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# construction, control and family planning in Tanzania: some bodies the same and some bodies different

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## abstract

The benefits of family planning for those who desire it, and the possibilities of coercion against those who do not, are well-known aspects of international population policies. Family planning technologies, more than simply a means for preventing conception, are involved as identity artefacts in the construction of bodies and in the reproduction of power relations. As such, modern contraceptives, organized by and implemented through, donor-funded programmes constitute a discursive apparatus through which *scattered hegemonies* are disseminated. Women's use of family planning, traditional and modern, allows them to counter the expectations of these hegemonies at some times, and to embody them at others. Both service providers and clients, construct identities, referenced through women's bodies, using the discourses of international population control and family planning. This paper uses data collected in Tanzania to understand how notions of modernity in the family planning programme construct Tanzanian female bodies as 'traditional' and 'modern', how these discursive inequalities reflect and compound material disparities and how these logics come into play in the ways that women construct themselves and each other.

## keywords

Africa; contraceptives; biopower; development; family planning; modernity



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## introduction

> [Sex as a political issue] was at the pivot of the two axes along which developed the entire political technology of life. On the one hand it was tied to the disciplines of the body: the harnessing, intensification, and distribution of forces, the adjustment and economy of energies. On the other hand, it was applied to the regulation of populations...
>
> (Foucault, 1980: 145)

> Probably the time has not arrived to tell people that they should decrease population – that's what they're against, therefore, we tell them that the mother needs to wait, this will bring healthy children. We tell her of the cost of education. Then ultimately the goal is that they have reduced fertility.
>
> (Tanzanian Regional Medical Officer)

Population policies are state interventions into some of the most intimate and private aspects of citizens' lives. Both the benefits of family planning for those who desire it, and the possibilities of coercion against those who do not, are well-known aspects of international population policies. In Africa, such policies are implemented through donor-funded family planning programmes that promote modern contraceptives (see Warwick, 1982). This development *intervention* (Ferguson, 1994) arises out of the view, known as the demographic paradigm (Freedman, 1999), that overpopulation is a fundamental development obstacle. Population control, a manifestation of self-discipline or governmentality, is linked to the larger neo-liberal project of development. Because a considerable part of the 'othering' of Africans involves a disproportionate interest in their sexuality (Mohanty, 1991), control over reproduction holds particular weight in signifying an ability to control one's self.

This paper uses data collected in Tanzania to understand how notions of modernity in the family planning programme construct Tanzanian female bodies as 'traditional' and 'modern,' how these discursive inequalities reflect and compound material disparities and how these logics come into play in the ways that women construct themselves and each other. 'Discipline in general, like its most rational offspring, bureaucracy, is impersonal. Unfailingly neutral, it places itself at the disposal of every power that claims its service and knows how to promote it' (Weber, 1978: 1149). Family planning technologies, more than simply a means for preventing conception, are involved as identity artefacts in the construction of bodies and in the reproduction of power relations. As such, modern contraceptives, organized by and implemented through, donor-funded programmes constitute a discursive apparatus through which *scattered hegemonies* are disseminated.

Grewal and Kaplan (1994) have used the term *scattered hegemonies* to describe the character of relationships of power that are simultaneously both hegemonic and plural. These *scattered hegemonies* come out of the globalization of ideas, mobile capital, and multiple subjectivities. Acting in conjunction with other patriarchal discourses of controlling women's bodies, the hegemony of the

definition of population as a 'problem' and modern family planning as its solution becomes scattered throughout all levels of the Tanzanian experience. The global population discourse, service providers' constructions of identity, expectations of local communities and control of husbands, are all sites for both compliance and resistance. Women's use of family planning, traditional and modern, allows them to counter the expectations of these hegemonies at some times, and to embody them at others.

In order to transmit modern family planning as the mechanism for regulating diverse bodies and populations, the population discourse implicitly constructs a particular African body, essentially the same, and essentially different from its referent, the white, middle-class Western woman (Oudshoorn, 1996). When this laboratory body and real bodies and practices do not match, negotiation and definition takes place at the local level. Service providers have their own vested interests in the opportunity to increase their own symbolic and material capital in a context of economic struggle. However, they must negotiate the fit between the expectations from above that bodies are the same, and the realities from below that bodies are different. The 'bodies' in question are indexing Tanzanian women (Bordo, 1990) who find themselves at the centre of a complex web of power relations in which there is no level playing field for the negotiation of health services (see Whiteford and Mandeson, 2000).

In the next section, I outline the theoretical underpinnings and methodology of the fieldwork. Then, I describe the Tanzanian National Population Policy. The next section examines how notions of 'tradition' and 'modernity' are defined at different policy levels. Section five investigates the ways the service providers themselves embody the apparatus of family planning. Section six describes family planning's identity artefacts and examines the constructions of identity that take place between service providers and their clients. In section seven, I examine some of the practices of reproductive control that Tanzanian women use to acknowledge, respond to and challenge these different powers over their bodies. In the final section, I draw some conclusions about how popular dichotomies between 'traditional'/'modern,' compliance/resistance and essential/constructed become unintelligible in the context of the lives of Tanzanian women.

## the need for disciplined bodies in a chaotic context

Nowhere is the link between individually disciplined bodies and national 'development' more explicit than in the discourse of population as it is presented to Third World women.[1] The productive and liberating power of contraceptives situates them neatly within notions of bio-power and development, with its emphasis on the creative and potentially fulfilling aspects of governance. This

**1** I use the term 'Third World' as described by Johnson-Odim (1991: 314) to

refer to 'underdeveloped/overexploited geopolitical entities, that is, countries, regions, and even continents; and to refer to oppressed nationalities from these world areas who are now resident in 'developed' First World countries'. These are men and women whose lives are shaped by the struggles against neo-colonialism, imperialism, capitalism and gender subordination (Doezema, 2001).

contrasts with repressive or coercive power of colonial imposition (Brigg, 2002). Bio-power coalesces around two distinct poles: the human species (as defined by scientific categories such as population, fertility, etc.) and the human body (as an object to be manipulated and controlled) (Rabinow, 1984: 17). Thus, within the demographic paradigm, modern contraceptives function as the ultimate 'technologies of sex' (Foucault, 1980) linking the individual body with the body politic.

Discourse, 'an interwoven set of languages and practices' (Crush, 1995: xiii), may be understood as 'all that is written and spoken and all that invites dialogue or conversation' (Rosenau, 1992: xi). Family planning, as a type of 'development' intervention, includes symbolic and material 'cargo' (Long and Van Der Ploeg, 1989). Drawing on Ferguson (1994), I argue that the languages, artefacts and practices of family planning, act as an *apparatus* in creating the 'problem' of population and in structuring the parameters of acceptable solutions. As argued by Kuhlmann and Babitsch:

> The creation and dissolution of borders depends not only on technological opportunities. These processes are equally dependent on power constellations within society, or, in other words, on which social actors with what specific interests successfully acquire powers of definition in negotiating new/old/transcendent boundaries.
>
> (2002: 440)

However, the disciplining power of contraceptive technologies does not come from a single, unilateral agenda, but is linked to many different representations of control of women's bodies, including the capacity of reproductive self-control by women themselves. It is the diffuseness of its power, usually the absence of overt force, yet the ordering mechanisms of bodily governance (see Brigg, 2002) that we see when we analyse qualitative data from Tanzanian clinics.

Despite a new emphasis on 'male involvement' in contemporary reproductive health discourse, the population problem and its technologies have always been characterized in feminine terms. The modern state requires a particular type of modern disciplined bodies. However, Foucault failed to recognize the explicitly gendered nature of associating undisciplined bodies with things pre-modern, traditional, backward and feminine (see also Lock and Scheper-Hughes, 1996). 'Women presented a particular problem to the onward march of reason' (Apffel-Marglin, 1996: 151). The disciplined body feminine is necessary to create the modern body politic/economic. The body politic is defined by Lock and Scheper-Hughes (1996: 45) as 'the regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, work, leisure and sickness'. The body economic is linked to the physical body through the development of *bio-power:*

> bio-power was, without question, an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of

> bodies into the machinery of production and the adjustment of the phenomena of population to economic processes.
>
> (Foucault, 1980: 140–141)

In the colonial relationship, the bodies of women were under rigid surveillance and regulation according to the demographic panic of the 1920s, and while the justificatory strategies have shifted, modern family planning also remains within a geo-political context of inequality (see Hunt, 1988, 1999). Indeed, it is these feminine experiences that most call for control by disciplining practices, historically rooted in Africa's relationship to the West.

Tanzanian women who want to use modern family planning find themselves in a context of power imbalances that limit their choices. Yet, to situate family planning users within discourses that condition and structure their choices in unequal ways is not to deny that they have agency. Tanzanian women are themselves giving definition to the processes of family planning, even when these actions are constructed through and drawing upon global logics. Within this context, women do choose to use the methods promoted, as well as others, to meet their goals of family planning. In this way, family planning practices, both 'traditional' and 'modern' are used by Tanzanian women to counter *scattered hegemonies*.

This article is based on a larger research project on the global population discourse in Tanzania. In two field trips to Tanzania for a total of two years, in 1995—1996 and 2000, I conducted interviews with providers and women attending for care, and observed clinic visits in maternal and child health/family planning (MCH/FP) clinics. During the first trip, I worked at 10 clinic sites (equally distributed between urban and rural areas) in the Morogoro, Ruvuma and Kilimanjaro Regions and interviewed 200 women. Genuinely random sampling of this community was impossible, so I chose a sample of convenience by interviewing any non-pregnant woman of reproductive age who attended the clinics on interview days. The sample was structured to draw an equal number of respondents who were and were not currently using family planning. The clinics were selected in consultation with local health officials to represent variation in service provision environments, and the regions chosen represent areas of high, medium and low contraceptive use. In 2000, I spent six months researching contraceptive decision-making in Kilimanjaro Region. I have made brief trips back to Tanzania in 2002 and 2003 for research dissemination.

## the state, the body and the national population policy

Tanzania has an ambivalent history with issues of family planning and population. In 1959, it was one of the first countries to introduce family planning services

through what would become the Family Planning Association of Tanzania (UMATI). Yet it has been one of the last countries in Africa to prepare a comprehensive national population policy. Tanzania's historically socialist government was known since independence as a leader among Third World countries in advocating an alternative path to development that promoted 'African solutions' to 'African problems.' In spite of Tanzania's reluctance to sign on to the global population agenda, its current population policy and National Family Planning Programme are comparable to those in most other African countries. A national policy is a strong indicator to the international community that a government recognizes that it has a population 'problem' as defined in a particular way, and that it is a candidate for assistance in the realm of family planning programmes (see Barrett and Tsui, 1999).

The shift in the government's stance on population issues was related to its international context. As described in a donor document:

> Until the mid-1970's, Tanzania and many other African countries didn't see increasing population as a problem. In fact, the government considered its population to be small.[2] However, the country's leaders have shifted from this pro-natalist position to one of planned population growth and the balancing of population and development objectives.
>
> (United Nations Population Fund, 1994: 7).

A 1989 World Bank report describes Tanzania as facing a '*serious population problem*' (World Bank, 1989: 20).[3] The Bank spells out its contraceptive solution:

> [O]ver the coming years it will be necessary for Government and for donors to concentrate efforts on expanding family planning services and provision of contraceptives throughout the country...
>
> (World Bank, 1989: 20)

Diverse organizations with different but convergent goals gained influence in Tanzania simultaneously, so while this did not have the overt intention of a common front organized to bombard the government with anti-natalist propaganda, it did have that outcome.

After five years of negotiations and revisions, the National Population Policy was adopted in 1992, and the National Family Planning Programme developed as its primary implementing arm. In light of the economic crisis and structural adjustment reforms,[4] 'the national population programme is mainly financed by multilateral and bilateral assistance' (United Republic of Tanzania, 1994: 28).[5] Therefore, clinic-level contraception has been shaped by the priorities of Tanzania's donors and lenders, as well as by the crisis in state social service provision as I describe in detail elsewhere (Richey, 2003: 1). While the Tanzanian programme followed the discursive shift from population control to 'improving reproductive health' after the 1994 Cairo Conference (see Hodgson and Watkins 1997), such a diverse and expensive agenda has proven difficult to implement.

**2** It is worth noting here that the United Nations conducted a study of the demographic situation in Tanganyika in 1949 and recommended that a faster increase in population was needed, see Mkini (1980: 65). The colonial and early independence governments followed these recommendations.

**3** For a discussion of the links between Tanzania's population policy, structural adjustment policies and the World Bank, see Richey (1999, 2003). For an example of how the IMF and World Bank have come to dominate the African health sector see Turshen (1995).

**4** Despite an optimistic outlook during its early independence, Tanzania's economy was in shambles by the early 1980s, and the country began to undertake economic reforms commonly termed 'structural

In practice, vestiges of global population control ideology are laid over local prejudices to form new modes of identity distinction and control. I am not arguing here that modern contraceptives should not be made available to Third World women, simply that their prioritization in the Tanzanian family planning programme reflects an interest in contraceptive continuity, not one in increasing the choice of individual women. As Bledsoe *et al*. (1998) argue from their case study in the Gambia, most African women are not only happy to have contraceptive options; they would probably like more. Farmer (1999) convincingly argues that critical scholars need to avoid the 'Luddite trap' where addressing the social roots of disease is held to be incompatible with advocating the delivery of high-quality, high-tech healthcare. However, technology, as we all know, is never neutral; thus, feminist critiques of technology and policy can provide useful tools for analysing contraceptive meanings (see for example Yanoshik and Norsigian, 1989; Bordo, 1990; Jacobus *et al*., 1990; Ginsburg and Rapp, 1995; Lykke and Braidotti, 1996). In the context of international population policy, this needs to be read alongside work linking feminist theory with class, race and technoscience (see for example, Clarke and Olesen, 1999) to provide a critical perspective for examining population policies whose targets are primarily poor, Black women.

## making sense of the dichotomy between 'traditional' and 'modern'

Contraceptives take meaning from the contexts in which they are understood: they are both technological 'facts' and mental 'conceptions' (Russell and Thompson, 2000: 4). 'Modern' is used to describe behaviour patterns and fertility desires that bring about a 'demographic transition' (see Kirk, 1997) as well as the types of contraceptive technologies that should assist couples in realizing these goals. In Tanzania at the time of fieldwork, these were: pills, IUD, injection [Depo Provera], diaphragm/foam/jelly, condom, female sterilization and male sterilization (Ngallaba, 1991/92: 31). Implementing national population policies in Africa rests primarily on the provision of modern contraceptives for limiting and spacing births. Yet, communities in Tanzania also have various 'traditional' ways for achieving these ends.

One way that service providers construct their own identities within the clinic setting is to contrast them to identities and practices known as 'traditional'. However, this identification is not merely local in its genesis. There is both an international and a national context of discourses on tradition in terms of family planning. Contraceptive practices, in their use and discussion, can become signs for larger conceptualizations of the 'modern' or lack of it (see Rutenberg and Watkins (1997) for similar evidence from Kenya). While using modern family planning is certainly not the only way of signifying one's modernity, it provides the opportunity for asserting an identity that is progressive, regulated, scientific and

adjustment.' Structural adjustment has meant many things to the country, including a limitation of government deficit funding and the introduction of user fees in the health sector.

**5** For a discussion of the links between Tanzania's population policy, structural adjustment policies and the World Bank, see Richey, 1999. For an example of how the IMF and World Bank have come to dominate the African health sector see Turshen, 1995. The main donors in this realm are the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA). Other donors active in the health sector include the World Bank, Denmark, the United Kingdom and the Netherlands.

Western. This identity is embedded in the international population discourse and passed down to service providers and local women through the apparatus of modern family planning.[6]

**6** It is important to note that I am discussing both modern and 'traditional' methods in the framework of the international population discourse as embodied by the National Family Planning Programme which is itself a modern construct emphasizing modern methods. The informants in this research are all engaging in knowledge production from a modern bias. I did not interview traditional healers (*Waganga*), nor did I seek out women who had long experiences using 'traditional' methods.

Within the international population discourse, traditional contraception is, at best, a poor choice of means for achieving the goal of fertility control. As Johnston-Hanks (2002: 229) elaborates, 'some program-oriented groups do not consider 'traditional' methods to be contraception at all'. Methods labelled 'traditional' in the Tanzanian Demographic and Health Survey (DHS) have been limited to three types: 'periodic abstinence (rhythm method), mucus method, and withdrawal' (Ngallaba, 1991/92: 31), or by the 1999 survey 'mucus method' had been replaced with 'lactational amenorrhoea.' Most of the methods described by women in interviews as traditional contraceptives fall outside of the DHS categories of 'tradition'. The traditional methods that count for the official discourse are those that modern science documents as being somewhat effective, and thus, 'tradition' is redefined according to the progress of modern science. A telling example from a neighbouring country, Uganda, illustrates this point. In the most recent Ugandan DHS, the categories were redefined to classify 'breastfeeding' as a 'modern' contraceptive. It was explained to me at the official dissemination of the survey that science had now confirmed breastfeeding as an 'effective' method. Thus, breastfeeding has been re-defined as modern, while 'tradition' is a category reserved for methods whose effectiveness remains scientifically unverified.

Any method of family planning usage, however effective, may also be understood as a sign of the desire to prevent conception and the power, to some degree, to do so. The Senior Population Program Specialist in one of the donor missions told me that 'withdrawal is an unusually common method in Tanzania'. He went on to say that 'there are some people who don't trust modern methods.' When I asked about the religious-based service providers who are teaching 'natural' family planning he said 'if someone has five kids and is using natural contraception then they are just stupid!' Of course, taking into consideration that the average desired fertility at the time was approximately six children, it would seem that couples in the scenario described by the specialist may have been successfully achieving their fertility objectives. Nonetheless, they were not successful modern family planners.

Traditional methods are conspicuous in their absence in donor documents, minutes and publications. However, one exception is the discussion of how traditional family planning methods reflect a larger problem for international family planning promoters — the 'traditional' mindset that serves as a barrier to the adoption of contraceptives. An entire section on 'Traditional Values, Beliefs and Attitudes' of a paper entitled 'The Social Soundness of Supporting Family Planning in Tanzania' explains the traditions which 'contribute to, and support high fertility.' As listed in the report, these are:

- Status and prestige attained by having children;
- Having many children confirms one's virtue;
- Self-image enhanced by producing children;
- A man's lineage is continued through his children;
- Proof that one has been favoured by spiritual forces and deceased ancestors;
- Short-term economic gain provided by children through farm labour;
- Long-term economic gain provided by children by caring for parents when they are old;
- Lack of forward planning and belief in fatalism;
- Polygamy;
- Taboo against husband and wife discussing sexual matters;
- Fostering children;
- Early marriage for women;
- Infant mortality and the fear of children dying or becoming disabled

(USAID, 1990: 61,62)

This list contains an eclectic mix of beliefs and practices, some relating to material conditions or practices, and others to attitudes, that perpetuate what Uma Narayan has called 'blaming culture' (Narayan, 1997). 'Bad culture' is to be countered programmatically by educational messages promoting the small family norm. Typical of modernization discourses, 'tradition' is characterized by a lack of knowledge and the assumption that if people just knew better, they would abandon their traditional ideas.

At the national level of policy making and implementation, traditional and modern descriptively reflect the dual contexts in which Tanzanians at this level find themselves – implementing a population policy that is funded by donors and situated firmly within the global population discourse, and at the same time, aware that many family planning practices existed both before the introduction of modern family planning and outside its scope. Tanzanians responsible for implementing the population policy construct their own category of traditional contraceptives with their correlating users, traditional women. These methods take on a mythical historical meaning, emphasizing that in the past, Tanzanians were capable of controlling their own fertility and they had the means to do so. Therefore there is a thread that links modern family planning's biomedical contraceptives with Tanzanian tradition (see also Watkins (2000) on Kenya).

The notion that traditional family planning was lost knowledge was explained, to my surprise, by a Senior Statistician in the Planning Commission working on the population policy. He told me that he was interested in knowing more about traditional family planning methods:

> How did they work? Perhaps there are different conditions now, but we need to find out more about them. People won't reveal the traditional methods ... for example, my mother had only 3 children. How did she do it?

Other informants also told me that the generation of their parents (or grandparents) knew how to space children. This knowledge had somehow been 'lost' in the transitions between generations, so 'now people don't know how to space and they are getting pregnant every year.'[7]

The portrayal of traditional methods as 'lost knowledge' is interesting for two reasons. First, it implies that both the motivation and the means for child spacing were in existence before the introduction of modern family planning services. Thus, child spacing is not a foreign import, but an off-shoot from indigenous knowledge. This has important political implications for policy makers and implementers who want to stress the ways in which the population policy is a *Tanzanian* response to *Tanzanian* needs as opposed to being an imposition by outsiders. This knowledge has somehow been lost (or corrupted, or eclipsed) by the new regime of modern family planning. Responses to this transition are either that more research needs to be done to reclaim this 'lost knowledge,' or that couples should now adopt modern methods which are of the same nature as methods used traditionally in the past.

A second issue that stands out from the conceptualization of traditional methods as lost knowledge is that these methods are being equated with their modern equivalents. Therefore, instead of considering traditional family planning as a behavioural process (such as post-partum abstinence, withdrawal, or prolonged breastfeeding) it is considered, like modern methods, as a *device* that one uses to prevent births.[8] Therefore, when the knowledge of what this thing was or how it was used is lost, it is no longer functional as a family planning method. When the traditional devices are no longer a viable option, modern methods offer a convenient and effective substitute. The effectiveness of the behavioural methods of family planning relied on involvement of both sexual partners, while, except for the condom, the modern devices' reliability and effectiveness are dependent on female efficacy.

This shift from old bodies to new ones was explained as inevitable with the changing times. For example, when I asked Community-Based Distribution (CBD) agents of a family planning village project about traditional methods they described the following method of *kuweka pigi* [a method involving tying a string around your waist to prevent conception]:

> In the past these worked well [everyone agreed on this, even when I probed sceptically], but today the *waganga* [traditional healers] are not like the *waganga* in the past. People have no faith – they can't use them today, so today we have *njia za kisasa* [modern contraceptives]. These [traditional] methods have expired.

I was surprised to find service providers explaining the effectiveness of a 'traditional' method. Most service providers, as I will explore later, exclusively associate themselves with the provision and use of modern methods. However, these providers all agreed that the *pigi*, a popular method with some of my

**7** While Tanzanian policy makers did not try to explain why this had happened, women from Lusewa village told me that when education became mandatory, they could no longer hold the same initiation ceremonies to pass on teachings as they had in the past. Other works such as Van Eeuwijk and Mlangwa (1997) and Tumbo-Masabo (1994) describe the gap between the initiation ceremonies and modern education about sexuality in Tanzania.

**8** '[Hu]man-made' traditional contraceptive devices described by my respondents included herbs to ingest and tying a string around the waist. Ntukula (1994: 112) includes the use of a piece of cloth inserted into the vagina before intercourse and covering a pot symbolic of a woman's fertility.

respondents, was considered a legitimate method – in the past. By adding the time dimension, they could maintain their own modern identity, as the distributors of *njia za kisasa,* while also recognizing that many people did (and do) use traditional methods. Echoing the discourse of policymakers, there is a construction of a loss of knowledge due to the failure of contemporary traditional healers coupled with the loss of faith of their clients.

A central link between family planning and modern women's body identity came out during an informal conversation with a service provider who had been working at a regional hospital in maternal and child health for many years. She explained that times have changed and women do not want as many children as their parents had:

> You see women who have had many children – they have breasts that hang down to here [she demonstrates with her hands cupped at her stomach] – breasts like socks!

This description of how non-modern women embody their backwardness in 'breasts like socks' holds an implicit comparison to a universal modern ideal woman who would never have so many children as to compromise her body's aesthetic qualities (or at least she would not have to breastfeed them all). The interpretation by the service provider of this woman's exaggerated fecundity as embodied in her breasts is a physical manifestation of the link between femininity, maternity and excess. Such breasts might have represented many different things: maternal generosity, physical depletion, or simply normal ageing. I think this also suggests that the situatedness of the service provider between the international population discourse and the local level women over whom she is to be an authority shapes the ways in which women read notions of 'tradition' and 'modernity' into bodies.

## service providers as the embodiment of modern family planning

In local clinics, modern family planning has come to signify a transition to modern bodies constructed simultaneously *vis-à-vis* their non-modern sisters. The ways that modern bodies are constructed as identities has both local and global dimensions. Service providers signify their modernity by learning the lessons of their training in 'Comprehensive Family Planning,' passing this knowledge on to others, and also by embodying this very knowledge.

A District Level Maternal and Child Health (MCH) Coordinator, elaborated on the reasons women now think of children in terms of resources spent per child:

> In the past two or three years, life has gotten much more difficult – now you have to pay for everything for children. Also because of cost-sharing – people have gotten the idea to reduce their family size. Even extended families have begun to change. Workers used to have 4 or 5 children, but now they are thinking of 2 or 3 at most. It is different than in years

> past. If you have to advise others to space and limit their children, then you have to set an example. Now, especially family planning service providers have changed a lot and they use family planning often.

I was surprised that when I asked her questions meant to elicit her professional viewpoint about how family planning clients were reacting to socio-economic change, she responded to me from a personal level. Perhaps not about her own life *per se*, but about the lives of women, such as herself: 'workers' and 'family planning service providers'. These women were the ones who really understood the changes going on around them. They had the insight to recognize the instability brought about by economic restructuring and, as they had been taught at during seminars, sensitization workshops and technical training sessions, had adjusted their behaviour appropriately. They had taken on new modern bodies and identities in response to the demands of the realities of modern economic life.

The importance of modern family planning offers interesting opportunities for some Tanzanian women who serve as 'go-betweens' brokering these imported technologies. Service providers are able to use the population discourse strategically to build their own symbolic and economic capital (see Bourdieu, 1991). The more important the 'problem' of population in official terms, the more significant the role of those persons responsible for solving the problem. This status is deepened by donor commitment to funding the national programme. At the same time, family planning as the pre-eminent solution to women's and children's health problems provides legitimacy from below. Infant and child mortality and morbidity, maternal mortality, poor nutrition and disease are all locally felt health needs. Therefore, interventions that purport to deal with these important problems are welcomed. Local level service providers are equipped with the tools that can enable women to control their fertility, and serve their families and nation through limited childbearing. One of the standard health education *(elimu ya afya)* talks, entitled 'The benefits of using family planning' included a demographic explanation by the service provider: 'If there are less people, the government can provide better services, and there will be more children with education.' The benefit to the nation as a whole if individual women will use family planning attempts to link personal incentives with demographic considerations: harnessing the energies of the individual toward regulation of the population.

## situating knowledge, identity artefacts and negotiating bodies

The ideology and identity artefacts of modern family planning reproduce power relations of the international population discourse in the local context. Service providers are, almost always, Tanzanian women, but family planning as a series of practices embedded in global relations of competing and unequally funded

'development' agenda provides a means by which service providers can distinguish themselves from their clients. Family planning service providers are marked or identified at the clinic level by their knowledge of modern methods. These technologies are designed for bodies that are the same, but when they are implemented in the real-world context, bodies are different. Service providers are then in the difficult position of negotiating between the needs of the different bodies and the expectations of the family planning apparatus.

Family planning service provision as an impetus for donor funding has provided a channel for personal and professional gain. Contrary to my expectations before going to the field that family planning may be resisted in vociferously Catholic areas or that the increased repertoire of services on an over-taxed health care system would be resented, all service providers expressed positive dispositions toward the provision of modern family planning. Service providers want to become trained in family planning because training means attending classes, usually in the regional capital city, where they are given room, board and a *per diem*. Completion of this training also opens up avenues for future training — refresher courses, specialized courses, or expansion of basic training all provide another opportunity for increased material and symbolic capital. These professional opportunities are particularly welcomed in the context of immense scarcity resulting from the economic crises (see Raikes, 1992).

The power of language came up in my research as one important theme characterizing the relationship between service providers and clients.[9] English instead of Swahili is the family planning language in areas of training, educational materials, and supervision. I conducted all of my research in Swahili, and initially I considered the idea that perhaps service providers were using English words in my presence in an attempt to help me understand what they were doing. However, as time passed and I saw the same juxtaposition of English with Swahili, even in written materials that were obviously not meant particularly for my observation, I began to understand the use of English as a signifier of one's expertise, professionalism, and ultimately one's modernity.

The presence of English as the family planning language can be attributed at one level to imported knowledge about imported technologies — the contraceptives themselves are manufactured in English-speaking places, the technical advisors who come to support the Ministry of Health are English-speaking, and the overseas training and study-tours given by donors to top level officials take place in English-speaking environments. However, at another level, the choice to use English in a context where the majority of those hearing it would not understand its meaning acts as a signifier of service providers' access to specialized knowledge and control over its corresponding technologies.

Training of service providers occurs through rote memorization of precepts in English with little attempt to situate them in a social/cultural context. However, it

**9** Adeokun (1991) notes that 'most of the key terms used in family planning carry both ordinary and specialized meanings' which can be confusing to service providers and the general public. He gives an anecdote from a physician who told of a woman who had introduced a bed-spring coil into her vagina in the mistaken belief that she was adopting the IUD, also known as the 'coil.' Other terms he mentions with multiple meanings are 'pills' and 'injection.' These problems are exponentially increased when terminology is taken from one language to another.

does situate them as educated women of high status. Service providers inviting me to observe when counselling was being conducted for new clients said things like, '*Twende. Sasa tunafanya* informed choice' [Let's go. Now we are going to do 'informed choice']. The English words inserted in Swahili discussions had meaning only to me, other highly educated listeners, and service providers trained in family planning. Very few clients would have any idea what was about to be done to them. Also, during training, service providers made educational posters depicting intervention flow charts, potentially dangerous side effects associated with specific family planning methods, and even clients' rights – in English. These posters were then brought back to the service provider's clinic and displayed on the walls. However, aside from telling foreign visitors that family planning was taking place at the clinic, these materials did little to improve the quality of care at the clinics because most were incomprehensible to the majority of their viewers. Few if any of the clients could read the posters stating their rights in family planning clinics. Few if any service providers read them after the training seminars were over, and they often had difficulty explaining what the message meant in practice. The unintended result of the production of educational materials in English is to remind clients of the gaps between themselves and the service providers who are supposedly able to understand the foreign messages.

Finally, the family planning supervision guidelines were similarly done in English.[10] I observed family planning supervision in one district and witnessed first-hand the difficulties of supervision-in-translation. While in theory, anyone who would be responsible for supervision at this level would have been able to understand English, in practice, using guidelines which are written in English demands that more time and energy be put into translation than in supervision itself. Questions involving more difficult concepts, often surrounding provider–client interaction and/or sensitive issues of reproductive health, were skipped over to save time. Priority was given to the meticulous collection of service provision statistics from the clinic records as required by the national programme and its donors. While English served as a bridge between local family planning and international consultants and funders, it served as a barrier between providers and their clients.

**10** Also, important policy documents such as the 'National Policy Guidelines and Standards for Family Planning Service Delivery and Training' which I observed in regional MCH offices and the 'Client-Oriented Provider-Efficient Services: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services' which was available at an NGO clinic were in English as well.

Modern family planning comes to the clinic with its own set of tools and supplies. These things distinguish it from other less-funded, and therefore, apparently less important, clinic activities. In light of the international discourse on 'quality of care' that should be received by clients in family planning clinics, Tanzanian clinics are supposed to be brought up to standard for providing services. Most of this improvement is predicated on re-structuring other clinic activities so that family planning will have its own room. Ideally, clients will be counselled and examined in rooms that guarantee their privacy. Donors fund limited improvements to clinics that will be used as training sites for family planning courses. At one such site where I worked the MCH coordinator told me:

> When the clinic became a training site for family planning, they did renovations on the building, provided instruments, a lamp, bed, cabinet, sterilizer – all coming from the FPU [family planning unit, 1992]. At the time of training, the students come with soap, *jik* [bleach], and gloves.... we get higher morale for our work with family planning because we have gotten proper books for keeping records in, etc.

As indicated by the MCH Coordinator, the perception of 'higher morale' due to a more professional environment is important. I would suggest that this is true even though the improvements brought into the clinic by its association with modern family planning are often only a coat of paint over crumbling walls. These things that come together with the family planning ideology act as identity artefacts: creating an identity for those women who control them. Service providers are in the position of translating and interpreting these methods for their clients. However, the methods were designed with a preconfigured user whose body is not the same as the bodies in the Tanzanian context (see Oudshoorn, 1996). Drawing on Kuhlmann and Babitsch's (2002) attempt to reconcile constructivist and materialist perspectives on the body and health through a reading of Haraway (1991) and Grosz (1994), a different context makes a different body. Nutrition, exposure to disease, physical activity levels, pregnancy and childbearing histories are all markedly different between one context and another. The assumption by the global population discourse is that Tanzanian bodies are the same in so far as they can be expected to resemble laboratory results and Western women's bodies regarding contraceptive effectiveness and side effects. However, they are ultimately defined as different bodies that do not need the same level of care as Western bodies, justifying culturally relative notions of 'quality'.[11] Modern methods themselves come with a preconfigured body context that may or may not be present in Tanzania. Norplant® insertions require a sterile surgical environment and a skilled technician trained in their insertion and removal. IUDs require a sexual relationship that does not expose the user to disease and regular internal examinations by a health care provider. Contraceptive pills must be stored in a dry place away from vermin and must be taken at regular intervals. All of these methods require that a woman not be pregnant when she begins them, with possible adverse effects to the developing foetus if she has already conceived. The connection between bodies, the body politic and the political economy of development intertwine in ways that confront the reductionist notions of a technical fix to the population 'problem'.

**11** Different standards explain why women in rural Tanzania can receive oral contraceptive pills from their neighbours after responding to a checklist of questions, while women in the West are likely to have them prescribed during a visit to a medical doctor.

As I describe elsewhere (Richey, 2003), Tanzanian clinics were lacking in expendable supplies such as gloves, necessary for examinations, bleach for sterilization of instruments, and sometimes syringes for injections. Service providers told women to buy their own expendables to bring to the clinic if they wanted a method that required them. Clean water supply, blood pressure cuffs, and pregnancy tests were regularly missing in all of the government clinics where I worked – even the regional hospitals. The existence of proper lighting is assumed in

the implementation of many modern contraceptives and in any manifestation of the examination. During one day of clinic observation, service providers attempted to do a pelvic examination for an IUD insertion in a rural health centre where there was no electricity, and no battery or solar-powered light.[12] They had a difficult time seeing well enough to conduct the exam and were faced with the dilemma of how to cope when the environment itself limited their ability to provide good quality of care. Opening the curtain would violate the client's right to privacy, as the examining room looked out onto the busy hospital courtyard; leaving it closed would leave the room in darkness. One service provider tried to manipulate the curtain to let in a thin stream of light while the other attempted to perform the examination. They had to direct the client to move down on the table to position her body in the ray of light so that they could examine her. Two service providers in turn looked into the woman's body. Unsure of their expertise in this situation, they asked me to help them, to which I politely declined as I have no medical training. The client's own body presented an uncooperative circumstance. The young woman had come seeking contraception, but upon examination it was determined that she was already pregnant. After the exam, knowledge of this pregnancy was translated aloud by the service providers to the woman to mean that she could not receive the IUD, and she should expect another baby. When the client had left, the service providers expressed their frustration to me, telling me how difficult it was to do their work in such an awkward context.

**12** Normally, I declined offers to observe internal medical procedures as I felt that even with consent it was not appropriate for my research. My presence in this moment was accidental: the same space was used for a number of activities, and I had been talking with another service provider on a bench on the other side of the room. When I realized that they had instructed the young woman to prepare herself for a pelvic exam, my dilemma was over whether to get up, explain my departure, and leave the room which would require opening the only door which led to a crowded waiting area and would expose the room to others, or to stay put and try to be as unobtrusive as possible. I chose the latter.

The overall disjuncture between modern technologies as identity artefacts and the material context in which these service providers are operating also contributes to a certain construction of women's practices and bodies as non-modern and therefore thwarting the correct usage of these technologies, and thus limits women's access to certain methods. Service providers regularly told me that women were forgetful, and thus could not be trusted to take a pill. Women were also commonly scolded by service providers when they came to the clinic without their appointment card, or if they came on any day, earlier or later than their prescribed return date. These women themselves could not be trusted to discipline their bodies into the proper regime of childbearing and contraception.

While a 'cafeteria approach' with a choice of methods is provided in theory, the items which are given preference in training service providers and in presentation to clients are determined primarily by how effectively they promote the disciplining of women's bodies. As one service provider in a rural clinic on Mt. Kilimanjaro explained to me: 'If you see a woman, you can look at her and you will know if she is likely to forget, and then you should advise her —'Why don't you use an IUD.''

Service providers are accustomed to 'looking over' and 'sizing up' their clients to access their contraceptive needs. How a client and her children are dressed, her vocabulary, language and accent when she speaks, her posture of confidence or submission, her friendship with someone in the clinic — all of these become part of

the environment conditioning the relationship between service provider and client, Foucault's normalizing power of a judgmental gaze. These indicators of the client's identity are then interpreted through the lens of the service providers' official training. The population imperatives are intertwined with others on age, femininity, class and others to shape the kinds of choices that service providers believe that women should make. Speizer *et al*. (2000) argue from survey data that Tanzanian service providers unnecessarily restrict access to contraceptive methods because their training and supervision is inadequate, but they also mention that providers' own norms and attitudes may be important. Even feminist health providers may 'overlook subtle coercive or eugenicist public policies advanced by people with a political agenda of control of the reproduction of certain groups: low-income women, women of colour, and young women of all colours and classes' (Begus, 1998: 221). While technologies are pre-configured for the generic, Western body, in the context of implementation, identity matters.

## women's responses as both complying with and countering scattered hegemonies

Planning one's family, through whatever means, has been a sign of disciplined bodies, upholding the social order and perpetuating values of self-control, restraint and prudence (Johnston-Hanks (2002) makes a similar argument for Cameroon). Tanzanian women interviewed in clinics described both 'traditional' and 'modern' means for planning one's family. In most cases, women described the *njia za hospitali* [hospital based methods] first, and I had to follow up with a specific question about the existence of traditional methods. Almost a third of all respondents described a traditional method to me when I asked about ways that women could plan their families. These included calendar, mucus, withdrawal, external traditional methods like the *pigi,* internal traditional methods such as ingestible herbs, and abstinence. In ways similar to the discourses of international donors and of national level implementers, traditional family planning was talked about by women in two very different ways: as either a 'lost knowledge' or as the indigenous equivalent to modern contraceptives. The language used and the needs articulated around all methods were the same. Women questioned the effectiveness and the side-effects of all types of contraception. The identity issues for women appeared to be different than those for service providers: women saw modern identity as arising from the outcome, not the method choice itself.

Informants described how traditional practices emphasized this issue of discipline. Miriam, a 36-year-old mother of three living children answered my question of whether it was an embarrassment for a woman to have her children close together explaining, 'Yes. It is a big shame to have your children one right after the other. You can't be respected in your community if this happens.' Miriam had the 'modern' outcome of a well-spaced, well-planned family, yet she did not use the modern

route for achieving it. The incompatibility between traditional methods and modern bodies was not described as a question of anachronism and loss of power, but one of ineffective service provision and poor quality of care on the part of the traditional healers. For example, one woman from a village in Morogoro Region explained:

> There are traditional methods of family planning, like roots to wear. However, they aren't very reliable. You can use them and not know if they are genuine. Some are just lies and are able to kill children. The traditional healers are just looking to make some money. They are all from Tanga [a different region], none are from here.

The issues of reliability and side effects, and even the idea of an imported, and therefore, suspect knowledge, come through in this sort of discussion of traditional methods.

The idea that a gap exists between the 'lost knowledge' of traditional practices and the adoption of the new modern regimen as discussed by Tumbo-Masabo (1994) was also articulated by women whom I interviewed. For example, one respondent from a village where traditional methods of birth spacing based on post-partum abstinence were encouraged explained, 'Nowadays, women have many children – more than in the past. Every year they have another child.' She went on to describe how her own mother had waited until after three years before having another child, planning to space her births. In the opinion of some, usually older women, modern women are not as effective as the previous generations in spacing their children. So, like the government officials, these women are interested in this 'lost knowledge' and in better disciplining of the younger generations. There is a sense of anachronism that while the traditional methods no longer work for modern bodies, the modern methods are not making the grade either.

Women's room for manoeuvre within the formal health care system was limited. From my observations, it seemed that women who came to clinics were aware of the 'correct' stance on contraception, and if they deviated, it was by quietly not complying or by staying away from the clinic. Some women continued to use 'traditional' methods, others used modern methods sporadically and for short periods of time, and still others used no family planning at all. Of the women interviewed, more than 75 per cent had ever used a method of family planning.[13] In fact, of my sample of women who were *not* using family planning at the time of the interview, half had used some method in the past.

**13** This number is so high because it does not represent the overall population, as one half of my sample is made up of women who were current users of modern family planning. For a detailed description of the declining care in Tanzanian clinics see Richey (2003).

Each instance of use or non-use of a method may provide women with a way of countering the expected dichotomy that traditional methods are for traditional bodies and modern ones for modern bodies. Yet the women who used them did not privilege one type of method over the other. One example comes from Asha, a 28-year-old woman who had used *dawa* [medicine] she received from an old woman who enclosed it in a cloth and tied it around her waist. She used this method in spacing the births of her first three children. After a miscarriage four years later,

Asha decided to use pills. She said that she wanted to use them instead of the traditional methods because, as she explained:

> If you get bad traditional medicine, you can lose your ability to give birth completely. If you use the hospital methods and then something goes wrong, you can come back, and they can treat you. Therefore, it is better to use the hospital methods.

Asha's description of how it is better to use modern methods in case there is any problem of side effects runs counter to the voices of other women who fear these methods specifically because of their side effects (Johnston-Hanks, 2002; Rutenberg and Watkins, 1997; Russell *et al.*, 2000). It also calls into questions assumptions about the relationship between traditional healer and client. It shows that both types of methods are being considered in the same way, as strong technologies for intervening in one's reproductive process.

Some other women were using modern methods to circumvent, while appearing to uphold, traditional expectations of body discipline (see Bledsoe, 2002). For example, a number of young women in Kanga, a village where modern family planning was not widely used, told me that they had used condoms. When I questioned the circumstances surrounding this choice, I found out that modern family planning was a literal replacement for a traditional method. In this community, women were expected to abstain for sexual relations during the post-partum period until the child was weaned. A young woman elaborated that 'condoms are good when nursing a child because the semen will spoil the breast milk.' By using condoms, women were able to have the effect of having met the traditional expectations of their community while actually returning to sexual activity with their partners, and thus preventing a loss of power in this realm. Interestingly, it was the 'traditional' expectation and belief that women described as driving their choices toward modern contraception. Women whom I interviewed also used modern family planning methods to circumvent their partners' fertility desires and to counter male control over reproduction. In my interviews, 14 per cent of women said that they started using modern family planning without their partners' knowledge and 4 per cent of women said that secrecy was the reason they had chosen their particular modern method over other types.

While family planning, or contracepting, represent a series of material practices, that is, women use actual devices or engage in behaviours that result in physical, material consequences – they have pregnancies or not, they have side effects or not. Family planning practices also have a level of meaning that is symbolic – defining oneself as a particular type of person. The understanding of modern family planning for modern women with modern bodies and traditional methods as part of a traditional mindset as an obstacle to this identity did not make sense in the body practices of Tanzanian women. The outcome of planning one's family, usually articulated as not having births too close together, but also in some cases,

as not having more children than you could care for, was more significant in women's self-described understanding of who was modern and who was not. However, the narrow focus of the family planning apparatus on limiting population growth made it more difficult, but not impossible, for women to make their own reproductive choices.

## conclusions

Tanzanian women are pragmatic (see Lock and Kaufert, 1998) in their reproductive strategies, but their 'choices' are also prearranged by nearby and distant discourses. A 'development' apparatus creates problems, like 'overpopulation' in a way that structures the kinds of interventions that are possible for their solution (see Ferguson, 1994), yet these do not determine outcomes (see Cruikshank, 1999). Still, as Watkins (2000: 747) argues, 'fertility declines, if and when they occur, are almost invariably portrayed as resulting entirely from the agency of individual local actors: colonial governments and the World Bank are rarely seen, nor are gossip networks'. Modern contraceptives function as the ultimate 'technologies of sex' (Foucault, 1980) disciplining bodies through their life-giving powers of emancipating the modern subject (by freeing women and families from the burdens of children). We cannot understand contraceptive 'choice' as taking place in isolation from the differing and contested notions of 'development' and modernity.

To some extent, Tanzanian women, both providers and clients, present their own 'alternative modernity' (Appadurai, 1991), as the multiplicity of their responses fall neither into categories of contest or compliance with expected modernity. Chatterjee and Riley (2001) have elucidated a similar argument in the case of India. Yet, women come to talk about family planning as 'modern' in ways that reflect their understandings of tradition and the global logics of population control. Women, both alone and with their partners, have always intervened in the fertility process, but these practices have not always been linked to an agenda of national development or to solving a global problem.

The very modern technologies that identify service providers as experts also require them to negotiate between the demands of local clients – with bodies-in-context that is not the same – and the family planning expectations that bodies will be the same due to the preconfigured user of each technology. The discourses of modern contraceptives, like other body technologies, 'efface the materiality of the body and the social contexts within which bodies are experienced and constructed' (Brush, 1998: 22). When 'other' bodies exhibit their differences, it is the service providers who must negotiate and translate between expectations. Reflecting the perceptions of a global population discourse that blames Third World women for over-production, and perhaps more than a bit of job-frustration, service providers construct their own notions of these un-disciplined bodies that are constantly

thwarting the providers' best attempts to 'modernize' them. Local women in this context of layered and unequal power relations and constructions of their own identity choose to accept or reject modern family planning according to their own perceptions of need. Women mixed methods and mixed messages in their practices of family planning. Different kinds of modern and traditional technologies were used sometimes to comply with and other times to counter the *scattered hegemonies* of construction of their identities and control of their bodies. The entire dichotomy of 'traditional' and 'modern' constructed at other levels of the Tanzanian discourse on family planning did not make sense in the lives of women themselves.

Because relationships and meanings are discursively constructed, for example, as 'traditional' or 'modern,' does not mean that there is no material reality to which these constructs at some level refer (see Vaughan, 1991). Indeed, from the state of Tanzanian clinics dilapidated by years of mis-placed economic policy to the problems experienced by women and their families when they are unable to dictate the character of their reproductive lives, there are problems understood by diverse viewers with differing levels of power, interest and perspectives. However, I would argue that discourses of development need to be re-imagined in ways that can account for Tanzanian women's multiple positions both countering and perpetuating *scattered hegemonies*, and development interventions must become more accountable for the ways in which their content, priorities and assumptions serve to shift the balance of power toward some actors and away from others.

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