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“Nowadays who wants many children?” Balancing Tradition and Modernity in Narratives Surrounding Contraception Use Among Poorer Women in West Bengal, India

By Devalina Mookerjee¹

Abstract

This paper investigates how poorer women in West Bengal, India balance the ideas of modernization and tradition in their choices to use birth control. Ideologically, Indian women have traditionally been placed within the context of the home and valued principally as wives and mothers. Children, therefore, are tremendously important for women within this framework. In contrast, the ideology of the relatively well structured and very large family planning program asks especially poorer women to have fewer children for the good of the family and the nation.

How do poorer, predominantly illiterate women balance these two oppositional ideas in an area that is of such importance in their lives? Qualitative feminist interviewing conducted in government family planning clinics is used to investigate how these women negotiate fertility control decisions with themselves and others, and how they place these decisions in the chronological borderlands between tradition and modernity in a changing world.

Keywords: Women, Contraception, Change, India.

Introduction

Forty-eight percent of currently married women aged 15-49 in India practice some form of family planning, according to available figures (International Institute for Population Sciences, 2000). Taking the decision to control fertility is not an easy one for most women, as they have to consider economic, social and cultural factors while making the decision (Visaria, 2000).

Women's voices are not often present in the literature that surrounds family planning programs in developing countries (Ramasubban & Jejeebhoy, 2000). Most often the loudest voices are those of governmental policymakers, with quantification in demographic terms being the method of choice when dealing with population control issues.

While quantification is essential when dealing with numbers this large, what is also essential is a perspective into women's stories as they tell them. The project on which this paper is based involved interviewing women in state subsidized family planning clinics in West Bengal, India for their experiences with obstetric and gynecologic care and fertility control.

Since independence, the Indian national identity (insofar as a country as diverse as India can be thought to have a national identity) has seen itself in transition to the modern world (Indian National Congress, 1949; Mahadevan et. al., 1989; Ram, 1996). The nation is in transition, in a sort of chronological borderlands between the old and the new worlds. The values of the old world are frequently in opposition with the values of the

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new one, and this makes it difficult to negotiate decisions that involve conflicting views of the world such as in the area of fertility control.

Qualitative interviewing based on feminist principles is used to interview women in waiting areas of government family planning clinics to find out how they negotiate these decisions with members of family and themselves. This paper discusses the concerns and uncertainties they express about fertility control, and the ways this decision impacts their lives on several levels.

Rationale

Since the 1950s there has been much concern in India and other parts of the world about population trends (Panandiker & Umashankar, 1994; Warwick, 1982). This has resulted in an enormous push on the part of the Indian government in the area of fertility control. Women have largely been the targets of this initiative, as most areas surrounding children and fertility are considered within their domain.

It is important, therefore, to have an understanding of women's perspectives on fertility control and regulation. It is through such understanding that programs that provide birth control technology and counseling can be sensitized to women's needs in this essential yet delicate area.

Methodology/ Details

The interviews took place at three family planning centers in the state of West Bengal in eastern India. West Bengal has an area of 88752 sq. kms. and borders Bangladesh in the west and the states of Bihar and Orissa in the east. Northern Bengal is in the foothills of the Himalayas and in the south lays the Bay of Bengal (Mansingh, 1998). The state of West Bengal has a population of 80,221,171 (Census of India, 2001). Its capital city, Kolkata (formerly Calcutta), has a population of 13,216,546 (Census of India, 2001). The language spoken is Bengali, and this is the language in which interviews were conducted.

The first center at which interviews with women were conducted was M.R. Bangur Hospital in South Kolkata. Bangur's family planning clinic is located within the hospital premises, and like all other government run family planning units, is part of the Mother and Child Health (MCH) program of the Government of West Bengal. Called an Ante Natal Clinic (ANC), it also offers gynecological, immunization and ante-natal services. Interviews took place in the waiting area, a large room where women congregate waiting for their names to be called to go in to see a doctor. Being a first tier referral hospital, complicated cases from all over the state are sent to Bangur for medical care, thus making it possible to meet women from all around the state in the waiting area. Predominantly, however, most of the clientele are from Kolkata and its environs.

The second center was Diamond Harbor Sub Divisional Hospital, about two hours by bus from southern Kolkata. Diamond Harbor is a semi/sub urban town located on the bank of the Ganga with a fairly large industrial and tourist related trade. The ANC in Diamond Harbor is within the hospital grounds, but about a five minute walk from the main buildings. The waiting area is much smaller than that at Bangur, and women frequently have to wait outside the clinic if there are more than twenty or so patients.

Mogra Haat II, the third health center is located in a rural area about an hour and a half by train from Kolkata. The hospital at Mogra Haat has no ANC unit, but female

healthcare workers go into the field and visit women in the surrounding villages in their homes. The primary purpose of these visits is to provide birth control information and technology, immunization for children, and basic health and sanitation advice to mothers. Research was carried out by traveling to villages with healthcare workers and interviewing women in their homes.

Approximately thirty interviews were conducted at each venue, over a period of a month and a half per center. Some of these interviews were taped and some not, depending on the preference of the woman interviewed. Additionally, field notes and a journal were maintained over the entire period. Clinic staff and doctors, and field based healthcare workers were also interviewed to better understand the environment in which patients receive care in these contexts.

Who are the women using the public healthcare system? In India, people do not ordinarily use the public healthcare system unless they cannot afford much more expensive private health care (A. Bannerjee, personal interview)². As the public system is government subsidized, it costs Re 1 (about 2 cents) for women to see a doctor. If the clinic has medicine available, the patient is given medication for free. If it is not available, it has to be bought at full price from nearby pharmacies. However, there is widespread awareness among staff and patients that the resources of the system are very stretched due to the sheer numbers of people seeking care at these centers. The women who come to the public healthcare system to receive care, therefore, are among the poorest, and have access to the least channels of information about health and other issues.

This context makes it extremely important to gather data using methods that are woman centered, as these women are already disempowered and voiceless to a great degree (Spivak, 1999). This project uses interviewee centered techniques based on feminist principles (Olesen, 1994). In particular, it uses primarily “phenomenological interviewing” which is interviewee guided investigation of lived experience (Reinharz, 1983). The interviews were conducted in an unstructured, open-ended manner that made them more like conversations than traditional interviews. As researcher, I had a broad list of topics I wanted to discuss with each woman. These included children, birth control, family (marital and premarital), gynecological issues, childbirth related issues and finances for healthcare among others. Normally, interviews started with me asking some basic information related questions. Then the woman and I would start talking about children and birth control, and beyond that point the person I was interviewing had control of the interview. Some women would talk almost exclusively about one particular topic, and only touch on the others. Sometimes a conversation that began with concerns about birth control technology would move through four or five or more topics before the woman had to leave the interview. The principal concern was to document women’s voices expressing concerns that were important in their lives.

As the conversations progressed, I realized that women were expressing similar concerns (Agar, 1996). The women’s narratives, distinct and individual in themselves, strongly echoed each other in uncertainties, worries and feelings of inadequacy as women, wives and mothers in their situations. This happened also within the interview context itself; as other women would occasionally enter into an interview situation, and

² Dr. Arup Bannerjee is Chief Medical Officer of Health III for South 24 Paraganas, the district in which all three centers are located in the state of West Bengal.

there would ensue a conversation between three or four women, agreeing, disagreeing, or making suggestions to each other.

What, then did women talk about in these contexts? They talked about topics as diverse as value conflicts, mothers-in-law, and the education system. But one topic they kept returning to was motherhood, and what it meant to them both culturally and as individuals. Children and mothering were discussed over and over again, and this paper is based on the sections of the conversations that centered on this topic.

Backgrounding the cultural value conflict

Motherhood is a certainty for many women around the world. This is especially so in India, where most girl children grow up with the near certainty that they are someday going to marry and have children, and that the role of wife and mother is going to be of foremost importance in their lives (Krishnaraj, 1997; Seal, 2000). This is a two edged sword, because while it is true that women achieve more power in Indian society as they grow older, have children, and become more essential to the family structure, it is also true that this power is only achievable within certain narrowly structured cultural norms, and within the context of the conventional family (Bose, 1995). Be that as it may, it is unarguable that within the structure of the Indian family, having children and mothering them brings to a woman a measure of social power that an unmarried or motherless woman finds it difficult to attain except in the most non-traditional settings.

Undeniably, there have been women of power in both ancient and modern India (Lalita and Tharu, 1991); but for the common woman, there are myths, legends and folktales that have reinforced the ideal of the woman who protects and cherishes her family even at considerable cost to herself. *The Ramayana*, for example, a quasi-religious epic familiar to almost every child growing up in India deifies women who sacrifice their selfhood at the altar of their husband's duties and obligations, and for the ultimate good of their children (Swami Venkatesananda, 1989).

Children are therefore tremendously important in a woman's life. Marriage and children denote womanhood and a sense of place, and a woman is required by spoken and unspoken social law to maintain this at all cost (Mukherjee, 1999). As in many other developing countries, children also provide labor inside and outside the home, and denote economic security for their parent's old age, among other things (Chattopadhyay-Dutt, 1995).

India's independence movement, culminating in the gain of political independence in 1947 brought an interesting twist to this theme of woman as creator and protector of the home. Chatterjee (1993) discusses how during this time even while women were going out of the home to fight for independence in solidarity with men, they were still being ideologically perceived as not only guardians and protectors of the home, but also sanctifiers of cultural pollution. It was felt, Chatterjee (1993) claims, that because men had to go out and associate with the polluting foreigner, the woman had to be traditional in all her values so she could keep the home authentically 'Indian'. For a woman, these would include protecting the sanctity of the home and sacrificing her interests for that of the family. So even while larger numbers of women were leaving the home for work, this ideological construct placed the woman at home with her children.

Because children are so valuable within the culture it may be reasonable to assume that it would be convenient to have more instead of fewer, especially in families where

hands are required for labor. Additionally siblings form communities of support for each other and for aged parents. For example, as in many other developing countries, older siblings have traditionally helped younger sibling's education and job searches (Kokole, 1994).

There has, however, been concern for a while about population issues in India. This concern began pre independence India within the Indian National Congress, among other places. It was felt that the size of the Indian population would be a hindrance on the country's road to development (Govt. of India, 2000). The Indian National Congress went on to form independent India's first government, and the family planning program, the first of its kind in the world was established in 1951/1952 (Desai, 1998; Panandiker and Umashankar, 1994).

The family planning program in India has principally focused on getting women to regulate their fertility, except during the Emergency in 1975-1977, when it relied on vasectomy to meet population control targets. Over the years, the Ministry of Health and Family Welfare has created campaigns that have consistently carried the 'small family, happy family' message in one way or another. The merging of family planning programs with ante/post natal services is significant, because it means that it makes it more convenient for women to access birth control services, as immunizations for children, and to a much lesser degree ante and post natal care, is largely seen as essential. In these clinics, staff are geared toward asking women to use permanent fertility control if the woman comes in around the time of her second child (or beyond), and birth control to space a second birth if a woman comes in around the time of her first (N. Bose, personal interview)³.

This, in addition to economic factors like rising rates of un and under employment have created a situation where awareness of fertility control is wide, and 73% of women in urban areas and 65% in rural areas are currently on birth control in the state of West Bengal (International Institute of Population Sciences, 2001).

What women said about having/ not having children

Straightforward conflict is most often a result of a woman not wanting to have a/ another baby and her marital family opposing her. The most powerful figure in the opposition is most often either the husband or the mother-in-law or both. This is fairly common and has been documented (Seal, 2000).

If there is marital family opposition to the use of birth control, this research found, a woman has to be very careful about where she goes for information about this. As sexuality and birth control are matters of *lajja* (a culturally loaded word meaning shame/embarrassment and women's privacy issues). The primary fear is of being discovered, and there being material effects on the woman's life. One woman at Bangur said:

I think if my mother-in-law found out that I was using this (birth control) she would tell everybody, just to make me stop.

So why are their husbands and mothers-in-law so intent on women having more children than they already do? Most often, this has to do with the sex of children.

³ N. Bose is a Social Welfare Officer (SWO) at M.R. Bangur Hospital in Kolkata. She provides counseling to women coming in to the ANAN clinic at Bangur.

Daughters leave the home and go to marital homes, so parents cannot really rely on them for financial and other kinds of support in their old age. Women experience ambivalence due to the competing nature of reactions to various factors. For example a woman may not want a child because she does not want to bear another baby, but may recognize that her mother-in-law is looking out for the woman's own good in the long run when having more children is higher insurance that at least one of her children will take care of her when she is older. One woman at Bangur said of her mother in law:

I know she thinks that because I have two daughters no one will look after me when I am old, but I don't want any more children. Besides, what if I have another daughter and not a son? Then will she tell me to have another child?

Another woman at Diamond Harbor said:

I think my daughters will take care of me, my sons in law are both very nice, but sometimes I think, this has never happened in our country (daughters taking care of aging parents), what if they don't do it? What will happen then?

Given such uncertainties, why are so many women opting for limiting and/or spacing births? The word most often heard in an answer is *aajkaal*, meaning literally, in the world of today. This is a powerful concept in these women's lives, as it was used often and extensively in the context of several other powerful concepts, namely education, money, work/ jobs, and, significantly, birth control.

Aajkaal implies several things within the interviews. It is a forward looking word, it means being "modern" and progressive. The word "modern" was also used, but only by the handful of women that used a few English words. In this context, it gains especial power because the unstated and occasionally stated assumption behind the word is that the world of today is different from the world of yesterday and therefore demands different strategies for survival.

Forward thinking women, it emerges from the interviews have lives substantially different from women who insist on being mired in yesterday's world. One woman at Diamond Harbor said:

My mother and grandmother had so many children; I have six brothers and sisters of my own (as opposed to cousins). But now the world has changed, and you cannot do that sort of thing even if you wanted to.

Did she want to? She says:

I don't know, I have two children. I may have had one or two more, but in today's world I don't know.

Women who have decided to limit births frequently expressed disapproval toward those they know who had not taken the same decision. These women were seen as

backward thinking or unthinking, and too mired in tradition in a negative way. The decision to not have children was also seen as an act of independence, and it was contrasted with those who are not capable of taking such a step in their own lives. One woman in a village called Parui in Mogra Haat II said about her neighbor:

She does whatever they (the marital family) tell her to. So she went with me to get a copper T (IUD) and her husband objected so she did not. My husband objected too then, but I told him that I would (...) now I have it and he is ok with that. Sometimes women have to do these things.

As already discussed, younger women find it more difficult to take these decisions than older women. As their status rises with age, women become more comfortable with talking about families opposing them, and take pride in their own decisions. A woman of forty-one at Bangur said:

In that time it was unheard for a woman to do such things. But I had three children already and I did not want any more. So I came here and got it (the IUD) and did not tell my husband, he did not find out until much later, and he was really angry with me (...) but I had children already so I kept it. Today things are different

This sentiment is echoed by counseling staff in the AN clinics, who also agree that things are different today, but because the need to limit population has become greater than it was. Among the more important functions of the counseling staff is convincing women to space or limit births through the use of birth control. They use two distinct strains of argument (a) having fewer children is good for the woman's family and her children, and (b) the nation's prosperity depends on women having fewer children. Both arguments, it seems, have an impact on women's minds. Several women brought up both these arguments in discussions about birth control, and used almost exactly the same words as I heard them from the SWOs (Social Welfare Officers).

The first argument women understand as something that translates directly into their lives. As one woman at Diamond Harbor with three children, pregnant with her fourth at the time of this interview said:

Everyone knows that if you have fewer children you can feed and clothe them better, give them an education, make their lives better than yours. When she (the SWO) told me this I felt that she knew about my life.

The second argument is a little broader in scope, and several women stated this as a reason for not having any more children than they already had. It goes that the nation has limited space and resources, and if women keep having babies, there will soon be no resources left. Too many people mean that every one gets less. An important part of this argument is that if women have too many children and resources really do run out, places such as government subsidized clinics will not exist anymore. This was seen by many women to pose a direct threat to their already difficult lives. One woman at Bangur who was waiting to have an IUD (Inter Uterine Device) inserted said:

I wanted another one (she has two children), but then Didi (N. Bose, SWO at Bangur) told me that if I kept having children the government would not longer be able to have places like this in a while (...) so I decided not to have any more (...) we are poor, I can't see a private doctor.

Women are therefore led to see their own interests as intertwined with the nation's interests, and see limiting births as beneficial to both themselves and their families, and to the nation as a whole.

From the foregoing paragraph, it may seem that staff at AN clinics play an instrumental role in women deciding to use fertility control. While it is true that some women who might not otherwise limit their fertility are persuaded to do so by clinic staff, a majority of women at AN clinics make the decision to use fertility control before they arrive at the clinics. Interviews with clinic clients and staff, as well as observation within the clinics showed that most women came to the clinic with their minds already made up with regard to contraception use.

The concept of *aaajkaal* is very appropriately applied to the use of contraception in India. Social change, as implied in *aaajkaal* is visible in both the number of women who make the decision to use contraception today, and the reasons they provide for limiting fertility. For example, in 1991-92, about 47 percent of ever married women in India reported the use of contraception. This figure was up to 55 percent in 1998-99 (International Institute of Population Sciences, 2000). The world of today is then seeing women increasingly decide to limit the size of their families, as it is seen to be contingent in the new world to do so. N. Bose, Social Welfare Officer at Bangur comments that there are very many more women using birth control with their family's permission and support today than there were even five or six years ago (N. Bose, personal interview).

Why has contraceptive use gone up so rapidly? Women provide reasons that are primarily economic in nature. They evaluate current and probable future incomes, and decide to have children or use fertility control based on the kind of life they want to be able to provide for their children.

At least some of these calculations are based on projections of a single income supporting a family. Several women I talked with had husbands who had non-regular or non-existing sources of income. In many of these cases, the woman was running the household on her meager income. One woman at Mogra Haat in this situation said:

How can I even think of having more children? I can barely feed my family.

Another at Diamond Harbor said:

I tell my mother in law that when her son stops drinking and gets a job I will have a son.

If the husband is un- or under-employed, this means that the woman and her family have to stay with relatives, usually in very cramped quarters. Additionally, the meager income that she brings into the home is all that can be counted on in terms of a reliable

source of money. In such cases, women usually get full support from husbands and marital families in their desire to use birth control, as having more children is seen as a burden on the extended family.

However, even as women take the decision to use birth control, with family support or without, many of them face deep uncertainty about how this decision is going to affect their lives in various ways. Many have deeply ambivalent reactions to not having children. Within the interview situation women recognized and talked about this uncertainty as often as they did not, and the ambivalence is occasionally recognizable only in later perusals of the interviews.

Broadly classified, these anxieties seem to stem from fears about (1) children dying as infants or adults, (2) not fulfilling duties as wives and mothers (3) Their own and their children's futures in terms of community and support. These anxieties are magnified when a woman does not have support from a husband or marital family in her decision to use birth control, because she is well aware that if they are proved right in their opposition, this could have material effects on her life.

India's infant mortality rate is not as high as many other developing countries and is falling rapidly. It stands currently at 68 deaths per 1,000 population (International Institute of Population Sciences, 2000). West Bengal's infant mortality rate is 49 deaths per 1000 live births (International Institution of Population Sciences, 2001). What the statistics do not tell, however, is that almost every baby that dies belongs to a woman who grieves for it, and lives in fear that another child of hers might suffer the same fate. Several women talked about "someone (she) know(s) who knows" a woman who had three children, and thinking she was not going to have any more, she apparently had an 'operation' (a tubal ligation). Shortly after the operation, she lost all her three children in a train wreck/ drowning accident/ road accident (there are several versions of this story). It is fairly clear that the story is apocryphal, but the fact that women would repeat it is a clear indication that this is a real possibility in their minds. Women who have at any point lost a baby are extremely wary of using birth control, as are those who have lost a baby in the family.

A child dying while young is another real possibility. One woman at Mogra Haat II with sons aged nine and eleven said:

My sons are no longer very young, but they cross the train tracks on the way to school, and I worry about that. I know there are a lot of accidents on the tracks, and I know they play there even though I have asked them not to.

Worries such as these make women wary of permanently and prematurely ending their fertile years. Hence, they prefer to use the pill or IUD which present the possibility of a rapid and uncomplicated return to fertility. However there are others who choose to have a tubal ligation even while being aware of the real danger of becoming permanently infertile. Paradoxically, the fact that this procedure is permanent seems to be a reason in favor for those women choosing to have this operation. An older woman (aged anywhere between thirty and forty, she said) interviewed at Diamond Harbor said she went by herself and had a ligation in a local clinic without consulting her husband. She was smiling when she said:

So I went back after the operation, and he asked where have you been?
And I said that I had had the operation. He was very angry, but what could he do? I had done it.

In this particular case, she was at an advantage because her husband was living off her income, but women dependent on their husbands for financial support find it difficult to do this. What many of these women do is that they wait until they are visiting their parent's home, and then have a ligation. Being a relatively simple procedure, it leaves practically no scars, and the woman goes back to her marital family secure in the knowledge that she will not get pregnant again. This is not as infrequent as it may seem. During the course of this research, the clinic at Diamond Harbor held two ligation 'camps' as they are called, and four women on the first day and five on the second said that they were currently visiting their parents homes as their marital families would not allow them to terminate their fertility. One of the women interviewed on the first day said:

I did not want to do this, because I have only two children, and one of them is sickly. But I tried the pill, and my husband found out and threw them away. I thought of the copper T (an IUD) but I know there is a string that my husband may see, so I have to do this.

She went on to say that she would not be telling her husband that she had been to the 'camp' because there was the very real possibility that he would throw her out of the house if he knew that she was no longer fertile.

A second range of worries women experience with regard to not having children is a direct result of value shifts in a changing world. As already discussed, most of these women grew up with the idea that being a wife and mother was going to be the most important role in their lives. In a culture where a greater number of children were traditionally better, how does a woman now adjust to the idea of voluntarily limiting her own fertility? Culturally, a woman is not supposed to call or refer to her husband by his name as a mark of respect. How does she tell him that she no longer wants to bear his children? This is an issue that causes anxiety for women, even while they are aware that birth control may help their families have a higher standard of living. As one woman in a village called Lakhikantapur in Mogra Haat II put it:

When I got married, my mother told me that I was to listen to my husband. Now I tell him that I will not have another child, it is a hard thing for me and for him (...) but my husband is a good man, he takes care of me, so I have been lucky.

Some fears are material and may turn out to be justified as when women fear that if they disobey a marital family and/ or a husband in this vital area, their lives may become much harder than they already are. A woman who had come into the AN clinic at Bangur to have her fourth child immunized expressed this fear:

My mother in law says that if I use anything to stop having babies, she will take my children away and throw me out. She says that I will never see them again. Why should I take this risk?

This sentiment was echoed by other women interviewed who had decided not to use birth control. The fact is that for many of these women, being thrown out of a marital home amounts to disaster, as parental homes will rarely take back a woman thrown out of her marital home in disgrace (Sen, 2001).

Women who express such fears seem to find ways of dealing with them in a manner that makes them feel better about their situations. They say that they love having babies, that they have a duty to their children to provide them with siblings, that having more children means that their old age will be comfortable. One woman in Diamond Harbor said:

My children are my life. Even if my husband told me to have a ligation tomorrow I would not do it (...) but he wants more children, so it is my duty as his wife to have children.

As the quotation above shows, the concept of duty is very strongly embedded in this worldview. One of the offshoots of this is a situation that is complex and has to be discussed in some detail.

Having fewer children means that a woman is no longer needed full time at home and can go out and seek waged employment, assuming she is allowed by her family to do so. Economic compulsions and a strong desire to provide education and a higher standard of living for their children also contribute to women leaving the home for work. However, when they do so, women suffer from strong feelings of guilt about not fulfilling duties as wife and mother at home. These feelings of guilt seem to persist even when the woman is confident that the care her children are receiving while she is out to work is adequate. Most often caregivers at home are other female members of the family, usually a mother-in-law, a sister-in-law, or a mother who lives nearby. Occasionally this guilt is compounded when children accuse their mother of being out of the house when their friends or cousins mothers stay at home, or when something happens to a child while a mother is out at work. One woman at Bangur who works as a maid for a living brought up in an interview the time her son cut his leg very badly and had to be brought to the hospital by her aged mother:

When I came home that night I wanted to stop working and stay home for my children. He was very badly hurt and had been calling for me (...) (But) I knew that if I did that my children would have to stop school. We do not have the money to send them to school on only my husband's salary.

A related worry is that by having fewer children, women believe that they are depriving their sons and daughters of the kind of family structure that they need for support. Most of the women interviewed in this study grew up in homes with several children. Some of these children were their own siblings, and others cousins who lived in

the same house or ones in the same area. As migration has caused fewer and fewer families to live under the same roof or in close proximity (Duvury, 1998), there are simply less people of the same age around for children to play with or older children to potentially receive protection from. Several women mentioned this phenomenon during the interviews. One woman at Bangur said:

When I was growing up there were my five brothers and sisters, and four other cousins around. I look at my son and think; he will never be able to have a childhood like mine.

Later during the interview she added that her son kept asking her to bring him a brother or a sister, and though she and her husband had decided not to have another child, she was actually considering having one more, just to keep her son company.

This is not just a question of fun or good memories. Siblings form communities of support around each other. Like elsewhere in the developing world, older siblings frequently help younger ones through school, and sometimes pay for higher education. They are also expected to be present when help is needed in any capacity. In such a cultural context, having only one sibling or none is truly problematic.

Women see this and are troubled by it. However, as much as many of these women would like to provide their children with communities of support, they recognize that, too, to be a problematic option.

Conclusion

Women's stories about birth control do seem governed by very problematic options. In some cases there are no real options at all, but the very fact that there are options available to others makes the situations for women that do not have them even more problematic.

Women walk lines and negotiate borderlands of uncertainty and certainty, emotion and logic, looking forward and maintaining tradition in ways that make sense in their lives within their contexts. As this paper shows, they differentiate finely between what they want and what they need, and the wants and needs of significant others around them.

It is this complexity that needs to be understood by the health care system that runs the clinics at which these women were interviewed. At Bangur, I was sitting in a Social Welfare Officer's room when a woman came in asking for information about immunizations for children. As is the norm, she was asked how many children she had. When she said she had three, the SWO immediately started telling her why she should have a ligation, and what she had to gain from not having any more children. I later interviewed this woman, and during a discussion about her meeting with the SWO she said: "What does she know about my life? No one but me knows about my life."

This is not to say that the health care workers are indifferent, or that they do not care about women coming to the clinic. They frequently care very much, but they are overworked and underpaid for their efforts.

This is why work such as this is important. As long as the public health care system sees women as potentially infinitely fertile, it will not be able to evolve ways of taking care of them in a way that contextualizes and understands their very real concerns. And

clearly, there is a need to understand these concerns and address them within the public health care system.

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