena. When the need arose for Asena to enter formal employment, she welcomed the opportunity and looked forward to the independence that it promised. Asena became a domestic worker, which was common for rural women seeking working opportunities in urban centres. This work was tedious and isolating. In search of a better working experience, Asena gained employment in the export-garment-production industry where she earned 75 cents an hour. It is important to note that initially Asena welcomed the prospect of paid employment. Paid work is an experience in which some women in Fiji want to participate. However, the opportunity for independence was soon overshadowed by the poor conditions in which she was forced to work.

The difficulties women entering paid work face in Fiji extend beyond the poor working conditions of their employment. As Asena's story illustrates, women are often required to spend long hours in paid and unpaid work. Instead of being 'dominated' by children and work in the home, Asena's life became dictated first by long working hours and second by the housework that faced her on her return. When Asena moved to Suva, she lived in a small apartment with her parents and cousin. Shortly after, her husband joined her. Her story continues:

The male family members in Suva shun housework. This means Asena's day begins around 4.30am preparing the family's breakfast, and doing washing and ironing. Factory work begins at 7.45 am with a fifteen minute tea break and thirty minutes for lunch. She usually finishes at 5 pm but often works overtime, including Saturdays, at the same rate. In the evening Asena resumes domestic duties. Despite the long hours in formal employment, her wages are inadequate to meet her family's expenses. One week her wages were arbitrarily deducted (Leckie, 1997: 128-9).

This story significantly challenges the full citizenship narrative articulated by key informants and evident in the family planning literature. Empowerment and control through participation in paid work is not the experience of many women in Fiji. The

positions available are often menial and unstimulating. Research presented by Bargh (2001) and SPC International (2006), described below, highlight the high percentage of women in low-paid labour. This research suggests that Leckie's account of Asena's story could be the story of many working women in Fiji.

Research by SPC International (2006) narrates a sombre description of the position of women in the Fijian labour market. SPC International finds that in Fiji the work is highly stratified by gender. This research indicates that employment for women in Fiji since the 1990s has been concentrated in the manufacturing and processing industries. This employment is unstable and poorly paid, suggesting that neither financial security nor social development is the outcome of women working under these conditions. Bargh (2001) supports these findings. She found that increased competitiveness in the global market and the Fiji government's desire to promote national economic growth has led to an exploitation of labour in Fiji, particularly of women in the garment manufacturing and food processing industries. Labour standards have dropped as a result of a greater emphasis on high productivity levels; consequently the working conditions for a large sector of the employed female population in Fiji are poor. How exploited labour contributes to women's empowerment is questionable. It is easy to prescribe remedies to women's disempowerment; however, this research suggests that the empowerment discourse requires closer attention to the reality of how their strategies are manifested in local communities.

The data collected by SPC International (2006), Bargh (2001) and Leckie (1997) discredit the full-citizenship narrative offered by those who are advocates of family planning and modern technologies of contraception. Their findings indicate that the experiences of women in the formal economy in Fiji are far from empowering. Many of the positions available to women are tedious, unsatisfying and low paid. Whilst women's location in a limited range of jobs within the formal economy does not mean that women should 'give up' and retire from paid work, it does question the empowerment discourse. Proponents of the full citizenship narrative also fail to consider the double shift that many women face when they are responsible for domestic and formal work. This is a problem that transcends cultural differences. Women in western countries who participate in paid work also spend more hours

doing childcare and domestic work than their male partners. The empowerment discourse does not address these problems.

Small Families are Happy Families

Many of the key informant participants argue that family planning improves a family's access to resources. This philosophy contends that smaller families require fewer resources and furthermore, that members of small families are better resourced. Latu shares this point of view. She states that “[a] small family, [is] well resourced and manages well financially and socially [they are] ... a role model to other families who are struggling with too many children.” Robertson also advocates the implementation of family planning to restrict family size as a way of avoiding poverty and improving quality of life. She states that family planning allows couples to have small families, where, “[t]heoretically there should be more money to spend on fewer children so quality of life improves, i.e. there are more resources”. Asena's story suggests there is a need to look sceptically at this position.

The resource narrative has been used since the beginning of development programmes to promote the adoption of family planning programmes. This is evident both at the international level and within the local Fijian context.⁷⁶ This narrative suggests that children are economic burdens. This attitude is a relatively new phenomenon and one that is specific to the industrial world. Until recently, children and large families have been a requirement of families for social security, as rural production and subsistence-based living have relied on the participation of children to work the land (Mies & Shiva 1993). If women are not employed in the formal labour market, their participation in economic activity remains invisible. The statistical omission of women's and children's labour from analyses of the subsistence economy represents women as unproductive even when they contribute to the material wellbeing of their households. Furthermore, this narrative suggests the availability of a family's resources is determined by the size of a family and that individuals can use family planning strategies to ensure they have adequate resources for the children they deliberately conceive. Constructing poverty as a phenomenon determined by

⁷⁶ See Chapter Two: Literature Review and Theoretical Framings for a more detailed exploration of the international narrative and Chapter Three: History of Family Planning and Empowerment in Fiji to see how this narrative played out in the Fiji context in the 1960s.

individual choices ignores the role of state policies, colonisation, capitalism, politics or the myriad factors that can affect the availability of resources to individual families (Bandorage 1997; Gupta 2000). The strategy of using population control and family planning to remedy poverty places full responsibility on women while it ignores other significant contributors to world poverty. Accordingly, the approach to family planning makes women responsible through their personal choices for the economic wellbeing of their households and constructs the 'good' mother as someone who controls her fertility and has a smaller family with two to three children.

The resource narrative implies that women must engage in paid work in a capitalist environment in order to become empowered. Bargh (2001) comments that subsistence forms of activity, which account for approximately 70 percent of production in the Pacific, are under-valued. She states that subsistence production

is often not regarded as being "real" production by Neoliberals; like the labour of women in the home, subsistence production is not conceived of by Neoliberal theory as "proper" production and work. This highlights the way in which Neoliberal analysis fails to perceive of activity beyond that which takes place in the market place... There is a limited capacity in such a view to perceive other cultures and political economic systems with respect. (2001: 7).

The notion that economic production will empower women is constructed in an environment which dictates how economic production and economic security is to be achieved.

Family Planning and National Economic Development

The key informants' believe that fertility control is important because it advances the nation's economy from which women and whole communities are said to benefit. Dr Garimella, for instance, states, "Now the number of children is usually 2-3 [per] family ... this leads to an upliftment [sic] of the socioeconomic condition of the families as well as society". Similarly, Latu adds that, "Socio-economic development" is anticipated to make improvements at the "family level, at community level and at national level." This is not a new argument. Economic development has been promoted for many years to reduce poverty and improve the quality of life for people in developing countries (Leftwich 2000). National economic development has been defined as dependent upon the participation of women in the formal economy and a reduction in the numbers of births per childbearing woman (Moser 1993). The

narrative of adequate resources illustrates that economic development, and ‘underdevelopment’, remain critical rationales for implementing family planning. It suggests that some of the political and economic agendas identifiable in early family planning initiatives remain in contemporary family planning programmes and are integrated into a new rhetoric about ‘women’s empowerment’.⁷⁷

Birth Rates and Women’s Economic Development

A preliminary analysis of birth rates and the economic development of Fiji indicates that reduced birth rates are associated with economic growth; however, further analysis illustrates that this argument is simplistic. The figures detailed earlier prove that generally crude birth rates have declined since the introduction of family planning.⁷⁸ Since this time, Fiji’s GDP per capita has progressively risen. The GDP in 2004 was \$US 2, 061. This is up from \$US 1, 116 in 1960, \$US 1, 404 in 1970, \$US 1, 864 in 1980 and \$US 1, 952 in 1990.⁷⁹ While these statistics appear to support the association between reduced birth rates and economic growth, economic growth was greatest between the 1970s to 1980s when there was the smallest decline in birth rates. What is also significant is that the largest decline in birth rates occurred during the 1980s to 1990s when initiatives to include women in the development process began. However, this was a period of relatively low economic growth. This challenges the correlation that is often made between economic growth and reduced birth rates. It is important to note that a variety of factors might contribute to low economic growth. There was significant political instability in the 1980s and two military coups in 1987. High rates of Indo-Fijian emigration followed the coups when indigenous Fijians achieved political control of Fiji in 1990 (Ewin 1998). These factors indicate that trying to make a correlation between birth rates and economic growth and decline oversimplifies a very complex situation.

Furthermore, this research challenges the idea that national economic development is a prerequisite to poverty alleviation and women’s empowerment. Economic participation is often constructed as critical to empowering women because it is supposed to alleviate poverty and provide women with increased autonomy. However,

⁷⁷ See Chapter Two: Literature Review and Theoretical Framings.

⁷⁸ Note that this has already been presented in Chapter Five on page 90.

⁷⁹ UN System Wide Earth Watch (2006).

analysis of relevant statistics suggests that there are strong reasons for questioning the validity of that argument. Chung (1999) has shown that national economic growth has not reduced the poverty experienced by women in Fiji. This view is supported by Slatter who argues that national economic growth does not always correlate with an improved quality of life for the majority of the country. The money often goes into growth areas such as tourism and little is directed at improving health and education services. Bargh (2001) similarly argues that economic development does not necessarily reduce poverty. She states that “Fiji is often held up as the example of 'successful' export orientated strategies”, but she demonstrates that the gap between the rich and poor is becoming increasingly wide. The Fijian economy is recently said to be advancing and in 1999 was estimated to have grown 7.8 percent. However, between 1992 and 1997 Fiji’s Welfare Department showed that appeals for family financial assistance rose 46 percent (cited in Bargh 2001). These findings indicate that strategies to empower women are concerned with improving macro level indicators of national growth rather than women’s wellbeing and quality of life.

Visual Documentary Sources: A Trajectory to Articulating the Full-Citizenship Narrative

Images from two contraceptive pamphlets, *Your Choices in Family Planning* and *Contraception: Your Choice*, and the *Population and Poverty* image concisely summarise the empowerment discourse that is the focus of critical attention in chapters Five and Six. The first two images are the covers of two pamphlets sent to me by Dr Garimella. Their purpose is to educate women in Fiji on the contraceptives available to them and to inform them of the advantages and disadvantages of each method. Both images depict two small Fijian families. The families appear healthy and happy; they are well clothed and appear to have had access to food, shelter and all their basic needs. In one case, the family is shown against the background of a well built, contemporary domestic dwelling. The images suggest that having small families and using fertility control contribute to overall wellbeing, happiness and material prosperity. The real impact of these images becomes clear when they are contrasted with the image *Population and Poverty* below which appears in the *State of the World Population* (UNFPA 2004), in the chapter ‘Population and Poverty’.



Figure Two:
Your Choices in Family Planning
Marie Stopes International Fiji (nd a)



Figure Three:
Contraception Your Choice
Marie Stopes International Fiji (nd b)

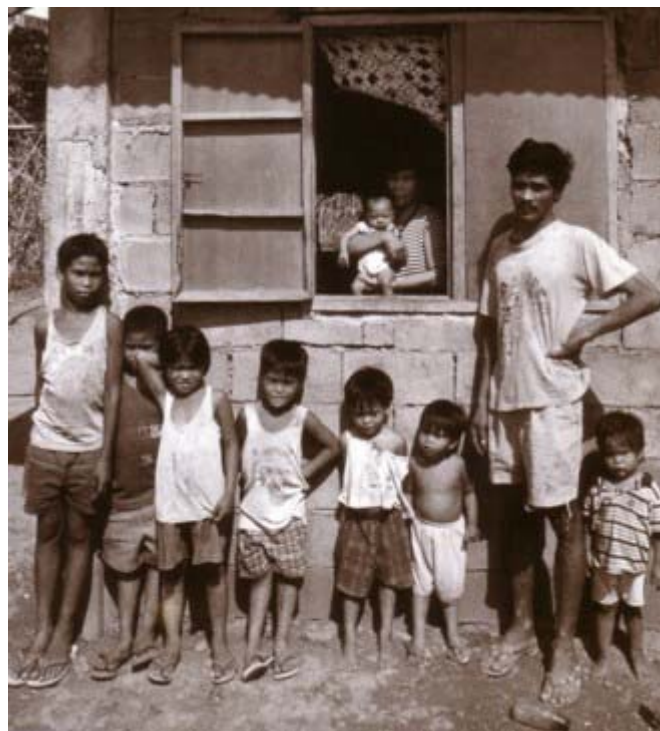


Figure Four: *Population and Poverty* (UNFPA 2004: 10)

The family represented in this image contrasts greatly with the families presented in the contraceptive pamphlets. Unlike the first two images, this family is large; the image suggests that they are undernourished, unhappy and poverty-stricken. The woman in this image is positioned inside the home, beneath shadows and barely visible. This contrasts with the way women feature in the foreground of the first two images. She is also literally presented as ‘holding the baby’ while in the first two images, men are holding the youngest children suggesting family planning encourages gender equality. The dominant message of these images is that family planning improves the quality of life for families in developing countries, is empowering for women and encourages men to be more active caregivers.

Family Planning and Heterogeneity

This investigation into the empowerment discourse throughout the previous two chapters has illustrated that the discourse prescribes generic strategies, which advocates family planning for women’s empowerment. Chapter Five demonstrated that family planning is advocated for enhancing women’s choices and improving their health, both of which were closely associated with women’s empowerment. Additionally, this chapter has shown how family planning is prescribed to make women ‘full citizens’ and make them more ‘complete’, autonomous and empowered individuals. However, an investigation into family planning in Fiji demonstrates that ethnicity, occupation, education, age and marital status influence how women engage with family planning practices. The needs of women change depending on these factors and, no doubt, a variety of other external influences. This illustrates that women are a diverse group of people suggesting that one empowerment discourse is inadequate to improve the quality of life for all women in Fiji.

Since the debut of family planning programmes, Indo-Fijians have consistently been more accepting of small families and of family planning than Fijians, who have shown greater resistance to fertility control programmes (Roizen et al. 1992). Today this trend continues. Latu states that “[m]ore Indo-Fijians use FP [family planning than] when compared to indigenous Fijians”. This is confirmed by Robertson who maintains that “Indians are more likely to have fewer children as a result of using

family planning.” Chandra argues that Indo-Fijian parents felt they were able to provide a better life for a small family. They viewed large families as being costly and associated large families with a lower standard of living. Small families breed “quality children” (2000:71). In rural areas, having small families was partially associated with insecurity among Indo-Fijians about the future of land tenure arrangements; parents preferred small families as they were unsure how they would be able to provide for their families in the future.

In the Fijian community, however, understandings about family size were quite different. Focus groups indicated that for older Fijians, large families with five or more children were important, particularly to the rural sector. Families with as many as 8 to 10 ten were not uncommon. Chandra explains that,

There were religious, socio-cultural and economic explanations for the preference for large families among Fijian adults. Older men in the villages had indicated explicitly that large families were important, as there was much land for their people to live and work. Children were seen as old age support and wealth for the households (2000: 72).

Families with four or five children were considered small by older men and women in the Fijian community.

The reported differences in orientation to family size among Indo-Fijians and Fijians reflect historical and economic differences between these communities. The Indo-Fijian population has its origins in attempts to increase the paid labour force and has predominantly been involved in the formal economy (Sutherland 1984). They continue to dominate the commercial sector today as opposed to the Fijian population which has been concentrated in subsistence-production (Chung 1999). Large families are useful in subsistence economies, but are more of a financial drain for people involved in capitalist production, particularly if they are located in urban areas.

My interviews also suggest that there is an ethnic division in the preferred methods of family planning. While the key actors suggested that tubal ligation was significant for both Fijian and Indo-Fijian women, Fijian women were identified as favouring pills or injectables whereas Indo-Fijians preferred condoms or IUDs (Chandra 2000). This position is supported by Dr Garimella. She states that,

TL [Tubal Ligation] is the most popular choice for those who completed their families.... Injectables as they are convenient (sometimes the partner may not be agreeing for FP) and

Fijians opt more. IUD is the other popular choice and more common with Indian community. Pills and condoms are the other important methods. Pills are used more than the IUD.

This indicates that while there is similarity among Fijians and Indo-Fijians with respect to the uptake of tubal ligation, people in different social, economic and ethnic groups have different needs and varied preferences with respect to specific birth control technologies. In Chapter Three, I provided an historical overview that indicated some of the reasons for the different engagement of Indo-Fijians and Fijians with family planning. They have experienced different population control policies, been concentrated in different modes of production and have experienced different generational influences due to the indentured labourer process which primarily brought young Indians to Fiji with consequences with respect to the dynamics of household and community development.⁸⁰

Ethnicity is not the only defining factor in determining how women engage with family planning. The interviews with key informants suggest that educated and/or employed women are more likely to use family planning than women who are uneducated or are not involved in the formal sector. Dr Garimella states that, “[e]ducated women accept FP [family planning] more than the others”. Rufina Latu affirms this claim stating that, “[t]he more educated a couple/individual is, the chances are that they use FP and vice versa”. Robertson similarly confirms this position, stating that, “[e]ducated women tend to use FP [family planning] services more than uneducated women. Often these women access contraception through private pharmacies”.⁸¹ Similarly, most family planning users are employed, this is affirmed by Dr Garimella, Latu and Robertson. Dr Garimella states that “civil servants and others in the private sector and also the garment factory workers” mostly use contraception. Rufina Latu affirms that, “[t]he tendency is that working women will want to use FP [family planning] because having too many children affects their work and employment”. Robertson affirms that, “Women working in paid jobs and

⁸⁰ See Chapter Three: History of Family Planning and Empowerment in Fiji for more details.

⁸¹ The connotation of using private health care facilities is that women seek to enhance their privacy and also seek to avoid the judgements of public family planning providers. This provides an insight into the position of family planning in Fiji, suggesting that family planning is yet to be openly accepted in Fijian culture. Robertson also states that educated women have the financial capacity to attend private pharmacies. Therefore, whilst educated women may use family planning because of their understandings of family planning, it may also be because they have the financial means of obtaining family planning services in a way that optimises privacy.

professional women tend to use FP more than women working in the non-formal sector”.

Age and marital status constitute additional factors that influence how women in Fiji engage with family planning. Annette Robertson affirms that, “[y]outh tend not to use FP services because of cultural/religious/family barriers and because FP services are not youth-friendly.” Timaima Tuiketai states that, “FP is generally available for both single and married women – the choice is there. But generally we encourage all married couples or women to use some form of FP to prevent ... unwanted and unplanned pregnancies.” The majority of family planning users are married⁸² (Latu). This seems to be consistent with the cultural and moral values of Fiji which oppose sex before marriage. Using family planning services before marriage would indicate a breaking of this moral precept.

Religion also affected how women engaged with family planning. My interviews show that religion can discourage women using family planning. Timaima Tuiketai states that there is resistance to family planning, “[t]o some extent ... from the religious groups esp[ecially] the Roman Catholics, particularly on T/L [tubal ligation]. But couples do agree after they are explained in detail with patience the real hard facts about FP and objectives and goals that it is to give quality of living to the family rather than limiting the number of children”. Rufina Latu affirms this rhetoric. She indicated that very few men use family planning and some are unhappy with their wives using family planning as they think that it will make them sick. Older people are more likely to oppose family planning than younger generations.

There is a tendency to homogenise family planning users as one uniform group - women. However, a critical analysis of family planning in Fiji illustrates that women experience family planning in unique and diverse ways. They have different rationales for limiting or not limiting their family size, different histories, cultures, religions and

⁸² The Adolescent Reproductive Health Programme (ARH), however, is working to encourage sexually active youth to use contraception and practise safe sex. Annette Robertson states that men in Fiji do not use family planning: this is reconfirmed by Dr Garimella who affirms that, “[a]round 1% of our clients may be men”. However, statistics provided by Rufina Latu who works with youth reproductive health, calculates that, “[i]n the ARH project for young people at least 50% of clinic visits are young men.” This indicates that perceptions of family planning and sex are changing in Fiji.

current issues that affect how they practice family planning. The global and uniform nature of the family planning discourse tends to ignore the different needs and desires of different women. There are many contributing factors that influence how women engage with their fertility, their bodies and family planning technologies.

Empowerment as Social Control: Behind the Benevolent Exterior

As this thesis has illustrated, the empowerment discourse associates the use of modern methods of contraception with many positive outcomes for women, their households, their communities and the nation state. These positive outcomes include control over the number of children they will conceive as well as choice as to when they would have the children, personal ownership of their bodies, and enhancement of their civil rights and equality with men. The use of family planning has also been associated with good health, poverty alleviation and economic prosperity at both local and national levels and personal development for women. These promises suggest that family planning is central to achieving women's empowerment. It is a discourse that is undeniably appealing, which makes it all the more powerful in constructing women's developmental aspirations. However, Chapters Five and Six have illustrated that, in practice, the empowerment discourse and the strategies it suggests do not always have positive outcomes. Empowerment strategies are often presented as potentially offering women greater autonomy, improvements in their health and changes in the nature of their working day. However, these changes may simultaneously create new forms of subordination and subject women to new forms of control.

The empowerment discourse, whether informed by choice, health or full citizenship narratives, constructs the desires to both limit family size and to engage in paid work outside of the home. This creates the subject position of a woman who chooses to limit her fertility, embrace health for herself and her children and involve herself in the formal economy. Family planning and modern contraceptives provide the means of disciplining women's bodies to become 'empowered'. Empowerment, including multiple narratives about choice, health and full-citizenship are thus powerful and persuasive discourses that evoke desire and hope. Few people dispute the benefits of these narratives as they are assumed to be universal desires which in themselves

embody positivity. In this regard it is interesting to look at the empowerment discourse as a version of Foucault's biopower in exercising disciplinary and regulatory control over women's fertility.

What is interesting about the empowerment narrative is that it incorporates development strategies that have been priorities of development agencies for many decades. In the past, population control and economic development strategies have often been coercive (Gupta 2000). The empowerment discourse is a different strategy to achieve similar goals to past population control initiatives. As Foucault argues, the most powerful way of achieving social change and control is "not through threat of violence or force, but rather by creating desires, attaching individuals to specific identities" (Sawicki 1991: 67). The most effective discourses are those that create the possibility for women governing and disciplining themselves to achieve the goals identified by powerful political elites. One way in which this discipline is evident is the increasing contraceptive prevalence rates and the increasing number of women who are involved in the formal economy. It is also evidenced by a comment made by Tagicakibau who states "[s]ome women of certain faiths which do not access to outside family planning advice, can also be subjects of ridicule if they do not plan the spacing of their children." Couples who engage in 'abnormal' behaviour, such as having large, 'poorly' spaced children are ridiculed, which in turn teaches other families what constitutes normal or abnormal behaviour. This in turn promotes and encourages women to adopt modern methods of family planning. In Chapters Five and Six, I have examined how the empowerment discourse operates as a form of social control that involves the operation of power with respect to populations without the overt use or abuse of power.

Critical Reflections

This chapter has explored the role of the full citizenship narrative in the empowerment discourse. This narrative is primarily centred around encouraging women to enter paid work and its perceived associated benefits. The chapter found that, like the choice and health narratives explored in Chapter Five, closer inspection of the how this narrative plays out in practice suggests that the strategies advocated by the empowerment discourse do not always empower women. Furthermore, they create new issues and

different forms of subordination. In the case of the full citizenship narrative, instead of being controlled by their fertility, women instead became controlled by capitalism, the neo-liberal market and the double burden of being responsible for work both inside and outside the home. It found that the empowerment discourse was a useful tool that could be employed by development agencies to control populations and stimulate capitalist growth. This chapter also analysed visual sources to further explore what messages family planning services are sending to women. The chapter concluded by exploring the empowerment discourse and fertility control technologies as a form of 'biopower'. It found that the empowerment discourse acted as an insidious form of social control.

CHAPTER SEVEN

Conclusion

Introduction

Women's empowerment is used as the principal rationale for implementing family planning within contemporary international development programmes. The promotion of this discourse is also made available in the print media that publicises these programmes, including websites and information booklets. This thesis has explored whether a similar empowerment discourse was used within family planning programmes in Fiji. Consideration of historical sources, official statistics, existing documents and email interviews with key informants indicated that the goal of women's empowerment was a significant component of family planning. This was followed by a critical analysis of the discourse to assess its assertions and its role within family planning and development programmes.

Review of Key Findings

An empowerment discourse was evident in Fiji. It was present in the accounts of those creating family planning programmes at the strategic level, in addition to those advocating and implementing fertility control to women in local communities. I found that three narratives - choice, health and full citizenship - primarily informed the empowerment discourse used by the key actors interviewed for this study. The ideas expressed by the Fijian Ministry of Health, the UNFPA, a family planning practitioner and a women's rights activist about how to empower women were closely aligned with the narratives and rationales that informed the international empowerment discourse. Examples of this discourse are evident in the ICPD Programme of Action and the Millennium Development Goals.⁸³

⁸³ UNFPAa (2005); United Nations (2005); UNFPA (no date), UNFPA (2004).

The narratives, both local and international, included generic 'stories' about the ability of family planning to empower and advance the quality of life of women by providing solutions to the professed problems associated with high birth rates. In Fiji, the choice narrative presented family planning as giving women the opportunity to control the number and spacing of their children in the promise of greater autonomy, through the provision a wide range of 'modern', safe, effective and reliable methods. The health narrative promised women that the adoption of family planning will improve their health, as fertility control limits the risk associated with multiple pregnancies. Furthermore, the full citizenship narrative encourages women to reduce their family size in order to counter the poverty associated with large families and to enable women to enter in paid work and contribute cash income to their household. Participation in paid work is presented as having the multiple benefits of creating material wealth for families, contributing to the advancement of women's rights and their personal development as well as enhancing the development of the national economy. These narratives position empowered women who control their fertility as 'modern' subjects.

Narratives that describe the possibility of women improving their lives through family planning incorporated arguments used in earlier family planning and development programmes to justify fertility control intervention. The power of the empowerment discourse lies in its capacity to capture the multiple agendas promoted by development institutions over the past sixty years in a language that has more positive connotations. The empowerment discourse focuses on what will be better for women if they embrace modernity. Benefits articulated by the discourse include control, both over their bodies and their lives more generally, better health, greater resources and material wealth, and independence and self-determination.

The empowerment discourse is an effective version of disciplinary power. It is a vivid illustration of Foucault's understanding of how people are encouraged to embrace certain subject positions, in this case, the modernist category of 'empowered woman'. Attempts to become a modern woman propels them to use modern methods of contraception, reduce the size of their families and enter paid work; indeed, the very goals development agencies have been pushing for the past sixty years. The empowerment discourse invites women to construct themselves as modern subjects. It

potentially motivates them to control their own fertility in the interests of their own and their families' wellbeing. The empowerment discourse constructs subjects who seek to assert control over their lives. Women are invited through this discourse to embrace the attractions of the modern subject and engage in self-surveillance and discipline, taking pills and opting for tubal ligation. If they do this, they are constructed as choosing subjects who can reap the benefits as asserted by the empowerment discourse.

The choice narrative was a major contributor to the empowerment discourse. The narrative suggested a future orientated scenario in which women would achieve greater self-determination through controlling their own fertility. This control was to be achieved primarily with respect to decisions about the number and spacing of their children. Core to this narrative about becoming a self-determining person was choice with regard to contraception. This story about empowerment through choice focused on the opportunities for women to choose among a wide range of modern, safe and effective contraceptive methods. Critical examination of this narrative illustrated, however, that what was presented as 'free choice' was instead 'informed choice'. Particular ideas about 'good' choices were strongly presented to women accessing family planning services in Fiji. This was with respect both to what constituted an appropriate family size and methods that were 'best' for achieving this. This generic narrative about how to be empowered through choice in relation to contraception limited women's opportunities to choose to have large families or adopt 'natural' or traditional methods of contraception. The 'choices' that were promoted as being most empowering to women, privileged 'modern' industrial worldviews and, accordingly, positioned traditional practices, knowledge and philosophies as disempowering and subordinating to women.

I found that there was an over-representation of long-term methods of fertility control in Fiji. Informants claimed that women in Fiji 'preferred' long-term solutions to birth control. However, I queried how choices with respect to fertility control were presented to women. The way in which the informants articulated the notion of choice among alternative methods suggested that those implementing family planning had a significant role in directing the methods of contraception women in Fiji would use. It also suggests that international agreements on the need for effective reduction in

fertility⁸⁴ have convinced family planning practitioners in Fiji that ‘less problematic’ long-term solutions are the ‘best’ choice for women as individuals.

These findings problematised claims about the level of ‘choice’ available to women in Fiji. I consequently questioned whether the narratives about choice extended women’s opportunities to choose or were, rather, opportunities for women to engage in forms of body discipline and control consistent with the agendas of development institutions. They also indicate that those involved in implementing family planning programmes have been enrolled in the empowerment discourse and convinced by the narratives asserted by the development agencies about the incurred benefits for women. This reinforces the hegemony of the empowerment discourse as a form of disciplinary power in regulating women’s ‘choices’ and behaviour.

I argue the impact of encouraging women to use long-term solutions of birth control has limited women’s rights to choose the ‘appropriate’ method. Ironically, this restriction occurs in an environment where an image of unlimited free choice and self-determination is present. As illustrated in Chapter Five, the contraceptives women in Fiji ‘chose’ to use also have a negative effect on the health of some family planning users. Interestingly, this is in direct contrast to the rhetoric of family planning programmes where fertility control is closely associated with ‘good’ health. The health narrative depicts family planning as an essential component of women and children’s wellbeing – they are constructed as increasingly healthy as a result of a reduction in the number of children conceived. However, many of the side effects of the technologies experienced by women in Fiji were inconsistent with their perception of good health. Understandings of ‘good’ and ‘bad’ health which differed from the ‘modern’ precept suggested that the western nature of the technologies were incompatible with this setting (see pages 84-87 for details on these side effects).

I found that the narrative of women achieving ‘full citizenship’ also emphasised the importance of fertility control to women’s empowerment. This narrative brought in stories about individual rights, material wealth and economic development as the outcomes of women having control over their fertility. Significantly, this narrative has

⁸⁴ UNFPAa (2005); United Nations (2005); UNFPA (no date), UNFPA (2004).

also positioned these ‘modern’ stories as more valuable than ‘traditional’ measurements of success and wellbeing. In addition, this narrative promoted the participation of women in paid work and prescribed family planning as a means of enabling women to pursue this ‘opportunity’ as equal citizens. This account of citizenship suggests that women can only achieve the status of citizens through selling their labour in capitalist relations of production or state sponsored service provision. Ideas about ‘rights’ drew on ideas from the women’s liberation movements of the 1960s and 1970s to promote family planning and the participation in formal labour. These ideas were important in suggesting that women who had fewer children would be better able to enter paid work and access their own earnings. Participation as individuals in the formal economy was seen as contributing to their self-determination, personal development and financial autonomy.

Closer inspection of this narrative, however, and an investigation into opponents of this generic story about how women might insert themselves into the position of ‘citizen’, illustrated the individualistic features of these rights narratives. Nagusuca claimed that the pursuit of human, women’s and individual rights were eroding the local Fijian culture.⁸⁵ This position might be challenged by feminists in Fiji and the Pacific, such as Griffen (in De Ishtar, 1994) and Slatter (in De Ishtar, 1994), who argue that culture is too often used as an excuse to allow the perpetuation of patriarchal powers and the continued subordination of women. It is in this context that the empowerment discourse, and its associated narratives, is most powerful. The discourse draws on women’s potential aspirations to be free individuals and makes great promises as a tool of persuasion. However, the empowerment discourse provides solutions that are based on specific western understandings of empowerment, which might be shaped by political and economic agendas.

The provision of family planning as a route to improving women’s access to resources was also a critical component of this narrative. The informants contended that fewer children would provide women and their families with greater resources. This was based on two assumptions. One argument maintained that small families would enable women to enter paid work. This had the double benefit of improving families’

⁸⁵ See page 97.

financial status in addition to freeing women from domesticity and contributing to women's autonomy. However, an investigation of the position of women in the contemporary labour market in Fiji showed that what the narrative asserted as being empowering, was not always the case in practice. Women were primarily engaged in low paid and menial work involving little personal autonomy and less able to care for their families than when in subsistence-based work. Furthermore, women were stuck with the double burden of long hours of poorly paid work outside the home and continued responsibility for childcare, cooking and domestic work at home. Family planning advocacy also asserted that smaller families require fewer resources. However, this was based on an industrial and Eurocentric worldview that prioritises capitalist production. It disregards the subsistence-based economies and the benefits to family groups associated with subsistence production which women internationally combine with child care and domestic work.

The final argument that contributed to the full citizenship narrative relates to national economic development. In this context, national economic prosperity is associated with low levels of poverty. High rates of participation in the formal economy as well as low birth rates are associated with economic development. In this regard, reduced poverty is presented as an additional reason to encourage women's fertility control and to encourage women to enter paid work. However, this investigation found that in the case of Fiji, economic development was not associated with positive changes in poverty rates or the living conditions of the majority of its citizens. The full citizenship narrative and its contributing arguments, while focusing on how women might be empowered through family planning, significantly reflect a neo-liberal market approach to development.

Fiji was a particularly useful country for exploring the use of an empowerment discourse to rationalise and promote family planning. Population management policies have been evident in Fiji since the early colonial period. The aims and rationale behind these policies, however, have changed over time. The centrality of population debates in Fiji highlighted the political nature of population control policies in Fiji, be they pro or anti-natal, and consequently directed my analysis of the empowerment discourse in this setting. Population control is initially focused on one ethnic group, which is seen as problematically fertile relative to the indigenous

population. Initial acceptance of strategies associated with containing Indo-Fijian fertility has meant that there is overall more acceptance of family planning in the Fijian context

The contribution to discussions in this field by Abu-Lughod (1993), Kabeer (1994), Parpart (1993) and Sen and Grown (1987) caution against homogenising women's experiences. They argue that generic development policies are ineffective. They contend that what is believed to be effective in one context does not mean that it will have the same results in another setting. The ethnic diversity of Fiji and the different histories of the Indo-Fijian and Fijian women rendered this context useful for illustrating the importance of this critique. Through exploring family planning in Fiji, it became evident that fertility control practices impacted on and engaged with women differently. This outcome contrasts with the family planning empowerment discourse, which often advocates the benefits to women in a uniform manner. In Fiji, ethnicity, age, occupation, education, marital status and religion affected how women interacted with family planning programmes and technologies. For example, the Indian population was generally more accepting of family planning than indigenous Fijian populations (Roizen et al., Chung 1999). Women who were educated or formally employed were also more likely to use family planning than those who were not, as were women who were married. Attention to differences between women is necessary, if family planning strategies are to be developed that are relevant to women of different ethnicities who make decisions about fertility control in different cultural, historical and economic contexts.

Critical Reflections

This thesis has examined the international empowerment discourse, and its associated narratives: 'overpopulation/poverty', 'health' and 'rights'. This discourse provides a significant rationale for implementing family planning in developing countries. It has explored whether this discourse was manifest in Fiji. My research has found that an empowerment discourse was evident and illustrated that the narratives, 'choice', 'health' and 'full citizenship' informed the discourse. It found that the empowerment discourse was not always empowering in practice and that women's empowerment was often constructed as the empowerment of individuals rather than families and

communities, reflecting the western nature of its origins. It has posed questions about the practicalities of implementing a global strategy for ‘empowering’ women and has demonstrated that, in the case of Fiji, one strategy to empower all women was ineffective. It finds the empowerment discourse to be an unmistakable example of Foucault’s biopower. This thesis demonstrates how the discourse invites women to be ‘empowered’ and prescribes the adoption of modernity, modern contraception, small families and formal work, to become an empowered subject. The same goals development agencies have been pushing for the past sixty years.

This investigation has raised critical questions about the empowerment discourse and family planning practices. However, whilst I have raised many issues with the empowerment discourse, my wish is not to claim that family planning is necessarily disempowering, only that there is a need to question the assumptions about empowerment and its associated stories about ‘health’, ‘choice’ and ‘full-citizenship’. I consider that a more community-focused approach to empowerment and a range of context specific strategies are required. While the empowerment discourse has the potential to be a useful tool for promoting social change and improving the quality of life for women, or any marginalised group, the current strategies tend to perpetuate the historical agendas of development institutions. Advocates of the empowerment discourse invite women to be empowered through voluntary participation in the disciplinary regimes of contraception and sterilisation. The advantages to most women in Fiji of becoming modern, ‘empowered’ subjects with enhanced individuals rights has to be examined critically. This has been the analysis offered in this thesis.

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APPENDIX ONE

Information Sheet

<u>(Working) Title</u>	Modernising Motherhood: Family Planning ⁸⁶ and the Politics of ‘Modern’ Development in Post-Colonial Fiji
<u>Researcher and Institution</u>	Fleur Dewar, MA candidate in Sociology at the School of Sociology and Anthropology, University of Canterbury, Christchurch, New Zealand
<u>Aims of the research</u>	The aim of this research is to explore links between family planning and development. I am particularly interested in the possible effects of family planning on the lives of women and men in Fiji.
<u>Your involvement</u>	I am interested in communicating with people, via telephone and email, who have expertise in the areas of gender, health and family planning in Fiji.
<u>Use of the information</u>	Responses to the questions I ask may be used in my thesis and will contribute to an understanding of the complex relationships between family planning and development.
<u>Confidentiality</u>	Pseudonyms may be used if you do not wish to be personally identified.
<u>Right to Withdraw</u>	You have the right to withdraw at any stage of the research process. If you withdraw, any information you have given will immediately be destroyed and eliminated from the final project.

For further information on this project please contact:

Fleur Dewar

⁸⁶ In this context, family planning is referring to western ideas and technologies developed to space children and control births.

School of Sociology and Anthropology,
University of Canterbury,
Private Bag 4800,
Christchurch,
New Zealand

fsd11@student.canterbury.ac.nz
+64 3 366 7001 extn: 4957 or
+64 21 175 4151

APPENDIX TWO

Dr Garrimella, CWM Hospital Fiji
Interview Questions⁸⁷ for interview with Fleur Dewar
University of Canterbury
New Zealand

1. Your role

- a) What is your position at the CWM hospital?
- b) What does your job involve?

2. Family Planning

- a) What are the primary reasons women give for accessing family planning and using your service? Why do you think people want to access family planning?
- b) What do women in Fiji see as the advantages of family planning? Do they talk about any disadvantages?
- c) I understand that you offer a variety of different methods of contraception to family planning users, what are these methods?
- d) Which forms are most likely to be used?
- e) Why do you think these are the most popular forms of contraception in Fiji?
- f) What do you think prevents people from using family planning and 'modern' methods of contraception?
- g) How do people come to find out/learn about family planning? Are connections through friends, neighbours and family important?

⁸⁷ NB: WHEN ANSWERING THESE QUESTIONS PLEASE ACKNOWLEDGE ANY ETHNIC DIFFERENCES THAT MAY BE APPLICABLE

h) What information do women using your service receive about family planning? Do you have any pamphlets or information sheets that you could send me?

i) Are any incentives given to women who use modern methods of family planning?

j) What family planning initiatives, both past and current, have been implemented in Fiji?

k) Were they successful?

l) Have they changed over time? How?

m) Do you think accessing family planning is important to women in Fiji? Why?

3. Clients

a) Who is family planning primarily aimed at?

b) Are there any ethnic differences between those who use family planning and those who do not?

c) Are there educational differences between those who use family planning and those who do not?

d) Are there age and generational divisions between those who use family planning and those who do not?

e) Are those who use family planning more likely to be single or married?

f) Are women who use family planning more likely to be active in the formal economy (for example in paid jobs)? Are they more likely to be involved in certain sections of the economy or certain jobs?

g) Is contraception seen as a responsibility for men in Fiji?

h) Do men use family planning services? If so, what percentage of your clients are male?

i) Do you see men in the future playing a more important role in family planning in Fiji?

j) On average, how many new clients do you have each month? Is the number growing?

m) Of the women who access family planning for the first time, how many clients are still clients at the end of the year?

4. Families and Culture

- a) Is there resistance to family planning in Fiji?
If yes, how is this resistance demonstrated?
- b) Has family planning had any effect on relationships within families and their composition? If so, what are the effects? What do you think about these changes?

5. Context

- a) Has family planning improved the lives of women in Fiji? How?
- b) When implementing family planning – what are your main goals?
- c) What role do you see family planning playing for people in Fiji?
- d) What is the aim/purpose of family planning beyond fertility control?
- e) How do the lives differ between family planning users and those who do not?

Rufina Latu: (ARH Advisor) Interview Questions⁸⁸ For Fleur Dewar, University of Canterbury, New Zealand

1. ARH

- a) What kinds of projects does the ARH facilitate?
- b) What are the primary goals of the ARH?
- c) Where does ARH funding come from?

2. Family Planning

- a) Why do you think accessing family planning is important to women in Fiji?
- b) How do the lives differ between family planning users and those who do not?
- c) What family planning initiatives/ARH, both past and current, have been implemented in Fiji?

⁸⁸ NB: WHEN ANSWERING THESE QUESTIONS PLEASE ACKNOWLEDGE ANY ETHNIC DIFFERENCES THAT MAY BE APPLICABLE

- d) Were they successful? How?
- e) Have they changed over time? How?
- f) What sort of quality control is the ARH involved in?
- g) Do you have targets for recruiting new family planning users?
Per month, how many new users would you hope to enlist?
- h) How many new users are still using family planning after a year?
- i) How do people in Fiji come to learn about family planning?
- j) What kind of information does the ARH produce for the people of Fiji? Do you have brochures/ educational pamphlets that you distribute in Fiji that I could access?
- k) Does the ARH have a target group? Who is this?
- l) What prevents people from using family planning?

3. Clients

- a) Are there ethnic divisions between those who use family planning and those who do not?
- b) Are there educational differences between those who use family planning and those who do not?
- c) Are there age and generational divisions between those who use family planning and those who do not?
- d) Are those who use family planning more likely to be single or married?
- e) Of the women who use family planning, are they economically active?
- f) Are there employment and labour divisions between the women who use family planning and those who do not?
- g) Does family planning/ARH apply to men in Fiji?
- h) Do men use family planning/ARH services?
- i) What percentage of your clients are male?
- j) What role do you see men playing in family planning in Fiji?

4. Context

- a) Has family planning improved the lives of women in Fiji? How?
- b) What is the aim/purpose of family planning beyond fertility control?
- c) When implementing family planning – what are your main goals?
- d) What role do you see family planning playing for people in Fiji?
- e) Is there resistance to family planning in Fiji?
If yes, how does this manifest?
- f) Has family planning had any impact of relationships within families and their composition? If so, how? What do you make of these changes?

**UNFPA Fiji
Interview Questions⁸⁹ for Fleur Dewar, University of Canterbury,
New Zealand**

1. Your Role

- a) What is the role of the UNFPA in Fiji?
- b) What is your relationship with the Fijian government?
- c) What is your relationship with other local NGO's?
- d) What is your relationship with health services in Fiji?
- e) What are the central goals of the UNFPA?
- f) How do you propose implementing and actioning these goals?

2. Family Planning

- a) Why do you think accessing family planning is important to women in Fiji?
- b) How do the lives differ between family planning users and those who do not?
- c) What family planning initiatives, both past and current, have been implemented in Fiji?
- d) Were they successful? How?

⁸⁹ NB: WHEN ANSWERING THESE QUESTIONS PLEASE ACKNOWLEDGE ANY ETHNIC DIFFERENCES THAT MAY BE APPLICABLE

- e) Have they changed over time? How?
- f) What sort of quality control is the UNFPA involved in?
- g) Do you have targets for recruiting new family planning users?
Per month, how many new users would you hope to enlist?
- h) How many new users are still using family planning after a year?
- i) How do people in Fiji come to learn about family planning?
- j) What kind of information does the UNFPA produce on family planning for the people of Fiji? Do you have brochures/ educational pamphlets that you distribute in Fiji that I could access?
- k) Does the UNFPA have a target group? Who is this?
- l) Are there incentives given to women who use modern methods of family planning?
- m) What prevents people from using family planning?

3. Clients

- a) Are there ethnic divisions between those who use family planning and those who do not?
- b) Are there educational differences between those who use family planning and those who do not?
- c) Are there age and generational divisions between those who use family planning and those who do not?
- d) Are those who use family planning more likely to be single or married?
- e) Are women who use family planning more likely to be active in the formal economy (for example in paid jobs)? Are they more likely to be involved in certain sections of the economy or certain jobs?
- f) Is contraception seen as a responsibility for men in Fiji?
- g) Do men use family planning services? If so, what percentage of your clients are male?
- h) Do you see men in the future playing a more important role in family planning in Fiji?

4. Context

- a) Has family planning improved the lives of women in Fiji? How?
- b) What is the aim/purpose of family planning beyond fertility control?
- c) When implementing family planning – what are your main goals?
- d) What role do you see family planning playing for people in Fiji?
- e) Is there resistance to family planning in Fiji?
If yes, how is this resistance demonstrated?
- f) Has family planning had any effect on relationships within families and their composition? If so, what are the effects? What do you think about these changes?

Ema Tagicakibau
Interview Questions⁹⁰ for Fleur Dewar, University of Canterbury,
New Zealand

1. Your role

- a) Have you been involved with family planning, women's rights and/or empowerment in Fiji? If so, could you explain *how* you were involved?

2. Family Planning

- a) Do you think accessing family planning is important to women in Fiji?
- b) What do you see as family planning's primary role?
- c) What advantages does family planning offer women in Fiji? Any disadvantages?
- d) Has family planning improved the lives of women in Fiji? How?
- e) I understand that you have been active in supporting women and trying to improve the quality of lives for women in Fiji, do you see family planning as a part of this process? If so why?
- f) Have there been discussions in community organisations about the benefits of family planning to women who access it?
- g) What sort of benefits?

⁹⁰ NB: WHEN ANSWERING THESE QUESTIONS PLEASE ACKNOWLEDGE ANY ETHNIC DIFFERENCES THAT MAY BE APPLICABLE

- h) Do people make judgement about those who do/do not use family planning? If so, what sort of judgements? Who is likely to make such judgements?
- i) How do the lives differ between those who use family planning and those who do not?
- j) How do people in Fiji come to learn about family planning?
- k) What prevents people from using family planning?

3. Clients

- a) Who is family planning primarily aimed at?
- b) Are there ethnic divisions between those who use family planning and those who do not?
- c) Are there educational differences between those who use family planning and those who do not?
- d) Are there age and generational divisions between those who use family planning and those who do not?
- e) Are those who use family planning more likely to be single or married?
- f) Are women who use family planning more likely to be active in the formal economy (for example in paid jobs)? Are they more likely to be involved in certain sections of the economy or certain jobs?
- g) Is contraception seen as a responsibility for men in Fiji?
- h) Do men use family planning services
- i) Do you see men in the future playing a more important role in family planning in Fiji?

4. Context

- a) Has family planning improved the lives of women in Fiji? How?
- b) What is the aim/purpose of family planning beyond fertility control?
- c) When implementing/advocating family planning – what are the main goals?
- d) What role do you see family planning playing for people in Fiji?
- e) Is there resistance to family planning in Fiji?
If yes, how is this resistance demonstrated?

f) Has family planning had any effect on relationships within families and their composition? If so, what are the effects? What do you think about these changes?

Timaima Tuiketai, Ministry of Health Fiji
Interview Questions⁹¹ For Fleur Dewar, University of Canterbury,
New Zealand

1. Your role

- a) What is your role within the Ministry of Health Fiji?
- b) What does your job involve?
- c) How does your job relate to family planning?

2. Population Control

- a) Does the Fijian government identify population as an issue in Fiji?
 - i. If yes, on what grounds is this an issue?
 - ii. Are there differing/conflicting opinions about this?
- b) Have other groups/organisations, both local and international, identified population as being an issue for Fiji?
 - i. Who are they?
 - ii. On what grounds?

3. Family Planning

- a) What year was family planning established in Fiji?
- b) How did family planning come to be a part of the Fijian health care system?
- c) Do you think accessing family planning is important to women in Fiji? Why?
- d) In what respect does the Ministry of Health provide support for women accessing family planning?
 - Financial resources?
 - Quality control?
 - Facilitate NGOs access to finances and resources who then provide

⁹¹ NB: WHEN ANSWERING THESE QUESTIONS PLEASE ACKNOWLEDGE ANY ETHNIC DIFFERENCES THAT MAY BE APPLICABLE

support?
Implement programmes in schools?
Other?

- e) Why are women accessing family planning services?
- f) Of those who use family planning are they economically active? And in what kinds of employment are they involved in?
- g) Is the Ministry of Health involved in implementing, endorsing and encouraging family planning in Fiji? How and why?
- h) What family planning initiatives, both past and current, have been implemented in Fiji?
- i) Have these initiatives been assessed?
- j) Have family planning initiatives changed over time? How?
- k) Where does funding for family planning in Fiji come from?
- l) Does the funding for family planning impact on what forms of contraception are offered? How?

Context

- a) What are the main goals of family planning?
- b) What role do you see family planning playing for people in Fiji?
- c) What is the aim/purpose of family planning beyond fertility control?
- d) Has family planning changed the lives of Fijian women? How?
- e) What opportunities does family planning offer Fijian men, women and families?
- f) How do the lives differ between family planning users and those who do not?
- g) Does the Ministry of Health and the Fijian government have any current goals specifically in regard to women in Fiji?
- h) What are these goals?
- i) How does it propose actioning these goals?

5. Families and Culture

- a) Are there ethnic divisions between those who use family planning and those who do not?
- b) Are there educational differences between those who use family planning and those who do not?
- c) Are there age and generational divisions between those who use family planning and those who do not?
- d) Are those who use family planning more likely to be single or married?
- e) Are women who use family planning more likely to be active in the formal economy (for example in paid jobs)? Are they more likely to be involved in certain sections of the economy or certain jobs?
- f) Is contraception seen as a responsibility for men in Fiji?
- g) Do men use family planning services? If so, what percentage of your clients are male?
- h) Do you see men in the future playing a more important role in family planning in Fiji?
- i) Has family planning had any impact on relationships within families and their composition? If so, how? What do you make of these changes?
- j) Is there resistance to family planning in Fiji? If yes, how is this demonstrated?