

**REPRODUCTIVE RIGHTS  
OF YOUNG MARRIED WOMEN IN URBAN SLUMS OF BANGLADESH**

by

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## TABLE OF CONTENTS

ABSTRACT .....	3
1 INTRODUCTION .....	4
International Movements: Population Control to Reproductive Rights .....	5
History of Family Planning Programs in Bangladesh .....	9
Social Influences on Women’s Reproductive Rights in Bangladesh .....	16
Married Adolescent Women in Urban Slums of Bangladesh .....	20
2 METHODOLOGY .....	24
Data Analysis.....	25
Study Sample .....	26
3 RESULTS AND DISCUSSION.....	27
Access To and Use of Family Planning .....	27
Reasons for using contraception.....	28
Problems with FP Methods and Services .....	31
Poverty and Life in an Urban Slum .....	34
Husband’s Authority and Women’s Economic Dependence .....	36
Reproductive Rights in the Context of Constrained Choices .....	39
4 CONCLUSION .....	45
REFERENCES .....	46
APPENDIX .....	50

## **ABSTRACT**

Reproductive rights, including the right to respect for one's physical body, the right to freedom from abuses such as unwanted sex and unwanted pregnancy, the right to autonomy and self-determination in matters related to one's reproduction and sexuality, and the right to equal access to health services, are fundamental human rights. However, women's reproductive rights have historically been undermined by donor-driven policies and programs to limit population growth in developing countries such as Bangladesh. While family planning programs in Bangladesh have substantially improved women's access to contraception, the emphasis on controlling population growth has comprised women's health and wellbeing. Furthermore, the context of male-dominance, traditional gender norms, and persistent poverty continue to constrain women's ability to effectively make and carry out decisions concerning their sexuality and reproduction. Based on data from 12 in-depth interviews with married adolescent women in urban slums of Bangladesh, I aim to explore the factors that continue to shape and constrain reproductive rights. My findings demonstrate three main categories of constraints on women's reproductive rights: 1) problems with family planning methods and services, 2) husbands' authority in decision-making and women's economic dependence on their husbands, and 3) the context of poverty and insecurity in urban slums. Overall, reproductive rights cannot be understood outside of the social, economic, and political context of women's everyday lives, and reproductive rights for all will only be achieved through a global commitment to social and economic justice.

## Chapter 1

### INTRODUCTION

“Contraception alone does not provide the conditions requisite for freedom. If it assures women that the reproductive decisions they make can in fact be carried out, it does nothing to assure them that the decisions themselves are within their control” (Michaels 1987: 211).

The right to reproductive freedom encompasses much more than access to and voluntary use of contraception; it means having autonomy over one’s body and access to resources that enable that autonomy. Feminist scholars Sonia Correa and Rosalind Petchesky (1994) outline four aspects of reproductive and sexual rights: (1) *bodily integrity*, or the right to respect for one’s physical body and to be free from abuses such as unwanted pregnancy and unwanted sex; (2) *personhood*, or the right to self-determination in matters related to one’s reproduction and sexuality; (3) *equality*, or equal access to health and other resources across not only lines of gender but also race, class and other social divides; and (4) *diversity*, or the right to respect for one’s group identities and cultural differences. Concerns for upholding reproductive rights have been expressed by human rights activists and women’s health movements around the world, but require special attention in developing countries such as Bangladesh, where top-down, donor-driven programs to control women’s fertility and reduce population growth have historically undermined women’s health and autonomy. Additionally, patriarchal structures, traditional gender norms, persistent poverty, and other socioeconomic factors have constrained and continue to constrain women’s

ability to effectively make and carry out decisions concerning their sexuality, fertility, and reproductive health. In order to understand the condition of reproductive rights of women and girls in Bangladesh today, it is necessary to take into consideration the historical context of reproductive health and family planning programs both nationally and internationally.

### **International Movements: Population Control to Reproductive Rights**

Long before the discourse of reproductive rights gained any significant traction in the international sphere, most advocates for family planning programs in developing countries were concerned about limiting global population growth. These concerns have their origins in Thomas Malthus's (1798) *Essay on the Principle of Population*. Malthus posited that, unless held back by "preventative checks," the exponential pace of human population growth would quickly surpass the earth's capacity to produce enough food. This logic formed the basis of the neo-Malthusian arguments for population control that emerged in the years after World War II. Neo-Malthusians redefined the problem of overpopulation as an issue rooted exclusively in developing countries, and one which threatened to undermine living standards in the West (Bovill and Leppard 2006). This conceptualization of overpopulation reinforced global power inequalities, as Western countries used their influence to control population growth in the developing world almost by any means necessary. Furthermore, it overlooked the developed world's contribution to the consequences of overpopulation – as feminist scholar Betsy Hartmann points out, the "consumption explosion" in the industrialized world had put more pressure on limited natural resources than the "population explosion" in the developing world had (Hartmann 1987).

Nonetheless, powerful Western nations and financial institutions began to implement population control measures in developing countries around the world to address the “problem” of overpopulation. The actors carrying out this agenda are referred to by various scholars as the “population establishment” (Marden et al 1982; Smythe 1998), and include the U.S. Agency for International Development, the United Nations Population Fund (UNFPA), the World Bank, as well as other governments and institutions. The population policies implemented by this establishment tended to focus on the very narrow goal of reducing women’s fertility rates, and ignored broader social and economic contextual factors. The approach they adopted was based on the assumption that given sufficient funding, technology, and management techniques, birth control services could be effectively delivered in developing countries, even without the foundation of basic health systems or improvements in social and economic conditions (Eager 2004). As a result, critical scholars have argued that “population control programs became synonymous with top-down, target-driven, often coercive, occasionally violent, sterilization and contraception programs” (Rao and Sexton 2010: 3).

Over the 1970s and 80s, these strategies began to be met with harsh criticism. Women’s health and rights activists argued that the narrow focus of the population establishment on increasing contraceptive prevalence and reducing fertility rates ignored the broader context of women’s health and wellbeing. Indeed, women’s health and reproductive rights were not considered a priority by the population establishment compared to the imperative to limit population growth (Hartmann 1987). By the 1990s however, pressure for a reassessment of population control had mounted significantly. Petchesky (2003) describes how women across the world, in both the global North and

the global South, advocated for reproductive and sexual rights as human rights. In the U.S. and parts of Europe, women fought conservatives for control over their bodies and the right to abortion as part of the “second wave” feminist movement. Black feminists and women-of-color activist groups were also pioneers in the movement for reproductive rights during this time, linking this platform with issues of poverty, racism and social welfare. In the global South, local women’s groups mobilized to demand reproductive health and rights in unique ways, depending on the context – Latin American women’s organizations for example pursued these goals in conjunction with movements for democracy and citizenship, while South Asian women protested mainly against the violation of rights in donor-driven sterilization policies. In addition, Petchesky argues, women in the global South pursued a broader and more integrative direction for the women’s health movement, linking the impact of harsh austerity measures and debt repayment policies to women’s health (Petchesky 2003).

As a result of the pressure from these initiatives, there was a gradual shift in the discourse on population and development, from population control to reproductive rights. This shift can be evidenced by the dominant concerns expressed at the international conferences on population and development organized by the UNFPA every ten years. Up until 1994, these meetings addressed criticisms of the population establishment but largely did not include women’s voices or the concern for reproductive autonomy. At the 1994 International Conference on Population and Development held in Cairo, Egypt (referred to as the Cairo Conference), women’s health and rights activists succeeded in including reproductive rights in the conference’s Programme of Action. In contrast to previous meetings, the document

that was produced from the Cairo Conference recognized gender equality and women's empowerment as essential elements to both reproductive health and sustainable development. It also explicitly called for the elimination of demographic targets, incentive schemes, and quotas in family planning programs. Although many feminist scholars questioned whether the conference was indeed a genuine recognition of and commitment to women's reproductive freedom, or simply "population control with a feminist face," the Cairo Consensus nonetheless represents a significant historic achievement (Petchesky 1995: 156).

Overall, from the neo-Malthusian push for population control in the 1960s to the discourse of the 1994 ICPD, decisions and activities at the international level have considerably shaped and influenced the lives of women in developing countries, especially in relation to their reproduction. The population control agenda helped expand access to contraception in many developing countries, but also ignored different social and economic contexts, violated human rights, and isolated family planning from concerns for women's health and empowerment. Bangladesh, a small, densely populated country in South Asia, is an interesting case for examining the ongoing consequences of the population control agenda and the current context and conditions of women's reproductive rights. After decades of intensive family planning programs, Bangladesh has experienced a dramatic decline in total fertility rate, from about 7 births per woman in the mid-1970s to just 2.2 births per woman in 2010, along with a huge increase in the rate of contraceptive prevalence, which was at 61.2% in 2012 (World Health Organization). Such significant changes have led Bangladesh to be championed as a "success" by the World Bank (Cleland et al 1994), yet as noted previously, women's reproductive rights encompass much more than just access to

contraception. In order to understand women's reproductive rights in Bangladesh today, it is important to note the recent history of family planning programs in Bangladesh and their implications for women.

### **History of Family Planning Programs in Bangladesh**

Family planning programs and policies over the course of Bangladesh's history have impacted the reproductive rights of women in significant ways. Specifically, intensive donor-funded population programs, door-step delivery of contraceptive methods, female family planning workers, and health and population sector reforms, among other factors, have contributed to the expansion of access to contraception and changing of reproductive norms. At the same time however, these factors have often violated reproductive rights, through coercive sterilization practices for example, or have failed to challenge underlying social conditions, such as poverty and gender inequality, that constrain reproductive rights by limiting women's autonomy.

As discussed in the previous section, international donors and institutions played significant roles in shaping the population policies and programs of developing countries, and Bangladesh is no exception. After the devastating Liberation War in 1971, in which Bangladesh won its independence from Pakistan but lost many human lives and considerable physical infrastructure, the country developed a heavy reliance on international donor assistance. This meant that most policy and organizational changes initiated by the government of Bangladesh were based on the priorities of the donors (Jahan 2003). For USAID, the World Bank, and other institutions that were heavily involved in shaping Bangladesh's early population policies, one of the top priorities was controlling population growth by reducing women's fertility rates (Hartmann 1987: 210). Thus, the five-year health and population policies adopted by

the Bangladesh government beginning in 1973 largely emphasized vertical family planning service delivery, including sterilizations, intra-uterine device (IUD) insertions, and condom distribution. Even though the branches of health and family planning were united under the Ministry of Health and Family Welfare in 1976, most of the resources still went to family planning, and family planning programs remained largely uncoordinated with maternal and child health activities (Larson and Mitra 1992).

The emphasis on population control in the early years of Bangladesh's health and family planning programs had significant implications for health and human rights. During the 1970s and early 1980s, sterilization was the main strategy of the family planning program (Schuler, Hashemi, and Jenkins 1995). Village midwives and members of the public were paid for referring clients to sterilization clinics, and "family planning workers who failed to meet monthly sterilization quotas could have their salaries withheld" or lose their jobs (Hartmann 1987: 214). Because of these incentives, family planning workers spent much of their time promoting sterilization, rather than advocating for other, safer methods of contraception or addressing women's reproductive health needs (Schuler, Hashemi, and Jenkins 1995). Women and men undergoing sterilization were compensated as well – each person agreeing to be sterilized received about 175 *taka* and an item of clothing or food, which was often desperately needed due to the poverty and food scarcity present in most of rural Bangladesh. In fact, Hartmann notes, sterilization rates typically rose during the lean season before the harvest, when rural villagers were particularly desperate for cash to buy food. These strategies of direct compensation were discontinued in 1985, but up to that point, USAID had financed 85% of incentives and referral fees. Even though the

U.S. Foreign Assistance Act prohibited the use of U.S. funds to pay for involuntary or coerced sterilizations, USAID was able to skirt this restriction with euphemistic jargon – incentives were referred to as “compensation payments” and “continuous motivation schemes” (Hartmann 1987). Overall, the donor-driven emphasis on sterilization in Bangladesh resulted in clear violation of reproductive rights, and furthermore compromised women’s health in favor of control over women’s fertility.

Family planning programs in Bangladesh also significantly expanded women’s access to other contraceptive methods; from the 1970s to the 1990s, contraceptive prevalence went from 3% to 45% among married women (Schuler, Hashemi, and Jenkins 1995). This increased access is largely attributable to a specific strategy utilized by the government of Bangladesh – the doorstep delivery of family planning services by female family planning workers. Because Bangladesh is a highly conservative, patriarchal society and the majority of its population is Muslim, women have limited mobility, especially in rural areas. To overcome this barrier, the government of Bangladesh brought family planning services directly to rural women. Between 1976 and 1980, 13,500 female family welfare assistants were hired and trained to make home visits and teach women about various methods of contraception, motivate them to use contraception, directly deliver methods such as pills and condoms, as well as refer them to government clinics for clinical methods of contraception, such as the IUD and sterilization (Schuler, Hashemi, and Jenkins 1995). Due to the success of this strategy, the government and non-governmental organizations continued to implement it and on an even larger scale; by 1990, there were 2,354 rural family welfare centers and 24,000 female family welfare assistants (Cleland et al 1994).

Village-based family planning workers have been instrumental in expanding access to contraception for women in Bangladesh and have also resulted in dramatic normative changes around family planning and women's reproductive autonomy. A study by Kamal and Sloggett (1996) found that in rural areas of Bangladesh, visits by a family welfare assistant increased the odds of contraceptive use almost eight-fold. Family planning workers also played unique roles as agents of change – in addition to supplying contraception, they helped reduce women's fears of contraceptive technology, advocated for smaller fertility preferences, and mobilized male support for contraception (Simmons et al 1988). In their analysis of family planning as a social norm in Bangladesh, Schuler et al (1995, 1996) demonstrate how village-based family planning programs transformed reproductive norms by defining family planning as a domain for women's initiative – family planning workers at the village level mostly spoke with women in their visits, and gave them the language they could use to suggest the idea of family planning to their husbands. They argue however, that “changes in reproductive norms do not constitute a transformation in gender relations”, and in fact the doorstep delivery-based family planning program may have even reinforced traditional behavior and patriarchal structures (Schuler et al 1995:134). Because women did not have to leave their homes to access services, their exposure to the public sphere remained limited and they became reliant on family planning workers for information and supplies. Furthermore, the portrayal of family planning as a women's domain limited men's participation in contraceptive use; men typically saw family planning as simply a “natural extension of women's traditional responsibilities” (Schuler et al 1996: 72). While it was not the objective of the family planning program to address gender inequality in Bangladeshi society, it is

nonetheless important to recognize that access to contraception does not solve the larger problem of women's subordination.

In the late 1980s and early 90s, family planning activities in Bangladesh began to give more attention to the broader context of women's health and empowerment. As previously mentioned, the 1994 ICPD helped push the population agenda in the direction of reproductive health and gender equity. Bangladesh, as a signatory on the Cairo Consensus, adopted the ICPD definition of reproductive health and thus, along with pressure from international donors, initiated policy and structural reforms to reflect this new focus (Rashid 2011). In 1996, Bangladesh adopted its Health and Population Sector Strategy (HPSS) along with a five-year national Health and Population Sector Program (HPSP) in 1998. Notably, among the reforms in the HPSS and HPSP were shifts from vertical projects focused on narrow goals and targets to integrated service delivery, which unified basic health services with family planning (Jahan 2003). The HPSS involved communities and civil society in the planning process, demonstrating a commitment to participatory planning. Finally, in line with trends that were also occurring globally, the reforms included the adoption of a gender-mainstreaming approach, which applies a gender equity framework to all programming rather than just to isolated women's projects.

While these policy reforms theoretically would have led to an improvement in women's reproductive rights, there were significant gaps between the design and the implementation of the reforms. Due to the government's weak institutional capacity, little has been accomplished in terms of implementing integrated reproductive health programs on the ground (Rashid 2011; Jahan 2003). Civil society groups, while part of the planning process, were excluded from the implementation phase. These limitations

were exacerbated when a new government assumed power in Bangladesh in 2001; opponents of the reforms effectively stopped the restructuring process of the HPSP (Jahan 2003). While policy and structural changes have the potential to improve the reproductive health of women in Bangladesh, the realities of political instability and failure of the government to effectively engage civil society continues to hinder this progress.

The government of Bangladesh's failure to deliver on its commitment to the ICPD agenda is also related to the lack of international funding for sexual and reproductive health programs. While the international community agreed to financial targets for a comprehensive program of action for reproductive health at the 1994 ICPD (\$22 billion by 2015 with developing countries covering two-thirds of the costs and the international donor community covering the remaining third), these targets have not been met (Senanayake and Hamm 2004). Furthermore, the terms and conditions that donors attach to aid pose limitations to effective implementation of reproductive health programs. For example, the "Global Gag Rule", a policy most recently reinstated by the Bush Administration in 2001, disqualifies any foreign nongovernmental organization (NGO) from receiving USAID funding if they engage in abortion-related activities. As a result, the International Planned Parenthood Federation, which refused to sign the Global Gag Rule, immediately lost \$12 million in USAID funding. Additionally, \$34 million in funding that previously had been approved by the U.S. Congress for UNFPA was withheld in 2002<sup>1</sup>.

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<sup>1</sup> President Obama restored funding for UNFPA in 2009.

A purely political move, the Global Gag Rule has severely impeded the efforts of local organizations to ensure access to essential reproductive health services (Senanayake and Hamm 2004), including in Bangladesh. The Bangladesh Rural Advancement Committee (BRAC), one of the largest NGOs in the world which provides reproductive health services to millions of men and women in Bangladesh, had to withdraw its requests for USAID funding as a result of the Global Gag Rule (Baird 2004). Although abortion is prohibited in Bangladesh, a method of early-term abortion called menstrual regulation (a method of vacuum aspiration used within 8-10 weeks after a missed period) is legal (Dixon-Mueller 1988). Under the Global Gag Rule, BRAC and other NGOs providing menstrual regulation services would not be eligible to receive USAID funding. Overall, the political agendas of international donors as well as national policies significantly constrain the reproductive rights of women in Bangladesh.

In addition to changes in family planning policies and programs, it is also important to note the broader social changes occurring in Bangladesh in the latter half of the 20<sup>th</sup> century. Caldwell et al (1999) points out that the fertility decline Bangladesh experienced from the 1970s to the 1990s can be attributed to socioeconomic and demographic changes, as well as the initiatives of family planning programs. For example, the urban population of Bangladesh had grown tremendously, from 6% of the total population in 1965 to 20% by 1997. Girls' enrollment in primary education increased, and the explosion of the garment industry in urban centers of Bangladesh led to the employment of a considerable number of young women from poor families. These changes, Caldwell argues, affected the demand for family planning in Bangladesh, and they are therefore important to note in this historical

analysis. However, because these are broad changes that affected many aspects of women's lives, and in different ways, it is difficult to link any of them directly to changes in women's reproduction and their ability to effectively carry out decisions regarding their fertility.

In sum, a historical analysis of Bangladesh's population programs and policies demonstrate how the reproductive rights of women have been upheld and violated, expanded and constrained. Donor-driven population control activities helped finance needed family planning programs, yet compromised concerns for health and safety by incentivizing sterilization. Village-based female family welfare assistants increased women's access to contraceptives, while leaving traditional gender norms and patriarchal structures largely unchanged. The global push for reproductive rights by women's health activists contributed to health and population policy reforms in Bangladesh, yet these reforms have failed to be effectively carried out. The population establishment would point to the increase in contraceptive prevalence and the reduction in fertility rates as indicators of "success" of family planning programs in Bangladesh, and I do not mean to detract from the importance of accessible contraception to women worldwide. However, this narrow construction of success, defined in terms of limiting population growth, masks the underlying social factors that continue to limit women's reproductive rights in Bangladesh. Thus, the next section will discuss the contemporary social context of Bangladesh and what that means for women's reproductive rights today.

### **Social Influences on Women's Reproductive Rights in Bangladesh**

As previously emphasized, access to contraception through family planning programs does not guarantee the ability of women to exercise control over their

fertility; there are a variety of complex social and economic factors that influence women's reproductive health and constrain their reproductive freedom. In Bangladesh, these factors include, but are not limited to, male-dominance and gender norms, violence against women, social pressure from extended family and in-laws, and the effects of poverty. It is important to note however that while these factors are prominent in Bangladesh, they affect women in different ways depending on context, such as different geographic regions or economic conditions. Therefore, in this section I will provide some examples of social and economic influences on women's reproductive rights, and then go into more detail on a specific demographic of women in Bangladesh in the following section.

Bangladesh is a predominantly Islamic, male-dominated society. The practice of *purdah*, which limits women's mobility and is closely related to concerns for female chastity and family honor, has traditionally excluded women from working outside of the household (Salway, Jesmin, and Rahman 2005). Women's identities are closely intertwined with their roles in the family, including and especially their reproductive role. However, because the extent and influence of male-domination in Bangladesh varies by class, geographic region, religion, and has also changed over time, it is important to avoid a universalist or normative notion of patriarchy, and to challenge dominant discourse that depicts "a caricature of the subordinate, disempowered Bangladeshi woman" (Feldman 2001: 1099). A noteworthy example of this variance is the difference between rural and urban settings in women's experience of male dominance. Since the 1980s, urban centers of Bangladesh have experienced burgeoning growth in the export-based ready-made garment (RMG) industry, in which an estimated 70-80% of those employed are women (Kibria 1998). A variety of factors

drive women into this sector of paid employment, not the least of which is extreme poverty, but work in garment factories for some women offers a level of social and economic independence (Kibria 1998). A 2005 study of women's employment in urban Bangladesh confirmed this, finding that women working for pay were more likely to manage money, shop for household items, and have mobility outside the home than non-working women (Salway et al 2005). Nonetheless, the authors also found that despite these trends, women's employment had not significantly challenged gender identities, and that other social and economic structures that discriminate against women limit the impact of employment on other areas of their lives. Ultimately, the impact of patriarchy on women's lives is highly nuanced; male-dominance in Bangladesh undoubtedly constrains women's reproductive autonomy, but it does so in different ways depending on context.

An example of how patriarchy in Bangladesh is differently constituted and challenged in relation to reproductive health and rights is a study by Gipson and Hindin (2007) on rural married couples. In 19 in-depth interviews, the authors found that many women acted independently and often contrary to their husbands' desires in their use of contraception – they took pills without telling their husbands, or didn't take pills that their husbands gave them. The authors suggest that, as previously mentioned in this paper, family planning in Bangladesh is constructed as a woman's domain, where women have some level of control. Again however, this control depends on context; Gipson and Hindin found that new wives were relatively powerless in negotiating fertility and contraceptive use with husbands and extended family, while older wives established in their households typically had the authority to express and carry out their fertility preferences.

In Bangladesh, domestic violence is also an indicator of male-dominance and has significant implications for reproductive health. As stated at the beginning of this paper, a key component of reproductive rights is the right to respect for one's physical body and freedom from physical and sexual abuse (Petchesky and Correa 1994). Yet according to the 2007 Bangladesh Demographic and Health Survey, nearly one in two ever-married women (49%) have experienced some form of physical violence by their husbands, and nearly one in five (18%) report having been physically forced to have sex by their husbands against their will. In fact, the most common source of serious injury among women in Bangladesh is domestic violence (NIPORT 2009). This level of violence in Bangladesh has direct impact on women's reproductive health. A study of spousal abuse in urban slums of Bangladesh found that abused women suffered from gynecological problems significantly more than non-abused women, and were also significantly less likely to use contraception (Salam, Alim, and Noguchi 2006). A similar study in Bangladesh found that women experiencing physical intimate partner violence were significantly more likely than non-abused women to report an unwanted pregnancy, miscarriage, induced abortion, or stillbirth, both ever and in the past five years (Silverman et al 2007).

In addition to male dominance and domestic violence, poverty is another factor that considerably constrains reproductive rights, and it does so in a variety of ways. Poverty restricts access to healthcare, such as treatment for sexually transmitted diseases or infertility, as well as other resources that enable good health. The context of poverty in Bangladesh, in conjunction with male-dominance, also means that women are typically economically dependent on men, which limits their autonomy to spend money on reproductive health services. Additionally, poverty shapes the context

of marriage for many women in Bangladesh and thus is related to reproduction. In their study on marriage among the urban poor in Dhaka, Jesmin and Salway (2000) found that in spite of the negative aspects of marriage, such as marital discord, violence, insecurity, and instability, marriage remains a necessity for many women in order to maintain social and economic protection. Various factors, including the unstable nature of life in the slums, the harassment single women face from men, and the difficulty of returning to one's natal village, force women in urban slums to marry. Given that marriage for women in Bangladesh often entails spousal violence and sometimes forced sex, there are implications of this for reproductive rights. Ultimately, poverty severely limits the choices women have to ensure their own security and wellbeing.

Overall, there are many social factors that, in conjunction with family planning policies and programs, shape women's reproductive rights in Bangladesh. However, the nature of these influences is complex and varies based on context. For example, as already demonstrated, the context of urban slums is one of particular vulnerability and insecurity for women, especially young women. The next section explores this unique context and how it shapes and constrains reproductive rights.

### **Married Adolescent Women in Urban Slums of Bangladesh**

Dhaka, the capital of Bangladesh and the fastest growing megacity in the world, has experienced a high rate of urban growth in the past few decades. This is largely due to the influx of poor migrants from rural areas, where landlessness and underemployment is prevalent (Nahar and Amin 2009). The infrastructure of Dhaka city is severely ill-equipped to handle such a growing urban population, and thus about a third of Dhaka's residents live in slums and squatter settlements, which are

characterized by poor housing conditions, high density, limited environmental services, and extreme poverty and vulnerability (Hossain 2007; NIPORT et al 2008) Slum dwellers, typically living illegally on either government-owned or private property, are faced with the constant threat of eviction, as well as persistent environmental disruptions; research from the 2006 Bangladesh Urban Health Survey (NIPORT et al 2008) found that 70% of slum residents surveyed had been forced to abandon their homes at least once due to flooding during the rainy season. Slum dwellers are mostly involved in low-paying jobs in the informal economy (rickshaw pulling, begging, street vending, etc.), and a considerable portion of their limited incomes goes to basic necessities like food (Hossain 2007). Related to this poverty are indicators of health and wellbeing among slum dwellers, especially for women – the 2006 Bangladesh Urban Health Survey found that women living in urban slums were twice as likely to be undernourished as women in non-slums, and reported higher rates of complications during childbirth. There is also less access to education – the median years of education for women living in urban slums was only 2.3 years, compared to 4.3 years for men living in slums, and 7.2 years for women in non-slum areas.

Within the urban slum environment, women's experiences of life are significantly different from men's, especially in relation to their reproductive roles. As previously mentioned, young women living in urban slums are practically forced to marry at an early age in order to secure social and economic protection. Sabina Rashid (2006a, 2006b) is among the very few scholars who have qualitatively explored the reproductive experiences of married adolescent women in urban slums of Dhaka. Among the 153 adolescent women she interviewed, the reported average age at marriage was 13.5 years (even though the legal age of marriage in Bangladesh is 18

for girls and 21 for boys). Rashid found that in-laws and other family members placed high importance on the fertility of newly married adolescent women, and young women themselves were concerned about the need to “prove their fertility” as soon as possible, as this can be reason for their husbands to desert them. Consequently, married women in urban slums begin childbearing at an early age, often before they are ready; Rashid found that among the 153 young women she surveyed, 128 said they felt compelled to have children soon after marriage when they were not yet emotionally or physically ready. Indeed, survey data from the 2006 Bangladesh Urban Health Survey found that adolescent women from urban slums were almost twice as likely to be mothers as adolescents from non-slum areas (NIPORT et al 2008).

Rashid (2006a, 2006b) describes how married adolescent women make decisions regarding their fertility in the context of severely constrained choices. Many of the women she interviewed were concerned about the “poisonous” effects of contraception on their bodies, fearing that continued use of contraceptive methods would lead to infertility. Despite these fears, Rashid notes that married adolescent women wanted methods to control their fertility, especially after their first or second pregnancy. Nearly half of the young women she surveyed were using a contraceptive method, with poverty and concerns about being able to feed their children being the main reasons for using contraception. At the same time, married adolescent women also realized the social value of children; “social acceptance and security in the marital home were established through fertility, particularly the birth of a son” (Rashid 2006a: 155). In the case of marital discord or conflict between their husbands, themselves, and sometimes their husbands’ other wives, young women hoped that the birth of a child would improve the marriage. Finally, Rashid notes that as young urban women

have begun to enter the paid workforce, their status has changed; family members and in-laws in some instances prioritized the economic productivity of young women over their traditional reproductive role. In the context of these constraining factors – poverty, economic conditions, marital insecurity, household politics and conflict – married adolescent women make pragmatic decisions regarding their fertility in order to gain security and to survive.

The research by Rashid on married adolescent women and research on the context of concentrated urban poverty demonstrate the unique factors that shape women's reproductive experiences. For young married women in urban slums of Bangladesh, multiple identities (as young women, as garment factory workers, as new wives in their in-laws' household, as rural migrants, as mothers, as urban slum dwellers) intersect within larger political, social, and economic structures to shape their reproductive and sexual health experiences, ultimately creating an environment of particular vulnerability and insecurity where reproductive rights are constantly negotiated and compromised. When viewed in the broader context of donor-driven population policies, international women's movements and national family planning programs, as I have done in this paper, the context of reproductive rights for young women in urban slums of Bangladesh can be understood in even more depth. Overall, numerous factors at multiple different levels all converge to shape reproductive experiences. In order to reveal the complex nature of these factors, as well as identify possible solutions to address them, I turn to the lived experiences of young women in urban slums of Bangladesh and situate their perspectives at the center of my analysis. Through in-depth interviews with these young women I ask: what factors continue to shape and constrain the reproductive rights of adolescent women in Bangladesh today?

## **Chapter 2**

### **METHODOLOGY**

This research is based on data from 12 semi-structured in-depth interviews with married adolescent women conducted over a period of 3 weeks in January 2013. The women who participated in this study were recruited from two different slum areas of Dhaka that were selected purposively based on their close proximity to the Center for Reproductive Health at ICDDR,B where I was working. The slum areas had been previously defined by a 2005 mapping and census project of urban slums in Bangladesh (CUS, NIPORT, and MEASURE Evaluation 2006). I chose to recruit women from two different slum areas in order to see if there might be any differences in their experiences based on location and the nature of the slum.

Because I do not speak Bengali, the language spoken in Bangladesh, I hired a Bangladeshi anthropology student as my research assistant to conduct the interviews in Bengali. I developed the interview guide and reviewed it with my assistant to ensure that the questions were culturally relevant. Although I did not conduct the interviews, I was present during all of them. The interviews were conducted in the homes of participants, audio-recorded, and lasted for approximately one hour. My research assistant also completely transcribed and translated the interviews into English. No names or other identifying information was collected from participants during data collection. In the results and discussion sections of this paper, respondents are referred to using pseudonyms or their ages.

Eligibility criteria for participants in the study included being married, female, and between the ages of 13 and 19 years. The study was limited to married women because of the extreme social stigma attached to premarital sex and the premarital use of contraception in Bangladesh and the challenges this thus would have posed to the research process. We went door to door to recruit participants for the study and also employed snowball sampling; thus the selection process was not randomized. These techniques were used because of the methodological challenges of gaining access to married adolescent women in urban slums of Bangladesh. Rashid (2007) describes how several gatekeepers, including husbands, in-laws, and co-wives, control access to these young women, and the issue of gatekeepers is especially relevant and challenging when the research involves sensitive topics like family planning. Therefore, during the recruitment we had to ask the permission of the participants' parents, in-laws, and/or husbands prior to the interview, in addition to gaining consent from the participants themselves. Out of about 19 women that we approached to recruit for the study, four were ineligible due to age (too young/too old) or marital status (not married/not currently living with a husband), and three did not want to participate (mostly due to being too occupied with household chores). So in total, 12 young women participated in the study. Additional interviews may have strengthened my findings, but due to my limited amount of time in Bangladesh this was not possible.

### **Data Analysis**

To analyze the data, I used a multistep coding procedure that utilized both inductive and deductive codes. Based on my research questions, I had an initial theory of the codes I would find in the data, such as decision-making and reasons for using

family planning. After reading the transcripts multiple times, I identified other codes from the data as well, identifying 12 codes in total. After analyzing the data by employing these 12 codes, I read the sorted data and identified specific sub-codes. From this step of the analysis, certain recurring thematic concepts were identified, such as poverty and the importance of respecting a husband's words. These themes were exemplary of the main concerns of the participants; I weaved together these concerns from the different codes and sub-codes to identify three main categories of constraints on respondents' reproductive rights: problems with family planning methods and services, husband's authority and women's economic dependence, and poverty in urban slums.

### **Study Sample**

Participants ranged in age from 13 to 19, and the median age was 18. All had been married only once. The age at marriage ranged from 12 to 16, and the median age at marriage was 14. Four out of 12 participants had never received formal education; the education level ranged from none to Class 8, and the median level was Class 4. Eight out of 12 had been employed either currently or previously in factory work, and all had husbands who were employed in some kind of work, whether formal or informal. Husband's age ranged from 18 to 30 and the median age was 23.5. Nine of the participants had had arranged marriages, and the remaining three had love marriages. Eight out of 12 had one living child, one participant had two living children, and the remaining three had no children. Two participants were pregnant at the time of interview.

### **Chapter 3**

## **RESULTS AND DISCUSSION**

### **Access To and Use of Family Planning**

Of the twelve women interviewed, all had used or were currently using a modern method of contraception. All knew about multiple family planning (FP) methods, and most had heard of at least pills, condoms, and injectable methods of contraception. Some had heard of traditional methods (such as “safe period” also known as rhythm method), but only one respondent had consistently used a traditional method. At the time of interview, nine of the twelve respondents were using a modern method of contraception; six of those nine were taking contraceptive pills, and the remaining three were using injectables. Of the three respondents not using a method of contraception, two were pregnant and one had recently delivered a baby.

Respondents obtained methods of family planning from pharmacies in or near to the slum, from aunts or other family members, from community health and family planning workers, and directly from health clinics (government, private, or NGO). Respondents reported that packets of pills could be purchased from pharmacies within or near to the slum at an affordable price; thus there seemed to be no economic or geographic barriers to accessing contraception. Most often, husbands or other family members purchased pills for the women interviewed; five respondents mentioned that they would not buy pills from the pharmacy because they felt ashamed to and/or because the person selling the pills was male. Three women however mentioned that they were comfortable purchasing the pills themselves.

## Reasons for using contraception

There were two main reasons respondents expressed for using a method of contraception to avoid pregnancy: being too young or too physically weak to carry a baby, and not being able to afford the cost of a/another child.

All respondents mentioned receiving messages about being too young to begin childbearing, and these messages often came from multiple individuals, including mothers, aunts, husbands, and neighbors. The following quote for example reflects a typical response:

My mother tells me, 'You have to take the pills if you're going not to have a child now. After one or two years you can have a baby.' She thinks that I'm too young to have a baby now. My husband also says that, 'You are too weak to have a child so you have to take the pills; and you are too young, you can't take care of children now.'

- 13-year-old respondent

Respondents were typically in agreement with these messages about the importance of avoiding early childbearing. In some instances, young women initiated the discussion with their husbands or family members about being too young to have children. One respondent, who had an arranged marriage at age 14, described:

On the first day of marriage I told my husband about the family planning method. I told him, 'I think we should have a baby later, I'm too young to have a baby. Maybe I will face some problems if I have a baby now...maybe I will become weak, my baby will have a low birth weight or suffer with malnutrition. You know that I'm too young now to have a baby even though I married you.'

- 17-year-old respondent

Concerns about avoiding early childbearing were often directly linked to the health complications it could potentially cause. For example, an 18-year-old respondent recalled, "When I became pregnant people from my village said, 'You are too young now. You and also your baby will die during delivery.'" Occasionally,

realities that respondents had directly witnessed or experienced contributed to the perception of early childbearing as dangerous for both mother and baby; a few of the respondents mentioned having complications during childbirth and of the 10 respondents who had ever been pregnant, three had experienced stillbirths or infant deaths. One respondent described the life-threatening dangers of early childbearing in the context of realities she had witnessed at work:

If you become pregnant at an early age you may die. Girls who were working in the same garment factory as me, eight were pregnant and only four are alive now. If you become pregnant at an early age you may need an operation and a lot of money is needed for an operation.

- 17-year-old respondent

As reflected in this quote, concerns about the health risks of early childbearing were woven into economic concerns about being able to pay for the delivery and any potential operations. Indeed, the second reason respondents expressed for using contraception to avoid pregnancy was the steep monetary cost of pregnancy, childbirth, and childrearing. Common responses included:

I do not want to have a child now. We are newly married and do not have enough money now. When my husband and I gather a lot of money, then we will have a child.

- 13-year-old respondent

If I become pregnant now then I won't be able to go outside for work. My husband's income is low. If I don't go for work then I won't be able to bear the cost of rent and food.

- 19-year-old respondent

I will wait 5 or 6 years to have another baby because I needed an operation for the first baby and we needed a lot of money for this, so if I have another baby now my husband won't be able to afford the cost.

- 19-year-old respondent

As these responses demonstrate, there were many economic reasons for using contraception to avoid pregnancy. The women interviewed mentioned the various

expenses that came with bearing a child, such as having to pay for nutritious food during pregnancy, the costs of potential complications during delivery, and the expenses of feeding and educating children. As a result, respondents expressed wanting to use contraception to limit their total number of children, and most mentioned not wanting to have more than two. This reflects Rashid's (2006) finding that poor married adolescents have adopted the rhetoric of family planning campaigns that connects smaller family size to improved economic conditions and better quality of life. As this 18-year-old respondent described:

To raise a baby now-a-days is too difficult. My elder sister has three girls and one boy...I asked her, 'Why do you have four children? You should have two, because if you have two you can take care of them properly, they will be educated well.' Now-a-days the cost of living is too high. If you have two babies you're able to afford all of their costs, but we are poor; we do not have enough money to bear the cost of more than two babies.

Overall, it was clear from the interviews that married adolescent women desire to control their fertility. All 12 respondents were using or had used modern contraceptive methods at the time of interview, and the reasons for using contraception to avoid pregnancy included both being too young to begin childbearing or the economic costs of childbearing. Various factors however shaped the reproductive experiences of the young women interviewed in other ways besides their ability to access and use contraception. Specifically, problems with FP methods and services, poverty, husband's authority and women's economic dependence on their husbands constrained the choices available to married adolescent women and therefore shaped the reproductive decisions they made.

## **Problems with FP Methods and Services**

Although respondents had access to and used a variety of FP methods, the quality of these methods and their experiences using them were not always positive. During the interviews all twelve respondents brought up problems and challenges they faced with using modern contraceptive methods. These challenges ranged from bad side effects to misinformation and fears about certain methods to negative experiences with healthcare providers. Furthermore, these challenges had implications for reproductive health; many of the young women interviewed experienced unwanted pregnancies, suffered from method-related complications, and overall struggled to find FP methods suitable to their needs.

The problem that was most frequently raised by respondents was the negative side effects from taking pills, injectables, or implants, and these side effects included headaches, abdominal pain, feeling weak and/or faint, loss of appetite, vomiting, poor vision, and irregular menstruation. As a result, many of the respondents had discontinued use of a method or were unsatisfied with their current method. Respondents using pills frequently mentioned not liking to take them or purposely taking them less often in order to minimize the impact of the side effects, and this irregular use sometimes led to unintended pregnancies. Three out of the twelve respondents reported at least one unintended pregnancy as a result of irregular contraceptive use.

Caught between negative side effects and the need to control fertility, married adolescent women struggled to find suitable methods, and sometimes compromised their wellbeing as a result. For example, an 18-year-old respondent with five years of education, had an arranged marriage at age twelve and began taking contraceptive pills shortly after. Due to the negative side effects she experienced from the pills, she took

them infrequently and became pregnant unintentionally a few years after her marriage. At the time of interview, she was still having trouble finding a suitable contraceptive method, as expressed in the following quote:

After my daughter was born I started taking injections, and I'm still taking them now. I'm facing some complications from this, like bad headaches and bad pain in my stomach, so I don't like to take this. But what I can do? I have to take the injections because I often forgot to take the pills, and with the pills I felt bad headaches, was vomiting, and didn't have an appetite.

Another challenge with using contraceptive methods was the lack of information. Most of the young women interviewed were not given adequate information about family planning methods, including which methods were appropriate for different ages and lifestyles, what the side effects were, and how to properly use them. At times, this lack of information had serious implications for reproductive health, as it led to method-related complications or unwanted pregnancies. This case is exemplified by the story of Fatima, a 16-year-old respondent with four years of education who had a love marriage at age 14. Fatima recalled her first experiences using family planning, saying that:

We had no idea about family planning methods when we got married. On the first day of my marriage I learned about the family planning method. My sister-in-law gave me pills to take but said nothing about it. If my sister-in-law had described in detail about this, about why I should take these pills, then I would have taken the pills and not become pregnant.

Without knowing about family planning methods or the purpose of contraceptive pills, Fatima did not take the pills her sister-in-law gave her and thus became pregnant shortly after her marriage. After the birth of her first baby, when she was 16, Fatima heard about the implant method (a matchstick-sized rod inserted in the arm) from a health worker who came to her sister-in-law's home. She went to a health

center and got the implant put in, but experienced considerable negative side effects from it and later on went to have it removed. She remarked that:

When I went to the health center the health worker said that in my arm under the skin she could see something oily around the implant, and if I had waited more days [to get it removed] I would have died from infection.

Fatima felt misinformed about the suitability of this contraceptive method for someone her age, saying that, “I didn’t know before that I was too young to take this. Even though the health worker knew that girls my age should not take this, she didn’t tell me.”

In addition to a lack of information and quality services, there were many misconceptions about certain FP methods that contributed to the fears and experiences that young women had. The most prominent misconception was that contraceptive pills could “burn the stomach” and thus lead to infertility. For example, an 18-year-old respondent, who was married at 16, commented that:

After one month of my marriage my aunt told me, ‘Now you can stop taking the pills because if you keep taking this your stomach will burn and then you will be barren forever.’

Fears and misconceptions about certain FP methods often motivated the women to discontinue a method or use it infrequently, which occasionally led to unintended pregnancies as previously mentioned.

Multiple problems with FP methods converged to shape the choices and experiences of the young women interviewed, and this is demonstrated by the story of a respondent named Mala. A 19-year-old woman with two years of education, Mala stopped taking pills because she was afraid that taking them would cause her to become barren, and thus became pregnant when she was 14. After the birth of her first baby, Mala searched for other FP methods, and a NGO family planning worker

suggested that she take the implant. Like Fatima, Mala also had a negative experience using the implant as well as with the healthcare providers. She described her experience at the health clinic, saying that:

[The doctor] asked me how old I am, how long I've been married, the age of my first baby ...after hearing all this she gave me the implant. Then she gave me some vitamins and told me not to carry heavy things and to avoid heavy work. Then I asked [the doctor], 'We are poor, if I don't work, who will feed us?' The doctor was laughing then.

After getting the implant put in, Mala suffered from negative side effects and sought for a way to remove the implant. She said:

I was becoming thinner day by day. Then I discussed it with the doctor. She said that the implant is for five years, after five years you can take it out. Then I thought nothing will happen if I try to bargain with the doctors, and if I go to another place to take it out it will be expensive. So, I'll take it out after five years...then I went to another doctor, and she said that you will continue to suffer from these complications until you remove the implant. Because of taking the implant you are sick and suffering from anemia.'

Finally, Mala had the implant removed. She expressed her regret at ever having the implant put in, saying that, "Many of the women in this slum have gotten the implant; if they had shared with me their negative experiences I never would have taken this."

Like all of the respondents, Mala and Fatima made reproductive decisions in the context of the constrained choices they faced. These constraints included not only a lack of adequate information, poor quality FP services, and negative side effects from FP methods, but also the constraints of poverty and male-dominance.

### **Poverty and Life in an Urban Slum**

Concerns about poverty were one of the two main reasons young women used contraception to avoid pregnancy. However, the effects of poverty were far-reaching,

and affected reproductive experiences in other ways besides the decision to use contraception. In fact, all decisions regarding family planning and reproduction were made within the context of poverty, and economic concerns were a constant theme in the narratives of the respondents. For example, nearly all respondents mentioned the high living costs in urban slums of Dhaka. As this 19-year-old respondent commented:

My husband says that we will have two babies. If you have more than two babies you can't bear all the costs because life is very difficult today, the cost of living is increasing day by day.

As a result of the high living costs and the constraints of poverty, young women made economic decisions that were directly linked to their reproductive decisions. For example, deciding to go to work was a decision a few of the women made so that they could gather enough money to raise children. A 15-year-old respondent with five years of education and no children was employed in a garment factory at the time of interview. She commented, "My husband told me to go back to work and I agreed because if we together gather a lot of money then we can make a decision to have a child." Another respondent, a 19-year-old named Nadia with a newborn son, contemplated the economic decisions she would have to make regarding her child:

Before marriage I never went for work, but I'm thinking about going for work when my baby gets older. I won't go for work now because there is nobody here to take care of him. But for my baby's future [my husband and I] both have to work ...in Dhaka it is very difficult to support your family if husband and wife do not both work; living cost is very high here and it is increasing day by day...I have to think about my baby's future. For his education, to feed him, we need a lot of money. All of my husband's income goes to pay for rent and food. When my baby is two years old I'll go for work.

Nadia's response demonstrates how reproductive decisions are intertwined with economic decisions, and how poverty is a persistent factor shaping both. It also

shows the difficulties of life in the urban slum environment; the majority of the women interviewed had migrated to Dhaka from their natal villages in other areas in Bangladesh, and therefore often had limited social support systems in the slums. As one 17-year-old respondent mentioned regarding her infant daughter, “It is too difficult to raise a baby here. If I was in the village my family would take care of her but in Dhaka we have no relative who can take care of her.”

Finally, as reflected in Nadia’s quote, while all respondents expressed concern about the constraints of poverty, many hoped that their economic and reproductive decisions would lead to better outcomes for their children. Mala, for example, discussed her decision to delay her next pregnancy in relation to her economic condition and her wishes for her newborn daughter:

I will wait to have another baby until my first baby gets older because living costs are increasing day by day. If you have more than two babies you can’t educate or feed them properly...my dream is that my baby will be well-educated one day. I will never depend upon my husband to educate them. I will try to make my daughter well-educated so that one day people will say that although I am a garment worker my daughter is well-educated.

Mala’s point that she “will never depend on her husband to educate them” relates to another factor that played into reproductive experiences and decisions: the husband’s authority in decision-making as head of the household, and women’s economic dependency on their husbands.

### **Husband’s Authority and Women’s Economic Dependence**

The authority of the husband in decision-making processes was another constraint on the reproductive autonomy of the young women interviewed. While most of the women seemed to have freedom to decide which method of contraception to use, or at least the freedom to negotiate different methods of contraception with

their husbands, husbands still had the final say on the decision of whether or not to have a child. As previously discussed, family planning in Bangladesh is typically constructed as a women's domain, or a component of women's traditional responsibilities. Thus, many of the young women interviewed described talking about different methods of contraception with their mothers, aunts, or mother-in-laws, as well as proposing the ideas of using contraception to their husbands. The following quotes reflect common responses:

I discussed [taking the injection] with my mother. My mother says, you can take the injection, it is a better method than the others...I also talked about taking the injections with my husband. My husband said that, 'if you want to, then you can take it.

- 18-year-old respondent

[I told my husband], so, what are you thinking about the family planning method? Then my husband told me, 'you can take injections,' but I said that I am afraid of that so I will take pills. After that my husband bought pills from the pharmacy.

- 17-year-old respondent

Although these quotes demonstrate that women had some power in deciding which method of contraception to use, these discussions and decisions were still made within the context of male-dominance. Husbands had the final authority over reproductive matters, and nearly all of the respondents expressed the importance of obeying their husband's wishes. A common response among respondents was, "I should respect my husband's words." Not obeying a husband's wishes was occasionally met with negative consequences. As one 18-year-old respondent remarked, "You always have to fulfill your husband's demands, if you don't do this your husband will be angry with you." Another example is this experience from a 15-year-old respondent, who shared:

One day I was joking with my husband and said that I wanted to have a child. After hearing this, my husband became really angry and said 'I'll send you back to your mother's house.'

A 19-year-old respondent, Rehana, also voiced these sentiments. Rehana became pregnant unexpectedly after discontinuing use of contraceptive pills without discussing it with her husband, and expressed that:

I think that having a child and the number of children you have should be determined by your husband. You see, without talking with my husband about this I became pregnant; if I had discussed it with my husband first it would have been better for me.

When asked about her future plans for having children, she continued saying:

I should respect my husband's word, he can give me a good decision. I've gotten pregnant without permission from my husband before. If I do this again my husband will be angry with me.

While deciding what method of contraception to use was something respondents' typically had control over, decisions over when to have children, how many children to have, and even whether or not a pregnancy would be aborted were commonly made by their husbands, and often their husbands' parents as well. This reflects Rashid's (2006) finding that in-laws have considerable influence over women's reproductive decisions. A 16-year-old respondent voiced how the opinions of her husband and mother-in-law shaped her reproductive decision-making:

When I got pregnant my husband said, 'You are too young to have a baby, you will die. I'm thinking about the abortion.' Then my mother-in-law said, 'It is difficult to deliver a baby but it is more difficult to abort a baby.' Then I decided to keep the baby.

Related to husbands' authority over their wives' fertility was the economic dependence that women had on men. Multiple respondents, when asked to elaborate on the point of their husband's control over decisions-making, identified economic power as the underlying explanation. Although many of the girls had worked prior to

becoming married, the majority of them were not working at the time of interview, and thus depended on their husband or their husband's family for money and basic necessities. This economic dependency often translated into a limited ability to make decisions, as described by this response from an 18-year-old respondent:

Respondent: You have to always fulfill your husband's demands. If you don't do this your husband will be angry with you.

Interviewer: Why do you have to fulfill your husband's demands?

Respondent: Because, my husband feeds us, he earns money, so I have to obey all my husband's words. If I have money my husband will respect my words. My sister-in-law is working in a garment factory and she earns money; because of this her husband respects her words.

The direct relationship between decision-making authority and economic power is further demonstrated by this response from a 16-year-old young woman:

If your husband bears all the cost of the family then you have to respect his decision. We women are nothing – if the women have money then we can make a decision.

Without money or a job to bring in income, married adolescent women often felt they did not have the power or authority to make and carry out decisions regarding their fertility, regardless of whether or not they were using contraceptive methods. The close relationship between poverty, economic dependency, and husbands' authority reveal how intertwined these various constraints on women's reproductive lives are and how they converge to shape reproductive experiences.

### **Reproductive Rights in the Context of Constrained Choices**

The various constraints on young married women's reproductive choices are not entirely distinct from each other; rather, they intersect and reinforce each other to create the context of lived reproductive experiences. In fact, as Rashid (2006)

emphasizes, reproductive and sexual experiences cannot be understood outside the context of the social, political and economic conditions that shape everyday life.

The convergence of multiple constraints on reproductive experiences is exemplified by the narrative of Rehena, an 18-year-old woman with two daughters and no formal education, who had a love marriage at age 13.

Although she and her husband wanted to wait before having their first baby, Rehena didn't like taking the pills due their negative side effects and also often forgot to take them; she thus became pregnant unexpectedly about a year after her marriage. She mentioned that her husband had wanted to wait five years before having a child, "because he wanted to gather some money; now-a-days it's too expensive to raise a baby and the cost of living is increasing every day..." Her husband was worried about the family's financial situation as well as living in the slum. When Rehena became pregnant again about a year after the birth of her first child, she considered getting an abortion. She commented:

I was very weak and suffering from jaundice during my second pregnancy and I wanted to get an abortion but my husband told me, 'if you do this what will I say to Allah? Who will be responsible for this? Why didn't you tell me that you stopped taking the pills? You know that my economic condition is not good now. You are pregnant now, you have to take nutritious food, and for this I need a lot of money....' My husband was also worried about our social status. He said to me, 'what will people say if you abort the baby?'

As a result, Rehena did not get an abortion and gave birth to her second baby. Three of the 12 young women interviewed mentioned having considered getting or having wanted to get an abortion, although none reported actually getting an abortion. Various factors, from the legality of abortion to its social stigma, prevent women in Bangladesh from accessing abortion services, even though as Petchesky (1980) notes, safe, legal, funded abortion is a critical aspect of reproductive rights.

After giving birth to her second child, Rehana became pregnant again after forgetting to take the pills. Her husband became very angry because of this and threatened to leave her. She recalled her husband saying,

‘Why did you do this? The number of our family members is increasing day by day. I have to feed my babies, and we still don’t have a home yet. We have two girls, for their marriage we need a lot of money.’

When her mother-in-law heard about the pregnancy, she told Rehana’s husband, “She is pregnant now, Allah gave you this baby. If you try to abort this Allah will not forgive you. Your wife made the mistake, what can you do now?”

Overall, Rehana’s story reflects the intersection of multiple constraints that came together to shape her reproductive experiences. Because of the negative side effects of the pills, Rehana took them infrequently and thus had three unintended pregnancies. Arguably, if she had access to better quality family planning services and more information about other methods, she would have been able to more successfully carry out her intentions regarding her fertility. Furthermore, the power inequality between her and her husband prevented Rehana from seeking an abortion and placed the blame of the unexpected pregnancies solely on her. The context of male-dominance meant that Rehana experienced threats from her husband as a result of becoming pregnant, and, along with the precarious and insecure nature of life in the slum, meant that she had few options for dealing with these threats other than obliging to her husband’s demands. It is relevant to note that Rehana’s husband, as a “religious person,” thought that women should remain at home; as Rehana mentioned, “No women in my husband’s family go outside for work. My husband doesn’t like it...it will be a matter of shame if I go for work outside the home.” Thus Rehana’s economic dependence on her husband also constrained her ability to make and carry out

decisions regarding her fertility. Finally, all of these factors occur within the context of poverty, shaping not only Rehana and her husband's reproductive decisions but also all of their interactions, which indirectly shape Rehana's reproductive health and autonomy. Ultimately, it is in this context of constrained choices that Rehana makes decisions regarding her reproduction, and it is in this context of constrained choices that we understand what reproductive rights mean for married adolescent women in urban slums of Bangladesh.

In summary, married adolescent women in urban slums of Bangladesh make reproductive decisions in the context of severely constrained choices, and therefore their reproductive rights are constantly being negotiated and compromised. From these interviews, it is clear there are many constraints to reproductive freedom, beyond the ability to access and use methods of contraception. These constraints include problems with FP methods and services, male-dominance and women's economic dependence, and the context of poverty and life in urban slums. Among these, the constraint of poverty seemed to be most central to the concerns of the young women I interviewed. Worries about being able to afford the costs of bearing and raising children were a consistent theme throughout our discussions, and reproductive decisions were inevitably linked to economic decisions. Poverty however not only directly shaped reproductive health, for example by limiting access to safe, high quality family planning methods or by constraining the ability of women to pay for health services during delivery, but it also indirectly shaped the reproductive experiences of married adolescent women. Economic dependence, limited income, and unstable nature of life in the slum meant that women had few options for ensuring their own security and wellbeing. Ultimately, as Petchesky (2000) aptly describes: "reproductive and sexual

rights for women will remain unachievable if they are not connected to a strong campaign for economic justice and an end to poverty.”

Given this evidence for the connection between reproductive health and economic justice, Petchesky (2000) further emphasizes what must be done in order to secure reproductive rights for women around the world. She argues that while it is no longer necessary to convince global organizations such as the United Nations that basic needs such as health, education, and gender equality are fundamental human rights (the 1994 ICPD is a testament to that), there is still existing fragmentation among various movements for human rights and a lack of recognition for the inherent connections between them. The actions of the World Bank for example are especially contradictory – the Bank commits large sums of money to health projects, such as fighting HIV/AIDS, but continues to prioritize the control of private companies over prices for vital drugs, and maintains the system of conditional loans, trade liberalization, and private markets that pushes poor countries, as well as poor women and their families, further into debt. Petchesky (2000: 16) cites the demands for structural and economic change made by the campaign, “Health for Women, Health for All NOW”, including:

- “that national budgets reallocate funds away from militarism and toward health and other human development priorities;
- that rich countries and international finance institutions substantially reduce the debt burden of poor countries;
- that fair trade should replace protectionist policies as well as the loans and foreign aid that perpetuate dependency; and

- that transnational corporations that profit from health be subjected to international human rights standards to assure that profit-maximizing practices such as patent monopolies do not override the life-and-death concerns of the people”

These demands are significant because they go beyond the recognition that reproductive and sexual rights are human rights to actually address the underlying causes of why reproductive rights have not yet been achieved. Economic justice, to most people, would seem irrelevant to reproductive and sexual health. Yet the voices of young, married women in urban slums of Bangladesh articulate the interdependency of reproductive rights and economic justice, and thus these demands made by the Health for Women campaign are seen as not only relevant, but urgently necessary.

## **Chapter 4**

### **CONCLUSION**

Overall, achieving reproductive rights for women around the world begins with how we understand and conceptualize reproductive rights. On a micro level, women's experiences must be viewed within the context of nuanced social norms and gender roles, avoiding universalist assumptions and placing women's lived experiences at the center of our inquiries. The goal of reproductive rights may be universal, but the context in which those rights are realized is extraordinarily complex and particular, and thus recognizing differences and respecting diversity is critical. Equally important is to understand women's experiences on a macro and historical level; we must place reproductive rights in the broader framework of global capitalism, racism and the oppression of ethnic minorities, the exploitation of the poor as source of cheap labor, power inequalities between the global North and South, and the persisting legacy of colonization. We must challenge ourselves, as feminists, as researchers, as public health professionals, to look closer at the particular while never losing sight of the larger forces that sometimes seem so inevitable we take their existence for granted. Only by doing this will we truly understand the root causes of the health inequalities and injustices that we see today, and only by doing this will we realize the changes necessary to achieve reproductive rights, as fundamental human rights, for all.

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## **Appendix**

### **INTERVIEW GUIDE**

Background information - How old are you? What is your level of education? How old is your husband? Is your husband employed? If so, what is your husband's occupation? Are you employed? If so, what is your occupation? How old were you when you got married for the first time? Did you have a love or arranged marriage? Have you been married more than once? How old were you when you became pregnant for the first time? How many pregnancies have you had? How many childbirths? How many living children do you have now - male or female?

1. Knowledge, perceptions, and discussion of family planning
  - a. Do you know of any methods that men or women use when they want to wait before having another child or when they don't want to have any more children? If so, what are they? (female or male sterilization, pill, IUD, injectables, implants/Norplant, condoms, safe period, withdrawal, other)
  - b. What do you know about these methods? Describe the methods you know of in detail.
  - c. What are your thoughts about using something or doing something to control pregnancy or avoid becoming pregnant? In your opinion, should it be done or not?
  - d. What is your husband's opinion on using something or doing something to control pregnancy or avoid becoming pregnant? In his opinion, should it be done or not?

- e. What are your thoughts or perceptions about these methods? In your opinion, are they useful? Effective? Harmful? Affordable?
  - f. What are your husband's thoughts or perceptions about these methods?
  - g. Have you ever talked with your husband about family planning? If so, describe in detail the most recent time you talked with him about family planning. Who initiated the talking?
  - h. When was the first time you heard about family planning methods - before or after your first marriage? From whom/where did you hear about them?
2. Use of family planning methods
- a. Are you or your partner currently using any method or doing anything to avoid becoming pregnant? If so, what are you doing or using? Who is doing this or using this method - you or your husband? If you, why not your husband? If your husband, why not you?
  - b. If currently using a method of family planning, what are your reasons for using a family planning method right now? If not currently using, why?
  - c. When was the first time you did something or used something to avoid becoming pregnant? Which method? What were your reasons for not wanting to be pregnant then?
  - d. What other methods have you used in the past? What were your experiences like using those methods? Describe in detail a positive or negative experience you have had using a method of family planning. How did this affect your use of that method in the future?
3. Obtaining family planning services

- a. From where or whom can family planning methods be obtained? Describe as many sources that you know of.
  - b. The most recent time you obtained a family planning method, where did you get it from? Describe in detail how you obtained this method.
  - c. In the past, have you ever experienced any challenges in obtaining a method of family planning? Describe in detail a specific experience.
4. Barriers to obtaining and using family planning services
- a. If you want to do something or use something to avoid becoming pregnant, what are some of the things that might make it hard for you to do so?  
(*probe*: physical barriers? economic barriers? religious barriers? husband or other family member? health facility staff? unknowledgeable of ways to avoid becoming pregnant?)
  - b. Can you think of a specific time you wanted to obtain a method of family planning, but were unable to do so? Describe this experience to me in detail. What was the reason you were unable to access a method of family planning?
  - c. What would make it easier for you to obtain family planning or MR services if you needed them?
5. Pregnancy and childbearing
- a. Would you like to have another child now, would you like to wait sometime before having another child, or do you not want any more children? Why?

- b. Before you got married, what were your thoughts about having children?  
Do you have any thoughts about when you wanted to have children or how many you wanted to have?
  - c. Right after you got married for the first time, what were your thoughts about having children? Did you want to have children right away or did you want to wait? What were your husband's or family's thoughts about having children?
  - d. What were your thoughts the first time you found out you were pregnant? Describe that moment to me in detail. How old were you at that time? Did you want to become pregnant then? What were your reasons for wanting or not wanting to be pregnant?
  - e. The other times you have been pregnant, did you want to become pregnant then? If you didn't want to be pregnant, what did you do?
6. Decision making and control
- a. In your family, are there decisions made about the number of children to have and when to have them? If so, who makes those decisions? How are these decisions made?
  - b. The most recent time you started using a method of family planning, who made the decision to start using this method and how was the decision made? Describe in detail.
  - c. Have you ever terminated a pregnancy, or thought about terminating a pregnancy? If so, how was the decision to keep or not keep the baby made? Who made the decision?

- d. In your opinion, who or what, if anything, determines or influences how many children you will have?
- e. Do you think that having children is something that girls your age can control? Do you personally feel like having children is something you can control? Why or why not?