Changes in Attitude of Two Generations of Women Towards Menstrual Regulation in Urban Bangladesh

A Research Paper presented by:

Azmarina Tanzir

(Bangladesh)

in partial fulfilment of the requirements for obtaining the degree of

MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Governance, Policy and Political Economy

(GPPE)

Specialization:

Women and Gender Studies

Members of the Examining Committee:

Dr Wendy Harcourt

Dr Sylvia I. Bergh

The Hague, The Netherlands
December 2016

Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

Inquiries:

Postal address:

Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

Telephone: +31 70 426 0460
Fax: +31 70 426 0799

Acknowledgements

I want to extend my heartfelt thank to my supervisor Wendy Harcourt, for sharing my excitement and interest about the research topic. I am grateful for her encouraging comments, guidance and patience with me. I would also like to show my appreciation to Sylvia I. Bergh for being the critical reader I needed and for bringing me back to the track when my RP seemed to get derailed from time to time.

To my family for supporting me in all of my quests. To my friends in ISS, especially Suchismita, Tanmoy and Bhaskar for their input, ideas and criticism that were fundamental to this research. To Zahid Kawser, for being my home away from home and teaching me how to smile flaunting my broken teeth.

Finally, my utmost gratitude to the voices that speak in this research. Their stories of struggle and survival humble me, their strength and stance to weather the storm of everyday life encourage me.

Contents

List of Tables

List of Appendices

List of Acronyms

AJPN	American Journal of Psychiatry and Neuroscience
APA	American Psychological Association
APPJ	Asia Pacific Population Journal
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BDT	Bangladesh Taka
BFS	Bangladesh Fertility Survey
BIDS	Bangladesh Institute of Development Studies
BMA	Bangladesh Medical Association
BMC	Bangladesh Medical College
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CNG	Compressed Natural Gas
CPR	Contraceptive Prevalence Rate
CRR	Centre for Reproductive Rights
DMCH	Dhaka Medical College Hospital
DYD	Department of Youth Development
FPAB	Family Planning Association of Bangladesh
GDP	Gross Domestic Product
GED	General Economics Division
HIES	The report of Household Income Expenditure Survey
HSC	Higher Secondary Certificate
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IDE-JETRO	Institute of Developing Economies, Japan External Trade Organization
IDS	Institute of Development Studies

IPV	Intimate Partner Violence
IUD	Intrauterine Device
MATLAB	Matrix Laboratory
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MOWCA	Ministry of Women and Children Affairs
MOYSPORTS	Ministry of Youth and Sports
MRM	Menstrual Regulation with Medication
MR	Menstrual Regulation
MVA	Manual Vacuum Aspiration
MYC	Ministry of Youth and Culture
NAC	National AIDS Committee
NIPORT	National Institute of Population Research and Training
NWDP	National *Women Development Policy*
Plancomm	Bangladesh Planning Commission
SDG	Sustainable Development Goals
SES	Socioeconomic Status
SRHR	Sexual and Reproductive Health and Rights
SSMCH	Sir Salimullah Medical College Hospital
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNESCO	*United Nations Educational, Scientific and Cultural Organization*
UNICEF	United Nations Children's Fund
UN	United Nations
WEF	World Economic Forum
WHO	World Health Organization

Abstract

Menstrual Regulation (MR) has been part of Bangladesh's national family planning program since 1979. This research explores the changes in attitudes towards MR between two different generations of women in urban Bangladesh belonging to different socioeconomic class, marital status and religious identity. By focusing on women's narratives, this research provides an evidence based critical understanding of urban Bangladeshi women's subjectivities and their experience in negotiating services as they navigate the difficulties around having to undertake MR.

This study contributes to the discussion on gender equality in relation to SRHR as being an empowering, not population control discourse. It also stresses on the importance of ensuring that information about MR is made available widely as a legal procedure that would gradually contribute to eliminating social stigma. What the respondent's stories show is that it is important to tackle societal stigma towards MR/abortion, in order for Bangladesh to move forward in its aims to achieve gender equality.

Relevance to Development Studies

Academic and social research focus predominantly on women in rural areas of Bangladesh and urban women's MR experience is missing from the literature. This research contributes to the field of development by bringing in urban women's undocumented narrative into existing MR literature.

Keywords

Menstrual Regulation, Abortion, Urban Women, Stigma, Attitude, Intergenerational Narrative, Intersectionality, Body Politics, Empowerment.

Chapter 1 Introduction

1.1. A Prologue

"I really didn't feel anything about the abortion because it was impossible for me to bear the expenditures of another child. Although everyone warned me, I stood by my decision." [Sheela Parvin(30), Interviewed on August 2016, translated]

"Of course I felt like I was committing a sin, and that I should not do this. People would see me in a negative light if word of it got out. But, unfortunately we did not have the money to raise another child and had to do it."[Salma Akter(60), Interviewed on August 2016, translated]

In these quotes two Bangladeshi urban women have undertaken an abortion due to similar reasons, but their reflections show very contrasting emotions. My RP explores what those differences in experience and emotions are about. Sheela is a readymade garment worker in her early 30s, recently married and had an abortion in 2015. Salma is a widowed homemaker in her mid 60s who had an abortion back in 1986. Both women live in urban Dhaka, and took the decision to have an abortion because of financial constraints in consultation with their spouses. They both accessed the service at a nearby government health center. But there is a stark difference in their attitude towards abortion. Salma has an apologetic approach when talking about her abortion experiences thirty years ago, whereas, Sheela, thinking about her recent abortion has a confident tone and is clear the decision was the pragmatic one given the context. My interest is about the change in attitudes of these women regarding abortion. Is this an example of historical attitude change among the two different generations in Bangladesh? If so why?

Unwanted pregnancies and the means of ending them have existed for centuries. Today abortion is a common gynecological experiences across all geographic locations (Kumar 2009) but the impact of abortion on women, families, communities and societies differ drastically. In Bangladesh, abortion is legal but highly restricted. The current abortion law in Bangladesh is based on highly restrictive British Colonial law, written in 1860, that permits abortion only if the mother's life is in danger (Council of the Governor General of India 1860). Abortion is not permitted: to preserve physical health, to preserve mental health, because of rape or incest, fetal impairment, or more broadly economic or social reasons. However there is a medical procedure which the government terms Menstrual Regulation (MR) which involves vacuum aspiration to bring on menstruation (and end any pregnancy) which is legal in the first trimester. Doctors can perform the intervention up to ten weeks, paramedics are allowed to provide up to eight weeks after the woman's last menstrual period.

MR has been part of Bangladesh's national family planning program since 1979. In 2010, an estimated 653,100 MR procedures were performed in health facilities nationwide. Two-thirds of the procedures were performed in public facilities, including Union Health and Family Welfare Centres. The annual rate of MR was 18.3 per 1,000 women aged 15–44. Nationally, the annual abortion rate was 18.2 per 1,000 women aged 15–44 (Vlassoff 2012). According to an investigation report published in Dhaka Tribune, despite the legal provision, unsafe abortion continues to take place, especially in cases where girls become pregnant before marriage. In

Dhaka, there are at least 2,000 unregistered places where late abortions are performed and in many cases, these procedures are undertaken by traditional birth attendants or nurses and statistics show an estimated 572,000 women suffer from complications arising from unsafe abortion every year (Dhaka Tribune 2013). Number of abortions in the capital has been increasing and the rate is alarming in recent years. The exact number is impossible to find because most of them are done illegally (Islam 2014).

Background to the Research Problem: SRHR in Bangladesh

The policy of Bangladesh legalizes MR but criminalizes abortion. The different nuanced meanings of MR in the past four decades, its service provision, limitations and strategic usage require a comprehensive study that brings in women's perspectives. On the surface, the problem seems one dimensional- the legality and illegality of abortion. However, the complexity encompasses more than just the issue of legality. Legal restriction on abortion jeopardizes women's health but their relationship to social pressures of secrecy, denial and discrimination requires more scrutiny (Kumar, et al. 2009). Evidence based and women-centered knowledge from women's narratives allow us to understand in more depth MR and the change in women's attitude towards MR over generations. In MR Service provision, three actors are involved - state, service provider and the potential client or women. The level of knowledge, attitude and practices of these three actors regarding MR and the women's ability to access or not the services are interlinked. I am interested here in several questions: What knowledge do the policy makers possess about MR, whether the state legislation and policy makers perceive MR only as a health and population control issue or as a tool to control women's body, what is the attitude of state towards women's rights and reproductive health and rights issues and what are the international policies and conventions the state wants to be part of, what kind of training the state provides to the service providers- all these directly affect the women's MR narrative and experiences.

Recent MDG report states that Bangladesh has achieved great improvements in the field of maternal health. Maternal Mortality Ratio (per 100,000 live births) has fallen to 170 (The Maternal Mortality Estimation Inter-Agency Group 2013) which was 575 in 1990. The condition of contraceptive prevalence rate (%) shows the same where it has been increased by 62.4 per cent (Bangladesh Demographic and Health Survey 2014) from 39.9 per cent in 1990. In the policy arena Bangladesh took a gender sensitive approach with enactment of Bangladesh Women Development policy with an aim "to establish gender equality in politics, administration, other areas of activity, socio-economic activity, education, culture, sports and in all areas of family life" which shows how the discourse of policy has changed over the years (Ministry of Women and Children Affairs 2011).

Shuchi Karim's (2012) recent study on Bangladesh middle class women's sexuality confirms also an improvement in women's lives. She points to increasing participation in higher education, more financially secure jobs, and the possibilities for women to move out of family homes to different cities, countries and continents. "These movements are having a profound impact on their expressions of self and their sexualities. The discourse of middle class Bangladeshi sexualities has moved from being only stories of victimhood, discrimination, and oppression to narratives of aspirations, strategies and empowerment", as Karim suggests, there exists "multiple,

ambiguous, paradoxical 'sexual spaces' within the middle class family-household, socio-symbolic worlds within which diverse sexual desires, identities and practices can be accommodated" (Karim 2012:14).

Going deeper into these findings, the research looks at whether these improvements in changing knowledge and attitude towards SRHR has led to a generational shift regarding MR services among urban women over the last 40 years.

This research explores the changes in attitudes towards Menstrual Regulation (MR) between two different generations, represented by Salma and Sheela in urban Bangladesh, and to look at these changing attitudes and changing stigma. I do so in the context of the policies related to MR and SRHR in Bangladesh of the past four decades. I look at these questions by using feminist theory intergenerational and intersectional methodology to investigate the first person narrative of women. I do so in order to provide an evidence based critical understanding of urban Bangladeshi subjectivities and their own experience in negotiating services as they navigate the difficulties around having to undertake MR.

Overall Objective

The overall objective of the research is to understand intergenerational change in urban women's attitude towards and their experiences of MR services in the context of Bangladesh over the past four decades.

The main research question is:

- Has there been an intergenerational change in perspective, knowledge and experience of married and unmarried urban women about MR over the period of 1971-2016?

Sub-questions:

a) What is the level and source of knowledge of urban women (married and unmarried) about MR and SRHR issues?
b) What is the perception of urban women (married and unmarried) about MR and SRHR issues?
c) What sorts of stigma exist among urban women about MR?
d) What are the factors that influence the MR seeking experience of urban women (married and unmarried)?

1.2. Outline of the RP

Following the introduction I set out in the first chapter my theoretical approach along with the methodology including rationale and use of the different methods, my positionality as a researcher and the constraints and feasibility of further research on MR. This chapter also sets the introductory context of MR and abortion in Bangladesh that gives birth to some questions which I have specified in the objectives of this RP.

The second chapter reviews the history of MR in Bangladesh and illustrates and how attitudes and stigma change among women according to marriage status, age, class, and education. This chapter also illustrates the major changes in policies, remarkable initiatives and movements that took place and helped in shaping the current status quo in the health and women's rights sectors of Bangladesh.

The third chapter focuses on narratives of respondents from four decades – their knowledge about SRHR issues and the sources of their information. It looks at their experiences and the difference in environment and quality of service that they have received. This chapter also depicts the stigma, social norms and other constraints and impacts women has to go through while opting for MR and a comparative analysis of different generations and socio-economic classes over the past four decades has been also included in the chapter.

The fourth and final chapter concludes the study by looking at the changes over time between the two different generations. It also suggests a way forward based on the study done in the RP.

1.3. Theoretical Approach

> "…in societies stratified by race, ethnicity, class, gender, sexuality, or some other such politics shaping the very structure of a society, the *activities* of those at the top both organize and set limits on what persons who perform such activities can understand about themselves and the world around them" (Harding 2005:221)

My research is qualitative and feminist in approach. A feminist approach to research raises philosophical issues of ontology and epistemology. In this research I delineate a method of constructing knowledge effectively from the experience and insights gathered from women (in this case two generations of Bangladeshi women. I am guided by critical theory that is aimed at creating social change to gender norms. Coming from a mixed background of Humanities and Social sciences, I recognize the power of narratives and subjectivity in knowledge production process.

Feminist Standpoint Theory

In this study, I aim to analyse the standpoint of Bangladeshi women of different socio economic classes. I am interested in the knowledge that emerges primarily from the women's actual experiences, Empirical observation therefore guides my research and the methods and I use feminist stand point theory to analyse the data gathered. This feminist empiricism is embedded within a feminist standpoint epistemology (Harding 2004). In other words, to explain the effects that different kinds of experiences have on the production of knowledge by women, I use standpoint epistemology. In this approach the standpoint of women of different classes is understood as knowledge coming from the women's class based, generational and emotional embodied experiences. Knowledge on bodies is "irreducibly interwoven" (Harcourt 2009:22) with social, cultural and economic discourses and are cultural products on which "the play of power, knowledge and resistances are worked out" (Harcourt 2009:22). Keeping in mind the argument "the languages through which knowledge is produced and deployed within feminism affect the representation and strategic employment of that knowledge" (Cornwall et al. 2010:6), instead of treating women as a simple, singular point of empirical knowledge-gathering, I examine their situated narratives as complex and contested. I take up the proposal of Andrea (Cornwall 2010) that feminist attachment to certain ideas about what is needed to improve women's lives needs to be analysed in terms of the affective power of the deeply held beliefs about women that that is encoded in gender myths and feminist fables. My work aims to decode the gender myths and fables around MR in Bangladesh in the historical time period I am covering but looking carefully at women's experience and understanding of the impact of the experience on their lives.

My aim is to employ feminist empiricism in order to draw situated knowledge from first person narrative of women in order to look beyond the homogenizing version of 'third world' Bangladeshi women within gender and development analysis.

Feminist Standpoint Theory has enabled me to explore how MR is experienced and practiced. In Harding's words "Starting off research from women's lives will generate less partial and distorted accounts not only of women's lives but also of men's lives and of the whole social order"

(1993:56). This theory can be traced back to Marxist theories that looks to the proletariat narrative as a better research framework than the conventional or bourgeois narrative. Feminist Standpoint Theory sees women's views as important in understanding the histories of social embodied behavior. As Harding explains " to see beneath the appearances created by an unjust social order to the reality of how this social order is in fact constructed and maintained" (1991:127). To do this, we need more than just a perspective- we need a "women's standpoint" that argues for women's narratives as starting point of enquiry. As the research deals with MR issues in Bangladesh, the feminist standpoint takes into account the women in the society and analyse their embodied experiences accordingly. This framework also allows us to understand the specific context of Bangladesh with regard to gender inequality. A woman's experiences with MR in Bangladesh are radically different from other contexts, particularly those of the global North. The research aims to give voice to Bangladeshi women in order to generate a compelling account of MR in Bangladesh from women's perspective, and in a way that enables the women who have participated in the research to have agency over the narrative.

Intersectionality

The concept of intersectionality also informs my work. Intersectionality is used in critical social science theories to describe the ways in which oppressive institutions (racism, sexism, classism, ability, ethnicity, among others) are interconnected and cannot be examined separately from one another. Applying intersectionality in the context of policy allows researchers and decision makers "to move beyond the singular categories that are typically favoured (e.g. gender, 'race' and class) in policy analysis to consider the complex relationships and interactions between the aforementioned trinity and other social locations and identities…" (Hankivsky et. al 2012:18). The RP applies intersectionality approach to analyze information regarding Sexual and Reproductive Health Rights and MR issue in order to find patterns that can define how different forms of oppression intersect and impact women in diverse ways. Iyer et al (2008) point out that class is a gendered phenomenon and the rising health care costs are more severe for women of lower classes. Therefore costs of health care need to be understood by examining the intersections between gender and class, and their impacts on women's health status and health care access. In the sample population for this research, there are women of different socio economic classes and women from different generations as well as belonging to different marital status and religious identities. Using intersectionality I can look at the reproductive health rights and MR issues pattern across different classes, religions and generations in order to see if there are any similarities or differences in the experiences.

As class, race, gender, age and ability (among others) define our individualities I cannot just measure 'women' as if all women belonged to a "homogenous, unconnected and static" group, rather 'women' are a "dynamic, intersectional and fluid" (Manuel as cited in Hankivsky et. Al 2010:16) entity whose experience of oppression varies. The RP aims to comprehend what is created and experienced at the intersection of different axes of oppression regarding women's reproductive and sexual health, using intersectional approach to analyse narratives of women from different class, age, religion and marital status in order to recognize "the multidimensional and relational nature of social locations and places, lived experiences, social forces, and overlapping systems of discrimination and subordination" (Hankivsky et. al 2010:3). The RP aims to unearth the differential effects of SRHR and MR related state policies on women from

diverse economic background, age, marital status and religion in a patriarchal Bangaldeshi urban context, in order to examine how power relations are maintained and reproduced. In this examination I look at how different women resist and challenge the oppressing system navigating through the existing social norms. Intersectionality analysis, following Bauer (2014), opens up "the potential for examination" between "dimensions of oppression or privilege" across these different levels.

Sexuality, Body Politics and Development

Sexuality has become part of different development approaches and debates over the past decades (Harcourt 2009). As explained above, I am taking a feminist theoretical approach to dissect the social issues regarding women's lived experiences of sexuality and decision making in relation to MR in women's lives in Bangladesh. Key to my understanding of these women's lives is how women are aiming to overcome gender inequality which I examine through participatory methods and reflexivity that take into account my participants and my own experience and action.

Women's involvement in body politics - fighting for reproductive and sexual rights has been central to the framing of gender and development policy since the 1980s. While development discourse has a history of looking at sexuality within a reproductive and sexual health or rights-based approaches, feminists/activists (Harcourt 2009; Correa et al. 2008; Cornwall and Jolly 2006), have criticized these existing discourses and approaches to development that target women as objects rather than subjects (with agency) in development policies. Bangladesh has been part of global development projects that target women, often ignoring their own needs and lived realities. This research instead uses a feminist approach in order to challenge the hegemonic narrative on women's bodies in Bangladesh. The framework, as explained above, seeks out women's own narratives and analyzes their experiences and actions in order to challenge hegemonic understanding of the female body. In medical discourse the body is objectified by the researcher reduced to a number, or a body without agency. A feminist approach instead looks at how bodies are regulated by medical discourse. In seeking out women's stories the researcher also challenges the methodology that puts distance between the researcher and the researched (Taylor 1998:379). Since our "embodied realities implicate our understanding of bodies" it is important to realize "which bodies are producing knowledge about which other bodies" (Harcourt 2009:13). The method of listening and acknowledging the women's own experience is very important to challenge the hegemonic medical discourse informing development practice. Hence the importance of interviewing the respondents on their own embodied experiences of MR.

Medical discourse is part of the patriarchal gaze and regulation of women's lives. According to Kabeer (1994) gender inequities are built into the structure of families and national government hierarchies. The gender and development discourse with its shift in focus from women to gender recognizes that patriarchy operates "within and across classes" and advocates for "strengthening women's legal rights" (Visvanathan 1997). However, gender analysis had become "counter-productive" in some cases as it has been used to "side-step a focus on women and on the radical policy implications of overcoming their disprivilege" (Jackson and Pearson 2000:21). Power relations may appear so "secure and well-established" in the patriarchal edifice of society that

subordinate groups are often incapable of imagining "alternative ways of being and doing" (Kabeer 1994). Through feminist analysis I aspire to draw attention to the fact that "social rules, norms, values and practices" (Kabeer 1994) play crucial role in concealing the pervasiveness of male dominance and any attempt at empowerment have to consider the trade-offs women make to cope with the results of oppressive relationships experienced in their lives.

1.4. Positionality of the Researcher

As discussed above, in reference to feminist standpoint theory, good empirical investigation does not require that we remove ourselves entirely from the subject, indeed there is no such thing as value free objective study as imagined by the scientific method. It is important to recognize researcher-subject relation, and to try to blur lines between subjectivity-objectivity. There exists an inter-subjective realm in which both reside: in contemporary life history research the researcher is visible, and a reflexive stance can actually enhance the research (Karim 2012). Cole and Knowles (2001) underline that the principle of life history research is the relation between the researcher and informant (based on ethics, sensitivity, respect and trust). This includes mutuality where both researcher and informant are clear about the process and outcome of the research – including discussions of confidentiality and risks; as well as developing empathy through reflexivity. My positionality as young childless divorced woman from middle class Bengali community made me both an "insider" as well as "outsider" to the respondents. Older women were hesitant due to my age and the natural habit of not explicitly talking about such sensitive issues. They were struggling for "proper" words such as scientific terms of menstruation, abortion, MR and so on. They were consciously trying to avoid the local terms used for such phenomenon as if it would demean their status in front of a female researcher who seemed to belong to their social strata but was also different from them due to my educational degree and as a researcher from a foreign university.

1.5. Methodology

The attitude, level of knowledge and experience of services of the two generations of women, is examined taking into account the marriage status, age and class. The study interviewed 40 respondents clustered into two generations - Pre 90s generation and Post 90s generation. The "Pre 90s generation" of women are those who underwent MR during the period of 1971-1990 and the "Post 90s generation" will be used to refer to women who experienced MR in the period of 1991-2015.

The division of the different generations has been done based on the SRHR policy landscape of Bangladesh. As Bangladesh grew economically through the rapid growth of the ready-made garments industry during the 1990s(Mandle 2013:1); family planning policy was tailored to meet the rising change in family dynamics as women were hired as garments workers in a higher number than men(Nazneen, et al., 2011:11). This change in gender parity gave women greater economic independence more equality in decision making in the family planning process. Government policy in the 1990s entwined development policies with family planning. The resources allotted to family planning increased and the government also sought to seek NGOs

and Private sector to go with the government policy narrative (Randall 2012:6). See below for more details on these changes.

The methodology chosen looks to understand how the women, who experienced these policies themselves, are regarded as subjects rather than objects of the policy. The focus is on how they negotiated and navigated through the provisions that were available. Having listened to these women's concerns the RP then has the evidence to analyze how the changes in policies translated into qualitative change in attitude and service seeking behavior of the women.

Methods

My primary investigation is about the change in women's knowledge, experience and attitude about MR in last four decades. I collected data in a visit to Bangladesh during the months of July and August, 2016. I have used the following methods to collect data to explore these changes:

a. Oral history

b. Semi-structured guided interview

Participants in the study

I have interviewed a total of 40 women, amongst which, eight respondents have reported going through an MR in the 1981 – 1990 time interval. Data on MR undertaken between 1991 and 2000 have been collected from 13 women. 11 respondents had undergone MRs during 2001-2010 and eight in the last six years – from 2011 to 2016. Three out of 40 women were pregnant out of wedlock while receiving the service; the rest were married at the time of the procedure. Private clinics were used by 15 women; home based services were availed by **one** of the respondents; while the rest sought government medical centers. Thirty Four (34) of the respondents were Muslims, five were Hindus and one woman identified herself as a Protestant Christian.

In Bangladesh class is a complex issue that does not solely depend on the income level of an individual,, it is also associated with social values, dress codes, friends, associations, relations, politics, religion etc. Karim explains,

"Middle class is not explicitly categorized in economic statistics in Bangladesh, and it is mainly understood as a self-identified class identity that one usually carries as part of family legacy. The spectrum of income capacity within the middle class is wide, and one can position him/herself at different income points at different stages of life" (2012:12).

In the study respondents have been categorized into class based on their self identification of belonging to a particular social class and their monthly income (in cases they were unemployed, the household income).

Monthly Income (BDT)	Socio-economic Class
Below 10,000	Lower Class

10, 000 to less than 20, 000	Lower Middle Class
20, 000 to less than 35, 000	Middle Class
35,000 to less than 50, 000	Upper Middle Class
50, 000 and above	Upper Class

Table 1: Income based socio economic classes

Table outlines the income ranges that have been used to classify our interviewees into their socio-economic hierarchy.

Total number of respondents: 40

Lower class	Lower middle	Middle	Upper middle	Upper
09	08	13	07	03

Table 2: Number of women of different classes interviewed

Table shows the numbers of women interviewed by class.

Three of the respondents had illegal abortions, as they were over time period allowed for MR. They resorted to undergoing the procedure illegally through private clinics, or at home with the help of a quack.

My sample size also incorporated a mix of women from older and younger generation, both married and unmarried:

Abortion in Pre 90s (Older generation)	Abortion in Post 90s (Recent Generation)
8 respondents	32 respondents

Table 3: Number of respondents of different generations

Married	Unmarried
38	02

Table 4: Married and unmarried respondents

I have selected the responses from three women and presented them in the form of oral histories. The respondents include a married woman (upper middle class) who had undergone a procedure in 1976, and two unmarried women (upper and middle class) between which, one went through an MR in 1995 and another in 2016.

Respondent Collection Techniques

As the personal experience of MR in Bangladesh is not widely talked about finding respondents had to rely on several techniques. To this purpose I reached out to women using the following entry points:

- Snowballing method

- Social network-based women's groups
- Friends and ex coworkers at Family Planning Association Bangladesh (FPAB)

Rationale of Three Oral Histories

The oral histories have been chosen according to the year the respondents had MR services in order to understand the changing attitude of these women towards MR across the generations and how their experiences differed from each other as they represent the narratives of both married and unmarried women.

The first narrative is of an elderly woman who had an MR procedure in 1976, as a result of financial and familial crisis. Although it was her own in-laws that influenced and supported her in going through with the treatment, subtle indications of judgment would be given from time to time from the same family members, in the form of jokes and indirect taunts. This reflects how negatively pregnancy termination was viewed in earlier times.

The second and third oral histories feature unmarried women – both educated and independent,. The second interviewee underwent MR in 1995 after failing to convince her (then) boyfriend to marry her. She went through immense emotional turmoil and felt guilt-striken and says she was disgusted with herself. She was also exiled from her house because of her pregnancy, although she was eventually taken back. Now married with two kids the woman looks back at her MR experience with much guilt.

The third oral history recounts a similar but more liberated experience. It tells the story of a young woman in her early 20s (socio economic upper class) who considered sex to be a romantic endeavor and believes it is entirely a woman's choice to decide when to be a mother. Due to contraceptive failure she became pregnant and she 'googled' the different MR options before visiting her doctor. "I took the pills for MR on a weekend and resumed office next week. I'm not ready for marriage or children yet" she informed the researcher. As an energetic educated young woman she prefers to keep her MR a secret as most people in her environment would talk about her unwanted pregnancy in a negative way. "Why should I give people chance to judge me on my personal issues? My life, my choice!" she told me with confidence.

1.6. Methodical Challenges and Ethical Issues

Given the sensitivity of the subject it was very important to create an enabling environment during my interviews by assuring the women about the confidentiality of the information they shared with me

During the interviews, which were undertaken in Bangla, I used neither video tape nor audio recorder. I took handwritten notes which were later translated into English by the author for analysis. Five of the interviews were carried out by the others in my close network as the locations were outside Dhaka and unreachable during the short period of the field study. As guidance the interviewers were briefed about the research purpose and given the semi-structured questionnaire which was used for the interviews. Respondents were assured that all the

information will be used for research purpose only. Since MR is an intimate experience and painful issue for women to reflect on, some of them were tearful when being interviewed and needed psychological counseling afterwards. A psychiatrist/counselor from Dhaka Medical College was referred to in two cases.

1.7. Limitation and Scope of Further Research

The study should be taken as a microcosm rather than a complete picture of MR in Bangladesh. The focus is on a handful of women's lives in urban areas in Bangladesh. In order to get more elaborated picture about change in knowledge, attitude and practices regarding MR throughout four decades, the study would need to be done much more broadly. More in-depth data would allow a more in-depth conclusion. Such a study requires ethnographical approach, so that emotions, feelings, experiences of women could more carefully depicted, but this would have required much time than the five months allowed for the RP. The study is qualitative in nature though in the future a qualitative study could be conducted on this topic in more areas and with a larger sample size. This study covers respondents only from urban areas, a study that includes both urban rural and urban areas would allow for an interesting comparative analysis. In this study, women are the sole respondents but if could, the attitude of men in order to understand the gendered change in social structure throughout four decades, could be more interesting.

Chapter 2 History and Demographic Context of Bangladesh[1]

In this chapter I will give an overview of Bangladesh focusing on trends in fertility and age of marriage, changing trend of urbanisation and its impact on women, maternal mortality rates and trends in women's reproductive health status. I will also give an overview of family planning policies and MR research in Bangladesh exploring how MR issues have been treated at the academic and feminist level. The chapter also includes a snapshot of feminist movements in the past four decades in Bangladesh.

2.1. Demographic Context of Bangladesh

With increasing migration, population of urban women is on the rising trend in Bangladesh. The following table shows urban woman population by division, along with the sex ratio (male to female ratio) in 2011:

Division	Enumerated Female Population 2011 in thousands	Sex Ratio
Bangladesh	71,064	100.3
Barisal	4140	96.8
Chittagong	14,316	96.1
Dhaka	22,915	103.9
Khulna	7,781	100.0
Rajshahi	9,146	100.4
Rangpur	7,840	99.8

[1]Located in South Asia, Bangladesh covers an area of 147,570 square kilometers. The total female population of Bangladesh in 2010 was 74.91 million (Bangladesh Bureau of Statistics 2010). Population density by nation has been consistently increasing globally during the past 45 years. Bangladesh remains as one of the geographically smallest nations but one with the largest population density. In 2015, Bangladesh had 1,237 people per square kilometer of land, making Bangladesh one of the most densely populated nations globally (The World Bank 2015).

Sylhet	4925	99.1

Table 5: Urban woman population by division, along with the sex ratio (Haque 2011)

Age-specific and total fertility rate (TFR), the general fertility rate (GFR), and the crude birth of urban and total population (2011) is as follows:

Age Group	Urban	Total
15 - 19	91	118
20 - 24	121	153
25 – 29	95	107
30 – 34	58	56
35 – 39	19	21
40 – 44	4	6
45 – 49	1	3
TFR (15 – 49)	2.0	2.3
GFR	76	91
CBR	20.6	22.6

Table 6: Age-specific and total fertility rate (TFR), the general fertility rate (GFR), and the crude birth of urban and total population (Haque 2011)

Percentage of urban married women using contraceptive is 64%, as opposed to 60% in rural areas. By division, in Barisal – 65%, Chittagong – 51%, Dhaka – 61%, Khulna – 67%, Rajshahi – 67%, Rangpur – 69%, Sylhet – 45% (Haque 2011). The different measures of fertility rate such as TFR, GFR and CBR are crucial to my study as many respondents have stated unplanned pregnancies as their main reason for undergoing abortion/MR. Use of contraceptives by and large affect the rate of abortion/MR and thus the above statistics is of great importance to my study.

Trends in fertility total fertility rates by division in 2011 are

Barisal	2.3
Chittagong	2.8
Dhaka	2.2
Khulna	1.9
Rajshahi	2.1
Sylhet	3.1

Table 7: Trends in fertility total fertility rates by division (Haque 2011)

Marriage generally occurs early for women in Bangladesh. Among women aged 20-49, 71 per cent are married by the age of 18, and 85 per cent are married by the age of 20. Women in rural areas marry even earlier, with approximately 75% of the girls being married before the age of 16, and only 5% being married after 18 years, which is the legal age of marriage for females in Bangladesh. (M Rahman et al. 2008).The average age of marriage for women in urban areas is 16.2 as opposed to the rural areas, where it is 13.7 (M Rahman et al. 2008). Bangladesh Demographic and Health Survey (2014) analysis depicts a steady increase over the last three decades, in the age at which Bangladeshi women have their first marriage. The median age at first marriage among women age 20-49 increased from 14.4 years to 16.1 years in the period 1993-94 to 2014 (Mitra & Associates 2014).

Trends in fertility in Bangladesh since the early 1970s can be examined by observing a time series of estimates produced from demographic surveys fielded over the last four decades, beginning with the 1975 Bangladesh Fertility Survey (BFS). The Total Fertility Rate (TFR) declined sharply from 6.3 births per woman in 1971-75 to 5.1 births per woman in 1984-88. This was followed by another rapid decline in the next decade resulting in an average drop of 1.8 births per woman. In the 1994-96 periods, there was an average of 3.3 births per woman. The TFR declined further by one child and remains at 2.3 births per woman (Mitra & Associates 2014). The average household size in the time period 2005-2010 had decreased from 4.85 children per household to 4.5 children per household (Bangladesh Bureau Of Statistics 2010).

Close to half of Bangladeshi women (48 percent) have given birth before reaching age 18, while 70 per cent have given birth by age of 20. The survey also states that delayed childbearing is strongly related to education among women age 15-19 years. However, 18 percent of teenagers who completed secondary or higher education in Bangladesh have begun childbearing compared to almost half of those with no education (48 %) (Mitra & Associates 2014).

Overall mortality rate among women of reproductive age has declined mainly due to increase in proportion of deliveries by medically trained providers. Maternal mortality declined from 322 in 2001 to 194 in 2010 (MICS), a 40 percent decline in nine years. 43.5% of women age 15- 49

years with a live birth in the last 2 years were attended by skilled health personnel in 2012-2013, from 24.4% in 2009.Use of institutional delivery facilities, improved ante natal care (ANC) and post natal care (PNC) and Information, Education and Communication(IEC) have yielded progress but challenges remains in reproductive health care.

These statistics show an average which suggests that despite seeing improving indicators in the urban areas, rural areas continue to lag, and drive the national average upwards.

2.2. Family Planning Policies and MR Research

During the tumultuous East Pakistan period (1947-1970) the country went through major political upheaval which impacted on sexual and reproductive healthcare as programs that were not funded even if there were such programs since the 1960s (Choudhury et al., 1987:373). As a result there were poor family planning services in East Pakistan (Bradley et al. 2009:6).

East Pakistan government supported one form of contraceptive which was the "intrauterine device" (IUD) which was not effective. Slowly there was growth in the use of other forms contraceptives (Cleland et al. 2006; Choudhury et al. 1987). According to the government policy from 1960 to 1964, clinic centric family planning was offered but it had very little impact. During 1965-70 there was the field based approach with full time staff assisting a part time village organizer known as '*dai*' or traditional mid-wife in rural Bangladesh. This effort was eventually shuttered due to the war and the East Pakistan family planning program (Randall 2012:5).

When the new nation of Bangladesh emerged from war in 1971; development in family planning was a paramount priority for the government and development aid actors(Cleland et al. 2006). From 1972-74, the government made family planning program the responsibility of the Ministry of Health.

This history and its subsequent story is set out in Table 8:

History of SRHR in Bangladesh

Time Period	Policies	Core Points	Constraints (If any)
1972-1974	Post War Abortion	Due to gender crimes during the 1971 war, the Bangladeshi government had legalized abortion for a short period, so that victims could terminate their pregnancies. This was the only time when abortions were legal in Bangladesh. The procedures were carried out by untrained personnel, after desperation calls. This period is viewed as a dark part of Bangladeshi history. (Hirsch 2012)	
Before 1975	Government Stabilization Policy	Aimed at recovering the nation from a fatalistic increase in birth rate as a result of the Liberation War. Involved training of doctors and female community health workers, and distribution of family planning commodities.(Randall 2012)	
1975	Contraceptive Distribution Project	A top down approach on making contraceptives available. Basically, already existing government-sanctioned family planning services minus the irregular visits from health workers. (Randall 2012)	
1975	Maternal and Child Health Program	Multi-sectorial program involving mass recruitment of full-time field community workers. Launched on account of Matlab approach working better than clinical approach. (Randall 2012)	
1976	Introduction of the first Bangladesh Population Policy	Ultimately aimed at lowering the birth rate by the propagation of modern contraceptives. Community based healthcare workers were to target the population and enact the policy in reality. (Randall 2012)	The policy was thought to be colossal task for newly independent nation. The SRHR aspects were not as pronounced during this era, women and gender were untouched altogether.

1977	Family Planning Health Services Project	Distribution of versatile contraceptives like IUDs and sterilization. (Randall 2012)	
1975 – 1977	Comparison between CDP and FPHS	Matlab district was divided into two: Treatment Area (TA) receiving FPHS services and Comparison Area (CA) receiving CDP. TA was better than CA. Under TA, 1) fortnightly visits by health workers, 2) Family planning and Contraceptive (both temporary and permanent) advice were provided. Resulted in lower fertility and child mortality rate. (Randall 2012)	
1980s	Expansion of the services under the criteria of the existing policy	This period was the encouragement of the NGOs into this sector. "Multi-dimensional" approach was taken to cover the broad aspects of family planning program. This period also saw the expansion of SRHR services such as MR being provided to women. (Randall 2012)	The gender and women aspect of the policy still lacked behind, even though there had been efforts by the NGOs to bring this to light.
1980s	National Council for Population Control	Aimed at ensuring high-ranking government officials have major control over policy narrative. (Randall 2012)	
1985	Broad-scoped Family Planning Program	Access to satellite clinics in distant and rural areas, where normally government clinics could not reach. Increased involvement by the community leaders and NGOs. (Randall 2012)	
1970s to 1980s	Establishment of Women Development Broad and Expansion of its programs	After the liberation war, the rape survivors were given rehabilitation in an ever conservative society. Afterwards, the Women Development Board was established to take care of the issues that surrounded the rape survivors. It later sought to cover employment opportunities of women and in turn give them self-reliance.	As a post-war period, the development was limited to the rehabilitation rape survivors and eventually women's employment. The policy was missing in action as it was not in the development agenda at that period

		(Randall 2012)	
1990s	Involvement of Public Media in Family Planning	1) A campaign was undertaken to increase male decision making about contraception through TV, radio, movies and mobile vans. 2) Harassment of female community health workers was decreased using a character in a soap opera, Laila, who worked as a community health worker. (Randall 2012)	
1990s	The improvement of the services under the purview of the existing policy	This period saw enhancement of the services provide in terms of family planning and SRHR. Concerted effort on public-private partnership in helping push the boundaries of the existing policy. (Randall 2012)	This period saw enhancement of the services provided in terms of family planning and SRHR. Concerted effort on public-private partnership in helping push the boundaries of the existing policy.
1994	National Child Policy	Ministry of Women and Children Affairs initiated National Child Policy mentioning only a little on child marriage, early pregnancy and maternal mortality, though there are a strong relation among these but linkage was not established there. (Ministry of Women and Child Affairs 1994)	
1990s to 2000s	Adoption of Convention of the Elimination of All Forms of Discrimination Against Woman (CEDAW) and MDGs	CEDAW paved a pathway for the government to development their policy on women's development in the country. The eventuality of MDG and the prospect it had for the overall developmental of the country caught the government's scopes. This resulted into the government understanding their importance of gender equality. (Banu 2012)	The developmental nature of the policy making did the address the issues in a complete manner. The policy itself was not being developed at that time, even though this was the starting point
2003	Introduction of the 2004 Population Policy	This policy saw the updated clause that took years of research to establish the growing developmental needs to the government. (Ministry of Health and	The language used in this policy was a conservative coalition government and even though they attempted to meet the MDG gender

		Family Welfare 2004)	standards. They did address the issue comprehensively to make an impact
2003	National Youth Policy	Ministry of Youth and Sports formulated National Youth Development Policy-2003 for the development of youth by involving them in different types of activities. This policy described different objectives including providing pragmatic and vocational training for employment generation; involvement of youth in different social services like vaccination programs, halting HIV/AIDS programs; equal opportunity of male and female in decision making process in local and national level; and providing training for youths to ensure good health and human rights for them. This policy identified some problems with youth such as drop-out from education, taking drugs, prone to HIV/AIDS. Besides, this policy briefly described rights and responsibilities of youths. (Department of Youth Development 2003)	
2011	Introduction of the first Women's Development Policy	This policy sought the meet the growing gender inequality in the country that the women faced for decades. It sought special budgetary concession on training of the governmental, judiciary and security offices. This also closed the gap on clearing defining the role on women in the public space and society. It also sought to gather research data to advance the future plans in sight of the government. (Ministry of Women and Child Affairs 2011)	As a first time policy, it covered a lot of the issues but it still did not cover by glaring issues in governance in the grass root level and the issues women face in today's Bangladesh. As a developmental centric policy, it only seeks to do the bare minimum required to meet the international standards.
2011	Social Marketing of	Retail shops were used to increase availability of contraceptive commodities to men and women alike.	

	Contraceptives	(Ministry of Women and Child Affairs 2011)	
2011	National Child Policy (Revised)	From the shortcomings of previous policy, a revised National Child Policy was enacted where gender equity was ensured by addressing girl child and their rights in education and other sectors. Issues like protection of child marriage and adolescent sexual reproductive health rights were also emphasized. (Ministry of Women and Child Affairs 2011)	
2012	Entanglement of family planning policy with development policy on account of increasing female garments workers.	1) Resource allocated to family planning was increased. 2) NGOs and Private sectors were made to be involved with government policy narrative. (Randall 2012)	
2012	Introduction of the 2012 Population Policy	This is the first policy of kind to address the SRHR, Gender Equality in a comprehensive manner. This as many policies of the government are linked to the developmental agendas set by the government. Even though the policy address many lingering issues in a broad manner. It left many issues such as abortion rights and burden of family planning responsibilities in a grey area legally which hinders progress that they are themselves trying to achieve. (Ministry of Health and Family Welfare 2012)	
2015	National Youth Policy (Draft)	This policy is the outcome of the different backdrops of 2003's policy.. Whereas, sexual reproductive health right is a major issue for present times, but previous policy mentioned only a	

		little on this regards. Besides, the matter of gender sensitivity was highly challenged in that policy. Family planning programs awareness provision are made in this policy, this policy also includes awareness of STI/STD's, how unwanted pregnancy can lead socio-economic downfall for a youth and spreading knowledge about reproductive health and sexual health. (Department of Youth Development 2015)	
2015	Sustainable Development Goals (SDGs)	After the MDGs time period (2000-2015).SDGs set up a total 17 goals including zero poverty; zero hunger; good health and well-being; gender equality and so on. While the goal 'good health and well-being' states that only half of women in developing countries have received the health care they need, and the need for family planning in increasing exponentially, while the need met is growing slowly-more than 225 million women have an unmet need for contraception. So, GoB considers this issue serious for the development of the country. (General Economics Division 2015)	

Table 8: History of SRHR in Bangladesh

2.3. Feminism and Women's Rights Movements

Governmental Policies on SRHR deeply affected the Bangladeshi women. The women's rights movement throughout its history from the 1970s struggled for the liberation of Bangladeshi women fighting the conservative patriarchal narrative. The move towards women's empowerment has been slow, but policies now recognize gender inequalities and Bangladeshi feminist movements have managed to continue despite the harsh conditions.

From 1970s feminist movement began in Bangladesh in response to the rape victims of the liberation war of 1971. Around 25,000 women became pregnant due to the this use of rape as a weapon of war and form of terrorism. Many suffered from crude self-administered abortions, others committed suicide, or infanticide (Hirsch 2012). Bangladesh government recognized the victims as "*Birangona*" or war heroines in order to give a social value on their sacrifice. The government provided medical aid, including treatment of diseases and the abortion of unwanted pregnancies, and in addition rehabilitation centers were set up.

Despite these emergency measures, in the 1980s, the situation of women's rights in Bangladesh was not strong. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), an international treaty adopted in 1979, became a rallying cry for the women's movement even if it was not always respected despite the women's movement's long painstaking and diligent work for these rights (Banu 2012).

The subject of body politics emerged in the 1990s around the issue of reproductive health. and rights. The idea of women's body as site of resistance gained momentum in this period, by demanding choice and access to information regarding alternative contraception and standing against state population control. Body politics also included the question of 'prostitution' and 'sex work'. Demanding rights to livelihood and recognizing 'sex work as work' during the late nineties was one of the most controversial public campaigns in the late 19990s. In the year 2000, a High Court declared 'sex work' a legitimate profession. Another revolutionary legal gains of women's movement was direct election in reserved seats in national parliament and local level in 1997 (Banu 2012).

Entering into free market economy in the early 1990s, Bangladesh became more globally integrated and so did the voice of women. A 'third-wave movement' in Bangladesh joined the global feminist movement (Walker 1996) with a campaign against violence against women including domestic violence, physical abuse and sexual harassment. Alongside these struggles, women were lobbying for more political and economic power as part of their struggle for empowerment..

After 2000, use of Internet and other communication technology shaped women's right movement in Bangladesh into an international one. By adapting 'Millennium Development Goals' (MDGs) many Non-Governmental Organizations (NGOs) shifted their focus to Goal 3 of the MDGs 'Promoting Gender Equity and Empowering Women' (United Nations 2015).

At this point of time issue of body politics was raised in different ways within the women's right movement of Bangladesh. The "violated bodies", "reproductive bodies", "productive bodies",

"sexualized bodies"- all were some debatable, discussed, and pronounced agendas in different times (Harcourt 2009).

Today more women in Bangladesh speak out in favor of complete agency in terms of entitlement (social, political, economic and physical). From this we can conclude that Bangladesh is highly integrated into global world with its physical and social infrastructure, and the Bangladeshi women's movement is linked closely to western feminism.

2.4. Bringing in Urban Women's Narratives into MR Literature

Though SRHR has been an important human right issue especially after 'International Conference on Population and Development (ICPD)' in the 1994, researchers on SRHR issue in Bangladesh were able to speak only about demography, family planning and women's health issues. Most of the MR research was done under the subject of obstetrics and gynecology. The opening up of discussion and research on sexual and reproductive health in both academic and non-academic study is a recent phenomenon. Research done by Suchi Karim and Runa Laila focused on the sexuality and reproductive health practices individually can be identified as the cursor for the new exploration into these topic in Bangladesh. As a conservative society, even the research field is not often explored as they intend to expose the conservative narrative that underlies the society around.

After the waiver of abortion law immediately post independence war in order to allow unwanted pregnancies from rape during war, the concept of MR was introduced into Bangladesh. In 1974, the government started to increase awareness and accessibility to MR in selected urban clinics with the purpose of birth control so that families had a backup in case of failure in contraceptives (Piet-Pelon 1994). Women who avail MR are profiled to be more likely from urban areas and from wealthier family background (Vlassof et al. 2012). The two most important factors that influenced the decision to get MR were to avoid unwanted pregnancies due to financial hardships of raising a child (Islam 2004). Some of the major barriers faced by women to access MR services are fear and objection from families and husband, but many also claimed cost, distance from centers and lack of information about the services act as obstructions to availing MR. There are also limitation of gestational age that acts as a factor behind refusal of such services (BMA 2014)

The issue of MR has largely been researched under the broad umbrella of population science and has been looked upon strictly as a women's health issue rather than from women's rights perspective. Looking at the population size of women in Bangladesh, it seems apparently appropriate to look at MR as a health issue. It is due to the fact that many women who are on the verge of borderline economic sustainability, having more child than their financial ability can cause health concerns for the woman and her family; this is why outlook on a health perspective is necessary in this paper. In the year 2013, a study has been conducted by Population Council titled "Introducing Medical MR in Bangladesh" with an objective to examine the feasibility and accessibility of introducing MMR through government and NGO providers in Bangladesh. This study looks at the health and population perspective of implication of MR and Medical MR where sexual and reproductive health rights are rarely examined (Yasmin et al. 2015).

The Population Council of Bangladesh conducted a series of studies on 'MR Impact on Reproductive Health in Bangladesh' which sees MR as one of the options for population management and the right-based issue was ignored. Health service provision is a big issue in Bangladesh. In a low resource and densely populated country like Bangladesh health management becomes the first priority for government instead of the right-based issues. It is, therefore, natural that the policy treats pregnancy as women's health issue and MR as a tool to address it. However, with the increased sense of agency and rights among women across Bangladesh the issue of dealing with MR from a rights perspective is emerging.

Recent studies by Bangladeshi feminist scholars explain why and how this rights perspectives is emerging. Karim's "Living Sexualities: Negotiating Heteronormativity in Middle Class Bangladesh" (Karim 2012) explains how sexualities are point of contestation and how women especially under the hegemonic narrative negotiate the heteronormativity that is imposed upon them. As study upon sexuality in middle class Bangladesh it shows; the average Bangladeshi women and men's negotiation with sexuality and how it affects their lives decisions. Runa Laila's thesis on "Reproductive Health Practices in Rural Bangladesh: State, Gender And Ethnicity" (Laila 2016) takes a look into the practices of SRHR in indigenous "Garo" communities in rural Bangladesh. In the purview of the research it explains a commonality between the urban and rural woman but are different in terms of negotiating due to the vast differences in cultural motivations.

Like other SRHR issues, in case of MR the widespread belief that experts know more than the clients of service themselves predominates. Therefore, the voice of women and their thoughts/knowledge about the issue are undocumented. Some studies do exist such as "Perceptions of Women about Menstrual Regulation Services: Qualitative Interviews from Selected Urban Areas of Dhaka" (Nashid & Olsson 2007), that provides analysis of perceptions of the women about MR and provide food for thought for this paper.

Academic and social research focus predominantly on women in rural areas of Bangladesh (Khan et al. 1984; Ahmed et al. 1996; Bhuiya et al. 2001; Rahman et al. 2003; Singh et al. 2010; Huda et al. 2013; Islam 2015) and urban women's MR experience is missing from the literature. Most MR services in Bangladesh delineate the health, economic and social factors relating to MR. Sufficient data exists to back up the health and safety concerns of MR as well as statistics over the years about users and their socio-economic profiles. What is missing is the approach from a women's rights and bodily autonomy. In the interviews and oral histories undertaken in this research I seek to address that gap with the narratives of urban women. This research seeks to show class and generational difference in order to give the women who have participated agency over their narrative, one that is lost in the conventional research on MR.

Chapter 3 Narratives from Four Decades- an Analysis

The narratives collected from 40 respondents are divided into two generations- Pre 90s and Post 90s for the purpose of a comparative analysis in order to understand if there is any change in their level of SRHR and MR related knowledge, and experiences of accessing services. The findings are presented in three sub-chapters. The structure of the sub-chapters include first the analysis of data collected from the Pre 90s generation women followed by the data gathered on same topics from post 90s generation women. A comparative analysis is made of both the generations' knowledge, attitude and experiences along with an analysis of the change in government's policies over the generations.

This section addresses the following question:

has there been an intergenerational and intersectional change in perspective, knowledge and experience of married and unmarried urban women about MR over the period of 1971-2016?

3.1. Changes in the Level and Sources of SRHR and MR Related Knowledge

In this section we will look into the generational differences based on the following factors of knowledge level and sources of information which is also summarized in a table at the end of the section:

- Attitudes to menstruation and mother hood
- Attitudes to contraception
- Knowledge about abortion/MR
- Importance of Social Media
- Impact of government policy

(The summary table has been put at the end of the chapter)

3.1.1 Knowledge of and Attitude to Menstruation, Motherhood and Contraception

In order to understand the level of knowledge and attitude to menstruation and motherhood, respondents (married and unmarried) were asked about the level and source of knowledge on menstruation and motherhood and their attitudes towards these. The data gathered from the interviews indicates the level of SRHR and MR knowledge women from both the generations possess and how it has been changed over the generations.

The collective image of the Pre 90s generation respondents is one of a strict patriarchal society. Knowledge about SRHR is heavily stigmatized, within the dominant Bangladeshi culture. The women are rarely informed in detail about female anatomy, sexual health and reproductive rights and pregnancy options until after menstruation or marriage. The majority of young women learn about SRHR issues once they are seen as reproductive. For most of the cases, pre 90s generation

women stated that they could come to know about menstruation and motherhood after they had their first menstruation and mostly after their marriage unlike women of post 90s who have gone through a better situation. A fewer number of woman (09) from post 90s viewed that they did not know anything about menstruation and motherhood before their marriage. One of the women from pre 90s generations stated that-

> *"Before I got married, I knew absolutely nothing about why people become pregnant. (....) My shyness kept me from ever asking questions about it, because I thought that an unmarried girl should not know about these things." [Rahela Banu (50)]*

The Pre 90s generation respondents state that it was friends and relatives who informed them about menstrual hygiene. This source of information gave an incomplete picture of SRHR issues and respondents said that supplementary questions were not encouraged. They spoke of social stigma that was deep seated, influenced and strengthened by dominant cultural understandings of femininity. This understanding of being a "good woman" was the dominant narrative of women of Pre 90s generation. Instilling moral fear into young women appeared to be a common tradition, and likely patriarchal in origin according to respondents of this generation.

The respondents from Pre 90s generation became sexually active after their marriage and coincidentally all the respondents became pregnant by the end of first year of marriage. Further probing into how they saw sexuality drew out responses such as "*the sole purpose of marriage is furthering your family line", "my husband hated using condoms", and "my in laws wanted babies"*. While answering about their attitude regarding pre-marital sex, women from pre 90s generations expressed a similar opinion. A woman from pre 90s generation stated- *"People who indulge in sexual relationship before marriage, these sinners won't even be given space in hell." (Strong force in words)*

Among the pre 90s generation women, three(03) of the respondents mentioned they were able to negotiate condom use or some form of long term family planning methods with their husbands only after they had few children. None of these women from pre 90s ever went to a shop to buy condom or birth control pills. When asked if they did, two of them laughed at the idea of a married/unmarried woman buying condoms. The idea that a woman is an individual rather than being seen solely as the bearer of children where motherhood is the only purpose of her existence seemed to be an alien concept to this group of respondents.

However, post 90s generation respondents showed a different scenario regarding their knowledge and attitude about menstruation, contraception and motherhood. As more women started joining workforce with greater number of educated women from post 90s generation compared to earlier generation women, some of them (08) replied that they knew about MR and motherhood before their marriage. They replied assertively about proper ways of menstrual hygiene and ways of birth control. 13 of the respondents from post 90s generation mentioned being able to negotiate condom use with their partners and seven women stated that they went to shop for buying condoms or emergency/regular birth control pill. Most (09) respondents of post 90s generation women informed that they had sexual intercourse before getting married and they do not see it as a sinful act or something that should be judged or stigmatized. Fewer respondents (02) from post 90s generation were found who became pregnant within the first year of marriage. This number surely indicates that younger women prefer to not get pregnant as early as their previous generation rather more women are involved in workforce. So, their

knowledge about MR, abortion and motherhood is relatively better compared to the knowledge of pre 90s generation women.

Most of the 40 respondents were not aware of the legality of pregnancy termination in Bangladesh. Out of 40 respondents, 23 women stated of having no idea about abortion and MR laws and only a few (06) from post 90s stated that they know something about MR law whereas some stated that there is no law about this and some stated that MR is "absolutely" illegal. Despite the real differences in methods, timing and circumstances of pregnancy termination, from the 40 respondents it seems that women could not distinguish between MR and abortion and they think these two forms are same and that is absolutely a hospital/clinic's matter. Most women were made aware only after they conceived, as can be seen in the response from Helen-

> *"After just three weeks of pregnancy, my husband and I went to see a doctor in a hospital. I was in an immense rush because the pharmacy doctor had informed us that a law exists in our country regarding abortion/MR. So I wanted everything to go as fast as possible."*

This inconsistency in information is acute among the older generations, whereas women of younger generations (Post 90s generation) possessed more information about modern family planning methods, MR and MR services. Within the lower socioeconomic class the level of inconsistencies and misinformation were found more acute compared to higher class women and middle class women.

3.1.2 Attitude to Sex

In Bangladesh women who seek an MR before marriage may be labeled as "promiscuous" or worse and this taint can put their chances of marriage at risk. MR before marriage is considered as an evil task without considering social class and generations. However, a trend of silent acceptance has started among younger generations but older generation does not accept it by any means. With an increasing number of women opting for higher education, professional careers and an inclination towards choosing their own life partners, intergenerational trend of change in how women feel about sex outside wedlock is evident.

The difference between women respondents of Pre 90s generation was the end of the otherwise expected 'automatic' relation between sex and marriage. Among the new generation of young people whose lives are directly influenced by globalised culture codes, which are economically solvent and experience less mobility restrictions the notion of romance is stronger than that of marriage. Educated middle class and self solvent lower middle class women from Post 90s generation wanted to have a boyfriend and a sexual relationship that would be expressed outside compulsory legal boundaries. They showed less occupancy with MR and sexual stigma in the society although they preferred a curtain of privacy to avoid being judged by others.

> *"The abortions were kept completely under wraps – only the closest of the closest members of the family and friend knew about them, because I feel it is my personal choice what I want to do with my body." [Laila (28)]*

3.1.3 Importance of Social Media

In the 1980s, very few houses in a neighborhood used to have television, and the only channel that used to exist was Bangladesh Television (BTV), the nation's single state-owned network. While educational programmes related to agriculture, demography and our heritage were featured, not much was shown about SRHR issues until the early 1990s, when the animation series *Meena* was introduced to the masses and immediately became a household name. *Meena* dealt with all sorts of issues of gender inequality including education – with its very first episode focusing on how daughters should not be excluded from going to school, early marriage, eve-teasing, dowry, as well as HIV/AIDS and how it is spread. That women's issues came into focus is in large part due to the success of the series.

Afterwards, campaigns relating to contraception were endorsed through TV, radio, movies and mobile phones. Once again television adopted the means of a character named Laila, a healthcare worker, to bring to light the harassment that these women face on a daily basis while trying to create awareness about SRHR issues.

Access to Internet connection was present since the early 90s through dial-up method, but it was a time when computers were seldom bought by households. Even when a family did have a computer, the sluggish speed of dial-up made it quite difficult to get access to quick information. It is only in the last decade that we have seen massive growth in the Internet industry. With high speed internet, finding information about SRHR issues has been made easier. Google has been a key source of pregnancy/conception/abortion-related information for the post-90s generation. With the advent of Facebook, sharing of SRHR videos and articles have been made possible, a feat that people were not capable of in the pre-1990 era.

Access to education, use of technology and change in social attitude exhibits a better understanding on SRHR among younger generation. Technology has changed the scenario of how Post 90s generation women access SRHR information using internet. Respondents from this generation mentioned google search engine, facebook, youtube, social network based women groups, FM radios and electronic media (TV, film, porn) as their sources of information. Six (06) respondents from educated middle class mentioned using google search engine as a frequent tool to search for SRHR and MR related issues in detail. Working women from lower middle and lower class strata mentioned NGO advocacy campaigns and clinics providing information about HIV AIDS, STD, menstrual hygiene and modern family planning concepts in the urban slums. All the respondents from the Post 90s generation knew more scientific knowledge about HIV/AIDS and menstruation in comparison with the older generation.

3.1.4 Impact of Government Policy

According to the national policies on HIV/AIDS and STD related issues and National Strategic Plan for HIV/AIDS 2004-2010 all formal and non-formal educational institutions to have HIV/AIDS/STD education in curriculum as a personal and developmental issues along with capacity building for teaching and research, and firming conversation forum and research on these issues (National AIDS Committee 1996). Likewise, Bangladesh population policy and adolescents reproductive health strategy suggest effective propagation of adolescent reproductive

health knowledge and information through school syllabuses in secondary and higher secondary school along with review and modification of existing syllabuses and its proper execution in classroom teaching-learning process (Government of the People's Republic of Bangladesh 2004; Barkat & Majid 2003). The change in level of knowledge in both the generations can apparently be associated as an impact of the policy implementations.

So generational change in attitude towards SRHR and MR issues as found after interviewing 40 women from two generations can be summarised in the following table:

	Pre 90s generation women	Post 90s generation women
Attitudes to menstruation and mother hood	-Menstruation is "*a natural process", "It happens as per Allah's wish"* -family/Relatives are the predominant source of information -indicates a girl's marriage eligibility -motherhood completes a woman's life	- Menstruation is a physical change during puberty -friends, home economics textbook, TV, radio, movies, google search engine, porn movies, NGO advocacy campaigns - motherhood is a choice and the decision must be made by women in consultation with her partner -mixed reaction about pre-marital sex
Attitudes to contraception	- a private matter between a husband and a wife - an uncomfortable topic of conversation - associated with sin and wrongdoing because it acted as a hindrance in the way of pregnancy, which is considered a "blessing".	- Contraception usage has increased, but the choice of protection (i.e. the type and whether or not to use it) is largely based on the men's preference – prefer to be "careful" through protective measures in order to avoid the possibility of abortions/MR.
Importance of Social Media	TV and radio were the only form of social media that was available to the women, and that too very rarely. It was more common to find one house in a neighbourhood with a TV, or weekly shows of few programmes were provided via projectors. With	Television has been cited as many as a viable source of information on SRHR issues. Internet has been mentioned, but only by educated middle, lower middle and upper class women.

	such low access to social media, importance of social media in making termination decisions was minute at best.	
Impact of government policy	Women had little or no knowledge, did not at all take into consideration the legality of the procedure while deciding on termination.	The vast majority still has little to no idea about the legal concepts of abortion/MR.

Table 9: Attitude change and impacts in two different generations

3.2. Stigma Around MR and SRHR Issues in Urban Bangladesh

Abortion stigma is neither natural nor "essential" and relies upon power disparities and inequalities for its formation (Kumar et al. 2009). Respondents' replies during the interviews unfold the various social, religious and political processes that favor the emergence, continuation and normalization of MR stigma in Bangladeshi urban society. The section analyses the responses of the two generation of women to understand why and how the existing conservatism and hegemonic narrative of MR exists and have existed through generations in urban context of Bangladesh. Pervasive myth of asexual youth, ignorance about the legality of MR, theological narrative's dominance and fear of social exclusion have contributed in spreading MR stigma among generations. This section also shows how the young generation of women even amidst such society of secrecy are talking more openly about sex to break the taboo and stigma around SRHR.

3.2.1 Fear of Social Exclusion

Goffman (1963) conceptualizes stigma as an "attribute that is deeply discrediting" that negatively changes the identity of an individual to a "tainted, discounted one". Despite their emergence in various settings, the experience of stigma is played out in a "local world", that is the context of social relationships and cultural constructs (Yang et. Al 2007). MR transgresses "three cherished 'feminine' ideals" according to Kumar et. al (2009) and he identifies the ideals as perpetual fecundity; the inevitability of motherhood; and instinctive nurturing. These ideals are the patriarchal construct to keep women in society subjugated no matter the socio-economic background.

Stigma around MR experienced by both the generations of women has been found to be same in nature. That it is a heinous crime and akin to murder is a viewpoint that has persisted from ancient times to this very day, as we can see from the following example.

Here we have Saleka Begum (pseudonym), a 60 year old woman, who is distraught over undergoing an MR procedure because religion classifies it as *"Kabira Gunah"*, an arena of sins that is unforgivable in Islam. She also believes that her decision to go through with the treatment is equivalent to killing. In addition to her fear of how religion treats women who have gone through such treatments, her dread of society is also obvious, as she felt the necessity to hide the fact that she had undergone an MR. All the women of Pre 90s generation interviewed expressed guilt, remorse and fear of being judged by their families and society. They never told outsiders with the fear of being judged as selfish or sinful, as they were certain they would be. Nevertheless, women from the Post 90s generation also considered MR procedure as a *"necessary evil"* that they could not avoid. Five women from post 90s feel MR or even abortion as a necessary process for their well being. Unmarried women who went through the procedure admitted of facing harsher treatment by the people who knew about the event, as the act of having sex before marriage was also considered sinful. All the respondents from both the generations admitted how society negatively judges sex before marriage and possess an intolerant outlook, however, when it came to personal standpoint the Post 90s generation women showed

less rigid attitude towards pre-marital sexual activities and MR. They personally seem to have lesser judgmental attitude towards unmarried women having MR or married women having MR due to other reasons than health and financial condition.

Post 90s women from lower middle and lower class sarcastically talked about Bangladeshi society's hypocrisy regarding sex and MR. It is evident from the interviews that for middleclass women social and cultural pressure is very strong. While economic hardships are less of a concern for women of this class, the social pressures of living up to traditional roles of the "ideal" woman from "good" families with strong morality and principles has a deep effect on their psyche. The climate of secrecy surrounds this particular class considerably more than that of the other classes.

In contrast, lower class women with little or no education are less stigmatized against because monetary pressures are stronger. They are able to justify their decisions by saying that they "did not have a choice" or that "there was no other way out". Their community and family who also face similar economic hardships, tend to be more empathetic and understanding of their choices in contrast to the typical middle class, who are more ruled by deep seated conservative conventional values.

The interview data analysis show that in Bangladeshi society the archetypal construction of feminine over the generations is: female sexuality solely for procreation and the inevitability of motherhood. To choose to avert a specific birth using MR, counters prevailing views of women as perpetual life givers. Listening to narratives of 40 women from two different generations have led me to believe this notion has not changed fundamentally over the years in older generation. However, younger generation due to their exposure to economic emancipation, freedom of movement and decision making possess a body rights based concept of female sexuality. The analysis shows that stigma around termination of pregnancy decision is perpetuated by systems of unequal access to power and resources, narrow and rigid gender roles and systematic attempts to control female sexuality. In Link and Phelan's (2001:367) words:

"Finally, stigmatization is entirely contingent on access to social, economic and political power that allows the identification of differences, the construction of stereotypes, the separation of labeled persons into distinct categories and the full execution of disapproval, rejection, exclusion and discrimination."

3.2.2 Ignorance About Legality of MR and Dominance of Theological Narrative

MR is a legal medical process in Bangladesh. However, most of the women interviewed did not know this fact. The interviews reveal that for most of the women receiving primary SRHR information from family/relatives who were also ignorant of the legality of MR as a pregnancy termination method have reported fear of an omnipotent Lord condemning them to eternal hellfire. The perception of having "taken a life" based on Holy Scriptures has been stated at many times. Words such as "felony" and "unforgivable sin" have heavily been associated with the term abortion. People's judgment, and God's wrath befalling upon them has been cited as prime fears by women. Ostracization or banishment from society has terrorized women to the point that they rarely want to share their MR experiences with anyone outside the family. Many

of the interviews reveal that only women who have been ill or in some sort of physical predicament are not judged for going through with the procedure. However, most (31) of the respondents who went through MR experience described how they were labeled as promiscuous, sinful, selfish, dirty, irresponsible, heartless or murderous by their friends, relatives and even service providers on different occasions. During the interviews women showed their disgust and anger by rhetorically asking the fundamental question "why are we judged and stigmatized for using a legal medical procedure?"

Silence and fear of social exclusion keeps women and others from speaking out in support of those who do choose to do MR, thus sustaining the negative stereotype. In reality, women who have had MR may even take public stands against it. Nine women from both the generations told they publicly spoke against MR in fear of being judged and stereotyped. This climate of hypocritical secrecy around MR shows that only making MR legal as a process does not necessarily make it acceptable to people because the entire procedure is seen from a socio-cultural and theological viewpoint. The respondents who are form pre 90s recall the clinics that provided MR and abortion services referred to as 'cursed' place carrying out 'anti-religious' activities. The respondents described MR or termination of pregnancy as a 'delayed' or 'missed' menstrual cycle, a 'dropped' or 'lost' pregnancy, or in terms that communicate the impermanence of pregnancy without assigning agency to anyone. Most women in these responses used words such as "*baccha nosto kore fela*", "*beccha fele deoya*", "*gorvo nosto kora*", "*balai dur kora*", "*gopon jhamela sesh kora*" etc. which means to ruin or destroy a baby. This language was majorly used by women of middle or lower middle class and the post 90s generation of women.

The patriarchal construct makes it hard for many women to come to term with their decision and leave them with mental dilemma. As a deeply religious society, Islamic theology in its loose societal form has equally grasp over the society. As society's conservatism is intrinsically amalgamated with the loose form of Islamic theology; it forms the majority of the moral viewpoint imposed on women in the society. Through the interviews, we find that there is blurring in the knowledge of the women regarding what one's religion dictates, what society's view on the matter is, and what the family environment dictates. The confusion lies at the source of the information, and this is present in most households based on the interview sample. The respondents interviewed spoke of the cultural and religious influence, without any clear distinction between the two. Respondents from Pre 90s generation showed signs of guilt or sorrow as they described their experiences, and felt compelled to provide justification for their decisions.

3.2.3 Breaking the Taboo- Openness About *'Sex-talk'*

The societal taboo on the conversation about SRHR and sexual activity in general has been on the decline over the years. Post 90's generation women used more colloquial terms while talking about SRHR and MR and felt relaxed and at ease. Most of the respondents (28 out of 40) reported having discussed with close friends and relatives issues such as love, sexuality, porn movies, erotic desires and curiosities. A good portion of respondents from post 90s (10) mentioned that they are more open to having these discussions with their own children, unlike

they were able to with their own parents. One of the women from post 90s generation stated that-

"I cannot imagine talking with my mother about sexuality or any taboo issues till date; however I have talked about menstruation and emotional changes during puberty to my daughter." (Interviewed on August 2016, Dhaka (translated))

However, women interviewed from Pre 90s generation were found to be nervous and at discomfort when answering questions regarding SRHR issues or when asked about their family planning decisions. The reason for this is assumed to be the individual level stigma. The culture of secrecy the older generation was brought up in preferred seeing the youth as asexual. It was observed that elderly women in the respondent group were highly uncomfortable, worried or shy in discussing SRHR matters. The socio-religious values are pushed towards the women as they grow up with this narrative all around them, this causes them to develop the bias as patriarchal values are such that they cannot openly deal with issues such as sexuality. This also affects their psyche in such a manner that they are bound by the very narrative that seeks to subjugate their status in the society. The interviews show a change in the narrative is taking place, slowly but surely. Younger generation women collectively agreed that openness about sexuality and healthy sexual conversation within families and among friends can break the vicious circle of stigma around women's sexual and reproductive health.

3.3 Change in Quality of MR Services

MR decision making is a dynamic process. Although factors such as attitudes toward fertility control, socioeconomic situation, age, and expressed desire for additional children may be relevant, they alone do not predict fertility behavior; women with similar stated family-size desires and attitudes, for example, do not necessarily make the same decisions regarding contraceptive use, pregnancy, or termination of pregnancy.

Following on from a discussion of attitude and stigma I now turn to the actual experience of MR. The discussion is divided into three parts:

a) Who takes the decision, why and how

b) Experiences

c) Environment of the service

Cultural values in Bangladesh indicate men must be decision-makers since they are considered more powerful and intelligent than women. This dominance is furthered when the man is the sole earner of the household. When women however have a greater control over economic resources, they are able to outweigh the social norms of the man's dominance in decision making process (Mundigo and Indriso 1999).

In order to understand the decision making process and mentality of the women, interviewees were asked how and when they came to decide on taking this procedure, who influenced their decision to which extent and what was reason for them taking this procedure.

Majority of the interviews taken from women of lower-middle and lower class indicate that the decision to go through with MR was not taken solely by the woman, but to large part influenced by the husband and in some cases by third parties such as neighbors, relatives and doctors. In some cases, it was seen that the proposition to get the MR was made by the husband on the account of health or financial concerns and interview suggested that these women 'agreed' or came to a mutual decision after discussion.

Most decision making, according to the interviews, are influenced by other actors more than the woman. This has happened because either the woman was unaware of what to do in such situations or because she felt like she had to discuss with someone who was more knowledgeable and capable than she considered herself. This form of dependence on others is predominant in most women from lower middle to lower class families, sometimes present in upper class families as well.

We examined the relationships between a variety of social factors and the actions the women took to terminate pregnancies. The woman's age at the time of the pregnancy had no consistent relation to the actions she took, although younger women were slightly more likely to take strong steps. The Post 90s generation women in our study reported that it was the response of the man and not that of other kin that had a direct bearing on their decision. They usually discussed their plans with their partner before they took any action, and his response to the pregnancy was often the single most important factor influencing outcome. If the man advised abortion, married women responded that they followed the advice. In case of unmarried respondents the decision was taken by the women but of course bearing in mind the patriarchal norms and challenges of

their surroundings. However, the Pre 90s generation women mentioned unanimously how the pregnancy termination or continuation decision was mostly made or heavily influenced by their in laws. Living in a joint family as homemaker, financially dependent on the husband or his extended family made the women consider and obey what the in laws want. Due to living in a closely knit society and joint families, there was no escape from "what would people say" ["*loke ki bolbe"* an expression used frequently in Bangladeshi society to indicate how much we care for what other people would think of our action .

In the Post 90s group we studied, relatives were not asked-nor were generally called upon for emotional support and advice in whether to continue the pregnancy. Instead, it was the partner from whom women sought both financial and emotional sustenance. Our interviewees strongly suggested that the increased trend toward nuclear families in a rapidly urbanizing part of the world was already a reality for the women in our study. One implication of this trend was that primary responsibility for children rests exclusively with the parents and not with the larger kin group.

3.3.1 Reasons Behind the Decisions

On the question of reasons behind the decision, the reason for taking MR according to most of the interviews were either health concerns, family planning or financial distress, irrespective of socio-economic background.

Health concern was a primary reason for many of the respondents. Most (21) decided based on direct health complication that they were facing due to the pregnancy such as breathing problems, discomfort and pain, some were forced to get the MR/abortion due to possible miscarriage or life threatening factor. One of the other factors that many considered was the age difference between the two pregnancies and when made aware of the possible health hazards of births at such as proximity, decision to get an MR became inevitable for some interviewees.

Financial circumstance also played an important role in many of the decision and surprisingly so, this was irrespective of socio-economic strata. While seven (07) interviewees terminated their pregnancy because they already had couple of children to feed and could not afford to raise another child with the meager income of their husband, another interview despite being well-off decided to take MR twice to control the time at which they had a child so that the family could plan and foresee future financial expenses for the children.

Not yet ready for motherhood is another reason for seeking MR services according six (06) of the respondents who all belonged to the Post 90s generation. These women irrespective of their marital status thought motherhood is a phase of life they are not yet ready for due to study, career prospect, or unable psychologically to shoulder the responsibility.

3.3.2 Experiences

The experience of the women who decided to receive MR Service in this study has been evaluated from grounds of their experiences before, during and after the procedure.

Most women interviewed received initial information about the processes from their families and then afterwards from doctors, this is almost same over the generations. This means their first avenue of information in the process is from an informal but comfortable source. As seen from

most of the interviews, people from even the lowest socio-economic strata did not have a lot of difficulty finding information about the process. Most cases, there was a clinic or hospital nearby that they could get access to and when they wanted to, they had a doctor or expert they could ask. The quality of information available was not evaluated however.

The healthcare center or clinic to get the procedure done was also quite accessible. Most interviewees, when asked how they went to the clinic or hospital to get the procedure, answered with bus or rickshaw, indicating that the facilities were within the reachable area. One of the interviewees who had the procedures done twice got them from two different parts of the country as indicated in her interview:

> *"I got it from my hometown in Rongpur the first time. And the second time I performed it via medicines from a private hospital in Mohakhali. My husband went with me in a rickshaw the first time, and I was accompanied by a friend in a CNG (a three-wheeler auto rickshaw) the second time."*

Most of the procedures done were also within the first three months of pregnancies with a few exceptions. This however did not indicate the legality of the procedures. Some interviewees while agreeably got the MR within the legal time frame, claimed to have done so through an illegal channel when asked whether the mean was legal or illegal. They did not elaborate on the exact process of how they got information about the mean if illegal due to obvious concerns, but they also did not indicate on why they chose the illegal measures over legal ones which means it can be any reasons from geographical inaccessibility, financial burden or possible social stigma associated from getting MR done from an official channel.

When the procedure is illegal, it is much more risky, pricy and painful as indicated by the interviewee below:

> *"I was taken to the Al-Sami clinic and it cost us 12,000tk since it was illegally administered. I was given all the information about my health and the differences between abortion and MR. The place was hygienic and the people were nice but the doctor was not careful about the procedure. There was no counseling offered and after the procedure I had an infection, diarrhea, fever and vomiting tendencies. I had to consult another doctor from a healthcare center and he was better"*

Even during the interview, her body language indicated she had suffered a lot during the procedure. She had to wait a significant amount before she could meet with her doctor and even then was *"tied down by my hands and legs when the syringe was inserted".* The experience projected the unfortunate nature of suffering that these interviewees had to face during this process. Experiences as such indicate the lack of empathy as well as support that these women lack in.

Interviewees availed the service from public hospitals such as Dhaka Medical College Hospital, Salimullah Medical College Hospital, Mitford Hospital, while some availed it from private service providers. The cost in the public hospitals from most interviews indicated would from 1000 to 1500 BDT while it can be much more expensive in private hospitals, as indicated by the interviewee quoted below. Interviewees from lower to middle class availed these services from public hospitals considering the differences in costs.

Other than a few exceptions, most interviewees claimed the service provided was fairly good and the environment was hygienic and clean. There was no detail described on what was considered

hygienic but the word fairly indicated that they were satisfied with the process and the environment provided.

In terms of behavior of service givers in these establishments, while most people claimed the caregivers or nurses were comforting, the doctors according to some interviews were relatively nonchalant, seemed busy and did not always give them all the information about the entire procedure or possible side-effect post procedure. Most places did not have a counseling facility, which is considered an essential factor in a basic healthcare system. According to American Psychological Association's Task Force on Mental Health and Abortion concluded that "among adult women who have an unplanned pregnancy the relative risk of mental health problems is no greater if they have a single elective first-trimester abortion than if they deliver that pregnancy" (Upadhyay 2010)

However, one of the interviewees faced a lot of concerns in terms of this aspect as indicated by her answer to the questions regarding service and environment:

> *"I got the service at Mitford Hospital at 500tk charge. They didn't explain anything to me and there were a lot of health issues. The hospital was crowded so we had to wait a long time and it wasn't easy to talk to the doctor but if I have to I will go back to that hospital, because I'm poor and I can't afford to spend too much money to visit a doctor."*

Some of the aspects we have to consider from the above interviewee is that her service was illegal as she claimed and it was also significantly cheaper than the cost that other interviewees they indicated they had to incur from the same procedure from a public hospital. The quotation also signals a sense of helplessness that ensured the experience. Despite being dissatisfied with the substandard service provided, she claims she will likely re-visit the same hospital if required later because she cannot afford anything more expensive.

Considering the immense mental stress a woman in Bangladesh faces when going through these procedures, she is as indicated by most interviews anxious, nervous and in a fragile state of mind through the entire process. On top of that, the financial distress deprives them of some basic healthcare facilities they deserve as human beings. While women from higher income strata of society take such services for granted, some women of lower socio economic background are compelled to avail below standard services even when it comes to MR which is medically intrusive service that requires a good healthcare provision for successful and healthy life.

Generations based analysis does not find any considerable differences and respondents were taken from different clinics/or hospitals who recently experienced their MR. On the other hand, social class based analysis find a huge difference where higher class home get a good environment in private clinic. Environment of lower class is found to be worst, sometimes they have their MR in a tiny dark room with inexperienced nurses or attendants. Interesting fact is respondents from lower social strata preferred receiving services from these unauthorized personnel at their home based service center rather than going to a government health facility due to the longer waiting period, higher cost and "bad behavior" of the service providers.

Chapter 4 Concluding Remarks

In this research, I intended to shed light on realities rather than solving a research hypothesis. While I was writing this research paper, Bangladesh topped the South Asian countries in gender equality for the second consecutive year in the Global Gender Gap Report 2016 published by the World Economic Forum (WEF). Undoubtedly Bangladesh has made notable progress in the fields of human development. The situation of women has improved in ways that could not be imagined four decades ago. But has this on-going "development" and "empowerment" process, modelled after the images of the Global North, been translated to a change in the generational understanding and practice of women of their entitlement to individual sexual and reproductive health choices? Based on the narratives of the women in this study, we can see an important generational shift in women's situation in terms of exercising sexual autonomy and enjoying overall independence.

Starting off this study from women's narratives using feminist standpoint theory has been useful in understanding the complex and contested nature of the Bangladeshi urban women's embodied experiences. The plethora of existing medical research and case studies on MR have treated women's body as a "study object" from medical perspective and failed to realize the complexities of women's MR experiences based on their social class, age and marital status. Looking beyond the quantitative figures of MR discourse, and delving deeper into women's lived experiences this study shows that younger generation of women do not see MR solely as post marriage family planning method, rather the new generation of young people whose lives are directly influenced by globalised culture codes, who are economically solvent and experience less mobility restrictions, the notion of romance is stronger among them than that of marriage and child bearing.

The intersectional analysis of narratives from different generations, classes, and marital status of women, show that though patriarchy still dominates Bangladeshi society and culture, comparing the Pre 90s and post 90s respondent accounts, the situation of women's sexual & reproductive health rights (provision on MR, use of contraception, knowledge of SRHR issues), participation in decision making process regarding family matters and exercising bodily freedom has improved. Economically self dependent unmarried women, irrespective of their social class and religion tend to have higher authority over their decision making in this case compared to the married women. It is found from the analysis that conservative religious norms and context do not make a difference in the situation or be a barrier to the women's freedom of decision making as long as she is economically independent.

The findings indicate that urban women from the post 90s spoke of a better experience in terms of MR, abortion and other sexual and reproductive health rights compared to the experience of pre 90s women. At the beginning of 90s, when urban women from the middle classes started to enter be more educated and entered into the workforce this financial independence has led to greater participation in family decision making process. They are therefore comparatively in better position in terms of exercising autonomy over their own body in terms of SRHR issues. Unmarried women of both middle and lower classes consider themselves more accountable for their actions and are not dependent on any husband or in laws, tend to exercise their bodily

rights with more freedom. If we scrutinize this shift from the point of view of socio economic class along with ages, we see that middle class urban women of post 90s possess have better knowledge on MR and use of contraception compared to women who are from pre 90s.

A similar outcome has been found regarding the different taboos. Taboo towards MR is wide spread still but the analysis of women's embodied experiences show trends of change as women of the younger generation are more educated and more confident and less dependent on men. Middle and higher class, educated women of post 90s have fewer taboos in terms of SRHR. Post 90s women are bold about undertaking MR and they feel less guilty compared to women of pre 90s. Women belonging to the lower income class of the younger generation were found to be less judgmental about MR services than women from higher and middle class. However, women still hide their MR/abortion experience. Even if the level of stigma is not same for women from all generations, all speak of stigma. Interestingly, even if society considers pregnancy in unmarried women a huge societal crime, unmarried women, we saw in the study, overcome this taboo considering it is their own bodily right to exercise MR. Still, unmarried women undertake MR secretly. As do married women, who consider that the less people know, the less the chance of being stigmatized. From a religious and social point of view, before 90s and post 90s, stigma for unmarried women getting an abortion or MR remains very high, while for the married ones stigma remains but is less intense.

In Bangladesh SRHR issues seem not to have moved much from target discourse of SRHR dealing with problems such as HIV/AIDS prevention and family planning/fertility control. However in the course of the research from the narratives collected there does seem some positive impact of SRHR policy discourse as there was a change in level of knowledge between the two generations. Access to formal education and inclusion of some SRHR issues (menstruation, physical changes during puberty, HIV/AIDS prevention), use of internet and electronic media for advocacy and advertising on fertility control issues and HIV/AIDS prevention have resulted in positive change of knowledge among younger generation. Post 90s women reported to know more about SRHR issues, HIV/AIDS and fertility control measures than their earlier generation. However, the women suggested inclusion of MR related information in the textbooks and SRHR advocacy materials in the electronic media would benefit women as many are unaware of MR's existence as a legal pregnancy termination procedure. This clearly shows that enacting appropriate policy needs to include ensuring awareness among the people for whom the policy is aimed.

One strong finding of the research is that the absolute absence of post MR mental health counseling affects the psychological well being of the respondents on different levels. Irrespective of the age, class, marital and religious identity, women interviewed talked about tackling their post MR psychological trauma in their own personal ways ("shutting it out", "locking it away") which most often left a long term damaging impact on their mental wellbeing and their ability to have relationships. Since the state policy does not recognize MR as a pregnancy terminating procedure, the provision of psychological counseling post MR is not considered. None of the clinics/doctors the women went to for MR services prescribed psychological counseling. We could therefore conclude that almost all the Bangladeshi women undertaking MR suffer from post MR psychological trauma due to the absence of psychological counseling.

There has been positive shifts in policy approach of government and some success across the generations are visible, however, more can be learnt by listening to the women's own experiences, understanding the different impact according to age, class, and marital status. Bangladesh government has been very strict against all forms of violence against women including (but not limited to) acid violence, rape, stalking, internet bullying. Strict implementation of anti-dowry act, child (anti) marriage act, act against acid violence and law against violence against woman and child are some evidences that show how the situation is improving over decades. Besides, implementation of 'National Women Development Policy-2011' is clear evidence of how Bangladesh is improving gradually in gender sensitivity but the analysis of the narratives also show the inadequacy of the state policies implemented to combat the existing climate of stigma and secrecy around SRHR issues. If Bangladesh fails to move beyond a conservative approach of dealing with sexuality as a fertility control issue instead of taking into account real life SRHR attitudes and practices within class-gender-age dynamics are, then the state not be able to continue to reduce gender disparity and protect women's sexual and reproductive rights.

While my research based on just a few women's experience is primarily exploratory in nature, I have gathered evidence that needs to be taken into account by both policy makers and academic researchers. The changes in attitude among generations in women of urban Bangladesh based on their own narratives which shed light on how fertility control/family planning discourses from a sexual and health rights are experienced. This study contributes to the discussion on gender equality in relation to SRHR as being an empowering not population control discourse. It also stresses on the importance of ensuring that information about MR is made available widely as a legal procedure that would gradually contribute to eliminating social stigma. What the respondent's stories show is that it is important to tackle societal stigma towards MR/abortion, in order for Bangladesh to move forward in its aims to achieve gender equality.

References

Alamri, Y. (2011) 'Islam and Abortion', *JIMA* 43(1):39-40.

Ahmed, S., Haque. I, Barkat-e-Khuda, Alam. S (1996) *Abortion in rural Bangladesh: Evidence from the MCH-FP Research Project.* Dhaka: ICCDR,B.

Amos, V. (1984) 'Challenging Imperial Feminism', *Feminist Review* 17(1): 3-19.

Anderson, S. and M. Eswaran (2009) 'What determines female autonomy? Evidence from Bangladesh', *Journal of Development Economics* 90(2):179-191.

Anon (n.d.) *Statistics and Informatics division.* Accessed 25 October 2016 <http://www.sid.gov.bd/>

Aziz, K. and W. H. Mosley (1991) *The History, Methodology and Main Findings of Matlab Project in Bangladesh.* Saly: International Union for the Scientific Study of Population.

Bagheri, A. and L. Afshar (2011) 'Abortion in Different Islamic Jurisprudence: Case Commentaries', *Asian Bioethics Review* 3(4):351-365.

Bangladesh Bureau Of Statistics (2010) 'Report of the household income & expenditure survey'. Accessed 25 October 2016<http://www.bbs.gov.bd/WebTestApplication/userfiles/Image/LatestReports/HIES-10.pdf>

Bangladesh Demographic and Health Survey (2011) 'Bangladesh Demographic and Health Survey-2011'. Dhaka: National Institute of Population Research and Training.

'Bangladesh Penal Code' (2016) harvard.edu. Accessed 25 October 2016 <https://www.hsph.harvard.edu/population/abortion/BANGLADESH.abo.htm>

Banu, A., 2012. *Feminism in Bangladesh:1971-2000,* Dhaka: s.n.

Barkat, A. & M. Majid (2003). *Adolescent Reproductive Health In Bangladesh: Status, Policies, Programs, and Issues.* Accessed 14 August 2016< http://www.policyproject.com/pubs/countryreports/arh_bangladesh.pdf>

Bauer, G.R. (2014) 'Incorporating intersectionality theory into population health research methodology: challenges and the potential to advance health equity', *Social science & medicine* 110: 10–7.

Begum, F., S. Zaidi, P. Fatima, L. Shamsuddin, AK. Anowar-ul-Azim and RA. Begum (2014) 'Improving manual vacuum aspiration service delivery, introducing misoprostol for cases of incomplete abortion, and strengthening postabortion contraception in Bangladesh', *International Journal of Gynecology and Obstetrics* 126:S31-S35.

Bhuiya, A., A. Aziz and M. Chowdhury (2001) *Ordeal of Women for Induced Abortion in a rural area of Bangladesh.* Dhaka:Centre for Health and Population Research.

BMA (2014) *The Law and Ethics of Abortion: BMA Views.* Accessed 12 September 2016<http:// www.bma.org.uk>

Bongaarts, J. and Sinding, S. W. (2011) 'Population Policy in Transition in the Developing World', *Science* 333(6042):574-576.

Bradley, S. E., H. M. Schwandt and K. Shane (2009) *Levels, trends, and reasons for contraceptive discontinution.* Maryland: s.n.

Cecile Jackson and Ruth Pearson (eds.)(2000) *Feminist Visions of Development. Gender Analysis and Policy.* Baskerville: Routledge.

Coles, A.L. and J.G. Knowles (2001) *Lives in Context : the Art of Life History Research.* California: Walnut Creek.

Chaudury, H. (1980) 'Female status in Bangladesh', *Bangladesh Institute of Development Studies* xvi:176.

Choudhury, A. Y., S. R. Choudhuri, M. N. Huq and A. R. Khan (1987) 'The way ahead for family planning in Bangladesh', *World Health Forum* 8(3):373-378.

Chowdhury, A. M. R., A. Bhuiya, M. E. Chowdhury, S. Rasheed, Z. Hussain and C. L. Chen (2013) 'The Bangladesh paradox: exceptional health achievementn despite economic poverty', *Lancet,* 382(9906):1732-1745.

Cleland, J., S. S. Bernstein, A. Ezeh and J. J. Innis (2006) 'Family planning: the unfinished agenda', *The Lancet* 368(9549):1810-1827.

Cornwall, A. and S. Jolly (2006) 'Introduction:Sexuality Matters', *IDS Bulletine* 37(5):1-11

Correa, S., R. Petcheski and R. Parker (2008) *Sexuality, Health and Human Rights (Sexuality, Culture and Health).* London and New York: Routledge.

Council of the Governor General of India (1860). *Penal Code.* Accessed 12 September 2016<http://ncw.nic.in/acts/THEINDIANPENALCODE1860.pdf>

Dailard, C. (2003) 'Understanding 'Abstinence': Implications for Individuals, Programs and Policies', *The Guttmacher Report on Public Policy* 6(5):4-6.

Daily Star (2013) *Daily Star.* Accessed 6 August 2016<http://www.thedailystar.net/news/number-of-women-rising-in-police-force>

Daily Star (2015) *Daily Star.* Accessed 6 August 2016<http://www.thedailystar.net/country/rape-repression-women-increases-bangladesh-report-says-162682>

Davanzo, J., A. Razzaque, M. Rahman, L. Hale, K. Ahmed, M. A. Khan, G. Mustafa and K. Gausia (2004) *The effects of birth spacing on infant and child mortality, pregnancy outcomes, and maternal morbidity and mortality in Matlab, Bangladesh.* Santa Monica: Rand Labor and Population.

Department of Youth Development (2004) *National Youth Policy,* Dhaka: Ministry of Youth and Sports.

Department of Youth Development (2016) *Draft National Youth Policy,* Dhaka: Ministry of Youth and Culture.

The Dhaka Tribune (2013)Accessed 10 October 2016<http://archive.dhakatribune.com/safety/2013/sep/09/unsafe-abortion-putting-women%E2%80%99s-health-stake>

The Dhaka Tribune (2014) Accessed 25 October 2016<http://archive.dhakatribune.com/crime/2014/oct/17/illegal-abortions-rising-alarming-rate-capital>

Directorate Genral of Health Services, Ministry of Health and Family Welfare, Government of the people's Republic of Bangladesh (n.d) *National Policy on HIV/AIDS and STD related issues.* Dhaka: Ministry of Health and Family Welfare

Ferdousi, N. (2014) 'Child marriage in Bangladesh: Socio-legal analysis', *International Journal of Sociology and Anthropology* 6(1):1-7.

Field, E. and A. Ambrus (2006) *Early Marriage and Female Schooling in Bangladesh.* Cambridge: Harvard University.

Financial Express (2013) Accessed 6 August 2016<http://print.thefinancialexpress-bd.com/old/index.php?ref=MjBfMDZfMTBfMTNfMV8yN18xNzIzNDA%3D>

General Economics Division (2015) *MDG Bangladesh Progress Report,* Dhaka: Bangladesh Plannning Commission.

General Economics Division (2015) *MDGs to Sustainable Development Transforming our World: SDG agenda for Global Action (2015-2030),* Dhaka: Bangladesh Plannning Commission.

Guttmacher Institute (2012) Accessed 25 October 2016<https://www.guttmacher.org/fact-sheet/menstrual-regulation-and-induced-abortion-bangladesh>

Harcourt, W. (2009) *Body Politics in Development: Critical Debates in Gender.* London: Zed Books.

Hankivsky, O. (ed.) (2012a) *An Intersectionality-Based Policy Analysis Framework.* Vancouver, BC: Institute for Intersectionality Research and Policy, Simon Fraser University.
Hankivsky, O., C. Reid, R. Cormier, C. Varcoe, N. Clark, C. Benoit and S. Brotman (2010) 'Exploring the promises of intersectionality for advancing women's health research', *International journal for equity in health* 9(1):5.

Hirsch, M. L. (2012) *Women In Siege.*Accessed 5 August 2016<http://www.womenundersiegeproject.org/conflicts/profile/bangladesh>

Hossain, M. K., N. I. Mondol and N. Akter (2011) 'Reproductive Health Rights of Women in the Rural Areas of Meherpur District in Bangladesh', *J Reprod Infertil* 12(1):23-32.

Howlader, M. H., T. Shovo, Bushrat-E-Jahan, K. M. Nazmul and T. K. Jodder (2013) 'Scenario of Women's Reproductive Health Rights in Rural Bangladesh', *Bangladesh Research Publication Journal* 8(3):186-190.

Huda, F. A., A. Ahmed, E. R. Ford and H. B. Johnston (2015) 'Strengthening Health Systems Capacity to Monitor and Evaluate Programmes Targeted at Reducing Abortion-Related Maternal Mortality in Jessore District, Bangladesh', *BMC Health Service Research* 15(426).

Huda, F.A., S. Chowdhuri, Y. Robertson, N. Islam, B.K. Sarker, A.J. Azmi, and L. Reichenbach (2013) *Understanding Unintended Pregnancy in Bangladesh: Country Profile Report*. STEP UP Research Report. Dhaka: icddr,b.
Huda, F. A., T. D. Ngo, A. Ahmed, A. Alam and L. Reichenbach (2014) 'Availability and Provision of Misoprostol and oMedicines for Menstrual Regulation among Pharmacies in Bangladesh via Mystery Client Survey', *International Journal of Gynecology and Obstetrics* 124:164-168.

Islam, A. and T. Biswas (2015) 'Mental Health and the Health System in Bangladesh: Situation Analysis of a Neglected Domain;, *American Journal of Psychiatry and Neuroscience* 3(4):57-62.

Islam, K. S. (2012) 'Breaking down the Birangona', *International Journal of Communication* 6:1-18.

Islam, M. M. (2004) 'Menstrual Regulation in Bangladesh: An Unrecognized Form of Contraception', *Asia Pacific Population Journal* 19(4):75-97.

Islam, N. (2015) 'Reproductive Health Service Provision Gaps in Bangladesh', *African Population and Health Research Center*. Accessed 27 April 2016<http://aphrc.org/reproductive-health-service-provision-gaps-in-bangladesh/>
Islam, U., 2014. Accessed 25 October 2016<http://archive.dhakatribune.com/crime/2014/oct/17/illegal-abortions-rising-alarming-rate-capital>

Iyer, A., G. Sen and P. Ostlin (2008) 'The intersections of gender and class in health status and health care', *Global public health* 3(1): 13–24.
Kabeer, N (1994) *Reversed Realities: Gender Hierarchies in Development Thought*. London: Verso

Kamal, N. (2003) *Plateauing of Total Fertility Rate (TFR).* Accessed 12 September 2016<http://centers.iub.edu.bd/chpd/Pub%20Pap_Platueaing%20TFR_NKamal_2003.pdf>

Karim, S. (2012). *Living Sexualities: Negotiating Heteronormativity in Middle Class Bangladesh.* Rotterdam: International Institute of Social Studies.

Khan, M. M. (2009). *Political and Administrative Corruption: Concepts, Comparitive Experiences and Bangladesh Case*. Dhaka: Transparency International, Bangladesh.

Khan, A. R., S. F. Begum, D. L. Covington, B. Janowitz, S. James and M. Potts (1984). 'Risks and costs of illegally induced abortion in Bangladesh', *Journal of Biosocial Science* 16(1):89-98.

Koishorkal (2016) *Current Situation of Sexual and Reproductive Health in Bangladesh.* Accessed 14 August 2016<http://koishorkal.com/?page_id=674>

Kumar, A., L. Hessini, & M. H. Mitchell (2009) 'Conceptualising abortion stigma', *Culture, Health & Sexuality* 11(6):625-639.

Laila, R. (2016). *Reproductive Health Practices in Rural Bangladesh: State, Gender and Ethnicity.* Rotterdam: International Institute of Social Studies.

Law Commision (2004). *Review of Legal Education in Bangladesh.* Dhaka: Law Commision of The People's Republic of Bangladesh.

M Rahman, M Islam and M Hossain (2008) 'Female Age at Marriage of Rural-Urban Differentials in Bangladesh', *The Internet Journal of Biological Anthropology* 3(2)

Mandle, J. R.(2013) *From Growth to Development in Bangladesh.* Hamilton: Economics Faculty Working Papers.

Ministry of Health and Family Welfare (2004) *Government of People's Republic of Bangladesh.* Dhaka : Ministry of Health and Family Welfare.

Ministry of Health and Family Welfare (2004) *Bangladesh Population Policy.* Dhaka: Ministry of Health and Family Welfare.

Ministry of Health and Family Welfare (2012) *Bangladesh Population Policy.* Dhaka: Ministry of Health and Family Welfare.

Ministry of Women and Children Affairs (1994) *National Child Policy.* Dhaka: Ministry of Women and Children Affairs.

Ministry of Women and Children Affairs (2011) *National Children Policy.* Dhaka: Ministry of Women and Children Affairs.

Ministry of Women and Children Affairs (2011) *National Women Development Policy.* Dhaka: Ministry of Women and Children Affairs.

Mitra & Associates (2014) *Bangladesh Demographic and Health Survey.* Accessed 14 September 2016<https://dhsprogram.com/pubs/pdf/FR311/FR311.pdf>

Motta, S. (2011) 'Feminism, women's movements and women in movements', *Interface* 3:1-32.

Mundigo, A. I. and C. Indriso (ed.)(1999) *Abortion in Developing Countries.* Delhi: World Health Organization.

Nashid, T. and P. Olsson (2007) 'Perceptions of Women about Menstrual Regulation Services: Qualitative Interviews from Selected Urban Areas of Dhaka', *Journal of Health Population Nutrition* 25(4):392-398.

Nazneen, S., N. Hossain and M. Sultan (2011) *National Discourses on Women's Empowerment in Bangladesh: Continuites and Change.* Brighton: IDS Working Paper.

Pallitto, C. C., C. Garcia-Moreno, H. A. Jansen, L. Heise, M. Ellsberg and C. Watts (2013) 'Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence', *International Journal of Gynecology and Obstetrics* 120:3-9.

Pedersen, W. (2003) 'Abortion and depression: A population-based longitudinal study of young women', *Scand J Public Health* 36(4):424–428.

Piet-Pelon, N. J. (1994) *Menstruatual regulation impact on reporductive health in Bangladesh: A literature review.* s.l.: USAID.

Phillippa Goodwin, J. O. (2007). 'Women's reflections about their past abortions', *Psychology and Health 22*: 231-248.

Rahman S.A., J.O. Parkhurst and C. Normand (2003) *Maternal Health Review: Bangladesh.* Dhaka: Bangladesh Ministry of Health and Family Welfare

Randall, E. (2012) *Family Planning Programmes Review.* London: Population Matters.

Schuler, S. R., S. M. Hashemi and A. H. Jenkins (1995) Bangladesh's family planning success story: a gender perspective. *International Perspectives on Sexual and Reproductive Health* 21(4):132-166.

Shams, A. E. (2014) 'Maternal mortality in Bangladesh: a Countdown to 2015 country case study', *The Lancet* 384(9951):1366 - 1374.

Singh S., A. Hossain, I. Maddow-Zimet, H. Ullah Bhuiyan, M. Vlassoff and R. Hussain (2012) 'The incidence of menstrual regulation procedures and abortion in Bangladesh,' *International Perspectives On Sexual And Reproductive Health 38*(3): 122-32.

Sultana, A. (2010-2011) 'Patriarchy and Women's Subordination: A Theoretical Analysis', *The Arts Faculty Journal, University of Dhaka* 4:11-16.

The Daily Star (2015) *Govt to revise national youth policy.* Accessed 28 July 2016<http://www.thedailystar.net/city/govt-revise-national-youth-policy-141331>

The New Age (2015) *Nat'l youth policy earns praise.* Accessed 28 July 2016<http://newagebd.net/142902/natl-youth-policy-earns-praise/>

Tong, R. (ed)(2009) *Feminist Thought: A More Comprehensive Introduction.* Boulde: Westview Press.

UNFPA, UNESCO and WHO (2015) *Sexual and reproductive health of young people in Asia and the Pacific: A review of issues, policies and programmes.* Bangkok: UNFPA.

UNICEF (2010) *Women and girls in Bangladesh.* Dhaka: s.n.

United Nations (2015) *Millennium Development Goals.* Accessed 6 August 2016<http://www.un.org/millenniumgoals/>

United Nations (2015) *Sustainable Development Goals.* Accessed 08 August 2016<http://www.un.org/sustainabledevelopment>

Upadhyay, U. D., K. Cockrill and L. R. Freedman (2010) 'Informing abortion counseling: An examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues', *Patient education and counseling* 81(3):415-421.

Vlassof, M., A. Hossain, I. Maddow-Zimet, S. Singh and H. U. Bhuiyan (2012) *Menstrual Regulation and Postabortion Care in Bangladesh: Factors associated with access to and Quality of Services.* Accessed 14 August 2016<http://www.guttmacher.org/sites/default/files/pdfs/pubs/Bangladesh-MR.pdf>

Walker, R. (1996) Becoming the Third Wave. *Ms. Magazine* 11(2(2)): 39–41.

World Bank (2016) *Helping Bangladesh Reach Middle Income Country Status.* Accessed 28 July 2016<http://www.worldbank.org/en/news/feature/2016/04/07/World_Bank_Group_s_New

_Country_Partnership_Framework_helps_Bangladesh_Reach_Middle_Income_Country_Status
>

Wrye, H. K. (2009) The Fourth Wave of Feminism. *Studies in Gender and Sexuality* 10(4).

Yasmin R., U. Rob, T. R. Das and F. U. Ahmed (2015) 'Increasing access to safe menstrual regulation services in Bangladesh by offering medical menstrual regulation', *Reproductive Health Matters* 44(1):67-74.

Yunus, M. and T. Yamagata (2012) *The Garments Industry in Bangladesh*. Chiba: IDE-JETRO.

Visvanathan, Nalini (1997) 'Introduction to Part 1', in Nalini Visvanathan, et. al. (eds) *The Women, Gender and Development Reader*, pp. 16-32. London: Zed Books.

Appendix I: Interviewee List

SI	Ref. ID	Class	Year	Marital Status	Legality	Interview Date	Where	Service Type
1	Irin 1	Middle	1991	Married	Legal	28th July 2016	DMC	Public
2	Irin 2	Lower	2004	Married	Legal	28th July 2016	DMC	Public
3	Irin 3	Middle	2011, 2013	Married	Legal	16th August 2016	Rangpur Medical, Mahakhali Pvt. Clinic	Private
4	Irin 4	Upper Middle	1985	Married	Legal	16th August 2016	Private Clinic	Private
5	Irin 5	Lower	1999	Married	Legal	30th July 2016	Sir Salimullah Hospital	Public
6	Orthy 1	Upper Middle	1999	Married	Legal	28th July 2016	DMC	Public
7	Orthy 2	Middle	1998	Married	Legal	16th August 2016	DMC	Public
8	Orthy 3	Middle	1985	Married	Legal	30th July 2016	Aminpur Hospital Pabna	Private
9	Orthy 4	Middle	1995	Married	Legal	30th July 2016	Home	Home
10	Orthy 5	Middle	2001	Married	Legal	5th August 2016	Hobiganj Sadar Hospital	Public
11	Priti 1	Lower Middle	1997	Married	Legal	30th July 2016	DMC	Public
12	Priti 2	Lower Middle	1988	Married	Legal	30th July 2016	DMC	Public
13	Priti 3	Lower Middle	2006	Married	Illegal	5th August 2016	Al Sami	Public
14	Priti 4	Lower Middle	2013	Married	Illegal	5th August 2016	Jahanara Clinic	Private
15	Priti 5	Lower	2004	Married	Legal	15th August 2016	Mitford	Public

16	Ratri 1	Lower	1993	Married	Legal	30th July 2016	DMC	Public
17	Ratri 2	Upper Middle	1992	Married	Legal	5th August 2016	Private Clinic	Private
18	Ratri 3	Middle	2013	Unmarried	Legal	5th August 2016	Private Clinic	Private
19	Ratri 4	Lower	2002	Married	Legal	15th August 2016	Private Clinic	Private
20	Ratri 5	Middle	1997	Married	Legal	15th August 2016	Private Clinic	Private
21	Rozi 1	Lower	1994	Married	Legal	5th August 2016	DMC	Public
22	Rozi 2	Middle	1998	Married	Legal	15th August 2016	DMC	Public
23	Rozi 3	Lower Middle	2013	Married	Legal	15th August 2016	Private Clinic	Private
24	Rozi 4	Lower	2009	Married	Legal	25th August 2016	Mohanagar Clinic	Private
25	Rozi 5	Lower	2006	Married	Legal	25th August 2016	Mitford	Public
26	Akif 1	Upper	2015	Unmarried	Legal	15th August 2016	Square Hospital	Private
27	Anika 1	Middle	1988	Married	Legal	28th July 2016	DMC	Public
28	Anika 2	Lower Middle	1989	Married	Legal	28th July 2016	DMC	Public
29	Anika 3	Upper Middle	2009	Married	Legal	30th July 2016	Queen's Hospital	Public
30	Anika 4	Lower	1994	Married	Legal	30th July 2016	Sir Salimullah Hospital	Public
31	Anika 5	Upper Middle	2016	Married	Legal	5th August 2016	Sir Salimullah Hospital	Public
32	Anika 6	Middle	2008	Married	Illegal	5th August 2016	Mymensingh Swadesh Hospital	Public

33	Humayra 1	Lower Middle	2007	Married	Legal	28th July 2016	DMC	Public
34	Humayra 2	Lower Middle	2004	Married	Legal	28th July 2016	DMC	Public
35	Nawaz 1	Upper Middle	1983, 1987	Married	Legal	28th July 2016	Private Clinic	Private
36	Nawaz 2	Upper	1995	Married	Legal	28th July 2016	Private Clinic	Private
37	Orthy 6	Upper Middle	1995	Married	Legal	15th August 2016	Hospital in Mirpur	Public
38	Orthy 7	Middle	1986	Married	Legal	15th August 2016	DMC	Public
39	Orthy 8	Middle	2014	Married	Legal	16th August 2016	PG	Private
40	Orthy 9	Upper	2009, 2012, 2015	Married	Legal	19th August 2016	Private Clinic	Private

Appendix II: Semi Structured Interview Guideline

Respondent's information:

- Age :
- Gender :
- Marital Status :
- Educational Qualification :
- Economic Background :

In Bangladesh social strata is a value based term. The amount of money earned as a monthly income does not always necessarily reflect the person's socio-economic standing. To understand it from the respondent's perspective, the following questions must be asked to know which social class the respondent believes they belong to:

- Are you working? If yes, what is your monthly income?
- If you are unemployed, where do you source the finances you require for your living? (If they are financially dependent on their family, must ask who is the main earner in the family and how many people in the family earn/are employed)
- How do you spend your/family earning? How much say do you have in deciding where to spend the money?
- Which socio-economic class from upper/upper-middle/middle/lower-middle/lower class do you think you belong to? Why do you think you belong to this class?

Knowledge about sexual and reproductive health:In Bangladesh SRHR information are mostly communicated through informal medium, for example, family, friends, neighbors, relatives. It is therefore important to probe into how the respondent received information regarding SRHR issues and how much they know about it.

- Do you know why women menstruate?
- How much do you know about child-birth?
- Who, when and how did you get these information? (school, community clinic, doctor etc.)

Personal information and opinion about sexual and reproductive health:

- Get to know about her personal opinion and social and religious values regarding sexual and reproductive health – their idea/opinions about subjects such as premarital sexual relations, post martial sexual relations, menstruation etc., societal and religious views on these matters and how these views differ from/are similar to their personal opinion on the matter.
- Are you aware of menstrual regulation (MR) /abortion? Where did you hear about it for the first time, who did you hear it from and how much do you know about this concept?
- Have you ever searched for information on this topic? If so, which sources did you use to search?
- What do you know about abortion in social and religious context? What are your personal views on the matter?
- Do you have any idea about the current laws regarding abortion of Bangladesh?

- Are you familiar with the term 'Totka'. If yes, how do you describe it and from where did you hear about it?
- What do you know about abortion/MR?
- What do you know about conception? How/Why do people get pregnant? What is the difference between miscarriage and abortion?

Knowledge/Experience regarding abortion/MR

- Have you ever gotten an abortion or thought about getting one?
- If yes, then when did you do it/think about it? Was it before marriage that you did/thought about it? Why did you get it/think about it?
- What was the process of this decision making? Who influenced/helped you take this decision? (your own/doctor's advice/someone else) What was your mental state at the point at which you made the decision? What were your thoughts? Did you think you were committing a crime? Was it the right decision? Did/Do you think about it later on?
- After you decided to get an abortion, did you find it difficult to get information about the process?
- Did you face any difficulty in getting access to the process of abortion?
- How did you get to the clinic? Were accompanied by anyone?

Questions regarding the healthcare (If this respondent has said yes to the questions above)

- Where did you get the service?
- How much did it cost you? Was it legal/illegal mean?
- Were there any risks to your health? Were you told about the difference between MR and abortion and did they fully inform you about the procedure?
- What was the standard of the service? Was the place hygienic? Did the caregivers behave well? Were there any counselling services available? Did you go to any place for post-procedure check-up? If so, where?

Questions regarding her psychological/mental state

- Have you experienced any changes in the attitude you have towards yourself? Did you feel guilty/like you had committed a crime of some sort?
- Did the people who know about your procedure judge your decision or treat you differently once they found out about your decision?
- Does anyone try to warn/scare you by making references such as – God will punish you for this, you will face problems the next time you want to conceive, you will be cursed etc.
- Did you get your abortion/MR in the first 3 months of your pregnancy? If not, which illegal channel did you use to receive the service?
- (If the respondent was unmarried when they got the abortion) Did anyone accompany them to the procedure? If so, who? How did they handle the situation later on in life?
- In the case where you wanted to get an abortion but you did not end up doing so, what were your reasons for not getting that abortion? – familial/financial situation, societal concerns etc.