Contraception: Let it be a Women's Choice

By Rahat Fahmida

WOMEN'S health and reproductive rights has for long been everyone else's business other than theirs. This is especially so in this country. Population control policies of recent years have resulted in harm to the health of many women and children. For the birth control movement to become a popular cause that reaches people of all classes, it should result in the self determination of women through increasing the real choices they have in contraception. Contraception choices would however be insufficient without making the birth control programme a part of an overall programme of good medical care, education, primary health care facilities, respect and equal opportunity for all women. *The Daily Star* talked on this vital issue with a well-known social scientist Dr. Sajeda Amin. She has for long worked on related issues and is now a research fellow with Bangladesh Institute of Development Studies (BIDS).

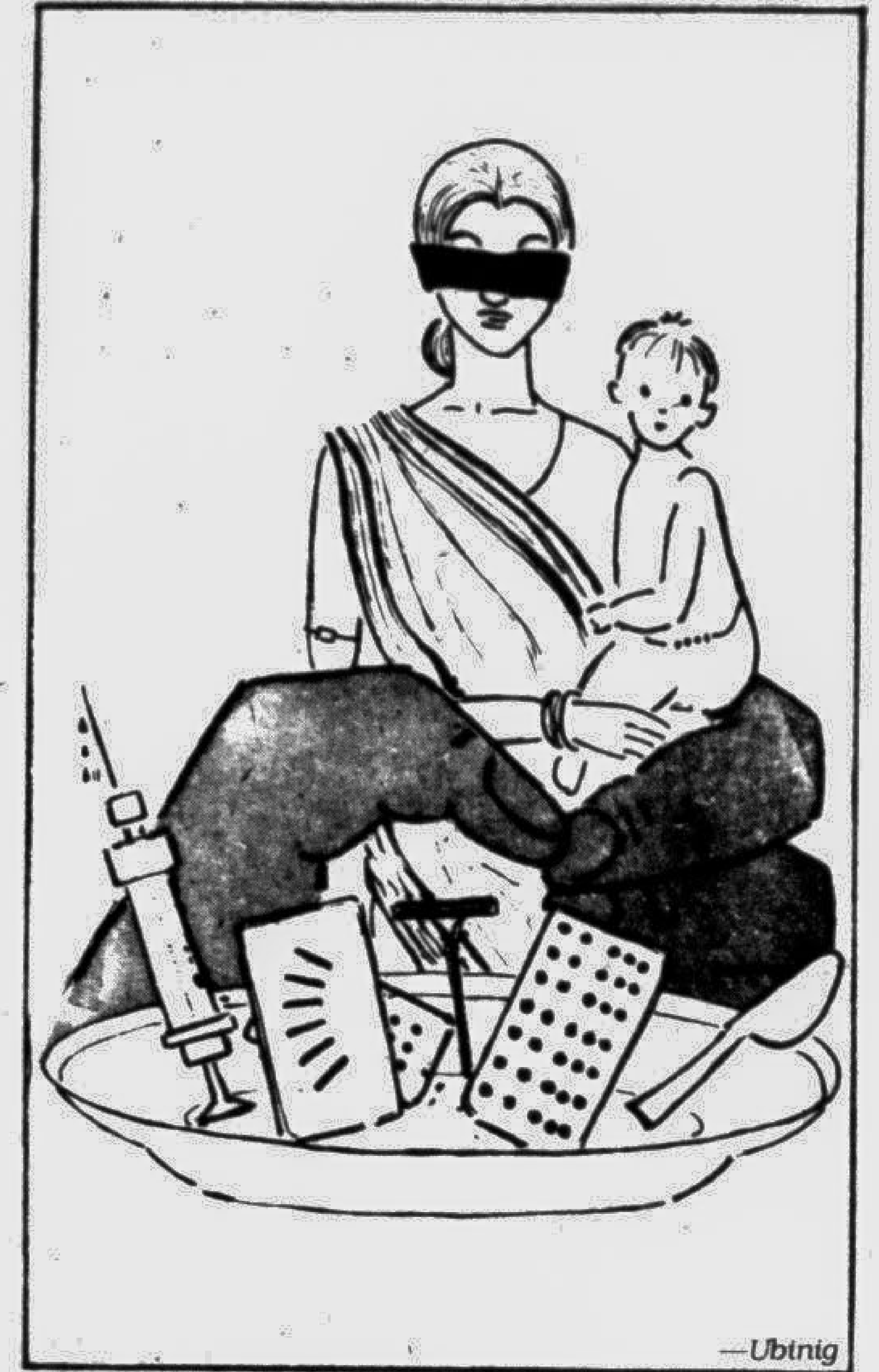
Talking about whether contraceptive policy or the theory of contraception is quite a recent phenomenon in this country, Sajeda Amin said, that most of the contraceptives that are in use today were discovered in the past 40 years. To that extent birth control with aid of modern contraception is a relatively recent world phenomenon. The practice of controlling births through more traditional methods of abstinence and withdrawal dates back hundreds of years. The demographic transition began in Europe more than 200 years ago, and quite a lot was probably known about birth control even in medieval times.

There has been a prejudice that this notion is confined to just one particular class of our society. Reasoning this theory the social scientist of BIDS said, "The vast majority in our part of the world lived under conditions of natural or uncontrolled fertility with average umber of children born to women around seven births in a lifetime as late as the 1970s in Bangladesh. A very small number of urban, educated women began controlling their reproduction more than a generation ago, meaning around the middle of this century. However, they were too few in number and did not make a significant impact on overall fertility.

"The fertility decline that has occurred in the last 20 years, has taken place across the board. Fertility decline is not significantly differentiated by class or education level."

Explaining briefly, what would it take to go into an appropriate at the same time integrated family planning programme — reaching the majority, she said, "Since the decline in fertility has been undifferentiated by class there is no apparent reason to think that fertility control per se requires any modification. There are large differences by class and education in the type of contraception used. Poor women are more likely to be sterilised while the use of the pill and condom is more prevalent among educated women. Programmes would do well to increase the use of the pill and condom in general — these will require ensuring access to supplies, education for proper use, and greater cooperation from partners (in the case of condoms or other barrier methods)."

Clarifying the notion about the impact of education on these crucial issues, Sajeda Amin said that most studies show, women with at least primary level education have


—Ubinig

lower fertility. Since that level of education for women is still a privilege that very few women enjoy, and education is highly associated with income and social status, the apparent influence of education of fertility is probably exaggerated.

On the other hand, isn't the religious biasness an obstacle? To this she said, "Some degree of influence is exerted by anti-contraceptive sentiments among religious leaders. In general, I do not see resistance from religious factions as a major impediment to the programme. This is probably because contraception is seen as a tool for population policy and not as a means of giving women greater control over reproduction. Population control is probably seen as a desirable social goal by religious leaders; the emancipation of women is most likely not an end that traditional circles will condone."

We know too well, that contraception in most cases is targeted to women. Sajeda Amin reassured this theory, "Yes, the methods that are most common are those used by women. Use of the condom or vasectomy are much less popular. However, men still retain control over the process of birth control in the sense that most women cannot use contraception without the approval of their partner."

Talking about whether the decision to contracept is imposed, this social scientist said, "The dominant ideology is to have few births — "*dui shontani jotheshto*" and that is what drives women to control births. However, it is difficult to say that this is imposed, because women do internalize the message and few women can be found to say they want large families. Women's reproductive choices are "controlled" by a whole range of factors: the state decides how much and what contraceptives are made available; families decide when a woman can and cannot use contraception and what method she uses; social norms dictate how free a woman is to seek out these choices. But that is not to say that women would opt to not contracept if given the choice."

Women in this country have very little choice regarding the pros and cons of the available contraceptives.

Advertisements are often deceptive and drug stores have no information what so ever. To this Sajeda Amin said, "an easy step to give her the choice is, to increase the access to information about health risks related to controlling (or not controlling) births.

Women's rights in terms of reproductive or any other kind of choice, and definitely control over her own sexuality, runs contrary to most of our values regarding women's place in society. What is needed is a cultural and economic revolution that will grant women equal rights and legitimate space in public and private life.

I personally think, that the first step in such a process should be the creation of economic opportunities to increase their access to and control over resources.

"There has been a move towards greater sensitivity to women's health needs in the family planning programme, but much remains to be done. Providing information about side affects and contraindications regarding particular methods, good follow up, availability of accessible and high quality health care, and finally promoting access to low dose pills and the whole range of barrier methods that are practically non-existent in Bangladesh are changing that will greatly enhance women's ability to make free and informed choices."

Noorjahan Once More—

JUST a month back, 22-year-old Noorjahan's 'suicide' that rocked the whole country has had marginal follow-up.

Immediately after this barbarious incidence, a three member team of Maleka Begum, Khaleda Mahbood and Baby Moudud, from Bangladesh Mahila Parishad went to Chatakchara village of Moulavibazaar district, in Sylhet. This organisation, which has been fighting to implement women's rights for years together, went to investigate the case, accompanied by their Moulavibazaar general secretary, Maya Dhar. After coming back to Dhaka the team along with other members organised a press conference, rally and other meetings protesting the incident and demanding immediate legal action against the criminals.

Again a Bangladesh Mahila Parishad team with one of their advocates went to the village for a follow-up of the issue. It reported on the rather slow-paced developmet in that the local magistrate in Moulavibazaar filed three cases against the local imam and five of the *panchayet* leaders of that village. One case alleges the compulsion for Noorjahan to commit suicide caused by insult and humiliation. The other on the ground of violating the law by taking the law in their own hands, which is an criminal anti-state activity. And lastly but most importantly, for repression of a woman.

On the other hand these panchayet leaders and the Imam put forward a petition for bail, but it was turned down.

Noorjahan was a prey of rivalry between Matiib, her second husband and village panchayet leaders. Their enemity was based on usual village politics regarding illegal possession of land which actually belonged to the forestry department. Matiib, as an ex-Answer personel, was courageous to revolt against this — and had enemies among the powerful group in the village. But unfortunately, his young wife had to pay the price in the cruelest manner conceivable by civilised person.

—by R. Fahmida

Sufia's Story

By Shahnaz Begum

TWENTY-EIGHT-YEAR old Sufia is from Gopalganj district. The mother of five decided to use a plastic coil as a permanent birth control procedure. The couple had no information whatsoever about the pros and cons of the procedure. They forgot all about the coil a few days after it was inserted — assuming it had "fallen out."

Five years later, Sufia developed a reddish inflammation on her stomach that was accompanied by excruciating pain in the pelvic region. Sufia was eventually taken to the clinic after the quacks failed to cure it with their "traditional" methods. On examination, the doctor at the clinic said that the tumor(?) would be cured by extraction of pus by an incision.

During the procedure, the doctor noticed something whitish under Sufia's skin and pulled it with mosquito forceps. Out came the plastic coil, accompanied by a flood of pus and contaminated blood. Sufia was immediately sent to the Sadar hospital for treatment and died en route.

Sufia might not have accepted the system if she had had sufficient information about the dangerous side effects of the procedure. She had a right to access to such information. But Sufia is not a rare case, women are generally not being given sufficient correct information about the procedures available to them from the authorities.

Every person has the right to know about anything that could harm even a thousandth of his or her body, as they do, about birth control procedures. The purveyors of these procedures know far more about the pros and cons than the average person — the end user — does. Therefore, it's the moral duty of the suppliers of these procedures to fully inform the users.

The field (?) of Bio-ethics has grown up around the concept of information on things that could harm a person's body and full disclosure of that information. There are two facets to Bio-ethics:

(a) Providing sufficient information about a procedure to the person it is going to be applied on and ensuring that the person is not provided with wrong or misleading information.

(b) Informing that person on the technical status of the procedure, i.e. informing the person if the procedure is experimental, fully researched, or ready for safe application on humans.

Bio-ethics also involves application of a procedure on a person after an assessment of that person's physical condition and his or her express permission to do s . The rules of Bio-ethics were not followed in Sufia's case. In addition, medically a woman may not use birth control methods if she has any of the following six conditions: high blood pressure, anaemia, a heart condition, ulcers, jaundice, and diabetes.

Statistically, 60 per cent of this country's women are anaemic. In addition birth control methods have been formulated for Western women, who have different health profiles and who weigh more than 120 lbs (55 kg). These methods are wholly inappropriate for the poor, malnourished, and generally unhealthy "Sufias" of this country.

Women of this country are generally less health conscious and some don't even have the general common sense to consider the pros and cons of any general issue. They are set upon by the steam roller of birth control under such conditions, unaware of any alternative birth control methods. These Sufias accept birth control without any physical check-ups in the hope of creating a stable family. In most cases, these women are encouraged to accept birth control to fulfil government quotas.

Not all women who accept these methods without sufficient information and safeguards end up like Sufia. But almost all methods have temporary and permanent side-effects. Temporary side-effects include: headaches, vertigo, nausea, irregular menstruation, vaginal inflammation, and heart palpitations. Permanent side-effects include: reduced breast milk, breast cancer, hereditary infertility, anaemia, weakening of the optic nerves, etc. It is not that the government and non-government officials are unaware of these effects but they are indifferent. In many cases, they are even unwilling to provide follow-up care to the women accepting birth control.

—Translated by Shahed Aziz

Diary of a Working Mother

By Shaheen Anam

OF all the calamity that can befall a working mother, the worse one is when a child is sick. And to add to the tragedy, she might at the same time be expected to meet a deadline at the office. She is caught between her love for the child and her professional commitment. She instinctively wants to throw the job to the wind and say, to hell with the profession. On second thoughts she knows that this is not a very wise thing to do, especially when she has to prove to the world that a woman can perform as well as the man in the professional world.

In a world where, your professional commitment is judged by the number of hours you keep at the office, women are at a definite disadvantage. The demands made on a woman, especially if she is a mother, is very unique and cannot be compared with that of a man. Without undermining a man's devotion to the family, one can safely say that a child's illness never has the same affect on the father's professional life, as it has on here. So, what does the poor mother do? First she feels guilty because the child is sick. It is her fault ofcourse, and even if nobody says it, she knows that she is to blame for it. "There must be something that I overlooked", she says to herself, "I let her play in the garden for too long" or "I did not dry his hair after bathing him" and the most common one is "I work outside, and therefore my children are neglected". After the initial self blaming, she usually attacks the crisis head on. If she gets the support of her husband and other family members that her life is made that much easier. If she doesn't than she does it alone. She takes the child to the doctor, pretends to look brave when the doctor says that the child has an acute asthmatic attack. She holds her tight even if her heart breaks and allows the doctor to puncture the little hands four times to find the vein and give the intervenous injection. She makes a stern face when the child refuses to take the bitter medicine and stays up night after night without complaining.

Yet after doing all that she manages to go to office on time and tries to perform as well, if not better, than her male colleague. Meanwhile, at the back of her mind she is also thinking of the report that she was suppose to complete. This is very important to her work and she does not want to let her boss down. What does she do then? First, she frantically starts to call her friends, relatives anyone who will come and baby-sit (this is ofcourse, if for some reason, the husband is away or is tied up some place. Fortunately our society still believes in the extended family system. There is always someone who will be willing to come and look after a sick child when mummy is away, which is very much appreciated by the working mother. She then rushes to the office and completes her assignment barely on time. The boss excepts it with a matter of fact smile, totally unaware of what she has gone through to accomplish this.

Going back to the guilt factor, society makes the working mother feel guilty in many overt and covert ways. A slight remark, an unintentional suggestion, is all that is needed to make her feel that she is responsible for all the ills that befalls the family. The reason ofcourse is because she works outside the home. People very casually cite the example of the West and say "look at what is happening to young people of that society because the mother is too busy building her career." This is obviously a very simplistic analysis of the problem. There is absolutely no data or research to prove that working mothers' children are worse off in anyway than children of mothers who do not work outside the home.

There is also a perception among many that mothers, who do not opt for a career to take care of her children, are better mothers and are more devoted to them than career mothers. Well, I just want to say that this is an unfair and cruel statement about us. We love our children just as much. Their pain and discomfort tears at our heart just as anyone else. Leaving a sick child at home and going to office is not something a working mother enjoys doing. She has just opted to take on the challenging role of being a good mother and a good professional too. To accomplish this, she needs the support of everyone, her husband, children, friends and colleagues.

Women's Health in Bangladesh and Role of NGOs

By Dr. Sadia Afroze Chowdhury

WOMEN in our society have always taken a self sacrificing role with her needs and health coming last and being of the least consequence — a role accepted and passed on from generation to generation.

Let us go through the stages of a women's life. A female offspring like her male sibling has a high probability of being born with low birth weight. A World Bank study states that over 30% of babies in Bangladesh are born with weight below 2500 gms (the cut off point for normal birth weight). The health parameters of this country suggest that infant mortality is greater in male infants. However, child mortality is greater in girls and women have a slightly lower life expectancy. In the first five years of life, more girls are seen to suffer from third degree malnutrition than boys. So in effect an infant's reproductive health starts in utero.

Role of NGOs

NGOs operating in Bangladesh are large in number and varied in activities. Officially, any organization ranging from sports clubs and cultural groups to those addressing poverty of the people, registered with the Social Services Department under the Social Welfare Ministry of the government, is usually termed as NGO. The current number of such NGOs stands at over 13,000 out of the nearly 5 per cent receive funds from foreign donors for health related activities. They have earned a reputation in extending support and services to the poor at the grass-roots level.

However, some NGOs have been known to undertake "special" programmes, specifically in the area of health and family planning. To ensure an effective delivery of health services and family planning to the poor, the NGOs have either strengthened the existing health care system or have developed appropriate institutional structures and mechanisms. Some NGOs have developed the system of providing health and family planning services to the poor through outreach centres, while some others have directed their efforts towards providing such services through static centers. These "special" programmes of NGOs have, in fact, developed systems and institutional structures for creating a sustainable health care system at the community level through people's participation.

Contributions of Gonoshasthya Kendra, Radda Barnen, BAVS, Concerned Women for Family Planning, Bangladesh Family Planning Association, BRAC, CARE, and BPHC supported organizations in providing maternal and child health (MCH) and family planning services are noteworthy.

NGOs are generally engaged in community based distribution type of activities, but a few of them are carrying out specialized functions. Bangladesh Association for Voluntary Sterilization (BAVS) has focused its activities on surgical contraception; Family Planning

Association of Bangladesh (FPAB) in addition to offering surgical contraception services have also evolved effective ways to make available the other methods of contraception; Bangladesh Association for Maternal and Neo-natal Health (BAMANEH), Bangladesh Association for Prevention of Septic Abortion (BAPSA), Bangladesh Women's Health Coalition are involved in MR and prevention of septic abortions, while other organizations are mainly engaged in primary health care, maternal health care and child survival services, training and universal child immunization. The Swanirvar family planning project, which focuses on community development through self reliance works primarily in rural areas.

BRAC has emerged as the largest national level NGO with over 5000 full-time staff. Family planning service delivery was a definite focus of the programme in the early 70s. But it has expanded its horizon further to the development of cost effective programmes of service delivery in primary health care, rural development and income generation activities specially for women and education, and its contribution in these field is well known. Many of its programmes have been replicated elsewhere in the country, and BRAC has provided technical assistance to the Government in pertinent areas.

Ganoshasthya Kendra (GK) began operations in Savar, close to Dhaka, in 1971, and over time has spread to other parts of the country, besides providing varied technical assistance to the government. Its primary focus has been the development of an integrated low-cost and sustainable health care system in Bangladesh, catering to the rural poor, and run mainly through para-professionals and TBAs from the local community. Besides medicare, provision of family planning services at the doorstep of the masses is a major element of the project. Income generation activities of women have also been developed in the process.

The Concerned Women for Family Planning (CWFP) has emerged since its inception in the mid 70s as a major NGO providing reproductive health services besides family planning and child health and immunization. One of its initial programmes was in the area of menstrual regulation (MR) and surgical contraception reflecting great unmet demand. This however had to be discontinued due to funder/resource constraints.

Bangladesh Women's Health Coalition (BWHC) provides high quality, comprehensive reproductive health care at reasonable cost. Founded in 1980, the BWHC operates six clinics in low-income neighbourhoods in urban and rural Bangladesh and serves 75,000 women and their children annually. Services include counselling, contraception, menstrual regulation basic child and women's health care, antenatal and post-partum care. Low overhead, high volume, and multiple services make BWHC's high quality care inexpensive. BWHC clinics, however, can serve only a small fraction of the women in need.

This reveals that to date the major focus of the NGOs has been on the delivery of those family planning/contraceptive services which have been approved by the government. Education as well as counselling have also been incorporated into the programme to some ex ent. However one has to remember that NGOs serve approximately 10% of the population. Therefore these services have to be made accessible and available to the larger percentage of people. In addition increased emphasis needs to be given on the male methods, and on the necessity of comprehensive services i.e. catering to the needs of the woman as a whole.

Besides this, there is the advocacy role that NGOs have played competently in several fields. I probably is for the NGOs to be innovative and generate a more thorough definition of reproductive health — women and men included, define the roles and responsibilities of each, and determine the interplay of other factors such as the community, the family, the peers, service providers, researchers, managers and advocates in this and, finally provide a platform on which all could meet.

This article is an abridged version from a paper prepared for the Annual National Convention on Reproductive Rights and Women's Health at Dhaka.

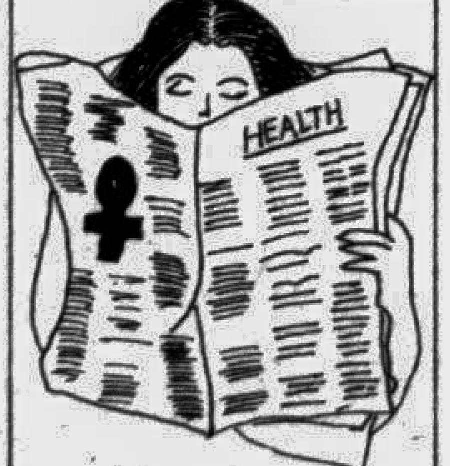
What is Reproductive Health Care?

It is comprehensive, providing:

- Education on sexuality and hygiene;
- Education, screening and treatment for reproductive tract infections, and gynecological problems resulting from sexuality, age, multiple births and birth trauma;
- Counselling about sexuality, contraception, abortion, infertility, infection and disease;
- Infertility prevention and treatment;
- Choices among contraceptive methods, with systematic attention to contraceptive safety;
- Safe menstrual regulation and abortion for contraceptive failure or non-use;
- Prenatal care, supervised delivery and post-partum care;
- Infant and child health services.

It is high quality:

- Treating clients with respect and compassion;
- Following them up.



It is premised on informed choice:

- Providing full information;
- Encouraging continued use of services, rather than just initial acceptance.

How can it be implemented?

By building on existing programmes through:

- Revised staff training content and procedures;
- Intensified staff supervision and modified reward systems;
- Additional services to ensure choices, safety and effectiveness

By expanding available resources through:

- Collaboration among programmes;
- Public education and advocacy to broaden political support.

SOURCE: Population Control and Women's Health: Balancing the Scales; Germain A, Ordway J.

Corrigendum

The designation of Maleka Begum was misprinted as the General Secretary of Bangladesh Mahila Parishad. It should have been ex-general secretary. The error is regretted.