

## **URBAN MALAYSIAN WOMEN'S EXPERIENCES OF ABORTION: SOME IMPLICATIONS FOR POLICY**

Siti Fathilah Kamaluddin

*Malaysian women exhibit a range of reactions to their experience of pregnancy termination. Personal narratives of these women illustrate the many cultural constructions, experiences and reasonings for terminating pregnancies. Pragmatic reasons for pregnancy termination appear primary in the decision-making process. The crisis is not a moral one. Rather it pertains to how women can fulfill their roles and responsibilities as wives, mothers and workers under changing family conditions. Women are held responsible for the preservation of family stability and family honor, and for selecting the type of intervention needed to preserve both.*

*Wanita Malaysia mempamirkan beberapa jenis reaksi berlainan terhadap pengalaman penamatan kehamilan mereka. Naratif naratif peribadi mereka menggambarkan latar belakang kebudayaan masing masing yang selanjutnya mempengaruhi pengalaman dan pemberian sebab yang berkaitan. Sebab-sebab penamatan kehamilan yang di kemukakan yang bercorak pragmatik merupakan yang terunggul sekali dalam proses pembentukan keputusan. Krisis yang di alami tidak ditafsirkan dengan menggunakan ukuran moral. Di sebaliknya ia berkaitan dengan persepsi wanita tentang peranan mereka sebagai isteri, ibu dan pekerja dalam keadaan kekeluargaan yang sering berubah. Wanita di pertanggungjawabkan dengan peranan menstabilkan kedudukan dan maruah keluarga mereka. Pemilihan cara pengguguran yang di lakukan memenuhi keperluan tersebut.*

For much of this decade, Malaysia has been participating in an economic boom. Women workers have been disparately affected by flexible accumulation strategies begun in the mid-1980s and which have continued into the present. They have experienced changing social patterns in work and family in conjunction with these economic transformations. These include a shift in migration patterns for Malay working-class women from rural agrarian lifestyles to contemporary urban living and factory work. Consequently, extended family arrangements for childcare have become increasingly unavailable while affordable private arrangements remain beyond the reach of most factory women.

Marriage for women of all ethnicities has also shifted to later ages with more Malay women remaining single. The combination of better nutrition, earlier

menarche and later marriage may result in more young single women being sexually active before marriage and perhaps requiring pregnancy terminations.

## INTRODUCTION

This article is based on a study which focused on a sample of women in Penang, Malaysia who underwent pregnancy terminations at a private clinic during a period of three months in 1993 (Kamaluddin 1995). The focus here will be on urban Malaysian women's experiences of abortion and on some policy implications that can be drawn from this study.

Field research was carried out at a family planning services clinic where I worked for three months doing educational counseling. Both qualitative and quantitative methods were used as investigative research tools. These took the form of in-depth interviews, participant observation, document analysis, library research and computerized data analysis of client records. Fieldwork was limited to a single clinic sample of primarily Chinese, Malay and Indian women from all social classes.

Computerized data analysis of client records from over a six and a half-year period provided a client profile of abortion-seekers at this clinic in Penang. They tended to be Chinese, married, in their late twenties, coming for their first pregnancy termination to this clinic, and to be prior users of contraception. Increasing trends of younger, single women and of non-Chinese women visiting this particular clinic were indicated although reasons for these trends remain speculative at best. These quantitative results have been described in detail elsewhere (Kamaluddin 1997a).

The interview sample for the qualitative portion of the study consisted of more Malay women, who tended to be married factory workers, than those of other ethnicities. Thirty-nine women were interviewed on their abortion experiences. Of these, 19 (49 percent) were Malay, 11 (28 percent) were Chinese and nine (23 percent) were Indian. Four were between the ages of 15 and 19, 15 were between 20 and 29, 18 were between 30 and 39, and two were between 40 and 44 years of age. Thirty-six were from working-class and three were from middle-class backgrounds, as determined by either their occupation or the occupation of their spouse.

## CULTURAL CONSTRUCTIONS OF ABORTION

Malaysian women's constructions of abortion suggest differences from their counterparts in the West. Malaysian women place importance on the cleansing and regulating aspects of triggering menstrual flows (Kamaluddin 1997b). Pre-pregnancy termination interventions such as taking herbs, pills, hormonal injections and other private attempts to bring on menstruation underscore the menstrual regulating aspects of abortion.

Local abortion terminology varies by ethnicity. Most Malay women used the terms "*cuci*" [cleanse] and "*buang*" [discard] to describe having pregnancy terminations. Many Chinese women used the terms "*la sum bo lai*" [my period has not come] or "*say ginna*" [wash child] when requesting pregnancy terminations. Indian women might say "*vayiru kaluvanam*" [I need stomach washing, I have no period]. Additionally, post-pregnancy termination healing processes such as diet and exercise restrictions followed by some of these women suggest that they viewed abortion as a form of interrupted childbirth.

When conversing with English-speaking clients, clinic nurses would use the term "washout" to describe the procedure the clients sought. Most likely, this term is a direct translation from the Malay, Hokkien and Tamil colloquial terms for abortion. More rarely the English word "washoff" was used. When talking with each other, nurses and doctors used the abbreviation "MR" for menstrual regulation, the term that was used for official and legal purposes in client records to describe the pregnancy termination process.

## REASONS FOR TERMINATION

One interesting aspect of this study centered on the reasons behind women's needs to terminate their pregnancies. This focus may be used to shed some light on issues and problems in women's lives that need to be addressed more generally. In Malaysia as elsewhere, women seek termination of unwanted pregnancies for many reasons. An examination of these reasons may provide a cross-cultural comparison of features unique to Malaysian society and may also illustrate commonalties across cultures.

The 1993 strategic plan of the Federation of Family Planning Associations of Malaysia discussed the unmet need for family planning services in terms of families who wished to 1) limit family size, and 2) space births (FFPAM 1993: 12). This might have been a rather narrow definition for such services, considering the wide range of reasons women were choosing pregnancy terminations or seeing the need to have them.

Women had many types of reasons for seeking pregnancy terminations at the clinic. They may be summarized as financial, social, medical and miscellaneous reasons. Some women expressed financial concerns as the principal reason behind seeking pregnancy terminations. They were unable to bear the financial cost of having and raising an additional child. Some could not afford to have a child at that point on time. For others, their families were already complete and an additional child would have been an unnecessary burden.

Childcare was an increasingly salient concern voiced by working women. Malay factory women especially brought this up as their reason for wanting pregnancy terminations. Since they had been displaced from rural areas, their families were frequently out-of-state. Consequently, there were no extended family resources to fall back on for childcare. Many women cited lack of childcare facilities at work and at home as an impossible situation to deal with. Although there were private daycare centers in Penang, these were relatively unaffordable for working-class women. Their only means of childcare lay either with relatives or neighbors. In addition, these women knew that maternity leave in most factories would not allow them time to breastfeed their child beyond the first month or so after childbirth.

Apart from financial concerns, there were also societal values that prevented women from wanting to continue with their pregnancies. Some women did not want to continue with their pregnancies when these had been the result of rape. Clinic nurses were unaware of any cases where pregnancies had been due to incest even though incest does occur in Malaysian society. Prostitutes usually did not want pregnancies. There were married women who were not yet ready to have a family and single women whose marriage prospects would have been ruined were they to continue their pregnancies. There were Chinese women who were second wives whose children had no inheritance rights, so it made no sense to have children in that situation.

There were also a variety of miscellaneous reasons for termination, many of which had social origins and social consequences. Some pregnancies were the result of extramarital affairs. Some women were drug addicts and would have been unable to care for their child. Some had husbands who were involved with other women so they were not ready to deal with having children at that time. Some were coerced into having a pregnancy termination because their partners were unwilling to have a child. Some were high school or college students who were unable to handle pregnancies at that time of their lives.

Pregnancy terminations were also performed for medical reasons, although these were more frequently carried out in government hospitals where they were free of charge. These cases would usually involve the poor health of the mother,

which was a legitimate reason for termination under the law. Women who wished to abort for health reasons would visit the clinic to avoid the long delays expected at the local hospital. It was also possible for mentally retarded women to have abortions performed on them although such cases were rare. Here, it was usually at the request of parents rather than the woman herself to have the procedure done. There are apparently no laws governing the rights of the mentally retarded in this regard and parents who ask for and pay for the pregnancy termination are usually accommodated.

A significant proportion of women expressed a lack or insufficient knowledge of contraception. These were usually younger and single women. According to one of the clinic doctors, however, some women learn about contraceptive methods when they are in recovery at the hospital after the birth of their first child. In some cases, abortion was used as a method of contraception. There were also cases of lack of access to contraceptive knowledge. Single women anywhere in Penang could not obtain contraceptives other than condoms. Contraceptive failure was also a stated reason for termination. There were women whose partners were unsupportive of or even opposed to using contraception.

## WOMEN'S EXPERIENCES

The complexity and diversity inherent in women's experiences mediated by class, ethnicity, religion, and familiarity with the pregnancy termination procedure itself were illustrated through their stories. Further complicating the picture were the reasons women gave for their decision to terminate their pregnancies. While some reasons may be common across cultures, there are also culturally specific motivations underlying some Malaysian women's actions. At the core is a focus on women regaining their health so as to be able to function as good wives, mothers and workers.

Clinic doctors and nurses provided their interpretations of client behavior, of women's constructions of their experiences, women's interactions with male partners and the sociopolitics impinging on their decision-making processes. However, women's narratives and constructions of their abortion experiences formed the heart of this study for it is through women's voices that we achieve a sense of the thoughts, feelings, reasonings and rationales behind their actions.

There was no evidence from women's narratives to suggest that their pregnancy termination experience or that the events leading up to it are a life crisis. Most women had already discussed this decision with their partners before coming to the clinic. It is possible that in their pathway to the clinic, i.e. the various steps

along the way to reaching their decision to visit the clinic, the issues surrounding their decision to abort had been more or less resolved.

The decision to abort had many dimensions. For women who were still undecided when they got to the clinic, there were circumstances, which helped them decide. One of these "helping" actions or, as one staff member described it, of "tipping the scale" was the informational counseling services with clinic staff. For Malay women especially, the size of the fetus on the ultrasound scan was a helping action as well. Malay women feel that as long as the fetus is a "clot of blood," the pregnancy termination is permissible. This "clot of blood" [*ketul darah*] usually means a fetus of up to three or four months. The ultrasound scan which they could observe for themselves confirmed their expectation of not seeing a human form or of seeing a small enough form to fit their "clot of blood" imaging requirement. According to the clinic director, single Malay women were more likely to act similarly to Indian and Chinese women who were more certain to abort regardless of fetus size.

Another factor that appeared to affect the decision-making process and the way women felt about themselves after their procedure was the degree of attachment toward the fetus within. "I have no feelings yet for this baby," said one woman. "*Tak sayang lagi*," [I do not love it yet] declared another. For some Muslim women, this may be related to the Islamic injunction against abortion after the soul is present in the fetus (Rahman 1987).

From my observations and from nurses' discussions about clients, the two general exceptions to this ease of decision-making were a) women who were coerced into having pregnancy terminations and b) women with moral or religious convictions that proscribe abortion. For women with religious convictions, the decision to abort ranged from ambivalent to unambiguous. One Catholic Indian woman was against abortion in principle but had hers willingly. According to the clinic director, this attitude was not uncommon. He explained it as a form of elitism in that some women rationalize that it is all right for them to have the choice of pregnancy termination but that this right should not be extended to others.

Some women of varying religious convictions commonly expressed guilt. One woman claimed, "It's murder," while another said, "What God has given you, you can't take it away." One Catholic Indian woman who had one prior pregnancy termination of twins and who was pregnant a second time had sought counseling from a priest. She remembered that before her first pregnancy termination she could feel "the hearts beating inside me." Some women expressed post-pregnancy termination anxiety as a fear of punishment, thinking

they might become infertile. A Malay woman said it was a sin if you had too many pregnancy terminations.

The level of pain and how women reacted on the operating table was another indication of their anxiety. Some women cried, or trembled. Some felt a level of pain that may have been greater than one would expect under the circumstances. Some stayed awake despite being fully sedated. Others cried afterwards in the recovery room or felt depressed.

There was a range of reactions by women to the actual procedure. All but one of the women I counseled wanted to know the details of the medical procedure they would be undergoing. For women who had never had a pregnancy termination before, the fear of the unknown was apparent in their conversations with the nurses and with me. Young single women who had not experienced childbirth especially had no frame of reference. These women tended to ask for full sedation so that they would not be aware of the pain or discomfort they perceived they would experience.

The women who were in control and unambiguous about their decision were usually calmer and more stoic in the operating theater. These were usually women with relatively good support systems. Most women simply needed someone to hold their hand for comfort during the procedure. Some women recovered within fifteen minutes of their procedure while others needed a couple of hours in the recovery room.

In sum, the women studied came from diverse situations, had different constructions of meanings of abortion, presented a range from clarity to ambiguity about the procedure and a range from painlessness to severe anxiety during the procedure itself. Most women did not view abortion as a life crisis but attached a multiplicity of definitions to their experiences, while also voicing religious and moral concerns over their decisions.

## WOMEN'S NARRATIVES AND REASONINGS

Women's narratives revolved around concerns for their health, the health of their families and with the moral construction of being good wives, mothers and, in many cases, workers. Although men exercise dominance in and out of marriage, societal expectations commonly place responsibility for the stability of the family on women. Women exert control over their bodies to the extent that they are expected to regain their health and resume their duties as wives, mothers and workers. Responsibility for the outcome of reproductive behavior

in this scenario includes the selection of an intervention (i.e. a pregnancy termination) to preserve family stability.

**a) NHT: I've been here eight or nine times already**

For some women, especially those who had had a pregnancy termination before, the procedure seemed routine. A case in point was NHT, a five-time clinic client ["I've been here eight or nine times already"] who was well versed with the clinic and its procedures. She lived close by and even dropped by for casual visits occasionally. She said she felt "scared" the first time and asked for full sedation during her MR. The next one or two times were also with full sedation. Then she became "more brave" and now did not need sedation.

The reason she gave for having her washout was that she had three boys and wanted a girl for her next child, but was not sure if she would have another. Her facial features were drawn. She looked older than her 34 years, had a loud voice and came alone to the clinic. She was the wife of a Malay policeman and was Chinese. Although she had used an IUD in the past, she was not currently using any contraception. She complained that her husband could feel the string from the IUD and requested the doctor snip it off for the new IUD she was inserting after her washout.

**b) RMA: It's a life, isn't it?**

Some of the same Malay, Chinese, and Indian women who appeared emotionally unaffected by their decision to abort before the procedure, as well as others, experienced deep conflicts about what they were doing either during or after their pregnancy terminations.

RMA, a 33 year old Malay factory worker with three children, the youngest of whom was seven months, appeared outwardly calm during the admissions counseling process, but visibly trembled when on the operating table. The nurses put a blanket over her and she calmed down as we went through our deep breathing exercises together. When I asked her about her feelings on having the procedure during her follow-up visit, she said in Malay:

If it's already formed, it's not good. It's a life, isn't it? If it's done at the beginning, it can be washed. That's why on the day of the washout I felt frightened. Frightened because of God, feeling I was doing something wrong. Even though it was still newly formed. That is why I often tremble.

This client was one of the few Malay women who agreed to be interviewed on tape. I sat with her outside the clinic as she waited for her husband to pick her up since the clinic had closed for the day. She asked me questions on the size of the fetus at her stage of pregnancy and I showed her pictures from a book that I had on what it would look like. She seemed a bit relieved.

Still, conflicts were plentiful. Such conflicts arose during different stages of the abortion process for different women. Some Malay women, as previously stated, depended on the ultrasound scan and screen to decide if the fetus was a life and should be kept. Women of all ethnicities asked questions regarding the size of the fetus after the procedure was over. A few wanted to see the products of conception. Some experienced the pregnancy termination procedure itself as extremely painful despite being partially sedated, and others cried inconsolably either in the operating theater or in the recovery room. When questioned during their follow-up visit, they said they had some religious or moral conflicts as to whether they were doing the right thing but, for a variety of reasons, had to have the procedure.

**c) SDS: My children need to have the best**

Two 31 year old middle-class, English-speaking Indian women, both teachers, had differing reasons for terminating their pregnancies. SDS had two children and felt that her family was complete. Because she was unable to use either the Pill or IUD for medical reasons, she and her husband had been using condoms and the rhythm method and the pregnancy was a "complete accident."

Since we didn't want to have any more, he said he feels nothing towards this baby here. He said, I've got no feelings for it yet, so before it's too late, before he gets any attachment towards it, might as well abort it. No doubt it's our child and we're doing something wrong, but we need to be comfortable. Then my children need to have the best, you see, so we must make sure that we can provide the best. That's how I felt that I also should go for it, you see. I was thinking twice. He wasn't.

Then I also made up my mind. Then we came the next day. Got everything over. Then went back, but I just can't forget it. Each time I close my eyes I keep thinking about the fetus and the ultrasound. I know it's part of me also, you see, and has been washed away. I felt a bit guilty first. Slowly I got to overcome it. Since I also, you see, made my decision to wash it off.

It took at least two days for me to recover. My husband says it's nothing, actually it's part of life also, this is nothing to hide. Just forget about it and go on. You've got your routine to do. Take care of your other children also. You'll slowly forget it. That's about it. Overcome it. And I've gone to school. And things became normal to me and I feel much relieved after that. Because I was having morning sickness and this and that. Once it was washed out, everything was back to normal. And I really appreciated life after that, how life is wonderful without a baby.

**d) PK: Why did I do this?**

The second woman, PK, had one child, an unusually good family support system and, for her as well, the pregnancy had been unexpected. Her career as a teacher was to be affected by this event since she was scheduled to attend a year-long course furthering her teaching skills. She felt that her priorities at this time did not include taking care of another child. We discussed her experience during her follow-up visit to the clinic.

Actually I was quite surprised I was pregnant because for the first baby, we waited for one year and we didn't know the reason why it took me so long to become pregnant. Because every time we went to check with the doctor, he says it's normal. You have to wait sometimes. So after my first baby we didn't really plan because all in my mind was I won't be pregnant that fast. So all we did was, you know, check for the safe period. That's what we did. We didn't use any contraceptive pills, condom and other stuff.

So my period supposed to come around 26th of May, didn't come. Then I was all prepared to go for the course and this course I've been waiting to get. First I rejected it two years ago. So if I don't go for this I lose seniority, a lot of things I lose. So didn't come. Deep in my heart could say I was quite happy. I hoped that I'm pregnant. And also on the other side I hope it's not. You know, it's like the two things fighting. So I said, maybe it's late, it's not pregnancy, maybe my period is late. So when it came to 30th, I told my husband, I said, maybe I'm pregnant. Because although the symptoms was not there, but I felt very hungry. Very hungry and all that...

So came and I talked to my mother. My mother said, my daughter is still small, one year four months. So if I'm going to have another baby and it's due in February next year, 1994, then my course will

start in June also, so I'll have two child to take care, so it'll be more difficult. So again had to discuss with my husband. Then we agreed to abort. But before that, my mother told me, take pineapple and all that to let it come out. Take Coca-Cola, it's very effective. So I said, I don't want to try all this stuff, internally it might affect, we don't know what the early causes...

So my sister was the one who introduced this clinic to me. She said, go to Klinik X and find out about it. So that's how I came here. But now since I'm in the course and I find the work is so heavy, sometimes I do sit down and think to myself why I'm here and why did I do this? [Laughs] I should have been in Sabah and, you know, having my second child. I mean, it's all for the best, lah<sup>1</sup>.

Some clinic clients came from outside the city or state to have their pregnancies terminated but the proportion of such clients was unknown. Most of these clients came from within a radius of 20 miles of the city. There was one case of a client coming with her family and boyfriend from a town about 150 miles away. According to clinic nurses, there had also been rare cases of women flying in from other states for their pregnancy terminations.

Ambivalence and feelings of contradiction seemed almost routine among the women interviewed. They seemed to give much thought and consideration to the matter, which was also negotiated with others.

**e) RY: If I have this baby, it might not be healthy**

Some women were unable to carry a pregnancy to term because of health reasons. A 35-year-old Malay housewife of poor circumstances and with a history of high blood pressure came with her spouse and child to seek a pregnancy termination. Both she and her spouse had a grade school education. Although they had not needed to use contraception in the past due to subfertility, they were now willing to try the IUD and had a very accepting attitude towards contraception. She wanted to limit the size of her family and was also afraid that medications she had taken for her recently diagnosed diabetes would have an adverse effect on the developing fetus. She was a fairly large woman who seemed nervous, yet was very open in demeanor. We spoke in Malay:

If you can, you should have a washout, the other clinic doctor told me. Because the diabetes could be dangerous, he said. If I have the baby, there's danger of birth defects because I've taken a lot of

medicine. I went back home and asked my husband. He said, if you're already not very healthy, it's better that we abort [*cuci*]. In the future, if we have the baby and it's not healthy, we'll be in trouble, he said. That's what he said, *lah*.

After that, I went back to Klinik B a second time. He said they could do the washout but that it would cost \$800. At first, he wanted \$1,000. To which I replied, how can I afford that? [*Laughs*] I don't work, only my husband works. OK, *lah*, I will do it for \$800, he said. I asked him, can't you make it cheaper? I can't, he said. If you want it, you come back tomorrow.

I went home and discussed it with my younger sister. She told me to keep the baby. The washout was close to \$1,000. It would be better to give birth. After the baby is born, it won't cost that much. Life is not easy for us. I agreed.

Then there was a neighbor across from my house. His sister told me there's a clinic, Klinik X, try to go and see them, she said. That clinic is good, she said. We can discuss it with them. OK, so I tried coming here. Asked the doctor, he said I can have a washout. Moreover, I had taken so much medicine, right? Everyday almost ten pills. It made me feel better, and when I took that medicine I didn't have to go to the bathroom so often. If not, every fifteen minutes I would have to go. With the medication, it slowed down to every half-hour.

The medicine I used came from tree bark and roots. First I dried them. Then I ground them up into powder. I took it to the Chinese pharmacy to make it into powder. After that, I put the ground up powder into capsules. With that medicine I was able to stand it a bit more.

## PATRIARCHY AND SEXISM

In Malaysia, it is not uncommon (but largely undocumented) for men of all ethnic groups and classes to practice polygamy and concubinage. Islam allows men to have four wives legally. Traditionally, Chinese men take many wives to enhance their prestige and social standing, or as a matter of simple convenience. The preference for sons also motivates some Chinese men to take other, usually younger, wives if their first wives do not bear them sons. Indian men may engage in common-law marriages with more than one woman. Although

monogamy legally applies to non-Muslims, men are not sanctioned or punished by law if they break this rule.

Reliance on marriage and husbands as a means of income has left many women relatively powerless. Male dominance is frequently reasserted by the power of money. Restricted economic opportunities for women have their origins in the Malaysian class structure. Income based on educational credentials is deeply rooted in the Malaysian economic opportunity structure.

The British-based western-style educational system never intended education for the masses. After Malaysia attained its independence, however, mass education was encouraged and made compulsory in theory for all children. In practice, children of poor and working-class parents often had to forego schooling in order to help the family make a living. If there was money for schooling, it would be male children who were afforded such opportunities. Even after high school graduation, women would either stay home and help their parents doing farm work, plantation work or running small businesses, if they were rural. In the cities, poor and working-class women would become shop clerks, secretaries, servants or work in small businesses. Today they prefer working in factories for increased earning power.

Even for children of the middle and upper classes, Malaysia's post-independence education system has never been structured to absorb all eligible students into its polytechnics, colleges and universities. Like other developing countries, its elitist structure can only absorb a portion of college-eligibles. Many women, therefore, tend to rely heavily on marriage as a means of upward economic mobility.

A significant factor in explaining unexpected pregnancies flows from the treatment by some Malaysian men of their women partners. Male chauvinism and sexism, buttressed by religious and patriarchal cultural patterns, permit men to place the sole responsibility for contraception on women, in some cases, while restricting the types of contraception their partners use, in others.

In my study, one man confided to the clinic nurse during admissions counseling that he was not really keen on sex, that he and his wife had been just "fooling around" on that occasion which had resulted in her becoming pregnant. This couple was currently using the rhythm method. The wife did not know how she had become pregnant. Yet she was making her appearance for her fourth pregnancy termination at the clinic and felt that women had to suffer in their lives in order to keep their husbands happy. During admissions counseling, the husband refused to consider the IUD or oral contraceptives for his wife, a

factory operator, because he said there were side effects. While appearing to protect his wife's health, he also cut off most avenues of reliable contraception. Doctors at the clinic appeared to corroborate these observations. According to one of them, men are reluctant to use contraception and view it as women's responsibility:

Men, I think, are still very, very reluctant where contraception is concerned... When I want to persuade them to use some form of method because I see them coming repeatedly, then they say waste of energy, money and all this. Sometimes the girl, the lady, tells us, you see, "I'm willing to use an IUCD, you see, it's my husband who doesn't want it." Then, some men out and out say, "Don't want." No reason given. I just don't want. Then you can't talk to such people, you see. Very adamant.

Some people, you do convince them, the husbands. And where condoms are concerned, the men, if they don't want their wives to take any precautions, are complaining. You see, the condoms if they use, they say they don't find sex quite natural in the way that it should occur. They feel it's some sort of barrier. And the time of going and buying, stocking, putting it on, all this, they all say, you know, trouble, disturbance on the way. So they like to take the easy way out. That's what I'm seeing.

But basically when I feel that both of them do need some form of contraception, either the man or the lady, I do talk to both of them. Of course, you can convince mostly the women only, you see, and then the husband's part of it is to accept the wife taking some form of precaution...The men, I think, they don't take much responsibility. Anyway, I see from the many people I spoke to, men feel that contraception is the woman's responsibility. That's how they feel, I think.

There are very little options left to the man. As it is, we don't have any male contraception as such in the form of a pill or what...Condoms is out. The other thing is vasectomy, you see where your family's completed and you don't want to. There are men who come forward to that -- very, very few. And the community -- it's the Chinese which are the most who come forward with this. Muslims -- out. They feel they are giving up their manhood with vasectomy. Some people they feel very strongly about this. Indians -- they don't mind, but the population thing -- we get very few of them. When I was working in the

hospitals, the Indians, quite a lot also. They do come forward, *lah*, but you have to convince them a bit. They just don't come forward on their own like that, you see. Chinese people, I think, most willingly come forward. (Dr C)

When women's options in life are restricted by narrow economic opportunities, especially when they are working class, reliance on marriage and male "protection" becomes the obvious and only "choice." Thus, it becomes relatively easy for men to decide who will take responsibility for contraception, if their partners should use any in the first place, what types of contraception should be used and for how long. Thus one hears of cases where rural Malay women travel long distances to rural family-planning clinics in other districts just so their spouses do not find out they are buying and using contraceptives.

From this study, it appeared that clinic staff might be more conscious and aware of how oppressive living conditions were for some women than were the women themselves. Perhaps due to their extensive experience with thousands of women undergoing this life experience, female staff especially voiced their concerns about wanting to help women. To paraphrase one nurse, many men saw the clinic in much the same way they would an auto repair shop. They needed their women fixed or repaired like a car. The nurses were vocal in describing the insensitivity of many men towards their female partners visiting the clinic.

Maybe about five percent, they are willing to go upstairs, accompany their girlfriend or wife, which we stop them. About five percent of them are quite concerned. Until the partner comes down they are a bit restless. What's going on? They want to know. Very less, five percent, I would say. The majority, they just leave them here, they just go home. Certain time they just come and get. Big job done, finish it off. Five percent of them will be hanging around here quite concerned. How is she? Is she all right? Very less men of this category. (Nurse P)

Maybe we can help the women fight for their rights when it comes to decision-making. No matter how much we teach them somehow they think of their husbands. Then they come back. Just like for you to sit in. Just explain to them. They got to ask their boyfriends. Not something serious. A counselor to sit in, they have to ask their boyfriend, not even their husband. Cannot even decide for themselves. And they are old enough; they are working. (Nurse OG)

Regarding contraceptive methods, they got to ask their boyfriend, ask their husband. Can or not? Ask for permission first. (Nurse OI)

Most of them say no, no, no, I don't want her to use anything; I'll use the condom. In the end, they won't use. They come back, another MR. (Nurse P)

The constant negotiation of kinship roles within the circumscribed limits of patriarchal family structures, women's agency within such limits and their resistance to these limiting structures are illustrations of oppression in women's lives. With limited input in family decision-making but with sole responsibility for reproductive outcomes, women may be restricted in making decisions that may be more in consonance with their own wishes and needs.

The male Indian doctor at the clinic related some other illustrations of women's relative lack of power with respect to male control over their lives to me, one of which is excerpted here:

There are other patients also; they are the same thing. Indian patients also. Another lady. "He's having another lady. He's not giving us anything also, two, three kids, I'm looking after. I'm working in a factory, looking after them, he's having another girl. He doesn't come home. Once in a way he comes." "And then he comes to you for sex only, you know. Why do you entertain this kind of man?" I just tell them, you are the loser...

Just imagine, I'm asking this Indian girl, "Can't you stand up to him and talk? He's having a girl there and you are aware of it, and he's not supporting the family and you get pregnant, you go and borrow money. He's not even giving you money for this procedure. Don't you stand up to him and ask him?" "If I ask, there'll be lots of problems in the family." She says, "When I ask him, he says, you don't ask about all that. This is my private affair, don't interfere in this." They are scared to stand up to them, for what reason I can't believe.

Researcher: Well, there could be the threat of physical violence. That could be one possibility.

Doctor: Violence is there. Of course, they do say that. "When I ask anything, he hits me." They do admit to that also. Then I say, "What about your elders, your people?" "Oh, they don't want to

interfere." "Why?" "Because I fell in love with him." (*Doctor laughs helplessly*).

The truly daunting array of forces working against some Malaysian women's autonomy thus included the lack of mediatives such as familial support systems as well as cultural patterns and religious mores which reinforced and reinscribed female deference to male authority within the family.

## DISCUSSION

Contraceptive methods and information are often unavailable to young, single women and this may be reflected in a rising trend in abortion statistics for this group of women. Patriarchal attitudes and behaviors are partly responsible for causing unexpected and/or unwanted pregnancies. Restricted economic and educational opportunities for women mean that men continue to dominate women's lives and life options not only, but surely, in terms of reproduction.

The concern over childcare for working-class women may well serve as an indicator of the changing family under industrializing postmodern conditions. In her recent study of postmodern families in California's Silicon Valley, Judith Stacey (1990: 254, 252) maintains that it is working-class families, not middle-class ones, that have been the harbinger or bellwether of change within families.

Postindustrial transformations encouraged modern, working-class families to reorganize and diversify themselves even more than middle-class families... African-American women and white working-class women have been the genuine postmodern family pioneers, even though they also suffer most from its most negative effects. Long denied the mixed benefits that the modern family offered middle-class women, less privileged women quietly forged alternative models of femininity to that of full-time domesticity and mother-intensive child-rearing. Struggling creatively, often heroically, to sustain oppressed families and to escape the most oppressive ones, they drew on "traditional" premodern kinship resources and crafted nontraditional ones, lurching backward and forward into the postmodern family.

Although Stacey is referring to the revolution in family life brought about by depressed economic conditions in the industrialized West and by the leaner, meaner flexible accumulation strategies of the mid-1980s up through to the present, this revolution has had its counterpart in industrializing countries where demand for cheap female labor also had ripple effects on family lives. With increased working opportunities but few accompanying social welfare policies

for working women in Malaysia, women are feeling squeezed between having to provide for families and not having the means with which to tend children. One result is that many of these women are choosing "voluntarily" to limit family size to a sustainable number, in many cases to two children, as promoted by population controllers.

In this study, male partners of these women seem amenable to change to the extent of accepting smaller families as well but on the whole are not committing to increased roles in family maintenance, i.e. to increased housework or child-care responsibilities. Rather they seem to be relying on female extended family kin, neighbors or rarely affordable private day-care arrangements to resolve this problem. Some men also appear not to be exhibiting more flexible or responsible attitudes towards contraception or taking increased responsibility for it. On the other hand, many male partners appear to be implicitly or explicitly condoning abortion despite religious and other sanctions against it. Specifically, Malay working-class women who form the new urban proletariat appear to be undergoing transitions in family formations. With factories exercising strict discipline over these women's lives as well as their bodies (Ong 1987) and with the lack of adequate maternity leave and childcare, these women's childbearing and -rearing options are being limited. One practical solution seems to be to control births.

For Chinese working-class women who traditionally have arrived earlier in cities and to urban life and who also have had to contend with male dominance, their options appear better defined. They have made the transition to financial independence earlier on and therefore display fewer contradictions, i.e. covert cultural norms regarding abortion appear not to contradict overt ones. Religion also appears less of a hindrance to decision-making.

Indian women of the lower classes may have the most difficulties in terms of dealing with male dominance, lack of resources and support systems, and religious proscriptions of abortion. Due in part to racism, many of these women have been relegated the most menial jobs in Malaysian society and historically have remained poor.

Middle-class women of all ethnicities have a relatively easier time with their pregnancy termination experiences by reason of class privilege itself which affords them easier access to money, contraceptive information, support networks, affordable child-care and increased options for medical care.

Despite the attempt to flood Third World countries with contraceptives to curb "profligate procreation," the use of abortion as a primary and/or backup contraceptive method appears to be increasing in Malaysia. Many factors may

account for this, not the least of which are the failure rates of contraceptive methods themselves. A second factor is the ineffectiveness of contraceptive education targeted toward women who use contraceptive devices. Third is the prevalence of male chauvinism and sexism either in not using contraception or in restricting contraceptive use by female partners.

Failure rates of contraceptive methods are seldom discussed in the literature on family planning in Third World countries. There is a cumulative risk of pregnancy the longer a method is used that is either seldom acknowledged or inaccurately estimated, sometimes even by contraceptive counselors (Shaklee and Fischhoff 1990). Most studies of contraceptive effectiveness measure failure rates that occur during only the first year of use. For example, on average, one woman in a hundred may get pregnant while using the Pill for a year, giving the Pill an effectiveness rating of 0.99. Over five years, the cumulative risk of becoming pregnant is 0.95 (or 0.99 to the 5th power), meaning that five women out of a hundred could become pregnant in a five-year period of pill use. Over ten years of pill use, the risk is 0.90; one woman in ten has a chance of becoming pregnant then. Pill use is also considered the most effective means of modern contraception besides abstinence or sterilization. Other less effective methods have higher cumulative risks for pregnancy. These risks are seldom touted by family planning agencies or imparted to women during contraceptive education.

Even though most IUDs have effectively been pulled from the shelves in the United States due to the threat of litigation, they are still being promoted as effective at the clinic I studied as well as elsewhere in Malaysia. However, only a few brands are now available. In terms of effectiveness, IUDs fare less well than the Pill and their negative side effects were not always acknowledged to clinic clients.

Norplant, the contraceptive implant, was unavailable at the clinic at the time of the study. Depo-Provera was available but seldom administered to Malaysian women. Only women who requested this particular method were given Depo-Provera and in Penang, these were mainly Indonesian women migrant workers who were familiar with and used to it. Unlike Malay women, Indonesian women did not seem to mind the lighter and oftentimes irregular menstrual flows associated with this method of contraception. The clinic director did not discuss what the reactions of Chinese and Indian women in Malaysia were to contraceptive implants but the implication was that they were somehow not amenable towards them either.

In Malaysia, as elsewhere, there has been a recent shift from oral contraceptives to barrier methods, partly in response to perceptions of an increased health risk

with Pill use and partly in response to AIDS prevention education. One of the effects of this shift, when coupled with an underestimation of the long-term decrease in effectiveness of contraceptives and accompanying increase in contraceptive failure rates, will likely be an increase in the need for abortion services for terminating unexpected and unwanted pregnancies.

Given the time constraints during one-to-one counseling at this clinic and during contraceptive counseling at state-supported family-planning clinics, the amount of information that would have to be retained by women who may not be literate would appear to be daunting. In addition to information overload and limited time spent with each woman, the information imparted may sometimes be incomplete, thus causing accidental misuse of contraceptive devices. Other clients go off the Pill because of excessive weight gain, a common effect among Malaysian women, and do not or are unable to use substitute methods.

Even in the United States, 40 percent of pregnancies among women aged 30-34 are unplanned (Asnes 1994: 69). Women over 35 who become pregnant are likely to do so by accident. Why this should be happening in a literate, technologically advanced country is confounding even the experts. Various reasons for contraceptive ineffectiveness have been proposed. One is that 12 percent of women who use contraceptives use "unreliable" methods such as withdrawal and rhythm. Another is that women are not getting enough information about the method they use. A third is that current methods are unappealing, so women are getting either themselves or their partners sterilized. Whether they choose to opt out of choice or from a perceived lack of it is presently unknown.

In a recent article on birth control in a popular American magazine, *Working Woman*, the author (ibid: 84) concludes:

In theory, our contraceptive universe is expanding. But when you consider that of the two birth-control methods most recently approved by the FDA, one could make you stop menstruating, lose your hair and get fat (Depo) and the other squeaks (the female condom), it's almost enough to make you choose celibacy. Or the rhythm method.

There must be a better way. It may mean accepting some side effects, such as menstrual pain and hormonal bloat, that might not be so bad if you're prepared to deal with them. In fact, such inconveniences are pretty minor compared with the side effect that too many women now choose by default: unplanned pregnancy.

The outcome is that the state of contraceptive effectiveness in both the United States and Malaysia appears severely wanting.

#### IMPLICATIONS FOR POLICY

As greater numbers of working-class women filter into the workplace in Malaysia, a clear message resonates out of their experiences with pregnancy termination. They are saying they cannot deal with having large families while simultaneously going to work and not finding adequate and affordable child-care provision. If a relative cannot be found either nearby or in the woman's rural village to provide this service or private day-care services prove unaffordable, women, especially factory workers, will reduce their family size for very pragmatic reasons. Therefore, the government's policy of pronatalism for this target population will be largely unsuccessful. What women are saying is that they cannot make large families a reality in urban areas on low wage incomes.

Another clear indicator of this, apart from choosing pregnancy termination as a method of limiting family size, is that the number of cases of infant abandonment has become an increasingly visible problem in large cities (Editorial 1994: 6). Newborn babies have been abandoned in shopping malls. Child infanticide cases have also been cited as happening more frequently, as have been child abuse cases, in particular within Malay families. The stresses and strains brought about by an industrializing economy have been given as the root causes of these social phenomena. It could also be said that unfettered capitalism not only creates changes in economic relations but in family or kinship structures as well.

It is not a stretch of the imagination to conclude that affording women wider economic opportunities in conjunction with social support for their caregiver and child-rearing duties and responsibilities would help stabilize families and even birth rates. At least that is currently what population planners in the international arena (Chira 1994: A1(2)) are arguing. Women's groups are challenging the notion that dispensing contraceptives alone leads families to have fewer children or gives women a voice in making that decision. Studies have shown that there is a correlation between increased educational level for women and smaller families (Jain, 1981). Women's health advocates are demanding that resources, therefore, be spent on improving the lives of women in developing countries rather than on tying their tubes, inserting IUDs or pushing pills (Abdullah 1993).

At the same time, women are making choices about whether or not to have a child in situations of restricted opportunities for self-determination and self-assertion. Most women have to contend with satisfying their male partners' wishes and desires even to the point of detriment to their personal health. Male dominance as exerted through economic power, religious sanctions, sexism, discrimination and a climate of male social control undermines women's rights as human beings to exercise control over their bodies. It is partly through economic equality that these wrongs can be righted.

One of the more important conclusions based on this study was that contraceptive education targeted at working-class women who are not necessarily literate or literacy-friendly needs to be appropriately and effectively transmitted. Materials should lean towards audiovisual rather than written media. Materials translated into languages other than English would greatly help many working-class women. Counseling sessions need to be more thoroughly and efficiently managed especially in family-planning clinics so that contraceptive methods are fully understood as to effectiveness and use. This may help reduce the abortion rate as well as the repeat abortion rate (having more than one abortion in a reproductive career).

Along the same lines, it might also be advantageous and empowering to women in general and to working class women in particular to have discussion groups organized around contraceptive and sexuality education. In educating women around their bodies, this exchange between women and health providers may prove invaluable in needs assessment regarding pregnancy termination service provision and, at a higher level, may shift the focus to a bottom-up approach in government implementation of family planning policies. Sex education in schools also needs to be promoted.

At the structural level, there needs to be a change in the laws regarding abortion. For although the law as it stands has been liberalized in recent years, it remains vulnerable to attack by religious fundamentalists and political conservatives. Not only do the rights of women need to be strengthened by laws advocating women's right to abortion on request but there also needs to be a reframing of abortion in terms of women's health and reproductive choice. Access to clinical abortion at present is dependent on the whim of doctors who are perhaps motivated by profit, feminist ideals, medical integrity or some combination thereof. What is really needed is a clear statement of what women are entitled to under the law so that no ambiguity remains regarding their rights. Without laws stating what is legally guaranteed women can never be completely certain of what they are entitled to. Some Malaysian doctors may state that abortion is illegal and refuse to perform them out of moral concerns. In actuality abortion is legal under restricted conditions and doctors have been granted quite

some discretion in performing them. Rewriting laws so that decision-making power is given to women is therefore extremely important.

## CONCLUSION

From the previous exploration of women's experiences, narratives, and reasonings with respect to abortion, some relevant conclusions may be made. The decision to abort, while not traumatic in many cases, is mediated by informational counseling. Other mediating factors include the use of the ultrasound scan to confirm fetus size and conformity with religious prescription, the degree of attachment to the fetus and the degree of support obtained for, and unambivalence with, the decision itself. Moreover, for some women with moral opposition to abortion, the decision may involve conflict or ambivalence. However, the focus of women themselves appears to be on regaining their health so as to being able to perform their duties and functions as wives, mothers and workers.

Malaysian women exhibit a range of reactions to their experience both before and after their pregnancy terminations. Personal narratives of the women themselves illustrate the many cultural constructions, experiences and reasonings for having abortions. Pragmatic reasons for pregnancy termination appear primary in the decision-making process. The crisis is not a moral one. Rather, it pertains to how women can fulfill their roles and responsibilities as wives and mothers under changing family conditions.

While social conditions have changed rather dramatically especially for women working outside the home, patriarchal attitudes have not. Lack of childcare seems a particularly salient concern for working-class women who face an unfriendly childcare situation both at work and at home. Women are held responsible for the preservation of family stability and family honor, and for selecting the type of intervention needed to preserve both.

In this study, women have aptly demonstrated their willingness to abort pregnancies when the quality of their lives and the lives of their family members has been seriously compromised. They have talked of the complexities involved in making these decisions and have even overridden religious proscriptions against such actions for the better interests of their families and themselves. Rather than viewing abortion as a life crisis, women (and some men) see decisions regarding abortion as an added responsibility tagged on to the role of wife, mother and worker in a society where family roles and women's roles in them are changing.

## ACKNOWLEDGEMENTS

I am deeply grateful to Dr. S. P. Choong, without whose assistance the study upon which this article is based would not have been possible.

## NOTES

- <sup>1</sup> The Malay word "lah" is appended at the end of sentences for emphasis much in the same way the word "eh" is appended on to sentences in Canadian and Australian English.

## REFERENCES

- Abdullah, Rashidah, 1993, "Changing Population Policies and Women's Lives in Malaysia," *Reproductive Health Matters* 1 (May), 67-77.
- Asnes, Marion, 1994, "Birth Control Over 30," *Working Woman* (July), 69-72.
- Chira, Susan, 1994, "Women Campaign for New Plan to Curb the World's Population," *New York Times* (International Pages) (Wednesday April 13), A1, col 2.
- Editorial, 1994, "Ketegangan Punca Keganasan," [Stress as the Source of Abuse] *Utusan Malaysia* 80 (April 5), 6.
- Federation of Family Planning Associations of Malaysia, 1993, *Consolidated Strategic Plan (March 5, 1993)*, Penang, Malaysia: FFPAM Draft.
- Jain, Anrudh K., 1981, "The Effect of Female Education on Fertility: A Simple Explanation", *Demography* 18(4) (November), 577-95.
- Kamaluddin, Siti Fathilah, 1995, *Women's Experiences of Abortion in Urban Malaysia*, Ph.D., University of California, San Francisco.
- Kamaluddin, Siti Fathilah, 1997a, "A Profile of Women Seeking Pregnancy Terminations in a Clinic in Urban Malaysia," *Malaysian Journal of Medical Sciences* 4 (1), 59-70.
- Kamaluddin, Siti Fathilah, 1997b, "Cultural Constructions of Abortion," *Akademika* 51 (July), 77-93.

Ong, AiHwa, 1987, *Spirits of Resistance and Capitalist Discipline: Factory Women in Malaysia*, Albany NY: State University of New York Press.

Rahman, Fazlur, 1987, *Health and Medicine in the Islamic Tradition: Change and Identity*, New York: Crossroad.

Shaklee, Harriet, and Fischhoff, Baruch, 1990, "The Psychology of Contraceptive Surprises: Cumulative Risk and Contraceptive Effectiveness," *Journal of Applied Social Psychology* 20 (5), 385-403.

Stacey, Judith, 1990, *Brave New Families: Stories of Domestic Upheaval in Late Twentieth-Century America*, New York: Basic Books, Inc.