Title
Women's experiences of abortion in urban Malaysia

Author
Kamaluddin, Siti Fathilah

Publication Date
1995

Peer reviewed|Thesis/dissertation

WOMEN'S EXPERIENCES OF ABORTION IN URBAN MALAYSIA

by

SITI FATHILAH KAMALUDDIN

DISSERTATION

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

SOCIOLOGY

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

ACKNOWLEDGMENTS

The research project upon which this dissertation is based was undertaken in Penang, Malaysia in June through August of 1993 and in June of 1995. I am indebted to the University of California, San Francisco's Graduate Division and the University of California, Office of the President for a Graduate Student Research Award and leave of absence respectively which made this study possible.

Thanks also go to my Dissertation Committee members, Professors Virginia Olesen, Judith Barker, AiHwa Ong and Wazir Jahan Karim, for their support and enthusiasm for this research project. In particular, my Committee chair Professor Adele Clarke was invaluable for her time and help at all stages of this study, especially via e-mail across the Pacific when UCSF seemed a world away.

In the field, my sincere appreciation goes to the clinic director where I conducted my research for opening his clinic to outside intrusion and observation and who, for reasons of confidentiality, must remain anonymous. His unfailing enthusiasm and support for his staff and clients and his commitment to women's rights in an uncertain political climate deserve commendation. My gratitude towards his staff and clients who agreed to participate in this study is unbounded since without them, Malaysian women's voices would still be silent on these issues.

Lastly, my family in Malaysia deserves a huge note of gratitude for being there with unfailing love and support. My mother, Edith, brothers, Latif and Arus, and sisters-in-law, Intan and Lean Sim, provided logistical and emotional support every

step of the way despite having differing personal convictions on my topic of study. My nephews, Simran, Sahaj and Adrian, and niece, Sabrena, made the working vacation fun into the bargain.

WOMEN'S EXPERIENCES OF ABORTION IN URBAN MALAYSIA

SITI FATHILAH KAMALUDDIN

ABSTRACT

This study describes, explains and analyzes women's experiences of abortion in a large city in Malaysia. It is limited to a single clinic sample of primarily working-class Chinese, Malay and Indian women who had abortions during a period of three months in 1993. It also describes the clinic environment in which they underwent their abortion procedures.

Some background information on the social and political climate of the country is provided as context for the study. Penang, the city in which the study took place, is a principal manufacturing site for the electronics industry. Consequently, its population has a high concentration of formerly rural Malay women who now work in urban factories. In addition, the city has a majority Chinese population.

The profile of women who have abortions at this clinic, from statistical records gathered over a six and a half year period, indicates that they tend to be Chinese, in their late twenties, married, having their first abortion, and to have used contraception in the past. There are trends towards an increasing rate of Malay women and for younger women of all ethnicities to be coming in for abortions.

Abortion constitutes a gray area both legally and socially in Malaysia. It is considered a cleansing process as well as a method of menstrual regulation. It is viewed within a contextual frame of Malaysian women being wives, mothers and workers in a society undergoing transitions in family roles and responsibilities. The

lack of access to efficient and effective contraception may result in abortion being used as the primary method of contraception by some women.

Several policy implications arise from this study. One is that there is enormous potential for educational information on sexuality and contraception to be made available to working-class women who would respond best perhaps to audio-visual educational media. Another is that counseling is a desirable option for women both pre- and post-abortion. The lack of affordable child-care resources for working-class women may also contribute to unwanted pregnancy termination. Finally, contraception itself has many pitfalls which are not publicly acknowledged and which perhaps should be.

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLES

TABLES (Continued)

1. INTRODUCTION

In a feminist utopia, a woman's body and sexuality would be hers to control. Her ability to bear children would not determine her role in life nor be subject to the arbitrary needs of the state. She would be able to assume that good health, both mental and physical, was a basic human right that would be upheld by humane state policies. In much of the world we live in, however, women's lives are subordinated to the will of a patriarchal capitalist state and the institutions such as medicine, law and religion which help uphold it.

Issues of power and control cannot be separated from the domain of women's health anywhere in the world. Abortion is one arena where the dynamics of male power and control over women's bodies are played out or, to use Foucauldian terms, where male power is inscribed upon women's bodies (Foucault 1978, 1980). Legal, medical, social and religious constraints impinge upon the lives of women in such a way that abortion on request, which most feminists and I construe as a basic human right and component of women's reproductive health, becomes thwarted.

Access to abortion in the contexts of family planning and health care in general is determined by laws, policies, public allocation of funds for service provision, and personal financial resources (Jacobson 1990: 12). In Malaysia, these dynamics affect women's decisions to terminate their pregnancies in several specific ways. First, legal restraints limit the availability of abortion. Second, the medical system limits availability through cost and aspects of quality of care. Third, religious and social

mores help shape women's decisions and abilities to terminate unwanted pregnancies.

There have been indications that the incidence of abortion has been rising over the years (Thambu 1975; Arshat 1985). In addition, the provision of pregnancy termination services at private clinics in major cities is now more visible than it was a decade ago. Why this is happening is not entirely clear and studies of the social aspects of these phenomena have not yet been undertaken.

The contexts in which pregnancy termination services are provided in each country vary. In some western countries, the morality of pregnancy termination is debated, and may even become a contestation of the meaning of motherhood which then shapes the contours of pregnancy termination service provision. In the United States, for example, pro- and anti-abortion advocates differ in their definitions of when human life begins, on how important a role motherhood is to women, and on whether ethical values such as individual autonomy or a woman's right to control her body may override other concerns. These differences in beliefs and values are derived from different socioeconomic backgrounds, philosophies and life choices. More recently, violent acts (including murder) by anti-abortion forces against clinic providers have brought these conflicts to new levels of hostility and opposition. Congealed into opposing camps and political lobbying groups, both pro- and anti-abortion forces continue to influence abortion policy in the United States (Luker 1984: 214; Petchesky 1990).

The arena of abortion rights also includes a multitude of interest groups with different concerns, such as scientific groups, family planning groups, medical groups, pharmaceutical companies, women's health advocates, politicians and government regulatory agencies (Clarke 1990), but most come down on one or the other side of the abortion issue.

In Southeast Asia, with a history of rapid population growth due especially to the need for large families to support agrarian lifestyles, to early age at first marriage for women, and to cultural, religious and other barriers against the use of effective contraceptive methods, the morality debate has been muted. It has never been taken to the level of explicitly affecting government policy decisions. Here, population growth has been attacked as a pragmatic problem to be overcome by various methods of regulation, a programmatic approach initiated by a neo-Malthusian western discourse promoting population control. This limitation of population approach was sustained at least up until 1984, when a pronatalist policy was subsequently adopted by the Malaysian government.

1.1 Intent and Scope of Study

The central question that forms the basis for this research is: What are women's experiences of abortion in Malaysia? This study seeks to discover what the experiences of abortion for a sample of Malaysian (primarily Chinese, Malay and Indian) women are, what the social constructions of abortion are and how the meanings given to pregnancy termination help structure the experiences of it in the Malaysian context.

From this central question, other questions can be derived dealing with access, availability, and the quality of care provided by health care delivery systems. Some of the supplementary questions this study seeks to answer are: Why do Malaysian women have abortions? What conditions might lend themselves to the phenomenon of pregnancy termination becoming more visible now than in the past? How do women maneuver within "the system" to gain access to pregnancy termination services when they need them? How might the concept of health be broadened to include a workable local Malaysian definition of a reproductive rights framework for women? Finally, how might workable local definitions of reproductive rights be constructed and be inclusive of ethnic (Malay, Chinese and Indian) perspectives?

One of the original aims of this study was to foreground traditional as well as modern medical pregnancy termination services. In Malaysia and Thailand, for example, herbal abortifacients as well as massage are used as pregnancy termination methods, the latter with documented success (Singnomklao 1985). Without idealizing traditional methods or maintaining that possibly unhygienic methods should be valorized equally alongside proven safe medical procedures, my intention was to foreground traditional methods of pregnancy termination as viewed as legitimate within their cultural contexts and safe when performed hygienically.

Although issues of safety and of how women assess the comparative risks of contraception versus pregnancy termination versus birth, and of cumulative risk and contraceptive choice, have been studied in various cultures (Tanfer and Rosenbaum

1986; Shaklee and Fischhoff 1990), these are not aspects studied here. This study only focuses on the abortion experiences of women using the western medical system as it exists in Malaysia.

1.2 The Research Approach

The theoretical and methodological approaches taken in this study were derived from the controversial nature of the topic itself and from my interest in it as a feminist. Abortion is a politically charged subject in the West. A recent example of such discord was seen at the 1994 United Nations Conference on Population and Development in Cairo, Egypt, where abortion funding was again the battleground between religious conservatives and pro-abortion forces. Population control policies that resulted from the Conference were still seen by most feminists as coercive and abusive to women (Reist 1995).

As a feminist, the purpose of studying in my native country was to see how abortion in a non-western setting fit with western feminist theories, if it did at all. In line with my own viewpoint, feminist approaches that claim the right to abortion as women's right and as a fundamental human right were intrinsic to the theoretical approach taken.

The voices of Malaysian women have largely been silent regarding their experiences with abortion. Moreover, the subject of abortion has rarely been studied qualitatively in the Malaysian context. These circumstances provided the incentive for an exploratory approach that would allow for 1) the voices of women to be heard, and 2) theoretical interpretations to be generated from the Malaysian context and perhaps applied cross-culturally.

Grounded theory and ethnography are two approaches particularly suited to accomplish these goals and were thus chosen for this study. The former comes from the sociological school of symbolic interactionism, the latter from sociocultural anthropology.

1.2.1 Theoretical Approach

This study takes a feminist approach toward women's reproductive health. This approach encompasses the socialist feminist view that women should have the right to decide if and when they want to continue with a pregnancy, and that state policies should support this choice (Petchesky 1990). At a broad theoretical level, abortion is only one plank of a reproductive rights platform for women. Although this is acknowledged to be a western feminist perspective, this framework is useful for it provides a starting place for development of a woman-centered approach to health care.

Despite ongoing debates between western and nonwestern feminists on what serves the best interests of nonwestern women (Alexander 1990; Akhter 1992), a reproductive rights framework was assumed in the theoretical approach taken in this study. Reproductive rights for women encompass the right to determine whether or not to have children, how many children to have, when to have them, and the right to make free and fully informed choices from a wide range of safe, effective and affordable contraceptives (Mintzes 1992: 17).

Also inherent in the approach taken was the radical feminist notion that woman-centered care should form the basis of health service provision, and that control over health care options such as pregnancy termination services should be women-

controlled wherever and whenever possible (Raymond 1989). As much as possible, an inclusion of traditional pregnancy termination methods and practices that have historically been the domain of women also informed the course of this study, although western pregnancy termination service provision was the main focus here.

1.2.2 Methodological Approaches

As mentioned, grounded theory and ethnography were particularly suited for this study. Participant observation and open-ended interviews, key methodologies of both, were the primary modes of fieldwork undertaken.

1.2.2.1 Grounded Theory

Grounded theory techniques based on the work of Glaser and Strauss (1967) and Strauss and Corbin (1990) were used in sampling design, data collection, analysis and interpretation. "Such techniques are especially useful in providing information about phenomena that have not been subjected to much formal investigation, and about which little is known. They are also appropriate for the illumination of basic social and psychological processes" (Sandelowski et al 1989).

"The grounded theory approach is a qualitative research method that uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon" (Strauss and Corbin 1990: 24). It is "characterized by the simultaneous and ongoing collection, categorization, and interpretation of data, the deliberate sampling of comparative groups of subjects, all of whom can illustrate the evolving phenomenon being studied, and the ongoing use of measures to ensure the validity of the study. Grounded theory research is a recursive process in which tentative theoretical explanations are continually generated on the basis of

incoming data, and in which sampling and data collection techniques are continually modified to confirm or refute these explanations" (Sandelowski et al 1989: 79).

A major underlying principle of grounded theory methodology is that it is data-driven. Theory evolves from the data obtained, so that the researcher does not go into the research project with the objective of either proving or disproving a previously generated hypothesis. Rather, theory is generated from and is entirely dependent upon the data collected, analyzed and interpreted.

1.2.2.2 Ethnography

Leininger (1985: 35) defines ethnography as the "systematic process of observing, detailing, describing, documenting, and analyzing the lifeways or particular patterns of a culture (or subculture) in order to grasp the lifeways or patterns of the people in their familiar environment." It is based on intensive fieldwork and participant observation. Through the taking of notes, interviews with key informants and others, document analysis and triangulation of these methods, the ethnographer aims to describe the structural aspects of a culture as well as develop and construct cultural categories.

1.3 The Research Methodology

One of the major aims of this study is to describe and analyze the experiences of Malaysian women who are having or who have had pregnancy terminations. To achieve this objective, I used both qualitative and quantitative methods of data collection and analysis. Prior to my research in the field, I visited a feminist-based abortion clinic in northern California twice for a total of three days, to observe how

counseling techniques and pregnancy termination procedures were handled in an American setting. Most of my field research was carried out at a family planning services clinic in Malaysia where I worked for two and a half months doing educational counseling.

During that time, I interviewed both clinic staff and clients, analyzed computerized client records, drew up a client profile based on these records and examined written staff procedures and literature given to clients at the clinic. I also sought a sample of women who had had pregnancy terminations outside the clinic and who were willing to be audiotaped during interviews. I talked to academicians and public health advocates who were interested in women's health. Finally, I undertook library research both at the University of California in San Francisco and Berkeley as well as at the Science University of Malaysia in Penang to obtain primary and secondary written resources on this subject.

1.3.1 Participant Observation

"Participant observation is especially appropriate for scholarly problems when little is known about the phenomenon, there are important differences between the views of insiders as opposed to outsiders, the phenomenon is somehow obscured from the view of outsiders, and... the research problem is concerned with human meanings and interactions viewed from the insiders' perspective" (Jorgensen 1989: 12-13). It is particularly appropriate for exploratory studies, descriptive studies, and studies that attempt to generate theory.

The study took place at a family planning clinic in Penang, Malaysia from May through August of 1993. A short follow-up visit occurred in June of 1995. I lived

with my brother and his family about four miles from the clinic where I did my research. The clinic director lived in the same housing development that we did, which was largely middle-class by Malaysian socioeconomic standards. For a person of upper-middle class origins, the director lived quite modestly. Coincidentally, my family belonged to one of the same social/sports clubs he did, so we occasionally ran into each other there. Being a political progressive, he was also interested in talking about women's health issues with some of my colleagues who were also graduate students. Two of them and I were invited to his home once for dinner towards the end of my stay to discuss grassroots activism. My interactions with him were always cordial and just a bit formal due to his elevated status as a doctor and an upper-middle class person.

The nurses and I interacted much more casually, although they also maintained a politeness towards me as an outsider and researcher. Our lunches together served to break down most formal barriers as these were usually times of conviviality and relaxation. During mealtimes, nurses would relate stories about particular clients or humorous events. Once or twice I cadged a ride home from nurses living my way. Usually one or another of my sisters-in-law would rotate picking me up from the clinic. The nurses had some idea of my family background from these informal encounters with members of my family. One weekend, about the second week into my research visit, I signed up for a walk-a-thon in which several of the staff nurses were participating. This also provided an opportunity for the nurses and me to interact on a social basis.

Interaction with the other two clinic doctors occurred on a more limited basis. The female doctor who ate with the nurses and socialized with us was far more accessible than the male doctor who tended to stay in his office and have his meals sent up. She also tended to be more sociable while he appeared reserved.

Being at the clinic for about seven hours a day allowed me to become a part of the daily routine. I sat behind the reception desk so that I could view clients in the waiting area and vice versa. I was able to see who came to the clinic, what means of transportation they used, whom they brought with them and how they interacted with the people they came with and with clinic staff.

Occasionally, I would go upstairs to the recovery room and talk to the staff nurse on duty. This also gave me a chance to observe women as they recovered from their procedures. If it seemed appropriate, I talked to women at their bedside, asking them how they were feeling and offering them contraceptive and after-care information if they indicated an interest in such matters.

1.3.2 Open-Ended Interviews

Open-ended unstructured interviews constituted the essence of the research study. Thirty-nine clinic clients and three other women from outside the clinic were interviewed on their abortion experiences. The sample was self-selected from women within the clinic population who agreed to be interviewed. The other women who agreed to be interviewed were contacts I made through personal networks.

For the clinic sample, about a third of the women were interviewed primarily during their follow-up visits a week or two after their procedures. Others in the

clinic sample were interviewed during admissions counseling, while waiting in the staging area or later in recovery. All these women were asked to talk about their experience from the time they learned they were pregnant until the present. Few women agreed to be audiotaped. Nevertheless, written notes of interviews, case histories and demographic data were gathered on all clinic participants.

Women interviewed outside the clinic did so on neutral ground outside their homes. These women were asked to narrate what they recalled of their experiences from the time they learned of their pregnancy until the time they felt they had fully recovered from their abortion experience. Each interview took from twenty minutes to two hours, depending on the willingness of each participant to discuss and divulge details of their experience.

Because of the self-selection by clinic clients and the language barrier imposed upon us, i.e. I could speak neither Chinese nor Indian language dialects, the study sample was necessarily skewed by class and ethnicity. It was divided into two subsamples: English-speaking middle-class women of all ethnicities, and Malay working-class women.

1.3.3 Document Analysis

Clinic clients had case histories written up on paper forms before they were entered as data into a computerized system. This allowed me the opportunity of scanning the forms before the data entry procedure was performed. The information on the forms was useful in allowing me to track actual case histories of clients, many of which went back several years.

In addition, the clinic used written administrative procedures that were publicly displayed to staff members on bulletin boards. These allowed me to trace the work methods and work flows employed by clinic staff in the performance of their daily routine, which were not immediately obvious to a non-medically-trained researcher like myself.

1.3.4 Computerized Data Analysis

In order to draw up a historical profile of clinic clients, I drew upon my background in computer programming to learn the data retrieval and manipulation language used by the database management system that housed client records for the last five years. Having mastered it, I proceeded to aggregate the data in the form of a client profile. I developed this profile in consultation with the clinic director and shared the results with him. The profile generated a clear demographic picture of who came to the clinic and also provided trend data over a five year period. A follow-up visit two years later extended this analysis to a six and a half year period.

1.3.5 Library Research

Prior to, during and after the field research was carried out, I collected primary and secondary material on abortion as it occurs in Malaysia and internationally from academic libraries both in the United States and Malaysia. Newspaper and magazine articles were also collected during the research project from local sources. Interestingly, during the time I was in Penang, the subject of abortion was brought up as a public issue in the national newspapers as part of an attempt by medical specialists to address its widespread use and availability. This focus on

abortion in the national media lasted for a few weeks and then quietly faded from view.

1.3.6 How I Applied the Research Methodology

When I arrived at the research site, I incorporated grounded theory methodology into my research in several key ways: to have as few preconceptions as possible about the topic being studied, and to let themes emerge from the data. Other grounded theory techniques were not as easily applied. My approach was to let my senses reign and take in as much as I could from the experience of being at the clinic. I sought to let the *gestalt* of it impress itself upon me and to work from there, in a more ethnographic frame.

Another link to grounded theory was constant comparison. I tried as much as possible to be aware of the differences between the clinic I had observed in northern California and this clinic in Penang. Using this constant comparative approach, the differences which imposed themselves upon my senses are what I decided to focus on in my study. Hence the foregrounding of abortion terminology, the symbolism of menstruation, and pre- and post-abortion interventions. These themes emerged and made themselves apparent to me as an observer during my clinic stay.

Analysis of the qualitative data was then a process of seeing what themes emerged from the data and following up on these themes with clinic staff and clients as far as they could be taken. Because my stay at the clinic was relatively short, analysis of data based on my interaction with and interviews of clinic clients

and staff was carried on continually through repeated readings of notes and interviews. However, only the most apparent themes were followed up on.

A major difficulty was the reticence of women to verbalize their feelings, intellectualize their experiences, apply analytical insights or even to disclose their real feelings. Much of Malaysian and, in particular, of Malay women's culture is based on modesty, shyness and not publicizing one's private thoughts, especially to strangers. Thick description (Geertz 1983), especially of women's experiences as told by the women themselves, was therefore not much of a real possibility.

Despite separate and unique cultural heritages based on ethnic background, I find that Malaysian women of different ethnic backgrounds also possess a shared identity by virtue of having shared a history and the same geopolitical space over time. In other words, Malaysian Chinese women and Taiwanese Chinese women may share many cultural characteristics, but there is an "Malaysian-ness" that also distinguishes the former from the latter. It was this common identity that I hoped to capture through these women's stories. I was determined therefore not to marginalize any ethnic group, even though this would not always be possible due to restrictions on my study sample size.

Because these were diverse women of different ages, ethnicities, ethnic heritages and social classes, it was difficult to encompass their divergent processes within an overarching gloss or theoretical framing. Thus the outcome of this approach was a thematic/issues-oriented analysis rather than a "classic" grounded

theory focused on basic social processes of women's experiences of pregnancy termination. Instead grounded theory was a tool used for discovery and description.

1.4 Organization of the Dissertation

I begin this study with an overview of abortion as it occurs in Malaysia. This serves as necessary background material for the literature review on abortion that follows for without prior knowledge of the Malaysian context, a critique of the literature as it applies to the particular situation of Malaysian women would be premature.

Structural and individual conditions for the provision of pregnancy termination services in Malaysia are examined in the second chapter. The impact of legal, medical and religious institutions is discussed. Changing socioeconomic conditions and the demographics of abortion are described. Categories of analysis include ethnicity, class, marital status and residential location for these factor into whether and how women historically have sought pregnancy termination services.

The third chapter consists of a critique of the existing literature on abortion as a social phenomenon and as a women's health issue. This critique is based on literature dealing with theoretical concepts providing a framework with which to explain and analyze the phenomenon of abortion as it occurs in the Malaysian context. Postmodernism and Third World feminisms, abortion theory, population control ideologies, reproductive rights frameworks and international perspectives on women's health are the major schools of thought examined.

Socialist feminist and radical feminist perspectives are primarily used in this analysis. The central concept undergirding the discussion is that women's lives are

subject to both capitalist and patriarchal structures which oppress and constrict in simultaneous and specific ways. Postmodernist theory is also used to underscore abortion as a local phenomenon occurring within a specific social context.

The fourth chapter leads off with a description of the research setting, a summary of pregnancy termination services available at the national and local level and an ethnography of the clinic. This chapter includes a quantitative look at the makeup of clinic clients over the last six and a half years and an analysis of this profile.

Chapter Five examines the cultural constructions Malaysian women give to abortion through their use of abortion terminology. It speculates on possible theoretical interpretations and meanings applied to Malaysian women's constructions. Pre-pregnancy termination interventions are also described as they further illustrate the complexity of meanings given to the pregnancy termination experience.

The sixth chapter consists of the narratives of women's experiences at the clinic and the myriad reasonings they give to their experiences. The central question of the study will be addressed in this chapter, i.e. what women experience and how they interpret their experiences before, during and even after their pregnancy terminations while they are still undergoing their recovery process. Chapter Six also provides an analysis and interpretation of findings from the preceding discussion.

The final chapter summarizes findings and conclusions. It also discusses some policy implications that are outcomes from the study and proposes some future directions for research.

2. CONTEXT AND BACKGROUND

Malaysia is rapidly changing economically with an 8.9 percent annual growth rate projected for 1995. It is one of the fastest growing economies in Southeast Asia at present. Although some of the statistics mentioned below may be outdated, they nevertheless give a sense of the context in which this study was carried out.

I begin with a broad summary of essential economic facts about the country and society. I also touch briefly on the immigration history of the country. Ethnicity, class, religion and gender play major roles in how the society is structured and in determining to whom its economic benefits accrue. Then, some background and history on abortion in Malaysia is provided, followed by an examination of the major institutions which codify both attitudes towards abortion and the larger issues of women's roles and rights in Malaysian society. The underlying currents of urbanization and industrialization are also examined. This provides some context for discussing the demographics of abortion that follows.

2.1 Malaysia: General Background

Malaysia is a country of 19.2 million people, 45 percent of whom live in urban areas (Correspondent 1994a: 48). In terms of its relationship to developed and other developing countries, the per capita GDP (gross domestic product) income in 1994 stood at US$7,992 compared to US$22,595 for the United States (Correspondent 1994b: 52).

Once a British colony called Malaya, Malaysia (composed of Peninsular Malaya, Sabah and Sarawak) gained its independence from Britain without bloodshed in 1957. It now has a federal government of 13 states and one federal territory, and is

a parliamentary democracy with a king who is chosen from one of the sultans of each state every few years. Legal jurisprudence reflects the influence of British common law.

Peninsular Malaysia has relatively good communication facilities; in 1984, one in 20 persons had a phone, one in 10 had a TV set and one in 100 had a radio (Bunge 1984: xix). More recent statistics indicate that in 1994 one in 10 persons had a telephone (Correspondent 1994a: 48). Moreover, cellular phones are in evidence everywhere. The East Malaysian states, Sabah and Sarawak, separated from peninsular Malaysia by 500 miles of sea, are much less developed economically and infrastructurally.

Internationally, Malaysia is a member of the United Nations and of many of its agencies, including the World Bank. It is also a member of the International Monetary Fund, Asian Development Bank and Movement of Non-Aligned Nations.

The ethnic composition of Malaysia is roughly 56 percent Malay, 33 percent Chinese, 10 percent Indian and 1 percent others (Eurasians, indigenous peoples, Europeans). Malay is the official language but Chinese and Indian dialects are spoken, and English is widely used in government and business. Literacy rates have been between 45-70 percent, varying by state and language (Tan 1982: 97); in 1994, the literacy figure was pegged at 78 percent (Correspondent 1994a: 48). Malays are usually Muslim; Buddhism, Confucianism, Taoism, Christianity and Hinduism are the other religions professed by Chinese and Indians.

Industry and agriculture are the economic mainstays of the country. Rice, rubber, palm oil, coconuts and timber are grown commercially and contributed to 24 percent of Gross Domestic Product in 1982 (Bunge 1984: xviii). Manufacturing, tin mining, textiles, electronic equipment and assembled machinery are important industries. The other important sector, government services, generated 28 percent of new employment between 1975-82 (Bunge 1984: xviii).

Because income and living standards have a major impact on health, and since Malaysian society is economically stratified by ethnic group, an examination of its income distribution is warranted. Thirty-seven percent of the rural and 12 percent of the urban population lived below an unspecified poverty line in 1980 (Bunge 1984: 300). During the mid-term review of the Fifth Malaysia Plan, 1986-90, this poverty line was specified as US$1,800 per year for a household of 5.14 persons. Slightly more than 17 percent of Malaysians are currently living at or below this line. Although the incidence of absolute poverty has decreased, with inflation and a rising cost of living, relative poverty has increased from the mid-1980s to the present (Ng and Yong 1990: 11). The poorest live in rural agricultural households outside of estate plantation or rice-farming areas.

In 1979, the poorest 40 percent of Malay households earned half that of similar Chinese households and slightly more than half that of Indian households. Rural Malay households and primarily rural Indian households on estate plantations tended to be equally poor. In 1976, rural households were almost three times as likely as urban ones to be poor; the poorest state, Kelantan, on the northeast coast

of peninsular Malaysia had 55 percent of the population living in poverty (Bunge 1984: 142). These rates have not changed significantly with time (Nash 1988: 8). Regional development tends to be biased in favor of the western coastal states of peninsular Malaysia, where urban settlements predominate.

In a 1979 government survey, women earned about 20 percent less than men in the same occupational categories; they are still underrepresented in skilled, high income occupations (Daud 1988: 119). Currently, about 47 percent of the total labor force are women. An income survey in 1973 indicated that income distribution was highly skewed: the bottom 40 percent earned 11.2 percent of national income while the richest 20 percent earned 56.1 percent of income. Despite a large and relatively unchanging gap between the rich and poor, Malaysia has significantly improved standards of living due to pension and insurance benefits given to workers, and improved health and educational services (Bunge 1984: 143-4).

The Malaysian *ringgit* or dollar is the unit of currency. In 1987, the mean monthly household income was MR$1,948 (US$780) for the top 20 percent, MR$665 (US$266) for the middle 40 percent, and MR$262 (US$105) for the bottom 40 percent of wage earners. Ethnic differentials in income are evident in that Chinese earned a monthly average of MR$2,478, Indians MR$1,819, Malays MR$1,542 and others, primarily foreign nationals, MR$7,530. (Jomo 1989: 44). The top 20 percent of income earners includes administrative and professional people of middle- and upper-class status with social values distinct from those of the lower

classes, who make up the majority of the population. A further indicator of social class is evident in monthly house rental payments. Average monthly rents range between MR$100-$450 for lower class, MR$300-$1800 for middle-class, and MR$1,000-$5,000 for upper-class households (Goh 1985: 51).

Rural dwellers earned about three-fifths as much as urbanites in 1987 (Jomo 1989: 44). Ng (1991: 191) stratifies rural Malay households into one of three income categories, based on land ownership, per capita income and employment status: *senang* (easy), *sederhana* (moderate) or *susah* (difficult). Although there is no landed gentry as such, these categories might be considered as proxy indicators of social class.

2.1.1 Immigration Histories of the Malays, Chinese and Indians

A truncated immigration history of Malaysia is presented below. Because the Malays are the earliest inhabitants of the country, their presence is merely noted, while the later migrations of Chinese and Indians are explained in greater detail.

2.1.1.1 Malays

Although Malays are the majority group in Malaysia, they are not indigenous people but are themselves immigrants. Their origins are uncertain but they are thought to have come either from southern China or Polynesia. They came much earlier to Malaya than the Chinese and Indians and laid claim to it as their homeland. Intermarriage rates between Malays, Chinese and Indians remain low, under 10 percent for the country as a whole. Early immigrant Chinese-Malay, Indian-Malay and colonial-local (called Eurasian) intermarriages spawned minority

communities with a distinctive local flavor but the three main ethnic groups remain relatively heterogeneous.

2.1.1.2 Chinese

The first Chinese came to Southeast Asia and Malaya as traders and emissaries of the Chinese emperor's court seeking tribute for China. From the ninth to the eighteenth centuries, they traded with Malays in all parts of the peninsula but preferred to settle on the east coast which was closer to China. "Trade with China and the recognition of China were central to the early empires of the region, including Malacca. But the major wave of Chinese settlers came later, coinciding with the development of the export economy and colonial intervention" (Bunge 1984: 98).

Even before British rule began in 1824, there were a reported 3,000 Chinese settlers in Penang in 1794 (Khoo 1988: 182). In successive decades of the early nineteenth century, Chinese came to Malaya as laborers in pepper, gambier and sugar plantations and later on as workers in the tin-mines. They settled on the west coast on Malaya which was rich in tin and fertile for agriculture. These were mostly male immigrants primarily from the southern Chinese provinces of Kwangtung and Fukien. Starvation, poverty and overpopulation pushed them to emigrate to seek better livelihoods.

Thousands of Chinese came especially after the British established Singapore as a major trading center in 1821 and after tin was discovered in Malaya in the 1840s. Finally, when rubber was introduced in the late nineteenth century, the Chinese were among the first growers and owners of both small and large rubber plantations

(Khoo 1988: 198-9). They were middlemen, shop owners, farmers and fishermen and controlled major sectors of the Malayan economy during the British colonial and immediate post-colonial periods.

The emigration of women from China was illegal until 1911 when the Manchu dynasty ended (Jaschok and Miers 1994: 19). Many women, however, arrived as prostitutes and servants. During the 1930s, women were allowed to emigrate legally and the sexual imbalance began to decline for the Chinese in Malaya. In the 1950s, female emigration was stopped by the Chinese government, but by then, Chinese girls in Malaya were going to schools and many women were working outside the home in working- and middle-class occupations.

As they settled in Malaya, the Chinese occupied specific professions and geographical areas according to the Chinese dialect they spoke. The largest dialect groups now are the Hokkien concentrated in Penang and the Cantonese in Kuala Lumpur; Hakka and Teochew communities are spread elsewhere.

Intermarriage among dialect groups has grown common so that the primary distinction among the Chinese is social class. "English-educated" versus "Chinese-educated" delineates the upper- and middle- from working-class Malaysian Chinese. The English-educated Chinese are more closely linked with Malays and Indians of similar social status while the Chinese-educated tend to live and work in self-styled Chinatowns.

2.1.1.3 Indians

The earliest Indians came to Malaya as traders and seamen. Because of its strategic position between India and China, there was a two-way direct exchange of goods between India and Malaya. As early as the second century AD, there has been evidence from Chinese sources of an Indianized kingdom called Langkasuka which covered parts of Malaya (Arasaratnam 1979: 4).

Official records indicate that early nineteenth century migration brought south Indian Hindus and later Muslim merchants from Bengal, Coromandel and Gujerat to Malacca and Penang, two Malayan trading ports. By the end of the nineteenth century, these traders had intermarried and had been absorbed into the Malay community, whose cultural values were not entirely alien to the Indians.

Because of population density pressures, south Indians began migrating to the British colonies in the early to mid-nineteenth century. They came to Malaya to work in sugar and coffee plantations as indentured laborers. These were mostly men, although small numbers of women were also transported as prostitutes. The indenture system was halted by the British government in 1910 because of abuses within it and also because coffee and rubber planters did not like or use the system.

While the majority of Indians came from Madras, there were also skilled workers recruited from Bengal, Punjab and Maharashtra for the railways, police and military. For the last quarter of the nineteenth century, the indenture system was replaced by the *kangany* system where a foreman (the *kangany*) was responsible for recruiting families from his own village in India. This lasted until 1938 when the Indian government banned emigration. According to the census of 1931 of Madras

state, these emigrants were primarily from the untouchable and poorer castes but some higher caste members also chose to emigrate (Arasaratnam 1979: 26).

In the twentieth century, migration of Indians was closely tied to the growth of Malayan rubber and, later, oil palm, industries. During the Great Depression, there was large scale repatriation of immigrant laborers to their native country. Then many Indian laborers were also sent to work on the 'death railway' in Thailand from Malaya in World War II. This railway project linking Burma and Thailand was never completed but the death toll from working in the jungles exceeded tens of thousands. After the war, there were about half a million Indians in Malaya (Arasaratnam 1979: 31).

Migration of upper caste educated Indians was not as easily documented or measured. Ceylonese Tamils were the first to come in as clerks in the British bureaucracy in the 1890s. They also came to work in the railways, postal services and treasury offices. Malayalees from Madras and other south Indian states also came as clerks. In the twentieth century, Tamils came in as professionals – journalists, doctors, lawyers and teachers. Traders and entrepreneurs from northern India – Parsees, Sindhis, Gujeratis – also came in the early twentieth century.

After World War II, Indian immigration to Malaya was more heterogeneous with Punjabis, Bengalis and Malayalees coming after the partitioning of India. With growing urbanization, they moved from estates to towns mostly along the west coast of Malaya. When estate plantations were subdivided in the 1950s, more Indians migrated to towns to find work. Although there are still communal enclaves

in the cities, middle-class Indians have moved into multiethnic suburbs. They tend to be overwhelmingly south Indian (Tamil, Malayalee and Telugu) with a minority of north Indian origin. About 80 percent of the Indian immigrants to Malaya were Hindu and this proportion is still assumed in the current population (Arasaratnam 1979: 162).

2.2 Historical Background of Abortion

The status of abortion services in Malaysia roughly measured by level of economic development lies somewhere between that of its neighbors, Thailand and Singapore (see Appendix A). Malaysia is less rural than Thailand, the rural/urban split being 55/45 percent compared to Thailand's 80/20 percent. However, it is not as industrialized as Singapore; the per capita GNP of Malaysia is one-fourth that of Singapore. Like its neighbors though, Malaysia has grappled with significant population growth rates over the post-World War II years. Although both Malaysia and Singapore consist of the same mix of ethnic groups, Chinese, Malay and Indian, in Malaysia the majority group are the Malays, whereas in Singapore they are the Chinese. Thailand provides western pregnancy termination services under limited circumstances, while Singapore offers pregnancy termination on request (Sachdev 1988: 20). In both countries, pregnancy termination is provided in government hospitals for a nominal fee (for about US$2 in Singapore), but costs considerably more in private clinics. This holds true in both urban and rural areas.

In Malaysia, because of the high rate of rural dwellers and limited numbers of providers in some rural areas, access to legal abortion has remained primarily the prerogative of urban women. The average cost of a pregnancy termination is

MR$250 (US$100) in a private clinic, and is free if performed in a government hospital. Private care can be assumed to be affordable for most middle-class women. Despite a comprehensive rural primary health care system that is state-run and state-subsidized, a 1977 study showed that 18 percent of induced abortions were still performed using herbs and medicines from traditional medical practitioners (Vachher and Yusof 1978: 50). The same study revealed that one out of 10 married women admitted to having had at least one pregnancy termination (Ngin 1985: 31). According to the director of a private clinic (Personal communication, 1992), the rate of repeat pregnancy terminations can approach 40 percent.

Overall, the profile of a woman having a pregnancy termination in Malaysia is that of a married woman in her late twenties, having had children, and most likely to have practiced some form of contraception (Vachher and Yusof 1978: 53-4). This somewhat dated profile may be changing for recent figures indicate a premarital pregnancy rate of 6 percent for women aged 20-24 in Malaysia (Jacobson 1991: 48). Like Singapore, in a rapidly changing society, abortion trends may be reflecting certain shifts in women's sexual behavior and in economic conditions.

2.3 State Institutions

Law, medicine and religion are three institutions which frame the provision of abortion services in most countries. Malaysia is one of several countries with restricted service provision, i.e. abortion is officially sanctioned by the state in limited circumstances. What follows is a discussion of the legal, medical and religious institutions which influence women's access to pregnancy termination services.

2.3.1 Law

Induced abortion within the context of the Malaysian penal code used to be illegal and punishable. Prior to 1989, abortion was only allowed in order to save the life of the mother. Under Sections 312-316 and 511 of the Malaysian Penal Code, the punishment for performing an abortion either by another person or by the woman herself was up to three years of imprisonment and/or a fine for pregnancies in the early stages of gestation. After quickening, the same offense was punishable by up to seven years in prison and/or a fine. If an abortion was performed without a woman's consent, the abortionist could serve up to twenty years in prison. If the pregnancy termination resulted in the death of the woman, life imprisonment could result.

These laws were based on English law, specifically on the 1938 *Bourne* decision in England where Bourne, a physician, was prosecuted for terminating the pregnancy of a 14-year old girl who had been raped by two soldiers. The court ruled that if the life of the woman as determined by a medical practitioner was endangered as a result of the pregnancy, abortion under those circumstances would be legally sanctioned; Bourne was thus acquitted (Wilson 1971).

In 1984, in the case of the *Public Prosecutor v. Dr. Nadason Kanagalingam*, a Malaysian court ruled that the doctor was guilty of performing an abortion that was not unconditionally for the purpose of saving the woman's life (Sinnadurai 1987). However, abortion laws have seldom been applied to punish medical practitioners who contravene the law by providing abortions to women for reasons other than those legally permissible. Documented cases of such prosecution are relatively rare.

Rather, the majority of prosecutions have been carried out against medical practitioners who, due to incompetence, caused the woman severe or fatal injury (Lee 1989; Baharom 1990).

In 1989, the law was liberalized to allow a medical practitioner to perform an abortion if it was judged that carrying the pregnancy to term would constitute a risk to the mental and/or physical health of the mother greater than if the pregnancy was terminated (Correspondent 1990: 1209). The law was unclear whether this judgment could be extended to non-qualified practitioners who operated in good faith for the purpose of avoiding harm to the prospective mother. The law notwithstanding, a recent estimate showed 11 percent of women resort to abortion to terminate unwanted pregnancy (Cleves 1990: 2).

The reform of abortion laws did not go unnoticed by doctors, lawyers and women's rights activists. Yet at the time, not much publicity was given to these reforms either in the popular or medical press. Interviews with doctors (Personal communications, 1992) indicated that they were unaware of the medical establishment lobbying for changes in the law, although the Malaysian Medical Association had recommended reforms in previous years (Rajeswary 1987). Rather it can be inferred that a coalition of lawyers and activists for women's rights was the prime motivator of change. Medical practitioners expressed reservations to the press that the new liberalization, which gave physicians the flexibility to determine if women qualified for pregnancy terminations, would open up the field to abuse and to abortion on request (Nambiar 1989).

2.3.2 Medicine

In Malaysia, the western medical system began during British colonial times. The degree of self-interest out of which the medical system evolved has been debated. Chee (1988) maintains that western biomedicine was developed primarily for the benefit of colonials and a few local elites. Phua (1989) maintains that the benefits accrued to a wider population, while providing the infrastructure of a primary health system that was better than that of many of its neighbors' in the mid-1950s.

Many of the class trappings of the British social system were transplanted to what was then called Malaya. This included the "ward class" system which segregated patients according to ability to pay – first class for colonials, second class for local elites and third class for the masses. There was also a rigid ranking of appointments at all levels in the medical hierarchy and strict attention was accorded to titles and seniority. The head of the medical hierarchy was a white colonial; no locals were allowed at this level.

Links to western models of health care have been preserved to the present. Professional training and accreditation are still tied to standards derived from British medical colleges. Local universities base their medical curriculum on western biomedicine, with little attempt to incorporate traditional systems of medical knowledge. This also reflects social class differences entrenched under the colonial system. The picture that emerges of the Malaysian medical establishment is generally a conservative one, i.e. it is a system that is tradition-bound and slow to change. There are currently 8,831 doctors registered with the governing

professional body, the Malaysian Medical Council, of which 55 percent are in the private sector (Correspondent 1995b).

Many medical doctors are generally hesitant to discuss their stand on abortion since they are bound by the Hippocratic oath to preserve life, which some take to include the life of the fetus. Some physicians in government hospitals and private clinics are still unaware of the 1989 reform of abortion laws and are quick to assert that abortion, under most circumstances, is illegal. Conversely, it is a lucrative business for some doctors in private clinics. While abortion on request is illegal, pregnancy terminations are performed quite freely in such clinics. According to Jacobson (1990), this makes Malaysia a "lapsed law" country since abortion on request is quietly overlooked by the authorities when it occurs, except when medical incompetence results in severe injury.

Traditional medical systems have had a significant role in providing access to abortion as well. Each Malaysian ethnic group has its own health and healing belief system, each of which proposes different solutions for terminating unwanted pregnancies. Historically, Malay medicine has used herbal abortifacients and massage as methods (Gimlette 1915; Sambhi 1977). Some of the abortifacients documented by an early twentieth century British medical officer are the root of the croton oil plant, plumbago root, unripe pineapple, papaya seeds, and black pepper combined with honey and ginger root (Gimlette 1915: 67-73). These medicinal plants, herbs and fruits were to be ingested in the belief that this would cause uterine contractions and expulsion of its contents.

Traditional health beliefs play an important part in determining some of the conditions under which abortion may occur. Harmony is extremely important in Malay pregnancy and childbirth.

> Women who find themselves inconveniently pregnant may attempt to expel the embryo by making their wombs uncomfortably hot, using deep abdominal massage, which brings 'hot' blood to the area, and ingesting 'hot' substances, like unripe pineapple and yeast, which actually can cause strong uterine contractions. These measures are thought to work, however, only if some essential disharmony already exists between the mother and her embryo. If the embryo is *sayang* (comfortable and firmly fixed, with overtones of affection), if the mother and child are *sesuai* (in harmony), nothing will dislodge it from its resting place (Laderman 1987: 361).

Massage as a method of pregnancy termination has been described by one medical researcher with a western medical perspective as being brutal, and possibly endangering to the life of the woman if complications result (Sambhi 1977: 3). The traditional healer massages the abdomen using oil, first lightly then deeply for about an hour. She may sometimes use her heel to apply a stronger massage. The intended effect is to cause bleeding and the eventual expulsion of the contents of the uterus. It is still alleged to be the most popular method of abortion in villages (Sambhi 1977: 3).

Menstrual regulation (MR) or extraction is acceptable among Chinese women in both rural and urban areas (Ngin 1985). Herbs and pills are commonly used to bring on menstrual flow. They can be bought in Chinese pharmacies under various pseudonyms, such as "bone-setting pills." They are taken after a woman has missed a period either to avoid the possibility of a pregnancy or to cause a pregnancy termination (Ngin 1985: 35). The Chinese cultural ambivalence about when a fetus

becomes viable allows the "abortion" to occur without negative sanctions against such action. MR is also the euphemism for dilatation and curettage (D & C) performed in private clinics when used in the first 4-8 weeks after a missed period. The word "abortion" can thus be avoided in medical records (Personal communication, 1992).

No data on Indian pregnancy termination practices was found. According to official estimates, the death rate for abortions in Malaysia was 0.8 per 1,000 women in 1972 but no comparable data for abortion rates, or the number of abortions per 1,000 women aged 15-44, was available (Thambu 1975: 261). Since less than half of all deaths are medically certified, medical statistics, though well-recorded, are incomplete and certainly not determinate.

2.3.3 Religion

In the Islamic tradition, there are contradictory statements about whether abortion is permitted. According to one scholar, there is nothing in the Quran expressly forbidding contraception, family planning or abortion (Rahman 1987: 113). In fact, contraception via withdrawal was a pre-Islamic practice in the Middle East. Through the interpretation of the Quran, theologians have permitted contraception and pregnancy termination up to four months in keeping with the belief that the fetus becomes "infused with life" at that point (Rahman 1987: 114). This was never social policy, but allowed as unwritten individual practice. In many Muslim countries today, the higher *Ulama* (religious leaders)

> generally allow family planning as an individual family's decision but strongly oppose it as an official policy. This is connected with a widespread belief, political in nature, that the idea of population control has originated

> in the West, which is frightened by the rising tide of the Third World population and therefore wants to control its growth (Rahman 1987: 117).

The literalist school of law of a minor but growing Muslim sect, the Zahiri, absolutely forbids contraception and abortion. Most Muslims in Malaysia are Sunni Muslims.

Hinduism, which holds life sacred from conception, forbids abortion (Coward 1989). Buddhism also harbors a similar proscription for the same reason. However, in Japan which is primarily Buddhist and where abortion is legal, aborted fetuses are paid homage to, ritualized in quasi-religious ceremonies and regarded as "water children" (LaFleur 1992). In this instance, religious and traditional symbols of life and death are interwoven to accommodate the occurrence of abortion. Catholicism within Christianity forbids abortion. There is no apparent proscription against abortion in Confucianism.

A force to be reckoned with since the early 1980s has been the rise of Islamic fundamentalism in Malaysia. Some of the consequences of this have been an increasing Islamicization of the state, ethnic and gender polarization, and a growing divide between fundamentalist and more secular Muslim Malays. The introduction of *syariah* (Islamic) laws to supersede civil law for all Muslims has resulted in a loss of property rights for women. There has also been the institutionalization of a puritanical moral code largely applied against women.

The effect of this religious fundamentalism on abortion has been a chilling one. Some western medical personnel are hesitant to help Muslim women have pregnancy terminations for any reason for fear of a possible fundamentalist

backlash. They also fear that fundamentalists may rescind the recent gains in abortion law liberalization if and when they choose to do so.

2.4 Sociopolitical Conditions

For the last thirty years, population policy has been encapsulated in law in accordance with development objectives of the state. The First Malaysia Plan (1966-70) proposed that Malaysia reduce its annual population growth rate to 2 percent by 1985. This was made concrete in the Family Planning Act, 1966, which established a National Family Planning Board. Thus the government officially began its family planning program, providing family planning services to married couples and helping to reduce the annual growth rate from 2.8 percent in 1960-70 to 2.5 percent in 1970-82 (Chee 1988: 164). Current statistics put this growth rate at 2.6 percent (Correspondent 1994a: 48).

Going beyond its original mandate, the National Family Planning Board also became involved in implementing social programs for poor women and children in urban areas. These programs provided job training skills for working-class mothers in urban squatter areas with the ultimate goal of reducing family size (Siraj 1985: 272). According to Chee (1988), based on current trends, the population growth rate is projected to further decline to 2 percent for 1980-2000 and to stabilize at a population of 33 million in the year 2005.

More recently, however, there has been scholarly debate on the merits of a population policy change unveiled by the Malaysian government (Zulkifli and Yusof 1985; Chee 1988). In 1982, the Prime Minister stunned the nation by calling for a population target of 70 million by the year 2100 in order to produce a domestic

market large enough to support heavy industrialization and a self-sustaining consumer base modeled after South Korea and Japan. This pronatalist policy, coming after almost twenty years of impressive population reduction efforts signaled an about face in government policy. It does not appear to have been influenced by Islamic fundamentalist pressure since the Prime Minister, a moderate Malay, has sought to contain fundamentalist expansion, and there was no overt lobbying for such a policy reversal at the time. As Chee (1988) points out, however, this population target is in fact quite attainable assuming an annual growth rate of less than 1.5 percent. What was surprising was the change in government policy and approach.

Since that pronouncement, reaction by World Bank and other international agencies has not been extensive. In a publication put out by the International Planned Parenthood Federation, Jones (1985) considered the implications of this policy and concluded that the concept of an optimum population was an illusory one; by the time the target is reached, the underlying conditions will have changed, thus negating the intended effect. He also inferred that since the population target was to be reached by the year 2100, fertility rates would not have to rise, but rather would have to decline very slowly, at a Total Fertility Rate (TFR), or the average number of children per woman, of 0.1 every five years (Jones 1985: 15). Since this slow decline is highly unlikely, the government has cast about for ways to increase childbearing. Family planning, therefore, has not been stopped, but emphasis is

now placed on birth spacing, infertility management, genetic and marriage counseling, and family life education.

Criticism of this policy has come mainly from environmental groups within the country, such as *Sahabat Alam Malaysia* (Friends of the Earth). Health researchers were uncertain as to whether this policy would be an overall boon or bane to the country (Zulkifli and Yusof 1985; Chee 1988). The government, however, showed that it was serious in its intent. To achieve the target, changes were made to laws in family planning, finance and employment in 1984. The Family Planning (Amendment) Act, 1984 changed the title of the 1966 act to the "Population and Family Development Act, 1966" and substituted the words "population and family development" wherever "family planning" occurred. The focus of family planning was changed from reducing family size to increasing it.

In 1989, the international agency-funded family planning associations officially split from the government-funded family development associations, with each branch carving out different geographic territories of service provision. From interviews with a former state family planning official, the split appears to have occurred on an urban/rural basis, i.e. urban areas retained family planning, while rural areas were targeted for family development (Personal communication, 1992). While the family planning agencies continue to advocate for contraception and birth control, the other agencies promote family development in line with government policy. Both branches interact on the common ground of promoting family health, although by using different and apparently contradictory strategies.

Further government incentives were put in place to encourage women to have at least five children. The Finance Act of 1984 amended the Income Tax Act to provide greater tax relief for families with up to five children. The Employment (Amendment) Act of 1984 gave working mothers maternity benefits for up to five children so that women were encouraged to stay home instead of working outside the home in order to care for their children (Sinnadurai 1985).

It appeared that there was also a race-based agenda inherent in these policies in that Malays with traditionally higher fertility rates were being asked to reproduce in greater numbers to keep the ethnic base of future political power intact. A younger age structure of Malays, and rural agriculturally based women being more likely to have larger families for cultural and socioeconomic reasons, made this policy selective in its outcome (Hirschman 1986: 165; Khor 1990). A physician privately asserted that reports from medical staff on the primarily rural and Malay-populated east coast have shown an increase in women of older age groups having their fifth or sixth child with increasing risk to their health and safety (Personal communication, 1992).

Apart from state institutions, major social forces have had an effect on how and why women have abortions in Malaysia. These have been the developmental forces of urbanization, industrialization, westernization and feminism.

2.4.1 Urbanization, Industrialization and Westernization

Malaysia is one of a number of Southeast Asian countries with high rates of economic growth. At the same time, the infrastructures of these countries are insufficient to absorb the large numbers of their population in employment.

Furthermore, the domestic markets in these countries are insufficient to support import-substitution policies, i.e. the manufacture and sale of their own primary products for the home market (Safa 1983: 4). Therefore, over the last twenty years, they have pursued economic policies based on export-processing industries, whereby multinational corporations have set up labor-intensive manufacturing and assembly plants in "free trade zones" in these countries.

It is usually women who are recruited for these industries. In Malaysia, 90 percent of the over 80,000 workers in the free trade zones are women (Karim 1985: 20). The women recruited to work in these industries are young (usually aged between 16-25), single, on average have a sixth grade education, are primarily rural, and are viewed and promoted as a pliant and tractable work force. In 1990, total female employment in the manufacturing sector had increased to over 442,000 (Ismail 1991: 33).

The division of labor across national boundaries is a comparatively new phenomenon and the position of women in this new constellation of labor is most easily examined in the manufacturing industry. Women from rural areas who form the majority of the electronics assembly workforce are now connected in a seamless web of production relations with women workers in other countries, more often than not, in a sphere of competition. Capitalist logic that seeks out low labor costs has spurned the regulated and unionized industrial work forces of advanced capitalist countries for the low-waged havens offered by non-unionized, newly

industrializing countries, following the regime of flexible accumulation (Harvey 1989).

To a large extent, the structure of the work environment for rural women has been crafted by the state. In collusion with multinational corporations, the state has provided the infrastructure and the capital (or lack of capital) for free trade zones to exist and has promoted them as legitimate development strategies.

While partly solving the unemployment problem, the state has perpetuated a number of insidious effects through its actions. On one hand, there has been the enrichment of a few wealthy officials and industrialists at the expense of a new urban proletariat, although this view has been disputed by Lim (1983). On the other hand, there has been ample documentation of the collusion of state and multinational regarding the suppression and control of factory workers in many Southeast Asian nations (El-Sanabary 1983; Safa 1986; Ong 1987).

Another effect of this industrial policy has been the diversion of natural and national (human) resources away from local production and consumption toward exports and foreign exchange, which does not help an industrializing nation be self-sufficient. On the contrary, it serves to drain the industrializing nation of its natural resources.

The creation of an urban working class from previously rural young Malay women has a relatively greater significance in terms of changing views on sexuality and possibly repercussions for changing sexual behavior. Rural Malay women were traditionally brought up to be shy and modest, keeping their sexuality under wraps

until marriages were arranged for them by their parents. They did their share of housekeeping as part of the work of maintaining a household, with relatively little direct supervision (Ong 1987).

However, when they were literally transported to urban factories to work in electronics and textile production, their lives changed, often dramatically. Life on the factory floor was one of relentless supervision. Even though factory owners promised the parents of these workers that they could entrust their daughters to the owners' safekeeping, conflicting messages were given to the young women. Cosmetics classes and beauty contests were staged and the most crass aspects of consumer culture were promoted by corporate management to socialize them to urban living. In the work environment, they came into contact with men as colleagues and supervisors and, although office romances were not condoned, some amount of dating outside of work transpired, occasionally even across ethnic lines (Daud 1985; Karim 1992).

Living away from home amidst pressures to be seen as modern and sophisticated has had effects on living arrangements for some working-class women who work in factories. Some have chosen to live in the same building complexes as their partners, but few actually cohabitate (Daud 1985: 113). The label *Minah Karan* ("Liz Electric"), a play on the word "electric" as a pejorative with connotations of being sexually suspect, is both a cause and effect of this perceived sexual promiscuity. Both rural and urban men who feel threatened by the change in rural women's role

of housewife to wage earner have accused these women of immoral behavior, venting their anger by labeling them thus.

This label also serves as a convenient form of patriarchal social control over women's sexuality in the same way that a wolfwhistle asserts male dominance over women as sexual property. In such a sexualized landscape, it is possible that premarital sexual activity is increasingly likely to occur.

The long term effects of the sexualization of these working women have not been studied, especially after they leave or are forced to leave factory work because of retrenchment, health problems associated with the work, or other reasons. The assumption has been that they get married and eventually drop out of the workforce, and that they are somehow able to survive economically. Whether the sexualization that occurs on the factory floor constructs prostitutes downstream after they have outlived their labor utility remains undetermined. There may be other likely outcomes as well, but these remain undocumented.

One reason why factory women are focused upon in this study is because of the possibility that they may contribute to the rise in the incidence of abortion in certain urban areas. Furthermore, this particular group of women has previously been studied because of the interest in women working on the global assembly line. Other Malaysian women have not been in the sociological limelight to the extent that this type of Malay working women have.

Another concomitant change that may be related to westernization and industrialization is the rate of younger, single women getting pregnant and seeking

pregnancy terminations. Recent newspaper reports (Edwards 1993: 6) suggest that teen pregnancy rates and abortions being performed are rising in major urban areas such as the Klang Valley which includes Kuala Lumpur, the capital city.

A local obstetrician/gynecologist in the Klang Valley who also performs abortions reported that his data showed teen pregnancy rising by approximately 10 percent annually and half of all pregnancies including a significant number of teen pregnancies in the Klang Valley being aborted. He attributed this rise to the inability of single women to get contraceptives at family planning clinics, a policy that the Federation of Family Planning Associations of Malaysia recently rescinded.

2.4.2 Feminism

One other major force in the sociopolitical arena having an influence on women's lives has been feminism. Its impact is variable and subtle. Although one might be tempted to think of it as a wholly western import, this assumption might be tempered somewhat by considerations that predate western colonialism or contemporary western-influenced media. Malay society has been described as being relatively egalitarian historically in its treatment of the sexes (Firth 1966; Atkinson and Errington 1990; Karim 1992). While Chinese and Indian societies have historically emphasized the importance of males over females, contemporary Malaysian society lacks some of the rigidity of these traditional patriarchal societies.

There have been women's groups organized for political change in Malaysia going back at least 45 years. There were women's auxiliary units in the anti-colonial and nationalist struggles. There were also women worker protests against unfair labor conditions in the 1930s, but the history of labor struggles in Malaysia has for

the most part been a dismal one. Neither of these groups claimed a feminist agenda. It is relatively recently in the 1980s that women's groups with a feminist perspective have challenged the status quo and gone beyond welfarist aims.

> Women's organizations in Malaysia range from women's wings of political parties, both right and left, government-sponsored women's groups, to non-governmental women's organizations. The latter again range from service-oriented bodies such as Women's Institute, middle-class alliances (National Council of Women's Organizations), to more activist groups such as the All Woman Action Society (AWAM) and the Sabah Women Action-Resource Group (SAWO) (Ng and Yong 1990: 7).

The history of women's activism stems from early attempts at gaining access to education. Besides fighting in the anti-colonial struggle, women have also lobbied for middle-class issues such as equal pay in the public sector, entry into the civil, diplomatic and legal services, reforms in family and divorce law, improvements in income tax and pension benefits for married women, and for appointment on juries and religious councils (Ng and Yong 1990: 9).

The liberalizing influence of an overseas education for many men and women has been responsible in part for the recent rise in feminist-based activism. Malaysia's seven universities have only been able to absorb a minority of college-eligible students. In addition, education policies restricting college places by ethnicity have forced many students abroad either on scholarships or by private means. Returning students make up a percentage of activists working for women's rights.

Most recently, issues of violence against women have been championed, resulting in increased penalties for rape and a heightened public awareness on

domestic and family violence. Workers' rights struggles have not had similar success since they represent a more direct threat to a patriarchal capitalist state. Rape law reform was seen as a humanitarian appeal to justice and since it did not pose a threat to state power was supported by the press and public. A middle-class bias in the composition of government-sponsored women's groups also contributes to the ignoring of issues of poor and working-class women.

The liberalization of abortion laws in 1989 came directly on the heels of the Domestic Violence Act, which was the culmination of a two-year campaign by a majority of women's groups, both of feminist and welfarist identification. In 1985, a joint workshop between grassroots and government-sponsored women's groups led to a memorandum to the government recommending that all laws which discriminated against women in civil, family and labor affairs be reformed. Abortion law reform may possibly be seen as one of the steps taken to appease the clamor for change.

2.5 Trends Influencing the Incidence of Abortion

It is within these medical, religious, legal, economic and sociopolitical contexts that certain trends have occurred. Some of these trends may provide links to the profile of pregnancy termination seekers in Malaysia. They consist of demographic, fertility and marriage patterns, contraceptive use, age at menarche, and changes in women's sexuality. These trends are by no means the only links to the incidence of abortion in Malaysia, but rather are some of the most apparent ones for the purpose of this study.

2.5.1 Who Has Abortions and Why

The 1984/85 Malaysian Population and Family Survey (MPFS), which surveyed 4,100 women of childbearing age in a national representative sample, pegs the rate of induced abortion at 6 percent of all pregnancies ending without live birth, which includes spontaneous and induced abortions, and stillbirths. More urban women have induced abortions than do rural women, partly because access to pregnancy termination services is easier in urban areas, but also perhaps because under-reporting of illegal pregnancy termination practices in rural areas occurs. Chinese women are reported to resort to pregnancy termination in higher numbers than Malay or Indian women. This again may be due to differential access to pregnancy termination services. Chinese tend to predominate in cities and large towns, whereas Malays tend to be rural. There also may be a differential willingness, according to ethnicity, to report it.

The number of pregnancy terminations being performed in government hospitals shows a steady increase over the years 1960-78 and there is no indication that this trend is changing (Thambu 1975; Ng and Sinnathuray 1975; Sinnathuray et al 1977; Arshat 1985). Most major cities now have private clinics where pregnancy terminations are performed on request. A recent informal study of 40 clients of one such clinic located in a major city with a free trade zone revealed that the largest proportion of women were Malay, between the ages of 20-24. The most frequently cited reason for wanting a pregnancy termination was an unexpected pregnancy, perhaps because of being single. Other reasons cited were the spacing of births, financial reasons, career reasons, embarrassment due to age (being a grandmother),

rape, divorce, health reasons, possibility of the child being born with birth defects (eugenics), limitation of family size, and other unspecified reasons.

A previous study carried out in the same city as the above study at a government hospital indicated similar findings; the typical pregnancy termination seeker was Malay and/or in her twenties (Kumar 1984). Because young women workers in free trade zones tend to be overwhelmingly Malay, this profile may be skewed towards Malays for cities in which these zones are located.

2.5.2 Demographic and Fertility Transitions

Since Malaysia became independent by peaceful means from Britain in 1957, both mortality and fertility rates have declined for all three ethnic groups. This demographic transition to smaller families has been attributed to delay in age of first marriage (including an increase in the proportion of women who never marry), to improvements in the standard of living, literacy and education levels, and to the increased acceptance of contraceptive methods. Contraceptive use increased from 14 percent in 1966 to 53 percent in 1974 (Cleves 1990: 1-5). The 1984/85 MPFS reported a further increase to 77 percent (Arshat et al 1988: 78).

This demographic transition (from high mortality and fertility to low rates of both) has been touted as the norm for industrializing countries and has been linked to increasing levels of education and income. In Malaysia, the Total Fertility Rate declined from 6.2 in 1958 to 3.7 in 1983, with much steeper declines for Chinese and Indians than for Malays (Hirschman 1986: 161).

2.5.3 Marriage Trends

For Malays especially, the postponement of what used to be traditional early marriage may be seen as having consequences for premarital sexual behavior. For Malay women, the median age of first marriage has risen from 16.6 in 1947 to 20.5 in 1970 to 22.0 in 1980 (Hirschman 1986: 165). Indian women have paralleled this course of events, whereas Chinese women have married on average two years later than other women. For all women, this delay has been attributed to rising levels of education, increased wage-earning opportunities, and a break away from parentally-arranged marriage and spouse selection.

Another shift in marriage patterns has been the lowering of divorce rates for Malays; in the 1950s, the predominantly Malay east coast states had divorce rates that were among the highest in the world. No relationship to religion could be discerned since other Islamic populations elsewhere did not exhibit the same trend (Hirschman 1986: 166). Traditional Malay culture allowed women to own property so that although divorces were relatively easy for men to procure, women were not left destitute and were likely to remarry. Malay women could ask for divorces by petitioning the religious courts while men merely had to state their intention of divorcing their spouse in front of a religious official (Ariffin 1994: 124).

A striking trend is the rise in single Malay women aged 15-49, from 12 percent in 1957 to 36 percent of all Malay women of child-bearing years in 1980. This can be attributed to the decline in teenage marriage and the postponement of first marriage. An increasing number of Malay women aged 35-49 are choosing to remain single; this rate increased from 2 percent in 1957 to 3.7 percent in 1970 to

7.7 percent in 1980. This is not simply an urban trend but is reflected in rural marriage rates as well (Hirschman 1986: 176). Women who are marrying later are having fewer children, possibly due to a smaller biological window of opportunity, but also because of the increased use of contraception.

2.5.4 Contraceptive Use

Non-Malays are higher users of contraception. At low levels of education, Malay women have fewer children than Chinese or Indian women, but at higher levels, they tend to have more children than Chinese women (Hirschman 1986: 178). Contraceptive use is most frequent among the urban, Chinese and most educated, and least likely among the Malays and least educated (Arshat et al 1988: 79). About 20 percent of Malay women use "efficient" (by western medical standards) contraception compared to 54 percent of Chinese and 45 percent of Indian women.

According to the 1984/85 MPFS, the most popular methods in use were the Pill (23 percent), herbs and traditional methods (17 percent), condom (15 percent), sterilization (15 percent), rhythm (14 percent), withdrawal (8 percent), IUD (4 percent), abstinence (4 percent) and injection (1 percent). Unlike western women, most women were not using contraception between the time of marriage and birth of their first child, reflecting the widely held cultural assumption that marriage and child-bearing go together. Use of the Pill fluctuated from 50 percent in 1974 to half that figure in 1985, signaling a swing toward traditional and natural methods of contraception such as withdrawal and rhythm, possibly because of the link of the Pill to cancer as well as its unwieldiness and distressing health effects. Shortness of breath, headaches, and palpitations were major complaints of early Pill users in

Malaysia (Ooi 1971: 180). Although this may be attributed to high dosage pills that were manufactured in the early 1970s, these effects may be remembered and passed on to later generations of women. It is also possible that Third World dumping results in high dosage pills being left on the market, so that these ill effects are still being felt. This trend away from oral contraceptives to barrier methods has also occurred in the United States among young married couples, and researchers speculate that this has also been due to health concerns over the Pill (Shaklee and Fischhoff 1990: 400).

This same trend has been noticed in neighboring Singapore where the use of contraceptives among married couples dropped by nearly 10 percent between 1982 and 1992, according to the latest statistics from the Population Planning Unit there. A 1992 survey showed that 64.8 percent of women of child bearing age or their spouses used birth control methods, compared to 74.2 percent in 1982. Using condoms was the most popular method of contraception, followed by sterilization and rhythm method of natural family planning. The data on contraceptive use in Singapore were collected in a nation-wide survey involving 2,501 married women aged 15-44. In the past decade, the average rate of contraceptive use had been 74 percent, higher than in industrialized countries like the United States, Switzerland and the United Kingdom (Correspondent 1994c).

These statistics say nothing about sexual behavior, especially premarital sexual behavior. It is conceivable, though, that with increased opportunities for wage-earning and with delayed marriage, young single urban women of all ethnic groups

are increasingly likely to have premarital sex and without using contraception, thereby increasing the likelihood of requiring abortions.

In fact, the 1988/89 second Malaysian Family Life Survey (MFLS) considered questions concerning premarital sexual behavior inappropriate, so that this subject remains a gray area. Pregnancy outside of marriage is still considered a cultural transgression. According to a clinic director, single women who visit abortion clinics usually declare themselves married when filling out marital status on medical forms (Personal communication, 1993).

According to the 1984/85 MPFS, about 6 percent of women had children conceived before marriage (as deduced from date of marriage and date of birth of first child), with Chinese women being more than five times more likely to have this experience compared to Malay or Indian women; urban women were more likely than rural women to do so.

2.5.5 Menarche and Female Sexuality

There have been several studies linking age at menarche with a host of biological and socioeconomic variables. According to the first MFLS of 1976/77 in which 1,262 households were surveyed, the mean age of menarche for Malaysian women was 13.71 years (Tan et al 1983: 3). According to unofficial findings of the 1988/89 second MFLS, this mean is now 13.54 years. When analyzing birth cohorts by ethnicity, it was found that the mean age of menarche substantially declined for Chinese and Indian women but remained relatively unchanged for Malay women. Indians had the lowest mean, followed by Chinese and Malays.

> For the Chinese, age at menarche and breastfeeding activity have historically declined, which, by themselves, would have produced increasing

> fertility. The opposite has occurred, due to rising age at marriage and increasing contraceptive use. These patterns appear to characterize many groups in most countries that experience sustained socioeconomic development (Tan et al 1983: 16).

Since 1930, the average age of menarche has been declining for all three ethnic groups (Tan et al 1983); this decline has been correlated with increasing levels of education and gains in living standards. Other studies have linked a decline in the mean age of menarche with improved nutrition.

Studies elsewhere have shown that age at menarche is an important correlate of age at first sexual experience. Unfortunately, no data on age at first sexual experience is available since such queries would be considered taboo or culturally inappropriate in Malaysia.

Earlier sexual activity may factor into explaining the increasing number of single women seeking pregnancy terminations. Contraceptive use is relatively low among Malay and Indian women. Other trends are earlier age at menarche due to better nutrition, postponement of marriage, and unsupervised, formerly rural, young women working in urban factories who, as a consequence of which, have been labeled sexually suspect. The combined effect of these phenomena may result in women becoming sexually active at an earlier age.

2.6 Recent Ethnographies of Urban Malaysia

There are very few ethnographies of urban life in Malaysia and fewer still which focus on families and family theory. [Some seminal works on Malay women will be examined in the next chapter, focusing on changing work roles under multinational capitalism (Ong 1987) and Muslim women and the influence of religion on

women's rights (Karim 1992)]. Almost no work exists on middle-class women or on Chinese and Indian women in Malaysia (Stivens 1992: 215-6). Nevertheless, a brief attempt will be made here to underscore some of the salient features of Malaysian women from the three major ethnic groups as wives, daughters, mothers and as workers.

About 44 percent of all Malaysian women aged 15-64 work outside the home (Yahya 1994: 35). There are almost no ethnographies of urban Malay women other than factory women. Rural Malay women have been described in a number of anthropological works (Firth 1966; Strange 1981; Laderman 1983). In rural areas, Malay newlyweds tend to live in the village of one of the couple's parents (Strange 1981: 127). In urban areas, they tend to live where the jobs are, which may mean in a big city such as Kuala Lumpur or Penang, away from their families.

According to Malay custom and the Islamic religion, the man is the head of the household. An aging mother or grandmother of the wife's family may stay with them, as women have primary care-taking responsibility for the elderly. According to Strange (1981: 132, 134-6), men often remarry so that it is rare to have an aging father or grandfather in the household. She describes the lives of some rural Malay women as follows:

> Her birth order can determine many aspects of her life. In some families, for example, eldest daughters receive no education beyond the primary level because they are needed at home to care for younger siblings and to take other household responsibilities; younger sisters go on to secondary school...Children of both sexes are wanted and loved by the average Malay parent but a sexual mix is preferred...
>
> Ideal behavior for her potential roles as wife and mother is inculcated in a girl during her early years. She learns, through being daughter and sister, attitudes and behavior patterns for a life time. She is taught to be dutiful, self-

> effacing, and modest; to have a strong sense of the proper way to comport herself, particularly in the presence of men; and to know that her behavior reflects on her parents and other family members... A family's women bear its honor...
>
> A daughter... learns that a woman's primary goal is to be a wife and mother, and that whatever else she might be is secondary... Girls are... trained not only to run a household but also to help support it through agricultural and other labor... Married women are expected to be obedient to their husbands and to continue being modest and self-effacing...
>
> There is often a relaxed and joyful aspect to family life, a flexibility that accepts the unexpected, and a more-the-merrier accommodation of kin and friends.

Repute or preservation of family honor become the charge of women. Women learn to manage their sexuality within a strict moral code. Yet, there is some pressure on Malay women to look attractive to men. According to Omar (1992: 69), many rural Malay women take herbs (called *jamu*) to make themselves look younger and stronger. There is no similar imperative for men to look attractive for the opposite sex although some Malay men also use herbs to increase sexual virility. In urban areas, some of these behaviors and attitudes may be tempered by western educations so that options such as remaining single and/or having careers figure more prominently in some Malay women's lives.

Chinese women in Malaysia had distinct advantages compared to their counterparts in China. According to Lebra and Paulson (1980), there were three such advantages, each tied to the immigration history of the Chinese in Southeast Asia. When Chinese men first came, they left their wives behind in China and sometimes intermarried locally. In the 1920s and later, when Chinese women began to emigrate to Malaya in large numbers, they tended to marry Chinese men. Some Chinese men already had a wife in China but favored the second wife who

was closer at hand. The subsequent rise in status of the second wife was a significant departure from traditional Chinese custom.

Because of their initial scarcity and their economic value when they arrived, Chinese women often went into business with their husbands or worked outside the home in service industries, for example, as market vendors, domestic servants, restaurant workers, seamstresses, shop assistants, shopkeepers and beauticians. A tradition of Chinese women in the work force was established. They were now considered to be assets rather than burdens as they had been in China. Their activity in private-sector business was another departure from traditional roles.

A third departure from tradition occurred during the 1930s when unaccompanied women emigrated from China in search of work. These were probably unmarried daughters sent abroad to work in order to remit money home to families, taking the place of sons in the traditional Chinese family order. This brought such women increased freedom and status within the Malayan Chinese community.

Despite these gains in status, Chinese women lived with the insecurity of divorce or abandonment. Colonial law gave second wives the right of inheritance (Lebra and Paulson 1980: 162) but offered no protection in cases of divorce or abandonment. Children of second wives did not have inheritance rights. Even today, divorced Chinese women are not easily accepted in Malaysia.

Compulsory education was not provided to all girls until the post-colonial period in Malaya. When it became available, it provided opportunities for Chinese women

to improve their self-images and their lives. It also gave middle-class Chinese women the chance to travel abroad and to experience greater economic and personal independence from their families. Educated working Chinese women of all social classes did not appear to subordinate themselves to men in the traditional Chinese way (Lebra and Paulson 1980: 236).

Filial piety still retains its strength within family relationships. Unmarried daughters traditionally live with their parents either because of economic reasons or because they do not want to hurt their parents' feelings by moving away (Lebra and Paulson 1980: 145). Many single working women still remit part of their income to parents. Compared to Malays and Indians, Chinese women marry later (at an average age of 26 years) and more of them choose to stay single (Ariffin 1994: 63). Younger family members usually help care for the elderly. Chinese marriage and burial customs help maintain the continuity of tradition within Chinese families. In summary (Lebra and Paulson 1980: 233):

> A pronounced development in Southeast Asian ethnic Chinese communities is the waning of patriarchy. Linked with the divorce of the Chinese patrilineal unit from landholding, the Chinese family has developed along other lines in Southeast Asia. In some cases shopkeeping has replaced landholding as the economic link with the patrilineal family. Urban residence patterns... are a primary factor that has contributed to the shrinking size of the extended family. Many respondents today feel more strongly the bond with mothers than with fathers. This mother-daughter bond has contributed to an improvement in the status of women in the workplace. Women are able to make a lifetime commitment to work because their mothers or mothers-in-law are willing to care for their children... A mother does not automatically live with her eldest son but is just as likely to choose to live with her daughter. There is a strong feeling among Chinese women that the "Chinese raise their daughters better than other ethnic groups."... It is only among poor families who cannot afford to educate all their children that favouritism is shown to sons.

There are few if any works on Indian women in urban Malaysia. Indian women have the highest labor force participation rate compared to women of other ethnic groups. In 1990, about half the employable Indian women in the population worked outside the home (Yahya 1994: 38). A few studies on estate plantation women have been carried out and the health situation of women working in rubber estates has been assessed as being pretty dismal. Less than half of all rubber, oil palm, coconut and tea plantations had child-care facilities in 1980 (Oorjitham 1994: 168-9). Women in estate plantations work because they have to support their families. They also assume double or triple workshifts as wives, mothers and wage earners. Some of the problems they encounter as estate laborers are "low education, low nutritional levels, fatigue and alcoholism, wife battering and low levels of family planning" (Oorjitham 1994: 170).

In urban areas, Indian women tend to be at both ends of the economic scale working as laborers, domestic helpers, tradespeople and market vendors as well as in the professions as teachers, doctors, lawyers and engineers. As with Chinese and Malay women, many middle-class Indian women are also housewives who do not work outside the home.

During the years after World War II, the female-to-male ratio for pupils enrolled in schools was highest for Eurasians and Indians (Arasaratnam 1979: 186) indicating their awareness of the importance of education. The division between English-educated and non-English-educated Indians serves as an indicator of social class. Women with Tamil-language educations normally do not have occupational

mobility and most Tamil-language schools are in estate plantations. Urban English-educated Indians make up a disproportionate number of the population of physicians, lawyers, engineers and teachers and many in these professions are women.

The influence of India's caste system on Malaysian Indians has been attenuated because of geographical distance from India as well as for other reasons. However, most Malaysian Indians are Hindu and religion still plays an important part in Indian family life in determining the roles of women. Hindu mythology and teaching ascribe women to the primary roles of wife and mother. Wives are meant to be good, benevolent, dutiful and under the control of their husbands. Mothers are seen as fertile, but with an element of danger and uncontrollability, and still under the control of male family members, either husbands or sons (Wadley 1992: 117-8).

In the cultural heritages of all three ethnic groups, virginity for women before marriage was an important norm, perhaps more so in rural than in urban areas. However, premarital sex appears to be becoming more acceptable in recent years, at least in urban areas. A 1984 University of Malaya survey of 3,000 people between the ages of 20 and 40 of all ethnic groups and social classes revealed that 28 percent had had sex before marriage and that 11 percent had had five or more sexual partners (Correspondent 1995a: 38). Another informal study (no citation given) of 1,200 people aged 15 to 21 reported that 9 percent of them had been sexually active (Correspondent 1995a: 38).

In addition, a very recent society-wide phenomenon has been the acknowledgment of teenage promiscuity with all the stigmatization this infers. In local usage, the term *"boh sia,"* a Chinese Hokkien dialect word meaning "no voice" or "soundless," has been coined to imply the availability of teenage girls for sex with no hint of objection, refusal or rejection (Bee-Ej 1994). The term applies to teens of all ethnicities.

It is worth noting that Malaysia tends to be a homosocial society, i.e. relationships are regulated so that cross-sex social interaction occurs infrequently. Most schools are single-sex and it is only during the last few years of high school or at university level that contact with the opposite sex becomes normalized. Arranged marriages are still quite common in both Indian and Malay cultures but less so among urban, middle-class families.

2.7 Summary

There are gaps in both the medical and social science literature which make a complete analysis of the phenomenon of abortion in the context of Malaysian women's health impossible to achieve at this stage. One example is the absence of either government or private research statistics of annual abortion rates, or the number per 1,000 women of reproductive age (15-44) who have had abortions. Without these figures, it is impossible to grasp the extent of the incidence of abortion compared to neighboring countries, such as Thailand and Singapore, whose medical record-keeping avails us of such statistics, however approximate (see Appendix A).

The virtual impossibility of obtaining such data is compounded by the restricted nature of legal pregnancy termination service provision, the use by women of traditional methods resulting in unrecorded numbers of abortions, the ambiguity of abortion terminology which obfuscates the actual number of abortions carried out, and the partly clandestine nature of many operating private pregnancy termination clinics. At the root of this veil of silence is the taboo subject of sexuality, in which abortion plays a part.

What does show up in the available statistics is a trend toward increasing numbers of abortions annually during years in which the research was conducted, primarily in the late 1960s to mid-1970s (Ooi 1971; Ng and Sinnathuray 1975; Thambu 1975; Sinnathuray et al 1977). Accounts in the 1980s attest to the increasing availability and visibility of private pregnancy termination clinics and to an apparent increase in the desire for pregnancy termination services, but these accounts are far from conclusive (Arshat 1985; Singh 1985; Consumers Association of Penang 1986; Correspondent 1986; Lee 1989; Baharom 1990).

A second gap in the literature is of research on gender and sexuality. There have been accounts of the interaction of Islam and Muslim women's sexuality, as well as the changing sexuality of Malay women as they migrate from rural to urban working environments (Daud 1985; Ong 1990a, 1990b). There is also a limited ethnographic literature on rural Malay women in terms of childbirth and post-partum healing (Laderman 1983).

What is also needed are contemporary accounts of sexuality by gender, class, ethnicity and locality of residence that would flesh out the historiography of how sexuality in general, and pre- and post-marital sexual behavior in particular, have changed over time. This would be helpful in decoding abortion trends and the reasons behind them. This would also allow an analysis of Chinese, Malay and Indian middle- and working-class sexualities to be undertaken and to see how each might differ according to rural or urban lifestyles.

3. LITERATURE REVIEW AND CRITIQUE

To situate abortion in an international context requires an examination of theory that is cross-cultural in its implications. United States-based theories and/or western frameworks may or may not be transferable across cultures. With this caveat in mind, and remembering that social contexts shape meanings and beliefs, I will summarize and critique the literature in six main areas: a) earlier western feminist theories pertaining to women's position in society, b) postmodernist theories, including Third World feminisms, with respect to discourses on the body, c) abortion theory directed from western feminist perspectives, d) population control ideologies as distinct from e) feminist / women's reproductive rights frameworks, and f) women's health in international perspective.

A critical analysis of the theoretical literature on abortion focuses on what is currently undocumented but needed for a more complete analysis of the topic, as well as on what in the available material is applicable to the situation in Malaysia and what is not. Various theoretical ideas are examined here for their applicability and theoretical soundness in the context of abortion in the Malaysian situation.

3.1 Feminist Theories

Since I am approaching abortion from a feminist perspective, some basic elements of the strands of feminist theories will be defined initially and then critiqued. There have been three main streams of feminism in academic discourse: socialist, liberal and radical (Fee 1983: 18). A crudely drawn distinction between them is that socialist feminism lays the blame for female oppression on patriarchy and capitalism, liberal feminism blames it on "the system" (the sociopolitical system

each individual is socialized into) or on "a set of customary and legal restraints that blocks women's entrance and/or success in the so called public world" (Tong 1989: 2) while radical feminism blames it on all men. Patriarchy, simply defined, is the institutionalized rule of men over women through "a system characterized by power, dominance, hierarchy, and competition" (Tong 1989: 2).

In this study, I have chosen to draw more deeply from socialist and radical feminist perspectives because of the greater potential for fundamental social changes that these two perspectives offer. They both demand structural changes compared to the incremental approaches to social change and improvements of the position of women sought by liberal feminisms. Therefore, the liberal feminist perspective will be dealt with cursorily, while the others will be described in more depth. Even so, these are merely synopses of much more elaborately argued theoretical points. Moreover, each theory presented here is itself an umbrella under which many more different subperspectives, debates and contestations were and are taking place.

There are ways in which this tripartite division of feminist theories is now dated. However, I wish to retain it here as the two threads of socialist feminist and radical feminist theoretical frames continue to retain their salience for my analysis. That is, both separately and together, these framings remain both coherent and analytically useful in understanding abortion in Malaysia. More recent developments of feminist postmodernism, theories of the body, and postcoloniality are discussed separately

below. Their integration with some of the earlier frameworks in empirical studies is only now getting off the ground.

3.1.1 Liberal Feminism

Liberal feminists base their claim on a gender theory of inequality, unlike socialist feminism that is based on gender oppression. Here, equal opportunity is limited by sexism and racism, which diminish women and their capacities to become full human beings. Liberal theorists believe that men and women can be educated to see the reasonableness of this critique and to propose reforms of political, social and educational institutions to rectify the injustices done to women. They appeal to values of individualism, choice, freedom and equality of opportunity (Lengermann and Niebrugge-Brantley 1988: 418).

Examples of research carried out under the banner of liberal feminism are: deconstructions of sex, gender and how "doing gender" is continually reinscribed and reinforced (West and Zimmerman 1991), the invisible work that women do in social interaction (Fishman 1982), the gendered organization of work and the division of labor (Acker 1991), social constructions of health and caring (Lewin and Olesen 1985), and sex roles in marriage and in the family (Bernard 1982).

The strength of liberal feminism is its reform orientation. Using liberal feminist theory, part of the agenda of reform through gender role equity and, to a lesser degree, through role change, has been implemented. This can be seen in legal-political actions against employment discrimination and various policy actions rectifying discrimination against women. These mainstreaming actions have been largely consonant with the goals of white, middle-class women.

The weakness of this approach lies in its deliberate ignorance of power relations between men and women; it denies the reality that patriarchy merely extends itself by coopting women into its ranks and is thereby strengthened, not eroded.

3.1.2 Socialist Feminism

Socialist feminisms purport to link knowledge of class oppressions from Marxism, and of gender oppressions from radical feminism. Such theories seek to define the commonalties and variations in women's experiences of subordination. A second focus is to "describe and explain all forms of social oppression using knowledge of class and gender hierarchies as a base from which to explore systems of oppression centering not only on class and gender, but also on race, ethnicity, age, sexual preference, and location within the global hierarchy of nations" (Lengermann and Niebrugge-Brantley 1988: 426-7). The term most used to describe these systems is "domination" (Smith 1987).

The basis for socialist feminist analysis is historical materialism, where social and economic relations condition ideas and ideology, but the analysis moves beyond mere class oppression to broader areas and an array of institutional mechanisms of social inequality. Socialist feminists see changes in women's reproductive functions and economic and emotional sustenance of others as part of redefining the material conditions of life. The strategy for change lies in the exposure of the macro-micro system of exploitation as a revelation of "false consciousness." Through this knowledge, collective freedom is to be sought.

In other words, gender oppression is interpreted in the same way as class oppression. In Marxist class analysis, property owners make up the dominant class

while workers, as the subordinate class, produce wealth for the owners. This unequal relationship is the essence of exploitation and the historical basis for conflict between classes. Members of the lower class accept their status as natural through "false consciousness" and do not realize their life chances are directly linked to their class oppression. When workers gain "class consciousness," they question the legitimacy of the social system and class conflict begins. Socialist feminism makes a parallel argument, with men as the dominant class and women in the subordinate position.

A strong link between feminism and Marxism is made in socialist feminist analyses of gender by introducing dialectic materialism into the theoretical framework of patriarchy through use of the term "capitalist patriarchy" (Eisenstein 1979; Hartmann 1979). According to socialist feminists, patriarchy is a parallel system of oppression to capitalism, also determining of the character of society as class relations. This view implicitly rejects the notion that all social relations, including those between men and women, are determined by the mode of production. It also rejects the Marxist notion that society can be understood as a unified whole; rather, it posits the independent genesis of patriarchy, and relative autonomy between it and the mode of production. Gender and class oppressions are intertwined, but socialist feminist theory is unclear on what basis patriarchy can be overcome, although a combination of social activism and structural changes in social policy are strategies that are recommended.

Further distinctions mark socialist feminists from Marxist feminists. Marxist feminists see class as the primary contradiction in social relations and gender as embedded within the class system. To Marxist feminists, the causes of inequality are embedded in the organization of capitalism, and the solution to gender inequality is an end to class oppression (Lengermann and Niebrugge-Brantley 1988: 419-20). Socialist feminists, on the other hand, maintain that any effort at social analysis must be undergirded by a historical materialist analysis, i.e. "theory that probes the broadest of human social arrangements, domination, and yet remains firmly committed to precise, historically concrete analyses of the material and social arrangements that frame particular situations of dominance" (Lengermann and Niebrugge-Brantley 1988: 428).

A socialist feminist analysis of abortion in Malaysia, for example, would need to investigate the phenomenon as it occurred in a specific historical context (the late twentieth century), subject to ethnic, class, gender and rural/urban dimensions. An alternative mode of analysis would be the study of two related phenomena, such as female industrial workers (*maquiladoras*) on the Mexican border, as has been undertaken by Fernandez-Kelly (1983), with female Southeast Asian free trade zone workers, to compare and contrast the similarities and differences of the interactive mechanisms of patriarchy and capitalism under similar but distinctive conditions.

Socialist feminists have done research in several fields of study. Anthropologist Sacks (1974) and political scientist Eisenstein (1979) have studied some of the causes of gender inequality and oppression. There has also been social science

research on the maintenance and reproduction of gender systems (Hartmann 1984), dual arena analysis or women's work in the private versus public domains (Hochschild 1989), the social consequences of gender stratification (Ward 1984), women's oppression by the medical establishment (Ehrenreich and English 1978), nationalism and sexual politics (Tohidi 1991), women and work in the postcolonial era (Westwood 1991) and women's low-waged employment and exploitation in offshore manufacturing (Fernandez-Kelly 1983; Safa 1986). It may be argued that some of the best studies on women in nonwestern countries have been carried out by Marxist and socialist feminists, analyzing how western and nonwestern patriarchies interacted as capitalism was or is imposed on traditional economies.

The strength of the socialist feminist analysis of gender lies in its ability to draw upon the parallels of Marxist class analysis and use the gender-class paradigm as well as the neo-Marxist concept of ideological state apparatus to explain how women are oppressed. This "feminist materialism" purports to link the condition of women as an oppressed class with vested state interests which uphold the system. One illustration of this link is the abortion struggle where state interests in maintaining a labor supply through the control of women's reproductive functions outweigh all other considerations, including the individual right to privacy.

The primary weakness of this viewpoint is that in combining elements of class and sex oppression, the holistic integrity of Marxist theory has been sacrificed. Marxism can be described as "the study of the material and historical relations that make possible the exploitation and oppression of one social group by another"

(Burnham and Louie 1985: 62). A critique of socialist feminism by Marxists, however, is that they have taken historical materialism as an internally consistent and comprehensive, i.e. monist, system and broken it up into a dualist system.

Instead of social development rooted in the property (class) relations and level of productive forces, society is conceived as a composite of two systems: patriarchy and mode of production. Economic relations between classes and sexual/reproductive relations between men and women become the two equal parts of which society is composed. "Relations of reproduction," however, do not fit into traditional Marxist categories of material production. Without a material basis for rooting the differences between men and women, it is unable to identify the precise social, economic, sexual or political transformations that would be necessary for patriarchy to be eliminated.

More recent theory has tended to focus on economic justice as the underpinning of the socialist feminist agenda. Socialist feminist theory has become more effective in attending to social and economic injustice predicated on gender, race and class and has succeeded in broadening its base to encompass all women regardless of color and social class (Froines 1992).

3.1.3 Radical Feminism

Radical feminists view patriarchy as the fundamental oppression and cause of social inequality and maintain that it is upheld by male violence toward women. They see patriarchy being overcome by raising women's consciousness, rejecting male-dominant values and uniting with other women in support and defense. They do not see a dialogue with men but rather a confrontation and overcoming of male

dominance as the solution. An element of separatism pervades this perspective as women create woman-centered institutions and subjectivities.

Radical feminists have perhaps a clearer analysis of gender as a system of domination of men over women, which they call patriarchy. For radical feminists, gender is the fundamental oppression, transcending boundaries of class and race. Patriarchy exists because men have vested interests in keeping power relations in their favor. Women are necessary for procreation, to satisfy sexual, emotional and daily material needs of men, to act as symbols of male power, and to perform lower status and low paid jobs in the economic hierarchy.

To maintain their power, men use violence, while also upholding their system through the economic, ideological, legal and emotional structures, in much the same way as Althusser's (1971) "ideological state apparatus" upholds capitalism. The violence can be overt or covertly applied to the institutions of exploitation and control through standards of fashion and beauty, ideals of motherhood, monogamy, chastity, the regulation of sexuality, sexual harassment in the workplace and on the street, medical practices of obstetrics and gynecology, Freudian psychoanalysis and psychotherapy, and unpaid household work and pay discrimination in wage employment.

Radical feminists claim that patriarchy also perpetuates rape, sexual abuse, prostitution, battering, incest, child abuse, pornography and sadism. Moreover, radical feminism makes cross-cultural links to violence in the practices of witch and widow burning, wife murder, female infanticide, persecution of lesbians,

footbinding and female genital mutilation (Lengermann and Niebrugge-Brantley 1988: 424). A variant of radical feminism called cultural feminism tends to essentialize women as nurturing, non-aggressive, closer to nature and communally-oriented, and to posit a moral superiority to men.

Early radical feminists (Firestone 1970; Morgan 1968, 1970) maintained that women would only be free when they could separate themselves from reproductive functions and were consequently seen as individuals, fully revoking the "biology equals destiny" argument. A restructuring of the traditional nuclear family was necessary for this transformation of power relations to happen. These feminists also called for the diffusion of child-rearing and child-bearing roles across society. They claimed that economic self-determination, sexual freedom and the integration of women and children into all of larger society would destroy those institutions that segregated the sexes or barred children from adult society.

Radical feminists have greatly contributed to the research on violence against women (Daly 1978; Barry 1979). Some other contributions have been in the areas of female sexuality under patriarchy (Rich 1994), and on reproduction and women's health issues (Alexander 1990; Raymond, Klein and Dumble 1991; Akhter 1992).

The strength of radical feminism lies in its vision of structural change and of an alternative power relationship between men, women and children. This perspective also claims that power relations can be altered only by women taking power, not by their asking for it. Using this theory, radical feminists have put this tenet into practice by constructing alternative social realities in the form of women-only living

spaces, recreational facilities, music festivals and employment opportunities. They have also developed alternative parenting and child-rearing practices. In so doing, radical feminism challenges the male-centered dominant social reality and provides an alternative reality which, although separatist, offers balance and the concrete space for women to visualize and create a woman-centered reality.

The weakness in this viewpoint is that it does not answer the question: what of the men? The place of men in the new society is not described, so that a mere power reversal is assumed. In seeing men as "the enemy," radical feminism relegates half the human race to obsolescence, without a possibility of reconciliation or negotiated settlement. Radical feminist theory implies of the struggle between the sexes, as Marxism states of class struggle, that oppression can only be overcome by a victory of one class over the other.

3.2 Postmodernist Theory

One of the significant recent developments in social science theory has been the advent of postmodern approaches which foreground differences and advocate the hearing of multiplicities of voices. This has been a boon for propelling the voices of Third World feminists into the foreground of discussion (Mohanty 1988; Grewal and Kaplan 1994). Postmodernism can therefore be credited with allowing the hegemony of western feminist discourse to recede momentarily, providing a window of opportunity for other voices to be heard. Nonetheless, it remains an open question whether these Third World feminist voices will be heard by western feminists when postmodernism has had its day. As postmodernism has adeptly provided the impetus for deconstructing various hegemonic discourses, feminism

itself is still grappling with reconstructing a more inclusive feminist theory along race, class, gender and national lines. According to Grewal and Kaplan (1994: 3),

> most of the recent collections on postmodernism do not consider the role of colonial and postcolonial modes of representation in the construction of modernity and postmodernity. On the other hand, the recent publication of texts that address nationalism and colonialism in the context of theories of culture and modernity do not rigorously address feminist participation in these discourses... (W)e strongly feel the need for viewpoints of feminists from various locations around the globe.

Postmodernist discourses deconstruct and throw into doubt beliefs about truth, knowledge, power, the self, and language which have been rooted in Enlightenment principles (Flax 1990: 41). By so doing, postmodernism has cast doubt upon how feminists have thought about gender, maintaining that theory should be ad hoc, contingent, limited in its application and context-specific. While this approach holds several dangers for feminist theorizing because it disallows universalizing (Hartsock 1990: 159), it has also allowed previously disenfranchised voices (also known as subjugated knowledges, or voices of the "Other") to break through to be heard. It allows for diversity and variety of experience, eschewing reductionisms and essentialisms in any form.

Postmodernist theory often uses Foucauldian formulations of power to analyze relations between the sexes, between subject and state, and between colonizer and colonized, among others. Foucault maintained that not only was power exercised by the state and its ideological institutions, as Marxism contends, it was exercised upon individuals in everyday life through the disciplining of human bodies and minds (Foucault 1980: 59-60). Within this arena of power analysis, the issue of

appropriation of the body by the state for ideological purposes in the present era of late capitalism is relevant. State policies of pronatalism, antinatalism, etc. clearly frame national goals.

With flexible accumulation (Harvey 1989) comes policies of flexible aggregation of resources (including human capital) pooled in efficient ways to meet the needs of specialized markets. The ramifications for labor are that workers, especially blue-collar workers, are driven to the periphery, become expendable and join the ranks of the industrial reserve armies of women, immigrants and minorities. In the process, the state has to mold and shape workers and their bodies to meet the needs of these new forms of production.

Martin (1992) asserts that new kinds of bodies are emerging as a result of these changes, transforming themselves "from Fordist bodies held by disciplined order in time and space and organized for efficient mass production, to late capitalist bodies learning flexible response in rapidly collapsing time and space, bodies which nonetheless contain (contradictorily) increasingly sharp and terrible internal divisions" (Martin 1992: 134).

In making links between the state, Islam and women's bodies, Ong (1990b) asserts that Malay women's bodies were vested with the twin tasks of upholding male and state authority when the process of industrialization threatened patriarchal control of women and ideological control over the citizenry. Islamic tenets of female subservience through modes of dress and behavior were inscribed to counteract what was perceived as a burgeoning class of economically independent

working-class women. Motherhood was also reinforced as a suitable goal for middle-class women, to alleviate threats to Malay men and a politically Malay-dominated state respectively. But rather than seeing Malay women as either passive or active, Ong (1990b: 272) asserts that the agency of these women was shaped by both self-interest and group identity, i.e. by agreeing to dress conservatively, bear more children and stay out of the work force to reduce competition for (male-desired) jobs, they preserved and extended their privilege as middle-class Malay women.

While this strategy may have worked for Malay middle-class women, Karim (1992: 208) asserts that the majority of young working-class Malay women whose lives have been economically advanced by factory work reject both western and Islamic forms of behavior as extreme and undesirable. They steer instead to a 'cultural core' of Malay customary *adat* codes and religious values that have been more in keeping with traditionally more egalitarian gender relations forged in rural life compared to Islamic codes, which are patriarchal in origin (or have been interpreted as such) and deleterious in their effects on women. While there are no links made between women's bodies and the state in Karim's (1992) work, there is a strong sense of women's agency and choice in the direction of preserving historically complementary gender relationships between men and women.

Bilateral relationships between men and women serve to equalize power relations and preserve women's decision-making capacities. However, bilaterality does not extend to the interaction of women seeking pregnancy terminations with

doctors in the western health care system, where social controls are still in place to reinforce power relations between women's bodies and the state. Some of the strategies employed by women include resistance, submission or choosing alternatives to the hegemony imposed by the western medical system.

Hegemony, as defined by Gramsci and elaborated upon by Williams (1977), encompasses culture and ideology, but goes beyond these to include "a whole body of practices and expectations over the whole of living," and is "the lived dominance and subordination of particular classes" (Williams 1977: 110). At the same time, "forms of alternative or directly oppositional politics and culture exist as significant elements in the society" (Williams 1977: 113). These alternative processes are important not only in themselves but as indicators of what the hegemonic process has had to work to control.

Foucault challenged the idea that power operates only by means of prohibitions, maintaining instead that a complex network of disciplinary systems and technologies also exerts hegemony in a decentralized and normalized fashion. Here, the individual is finally controlled by "a discourse through which his or her physical and emotional essence is sought" (Amir and Biniamin 1992: 8). In addition,

> professional practices in modern society both create moral boundaries and serve gatekeeping functions, demarcating good and evil, deviance and normality, insiders and outsiders. Because professionals police the social margins, as it were, they often control values, beliefs, and their related social practices that are in turmoil (Davis 1985: 14).

Social control is one means by which women have been deprived of the right to choose abortions for themselves. This control over society manifests itself in various aspects of the Malaysian state's centralized, authoritarian political structure, e.g. through the lack of organized structures for political dissent, through laws restricting women's right to abortion, and through the sanctioning of western medical practitioners as gatekeepers to abortion.

According to Foucault, where there is power or social control, there is also resistance (Foucault 1978: 95-6). In the case of Malaysia, this resistance to limited abortion access takes several forms. One of these is through the very language by which abortion is referred to. Abortion is defined colloquially as "D & C," euphemistically as menstrual regulation (MR), and formally as "early pregnancy wastage" in the medical literature. The ambiguity of such terms indicates to some degree the need to get around the legal restrictions on abortions.

A "D & C" (dilatation and curettage) or "dig and clean" in local usage allows a woman to say publicly that she is going for a legitimate medical procedure rather than for an elective induced abortion, thereby skirting the potential social disapproval associated with this act. The ambiguity lies in the possibility that she requires a D & C for legitimate nonabortive medical reasons. The term "D & C" is used in the same way in Kenya, also within a context of ambiguity as to what is actually being performed. (Baker and Khasiani 1992).

Menstrual regulation is another form of getting around the law. It is the euphemism for bringing on a woman's delayed menstrual period and allows a

doctor to perform a termination of pregnancy on a woman whose menses are up to four weeks late without performing a pregnancy test beforehand. The fact that a fertilized egg may be removed as part of the procedure may be regarded as a happy coincidence. The MRs performed as D & Cs in private clinics are recorded as MRs, which gives both doctor and client a legitimate "out" in prescribing and performing pregnancy terminations (Personal communication, 1992). Menstrual regulation can also be performed using traditional herbal medicines gotten in Chinese medical pharmacies (Ngin 1985).

A second form of resistance where the official text of law is subsumed within the subtext of noncompliance is illustrated by the nature of "lapsed law." Local authorities turn a blind eye to the existence of private pregnancy termination services where abortion on request occurs in women's health clinics. Despite the existence of federal sanctions, these services are sustained by collusion at the local level, private information networks and some degree of secrecy. The clandestine nature of private pregnancy termination services is offset by the clinics' outward appearance of propriety, i.e. they offer obstetric and gynecological services, and/or outpatient surgery, while providing pregnancy termination as a non-publicized service.

Third, medical pluralism or the existence of parallel medical systems, western and traditional, provides some degree of choice for women seeking pregnancy termination. Traditional Malaysian (Chinese, Malay and Indian) healing systems have various imputations of cause for a single illness and for various illnesses

deriving from a single cause. For example, traditional Malay medicine attributes illness to supernatural as well as physical causes. Furthermore, certain foods may cause or cure different illnesses (Chen 1981: 127-8). Such systems allow different health-seeking options to be exercised in a society where control over one's body or fate is uncertain and where control may be completely outside one's domain. Different health-seeking options may be an attempt at establishing or re-establishing such control over one's life. These options may allow a woman to choose a method of pregnancy termination that is most comfortable for or, at minimum, accessible to her. The existence of complementary health systems possibly reduces the hegemonic effect of the western system, helping to shift the balance of control towards the individual.

3.2.1 Third World Feminisms

Along with the opening up of feminist discourse to nonwestern voices has been the notion of gender as a local social and historical construction. The commonality of women, therefore, is seen not to be their biological similarity or commonality of oppression under patriarchal systems, but rather one of a common context of struggle for changes in power relations at all levels (Mohanty 1991). This encompasses redefinitions of bases for power, recontextualizing definitions of sexuality, redefining roles for men and women and re-ascribing the relation between individuals and the state. In other words, the bases of a more inclusive feminism have the potential for a closer adherence to the radical nature of feminism itself.

A related benefit of Third World feminisms is that they allow, if not mandate, the needs of Third World women to be self-defined and self-determined, rather than to be assumed to be identical to the needs of western feminists. Additionally, they assert that there needs to be a delineation between whose needs are being served when the category of "Third World women" is applied, i.e. which women's needs are being addressed? Axes of race, class, gender and nationality would have to be examined before such a determination is made.

On the negative side, the locality and specificity of sites of feminist struggle, i.e. its many local forms, make it difficult to bridge across nations without coalition- and consensus-building, itself often a time consuming effort. There is the related difficulty of the postmodern dilemma of creating stable categories for purposes of analysis and policy-making, when categories themselves are shifting and contested terrains.

Third World feminists have usually situated themselves in relationship to a postcolonial world in which hierarchies of race, class, caste and gender were apparent. Feminist scholars have looked at how white masculinity embodied colonial rule, creating and imposing a model of white male rule as legitimate through various ideological means, such as chivalry myths, Christianity and social Darwinism as well as through codes of sexual violence (Mohanty 1991: 16).

This legacy of colonial ideology continues today in countries which adopt judicial and administrative models from the colonizer country which implicitly contain racial and sexual formulations of identity which derive from white male

relations of ruling. Postcolonial governments such as Malaysia have attempted to regulate sexuality along middle-class, conjugal, and heterosexual lines where previously the cultures had tolerated a far wider range of sexual expression. For example, referring to the part of island Southeast Asia which includes Malaysia, anthropologist Shelly Errington (1990: 39) states that "gender differences tend to be downplayed in ritual, economics, and dress; kinship terminology and practice tend to be bilateral; and male and female are viewed as complementary or even identical beings in many respects." Hierarchy by age or seniority, and complementarity, provide the axes against which much of the symbolic order of these societies is drawn. Fusion, rather than differentiation, of male-female characteristics is believed to constitute power and potency (Errington 1990: 51-2).

A recent study by a Malaysian anthropologist (Karim 1992) presents the view that traditional Malay custom (*adat*) works in favor of women's equality in that country while Islam, the religion of most Malays, does not. She links gender, religion, class and other structural formations by claiming that

> throughout history, Malay culture, in *adat*, has ensured women a position equal to men and that *adat* constructions of gender regularly attempt to redefine and reaffirm women's social contributions in the long term. Hence, despite former and current patriarchal developments in thinking through Islam and religious orthodoxy, the religion is often operationalized according to these indigenous reconstructions of culture and gender. In this sense, Malay *adat* as an 'equalizer' actively attempts to formulate women's position vis-à-vis men in non-hierarchical ways despite Islamization and other allied processes (capitalism, industrialization and modern bureaucracy) which become subject to male interpretations which are usually made to favour men rather than women (Karim 1992: 219).

It is impossible to generalize, however, on racial, sexual and identity formations without taking historical context into consideration. The general if somewhat totalizing statement that may be made is that among many postcolonial capitalist countries, there is a tendency to embrace a western middle-class, patriarchal sexuality with the ensuing male double standards of morality. Revivalist right-wing religious dogma also helps bolster male-supremacist state ideology (Mernissi 1991).

Given this postcolonial background, many Third World feminists see the postcolonial state as a nexus for oppressive relations. In this sense, these Third World feminists are united with western feminist ideas in seeing the state as regulating gender and sexual relations through the implementation of policies affecting the family, housing, the labor force, education, child care, taxation, etc. Such analyses invariably make connections among the state, class interests, public policy and often ethnicity as well.

Feminist anthropologist Stivens (1992) has made mention of some particular difficulties of writing about women in Malaysia. At an overarching level, local scholars using western intellectual analytical models have found it difficult to reconstruct paradigms that have only recently undergone deconstruction by western feminists. Secondly, much of previous social science research carried out at the local level by male scholars has been androcentric, rendering gender and the role of women invisible. More recent research by feminist scholars both locally and from abroad, however, has partly rectified the situation by weaving together analyses of

gender, class and the position of working-class women in the new international division of labor (Stivens 1992: 214).

A third area of concern has been that research on Malay women has outweighed that done on women of other ethnicities living in Malaysia such as Chinese and Indian women. This pattern of research itself serves to reinforce and perpetuate Malay cultural hegemony. Lastly, some local feminist scholars are loathe to confront certain patriarchal aspects of religion, sexuality and other oppressive forces for political reasons. Confronting religious fundamentalists may have unpleasant consequences. Furthermore, some progressive academics and community activists have been detained without trial by the government as recently as 1987, demonstrating that government tolerance for academic freedom is limited. New discourses which escape these difficulties have yet to be applied. In the section below, I will attempt to make some connections between changing social conditions and shifts in identity formation within some classes of Malaysian women in this postmodern landscape.

3.2.2 Gender, Identity and Sexuality

Changing economic conditions in Malaysia in the past twenty years have influenced attitudes and social values to some extent. Moral values as reflected in women's sexuality may be changing. While men's sexuality may be changing as well, this remains beyond the scope of this study. The relatively recent influx of young rural Malay women into the industrial urban labor force and the consequent challenges to male authority, the loosening of family and community control over

women's sexuality, and women's increasing independence and earning power have created considerable turmoil for traditional social systems (Ong 1990b).

Ong (1990a) discussed the formation of a new female identity for formerly rural Malay women working in urban Japanese-run factories in free trade zones. The modesty, i.e. moral virtue, of rural Malay women continued to be protected in urban factory settings by rural men from the same background while these women continued to work within commuting distance of their villages. Ong maintains that the difference in power relations that resulted from women's increased earning power was balanced by the moral authority of men who kept "their" women pure. She also acknowledges that despite external forces of family loyalty, Islamic asceticism and male authority, this new sense of power has allowed women to resist traditional definitions of female identity and remonstrate by participating in consumer culture, using their savings to plan alternative careers, refusing arranged marriages and predisposing themselves to premarital sexual activity (Ong 1990a: 420).

I would also suggest that labor shortages within the past three years in Malaysia have resulted in the busing of women to free trade zones from out-of-state, in effect loosening familial ties by making it more difficult for women to return to their rural villages. The "protection" system by which village males had extended their authority by guarding the moral virtue of working women from their villages is now also diminishing so that factory women are increasingly free of traditional moral and disciplinary strictures. They may now rely upon urban and perhaps more urbane

males for emotional comfort, which may lead to taking risks with personal safety and moral judgment, and may open themselves up to the possibility of sexual exploitation. A recent work on Malaysian factory women observes that "Malay and non-Malay men often form liaisons with these girls, not so much for the purpose of marriage but merely to establish temporary sexual relationships" (Karim 1992: 201).

While the research does not indicate if Malay women themselves are looking for temporary liaisons, this remains a possibility. There is some evidence that Malay women (and men) are marrying later in their twenties than in previous years and that increasing numbers of Malay women are remaining single (Hirschman 1986).

According to Ong (1990b), partly in response to the changes in female identity formation and the attendant loss of some male control over female sexuality, Malay womanhood has been redefined in Islamic fundamentalist terms to maintain male authority and social order in ways that preserve Malay class privileges but reinforce traditional sex roles. Fundamentalist Islamic tenets were applied towards and taken up by Muslim women of all social classes as part of a college-based movement begun in the late 1970s. "Almost overnight, large numbers of university students, young workers, and even professionals began to enact - in prayer, diet, clothing, and social life - religious practices borrowed from Islamic history, Middle Eastern societies, and South Asian cults" (Ong 1990b: 267), cleaving a dichotomy in dress and philosophy between fundamentalist and liberal Muslims. Although the *dakwah* (fundamentalist Islamic) movement has waned in popularity, it still maintains a critical mass of support in Malaysian society today.

The fundamentalist claim that a woman's body should be covered to hide what is considered erotic for men itself veils the heterosexist assumption that a woman is responsible for male sexuality and that males themselves bear little if any responsibility for their own sexuality. This assumption has yet to be challenged, yet its implications for women's agency as individuals and as a social category are many.

In a recent study of east coast Malay women, Rudie (1994) examines gender relations in a region that is both more religiously conservative and culturally more permissive of women's roles in the public sphere than in other parts of Malaysia. Here working-class Malay women have greater economic freedom since they earn independent incomes through marketplace-selling. Rudie (1994: 297-8) contends that the tight homosocial nature of this society diminishes the possibilities for power struggles in cross-sex relationships and that in family relationships, seniority prevails over gender hierarchies. Nevertheless, males are still dominant in political and *bu*reaucratic matters. Conflicts of power are thus muted.

While changes in their economic standing may signal increasing conservatism in roles for some Malay women, they may bring about liberalization for others. Urban middle-class women who have either not been subject to or not taken up the religious strictures of fundamentalism have found increasing levels of economic independence with industrialization. Western feminism has made its presence felt not only in academic circles but in social, political and legal reform. While the state does not celebrate feminist ideology, it also has not viewed social services such as

rape crisis centers and battered women's shelters as threats to state authority, perhaps because local feminists have framed their arguments as humanitarian concerns rather than in terms of gender oppression within a capitalist patriarchy.

3.3 Abortion Theory

The framing of abortion as "the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood, and young women's sexuality are contested" (Petchesky 1990: xi) seems to apply in the local context of American society. Luker (1984) makes a similar claim that abortion holds a larger symbolic meaning for different groups within the United States, which ultimately crystallizes into pro- or anti-choice stances on whether abortion should be legal. These theses may or may not necessarily hold across all societies, given the historical specificity of social conditions that are unique to each. In addition, they may not hold in societies which do not have traditions of public debate and dissent which "contestation" by definition requires.

In some societies, abortion has not been framed in the same terms as in the United States and the struggle over the legality of abortion and abortion rights for women, if such a struggle occurs in the public domain, takes place under different social conditions. In some socialist or socialist-oriented societies, such as Cuba and Sweden for example, abortion has been framed as a public health issue and as a social right of women (Petchesky 1990: xxv). Incorporated into a broader social agenda, it does not appear to have raised concerns over the meaning of motherhood or contestations over women's sexuality.

On the other hand, Petchesky's (1990) argument that abortion is part of a larger ideological struggle between women and the state seems to fit in the case of Singapore. Abortion on request was made an incentive for an antinatalist policy by the government in the 1970s and 1980s despite local dissent. It was subsequently used as a backup means of contraception by women, as revealed in repeat abortion rate increases, while it successfully reduced population growth which was the original intent of the policy.

Contestation over the meaning of motherhood as described by Luker (1984) does not currently apply in Malaysia only because feminism has not taken hold to such a degree that options for women are broad enough to generate controversy. That is, the nuclear or extended heterosexual patriarchal family is still widely upheld as the only available choice for women choosing marriage, and is sustained across ethnic and class lines. Unlike the United States, where level of education appears to mediate views on what women's roles should be, which in turn may be linked to ideological position on abortion, there is no documented link between education, views on motherhood and abortion rights advocacy in Malaysian women.

3.4 Population Control Ideologies

From the preceding discussion, it seems obvious that the master paradigm concerning abortion in Malaysia, as well as in some other Southeast Asian countries, is not one of a contestation over rights, morality, or the meaning of motherhood, as has been the case in several western countries (Luker 1984; Ginsburg 1989). Rather, it has been the linking of a neo-Malthusian ideology to

national development or industrialization policy, the direct link being overpopulation and poverty. For developing countries, this tie was made an explicit condition of lending policies by western funding agencies, and for about twenty years (c1960s-1984), Malaysia conformed to this ideological imperative when it sought such funds (Chee 1988: 166). Abortion policy as part of overall population policy was just one of an array of strategies with which overpopulation, and thus poverty, was to be fought if western aid was to be available.

A major criticism of the population control paradigm is that it serves the cause of imperialist powers for it poses the problem of unequal economic growth between the developed and developing countries as one of overpopulation in the developing countries rather than as the result of colonial extraction and depletion of resources of the developing by the developed countries (Chee 1988: 166) and vast northern overuse of resources. In fact, some developed countries have denser populations and fewer natural resources so that the relationship between economic development and population is a tenuous one at best.

Population control theorists have often used demographic transition theory to justify their aims, i.e. population control is needed to bring about a fertility decline, which results in decreased poverty and increased economic growth. Fertility declines were meant to progress from high mortality and fertility rates to low rates of both. The fundamental transition here lies in the shift of children from economic assets to economic liabilities (regardless of other meanings imputed). In revising this theory, Hartmann (1987) suggests that it is not merely the increase in technology

and healthier and better standards of living but rather the shift in distribution of wealth and wider dissemination of public services to all segments of society that provide the catalyst for change toward smaller families.

Rather than population control programs, it is transformations from social and economic structures that perpetuate poverty and the need for many children to survive that are responsible for demographic transitions. Some examples of this have been seen in Cuba, South Korea and China. Malaysia, along with many other developing countries, may be stuck in a phase of low mortality and high fertility rates because the requisite structural reforms have not yet occurred. But this is now profoundly complexified by the pronatalist state policies in place over the past decade.

Demographic transition theory has been used to buttress population control ideology. It may also be critiqued for being universalizing in nature. Despite these criticisms, the modifications to it described by Hartmann (1987) in linking social reform, such as extension of education, employment and health benefits across class lines, with a reduction in fertility, provide a useful framework with which to connect the need for safe effective pregnancy termination with the need to reconceptualize the meaning of health in broader social terms.

Demographic transition theory may also be criticized for being economic-rationalist and universalizing in its conceptualization of the motivations for human reproductive behavior, i.e. that changes in fertility can be induced solely by the manipulation of economic incentives, without taking cultural factors or the

specificity of local conditions into consideration. A recent study (Salaff 1988) has shown that this thesis may hold under very specific conditions of tight social control over a small city-state, Singapore. When economic incentives and disincentives were applied to reduce population growth, married couples in general changed their beliefs about family size to conform to government-sanctioned ideals. In Malaysia, its larger neighbor, state policies are unable to penetrate to the village level on logistical grounds alone so the same effectiveness cannot be attained.

3.4.1 Capitalism and Nationalism

Although somewhat less intrusive than Singapore in the private lives of individuals, the Malaysian state can be viewed as colluding in its own exploitation and in that of its citizens when it implements population policies that 1) may prove detrimental to the health of women, and 2) relegate women to traditional roles that are generally of low-status, i.e. to those of homemaker and child-rearer. With a target population of 70 million to be reached without concomitant improvements in infrastructural support such as health and housing, it is quite logical to assume that disincentives to population control will be enacted, making birth control including pregnancy termination services less accessible or available to women.

A noticeable effect of the capitalist framing of both pronatalist or population control policies is the use of women and their bodies for financial (cloaked and expressed as national) interests. Modern technology has been introduced in many sectors of the economy as westernization and transnational economics help shape much of Malaysia. The displacement of women's labor in agriculture and their movement into the manufacturing and service sectors, and women's adaptation to

new technology at the office and factory level have implications for their health. Rather than harnessing industrial policy for the overall betterment of its people through the promotion of economic self-sufficiency, the state plans to do the opposite by linking development with transnational corporatism. The beneficiaries of such policies would seem to be the industrial and other ruling elites of the country.

The rhetoric of nationalism has been analyzed recently (Heng and Devan 1992: 356) in terms of asserting that postcolonial states attempt to feminize whatever they deem to be anti-national. By feminizing politically weaker groups while simultaneously associating strength with nationalist rhetoric, groups with power may then justify discriminatory social policies enacted against less powerful groups. Framed in terms of national interest, the government of Singapore has recently normalized certain classes (e.g. poor or working-class) and ethnicities (e.g. Malays) as being "soft" or feminized, and has used this rhetoric of the feminized "Other" to manipulate social and political policy to its advantage. In pursuing an active eugenic and antinatalist policy in the late 1980s, government officials began urging Chinese middle- and upper-class women to reproduce in larger numbers as a patriotic duty, while actively discouraging non-Chinese (Malay and Indian) and lower-class women, the "Others" of record, from doing so. The government was concerned that college-educated and Chinese women were not producing enough "intelligent" children to compensate for the higher birth rates of lower-class and non-Chinese women producing "less intelligent" offspring. State fatherhood, i.e.

political leaders as patriarchs and the body politic as subordinate family, is a discourse of power well entrenched in many Southeast Asian countries, making the application of power in the form of "father knows best" policies easier to enforce.

As a discourse of power in Malaysia, state fatherhood can be seen in the relatively unquestioned rhetoric on the "70 million" population policy, i.e. a government-mandated population target of 70 million Malaysians by the year 2100, and the manipulation of women's bodies in the national interest. The feminization of the "Other" as anti-national seems less applicable since the Malaysian state, unlike Singapore, is Malay-dominated and cannot feminize the non-Malay (Chinese and Indian) communities because of a different balance of power. Whereas in Singapore, the Chinese dominate both politically and economically, in Malaysia, the Malays hold political sway while the Chinese dominate economically. Pronatalism in Malaysia aligns national interest with Malay political dominance, with women's bodies as the site of ongoing struggle for political power through numbers.

3.4.2 Influence of Religion

Following the socialist feminist argument that abortion policy reflects the needs of the state (Petchesky 1990), prior to the 1984 turnabout in Malaysian population policy, expediency would have dictated that abortion on request be the order of the day, as is the case in Singapore. That it was not suggests that other factors even then mediated against such a policy despite supposed "imperatives" of development. One possible factor may well have been the influence of religion, in particular of Islam, especially in its more fundamentalist forms.

Although Islamic teachings do not expressly forbid abortion, these views may not be widely known because conservative members of the religious hierarchy have tended to interpret Islamic teachings as so doing. The Quran indicates that the fetus has to pass through various phases before becoming a human being with a soul (Omran 1971: 516). But local interpretations vary and since Malaysia experienced an Islamic revivalism in the late 1970s through the 1980s, this may have served to dampen attempts at liberalizing abortion laws.

3.5 Reproductive Rights Frameworks

Western abortion rights theorists who advocate abortion for women as reproductive choice or freedom usually draw upon a reproductive rights framework to argue their case. Reproductive rights frameworks distinguish themselves from population control ideologies in several meaningful ways. As stated in chapter One, reproductive rights for women encompass the right to determine whether or not to have children, how many children to have, ideally when to have them, and to be able to make free and fully informed choices from a wide range of safe, effective and affordable contraceptives (Mintzes 1992: 17). This theoretical framework uses women's reproductive needs as individual and cultural beings, not controlling population growth, as a basis for policy (Mintzes 1992: 9). It places control over reproductive choices, but not the sole responsibility for contraception, in the hands of women.

Reproductive rights defined broadly encompasses a wide range of feminist demands within a human rights and social justice framework. These demands include equal pay rights, environmentally safe workplaces, accessible and adequate

quality child care, safe abortion and contraceptive choices, the right to reproductive education, decent medical care, control over birth options and reproductive technologies, the right of lesbians and women with disabilities to have children, the need for men to share in parenting and housework, and an end to oppression for all peoples (Fried 1990: x; Hartmann 1987: 53).

Before a critique of reproductive rights frameworks can be made, a distinction needs to be drawn between old and new reproductive technologies. This is necessary because old reproductive technologies constitute a distinctive other terrain from the new; the former are aimed at preventing conception while the latter promote fertility. Old reproductive technologies include contraception, abortion (including the relatively recent "abortion pill," RU486) and sterilization. Some key works in this area have been authored by Arditti and colleagues (1984), Clarke (1984), Fried (1990), Hartmann (1987), Raymond et al (1991) and Shapiro (1985). New reproductive technologies include artificial insemination, in vitro fertilization, human embryo transfer, cryopreservation, egg and sperm donation, surrogacy and other "infertility treatments" (Elmer-Dewitt 1991: 58). Some key works here include those by Corea (1985), Petchesky (1990), Raymond (1989) and Stanworth (1987).

In attacking neo-Malthusianism and the increasing lack of reproductive control it affords women, Hartmann (1987) asserts that contraceptive research has been directed toward removing control over contraceptive methods from women in much the same way that women have been removed from active participation in the birth process. Low technology birth control methods such as the condom and

diaphragm are not actively promoted by population control agencies because they are considered under the user's control and thus not adequately effective (Hartmann 1987: 32).

But not all feminists agree that reproductive rights serve all women's needs equitably. Some feminists in developing countries (Alexander 1990; Akhter 1992) question the slogan of reproductive rights as racist and classist. They claim that it is racist because it is primarily a demand of western women claiming to speak for all women, and classist because the language of "rights" stems from bourgeois individualism and does not speak to women in countries which have yet to offer civil liberties and democratic rights to its citizens.

The reproductive "choices" which most poor women in developing countries are given are shaped by the population control establishment; therefore, the cry for choice of contraceptives rings hollow. Before reproductive rights can serve any purpose but an extension of population control in these countries, a social transformation needs to happen (Akhter 1992: 1-8). In the social context of many developing countries, reproductive rights cannot be meaningful, except to a few elite upper- and middle-class women.

In other instances in developing countries, and when cloaked under the banner of individual rights, abortion may be used to extend and reinforce male privilege. In India, sex selective abortion serves this purpose (Alexander 1990), magnifying gendered differences in access to life (Moen 1991: 232).

On another front, there is an erstwhile and ongoing debate in western feminism between socialist and radical feminists concerning different strategies of control over new reproductive technologies (Raymond 1989; Vanderwater 1992). Socialist feminists such as Petchesky (1990) and Stanworth (1987) advocate working toward control over the new technologies and their use and focus on women's right to use the technologies for their benefit. This assumes technology may be wrested from male control and harnessed in the interests of women. Radical feminists such as Raymond, Klein and Dumble (1991) take a critical stance on science and technology applied to women's bodies in the form of long-term contraceptive implants or new reproductive technologies. They advocate either a ban on the use of certain high-tech solutions to reproductive problems or the creation of low-tech women-controlled solutions, e.g. self-help menstrual extraction instead of surgical techniques for early pregnancy terminations.

Socialist feminists such as Petchesky (1990), Dixon-Mueller (1993), Clarke (1984) and others have also mounted serious critiques of science over the last twenty years in attempts to situate old reproductive technologies such as contraception and abortion within reproductive rights frameworks. Sterilization abuse (Clarke 1984; Shapiro 1985) is one documented example where science has been used to implement social engineering policies on behalf of the state by involuntarily sterilizing minority, working-class and disabled women in the United States and Puerto Rico.

Radical feminists hold a more skeptical view as to whether science, which in many ways is primarily a male domain, can be controlled or geared to meet the diverse needs of women. They question the basis of a reproductive freedom which is grounded in a social context where women are powerless to effect real choice and where power structures are primarily male-defined and male-controlled.

The socialist feminist strategy for reproductive control is to keep abreast of new reproductive technologies and lobby for their use and control by women. This includes wanting to be in at the design stage of research, deciding what will be created and participating in the creation and testing of new technologies. Radical feminists reject this strategy as self-defeating and opt instead for alternatives to high-technology solutions. These alternatives may be low-tech or self-help measures or they may be institutionally female-defined solutions.

Radical feminist theory, which validates the importance of women's knowledge and experience, promotes the role and service of midwives in the provision of health care during and after birth in countries where traditional birth attendants often vie with western medical practitioners. Although they may differ in approach, both socialist and radical feminists have historically been united in the promotion of women-centered knowledges and experiences as part of gaining reproductive rights for women.

Both perspectives, however, originate in the West where democratic freedoms and individual rights are usually enshrined in law. Non-western feminists have been critical of this approach because the rights to privacy and the pursuit of happiness,

for example, are not givens in many of their countries and so the language of rights does not speak to their issues. However, the common context of struggle against patriarchy and the oppression of women requires strategies and local solutions to what may or may not be universally-felt problems. Local strategies based on western theories are one possible solution if or when locally-derived theories are unavailable or prove ineffective.

These themes recur in ongoing north-south debates in the feminist literature on international reproductive rights. Petchesky and Wiener (1990), for example, have reported on the debates that took place at one such congress on global feminist perspectives for reproductive rights and reproductive health. While western feminists were concerned with how to incorporate reproductive rights into international human rights instruments generated by the United Nations, Third World feminists restated their concerns with the basic need to link reproductive rights and women's health to issues of poverty, economic crisis and to local conditions specific to each country (Petchesky and Wiener 1990: 29-31).

3.5.1 Individual Rights and Freedoms

Nowhere in this discussion of access to pregnancy termination services has the rhetoric of women's rights or a woman's control over her own body been used. This is principally because the concept of individual rights is largely absent in Malaysian society. Yet this liberal feminist viewpoint could provide a possible starting point for raising women's consciousness, elevating the position of women and providing the basis for requesting pregnancy termination services as women's right.

The extent to which women control their own bodies and have actual choices through which they may implement that control is basic to determining the course of their lives and subsequent status in any society. Controlling pregnancy is one of the most fundamental dimensions of women's control over their own lives. To be able to control the outcome of those pregnancies when socioeconomic or other conditions are unfavorable for having children is a bottom line survival issue for women.

From my perspective, it is therefore crucial that decisions to terminate pregnancies be women's choices and women's right, not be subject to male authority whether in the form of a spouse, a physician or the state. That it lies in the hands of medical practitioners in Malaysia is an artifact of both the hegemony of western medicine and of patriarchy. Traditional medicine offers a greater degree of autonomy for women since these pregnancy termination methods are essentially self-help or low-tech, without need for male mediation, but the control may be offset by the questionable efficacy and the risks and discomforts of such methods (Laderman 1983).

The class and ethnic bias in government policy affects poor women most since it is lower-income women who mainly utilize state medical facilities and services. As an alternative to the western model of individual rights for women choosing pregnancy termination, it might be possible for Malaysian feminists to organize discussion groups among poor women on sexuality education. In educating women

about their bodies, women and not the state may be better able to affect population policy (Barroso and Bruschini 1991: 153-72).

Women who can afford it seek help from private practitioners and institutions in Malaysia or elsewhere. While it is commendable that there exists the choice of traditional practitioners to serve the needs of lower-income women, this does not exempt the state from providing adequate health and social support, including the provision of safe and accessible pregnancy termination services. The health of all women is ultimately at stake.

3.6 International Perspectives on Women's Health

At the cross-cultural level, recent public health research (Sen et al 1994) as well as medical anthropology has addressed issues of women's health. According to anthropologist Whelehan (1988), there has been a selective interest in reproductive health, concentrating on women's traditional biological roles around pregnancy, child-bearing and menopause, and more recently on sexuality, as well as on women as passive recipients of health care. Whelehan and others (1988) attempt to redress this issue by focusing on women as active participants in health care for their own needs: how women achieve and maintain health, and how they deal with threats to it such as stress caused by overwork or by forces of cultural change.

Theoretically, women across cultures meet their health needs during their life cycle through "deliberate, rational decision-making processes, syncretizing traditional and western medical beliefs and practices, and applying a sense of satisfaction achieved in earlier life to deal with health and status concerns of later life" (Whelehan 1988: x). For example, Malay women in Brunei, adjacent to East

Malaysia, who experience stress from overwork actively seek out traditional healers for herbal remedies and massages, and use family and relatives for emotional support (Kimball and Craig 1988: 170). The principle of women as active agents can perhaps be extended to women who seek out pregnancy terminations in Malaysia.

There has also been literature on "women in development," with health as a subtopic. These monographs usually provide a world-wide overview of women in developing countries. They are sometimes put together under UN-organization auspices and are generally of a piece, with statistics on the "developing world" and generalizations applied across the board. In a recent example (Smyke 1991), key health issues for women are defined as primary health care, reproductive health, occupational health, lifestyle issues, cancer, AIDS, women with disabilities, elderly women, refugee and migrant women, and women as consumers of health-related products. Factors influencing women's health are listed as being economics, status of women, demographics, politics, education, environment, food and nutrition, traditional practices, local health risks, violence and exploitation (Smyke 1991: Table of Contents).

One critique that can be made of the theoretical literature on women's health in international perspective is that attempts at lumping "women in development" and "Third World women" into a single category of analysis are ultimately self-defeating. Such attempts have been made in some UN-based publications (e.g. Smyke 1991), resulting in analyses which are too general to be applied to any one

country or region of the world. These publications essentialize women of the "Third World" through a hegemonic gaze and discourse.

How has this gaze manifested itself in the discourse between western and Third World feminists and in western perceptions of Third World feminist issues? Who gets to define Third World women and how are they contextualized? Recent writings by Third World feminists suggest that Third World women have been essentialized as the "Other" by many western feminists in monolithic terms as underdeveloped, illiterate, poverty-stricken, and living within oppressive traditions in overpopulated, hierarchical societies. Mohanty and her colleagues (1991) and Ong (1988) maintain that these analyses freeze Third World women in time, space and history, without locating them within a sociohistorical context or giving any notion of the dynamic and fluid nature of social forces acting upon them. The agency of Third World women as social actors is thus rendered invisible.

Mohanty (1988) counters with an example of a 1982 study by socialist feminist scholar Maria Mies in which historically and culturally specific structures of patriarchy form the basis of the latter's analysis of how a particular group of women (lace-workers in India) are exploited by a hegemonic economic world market. The analysis also points to how women are able to resist and subvert the production process at various stages. It contradicts the oftentimes reductionist studies of Third World women by showing them to be active participants in the development process.

This western hegemonic discourse is partly based on western constructions of whiteness or of how white women see themselves in opposition to nonwhite others. As Frankenberg (1988) has explicated, notions of whiteness contain a subtext of colonial impulse and expression. The unequal power relations that devolve between white academics and nonwhite research subjects has also been acknowledged (Patai 1991).

Tsing (1993: 8) adds that an alternative to the western gaze "lies in situating local commentaries within wider negotiations of meaning and power at the same time as recognizing local stakes and specificities." Karim (1992) also makes a theoretical case in support of gender systems in non-western countries that are less hierarchical and more bilateral in nature. When examined through this prism, patriarchal systems appear to be mediated by local historical conditions in favor of granting more power to women. According to Karim (1992: 4-5):

> (t)he assumption that one should begin with the premise of unequal power generating gender hierarchies is not necessarily relevant in non-Western civilizations which derive a theory of knowledge from concepts and values of bilaterality, the need to maintain complementarity and similarity rather than hierarchy and opposition, the need to reduce imbalances through mutual responsibility and co-operation and the value of sharing power between supporters and followers. Bilaterality does not concern itself with relations between the powerful and the powerless but the powerful and less powerful.

Even so, she admits that in the case of Malaysia, recent Islamic interpretations of the role of women in society have reinforced patriarchal values and a conservative moral climate where previously the status and value of women had been slanted towards egalitarianism.

3.6.1 Western Medicine as an Alien System

Concepts of health and biomedicine have also been critiqued as being western impositions on local cultures. One of the earliest implications of the legacy of colonialism on health and the health care system in postcolonial societies was a health care infrastructure skewed toward the provision of health care to workers who were essential to the colonies' productivity and the neglect of people located in the interiors of those countries or on the periphery of resource extraction (Chee 1982; Manderson 1987). Health was initially conceptualized as an extension of colonial ideology.

The introduction of western medicine to Malaysia in the early twentieth century, symbolized by the inauguration of the Institute for Medical Research in 1900, resulted in the eventual displacement of traditional systems of healing as the dominant mode. Colonialists were primarily interested in deploying western medicine for their own interests, not for the welfare of rural dwellers. Western medical systems developed in major urban areas were based on ability to pay, thus reflecting and preserving class interests. Cures for malaria and scrub typhus, two diseases affecting both colonialists and laborers clearing jungles, were actively researched and treatments were found. At Independence, Malaysia was left with a western medical system serving the towns and traditional healers serving the poor and rural areas.

Government health policy since then has successfully helped construct a rural health system based on western medicine. However, traditional systems are also largely intact despite attempts at partial displacement through the regulation of

certain traditional medical practices and reflect the basic urban/rural rich/poor dichotomies. The alien quality of western medicine and the familiarity of traditional healers based on a longer history of their being part of their cultures and communities and who provided support for community needs are reflected in the choices poor and/or rural women make when both systems offer pregnancy termination services.

3.6.2 Access to Abortion Services

The rural/urban split roughly demarcates women's access to western pregnancy termination services. It serves also as a rough proxy for ethnicity and class as most rural people tend to be Malay and poor. Traditional methods of pregnancy termination are therefore more accessible to rural Malay women, either by preference or because of availability. Some areas of the country are unserved by either western or traditional systems of medicine and for women in these areas, pregnancy termination services are as unlikely to be present as is primary health care. Another underserved group would tend to be estate plantation dwellers, primarily Indian women employed as rubber tappers, whose poverty rates are high. As one gets closer to urban areas, women's options and access to pregnancy termination services would tend to increase.

In addition to locality of residence, education and income are other variables affecting women's access to pregnancy termination services. As with contraceptive use, women of different ethnic groups with value systems derivative of different levels of education and income (as well as ethnicity), vary in their acceptance of western medical services including pregnancy termination services. A study

conducted in a Chinese village revealed that "women avoided the pill because they considered the risk of taking it to be greater than that of an unwanted pregnancy; pills are thought to be 'heaty' so if taken at all were taken at intervals of two to three days thus providing no contraceptive benefit at all" (Cleves 1990: 2).

Marital status and the stigma of being single and pregnant may influence which women use western versus traditional methods of pregnancy termination when these services are available. Records show that the overwhelming majority of women seeking pregnancy terminations in government hospitals are married (Vachher and Yusof 1978). An unmarried woman is likely, therefore, to use traditional methods or, if she can afford it, to seek a pregnancy termination in a neighboring country such as Thailand or Singapore where her anonymity might be preserved. Prevailing standards of morality among all ethnic groups in Malaysia still prevent single motherhood from being tolerated, much less accepted. Religious values form the underpinning of some of these moral standards.

3.7 Summary

From the previous discussion, some pertinent theoretical issues in terms of research on women in the Malaysian context may be framed. Abortion may be a contestation about motherhood or the sanctity of life in some societies such as the United States, but may be an established social practice with different local meanings attached to it in other cultures and societies.

Abortion coupled with economic and other incentives to promote government population policy may work in a tightly-controlled state like Singapore, but not as well in Malaysia which tends to be less socially-controlled. The Malaysian

government's pronatalist policy is further mediated by the recent liberalization of abortion law. Nevertheless, the influence of religion and fundamentalist religionists may have a chilling effect on the moral climate of the country which, in turn, may affect both individual women's decisions to terminate unwanted pregnancies as well as access to pregnancy termination services.

Local and country-specific reproductive rights frameworks may be more theoretically and practically salient than western models. In addition, international health perspectives may have limited applicability when they unwittingly portray Third World women as an undifferentiated mass, as passive victims, or as the "Other" in contrast to white, middle-class western women. To its credit, postmodernism has potentially allowed Third World feminists a louder voice in self-definition and self-determination. Even so, many of these feminists retain the notion that the postcolonial state often does not act in the best interests of women but rather in the repressive ways of their colonial masters when dealing with matters of sexuality and class.

Western medicine, as one example of postcolonial domination, may only complement and in some instances may be alien to local or traditional pregnancy termination methods. Furthermore, access to abortion may be skewed along class and rural/urban lines established during colonialism. Though restricted by law and, in some cases, dependent on individual physicians' religious and moral beliefs and/or profit motives, access to abortion is tempered by a Malaysian health system that is still relatively affordable.

Control over women's bodies by the state in the interests of capitalism and nationalism might have mixed results. This might be because the resulting pressures on the family produce unintended consequences such as a reduction in desired family size despite government pronatalist policies. A final point is that in an industrializing state, it is working-class women perhaps more than any other class of women who act both as agents and objects of change within the family and in male/female relations.

4. THE CLINIC

4.1 Penang: General Background

Penang is an island of about 135 square miles located off the northwest coast of peninsular Malaysia. During its years as a British colony, it earned a reputation as a retirement haven with good shopping and an easy lifestyle. It used to trade in spices, pepper, cloves, sugar cane, tapioca and rubber. Located at the northern end of the strategic waterway of the Straits of Malacca, trade was its raison d'être as a colonial outpost. Traders from Scotland, China, India, Arabia, Armenia, Indonesia and Burma emigrated and settled there. It remained a free port until a few years after the British left in the late 1950s.

The legacy of the British included colonial architecture, a British-based education system for the local elite which included missionary schools and English as the common language of discourse, domestic servants for those who could afford to have them, English civil law and a self-perpetuating government bureaucracy. Underlying this was a local culture that thrived on hard work, initiative and a love of the land.

In the 1960s, the new state government began to pursue a different and largely successful blueprint for economic survival. They set up industrial export zones and, with the enticement of tax incentives and cheap female labor, attracted multinationals from the United States, Germany and Japan to develop manufacturing plants in Penang. They also promoted the island as a recreational spot for foreigners. Today the state makes its living primarily from tourism and the manufacture of semiconductors. The emphasis on industrial development has

shifted from being a low-cost unskilled and semi-skilled factory town to a research and design-oriented skilled labor resource center along the lines of neighboring Singapore (Vatikiotis 1994: 76).

This rapid transition has brought with it most of the advantages as well as the concomitant problems of urbanization, industrialization and postmodern multinational westernization. As Penang modernized and the cost of living rose, domestic servants became scarce so that women workers from other poorer countries such as the Philippines and Indonesia arrived to take up the slack. Local working-class women preferred factory to domestic work. The work of women in these factories helped fuel Malaysia's current economic boom.

4.1.1 The Research Setting: The City

Penang's two major industries are the manufacture of electronics and semiconductors, and domestic and international tourism. Because of its diverse historical influences stemming from its colonial trading port status, it may not be typically representative of cities and towns in Malaysia. As an analogy, San Francisco would not be representative of most American cities because of its relatively open acceptance of immigrant populations, its highly educated population, liberal outlook, etc.

Factors which contribute to making Penang unique are: a) it is the only Malaysian state with a majority Chinese (53 percent) population, compared to a 35 percent distribution in the population nationwide (Correspondent 1992: 61); b) the sample in this study is primarily urban while Malaysia as a whole is 45 percent urban (Correspondent 1994a: 48); c) there is an industrial free trade zone in Penang

which results in large numbers of out-of-state rural young women being resident in an urban area; and d) as an international tourist center and historical trading port, Penang tends to be more cosmopolitan in outlook than most other cities in peninsular Malaysia.

Although representativeness of the data may be at issue in this study, some homogeneity of participants at this particular family planning services clinic in terms of social class and ethnicity, i.e. working-class Chinese women, was anticipated going in to the study. In other words, class and ethnicity in this clinic sample would not be represented in proportion to their occurrence in the Malaysian population. Because of the self-selection that occurred by study participants, there were two resulting subsamples: one of Malay working-class women and the other of English-speaking middle-class women of all ethnicities.

4.1.2 Abortion Services in Malaysia and Penang

Abortion services appear to be available in every major city and a few towns in west Malaysia and are likely to be more prevalent on the developed west coast. They are reported to be available in the Klang Valley surrounding Kuala Lumpur, Penang, Sungei Petani, Alor Star and Kota Bharu from interviews with clinic clients. Newspaper reports also claim that clinics providing pregnancy termination services exist in Ipoh, Johor Bahru and Kulim (Correspondent 1986).

The family planning clinic where I did my research was unique in a number of ways from other clinics that provided pregnancy termination services. According to the clinic director, other privately run clinics do not provide contraceptive counseling in as much detail or encourage the use of contraception as much as his

clinic does. However, the state-run Family Planning Association clinics in Penang naturally do provide counseling on contraceptive options.

The clinic director's claims were substantiated during interviews of women who had had abortions performed elsewhere. These women had had pregnancies terminated in public hospitals, private maternity homes or health clinics. One woman had had a suction aspiration performed under general anesthesia in a private maternity home in Kuala Lumpur. She mentioned she had received no counseling about the medical procedure but did get an explanation of the overall process. Another woman did not receive contraceptive counseling at a private health clinic she visited in Penang. A third woman who had had a D & C chose a private medical center in Penang where she worked as a nurse and also received no contraceptive counseling.

Another difference between the research site and other clinics was the attention paid to client needs. At my research site, there has been a conscious effort to recruit female doctors since many Malaysian women feel shy undressing in front of and being examined by male physicians. From client interviews, other clinics tended to have only male doctors in attendance but this may not hold true for all clinics offering pregnancy termination services.

This clinic was probably similar to other clinics in the medicalization of the entire procedure. The presence of nurses in uniform, doctors, operating theaters and recovery rooms, and the use of drugs and pharmaceuticals help foster the image of

western medicine as authoritative and effective. This image would most likely be fostered at other clinics using the western medical model.

4.2 Ethnography of The Clinic

I reported to the clinic on Monday May 31, 1993, after having talked on the telephone with Dr. A and his head nurse, Mrs. C. There was some confusion over whether the clinic was to be open Monday or not since it was a public holiday. The doctor did not know, so he had me call his head staff nurse to confirm. She said it was going to be open that Monday.

On the first day, I was introduced to the staff, shown around the clinic complex, and witnessed three pregnancy terminations as they were being performed in the operating theater (OT), positioned next to the doctor and looking right at the women's cervical areas. At the time, I experienced no negative emotional or psychological after-effects, or so I thought. But from the next day onward, I never went to the doctor's end of the table again. I felt that I had overdosed on seeing blood and other contents being extracted from women's uteri.

4.2.1 Clinic Setup

The clinic was housed in a two-story building located just off the main road about three miles from a major industrial export processing zone (or free trade zone, as it was locally called), and about ten miles from the center of downtown. It was accessible by public transport. Most clients came with someone else by motorcycle, car, taxi or on foot. Some brought their children along. The clinic was set back from the road, affording some privacy for occupants and clients. The sign on the outside said it was a family planning clinic, and next to the front door was a

signboard detailing the services provided, and a reminder that general practitioner services were not available. Abortion was not mentioned; pap smears and the issuance of contraceptives were included on the signboard.

When you walked into the clinic, you walked into the main reception and waiting area. The nurses' station and cashier's desk ran alongside the right side of the room, with wall seats around three sides of the room. Adjacent to the reception desk was a partitioned area where intake counseling was given. This gave a semi-private, semi-public environment for counseling, although when operating at full capacity and volume, privacy was assured, with one counseling session drowning out the next.

Intake counseling on a one-to-one basis went over a client's medical history, contraceptive history, and details of the last menstrual period to estimate the duration of pregnancy. Men, women and sometimes children accompanying clients waited in the reception area. Some men brought their mobile phones with them and conducted business while waiting for their partners to come downstairs after recovery. There were also a couple of benches outside where family members could sit. I once saw a man bottle-feeding a young child while waiting outside for his spouse.

Counseling also included the determination of a client's socioeconomic status by a nurse for purposes of setting fee charges, and an abbreviated informed consent procedure. Nurses judged a client's ability to pay based on factors such as appearance, age, client's occupation, partner's occupation, number of children, and

number of prior pregnancy terminations. Although it was not clinic policy to be punitive towards women with prior pregnancy terminations, the nurses felt there should be a financial disincentive against using abortion as a contraceptive method. Doctors were allowed by the clinic director some input as to what clients should pay, but nurses provided the main input to this decision based on the criteria described above. I was told that at least one other clinic charged young, single women more than other types of clients in an attempt to be punitive and to discourage unmarried women from having abortions. The clinic I studied did not follow this practice.

The average take-home pay per month of a factory worker is MR$400. A pregnancy termination ranges in price from MR$100-$350, depending on the services required and the nurses' estimate of a client's ability to pay. Most clinic clients are working-class women, the majority of whom are married with children. Although this clinic makes it relatively affordable for such women to pay for pregnancy terminations, other clinics in the city charge higher prices for similar services, in some cases pricing them out of the reach of most working-class or poor women.

During counseling, nurses mentioned the one percent chance of infertility as a consequence of pregnancy termination and that if a medically incomplete abortion occurred, the clinic would offer a repeat procedure at no charge. If a male partner was present, his signature would be requested to confirm the client's understanding of these terms. In the past, some partners had disagreed on whether to continue or

terminate pregnancies and the unhappy partner in the situation had threatened the clinic staff with legal consequences. At other times, clients had blamed their pregnancy terminations for their subsequent inability to conceive. The clinic director had therefore instituted this policy as a measure of protection. It was not part of any wider regulation of pregnancy termination services by the state. There was also a requirement for women not yet legally adults to have their partner agree to accept responsibility for their actions.

The signature of the male partner was usually asked for after the nurse had informed them both of the one percent chance of infertility as a possible consequence of pregnancy termination, and of the possibility of a second pregnancy termination procedure if the first resulted in an incomplete abortion. If no male partner was present, an accompanying relative's signature was sought. In rare cases where women came alone, they would sign for themselves, if they were over 18 years old. Minors were asked to obtain their parents' consent, but if a teenager was unable or unwilling to do so, the clinic would allow her to sign on her own behalf. This constituted the informed consent procedure.

The signature of a male partner or family member could be construed as being sought not only for legal protection but also as social affirmation of support of the woman having the pregnancy termination. According to clinic staff narratives, however, the overriding concern appeared to be the need for legal protection.

Privacy within the clinic environs did not extend to the reception area. Here each woman's privacy was violated by nurses' very public instructions to fill a urine

sample, on how to take oral contraceptives and how much to pay, all of which were done within earshot of the waiting room audience. What was normally private was bared; the flip side to this was that what was usually taboo became normalized in a very short time. In a surreal way, there was a "show" going on and attention was riveted on the spectacle in progress, whether it was nurses talking over the intercom or telephone, giving clients instructions, or clients putting on their own show and going on display for the entertainment of the rest of the room. When the reception area was fairly empty, nurses would congregate behind the nurses' station and talk busily. Sometimes Dr. B, the female doctor, would join in. It appeared that everyone preferred the clinic busy with people to having to fill in the lull themselves. Rainy days and some afternoons could be slack but business was usually brisk.

The walls of the waiting area were decorated with a few family planning posters, one claiming that low dose pills provided no weight gain, while a couple of others proclaimed that you could not get AIDS from toilet seats or hugging. There were some family planning magazines lying on a side table, together with travel magazines from many airlines, a testimony to the clinic director's frequent travels. The decor was nondescript and functional rather than aesthetically pleasing. It had been a while since the walls and ceiling were last painted.

Beyond the waiting area was a bathroom, two doctors' examining rooms, and then came the kitchen-cum-computer work area. The entire building was air-conditioned; piped-in music was played via cassette tape from behind the nurses'

station. There was an adjoining building which belonged to the clinic director with a kitchen where nurses took their tea-breaks and lunches, and a living room area for clinic staff to rest.

One removed one's shoes before walking upstairs into a staging area. From the staging area, one could observe traffic between the two operating theaters (OTs), the third doctor's room, the recovery area, and the bathroom. The recovery room had nine beds, a nurse's table and an additional adjoining bathroom. There was also a back room where cleaning materials used by the clean-up crew (locally called *ayamahs*) were kept and where wet materials were hung out to dry. In between the two operating rooms, and only visible to nursing staff, was an instrument set-up area or sluice room where instruments were cleaned and sterilized.

4.2.2 Staff

The staff consisted of three doctors, eleven nurses and two cleaning women or *ayamahs* as they were called. The doctors were Chinese and Indian, of whom one was Hindu, the other a Sikh. The Sikh doctor was female, the others male. There were two Indian nurses, the rest were Chinese, and all of them were tri- (Malay, Chinese, English) or quadrilingual (adding Tamil). The two *ayamahs* were Indian. There was also a Chinese accounts clerk-cum-programmer, who kept the clinic books as well as maintained the computerized client records system of the clinic which was quite sophisticated. The complete absence of Malay staff was somewhat surprising and may have made the clinic experience a little less comfortable for Malay clients. The nursing profession in Malaysia draws from all ethnic groups

including Malays, although Malays remain underrepresented as doctors. It would be normal, therefore, to expect an ethnically diverse staff in most clinic settings.

My relationship with the nursing staff developed over time. Most of the nurses were working-class. I was conscious that my position as a relatively highly educated researcher of middle-class background tended to reinforce my outsider status, but I tried not to let class differences interfere with our interaction. The head nurse, Mrs. C, had been trained in England, and the others were locally trained. The first time I had lunch with the nurses (and this was a deliberate attempt on my part to socialize on their terms), I asked if anyone had gone to my old secondary school to establish common points of history and interest. One nurse, L, had attended my convent school and another, LP, had been to a sister convent school. This broke the ice.

The nurses had been primed by Dr. A to expect me there and to help me in whatever way they could and this proved true throughout the length of my clinic stay. They were always helpful, ever solicitous of my needs, even when I myself did not feel very motivated to keep up a professional front. Every morning, I would be greeted with a cheery and seldom perfunctory, "Good morning, F," from one (usually L) or more of them, offered a cup of tea, coffee or Milo until they became used to my routine of many years of not eating or drinking anything before lunch. Mrs. C made a point of asking me if I had had clients for the day at least twice a week.

My previous observation of an abortion clinic had been in the San Francisco Bay Area in the United States. It had been a feminist-centered, collectively run clinic

where pregnancy terminations were done in a minimally medicalized setting. Women who came to the clinic were counseled both in groups and individually at a pre-procedure session, given literature on the process, related risks, their options for medication, and aftercare procedures. The emphasis was on giving women the power to decide what they wanted to do throughout the process.

Following counseling, these Bay Area women had laminaria inserted overnight to soften their cervices, and returned the next day for the actual surgical procedure. This was done on a table with the women minimally sedated in a room with a physician, an assistant and a counselor present. The only visible signs of medical instruments were the electric vacuum aspirator and a drawer containing cannulas. Except for the physician in whites, everyone wore plain clothes. Outside this room, staff conversed in normal tones and there was an air of casualness that made the clinic appear rather homey. This type of clinic was atypical, even for the Bay Area. Most abortion clinics would have tended to be organized hierarchically and the setting would have been more medicalized than in a woman-centered collectively run clinic.

In contrast, it was apparent that the pregnancy termination process in this Malaysian clinic was performed in a highly medicalized environment with references to patients, the performance of the procedure in operating theaters with women being made to lie on their backs with their feet up in stirrups, and medical staff wearing uniforms. The clinic director mentioned to me, though, that he had experimented with the dispensing of uniforms but had found that women would not

comply with nurses' orders as readily in that instance. The compromise then was to allow nurses to pick their own design for uniforms once every two years or so. All nurses currently wore a professional-looking purple short-sleeved blouse and knee-length skirt, which could be alternated with pants. The nurses' uniforms thus acted as a "badge of office" to prevent their authority from being challenged. I was asked by the clinic director to wear a uniform as well so I came to the clinic every day in "whites."

4.2.3 Work Flow

Office hours were from 8.30am-4.30pm Monday through Friday and 8.30am-12.30pm on Saturday. The work flow was organized so that there were three team leaders who rotated being in charge of the cash register, OT and the recovery room. Mrs. C was the head nurse in overall charge. On busy days, the work was batched so that the morning shifts (8.30-10.00, 10.30-12.00) allowed each of the three doctors to have two batches of three clients, for a total of eighteen. In the afternoon shifts (2.00-3.30, 3.30-4.30), there were again two batches of three clients per doctor. On less busy days, the batches were decreased to two clients.

The busiest days of the clinic were Monday, Tuesday and Saturday. Many women worked outside the home and the half day on Saturday was convenient to take off work. Some women came in during the morning and had to leave by noon so that they could be back at work in the afternoon. These were women for whom return appointments had been scheduled, not ones on whom pregnancy terminations had been performed. The latter were advised to go home and rest. Post-pregnancy termination follow-up visits were usually scheduled for Wednesday

through Saturday when the clinic seemed less busy. The time spent waiting to see a doctor was usually between five to forty-five minutes, depending on the volume of business and the number of physicians available at the clinic. Sometimes doctors took the day off for vacation or other purposes which increased the logjam of clients. The nurses, however, had a fairly efficient workflow in place so that between 35-40 clients could be put through in any one day.

Most early (6-9 week) first trimester pregnancy terminations were performed within the time span of a couple of hours during the first visit. After intake counseling, the woman waited to see a doctor for an ultrasound examination and further counseling. The doctor questioned the woman on her reasons for wanting a pregnancy termination, and provided some contraceptive counseling. If the fetus as shown on the ultrasound screen measured less than 10 millimeters (5 weeks), the doctor would recommend the woman return in a few days or within a couple of weeks, so as not to perform a "missed" abortion. If the doctor agreed with the woman that a pregnancy termination was needed, she waited in the staging area to be medicated. Then she was directed to one of two OTs for the procedure. These operating theaters were called "OT"s by clinic staff. I did not hear clients ever call them by any name.

There were options for medication which were usually determined by the nurse, depending on criteria such as parity, fetus' gestational age, marital status of client, and age of client. Medication included painkillers, antibiotics, anxiety medication, and antiemetics to control nausea. In addition, IV sedation was usually given to

nulliparous, young, single women, or for late terminations (discussed below). The amount of sedation depended on the doctor; two of them usually favored half-sedations, while the other favored a drug cocktail and full sedation for high anxiety cases.

A different schedule was followed for what were termed the "big cases," clients with pregnancies from 11-12 weeks and 13-15 weeks. These required clients to be at the clinic the entire day. In the morning, they were given Dilapan, an artificial form of laminaria used to dilate and soften their cervices. They rested on a bed in the recovery room, were routinely monitored for blood pressure, and ate a light lunch if they felt like it. If they were dilated enough by lunchtime, they were scheduled for the procedure before noon; otherwise, they were wheeled into the OT around 2pm. There was always a nurse on duty in the recovery room. There was no outward indication that the staff treated these women any differently from the early termination cases other than that the "big cases" were given extra attention in the recovery room both pre- and post-pregnancy termination. In general, however, they were charged more money for the extra medication and care-giving services provided.

4.2.4 Family Planning Services

Family planning services were routine and were offered to clients as part of the intake admissions and counseling process as well as during follow-up visits. Contraceptive counseling services were routinely provided here but not at other local clinics performing pregnancy terminations. This was congruent with the beliefs of the clinic director in enhancing reproductive options for women. The

nurse would have the woman call over the male partner, if present and waiting, when discussing future contraceptive means and sometimes also when the reasons for termination of pregnancy were being discussed. Contraceptive options were often shaped by nurses' perceptions of what would be best for the client. The quality of counseling services also depended on the amount of time available for each client. The nurses were well trained in contraceptive information, but tended to push the IUD, Pill and condom use, and to a much lesser degree the use of natural fertility awareness (safe period), spermicides (Rendalls), DepoProvera or Norplant. However, a unique method of using post-coital pills (usually taken four a month and called Postinor) was promoted for those women with out-of-town partners having sex on an irregular basis.

Condoms were not promoted as much as other methods since condom use by males was thought to be an unreliable method. Men were not assumed by the clinic staff to be responsible partners in contraceptive decision-making. It was understood that Malaysian men preferred to use condoms when visiting prostitutes but not with their other female partners. Disease prevention, sexually transmitted diseases and AIDS were not discussed. AIDS awareness was limited to a poster on the wall of the reception area which delineated the many ways AIDS could not be transmitted (via toilet seats, hugs, etc.) Some of the clients may have been prostitutes but their health needs were not addressed. Pap smears or testing for sexually transmitted diseases were not a regular part of the admissions procedure. Only a urine test was conducted routinely to check for heart or renal disease. Although there was no

AIDS testing, disposable needles and syringes were used in surgery and contact with blood was minimized through the use of rubber gloves.

4.2.5 Client Records System

My background in computer programming and analysis proved useful in analyzing client records. The client records system consisted of a customized computerized database management system called DBASE that ran on a network of personal computers housed in the back of the clinic. I realized if I was to analyze the data I would have to learn to program in DBASE III Plus, the database query language used by DBASE, so I began to read the in-house manual during my first week at the clinic. I also borrowed more software manuals from my brother as well as from the university library, which was located within a couple of miles of the clinic.

There was five years' worth of data on-line since the system was installed in October 1988. Prior to that, all records had been kept manually and, although they were onsite next door, were in a fairly inaccessible state. I found this out when I asked for pre-1988 records and Mrs. C said it would be an effort to get.

The database itself was split into two subsets because of size. Each client record had an identification key called a National Registration Identity Card (NRIC) number. The clients with lower ICs (i.e. older women) were in one database partition and the ones with higher ICs (younger women) were in another. After some skewed data analysis, the resident programmer pointed this out to me. To rectify the situation, I had to do two analyses, one of each partition, by computer program and then manually combine the results for the overall picture.

The computer provided a respite when things were slow and I did not have any clients to counsel or do follow-ups on. I also found it fun and interesting to learn DBASE and use it to extract a profile of the women who came to the clinic. Only averages and percentages were possible, since I did not have the necessary expertise to perform statistical correlations or multiple regressions using DBASE.

I had an interesting relationship with CH, the Chinese female computer programmer. It was part competitive part cooperative, in the Malaysian way of trying to be one up on the other in terms of knowledge and skills. The reasons for this were twofold: the Malaysian education system breeds competition, and Chinese culture tends to be hierarchical. Therefore, I would have to be placed either in a one-up or one-down position with respect to CH. Being aware of this, we were both jockeying for the one-up position.

4.2.6 Chronology of Events

During my first week at the clinic, I created a counseling script for pre-pregnancy termination counseling. After discussing my role with Dr. A, we figured that I would have three opportunities to talk with clients: when they were waiting to be first seen by a doctor, when they were in the staging area prior to OT, and post-pregnancy termination during their follow-up visit to the clinic. I reasoned that, most likely, women would not be interested in telling me their stories in the recovery room, since they might be groggy or disoriented from sedation, as well as be too wrapped up in their own feelings, or might simply want to leave the clinic as soon as they could. I thought the most relaxed time to catch them might be on their follow-up visit. Although I was warned that not all women would come back for

follow-up visits, I was not aware that the follow-up visit rate was only around 30 percent, until quite late into my stay.

My interviews were centered on the idea of talking to them during follow-ups. I discounted doing any interviews during the time clients were waiting to be first seen by a doctor because at that point, they would have only seen me at their counseling session and no trust or rapport would have been established between us. It was essential to talk to them after I had done my pre-pregnancy termination counseling with them and had accompanied them during the pregnancy termination procedure itself so that they would be comfortable enough with me to discuss details of their personal lives. This conclusion was arrived at intuitively as a Malaysian familiar enough with the culture to understand that most Malaysian women would resent someone whom they had just met asking intrusive questions about them. There needed to be a passage of time and experience with me before they trusted me enough to open themselves up to questioning.

During the first week, I also sat in on nurses' intake counseling and doctor's counseling to get an overview of the clinic experience from the client's point of view. I followed a client through the counseling and accompanied her to the operating theater. I then looked in on her in the recovery room. On my first day, I also witnessed the vacuum aspiration procedure being performed on three women. I was struck with the thoroughness of the doctors and nurses in verifying that all fetal parts were suctioned out. The products of conception were visually inspected for the fetal sac in early cases while the client waited on the operating table. For

"big cases," a nurse would reconstruct the fetal skeleton to make sure no body parts remained inside the woman's uterus.

I was also struck by the use of appropriate technology for the medical procedure itself. During my clinic stay, there were two electrical brownouts during which all electricity to the clinic and surrounding areas was cut off. The clinic was able to function normally during these times since the vacuum pumps in use were hand-held, not electrically-powered. During these brownouts, no air-conditioning was available, but windows were opened instead. The only holdup to surgery during a brownout was if a tubal ligation was being performed, since surgical instruments were electrically-powered in that instance. So far, that had not happened at the clinic.

Although I did not ask the clinic director how the decision to use hand-held instruments had been reached, it seemed to be the best one in light of the unreliability of the electrical supply in the area. From his frequent trips to the United States as head of the national family planning association, the clinic director was aware of state-of-the-art technology but for practical considerations may well have chosen to rely upon less technology-dependent methods of service provision. Similarly, when the water supply was cut off once or twice for public works projects in the area, the clinic director had buckets of water transported by car from his residence as a stopgap measure so that the clinic could continue its work relatively unimpeded.

During my second week, I began practice counseling in English with my first clients. It got better with practice. I also began translating my counseling script into Malay since the majority of clients in my sample were going to be Malay. Most Chinese and Indian clients preferred to talk in their own language, which effectively excluded me from their experience since I could not speak Hokkien or Tamil. This resulted in a sampling bias over which I had little control. I decided against getting a Chinese or Indian translator since that would have not been easy to accomplish. Instead I relied on the nurses to partly translate what their clients were telling them during the counseling sessions I sat in on with Hokkien- and Tamil-speaking clients. The forms used were in English so this made it easy for me to follow along as clients answered questions put to them by nurses during history-taking.

At the same time, I began learning DBASE III Plus and writing simple statistical analysis programs to discover the structure of the client database. At the end of week Two, I brought in my video on abortion counseling for a Saturday afternoon showing. I had obtained the video while in the United States which talked about some political and emotional issues as well as issues of process associated with the abortion experience from a liberal feminist perspective. I wanted the nurses to pick up on some of the issues and discuss them and perhaps bring out local perspectives on these and related issues.

This did not go as successfully as I had hoped since the showing of it was severely edited by Dr. A due to time constraints so that the nurses did not get a chance to watch all or even most of it. Some nurses also said they could not

understand the heavy American accents of the discussants in the video. Instead, Dr. A summarized its content and picked out the main issues as he saw them. I audiotaped the discussion which followed. Since the clinic director directed the conversation, it effectively prevented possible alternate routes the conversation might have taken had the nurses brought up issues they considered salient instead.

As I got more comfortable with the counseling process, I began to see the difficulties I would encounter in getting women to tell me their stories. These problems related to whether my setup was geared toward creating an environment of security, safety and confidentiality, or of the reverse. The key to getting women to open up hinged upon my treatment of them during a 10-minute pre-pregnancy termination informational counseling session during their stay in the staging area and of my accompanying them into the OT and being supportive of their needs. This time was used to build up a trust and rapport between the client and myself.

Some women would not feel comfortable having me sit in on their counseling sessions unless they obtained prior permission from their partners. These were primarily Malay women. Nurses noticed this tendency because they were the ones who acted as my advocate in getting clients to agree initially to be counseled by me.

Sometimes the nurses would schedule the client for medication or the OT before I had enough time to get through my counseling script, and sometimes there was too much time and not enough conversation. Additionally, my counseling skills were limited to reacting to clients on a human, common sense level, rather than as

a skilled, trained abortion counselor. My knowledge of counseling had been gleaned from watching the techniques of informational counselors at the abortion clinic in Northern California rather than from any clinical training. I did not pass myself off as a trained counselor but rather as a counselor-in-training at the clinic in Penang.

For Malay women, my rusty use of the language also hindered my ability to transcend class and ethnic barriers, but the fact that I was the only Malay staffperson around worked in my favor in getting Malay women to talk to me. Although the nurses at the clinic had excellent multi-lingual skills, the tendency to seek out one's own kind for emotional comfort played its part in Malay women preferring to talk to me, despite my language deficit.

The clinic director and nurses were interested in the western approach to counseling that I offered to clients. To reciprocate my being at the clinic, I gave out fliers and how-to cribsheets on counseling methods I had obtained from a San Francisco Bay Area feminist-centered abortion clinic. The head nurse especially seemed appreciative of my efforts at sharing this information with nurses and clients. At the same time, I made a conscious attempt not to rock the boat when observing staff-client interactions, except when my role as client advocate deemed it appropriate. There were a couple of times when I intervened on behalf of my clients in asking nurses to give particularly anxious women some sedation. These clients did not meet the criteria for being sedated and, even though they had requested sedation, had been overridden by the nurses. Because I was there at the

clinic director's request and also perhaps because I did not "overdo" such requests, the nurses tended to listen to my requests on behalf of clients.

One particular incident stands out in my memory where my intercession on a client's behalf resulted in a clinic policy change. Early in my field research during week Four, I sat in on the admissions counseling of a 20 year old single Chinese woman, who appeared to be a college student. She had been working on a cruise ship to Hong Kong for the last month and a half and had lost track of her last menstrual period since it had become irregular while on board ship. She was also now 13 weeks pregnant. She had come to the clinic with her boyfriend and was anxiously seeking a pregnancy termination. Both were well-dressed, English-speaking and well-educated. She seemed like a routine case to me.

About twenty minutes later, I was getting ready to meet her in the upstairs staging area for my pre-pregnancy termination counseling session and asked one of the nurses if she was up there. I was surprised to learn that one of the doctors had requested that she get parental consent before he would perform the pregnancy termination, and that she had left the clinic feeling very reluctant to tell her parents with whom she lived of her situation. According to internal clinic guidelines, 21 is the legal age of consent for Muslim women, while 18 is the adult age for others. Muslim *syariah* law regards women to be under the guardianship of their fathers till age 21, while civil law applies to non-Muslims. Since this young woman was legally an adult, I felt that the doctor had denied her access to a pregnancy termination based on his personal biases. This doctor was known for his paternalism

towards clients which was projected by his being overly cautious in dealings with clients. The other two doctors put the needs of their women clients before other concerns.

I immediately went to the clinic director's office and asked him what his policy on parental notification was and then informed him of what had just transpired. My argument was that if one was a legal adult, then one had to be responsible for the outcome of one's actions. Thus this client, having made the decision not to tell her parents, would have to deal with the consequences of this decision if it proved to have negative results. Furthermore, placing this burden on her would be adding a level of trauma to an already difficult emotional situation. The clinic director agreed with my arguments and talked to his head nurse. Apparently, the doctor who had requested parental consent was concerned that since she was a "big case," there might be complications that would require the parents of the woman to know what to do if that happened.

The upshot was that over the next couple of days, some nurses tried calling the client at home to get her to come back to the clinic, but she was never there. Although we never found out what happened to her, we assume she went elsewhere to get her pregnancy terminated. The clinic director later put out a memo that in cases where parental consent was a murky issue, all doctors should be notified prior to the client being asked to obtain such consent. This effectively neutralized the third doctor from denying access. I felt that my actions had been positive in helping women if situations such as this were to arise in the future.

However, some nurses took the side of the third doctor, and the doctor himself kept his distance from me until it came time toward the end of my stay for our interview together.

During weeks Three through Five I counseled clients and by the end of week Five I had thirty in the sample. When I reached the number adequate for my study sample size, I relaxed my effort to solicit study participants so that by the end of week Eight, I had 39 (twenty Malay, nine Chinese, nine Indian, and one Eurasian) study participants. This sample was composed of two subsets: a relatively small middle-class, multi-ethnic subsample in conjunction with a primarily working-class Malay one. I also realized at this rate, I would have to stay for four to six months if I were to do follow-up interviews for thirty women.

Nurses usually obtained about a 30 percent follow-up visit rate from clients, while I had close to a 50 percent return visit rate from my study sample. According to the head nurse, many women worked and could not afford a day off to come back for a follow-up. I had eighteen follow-ups at the end of week Eight of a planned three month field research visit. A larger proportion of clients I had counseled may have returned to the clinic perhaps as an outcome of the self-selection process, i.e. the ones more willing to be interviewed were also the ones more likely to return for a follow-up visit.

4.2.7 Staff Perspectives

During the course of my stay, some interesting conversations with nurses took place over lunch in the kitchen of the building next door. Dr. B, the female doctor, often joined us for lunch, while the two male doctors had their food brought to

them in their offices. This was in accordance with the traditional homosocial nature of Malaysian society and the status differences between doctors and other clinic staff. Dr. B liked to socialize and during our lunches she managed to dispense with the formalities usually associated with maintaining class barriers, i.e. she joked along with us and laughed at the sometimes ribald humor of the nurses. There were also sometimes jokes made at the expense of the male doctors which she tacitly condoned.

The nurses, many of whom were old-timers at the clinic, were generally supportive of women's needs and rights after having seen firsthand the problems that women faced in their relationships with men. A couple of them even seemed to have personalized their experiences at the clinic by choosing to remain single. They had internalized basic feminist principles through both the training they received from Dr. A, himself a feminist, and from their everyday work experience. They spoke of how they wanted to help women and how they saw their jobs as helping women, despite the stigma attached to working in an abortion clinic.

> Sometimes they say, "Oh, that place, you all do abortions." After that you tell them, "No, you are wrong, we not only do that, we do other things, anything to do with family planning." "Oh, is it? I didn't know. I thought you all only do this." They are not aware we are providing other family planning facilities like ligation, vasectomy, pills. So first idea they have is you all do abortions. Even a GP told me, "You all don't deliver kids, you all do the other way round." I said, "No, you're wrong. No doubt we don't deliver kids but we do other family planning methods, everything what you want." Which they are very surprised.
>
> Because they don't know that we provide these kind of services to them. All they think is abortion. This place is dirty. This place they all do abortions only. Until we explain to them, no, everything is available: pap smears, gyny, ... ultrasound scanning. We're doing service to the public. We're helping. We always tell them we help a lot of poor people, we're giving free IUDs, which they are not aware (Interview with nurse P).

In spite of wanting to help women, their experiences with repeat clients had in a sense also hardened them. About one in five clients they saw had come to the clinic previously for a pregnancy termination, but some of the nurses perceived this rate to be much higher, and cast the repeat clients in an exaggeratedly negative light. They saw these women as not wanting to take care of themselves, not listening to the counseling advice given to them, and using pregnancy termination as the contraceptive method of choice. In my discussions with nurses on this issue, I created the term "hard-core" to describe these repeat clients, usually meant for women with more than three pregnancy terminations who constituted less than 10 percent of clinic clients over the years. This term was picked up by the nurses in their references to such clients thereafter.

On the other hand, first-timers or women with no prior pregnancy terminations were viewed much more sympathetically by the nurses as being victims of contraceptive ignorance, accidental pregnancies or of having unwilling or reluctant partners in the use of contraception. Interestingly, even though nurses were knowledgeable on the different methods and effectiveness of contraception and counseled clients to use medically effective methods, some nurses themselves practiced less effective methods such as withdrawal, safe period, or nothing at all.

At times, however, the cynicism that arose with having to deal with clients who did not always tell the truth, something the nurses were experienced enough to distinguish, compelled them to laugh about the stories clients sometimes told. The nurses had a rating scale of top "performers" or those women whose stories of what

brought them to the clinic wanting a pregnancy termination outshone any others. The top rated story was from a woman who was a repeat client. Her reason for wanting a termination of pregnancy the first time was that her boyfriend had absconded or left town; the second time, it was because she had been raped and a third time, because her boyfriend had died. The nurses said that I should be there when she came the next time so that I could see what reason she gave then. What made her such a performer was that she would manage to sound pretty convincing until the nurse checked her history in the computer database and would find she had been at the clinic several times over the years, making her story less plausible.

Another top performer was a woman who said that she had no idea how she became pregnant but that a spirit was responsible for her situation. This story was told with relish and gave grounds for bouts of hilarity. The cathartic effect of these stories appeared to give nurses the energy to get through the rest of their workday.

The nurses felt that some women needed to lie or tell sob stories in order to get the clinic to perform the pregnancy termination for them or to try to get discounted charges for the procedure. They said they usually gave the client the benefit of the doubt the first time even if they had reservations as to the veracity of the client's story, but if a client came back a second time with a similar story, their sympathy would be stretched to the limit and they would treat the client with a little more skepticism. One nurse's attitude was that she wished all clients would tell her the truth because the clinic was going to help them anyway.

4.2.8 Closure

Toward the end of my clinic stay, I presented the clinic director with the results of my quantitative analysis, which he was interested in seeing and disseminating to his colleagues in the national family planning association (FPA). In our discussion of the client profile, Dr. A also gave me a few leads on what aspects of the profile needed further analysis based on his experience with the data. He consented in writing to this data being used for publication purposes.

A major difficulty I encountered during the project was getting women to be audiotaped. Most refused when asked. I succeeded in getting seven taped interviews, four from the clinic and three from outside sources. The three outsiders were not considered to be part of the 39 in the clinic sample. To compensate for the dearth of taped interviews, I taped the entire clinic staff, the doctors individually, and the nurses either individually or in small focus groups of three to five women. I asked Dr. A for a history of the clinic, and for the major issues of service provision as he saw them. The other two doctors were given a six page questionnaire to answer, which drew out their attitudes and experiences as doctors working in an abortion clinic. The nurses were given a list of eight questions to answer in an effort to obtain information of women's experiences from secondary sources.

Although the two cleaning women on staff were asked for interviews, they both declined for reasons which I could only surmise to be related to their class position. They were working-class women but because they did the dirty clean-up work, were lower in the occupational and social hierarchy of the clinic and were treated in a manner appropriate to their status by other clinic staff. They probably felt

uncomfortable being interviewed by an outsider and someone of a higher class position. The reason they gave was that they had nothing to say.

I ended my clinic research on Saturday July 31, 1993. This turned out to be a long day since Dr. A scheduled an afternoon workshop for all staff and invited FPA personnel to attend. I gave a fifteen minute workshop on western approaches to abortion counseling, during which time I stressed the need for treating clients with dignity and respect, the major need at the clinic from my perspective.

I had observed several instances of nurses talking down to clients of lower social status and had felt that power imbalances between clients and clinic staff were detrimental to the quality of service provided. The nurses themselves had on several occasions mentioned that they had encountered upper middle-class clients whom they termed arrogant and demanding so I knew they were at least sensitive to the existence of class bias.

> Those people who are really educated, I think they are more arrogant. Because they come here, they expect the best. The way when they talk to you, one kind, snobbish type, very demanding, like they got all the money in the world, you got to serve them as queen. These patients I think they are very hard to get along with (Interview with nurse LW).

I had hoped to increase their own sensitivity to clients in this way, but may also have alienated them by being critical of them in front of others at the workshop.

There were also discussions given by the three clinic doctors on medical issues concerning contraceptive methods. The conversation tended to be directed by Dr. A. During this workshop, the clinic as a "Well Woman Clinic" was discussed, which was the first time I had known that this clinic was indeed such a clinic.

According to G, my contact from the FPA, this is in name only. Her perception is that Dr. A wants to be seen as politically correct but is unwilling to implement strategies that would make his clinic preventative rather than curative with respect to women's health.

The next weekend, I went to a barbecue and overnight retreat for clinic nurses, doctors, support staff and their families at a bungalow belonging to Dr. A. This was an annual event given by the clinic director as a fringe benefit to his staff. It was purely recreational, but this year they had moved the date up a couple of weeks so that I could be included in the festivity. Apparently, Dr. A treats his staff to many benefits such as a shoe and uniform allowance, a monetary bonus that increases with years of service, free lunches, and a regular 9-5 workday, all of which help in staff retention.

Although it rained during parts of the evening, the staff members and their families managed to occupy themselves with cooking, karaoke singing, playing cards and mahjong, and taking pictures. I got to meet the family members of nurses and to interact with them socially instead of professionally. I also videotaped parts of the occasion and karaoked along with the staff. After dinner, Dr. A rallied the staff for a group photo and then proceeded with a semi-formal presentation of a surprise farewell gift for me from the staff. In return, I gave an impromptu speech where I commended the clinic staff for their dedication and stamina for the work that they did everyday at the clinic, and said that whenever I thought of them it

would be with a lot of love and respect. Later that night, I was given a ride home by two nurses. It was a fitting end to a productive and worthwhile stay at the clinic.

4.2.9 Epilogue

In June of 1995, I returned to the clinic in Penang for a short follow-up visit. Two years had seen numerous changes in the clinic environment. The nurses wore new orange uniforms, a couple of the single nurses had married and there was a new supervisor in charge of the nursing staff. There was also a new registered nurse hired to oversee the aftercare of clients in the recovery room.

Building plans had been made so that the entire clinic was to undergo renovation and redesign in the coming year. These architectural design changes were to reflect the ideas of the clinic director and new nursing supervisor that the clinic be more efficiently organized and client-friendly. For example, the waiting area in the reception room was to be moved outside the building so that clients would be separated from non-clients, affording the former more privacy during admissions and counseling. Bathrooms were being upgraded to provide modern restroom facilities. Examination rooms were to be separated from doctors' offices. The needs of women clients for respect and privacy were being taken into account in the redesign of the clinic building.

The primary purpose for my visit, however, was to collect more quantitative research data for the two years that had ensued since my last visit. I was able to successfully run some computer programs to collect an additional two years' worth of data and incorporate the results into my previous analysis. Despite a power outage covering much of the island during the last week and a half of my stay, I was

able to download the files I needed onto floppy disks and perform the statistical analysis on this data upon return to the United States. The computer programmer at the clinic, CH, was of invaluable help in my being able to accomplish this data recovery. She offered technical assistance for the duration of my stay.

4.3 Clinic Client Profile

This profile of clinic clients was derived from data analysis of computerized client records stored in a database management system. Although data was available for the period November 1988 through May 1995, most of the analysis presented here in tabular form covers the six and a half year period between January 1989 and May 1995. Furthermore, the total client base ranged in age from 11 to 50 plus, but for purposes of manageability most analyses focused on women aged 15-44. Chi-square tests were run on most tables and, unless otherwise noted, they were all significant.

TABLE 1

Clinic Abortion Case Load (01/89 - 05/95)

	Number of Clients Whose Length of Pregnancy is:						
	< 10 wks		10-12 wks		> 12 wks		Annual Total
Year	#	%	#	%	#	%	
1989	3658	94%	124	3%	117	3%	3899
1990	3693	92%	100	2%	223	6%	4016
1991	3411	92%	100	3%	188	5%	3699
1992	3531	91%	99	3%	250	6%	3880
1993	3310	90%	119	3%	263	7%	3692
1994	3363	90%	113	3%	279	7%	3755
1995 (partial)	1379	88%	31	2%	163	10%	1573
Total	22345	91%	683	3%	1483	6%	24514

The total number of clients has been constant over the last six and a half years (January 1989 - May 1995), i.e. approximately 320 per month or 3,800 per year.

TABLE 2

Total Client Base (Including Non-Abortion Clients)

By Age 15-44 (01/89 - 05/95)

Age	#	%
15-19	1890	8%
20-29	11086	46%
30-39	9055	38%
40-44	1945	8%
Total	23976	100%

Most women (median age = 29; mode = 26; mean = 29; std. dev. = 6.9) are in their twenties and thirties and the overwhelming majority of them are married. About 10 percent of clinic business consists of non-pregnancy termination related procedures such as vasectomies, insertion and removal of IUDs, tubal ligations, contraceptive counseling and reproductive health examinations. The percentage of male clients is insignificant, and female clients outside the age range of 15-44 do not constitute a significant proportion of the clientele at the clinic. Therefore, the figures in Table 2 are not significantly skewed by the inclusion of clients who visit the clinic for non-pregnancy termination services.

TABLE 3

Total Client Base: Ethnicity Trends (01/89 - 05/95)

Year	1989		1990		1991		1992	
	#	%	#	%	#	%	#	%
Ethnicity								
Chinese	2706	66%	2730	64%	2448	61%	2412	57%
Malay	906	22%	1026	24%	1052	26%	1158	27%
Indian	500	12%	512	12%	529	13%	610	14%
Other *	11	0%	21	1%	17	0%	34	1%
Total	4123	100%	4289	101%	4046	100%	4223	99%

TABLE 3 (continued)

Total Client Base: Ethnicity Trends (01/89 - 05/95)

Year	1993		1994		1995 (partial)	
	#	%	#	%	#	%
Ethnicity						
Chinese	2232	56%	2260	55%	863	51%
Malay	1183	30%	1208	30%	517	31%
Indian	521	13%	536	13%	251	15%
Other *	49	1%	83	2%	55	3%
Total	3985	100%	4087	100%	1686	100%

Key:

* Eurasian (Malaysian), Indonesian, Bangladeshi, Filipina, Caucasian, Thai, etc. (foreign)

Clinic clientele tend to roughly conform ethnically to their representation in the population of the state, i.e. 53 percent Chinese, 35 percent Malay, 12 percent Indian, and 1 percent Eurasian and others (Correspondent 1992: 61). This ethnic profile has been fairly constant throughout the history of the clinic, although there has been a gradual increase in the percentage of non-Chinese clients.

Over the last six and a half years, there have been more and more non-Chinese women visiting the clinic for pregnancy terminations and other purposes. In particular, the proportion of Indian clients has increased. Malay women who were

formerly underrepresented with respect to their proportion in the population of the state are now visiting the clinic in greater numbers. Similarly, women not of the three major ethnic groups have also come to the clinic in greater numbers. Fewer Chinese women in turn are coming for clinic services. Although figures for 1995 reflect semi-annual totals, there is no indication that these trends are being reversed.

The increase in female clients of other ethnic groups perhaps reflects the economic growth and changes in migration patterns of the city and country as a whole. There has been an influx of workers from surrounding poorer countries such as Indonesia, the Philippines and Bangladesh. Women from these countries are employed primarily in the plantation, construction and entertainment industries, as well as in domestic care services. Since their primary aim is to earn money to repatriate to their home countries, and children would hinder their capacity to work, many of these women opt for abortions to terminate unwanted pregnancies.

During my research stay, there were at least two Indonesians and one Bangladeshi who visited the clinic to have abortions. Some of these women had difficulties with language and in communicating their needs. Nurses mentioned that Caucasian women who were en route to other destinations on tour ships, for example, would also come by for emergency pregnancy terminations.

TABLE 4

Total Client Base: Age Trends (01/89 - 05/95)

Year	1989		1990		1991		1992	
	#	%	#	%	#	%	#	%
Age								
15 - 19	297	6%	313	7%	276	7%	339	9%
20 - 29	2223	43%	1899	44%	1838	47%	1851	50%
30 - 39	2195	42%	1707	40%	1523	39%	1293	35%
40 - 44	508	10%	393	9%	320	8%	255	7%
Total	5223	101%	4312	100%	3957	101%	3738	101%

TABLE 4 (continued)

Total Client Base: Age Trends (01/89 - 05/95)

Year	1993		1994		1995 (partial)	
	#	%	#	%	#	%
Age						
15-19	285	9%	297	10%	156	11%
20-29	1570	50%	1515	50%	683	49%
30-39	1098	35%	998	33%	476	34%
40-44	196	6%	208	7%	83	6%
Total	3149	100%	3018	100%	1398	100%

While the largest number of women seeking pregnancy terminations are in the 20-29 age group, many are also in their thirties. It is also worth noting that there is a growing trend toward young single teenaged and young adult working women under age 30 seeking pregnancy terminations, while fewer women in their forties are appearing at the clinic, perhaps as a result of increased experience with contraception or contraceptive knowledge. Another possibility is that fertility declines with age so that fewer women who are over forty become pregnant with unwanted fetuses and seek abortions as a consequence (Poopalasingham 1977: 15).

TABLE 5

Total Client Base: Age by Ethnicity (01/89 - 05/95)

Age	15-19		20-29		30-39		40-44	
	#	%	#	%	#	%	#	%
Ethnicity								
Chinese	1283	67%	5546	52%	4561	56%	1098	64%
Malay	394	21%	3150	30%	2256	28%	417	24%
Indian	189	10%	1395	13%	1131	14%	183	11%
Other	47	3%	496	5%	206	3%	21	1%
Total	1913	101%	10587	100%	8154	101%	1719	100%

TABLE 5A

Total Client Base: Ethnicity by Age (01/89 - 05/95)

Ethnicity	Chinese		Malay		Indian		Other	
	#	%	#	%	#	%	#	%
Age								
15-19	1283	10%	394	6%	189	7%	47	6%
20-29	5546	44%	3150	51%	1395	48%	496	64%
30-39	4561	37%	2256	36%	1131	39%	206	27%
40-44	1098	9%	417	7%	183	6%	21	3%
Total	12488	100%	6217	100%	2898	100%	770	100%

In aggregate totals over the last six and a half years within the clinic sample, Chinese women are coming in larger numbers in the teenaged and over forty age groups. Indian women in the 20-39 age group are also visiting the clinic in larger numbers. In the other age groups, women of each ethnicity are represented roughly in proportion to their population in the state.

TABLE 6

Total Client Base Between Ages 12-50 (01/89 - 05/95)

Year	Number of Clients	Average Age (in years)
1989	5460	30.7
1990	4456	30.0
1991	4045	29.6
1992	3827	28.8
1993	3209	28.5
1994	3101	28.4
1995 (partial)	1419	28.1
Total	25517	29.4

The average age of a clinic client is 29 years for 1989-95 (std. dev. = 7.4; range = 12-50; median = 29; mode = 26). There has been slight variation around this.

TABLE 7

Total Client Base: Estimated Income Levels (01/89 - 05/95)

Year	1989		1990		1991		1992	
	#	%	#	%	#	%	#	%
Monthly Household Income (in MR$): *								
300-599	10	0%	14	0%	23	1%	8	0%
600-799	383	10%	279	6%	302	7%	219	5%
800-1199	2057	51%	2020	475	2024	505	2313	55%
1200-1799	1196	30%	1503	35%	1310	32%	1272	30%
1800-1999	338	8%	459	11%	394	10%	392	9%
>2000	27	1%	25	1%	16	0%	19	0%
Total	4011	100%	4300	100%	4069	100%	4223	99%

TABLE 7 (continued)

Total Client Base: Estimated Income Levels (01/89 - 05/95)

Year	1993		1994		1995 (partial)		Total	
	#	%	#	%	#	%	#	%
Monthly Hsehold Income (in MR$):								
300-599	7	0%	3	0%	1	0%	66	0%
600-799	173	4%	147	4%	67	4%	1570	6%
800-1199	2212	56%	2161	53%	901	53%	13688	52%
1200-1799	1215	30%	1247	31%	508	30%	8251	31%
1800-1999	356	9%	496	12%	193	11%	2628	10%
>2000	22	1%	33	1%	16	1%	106	0%
Total	3985	100%	4087	101%	1686	99%	26361	99%

Key:

* MR$ = Monthly Household Income (Malaysian Ringgit or Dollar)

At current rate of exchange (July 1995), US$1 = MR$2.45

The sliding scale in use at the clinic is based on nurses' estimates of a client's ability to pay based on various factors such as visual inspection, number of wage earners in the household, occupations of wage earners, number of children in the household, and the number of previous pregnancy terminations a client has had. A

monthly household income of MR$2,000 and above would be considered middle-class while those below this level would be considered working-class.

The 1992 estimated GNP per capita in Penang was US$4,000 compared to a corresponding national estimate of US$2,800 indicating that Penangites are generally better off than those in many other parts of the country (Correspondent 1992: 61). The majority of clinic clients are working-class women with monthly household incomes of an estimated MR$800-1,199. As a point of reference, the average monthly wage of a factory worker in Penang is about MR$500.

TABLE 8

Total Client Base: Major Occupations (01/89 - 06/93)

Occupation	#	%
Housewives	8428	45%
Factory operators	3476	19%
(Malay factory operators	1367	7%)
Teachers	215	1%
Others	6616	35%
Total	18735	100%

TABLE 8A

Partial* Client Base: Major Occupations (01/89-05/95)

	Occupation	#	%
Not employed outside home	Housewives	6637	56%
	Unemployed	126	1%
Employed outside home	Middle-class Occupations		
	Teachers	172	2%
	Sales/businesswomen	171	2%
	Executives/managers	138	1%
	Nurses/nurses' aides	79	1%
Employed outside home	Working-class Occupations		
	Factory operators	1942	16%
	Clerks/typists	591	5%
	Seamstresses	490	4%
	Baby-sitters/domestics	376	3%
	Cooks/waitresses/kitchen helpers	150	1%
	Hawkers	147	1%
	Secretaries/cashiers/receptionists	92	1%
	Shop assistants	88	1%
	Hairdressers	76	1%
Others		541	5%
Total		11275	101%

* Based on half of the client database. Due to a data analysis error, only data for about half of the client database, composed of the older women, was analyzed here

About half of the clinic clientele are housewives who work within the home. A substantial number of these women are of working-class standing. Slightly less than one-fifth of the women who visit the clinic are factory workers and less than 10 percent of all clients are Malay factory workers. This goes against the conventional wisdom which speculates that it is single Malay factory women who populate the pregnancy termination clinics surrounding industrial trade zones. This phenomenon is not supported by the data at this particular clinic, which is located close to the FTZ (free trade zone). On the other hand, Malay women may be seeking herbal remedies and other abortifacients from local healers instead of visiting western medical clinics.

Occupations listed under the category of "Others" in Table 8 include hair stylist, office clerk, sales clerk, laborer, maid, street vendor, sex worker and street sweeper, which are working-class or pink-collar jobs. Only a small proportion of women hold middle-class jobs such as teaching, travel promotion or sales.

TABLE 9

Women Who Have Had One or More Abortions at the Clinic

During the Period 01/89 - 06/93 and 01/89 - 05/95

	Through 06/93		Through 05/95	
	#	%	#	%
Women with one or more prior abortions	3778		6015	
Women with no prior abortions	14269		16699	
Total	18047		22714	
Repeat Abortion Rate (internal to clinic)		21%		27%

When examining current and historical data of clients at the clinic, about one in four women has been to the clinic previously in the last six and a half years for a pregnancy termination. An earlier analysis of the repeat abortion rate showed that one in five women had previously had a termination of pregnancy at the clinic. The majority of clients have not been to the clinic for this purpose, which may be an indication of the benefits of contraceptive counseling at this clinic. This remains speculative since the repeat abortion rate internal to this clinic could be relatively low compared to repeat abortions done elsewhere for other reasons. Some clients could be going to other clinics if they are using abortion as a contraceptive method and would perhaps feel embarrassed returning to this clinic too frequently. Cost may be a factor but this clinic is relatively affordable to most working-class women.

TABLE 10

Women Who Have Had One or More Abortions at the Clinic or Elsewhere in Any Prior Year (Through 05/95)

	#	%
Women with no prior Abortions	12122	
Women with one or more prior Abortions	11768	
Total	23890	
Repeat Abortion Rate		49%
Average # of prior abortions		1.0

N.B. Field coded blank instead of zero included in number of women with no prior abortions

Nurses also ask clients for the number of prior pregnancy terminations they have had and enter the data in the client records system. However, this field was left blank in about 56 percent of the records. When blank fields were excluded from the computation of the repeat abortion rate, about two-thirds of all women had had at least one prior pregnancy termination.

The clinic director asserted that fields left blank meant the same as zero prior pregnancy terminations which may be a reasonable assumption to make. When fields coded blank were assumed to mean zero prior pregnancy terminations, the repeat rate dropped off to about 50 percent of the total sample. These self-reports

refer to women having had one or more prior pregnancy terminations at this clinic or elsewhere at any time in their reproductive careers.

The average number of prior pregnancy terminations women have had appears to be around one.

TABLE 11

Women Who Have Had One or More Abortions at the Clinic or Elsewhere in Any Prior Year By Number of Prior Abortions (Through 05/95)

Prior Abortions	Number of Clients	%
1	6542	56%
2	2956	25%
3	1211	10%
4	582	5%
5	254	2%
6-12	223	2%
Total	11768	100%

Of the clinic clients who have a history of prior pregnancy terminations, the majority of them have had just one and less than 10 percent have had four or more. However, the latter "hard-core" repeaters are clients who are remembered most by nurses, who tend to exaggerate their number and frequency of visits. These data again refer to women who have had prior pregnancy terminations anywhere and anytime during their reproductive careers.

It is unclear what the term "abortion" meant to these women, i.e. if it meant intentional pregnancy termination or miscarriage. Nurses filling out client histories would have asked if clients had been to the clinic before or if they had gone elsewhere to have a washout, the term locally used. It was left to the client to volunteer as much detail as desired.

TABLE 11A

Breakdown of Table 11 by Average Age of Clients With 1-5 Prior Abortions

Prior Abortions	Mean Age of Client	Std Deviation	Range
1	30.0	7.0	13-50
2	31.8	6.7	15-50
3	32.7	6.3	17-50
4	33.5	5.9	20-50
5	34.4	5.0	20-49

The average age of clients with one prior pregnancy termination was 30 years (std. dev. = 7; range = 13-50). As would be expected, the average and minimum ages increased with the number of prior pregnancy terminations.

TABLE 11B

Breakdown of Table 11 by Ethnicity of Clients With 1-5 Prior Abortions

	Number of Prior Abortions					
Ethnicity	1		2		3	
	#	%	#	%	#	%
Chinese	3464	60%	1554	67%	578	70%
Malay	1425	25%	444	19%	131	16%
Indian	769	13%	299	13%	105	13%
Other	132	2%	25	1%	12	2%
Total	5790	100%	2322	100%	826	101%

TABLE 11B (continued)

Breakdown of Table 11 by Ethnicity of Clients With 1-5 Prior Abortions

	Number of Prior Abortions			
Ethnicity	4		5	
	#	%	#	%
Chinese	269	77%	154	75%
Malay	50	13%	25	14%
Indian	40	10%	19	11%
Other	2	1%	2	1%
Total	361	101%	200	101%

Most women with one or two prior pregnancy terminations were Chinese and more Chinese women choose to terminate their pregnancies compared to others.

TABLE 12

Total Abortion Clients: Profile of Contraceptive Use

(01/89 - 05/95)

Contraceptive Users	#	%
Never used	5374	22%
Ever used	18612	78%
Total	23986	100%

The vast majority of clients have used some form of contraception before.

TABLE 12A

Total Abortion Clients: Age of Contraceptive Never-Users

(01/89 - 05/95)

Age of Never-User	#	%
15-19	1043	20%
20-29	3203	61%
30-39	836	16%
40-44	122	2%
< 15 or > 44	76	1%
Total	5280	100%

Of those who professed never to have used any form of contraception before, most were women in their twenties. The remaining non-users were primarily in their teens or thirties. Perhaps because of the introduction of sex education in schools and the availability of contraception to single women in local family planning clinics, both relatively recent policies, a lower proportion of teenaged women visiting the clinic have never used contraception compared to women in their twenties. It is also possible that younger women today are more sophisticated concerning matters of sexuality or may have families who are more willing to discuss sexual issues with them.

TABLE 12B

Total Abortion Clients: Ethnicity of Contraceptive Never-Users

(01/89 - 05/95)

Ethnicity of Never-User	#	%
Chinese	2399	46%
Malay	1603	31%
Indian	892	17%
Other	304	6%
Total	5198	100%

Of never-users, Chinese and Malay women were most likely not to have used contraception before their clinic visit. The relatively low rate for Indian women never having used contraception is difficult to explain. It remains speculative

whether this is an indication of mostly middle-class Indian women with prior use of contraception visiting the clinic in larger numbers or of Indian women of all social classes within the clinic sample being likely to have used contraception before. Perhaps the partners of these women are more willing to use contraception than men of other ethnic groups. Since the lives of Indian women in Malaysia remain under-researched, the possible reasons for this occurrence cannot presently be determined.

TABLE 12C

Total Abortion Clients: Profile of Contraceptive Method First Used by Ever-Users

(01/89 - 05/95)

Method First Used	# Users	%
No Method	6436	40%
Condom	3143	20%
Rhythm	2615	16%
Withdrawal	1813	11%
IUD	746	5%
Herbs	412	3%
Pill	353	2%
Postinor	142	1%
Spermicide	66	0%
Other (Depo, Norplant, douche, etc.)	310	2%
Total	16036	100%

Many women who had used contraception at least once previously did not use any method initially. Others appeared to use more "natural" contraceptive means such as condoms, rhythm and withdrawal when they used contraception for the first time. Artificial methods such as the IUD and Pill were much less preferred. Malay women were likely to use herbs obtained from their villages. Postinor, a type of pill usually prescribed for women with infrequent sexual activity, and spermicides were rarely the first methods chosen.

TABLE 13

Estimated Gestational Age of Fetus for Clinic Clients of all Ages (01/89 - 05/95)

Gestational Age in Weeks	#	%
First Trimester		
0-5	4031	18%
6-9	15028	68%
10-12	2017	9%
Second and Third Trimesters		
13-15	698	3%
16-36	344	2%
Total	22118	100%

The duration of a pregnancy was calculated during admissions counseling by both client and nurse using the date of a client's last menstrual period. This estimate was entered in the client's record and then later confirmed by ultrasound scanning. Although the calendar estimate was fairly accurate, in some cases there were wide discrepancies between it and the ultrasound scan result. Table 13 reflects data from the calendar estimate. Most women come for pregnancy terminations when they are 6-9 weeks pregnant.

TABLE 13A

Estimated Gestational Age of Fetus by Clinic Client Age

(01/89 - 05/95)

Gestational Age in Weeks	Client Age			
	15-19		All Others	
	#	%	#	%
First Trimester				
0-5	204	12%	3827	19%
6-9	1121	65%	13907	68%
10-12	264	15%	1753	9%
Second and Third Trimesters				
13-15	107	6%	591	3%
16-36	40	2%	304	1%
Total	1736	100%	20382	100%

The variation in average age of clients broken down by the estimated length of pregnancy is very slight. Based on experience, the clinic director intimated that he had noticed a worrying trend. Younger clients tended to come in later for their terminations, which appeared to be borne out by the analysis. This trend appears to be occurring in the United States as well. A larger proportion of younger (aged 15-19) clients were coming in as "big cases," i.e. with pregnancies of 10 weeks or later, and the reasons for this were unknown. In the West, several reasons are usually hypothesized: the "normal" irregularity of these young women would make them wait longer to "believe" they might be pregnant, as would their desire not to be, along with the time it took them to decide what path to pursue and get the information needed to proceed.

TABLE 13B

Estimated Gestational Age of Fetus by Clinic Client Ethnicity

(01/89 - 05/95)

Gestational Age in Weeks	Ethnicity							
	Chinese		Malay		Indian		Other	
	#	%	#	%	#	%	#	%
First Trimester								
0-5	1951	18%	1077	19%	440	17%	106	17%
6-9	7797	71%	3560	63%	1683	65%	396	63%
10-12	853	8%	614	11%	316	12%	75	12%
Second and Third Trimesters								
13-15	246	2%	250	5%	114	4%	31	5%
16-36	127	1%	115	2%	50	2%	21	3%
Total	10974	100%	5616	100%	2603	100%	629	100%

Chinese women tend to come in earlier for their pregnancy terminations than women of other ethnicities. Women who come in after they are 13 weeks pregnant (according to nurses' estimates) are more likely to be non-Chinese.

To summarize this chapter, the organization, management style and mode of operation of this clinic suggest an efficiently run, woman-friendly environment in principle which the staff manage to live up to in their everyday practices the majority of the time. The clinic director is sensitive to feminist philosophies and women-centered practices, at least in theory, and has the financial ability to mold the clinic according to his principles. Abortion access is very good. The clinic is affordable to most working-class women, unlike many other such clinics in the area. At the same time the press of legal issues and male prerogatives (as will be discussed later) help shape the outcomes and practices at the clinic. Providing contraceptive counseling in addition to family planning services is a unique service here. I did not visit other clinics but instead relied upon the statements of the clinic director and women who had had pregnancies terminated at other clinics to corroborate this assertion.

Over the last six and a half years, the client profile has been indicative of certain trends. The caseload has been constant at around 3,800 per year. More, especially younger, women are coming in later for their pregnancy terminations. Most clients are married women in their twenties and thirties. Ethnic representation is proportional to their occurrence in the state with a slight upward trend toward non-Chinese clients. Although still a minority compared to the total client base, more teenaged, single women are seeking pregnancy terminations.

The average age of clients is 29 years but this is possibly shifting downward in light of the higher representation of younger women clients. Most clients are

working-class women with monthly salaries in the US$300-500 range. About half are housewives, about one in five are factory workers and a small proportion are from the middle class.

Internally to the clinic, the repeat abortion rate stands at around 20 percent, while internally or externally (abortions performed elsewhere), more than half the women visiting the clinic have had a prior pregnancy termination. Less than 10 percent of women have had more than four pregnancy terminations; the majority have had one prior termination. The vast majority of clients have been or are contraceptive users. Of those not using contraceptives, most are in their twenties or teen years. Most women visit the clinic when they are six to nine weeks into their pregnancies. However, an emerging trend appears to be for younger women to come in later (after ten weeks or more) seeking terminations. The reasons for this trend are unknown.

5. CULTURAL CONSTRUCTIONS OF ABORTION

Before women's narratives of their abortion experiences are discussed in the next chapter, the language of, meanings ascribed to and social constructions of abortion as they occur in the Malaysian context will be examined. In addition, pre-pregnancy termination interventions will also be included as part of the way in which cultural constructions of abortion are framed in Malaysia.

There are at least four sources for the constructions of abortion presented from this study: the clinic staff, clients, cultural traditions and the politicized society at large. These constructions should be seen in the legal and historical contexts of abortion in Malaysia. Abortion is restricted in application in government hospitals, but is in effect performed on request by a number of private practitioners under the legal guise of menstrual regulation.

Comparatively, then, Malaysia is labeled as a "lapsed law" country in that anti-abortion laws are not enforced except in the most public (politically visible) domains. Menstrual regulation, which may have begun as a way of bringing on delayed periods of up to four weeks without prior pregnancy testing, has over time become the umbrella term to cover pregnancy terminations of up to twelve weeks or more in some cases, with a confirming pregnancy test beforehand.

One of the more interesting features of this study is the use of local terminology to describe the process being undergone. The term "abortion" is rarely, if ever, used by clinic staff or clients. In the larger society, the term "abortion" is used in English-language newspapers and by people who are familiar with abortion as a western

feminist issue but rarely in other domains. The clinic is called a family planning clinic and women's health is the official discourse within which menstrual regulation occurs.

The languages spoken in the clinic were English, Hokkien (a Chinese dialect), Malay and Tamil (the language of south Indians). The Chinese nurses were trilingual in English, Malay and Chinese. The Indian nurses spoke all four languages, which was fairly unusual. There are English-, Malay-, Chinese- and Tamil-language medium schools in Malaysia. Depending on social class and type of schooling, most people are literate in one or more languages. The language spoken at home, however, usually reflects ethnic background. Since Penang is majority Chinese with Hokkien in fairly wide usage, the Indian nurses at the clinic had picked it up. By doing so, a nurse could interact with any client except with a Tamil-only speaker, who would be taken care of by an Indian nurse.

Language and meaning are important because of the view that language does not merely serve as a vehicle of expression; it has the power to construct rather than merely to convey meaning (Barrett 1992: 203). The language used to describe pregnancy termination and the diversity of this language in the Malaysian context richly illustrates the relativity of meanings given to abortion. Furthermore this relativity appears to be shaped by gender, ethnicity, class and region, among other contributing factors.

The power to construct and not merely to convey meaning in the context of Malaysian women's words for pregnancy termination comes across most strongly in

both clinic staff and clients' usage of local terms. There is no clear legal or social sanction of pregnancy termination and this ambiguity is reflected in women's local constructions. Furthermore, since sex is a taboo subject, local terminology also appears only indirectly to refer to the sexual reproductive processes of which pregnancy termination is a part. There appears to be a distancing through language of the actual clinical procedure women have chosen to undergo. What follows is a description of local definitions/constructions of abortion.

5.1 Local Abortion Terminology

When conversing with English-speaking clients, clinic nurses would always use the term "washout" to describe the procedure the clients sought. This term most likely 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.

One client from the capital city, Kuala Lumpur, used the abbreviation "D & C" to describe her procedure. This stands for "dilatation and curettage" which involves enlargening the cervical canal with a series of rods or dilators, removing the contents of the uterus with a small ovum forceps and scraping the remaining tissue out with a curette (Tietze and Henshaw 1986: 85).

The most common technology used for pregnancy termination at the clinic consisted of a vacuum aspiration. For a pregnancy up to eleven weeks, a woman's cervix was first dilated using plastic rods. Then a flexible plastic Karman cannula

was inserted into the uterus to dislodge its contents from the uterine walls. The contents were then suctioned out using a hand-held plastic pump attached to the cannula. For pregnancies between twelve to fifteen weeks, the woman's cervix was first softened and dilated by the insertion of Dilapan, an artificial form of laminaria. She was also given a prostaglandin to stimulate uterine contractions. After the vacuum aspiration, a curettage would be performed to ensure complete evacuation of contents from the uterus.

When I questioned the clinic nurses who were primarily Chinese on the origins of the term "washout," they told me that this was the term that had been used during their on-the-job training as nurses at the clinic. The clinic director asserted that "washout" was the term he had heard other nurses use during their academic training. When I asked a clinic nurse if she knew which language the term "washout" was probably translated from, she said that it was probably from Chinese and specifically from Hokkien, the dialect most commonly used in Penang. The Hokkien word for "washout" is *"say,"* and the word for "abortion" is *"loh."*

Chinese-speaking clients had various ways of telling the nurses what they wanted. Frequently, they would say *"la sum bo lai,"* which means "no period" or "my period has not come." They might also say *"loh kea"* (abort son) or *"say ginna"* (wash child). Technically, there does not seem to be a Hokkien word for baby or fetus, the closest in meaning to the word *"kea"* being "child" or "son." Other frames of reference were *"keng ki bo lai, boey say"* (no period, I want a washout), *"boey pak chiam"* (I want a hormone jab to induce my period), *"boey cheaak eoh"* (I want

hormone tablets to induce my period), or *"boey giam jeo"* (I want a urine test). Other Hokkien terms used outside the clinic are *"loh sin"* (abort a body) for abortion and *"ka lowh sin"* (drop a body) for miscarriage.

According to Ong (Personal communication, 1995), there is a further distinction in the terminology Chinese women use. The term *"loh kea"* connotes what one can do for oneself spontaneously or naturally, implying perhaps a miscarriage. Washing, on the other hand, implies a medical, usually western, intervention where a hospital or clinic visit would be required.

Malay-speaking clients, and nurses speaking to them, would usually use the word *"cuci"* (pronounced choo-chee) which means to cleanse, to wash or to get rid of something unwanted. In one instance, a Malay client I counseled asked me the difference between *"cuci"* and *"gugur,"* meaning to miscarry, which seemed to imply that she made a distinction between induced and spontaneous abortion. I was unsure of how to answer her since my understanding was that both terms were interchangeable. Yet a third word, *"pengguguran,"* is the term used in Malay-language media to discuss induced abortion as a phenomenon in Malaysian society.

Nurses also told me that Malay women would sometimes tell them that they would make a decision on whether to keep the pregnancy or not depending on the size of it as seen via ultrasound: *"Kalau kechil lagi buang, kalau besar simpan."* (If it's still small, I'll throw it away; if it's big, I'll keep it.) *"Buang"* (to throw away) was another term by which the pregnancy termination procedure was labeled.

Another social construction of abortion among Malay women lay in the wish for bringing on menstrual flow (*"turunkan haid"*). While the importance of having regular periods seems to be particularly significant for Chinese women, Malay women also seemed to place a great deal of importance on the regularity of menstrual periods. When their periods were late, some would drink mixtures of herbs obtained from the local village midwife or healer or would go to a local health clinic to get injections or tablets to bring on their menstrual flows. Menstrual flow was also perceived as not to be stopped once begun, which may be one reason why contraceptive methods which result in irregular, light or no flows such as IUDs and DepoProvera are not very popular among Malay women (Clinic director: Personal communication, 1993).

The underlying elements of traditional concerns with menstrual regularity appear to be both avoidance of potential pregnancy and faith in the belief that regular periods indicate continuing good physical health. Such health monitoring may be primary ways in which some Malaysian women retain control over their reproductive lives. In other words, because they may lack control over contraception due to spouses unwilling to use any and refusal to allow their partners to use any, monitoring for regular periods may be the only means by which women may exercise control over their own bodies and lives. This explanation is speculative since women were not asked and did not explicitly talk about the reasons behind their need to have regular periods.

Tamil-speaking south Indian women were less likely to use the word *"karuthadai"* (abortion) than they were to say *"vayiru kaluvanum"* (I need stomach washing, I have no period) or *"pillai kalaikiruthu"* (I want to wash baby) when they were at the clinic and were asked what they needed. According to a Tamil-speaking nurse at the clinic, some Indian women were also likely to say they were coming for a "tummy wash" or to describe their pregnancy termination experience by saying "I had it washed" implying that they were completing what could have been a spontaneous abortion or miscarriage.

It is worth mentioning that even in English, there are many words for abortion which can obscure the clarity of what is actually happening to a woman. According to Tietze and Henshaw (1986: 5),

> the two major categories of abortions are "induced" and "spontaneous." Induced abortions are those initiated voluntarily with the intention to terminate a pregnancy; all other abortions are called spontaneous, even if an external cause is involved, such as an injury or high fever... Such diagnostic categories as "inevitable," "imminent," "incomplete" and "complete" abortion describe stages in the process of abortion, whether spontaneous or induced, and are significant only in relation to a specific point in time.

The terms "miscarriage" and "therapeutic abortion" are sometimes used to mean spontaneous abortion and legal abortion respectively. "D & C" may be used to describe the technology used in the performance of a therapeutic abortion as well as to describe the act of having had a pregnancy termination. Having had a D & C leaves open the question of it having been medically necessary or intentional pregnancy termination.

5.1.1 Abortion as a Cleansing Process

Some inferences may be drawn from this discussion of pregnancy termination terminology. First, the language used to describe the phenomenon employs imagery associated with water and the washing out of the uterus as a cleansing process. Water as a symbol of purification figures significantly in Islamic tradition and in Malay women's lives. The genesis for this symbolism may also be located in Buddhist tradition for Chinese women. Alternatively, women of other ethnicities and religious backgrounds may have carried this construction over into their cultures through proximity with Malay Islamic traditions.

There is a salience given to washing that applies differently across ethnicities/religious groups. Clinic nurses informed me that they had observed Malay working-class women in general having better personal hygiene than Chinese or Indian working-class women. This was based on their physical and vaginal examinations of clients. They believed that running water and soap were used with greater frequency for body-washing in Malay households than in those of other ethnic groups. Islamic prescriptions for cleanliness are quite specific and ablution with water is a common symbol of psychic purification. Malay women also tend to keep their reproductive tracts in better physical condition because, according to local sources, Malay men like their women "tight." A number of Malay women exercise to keep their vaginal muscles firm and ingest special herbs and foods they believe will keep their vaginas healthy.

Second, the ambiguity of the language used to describe pregnancy termination may also point to the ambiguous position of abortion legally and socially within

Malaysian society itself. The taboo nature of sex and sexuality together with the clandestine nature of pregnancy outside of marriage serve to marginalize or render invisible what are essentially public consequences of private acts. One effect, however, is to expose a double standard of patriarchal morality: unregulated sexual activity occurs despite sanctions against it. However, women are usually left to deal with the consequences of their acts, while men are not.

The use of "keep"/"throw away" terminology by Malay women may also be seen as constituting a callous disregard or disrespect for fetal life (if such life is believed to exist). This conclusion may, however, reflect a middle-class bias. Malaysian working-class women are oftentimes more direct and blunt in the way they speak while middle-class women tend to speak more politely and indirectly, especially when talking about sex or bodily functions.

Finally, translating terms from Malay to English itself may well obscure the various shades of meaning applied to these terms. "Keep"/"throw away," "leave in place"/"wash," "retain"/"discard" are only some of the possibilities that inherently come to mind. The underlying motivations of Malaysian women for using such terms can only be surmised here. Language may well serve to mask what is happening rather than to clarify women's motivations or actions.

5.1.1.1 Conceptualizations of Menstruation and Menstrual Blood

Further implications can be drawn concerning the local constructions of abortion. The "wash"/"cleanse" terminology conjures up images of wanting to wash away something unclean/unwanted. This may harken back to menstrual blood which, in both Islam and Hinduism, is seen as unclean and polluting. A Malay word

often used by clinic nurses to describe menstruation is *"kotor"* (dirty), a word understood but rarely used by Malay clients. Malay women prefer to use the Arabic word *"haid"* (Omar 1992) for menstruation, while the value-laden *"kotor"* seems to be the Malay word used both within and outside the clinic by non-Malays and Malay men to describe menstruation. When queried why they used the term *"kotor,"* both clinic doctors and nurses did not have an explanation other than that it was commonly used. Hence the constructions of abortion can be very local, even part of a specific organizational culture.

There also needs to be a distinction drawn between Malay custom (*adat*) and Islamicization of Malay culture, a thesis made explicit by Karim (1992). According to Karim (Personal communication, 1993), Malay *adat* treats menstruation as a health issue in that it sees women being physically weakened by it, whereas Islam casts a polluting metaphor over this physiological process. In neither construction is menstruation considered healthy or normal.

In contrast, according to Omar (1992: 81), in the Malaysian state of Melaka where she carried out her research on Malay women's views of the body, rural women see menstruation as natural and an important dimension of being women. Younger women between the ages of 16 and 26 especially kept track of the regularity of their periods for health reasons and to predict the onset of ovulation (Omar 1992: 82). To them, irregular or scanty flows meant the inability to know when they were ovulating. One implication could be that women may have been using some version of the "safe period" as their contraceptive method.

At the same time, these women did not interpret menstruation as weakening or polluting. They used *"datang bulan"* (the coming of the moon) or *"uzur"* (sick) to describe menstruation, while the men mainly used *"datang kotor"* (the coming of defilement/dirt) to describe it (Omar 1992: 80). Even though women used the word *"uzur"* to describe their condition while menstruating, they did not exempt themselves from work in the fields or at home on that account. Despite the proffered "definition of the situation" where the Islamic and male view attempted to portray menstruating women as polluting, these women resisted that definition with an alternative construction of the body and its functioning.

In a further allusion to the pollution metaphor (Douglas 1966; Ahern 1975; Faithorn 1975), a clinic nurse mentioned that some Malay male partners of clients refused to enter the clinic to wait for or to fetch their partners because, in their eyes, the entire clinic structure was polluting or *"kotor."*

In Hinduism, the connotation of menstrual flow being impure and/or unclean carries over into restrictions on female activity during menstrual periods. Menstruating women cannot carry *"kavadi"* (a ceremonial burden carried on the shoulders) during the Hindu festival of *Thaipusam* or attend temple services.

Although Buddhism itself does not see menstruation as unclean or polluting and places no behavioral restrictions on women, similar connotations of menstrual blood being impure or unclean seem to hold for many Chinese women as well. Local interpretations of Buddhism inhibit women from praying in temples during certain festivals while they are menstruating.

According to Ahern (1975), the term *"la sum"* is used to describe ordinary dirty things by Chinese women in Taiwan who also speak the Hokkien dialect. Menstrual blood and other bodily fluids women possess are seen as dirty or unclean partly because they are bad for the body (Ahern 1975: 194). Both menstrual blood and postpartum discharges that accumulate in the body are seen as polluting, superfluous and needing to be replaced by ordinary, good blood.

Ahern makes the association of menstrual and birth fluids with dangerous power. In her study of Chinese village women in rural Taiwan, menstrual blood is viewed as powerful because it is responsible for creating the flesh and bones of babies. The souls of developing fetuses are also seen as being created from the blood present in women's wombs.

> The escape of blood, any blood, from a living body seems to be associated with power. The life force in this power can be harnessed to produce a child, to please the gods with a potent offering, or to protect a person threatened by an evil spirit. At the same time, the destructive force in the power of blood portends death and danger – to the newborn child...
>
> The association of blood with both beneficial and destructive power may derive in part from the involvement of blood in both life and death. Blood is necessary for the development of a new life, but the menstrual blood that flows when a woman is not pregnant is, in a sense, a dead fetus. In earlier times, too, childbirth itself and the accompanying blood flow were all too often associated with the death of the mother, the child, or both (Ahern 1975: 198).

The power of women can be symbolized by their powers of menstruation and birth, or by their potential life-giving and/or life-taking capacities. It would appear that all major ethnic groups in Malaysian society allow men to express their fear of women's power by defiling and denigrating female reproductive powers. By ascribing impurity or uncleanliness to menstruation and/or other bodily fluids

associated with reproduction, these actions serve to diminish women's capacities in perhaps the only arena men have little control over. To the extent that Malaysian women resist these ascriptions and definitions, they exercise some level of self-determination over their bodies, body images and power in relation to men.

5.1.2 Abortion as Menstrual Regulation

In Chinese culture, "old blood" is seen as bad blood, needing to be washed away. The emphasis on regularity appears to be related to health as well as to avoidance of potential pregnancy. A delayed period is considered abnormal and cause for concern since the blood that is stored up has to be washed away. It has become common practice in Malaysia for doctors to issue hormonal injections and tablets to induce the late periods of women in general but those of Chinese women in particular, hence the term "menstrual regulation" (Ngin 1985: 35).

There are also traditional methods of menstrual regulation known to and primarily used by Chinese women. According to Ngin (1985: 33), these indigenous methods include

> eating pineapple with beer, stout, or wine; the various brands of Chinese menstrual induction pills; crocus; *da yeukh* (the Chinese term for abortifacient, usually made up of many herbs); "bone-setting pills"; drinks made from jellygrass; mung bean soups; water chestnut drink; barley water and other "cold" food items; *lok-san* pills (a common Chinese over-the counter pill for sore throat); and aspirin.

Since Chinese women have traditionally placed great importance on having regular periods, their construction of the pregnancy termination process places heavy emphasis on bringing about a period through whatever means to restore regularity. The history of menstrual regulation itself in Malaysia and some other

countries where it is legal suggests that initially doctors were allowed to prescribe hormonal tablets or injections to induce a delayed period without first confirming if a pregnancy had occurred. Then, over time, the line between menstrual regulation and abortion has been deliberately and/or unintentionally blurred. Traditional concerns with regularity were seemingly key elements in subsequent developments.

By foregrounding the regulation of one's menstrual period and not the possible existence of a fetus, these constructions de-emphasize the abortifacient consequences of "washing." Further, the director of the clinic that I studied maintained that in Malaysia, abortion is a social practice, not a politicized debate on the sanctity of human life. However, there are growing indications in the national media that this viewpoint is slowly being challenged by some fundamentalist Christians. There may indeed come a time when the issue of abortion might become a political and public debate, and women may have to interpret the meaning of abortion in a different social context and cultural climate.

For the time being, however, pregnancy termination is constructed as a health issue, i.e. women focus on regaining their health and stability through medical means in order to function effectively as wives, mothers and/or workers. There is a cultural and personal avoidance of a discourse on the fetus per se and a blurring of distinctions and definitions of what is happening to women's bodies. These constructions allow women to manage their bodies while simultaneously providing a space for some measure of power and agency in determining what is happening to them.

5.1.3 Abortion as Interrupted Childbirth

For some women, the way they constructed their pregnancy termination experience appeared to me to be related to how pregnancy termination seemed to fit within the experience of childbirth. This phenomenon became apparent when women began asking me while in recovery how they should take care of themselves in order to return to normalcy. They wanted to know if there were dietary, bathing and exercise restrictions to be followed, apart from what they had been told to do by clinic staff.

This seemed to follow along the lines of post-partum healing beliefs and practices from Chinese, Malay and Indian indigenous healing systems. Some nurses said that they encouraged clients to think of their pregnancy terminations as missed periods, rather than in terms of delivery. Nevertheless clients persisted in asking how to regain their health in terms of inadequately understood traditional post-partum healing processes.

Some Chinese women were concerned with replenishing and rejuvenating their blood supply because of their belief that loss of blood needed to be replaced immediately, otherwise their bodies would be weakened. Chinese women believe that after a washout or miscarriage, the body becomes weak (*"leng"*). The blood also becomes weak and the blood supply needs replenishing. According to a clinic nurse, certain tonics are taken (*"cheaak por"*) to help women rebuild the strength and energy within their bodies lost during pregnancy.

A slew of beliefs under the umbrella term of *"Tong Kwai"* is relevant here. *"Tong Kwai"* refers to the overall treatment of gynecological problems women

typically encounter. Such problems might include menstrual cramps, irregularity, delayed flow and weakness during menstruation. The treatment might also relieve various symptoms of menopause and pre-menstrual tension. It usually consists of a nutritive tonic that is believed to purify the blood, restore hormonal balance, reestablish menstrual regularity and cleanse the entire system.

Red wine was believed to have strengthening qualities and would normally be taken. However, the clinic specifically prohibited the intake of alcohol for at least a week post-pregnancy termination, and discouraged the use of strong wines such as "Dom" and "Wincarnis" which were locally popular. Other Chinese healing system beliefs for women in postpartum recovery centered on restoring balance and harmony within the body. Ginger was eaten primarily to get rid of excess wind.

Many Malay women followed certain dietary restrictions to heal the bones of the body which were believed to have opened up during pregnancy and childbirth and which would let cold air into the body. Warm or heaty foods were to be eaten: green vegetables, spinach, and cucumber, for example. There are numerous taboos (*"pantang larang"*) associated with pregnancy and childbirth (Laderman 1983) which some women followed, while others did not.

Some Indian women followed post-partum restrictions on bathing and wetting their hair. However, not as many Indian women talked about this aspect of their healing process as did women of other ethnicities. According to an Indian clinic nurse, hot spicy foods called *"rasam"* were usually eaten at home post-partum and after a pregnancy termination.

It appeared that working-class women of each ethnicity were more likely to conform to their ethnic healing system beliefs than were middle-class women. Either these aspects of healing were less important to middle-class women or they were more westernized in their approaches toward recovery from their pregnancy terminations. The literature on post-pregnancy termination care handed out by clinic staff and written in English, Malay or Chinese emphasized rest, staying away from heavy work and the use of pain-killers when necessary.

5.2 Pre-Abortion Interventions

A second interesting and perhaps unique aspect of the experiences of women who came to this clinic centered on the types of interventions they encountered prior to the pregnancy termination procedure itself. It appeared that intervening in the reproductive cycle was not unusual in the Malaysian situation and that a climate of intervention was by and large sanctioned legally, medically and even, in some cases, fostered by religion.

Menstrual regulation meant that some doctors or ob/gyns would prescribe pills or give progesterone injections to initiate menstrual flows from delayed periods. Some doctors would simply provide placebos. For some women, the sequence of events before arriving at the clinic included: 1) an initial visit to a doctor to find out the reason for her delayed period; 2) a request for pills or injections to initiate menstruation; 3) if menstruation did not result, other private attempts to bring on her period; 4) a second visit to the doctor to request a pregnancy test; then, 5) if it was positive, the decision to terminate her pregnancy.

After having ingested pills or having received hormone injections, the decision to abort may be partly based on whether women are willing to risk birth defects or other unknown side effects as a result of these earlier physical interventions. In other words, the interventions performed before pregnancy is confirmed may be deciding factors in the decision to abort because of the possible unknown effects to the health of a child carried to term. It may also provide a justification for termination since children with birth defects are not especially desired. No doctor is willing to guarantee zero birth defects in such cases.

One English-speaking working-class Indian woman, married with two children, whose husband accompanied her to the clinic, informed me that she wanted the child, but had taken Panadol for a headache and was afraid that something would be wrong with her baby. She did not remember if she had taken the medication before or after she had found out she was pregnant.

Another 37 year old Indian mother of four, which included a pair of twins, mentioned that she had had three previous pregnancy terminations. Initially, she had been on the Pill, but stopped after gaining weight on them. Her use of the rhythm method had failed. Now she seemed desperate for any effective method of contraception and was willing to try the IUD. The clinic she had been to about three years ago in a smaller town had not offered injections or pills, which implied that she was familiar with those interventions and had been expecting them.

Even Malay women not particularly tied to menstrual regularity are aware of and have used medical intervention to either bring on or delay their periods. A single

Malay woman, aged 23, who did not work outside the home had gone for an injection to "make it come out, but it didn't come out." She had been on oral contraceptives for a year, but did not renew her supply of them when the prescription ran out and had become pregnant with her partner. She had had one prior pregnancy termination, for which she had unsuccessfully used village herbs trying to bring on her menstrual flow. Another married Malay woman tried both injections and tablets to *"turunkan haid"* (bring down her menstrual flow). Both attempts were unsuccessful.

Muslim women who go on the haj, or pilgrimage to Mecca, are able to obtain a special injection given by doctors and sanctioned by religious authorities. This injection delays their period for a month because "impure" or bleeding women may not go on the haj. In this instance, the climate of intervention has been established for stopping menstruation by medical fiat, with medicine being the handmaiden of religion.

There are also ethical questions involved with these interventions. If there is to be responsibility attached to the medical dispensation of pills and injections to bring on menses, where does it lie? Should women be given the option of medical intervention before pregnancy is determined when such intervention appears relatively ineffective in preventing pregnancies but relatively profitable for doctors? Nurses at the clinic were of the opinion that women in these situations were desperate for any means of preventing pregnancy, and that doctors were merely accommodating these needs. Some doctors would issue placebos such as sugar pills

instead of hormonal pills so that there would not be any untoward effects on the possibly pregnant women. The morality of this "false treatment" is clearly problematic.

Cultural constructions of abortion are therefore extremely varied and context-specific. Whereas in the western context the moral and ethical aspects of fetal life help construct the pro-choice versus anti-abortion debate, in Malaysia these aspects are de-emphasized or backgrounded. The regulation of menstruation through the metaphor of washing or cleansing is foregrounded by all major ethnic groups, with the possible exception of Catholic Christians.

Within the Malaysian context, interventive strategies for bringing on menstrual flows are commonly practiced both in the private (home) and public (medical) domains. These strategies are undertaken before pregnancy is verified. After the pregnancy termination has occurred, post-partum healing processes are usually followed as part of completing the pregnancy termination experience.

6. WOMEN'S NARRATIVES, EXPERIENCES AND REASONINGS

Women's narratives and constructions of their abortion experiences form the heart of this study for it is through women's voices that a sense of the thoughts, feelings, reasonings and rationales behind their actions is achieved. The complexity and diversity inherent in their experiences mediated by class, ethnicity, religion, and familiarity with the pregnancy termination procedure itself are illustrated through their stories. Further complicating the picture are the reasons women give 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. The interplay of gender, morality and religion in shaping women's decision-making around abortion is discussed briefly. Finally, women's position in a patriarchal society and its effect on how abortion is experienced is considered.

6.1 Women's Narratives

There is 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 have 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 have been more or less resolved.

The decision to abort has many dimensions. For women who are still undecided when they get to the clinic, there are circumstances which help them decide. One of these "helping" actions or, as one staff member describes it, factors of "tipping

the scale" are the counseling services with clinic staff. For Malay women especially, the size of the fetus on the ultrasound scan is 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 can observe for themselves confirms 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 are more likely to act similarly to Indian and Chinese women who are more certain to abort regardless of fetus size.

Another factor that appears to affect the decision-making process and the way women feel about themselves after their procedure is the degree of attachment toward the fetus within. One woman said that she had no feelings yet for this baby, while another said that she did not love it yet. 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 are a) women who are coerced into having pregnancy terminations and b) women with moral or religious convictions which proscribe abortion. For women with religious convictions, the decision to abort ranges from ambivalent to unambiguous. One Catholic Indian woman was against abortion in principle but had hers willingly. According to the clinic director, this attitude is 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.

Guilt was commonly expressed by some women of varying religious convictions who said things like "it's murder," "what God has given you, you can't take it away." Another 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. A couple of young married women who were also athletes felt no pain and even talked throughout their procedure. One said she did not feel anything and had no sedation given. The other, whose mother had been a former client at the clinic, felt confident about her decision of not wanting a child at that particular time. During her follow-up visit, however, she told me that an anti-abortion article in a local newspaper had shaken her confidence in her decision. 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 revolve 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,

women are given responsibility for the stability of the family. 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.

6.1.1 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 does 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. 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.

During her follow-up visit, the nurses fussed over her son, whom she had brought with her, who was about nine, chubby-cheeked and cute. She brought a family-like atmosphere to the clinic each time she visited.

6.1.2 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. When she first visited the clinic to set up an appointment, she did not wear the Muslim *"tudong"* or headdress. 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.

On her follow-up visit, she was wearing the Muslim headdress, which surprised me. My assumption had been that Malay women who chose to wear the *"tudong"*

did so consistently, but I was wrong. I noticed that another Malay woman wore conservative Muslim dress during one visit and modern western clothes during her follow-up. The flexibility which some Malay women exhibited in their dress indicated to me that they were in some degree of control of their appearance, rather than fully captive to the dictates of fundamentalist Muslim norms.

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 and/or moral conflicts as to whether they were doing the right thing but, for a variety of reasons, had to have the procedure.

6.1.3 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 rhythm 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.

6.1.4 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 my husband told me, I think you better go and check to be sure about this. So when I went and checked, she told me that it was positive. I don't know what my feeling was. I don't know whether I was happy, whether I was sad. You know, very mixed feelings. So went back and discussed with my husband. So we talked about it. And I said I don't want to wait another year for the course because we have to *"tanggohkan,"* you know, hold on, wait another year. Said I already waited so long, I don't want to wait anymore. So he said, you go and find out about it whether it's possible for me to continue with my pregnancy and go for the course at the same time. And I found out I couldn't do it. I have to either abort or wait for one year. So he said, never mind, we'll come to Penang and talk about it with our family members.

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 KX 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*. So I just don't want to think about this at the moment. So just want to concentrate on my course. So maybe next year, when I go back to Sabah again, maybe I'll start to have my second child, *lah*.

Some clinic clients come from outside the city or state to have their pregnancies terminated but the proportion of such clients is unknown. Most of these clients come 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 have also been rare cases of women flying in from other states for their pregnancy terminations.

As a point of clarification, 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. 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.

6.1.5 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 grade school educations. 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, nervous-looking, and 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.

6.2 Reasons for Termination

One other interesting aspect of this study centers 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 wish to 1) limit family size, and 2) space births (FFPAM 1993: 12). This might be a rather narrow definition for such services, considering the wide range of reasons women are 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 this point on time. For others, their families were already complete and an additional child would have been an unnecessary burden.

Child care 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 child care. Many women cited lack of child care facilities at work and at home as an impossible situation to deal with. Although there were private day care centers in Penang, these were relatively unaffordable for working-class women. Their only means of child care 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/or 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. Contraceptives other than condoms could not be obtained by single women anywhere in Penang. Contraceptive failure was also a stated reason for termination. There were women whose partners were unsupportive of or even opposed to using contraception.

6.3 Gender, Morality and Religion

From an outsider's perspective, the question of how women deal with the morality of their actions, especially since there are religious proscriptions against abortion, is an interesting one. Apart from Confucianism and Protestantism, the majority of religions practiced in Malaysia, i.e. Islam, Buddhism, Hinduism and Catholicism, do not condone abortion.

This question has also been raised in a study of abortion in Japan. LaFleur (1992: 10-13) observes that Japanese women who are also practicing Buddhists do not overtly indicate moral conflict over having abortions. He claims that this seeming contradiction between moral proscriptions of life-taking and actual behaviors is not exclusive to Japanese Buddhists. The proscription of killing is also found in

Christianity, where capital punishment and theories of "just war" have accommodated this proscription to suit realistic needs. According to LaFleur (1992:12):

> the "interpretation" of seemingly unambiguous commands and precepts goes on all the time in religion. There are, in fact, a lot of adjustments between the strict ethical axioms that are laid down at the base of a tradition and the moral realities of everyday life in the present. There have to be. And these adjustments that take place "in between" are, in fact, the tradition. It is from within this tradition that today's person takes what is needed to put together for himself or herself a script for making moral decisions.

LaFleur calls this process of reconciling moral life and reasoning moral *bricolage* based on anthropologist Claude Levi-Strauss' notion of the bricoleur, an expert odd-job person who makes something useful and impressive out of leftover bits and pieces.

Scheper-Hughes (1992) also addresses the issue of moral decision-making in her study of infant mortality in the shanty-towns of Brazil and the degrees of attachment and grieving (or seeming lack of it) exhibited by family members for dying infants and young children. Although I do not wish to imply a parallel situation – economic conditions in Malaysia appear better than those portrayed in the poorer sections of Brazil – I do wish to bring out two salient points made by Scheper-Hughes. The first is that bonding theory, i.e. that mothers are intuitively attached to their infants from birth onwards, "has wide currency among medical and social work professionals. And it has shaped the way social theorists and even feminist philosophers and writers think about maternity and mother love, which has acquired the status of an empirically demonstrated scientific 'truth' " (Scheper-Hughes 1992: 409). This may

well be projected backward in time so that mothers are also felt to have maternal instincts for the developing fetus.

Secondly, western theories and concepts of maternal attachment, sentiment and love are usually culturally and historically bound. According to Scheper-Hughes (1992: 401, 408),

> mother love as defined in the psychological, social-historical, and sociological literatures is far from universal or innate and represents instead an ideological, symbolic representation grounded in the basic material conditions that define women's reproductive lives.... Maternal thinking should not be sentimentalized. The morality that guides mothers, especially poor mothers, may not follow "conventional" wisdom or dominant moral discourses concerning justice and equality.

I would include in these relativistic concepts Malaysian women's ways of dealing with the morality of having abortions. In my study, I asked women how they dealt with the moral and religious dilemmas they experienced. Some women maintained it was a matter entirely between themselves and God. Others gave their rationale based on wholly practical considerations. They cited lack of childcare, the need to restrict family size, economic considerations, single status, and many other reasons. These were practical accommodations to the reality of their lives. For some women, then, the moral path is the practical path that takes lived experience and everyday life into full account.

This should not be taken to imply that women made their decisions in a cavalier fashion. The overwhelming majority of women in this study demonstrated that they were aware of the moral and religious implications of their decision; nevertheless,

other practical considerations weighed more heavily with them and they consciously chose pregnancy termination over other options.

A nurse at the clinic, herself a Christian, was assertive in her assessment of the situation in which women find themselves. She counseled women thus:

> You cannot base all your thinking, all this, on the Bible book if you're a Christian. 'Cos I said, the book, that's based on many, many years ago, you see. Now we're at this century. You cannot take this thing into your life like that. That book doesn't control your life, you control your own self. What do you want in this life? You yourself have to decide. I can't decide for you. If you want to help yourself, you can (Interview with nurse K).

6.4 The Effects of Patriarchy on Women's Lives

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.

At the clinic, some men appear to be liberal in handing over responsibility of contraception to their female partners. But this can also be read as contraceptive irresponsibility. 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 appear 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. They hear from their friends. They come here. We're doing it still (Interview with Dr C).

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.

Polygamy does not benefit the self-esteem of women; rather, it pits women against each other for the attention of men. Witness the case of a gardener who brought in his sister-in-law whom he had made pregnant. He had both sisters as common-law wives, but the one whom he had initially married did not want her husband to have a child by her sister and therefore had coerced her into having a pregnancy termination. In this instance, reliance on marriage and husbands as a means of income leaves 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. Instead the British

trained a native elite to be petty bureaucrats and colonial lackeys. In the schools, individual creativity was stifled and rote memorization of texts was promoted instead. Education for women was irrelevant to the male colonial mind except for the professions of teacher, nurse and social worker.

After Independence, 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.

For example, in 1991, Taiwan graduated 110,000 high school students for 30,000 college places, an absorption rate of about 27 percent. Malaysia, in 1989, provided less than 20,000 admission slots for approximately 100,000 college-bound students, absorbing about 20 percent of eligibles. Many more students are left to fend for themselves even before they are allowed into the Sixth Form Matriculation

level. The attrition rate in the educational system from primary school to Sixth Form only allows 6 percent of all students to get to tertiary level, compared with 59 percent for the United States, 20 percent for Thailand and 38 percent for the Philippines (Murphy 1990).

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.

To place some of the findings of this study in a theoretical framework, I would like to suggest that women living in male-dominant societies like Malaysia tend to live in a state of psychic decenteredness. What this means is that women's lives tend to be governed by external forces so that their choices and lifestyles are subject to male rule. Because of this constant and consistent disempowerment, they are unable to live autonomous lives independent of men.

> Yet the failure to examine heterosexuality as an institution is like failing to admit that the economic system called capitalism or the caste system of racism is maintained by a variety of forces, including both physical violence and false consciousness...(W)omen-identified experience... embrace(s) many more forms of primary intensity between and among women, including the sharing of a rich inner life, the bonding against male tyranny, the giving and receiving of practical and political support... If we can also hear it in such associations as *marriage resistance*..., we begin to grasp breadths of female history and psychology which have lain out of reach (Rich 1994: 488).

However, rather than being in a state of false consciousness, women generally understand that life in male-dominant systems requires constant struggle for power and rights. This tension or stress is what I refer to as psychic decenteredness. By this I mean the feeling of having to constantly struggle against oppressive barriers or, if one concedes to the situation because of lack of choices, of being only indirectly connected with one's self and needs and desires.

Normally, these tensions or stresses become part of living so that women do not think of their lives as oppressive. For example, one woman told me that "women have to suffer" while she was waiting for her pregnancy termination procedure in the operating theater. However, certain life experiences tend to create fractures in this socially constructed reality. Abortion may be one such life experience for it forces women to deal with the circumstances that have brought them to this irreversible point. These circumstances might include having to deal with a lack of information regarding contraception and pregnancy or with a lack of contraception itself, having a partner unwilling to use contraception, facing religious proscriptions against contraception and/or abortion, dealing with contraceptive failure, or being a second wife whose children have no inheritance rights. Any or all of these factors might contribute to women's feelings of powerlessness and/or lack of control over their bodies and lives.

Coping mechanisms that could lead women to attempt to regain control over their lives at this point might include interpreting the experience of abortion in ways that allow them to mend the fracture in their social realities. It might also include

the process of moral *bricolage* to resolve the problems of unexpected or unwanted pregnancies in order to repair or make seamless once again the rupture to their lives and social realities. The level of psychic decenteredness experienced may be elevated or lowered as a result of this problem resolution process.

From this study, it appears that clinic staff might be more conscious and aware of this psychic decenteredness than are 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. This came through clearly in the focus group interviews that I held with them. They exhibited a consciousness of the oppressive conditions many Malaysian women assume to be part of everyday living.

To paraphrase one nurse, many men see the clinic in much the same way they would an auto repair shop. They need 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).

> Unless they truly cares for the girls, you know. Then they will be very concerned. In fact, every fifteen minutes they will ask you, how is she, is she all right, can I go up and see her, you know? Then you have to tell them that ... rest assured, she is fine. There are those who are very concerned and there are those who ... leave them here, have everything done, then don't bother

to come and take them out. Until the clinic closes, she have to take the bus or taxi back. I think that's not fair (Nurse OG).

This thing is created by both of them. So the poor lady has to undergo everything on her own. This kind of attitude the men must change (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).

Although Malay women are commonly thought to be more deferent than women of other ethnicities towards their partners as evidenced by staff and my own observations, there were also instances where Malay women resisted. In one case, a Malay woman whom I had asked for consent to interview told me she had to ask her boyfriend for permission. After asking him, she said that he had not consented for her to talk to me. I asked her if the permission was for my not counseling her or for not interviewing her. She said it was not given for anything. Then, while her boyfriend waited nearby, she proceeded to tell me her entire pregnancy termination experience as if his permission did not count.

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 decenteredness within 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.

To be fair, for men to stay at the clinic to wait for their female partners to recover and then take them home would probably result in the loss of a day's pay, so financial considerations might have to take precedence over other concerns. However, clinic staff are also perceptive enough to note general trends in the behavior of their clients and in that of their clients' partners.

Some other illustrations of women's relative lack of power with respect to male control over their lives were related to me by the male Indian doctor at the clinic:

> Yesterday I had a patient, a Malay patient with this IUCD for more than 3-4 years. And then, she's not been having her period for 2-3 years. That's one of the complications of the IUCD – amenorrhea for 3-4 months. We take it out and then they have a flow. The opposite is also true in some cases where they don't have a period and you insert the IUCD and then they have a flow. Mostly post-MR patients.
>
> This patient, she was OK with the IUCD for 3-4 years and then after 3-4 months she didn't have her period. Then she was worried. She was seeing one doctor and then he reassured everything was OK. She's come back again, second visit yesterday, not happy, she wants it out. Then I said, "Why do you want it out if everything's all right?" She says, "No, I'm mentally upset, you see. I don't have my periods. Of course, I know that I'm not pregnant but I still feel there's something wrong with me."
>
> The basic thing that's troubling them is cancer. I said, "If you're mentally tormented with the IUCD, then it's best that you remove it. Because every other sickness that affects you, mentally, physically, or otherwise, you'll blame it on the IUCD."... After removing it, she suddenly became very happy, joyful, cheerful (laughs) and she was joking... And then she says, "Now, doctor, I'll tell you truthfully why I wanted this out... My husband, he has left me 3-4 months ago, he's having another lady, and that lady, he is living out of her earnings. This kind of husband I don't want. And then I chased him out of the house. And then now I don't have my period, I've taken it out. I want to take this IUCD and show it to him the next time I come and show him it's proof."

I said, "What are you trying to prove?" She says, "He might think that I'm sleeping with other men." I said, "No, even if you take your IUCD out, he can still blame you for that." She said, "No, even if he says that, I'm out, then I should be pregnant, what, but I'm not pregnant... Just to tell that without the IUCD, also, I'm not pregnant. That means I'm not running around." I said, "No big deal, you don't want that man already." "No," she said. "I'm a Muslim. Unless he leaves me, I can't leave him... If he comes back, I have to entertain him. That's a true Muslim," she said. That's the second husband, you know. "If he doesn't leave you, you leave him. Don't entertain him, *lah*." "No, no," she said, "as a true Muslim, if he comes back, I have to oblige."

Researcher: "*Mesti layan*" (have to entertain him).

Doctor: "I have to take it because he's my husband."

Researcher: And if he comes back and decides he wants to have sex with her and she doesn't have her IUCD in, then she could even get pregnant.

Doctor: Ah, get pregnant also. I said, "You are open to that, you know that or not?" "Ah, that one, I can't help it. I'll tell him, *lah*, you slept with me." This is what happens, you see.

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" (laughs helplessly) (Interview with Dr C).

The truly daunting array of forces working against some Malaysian women's autonomy thus include the lack of mediatives such as familial support systems as

well as cultural patterns and religious mores which reinforce and reinscribe female deference to male authority within the family.

From the previous exploration of women's narratives, experiences 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 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 be able to perform their duties and functions as wives, mothers and/or workers.

The reasons for pregnancy termination run the gamut from financial to social and medical. Lack of child care seems a particularly salient concern for working-class women who face an unfriendly childcare situation both at work and at home. 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.

7. CONCLUSIONS

This study serves as an initial attempt to describe, explain and analyze the phenomena of abortion as experienced by some Malaysian women. The background, approaches and findings of this study are summarized below. Relevant conclusions that may be drawn from this study have also been assembled, followed by implications for policy and practice. Finally, some future directions for research are laid out so that other investigations may build on existing practical and theoretical data.

7.1 Summary

This study focused on a sample of women in Penang, Malaysia who underwent pregnancy terminations at a private clinic. The sample consisted of Chinese, Malay, Indian and other women from working and middle class backgrounds. It was carried out during the summer of 1993 with a one month follow-up site visit in 1995 and used in-depth interviews, participant observation, document analysis, data analysis of client records and library research as investigative tools.

Background information on Malaysia placed the study in its cultural, social and political contexts. At this time, Malaysia is 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. Changing social patterns in work and family are being felt and seen 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 child-care 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.

The major theoretical approach to this study has been feminist. I take the view that women in Malaysia live in a patriarchal society. Feminist analysis is therefore of primary importance in interpreting women's experiences and constructions of abortion. Radical and socialist feminisms in particular as they apply to Malaysian society provide the backbone for analysis. Postmodern and Third World feminisms seem to apply more than western feminist analysis here in that they open up the space for the voices of women at diasporic locations to be heard and validated. More importantly, Malaysian women are shown to demonstrate some forms of agency and resistance to oppressive family and sociopolitical conditions under which they live their lives. Population control theories and analyses are also examined for their relevance to the pronatalist policies of the Malaysian government.

An ethnography of the clinic, presented in Chapter Four, aims to bring to life the site at which this study takes place. Clinic doctors and nurses provide 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. The researcher's role and effect on the study are also discussed. Analysis of client records provides a client profile of abortion-seekers. They tend 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 are indicated although reasons for these trends remain speculative at best.

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. 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. At the core is a focus on women regaining their health so as to be able to function as good wives, mothers and/or workers.

Local abortion terminology varies by ethnicity. Most Malay women use the terms *"cuci"* (cleanse) and *"buang"* (discard) to describe having pregnancy terminations. Many Chinese women use 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 kaluvanum"* (I need stomach washing, I have no period). Additionally, post-pregnancy termination healing processes suggest that some Malaysian women view abortion as a form of interrupted childbirth.

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. Women are held responsible for the preservation of family stability and family honor, and for selecting the type of intervention needed to preserve both. Malaysian women exhibit a range of reactions to their experience both before and after their pregnancy terminations.

7.2 Conclusions

One of the original aims of this study was to conceptualize a reproductive rights framework for Malaysian women. It has become clearer from this investigation that reproductive rights in the Malaysian context take on different dimensions from those in the West. When women's basic needs like food, clothing, shelter and sustenance are taken care of, then it becomes easier to discuss higher-level needs such as moral decision-making and control over their bodies. Reproductive rights for working-class Malaysian women should therefore include access to contraceptive information and contraception, which could and should be considered a basic need. This translates into providing women with the necessary time and materials so that information is transmitted effectively. Such rights also include providing an environment in which ethnic and religious traditions are respected and incorporated as parts of ways of healing from the abortion experience. The treatment of women with dignity is an essential part of this environment of support and acceptance.

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.

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 child care, these women's child-bearing and -rearing options are being limited. One practical solution seems to be to control births.

Malay custom (*adat*) as expressed by bilaterality in gender relations (Karim 1992) may allow Malay men and women some latitude in joint decision-making that would not be so readily apparent in a traditionally patriarchal society. Bilateral relations may thus mediate some Malay women's decisions to have abortions. This may serve as one factor in helping women make their decisions despite the state's mandate that women's bodies serve the entirely opposite goal of increasing the population of the country.

In a similar vein, abortion may be legitimated covertly but not overtly by a disparity between gender ideology and actual behavior. This disparity has been examined in a Mexican case study involving working-class women known as *maquiladoras* living on the fringes of an industrializing society.

> Discrepancies between Mexican gender ideology and actual behavior suggest the use of alternative gender-based norms which do not coincide with popular notions of male dominance. These *covert cultural norms* can be detected through an understanding of the complex interplay between ideal sex-gender concepts, actual behavior, and the strategic use of pretense by Mexican men and women. These norms allow Mexican men and women to negotiate between traditional and *alternative* normative behavior investing women with the power to check, subvert, or complement male-dominant behavior (Del Castillo 1993: 237).

The Mexican women in this case held the economic purse-strings in households where males earned less, thereby contradicting the gender idealized norm of male as breadwinner. Economic power in some cases resulted in gender-role reversals which were hidden from public view by various "face-saving" techniques.

In the Malaysian case, covert cultural norms would allow the apparent contradiction between men exerting dominance while at the same time allowing women to make family-related decisions based on the women's increased earning power and the family's need for those earnings. This new cultural norm of legitimating abortion is thus attained through the coming together of these seemingly disparate features of Malay working-class women's lives.

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 more well 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.

7.3 Policy Implications

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 being studied as well as elsewhere in Malaysia. However, the supply of IUDs gotten for the clinic was in some way affected by the situation in the United States since the clinic director mentioned that only a few brands were 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. DepoProvera was available but seldom administered to Malaysian women. Only women who requested this particular method were given

DepoProvera 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.

In this study, the majority of women in the clinic sample and in the clinic population come from working-class backgrounds. Clinic nurses have observed that many such women do not read written literature on abortion after-care given to them, but discard these materials upon exit from the clinic. Knowing this, it would not be a stretch of the imagination to expect most women to pay closer attention to audio and visual information than to written information.

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.

For example, some family planning nurses advise women to take a break after using the Pill continuously for four years as a health precaution. During this hiatus in Pill use, women may not be instructed to use a substitute method, during which time they may become pregnant, mistakenly thinking they will remain protected during the time they are off the Pill. One clinic client gave this reason for wanting her pregnancy terminated. 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 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 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 (Asnes 1994: 84).

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

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 care-giver and child-rearing duties and responsibilities would help stabilize families and even birth rates. At least that is currently what is being argued by population planners in the international arena (Chira 1994: A1(2)). 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).

Dixon-Mueller (1993), for example, addresses issues pertaining to population control policies on a global scale from the viewpoint of a feminist demographer and policy analyst. She recognizes that feminists in many countries have become polarized into two camps: the antinatalists with western ideologies of the need for population control in the developing world, and pronatalists of nationalist and

fundamentalist bent in many developing countries, "both of which lay claim to the control of women's bodies and women's lives" (Dixon-Mueller 1993: x). According to her, radical feminists in some countries have balked at the use of women in a numbers game and at family planning programs they deem coercive. She maintains that this analysis which says that family planning programs should be rejected until the root causes of poverty are flushed out leave unanswered basic questions, such as how women should regulate their fertility in the meantime. She looks, therefore, for feminist solutions to what she sees as a global population problem.

Her answer is to promote the idea that reproductive rights are human rights that individual women are entitled to, that "population policies and programs would probably be unnecessary if women could exercise their basic economic, political, and social rights and genuine reproductive choice" (Dixon-Mueller 1993: xii). In addition, programs are needed to address the unmet need for reproductive health services to help women avoid unwanted pregnancies and unsafe abortion.

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 have 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.

At the same time, women are making these choices 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 has been that contraceptive education targeted at working-class women who are not necessarily literate or literacy-friendly 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.

In addition, the needs of women who are clinic clients should be respected. This may range from a simple matter of courtesy in treatment by clinic staff and respecting the wishes of women for decision-making in the abortion process itself to respecting their definitions and rituals in post-pregnancy termination processes and their needs for closure and healing.

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.

At the structural level, there also 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. Although it may not be politically popular or feasible (and may never be so), it remains the honorable and right thing to do.

It may be argued that a reproductive rights focus is inappropriate and that Malaysian women have more degrees of freedom in constructing their lives if abortion is not fought for as a right but sought in the ambiguous framings of

menstrual regulation. I do not agree with this interpretation for two principal reasons. When queried as to who should have the final say in allowing women to have abortions, most clinic clients say that it should be women's right to decide, not the government's or physicians'. Some middle-class women say it should be a joint decision with their physician.

Furthermore, without laws stating what is legally guaranteed, women can never be completely certain of what they are entitled to. Without such legal guarantees, 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.

7.4 Further Directions for Research

This study indicates that there are a number of directions in which research in this area may be taken. It might be useful to investigate the effect of ethnicity on women's experiences of Malaysian society to see what bearing this has on the particular experiences of abortion women tend to have. From this study, it is apparent that ethnicity does have salient effects on women's constructions of abortion. Furthermore, it can be construed that the ethnicity of the researcher tends to have an effect on responses elicited from women of different ethnic groups. Therefore, consideration might be given to having Malay researchers study Malay women, Chinese researchers study Chinese women and so forth so that the

intricacies of language, inter-ethnic communication and interpretive difficulties be minimized.

Another implication from this study might be to have the insider's view of the subject under study be foregrounded in future projects. Recent social science literature is rife with the view that dominance by the outsider gaze may be held up to scrutiny as being "Other"-oriented. Research of particular societies by local researchers is therefore to be encouraged. Despite the fact that local research projects in Malaysian universities tend to be severely underfunded and also government-controlled in some areas of study, it is still possible to conduct small-scale studies such as this one using interpretive methods and still generate valuable theoretical insights and practical implications.

A study such as this is also by necessity narrowly focused. In the original research proposal, the role of midwives and indigenous (i.e. non-clinical) methods of pregnancy termination were also to be studied. Such methods include massage and the use of herbal abortifacients. While this study was unable to include such research, it may be worthwhile, in light of the diminishing role of local midwives and the rise of government- and western-trained midwives, to record the experiences of women who have used indigenous methods of pregnancy termination successfully and local healers' methods of performing them.

Finally, research that foregrounds Third World women as active participants and not passive victims of society-wide development processes should be emphasized. It is hoped that this study makes a small attempt in that direction by giving

Malaysian women voices and self-representation over an issue that oftentimes has powerful and immediate effects on their lives.

BIBLIOGRAPHY

Abdullah, Rashidah. 1993. "Changing Population Policies and Women's Lives in Malaysia." Reproductive Health Matters 1 (May): 67-77.

Acker, Joan. 1991. "Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations." Pp. 162-79 in Judith Lorber and Susan A. Farrell (eds), The Social Construction of Gender. Newbury Park, CA: Sage Publications, Inc.

Ahern, Emily M. 1975. "The Power and Pollution of Chinese Women." Pp. 193-214 in Margery Wolf and Roxane Witke (eds), Women in Chinese Society. Stanford, CA: Stanford University Press.

Akhter, Farida. 1992. "The Eugenic and Racist Premise of Reproductive Rights and Population Control." Issues in Reproductive and Genetic Engineering 5 (1): 1-8.

Alexander, Jacqui. 1990. "Mobilizing Against the State and International 'Aid' Agencies: 'Third World' Women Define Reproductive Freedom." Pp. 49-64 in Marlene Gerber Fried (ed), From Abortion to Reproductive Freedom: Transforming A Movement. Boston, MA: South End Press.

Althusser, Louis. 1971. "Ideology and Ideological State Apparatuses (Notes Towards an Investigation)." Pp. 127-86 in Louis Althusser, Lenin and Philosophy. New York: Monthly Review Press.

Amir, Delila, and Orly Biniamin. 1992. "Abortion Approval as a Ritual of Symbolic Control." 1992. Pp. 5-25 in Clarice Feinman (ed), The Criminalization of a Woman's Body. New York: The Haworth Press, Inc.

Arasaratnam, Sinnappah. 1979. Indians in Malaysia and Singapore, Revised Edition. Oxford: Oxford University Press.

Arditti, Rita, Renate D. Klein, and Shelley Minden (eds). 1984. Test-Tube Women: What Future for Motherhood? London, England: Pandora Press.

Ariffin, Jamilah. 1994. Reviewing Malaysian Women's Status: Country Report in Preparation for the Fourth UN World Conference on Women. Kuala Lumpur, Malaysia: University of Malaya Population Studies Unit.

Arshat, Hamid et al. 1988. Marriage and Family Formation in Peninsular Malaysia: Analytic Report on the 1984/85 Malaysian Population and Family Survey. Kuala Lumpur, Malaysia: National Population and Family Development Board.

Arshat, Hamid. 1985. *"Jumlah Wanita Yang Lakukan Pengguguran Kian Meningkat"* (Number of Women Having Abortions Currently Increasing). Utusan Melayu (Sep 13).

Asnes, Marion. 1994. "Birth Control Over 30." Working Woman (July): 69-72.

Atkinson, Jane Monnig, and Shelly Errington (eds). 1990. Power and Difference: Gender in Island Southeast Asia. Stanford, CA: Stanford University Press.

Baharom, Raslan. 1990. "Girl Dies After Abortion, Doctor Nabbed." New Straits Times (Feb 6).

Baker, J., and Khasiani, S. 1992. "Induced Abortion in Kenya: Case Histories." Studies in Family Planning 23 (1): 34-44.

Barrett, Michele. 1992. "Words and Things: Materialism and Method in Contemporary Feminist Analysis." Pp. 201-19 in Barrett, Michele, and Anne Phillips (eds), Destabilizing Theory: Contemporary Feminist Debates. Stanford, CA: Stanford University Press.

Barroso, Carmen, and Cristina Bruschini. 1991. "Building Politics from Personal Lives: Discussions on Sexuality Among Poor Women in Brazil." Pp. 153-72 in

Chandra Talpade Mohanty et al (eds), Third World Women and the Politics of Feminism. Bloomington, IN: Indiana University Press.

Barry, Kathleen. 1979. Female Sexual Slavery. Englewood Cliffs, NJ: Prentice-Hall, Inc.

Bee-Ej. 1994. "Preying on Young Women." The Sun Magazine (Malaysia) (Monday November 7): 14.

Bernard, Jessie. 1982. The Future of Marriage, 2nd Edition. New Haven, CT: Yale University Press.

Bunge, Frederica M. (ed). 1984. Malaysia: A Country Study. Washington, DC: U.S. Government Printing Office.

Burnham, Linda, and Miriam Louie. 1985. The Impossible Marriage: A Marxist Critique of Socialist Feminism. Oakland, CA: The Institute for Social and Economic Studies.

Chee, Heng Leng. 1988. "Babies to Order: Official Population Policies in Malaysia and Singapore." Pp. 164-74 in Bina Agarwal (ed), Structures of Patriarchy: State, Community and Household in Modernising Asia. New Delhi: Kali For Women.

Chee, Heng Leng. 1982. "Health Status and the Development of Health Services in a Colonial State: The Case of British Malaya." International Journal of Health Services 12 (3): 397-417.

Chen, Paul C. Y. 1981. "Traditional and Modern Medicine in Malaysia." Social Science and Medicine 15A: 127-36.

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.

Clarke, Adele. 1990. Contraceptive Technological Choices: The Realignment of Social Worlds and Generative Entrenchment, 1925-1990. Paper presented at the Conference on Technological Choices: European and American Experiences. Bloomington, IN.

Clarke, Adele. 1984. "Subtle Forms of Sterilization Abuse: A Reproductive Rights Analysis." Pp. 188-212 in Rita Arditti, Renate D. Klein, and Shelley Minden (eds), Test-Tube Women: What Future for Motherhood? London, England: Pandora Press.

Cleves, Paul. 1990. "Births, Marriages and Deaths in Peninsular Malaysia." Geographical Magazine. Supplement. (February): 1-5.

Consumers Association of Penang. 1986. "Abortion - A Big Business." Utusan Konsumer (July): 2-3.

Corea, Gena. 1985. The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs, 1st Edition. New York: Harper and Row.

Correspondent. 1995a. "Behind Closed Doors." Asiaweek 21 (25) (June 23): 38.

Correspondent. 1995b. "Credential System to Enhance Health Care Quality." Bernama News Service (Kuala Lumpur) (March 31).

Correspondent. 1994a. "Vital Signs." Asiaweek 20 (17) (April 27): 48.

Correspondent. 1994b. "The Bottom Line." Asiaweek 20 (17) (April 27): 52.

Correspondent. 1994c. "Contraceptive Use Down Nearly 10% Since 1982: Survey." The Straits Times (Singapore) (February 2).

Correspondent. 1992. "An Asian Bazaar Since 1786." Asiaweek (November 27): 61.

Correspondent. 1990. "Malaysia: Changes in Abortion Law." Lancet 335 (8699): 1209.

Correspondent. 1986. "Thriving Business in Abortions." New Straits Times (Jul 4).

Coward, Harold G. et al. 1989. Hindu Ethics: Purity, Abortion, and Euthanasia. Albany, NY: State University of New York Press.

Daly, Mary. 1978. Gyn/ecology: The Metaethics of Radical Feminism. Boston, MA: Beacon Press.

Daud, Fatimah. 1988. "Women's Economic Role in Malaysia." Pp. 111-28 in Manning Nash (ed), Economic Performance in Malaysia: The Insiders View. New York: Professors World Peace Academy.

Daud, Fatimah. 1985. *"Minah Karan"*: The Truth About Malaysian Factory Girls. Kuala Lumpur, Malaysia: Berita Publishing Sendirian Berhad.

Davis, Nanette. 1985. From Crime to Choice: The Transformation of Abortion in America. Westport, CT: Greenwood Press.

Del Castillo, Adelaida. 1993. "Covert Cultural Norms and Sex/Gender Meaning: A Mexico City Case." Urban Anthropology 22 (3-4): 237-58.

Dixon-Mueller, Ruth. 1993. Population Policy and Women's Rights: Transforming Reproductive Choice. Westport, CT: Praeger Publishers.

Douglas, Mary. 1966. Purity and Danger: An Analysis of Concepts of Pollution and Taboo. New York: Frederick A. Praeger, Publishers.

Editorial. 1994. "*Ketegangan Punca Keganasan*" (Stress as the Source of Abuse). Utusan Malaysia 80 (April 5): 6.

Edwards, Anne. 1993. "Doc: Teenage Pregnancy Rising." The Star (July 14): 6.

Ehrenreich, Barbara, and Deidre English. 1978. For Her Own Good: 150 Years of Experts' Advice to Women. Garden City, NY: Anchor/Doubleday.

Eisenstein, Zillah. 1979. Capitalist Patriarchy and the Case for Socialist Feminism. New York: Monthly Review Press.

El-Sanabary, Nagat (ed). 1983. Women and Work in the Third World. Proceedings. Berkeley, CA: Center for the Study, Education and Advancement of Women, University of California.

Elmer-Dewitt, Philip. 1991. "Making Babies." Time (September 20): 56-63.

Errington, Shelly. 1990. "Recasting Sex, Gender, and Power: A Theoretical and Regional Overview." Pp. 1-58 in Jane Monnig Atkinson and Shelly Errington (eds), Power and Difference: Gender in Island Southeast Asia. Stanford, CA: Stanford University Press.

Faithorn, Elizabeth. 1975. "The Concept of Pollution Among the Kafe of the Papua New Guinea Highlands." Pp. 127-40 in Rayna R. Reiter (ed), Toward an Anthropology of Women. New York: Monthly Review Press.

Federation of Family Planning Associations of Malaysia. 1993. Consolidated Strategic Plan (March 5, 1993). Penang, Malaysia: FFPAM Draft.

Fee, Elizabeth (ed). 1983. Women and Health: The Politics of Sex in Medicine. Farmingdale, NY: Baywood Publishing Company, Inc.

Fernandez-Kelly, Maria Patricia. 1983. "The *Maquila* Women: Characteristics of the Work Force in Ciudad Juarez's Assembly Plants." Pp. 47-69 in Maria Patricia Fernandez-Kelly, For We are Sold, I and My People: Women and Industry in Mexico's Frontier. Albany, NY: State University of New York Press.

Firestone, Shulamith. 1970. The Dialectic of Sex: The Case for Feminist Revolution. New York: Morrow.

Firth, Rosemary. 1966. Housekeeping Among Malay Peasants, 2nd Edition. New York: Humanities Press.

Fishman, Pamela. 1982. "Interaction: The Work Women Do." Pp. 170-80 in Rachel Kahn-Hut, Arlene K. Daniels, and Richard Colvard (eds), Women and Work: Problems and Perspectives. New York: Oxford University Press.

Flax, Jane. 1990. "Postmodernism and Gender Relations in Feminist Theory." Pp. 39-62 in Linda J. Nicholson (ed), Feminism/Postmodernism. New York: Routledge.

Foucault, Michel. 1980. Power/Knowledge: Selected Interviews and Other Writings, 1972-1977. New York: Pantheon Books.

Foucault, Michel. 1978. The History of Sexuality, Volume 1: Introduction. New York: Random House.

Frankenberg, Ruth. 1988. White Women, Race Matters: The Social Construction of Whiteness. University of California, Santa Cruz: Dissertation.

Fried, Marlene Gerber. 1990. From Abortion to Reproductive Freedom: Transforming a Movement. Boston, MA: South End Press.

Froines, Ann. 1992. "Renewing Socialist Feminism." Socialist Review 22 (2): 125-31.

Geertz, Clifford. 1983. Local Knowledge: Further Essays in Interpretive Anthropology. New York: Basic Books.

Gimlette, John Desmond. 1915. Malay Poisons and Charm Cures. London, England: J. & A. Churchill.

Ginsburg, Faye D. 1989. Contested Lives: The Abortion Debate in an American Community. Berkeley, CA: University of California Press.

Glaser, Barney, and Anselm Strauss. 1967. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, IL: Aldine Publishing Company.

Goh, Ban Lee. 1985. Buying a House in Malaysia. Kuala Lumpur, Malaysia: Marican and Sons (Malaysia) Sdn. Bhd.

Grewal, Inderpal, and Caren Kaplan. 1994. "Introduction: Transnational Feminist Practices and Questions of Postmodernity." Pp. 1-33 in Inderpal Grewal and Caren Kaplan (eds), Scattered Hegemonies: Postmodernity and Transnational Feminist Practices. Minneapolis, MN: University of Minnesota Press.

Hartmann, Betsy. 1987. Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choice. New York: Harper & Row.

Hartmann, Heidi. 1984. "The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union." Pp. 172-89 in Alison Jaggar and Paula Rothenburg (eds), Feminist Frameworks: Alternative Theoretical Accounts of the Relations Between Women and Men. New York: McGraw-Hill Publications.

Hartmann, Heidi. 1979. "Capitalism, Patriarchy and Job Segregation by Sex." Pp. 206-47 in Zillah Eisenstein (ed), Capitalist Patriarchy and the Case for Socialist Feminism. New York: Monthly Review Press.

Hartsock, Nancy. 1990. "Foucault on Power: A Theory for Women?" Pp. 157-75 in Linda J. Nicholson (ed), Feminism/Postmodernism. New York: Routledge.

Harvey, David. 1989. The Condition of Postmodernity. Cambridge, MA: Basil Blackwell Inc.

Heng, Rebecca, and Janadas Devan. 1992. "State Fatherhood: The Politics of Nationalism, Sexuality and Race in Singapore." Pp. 343-64 in Andrew Parker et al (eds), Nationalisms and Sexualities. New York: Routledge.

Hirschman, Charles. 1986. "The Recent Rise in Malay Fertility: A New Trend or a Temporary Lull in a Fertility Transition?" Demography 23 (2): 161-84.

Hochschild, Arlie. 1989. The Second Shift: Working Parents and the Revolution at Home. New York: Viking Books.

Ismail, Faezah. 1991. "Health Checks on Female Workforce." New Straits Times (Jul 20): 33.

Jacobson, Jodi L. 1991. Women's Reproductive Health: The Silent Emergency. Washington DC: Worldwatch Institute.

Jacobson, Jodi L. 1990. The Global Politics of Abortion. Washington DC: Worldwatch Institute.

Jain, Anrudh K. 1981. "The Effect of Female Education on Fertility: A Simple Explanation." Demography 18 (4) (November): 577-95.

Jaschok, Maria, and Suzanne Miers (eds). 1994. Women and Chinese Patriarchy: Submission, Servitude and Escape. Atlantic Highlands, NJ: Zed Books.

Jomo, K. S. 1989. Beyond 1990: Considerations for a New National Development Strategy. Kuala Lumpur, Malaysia: Perpustakaan Negara Malaysia.

Jones, Gavin. 1985. "Towards an Optimum Population: The Malaysian Case." People (IPPF) 12 (4): 14-16.

Jorgensen, Danny L. 1989. Participant Observation: A Methodology for Human Studies. Newbury Park, CA: Sage Publications.

Karim, Wazir Jahan. 1992. Women and Culture: Between Malay *Adat* and Islam. Boulder, CO: Westview Press.

Karim, Wazir Jahan. 1985. "Malaysian Labour: Women in Industry (Electronic Woman)." Inside Asia 5 (Nov-Dec): 20-1.

Khoo, Kay Kim. 1988. "Chinese Economic Activities in Malaya: A Historical Perspective." Pp. 179-223 in Manning Nash (ed), Economic Performance in Malaysia: The Insiders View. New York: Professors World Peace Academy.

Khor, Geok Lin. 1990. "Fertility Preferences Among Malaysian Women: An Analysis of Responses to the New Population Policy." Journal of Biosocial Science 22 (4): 465-76.

Kimball, Linda A., and Shawna Craig. 1988. "Women and Stress in Brunei." Pp. 170-82 in Patricia Whelehan (ed), Women and Health: Cross-Cultural Perspectives. Granby, MA: Bergin and Garvey Publishers, Inc.

Kumar, Mukunda. 1984. *Kejadian Pengguguran di Pulau Pinang* (Incidence of Abortion in Penang). Penang, Malaysia: Universiti Sains Malaysia.

Laderman, Carol. 1987. "Destructive Heat and Cooling Prayer: Malay Humoralism in Pregnancy, Childbirth and the Postpartum Period." Social Science and Medicine 25 (4): 357-65.

Laderman, Carol. 1983. Wives and Midwives: Childbirth and Nutrition in Rural Malaysia. Berkeley, CA: University of California Press.

LaFleur, William R. 1992. Liquid Life: Abortion and Buddhism in Japan. Princeton, NJ: Princeton University Press.

Lebra, Joyce, and Joy Paulson. 1980. Chinese Women in Southeast Asia. Singapore: Times Books International.

Lee, Ah Chai. 1989. "Illegal Abortion: Doctor Charged." New Straits Times (Nov 8).

Leininger, Madeleine M. (ed). 1985. Qualitative Research Methods in Nursing. Orlando, FL: Grune & Stratton.

Lengermann, Patricia M., and Jill Niebrugge-Brantley. 1988. "Contemporary Feminist Theory." Pp. 400-43 in George Ritzer, Sociological Theory, 2nd Edition. New York: Alfred A. Knopf, Inc.

Lewin, Ellen, and Virginia Olesen. 1985. Women, Health and Healing: Toward a New Perspective. London, England: Tavistock Publications.

Lim, Linda Y. C. 1983. "Multinational Export Factories and Women Workers in the Third World." Pp. 75-83 in Nagat El-Sanabary (ed), Women and Work in the Third World. Proceedings. Berkeley, CA: Center for the Study, Education and Advancement of Women, University of California.

Luker, Kristin. 1984. Abortion and the Politics of Motherhood. Berkeley, CA: University of California Press.

Manderson, Lenore. 1987. "Health Services and the Legitimation of the Colonial State: British Malaya 1786-1941." International Journal of Health Services 17 (1): 91-112.

Martin, Emily. 1992. "The End of the Body?" American Ethnologist 19 (1): 121-40.

Mernissi, Fatima. 1991. The Veil and the Male Elite: A Feminist Interpretation of Women's Rights in Islam. Translated by Mary Jo Lakeland. Reading, MA: Addison-Wesley Publishing Company.

Mintzes, Barbara (ed). 1992. A Question of Control: Women's Perspectives on the Development and Use of Contraceptive Technologies. Amsterdam, The Netherlands: WEMOS Women and Pharmaceuticals Project and Health Action International (HAI Europe).

Moen, Elizabeth. 1991. "Sex Selective Eugenic Abortion: Prospects in China and India." Issues in Reproductive and Genetic Engineering 4 (3): 231-49. Boston, MA: Beacon Press.

Mohanty, Chandra Talpade et al (eds). 1991. Third World Women and the Politics of Feminism. Bloomington, IN: Indiana University Press.

Mohanty, Chandra. 1988. "Under Western Eyes: Feminist Scholarship and Colonial Discourses." Feminist Review 30 (Autumn): 61-88.

Morgan, Robin. 1970. Sisterhood is Powerful. New York: Vintage.

Morgan, Robin. 1968. Going Too Far: The Personal Chronicle of a Feminist. New York: Random House.

Murphy, Cait. 1990. "The Grandest Affirmative Action Failure of All." Wall Street Journal (Thurs Dec 27): A8(W), A8(E), col 3.

Nambiar, Rema. 1989. "Docs Hail Law on Abortion, But Fear Abuse." The Star (Apr 20).

Nash, Manning. 1988. Economic Performance in Malaysia: The Insiders View. New York: Professors World Peace Academy.

Ng, Cecilia. 1991. "Malay Women and Rice Production in West Malaysia." Pp. 188-200 in Haleh Afshar (ed), Women, Development and Survival in the Third World. Essex, England: Longman Group UK Ltd.

Ng, Cecilia, and Carol Yong. 1990. Malaysian Women at the Crossroads. London, England: CHANGE International Reports - Women and Society.

Ng, K. H., and T. A. Sinnathuray. 1975. "Maternal Mortality from Septic Abortions in University Hospital, Kuala Lumpur, from March 1968 to February 1974." Medical Journal of Malaysia 30 (1): 52-4.

Ngin, Chor-Swang. 1985. "Indigenous Fertility Regulating Methods Among Two Chinese Communities in Malaysia." Pp. 26-41 in Lucile F. Newman (ed), Women's Medicine: A Cross-Cultural Study of Indigenous Fertility Regulation. New Brunswick, NJ: Rutgers University Press.

Omar, Roziah. 1992. The Malay Woman in the Body: Research on Body, Reproduction, Reproductive Cycle and Rural Malay Women of Melaka, Malaysia. Berkeley, CA: University of California Ph.D. Dissertation.

Omran, Abdel. 1971. "Abortion in the Demographic Transition." Pp. 479-532 in National Academy of Sciences, Rapid Population Growth: Consequences and Policy Implications. Baltimore, MD: Johns Hopkins Press.

Ong, AiHwa. 1990a. "Japanese Factories, Malay Workers: Class and Sexual Metaphors in West Malaysia." Pp. 385-422 in Jane Monnig Atkinson and Shelly Errington (eds), Power and Difference: Gender in Island Southeast Asia. Stanford, CA: Stanford University Press.

Ong, AiHwa. 1990b. "State Versus Islam: Malay Families, Women's Bodies, and the Body Politic in Malaysia." American Ethnologist 17 (2): 258-76.

Ong, AiHwa. 1988. "Colonialism and Modernity: Feminist Re-Presentations of Women in Non-Western Societies." Inscriptions 3-4: 79-93.

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

Ooi, O. S. 1971. "The Demand for Abortion in an Urban Malaysian Population." Medical Journal of Malaysia 25 (3): 175-81.

Oorjitham, K. S. Susan. 1994. "The Development Process and Women's Participation in the Plantation Sector - A Macro Level Analysis of Trends and Patterns, 1957-1988." Pp. 157-73 in Jamilah Ariffin (ed), Readings on Women and Development in Malaysia. Kuala Lumpur, Malaysia: University of Malaya Population Studies Unit.

Patai, Daphne. 1991. "U.S. Academics and Third World Women: Is Ethical Research Possible?" Pp. 137-53 in Daphne Patai and Sherna Berger Gluck (eds), Women's Words: The Feminist Practice of Oral History. New York: Routledge.

Petchesky, Rosalind P. 1990. Abortion and Women's Choice: The State, Sexuality, and Reproductive Freedom, Revised Edition. Boston, MA: Northeastern University Press.

Petchesky, Rosalind P., and Jennifer A. Wiener. 1990. Global Feminist Perspectives on Reproductive Rights and Reproductive Health: A Report on the Special Sessions Held at the Fourth International Interdisciplinary Congress on Women. New York City: Hunter College.

Phua, K. H. 1989. "The Development of Health Services in the Colonies - A Study of British Malaya and Singapore." Asia-Pacific Journal of Public Health 3 (4): 315-23.

Poopalasingham, Sarojini. 1977. Psycho-Social Aspects of Patients Requesting Menstrual Regulation in Kuala Lumpur. Kuala Lumpur, Malaysia: University of Malaya Department of Obstetrics and Gynaecology.

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

Rajeswary, I. 1987. "MMA Calls for Reforms to Abortion Laws." The Star (Oct 9).

Raymond, Janice G., Renate Klein, and Lynette J. Dumble. 1991. RU 486: Misconceptions, Myths and Morals. Cambridge, MA: Institute on Women and Technology.

Raymond, Janice. 1989. "Reproductive Technologies, Radical Feminism, and Socialist Liberalism." Reproductive and Genetic Engineering 2 (2): 133-42.

Reist, Melinda Tankard. 1995. "The Feminist Challenge to Cairo." Human Life Review 21 (1): 53-64.

Rich, Adrienne. 1994. "Compulsory Heterosexuality and Lesbian Existence." Pp. 487-490 in Allison M. Jaggar (ed), Living with Contradictions: Controversies in Feminist Social Ethics. Boulder, CO: Westview Press, Inc.

Rudie, Ingrid. 1994. Visible Women in East Coast Malay Society: On the Reproduction of Gender in Ceremonial, School and Market. Oslo, Norway: Scandinavian University Press.

Sachdev, Paul (ed). 1988. International Handbook on Abortion. Westport, CT: Greenwood Press, Inc.

Sacks, Karen Brodkin. 1974. "Engels Revisited: Women, the Organization of Production, and Private Property." Pp. 207-22 in Michelle Z. Rosaldo and Louise Lamphere (eds), Woman, Culture and Society. Stanford, CA: Stanford University Press.

Safa, Helen I. 1986. "Runaway Shops and Female Employment: The Search for Cheap Labor." Pp. 58-71 in Eleanor Leacock and Helen I. Safa (eds), Women's Work: Development and the Division of Labor by Gender. South Hadley, MA: Bergin and Garvey Publishers, Inc.

Safa, Helen I. 1983. "Women and the International Division of Labor." Pp. 3-8 in Nagat El-Sanabary (ed), Women and Work in the Third World. Proceedings. Berkeley, CA: Center for the Study, Education and Advancement of Women, University of California.

Salaff, Janet. 1988. State and Family in Singapore: Restructuring a Developing Society. Ithaca, NY: Cornell University Press.

Sambhi, J. S. 1977. "Abortion by Massage - '*Bomoh*'." IPPF Medical Bulletin 11 (1): 3.

Sandelowski, Margarete, Diane H. Davis, and Betty G. Harris. 1989. "Artful Design: Writing the Proposal for Research in the Naturalist Paradigm." Research in Nursing and Health 12 (1): 77-84.

Scheper-Hughes, Nancy. 1992. Death Without Weeping: The Violence of Everyday Life in Brazil. Berkeley, CA: University of California Press.

Sen, Gita, Adrienne Germain, and Lincoln C. Chen (eds). 1994. Population Policies Reconsidered: Health, Empowerment, and Rights. Boston, MA: Harvard University Press.

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

Shapiro, Thomas M. 1985. Population Control Politics: Women, Sterilization, and Reproductive Choice. Philadelphia, PA: Temple University Press.

Singh, Harpajan. 1985. "Ex-Staff Tells of Abortions at Two Clinics." The Star (Oct 22).

Singnomklao, T. N. 1985. "Abortion in Thailand and Sweden: Health Services and Short-Term Consequences." Pp. 54-66 in Ciba Foundation Symposium, Abortion: Medical Progress and Social Implications. London, England: Pitman Publishing Ltd.

Sinnadurai, Visu (ed). 1987. Survey of Malaysian Law 1985. Kuala Lumpur, Malaysia: Malayan Law Journal Sendirian Berhad.

Sinnadurai, Visu (ed). 1985. Survey of Malaysian Law 1984. Kuala Lumpur, Malaysia: Malayan Law Journal Sendirian Berhad.

Sinnathuray, T. A. et al. 1977. Report on Maternal Health and Early Pregnancy Wastage in Peninsular Malaysia. Kuala Lumpur, Malaysia: Federation of Family Planning Associations.

Siraj, Mehrun. 1985. "Population Law." Pp. 271-4 in Sinnadurai, Visu (ed), Survey of Malaysian Law 1984. Kuala Lumpur, Malaysia: Malayan Law Journal Sendirian Berhad.

Smith, Dorothy E. 1987. The Everyday World as Problematic: A Feminist Sociology. Boston, MA: Northeastern University Press.

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

Smyke, Patricia. 1991. Women and Health. Atlantic Highlands, NJ: Zed Books.

Stanworth, Michele (ed). 1987. Reproductive Technologies: Gender, Motherhood and Medicine. Minneapolis, MN: University of Minnesota Press.

Stivens, Maila K. 1992. "Perspectives on Gender: Problems in Writing About Women in Malaysia." Pp. 202-24 in Joel S. Kahn and Francis Loh Kok Wah (eds),

Fragmented Vision: Culture and Politics in Contemporary Malaysia. Honolulu, HI: University of Hawaii Press.

Strange, Heather. 1981. Rural Malay Women in Tradition and Transition. New York: Praeger Publishers.

Strauss, Anselm, and Juliet Corbin. 1990. Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage Publications.

Tan, Boon Ann et al. 1983. Age at Menarche in Peninsular Malaysia: Time Trends, Ethnic Differentials, and Association with Ages at Marriage and at First Birth. Santa Monica, CA: The Rand Corporation.

Tan, Loong-Hoe. 1982. Malnutrition, Health Resources and Education in Peninsular Malaysia. ISEAS Occasional Paper no. 69. Singapore: Maruzen Asia.

Tanfer, K., and E. Rosenbaum. 1986. "Contraceptive Perceptions and Method Choice Among Young Single Women in the U.S." Studies in Family Planning 17: 269-77.

Thambu, Johan A. M. 1975. "Abortions - Government Hospitals Peninsular Malaysia 1960-1972." Medical Journal of Malaysia 29 (4): 258-62.

Tietze, Christopher, and Stanley K. Henshaw. 1986. Induced Abortion: A World Review, 6th Edition. New York: Alan Guttmacher Institute.

Tohidi, Nayereh. 1991. "Gender and Islamic Fundamentalism: Feminist Politics in Iran." Pp. 251-70 in Chandra Talpade Mohanty et al (eds), Third World Women and the Politics of Feminism. Bloomington, IN: Indiana University Press.

Tong, Rosemary. 1989. Feminist Thought: A Comprehensive Introduction. Boulder, CO: Westview Press.

Tsing, Anna Lowenhaupt. 1993. In the Realm of the Diamond Queen: Marginality in an Out-of-the-Way Place. Princeton, NJ: Princeton University Press.

Vachher, Manju, and Khairuddin Yusof. 1978. "A Psychosexual Study of Abortion-Seeking Behavior." Medical Journal of Malaysia 33 (1): 50-56.

Vanderwater, Betty. 1992. "Meanings and Strategies of Reproductive Control: Current Feminist Approaches to Reproductive Technology." Issues in Reproductive and Genetic Engineering 5 (3): 215-30.

Vatikiotis, Michael. 1994. "Survival Lessons." Far Eastern Economic Review (January 6): 76-8.

Wadley, Susan S. 1992. "Women and the Hindu Tradition." Pp. 111-36 in Doranne Jacobson and Susan S. Wadley, Women in India: Two Perspectives. Columbia, MO: South Asia Publications.

Ward, Kathryn. 1984. Women in the World-System: Its Impact on Status and Fertility. New York: Praeger Publications.

West, Candace, and Don H. Zimmerman. 1991. "Doing Gender." Pp. 13-37 in Judith Lorber and Susan A. Farrell (eds), The Social Construction of Gender. Newbury Park, CA: Sage Publications, Inc.

Westwood, Sallie. 1991. "Gender and the Politics of Production in India." Pp. 288-308 in Haleh Afshar (ed), Women, Development and Survival in the Third World. Essex, England: Longman Group UK Ltd.

Whelehan, Patricia (ed). 1988. Women and Health: Cross-Cultural Perspectives. Granby, MA: Bergin and Garvey Publishers, Inc.

Williams, Raymond. 1977. Marxism and Literature. London, England: Oxford University Press.

Wilson, Paul R. 1971. The Sexual Dilemma: Abortion, Homosexuality, Prostitution, and the Criminal Threshold. St. Lucia, Australia: University of Queensland Press.

Yahya, Siti Rohani. 1994. "The Development Process and Women's Labor Force Participation - A Macro-Level Analysis of Patterns and Trends 1957-1990." Pp. 23-52 in Jamilah Ariffin (ed), Readings on Women and Development in Malaysia. Kuala Lumpur, Malaysia: University of Malaya Population Studies Unit.

Zulkifli, Siti Norazah, and Khairuddin Yusof. 1985. "Population 70 Million: A Consideration of Health Aspects." Medical Journal of Malaysia 40 (2): 62-79.

APPENDICES

APPENDIX A

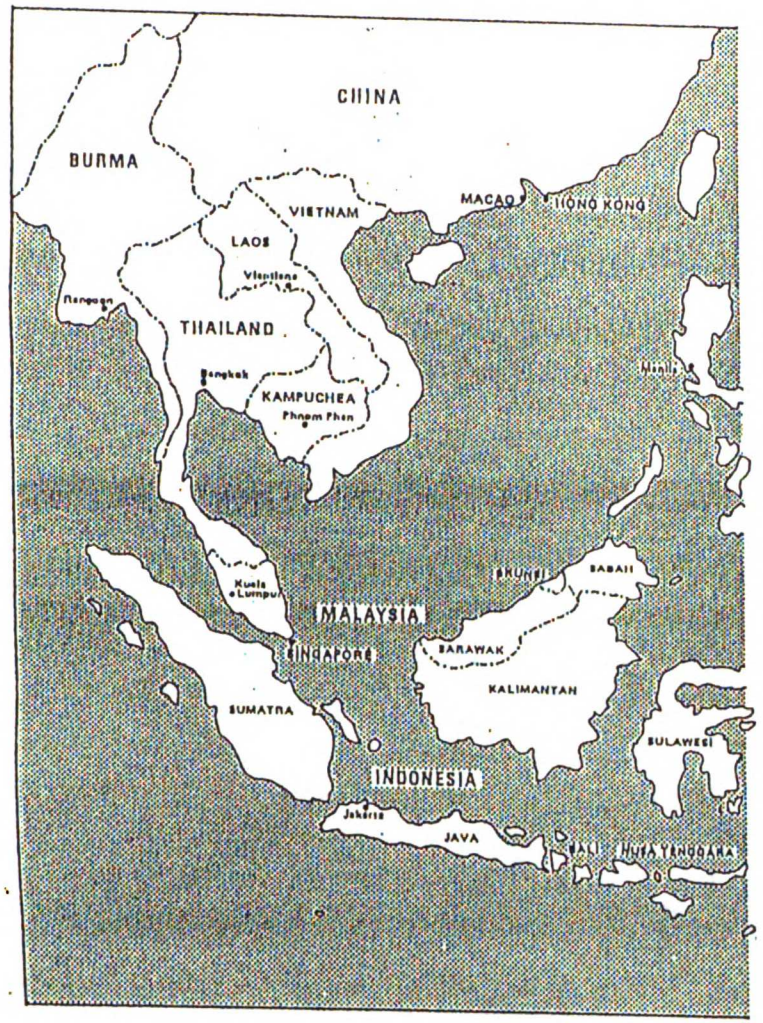
Some Basic Country Indicators

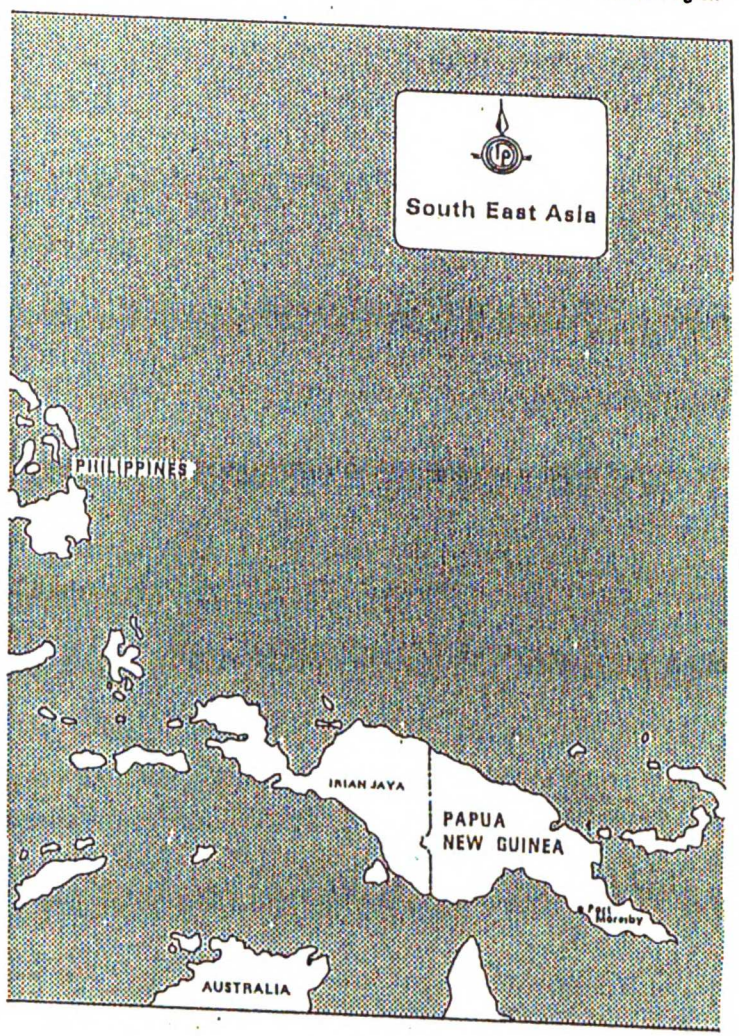
Country	Population (millions)[1]	Population Growth Rate (%)	GNP/ capita (US$)	Maternal Mortality Rate (/100000 births) (1990)[2]	Total Fertility Rate (births / woman) (1990)	Abortion Rate (/1000 women aged 15-44) (1981)[3]
Thailand	57.6	1.4	1,605	81	2.6	37.0
Malaysia	18.1	2.3	2,475	59	3.5	N/A
Singapore	3.1	1.1	13,600	13	1.7	28.8
U.S.	253.4	0.7	22,550	8	1.8	24.2

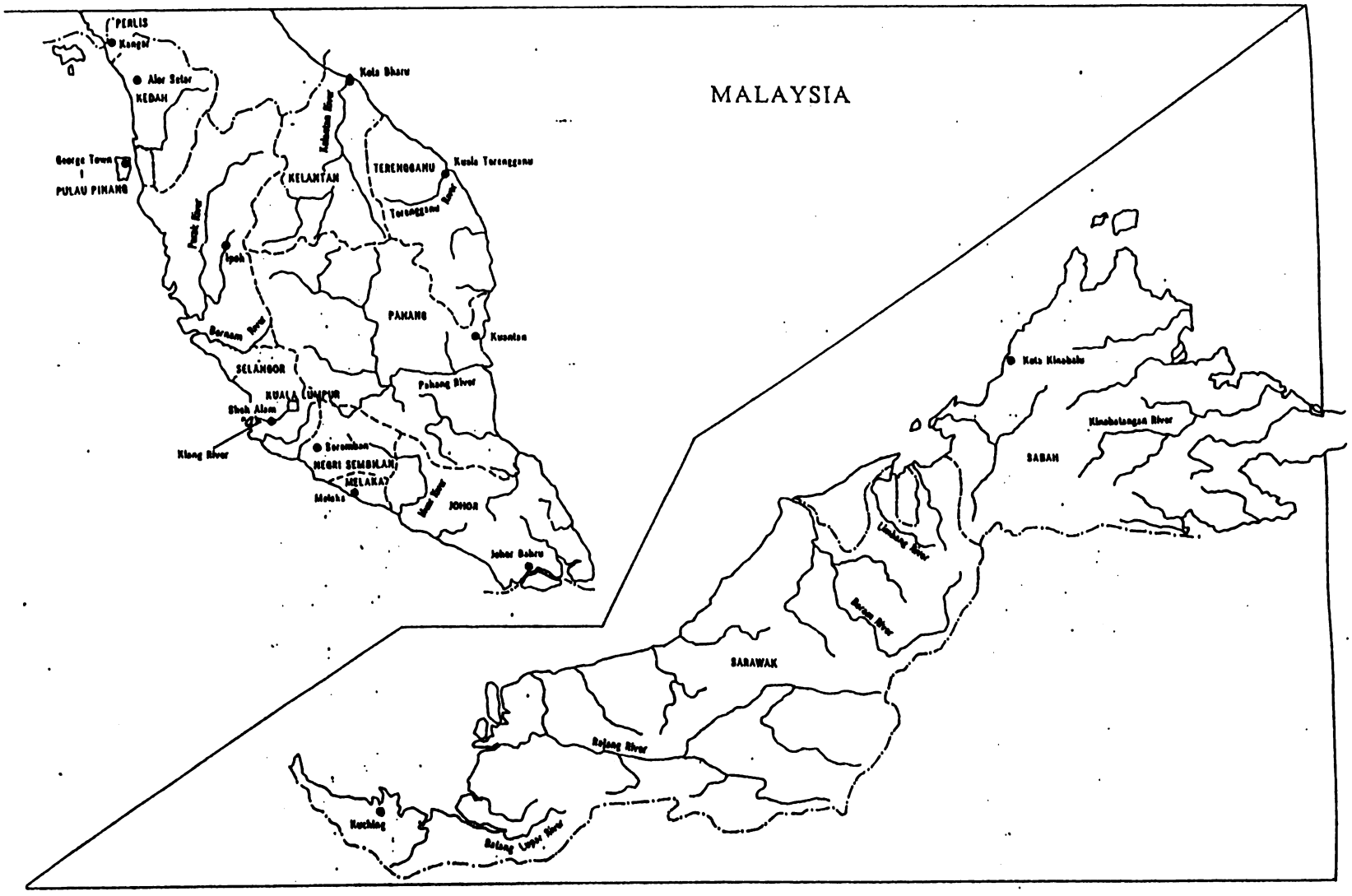
[1] Correspondent. 1992. "The Bottom Line." Asiaweek 18 (28) (July 10): 12-13.
[2] United Nations. 1991. The World's Women 1970-1990: Trends and Statistics. New York: United Nations Publications.
[3] Tietze, Christopher. 1986. Induced Abortion: A World Review, 6th Edition. New York: Alan Guttmacher Institute.

APPENDIX B

Maps of Malaysia


CHINA
BURMA
VIETNAM
MACAO
HONG KONG
LAOS
Vientiane
Rangoon
THAILAND
Bangkok
Manila
KAMPUCHEA
Phnom Phen
Kuala Lumpur
MALAYSIA
BRUNEI
SABAH
SINGAPORE
SARAWAK
KALIMANTAN
SUMATRA
SULAWESI
INDONESIA
Jakarta
JAVA
BALI
NUSA TENGGARA


South East Asia
PHILIPPINES
IRIAN JAYA
PAPUA
NEW GUINEA
Port Moresby
AUSTRALIA


MALAYSIA
PERLIS
Kangar
Alor Setar
KEDAH
George Town
PULAU PINANG
Kota Bharu
KELANTAN
Kelantan River
TERENGGANU
Kuala Terengganu
Terengganu River
Perak River
Ipoh
Selangor River
PAHANG
Kuantan
SELANGOR
KUALA LUMPUR
Shah Alam
Klang River
Seremban
NEGRI SEMBILAN
MELAKA
Melaka
Muar River
JOHOR
Johor Bahru
Pahang River
Kota Kinabalu
Kinabatangan River
SABAH
Limbang River
Baram River
SARAWAK
Rajang River
Kuching
Rajang Lupar River

APPENDIX C

Counseling Script (Unabbreviated Version)

I am going to explain the process which you will be going through on your visit here today. You will have gone through a registration and admissions counseling process already. During your counseling, you were asked for your medical history and also asked to drink a glass of water. This helps the ultrasound test which you will receive later in the doctor's office to confirm that you are pregnant. When your bladder is full, it pushes the uterus up and makes its contents more visible on the ultrasound scan.

The nurse also asked you about your contraceptive history to ensure that the contraceptive decisions you have been making are what work best for you. During admissions counseling, we also ask you what your preference for future contraception is, and if you need to use a new or different method from the one you have been using, should you decide that a new method would fit your current and future needs better. We have information on the benefits and disadvantages of each method for you to read, think about and discuss with your partner if you need to.

If you have any questions about these contraceptive methods, please ask a staff member at any time. Each woman has different needs and knows what will work best for her. We will facilitate what can sometimes be a difficult decision-making process by providing you with as much information as we can to help you make an informed decision, but the ultimate decision on contraceptive choice is yours.

We also ask that you tell us if you would feel more comfortable with a female doctor and we try to give you that choice whenever possible. We have three doctors on staff, one of whom is a woman.

The next step in the process is that you will see and be examined by a doctor. He or she will ask you questions on the reasons you wish to terminate your pregnancy so that both you and we at the clinic feel comfortable that this decision is the right one for you at this time. The doctor will also examine your uterus using ultrasound to confirm that you are far enough along in your pregnancy that a washout can be done successfully.

If the pregnancy is less than 10mm in size or if the pregnancy is ectopic (i.e. the pregnancy is outside of the uterus, usually in the fallopian tubes), a washout of the uterus may miss the pregnancy completely and the termination will be unsuccessful. In the case where your pregnancy is not far enough along, we will suggest that you wait a week or two before we attempt the procedure. In the case of an ectopic pregnancy, we will recommend that you go to a hospital or maternity home since we are unable to handle such cases. If both you and the doctor agree that everything looks OK so far, you will go on to the next step.

The next step is the procedure itself. Before you undergo the washout, there are a number of options for relaxation and pain relief that we offer, which were

discussed with you during admissions counseling. These options range from what requires the least medication to largely medicated drugs to kill the pain or relieve any anxiety you may feel.

First, it will help if you breathe slowly and deeply throughout the procedure. This slow, deep abdominal breathing helps relax the uterine muscles and relieves anxiety, prevents lightheadedness and hyperventilation. A staff member will be with you during the procedure to help you do abdominal breathing.

We also provide antibiotics to prevent infection and antiemetics such as Stemetil to help control nausea. Then there is valium, which is an anti-anxiety medication. Do not take this medication if you have glaucoma or are breastfeeding. Common side effects of valium are drowsiness, dizziness and loss of coordination. If you are diabetic, it may increase your blood sugar. Any woman using valium must not drive within six hours of taking it and must arrange to have someone drive her home from the clinic after the washout.

We also offer a painkiller called Talwin, which we give you. If you have a pregnancy beyond twelve weeks, we suggest you be sedated with an IV sedation. This is because the procedure takes a little longer and may be more uncomfortable for you if you choose to be conscious throughout the procedure. The effects of this pain reliever are felt within one to three minutes following the injection and last for three to six hours. The most common side effects are sleepiness, headache, clammy skin, nausea, vomiting and/or a dry mouth. Any woman using IV sedation must not drive within twelve hours of taking it and must arrange for her to be driven home from the clinic after the procedure.

If you do not choose to be sedated, you will be aware of the washout as it is happening. Fortunately, the washout itself is very short, lasting about one to three minutes. First, the doctor injects the cervix with a paracervical block to deaden sensation in the cervical area. You will feel a sharp sting when this happens. Then the doctor will insert a metal instrument called a speculum to spread the walls of your vagina apart. Then plastic dilating rods will be inserted to open the cervical canal leading from the vagina to the uterus. A plastic cannula attached to a vacuum pump is put through the canal into the uterus, and the contents of the uterus are suctioned out. The procedure for pregnancies up to twelve weeks takes about five to ten minutes; the suctioning goes on for about one to three minutes.

How much pain or discomfort you will feel varies enormously, depending on how far along you are, how clear you feel about your decision, what kind of support you are getting at home or in the workplace, and your individual sensitivity or threshold for pain. We try to make the process as comfortable as possible by giving you as much information and support for your decisions as we can, by being with you during the washout, and by offering a choice of mild relaxants and painkillers.

Many women feel a cramping sensation as instruments pass through the cervix and/or immediately after the washout as the uterus contracts to return to its normal size. The cramps range from mild to strong and are different for each woman. What might help to ease these cramps afterwards are hot water bottles, backrubs, orgasms, massaging your abdomen, lying on your tummy, having a cat sit on your

lap, and taking non-aspirin pain relievers such as Ponstan. During the procedure, the injection of Talwin also helps to relieve cramping.

Once the procedure is over, we will move you to the recovery room where you may rest for as long as you wish. For some women, the recovery process takes twenty minutes, for others it may take a couple of hours, depending on whether she has been sedated, and how fit she feels going into the procedure. The most immediate benefit you will feel is that the nausea goes away. Taking good care of yourself during the days and weeks after your washout can make a big difference in the way you feel. Please follow the instructions the staff have given you, and come see us for a follow-up visit in a couple of weeks so we can be sure there are no complications.

APPENDIX D

1. Questionnaire for Doctors

1. Age
2. Marital Status
3. Number of children
4. Sex
5. Religion
6. Ethnic background
7. Where did you primarily grow up (city, town, country)?
8. How did you come to choose medicine as a career? When did you make this decision?
9. Where did you receive your medical education? Where did you do your residency?
10. How did you come to decide on this specialty? Any previous ones? Who or what influenced you?
11. How long have you practiced in this community?
12. How and why did you decide upon this community?
13. Are you a current member of the MMA? Why or why not?
14. To what other (medical) professional organization do you belong?
15. Have you ever been formally questioned about your attitudes towards birth control, abortion or family planning? If yes, when, where, by whom?
16. What is your relationship to the Family Planning organization in this community? How regular is your contact with them?
17. If you discuss abortion with your spouse, what are his/her views generally? If those views are different from your own, how do you feel about that?
18. What types of contraception do you mostly prescribe? How do you determine what types are most appropriate for each patient?
19. Do you think there are contraceptives that are abortive rather than contraception-preventing? Do patients ever ask you about this distinction?
20. How do you define abortion?
21. Are you aware of any other physicians in the community, besides members of your specialty, who perform abortions?
22. Can you recall the circumstances of the most "medically" troublesome abortion you ever performed?
23. Have you ever refused an abortion to a woman requesting one? What happened? To whom was she referred?

24. Could you speculate on why abortion is so widely practiced (if you think it is), even when birth control is available? In other words, what prevents men and women from using contraception?

25. How do you ideally envision the participation of men and women in the use of contraceptives? What role should men play?

26. How do you feel about seeing only one half or side of a sexual relationship, when there are more than simply medical problems?

27. How familiar are you with the ruling on abortion as it applies in Malaysia?

28. Have you ever experienced any form of pressure from either the pro-choice or pro-life proponents?

29. What do you believe the physician's place ought to be in the moral controversy over abortion?

30. Although the swearing to uphold the Hippocratic oath is no longer required in order to receive a medical degree, how do you reconcile the liberalizing of abortion with Hippocrates' injunction against it? ("I will not give a woman a pessary to cause abortion.") Did you take the oath?

31. Are you familiar with any physicians or hospital personnel who will not participate in abortion? And who are not Catholic? May I ask what reasons they gave for their views?

32. In your clinical experience, have you ever seen a woman who has had difficulties with infertility or premature delivery and who had undergone a previous abortion? Have you heard that infertility and premature delivery are claimed to be consequences of abortion? What do you make of it? Do you or would you advise women seeking abortions of this claim?

33. Are there contraceptives which you prescribe that you personally consider less than perfectly safe? Do you advise patients to whom you prescribe these contraceptives of your thoughts on such matters?

34. How would you respond to legislation authorizing nonphysicians to perform abortions?

35. Have you ever used or heard of any physician using paramedic personnel for performing abortions?

I would like to probe with you more deeply the "varying situations" in which you would or would not approve of abortion. Put yourself in the position of a physician faced with any of these various circumstances, even if you have not been:

36. The pregnancy or childbirth is a threat to the woman's life

What kinds of conditions would you consider threatening? Have you ever had such a case?

37. There is a risk of congenital abnormality

How significant a risk would there have to be? How would you diagnose such a risk? Under what circumstances do you have women tested for such conditions? Have you ever had any cases in which you performed an abortion because there was, in your mind, significant risk of congenital abnormality? Describe the circumstances.

38. The pregnancy or childbirth is a threat to the woman's physical health

What threats to physical health have you diagnosed which persuaded you that an abortion was necessary? What threats might persuade you?

39. The pregnancy is the result of rape or incest

Have you ever performed an abortion for either of these reasons? Is there any case that stands out in your mind as troubling? (Your own or someone else's?) Could you describe it?

40. The pregnancy or childbirth is a threat to a woman's mental health

Have you ever performed an abortion for this reason? What were the circumstances? Upon whose diagnosis did you rely for determining what a threat to mental health is? Did you perform abortions when psychiatric indications were required for any therapeutic abortions performed? Do psychiatrists play any role in your decision to perform abortions today?

41. Being unmarried would be a problem

Would you explore how serious a problem? Have you ever had such a case?

42. The woman does not want the child

Would you ask if she ever wants children? If she never wanted children, would you advise abortion and sterilization? Have you ever had such a case?

43. The woman is financially unable to support the child

Have you ever had such a case? If you did, would you or did you propose ways to find finances? Would you draw a line (say in terms of income) over which this reason would no longer be convincing to you?

44. The woman is too old to have the child

In your mind, how old is too old? Have you ever had such a case?

45. The woman is too young to have the child

Would you distinguish between her judgment, your judgment, or her parents' judgment, if they were involved? Have you ever had a case where the parents were involved? In your mind, how young is too young?

46. The woman's education or career would be disrupted

Would you explore how disrupted? Have you ever had such a case?

47. The pregnancy is a result of contraceptive failure

Have you ever had such a case?

48. The pregnancy is a result of contraceptive failure and the contraception was prescribed by the physician being asked to perform the abortion

Have you ever had such a case? Is there a particular contraceptive you know that seems to fail more than others?

49. The pregnancy is the result of failure to use contraception

Have you ever had such a case? Do you have other feelings about this particular problem?

50. The pregnancy is not the result of rape, but the woman is not certain who the father is

Have you ever had such a case?

51. The woman requests the abortion because her husband (or whoever the father is) asks that she have an abortion

Have you ever had such a case?

52. The woman requests the abortion and refuses to give any reason

Have you ever had such a case?

53. The pregnancy is in the first trimester
Have you ever had such a case?

54. The pregnancy is in the second trimester
Have you ever had such a case?

55. The pregnancy is in the third trimester
Have you ever had such a case?

56. Have you ever been faced with or heard about women who have sought repeated abortions? What was or would be your reaction to this situation?

57. How would you relate the population problem with the practice of abortion?

58. In your view, who have abortions? (married, unmarried, young, poor, etc.)

I would like to ask some questions about that which is aborted in abortion. One way of focusing on the problem of when life begins is through the problem of viability.

59. Do you have a definition for this term?

60. With potential developments in the technology of prenatal care, how will you, as a physician, face the prospect that any abortion one performs may involve a viable fetus?

61. Do you distinguish, in the case of the fetus, between life and human life?

62. Are you familiar with or do you perform menstrual extraction, regulation, or aspiration? What are your views on this procedure?

63. At some point, pharmaceutical solutions to unwanted conceptions may become a reality, at least for the first trimester. Do you think that abortion practice (or your abortion practice) will decrease dramatically in such an event? Why or why not?

64. Are you familiar with any research being performed upon fetuses in or outside the community? Have you ever been approached and asked to provide fetuses for such research?

65. Do you recommend amniocentesis for the purpose of diagnosing genetic disorders in the fetus? How often? Who else in the community uses it?

66. Suppose a child were born deformed; could you ever see a suit being brought against you for not having taken precautions (namely, amniocentesis and abortion) against such a possibility?

67. Would you perform an abortion if you knew the reason why it was requested was that the woman or couple did not want a child of a certain sex?

68. What techniques for abortion do you generally use?

69. How much do you charge for an abortion?

70. Would you say that in the last three years, requests made of you for abortions have increased, decreased, or remained the same? How do you account for the change, if any?

71. How do you at present regard the issue of abortion as a right? In other words, should abortion not only be considered a woman's right but also an essential part of health and welfare policy?

72. Do you think that recent developments, such as the rise of Islamic/Christian fundamentalists, have discouraged you from performing abortions?

73. What do physicians have to contribute to the debate about the definitions of "human life" and "personhood"?

74. What was your reaction to the 1989 changes in the law that allow abortions when the mental and/or physical health of the mother is in danger - in effect, the rape and incest clauses have been dropped?

75. Do you think abortion will ever be made illegal again?

76. How would you characterize the mood in this community regarding family planning and abortion? Has it improved or gotten worse in the last three years?

77. How are you affected, if you are, by local groups opposed to abortion?

78. Have there been any changes in hospital/clinic policy regarding abortion?

79. Would you consider any of the work you are doing, or any of the work that you know your colleagues are doing in obstetrics and gynecology, experimental in nature; or would you describe your work as basically clinical? How do you assure yourself that what you are doing does not have possible long-term effects about which little is known?

80. What about male birth control in this country?

81. What do you think about test-tube baby research? Have you made any referrals to clinics offering this service?

82. Do you continue to refer patients requesting abortions?

83. Do you see any difference between abortion referrals and other types of referral, since you could competently perform an abortion? To whom do you refer?

84. What are the present charges for abortion?

Adapted from:

Imber, Jonathan B. 1986. Abortion and the Private Practice of Medicine. New Haven, CT: Yale University Press.

APPENDIX D

2. Questionnaire for Nurses

1. How long have you been at the clinic?
2. What motivated you to take this job?
3. What are the main concerns or problems you face with clients who come to the clinic?
4. What are the two best and two worst experiences with clients that you recall?
5. What are the reasons you have heard from women clients for having washouts or abortions?
6. What are the most frequently asked questions that clients ask?
7. Knowing that public perception (those who have never been to the clinic) can sometimes be negative, how does that affect you as a nurse at this clinic?
8. What is your reaction to women who cry or get depressed after their washouts?

APPENDIX D

3. Questionnaire for Clients

I. Background demographic information

1. Age
2. Marital status
3. Number of previous pregnancies
4. Number of living children
5. Place (zip) of residence; resides with whom
6. Number of years of schooling completed
7. Occupation
8. Month seen
9. Religious background
10. Ethnicity
11. Social class
12. Birth control method used since last menstrual period
13. Most effective birth control method ever used
14. Follow-up status
15. Post-abortion complications
16. Reactions to therapeutic abortion
17. Knowledge of birth control at first interview
18. Gestation by medical examination at time of first appointment

II. The Pregnancy

19. Have you been using any birth control method; if so, what and for how long?
20. How did you know you were pregnant?
21. How did you feel once you knew it?
22. Did you tell anyone? Who?
23. What was your decision?
24. Were you ready for a baby?
25. Did you consider other alternatives; if so, which ones?

III. Seeking Information

(If the answer to question 25 is "abortion," then ask the following questions):

26. Who gave you information about abortion?
27. Why did you ask this person in particular?
28. How long did it take you to find the person/facility that finally performed the abortion?
29. Were you worried about the safety of what you were doing?

30. Have you heard of anyone who has had an abortion?
31. Since you had the abortion, has anyone else come to you seeking the same information?

IV. The Abortion Procedure

32. When was it done (how many days, weeks, months ago)?
33. Where was it performed (at home, at a neighbor's, in a private clinic, in hospital)?
34. Who did the procedure?
35. What method was used?
36. What happened?
37. Were you given any medicine or drugs?
38. How did you feel?
39. What were you told beforehand about what was going to happen?
40. Did you pay anything for the abortion; how much did you pay?

V. Outcomes

41. What happened after the abortion; were you ill?
42. (If appropriate) What made you decide to go to the hospital?
43. How were you treated at the hospital?
44. Did you have any other problems; what were they?
45. How do you feel now about the abortion?
46. What advice would you give someone else in the same situation?

VI. Political Opinions

47. Do you think the government provides adequate services for women who need abortions?
48. Do you feel that government abortion policy should be changed?
49. If so, how do you think changes in policy will happen?
50. What kinds of groups would you like to see lobbying for these changes: family planning groups, women's rights activists, NGOs (non-governmental organizations), local political representatives?

Adapted from:

Baker, Jean, and Shanyisa Khasiani. 1992. "Induced Abortion in Kenya: Case Histories." Studies in Family Planning 23 (1): 34-44.