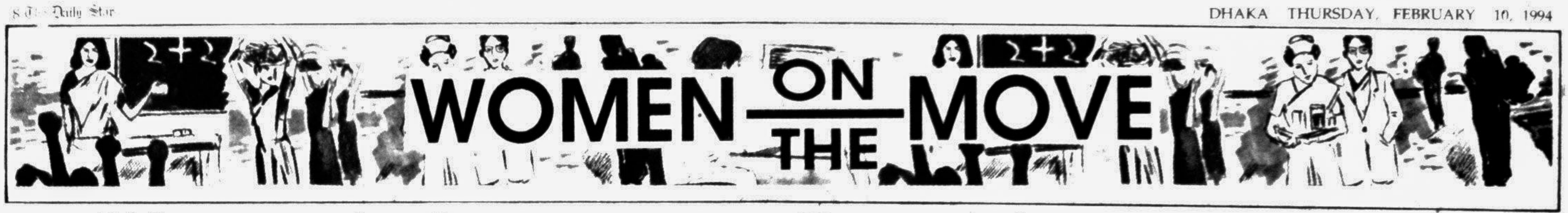

Women's Status and Reproductive Health

Courtesy RDRS

Reproductive health is becoming an integral part of health culture in its full significance of physical, mental and social well-being. This implies that people have the ability and choice to reproduce, to regulate their fertility and to have sexual relationship free from the fear of unwanted pregnancy and from contracting diseases.

Thus major elements of reproductive health include, safe motherhood, practice of family planning and management of infertility. To make reproductive health care provision most effective, one needs to understand the need for good quality care, coverage of the segments of population who need the care most and that the care should be based on the perspectives of the people being serve. Given the importance of the issue, The Daily Star brings out this special feature.


একদা ছিল কোমরে বিছা, বাজুতে বাজুবন্দ
এখন সুঁই, লাইগেশন, এবং নরপ্লান্ট--

Courtesy UBINIG

Implications of Women's Economic Roles for Their Health

by Simeen Mahmud

IN Bangladesh women's reality is in sharp contrast to that of women in most contemporary populations, with the exception of other South Asian nations excluding Sri Lanka. Relative to men, women experience a lower life expectancy. Women are exposed to higher mortality at all ages, including during the neo-natal period, and possibly greater morbidity as well, particularly from STD's, are subject to unacceptable maternal mortality and morbidity levels, and face greater undernutrition during childhood and young adult ages. By and large, these gender differentials in health and wellbeing may be linked to gender specific behavioural and investment strategies of households in terms of food intake relative to requirement, in the utilisation of public health and other services and in the allocation of household resources among family members.

Impacts of Women's Economic Activity on Wellbeing

Here, wellbeing is operationally defined as the capacity to be healthy and well nourished, to have healthy and well nourished children, to be able to regulate childbearing and to have a say in deciding the number of offspring. Research to date on the relationship between women's economic roles/activities and their wellbeing, as defined here, has identified two main pathways of impact on the above mentioned behavioural and investment strategies. The first is through the effect on women's direct access to material and non-material resources and the second is through the effect on women's time use patterns, both of which are variously shown to influence decisions and behaviours affecting health care utilisation by family members, child care practices and investments on children, fertility regulation (both spacing and limiting) through birth control, intra-family consumption and food allocation, and so on.

> Even if women have sufficient direct access to resources, the positive impact on wellbeing is constrained by the fact that, in general, women's economic activities cause them to suffer from excessive total work loads which can be further aggravated by participation in market work. This has a negative impact on both their own and their children's health.

Women's independent productive work has the potential to reduce their dependence on male kin by providing them direct access to resources and alternative sources of support and social identity. This may enhance women's capability to influence and implement decisions affecting their wellbeing and that of their children. Women in general are seen to allocate a higher proportion of their resources (both time and income) on subsistence consumption including food, housing and health care, especially of children and the elderly, relative to men. More specifically, women engaged in paid work, particularly outside the home, are more likely to regulate childbearing, seek medical treatment or terminate relationships that compromise their wellbeing.

Even if women have sufficient direct access to resources, the positive impact on wellbeing is constrained by the fact that, in general, women's economic activities cause them to suffer from excessive total work loads which can be further aggravated by participation in market work. This has a negative impact on both their own and their children's health and wellbeing by restricting their leisure and childcare time and by limiting the time available for accessing public health and family planning services. For example, inspite of having access to incomes through paid work, there are situations where maternal employment is associated with higher infant and child mortality and greater undernutrition of children.

While economic activity generally (though not always) provides women with a resource base, the greatest benefits to women, for example, in terms of regulated childbearing and increased expenditures on health care and food, accrue when they are able to directly control those resources. Similarly, the impact of paid work on women's own health and wellbeing and on child welfare largely depends on whether women are able to make income and time investments that are beneficial to them. The identified pathways of impacts are, therefore, mediated by powerful institutional forces that govern women's access to resources and the pattern of their income and labour investments.

Women's Participation in Productive Work

Clearly, women in Bangladesh perform their economic roles not only under situations of pervasive poverty and the absence of basic infrastructure, but additionally in the face of deeprooted inequalities in the gender relations of prestige, power and control over resources. In these conditions, women's economic activity, including market work, may do little if anything to enhance their voice in decisions that affect their health and wellbeing, or strengthen their capabilities to implement their own preferences regarding the utilisation of their income and labour resources.

When resources generated from women's economic activities are needed for meeting family consumption requirements, there is little option for investments in their health and wellbeing. Again, where women are already over burdened with domestic work, largely due to a lack of basic amenities like water and fuel but also due to gender stereotyping of domestic tasks, there is very little time to invest in accessing health and other services.

The above discussion suggests that policy approaches which treat women's productive work, especially paid employment, as instruments to increase their control over the investment of their income and time resources without incorporating the larger institutional context are inadequate. What is needed are strategies for strengthening women's capabilities to take into account their own needs for health and wellbeing. These may include the formation of new relationships and alliances centered around women's economic roles that enhance self-esteem and self-efficacy, access to independent information and peer support, and physical mobility. Experience indicates that such relationships enhance women's ability to weigh their own wellbeing relative to family size preferences, the health needs of their children, birth control preferences, and their own labour inputs.

In addition, strategies to increase women's participation in market work as a means to delay marriage and childbearing in order to reduce fertility levels, needs to pay attention to raising their skill and productivity levels if such work is to be socially and economically rewarding. They must also address the need to reduce women's total work burden, particularly their obligation to fulfil basic domestic responsibilities such as housework and childcare, both through increasing their access to basic services (clean water and fuel) and through creating awareness about the need for men to take more responsibility.

The writer is Research Fellow at BIDS.

Women's Perspective

Health Services and Quality of Care

by Sajeda Amin

Women's demands for health in general and reproductive health in particular are best understood as essential components of their demands for human rights. Access to health, freedom from disease and access to contraception are basic needs.

Yet, women's advocates and Family Planning programmers have traditionally been at loggerheads. The principal reason is that demographically driven, target oriented programmes are not respectful of women's rights and generally disregard their reproductive health needs. These are dangers inherent in programmes that are narrowly focussed on population and fertility control where women are treated as the subjects of fertility control.

This article will try to articulate women's demands with regard to health and hence their claims on family planning programmes in somewhat more positive terms. The Bangladesh Family Planning programme which after years of low performance has finally attained some success, owes much of its success in increasing contraceptive use to increased sensitivity to women's needs — the programme tries to emphasize choice, it has removed targets for workers, and most importantly, it employs a large cadre of women as its frontline workers. This should be a strong motivation for the programme to evolve further in this direction.

Yet, except for increasing contraceptive use, most other statistics indicate very poor health status of women in Bangladesh. Women have lower life expectancy than men. Maternal mortality rates are the highest in the world. Of all maternal deaths, 25 per cent are from preventable causes of hemorrhage, sepsis, toxaemia, abortion and obstructed labour. Although data are scant, there is evidence that reproductive tract infections are very common and usually go untreated.

Yet women's access to any kind of health care is primarily through either family planning or maternal health programmes. Women's health needs extend beyond their need for contraception and safe motherhood to freedom from malnutrition, hazards of domestic and industrial work and the threat on non-reproductive diseases. To adopt a holistic approach to health some immediate programmatic changes should be made.

Access

There is an urgent need to rethink home delivery strategies by adapting and modifying services but also by recognizing its limitations and preparing for contingencies when women will need to avail more sophisticated services.

Improving Client-provider interaction

Three critical issues in client-provider interaction in any setting are information, respect for the client and technical proficiency of providers. Providers in family planning and health care need to be sensitized about the need to provide information on side-effects, contraindications and risks as well as alternatives to the medical procedures a client is subject to. They need to be sensitized about the dangers of medical paternalism (doctor knows best) and encouraged to be sensitive to client needs — even when they may not seem legitimate. It is important to remember that perceived negative impressions about a contraceptive method can be as strong an impediment to proper use as real ones.

Choice

Closely related to the issue of quality is the matter of choice. It is now well-documented that there is substantial individual variation so that not all contraceptive methods are suitable for all women — variation ca occur due to age, living conditions, lifestyles and workload.

Infertility

Family Planning should include services to address issues of infertility as well as for fertility reduction. There is little data on the prevalence of infertility in Bangladesh.

Reproductive Tract Infections (RTI)

In general, health and family planning services are woefully inadequate in terms of preventing and treating reproductive tract infections. Yet RTIs are the major cause of morbidity in women of all ages — all the circumstantial evidence indicates very high prevalence even though there have been few studies to document prevalence.

To conclude, I turn back to the need to emphasize reproductive health in advocacy for women's rights. Women face special health risks which, in the context of Bangladesh, has led to higher female mortality and even to reduced capacity to work in certain capacities. In the absence of good health services women will continue to be severely disadvantaged in terms of their physical capacity to carry out their other responsibilities. Access to good reproductive health services is essentially a mechanism for providing equal opportunity to women.

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Women's Demands and Population Control

by Farida Akhter

WOMEN'S demands to have control over their reproductive functions have largely failed when this demand has been used as the mechanism to achieve population control goals. The population control goals are basically coercive apart from being grounded on racist foundation. They turn people of flesh and blood into "population", a dehumanised term to imply numbers only, a necessary ideological construction to dispose and terminate the "unwanted". Women's demands are contrary to such depopulating strategies. In the context of the overwhelming power of the population controllers to control the fertility of women the struggle for "reproductive freedom" must in essence be the struggle against population control.

The only common thing among all women, whether they are rich or poor whether they are black or white, is that they bear children in their bodies. So in principle, control over reproductive functions means the ability to have control over their own bodies. But this demand has become an abstract demand and in fact means differently according to socio-economic class differences of women. Decision of a woman with regard to her fertility is determined by her position within the family and the society. Women's reproductive functions therefore can not be reduced into the functions of uterus. They are social and political functions as well. This is well understood even by the population control establishment. Therefore, they have started talking about "raising status" of women. The result of the "enhanced status of women" of course must be to reduce the number of children they bear. In the context of the International Conference on Population and Development (ICPD, 1994) women's role has been given too much importance only for achieving a "successful" population programme. Racism is now hiding into a feminist mask.

The so called "special attention to women" is also seen by progressive women's movement as a form of cooptation of the language and demands raised by women in different countries. This issue was raised very seriously in the international symposium on People's Perspectives on "Population" held in Bangladesh during December 12-15, 1993. Women from Europe, America, Latin America, Africa, Asia and Pacific countries expressed their concerns that the population control agencies are coopting the language and their demands to confuse women's movement. In the Declaration, it was stated as the following:

These agencies (USAID, Population Council, Rockefeller and Ford Foundation, UNFPA, WHO and various pharmaceutical agencies) are now attempting to set the agenda for women's movements and organizations by co-opting their language — and individual to legitimize population-control policies. Although this co-optation plays a very divisive role and confuses issues, many women around the world are resisting this".

Women from around the world felt that this co-optation must be confronted and real issues of women must be brought forward. The agencies which are now talking about women's rights are also those, who violate women's rights by imposing on them harmful contraceptives, destructive economic models, militarisation etc. While women's right to decide and choose safe and effective contraception is recognised in their rhetorics. We find that they promote more and more provider-controlled, aggressive and unsafe contraceptive methods. Women reject provider dependency on such important matters of their life. Specially this provider dependency becomes more dangerous when the government follows a demographic driven policy under which women in the poorer class become the direct victim. Their bodies are only seen as the means to achieve such goals with the use of technology which are controlled by the family planning agencies. Coercion is now inbuilt within the technology. IUDs, hormonal injections and implants, like norplant are some of the example of technological coercion, apart from the coercion taking place in sphere of service delivery.

Lastly, I would like to quote from the Declaration of People's Perspectives on "Population" symposium, where women have denounced the possibility of any feminist population policy, as it violates and contradicts the basic premise of feminism. Their demands were articulated as the following:

- *"Women's basic need of food education, health, work, social and political participation, a life free of violence and oppression should be addressed on their own merit. Meeting women's needs should be delinked from population policy including those expressed as apparent humanitarian concerns for women. Women should have access to safe contraception and legal abortion under broader health care. These needs can only be met if all life is respected and accorded dignity. We demand an end to exploitation of people and the earth"*

The writer is Executive Director UBINIG a leading NGO

The Law of Inheritance

Implications on the Status of Women

by Salma Sobhan

IT should be understood that the passage in the Quran on which the Law of Inheritance is based is (in translation) only about 23 lines. Thus as has been observed "Although there are perhaps more Quranic regulations on inheritance than on any other single legal topic, these regulations are in no sense comprehensive". This has meant that the whole of the Law of Inheritance, which is a highly complex construct has been built up on the basis of interpretation based on the Quranic texts. When one talks, therefore, of "changing" the law one is referring to the interpretations of the law and obviously not to the texts. In this context it is worth noting that even though a verse of the Quran specifically gives a widow a year's maintenance "Ye shall bequeath your widows a year's maintenance without causing them to leave their homes" the application of this verse has been held by jurists to have been abrogated by the subsequent provisions made in the Quran for a widow to inherit a fixed share of her husband's estate.

The Quranic Heirs

In pre-Islam Arabia "the succession was confined to male agnate relations" The Quran mentioned and fixed shares for 12 new categories of heirs. 8 of these were women, of the 4 males one was non-agnatic (the uterine brother) and 2 were agnates who were excluded by a son of full age (the father and grandfather of the deceased) and lastly the husband.

Equality of Claim

Because of the text concerning provisions for children which says that "A male shall have as much as the share of two females" it is generally believed that males always inherit twice the share of females but this is not so. The uterine brother and sister inherit equally, so do the parents of the deceased if s/he leaves a father and a mother. Thus it is clear that where the male is given twice the share of a female the logic behind this is functional rather than judgmental. This point is made because when the estate is divided the brother's greater share is treated as giving him a better claim to his parent's estate which, of course, has not only no legal justification but also no mathematical justification (a brother only has twice the share of one sister not of all sisters together; therefore while one brother would get 50 per cent of the parental property if he also had two sisters, if he had three sisters he would only get 1/5 of the property while each of his three sisters would get 1/5 each). In fact the text above cited goes onto say that "and if there be women more than two, then theirs is two thirds of the inheritance and if one (only), then the half". The contradiction between the first part of the text and the second was resolved by the jurists by assuming that the second part of the text would only apply in the absence of any sons. It could possibly have been resolved in another manner.

> One of the factors contributing to seeing a son as more important than a daughter may be the fact that a son is seen to inherit twice a daughter's share.

The Collaterals' Entitlement

The rule by which the deceased's daughters cannot inherit their parents entire estate in the absence of a brother but have to admit the claims of an uncle or cousin is a rule that is purely based on the decision to treat the Quranic regulations as an "amending at" to the pre-Islam Customary law (which is what the Sunnis do) rather than to regard the Quran as laying down the basic elements of an entirely new legal system which is what the Shiahs do. "Any rule of customary law which was not expressly ratified in the Quran was tacitly rejected. And therefore because the Quran nowhere expressly ratifies the preeminent claims of the male agnates, as such, to the inheritance they have no privileged position".

Excluding the Collaterals

It is therefore possible to lay down that where a deceased person leaves behind as heirs only daughters, these daughters will inherit the entire parental estate (without prejudice, of course, to the rights of the other Quranic heirs). Such a law was passed in Iraq many years ago.

The Law Relating to the Bequeathable One Third

A testator has the freedom in traditional law to make bequests of upto 1/3 of his/her property but only in favour of someone who is not already an heir (a friend, a niece) In Sudan, Egypt and Iraq a testator was given the freedom to make bequests to whomsoever s/he wishes upto the 1/3 limit. This freedom could be incorporated in favour of females into the law here. These two changes would, it is felt, have the effect of improving a woman's status, reinforcing family planning policies and remaining within the parameters of the Law of Inheritance.

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