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Worried Lives: Poverty, Gender and Reproductive Health of Married Adolescent Women Living in an Urban Slum in Bangladesh

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National Centre for Epidemiology and Population Health
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Abstract

The thesis is concerned with the lives of married adolescent women in an urban slum in Bangladesh, and how the injustices of a harsh political economy impact on their bodily health and shape their reproductive experiences. My contribution in the thesis is to clearly demonstrate how political economic inequalities and social conditions - 'structural violence' contribute to adverse reproductive health experiences for poor married adolescent women. These disparities compel married adolescent women to make pragmatic choices, which puts their bodies and reproductive health lives at risk.

The parameters that determine married adolescent women's well-being and reproductive health are rooted in power relations and lack of access to political and economic resources. I argue that the term ‘reproductive health’ cannot be addressed without first addressing the context of extreme poverty, hunger and violence threatening men and women’s survival. Social and economic justice needs to be integral to solutions to improve the health of poor women and men.

The study is located in an urban slum in Dhaka, the capital of Bangladesh. The city has undergone immense transformation with industrialization and the migration of rural families into the city looking for food, shelter and jobs. Ethnographic fieldwork was carried out for fourteen months, and case studies, in-depth narratives and long-term participant observations provide rich empirical data. In addition, a survey was carried out to gather general background information, including young women’s reproductive histories.

Urban slum dwellers constitute thirty per cent of total fourteen million population of the city. Extremely poor urban migrants are unable to find affordable housing. They set up or rent shack settlements built on vacant or disused government/private land, on the margins of the city - usually in flood prone areas, never knowing when they might be forcibly removed. Most of the slum dwellers live on less than US $63 a month, holding onto insecure jobs, with many permanently unemployed. Young married women in the slums are extremely vulnerable in this unpredictable and insecure urban landscape because of their age, gender and poverty.

Chronic deprivation, harsh political and economic conditions and suffering are part of an everyday existence for poor married adolescent women and their families living in
slums. This raises many important questions: what do we mean by reproductive health experiences when we look at their lives? Can we separate reproductive health experiences from other aspects of their lives, the material, social and political-economic? How do the broader global, local and socio-cultural, political and economic factors affect health and reproductive health experiences and behaviour? How do young women make sense of and act in this dynamic and difficult urban environment with what reproductive health outcomes? What multiple effects might structural and social inequalities have on married adolescent women lives and their reproductive health experiences?

The thesis illustrates how conditions of poverty, unequal class, and gender and power relations structure risk for young women and leave them with few options. This is evident in the context of reproductive and sexual health negotiations and fertility behaviour. Poor married adolescent women construct a ‘political economy of the body’ and pragmatically acquiesce with decisions made by others, such as, unsafe sex, too many pregnancies, and forced abortions, even though they may violate their sense of bodily integrity and well-being. Health care services are dismal and fragmented. Abortions may be through legal or illegal means and are understood to further jeopardize young women’s health. Such pragmatism puts their bodies at risk, but gains them advantages and limited power within their social situation.

I demonstrate how disparities of power operate in the lives of poor married adolescent women and critically shape health meanings, reproductive health experiences and practices. It is imperative we acknowledge and address the inequalities within Bangladesh, as well as examine the global inequalities between the rich countries and poor countries all of which create an underclass, who are unable to realize their health potential. I maintain that unless issues of social and economic justice are tackled, in the long term, ‘reproductive health,’ and health in general, will not improve for the poor.
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Chapter One

Introduction

Two weeks in Farida’s life

Farida is a small, malnourished girl, about 16 years of age. She has been married for four years to Sayed and has a baby girl, who is 11 months old. Farida and her husband were temporarily living at her uncle’s home, located in a slum settlement in Dhaka City. After their eviction by the government from their own slum settlement in July 2002, they moved into her uncle’s home nearby. Farida was sitting on the bed when I walked in. She gave me a tired smile. Like most homes in the slum, it was no bigger than 30 square feet, tiny, damp and dark. There was a torn sheet on the bed and her baby girl sat on the edge of the bed crying. Farida informs me that she is three months pregnant. She whispers her news to me. She is anxious and tense because she does not know what to do. She is very worried about her husband Sayed (28 years old), as he does not have a job. Until recently he was working in a garment factory, but the factory shut down and he was not paid for the past few months. After the 11 September attacks in 2001 in the United States, there was a world recession and thousands of garment factories were affected in Bangladesh and shut down. Farida’s brother-in-law promised to help them financially but was facing difficulties himself. The World Bank together with Bangladesh government implemented a policy in September 2002 to reduce air pollution in Dhaka and banned thousands of diesel run baby-taxis [local three wheelers transport] from the streets. Farida’s brother-in-law, like thousands of poor urban men, was left unemployed.

Farida’s husband, Sayed, was working odd jobs, but his income was low, and fights were common in the household. Farida’s uncle is threatening to evict them because they have not been able to pay rent for the past two months. Farida claims her uncle is a heroin addict and wants the money to support his habit. Farida and her husband discuss her pregnancy and he admits that although they are both keen to have another baby, this was not the best time. He looks embarrassed and said, ‘we can’t keep the baby. Apa [sister] you know our situation now. You see how we are living. If I am lucky I can do some odd jobs and earn up to Taka 40 or 50 [AUS $1.00] a day but when I don’t have work, which is often, we go without food for days. We already have one child and we cannot manage with another. We will also have to move soon.’ Farida remains quiet. She points to the corner of the room and tells us how she found a big dead rat drowned in her large bottle of cooking oil. She and her husband laugh. There were two cockroaches roaming around
her tiny, muddy, uneven floor. I see one egg carefully set-aside on a plate on the floor. She is saving it to cook it for dinner. For a poor household to purchase an egg is a luxury.

A few days later we find out that Farida had a crude abortion and was bleeding profusely. With the help of a traditional healer, she had inserted a (plant) root into her vagina and had started bleeding. They rushed to the pharmacy and bought some medicines to control her fever and bleeding. A few days later, we find Farida lying on her bed on a torn, stained sheet, looking tiny, pale and very ill. She says, 'I am very scared. I don’t know what is happening to me. I feel very weak and I cannot get out of bed. I am terrified.' Farida bled for 10 days and after that her bleeding stopped. Prior to this, I had warned Farida of the dangers of an illegal abortion and we had planned to visit the clinic together to discuss options for a legal termination. She decided to have an (illegal) abortion because it cost her nothing. A termination from a clinic will cost about Taka 400 [AUS $10], money that they did not have and if they did they could not afford to spend. They needed money to meet their basic needs - food and rent. Her husband wanted to send Farida back to the village, but Farida’s mother, who is a widow and extremely poor, did not want to take on the burden of caring for Farida and her baby.

A week later Farida and her husband moved to another slum. Her husband found some temporary work as a labourer. She is happier as they have been eating better the last few days. While we chat, her baby plays on the muddy floor, half-naked playing with small stones and dirt. Three days later, her baby is sick with severe diarrhoea, vomiting and fever and they rush to a nearby hospital for treatment. Farida borrows Taka 2000 [AUS $50] from her elder brother for the treatment. Her husband would have to work for more than two months to repay that loan. However, her husband is struggling to find a job, and has started drinking and spending time away from home. We also find out [after some probing about ‘reproductive health’] that she is suffering from smelly and itchy vaginal [white] discharge. Farida finds sex painful but claims her husband does not want to understand her situation. She says, ‘My husband only brings home Taka 20 [AUS 0.50 cents] when he works. How are we supposed to manage? How will we pay rent? I pray that he [husband] finds a job, it so difficult for us to manage...’ When asked why she had not sought treatment for her smelly discharge, she responds, ‘to treat this illness will cost me money. Will I spend money on treatment or will I spend whatever money I have to buy food? I think the money spent on myself will be better used to buy food for all of us for three days...what options do I have? My husband is unemployed and I have a baby now...we have to eat!’
This thesis is concerned with the lives of married adolescent women in an urban slum in Bangladesh, and explores how the injustices of a harsh political economy impact on their bodily health and shape reproductive experiences. Farida’s life raises many important issues: what do we mean by health and specifically reproductive health when we look at her life? Can we separate reproductive experiences from other aspects of young women’s lives, the material, social and political-economic? Farida’s experiences illustrate the combined effects of dire poverty, class disparities, unequal gender and power relations that leave her and her family vulnerable, and also situates her body and reproductive health at risk. Her current life situation highlights the need to understand the wider structural and political economic inequalities in which the lives of the urban poor are embedded, which result in particular illness experiences. Farida’s story is typical of the countless stories I heard among poor urban married adolescent women who live an unpredictable and fragile existence, having no assets and never enough cash to save or plan for the future, as they struggle each day to survive.

Farida is desperately anxious about her family’s future, her husband’s unemployed status, impending rent payments, homelessness, and lack of money to buy food to meet her child’s hunger? Initially, Farida and her husband were left homeless after suddenly being evicted by the government from the illegal slum settlement they lived in. Working in an insecure, informal labour market, with little skills and education, urban poor men often remain permanently unemployed. Farida’s husband lost his job because of a recession in the world market economy and local conditions, which were out of his control. Soon after, her baby fell ill and they were in debt after borrowing money to pay for the treatment. Worries about her abortion and discharge problems - ‘reproductive health’ fade into insignificance as she and her family try to manage their basic needs and survive.

Urban health and poverty

Bangladesh is one of the poorest countries in the world, with an estimated GDP per capita of US $220 in 1993, ranking 146th out of 174 countries. The country is one of the most densely populated countries in the world, with 820 persons per square kilometre. Out of a total population of 145 million, almost half, at least 70 million live in absolute poverty in both rural and urban areas in the country (Perry, H, 2000).
There are several reasons for my focus on poor married adolescent women living in an urban slum in Dhaka, the capital city of Bangladesh. Increasingly, urban health and poverty are becoming important issues. The rapid influx of rural poor families to Dhaka has seen a rapid increase in urban population growth, slum settlements\(^1\) and worsening poverty. Forty to seventy percent of urban population growth is now attributed to rural-urban migration (Islam, N et al, 1997). It is estimated that by the year 2015, the population of Dhaka will be almost double to around 21 million, making it the ninth largest city in the world (Perry, H, 2000). Almost 60 percent of the urban poor population live in extreme poverty, with another 40 percent classified as living in 'hard core' poverty, meaning that families survive on a monthly household income of only AUS $62 (Islam, N, et al, 1997). Brutal poverty and uncertainty pervades the lives of the urban poor. They live in illegal settlements in squalid conditions. Moreover, the mortality levels of the urban poor are well above the rest of the city's population (Caldwell, BK., et al, 2000a). The mechanisms through which social change such as urbanization and its effects on health remain poorly understood and overlooked (See Kleinman, 1995; Cristakis, N. Ware and Kleinman, 1994). In Bangladesh, urbanization, rather than being a sign of economic progress, has also become part of the process of under-development leading to considerable urban poverty.\(^2\)

In Bangladesh, much of the research has focused on the lives of the rural poor. A number of pioneering studies on the urban poor, based on surveys and quantitative data, provide useful information on the socio-demographic characteristics of the slum population (See Islam, N, 1996; Islam, N, Huq Zahurul A.T.M. et al, 1996). In addition, some in-depth studies provide insight into the rural-urban migration phenomena, some of the gender aspects, health conditions, as well as social structures in slums (Paul-Majumder et al, 1996; Afsar, R, 2000; Wood, 1998a, 1998b).\(^3\) However, all studies lack

\(^1\) The United Nations definition of a slum is described as: an area characterized by overcrowding, deterioration, insanitary conditions, or absence of facilities and amenities which, because of their conditions or any of them, endanger the health, safety and morals of its inhabitants and community (cited from Thorbek, S, 1987).

\(^2\) Cities in the developing world have been portrayed in the demographic literature as privileged centers of comparative wealth with populations benefiting from modernization and a wide range of amenities, particularly health and education. However in recent times concerns have been raised that with continued urban growth fueled by the influx of the rural poor, this picture is no longer accurate. Cities – (this is particularly applicable to Dhaka) have instead become the location of some of the worst poverty, aggravated because it is often juxtaposed next to extreme wealth (Caldwell, BK., et al, 2001, See also John, C. Caldwell and Bruce K. Caldwell, 2002).

detailed ethnographic data. There is an overwhelming absence of ethnographic research focusing on poor married adolescent women's lives and their reproductive experiences and behaviour in Bangladesh (Nahar, Q et al, 1999).

Existing research on health in general and reproductive health in particular in Bangladesh is primarily seen through a biomedical lens. The social science and clinical literature on health has often involved examination of misconceptions, cultural gaps in knowledge, attitudes, traditional practices, problems with health services and so on, to explain the distribution of illness and disease among the poorer populations. Thus, existing studies tend to focus on individual, cultural and behavioural determinants and gaps in health services, which contribute to unfavourable health experiences for the poor. While micro-level factors of gender inequality and patriarchy are often mentioned, the literature remains silent about class and other larger inequalities that can directly contribute to illnesses and disease among the poor. Although poverty is mentioned, in most studies it is placed alongside other social factors, such as, culture, patriarchy, attitudes, gender, and so on, with each factor seen as playing a role in making individuals vulnerable to suffering and illness. While, these studies do provide useful and insightful data on particular aspects of health in Bangladesh, there is yet to be an analysis of the simultaneous effects of various structural and social factors, which produce adverse health experiences among the poor. My thesis addresses this gap in the literature by critically exploring the nature of inequalities and the structure of poverty [increasingly a global/local process], which contribute to particular life conditions for the poor and shape their health understandings and reproductive experiences (See Farmer, 1999).

International health agenda, donors & local health policies in Bangladesh

Of the 20 poorest countries in the world, Bangladesh is the largest recipient of foreign aid and the largest recipient of assistance in the population sector (Perry, H, 2000). The government and the international development agencies generally control aid

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4 Often the focus is on the individual’s shortcomings – failure to eat the right foods, get access to care, failure to wash hands, ignorance about public health – without acknowledging the constraints of poverty and lived realities which shape many responses and behavior of the poor.
coordination and management of health policies, research agendas and interventions. Currently, there are at least 13 multilateral and 18 bilateral organizations committing funds to the Ministry of Health and Family Welfare (Buse, K 1999). Since the 1970s the World Bank [most influential donor] and the Consortium of bilateral donor agencies\(^6\) have been providing assistance to the Ministry of Health and Family Welfare, through four successive five-year population and health projects, collectively disbursing approximately US $78 million a year during the mid-nineties (Buse, K, 1999). Other major donors outside of this large consortium include, USAID [primarily family planning], UNICEF [children and women’s health]; ADB [curative care]; UNFPA [reproductive health] and WHO [technical assistance]. The EEC and JICA [Japan aid agency] are relatively new players in the health program but poised to become major donors in the future (Buse, K 1999).\(^7\)

As Bangladesh’s dependence on international donor assistance started rising in the mid-1970s, the government began to initiate policy and organizational changes according to the prescriptions of the donors. These were based on a vertical family planning program service delivery and the bifurcation of the health and family planning services, with emphasis on family planning interventions (Jahan, R, 2003). The impact of the International Cairo Population Development [ICPD] recommendations in 1994 in Bangladesh has been to induce local policymakers to adopt [in paper only] an integrated service delivery structure abandoning the vertical structure of the past, which had separate departments for health and for family planning. Although the government has adopted the ICPD definition of health in official documents, and a wide range of stakeholders, including the Ministry of Health and Family Welfare, collaborated in drafting the overall Health and Family Population Sector Strategy (GOB, 1997), in reality, government clinics and hospitals continue to focus on maternal and child health

\(^5\) As Paul Farmer remarks, most studies tend to shy away from posing questions ‘in their full generality. To confront the big picture seems like an overpowering challenge’ (2003:xiii).

\(^6\) See Buse K (1999) for further discussion on the role of multilateral and bilateral donors in Bangladesh.

\(^7\) Kent Buse argues that the unstable and volatile political culture in Bangladesh (with rising corruption and lack of transparency) has led to the donor agencies questioning the legitimacy of successive administrations, and retaining a tight control over aid coordination and management. However, part of the blame also lies with donors who bear some responsibility for the absence of a coherent, comprehensive and credible plans for the health sector. These include, operating behind closed doors, inundating government officials with foreign visitors and other demands and inducing confusion through a constant barrage of contradictory policy prescriptions [competing with one another], as well as reorienting the agenda towards external priorities, thus weakening domestic ownership and support of it (1999:223).
and family planning, without an integrated reproductive health approach. The lack of integration and implementation of the reproductive health approach is blamed on the lack of donor commitment and reluctance of government officials, who prefer the vertical approach (Lush et al, 1999).

World Bank [a major donor & the most influential] believes a more sustainable approach for health is to improve health services for women and children. Other current measures being pushed by the World Bank, include reorganizing the public sector to provide more cost effective services; to broaden health reform through decentralization and improve cost recovering, by introducing fees for patients, and greater input from non-governmental organizations [NGOs] and the private sector (Abbasi, K, 1999). Currently, NGOs fill the gap in government services, and play an important role in implementing basic integrated reproductive health services at their clinics (Hardee et al, 1999). These include basic services and information for reproductive tract infections and sexually transmitted illnesses, including HIV.

The family planning programs have brought about considerable progress in Bangladesh, in lowering the total fertility rate from 7 in the seventies to 3.3 currently and increasing contraceptive prevalence from 7 percent to 49 percent in the country. However, there continues to be a real absence of improvements in other health and economic indicators.

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8 Hardee et al (1999) in their review of countries integrating the reproductive health approach, found in Bangladesh that directorates have their own vertical delivery structures and rarely co-ordinated their efforts and there appeared to be little political will to integrate. They also found that the service delivery system had many problems and there are few trained personnel who know how to handle reproductive tract infections and sexual transmitted illnesses. So despite the policy adoption of ICPD, less progress has been made in the tasks of setting priorities and of implementing the Cairo recommendations nationally (Lush et al, 1999). There is also concern now that there is an over emphasis on HIV/AIDS programs in health internationally and locally. Out of the 2.5 billion donors are contributing to health in developing countries, 39 percent was spent on STD/HIV/AIDS, while 30 percent on family planning services, and 24 percent on other reproductive health services and 8 percent on basic research, data and policy analysis (Singh, JS, 2003).

9 In the 70s where there were recommendations for more broad-based interventions with the focus on women. This was partially in response to international pressure to incorporate women into the development effort, recognizing their role as social and economic actors, while attention is primarily on their roles as child-bearers and child-rearers. Donors, bilateral development agencies and local NGOs accepted this ideology. Women were perceived not only as economic beings but also as gatekeepers of health. Accompanying this shift in the conception of women as workers was the reinforcement of women as mothers. At both the conceptual and program levels, stress was placed on women as the controllers of their family health status. In short, women became and continue to be the primary clients of health interventions (Feldman, S, 1987).

10 There is concern in that the outcome measures used by the Bank tend to be financial in focus rather than health oriented, with doubts about the sustainability of projects [Abbasi, K, 1999]. Due to the inadequacy of government services, there are 4061 NGOs working in the health, population and nutrition sector alone, with many providing family planning services to about one quarter of the eligible couples in the country (Perry, H 2000).
In particular, infant mortality and reproductive health remains dire (Ross et al, 1996; Jahan, R, 2003).

**Married adolescent women and reproductive health**

Presently, the reproductive health of adolescents is of growing concern globally and nationally. At the global level, the Program of Action of the International Conference on Population and Development, held in Cairo in 1994, placed great emphasis on the problems and needs of adolescents [defined as between 10-19 years of age by the World Health Organization]. The Program of Action recommended ‘in conducting sexual and reproductive health research, special attention should be given to the needs of adolescents in order to develop suitable policies and programs and appropriate technology to meet their health needs’ (UN, Asian Population Studies Series no, 156:1).

Consequently, in Bangladesh, in the five-year health and population sector program [HPSP] adolescents have been identified as neglected and targeted as an important component of reproductive health care by the government (Pratomo, H, 1999). Adolescents constitute more than 22 percent of the total population, with 13 million girls and 14 million boys in the country (Nahar, Q, et al, 1999). Poor married female adolescents, by virtue of their gender; age and poverty are an extremely vulnerable group, particularly, in the harsh and uncertain urban slum environment. The importance placed on fertility for newly married adolescent women results in high rates of adolescent fertility and lower rates of contraceptive use in the country. The current fertility rate between 15-19 year olds is 147 per 1000 girls, ranging from 155 in rural areas to 88 in urban areas. This is the highest 15-19 year old fertility rate for this age group in the world. Only about 30 percent of poor married adolescent girls use a method of contraception, which is much lower than the national figure of 49 percent for all women. A study found that the contraceptive prevalence rate in the slum is only 38-40 percent compared to 51 percent in the non-slum urban areas (Arifeen and Mookherji, 1995; GOB and ADB, 1998; BDHS, 1999-2000). Bangladesh has one of the highest maternal mortality rates in the world, estimated to be 320 per 100,000 live births, with

11 Adolescence – [10-19 years of age as defined by the WHO] is commonly defined as a time when young people are addressing the transition from childhood to adulthood. It is argued that in the context of
as many as 100 morbidities for every maternal death (Jahan, R, 2003). The consequences of early marriage and childbearing is not only a higher death rate among poor adolescent girls compared to boys aged 15-19 years [1.81 as against 1.55 per 1000 population] but also large numbers of non-fatal injuries, infections and disabilities (BBS, 1997).

Despite the heavily funded health and family planning interventions by government and NGOs, training of health workers and educating the poor through public health campaigns, it has to yet to translate into better health outcomes for the poor, particularly for poor women and their babies. Although there is some indication of improvement in female life expectancy from 58 to 60 years and a decline in infant mortality rates, from 105 deaths in 1985-1989 to 66 deaths per 1000 live births in 1995-99, it is disappointing to see little improvement overall\(^{12}\) (Jahan, R, 2003; BDHS, 1999-2000; Huq, N, 2004). Decline in maternal mortality rates remains insignificant, from 470 to 320 per 100,000 live births and contraceptive prevalence remains static from 49 percent to 50 percent (Jahan, R, 2003). In addition, health conditions are far worse among urban poor women and their families, who suffer from the highest morbidity and mortality levels in the country. The urban poor have lower immunization rates, lower tetanus toxoid coverage of pregnant women and contraceptive use, higher malnutrition rates, and higher infant mortality rates and deaths from infectious diseases (Perry, H, 2000; Islam, N, 1996).

This is despite Dhaka being the health centre of the country, with its concentration of government hospitals, private clinics and doctors (MOHFW, 1998a). Theoretically the urban poor have equal access to all the public health facilities but the reality is that, compared to demands and costs, very little is available to them (Islam, N, 1996). It is surprising that after more than 30 years\(^{13}\) and the expenditure of hundreds of millions of dollars in health interventions into Bangladesh, the overall health of poor women, pregnant and nursing mothers and infants remains deplorable by virtually any standard (Ross et al, 1996; Huq, N, 2004). It is crucial that we understand why there has been so little improvement in health, particularly women’s reproductive health.

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\(^{12}\) In Bangladesh, many policymakers would argue that overall trends in infant mortality and female life expectancy are the results that count. While it is important we are misleading ourselves if we choose to focus only on national aggregate data, rather than actual situation in the country, particularly those of the poorer populations.

\(^{13}\) Referring to after 30 years of Bangladesh’s Independence.
Critical exploration of ‘reproductive health’

Bangladesh is dominated by a monolithic bio-medical model of health policies and research. This interpretation of health automatically places it within the context of medicine and medical interventions, where bodies are monitored for [reproductive] disease (Lock, 1998). Health interventions implicitly follow biomedical definitions of health and focus narrowly on symptoms and treatment rather than more holistic approaches to causes of illness. Universal education in public health and biology and the availability of Western medical care¹⁴ are seen as preferred forms of intervention to improve the health situation of the country.

However, in the context of Bangladesh, where a majority of the population live in severe poverty, it is critical not to ignore the broader political, social and economic processes that contribute to certain life conditions, and particular illnesses and reproductive experiences for young women. The parameters that determine Farida’s reproductive experiences, like most poor women in the slums, are intricately tied to larger processes, and rooted in power relations and lack of access to political and economic resources. In this thesis, I argue that the concept of ‘reproductive health’ is virtually irrelevant in Bangladesh in the context of extreme poverty. Social and economic justice needs to be an integral part of the solution if we truly want to improve the health of poor women [and men]. In Bangladesh, there continues to be very little understanding or recognition in research and among policymakers of how structural conditions and political-economic disparities crucially make the poor at risk of adverse health experiences.¹⁵ This thesis thus adds to the voices of those scholars working in reproductive health, who argue that unless an understanding of larger material conditions, and gender and class inequalities are assessed and understood, attempts to improve reproductive health will fail (Denise Chevannes-Vogel, 1999; Obermeyer, 1999; Petechsky, 2000).

My contribution is to clearly demonstrate interrelations between social and political-economic conditions and cultural factors, which contribute to particular health

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¹⁴ The emphasis often tends to be on ‘behavior modification theory – many of these models are often irrelevant to the contexts in which ‘adverse’ health experiences occur.

¹⁵ Notable and outspoken exceptions are Dr. Zafarullah Chowdhury, whose is the founder of Gonoshasthaya Kendra, an NGO involved in work in the health sector. See Chowdhury, Z [1996:138].
understandings and reproductive experiences for married adolescent women living in the slum. Furthermore, I examine how macro and micro forces place poor families in difficult situations and compel married adolescent women to make certain choices, situating their bodies and reproductive health at risk. In a poverty-stricken environment, where choices are few and priorities constantly shift, ill health is often competing with many more pressing burdens in poor people's lives. I argue that it is imperative we address the inequalities within Bangladesh, as well as examine the global inequalities between the rich and poor countries all of which create an underclass, who are unable to realize their health potential. I maintain that until and unless these social and economic issues are tackled, in the long term, reproductive health, and health in general, will not improve for poor women [and men].

**Theoretical framework**

**Critical medical anthropology**

A number of perspectives and scholars have influenced my analysis of young women's lives and reproductive experiences in an urban slum. I place importance on the political economy of health and the social determinants of health. A critical medical anthropology perspective views 'health issues within the context of encompassing political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, re-order local ecologies, and situate cultural meanings, including forces of institutional, national and global scale' (Baer, Singer and Susser, 1997:3-4).

Critical medical anthropologists analyse how diseases are only immediate causes of human suffering, and the actual roots are political and economic forces both global and local in nature, which are present in the local health conditions. Disease is understood as being social as well as biological. Thus, efforts are made to focus on the social origins of disease and the links between social class, poverty, power and ill health, referred to as the political economy of health. Critical medical anthropologists also argue that biomedical institutions often function to maintain social inequalities (Baer, Singer and Susser, 1997).

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16 Morsy (1979) noted that political economy of health was the 'missing link in medical anthropology,' a conclusion supported by Hans A Baer (1982). Increasingly, the political economic perspective has become an important model in medical anthropology.
There are many sub-approaches within the critical medical anthropology framework; however, the main focus is the health consequences of global power relations. A fundamental question is how do global/social forces become embodied as individual experience? (Singer and Baer, 1995). The political economic approaches, range from those entrenched in Marxism to those more influenced by current social movements and theories concerned with the dispersing of power. There is no single approach dominating, with struggles ongoing between those who advocate post-structuralist critiques of biomedicine and those advocating political economy approaches (Morgan, L. M, 1998). The perspectives have also been criticized for being too critical of capitalism and biomedicine, with an over-emphasis on market systems, which ignores class relations and local power relations (Morgan, L. M, 1998), and neglects the existential lived experiences of individuals (Scheper-Hughes and Lock, 1987:137).

I extend the critical medical anthropological analysis into the domain of ‘reproductive health’ and carry out a critical reading of reproductive issues among poor married adolescent women living in an urban slum. In the thesis, I pay attention to global, as well as local processes, power relations and class inequalities, which situate the urban poor in particular ways, shaping their choices, agency and health experiences. I show how slum dwellers remain an underclass living on the margins of society, constrained socially, economically and politically, and vulnerable to the larger processes which impact on their everyday lives.

‘Structural violence’

In the thesis, I also explore how structural and social inequalities make young women vulnerable to adverse reproductive health experiences. Increasingly, critical perspectives ask how structural and social inequalities generate and maintain risk among individuals and groups to particular disease and illnesses (See Farmer, 1992, 1996a). Paul Farmer, (1996a, 1999, 2003), among others, points to the role of social inequalities in shaping the distribution of morbidity and mortality within and between populations. Farmer (1999) stresses that the socio-political context of a sufferer’s health is critical. Attention needs to be paid to causes outside the body, to structures and social hierarchies of gender, race, class, and how these relationships shape an individual’s power and access
to resources. All of these factors impact on agency, choices relating to health; and
global and local political economies, including State policies alter health and disease of

In understanding the creation, distribution and treatment of infectious diseases, Farmer
combines interpretative anthropology and political economy to capture the unequal
power structures and social processes that contribute to AIDS among the poor in Haiti.
He discusses the historical aspects of capitalism, which produce poverty and
underdevelopment in Haiti, urban migration, high unemployment rates, prostitution and
social disruption of family and marriages (1992). He illustrates how gender and power
inequalities leave women vulnerable to unsafe sexual experiences and HIV infections
(1992). He demonstrates how ‘context is all important’ and the Haitian situation
‘bespeaks of multiple forms of oppression, based on gender, race, class and global
location’ (Inhorn M.C. and K.L. Whittle, 2001:563). Farmer argues that to understand
the meaning and experiences of AIDS in Haiti, one needs to relate the cycle of political
and economic oppressions – ‘structural violence’ and social inequalities which have left
the Haitian poor, powerless and deprived, and structured them at risk for illnesses

I draw upon Farmer’s metaphor of ‘structural violence’ to explain the situation of the
urban poor in Bangladesh, who are socially and economically vulnerable and bear the
onslaught of many oppressions which impact on their lives, health and well-being.
There are various levels of ‘structural violence’ operating on the lives of the urban poor.
These include: (1) a harsh political economy which creates a violence of hunger and
poverty for displaced and neglected urban migrants in the city (2) institutional violence
by the State, police, and authority figures/leaders in the slum, and the health
system/services which also oppress the urban poor; and finally (3) physical violence -
gang warfare, criminal activities, sexual harassment of young women in the slum, as
well as widespread domestic violence in households. Some of the questions I explore
from this perspective include: What multiple effects might structural and social
inequalities contribute to urban poor families and what impacts do they have on married
adolescent women lives, shaping their reproductive experiences? Like the Haitian poor,
urban poor families who migrate to the city in search of a better life remain powerless

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17 By ‘structural violence’ Farmer refers to the ‘nature and distribution of extreme suffering’ which
and at the bottom of the social and economic hierarchy, and face continuous oppressions. Moreover, gender, class and power inequalities make married adolescent women vulnerable to harmful reproductive experiences.

Agency and resistance

Any discussion of ‘structural violence’ also draws on debates regarding agency and resistance of individuals who are constrained by oppressive conditions. Throughout the thesis, one is confronted by the overwhelming structural and social inequalities that contribute to difficult lives for the urban poor, particularly, impacting on married adolescent women’s lives and reproductive experiences. I show in the thesis, how acute poverty and competition over scarce resources force poor married adolescent women to tolerate bad marriages, abuse, forced sex, multiple pregnancies, and coerced abortions, with young women constructing a ‘political economy of the body’ (Petechsky, 2001) in their reproductive and sexual health negotiations. This is often at a cost to their bodies and health.

The reproductive experiences and behaviours of married adolescent women bring into relief issues of political economy, structural roots of poverty, power/ powerlessness, social hierarchies of age, gender and class, cultural practices, the State and biomedical interventions. My contribution to the literature offers a critical discussion of the lives of poor women which are embedded in conditions that allow for little to no choice. There are disabling structures that leave both poor men and women with no alternatives and little agency to change their position. Many authors are critical of the over emphasis on resistance in post-modern literature, when in reality there is little room for manoeuvre (Lock and Kaufert, 1998). Abu-Lughod is critical of romantic portrayals of resistance by anthropologists. She inverts Foucault’s statement of ‘where there is power, there is resistance’, to read, ‘where there is resistance, there is power.’ She argues that from this point of view, the behaviour and response of individuals to lived experiences can be read at times as resistance as well as a commentary on the networks of power (1990). Kielmann is concerned with the apparent contradictions and complexities in the way people pursue strategies of consent and dissent within the constraints existing in society. She notes that the practices which women carry out as individuals may negate the dominant ideologies as well as conform to it, with ambiguities clearly evident (Kielmann, 1998).
Lopez notes in her study on the medicalization of women's reproduction in Puerto Rico, that one must ask what concepts of 'choice' and 'voluntary' mean in the context of women's lives, who are positioned in particular ways because of structural realities (1998). Petechsky (1990:11) suggests that the critical issue for policymakers, international organizations and even women's groups are issues about economic justice and poverty, which shape decisions and behaviour related to reproductive health (See also Petechsky, 2000). Basu maintains that a focus on patriarchy/gender can distort the nature and extent of the importance of gender in health matters. Moreover, the obsession with gender issues encourages 'inattention to larger questions of poverty and economic inequality and the general socio-economic environment' (2000:26). Zaidi maintains that it is often gender inequalities that are seen as the major impediment to good health, and patriarchy usually blamed for causing a system of inequality. However, poor men and women suffer from the worst forms of discrimination in every country in the world. Not only are richer women in poor countries better off than their poorer sisters, but they are also better off than the poor men in their own country. While he acknowledges that the situation of poor women is much worse than poor men, overall within a country, one's position, whether male or female on the social and economic ladder determines access to resources and sculpts the health of individuals or social groups (1996). The thesis will illuminate the complexity of agency and choice as they emerge in poor women's everyday lives in the slum.

**Embodiment & phenomenology**

I also explore the phenomenological aspects of human suffering in the thesis. I pay attention to how global and local processes are embodied and impact on the lived experience of the body. I discuss how the urban poor make links between their extreme suffering and the emergence of a "folk ailment" *chinta roge* [worry illnesses], understood to cause a wide range of illnesses in their bodies. Their illness narratives of *chinta roge* are embedded in the wider social, political and economic conditions of their everyday lives.¹⁸

Scheper-Hughes and Lock (1987) draw the outline of an embodiment approach and contribute to understanding the sufferer experience through the concept of the 'mindful body.' They argue that the existential, subjective content of illness, suffering and healing as lived events have traditionally been neglected in anthropological research (1987). While the political economic approach emphasizes the influence of macro forces on culture and their responses, the existential view places importance on the sufferer's experience and the 'construction of illnesses and understandings mediated in the realm of experience' (Singer et al, 1988: 374). Scheper-Hughes and Lock (1987) propose a three-dimensional framework to better understand the linkages between mind, body and culture in understanding sickness in the body. This includes the 'individual body', characterized by concepts of self, mind, and body; the 'social body,' encompassing the symbolic dimensions of the body and social relations; and 'body politic', which is the regulation, surveillance and control of social bodies.

The task of bridging the three bodies - individual, social, and political remains the missing link in a critical discourse on illness (Schepers-Hughes, 1994). Informed by Scheper-Hughes and Lock 'mindful body,' and drawing on critical medical anthropology, I illustrate the relationship between human suffering, and the structural conditions of poverty in which individual lives are embedded and illnesses are experienced. In the slum, constant worries, hunger anxiety and distress have led to the articulation of the 'folk ailment' chinta rage [worry illness], which is seen to affect both men and women. Chinta rage is phenomenologically experienced in the 'lived body.' A wide range of illnesses is understood to occur in the body as a result of chinta rage. This highlights the complex relationships among the individual, social and political bodies (Scheper-Hughes and Lock, 1987) and between lived experience and culture. Accounts and interpretations of chinta rage reveal how illnesses are historically and socially dependent, and not exempt from broader social and political-economic conditions.

This thesis is strongly ethnographic capturing the political economic and social contexts, which impact profoundly on the urban poor, particularly on poor married adolescent women's lives. My findings are very relevant to disciplines of demography

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19 Lock and Scheper-Hughes (1987) acknowledge that the work of Mary Douglas [1970] and John O'Neill [1985] enormously influenced the mapping of the 'three bodies.' Mary Douglas refers to 'the two bodies' - the physical and social bodies. Recently John O'Neill wrote the Five Bodies: The Human Shape of Modern Society [1985], in which he discusses the physical body, the communicative body, the world's body, the social body, the body politic, consumer bodies, and medical bodies.
and other social sciences and public health. In Bangladesh, and in public health and anthropological literature, critical factors of structural, global and local inequalities, which produce specific kinds of suffering, disease and illnesses among the poor, remain understudied (Baer, Singer and Susser, 1997). The thesis aims to fill this gap by linking critical political economic theories with detailed ethnographic analysis. In doing so, I illuminate the broader structural, social, and political-economic circumstances that legitimise certain power relations and forms of inequality, and sculpt poor married adolescent women's lives and reproductive experiences in Bangladesh.

Structure of thesis

There are broadly four main themes in the thesis: Firstly, I explore the political economy of health and how macro and micro processes impact on the lives of the urban poor and shape health experiences, behaviour, choices and responses. Secondly, I explore 'structural violence,' and how institutional and social inequalities contribute to difficult lives for the urban poor and risky reproductive health experiences for married adolescent women. Thirdly, I illustrate how poor young women's lives are embedded in conditions, and have very little scope for agency and resistance. Fourthly, I examine embodiment and phenomenological aspects of human suffering among the urban poor.

The thesis demonstrates how constant poverty, hunger, economic scarcity and insecurity brought on by structural, social and political-economic disparities shapes the lives of the urban poor, particularly focusing upon married adolescent women. The discussions that ensue underscore some important points. First, broader political and economic conditions ensure that urban poor adolescent women and their families are seriously challenged in their abilities to improve their health. These include, brutal poverty, a harsh environment, class and gender hierarchies, dismal and fragmented health care, government neglect of urban slums, and widespread violence and gang wars, and police raids in slums. Forced evictions by the State result in systemic assaults against the poor, which also impacts unfavourably on their lives and health. Secondly, in Chapter Two and Four, I detail how the political economy and asymmetrical power relations generate and maintain inequalities which push the urban poor deeper into poverty as they fight to gain access to basic needs, such as food, shelter and employment. An increasingly

20 See also (Singer, M and Scott, S, 2003; Farmer, 1997).
interconnected world means that urbanization, global recession and international policies impact on the lives and job opportunities of urban poor men and women in Bangladesh. Finally, desperation brought on by the pressures of poverty are eroding family relation and support structures, with marital disruptions, polygamy and other forms of 'social and behavioural pathologies'\textsuperscript{21} including pervasive drugs and alcohol use, sexual violence and criminal activities appearing in the slum. All of these factors have direct and indirect bearing on married adolescent women’s lives, their bodily health and reproductive experiences.

I illustrate the ways in which extreme suffering is embodied and how health constructs are dynamic, changing and shaped by lived experiences, culture and social and political-economic realities in Chapter Three (Lock and Scheper-Hughes, 1996; Singer M et al, 1988). As circumstances change for the urban poor in an unpredictable environment, with poverty constraints and breakdown of family and social relations, concepts of health and sicknesses change according to lived realities. This theme continues in the later chapters. The urban poor speak of chinta roge [worry illness] and blame this illness condition on poverty and urbanization, a corrupt State and brutal police and the lack of adequate housing, lack of food and jobs and the breakdown of religious values, family and society. Grinding poverty, a miserable existence, and hunger are experienced phenomenologically in the lived body, resulting in a range of illnesses.

In Chapter Five and the subsequent chapters, I shift the focus to married adolescent women. In this chapter, I discuss experiences of chinta roge, which are seen to manifest as gender specific illness conditions of white discharge and weak bodies. While there are multiple understandings for white discharge, I focus on the chinta roge model of white discharge to show how meanings of illnesses can be shaped by conditions of life. Young women blame this condition on worsening political economic circumstances, unequal gender and power relations and hunger. In addition, nutrition campaigns by the government and NGOs, and local pharmacies and doctors have partly played a role in influencing such understandings of white discharge and weak bodies. In Bangladesh the health sector tends to be unregulated, with standards of care and treatment varying greatly. I demonstrate the negative influence of the informal and formal health sector, which promote and sell energy drinks and tablets as supplements for loss of energy and

\textsuperscript{21} Sugar et al, 2000.
for experiences of white discharge. Adolescent women who are too poor to buy food end up spending any savings on these tonics for relief. This exemplifies how biomedicine as an institution can be shaped by people's wants, but can also influence people's understandings of illnesses as well as their responses (Lock and Kaufert, 1998).

The role of biomedicine is a recurring sub theme in the thesis - how it shapes young women's lives and impacts on illness understandings and health care behaviour. While it is important to acknowledge the efficacy of biomedicine, it is important to also retain a 'constructively critical stance' (Lock and Scheper-Hughes, 1996:44; See Baer, Singer and Susser, 1997). The chapters in this thesis illustrate how poor women and their families cope with poor health care services, and are often exploited by biomedicine, thus further reproducing social and economic inequalities in society (Waitzkin, H, 1986).

In Chapter Six, and beyond, I move to detail more specific reproductive illness experiences for married young women in the slum. I demonstrate how the combined effects of structural, social and political-economic constraints create risky reproductive experiences for young women. Married adolescent women speak of the lack of control over their lives, coping with early marriage, husband's drug use, high marital instability, forced sex, too many pregnancies and husbands who are serially unfaithful. These conditions make them vulnerable to numerous reproductive illnesses. The increasing presence of medicine and medical interventions has created awareness among poor women of the risks of reproduction, with young women turning to clinics and pharmacies for pregnancy care. However, the reality is disappointing and expensive care at government hospitals and the proliferation of easily accessible unregulated pharmacies, private clinics and commercial diagnostic centres. Such centres promote various medicines, including injections and ultra-sonograms for pregnancy care, which not only end up exploiting poor young women, but can endanger their lives.

In Chapter Seven, I focus on a major reproductive concern for married adolescent women - infertility. Having children is important for young women to gain social recognition and acceptance. Young women are seen as primarily responsible for infertility problems, and men are not blamed. In Bangladesh, there aren't any affordable options for infertility treatment, because international and national health policies are
focused on fertility control and family planning is the main focus. Infertility understandings are changing as poor adolescent women now identify family planning use as a potential cause of infertility. Young women are caught in a dilemma between wanting to use a method to regulate their fertility but fear that long-term use may lead to fertility problems. The absence of government programs addressing infertility concerns causes young women to turn to indigenous healers. In addition, they are also taken advantage of by private clinics that provide technological ‘fixes,’ promised as cures for infertility. Dilatation and curettage (D&C) is one such ‘cure’ commonly promoted. The high costs of a D&C mean that most poor women are forced to rely on indigenous treatment. Furthermore, the lack of a State intervention impacts on contraceptive use and increases vulnerability for young women, who continue to be seen as primarily responsible for infertility and male infertility is totally neglected.

In Conclusion, Chapter Eight, explores how political economic conditions are impacting on actual fertility behaviour in the slum. The pressure to have children means that a large number of married adolescent women are forced to bear children before they are ready. High unemployment and substance abuse among men are leading to marriage disruptions, insecurity and incidences of polygamy among men. Young women hope that a child may cement their marriage and improve their husband’s behaviour. If a marriage is unstable young women hope to rely on their children as the continuing link to their husbands for emotional and financial support. However, cultural ideals of fertility and childbearing are being reshaped by poverty with some young women forced to terminate their first pregnancies. Brutal poverty, unequal gender and power relations, and micro-politics in the household, such as, competition between co-wives, in-laws and family members are some of the reasons given for forced terminations. Powerlessness force many young women to go along with decisions not to their liking but which will allow them to survive, with ‘reproductive’ concerns fading into the background. In this chapter, I also demonstrate that young women who do seek care for terminations cope with poor and inadequate health services. I describe how economic factors force impoverished health workers in the slum to rely on terminations as a means of supplementing their income. This has many consequences on poor adolescent women’s health, as they are often taken to private clinics by health workers for their own self-interest and end up paying more money for the service. Furthermore, private clinics carry out terminations beyond the safe period, and there is no follow up care provided for post abortion complications. All of this further jeopardizes young women’s health.
Choices are severely limited by institutional structures and social hierarchies of class, age, gender and harsh poverty.

This thesis identifies and contextualizes the interconnections of global and local political economies, structural violence and inequalities which: (1) frame suffering and meanings of illnesses for the poor; and produce and maintain vulnerabilities for families which contribute to adverse reproductive experiences for married adolescent women living in the urban slum. Farmer points out that epidemiology and public health are not interested in such broad analyses, and thereby neglect the underlying social-historical, political and economic processes that influence health and behaviour. As in Haiti, slum life in Bangladesh provides some lessons for social medicine, that the broader social conditions create and maintain poverty and inequality and do affect health outcomes for adolescent women and for the poor (Farmer, 1992; 2003). Listening to the voices of the urban poor, particularly married adolescent women brings into relief the political-economic conditions and structural processes that keep them at the bottom of the hierarchy. It is crucial that we do not leave unquestioned the wider forces that shape the context of [reproductive] health, if we truly want to make improvements in poor women and men’s lives and in their health.
Research methods

It is 9.00 a.m. and May 9th, when we arrive at Phulbari slum to observe people are running everywhere. As Nipu [my research assistant] and I walk along we notice blood splattered from Nur Islam’s [a leader/authority figure in the slum] home right up to the clinic. The entire mud path was covered in blood on the ground. We quickly enter the clinic. Sufia Khala [health worker who lives in the slum] says, ‘the leaders are fighting with each other about money and the rival gangs are also involved. The gangs are looking for Mostafa [another leader] to kill him. They didn’t find him but they found Kala Sayeed [another leader] and they cut his hands/arms. Now he won’t be able to work anymore. He was attacked in the stomach and they cut out his intestines. Someone rescued him and took him by rickshaw out of the slum.’ Sayeeda apa [another health worker who lives in the slum] says, ‘the situation is very hot [bad] and you don’t need to work in the slum now. You need to go home immediately. You don’t know when things can just happen.’ Just then someone screams out to us, ‘the police have come.’ Another woman waiting near us, said, ‘Some women say it is because of politics and others say it is about drugs and money. I think it is mainly votes and winning and losing elections.’ Someone else pipes up, ‘I knew it wouldn’t be long before this sort of violence starts again.’ The violence continued for 3 days and then on the fourth day we notice that sections 1, 2, 3 and 4, of the slum were quiet and there was a group of policemen sitting near the mosque. The grocery stores inside the slum were all shut.

What separates poor slum dwellers from other people living in Dhaka City is the climate of fear that surrounds their day-to-day lives. This excerpt gives you a sense of the environment in which my research assistant, Nipu, and I carried out fieldwork. Violence was a part of everyday life in the slum. If it wasn’t gang warfare, then it was police raids, or leaders oppressing residents, or household violence - domestic abuse, and fights and tension between neighbours, or fights among gamblers and drug addicts. The political economic conditions in the larger slum shaped my fieldwork strategies, and shifted the analysis towards a critical approach in understanding experiences of ‘health’ and ‘reproductive health.’
Methods

Fieldwork was carried out from late November 2001 to early January 2003. My research site was in Phulbari\textsuperscript{22} slum, in Dhaka. The slum was evicted in July 2002, but after the eviction, I continued to trace my respondents as they were scattered in the neighbouring areas and continued my fieldwork. I discuss the eviction in more detail in the next chapter. Data collection was planned in two main phases. The first phase was ideally to carry out a social mapping and then a survey of the slum to locate and identify married adolescent women. From the survey, I would select 150-200 married adolescent women for surveys. The final phase was an on-going process of selecting 50 married adolescent women from the surveys for repeated in-depth interviews, and long-term case studies of eight married adolescent women and their families and participant observations in the slum. However, while the plan was good in theory, in reality, I had to rethink some of my strategies once I started fieldwork, which I discuss later in this section. I had never worked in a slum before, with most of my research work carried out in rural areas of Bangladesh. Although the newspapers gave me a fair idea of the environment in slums - portrayed as crime ridden and extremely poor, I was unprepared for the tense and hostile situation in the slums.

I also decided to enlist the assistance of female research assistant to help me with data collection. Nipu had already worked for a number of years in a local research centre and had some experience working in rural areas in Bangladesh. I knew her briefly from my previous research work in Bangladesh. She was personable and more significantly, enthusiastic about working in the slums, an important consideration for me.

Slum selection

For the selection of a slum, I enlisted the help of BRAC, a local NGO\textsuperscript{23} that had fieldwork activities in urban slums all over Dhaka. We selected one of the largest slums, Phulbari slum, located in Pollabi thana. Pollabi thana, once a part of the greater Mirpur area, has recently been established as a suburb in its own right. Mirpur is located in the

\textsuperscript{22} Pseudonym
\textsuperscript{23} BRAC used to stand for Bangladesh Rural Advancement Committee, but is now referred to simply as BRAC. Set up in 1972, it is one of the largest NGOs in the world, employing 55,000 staff [both full time and part time]. Their main goals are poverty alleviation, micro credit and health for the poor, with field offices in both rural and urban areas.
northern periphery of Dhaka. It was originally developed in the 1960s as a satellite city for the non-Bengalis [Biharis] of the then East Pakistan. Mirpur is almost exclusively a

Table 1. Methods Employed in Phulbari Slum

<table>
<thead>
<tr>
<th>Methods</th>
<th>Data Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Surveys</td>
<td>153 married adolescent women - in some of the questions less than 153 women responded/ volunteered information*</td>
</tr>
</tbody>
</table>
| 2. Repeated In-depth Interviews - (from survey)  
  semi structured and free  
  flowing conversations;  
  participant observations | 50 married adolescent women, including families, and 12 husbands were also interviewed  
  Continued fieldwork with some adolescent women and their families, even after eviction |
| 3. Case studies - (from repeated in-depth interviews) | 8 married adolescent women and their extended families [parents, in-laws, siblings, whenever possible]  
  Continued detailed case studies after eviction |
| 4. In-depth semi-structured interviews | 6 Leaders in the slum  
  NGO workers  
  Clinic paramedic  
  1 religious leader |
| 5. Case Studies of Key Informants | Health Workers at the Clinic  
  From the beginning till the end of my fieldwork I continued to converse, observe and keep notes on their lives, behaviour, attitudes and experiences. I also carried out a formal interview with them about their work and the constraints they face in the workplace. |
| 6. Participant observations/ conversations | Men and women in the slum, including married adolescent women and their husbands  
  3 Club boys, 2 Heroin users,  
  The clinic in the slum  
  Women clients visiting the clinic |
| 7. Discussions/informal interviews with both formal and informal health providers | 1 Homeopath  
  3 Pharmacists  
  4 Traditional healers residing in the slum  
  1 Traditional healer residing outside the slum  
  2 Street sellers of medicines  
  2 Traditional birth attendants |
| 8. Collected and analysed secondary data - historical and current magazines, newspaper articles, and documents on events in Phulbari and other slums, drug raids, & criminal activities in slums, eviction documents, current garment industry crisis, transport sector ban, and so on. | Interviews, field notes and observations coded into Ethnograph qualitative software  
 Qualitative surveys analysed by SPSS software |

*This was shaped by many factors - timing, presence of individuals, interruptions by others, choosing to not respond, and so on.
migrant colony with only six percent non-migrants. Ninety percent of the migrants moved to Mirpur between 1960 and 1980 and the remaining ten percent arrived between 1981 and 1991. Mirpur presents a classical case of income inequality, with predominantly middle class people living in this area on one hand and very poor populations living in private houses under public housing [quarters] and in slums and squatter settlements on the other. Not surprisingly, it also has the highest proportion of squatter households, as most of the poor were resettled here after being forcibly evicted in 1975 from different parts of the city. There are many garments factories, gold and silver manufacturing factories, handicrafts, handloom shops and embroidery and lace work (Afsar, Rita, 2000).

Pollabi is divided into 5 sections – 6,7,10, 11, and 12. Pollabi has four wards –2, 3,5 and 6. Each ward is an administrative unit of a city. Each ward has its own ward commissioner who is elected by the residents of that area. My slum, Phulbari was located under ward-number 2 until its eviction. Although I refer to Phulbari as one slum, in reality, the area consisted of many thousands of households and sections within a larger contiguous area, and everyone referred to the place as Phulbari.

**Phulbari slum**

Phulbari was one of the largest slums of Mirpur until its eviction. The area consisted of 13 acres of empty government land, which had slowly grown over the past 15 years housing, and estimated at approximately 10,000 housing compounds, accommodating nearly 80,000 families - men, women and children (Daily Star, 2002). A large number of residents were living there for over 20 years. The slum was located near a main road, which has plenty of pharmacies, shops selling jewellery, medicines, clothes, food and tea stalls and a very busy market, where the women shopped for basics such as rice, lentils, vegetables and fish. The entrance to one section of the slum was a small narrow lane less than 4 feet in width, with rows of small shacks facing one another. The lane and houses were not visible from the main street. The physical layout of the slum not only limited interaction between the outside street residents and the slum dwellers, but also limited social interaction to the slum dwellers.
What confronted me when I started my fieldwork in the slum were the depths of poverty and misery I saw all around. The alleyways were tiny and congested, rooms with no fans, and drains overflowing with water, sewage and excretion, particularly during the rainy season. Skin infections were rampant among all - women, men, and children. Slum residents lived in tiny rooms/homes [the size of one home no bigger than 25 to 36 square feet] with mud floors and bamboo or tin/polythene covers, none of which shielded us from the blazing sun or pouring rain and stench from sewage and overflowing blocked drains. During my interviews with young women, I would often see rats and cockroaches running across the floor. Some rooms had a bed, often with tattered sheets, and some utensils, while other homes had no possessions, just a jute sheet [pati] on the floor and some utensils for cooking.

Phulbari was divided into many different sections, with some sections of the slum better organized with paved roads, whereas other sections were poorer and more congested, with varied shack structures. Many of these sections operated as separate slums, with many of the residents having little to no contact with individuals living in other sections. Basically, the vast area consisted of a number of slums divided into numerous sections, and referred to as Phulbari slum. My fieldwork was limited to sections 1, 2, 4 and initially 3, although as will be explained later, I stopped working there. Section 1 had one narrow main lane in the centre and lots of tiny alleyways everywhere where houses were placed in a zigzag manner on the muddy ground. The drainage was better here and the residents were very proud that they rarely had any criminal activities like murders, heroin sellers and sex workers. In this section, the lane was the focal meeting point for the community. Most mornings and late afternoons one noticed women and men standing and sitting outside their homes, gossiping, sharing stories about their life. There appeared to be a sense of community and some of the residents were friendlier and seem to actively take part in events in their section. This section had approximately 60 landlords, not including tenants, with households estimated at more than 200-250 households. A small concrete brick mosque in the middle divided section 1 and 2. The mosque was built with money collected from slum residents living in both sections 1 and 2.

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24 On its north side is journalist colony, south is the Muslim bazaar, east is baniohdah [slums] and the west side is B Block.
Section 2 also had one narrow cemented lane in the centre. However, this section was quieter and the people were less friendly. The residents would stay inside their homes and would rarely come out and sit or chat with one another. This was in marked contrast to section 1 and even section 4 where the men and women would sit and chat to each other in front of their homes. One reason for this could be that behind section 2, was a meeting place for gangs from inside and across the slum. There were approximately 60 landlords as well in this section, not including tenants, with households estimated at over 200 in section 2. At the end of the section 2, was section 3, which was well known as a troubled area. This particular spot where section 2 ended and section 3 began was where most fights, and harassment took place, including heroin deals. Most of the people were unfriendly and some were openly hostile, even after initial introductions by health workers. The leaders in section 3 would not assure us of our safety so after a few initial interviews; we decided not to carry out fieldwork in this section.

Section 4 was similar to section 3 and more typical of slum conditions in Dhaka City. This is where I also carried out much of my fieldwork. It was much poorer and the place was filthy with narrow muddy lanes and overflowing drains. There were no paved roads. There was heroin and other drugs sold openly near the field. Women also said that many incidents of rape and gang wars took place in this section. Sex workers were known to reside in this section. This was a very large section comprising of over 300 landlords and reportedly over 1800 households or more. There was a large sewage canal right through the centre of this section. Many of the homes did not have slab latrines. This much larger section had little sense of community. It was not surprising to just walk around the corner and discover that women and men did not know who lived barely 3 or 4 houses down. Some corners had their own group of close-knit neighbours and others did not. Some corners were extremely seedy, whereas others were less shabby, and appeared more welcoming. Some women were friendly and some were unpleasant, making it clear that they were not interested in talking to us. The health clinic was located in this section. There were several teashops where 90 percent of the leaders [powerful and influential people] in the slum would meet often to chat. Many of the leaders also had homes in this area, which they either lived in or rented out. While most fights and police raids took place in this section, it often had a ripple effect on all the other sections and it was not uncommon to have violence and raids spread to 1, 2 and 3.
Throughout my thesis, I refer to the Phulbari people as ‘slum dwellers’ and as ‘poor’ people. This is because over and over again, they identified themselves as ‘poor’ and as ‘slum dwellers.’ They always referred to Phulbari as a slum (basti).

Social mapping: ‘eviction fears & rethinking research strategies’

Although the initial plan was to carry out a social map after gaining entry in the slum, this strategy was abandoned. After brief initial introductions by an NGO staff to a few of the members in the community in section one, I began to carry out a social map of the community. This was to get a picture of the layout of the slum, including health centres and location of pharmacies etc, schools, mosques and layout of the place. I enlisted the help of a young man, Yusuf, about 16 years old, to assist us with the social map. I did not realize at the time that my actions would create problems. When we asked Yusuf to draw a map of this community, he seemed hesitant. We explained that we needed an outline of houses in this community. He sat on the ground and we sat around him. A few women and children showed up. We were all squashed in an old woman’s home. A woman piped up during this map exercise and muttered, ‘yes they are making a map. They are going to send it abroad to the original owners [who according to someone] lives abroad! They want their land back. The slum people are going to be evicted.’ After the comment, Yusuf partially completed section one and declined to draw a map of the other sections. I realized he was uncomfortable by my request. Yusuf’s behaviour and the woman’s comments confused me. Luckily my research assistant and I decided not to pursue the social map at the time.

It was only after spending considerable time in the field, that I realized the significance of her statement. Regarded as illegal occupants in this area by the government, the residents always lived in fear of being forcibly evicted from their homes. Unknown to me at the time, the fear of eviction was the upper most concern in the minds of the Phulbari slum dwellers. They were worried that the government would attempt to remove them from the slum at any given moment. In 1993, without any forewarning Phulbari was bulldozed and local thugs were brought in to intimidate and harass the women and men into leaving (verbal communication & Proshika, 1993). A month before the 1993 eviction, some government officials claimed that they needed to carry
out a survey in the slum to help ‘build a better drain’ for them. The leaders and the community quickly caught on to the deception and resisted the officials. Soon after, the government went ahead and evicted the slum dwellers. The government was unsuccessful and after a month the slum people returned and rebuilt their homes and their lives. However, much later, I was witness to the eviction in July 2002, when without any prior notices, the government broke the law and evicted the poor people from the slum. In less than three hours the entire slum settlements was bulldozed to the ground. Therefore, when I asked them to do a social map, not surprisingly they were suspicious of my intentions, especially after I had asked for layout of the entire slum. Word spread of our behaviour on that day and many were convinced that we were working for the government or police and remained suspicious of our intentions.

**Surveys**

With tensions running high because of eviction fears and the near disaster with the ‘social mapping’ I needed assistance. I realized quickly that I needed to gain some trust from some key members of the community. I had to show the respondents that they could trust me with information that they would not normally give out to strangers/outsiders. To create such a relationship I had to be guided by my own instincts about what is acceptable. I decided to introduce my research assistant, Nipu and myself to the three health workers living in the slum who worked in the clinic in section 4. I realized that I needed to meet some of the gatekeepers of the slum, if I wanted to work in the site long term. To identify and locate married adolescent women, I decided to enlist the assistance of health providers who lived in the slum as well as worked in the clinic located in the slum. Initially wary and suspicious of our intentions, the health workers warmed to us gradually. The health workers introduced us to the most powerful ‘gatekeepers’ of the slum – the prominent leaders of the community. In some ways the health workers themselves were the second set of gatekeepers to access married adolescent women and eventually they became my key informants as well. I discuss the role of gatekeepers later, but the health workers were crucial in helping us in our introduction into the slum and to access married adolescent women.

I wanted to carry out a survey of 150-200 young women from all four sections in the slum and in the end, managed to have 153 surveys to utilize for my data analysis. In some of the questions, less than 153 responses were recorded, and given the conditions
and environment of the slum, we relied on information volunteered without pressing or probing. I went door to door [in four sections of Phulbari slum] with the assistance of health providers and carried out a survey to locate married adolescents. Before I carried out each survey I had a checklist of questions I asked the married adolescent woman to ensure that she was between the ages of 10-19 years. Previous research with adolescents indicates that age reporting is problematic (Kishori Abhijan, 2002). Many don’t know their age and often younger or older report their age to be 20. There are no birth certificates and most parents are unable to recall the accurate age of their children. We had a checklist, 25 which we used to estimate the young woman’s age. This process was time consuming. Young women and their families were often guarded when we went door to door with the health workers. The surveys took about 7-8 weeks to complete.

<table>
<thead>
<tr>
<th>Table 2. Checklist to Check Age of Married Adolescent Women</th>
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<tbody>
<tr>
<td>How many years ago did you have your menses [menstruation]?</td>
</tr>
<tr>
<td>Ask about any siblings’ ages - how long after siblings or before siblings was she was born?</td>
</tr>
<tr>
<td>How long after 1971- liberation was she born?</td>
</tr>
<tr>
<td>How long after 1975 – Mujib’s [leader of the country] death was she born?</td>
</tr>
<tr>
<td>How long after 1981 - Zia’s [leader of the country] death was she born?</td>
</tr>
<tr>
<td>How long after 1990 – Ershad’s [leader of the country] removal was she born?</td>
</tr>
<tr>
<td>How long first menses or marriage was her first child born? How many children/gaps between children?</td>
</tr>
<tr>
<td>Did menstruation happen before or after marriage? How long before or after marriage did it occur?</td>
</tr>
<tr>
<td>If possible, one should cross check with parents/family members as well</td>
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</tbody>
</table>

This is because in some cases, we were unable to speak to the young women but persisted by returning to the household to convince husbands, landlord and tenants. Other times, violence in the slum, a bombing incident or a kidnapping, police raids and the murder of a young man delayed our work by days and weeks. The slum would become quiet and people were reluctant to speak to outsiders. We spent time with the health workers and observed activities in the slum and waited till the atmosphere calmed down before starting the surveys again. The process was exhausting and we never knew when we would be asked to leave, insulted or kicked out of their homes. I discuss some of this in detail later in this chapter.

25 This was compiled with the assistance of Dr. Khurshid Talukdar who has extensive experience on Adolescent health, Bangladesh.
The surveys were carried out to get general background information such as socio-demographic data, reproductive histories and young women’s experiences of health and reproductive illnesses. This would provide an underlying picture of the reproductive health problems young women experience in the urban slums. Households were selected from the margins as well as the centre, and those located close to the clinic and further away, so as to ensure I covered young women living in different parts of the slum. In section 1 and 2, which were much smaller, we managed to cover and interview almost all of the married adolescent women residing there. However, as a majority of my surveys are from section 4, it was more difficult to ensure rigorous sampling of married adolescent women. Violence, drug trade, distrust of ‘outsiders’ by the residents as most of them feared our intentions, and power relations in the household often determined my access and the time spent with young women. Thus, some of the survey and selection of young women for surveys, particularly in section 4 was partly based on opportunistic sampling, that is, if we found respondents [young women] available and agreeable to speak to us, we followed that up and included them in the survey. The surveys, field notes and observations during this period guided our next step, which was to gather more information in the repeated in-depth interviews with 50 married adolescent women and their families.

My study was not demographic but clearly ethnographic ‘with all the attendant subjective interpretations involved’ (Whittaker, 2000:11). It is important to point out that the purpose of the survey was not designed to determine prevalence of incidences of reproductive health problems, but rather exploratory, to get information on reproductive histories, assess decision-making, health seeking behaviour and understandings, and other constraints that may arise. My surveys are clearly not large enough to make claims of statistical significance, however, it is hoped that the surveys provide a snapshot of the conditions of life and an overview of the health issues and problems facing married adolescent women living in the slum.

The advantages of long-term field work
Repeated in-depth interviews
In the next phase of the research, I selected 50 young married women from the survey population, for a focused ethnographic study of their experiences and understandings of gynaecological problems and reproductive illnesses and the broader socio-economic,
political factors that affect their lives, behaviour and practices. Selections were made based on conversations with young women, eagerness of adolescent women to talk to us, rapport and relationship with particular women and their families, the nature of 'reproductive health problems' and willingness to talk about it. I also made sure that young women were selected from all the sections of the slum, 1, 2 and 4. The process was informal. In some cases, if young women dropped out or moved out of the slum, we would select another married adolescent from the survey to talk to. However, selections were also made spontaneously, depending on whom we met in the surveys, if the health workers referred us, and if the adolescent women were interested to speak to us in the surveys and were willing to build a relationship with us. Information gathered during this period was useful for observations and to develop lines of inquiry within the repeated interviews and case studies. This method of repeated interviews generated lots of rich data, with each sequence of observed events influencing what to see and listen to next (Sanjek, R, 2000). The research process was not linear but an on-going process and I often moved back and forth between field observations, repeated in-depth interviews/conversations, case studies and fieldwork observations.

Case studies & long-term participant observations
As my face became familiar, young women started talking about personal events, their lives and about others in the slum community. While interviews are an indispensable part of fieldwork, methods that are more informal reveal much about the field site. As Whyte pointed out, 'if people accept you and you hang around, and you'll learn the answers in the long run without even having to ask the questions' (1955:303). The long time spent in the field conversing with slum residents, the surveys, and repeated in-depth interviews and conversations resulted in close relationships with many different families in the slum. By now, trust was established with many and conversations were more free flowing and less like interviews. Context is very important and long term participant observations and time spent in the field gave me an insight into their lives - of what people say they do and what they actually do and why they behave in particular ways. During this period of repeated in-depth interviews and participant observations, we also focused on eight married adolescent women and their families, with whom we had formed a strong bond. My research assistant, Nipu and I carried out detailed continuing case studies of the households, by spending as much time as possible observing and conversing with the young women. We spent time with their extended
families, including spouses, in-laws and parents, whenever possible, eating with them, talking to them and helping them when they asked for help. We observed all the activities and interactions in the household and followed most of these families even after the eviction, till I completed my fieldwork in early January 2003. Long term follow up of case studies and participant observations allowed me to contextualize the data collected. I gathered over 700 pages of field notes based just on observations in the slum and case studies. The observations allowed me to also learn about events, which I could not have gathered through just direct questioning. This directed attention to particular issues that originated in the fieldwork observations, which I then probed in the repeated in-depth interviews and case studies (Sanjek, R, 2000).

The advantage of the ethnographic approach is that it entails a gradual and progressive contact with respondents which is sustained over a long period, allowing rapport and trust to built slowly over time, allowing the researcher to participate in the full range of experiences involved (Ulin, P.R. et al, 2002). After having spent long periods of time in the field, I found that increasingly, many of the married adolescent women and community members became comfortable and shared personal and intimate stories and events in their lives, which would be difficult to gather in a survey. They shared their concerns about increasing poverty and the impending eviction. Young women shared their concerns on socially taboo topics - marital instability, husband’s infidelity, polygamous marriages, family breakdown, and the high unemployment and substance abuse. They spoke of forced sex, abortions, sexually transmitted illnesses and too many pregnancies. In the surveys, or initial in-depth interviews, young women who had given fictitious stories about relationships with in-laws and spouses later revealed they were separated, or their husbands had remarried. Some young women, who had stated that their husbands were working, later admitted their partners were drug addicts and unemployed. Through interviews, observations and conversations, I was able to piece together much of the social conditions of slum life as it impacts on young women’s everyday lives, and shapes their relationships with neighbours, spouses and family. Often time spent with the young women and other informants, including family members and key informants ensured that data generated was true. Repeated conversations and greater time spent together allowed for crosschecking of statements (Huygens, Pierre et al, 1996).
Although I was able to gather some sensitive information from surveys, it was very little and most of the delicate topics were further revealed in the detailed and continuing interviews, case studies and from fieldwork observations. Sexual behaviour, or termination of pregnancies involve emotions, social sensitivity, power relations, and social networks (Huygens, Pierre et al, 2001); therefore information on more intimate aspects of sexual and reproductive health can only be gathered through more detailed in-depth and long term methods. Moreover, since abortions, sexual behaviour is stigmatised, reported levels will be low to almost non-existent in surveys, with information usually revealed gradually through a combination of ethnographic methods and observing context. In contrast, ‘scientific’ surveys on a research population have limitations, and portray a decontextualised and less complex reality. Some of the questions asked and responses given are interpreted within a narrow medical context, or answers may be given to please the visiting interviewer, with no way of checking accuracy of expressed responses (Huygens, Pierre et al, 2001; Sanjek, R, 2000:286). For example, in the surveys none of my respondents were forthcoming about witchcraft or black magic, often referring to such practices in my presence as ‘backward beliefs.’ However, long periods of observations and close relationships built up with young women and other families in the slum, revealed that witchcraft and black magic are widely believed, practiced and talked about.

Eviction – yields new and sensitive data

The most unanticipated and painful aspect of my fieldwork was when the entire slum was bulldozed, and it traumatized me greatly to witness the suffering of the thousands of poor people who were left homeless. It took me another 4-6 weeks to locate some of the slum residents, particularly those married adolescent women and their families, to whom I had become close. Many were scattered after the demolition in neighbouring areas. The eviction also yielded new and important data on the ‘politics’ in the slum, the activities of leaders, drug dealers and other covert activities, which residents were unwilling to share earlier. After the slum was demolished, the hierarchy that existed disappeared. Some leaders in the slum were less respected and feared, and some ex-

26 I ran into some leaders months after the eviction and on one of my follow up visits in December 2003/January 2004 – I found one of them working as a baby taxi driver. He was extremely embarrassed when he met me. Another leader continued to talk about the slum as it still existed and hoped to return, but most of his days were spent confined inside his home, avoiding ex-slum residents, sleeping and keeping to himself. His wife, formerly a well respected and feared woman in the slum neighborhood, was...
slum residents began to openly speak to us of police corruption, gang wars, drug trafficking and mercenary leaders who had extorted money from them, sexually harassed them and made their lives miserable. Ironically, the eviction led to formerly hidden stories surfacing and we learnt of incidents of rapes, sexual harassment, forced marriages and gang violence. However, while some young women and their families, were willing to mention names of the culprits, these conversations took place in hushed tones.

Health understandings

What does ‘HEALTH’ mean to poor married adolescent women?

I asked young women to ‘tell me about women’s health problems [mele roge], illnesses particular to young and older women and not men. Tell me about your experiences with reproductive illnesses...’ I would probe about vaginal discharge, menstrual irregularities, urinary tract infections, family planning methods, decision making and so on. Without fail, most of the young women mentioned poverty first, and then, not being able to eat, and worries, and weakness in the body, and the breakdown of personal and social relationships. They also mentioned vaginal discharge, menstrual problems, infertility, prolapse and a range of reproductive illnesses in my surveys and in-depth interviews. As I spent time in the field, I gradually began to realize that for married young women, health was conceived as more broadly, linked to their lived experiences and daily conditions of life. The daily conversations and observations with individuals directed my attention to the poverty, practical realities and dilemmas facing the urban poor, particularly married adolescent women. This made me shift my questions slightly from what do adolescent women do to also incorporate what larger factors constrained adolescent women, shaped their lives, health understandings and reproductive experiences. As I listened to young women open up and talk, a major step for me was disentangling the ‘reproductive health’ focus from the biomedical construct to allow for a critical approach to develop. My evolving critical analysis placed particular attention upon the political, social and economic inequalities that result in certain life conditions, which shape health meanings, behaviour and experiences. As Huygens, P et al

reduced to working as a domestic in a richer household, in a suburb away from their neighborhood. She hid the fact that she worked as domestic, but we found out from her sister [who did not get along with her], who informed us of their situation. Not everyone fared badly, but some of the leaders had lost their
(1996:230) suggest, it is ultimately the overall field situation, the ‘relationship between researchers and local communities’ which decides how to conduct research and ‘which questions to ask.’

Realities of long-term field work in a slum environment: entry through Gatekeepers

Health workers – facilitated our entry and acceptance into the slum

The health workers were my initial gatekeepers into the slum. During the initial period of our settling into slum life, I was entirely dependent on the health workers’ good will and cooperation. I was also aware that taking Nipu and I door to door to identify and locate married adolescent women meant extra work for them. There were many occasions when I had to coax them into taking me house to house, as field visits [although mandatory] were rarely carried out. Over time, we became extremely close to two of the health providers, Sufia and Sayeeda. We spent many hours with them, chatting about their work as well as their lives. They provided us with useful information on the clinic, the constraints in their work, and about various activities in Phulbari – from drug deals to ‘politics’, sex workers and married adolescent women’s lives and their health problems. They were very protective of us, and when tensions ran high in Phulbari because of violent crimes and police raids; they would warn us or escort us around the slum. During the entire period of our fieldwork, we also spent a considerable amount of time observing the local clinic in section 4, and spoke to many adolescent women and older women about their reproductive health problems, the treatment received and perceptions about services provided, and other health concerns. This was a good opportunity for me to also observe providers working in the clinic, talk to them about the clinic and explore their attitudes about their work.

Both Sayeeda and Sufia took us door to door to all four sections of Phulbari – 1,2,3 and 4 so we could carry out our survey. As I mentioned earlier, we decided not to continue our survey in section 3, because Sufia [health provider] warned us of the large numbers of drug addicts and dealers who hung around in that section. She was worried that we

power, authority and networks and their source of income – renting and extorting money from slum
would be harassed. Another factor that discouraged us was when Sufia approached one of the leaders of section 3 and asked if he could guarantee our safety, he remained non-committal. We decided to carry out our survey from only section 1, 2 and 4. Another issue I was worried about was possible bias in asking health workers to assist us in carrying out our survey. Would this affect how slum women perceive our position, for example in relation to health issues and family planning? However, we quickly found that both older and younger women were very frank about the services they receive and were willing to talk about their health problems and lives. It soon became apparent that although many of the young and older women knew the health workers, not all of them accessed the clinic, and most of the time the health workers did not carry out household visits regularly, so I did not have to worry about bias. Furthermore, having the health workers assist us with our survey was a turning point in my fieldwork. By introducing us, the health workers made it clear to the slum women that we could be trusted – they were our guarantors of legitimacy. Secondly, as one of the health workers was the sister- in-law of a powerful leader, her willingness to go door to door with us really made a significant difference in the way we were viewed, particularly in section 1 (where she lived).

**Seeking permission from powerful leaders in the slum**

Entry to the slum I later realized depended on the permission of the main leaders in the slum. Although there were a number of factions and leaders, the powerful authorities, referred to as *mastaans* [controlled the slum] decided who gains access to the community [further discussion in Chapter Two]. Long-term fieldwork would be virtually impossible without the local *mastaans* permission. On the first day of our door to door household visits in section 4, Sufia Khala [an elderly and well respected health worker], diplomatically suggested that we introduce ourselves to Hashem and Mustafa, both political leaders and feared by the tenants in the slum. Sufia Khala facilitated our entry by taking the first step and informing them that we were not government workers or NGO workers but were students who were interested in women’s health issues. We were asked to introduce ourselves to the main leader of the slum, Kabir who was the current government’s political party follower and ward secretary. Sufia Khala and I went up to him and salaamed him. She explained our purpose for being in the slum. He listened and then without smiling said, 'Apa [sister] as long you study what you say residents/tenants and drug couriers.
you are interested in then there should be no problems. But if you do have any problems, just let Hashem know. He will sort it out for you. We will learn from you and you will learn from us.' I was excited - we had just received permission to work in section 4 of Phulbari. The leader's permission came with a warning, 'not to investigate anything other than women's health, otherwise we could be in trouble.' We later realized why, as this section had a thriving heroin business run by the very same leaders in links with the police and political leaders in the government. In return for seeking their permission and sticking strictly to the topic on 'reproductive health' we were offered support and protection.

Lee and Renzetti (1993) refer to this exchange between the gatekeeper and a researcher as an 'hierarchy of consent' - where it is assumed that the leaders [gatekeepers] have the power and the right to permit their subordinates [the adolescent women in the slum] to be studied. Each section of the slum had their own leaders who were the gatekeepers of that section. They were the ones who basically controlled law and order and meted out 'justice,' collected money for water, electricity and other 'projects, to which tenants and landlords were forced to contribute [further discussion in Chapter 2].

This was a significant step forward for us because in order to work in the slum for a long period we needed to get permission from the leaders. If our research time was short it would not have been a problem, but to be seen spending time in the field for long periods would arouse curiosity and suspicion. With one of the main leaders giving us the green light to work, the chances of us being harassed by gangs, basically unemployed slum youths who worked for the leaders was much less. Much later in our fieldwork, Sayeeda informed us that the main drug leaders who lived outside the slum had asked questions to her brother-in-law about our presence, suspecting us to be police informers. Her comments highlight the importance of support by key people in the community, namely Sayeeda [another health provider] and her brother-in-law, Malek Master, a well known leader of Phulbari slum, defended us and informed them that we were students. She said, 'Apa when my brother-in-law was asked by Dulal (a well known and dangerous drug warlord) whether you were from the police he told them that you had come from Australia to study women's health. He told them that you would write your report and go back to Australia. He asked them not to give you a difficult

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27 Greeted him [salaam is to show respect].
Picture 1. Bulldozer Demolishing Section 1 of Phulbari Slum

Picture 2. Family sitting with newborn baby - waiting to be evicted
Picture 3. Poor drainage and sewage / sanitation

Picture 4. Slum life in Section 1 of Phulbari
time, as you were a student.' I was surprised and asked Sayeeda how he knew so much about our work. She said, 'I have spent time with both of you and I know that you are not a detective or a police person. You are here to learn about women's health and I explained this to my brother-in-law. Now he also trusts you!' This interaction also reveals that while we feared them, the mastaans and the drug lords were also scared of Nipu and I. Being outsiders and from a richer background, we were viewed as powerful, although I did not feel powerful at the time. At the beginning, Nipu and I were petrified of breaking rules and getting kicked out of the slum. It is only much later and particularly after the eviction, when I realized how vulnerable they were and how much they depended on me for support, with some leaders pleading with me to bring in journalists and get media attention for their plight.

Married adolescent women and their gatekeepers in the slum

The initial survey rounds with the health workers was useful as we were introduced to households and we noted down the list of names and households with married adolescent women in sections 1, 2 and 4. However, to our dismay, when Nipu and I returned to carry out our surveys [a few weeks later] many of the families had forgotten us or were coaxed into agreeing for the interview and some adolescent women had left the slum. Some were eager and others were openly hostile or indifferent. Overall adolescent women were friendlier and more inclined to talk to us, whereas the older women [50 years +] were cynical and unfriendly. The middle-aged women were also friendly, but this varied depending on which section/corner of the slum we visited. I suspected that some of the older women were sceptical about our intentions and whether we were going to motivate their daughters or daughters-in-law to use family planning.

Some of married adolescents were difficult to access because of unwilling 'gatekeepers' - mothers, mothers-in-law and husbands and even landlords in the household. The easiest to access were married adolescent women who lived with their husbands in separate households, or those who lived with their mothers. In other cases, sometimes we sought permission from the landlady or landlord of the household before accessing the married adolescent women. Some of the adolescent women were assertive and ignored their landlady and other family members if they were keen to talk to us. Some of them encouraged our entry into their homes by grabbing us by the arm and taking us directly into their rooms. However, in some cases, we had difficulty accessing the
adolescent woman for the follow up second or third interview because the landlady or mother-in-law made it clear that we were not welcome.

We quickly learned about the power dynamics in a slum household. More often than not, if the married adolescent had a mother-in-law – it was appropriate to seek her permission first; and if the husband was home, we had to seek his permission first. Our strategy was to flatter and build rapport with the mother-in-law in order to be able to access the married adolescent woman. One strategy Nipu and I developed was to split up, with Nipu speaking to the mother-in-law in one room [thereby distracting her] while I spoke to the married adolescent in the front of the house or while she was washing her clothes or cooking. Many of the young women did not want to speak in front of their mothers-in-law; whereas some suggested we come back later when they would have some privacy.

In most cases, the husbands were not in the house when we carried out our surveys. If the husband were at home, we would seek permission from him first. Only in four cases, the husbands denied us access to their wives. One of the men just said no. In another case, a husband walked into the room to find her chatting to me and proceeded to hit her. I ran outside for intervention. At this point the landlady [a senior leader’s wife] intervened, calling him ‘a thug and drug whore,’ and threatened to slap him. He left the room quickly. However, I ended the interview, as I did not want to cause any further trouble for the young woman.

In another two cases, the husbands resisted in more intimidating but covert ways. In one household the husband refused to leave [he stood at the doorway], so I was forced to end the interview quickly and left. In another case, a husband walked in halfway through an interview and just sat [whereas most men leave politely] and started asking me what sort of family planning methods I could give him. He then took off his shirt and lay down on the bed. I was uncomfortable and ended the interview.

‘Trying to fit in’ – but ‘viewed as informers’

When we arrived at the slum, we informed the leaders, slum residents and adolescent women and their families that we were only interested in talking to women about their health. However, one persistent problem I found during my ethnographic fieldwork was
that some of the slum dwellers did not believe that we were interested in learning about women’s health. They feared that my research assistant, Nipu and I were working on behalf of the government to steal their land. Others were convinced we were journalists, and worse, some thought we were working as police informers. Their suspicions are not surprising if one looks at historically how unjustly they have been treated by each successive government. Faced with repeated lies and bullying by the government, police, and local leaders, and in some cases, even by the NGOs, most of them remain wary and distrustful of outsiders. When I entered the slum initially in November, the slum dwellers had just won a case in the High Court giving them the right to stay on in Phulbari for another 6 months. I did not know this till later. A local human rights organization and a well-known influential lawyer had helped them with this case. Many were wary of my motivations. I remember during an interview, a young woman (in the presence of her husband) said, ‘Apa, [sister] are you sure you are not from the DB [detective branch]? Lots of people come here and try and take information from us. Often police informers come and pretend to be working elsewhere. They get friendly with the families and then try and get inside information about this area.’ Unfortunately nothing we said convinced her and we had to stop the interview and leave.

Throughout our fieldwork, Harun, one of the more hostile [and small time] leaders would sometimes follow Nipu and I when we walked around the slum. Sometimes he would suddenly accost us in the middle of our informal chats with women and ask us about work and how long we were planning to stay in Phulbari. Later we came to know that like many of the leaders of the slum, Harun was involved in selling heroin and marijuana. Bourgois, working in the inner cities of New York points out that individuals marginalized socially, economically, and culturally have negative long term relationships with mainstream society, and as such most drug dealers distrust representatives from that society (1995). In addition, the presence of a researcher is sometimes feared because it produces a possibility that deviant activities will be exposed (Lee and Renzetti, 1993). Furthermore, I was viewed as an upper class woman who was spending time in a slum, where most people from a better socio-economic status would not spend time. In fact many of the elites, particularly some of the business acquaintances I knew socially, made fun of me for wanting to spend so much time carrying out fieldwork in a slum. In the slum, I was also viewed with suspicion because unlike the quick surveys carried out by researchers in a space of a few weeks, we did not carry around tape recorders or obvious notebooks and pens.
Feelings of mistrust and fear remained with some of the slum dwellers even till the end of our fieldwork. As John Brewer suggests, the problem of ethnographic research is engendering the trust of respondents. In unpredictable and harsh environments, this may be more difficult to establish easily. In my case, it wasn’t just drug dealers who were scared, but also some of the adolescent women and their families. A few of them continually sought reassurance from us about the nature of our work, the purpose of the research and what was being written down about them, and so on (1993). Like Hey (2002), I tried to have non-exploitative relationships in the field, but ultimately I could not avoid the fact that I was more powerful than the adolescent women because of my class and background. I was aware that I was there to extract parts of their lives for my own use.

Worries about our personal safety

An important concern for Nipu and I was our personal safety, particularly when suddenly police raids or gang violence took place, or when we were followed by Harun [a hostile leader] around the slum. We were warned by both shopkeepers and slum dwellers to be very careful. One of the shopkeepers warned us of the dangers of working late at night. He said:

Apa [sister] you are new here. Why have you come to work here and what is your work? I informed him that we were students and we wanted to work with women’s health in Phulbari. He said, ‘Apa, [sister] the slum is a bad environment. Things suddenly happen. No one can say. Our advice to you is to get out as fast as you can before it gets dark in the evening! We have been living here since we were born and we are seeing everything that has happened. At any time crimes happen very suddenly in the slum.

Another shopkeeper also cautioned us, ‘You need to be careful. You are new in the slum and when they see someone new the slum people are suspicious and try to scare them even more.’ At the time of the fieldwork, [before the eviction], I remember reading old and new articles about criminal activities widespread in Dhaka slums, murders and drug trade, and how these areas are overrun by mafia drug warlords. Obviously, hearing such stories and our own observations of slum disturbances made us nervous and scared. Although we walked everywhere in the slum, we did avoid some of
the more dangerous areas – where heroin was sold and where drug addicted youths gathered to indulge in their habits. Drugs were frequently sold publicly in the slum and accessible to observation. We discovered a locked latrine that was filled with bottles of phensedyl [cough syrup] a popular drug choice for poor men in the slum. Throughout our fieldwork we remained anxious because we were women who were working in completely unfamiliar territory. In some areas, we took down field notes and in others we did not take notes till we left the area, depending on the environment and advice of the health workers. So although I was in charge of the research it was the health workers and others who were in charge of the field site. For the safety of Nipu and I, it was important to establish the boundaries of our fieldwork and our roles. Establishing a good reputation in the community and with health workers meant that if we were in danger we would be warned.

An outsider in the slum – a rich, ‘bengali foreigner’

I occupied multiple positions in the field. Having a dual identity-born in Bangladesh but having spent most of my childhood and college years in the West-I felt like I was more of a ‘halfie’ a term coined by Abu-Lughod (1991). Although my research assistant Nipu was immediately accepted as a Bengali, I was perceived as a foreigner. This is because Nipu has lived in Bangladesh since birth and spoke Bengali fluently. However, being an outsider helped me in my ability to make comparisons and differences, and the unfamiliar territory took on new meaning when viewed through my ‘outsiders’ eyes (Oliver-Velez, D et al, 2002). Moreover, since Nipu and I came from different backgrounds, and the variations in class and age [she was younger to me and unmarried] resulted in a range of perceptions, which enriched our data collection.

Many of the young women would laugh openly at my Bengali [native language] and my lack of understanding of many local terms, which my research assistant would have to explain to me. She would also help me rephrase questions if married adolescent women did not understand my questions or my accent. Being labelled as a foreigner had its advantages. According to Nipu, I had the advantage of directly asking about sensitive topics in interviews, without any disapproval because I was regarded as an outsider and therefore non-judgmental, and many young women spoke freely. Being a foreigner elevated my status somewhat as someone who lived in a far away country.
Being perceived as a foreigner also meant that when I offended anyone, I was usually forgiven for being a ‘clueless idiot.’ However, being viewed as a foreigner can also have its disadvantages in a stressful environment of the slum. In mid April, a most unfortunate event took place, which I feared would end my fieldwork in Phulbari. Nipu and I were carrying out one of the survey interviews in one of the corner sections of 4, when I was rudely interrupted by one of the older women in the slum. This particular corner was viewed as a dangerous corner in the entire slum. I had been warned but because my fieldwork had been proceeding smoothly I decided to go ahead with more surveys in this area as well. However, each corner within a section of the slum has its own rules, relationships, and networks. In the middle of one of our interviews a woman came inside the room [a heavy set dark 35+ woman] and shouted, ‘Who are you? What are you talking to the women about?’ I explained politely, ‘We are talking about women’s health problems.’ She shouted, ‘what secret things do you talk about? She started screaming at the women in the household, ‘these two women have come here and they are making our women bad.’ By now, a crowd of 10 women had gathered. She was enjoying the attention and she was screaming even more loudly, ‘Where are you from?’ I replied, ‘I am from here – I am Bengali’ She said, ‘no you are not from here– you are a Christian. Look at the way you speak. You are spoiling our women – don’t come here anymore if you do we will sort you out. Don’t ever come to our para (area) again.’

Completely shaken and very demoralized by the turn of events [and imagining the end of my Ph.D.], the next day we asked the health workers to intervene and explain to those women about our work. But much to our horror the women warned the health workers that if we returned to their area, they would get the [gang] boys to come after us. This was their way of bullying me [the upper class woman], to control my actions and my behaviour in their field site. However, it was more than that, they were suspicious of my intentions and much later, I found out that the woman who threatened us was a drug dealer in her corner. The health workers were worried and advised us not to return to that corner. We continued our survey, but had to move to another area of section 4 of the slum. Luckily for me this incident happened in April, and Nipu and I had already established a certain amount of trust with the health workers and a large section of the women in section 1, 2 and 4. If this incident happened at the beginning of our entry into the slum then we would have faced plenty of opposition to my work. As we found, working in a sensitive field site is a continual process of negotiation and re-
negotiation with respondents, which was the case for us in Phulbari slum (Lee and Renzetti, 1993).

**Close relationships & belonging**

As I spent time in field, I became close to many of the residents in the slum, particularly to some of the married adolescent women and their families. Some of the adolescent women’s husbands often went out of their way to give us time to chat to their wives. Monsura, Roshonara and Farida’s husband would immediately leave the room if we visited, thus giving us privacy and the space to chat to their wives. Sometimes they would even leave with the babies so that their wives could talk to us freely and uninterrupted. Many of the married adolescent women confided in us, sharing their personal stories, sufferings and worries. We would eat and sometimes rest [if it was raining] or even sleep in the afternoons at Sayeeda’s sister’s or at Aklima’s home. Some incidents in Phulbari raised our hopes of being finally accepted as part of the community in the slum. When Farida [married adolescent] gave birth to a baby boy, women stopped us in section one to inform us of the news. Another time was when Harun’s [marijuana seller and leader] son disappeared and everyone feared he was kidnapped [which is not an uncommon occurrence]; women sought us out the next day just to inform us that his son Imran had been found hanging out in a bazaar.

After working for more than 8 to 9 months in Phulbari, two incidents made me realize how close (apon) and involved we had become in lives of the women and their families in the slum. After the eviction of Phulbari residents, some of the young women and their husbands called on my mobile phone to give me their new addresses so Nipu and I could visit them in their new homes. One young woman, Monsura, took to calling me when her husband beat her up and if we had not visited for a few days. Another young woman Farida called to inform us she had returned from the village and another adolescent woman called me to ask me to accompany her to the local clinic. As a researcher, it was no longer possible to be objective or invisible. As Cassell points out, if a researcher is in a site for some time, as a ‘living, reacting fellow human being, rather than a human pretending to be a disembodied fly on the wall, the people you are studying will create a space, a role for you’ (Cassell, 2002:180). I reacted to what went on in the slum and in the lives of the married adolescent women. I would agree with some statements and disagree with others, disapprove of behaviour, be pleased with
others, and so on, and also became involved in assisting some women [particularly after the eviction], and even intervened in household fights and disputes among neighbours (See Cassell, 2002).

Another event, which made me realize that we belonged was in early June 2002. Some local NGOs came to the slum to talk to some of the local leaders about improving children’s health in the slum. Malek Master [one of the leaders of Phulbari slum] invited us to the meeting and informed the NGO workers, ‘these two Apas have been coming to this slum for a long time. They spoke to our women in this slum. They work with health issues. If you want to know anything about this slum you can ask them. I am the one who invited them to this meeting.’ Then Malek Master said laughing, ‘these two apas (sisters) are our own (apon). They know about us from the inside of our bones to our women (hari to nari)!’ The NGO workers were looking at us in amazement. I was surprised and very pleased. Then Malek Master turned to us for advice and said, ‘why don’t you go and see what they say? If you listen to them and you think that these NGOs may improve our slum then you can work with them and help us!’ Over the long period of fieldwork we wore many different ‘hats’ (Clatts, M.C. 1994). It was interesting to see our identities gradually changed from outsiders to adopted sisters [aunts, sisters and guardians], to mediators, to sympathetic listeners and to finally ‘honorary members’ in the community.

Generating theory from fieldwork

As I witnessed the suffering of the urban poor, particularly those of married adolescent women, my focus shifted to the larger political economy, which shapes their lives, health, behaviour and experiences. As I write of their experiences, attempting to

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28 It was difficult to be objective and not be affected by the unimaginable poverty I saw everyday. I had to be careful but felt compelled to assist some of the women, in my own way. For some women, who were desperate to seek care, we paid the slum NGO clinic the visiting fee (Taka 20) so they could access the clinic for free to access treatment. This also ensured that the husbands did not spend the money. Sometimes my research assistant and I would share our lunches, or bring gifts of fruit, vegetables or even meat, to share with young women and their families we were close to [because we were close we could also rely on them being discreet]. It was difficult to hand out money because of the sheer numbers of poor women and men living in the slum. I also took some women to a charity clinic in the city for their health complaints, paid for the treatment of an adolescent woman’s husband, who had been suffering for sometime. However, for the few young women that I did help financially, I selected those who were the most vulnerable [abandoned, widow, extremely poor], and this took place only after the eviction and towards the end of my fieldwork. I would argue that any loss in objectivity is more than reinforced by the trust gained, close relationships formed and the depth of the information I gathered from the young women and their families.
represent their lives, I choose my words carefully so I do justice to them. An 'active, politically committed, morally engaged anthropology' informs my research and analysis (Scheper-Hughes, 1995; Singer, 2000).
Chapter Two

‘Structural violence’ & social inequalities in the lives of the urban poor

The government ordered the demolition of Phulbari slum, despite court orders declaring that evictions without providing rehabilitation for residents are illegal. On the morning of July 25th, 2002, seven bulldozers demolished all of the shack settlements in Phulbari slum. Thousands of poor men, women and children watched in shock and sadness. Many were openly sobbing, while hundreds of government policemen stood armed nearby, ready to confront any resistance. Within 3 hours, the slum residents lives had been turned upside down and they had lost everything. Many of the residents had been living here for more than twenty years. Not a single shack remained, only empty land and rubble...

[field notes]

The above excerpt provides insight into the vulnerability and suffering of the urban poor. I argued in the introduction that to truly understand the ‘reproductive’ lives of married adolescent women, we first need to comprehend the wider political-economic and social inequalities in which the lives of the urban poor are embedded, which contribute to particular health experiences. This chapter contextualizes the conditions of life for the dwellers of Phulbari slum.

In Dhaka, slum dwellers constitute thirty per cent\(^29\) of a total of fourteen million population of the city. The poorest are from rural areas who are unable to sustain themselves because they are landless and jobless, migrate to the city in search of employment, food and shelter. Unable to find affordable housing, they build or rent shack settlements in slums (bastis), in low lying areas, which tend to be established near drains and sewage on vacant government or privately owned land, often on the margins of richer suburbs and commercial areas (Islam, N, et al, 1997).

Conditions of life in the slum are miserable, precarious and stressful. Urban poor men and women have marginal jobs and struggle daily to make ends meet. The slum

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\(^{29}\) Professor Nazrul Islam, Centre for Urban Studies (CUS) Dhaka, has done extensive work with urban slum dwellers and admits this is a rough estimate. Another person, Nawaz, Tanvir (1999) citing
dwellers are insecure in every aspect of their lives. Insecurity consists of not only personal security and employment, but they live temporarily in settlements without any legal right, never knowing when they might be forcibly removed from their place of residence. Government officials view slum residents as illegal trespassers. After the eviction, the slum dwellers from Phulbari who had lived there for more than 20 years were expected to ‘disappear’ and manage somehow, despite losing their homes and networks created in the community.

Phulbari slum, like most slums, was hierarchical in social structure, with people having differing income levels, type of housing and access to basic services such as water and electricity (See Wood, G, 1998a; Islam, N et al, 1997; Paul-Majumder et al, 1996; Afsar, R, 2000). Most of the slum dwellers lived under the rule of mastaaans, [authorities/leaders in the slums – mafia type godfathers] who have links with political leaders, government officials and the law-enforcing agencies. Mastaaans control and exploit residents for their own gains. Phulbari slum residents were compelled to rely on mastaaans as well as corrupt policemen and grassroots political leaders for access to land, housing and other basic resources [water, electricity], but at the price of subservience and exploitation. As a few studies show, urban poor people are heavily dependent upon their position within these structures, political powers and links (Wood, G, 1998a, 1998b; Paul-Majumder et al, 1996).

In the employment sector, male slum dwellers remain vulnerable as they work in irregular, low paid, unskilled wage labour, often remaining unemployed for days and even weeks at a time. In the context of Bangladeshi social and cultural traditions, it is men who are seen as the providers for the family and ordinarily adolescent women stop working soon after marriage. Despite cultural constraints, in reality, unimaginable poverty and chronic hunger forced many married and unmarried adolescent women in the slum to break with tradition and work outside the home to support their families.

Many unemployed men turn to readily available drugs and other forms of substance abuse, to escape from the miserable conditions in their lives. In contrast to rural areas, social relations are disrupted in slums [see discussion in Chapter Four]. Thus, men indulging in drug and alcohol abuse do not risk social sanctions from an increasingly

government figures, estimates slum settlement population to be about 26 percent in the city, though he thinks this is an underestimation and the actual figures could be much higher.
fragmented community. Within Phulbari slum, an underground economy of drug trade controlled by mastaaans and police was widespread. Mastaan leaders recruit unemployed and frustrated youths to work for them. Control over the lucrative drug trade led to factions and gang-feuding, resulting in violence, rapes and constant harassment of slum dwellers. Women without powerful male guardians or family support are most vulnerable in this environment, and this is discussed in greater detail in Chapter Four and the subsequent chapters.

The lives of the urban poor are adversely affected by the global market economy. For example, in Bangladesh ready-made garment factories are the major employers of primarily poor adolescent women, providing an income for thousands of poor families. However, the attacks of September 11th in 2001 in the US, a leading export market for Bangladesh, led to thousands of job losses and closing down of hundreds of garment factories in Dhaka city and elsewhere. A recession in the US followed soon after the attacks, which affected the export market of Bangladesh. This led to a loss of jobs for some married adolescent women and men in Phulbari slum, impacting negatively on their lives and relationships with family members.

In addition, global concerns for the environment led the Government of Bangladesh to ban the plying of air polluting local three wheeler motor vehicles in September 2002, resulting in thousands of job losses for poor men, and forcing a quarter of a million families into acute poverty. After the eviction in July, the Phulbari slum population was left homeless, and only a few months later, many families faced more disaster, as many men were left unemployed by the transport ban. Severe poverty among slum families is leading to the breakdown of relationships in the slum. Observations in the slum reveal that scarcity of food and insecurity often pitted family members against one another, creating tension and hostility within households and in the community.

This chapter is broadly divided into six sections. In the first section, I provide some general background information on the urban poor and review briefly how poverty, landlessness and economic globalisation have led to mass migration of rural families into urban cities in the past decade, leading to the rapid growth in slums in the City. Following this, I discuss the government's national housing policy and its indifference to the plight of urban slum dwellers. In section two, I introduce Phulbari slum, its history, and discuss in greater detail its demolition, which left thousands of families on
the streets overnight on July 25, 2002. In the third section, I examine the social conditions of life in the slum, such as basic services available, social structure, drug wars and gang violence, all of which impacted on the everyday lives of Phulbari slum residents. In section four, I discuss the employment situation for married adolescent women and their husbands, the growth of the underground economy and substance abuse among male slum dwellers. In section five, I discuss the global market economy and State policies that shape employment conditions for slum dwellers. Finally, in section six, I demonstrate how extreme poverty has eroded family support structures and disrupted social relations.

Social and economic transformations

Migration: poverty and landlessness

In Bangladesh, nearly 70 percent of a population of 145 million are living in extreme poverty. Poverty and chronic hunger are widespread. Poverty, landlessness and population growth are blamed for the mass migration of rural families into urban areas. Land remains the most important asset in the rural economy and it enhances a household’s productive base, but with increasing landlessness, families left with nothing are forced to migrate. In the past, the per capita cultivable land in Bangladesh was about one acre, but it is now less than 0.20 acres and it is lessening with the growth of the population. Despite attempts to ‘modernize’ agriculture, there are greater income differentials, with the few rural rich getting richer, and the numbers of poor and landless rising (Jansen, E, 1986; Alamgir, J, 1993; Afsar, R, 2000). Furthermore, between 1961 and 1981, there was cumulative partitioning of landed property through inheritance, leading to smaller landholdings. Secondly, market led factors have led to a differentiation between the poorest and the richer classes, contributing to increasing landlessness among the peasants and greater land accumulation among the well off (Adnan, S, 1993). In addition, natural disasters, floods which occur routinely, causing severe land erosion, always hit the poor the hardest in rural areas, forcing them to relocate to the city.31

30 Poverty line based on a daily per capita intake of 2122 cal for the rural areas and 2112 cal for the urban areas (Sobhan, R, 1999).
31 Small-scale studies of urban slums also show that social factors play a role, and a significant portion of recent migrants are divorced or deserted women from poor rural families who seek employment in towns.
Economic globalization, garment industries & the migration of poor women

As discussed in the introductory chapter, Bangladesh is very poor and has few resources either in physical capital or human capital. The country not only suffers from very poor health indicators, but also has one of the lowest literacy rates in the world. The literacy rate of the population of 15 years and above is 34.5 percent. The literacy rate for women is far lower (at 24.2 percent) while for men it is 45.5 percent.32

In order to overcome poverty, in the nineties the World Bank and other donors urged Bangladesh to embrace globalisation. Under directives from the World Bank, the government worked to privatise industries and introduce trade liberalization and environmental policies, which resulted in a wide range of macro-level structural adjustments. In addition, population growth and poverty have encouraged massive rural-urban migration, urbanization and rapid urban growth (discussed in greater detail in next section). The garment industry is an important part of this growth.

In the 1970s, economic globalisation resulted in an international division of labour, which profoundly impacted on employment opportunities for the poor in Bangladesh. The shift was spurred on by the rising costs of labour in advanced industrialized countries, which led to the search for 'quote free' cheaper labour in newly industrializing countries (Kabeer, N, 2001). As a response to this, Bangladesh set up some sub-contracting factories in the 1970s. Domestic entrepreneurs set these garment factories up with the assistance of East Asian investors who were knowledgeable of international markets and access to the required technology. In 1982, the Bangladesh government established a New Industrial Policy, offering incentives for export oriented manufacturing resulting in the industry expanding rapidly, increasing from a handful to around 700 in 1985, located mainly in Dhaka and Chittagong City.

The garment industries in Dhaka City offered employment for poor women who migrated from rural areas in search of employment. This is significant in the context of Bangladesh, where the cultural institution of pardah ideally requires that women, apart

because of greater acceptability and availability. Nai[a Kabeer (1989) argues that the slow rise of female migration and female headed households indicates 'household and female pauperization', signaling the breakdown of family based arrangements and entitlements, affecting women and their dependents.

32 The Human Development Index ranking for Bangladesh in 1997 was 123 out of 146, indicating low life expectancy at birth, low educational attainment and low income (www.hdo.org/Gender/Files/Bgd.pdf).
from minor girls, ideally remain secluded from contact with male strangers. *Pardah* prohibits women from going to public places, such as meetings and market places as well as taking part in public activities, which are seen as male activities. This ideology has its cultural root firmly entrenched in notions of honour (*izzat*) of women (Adnan, S 1993). The restrictions of *pardah* vary according to class, education and age. However, adherence to *pardah* norms is often more symbolic than real and poor women who are in need of outside work cannot afford to remain at home. Most women continue to observe *pardah* by covering their hair, body and face when out in the public domain, while others have reinterpreted it as a ‘state of mind’ rather than physical behaviour (See Simmons, R, et al, 1992).

Many studies document the inflow of families and poor rural women migrating from rural to urban areas, drawn to the factories. Thus, in a country where *pardah* is important, the advent of garment factories helped create a first generation female industrial work force working outside the home in the cities. By the 1980s, the apparel industry had replaced jute as the main export industry in Bangladesh, comprising of 76.57% of the export performance in 2001-2002. By 1995, there were already 2174 garments factories in Bangladesh, with the majority of them located in Dhaka. There are an estimated 1.4 million workers in garments, of whom about 80-90% are women and young girls between the ages of 14 and 25 (Ali, MH, 2003; Kabeer, N, 2001; Siddiqi, D, 2000; UNICEF, 1999).

A key factor in the accelerated growth of the garment industries is the MFA (Multi-Fibre Agreement). Instituted some 30 years ago, the international Multi-Fibre Agreement (MFA) set export quotas on all textile manufacturing nations. Some poor countries, like Bangladesh received larger quotas, which enabled them to attract foreign investment and sharply boost their earnings. Artificially protected from competition, they built their developing economies around the textiles industry. Between 1990 and 2004, for instance, Bangladesh’s apparel exports increased more than eightfold, from US$620 million to US$5.7 billion. The production of ready-made garments (RMG) has been one of the most important sectors of Bangladesh’s economy, employing about one-third of its industrial labor force (Mahmud, W, 2003). 33

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33 Bangladesh was successful in translating its comparative advantage of abundant cheap labor into lower price for goods, with private sector entrepreneurship and financial incentives from the government, the sector saw robust growth in recent years.
However, Bangladesh's incorporation into the global markets also means that it is vulnerable to the global recession, which occurred recently in 2001 in the world market. Periodic fluctuations in the import quota allocated to ready made garments from Bangladesh by the USA, EU and other major industrialized economies led to corresponding cycles of job losses and re-employment among workers, who are primarily female (further discussion later in this chapter) (Adnan, S, 1993). After January 1, 2005, MFA quotas will be phased out as dictated by the Agreement on Textiles and Clothing, an integral part of World Trade Organization (WTO) rules governing the industry. This will have major implications for the long term environment and economic situation in the country and especially for the poor.

In the case of woven apparel, Bangladesh imports about 80 percent of its main raw material: fabrics. Since many fabric-exporting countries will begin to produce clothing themselves once the quotas disappear, the global price of fabrics may increase, thus eroding Bangladesh's competitive strength. In addition, buyers are increasingly looking for reduced lead time – the gap between placing orders and receiving goods. Competing with countries that already produce cotton and maintain strong internal spinning and weaving sub-sectors will not be easy for a least developed country like Bangladesh. China has been especially quick to dominate the foreign market space as quotas in other industries disappeared. India, Pakistan, Vietnam, and many Caribbean and African countries will be some of Bangladesh's other major competitors in the US market (Mahmud, W, 2003).

This transition will test Bangladesh, both financially and socially. Given the poor economic and human resources (particularly poor literacy levels and widespread poverty) and competition within the global economic order, Bangladeshis and especially the poor have very little control over their economic livelihoods. Poor women, especially young female adolescents living in slums and working in the garment sector are particularly vulnerable to this changing situation, and will be hit the hardest. Society affords poor women little social and economic status and with few job prospects,

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34 In the wake of the 2001 global recession, Bangladesh's reliance on foreign countries as a market for exports and as a source of remittances has become obvious. If Bangladesh is to become less vulnerable to the economic fortunes of others, it will need to strengthen its domestic economy, creating jobs and markets at home. A strong domestic sector and an improved overall investment environment will provide
hundreds of thousands of them have become extremely dependent on the garment industries to survive. These factors are discussed and illustrated in detail later in this chapter.

Migration leads to population growth in urban areas

The population of Bangladesh was at 75 million in the early 1970s and has doubled to 145 million in 2002. Rapid migration in the past ten years has led to phenomenal growth in the population of all urban areas in the country, which grew by about 38 percent compared to only 10 percent growth in rural areas. Until 1961, less than 5 percent of its population was living in urban areas, but during the past two decades, the urban population has grown from 6 million in 1974 to 21 million in 1994, to nearly 30 million currently (Perry, H, 2000). Dhaka City bears the brunt of this rapid migration.

Poverty has increased among the poorer populations. In 1995/96, 47.5 percent of the population lived in poverty, with urban poverty rising by a third between 1988/96. In 1995/96, 17 percent of the poor lived in urban areas, compared to a lower 13 percent in 1988 (Sobhan, R, 1999). As discussed earlier, 61 percent of the urban poor live in households where the monthly household income is less than the minimum required for food and essential non-food items [almost AUS $120]. Forty percent of the poor urban population is classified as living below the level for ‘hard core’ poverty, meaning that their monthly household income is only Taka 2,500 [AUS $62.50] (Islam, N et al, 1997).

Creation of slums (bastis) in Dhaka city

A combination of factors have produced the widespread shack settlements referred to as slums [bastis] in Dhaka City, which have emerged as a dominant form of housing for

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35 Currently as of April 2004, One Australian dollar = Taka 40 (Bangladesh).
36 In Bangladesh, it is reported that the richest 10 percent control 41 percent of the total national income, when the poorest 10 percent of the population have access to only 1.84 percent of the national income. The same group of the rich, out of the ten percent, 325 people have defaulted bank loans worth Taka 10,126 crore, more than one fifth of the country’s total budget allocation of Taka 51,980 - for the 2003-2004 financial year. Many of these individuals continue to avoid jail or fines and have not been arrested. Many of them have strong links to political parties, and provide funding for elections and so on (New Age, 2003).
the migrants. Most of the urban poor cannot afford to live anywhere else. Scarcity of land in the City and inability to affordable housing, and no government plans to accommodate them, means that most urban slum resident set up homes or rent homes illegally wherever they find vacant disused land.

The situation is worsened by the land ownership structures, which are extremely asymmetrical. Seventy percent of urban residents do not own any land at all, while the distribution among the 30 percent is extremely unequal. Successive governments in Bangladesh have maintained highly selective priorities for allocating land for housing to mainly better off families and influential groups such as bureaucrats, military officers, members of parliament, business groups, where land is distributed at subsidized rates. In some areas, plots were developed after the acquisition of agricultural land from poor farmers at low rates (ASK, 2000). Like the distribution of land and wealth, the population distribution is very uneven in the city. Approximately one third or 3.3 million of Dhaka’s population only occupy 1038 acres of land [4 sq km] or less than 1 percent of the total land area, while the rest is owned by the richer families (Afsar, R, 2000). Thus, although the poorest [or low income groups] constitute 70 percent of the population, they only have access to 20 percent of the city’s residential land (Islam, N, 1996).

It is reported that there are over 3000 slums scattered all over the city, of which over 600 slums are reportedly on vacant government land, while over 2000 have been built on disused/empty private land. High population densities, and an absence of latrines, sewage and drainage facilities, and inadequate water and electricity supplies characterize slum neighbourhoods. One quarter of all urban slums are located in low-lying areas prone to flooding, and another 12 percent of urban families are in squatters [living temporarily at a site or in a small cluster of 3-10 households], or are homeless (World Bank and BCAS, 1998; ADB, 1998; Islam, N, 1996).

**Government housing policy & eviction of slums**

All slums are insecure and are subject to unpredictable actions on the part of government authorities. Most slum residents live in constant fear that municipal
authority or private landlords might evict them at any moment. The struggle of urban slum residents to establish and defend their slums on ‘illegal space’ is an enduring feature of the city’s history. The resistance takes place in the context of power struggles and constant manipulation with other local residents, government authorities, the police and other existing informal networks of leaders and criminal gangs (Wood, G, 1998a; 1998b). The eviction [often violently] of slum dwellers can be traced back to as early as 1975, to make way for colleges, development projects or to allocate and sell plots to middle class and richer families and for property developers. Although it is difficult to assess the actual number of slum residents evicted since then, a recent report documents that between 1989-1999, more than 45 slums were demolished [some twice], leaving millions of families homeless. It is reported that in 1999-2000 over 100,000 poor people were evicted from their slums (ASK, 2000).

In 1999, a government Minister outlined a number of reasons for the eviction, accusing slum residents of being criminals, and arguing that the unchecked growth of ‘dirty’ slums destroys the city’s orderly urbanization (ASK, 2000). Most government plans [still being discussed] are to relocate slum residents back to villages where they will be given basic housing, cooking arrangements and a pond for communal fishing and other needs. However most evictees have no land or homes or work to go back to in their villages (ASK, 2000). Many born in the slums consider Dhaka City their home, while others prefer to remain close to their slum areas or go in search of new slums in the same areas, as they need to remain close to their work. With very few initiatives taken by the government to invest in the rural economy, going back is not a feasible option for the urban poor.

The government’s National Housing Policy recognizes the rights of the urban poor for housing shelter and food. The document stipulates: ‘The government recognizes the difficult situation in which the poor live in these settlements and struggle to make their living and also constitute the growth of the urban economy...housing is one of the three basic primary needs of men [and women], and is as important as food and clothing.’ The policy document acknowledges that the government should avoid forcible relocation or displacement of slum residents (ASK, 2000, Ministry of Works, 1993). Despite a High Court order that forbids eviction of slum dwellers without rehabilitation,
slums continue to be demolished by successive governments (Daily Star, 1999a). Continued pressure from local human rights organizations, local and international agencies as well large-scale protests by slum dwellers have largely been ignored, with no real effort by the government to help the urban poor.

**Phulbari slum**

**The demolition of phulbari slum: ‘we are always at war!’**

Phulbari slum was born in the early 1980s. It grew from a few households to a few hundred to thousands in 2002. A leader said: 'At the beginning this place was just bare land with lots of sand. Then a few of us set up homes – it became about 1200 families by 1987. Now this same place has over 3400 households with landlords, and this does not include the tenants.' The government attempted to evict Phulbari residents in the eighties and then in the early nineties, but support from human rights organizations, non-governmental organizations (NGOs), and united resistance from the community, forced the government to back down. As I mentioned earlier, on July 25th 2002, with very little prior notice, hundreds of policemen surrounded the slum and 8 bulldozers demolished the entire place within a couple of hours. It is reported that 80,000 families were left homeless within a space of a few hours (Daily Star, 2002).

On the day of the eviction thousands of families stood and sat in huddled together sobbing and wailing, while any remaining shacks and structures were destroyed one by one. Everyone stood around till late evening watching till the bulldozers demolished the

38 Hereafter referred to as NGOs.
39 While rumors of an impending eviction were a common topic in the slum since my arrival, towards mid-July, people had begun to panic over 'confirmed' rumors, allegedly from the police that an eviction was going to be taking place in the slum soon. A week before actual eviction day, a police informant with links with leaders in the slum informed them of the impending eviction. An announcement was made the night before the eviction, over a loudspeaker and the community was asked to vacate the land immediately as the place was going to be demolished the next morning. Although many landlords began to dismantle their tin roofs and bamboo and plastic structures after hearing the announcement, everyone hoped that some miracle would take place and they would be able to remain. This deliberate method of informing residents at the last minute regarding eviction is a common practice by the State authorities (ASK, 2000). The residents were quick to remove their possessions from the land this time. This is because in 1993, they did not remove their shack structures when the armed police arrived to forcibly remove them. In the ensuing violence and confusion, the entire place was torched [some say by the police, others say by the slum residents themselves to make the police look cruel]. Thousands lost their possessions, despite being able to reclaim the slum, till 2002.
last and only concrete building in the slum, the mosque, before leaving. An angry young woman said:

Aren't we people? Aren't we human beings? This is mental torture on us, no notice, nothing and they kick us out. The rich just get richer and the poor, no one cares for the poor. They use us for their votes and then they just throw us away.' During the demolition, a leader’s wife in tears, cries out, 'Tell me, what fault have we done that everyone steps on us! Why has God made us poor? If anything happens to us, where will we go and stand? We have no one that if they break the slum they will give us a place to stay. In the village during the liberation war [in the early 70s], everything was destroyed. Now we come here and make a house and live our lives. But even over here we are always at war.' Thousands of people sat around looking weary and sad. People kept whispering, 'where will we go? Who will we stay with?'

The demolition took place with very little media coverage. During this period there were massive student demonstrations going on at the National University and the media was busy covering the events. The government was concerned about quelling the protests and meeting students needs as soon as possible. This brings into sharp focus the underlying policies and interests of the State in the experience of the two groups, slum dwellers who are poor and not important, and the middle class university students who are critical for the government’s future stability. When rumours of the threat of eviction spread a week prior to the event, efforts were made by some of the mastaans in the slum to enlist the assistance of some groups who were sympathetic to their plight. Human rights organizations, international donors, the press and some NGOs spoke in defence of the slum residents. The authorities/leaders who were regarded as the most powerful attempted to negotiate with various human rights groups and lawyers as well as NGOs during this period. Despite a large demonstration in the city by the slum dwellers a few days prior to the eviction and a press conference to alert the media, the demolition took place.

Many of the slum residents blamed the failure on the indifference of elite and bureaucrats and more specifically on the split among the mastaans in the slum, who were known to have alliances with rival political groups. According to rumours

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40 Student politics is an important part of Bangladesh’s history and students are known to have brought about the downfall of the government in the early nineties.
41 Except for one NGO, most NGOs did not get involved as they were worried about political persecution. This particular NGO that organized protests and rallies worked behind the scenes, but made an effort to help the slum dwellers.
circulating, some of the leaders were offered bribes and split over the question of resisting eviction. These divisions were taken advantage of and manipulated by interested political authorities, which further split the leaders into two factions; those opposed to the eviction and those who provided conditional support for the eviction. In this way, united action was stopped against the eviction. For their loyalty and conditional support for demolition, leaders were given other favours, such as cash, promises of land in the newly demolished area or in another site. Moreover, a large number of tenants and the constant arrival of new homeless families into the slum meant that some families did not have any special attachment to the slum, and were not concerned about the eviction.

**Conditions of life in phulbari slum**

The power and politics of the *mastaans* – controlling the urban poor

Slums have distinctive sub cultures and political practices. They are relatively homogenous but hierarchies exist, with differing incomes, power and status. There are higher and lower income households, older, more established residents and newer residents, landlords [richer and poorer – depending on their occupation], and tenants, who are usually at the lowest end of the hierarchy, who are transient. All slums are controlled by a group of men who refer to themselves as leaders, while ordinary slum residents privately call them *mastaans*. There are different levels of leaders in the slum (See Wood, G, 1998a; Islam, N, 1996; Paul-Majumder et al, 1996). There are the relatively harmless *mastaans* [leaders] who control sections of a slum, but then there are well known hardened criminals who are called *mastaans* who have authority over the smaller leaders of the slum. Thus, the leaders who control a slum have different levels of authority and hierarchy among themselves.

Phulbari slum was controlled by a group of lower and mid-level leaders/*mastaans* but there was one powerful *mastaan* (Mr. M) who commanded authority over everyone and

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42 One report found that certain *mastaans* received Taka 150,000 lakh [close to US $2000] as compensation for removal of some slums in the Mohammedpur area. This negotiated eviction bribe was carried out by 2 powerful MPs [members of parliament] and the Water Development Board. The plans were to construct a road which was part of a huge project funded by the Asian Development Bank and the government of Bangladesh. The MPs stood to make a lot of money from this project (Khan, Morshed, Ali, 2000).
was in charge of the entire drug trade in the locality. He was considered the ‘big boss’ of the neighbourhood. All *mastaans* usually have close links with politicians, municipal authorities, and the police in the neighbourhood. Political parties rely on links with local *mastaans* for electoral support and re-election of particular candidates in an area. A *mastaan*’s power base is further consolidated if the political party he belongs to forms the government. Thus, patronage relationships characterize slum politics, which extend from the slum all the way into the local authority and political parties.

There are two main political parties, the Bangladesh National Party [BNP] and Awami League [AL], run by two women leaders, which have dominated national politics for more than two decades now. The country has a bi-polar political system, but instead of stability, their confrontational politics and rivalry has affected the nature of democracy in Bangladesh. The two principal parties command together an overwhelming plurality among the voters and have strong grassroots support. Each party is well represented in the parliament and is sufficiently strong enough on the ground to challenge any attempt by a ruling party to impose its will on the national policy. There are a number of other smaller parties Jatiya Party, Jamaat -i-Islami, Islami Oikyo Jote, JSD [Rab], and independents who are too small to challenge the dominance of the two major parties and usually work in alliance with either political party (Dhaka Courier, 2001; Sobhan, R, 2002).

*Mastaans* have links with local ward commissioners who are elected government officials. Ward Commissioners jobs are lucrative because of the large amount of funds channelled through them for local development works, and an affiliation with the ruling party makes the ward commissioner even more powerful. Most commissioners work with *mastaans* and control ‘gun-running, tender tampering, mugging, extortion,

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43 He did not live in the slum but was a powerful underground mafia drug lord. Slum residents were too scared to talk about him, including the other leaders in the slum.

44 A recent report in a newspaper found that 60percent of Members of Parliament in the government have links with smuggling or criminal elements in the country (New Age, 2004).

45 The state of democracy in Bangladesh remains troubled. Following the popular overthrow of Ershad’s autocracy in December 1990, Bangladesh has had 3 democratically contested general elections in March 1991, June 1996, and October 2001. However the three parliaments which were successively elected have not functioned effectively. For much of the 5th and 7th parliaments, the principal parties, BNP and AL boycotted the parliaments. The prevailing crisis continues and the highly confrontational state of politics afflicts the democratic process and has frustrated the emergence of a system of accountable governance (Sobhan, R, 2002).

46 The ward commissioner of Phulbari, was arrested in October 2002, during one the army’s drives against ‘crime and corruption’ in October. Most of the ward commissioners have criminal records or are
grabbing of development work through manipulation and intimidation,' and the drug trade (Jahangir, R, 2001a). Ward commissioners make millions by using their political leverage, and instead of promoting local welfare, some of the money is given to the party, and the rest is used to consolidate the politician's base, while mastaans are hired to intimidate local populations and rival political candidates.

Given the situation described above, slum residents in Phulbari admitted to being intimidated by mastaans to vote for particular political parties/candidates.47 One of the leaders in Phulbari slum proudly explained, 'You tell your party people to go and stand in the vote station or on the way to the voting area. The slum dwellers who vote are told, 'if you vote, vote for x otherwise go home. The police themselves give false votes.' The police who are part of this culture of coercion and harassment are paid off by the mastaans and look the other way when vote rigging takes place. The police are underpaid, over worked and keen to make money any way they can. They come from the poorer social classes, have no real formal training and survive on bribes to make ends meet (Jahangir, R, 2001a).

Rehman Sobhan (2002) argues that the dysfunctional relationship between the political parties, mastaans and the Bangladeshi State is apparent in the enforcement of law and order, where political rivals are victimized by issuing warrants of arrest on real and imagined charges. He argues that it is the selective approach to the law that underwrites the emergence of the mastaan or musclemen culture as a major factor in political and social life. This allows for the patronage of the mastaans by political leaders, to ensure their own election and the retention of their political authority in their constituency area. As such, a nexus between politicians, mastaans, and law enforcement agencies, is embedded into the political, economic and social structure. A recent report by Transparency International48 found that Bangladesh ranked as the most corrupt nation,
particularly in areas of local governance, education and the police service for the past three years (Dhaka Courier, 2003a).  

**Basic services in Phulbari slum**

Access to amenities and basic services is limited both by the absence of rights to city services and an inability to pay by the urban poor. Most slum residents build networks and links with local leaders (*mastaans*) and even their wives, who act, as brokers, assisting them with access to basic resources, like land, electricity, and water, for a fee. The *mastaans* controlled the acquisition of and provision of amenities, such as latrines, tube-wells, water and electricity connections as well as interventions by NGOs in the slum. Illegal lines provided water for about half an hour in the mornings between 10 to 11 am. Not all the compounds had access to piped water, with many women lining up everyday to access water from other landlords who did, for which they paid a monthly amount of Taka 50 [AUS $1.50]. As water only came for 20 to 30 minutes, this resulted in long queues, tension and heated exchanges among the women who waited under the hot sun, fighting to get their share of the water. There were a few tube-wells installed by an NGO in section one of the slum, but everyone had to pay the leaders a monthly fee for access. There was electricity in the slum but no gas for cooking so most of the women relied on papers, cloth, plastic and wood, as well as other materials to cook on mud stoves.

There were two schools for the poorer tenants set up by two well-known NGOs in the slum providing basic primary education up to class five. NGO services are usually set up after seeking permission from the *mastaans* in the slum, who control sites and allocation of space in the slums. NGOs are widespread in Bangladesh and range from large international organisations [CARE, Caritas, Save the Children] to large national NGOs [BRAC, Proshika, Family Planning Association of Bangladesh], to hundreds of smaller local NGOs. Due to the inadequacy of government services in meeting all the health needs of its population, NGOs attempt to fill the development gap (Perry, H, 2000).

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49 Donors have recently expressed worries over the deteriorating law and order situation in Bangladesh since the 1990s and linked future aid to good governance (Daily Star, 2002f).

50 A World Bank study found that the lack of access to water in the slums means that the poor often end up paying more compared to others for this services - the tenants have to pay the *mastaans* [leaders] who in turn pay government middlemen for access (Zahid Newaz, 2003).

51 Local NGOs such as BRAC tend to be non sectarian national private development agencies operating in multi sectoral development activities (Perry, H, 2000).
Housing

The rent for a room in Phulbari slum depended on the size of the room and the basic services available in the compound, i.e., separate slab latrine, access to piped water. The richer landlords generally owned up to 4 to 5 rooms in one compound, and a thatched wall usually separated the compound from surrounding rooms. The poorer families just owned one room, which they lived in or rented. The rent for each room in the compound ranged from Taka 200-600 a month [AUS $ 5-15]. Out of the 153 married adolescent interviewed in the survey, 32% (n=49) owned a home (but lost it in the eviction), and 68% (n=103) paid rent to a landlord. In the poorer households, the rooms were built out of a combination of cardboard, bamboo, plastic, newspapers, straw and tin, offering little protection from rain or cold/hot weather. Out of the 153 in the survey, 14% (n=21) did not even own a bed, but slept on a jute mat on the floor. Some of the rooms were built out of a combination of cardboard, bamboo, plastic, newspapers, straw and tin. Other rooms had mud floors and some of the more expensive rooms had cement floors. Most landlords cannot afford bricks, steel or cement, as they are costly, and rely instead on low cost cheap materials. Insecurity and threats of eviction make it impractical to invest in higher cost materials for housing. The rooms provide little protection from rain, cold and extremely hot weather. While some landlords did not live in the slum, most did live in the same compound with their tenants. Many of the mastaan leaders lived in the slum, owning a large number of rooms, which they rented out.

Health services

Near the Phulbari slum locality, there are nearly 20 pharmacies, but only two reportedly had ‘qualified doctors’ and the rest served by untrained workers who diagnosed and dispensed medicines, which were often accessed by the slum residents. In Dhaka City alone, there is one pharmacy for every 1000 persons (Rahman S et al, 1999) and in the country, there are about 40,000 licensed private pharmacies with a very large number of unlicensed ones. Qualified pharmacists staff some, but most pharmacies have no qualified staff to sell and prescribe drugs. It is estimated that private pharmacies supply about 87 percent of the demand for drugs in the country as a result of shortages in the public health system. The growth of pharmacies is due to easy entry into this business, limited alternate investment opportunity, a shortage of drugs at government health centres, and few restrictions limiting over the counter purchases (World Bank, 2000). Near Phulbari slum, there are also two homeopathy shops; a well-known hakim
[traditional healer] and a street seller who treated mainly men’s sexually transmitted infections [STIs]. The slum residents regularly accessed care from these private practitioners and local pharmacists. The primary health care at local or community levels by the government is neglected for the urban poor in comparison to rural areas. It is reported that unlicensed private practitioners are most common ‘first contact’ primary care for the poor in the absence of cheap, affordable and available services. There are 220,000 such private practitioners in the country (Perry, H, 2000:58).

Until the eviction, there was also a health clinic (run by an international health NGO), located inside section four of Phulbari slum. The clinic was open everyday from 9 am to 11.30 am, except for Fridays. There were three health providers and one paramedic who worked in the clinic. The three health workers lived in the slum. To join the clinic cost women Taka 25 [AUS $ 0.50 cents], which included a certain amount of free medicines. The following services were listed as being provided: general health, family planning, antenatal care (provision of iron tablets, injections), care for reproductive and sexually transmitted illnesses, and urine tests to check for pregnancies. Menstrual regulation (pregnancy terminations) were available but not carried out at the clinic, but at the clinic’s headquarters. Most women went to the clinic primarily to buy family planning methods, for urine tests to check for pregnancies, antenatal care and for pregnancy terminations. The clinic did not provide any health service for babies, except free immunization services, once a week.53

52 The health care delivery is based on the Primary Health Care (PHC) concept which has five levels of service delivery 1) home and community level, 2) union level: union sub centres (UHC)/Health and Family Welfare Centre (HFWC), 3)Upazila level: Upazila Health Complex (UHC); 4) District Hospital and 5) National/tertiary referral level. This five-tiered system focuses its delivery mainly in rural areas, with urban areas neglected (Perry, H, 2000).

53 The clinic suffered from two main problems - long waiting periods and the inappropriate timing of the clinic. The early morning timings were unsuitable, as most women were busy collecting water [water came around 10 am in the mornings for 20 minutes], washing utensils, clothes, going to the bazaar and cooking. Women were free between 3 p.m. to 5 p.m. as most household work is completed by then. Not surprisingly, women were reluctant to sit and wait in the clinic for long periods when they had numerous chores waiting for them at home and many did seek care from nearby pharmacies and private practitioners.
Everyday life in the slum

Corrupt leaders & culture of gang wars and violence

Slum life is shadowed by violence. As discussed earlier, virtually every slum and section has its own leadership/mastaan structure, and mastaans usually employ ‘club’ boys to work for them in the slum. Club boys tend to be young unemployed youths deprived of adequate housing and unemployed they turn to gang membership because it offers them power, money and status. While girls are socialized to stay at home and are supervised more tightly because of fears of loss of virginity or a tainted reputation, boys are given freedom and mobility in Bangladesh (Blanchet, 1996). In the city, parents tend to lose control over their children, particularly their sons. Loss of land and no viable inheritance means that parents lose any associated prestige and dignity. Sons have access to their own income and see no reason to listen. A father explained: ‘If I ask my son to look for a job or anything else, he shouts, “What do you understand? Why do you talk so much.”’ For young men, prestige is now attached to fighting, and having links with mastaans.54

Socio-cultural notions of honour and shame are prevalent and reinforced among young girls and boys in different ways. Women are under tighter control to regulate their sexuality and gender relationships. Unmarried adolescent girls are ideally expected to maintain their ‘virginity’ till the time of marriage. In order to safeguard their ‘purity’, contact with men ideally should be limited to one’s family and extended relations (Blanchet, 1996). Boys gain honour by controlling women’s movement and behaviour, and now through involvement in gang membership and violence.

Gang wars were common between these armed youths55. Most of this violence was usually connected to rivalry and fights over territorial space and drug control. There

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54 While there is little documented methodically in the literature in Bangladesh on urbanization, youths and gang violence, various authors write of the prevailing gang violence in South African urban inner cities in the shanty towns. They blame the emergence of gangs on the massive social dislocation of youth in urban areas, and where extended families are disrupted if not completely destroyed (See Morrell, Robert, 1998; La Hausse, Paul, 1990). This situation is very similar to what is happening in Dhaka, Bangladesh now.

55 Press reports usually focus on the government’s anti-crime drive to eradicate drugs and criminal activities. Articles regularly appear on “successful” raids and how a stash of weapons or drugs were found in x and y slums. Many articles also blame the two main political parties for the increasing crime and lawlessness in Dhaka City, with the public increasingly frustrated at the lack of control over mastaans [a
were two main gangs that operated in the slum, but Mr. M and his gang of club boys were the stronger group and in charge of the drug trade in 2002. Drug profits were controlled by Mr. M but strategically shared with smaller leaders in the slum as well as with the police and local politicians. For Mr. M and his group to control the trade took time, which resulted in a bitter war covering a number of years (1999-2001), causing a number of deaths of young men. One young man explained the level of violence and terror everyone lived through, particularly in 2001:

Slowly the fights became bigger and bigger and the situation become unbearable. It came to a point when I would sleep hearing bombs going off and wake up hearing bombs going off. This was what life was like! I remember a gang of boys grabbed Awaal (rival gang member) and beat him up so badly. They made him drink his own urine. Then they chopped off his fingers and brutally murdered him!

Stories of police and gang brutality were common and passed around, increasing the nervous tension and fear of slum residents. In the slums, such violence seemed to be a way of gaining legitimacy and control over a powerless population that had no means to protest.

The mastaans and even their wives were known to regularly extort money from slum residents under the guise of contributing to ongoing lawyer fees for fighting eviction threats, fixing toilets and other small repairs. While most residents bitterly complained of contributing over the years, they did not refuse for fear of ugly reprisals. One older woman commented, 'I have one small home in the slum. These mastaans came to ask me for bribe of Taka 10,000 [AUS $ 250]. I grabbed their feet and pleaded with them as I could only give them Taka 500 [AUS $ 120]. Finally they agreed... in my home I have a young daughter, if I don’t give money then they will take my home or they may harm my daughter!' Women, particularly unmarried female adolescents were subject to sexual violence and harassment by rival gangs, but occasionally by resident club boys. Since most of the young hooligans have political links, they do not fear arrest. In a country where pardah and female chastity are fundamental principles, rape will end any

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creation of the elites and politicians] and political henchmen hired by political parties. While crime and violence is extremely poor in the city, it is the poor who are most vulnerable psychologically, physically and socially and lack access to legal aid. Slum areas are usually targeted as the den for all 'evil activities' in the media and in the perceptions of richer and middle class families.

Mirpur (where Phulbari slum was located) along with a number of other slums were listed as the some of biggest drug dens in the country (Dhaka Courier, 2002).
chances of a young woman ever getting married. Rape not only stigmatises the young woman but also her family. Rape results in a loss of honour and loss of social and family protection for the young woman, who is ostracized (Rozario, 1992; Adnan, S, 1993). The social stigma of rape is so great, that during the liberation war in 1971 in Bangladesh, thousands of women raped by Pakistani soldiers were not accepted back by their own family members and husbands (Hashmi, T.I, 2000). Ostracism of raped women is the most blatant illustration of the importance of maintaining women’s purity and chastity to a Bengali family and to a man’s honour (Rozario, S, 1992).

**Mastaans** were in charge of meting out informally justice in the community, which was open to much misuse and abuse, as they punished whom they saw fit. Residents were upset and suspected that fines were pocketed in these informal courts and punishments and beatings were given to innocent members in the community. According to one Phulbari resident, ‘Whoever has paid them the most amount of money wins the *shalish* (justice).’ However, for some families, *mastaans* played a constructive role in sorting out wayward husbands and sons-in-laws. However, in general most of the slum residents lived in a climate of oppression and fear.

**Raid by the police: intimidation and harassment of innocent men and women**

Under the guise of following government orders of cleaning out ‘criminals elements in slums’ the police carried out two late night raids between January and May 2002, in section 4 of the slum, and mostly innocent men were jailed.57 One landlady narrated:

Yesterday the police people came into the slum and took about 40 to 50 men away. Only seven have been brought back. They kicked my door. I said, “Who is it?” They shouted, “Open up.” My husband was shaking inside. I said, ‘Why are you so scared? We will be okay!’ Then the police asked me very rudely, “Why did it take you so long to open the

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57 Press reports usually focus on the government’s anti-crime drive to eradicate drugs and criminal activities. The reports tend to blame all of the urban poor for criminal activities in the slum. Usually, middle class and higher income families, view the slum residents with a mixture of indifference, sympathy, disgust and scorn. To give you an example, when Phulbari was being evicted in July, I shared this news with my colleagues and friends at work, but to my surprise most of them reacted positively to the news. Very few had sympathy for the slum dwellers. They said, ‘they are all thieves and criminals, the sooner we evict them, the quicker we can clean up our City. They are lazy, they sell drugs and have sex workers living there. Why should they get to live on government land illegally and we have to slog all our lives just to buy a flat for ourselves? Why should they get everything so easily?’
door?” I said, “Sorry I was breast-feeding my child.” They grabbed two of my tenants...they even wanted to take my husband but he said that he worked in a spectacles shop and after we pleaded with them they didn’t take him.

The women frantically ran around borrowing money to pay bribes of Taka 3000 to 5000 [AUS $ 1000-1200] to the police in order to have their husbands and sons released. The hardship this brings to poor households when loss of income is combined with payment of bribes is immense.

In addition to the two police raids, there was a violent gang fight between rival groups, which injured a number of men in May 2002. During this period, there was also the murder of a young man, a kidnapping of a young girl and two bombing incidents. There was an increased presence of the police during this time, but no one was arrested despite everyone being aware of the culprits. Violence usually flared which manifested itself in revenge, counter-revenge, increasing the cycle of conflict and inter-gang feuding. There were constant reports of large-scale possession and circulation of guns in the slum among gang members. Crime in the slum also highlights the gendered nature of violence, affecting men and women differently, with young men beaten, murdered or tortured and young women victimized by gangs as well as by husbands who are drug addicts.

**Employment conditions for the urban poor**

The urban poor are constrained by their complete lack of qualifications and the only work available tends to be labour intensive, stressful, low paid and at times dangerous in a highly competitive sector (Kabir A, 1998). As unskilled labourers, many of them remain permanently unemployable or engage in a number of jobs that fall primarily within the informal labour market. Many work as petty traders, domestic servants, casual labourers, and sex workers. In the informal sector, there is no insurance against old age, sickness, maternity or industrial hazards. Further, if a worker is sick, substitute workers quickly and easily replace him. As migration increases in the city, the pressure on the labour market will increase, making the sector over saturated and competitive (Opel, A, 1998).
Cash is desperately needed to pay for water, food, and rent and for goods and services in the City. Desperate for work, some of poor resort to home based manufacture of home made ink, cheap toys, such as strings of beads, plastic bags, bottle caps, brushes for shoes and cloths from animal hair. Some women sell snacks (dried fruit, bread) in the slum, but most families barely make enough to manage. The reality is that the only way for them to seek employment directly is to gain skills, which can help with access to the labour market. However, in Bangladesh, the State does not have any institutional facilities where the poor can learn skills and thus most do not have access to the formal labour market or better employment opportunities (Opel, A, 1998).

The employment situation in phulbari slum

Adolescent women’s husbands occupations

Out of the 153 young women interviewed in the survey, 135 volunteered information regarding their husband’s occupation, with one of the most common jobs being rickshaw work, with 23 percent (n=31) husbands involved in this labour intensive and low paid work. Men can earn from Taka 50-90 daily [AUS $2.00-1.00]. If the rickshaw is rented then Taka 30 [AUS 0.90 cents] is paid as rental fee, which means the person earns even less. Rickshaw pullers can easily lose their jobs if they are late with rental payments. To add to their miseries, even if rickshaw-pullers are able to save enough money to buy a rickshaw, the government has restricted the issuing of new licenses, thus the poor pay double the price [in bribes for fake licenses] to buy rickshaws in the open market (Opel, A, 1998). It is estimated that in Dhaka City there are 400,000 men employed in the rickshaw sector, representing more than 23 percent, contributing a total value of US $246 million in 1985-86 (Afsar, R, 2000).

Approximately, 8 percent (n=11) adolescent women’s husbands drive baby taxis and tempos and similar to rickshaw-pullers, pay extra money for fake licenses in order to ply the their vehicles. One can earn up to 150 Taka [AUS $ 4] driving baby taxis, but work is available only on alternate days because of the competitive labour market, where there are too few taxis and many unemployed men. The Mirpur area, where

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58 This is because some were separated, abandoned or sharing husbands with other women/co-wives.
59 Only 10 percent of rickshaw-pullers own their own rickshaws in Dhaka City, with the majority renting it from an owner [Opel, A, 1998].
Phulbari was located, is known for its concentration of handloom factories. About 14 percent (n=19) adolescent women's husbands are involved in weaving work. Weaving work is better-paid and more respected than rickshaw work. Rickshaw work is viewed as demeaning and only taken up as a last resort, whereas weaving work requires skills. Depending on how many saris one can weave in a day/week, a person can earn from Taka 500 to 700 per week [AUS $18].

<table>
<thead>
<tr>
<th>Occupation list for Men</th>
<th>Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rickshaw/van puller</td>
<td>31</td>
<td>23</td>
</tr>
<tr>
<td>Small business [grocery store, selling vegetables/fruit</td>
<td>15</td>
<td>11.1</td>
</tr>
<tr>
<td>Garments worker</td>
<td>19</td>
<td>14.1</td>
</tr>
<tr>
<td>Weaver [handloom]</td>
<td>19</td>
<td>14.1</td>
</tr>
<tr>
<td>Baby taxi/tempo drivers</td>
<td>11</td>
<td>8.1</td>
</tr>
<tr>
<td>Truck/bus driver</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>Day labourer</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Car driver</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Tailor</td>
<td>4</td>
<td>3.0</td>
</tr>
<tr>
<td>Salesperson in shop</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Rajmistra – electrician</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Own shop</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Carpenter</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Mechanic</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>No job</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Contractor</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Cook</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>135</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Approximately 14 percent (n=19) of the adolescent women's husbands are involved in garment factory work, which is better paid, with salaries ranging between Taka 3000-4000 per month [AUS $80-100]. The work is highly competitive and requires skills, which new migrants lack. Eleven percent (n=15) of husbands were selling vegetables, fish, and/or fruit in and around the slum neighbourhood earning up to Taka 40-50 [AUS $1.00-1.50] on a good day. However, profits vary seasonally, with summer being the worst time as unsold goods rot quickly, and goods are sold at cheaper prices to get rid of stock.

However, the garment and weaving industry as well as the transport sector was increasingly being affected by global and local factors and many young men and women were worried about the lack of available jobs in the city [further discussion later...
in this chapter. A combination of survey data, repeated in-depth interviews and probing in case studies, reveal that 19 percent (29) of the husbands did not work regularly at all, and many were either unemployed, or did not want to work. In addition, 8 percent (n=12) of young women volunteered that their husbands were heroin users, or addicted to alcohol and gambling.\footnote{While the survey provided information, in the in-depths and case studies, young women were more forthcoming.}

**Unemployment and substance abuse in the slum**

**Drugs – escaping from harsh realities of life!**

Considering the increasingly limited range of job options for poor men and the pressures to earn an income, it is not surprising that there was a thriving drug trade, with a large number of dealers and users in the slum. However, since many are reluctant to admit that their husbands are addicts, I would argue that 8 percent of husbands reported to be drug users is much lower than the actual situation.\footnote{A common sight during my fieldwork was observing men sitting in certain corners of the slum smoking heroin (very few inject heroin) and marijuana. Another common sight was groups of 4 to 5 men sitting around gambling every evening right outside their homes in the alleyways. Fights often broke out over money owed. Drug selling was also common and I observed this in the margins of section 4 and in section 3 of the slum.}

The problem of substance abuse is true not only for Phulbari, but is a growing problem all over Bangladesh. A recent article reported that there are approximately 2 million drug addicts in the country with approximately 174 drug dens in Dhaka City. Estimates range from 10,000 to 3 million heroin and pethidine addicts in Dhaka City, most of whom are the poorest.\footnote{A smaller percentage of the richer class and students in universities also indulge in heroin. The difference is that many do not work to support a family and have access to the few rehabilitation centers in the country and abroad. The least costly item is phensedyl, costing Taka 200 [AUS $ 5.00]. For more information see: http://www.chr.asn.au/Hidepi/Bangladesh.pdf} It is extremely difficult to get accurate estimates of the actual numbers of users in the country, but I would suggest that the problem is quite substantial. There are a wide range of drugs, such as phensedyl (cough syrup), heroin, opiates, cannabis, sedatives and contaminated sleeping pills, local and foreign liquors,\footnote{Bangladesh is a Muslim country and alcohol is banned.} which were available in Phulbari slum (Haque, M, 2002). Poor men and some women unhappy with their situation become involved in this type of work to support their families, a few become addicts themselves. Others turn to drugs to cope with the miserable conditions of life and their inability to support their families. When drug users...
run out of money, they usually resort to stealing, mugging, and even selling family possessions. Asma’s story is not unusual in the slum. She is a married adolescent (17 years old) and her husband is a heroin addict. He twice sold their household possessions to buy drugs. In September 2002, he sold her sewing machine, her only income earning opportunity to earn some quick cash for his habit. There are very few detoxification and rehabilitation programs in the country. The few are limited to the rich, and most of the drug users are very poor and do not have the money to attend them.\(^{64}\)

Slums in Bangladesh are low income, highly stigmatised areas and avoided by outsiders and mainstream businesses. Legitimate options are few for the residents and the drug trade offer economic opportunities. A male drug user illustrates the lure of the trade. He explains:

Do you know what Mintoo (now a leader) did before he became a big shot? He used to ride a tempo (local three-wheeler transport) and then overnight he is a powerful thug in the slum. His (drug) partner would drive a baby taxi. A baby taxi! From earning Taka 100 to 150 [AUS $ 2.50-5.00] every few days, they now earn thousands of Taka in a few hours! Then they became leaders of the slum. Where do you think they got their money? It came from the drug business. Then tell me Apa, who wants to work hard all day in an awful job making no money?

Although a Narcotics Control Act was established in 1990, successive governments are blamed for their indifference to cracking down on the drug trade, and accused of protecting vested interests, such as drug lords, corrupt political leaders and law enforcement agents, who are heavily involved in this trade. It is reported that most of the drugs are smuggled in from India, Pakistan, Myanmar and Nepal (Haque, M, 2002).

**Adolescent women’s occupations**

The survey of 153 married adolescent women revealed that 83 percent \(n=127\) remained at home. A majority of adolescent women said they stopped working soon after marriage, a finding that coincides with other studies carried out on young women

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\(^{64}\) For more information see: [http://www.chr.asn.au/Hidepi/Bangladesh.pdf](http://www.chr.asn.au/Hidepi/Bangladesh.pdf)
in Bangladesh. Many of the adolescent women\textsuperscript{65} cited husband’s disapproval, \textit{pardah} and family prestige as reasons. Studies have found that men frequently control the female labour in their household, sending young women to work or withdrawing them from the workforce (Salway, Rahman, and Jesmin, 2003). Research shows that most men view garment work as low prestige, as it involves working with male strangers and travelling back and forth from work at night (Kabir, A, 1998).

Many of the young women said that the role of the breadwinner lay with their husbands. This is not surprising because in Bangladesh, women’s roles as child bearers and family maintenance are emphasized, and men are depicted as providers, protectors and authority holders (Salway, Rahman, and Jesmin, 2003).\textsuperscript{66} Many of the young women preferred this ‘traditional’ role, desiring a man who would look after the household, while they stay at home taking care of the children. For many poor men, sending women to work is a sign of poverty and to incur a loss of prestige for the family. A woman working is in conflict with not only gender roles and identity, but it implies the inability of the man to fulfil his role as a provider (Kabir, A, 1998).

However, the reality is that increasing poverty and hunger means that poor married adolescent women [and men] are willing to forgo \textit{pardah} and cultural restrictions to work outside the home. They are increasingly becoming economic actors within the household, and ‘breaking the boundaries of permissible female behaviour’ (Kabeer, N, 1989). Nearly 10 percent (n=16) young women presently worked in garment factories and 3 percent (n=5) worked as domestic help in other peoples households and 4 young women were involved in sewing and tailoring work at home to earn money. In addition to this, in times of stress and cash shortages, at least 32 young women reported working off and on in garment factories and 9 relied on sewing and tailoring work during crisis periods, if husbands were sick or unemployed.

Although young women are driven outside their homes to earn cash, what is most acceptable for them is to be involved in income generating activities inside their homes. Young women engaged in part-time work such as sewing and embroidery at home can

\textsuperscript{65} Other studies have found that high levels of work participation are among those women who are not married, divorced, deserted or separated compared to those who are currently married who are least likely to work (Salway, Rahman and Jesmin, 2003).
earn up to Taka 10-20 [AUS $ 0.30 cents- 0.50 cents] for each shirt or *punjabī*\(^{67}\) embroidered, which is then sold in the shops for Taka 300-500 [AUS 0.75 cents - $13]. Sewing is seasonal work with the most money earned during Eid [Muslim religious festival] and a young woman can earn between Taka 100-400 [AUS 0.10 cents- $10].

The advantages to this sort of part-time work is that it allows young women to follow the norms of *pardah* by working from home, while allowing them to take care of their babies and young children.

For those poor adolescent women who work outside the home, the employment market is structured against them, with less scope to move up and develop their skills. There are some opportunities for adolescent women in garment factories and domestic labour (being the most common); but compared to men, scope for upward mobility in labour market and job options are far more constrained. Most young women tend to work in non-management positions in factories, working as ‘helpers’ but few hold positions as supervisors or managers, which are reserved for men (Salway, Rahman, and Jesmin, 2003). Other factors that restrict their employment to a certain extent are crime, sexual harassment, social norms and limited education. Out of the 153 young women surveyed, 51 percent (n=78) married adolescent women had never attended any schooling and only a handful had more than three years of education.

### Global & local forces affecting job market conditions for the urban poor

#### Garment industry

As discussed earlier, since Bangladesh was incorporated into the world capital economy, global market fluctuations do affect key industries, which impact on the livelihood of the urban poor. Soon after the attacks on the world trade centres on September 11\(^{th}\), 2001 in the USA, a total of 1,276 garment factories shut down in Bangladesh. This was because after September 11, air shipments were seriously disrupted resulting in major financial losses for the Bangladeshi garments sector and

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\(^{66}\) Another dimension of *pardah* is the rigidly laid down sexual division of labour within households, which ideally means indoor [household] work is for women and outdoor work is for men. (Adnan, S, 1993).

\(^{67}\) Traditional shirt worn by Bengali men.
recession in the US led to the cancellation of existing orders from the local USA market. The result was an overall decline in garment export of 10.6 percent during 2001. Reports estimate till 2002, 501 factories still remain shut and 2,25,000 women remain unemployed (Firdaus, N, 2002).

As mentioned earlier, 14 percent (n=19) of adolescent women’s husbands work in garment factories and a smaller percentage of married adolescent women work (off and on) in garment factories. Numerous adolescent women and their husbands were depressed and upset that they had not been paid regularly, and worried about food and future rent payments. Many of the young women and men were worried that garment factories were shutting down and were scared of losing their jobs. A report of the state of factories in the Mirpur area where the slum was located, found that out of a total of 336 garment factories, 25 had already shut down (Jahangir, R, 2001b). Another report estimates that out of 1.6 million workers, only a million received their salaries and overtime earnings, with the rest deprived (Ahmed, T, 2002).

Bangladesh, being least developed country, has a small internal market and suffers from lack of adequate capital. Due to the realities of industrial economies of scale and world tariff restrictions, the country’s local industries find it difficult to compete with more established and more developed countries. As discussed earlier, the local garment industry is bracing for difficult times ahead with global recession, and the abolition of the MFA (multi fibre agreement), US TDA-2000 and European Union’s [EU] special preference for Pakistan’s garment industry, and the accession of China into the World Trade Organization [WTO]. The USA and the EU are Bangladesh’s largest markets, consuming 95 percent of the apparel exports of Bangladesh (Firdaus, N, 2002).

The removal of the quota for ready garments after 2004, with the abolition of MFA, and new WTO sanctions come into effect, Bangladesh will be placed in a very difficult situation. Bangladesh is at risk of losing 50 percent of its apparel exports if the quota is eliminated, as it is unable to compete with other countries such as the big giants of China, India and Russia. The garment industry has already experienced problems from

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68 In view of the impact of the removal of quota after December 2004 for ready made garments, Bangladesh has pleaded for special measures including duty free access of its products to all countries, and exemption from anti-dumping duties. (Firdaus, N, 2002). This would protect the market share of apparel exports of the Least Developed Countries like Bangladesh [the categorization of the LDC status is assessed by the UN].
partial withdrawal of quota last year [2002], with exports declining by around 30 percent, while countries such as China India and Russia have increased their exports considerably (Dhaka Courier, 2003). After 2004, it is predicted that 800,000 poor unskilled workers [mainly young women] will become unemployed, creating socio-economic havoc in the lives of the poor. The fears are that these retrenched workers, mainly poor young women will be unable to return to their village homes, after adapting to the urban lifestyle, with nothing to offer them if they returned to the more ‘restrictive conditions’ of rural areas. Moreover, thousands of poor families in rural areas who are dependent on their daughters, sisters and wives incomes, from the garment industry will be very badly affected.

In addition, over 10 million people are dependent on this sector in Bangladesh. Industries such as the banks, insurance, hotels, tourism, transport, buying houses, and shipping have benefited and expanded because of the garment industry. The garment industry in the manufacturing GDP of the country during the fiscal year of 2001-2002 was about 29.7 percent (M.M. Jinnat A., 2003; Adnan, S, 1993).

The Government & World Bank policy to ban diesel run baby taxis

Renewed global concerns regarding the environment partially influenced a World Bank financed government policy to improve air quality and reduce deteriorating air pollution in Dhaka city [ESMAP, 2002]. The first step taken by the government was to ban petrol/diesel run baby taxis from the streets of Dhaka City in 2002. The plan was to introduce Compressed Natural Gas [CNG] environmentally friendly three wheeler baby taxis instead. Old style Baby taxis emitted pollution because of fuel adulteration, poor maintenance and inappropriate use of lube oils, whereas CNG taxis do not produce lead (Daily Star, 1998).

69 The garment industries pay US $ 35.50 million as interest and L/C charges to the banking sector. In the insurance sector, the premium earnings from the garment sector add up to US $ 5.83 million, and the sector pays US $ 62.33 million to the shipping business. The list goes on and on, with millions and millions of US dollars being paid to various sectors such as engineering, gas, tourism and hotel. While 72 countries of the least developed nations in the Caribbean and the Sub Saharan African countries have been offered duty free access to the US market, Bangladesh has been left out of the preferential treatment of the US government (M.M. Jinnat A. 2003).

70 A meeting took place on this issue as far back as 1998, called the ‘Integrated Approach to Vehicular Pollution Control’ which was jointly organized by the World Bank and the Department of Environment. (Daily Star, 1998).
As discussed earlier, this ban left a quarter of a million urban poor men and their families without any income. Although the government was praised for its plans to reduce pollution by introducing CNG run baby taxis, the manner in which the government implemented it was criticized, as it did not ensure a safety net for the urban poor. Eight percent (n=11) of adolescent women’s husbands drove baby taxis, while there were a large number of adolescent women’s fathers who drove baby taxis. Around this period in Phulbari slum, many adolescent women’s husbands and fathers who drove baby taxis were beginning to lose their jobs. Many of the men were tense about their family’s future with the recent eviction in July, as well as looming unemployment prospects. Not only had they lost their homes, but were going to lose their jobs.

The government decided that in the first phase, 12,500 two stroke three wheelers out of 18,000 would be removed from the first of September 2002, allowing only 5,500 to ply the streets till December 2002 (Daily Star, 2002a). After December, the remaining 5,500 would be removed from the streets and the new CNG baby taxis would take over. In the meantime, the remaining 5,500 taxis needed special route permits stickers to ply till December. The official cost for the permit was Taka 45 [AUS $12] but newspapers reports indicate that groups of middlemen, Bangladesh Road Transport Authorities [BRTA] officials and leaders of the Dhaka City Auto-rickshaw Association were charging Taka 1000 to Taka 2,500 [AUS $25-62] for these special permits. Despite the bribes, hundreds of desperate owners and drivers paid the permit fees (Daily Star, 2002b). On top of that the cost of a buying license to drive the new environmentally friendly CNG baby taxis is approximately Taka 600-800 [AUS $15-20]. The reality is that if anyone wants a new license they need to pay close to Taka 6000 [AUS $150] because of the numerous bribes taken by corrupt officials and middlemen, money the poor could ill afford.

As many could not afford the money for special permits some chose to secretly ply their baby taxis after the September 2002 ban. For example, Salma’s [15 years old and

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71 Verbal communication – World Bank official who expressed his unhappiness with the way the government handled the ban. He felt that the phasing out of the vehicles could have been done better in order to ensure that the poor families were not left in desperate situation.

72 During this period, the Minister of transport took great pains to emphasize that there would be replacement vehicles – 30 Volvo double decker buses, and 100 buses and new Singaporean company of taxi cabs to offset any transport problems the middle class would have with the removal of baby taxis off the streets (Daily Star, 2002a). The Minister never showed any concern for the thousands of poor families living in urban slums, who were left without any income because of this sudden removal of baby taxis. There was overwhelming support from the middle and upper class to the government’s ban on the baby taxis that were seen as a major cause for the pollution in the streets of Dhaka.
married] husband decided to drive his baby taxi in the middle of the night rather than during the day to avoid getting caught by the police. He was caught twice and had to pay the policemen bribes, which more than halved his earnings for that day. He was scared because extra police were deployed on the streets to ensure that only special permit baby taxis were plying. The police were under strict orders to seize illegal vehicles and take immediate action against any person caught driving without a permit (Daily Star, 2002c). Salma's husband admitted he was desperate to earn cash to feed his family, so he continued to take a chance. He feared beatings, the seizure of the vehicle, and even jail, but hoped he could pacify the police with bribes.

**Government restricts movement of rickshaws on the streets of Dhaka**

The next phase of the government's drive to improve air pollution and reduce traffic congestion was targeting rickshaw-pullers in the city who were blamed for creating traffic jams on the main roads. As I discussed earlier, 23 percent (n=31) of adolescent women's husbands in the slum plied rickshaws. On September 10, 2002, the government stopped 60,000 rickshaws from plying on the main roads in order to reduce traffic congestion [Daily Star, 2002d]. While this was a quick fix for the government, this was yet another example of the urban poor being unfairly marginalized. The implications of this new law meant that rickshaw-pullers were limited to working in restricted areas, ensuing reduced access to customers and less money earned. Moreover, any one caught plying an illegal rickshaw was fined and harassed by the police, and the rickshaw taken away in police-vans to be destroyed later. It is estimated that there are 400,000 illegal rickshaws in the city, with no proper permits and fake licenses [Khan, Morshed Ali, 2002a].

The large number of illegal rickshaws highlights the number of poor unskilled men who migrate from rural areas and are eager to take this up as a profession. The largest industry, which is garment factories, primarily employs young women. For poor urban men rickshaw work is easiest to find, as it can be dangerous, laborious, and owners will employ them immediately without verification of suitability. Every year, roughly during December/March, the two Eid periods, thousands of the rural poor men migrate to the city and live in slums and temporarily ply rickshaws to earn an income [Khan, Morshed,
Ali, 1999]. The recent drive to removal illegal rickshaws as well as to stop them from operating on the main thoroughfares seriously affected the incomes and lives of poor men and their families, who have very few employment options available to them.  

### Poverty, insecurity and ruptured social relationships

#### Unemployment & the cycle of debt

A harsh environment and unpredictable employment in the most uncertain sectors of the labour market means that the probability of food shortages remains high for the urban poor. These households constantly face crisis in maintaining their subsistence. As such, market fluctuations and a few days of unemployment as well as illnesses can lead to starvation in many households (Kabir, A, 1998). Out of the 153 surveyed, 18 percent of adolescent women said that their husbands had lost their job and had no income, and 7 percent of the husbands were sick and unable to work. Some young women relied on loans from NGOs and informal savings system in the slums as well as mone

The ability to earn cash income is especially important in determining food security and basic survival. In the survey of 153, approximately 29 percent married adolescent

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73 Officially there are 80,000 rickshaws registered in the city, but unofficially there are 400,000 rickshaw pullers working with fake licenses (Khan, Morshed, Ali, 2000a).

74 The weaving sector, which employs many of the urban poor men, is also increasingly affected. There are about 7900 weaving units producing Banarasi saris, employing 12,000 workers in Mirpur. Despite the large number of weaving units, the handloom industry is in dire straits because of the lack of quality support and government initiatives to ensure fabric production, improving its quality, thus expanding the market (The Independent, 2003). Fourteen percent of the adolescent women’s husbands in the slum were weavers. Weavers complained of competing in an unfair market where Banarasi saris from India are smuggled into the country and sold for much cheaper prices in the shops. Some of the young men in the slum shared concerns about their long-term employment prospects in the handloom industry. Lina (17 years old and married has two brothers who work as weavers in a unit and supported her father and family. In November-December 2002, both of the young men were finding it difficult to keep their jobs and started looking into other work opportunities without much luck. One of them had no income, whereas the older brother managed to find another job at one of the weaving units. This was a difficult time for Lina and her family as they had lost their homes in the slum.

75 A large number of the married adolescent women had their own informal system of savings referred as the 'lottery' system in the slum. Groups of ten women deposit Taka 5 daily into a common fund. After a few weeks, everyone draws a number, and the lucky winner receives all the money collected from the common fund. The winner then opts out of the game, but still donates her daily amount money till the next Winner is announced, until everyone in the group has a chance to win. Then the game begins all over again.
women admitted that in the past 6 months they did not have enough money to buy food and had to borrow on credit from shops, while others relied on the kindness of neighbours, landlady and family to manage. The additional burden for some families is that some continue to have links with family in the village and need to send money to them. Twenty-six percent of adolescent women's husbands have contributed Taka 200-500 [AUS $12] or less to their parents in the village. Almost 38.5 percent adolescent women admitted having debts, ranging from Taka 2000 - 10,000 [AUS $50-250]. Money was owed to many people, shop keepers, moneylenders, neighbours, friends and family members. This leads to a cycle of loans and debts and further poverty and suffering for adolescent women and their families.

Uneven support & uncertain lives – deprivation, hunger and hostility

Poverty, the absence of support and uprooted from familiar ties in the village, many urban poor residents build relationships by creating fictive 'kin' ties with others in the slum - the landlady and neighbours (Wood, G, 1998a, 1998b; Opel, A, 1998). For example, an older person will be referred to as uncle (chacha) or brother (bhai), and women as sisters, aunts (apa, chachi) to form relationships. This is to ensure that there is assistance when there is a crisis in the household. For example, Aklima (17 years old, married) and her neighbour Shanti were very close, and although Aklima had her family living close by, she relied on her neighbour Shanti for advice and financial loans when she had difficulties. Thus, social relations are significant resources in the survival of poor urban households. Studies show that the most vulnerable in the slums are not only those who have few material resources, but are also isolated from networks of social exchange (Opel, A, 1998; Wood, 1998a, 1998b; Paul-Majumder et al, 1996).

In Phulbari slum, patron-client relationships were common between the landlord and one's tenants. Networking and small reciprocal exchanges usually took place between the women tenants in the households as they were at home during the day. It was usually the landlady who involved herself in the affairs of her tenants, intervening in domestic disputes, carrying out informal trials, breaking up quarrels, ensuring water connections remained, and sometimes helping with food and even money. For example, when Monsura, a married adolescent woman went without food for days when her husband did not work, she relied on her landlady who sometimes shared her rice and vegetables with her. When Razia (14 years old and married) gave birth and fell ill and
was unable to work for a few days, her landlady assisted her with the household chores. Shaheeda, an orphan, 16 years old and married to a heroin addict often did not have enough money to pay her rent on time. Her landlady allowed Shaheeda to pay her rent late as well as intervened when the drug addict husband would become physically violent. Establishing a good relationship with familiar tenants was important to owners as this ensured there were low turnover of residents, and one received regular income from reliable and familiar tenants. Owners worried about renting rooms to troublemakers who could refuse to pay.

Brutal poverty ensures that relationships are short lived and fights between owners and tenants, neighbours and among kin were frequently reported and observed in the slum. Arguments would usually break out over food and money, both of which are extremely scarce commodities in the slum. Shoma (a married adolescent) moved out when her landlady accused her of trying to steal food from her kitchen one night. In another incident, two tenants had a falling out over unpaid loans, and a landlord slapped a tenant over unpaid rent money. Fights broke out over unfair food distribution with accusations of favouritism towards certain family members/individuals who contributed more money to the household compared to those who gave less. There were arguments between tenants, family members (in-laws, step-relations, siblings, parents) over who ate the last egg, got the biggest piece of fish, or who was given stale rice and water. Observations of family members and tenants going without food, while others ate, were not uncommon. Shumi lived with her stepmother-in-law and family. Her husband was finding it difficult to find work and had not been able to contribute any money for the past one week to the household. During the middle of the interview, everyone in the household sat down to eat but no one called her for the afternoon meal. I asked her if she had something to eat but she didn’t say anything. Then she said, 'For two days I have not had food to eat and neither has my husband. No one has offered me any food again today. When we contribute money then we will get food!' This reveals how poverty, limited resources and the need to survive are wearing away at traditional support structures.

**Conclusion**

The condition of life in Phulbari slum exemplifies the contemporary situation for most of the urban poor in the city. Asymmetrical power relations devastate the lives of the
slum dwellers who are far removed from the 'levers of control,' (Farmer, 2003:xvii), with their lives dominated by decisions taken by others – institutions, State, police, mastaaans and the wider community. Kabeer maintains that the process of poverty is not simply one of inadequate entitlements, but one of structurally reproduced distribution inequities (1989), and institutions, the market, civil society and State are firmly entrenched both socially and culturally in favour of the more powerful and richer classes in society. Realistically, the urban poor have very little room for manoeuvre (Wood, G, 1998b), and face a precarious existence with no prospects of ever moving out of poverty.

Rapid socio-economic transformations, landlessness, disasters, and grinding poverty have forced millions of rural families to migrate to urban areas in search of food, shelter and security. Unable to afford housing, they live in flimsy settlements in the city. Access to basic services such as rooms to rent, water, gas and electricity are negotiated by the mastaaans in the slum. Everyday life is a struggle and the slum dwellers bargaining power is severely constrained by their marginal status and poverty.

I clearly demonstrate the consequences of 'structural violence' in the lives of the urban poor where poverty, inequalities and political violence add to their suffering (Farmer, 1992, 2003). Crime, gang violence, and police raids emphasise how power and violence is rooted in the social as well as the wider structural and political system. Neglect by the State and political oppression by government authorities, mastaaans and police was prevalent in Phulbari slum. The urban poor were regularly subject to intimidation and torture, with money extorted regularly from them. Incidents of rapes and sexual harassment were common but poor young women and their families have little recourse to justice. The ambivalence of the state and other institutions, strong patronage from influential leaders and patriarchy perpetuate this violence and unequal gender relations. While violence and lawlessness are prevalent in the wider society, it is the poor who are subject to and battered by the intensity of crime and aggression and other forms of disorder in the slum. The economic situation of the poor makes it difficult for them to access free and fair trials, with police and lower courts accused of corruption.

One can observe the effects of structural disparities and a harsh political economy on displaced and economically excluded young men, who turn to destructive behaviour, getting addicted to substance abuse, involved in criminal activities and working for
local gangs and political parties. Young men are involved in gangs, in exchange for money, power and prestige. The reliance on substance abuse and the selling of drugs highlights the extreme economic marginalisation of urban poor men and impacts on married adolescent's women lives and well-being.

Scoones and Wolmer argue that markets are socially and politically embedded institutions, with access for the poor highly asymmetrical, influenced by the differential market power of different players, high transaction and entry costs and so on (2003). The international and local political economic order exacts enormous costs borne disproportionately by the urban poor. Economic globalisation has resulted in an international division of labour and a major consequence of this is any economic downturn globally impacts locally on poor workers, evident in the shutting down of hundreds of garment factories in Bangladesh after 2001. Moreover, global environmental concerns and internationally funded local reforms in the transport sector have affected thousands of jobs for urban men. Many are unable to make their way through the bureaucratic processes or pay the costly bribes to hold on to their jobs. Despite the crisis in households from unemployment, pressures of culture and male prestige prevent many young women from working after marriage.

Dire poverty and hunger [a near daily occurrence] creates a hostile and tense environment, and forces family members to compete with one another to meet basic needs. Rapid transformations in social conditions brought on by a competitive harsh urban environment are disrupting relationships and support structures. The narratives described in this chapter are not unique but typical of the broad experience of the urban poor living in slums and highlight how the poor cope, struggle, resist and manage under conditions of extreme deprivation and suffering.

In this chapter, I have outlined how structural, socio-political and economic factors create and maintain inequalities for the urban poor, who have little scope for agency. In the next chapter, I show how the suffering and degradation in the lives of the urban poor become embodied and experienced in the lived body. The urban poor speak of a ‘folk ailment’ chinta roge [translates as ‘worry illness’], and blame its emergence on structural and political economic conditions in their lives, with worsening poverty, powerlessness and insecurity. The discussions in the subsequent chapters will illustrate how knowledge of the body, health and illness in various societies and historical periods
is culturally constructed and contextually contingent (Lock and Gordon, 1998; Lock and Scheper-Hughes, 1996).
Chapter Three

*Chinta roge* - 'worry illness' in their lives

May 20, 2002 - I am talking to a kabiraj [traditional healer]. We are talking about illnesses in the slum and what illnesses he treats, when he suddenly launches into this short story:

A baby is born and falls on the ground screaming loudly. The baby thinks, 'what land have I come to? Is this a land of fire? This world is not good.' You will see as soon as a baby is born people start running around trying to feed her sugar and milk, to soothe her. After taking some sugar, the baby falls asleep again. Then people say, 'Oh look the baby is sleeping again.' The mother says, 'No, now the baby has come into this world. The baby will never again enjoy the peaceful sleep she experienced in the womb!'

Sabina: I don’t understand the meaning of this story? Can you tell me a little bit more?

Traditional healer: The world is not good now...[after a pause]...next door my neighbour, [he points] that woman she is so beautiful, isn’t she? Her husband left her with three children. She is on her own now, trying to look after her children. He has remarried. The husband is an indecent bad character man. The world has changed. There are new illnesses and so much poverty everywhere.

Sabina: What are the new illnesses?

Traditional healer: Now people have strokes all the time and more people have cancer and blood pressure [BP] problems. Previously there weren’t any of these illnesses. We [healers] can’t cure cancer and stroke and only doctors can cure these new illnesses. But the biggest illness of all is *chinta roge* [worry illness]. Everyone has *chinta roge* and there is no cure!

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76 I was speaking to him about the various illnesses in the slum and what illnesses he treated, when he suddenly said, 'there is one illness...a new illness that no one can cure.' This of course got me very interested and we ended up having a long discussion on *chinta roge*, [as outlined above], which led to me eventually gathering a lot of data on this discourse from lot of people in the slum, as well as outside the slum. I spoke to poor people on the streets and those who worked as domestic help in other people's homes about this *chinta roge*, and everyone appeared to be familiar with this term and the kinds of effects it can have on the body.
Sabina: What is chinta roge? Why has it come?

Traditional healer: Why shouldn’t it come? [He looks amazed that I ask such a question!] You see chinta [worry] has always been there, but nothing like now. Before people had less poverty constraints and they had less wants and needs. On top of that there were less people in this country. Now the society has changed and the country is filled with beymani [bad immoral people]. No one believes in anyone anymore. Now there are more people who are poorer. Only a few people have lots of money. In the past era a person would just eat and sleep, and live in peace. Now there is no religion and no rules. There is crime and murder and fighting...Now there are too many people and not enough land. Everything is all about money, money and money! Poor people’s chinta have increased.

Sabina: How can one cure this chinta roge?

Traditional healer: Don’t you know there is no treatment for this roge [illness]! A doctor or a healer can only try to cure illnesses and sicknesses caused by chinta roge, but not chinta itself!

Sabina: What can chinta roge do to the body?

Traditional healer: Chinta [Worry] itself is an illness. There is no medicine for this. If one has fever then you can go to the doctor for medicines. But for this, there are no medicines. This illness makes you thin. From chinta roge a person becomes thinner and thinner. They lose their appetite. People can die from worries [chinta]. Chinta roge [worry illness] can also cause a variety of illnesses in the body, such as, heart sickness [attacks], strokes, blood pressure, cancer, diarrhoea, jaundice, typhoid and white discharge77 [vaginal]. A person suffering from chinta roge can experience many problems such as feeling restless, and some also feel dizzy and weak...From worrying and worrying the person becomes weak. Look at us...we don’t know when we will get kicked out of this slum. We don’t have shelter, or food or money. From constant worrying, the head becomes hot and the person’s blood pressure goes up, then there are attacks in the heart or even strokes. I can give medicine for pressure, but I can’t give medicine for the chinta roge, which creates all these illnesses in the body. Do you know even a doctor cannot fix this illness! A doctor can give you sleeping tablets for you to sleep, but nothing else.

77 This is discussed in greater detail in Chapter Five.
Sabina: How can all this happen from worrying?

Traditional healer: The brain dries up because of constant *chinta*, which then affects the entire body...everything in the body is linked...the brain is the main *engine* and if the person is worried then other problems will happen in the body. For example, worries from emotional sadness in the heart [*moner roge*] - heart distress will lead to other sorts of illnesses in the body...

The urban poor spoke of an illness *chinta roge*, which literally translates as ‘worry illness’ in English. So what is it? What causes this worry illness? Although, the term *chinta* is a Bengali word meaning ‘worry,’ when did it become medicalized into a *roge* ‘illness’? What brought about its medicalization? The urban poor blame the origins of this illness on the harsh conditions of life, brought about by rapid socio-economic transformations, poverty, the breakdown of society and family, which have increased their suffering and led to increased *chinta* [worries] and sicknesses in their bodies. *Chinta roge* is associated with a wide range of emotional problems, physical complaints and existential conditions of the entire body. In everyday conversations, the men and women spoke of *chinta* [worries] causing ‘sleeplessness, loss of appetite, shaking, aches and pains’ and many other kinds of illnesses in their bodies.

Scheper-Hughes and Lock (1987) propose ‘three bodies’ at three levels of socio-cultural analysis to better understand the linkages between mind, body and culture to understand health and illness. Lock and Scheper-Hughes (1996: 65) suggest that folk idioms transcend mind, body and culture. ‘Folk ailments’ can be interpreted not just as culturally constituted idioms for the expression of individual distress but also as a ‘dominant, widely distributed and flexible metaphor for expressing malaise of social and political origin and for negotiating relations of power.’ Discussions of *chinta roge* [worry illness] speak of harsh political economic conditions and suffering which are embodied and expressed in the lived body. It is strongly believed by many in the slum

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78 In trying to read the sick body more effectively, Frankenberg (1986) proposes a general theory of ‘sickness as a cultural performance’ to connect the mind/body dichotomy. The extensively distributed cultural category of *nerves/nervios/nervos/nervra* usually classified as a culture-bound or culturally interpreted syndrome (Guarnaccia et al, 1988) can be interpreted as a cultural performance (Lock, 1993:142). In Latin America and Mediterranean, *nerves* have been described as the somatization of emotional distress originating in domestic work, work relations or gender conflicts (Davis, 1983), status deprivation (Low, 1981) marital tension and suppressed rage (Lock and Wakewich-Dunk, 1987). Nerves have also been described as the somatization of emotional distress originating from marginalization and structural inequalities among the Appalachians and Salvadorans (Van Schaik, 1989; Jenkins, 1994), and as a form of resistance (Scheper-Hughes, 1992).
that the deteriorating and poverty stricken environment has increased their tension and worries, creating adverse effects inside the body, resulting in a range of illnesses. The traditional healer makes links between structural and social insecurity and bodily vulnerability. He speaks of increasing deprivation, crime, insecurity, and loss of faith in society, all of which have made their bodies ill. A stronger, just and moral society with equitable wealth distribution would mean healthier and stronger bodies and not sick ones. Thus, symbolic equations are made between 'conceptions of the healthy body and the healthy society and the diseased body and the malfunctioning society'\(^79\) (Lock and Scheper-Hughes, 1996:57).

It is apparent that *chinta roge* is a dominant metaphor used to explain the slum people's socio-economic position and political marginalization, and is a microcosm of what is going on in their lives. Thus, *chinta roge* is a core symbol, a unifying metaphor to understand health and sickness among the poor, and illustrates the connections they make between mind and body and body and society.

This chapter is divided into two main parts. In the first part I discuss how people in the slum talk about this illness and their bodily experiences of it and in the second part, I discuss in greater detail some of the root causes of *chinta roge* as understood by the urban poor.

**Experiences of chinta roge [worry illness]**

According to the slum residents, everyone suffers from *chinta roge*, but it is the poor who have the most worries and therefore the most illnesses. They mentioned increasing poverty, neglect by the State, chronic food shortages, and shelter and cash insecurities. They spoke of the overall disintegration of the community, support structures, families and relationships.\(^80\)

\(^79\) Thompson S.J. and S.M. Gifford's (2000:1458) paper on the 'meanings of health and diabetes' among Aborigines living in Melbourne, discuss how when Aborigines speak of their diabetes and illness experiences, their discourses are embedded in their continuing struggles to maintain stability and find balance in their lives and future. For them, achieving a 'balance' in life requires the maintenance of 'meaningful connections to family, the land, the past and future, all of which are important for health and well-being.' Thus disruptions in any of these factors can lead to sicknesses and ill-health, such as diabetes in the body.
An adolescent’s father’s narrative reflects the daily anxiety of living with poverty and uncertainty and its affects on his health:

Imagine you owe someone Taka 100 [AUS $ 2.30], but you cannot repay it. Your honour will go away if you can’t pay for this loan. Then won’t you have chinta [worry]? The chinta roge [worry illness] has come from where, from money? Hasn’t it? From chinta you won’t want to eat. When you have no food in your stomach, it aches in hunger... then slowly you lose your appetite and you won’t be able to sleep. The chinta will invade into your blood and meat and bones, everywhere in your body. Then how will your health be okay? You tell me. Then your health will not be good. Then you will say, from worrying and worrying I don’t feel good anymore. But will you let your worries go?

For the urban poor, illnesses do not reside distinctly either in body or mind. Social relations and the wider world are intricately connected with the body and self, and the experience of illnesses does not distinguish between mind, body and self. The body is not seen as separate but a microcosm of the universe [Manning and Fabrega, 1973]. Numerous cross-cultural studies have documented the conditions that give rise to various cultural idioms referred to as ‘heart distress’ ‘nerves’, ‘debilidad’ and so on to convey physical sensations, emotional distress and personal, social and economic concerns [Kirmayer et al, 1995]. Like nerves, chinta roge is an embodied metaphor and ‘embodies the lived experience of daily life as a metaphor of physical, social, political, and economic distress that has specific meanings...’ [Low, S, 1994:142].

It is understood that chinta roge which begins in the head goes on to create multiple illnesses in the body. A middle aged woman shares her understanding of the impact of persistent worries on an individual’s body: ‘When a person has chinta roge, whether man or woman, the head becomes hot with worry and then your ‘pressure’ goes up, and then a heart illness or stroke happens!’ A traditional healer explained to me, ‘Apa [sister] everything is linked in the body, so if one area is affected slowly the rest of the body is also affected. Illness is like a tree which grows roots everyone, starting from the core, which is sick, the sickness spreads everywhere else.’ Many of the urban poor mentioned a range of emotional states and illness chinta roge can cause in the body. Some of the emotions include, tension, anxiety, and [moner oshanti] - sadness in the heart, and as discussed earlier, physical symptoms range from sleeplessness, weight loss, blood

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90 The root causes of chinta roge is discussed in more detail later in this chapter, in section two of this
pressure, and strokes to even cancer and jaundice. However, there were disagreements, regarding the types of illnesses caused in the body, with perceptions and experiences influenced at an individual as well as collective level. In a few cases it was found that when a doctor told someone that they were suffering from gastric pain or fevers, they did not disagree, but privately believed the root cause of the illness lay elsewhere.

Roshonara [married adolescent woman] said:

Look at me. My chest hurts from worrying so much. From the chest pains, my back hurts. Everyone says this is gastric pain.' When asked who is everyone, Roshonara replied, 'Doctors, pharmacies and others, but I know why my body is ill. I know what sort of pain this is. Whenever I worry too much I have this pain. And if I take pills my head reels...I know this pain is from worrying about my husband, he has lost his job. I worry about our future. How will we manage?

Scheper-Hughes suggests that illness is a form of body praxis, of bodily action. For while the body can be used to express a sense of belonging and affirmation, the body can also be used to express negative and conflictual statements, feelings of distress, frustration, powerlessness, resentment, sadness and loss (1994).

**Gender & chinta roge**

While it was generally agreed that everyone suffers from *chinta* [worries], there were debates among some of the slum residents whether men or women were more likely to suffer from *chinta roge*. Rebhun suggests that the way in which the experience of folk idioms fit into the micro-politics of family power is in their gendered nature (1994). A few of the men argued that males are more affected by worries than women. A number of men expressed anger and frustration at the harsh urban environment, which had robbed them of their jobs, respect and identity. Roshonara's husband Liton, who had recently lost his job, argued that since the men have the pressure of being the rice-winners for the family, they suffered from greater tension and *chinta roge*. He said:

Why do you ask her [wife]? Ask me about *chinta roge*! I have the *chinta roge*. I have become thinner. I suffer from tension all the time. I worry how will I pay the rent? How will I feed my family? I don't have a job. What will we eat? There is no end to this worry.
But women only have small worries related to household matters. Apa [sister], once a man gets married, a worry comes into their heads. They get four legs, as they have two legs and now they have their wife, another two legs to look after. Then even if it hurts to work or if they don’t want to work, for their wife they will still have to work! If they can’t give their wife rice and clothes, then the wife says, ‘You married me, so why won’t you feed me rice and clothe me properly?’ After sometime they have a child. Once you have a child, you get more tension in your head. We have to feed the child, educate the child and bring up this child. Then our chinta [worry] increases and from this chinta we get an illness!

A majority of the women, however, believe that they are more susceptible to worries. They argued that they suffered from chinta [worries] more often than males and blamed it on their husband’s inability and reluctance to provide for the family. A female said, ‘It is the women who worry more, about their husbands, whether he is going to work or not, and women worry about their children and about the future of the family.’ The moral connotations of worried behaviour are different for men and women in Bangladeshi society. According to women, men are able to express their frustration and worries compared to women who had to keep their emotions in check. When men became tense with chintas [worries], they usually drank and gambled, and often lashed out by beating their wives and children, with very little social consequences. For women, ‘sharing their worries’ was much more difficult, as they are less able to escape by taking drugs, or scream, or hit out, with their suffering more repressed, and commonly expressed through folk syndromes such as ‘weakness in the body.’ 81 It is well known in Bangladeshi culture that a woman is expected to suppress her emotions. A common saying in Bengali is, ‘buk phate to mukh photo na,’ which means that no matter what happens, a woman cannot say what she is thinking in her heart (ME Khan et al, 2002:239). Ideally, women are expected to be ‘tolerant, compassionate and selfless,’ and anything less is seen to be incompatible with their nature (Rozario, 1992). While men prove their masculinity by providing for the family, women gain respect and status in the community by being tolerant and control of outward behaviour and emotions.

Some men agree and believe that social norms and restrictions on women make them more receptive to worries and therefore chinta roge. Monsura’s husband said:
If a woman’s husband does not find work then the woman has more tension. Women worry much more because they have to stay at home all the time. Only if their husbands bring home food then they can eat, and if they bring them clothes, then only can they wear clothes! As men, we just go outside the home and we can eat outside and hang out with friends...that is why our worries are less than females.

Due to their subordinate position, both socially and economically, women are more vulnerable to insecurity and material loss than men. Thus a woman’s suffering is a consequence of her powerlessness vis a vis men (Rebhun, 1994), and a class based society which reinforces asymmetrical relations. Both poor urban men and women expressed feelings of helplessness in a rapidly changing environment, where the role of society, family and faith are diminishing and gender tensions exist because of desperate poverty, unemployment, women’s independence/dependence and men’s inability to provide for the family.

**Embodiment of chinta roge**

Embodiment concerns the way that people come to ‘inhabit’ their bodies so that these become in every sense of the term ‘habituated’ (Mauss, M, (1938) 1985). From the phenomenological point of view, all the activities of everyday life working, eating, sleeping and getting sick are forms of body praxis and express dynamic social, cultural and political economic relations (Schep-Hughes, 1994). Below I present two case studies of women, one older and the other a married adolescent, and describe their suffering and bodily experiences of chinta roge.

**Case study 1: Shoma’s story**

Shoma is Farida’s [married adolescent] stepmother. She blames chinta roge for causing ulcers and eventually cancer in her body. The problems began when she started to worry about unpaid loans and she eventually fell ill from the constant tension and anxiety.

Shoma married Hussain almost 7 years ago, when Farida [her stepdaughter] was only 12 years old. Hussain remarried exactly 40 days after his first wife died. He does not work and is supported by his children from his first wife. He has one small girl, 4 years old.

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81 This discussed in detail in the next chapter – conditions of chinta roge leading to weakness in the body and white discharge and weak bodies.
from his second wife, Shoma. We were talking about chinta roge when Shoma informs
us that about a year ago she suffered from a serious illness brought on by constant
chinta [worries]. She said, ‘Chinta happens because of poverty. How will we manage?
What will we do and how will we bring money into this world? The world is a worry
and everyone has worries. Chinta illness takes people down.’

Shoma explains the onset of her illness: ‘For a loan of Taka 9000 [AUS $ 225] I fell ill
with [gastric] ulcer. I had lent my hard-earned money to this woman but I didn’t get the
loaned money back. All I got back was Taka 4000 [AUS $100]. When I didn’t get back
my money I started worrying about whether the woman would pay me back. I was
always in tension. It came to a point when I could think of nothing else but my money
and that woman who borrowed from me. Would she pay me back? Was she lying?
Would she take off in the middle of the night? We are poor and every cent counts. I
became so upset that I could not sleep at night and I could not eat properly. The food
did not taste good. I could not swallow anymore from my misery and worries.’ Farida
[stepdaughter] interrupts to say, ‘Yes, ma [mother] became so ill she couldn’t move
from the bed. Because of her chinta [worries] she really was in a bad way. We were
worried. She was ill for one year.’ Shoma interrupts to state, ‘Because of the money
worries, I didn’t feel good about anything. I couldn’t stop thinking about the money
owed to me. I lost my appetite and my head was filled with anxiety. From this constant
worrying about the money, my health became bad. I became bedridden and the illness
spread inside me. From my worrying it went from my head to my ulcer to my whole
body and I became ill with cancer.’ Her husband interrupts to state, ‘You see, from so
much worrying, she became ill with cancer. After one year, and spending thousands of
Taka on her health, she recovered.’

Shoma feels guilty and believes that because she was taking interest for her loans it
might have brought on the worries and the illnesses. She said, ‘It is not Islamic to gain
any profit on loans. God has said work hard, eat and live honestly.’ She adds that Taka
50,000 [AUS $ 1250] was borrowed and spent on her illness treatment. To add to their
tensions, more money was needed 6 months later for her stepdaughter Farida’s wedding.
‘We spent almost Taka 40,000 [AUS $ 1000] for the wedding costs and dowry.’ Her
husband informs us that he had no choice but to pay the dowry money for Farida as it
was question of prestige and she was his eldest daughter.
Case study 2: Monsura’s story

Monsura, 16 years old, also complains that constant chinta [worries] have created all kinds of illnesses in her body. She often suffers from episodes of ‘palpitations, body shakes and cold sweats,’ when she is extremely worried and when she is hungry. She is anxious about her future, because her husband is frail and always sick with fever and colds. She has a ten-month-old son. Neighbours have told her that her husband might have a hernia/tumour in his body and to treat him will cost a lot of money. To add to her problems her husband has a drinking problem and does not like to work regularly. He complains of the tough and tiring hours required for work.

After finding her utensils dry and noticing she had not cooked any food for that day, she informs me that she has gone without food for the past two days, because her husband...
had not brought home any money. She relies on the kindness of Ratna Ma’s, her landlady who provides her with some scraps of rice and potatoes, and she rations out the stale rice and eats it with chillies and water. But her landlady is moody and cannot always be relied on. Monsura complains that her breasts are dry from no food and her son cried constantly for milk. She said, ‘When my husband comes home and says, “I can’t work,” I feel pain, anger and sadness. My heart fills with all kinds of emotions. I want to eat but I don’t want to eat. I have no money and I can’t eat. My heart feels heavy with sadness and chinta [worry]. I lie awake at night wondering that if only I had money then I would help him. We don’t have enough money to pay our rent. Now if something happens to him what will happen to me? This tension is chinta roge. That is why I am becoming thin.’ She informs me that she had not eaten all day, ‘All we have is rice in the home and I will buy some lentils and cook for him, but I don’t have the energy. Let me tell you, the chinta roge is the biggest illness of all.’

Monsura informs us that because of chinta roge every few weeks/months she suffers from fever, cold sweats and repeated shakes. Her illness episodes happened throughout our fieldwork and we were informed of at least 5 episodes during a period of 9 months. We noticed that the shakes would occur often after a particularly violent domestic fight or if the situation was miserable in her household and tensions were running high, i.e., no food or if her husband had stopped working and was mistreating her for money. She describes one of her attacks, ‘Apa [sister], yesterday, I nearly died. [Why what happened?] I don’t know. My hand and feet got cramps. Later my hands and feet became completely cold. My whole body started shaking. My hands and feet would not stop shaking. My whole body was burning up. My teeth were chattering and my legs shaking so much that he [husband] had to tie it with a cloth to keep it from shaking. My heart was beating so fast I thought I was going to die. I didn’t know what was happening. He panicked. After rubbing me with mustard oil for a long time my body stopped shaking. But he [husband] got such a fright he ran and woke up Ratna’s Ma [landlady]. She rushed over and massaged my hands and feet with mustard oil.’

When asked if this had ever happened to her before, she said, ‘This has happened to me a few months back and now again after a long time this has happened again.’ When asked why this happened to her, she informed us that she was constantly in tension. She said, ‘I am in a lot of tension...there are so many things on my mind that my body is becoming weaker inside.’ She complains of the constant tension of worrying about the
The narratives of the women speak profoundly of personal suffering aggravated by a harsh political economy, extreme poverty and unequal class, gender and power relations. In the first case study, Shoma’s chinta [worries] are compounded by insecure tenure and severe financial constraints. Her husband is older and he does not work and they depend on his children, her stepchildren to manage the household. This is her second marriage as her first husband had deserted her. She feels more vulnerable as she has strained relationships with her stepchildren and her husband often sides with them if there are any conflicts. She also worries because she has her own daughter, who is 6 years old and worries about the costs for her marriage and dowry. She shares her illness experience of gastric ulcer and then cancer, and blames it on constant worries over unpaid loans and spiralling debts, which made her lose her appetite, causing weakness in her body. For Shoma there is an additional element to her illness experience. She broke the moral rules of behaviour by taking an interest on her loans and believes she was punished as a penalty from God for her sins. Shoma believes, it is excessive worrying brought on by poverty, guilt and insecurity, which caused her cancer. More
recently, the strain of living continuously on the edge of poverty has made her body frail and a home for all kinds of illnesses.

In the second case study, we find Monsura’s world is falling apart. She is young and saddled with a baby son and a husband, who does not like to work regularly, which means that she often goes without food for days. Monsura lacks family support and does not have anyone she can rely on. Feelings of financial insecurity have infiltrated all aspects of her life. She remains in tension over rent payments. Since the eviction and the banning of the baby taxis, life is tougher. She worries about her family’s well-being and future. She is regularly subjected to violence from her husband, who is frustrated by his health and cash situation and lashes out at her. She is torn between worry, anger and sadness for the miserable situation she finds herself in. She despairs for her son who constantly cries because he is hungry but she is unable to feed him. Her excessive worries and hunger anxiety result in shakes, palpitations and cold sweats. Depending on her state, and if he can afford it, her husband has purchased tablets and saline [twice] to re-energize her body. Here we see the correspondence between *chinta roge*, social distress as well as hunger anxiety and its physiological effects on her body, (which is discussed in more detail in chapter five). *Chinta roge* is medicalized and is seen as requiring treatment from a health care provider. However, the treatment does not provide her with the food or comfort she so desperately craves, and is only a temporary solution.

Throughout this period, Monsura became increasingly despondent and talked about her life as worthless. Her articulation of *chinta roge* is one way of drawing attention to her problems and her way of expressing distress as well as asking for social and emotional support from her husband and others. Lock argues that an analysis of idioms of distress reveal that they can be a form of resistance for the oppressive conditions of life, and facilitate the ‘acting out of hidden transcripts… through which social contradictions are enacted’ (1993:142). *Chinta roge* in this sense is also a ‘master illness’ (Scheper-Hughes, 1992) an explanation for all kinds of social distress. Articulation allows individuals to substantiate their suffering and transform their experiences and feelings into a language to frame and give meaning to lived experiences and to share with others. It is one of the ways ‘people can give form [or meaning] to the chaos and uncertainty characteristic of the flux of life’ (Migliore, 2001).
When Shoma and Monsura spoke of symptoms of heart palpitations, insomnia, sleeplessness, ulcers and cancer, they were not just simple biomedical categories of illnesses, but also signify a particular symbolic status, filled with meaning about the sick body and the cosmos (Young, 1982; See also Tousignant, M, 1984). Merleau-Ponty (1963) proposes that the body communicates to the world and the world becomes expressed by the body. *Chinta roge* and its fluid symptoms of coughs, colds, insomnia, shakes and palpitations are what Lock and Scheper-Hughes refer to as ‘coded metaphors’ through which the urban poor can express their miserable conditions of life. The women and men in the slum are extremely poor and have sick, tired and hungry bodies and lead worried lives, which offers itself as a ‘metaphor and metonym’ of their current socio-political system and their extremely marginalized position in the present economic and political disorder (1996:66). In addition, for many young women in the slum, their illness experiences have a material dimension. Monsura constantly speaks of her constant hunger combined with daily anxiety, which leads to various illnesses in her body. Sickness and healing occur largely in this ‘lived body realm of the feelings and senses where our physical being and conscious being interact’ (Janzsen, John, 2002; Ots, 1991; 46-49).

**Origins of chinta roge**

**Urbanization & its social ills**

Urbanization and its ensuing social ills are seen as one of the primary causes for the medicalization of *chinta* [worries]. Opinions differed slightly regarding the causes of increased worries and *chinta roge* among the older and younger generation and among males and females. I questioned as many men and women as I could about *chinta roge*, about its origins to encourage reflection and discussion. In some situations, conversations of *chinta roge* were spontaneous. Although there was some dispute, what emerged from the discussions were three main themes regarding the origins of this illness. These include, (1) urbanization and poverty anxiety and as a consequence, widespread loss of faith [religion] in the community which has led to social and moral decay and corruption in society. This has led to (2) greater jealousy and hostility and incidences of ‘evil eye’ and black magic practices and ‘sending of sicknesses’ in the slum. Finally, poverty, unemployment and loss of faith have created (3) gender tensions
and the collapse of appropriate gender roles, creating instability in marriage and in the community and disrupting social relations.

**Poverty and urbanization: increase in suffering and worries**

The urban poor blame poverty and urbanization for the chaos and disorder in their lives, which according to them has increased their suffering and worries. Scarcity of land, population growth, and a harsh urban environment are blamed for the extreme deprivation in their lives. Older residents spoke of forced migration to the city where livelihoods and shelter are even more uncertain. Urbanization for the older population means leaving behind an ‘ideal rural life’ and adapting to a harsh urban environment, which was ‘filthy,’ ‘unhealthy’ and ‘immoral.’ The elders in the slum also made comments about an uncaring and disrespectful younger generation: ‘Daughters-in-law lie in bed all day and don’t respect their mothers-in-law;’ ‘pregnant women walk in public with their stomachs bulging out;’ ‘old married women leave their husbands to find younger grooms;’ ‘sons beat their mothers and steal from their fathers,’ and so on (See Lamb, Sarah, 1992). With increasing landlessness and poverty, parents and elders are losing the only authority and power they once had over their sons and daughters. Many young people now work independent jobs and do not rely on their parents for economic support.

Money or the lack of money was a recurring theme in the discussions. Daily life was a grind, worrying about the next meal, paying bills, rent and so on. A world characterized by uncertainty and powerlessness, cash provides the poor with an important degree of control over their lives. Shortage of cash was blamed for causing disruptions in family and social relations. Many slum dwellers complain that with the entry of money and cash economy in the cities there is more individuality and people are becoming more self-centred, instead of combining their resources together with their families. Elders spoke of societal changes in values and life expectations with the focus shifting from relations with people to relations with things and the accumulation of cash. Older peoples power bases are increasingly undermined by the changing values of the younger generation. Masquelier writes that capitalism shifts relations, with collective ties based on reciprocity shifting to individuals who are responsible for their own subsistence needs and social relations are mainly mediated through money (1993). The urban poor are faced with increasing pressures and monetary obligations. Cash is desperately
needed to survive but extremely scarce, and the need for it crucial. Thus, money then becomes a symbol of alienation from traditional values and it is feared as much as it is desired (Masquelier, A, 1993).

Loss of faith & corruption of mind, body and soul

Many believe that poverty, hunger and insecurity have led to an increase in crime and immoral activities because individuals are forced to compete with one another for basic resources, such as ‘food, clothes, shelter, and cash’, forcing many to lead a life of crime.\(^\text{82}\) Farooq’s [28 years old, has 2 children] comments capture the suffering of the urban poor:

If you need money won’t you steal if you need to feed your own hunger or your children’s hunger? But if you don’t eat then how will your health be okay? You tell me. But once you steal you worry about the next meal or next time you have to steal to manage... from worrying and worrying you don’t feel good anymore. Then slowly don’t you lose your iman [faith]?'

Losing one’s faith refers to a general loss of integrity and religious values among people in the slum and in the wider society. A person loses one’s soul and is unable to distinguish right from wrong. According to many, this has resulted in greater immorality and disorder in society. A majority of the slum residents believe that the current strife and misery in their lives are signs of impending doom in the world. People were less inclined to support one another, parents let down their children and children refused to support parents in old age. Families and marriages were breaking down. However, some young people ridicule the ‘gloom and doom theories’ of the older generation, but many agree that it is the poorest that are the most affected by worries and therefore by chinta roge. An older man said, ‘we are close to judgement day [end of the world]. Look around you, there is chaos everywhere, no one follows society’s norms and no one listens to anyone anymore. We are getting sicker and the world is getting sicker.’ Some slum residents also believe that decreasing faith in the community has angered God, who has ceased to intercede, except to cause more diseases, poverty and punishment in poor people’s lives. There is a perception that in the past there were

\(^\text{82}\) The links between moral decline and modernity in South Asia has also been documented elsewhere - See Sarah Lamb, 1992.
less doctors but fewer illnesses, but according to one woman, 'nowadays, there are more
doctors, but more diseases and more poverty everywhere.' Such millenarian visions of
the poor speak of not just illnesses in the body, but refer philosophically to a 'larger
sickness facing humanity' in India (Nichter, 2001:92) and 'moral decay' in Papua New

Loss of faith in the political order: corrupt politicians, police, leaders and state
The slum residents attribute a political cause to their bodily distress and experiences of
chinta roge. Many of the younger and older residents blame the wider community, the
politicians, elites, leaders (mastaans) and government bureaucrats of 'losing their faith'
and failing to look after the plight of the poor. The residents repeatedly said that the
State was uncaring and responsible for the 'increased chintas [worries] and sickness in
their bodies and in their lives.' Shahana [married adolescent] and her landlady shared
their thoughts:

The poor people in the slum cannot and do not have the means to do anything to help
themselves. The government does not stand behind us. They only stand behind the rich.
The government does not care. The slum is filled with crime and drugs and bad air and
illnesses. We constantly worry about our future and our health, but what does the
government do? The ministers just shake their heads and make large orders on their
mobile phones. All they want to do is to kick us out of our homes!

Many of the women and some men in the slum blame their various ailments, such as,
chest pains, loss of appetite and insomnia to chintas [worries] brought on by repeated
threats of eviction, which had been occurring for the past 10 years and their current
situation

Thus, violence and repression are embedded in the social environment as well as in their
bodies. Slum residents spoke of increased chinta roge because of tensions of living in
an environment filled with constant crime, including gang violence and brutal police
raids.83 One woman explained, 'you never know when there will be a fight and when
the police will come and you don't know whom they will grab and take away.' They
feared harsh interrogative methods from the police, demands for expensive bribes, and
imprisonment on trumped up charges. They shared their worries of police patrolling the

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83 See – (Green, Linda, 1998).
slums, particularly after a violent incident. Slum residents lived in terror that they might get picked on by the police for no reason, searched and questioned and subjected to verbal and physical abuse. Parents expressed worries that their adolescent sons would get involved in criminal activities or indulge in substance abuse and were terrified their young daughters would be sexually harassed by gangs in the slum.\textsuperscript{84}

Increased worries and sicknesses are also linked to the hard living conditions, poor diet and substandard congested housing conditions in the slum. The urban poor share their concerns about living in polluted and unhygienic slum, with scarce water and few proper latrines, clogged drains and overflowing sewage in the rainy months. Frequent articles in newspapers and in the radio and television about shrinking rivers, polluted air, ground water contamination with arsenic, toxic air, improper disposal of industrial, medical and household wastes (Rashid, H, 2003), have led to a greater awareness among the poor. They also spoke of crops fertilized with chemicals and pesticides, which they ate, the polluted air they breathed, and the lack of trees and congestion in the slums. Fatima [married adolescent] complained of the lack of proper gas lines in the slums, forcing most of the women to cook on stoves using wood, cloth, pieces of rubber tires, and paper, as fuel. She said, 'now we cook with cloth and wood. Cooking our food with cloth will give us cancer. We should help people but we don't. Apa [sister], people are dying of cancer and tuberculosis. People break old rubber tires to cook their food.' People spoke of how 'everything was now contaminated and nothing was pure anymore.'

As the poor are increasingly pushed aside by politicians and others and ignored in the political economy, \textit{chinta roge} can be seen as a 'protest of the body' (Low, 1994; See also Scheper-Hughes, N, 1992; Van Schaik, 1989), an expression of political meaning and a rejection of the dominant order. Their narratives reveal how institutional arrangements and practices reproduce inequality, domination and human suffering (Scheper-Hughes, 1992:171) in their lives. There is anger and frustration with the government, the leaders, the police and even the elite who are accused of neglecting and also abusing their rights. Thus, the current \textit{chintas} [worries] of both men and women slum residents can be seen as a response to the increasingly unstable, hostile social,

\textsuperscript{84} Similarly, many studies on 'folk ailment' show how terrorism and violence result in \textit{nerves}, which is a common complaint to express the anger and fear of victims (Sluka, 1989; Taussig, 1987; Jenkins, 1991, 1996, 1998).
Corruption of the poor - evil eye/ black magic & sickness

Jealousy, envy and black magic: binding your victims

Slum residents spoke of the widespread hostility and envy that pervades life in the slum. Everyone constantly spoke of 'enemies' and lived anxious and worried lives. People blame poverty and loss of faith to ill will in the community, which have made individuals nasty and jealous, and led to an increase in incidences of 'evil eye,' and black magic [*kufr*] to fatally harm others. A pervasive fear of the 'evil eye' and black magic has been noted by other researchers (Mahbub and Masud, 1997; Stark, Norris, 1993). Although it is acknowledged that black magic has always existed, the poor believe that the stressful urban environment has intensified the situation. According to one woman, 'We are the owners of all the illnesses that come on us. In the past there was less *chinta* [worry], black magic and healers. Now all you have to do is open your mouth and there is more *chinta* [worries], healers and black magic in our lives!' None of the healers openly admitted to practicing malign magic on others, although many of them did provide such services. The reason for the denial was moral because it was well

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55 Sorcery and black magic exist and thrive among not only the poorer classes but also among the middle class and affluent populations. The existence of magic is part of the Islamic religion and there are special prayers to ward off the 'evil eye' and keep oneself from sorcery and spells.
accepted that any healer who performed black magic was condemned to hell forever. Instead, most healers admitted to making spells to help people control the errant minds and hearts of husbands/wives, to ward off the 'evil eye' and to removing bad spells (black magic) sent on an intended victim.

Black magic is an expression of the underlying distress and anxiety because of rapidly transformed political economic conditions. Attempts at and accusations of black magic can be construed as a culturally prescribed means of for coping with and even alleviating conditions out of their control (Golomb, Louis, 1993). Sorcery or black magic [Kufr] may be performed with the help of a local healer, by taking a piece of nail, hair or other items closely associated with the victim, binding the item by magic formulas and then burying the item. According to some, such magic also involved the reading of the Quranic verses backwards. Often the name of the victim is written on a piece of paper with the name of the victim spelt backwards, with various chants muttered on the paper. The intended victim can change their behaviour towards someone, or fall sick, and even die. Sorcery and black magic as techniques were mentioned as conscious acts carried out by individuals to create sickness and misfortune in people’s lives, the deliberate staking out and binding of a victim. In contrast, ‘evil eye’ refers to the power of an individual to cause harm on other people, and even infants, through his or her gaze. A person cannot control his or her gaze and harm is caused by unintentional envious glances (Mahbub and Ahmed, 1997).

**Black magic: disrupting love affairs, marriages and relationships**

Those with whom one is competing for limited resources, for affection or economic support, are said to be the most obvious targets of black magic. Strife between co-wives, marital instability, fears a jealous ex-lover has done ‘sorcery’ to break up a relationship were frequent examples. Adolescent women mentioned worrying about vengeful ex-wives and ex-lovers doing *tabij* [sorcery] on their husband/boyfriend to make them ill and harm them. Extra-marital affairs and polygamous marriages generate jealousies and tensions between co-wives, who often wear amulets around their arms or around their necks to ward off any evil spells, sent their way. Shelly [married adolescent] explained

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86 Professional healers who practice black magic are known to charge a lot of money to conjure evil spirits to send sickness or misfortune to the intended victim. Although not openly talked about, it is fairly common to seek out healers to remove black magic or send it to people.
that when her husband did not marry his first lover but married her instead, the woman did a spell on her. She said:

I would lie in bed at night paralysed and unable to breath properly. My head was full of chinta. I knew that the cause of my chinta [worry] was Humaira [husband’s first love]. I went to the healer who informed me that someone had done ‘bandh’ [black magic] on me and he gave me an amulet to wear. After a few weeks, my chest was free from harm. She could not hurt me as he had closed my body.’

In Moni’s case [married adolescent], soon after her marriage she was always falling sick and her mother suspected that her mother-in-law had done a spell on her daughter because she did not want her to remain married to her son. After a particularly violent domestic dispute, Moni left her husband and moved back home. Her mother immediately took her to the village to visit her uncle, who was a well-known healer. He confirmed the mother’s worst suspicions and performed a special ritual on Moni to keep her safe from her mother-in-law’s spells.87

If a client is having repeated problems with his/her health or in his/her relationship, s/he usually suspects ‘an enemy at work’ and approaches a healer for advice and treatment. The client may also approach a range of health practitioners both allopathic and non-allopathic for health problems88 with no conflict between the several modes of therapy accessed. Usually after some initial discussion the healer will ask about a few people [ex lovers, co-wives, mistresses, in-laws] and the nature of their relationship to the client. Individuals feel they know who is responsible and this is often confirmed by a visit to the healer. The healer will give the client a few amulets for Taka 150 [AUS $3.80] to wear as protection from harm. During the ‘treatment’ process, the client usually returns to the healer a few times, so that the situation can be monitored, and if need be more potions and amulets are given.

87 These accusations of black magic were told to me much later when I had spent considerable amount of time in the field with the respondents. Many are reluctant to talk of these things, fearing that I would regard them as ‘backward and ignorant.’ Slowly, I found that there is a strong belief in the supernatural world, which co-existed with the world the urban dwellers lived in. I will discuss this further in the next chapter on infertility. Numerous stories revolved around supernatural beings called Jinns, who were able to come into live in the world and have sexual relations with men and women, steal babies and even marry humans.

88 There is wide range of possible causes of the illness with blame attributed to include humoral imbalance evil eye, black magic, infraction of moral rules, spirit world. There are finite number of symptoms and categories responsible for particular illnesses, with co-existing factors – God, magic, spirit world, human and non human, given as explanations. Causes may change depending on the situation and circumstances of the individual.
Healers admit that the most avid customers are women who usually visit alone or with other women, rather than with men. Women have their bodies ‘shut’ to ward off harmful spells sent from others or to avoid the ‘evil eye’. Babies have a large black dot painted on their foreheads to deflect the envious glances of infertile mothers and others. Particularly, adolescent women’s bodies because of menstruation and pregnancies are seen as most permeable and more vulnerable to evil spirits/spells, compared to men. A common request from women was to bring back errant husbands or lovers. Women also turn to healers for magic potions and charms to influence their lovers or husband’s behaviour, hoping to make them more loving, generous and hardworking or to bring them back. There were stories of husbands accusing their wives of putting a spell on them, and wives mixing magic herbs into their husband’s food. Young men and women turn to healers to make themselves ‘more desirable’ to the opposite sex, or someone they fancied. Lacking physical or economic assets, many try to manipulate magically those whom they compete for.

The ways in which traditional healers handle the curing process requires skill and manipulation. Healers or religious leaders are also brought to the home to exorcise the place from ‘evil’, which means locating harmful amulets and spells that may be hidden under pillows or scattered in the room. This is done in order to free the person from illness and misfortune. Healers always clarify that there are no guarantees of a cure, only what Allah has fated for the person. They stress that as healers they work only as a medium of Allah and are only able to do their best, imploring their clients to leave it to fate. By bringing a ‘higher power’ into the equation, they avoid accusations and anger for failure to resolve conflicts. To avoid failure, healers sometimes argue they cannot resolve an issue [e.g. bringing a husband back] as it may result in harmful consequences on the individual. For example in Razia’s case, when her husband abandoned her, she refused to blame it entirely on unpaid dowry and believed that her husband’s ex-lover may have done black magic to ruin their relationship. Her sister advised her to visit a well-known healer who confirmed her worst suspicions. The healer informed her that he could resolve the situation but it would require a lot of money to ask the powerful spirit world to undo the evil work done by the ex-lover. In addition, one of the consequences

89 This is discussed later in detail in the subsequent chapter on ‘understandings of infertility.’
90 Muslims refer to God as Allah.
was that her husband could become mad if magic was used to bring him back to her. Razia’s attitude wavered between belief and scepticism, but she did not request the healer to bring him back, as she feared the worst could happen. She said, ‘he is an only son and if he goes mad...how can I do that to his family or to him?’

Urbanization and extreme poverty have intensified the existing aetiology of ‘evil eye’ and black magic in the slum. Underlying worries and anxieties about interpersonal relations and instability, a competitive social environment, increasing marital insecurity and breakdown in support structures have led to greater vulnerability, particularly for slum women. In the urban slums, explanations of black magic in society are metaphors for disrupted social relations, and provide meaning to a fractured social order brought on by worsening political economic conditions. Furthermore, healers feel marginalized in the biomedical-urbanized environment, because of widespread awareness and availability of ‘modern’ medicines, pharmacies, hospitals and private health facilities. Therefore, healers tend to reinforce ‘black magic’ ideologies in order to ensure their power and role in the community continues and for their economic survival. Unable to fix the worsening social and political economic relations and increased suffering in their lives, the urban poor turn to traditional healers and observe rituals to symbolically to find meaning, and restore some form of order to the body, to the social situation and to their life world.  

The rupture of traditional gender roles: loss of faith & no pardah  
A disregard for traditions and moving away from the ‘lifestyle of ancestors’ are given as reasons for moral decay and increase in chinta [worries] by some. A majority of older women and men blamed the upheaval taking place in society, because of the ‘loss of faith’ by younger women who do not follow pardah norms anymore. As discussed earlier, pardah, literally meaning curtain refers to the practice of female seclusion. In the strictest sense pardah means keeping women confined within the home and covered in veils whenever they ventured out of the home. In a wider context it refers to modesty and restriction on their interactions with outside males (Papanek, 1982). However, in

91 Many in the slum preferred to return to the village to visit ‘traditional healers’ whom they viewed as ‘authentic’ compared to the healers in the City, whose skills were often viewed with skepticism.  
92 Comaroff and Comaroff discussing the existence of sorcery in Africa argue that the role of sorcery, healers and rituals offer a measure of control in the context of urbanization and rapid socio-economic changes (1993).
Bangladesh very few women follow *pardah* in the strict sense, but from puberty onwards, all women are expected to observe *pardah* in the wider sense (Rozario, 1992).

A number of men blamed urbanization with high unemployment and poverty for affecting relationships in the household and leading to the breakdown of *pardah* norms. They complained that increasing numbers of women were working outside the home and men were losing authority over their wives. The men expressed feelings of insecurity regarding their role within the household and in the community. One man said:

> Now you see how the control of the men has been removed and it is the women who influence the household and the husband...this is what this era is about. Today I saw my wife talking to another man and she patted him on the back and laughed. Then what did I do? I didn’t do anything? What can I do? Nothing! If you think of our aunts and mothers did the men ever see their faces? But now in this era, what do we do? Thousands and thousands of women walk the streets. The men cannot walk on the streets because of the women. There is no *pardah*.

With garment factories employing a majority of young women in Dhaka City, and a large number of men unemployed, it is not surprising that changing gender roles and power relations featured in the discussions about *chinta roge*.

Younger and older women justify that extreme poverty and the failure of men to protect their wives, has pushed many women to look for work outside the home. Many adolescent women said that men were failing to fulfil their social and economic roles as rice winners for the family. Women re-deploy cultural expectations in their favour to defend their ‘shameless’ behaviour. Jobeda [married adolescent, 16 years old] said, ‘The man is the woman’s *pardah*. If the men cannot keep their wives in *pardah* then it is the man’s sin. If the woman is forced to work outside the home to support her family, then it is the man’s fault and it is his failure.’ They argued that *pardah* can still be followed in one’s heart, ‘*pardah* is inside your heart and not in your eyes. If one’s heart is clean then everything is okay.’ This construct, which is not new, was employed successfully by the female family planning workers in the 70 and 80s, and shifts importance from the
external and physical rules of seclusion to an ‘internalised moral code of conduct’ (Simmons, R, et al, 1992:36).

Some of the younger and older women’s comments below reflect the tension and dilemmas of modernity, with benefits seen as far more ambiguous. An adolescent woman explained:

Now women's chinta has increased as well as lessened. Before women could not work outside the home. Now women are leaving the house and working and coming home at 10 or 11 p.m. at night. She is now earning an income. But in many cases, she is forced to earn an income. If a woman falls into trouble then not a single person comes forward. Before if a woman were in trouble the entire community would come forward to help the woman. But then again if a something happens to a woman's husband, then another husband comes to replace that man. No one thinks anything of it! This is the way life is now.

Collapse of gender roles — religious leaders blame women for ‘loss of faith’
The urban poor’s discourse on chinta roge has been partially influenced by religious sermons given regularly by the “Jama’at-i – Islami” party.93 This is a religious political party that has tapped into the frustration and dislocation of the poor, particularly urban males. The party is extremely critical of the changes in Bangladesh in recent years, proclaiming that the breakdown of society and gender norms demonstrates a loss of faith in the community and a symptom of society’s malaise, and a signal that the end of the world was near. Their speeches are catered mainly for poor men in both urban and rural areas, although women do attend their meetings. The sermons lash out at the increasing visibility of women in the workforce and outside the home. They conveniently make links between rising dowry demands and lack of pardah by women, and increased crime and faithlessness in society.

93 In 1971, soon after independence, Bangladesh was declared a secular democracy with a ban on all religion based political parties. In recent years, political agendas by various leaders led to the deletion of secularism from the constitution and Islam was declared as the state religion. As a result, Islamist parties such as the Jama’at-i Islami gradually have been reinstated as full participants in the electoral process [Shehabuddin, 1999]. The Jamaat-i Islami party was founded in 1941 by Maulana Sayyid Abu’l A’la Mawdudi, with the goal of developing a community to devout believers, which gradually shifted its ideology to one of governing muslims lives rather than on individual souls. Jama’at-i Islami takes its
Below is a short excerpt from a sermon held at a mosque in May 2002, which was attended by a crowd of approximately 350-400 men. A Jama`at-i Islami religious leader was preaching: 94

\[\ldots\] Hasn’t iman [faith] left our country? What is Iman? Iman is Rosool bani [the Prophet’s words about faith]. Amongst us how many faith-filled people are there? In this country the women’s population has increased. In a country where women do it all, on women’s words punishment and discipline is carried out, in this sort of a country how does Iman [faith] remain? We are men and we scream out about iman. Are we able to hold on to iman by letting women do everything...men have lost control... – we have lost iman. On the roads when you get out, all you see are women and you can’t see anything else... Islam has commanded that women be kept in pardah...

Hashmi (2000) argues that the emergence of the new female working class in the garment industries in urban areas and involved in credit programs run by NGOs have angered religious leaders and male elders, who are losing their power and control over poor women in urban and rural areas. These new institutions conflict with their own interests by taking away poor clients and providing them with credit and jobs thus makes them less dependent on them. Most of the religious leaders allege that NGOs are un-Islamic spreading western ideologies and Christianity. Despite the preaching of the Jama`at-i Islami, the party has failed to find significant voting support among what is generally considered a religious population, with more than 80 percent being Muslims.

Although people listen to the sermons and lectures, and many incorporate what suits their interests, they do not take at face value every word these religious figures utter, especially if it conflicts with their own interests or understandings of their reality (Shehabuddin, E, 1999). Hashmi argues that a gendered opposition is taking shape on women, both socially and economically by religious leaders, to provide the ideological framework to legitimise ‘male supremacy.’ Poor urban males, who complain of losing their sense of identity and status because of a harsh political economy, find the sermons a useful way to make sense of their displacement in the new urban environment, and a way to reinforce their masculinity (2000).

messages to women primarily through pamphlets and religious sermons/public lectures are directed at men at Mosques on Fridays or mid-week, and can run for as long as 5 days. 94 These religious sermons, called ‘waz mahfils’ are loud and can be clearly heard miles away from the mosque or the meeting place. Usually the religious leader shouts loudly on a micro phone/loud speaker and people living in houses near by can listen to the sermons. We captured the following preaching by standing on the roof of my flat, which is located close to the mosque in Moghbazar [a suburb in Dhaka City].
Conclusion

In this chapter, I show how suffering, general deprivation and political economic crisis in the lives of the urban poor structure their reality, meanings and experiences of health and illness. *Chinta roge* is a social illness. It communicates the consequences of social and political-economic inequalities in the lives of the urban poor. The urban poor speak of their struggle and desperation in a market economy, which has no role for them. The government, elites and local leaders (*mastaans*) are not interested in meeting their basic needs. Poverty and marginalization has led to a loss of faith, causing disruption in family relationships and gender and social roles, with increasing hostility, tension and conflict in their lives. The breakdown in society is leading to a breakdown in their bodies. *Chinta roge* is the idiom through which the poor reflect on their poverty, marginal status and the ongoing distress in their lives.

*Chinta roge* can be seen as a collective and embodied response to the *worrying* political-economic and social system. The urban poor struggle daily to meet their basic needs, and remain aware that they are exploited and remain powerless, constrained by structural and class inequalities, which contribute to their hardship. Their narratives are laced with stories of corrupt bureaucracies, an uncaring elite community, and a harsh political economy that sidelines and neglects them, causing widespread moral and social decay in their environment and ultimately in their bodies. *Chinta roge* is what Scheper-Hughes refers to in her discussion of nerves in Brazil, ‘an elastic category, an all-purpose complaint’ (1992:177), one that can be evoked by the urban poor as a way to cope with their frustrations and powerlessness. James Scott points out that the poorer classes have rarely been allowed to have the ‘luxury of open, organized political activity’ (1985:xv), and the articulation of distress physically can be seen as a way of expressing discontent and anger, and a form of body protest.

The experience of *chinta roge* appears to be universal, but poor women appear to be more vulnerable, constrained by patriarchy and unequal gender and power relations. Young women are both agents as well as victims of modernity with many disillusioned by the pressures of married life, destitution, and permanently unemployed husbands, some who prefer not to work. The narratives of the women demonstrate the interaction of the mind, body and society, and the individual, social, and body politic in the construction and articulation of illness experiences. Lock and Scheper-Hughes, point
out that 'sickness is not just an isolated event...it is a form of communication - the language of the organs - through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity and struggle.' (1996:70).

In this chapter, I illustrated the phenomenological aspects of human experience and suffering and its impact on the lived body. The analysis of chinta roge does not end here. In Chapter Five, I discuss married adolescent women’s experiences of more gender-specific forms of chinta roge, which manifest in particular illness conditions such as white discharge and weak bodies. However, before I do that, I will first discuss in the next chapter some of the major consequences of urbanization and poverty for married adolescent women, with changing marriage practices and marital life for young women in the slum. It is important to understand young women’s situation in this dynamic and changing urban environment, as it critically shapes their health understandings and reproductive experiences, which is clearly demonstrated in the later chapters of the thesis.
Chapter Four

Marriage in urban slums: eroding relationships, fractured lives & difficult choices

Introduction

Regarding issues of power, recently researchers have found that the combined effects of structural and social factors, such as, poverty, class, race, gender, or sexuality impact on individuals who are most vulnerable and marginalized (Parker, 2001).\(^{95}\) In this chapter, I show how the synergistic effects of a stressful urban environment, brutal poverty, unequal gender, class and power relations, have had a devastating impact on family life in the slum, and particularly on marriage practices and married life for poor adolescent women. It is crucial to understand the harsh conditions of life for married adolescent women and the constraints and dilemmas they face, because as subsequent chapters reveal, this critically shapes their health meanings, reproductive experiences and behaviour.

Marriage is both socially, culturally and religiously proscribed in Bangladesh. A woman’s only source of approved status is through marriage and motherhood. Therefore, marriage is a turning point in a young woman’s life, a major rite of passage, on which her future and fortune depends (Rozario, 1992; White, 1992). In a conservative country like Bangladesh, where interaction between the opposite sex tends to be monitored, and young women’s sexuality controlled, marriage allows individuals to have sexual relations without risk of social sanctions. Men are also expected to marry (Jesmin, S and Selway, S, 2000; M.E. Khan et al, 2002, Rozario, 1992).

Literature on marriage practices and adolescent women’s experiences of married life, their sexual negotiating abilities, level of autonomy and decision making and communication with husbands is sparse.\(^{96}\) The few studies provide useful insights into

\(^{95}\) See – (Farmer, 1992; Schoepf, B, 2001; Singer, M, 1998) – these authors looked at structural and social inequalities, which positioned individuals at risk, for AIDS.

\(^{96}\) Some of the literature on adolescent women in Bangladesh has to a large extent focused on unmarried adolescent women working in the garment industry and focused on issues of empowerment and mobility [Amin, S, et al, 1998]. A few surveys have concentrated on unmarried adolescents’ knowledge, attitudes and practices regarding health and other developmental processes [Nahar, Q, et al, 1999].
the underlying values and norms of society, which shape gender relations and female status, but present a fairly homogenous and unchanging picture of adolescent women’s lives in Bangladesh. Studies in rural areas suggest that young women because of their age and sex are less likely to have autonomy and decision-making powers, are confined by social norms and remain under the control of parents before marriage and after marriage under the control of their husbands/in-laws (Rozario, 1992; ME Khan et al, 2002; Aziz and Maloney, 1985). According to McCarthy (1967: 28) in Aziz and Maloney (1985) who carried out a study on newly married adolescent women in a rural area, new brides were expected to remain in pardah, work hard without complaining, not quarrel with family members, and have limited contact with members outside the immediate family.

The narratives of the young women in Phulbari slum for the most part support the prevailing view of gender roles existing in Bangladesh, but the situation in urban slums is far more complex, dynamic and complicated than what appears in the literature. Married adolescent women’s lives in the slum are filled with complexities and contradictions, fluid power relations and heterogeneous experiences, critically shaped by structural and social inequalities. I draw on a large number of narratives to show the diversity as well as the common themes running through adolescent women’s experiences. Within the slum there are poorer families and better off families, there are different income levels, networks and influences, which shape power and gender relations and the leverage of young women. Depending on where young women are situated, and depending on the kind of support they receive, be it from their spouse, family member, or even a leader in the slum, they are able to negotiate or re-negotiate their position.

The discussions on early marriage of young women in the slum reveal how urbanization and poverty have created disruptions in family life and relationships and increased insecurity for them. Crime in the slum and constant sexual harassment, pressures of dowry payments97 (money paid to the groom at the time of marriage, illegal, but a

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97 Studies and press reports document that dowry [cash or goods] is a key component of marriage negotiations. Cash can range from Taka 5000- up to Taka 50,000 [AUS $125 – 1250]. Goods in kind can be furniture, television set, bicycle, or a rickshaw. Often the bride’s family negotiates the amount to be given to the groom and his family at the time of marriage (Naved R, Newby M et al, 1997). Some researchers view dowry as evidence of the low status accorded to women (Abdullah and Zeidenstein, 1982; Lindenbaum, 1968). It has been interpreted by some as a form of female competition for ‘good, decent’ husbands (Stark, Norris, 1993).
common practice) and poverty are resulting in forced early marriages of young women by family members. On the other hand poverty is forcing many young women out of the homes into the workforce, leading to greater interaction with men and incidences of elopement and love marriages, in many cases, against the wishes of family.

Although a huge social stigma, marital breakdown, desertions and husbands remarrying or having more than one wife are not uncommon, with conditions exacerbated in the urban environment. This information is sensitive, and it is difficult to gather the actual statistics on the number of separations or polygamous relationships, but a long time spent in Phulbari indicates this is a growing concern and trend for young women. Unpaid dowry, high unemployment and widespread substance abuse among the men, are some of the reasons given for volatile marriages and instability. Many of the women and men blame unemployment and the resulting alienation of males for the widespread alcohol, gambling and drug use problem. Kabeer notes that poverty has led to the increased divergence of males and females interests, leading to the breakdown of the ‘moral economy of the family’ (1995). In the anonymous environment of urban slums, marriage break-ups are difficult to stop as families and relationships are fractured and ‘community’ in that sense does not exist. Therefore, men are less likely to experience disapproval and do not fear social sanctions as they would in rural areas (Jesmin, S and Salway, S, 2000).

The narratives of the adolescent women reveal that when husbands abandon their family responsibilities and family breakdown ensues, the effects for them are severe. Job opportunities are limited and the ones available are usually very low paid, changeable and with poor conditions. Abandoned adolescent women tend to be discriminated in the public sphere as well as socially in the slum. As such, social and cultural norms constrain women’s mobility and autonomy, and legitimise their exploitation (Kabeer, N, 1989; 1995). Competition for scarce resources and extreme poverty means that in many cases, after a marital break-up, adolescent women find it difficult to rely on their own family for long-term support. Some are caught in a bind and make desperate choices, such as turning to sex work or remarrying, often older men or already married men.

The differing ways adolescent women cope with their circumstances, such as, early marriage, difficult husbands/in-laws, lack of support from their own family, and marital instability illuminate the complex relationships between poverty, powerlessness and
gender relations. The case studies in the chapter reveal the social, economic and political dimensions of poverty, which have had damaging effects on families and particularly for adolescent women in the slum. Married adolescent women behave pragmatically within the structural constraints governing their lives, even though it may mean compliance rather than resistance to dominant ideologies.

The chapter is divided into four broad sections: (1) reasons for early marriage practices, and (2) the environment in the slum and the changing situation of marriage practices (3) married life and reasons for marital instability (4) and the coping strategies of married adolescent women. I cover a number of important issues in this chapter. In the first section, on reasons for early marriage, I discuss forced marriages of young girls because of the political and social environment in the slum. In the second section, I describe the changing situation in slums, the unfamiliar environment, disrupted networks and poverty, which makes it difficult for parents to find husbands for their daughters. Moreover, poverty is forcing young women into the workforce, which have both beneficial and harmful effects on their lives. I demonstrate the agency of some adolescent women who actively seek relationships and court men and others who manage to avoid forced marriages because of financial independence. In the third section I discuss the factors that shape married life, and the reasons for marital breakdowns, which reveal the extremely vulnerable situation of young women. Availability of cash, status, natal support, the role of in-laws, and financial independence of spouse can be important determining factors in the success or failure of a marriage in the slum. Finally in section four, I illustrate the limited options available to young women who try and cope as best as they can, despite the overall absence of societal and familial support.

**Reasons for early marriage in the slum**

**Crime & forced marriages: “we have to save our daughters from dangerous men!”**

In Phulbari slum, my survey of 153 married adolescent women revealed that that the average age of marriage was 13.5 years. While the legal minimum age for marriage is 18 for girls and 21 for boys, 51 percent of 15-19 year-old females are already married in
Bangladesh (BDHS, 1999-2000). In poor families, marriage is expected to take place soon after a young girl menstruates, at which time she moves directly from her own household to that of her husband’s and in-laws laws (Aziz and Maloney, 1985; Blanchet, 1996). The literature depicts traditional beliefs, control of sexuality, respect for tradition, and cultural and social pressures among poor families as the determining factors for early marriage practices (Aziz and Maloney, 1985; ME Khan, 2002). These reasons are important, however, there is an absence in the literature (exceptions are Rozario) of how poverty and ‘structural violence’ (Farmer, 1996c) can critically contribute to early marriage practices.

In Phulbari slum, the combined effects of poverty and the crime-ridden environment of gang violence and sexual harassment were important incentives for early marriage. Families feared rape and harassment of their daughters from both local and rival gangs. Nasima’s (married, 18 years old) mother explained that her daughter’s good looks attracted the wrong sort of attention and the family lived in dread that she would be harmed. Her mother said:

People would say things to my husband all the time about my daughters, especially about Nasima. They were all young and pretty. We found some good decent boys and we married them off. You see young girls were raped all the time a few years back in the slum. There were these two well-known members of a gang in the slum and they had a reputation for torturing unmarried girls. They started harassing Nasima because she was pretty. The day after Nasima’s wedding, she was sitting with her husband and chatting to him in their room. Suddenly the two mastaans and his gang of boys came into the room and grabbed her husband by the collar and dragged him out of the house. They said, “You are an outsider and you come here and try to have fun with our girls.” Then we said, ‘This is Nasima’s husband,’ but they wouldn’t believe us. Finally a few older men came

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98 International donors and local non-governmental organizations [NGOs] push for incentives for education or expanding livelihood opportunities for young women as alternatives for delaying early marriage (Kishori Abhijan, 2002). Educating poor families on the risks of early childbearing and high maternal and infant mortality rates are also widespread in health intervention messages. The assumption is that once families learn of the health risks, they will stop pushing their daughters into early marriage. Such suggestions may be useful, but overlook the contextual reality of poor people’s lives.

99 In a recent workshop in 2004 at Sheraton, Bangladesh, organized by the Population Council, on an ‘Early Marriage’ workshop, Rozario spoke of structural and social inequalities which contribute to early marriage practices in Bangladesh.

100 Many of these stories of crimes, rapes and threats of rape and names of perpetrators came out after the eviction. I believe that a major reason for people opening up to me was that after the eviction there were no leaders controlling their lives, and many landlords and tenants felt free to speak to me about these incidents. Secondly, many of these families had known me for longer than ten months or so. Even then,
forward and calmed them down and backed our story. Since she was married to him they had to let him go and leave her alone. I had to protect my daughters. I had to protect them [she repeats]. There was a girl...her name was Shumi. A few boys came over from block B [rival gang] and they tied her hands and feet and then they raped her...she was screaming but none of us dared come out of our rooms and save her...

In Bangladesh, ideally females are under tighter control to regulate their sexuality and gender relationships. Unmarried adolescent girls are expected to maintain their ‘virginity’ till the time of marriage and in order to safeguard their ‘purity’, contact tends to be limited to one’s family and extended relations. Culturally, females are taught from an early age on modesty and shame about their bodies, whereas males do not experience such pressures and are not judged harshly (Blanchet, 1996; Rozario, 1992). The maintenance of these ideologies is a form of ‘symbolic capital’, that is, families can use their symbolic capital to enhance their economic and social position and vice versa (Rozario, 1992). However, as discussions in this chapter later will also illustrate, economic constraints are forcing some families to forsake ‘symbolic capital’ in favour of meeting more basic needs.

These socio-cultural norms mean that in incidents of sexual harassment or rape males are rarely held accountable and the victims often get blamed. If young girls are attacked or molested in the slum, there is little sympathy for their situation. Instead of punishing the perpetrators, mothers are blamed for not guarding and monitoring their daughter’s movements, thus blaming the victim. In an incident of a young girl, aged 6, who was molested by a teenage boy, the leaders in the slum said to the mother, ‘Your daughters should first be kept inside the house, then come and complain about justice.’ There is a common perception that girls ‘who do not behave modestly,’ or ‘loiter about’ are deserving of violence and harassment (Caldwell, J.C. et al, 1998).

Despite the environment in the slum, not everyone chose early marriage as an option. Some families who had support in the village or elsewhere in Dhaka sent their daughters away particularly during constant gang violence in 2001 in the slum. However, not all adolescent women are vulnerable to sexual harassment, with the situation varying depending on the power and status and networks of the girls and their families in the

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these conversations took place in hushed tones and they repeatedly made me promise that I would not repeat this back to any of the leaders, as I knew some of the previous leaders in the slum.
slum. In most cases, adolescent girls born in the slum and who have male guardians [fathers/uncles/brothers] who are well off or are well connected with the leaders in the slum, or young women with personal (sexual) links with leaders have little chance of being harassed. They may face verbal taunts and gossip, but are rarely subjected to physical threats. Young women who are most vulnerable to violence are often poorer tenants/landlords, new in the community, separated/divorced, unmarried, and those who do not have male guardians or networks in the slum.\textsuperscript{102}

\textbf{‘She is young ... we can pay less dowry [cash] if we marry her off now!’}

For many poor families, an incentive for early marriage was the advantage of paying very little dowry is the girl is younger.\textsuperscript{103} However, it was not uncommon for the groom’s family to make demands for dowry later, after the marriage. With increasing urbanization and insecurity of jobs, a majority of grooms and their families see marriage as financial/economic investment for their future. Dowry [cash or goods] is a key component of marriage negotiations, and given by the bride/bride’s family to the groom. Cash can range from Taka 5000 - 50,000 [AUS $125 -1250]. Goods in kind can be furniture, television set, bicycle, or a rickshaw. Often the amount to be given is negotiated, but an inability to pay often means the end of the marriage. Attempts have been made by the government to ban the practice of early marriage and dowry payments through legislation, but in reality, the laws have still failed to prevent early marriage or the practice of dowry exchanges\textsuperscript{104} (Kishori Abhijan, 2002).

In the earlier case study, Nasima’s family is very poor, and her mother acknowledged that besides fear of sexual harassment by gangs, lower dowry costs was another reason for getting Nasima’s married at 11 years of age. She explained that Nasima’s age and

\textsuperscript{101} In 2001, there were lots of criminal activities and gang fights taking place in the slum.

\textsuperscript{102} The role of male guardians as protection for young women is discussed in more detail in the final chapter, when I discuss the value of sons/males for women in the slum.

\textsuperscript{103} Reports from rural villages of Narail in Bangladesh, found that the number of early marriages and divorce have increased dramatically in rural areas. The main reasons given for early marriage are paying less dowry for younger daughters and to protect their daughters from rapes/attacks from criminals and hoodlums (Daily Star, 2002g).

\textsuperscript{104} Lindenbaum [1981] argues that as a consequence of high male migration, there are an excess of unmarried females and a social shortage of eligible males in rural areas, making them in demand. Other researchers suggest that the spread of dowry practice can be blamed on high population growth combined with large differences in age at marriage, favoring grooms which creates an excess of brides and gives men the advantage in the marriage market (Siddique, D, 2002; Kishori Abhijan, 2002).
good looks meant that her in-laws demanded very little dowry. Many parents worried that an older daughter would lead to higher dowry demands. This is partially linked to the notion of purity and sexuality of a young girl,\textsuperscript{105} whereas an older girl\textsuperscript{106} may be viewed with more distrust and viewed as tainted, particularly in the urban context as poor adolescent women have more mobility compared to in rural areas.

'\textit{I can’t feed my daughter... better to marry her off!}'

Poverty is a major contributing factor for early marriage of young girls. Monsura, a pretty girl, 16 years old, was only 10 when her parents migrated to Dhaka. Her older brother worked in the army and supported the family. When he suddenly died in a drowning incident, her older parents were unable to support her and sent Monsura off to work in a garment factory. She said, ‘Although I was taller than other girls, I was still very young.’ Her aunt who worked in a garment’s factory organized her a job. Due to strict International Labour Organization laws\textsuperscript{107} against child labour that were being implemented in the nineties in many developing countries, including Bangladesh, Monsura was eventually fired from her job.

Employers were too scared of getting caught with child workers as the penalty was shutting down the factory. Unable to support her, Monsura’s mother took her back to the village and got her married. Studies show that a major reason for early marriage is that young women are unable to earn an income and become a financial burden on the family. By marrying them off parents can shift the burden onto the groom’s family (Naved R, Newby M, et al, 1997). Finding a husband was not difficult for Monsura’s mother. In rural villages, parents can select the groom through familial networks of information and support, so they hope that their daughters can make good marriages. If there is marital instability, families rely on local courts and networks to ensure responsible behaviour through social pressure and sanctions (Naved, R, Newby, M, et al, 1997).

\textsuperscript{105} Rozario discusses how for economic reasons girls from poorer families do not remain confined to the household in \textit{pardah}, thus the ‘purity’ of the girl is questioned (2002). If she is married off young, she is viewed as ‘pure’ [sexually], but the older she is, the more questionable is her honor and reputation.

\textsuperscript{106} There was a saying in the slums, 'kuri tho buri' which means '20 years of age is old for a woman!' They would laugh in amazement when I would say that 20 years of age is so young. Bengali women are perceived ‘unmarriageable’ after a certain age, I would say in the slums, it is after 16/17 years; and among middle class and even richer families in Bangladesh – mid twenties to late twenties, but not beyond 28 or 29 years of age (Rozario, 2002).

\textsuperscript{107} For further discussion see - Rashid, Harunur (2001).
Urbanization: disrupted lives in slums & changing marriage practices

Poverty, young women working & love marriages

Despite the retention of many of the traditional norms surrounding marriage practices, such as arranged marriages by kin relations, it appears that there are changes occurring in the slum. Many young women were proactive about selecting their own partners and getting married without parental permission.\textsuperscript{108} The survey of 153 married adolescent women, found that 53 percent, (n=81), more than half admitted to having a love/elopeement marriage.\textsuperscript{109} There are many factors for the increased incidences of love marriages. Acute poverty means that many parents rely on their unmarried daughters to work outside the home to earn an income, exposing many young women to the public domain. Financial constraints also mean that some parents are not interested or unable to get their daughters immediately married. They cannot afford the costs of dowry and may be unwilling to lose a valuable income source.

There is a breakdown in the monogamous family unit in the slum, and twelve married adolescent women admitted to having stepparents and siblings.\textsuperscript{110} Research has documented that relations within stepfamilies are complex and strained, and competition for limited resources means that stepchildren are treated badly (Jesmin, S and Salway, S, 2000). When discussing her home environment, Tanya [female adolescent] said, ‘There is a big difference between having your own father and having a stepfather...that is all I will say!’ Usually, if young women are able to support themselves and provide income to their families, the incentives for early marriage are

\textsuperscript{108} A study carried out in urban slums by Caldwell et al [1999] found that out of 157 girls, 22 percent claimed to have had a love marriage. This is a significant increase from 1.5% percent (out of 198 girls) in the early seventies. My study also found a very high percentage of love marriages.

\textsuperscript{109} They speak of it as ‘prem’ or love marriage and in many cases, the couple may run off and get married without parental permission or in some cases some one – a relative or an aunt, family friend may assist them in getting married. In most cases, the family eventually accepts them.

\textsuperscript{110} Information from survey, but mainly from in-depths and case studies, but I believe they are more families like this but the shame involved in speaking about it means that this is kept a secret. In many of these cases, I only found out after spending 11 months in the field with a particular family and it was unwittingly revealed in a conversation. To give you a sense of the problem, three of the female health providers had been married more than once and two of their husbands had had another wife at some point in the marriage. Even some of the older men and women said that their husbands had another wife either in the village or in another slum. While this is a very shameful topic, because I spent so much time with some of these families and in the slum, I was able to gather some initial information. I would argue that marital instability and polygamous households are much more common than we realize. Information like this is extremely difficult to capture in surveys or by quantitative data methods.
reduced (Naved R, Newby M, et al, 1997; Zohir and Paul-Majumdar, 1991), but young women are caught in a bind. They may face new opportunities with working and being able to save some money for future dowry costs, but poverty makes them vulnerable to exploitation from their families.

Not surprisingly, some young women become proactive and find their own partners, as they realize that their parents are unwilling or indifferent about their marital status.111 For adolescent boys and girls marriage allows them to have sexual relations without risk of social sanctions. For unmarried adolescent women, meeting potential partners is made easier as in urban areas they are free to walk to work, markets and shops, and have many more opportunities to interact with unrelated males (Naved RT, Newby M et al, 1997). Adolescent women and their partners who have love marriages against their parents’ wishes are initially ostracized and lose family support, but later out of pity may be accepted (Naved RT, Newby M et al, 1997). However, my case studies also show that some parents or community members quickly organize a marriage if a young couple is found in a compromising situation together. In this way, control of behaviour is enforced in an increasingly unpredictable environment and it also ensures that the adolescent woman’s reputation and honour is protected.

Love marriages are occurring because many parents find it increasingly difficult to find a suitable boy for their daughter in the unfamiliar urban environment. Extended family networks are disrupted by migration and much of the population is transient. Finding a husband is difficult considering the heterogeneity of the slum population and difficulty in finding out information on the individual’s background (Jesmin, S and Salway, S, 2000). Many parents publicly condemn love marriages, though, privately there were a few cases of parents condoning such behaviour and turning a blind eye to their daughters interactions112 with prospective suitors, who were usually single male tenants living in their compound or in the slum. Parents adopt this strategy in the hope of finding a ‘decent hardworking boy’ who will establish a close relationship with the girl and family, and not demand dowry,113 and after marriage continue to live in the slum. In this way parents hope to keep their daughters close to them.

111 I also heard stories of stepparents quickly marrying off adolescent girls so that they were no longer a burden on the family.
112 Not necessarily sexual.
113 In the case of two adolescent girls, Shoma and Mahmuda were recently engaged and their parents would often leave the room thus giving their daughters privacy with their husbands-to-be. It was only a
In many cases, parents still attempt to find males from their own district of origin [village] in the belief that such marriages last longer than the ones that take place in the city. However, not all adolescent girls are agreeable to arranged marriages organized by their parents and prefer to find their own partner. Beauty had turned down her father’s attempts to marry her off. She was working in a garment factory and earning an income and believed she deserved better than a ‘backward boy from the village.’ She also believed she had every right to find her own partner. The media influences these ideas. Television shows are filled with Indian romance movies, and relationships and encounters are often modelled from movie songs, heroes and heroines (Pelto, P.J, 1999).

I observed an argument between Beauty and her father and he slapped her in a fit of anger for rejecting a suitor. Farida [Beauty’s older sister] rushed home to confront her father. She said, ‘Do you feed her or clothe her? So what right do you have to hit her? Why did you hit her?’ Her father became quiet and left the room. Although Beauty’s father was both annoyed and humiliated he was unable to do much about the situation. He relied on his sons and Beauty’s earnings to manage the household and had little control over their behaviour. Many parents admit they have no authority over their children’s behaviour, particularly as many now work outside the home. As young women become financially independent, they are less wary of resisting orders from parents.

Adolescent women: initiating relationships & love affairs

What was surprising was the number of adolescent women who actively initiated a relationship and pursued men, with some young women resorting to manipulation. Some young women admitted going beyond exchanging notes, and sharing kisses. Although no one admitted to premarital sex, gossip and speculation circulated about particular young couples who were rumoured to have had premarital sex. Since most girls hold traditional values about marriage and sexuality, men sometimes use promises of marriage to persuade young girls to have sex or even go out on dates (Amin, S, Diamond I, et al, 1997). Friends of young couples provide alibis and help them find matter of weeks, before the young men had fallen madly in love and the amount of dowry ‘re-negotiated’ by the bride’s parents to a much smaller amount.
places to meet in private. One resident in section one of the slum was known to rent out her room to drug users and young couples.\textsuperscript{114} Although, socio-cultural values in Bangladesh prohibit premarital sexual activity, research indicates that about half of all young men in rural areas have already experienced premarital sex. These figures are lower for women, because they are subject to greater social control (Aziz and Maloney 1985).

Bulu [married adolescent, 17 years of age] took the initiative with her second husband when they were dating. She said, ‘Five days after he first gave me the flower, I gave him a red stone ring. I said, “let’s see your hand.” He gave me his hand and I put the ring on his hand. He said, “Why will you give me this? I should be giving you the ring instead!”’ According to Farida [married 18 year old], her sister-in-law Dilu deceived her brother into marriage, ‘Everyone knows that Dilu manipulated my brother into marrying her. She is very clever ... she made up her mind that she would marry my brother. She even threatened suicide if she was not allowed to marry him. My brother did not want to marry her. She said to the elders, “I am pregnant with his child. If he does not marry me I will commit suicide”...but on her wedding night she started menstruating!’

In some cases, gang boys were hired by adolescent women to ‘set up’ young men in a compromising situation, so they would be forced to marry the girl. Mahmuda [unmarried 14 year old] was desperately in love with Jamal. She explained that she was offered a deal by one of the gang members to arrange a situation so that her boyfriend would be forced to marry her. She said, ‘Selim [gang leader] said to me “give me Taka 1000 [AUS $40] and I can make Jamal marry you. You let us know when you meet him next time and we will pretend to catch you in a room together alone and then he will be forced to marry you.”’ She declined because she believed coerced marriages in such circumstances did not last very long.

Listening to adolescent women’s narratives, a discrepancy appears between traditional Bengali gender ideologies and the new situation young women find themselves in, where romances happen, hearts are broken, young women actively court males, even deceive them, and a few even admit to having sexual relations. For example in the case of Dilu, she was strong-willed and very independent minded, and rather than passively

\textsuperscript{114} She was an old widow and her sons were heroin addicts and this is how she managed to earn an income.
accept rejection, she was adamant about marrying the person with whom she had sexual relations. The interesting thing here was that she did not lose face for admitting to being pregnant; rather the male whose family lived in the slum stood to lose face in the community if he didn’t do the right thing by the adolescent girl. Dilu was the daughter of landlord in Phulbari. In Dilu’s case, her father was a richer and more powerful than her in-laws family, who were poorer landlords. Cases like this indicate that like men, young women are able to exert power and influence even over poorer men, if they have access to valued resources, in this case, class, status, and economic wealth. This highlights the significance of institutional support, class and gender hierarchies in understanding power relations and the level of manoeuvrability it affords the person. However, few women are as fortunate as Dilu. Extreme economic and social insecurity leads to tense and short lived marital relationships in the slum, leaving young women even more vulnerable.

Causes of marital instability in the slum

Dowry, class & status – money as compensation!

The cultural and religious ideal is the monogamous family, but the brutal conditions of everyday life in the slum make it extremely difficult for marriages to remain stable. Young women spoke of marital insecurity and blame it on financial constraints, unemployment and dowry demands. Unpaid dowry was mentioned over and over again as a major factor in causing marital strife. Political economic factors, such as, migration to the city and the lack of jobs, have resulted in an increasing demand of dowry from men115 (Lindenbaum, S, 1981). A number of other circumstances also impact on the stability of a marriage. These include: the economic situation of the adolescent woman’s natal household, if the husband is economically independent, if the young couple live with the in-laws, the strength of the relationship between the couple, and individual characteristics of the husband and wife.

Most of the love marriages in my survey involved little to no exchange of dowry. In the initial honeymoon period of the relationship men are not interested in demanding any

115 A study by Care International on 'Livelihoods monitoring and poverty profiles' found that more than 50 percent of the poor spend the most on dowry payments and loan repayments [be it to NGOs or credit lenders] (Daily Star, 2002b).
cash. However, over time, husbands and/or in-laws begin to feel cheated and either push for the disintegration of the marriage or mistreat the young girl till her family is forced to pay some money. In the case of Lipi (16 years old), she had a love marriage with Farhad but he left her after 8 months, because she was unable to pay the dowry demands made by his mother of Taka 25,000 [AUS $625]. Lipi said:

My family is poor and I did not have the money to pay him. It was a love marriage so my parents were not so supportive. When my husband would not fight back with his mother I lost all my faith in him. My heart broke. I became very sad. I knew that I was alone. After that, for no reason he would beat me and scold me all the time and then he left me.

The marriage was never officially annulled, a common situation in the slum, either the husband deserts the woman or she leaves because of serious mistreatment, and they both remarry. Despite laws in place, most families and adolescents are unaware of their legal rights in this type of situation. Moreover, the marriage document favours men, giving them the right to divorce women at anytime without a valid reason, without any such provision for women (Quader, S, 2002).

Class, wealth and status are also crucial factors, which affect whether in-laws accept the new bride into the family. Richer landlords do not approve of relationships with poorer families in the slum; families who live outside the slum disapprove of relationships with ‘slum girls,’ and if the boy’s family is in the village they usually disapprove of marriage with a girl living in the slum. In Lipi’s case, she was from a poor family and could not afford to pay the dowry, which was her only option to save her marriage. However, it is not known whether she would have been treated any better in the marriage, even after she had paid the amount. Despite dowry payments given, in some cases, richer or better off families continue to reject the bride because of her ‘lower class slum’ background.

Many grooms/in-laws ask for dowry payments and justify it as compensation for getting a “dark-skinned” bride. In Bangladesh “dark skinned” brides are considered ‘unattractive and inferior,’ and are especially a liability for poor parents who find it difficult to find willing partners and do not have a large amount of cash to entice

\[115\] Statistics released by Women’s Affairs Directorate under Women and Children Affairs Ministry show that some 2,026 women fell victim to dowry in eight years – between 1990 to 1997, of which altogether 2,126 women were mistreated and victimised for not paying the dowry amount (Rahman, M. 2002). A
families. Whereas if a girl is fair, then the dowry amount can be negotiated and reduced (See, Rozario, 2002). Thus for a fair skinned poor girl, her skin colour becomes a valuable economic resource, a new kind of dowry, which can be used instead of cash payments. For example, Suhela’s (16 years old) fair complexion meant that she did not have to pay any dowry at all. In contrast, Razia, 17 years old had a love marriage with her husband, but was later abandoned because of unpaid dowry payments. The boy’s parents’ primary objections to Razia were that she belonged to a poor family in the slum and she was very “dark-skinned.” Razia’s mother-in-law explained her justification in demanding Taka 20,000 [AUS $ 600] from Razia’s family, ‘The girl is so black [dark skinned]. We don’t mind…but we do want dowry.’ Even her husband explained to Razia’s best friend [who was sympathetic], ‘Look I am quite happy to take her back to the village with me but I have to justify why I married her. She is black [dark skinned], but if they [her family] pay the dowry then it will be easier to take her back with me and only then will they accept her.’

Some family members and adolescent girls are challenging dowry demands. The consequence is the end of marriage for the adolescent woman, but in some cases, the groom’s family does back down but the bride is vulnerable to future abuse from her in-laws. Many families justify their rigid stance because they fear that dowry demands are never-ending, turning into a long-term process of just grabbing cash. Particularly for families with more than one daughter, paying one son-in-law dowry means that the next groom will expect payments as well. The reality is that many admit to the futility of fighting dowry, which has become such a widespread and acceptable practice in the slum. Most young women, however, do not perceive dowry as wrong but a rightful claim on the part of their husbands. A large number of adolescent women expressed feelings of shame, anger and betrayal towards parents who did not pay and tolerated abuse from in-laws and husbands.

Dowry Strategies taken by young women
There were stories of resourceful young women unable to pay dowry finding different ways to please or outwit their in-laws to hold on to their husbands and marriages.

UNDP report found that 50 percent of married women in the country suffered either physical or mental torture over unpaid dowry demands in the last ten years (Daily Star, 2002i).
Shefali, 16 years old, fell in love and married Shuman, 21 years old. Soon after marriage, he moved into Shefali’s mother’s place in the slum and lived there rent-free. Shefali, who works in a garment factory, borrowed money from an NGO and her mother to give her in-laws Taka 10,000 [AUS $250] to soften any potential protests to the love marriage. Some young women save up their income from working in garment factories and buy their husbands a van-cart, rickshaw, or even a little shop. Rehana was married for 5 years, and borrowed money from her older sisters to set up a little shop for her husband. She felt vulnerable because her in-laws who were rich and powerful did not accept her and she desperately wanted to strengthen her relationship with her husband. In many cases, young men are already emotionally attached to their wives and ignore their parents’ protests for the added benefits, be it a job, free rent, cash/goods, or a working wife.

Lack of economic independence of husbands = no power

Power, status and the ability to negotiate in a marriage depended greatly not only on husband’s attitude, but also his economic situation. Despite paying Taka 5000 [AUS $125] dowry money, Shegufa, (18 years old and married for 3 years) was fed up with the way she was treated by her in-laws because her husband did not work regularly. She complained that she was made to work harder compared to her sister-in-law who was allowed to sleep all day because her husband contributed a sizeable income to the household. She said:

I had to work and I was pregnant. One day I was late in cooking the meal and my sister in-law kicked the rice over and said, “How dare you become fat eating off us?” She had slept all day whereas I had to cook, clean and wash clothes as well.’ But the crucial difference was Shegufa depended on her in-laws economically and thus was not treated with any respect. She said, ‘Where is my strength to respond? I had no power and no strength in the household because my husband prefers to roam around with friends instead of working.’ When Shegufa wanted to buy a sari or a dress she had to ask her mother-in-law who often humiliated her: I asked her, ‘Amma [mother] can I get this sari, I really like it.’ and you know what she said to me, “You already have a sari. Once your husband works properly, then you can buy a sari!”

117 A woman who is considered ‘dark’ but who has wealthy parents may also be able to attract a suitable
Feeling cheated and unable to tolerate the mistreatment any longer Shegufta returned to her natal home, threatening never to return, hoping that this would shock her husband into becoming more responsible. While Shegufta was able to return to her natal home, most parents are reluctant to support their daughters long term, because of financial constraints, but also because of the unsafe environment in the slum and socio-cultural pressures. One mother explained why she sent her daughter back to her abusive husband:

At this age for these young girls it is different, even if these girls are married and under their husband’s domain there are so many bad men out there who make life difficult for these girls. If I make her leave her husband then other men will make trouble for her. People will talk and say bad things about her. She is a very young girl. That is why I never say anything. Let him [her husband] remain the way he is...let it be But at least no one can say anything to her. She is still married.

Unemployment, domestic violence & marital insecurity

Household harmony and stability is undermined by men’s responses to unemployment. As discussed in the earlier chapter, surveys and in-depth discussions with young women revealed that 19 percent (n=29) of their husbands did not work regularly. The three major reasons given for their husband’s reluctance to work was the difficulty of finding jobs, laziness, and addiction to bad habits [drugs]. Fights in the household usually began when young women demanded money to meet essential household costs – rent, food, and milk for the baby. Unable to provide, husbands became angry and abusive, with some men taunting their wives about dowry money. Aisha, 16 years old, said as she sobbed, ‘We owe rent and there is no food for the past few days in the house. I told him to go to work. Just because I told him to go to work he turned on me and started screaming. “Beggar’s daughter you brought no money and then you tell me to work.”’ He started slapping me and pushed me off the bed. She whispered, ‘I just want someone who will shower me with love all the time, work properly and take care of me. He won’t even allow me to work.’

Aisha’s husband claims it was difficult for him to find regular work for the past few weeks. He said:

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groom in exchange for a large dowry (Rozario, 2002).
As soon as I walked in, she just started screaming away. She said, “Don’t you know there is no oil in the house, no onions, no food!” She said a whole bunch of things but I can’t remember but my blood began to boil. I was very angry. I was so angry that I don’t even remember what happened next but I know that I beat her up. What will I do? I do try and work, but there is no work and so I am stuck sitting at home. She does not want to understand, and all she does is scream and shout. Aisha wants to eat rice, but don’t I? I also have the same wants. When she goes without food so do I! When a man comes home and he has no money and no work and his wife is yelling and saying all sorts of things, then it is a horrible feeling! I feel terrible inside. I feel useless. I think that my wife does not value me. That I have no value! A man does not remain a man if he cannot work. We are supposed to feed and look after our family.

The stresses on poor urban men are leading to loss of male identity, and make it difficult for them to fulfil their role as a male provider. Many of the men complained bitterly of limited job choices and that only low paid and insecure jobs were available. Despite their poverty, some men were still unwilling to work in difficult and ‘menial’ occupations like rickshaw work for reasons of prestige and depended on odd jobs for quick cash or chose to live off their wife’s income. Thus, for young women the opportunity to work in a factory does not necessarily imply an improvement in status or rights, or autonomy, as many were compelled to work outside the home to meet subsistence needs (Adnan, S, 1993).

Despite the chronic shortage of cash in households, some of the husbands regularly spent money set aside for food on alcohol, drugs, and gambling. Men quickly become enraged if wives are reluctant to hand over any money and arguments quickly escalate into physical fights. When a young woman argues back and is beaten for her outburst, rather than receiving sympathy, she is usually blamed for being a ‘difficult and argumentative wife’ deserving of this treatment. Comments such as ‘she talks too much,’ ‘she is loud and misbehaves,’ and ‘why can’t she just tolerate and be patient?’ are commonly expressed. Sometimes neighbours do come to the defence of a young girl and complain to her husband and others about in-laws behaviour, but this is rare.

Young women spoke of a biased society that supports prevailing norms and expectations that favour men rather than women. Roshonara, an outspoken young woman, married for 7 years, said that when she fought back with her husband no one
comforted her: 'He does not like to work but our society attacks the women but not men. If I say a few words to him everyone remembers every word I said. They say, “Oh Roshonara is so bad look at the way she behaves with her husband.” Nobody has said anything to him even though he has never fed me or clothed me properly.’ Thus, gender norms are reinforced and reproduced by society and by men and women themselves, expecting women to make sacrifices and keep their husbands and in-laws happy.

Desertion, separations and co-wives: ‘a good woman eats one man’s rice!’

Although divorce is legally sanctioned, it is strongly disapproved of and detrimental to social prestige. Despite this, divorce and separations are taking place in the slum. Young women spoke of marital instability in their lives, with husbands remarrying or deserting them. Out of the 153 responses given on marital status by adolescent women in the survey and information further revealed in the in-depth interviews and case studies, it was found that 11 percent (n=17) of married adolescent woman said that they were divorced/separated or abandoned. Furthermore, 4.5 percent (n=7) of young women said that they were previously married and this was their second marriage, and another 4.5 percent (n=7) claimed that their husbands had a co-wife and spent time with both households. Another 3 percent (n=2) had separated but recently reunited with their husbands. The shame surrounding the issues means that marital disruptions tend to be underreported. For example, I found in the 50 repeated in-depth interviews, almost 20 percent (n=10) married adolescent women revealed eventually that their fathers had more than one wife, and in some cases, their fathers were spending time in both households.

The few studies available suggest that the breakdown and heterogeneity of the urban population heighten marital instability. When families migrate from the village to slums, this leads to the consequent disruption of the goshti [kin/lineage] system of an extended family. All this has led to the gradual erosion of the traditional socio-cultural

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Kabeer (1995) cites evidence that the insecurity of marriage is increasing particularly among the poor and argues that women are becoming vulnerable as men abandon their families. Jesmin S and Salway S. (2000) in their study of Dhaka slums, found that out of 732 households, 15 percent of ever married men and ever married women had experienced divorce (or desertion) at least once. Similar to my findings, qualitative data supports the picture that marriage is more unstable in the poor urban setting than among the rural population.
constraints against divorce. Marriage increasingly concerns only the couple, particularly in love marriages, rather than other members, so the wider family and relatives are less likely to intervene when marital problems set in. Further, as most families in the slums tend to be more nuclear oriented, support from the larger extended family tends to be absent (Salway, Rahman and Jesmin, 2003). Since slum society is relatively anonymous, it is easier for men as well as for women to hide their marital history and relocate and remarry without anyone else knowing and less chances of facing sanctions (Jesmin, S and Salway S, 2000). While the traditional framework of arranged marriages imposes a number of restrictions on young women, love marriages in urban areas offers them greater choice and freedom; but ironically less security and certainty is tied to such marriages.

Men are becoming increasingly polygamous. The law in Bangladesh does not ban polygamy but it is meant to be restricted and controlled. A man wishing to marry again needs the written permission of his first wife but in reality the woman’s permission is rarely sought and related laws are totally ignored. Most of the female adolescents were aware of the social stigma of ‘divorce/ separation,’ and desertion was viewed as a personal failure on their part. Young women who were abandoned by husbands who may have remarried were often gossiped about, insulted during quarrels and referred to as ‘bad women,’ and as ‘wives who could not eat their husband’s rice.’ ‘Not being able to eat a husband’s rice’ is a serious insult as it casts aspersions on a woman’s character and personality. The statement has various negative meanings, implying that the woman is intolerant, aggressive, and argumentative, lacks commitment to marriage and is a flighty person, the opposite of the ideal Bengali daughter/mother/wife. This reinforces expectations of appropriate behaviour for women. A marriage breakdown is usually blamed on the woman and not the man. An adolescent woman, Seema, whose husband had remarried, explained, ‘Men can marry ten times but no one comments, but if a woman marries even twice, everyone will talk. That is why we stay with the man!’ As Sharma points out in her discussion of Indian marriages, dependence on men holds a moral value as well as being an economic reality making it difficult for many women to acknowledge they may wish to leave unhappy and deeply unsatisfying marriages (1994).

Most adolescent women claimed to be currently married, in reality, not all husbands were regular residents in the households and not all of them made household
contributions. A large number of adolescent women chose to remain with their ‘partially absent’ husbands rather than be completely alone, and were willing to tolerate their husband’s second marriages, because the trade-off was at least continued social acceptance and economic security.

Nasima, 15 years old and with a young child, explained: ‘if one’s husband is not there, then what work will I do? How will I look after my child and bring him up? If one does not have a husband then one is always in tension - what will happen to me? Will someone harm me? My husband gives me Taka 40 [AUS 1.00] to do shopping, if I didn’t have a husband I would have to manage with very little. Will I go to the streets to find work?’ Nasima, like many married adolescent women, was saddled with a young child and with limited job prospects. She preferred to tolerate her husband’s second wife, rather than try and manage on her own.

Adolescent women expressed feelings of love and affection for their spouses, but were emotionally wounded by their husband’s infidelities and remarriages, but many tolerated for economic reasons. A common statement by young women when asked why they didn’t leave their husbands were: ‘Is it so easy to leave the husband? Can I just leave him? How many times will a girl get married in her life? What if the second husband is worse than this one?’ Publicly, young women reinforced the ideal behaviour expected of women and often said, ‘A good woman eats only one man’s rice rather than several men’s rice!’ However, the reality was complex and contradictory. If the marriage was difficult, or husbands misbehaving, adolescent women found ways and means to punish their men, leaving temporarily or permanently moving back home, confronting the second wife/lover, involving family/family to ‘sort out a wayward husband’ and by giving their husbands various ultimatums. The strategies taken depend on the level of family support a young woman can rely on, and if she is financially independent.

For men, one of the reasons for remarriage appears to be economic exploitation, to secure large amounts of a woman’s savings for their own purposes. Despite men expressing feelings of anxiety because of their inability to provide for their families, such norms are taking a backseat, with many exploiting the situation. Seema [18 years old] justified her husband’s remarriage: ‘he is still with her [second wife] because she works. She eats her own rice! My husband tells me, ‘she eats her own food and wears
her own clothes [she earns everything]. That girl works and gives all her salary to him every month, but look at me I don’t give a cent to him.’ However, Seema may also be downplaying her husband’s emotional attachments to his second wife and portraying it as merely a business transaction.

For Majeda 17 years old, to remain married to her abusive and lazy second husband was the only option open to her at this point. She had a stepmother and stepsiblings and her father was poor and she had very little support. Since it was her second marriage, she feared a break-up would ruin her reputation:

My husband said to me why don’t you work? He is bad and has another wife and has a child from that home. He does not feed or clothe me. He is lazy. I work to keep him with me. I don’t want people to say bad things about me. If I have fight in the slum, then the women turn around and say to me, ‘If you were good then why did your first marriage break up? You can’t even eat your second husband’s rice.

Despite this, Majeda like other married adolescent women who work, have a degree of independence and control over their own earnings, allocation of income and freedom compared to those who do not work. An income may not bring about a radical difference in the marriage, but adolescent women admit that it is a critical factor for better treatment by their husbands and to avoid confrontation and fights with their spouses. An income also means that adolescent women are less willing to put with abuse and neglect.

Marital breakdown: coping strategies of adolescent women

Working again but limited options

In cases of separation, the men simply moved away from their adolescent wives without formally resolving their legal status, thus leaving women in a state of ambiguity. Young women with children are left in a very vulnerable position and are compelled to choose between very difficult avenues of survival. They immediately begin to look for work, as many do not have financial and social support from their family or in-laws. Some start working [again] at a garment factory or as a housemaid, others turn to sex work to
manage the household. Although they may succeed in finding work, low wages, and discrimination in the labour force ensures that they are much worse off than households headed by men (Kabeer, N, 1989).

Although young women may break out of *pardah* to a certain degree and forced to be relatively independent, they enter a highly uncertain existence offered by the urban and industrial markets (Adnan, S, 1993). Garment work is increasingly insecure with factories shutting down. If a person is sick for only a few days, they are in danger of losing their job, as many of the adolescent women found. Not only were they fired; many were not paid for the overtime work they had done at the factory and complained of not receiving their salary regularly. Thus the increasing role of capital in the economy has the double-edged consequence of generating employment for women, or throwing them out of work, depending on market based considerations (Adnan, S, 1993).

There were a few stories of some young women who soon after being abandoned, turning to sex work to manage their households.\(^\text{119}\) The manner in which the sex workers are treated in the slum depends to a great extent on the status of the individual young woman and how much power and clout she or her family commands in the slum. Usually a young woman who lives alone is more likely to face problems than someone who lives with the support of male guardians in the slum. Parul, 19 years old, was abandoned by her husband a few years ago and has one young son who lives in the village with her mother. She was living on her own in the slum for past one year as a tenant. Although she claimed to work as a chef in a hostel, she was a sex worker.\(^\text{120}\) Indirect comments revealed that most residents were aware of her actual occupation.

Often in discussions, people were sympathetic when speaking of the plight of these young girls, but did not condone their behaviour. Discussions also revolved around the large amounts of money and gifts one received in this occupation, earning Taka 4000-5000 [AUS $ 1000-1200] and gifts of saris and jewellery. It isn't surprising that in the context of extreme poverty and lack of support infrastructures; young women may turn to this work to manage. In mid-June, some leaders and gang of boys in section one of

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\(^\text{119}\) A study of slums in Dhaka city alleges that 10 percent of young women, including girls as young as ten years of age living in slums, work as prostitutes (Akhter, Nasrin, 2002).

\(^\text{120}\) Key informants and cross checking revealed some of the sex workers living in the slum.
the slum threatened Parul and she was forced to move elsewhere. The rumour was that she was asked to or forced to share sexual favours with all the gang members, although what actually transpired remains a mystery. 121

Lipi, [who I mentioned earlier], also turned to sex work after her husband Farhad had abandoned her because of unpaid dowry. Her older sister alluded to Lipi’s ‘nocturnal activities.’ Lipi lived at home with her stepfather, mother and older sister in the slum and continued her ‘sex work,’ outside the slum. Her mother, however, was closely related to an influential leader in the slum, which meant that although everyone knew of her occupation, they never bothered her. In Lipi’s case, she contributed money to the household, and thus was not regarded as a liability by her family and was tolerated because of her income contribution. Extreme deprivation means that Lipi’s family was willing to forsake the reputation and honour of the family ‘symbolic capital’ (Rozario, 1992; Bourdieu, P, 1977) in the community in favour of meeting more basic material needs.

Moving back home but lack of support from family!
Competitive urban life, financial constraints, and the presence of co-wives, stepsiblings, means that many young women who move back home after being abandoned are viewed as a burden and cannot count on financial or emotional support. Parveen (17 years old), was abandoned by her husband after four years of marriage. He was involved in gang warfare in the slum and was forced to relocate when he received death threats from rival gangs. He left and married soon after. Out of desperation, she moved back home, but was immediately asked to look for work by her father to contribute to the household. Her father had three wives and her mother and stepmother and 5 siblings [including step] lived together in the same compound. When she moved back home with her young daughter she was often the target of anger by her step-relatives and father because she was occupying a room, which could have been rented out to someone else for cash.

121 We found her sobbing away near her room but we were unable to talk to her. Soon after she moved out. Later we pieced together what took place from our key informants who lived in section one of the slum.
Razia, whose husband has left her, and had returned to working in a garment factory had not been received her wages for the past two months. She complained that she was being treated badly by her family because of her failure to contribute to food expenses, and in response, her family was not feeding her properly. She went home for her lunch break one day and became very upset when informed that her lunch was not ready. She shouted:

This is the thirtieth day I have come home from work and I don’t find rice ready for me. I come home and I don’t get food properly. I don’t get food in the morning and I don’t get food at lunch time.’ Then she says loudly, ‘because I have not paid them [family] for 2 months [salary] that is why they are doing this to me.’ In the background, Razia’s father [who has a second wife and a son living elsewhere whom he supports as well] shouts at Razia’s mother, “I am not going to give you more than Taka 20 [AUS $ 0.5 cents] for food costs. Eat rice and water if you have to, tough luck. Let everyone go and work. I can’t feed anyone…

Razia stormed out of the home, hungry and tired and returned to the garment factory to work. The case studies illustrate the underlying strain, which extreme poverty places on family and relationships, with support systems completely breaking down, which have damaging consequences for young women who are left vulnerable.

Remarriage - no alternatives for adolescent women!

Many adolescent women who are abandoned spoke of ‘broken hearts’ and ‘waiting for their husbands’, hoping in vain they might return some day. Some young women were cynical about marriage and expressed hopes of getting a better job, leaving the slum or going abroad to work in the Middle East. The reality is that most of the young women remain in the slum, eventually meet someone else, have a love marriage, or agree to remarriage, as it is the only practical option available to them. National data on marital status indicates a higher percentage of divorced women than men, and women finding it difficult to marry again. However evidence, from my research and from another study in

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122 There are thousands of primarily poor men and fewer numbers of women [women are restricted from going abroad as laborers now] working as laborers and housemaids in the Middle East and countries like Malaysia. A big dream of many rural and urban families and even adolescent women is to be to send a son/husband/brother abroad to work in any of these countries. They save thousands of Taka to able to buy work permits and travel documents. Unfortunately there are many dubious visa agencies promising to organize the necessary work permits for a fee, but instead they end up ripping off these poor families.
the slum setting (Jesmin, S and Salway, S, 2000) indicates that poor women do manage to find partners to remarry. Sometimes, adolescent women marry older men or widowers or men who are already married. The fact that the young woman is no longer a virgin does not appear to be an issue, particularly if it is a love marriage and men are willing to be with a woman who has previously lived in another man’s home. The concern is more to do with the notion of sexual purity, which is the general behaviour of the young woman in relation to men. *Parda*, immobility, modesty, silence and dependency of women are very important qualities ensuring their sexual purity (Rozario, 1992) and by preserving their modesty/shame women can retain what Abu-Lughod refers to as ‘honour of the weak’ (1986). Often though, if the second marriage is arranged, parents emphasize that the first marriage ‘was nothing at all and she did not even stay with her husband at all’ [did not have sex].

As discussed earlier, cultural ideals mean that remarriage is considered shameful, and it took many months before some of the adolescent women admitted to being previously married, separated, having stepparents and sharing husbands with co-wives. Roshonara, a married adolescent woman, conscious of her father’s reputation because of his constant remarrying, said [after 10 months of spending time with her], ‘Don’t you think I got nasty comments all my life from others that my blind father remarried so many times? Do I want to be like my father and leave my husband and remarry?’ Remarriage was perceived as a social stigma by everyone in the slum, despite other studies indicating that this is lessening in urban areas (Jesmin, S and Salway, S, 2000). In urban areas, however, there is the opportunity for young men and women to relocate to another slum, which affords them privacy and ability to hide past marital history.

Young women with children who are abandoned by their husbands find themselves in a difficult situation. Ideally, they are expected to be ‘good mothers’ who are expected to focus their lives and future on looking after their children. To consider remarriage is perceived as young women giving into their ‘sexual needs and desires.’ The term *Langh/batar* [meaning sex partner] is a derogatory slang commonly used to insult women, referring to the second husband as a sex partner. During arguments, slum women often mock women who have remarried with remarks like, ‘Why did you marry again you shameless woman? Go back to your *lang* [sex partner] why don’t you?’ In household fights, even husbands are known to insult their wives because they were previously married. Monsura said, ‘When we fight, he shouts and tells everyone, “You
have been married more than once. If you were a good woman then would you be married twice or thrice, you shameless whore?” He shouts and people overhear. Later, won’t people laugh at me? Today he said to me all these things, tomorrow all the ones who heard this will make nasty remarks at me!’

In a few cases (although rare), young men expressed fears of ‘malicious gossip about their masculinity’ if their marriages kept failing or if successive wives left them. For instance, Shegufta’s [married adolescent] husband was desperate for her to stay and begged her not to leave him. According to her, he was worried that people would talk because she would be the second wife to leave him within such a short period of time: ‘He is scared because everyone will talk and say there is something wrong with him. Why do his wives keep leaving him?’ Despite these concerns, men are not as vulnerable as women. A man whose first wife leaves him may be regarded as a rather poor prospect, but he will not find it impossible to remarry.

**Family support for adolescent women in the slum**

Family and sibling support can affect the power and status of the adolescent woman, and her strength and ability to negotiate in her relationship with her husband and in-laws. Observations reveal that if the young woman has financial support (even if her parents lived in the village), and a strong bond with family members, she was less inclined to receive or put up with poor treatment and more likely to be assertive about her needs. In addition, if young men were dependent on the adolescent wife’s family for financial support or accommodation, the wife was in a better position to assert her needs and wants in the relationship.

For many young women, there is a strong awareness that marriage is a relationship in which trouble can be expected. This means that many make an effort to remain on good terms with siblings, particularly with brothers whom they can turn in times of crisis for moral and economic support. As in India, in Bangladesh it is practically impossible for a woman to leave her husband unless she has secured the support of her family for her cause (Sharma, 1994). In a minority of cases, such as Moni and Bulu [married adolescent women], both were fortunate to have parents who were sympathetic to their plight and supported their decisions. Bulu was only 12 years old when her stepfather and own mother arranged her first marriage to a hardworking boy who was previously
their tenant in the slum. When her mother and stepfather heard from Bulu about the constant abuse and beatings, they intervened. Her mother said, ‘I saw the young man hit Bulu. I knew how he was treating her. Then I became very angry. I got them married because I thought he would live in the slum and would be good to her. She is my only daughter.’ They waited for a few months but when the husband’s behaviour did not improve and Bulu refused to put up with it, her mother decided that Bulu would be better off without him. The marriage was annulled.

Similarly, Moni’s parents came to her rescue when she decided to leave her marriage after constant insults from her in-laws and husband. She said:

My father said to him, ‘If my daughter will suffer in your home, then let her suffer in my home, not in yours!’ I took my mother with me on the day I decided to leave him. My mother stood there as I packed my belongings and brought back the television and cabinet. My in-laws didn’t dare say anything to me because she was standing there.

Moni started living with her parents but six months later against her parents’ wishes, she reunited with her husband, who had acquiesced to Moni’s requests and rented a separate home from the in-laws. Despite the social stigma of divorce some parents are unwilling to overlook abuse of their daughters and encourage separation. In most cases, however, parents are not keen to see the marriage end and often they or other relations play the role of mediators to patch up relations between the couple.

Married adolescent women who have family support, particularly financial help, gain prestige and are generally treated better by their husbands and in-laws. When Sumi’s (17 years old) husband was sick, her brother lent them Taka 6000 [AUS $ 150] to pay for hospital costs and her husband went to her mother’s home for one week to recuperate. He was sick, Sumi’s elder sister visited often and bought fruit and vegetables for her brother-in-law. Sumi admits that she is treated very well by her in-laws and especially by her husband because she can rely on her family during any crisis. Unlike Sumi, when Shaila’s (16 years old) husband was sick with a hernia, she could not turn to anyone for support. Her brothers were in no position to help her out and her parents are very poor and lived in the village. Her husband abused her and her family for not paying for his treatment. Shaila said, ‘How can I hold up my head and face him? He is right to get angry because no one from my family has ever done anything for
him? Those who are treated badly by in-laws but still have support from their own family members, are better off. The contrasting lives of the young women illustrate how family environment and steady support from kin network influence whether adolescent women are vulnerable, and in the following chapters we will see the impact of this on health choices.

**Conclusion**

Poverty, interacting with gender and class inequalities creates situations of extreme vulnerability for adolescent women living in the slum. In this chapter, my aim was to show how social and cultural factors grounded in macro-level political and economic conditions, are critically disrupting kin relations, affecting men and women in different ways, and impacting on married life for adolescent women in the slum.

Adolescent women’s lives are complex, contradictory, and varied depending on a host of factors. Overall, larger forces restrict young women’s lives and they have limited control leaving them with little agency to manoeuvre their position. Although many adolescent women may be dependent on their husbands and families, they are not necessarily submissive or complete victims. Some do resist, although the constraints under which they resist, or make choices is very narrow. As Kielmann notes, research into the lived experience and pragmatics of behaviours by those who do not have power is crucial to understand the subtle forms of resistance as well as compliance that exist in local realities (1998).

Structural violence, including extreme deprivation is an important mitigating factor for early marriages of adolescent women in the slum. The response of families to the widespread crime and violence in the slum varied. While young women are vulnerable to rape and sexual harassment, the importance of class and status are influential factors in shielding some adolescent women from harm.

The influence of the global on local realities and its influence on marriage practices are evident in the urban slum. For example, Monsura was fired for being an under age worker [she was only 11 years old at the time] in a garment factory because of international labour laws being implemented in Bangladesh. As her parents were too poor to feed her they got her married. Growing industrialization and the introduction of
garment factories have pushed thousands of poor young women outside the home to earn a living. The tensions between empowerment and poverty are evident as well. Chronic deprivation means that some girls work outside the home and earn an income. However, parents may exploit their daughters and remain indifferent to their marital status or well-being.

Urbanization, disrupted networks and economic deprivation have displaced traditional practices and authority and ‘traditional’ marriage arrangements, with more and more young women and men choosing their own spouses and parents less in control of their children. In the past parents relied on land and other assets for their authority. Landlessness and poverty have inverted power relations in the household and given some adolescent women more voice in choosing or rejecting suitors. With increasing poverty many parents are unable to pay large dowry demands and many adolescent women actively find their own partners. The changing situation has compelled some parents to look for men in the slum rather in their home villages, focusing on prospective single male tenants as potential suitors for their daughters. It is evident that adolescent women are caught between the tensions of tradition, modernity and poverty. While some choose to listen to their parents and agree to an arranged marriage, others elope and risk ending up in bad marriages and losing family support.

Young women spoke of volatile and unhappy marriages. Urban males are increasingly economically marginalized. Unable to fulfil their familial obligations to their wives, many respond with frustration and physical violence. With few employment prospects and unhappy about unpaid dowry, some desert their wives and remarry economically solvent women. Other men are lost in a cycle of abuse. However, if the husband is economically independent and has a close relationship with his wife, then the marriage tends to be secure, despite interference from in-laws. Separations occurred usually over unpaid dowry demands made by the groom and his family.

A large number of adolescent women tolerate volatile and abusive marriages because of a lack of options. Many admit that persistent poverty and economic and social survival are major motivating factors for remaining married or remarrying. Although varied and complex the benefits of holding onto a husband can broadly be divided into 3 categories [1] social/physical protection [2] social acceptance and [3] economic security. Thus many women tolerate their husbands’ irresponsible behaviour and even co-wives. Many
of the adolescent women’s comments reveal their awareness of the unequal relations between men and women, but they also realize their vulnerable position, which leave them with few options.

Parental and family support is crucial in shaping young women’s vulnerability. Widespread deprivation, competition for scarce resources and disrupted family life affect the kind of support young women can rely on, with support uneven. Many adolescent women who are abandoned by their husbands are not always welcomed back into the natal home as they are seen as a burden. On the other hand, extreme deprivation also means that families don’t mind if daughters move back home, as long as they contribute to the household. Some young women turn to sex work to manage. Families and young women forsake their honour and reputation in exchange for cash. Thus, powerlessness and poverty means that symbolic capital for the community is forsaken to meet individual basic/material needs. For many separated young women, the absence of support forces them to eventually look for potential males to remarry. They sometimes end up marrying older, already married men. While, urban slums afford young women anonymity and space to restart their lives and remarry, their insecurity is greater.

The case studies illustrate the diversity, contradictions and complexity of married adolescent women’s lives in the slum. Young women engage in numerous strategies to attain personal goals, such as gaining economic security, coping with an unhappy marriage, or obtaining moral support. However, destitution and discrimination ensure that they have limited options both material and personal. Many find it difficult to overcome structural inequalities and traditional gender and socio-cultural norms, which constrain their agency. The struggle for survival and security can only be achieved at the expense of autonomy (Kabeer, N, 1989), and most adolescent women are dependent on the support of their husband or their natal family. As such, dependence mainly on men [fathers/ husbands/ brothers] continue to dominate young women’s lives, with local power structures culturally and structurally weighed against them (Salway, Rahman and Jesmin, 2003).

This chapter provided a detailed picture of the conditions of life for poor married adolescent women in the slum. In the next chapter I shift my focus to health and illness understandings for married adolescent women. I focus on the experience of chinta roge, and how young women make links between chinta roge and experiences of gender.
specific illness conditions of white discharge [vaginal discharge] and weak bodies, which are shaped by their social and political economic realities. Then the subsequent chapters focus on the reproductive health experiences of married adolescent women in the slum.
Chapter Five

Worries, weakness & hungry bodies - adolescent women's experiences of chinta roge

Introduction

Roshonara, a married adolescent woman, explains: See, many young women have chinta roge from poverty and tension...and white discharge [dhatu bhangey - white white coming out] comes out and makes the body weak. If you cannot feed your body food, then discharge will come out, making you weaker and weaker...Apa [sister] it is from your heart that all your illnesses start. If you are worried, sad or unhappy then your body is affected...Other kinds of discharge can also happen for many reasons, it can happen because a woman is dirty, if a husband is unfaithful...but that is different kind of discharge...

People draw on many different aspects of their lives and environment to construct medical 'truths.' When confronted with a health problem individuals and groups make use of and combine social and cultural factors, local knowledge and the physical and psychological dimensions of their experience (Pearce, Tola Olu, 1995:150). In chapter three, I focused on the discourse of chinta roge as one of social distress, as a metaphor for economic, social and political deprivation for the urban poor. In this chapter, I focus specifically on married adolescent women's experiences of more gender-specific forms of chinta roge. While there are several constructions to understand white discharge, I focus specifically on the explanatory model of chinta roge, white discharge and weak bodies, because in everyday conversations these explanations were a recurring theme among women in making sense of this illness condition. Adolescent women perceive the miserable conditions in their lives to directly affect the internal state of their bodies.

There are, however, many explanatory models given by older and adolescent women in the slum for understanding causes of white/vaginal discharge [dhatu bhange/hshada srab]¹² three, with a juxtaposition of folk and biomedical explanations. These include: the

¹² Both are Bengali terms and translated into English as vaginal discharge - Dhatu bhangeh - 'white white coming out' and Shada srab - 'white syrup.' There are also many other local names to refer to discharge, such as meho and promeho [which signifies a more serious form of discharge than meho].
stresses of poverty, weakness, being a woman, heavy household work and long working hours; reproductive and sexual health; humoral causes as well as biomedical models of bacteria and germs in the polluted slums.

There are only a few community-based qualitative studies on white discharge in rural areas of Bangladesh. All of the studies provide insight into the cultural domain of reproductive health, but the explanation of vaginal discharge is taken to be biomedically significant, with symptoms seen through a biomedical lens, rather than anthropological. Whereas in this chapter, I demonstrate how married adolescent women’s meanings, interpretations and experiences of white discharge are embedded in lived experiences. Singer et al. (1988:374) pay attention to how illness behaviour is constructed and reconstructed in the ‘action arena both from people’s culturally constituted set of meanings [encoded and embodied in symptoms, illness categories and ethno-etiological beliefs]’ and from the wider macro economic and social forces that sculpt life experiences. While, ‘symptoms are grounded in social and cultural realities of individuals’ (Good and Good, 1981:166, Good, 1994), these realities are grounded in specific political economic and historical settings (Singer et al., 1988; Lock and Scheper-Hughes, 1996). I illustrate how the interpretation of white (vaginal) discharge and weak bodies is also associated with worries and hunger anxiety, as well as the vehicle through which economic deprivation and gender suffering is expressed. Young women spoke of constant worries aggravated by harsh poverty and their powerlessness and vulnerability because of their gender, which result in loss of white discharge from their bodies.

In the first part of the chapter, I discuss adolescent women’s embodied experiences of white discharge, which are influenced by extreme deprivation and suffering, similar to the experience of nerves and hunger anxiety in Northeast Brazil (Scheper-Hughes, 1992). Young women make references to poverty, scarcity of food and unequal gender and power relations, which leave them weak and can lead to a loss of ‘white, 

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However, in the urban slum, all of the adolescent and older women referred to it as either dhatu bhangey or shada srab.

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Figure 1. Understandings of Causes of Discharge Among Married Adolescent Women in Slum

- **Chinta Roge**
- **Poverty**
  - Tension
  - Sadness
- **Weakness in the Body**
  - Hunger
  - Tension
- **Loss of 'calcium'/Nutrients** – no food in body
- **Supernatural world**
  - Jinns/bhuts
  - Body open to spirit world

**White Discharge 'Dhatu Bhanga'**

- If persists and left untreated becomes 'bad or abnormal'

**If discharge persists**
- Person gets thinner and thinner and wastes away and can even die

- **Abnormal discharge**

- **Reproductive Complications**
  - Itching – ulcers
  - Uterus – boils, sores
  - Infertility, cancer in the uterus

- **Reproductive**
  - Infertility
  - Blood loss
  - Pregnancy
  - Abortions

- **Sexual Relations**
watery discharge,’ from the body, depleting it of its essential nutrients. The second part of the chapter focuses on the medicalization of white discharge. Government and NGO nutrition campaigns, which promote eating ‘good foods’ for strong and healthy bodies, are influencing folk models, and women now link loss of discharge to loss of nutrients from the body. Moreover, women’s weak and hungry bodies are medicalised into an illness state by healers and pharmacists, requiring treatment. Married adolescent women do not perceive the experience of white discharge as fatal or serious, but a large number complained that discharge leads to the eventual ‘wasting away,’ of the body. It is perceived that it can be fatal for the woman if the body is not replenished with fluids and appropriate tonics. Nichter speaks of the ‘commodification of health’ (1989), where people purchase health by ingesting vitamins, tonics and syrups, from allopathic and non-allopathic healers to make their bodies healthy. These medicines represent ‘an antidote for the ills of modernity’ (2001:104). In the urban slums, doctors and pharmacists market vitamins and herbal drinks for women suffering from weakness or discharge. The reality is that extremely poor women often will save up money to pay for tonics and drinks costing them Taka 45-90 [AUS $1.00 - 2.00], which is the cost of almost two days of food shopping in the slum, rather than buy food, which their bodies desperately crave.

**Literature on white discharge/vaginal discharge**

The existing literature in Bangladesh on white discharge is within the reproductive health framework, and explores health beliefs, examines women’s health seeking behaviours; and assesses social and cultural constraints to accessing care. The studies share data on women’s beliefs, practices, fears and concerns about white discharge, and explanatory models of body and illness within the reproductive and sexual health context (Ross, J.L et al, 2002; Mahbub and Ahmed, 1997, Gazi and Chowdhury, 1998). Ross et al (2002) use of free listing, pile sorting and severity ratings identified salient categories and perceptions of illness severity, particularly for reproductive tract infections and vaginal discharge. The study elicited data on illness groups with information on the different strategies and care sought. A study by Gazi and Chowdhury (1998) explored the perception of rural women on causes, transmission and prevention of reproductive tract infections and sexually transmitted infections (RTI/STIs) as well as treatment patterns (see also Mahbub and Ahmed, 1997). From a biomedical perspective, women’s complaints of white or vaginal discharge suggest the prevalence of
reproductive tract infections. However, as studies show there are problems with an approach that equates self-reported symptoms with the presence of a specific disease (Koenig et al, 1998; Hawkes, et al, 1999; Garg, 2000).

The literature on white discharge locally referred to as dhata (semen loss in the Ayurvedic medical system) has focused on meanings of semen loss of men as symbolic of powerlessness or sexual concerns (Nichter, 1981). Some studies have made links between complaints of vaginal discharge and mental health (Patel and Oomman, 1999; Chaturvedi et al, 1995). This medicalizes it by treating it as somatic idiom of depression, and obscuring asymmetrical power relations that are expressed in women’s articulations of this illness condition. Studies on white discharge in India outline a comprehensive ethno-medical model of women’s illnesses. A majority of the research has found strong perceived links between discharge and weakness in the body, between humoral causes and discharge, and physical labour and weak bodies. One study reported perceived links between less/poor food, anxiety and stress as causes of discharge and weakness (Pachauri, S and Gittelsohn, J, 1994).

Both biomedical and cultural meanings of symptoms of white discharge have relevance, but to focus on complaints as purely signs of social stress is problematic, and to emphasize only the biomedical interpretations of discharge is to ignore the important cultural and metaphorical meanings of the symptoms (Trollope-Kumar, 2001). Nichter (1981), Lambert (1998) and Trollope-Kumar (2001) draw attention to the anthropological literature on the complex cultural meanings surrounding genital secretions in South Asia.124 Symptoms such as ‘white discharge’ as ‘idioms of distress’ in India (Nichter, 1981) or ‘heart distress’, chest pains and palpitations in Iran (Good, 1977) demonstrate how culture shapes illness and emotional distress is expressed through the physical body (Trollope-Kumar, 2001). Nichter points out, that for people in structurally powerless circumstances, the body may be the only way for them to express distress and resistance. Nichter studies white discharge as a bodily idiom of distress among women in South India. He notes that women with very limited options to vent their frustrations and tensions can find indirect and culturally appropriate ways by presenting somatic complaints to health services, constituting one of the few opportunities for them to receive some form of guidance and support (1981). Trollope

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Kumar-Karen interprets white discharge and weakness as terms that incorporate mental, physical and sexual elements. She argues that white/vaginal discharge needs to be understood more broadly in its cultural setting, as a polysemic symptom, ‘which speaks to both emotional as well as physical concerns’ (2001; See Ramasubbhan and Rishyaringa, 2001). Nichter (1981) and Trollope-Kumar (1999) have shown, the complaint of discharge/weakness may be a way of ‘speaking through the body’ about a variety of psychosocial and even sexual concerns. Thus for a woman who is powerless, experiencing loss of discharge takes on a deeper significance and her explanations become a ‘way of communicating through the body a complex set of cultural messages’ (Trollope-Kumar, 2001:263).

As discussed earlier, I extend the analysis further. I illustrate how married adolescent women’s bodily experiences; understandings and responses to white discharge are not just linked to sexual or reproductive health concerns, but reveal broader concerns about sick bodies and the current political economy, where poverty and hunger are integral part of their existence. Furthermore, I show how biomedicine and treatment behaviour take different forms in varied social and cultural contexts (Scheper-Hughes, 1992; Lock and Gordon, 1988).

Experiences and understandings of white discharge

**Chinta roge, poverty and weak bodies**

Among the young women, there were ambiguous and contradictory responses, but there was an understanding that white discharge can also be caused by *chinta* [worries], poverty and weakness in the body. This was not necessarily problematic unless the adolescent woman felt extremely weak and believed otherwise. Most, however, viewed any discharge that persists too long, changes colour and becomes smelly as *abnormal* discharge, a serious health concern, as it is understood to cause reproductive health problems such as ulcers in the vagina and infertility. Strictly speaking, all models of

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125 See – Hull Vet al (1996), who found that women in their study in Indonesia were told by the health providers that stress – too many worries and fatigue were the most common causes of their white discharge. See Ramasubbhan and Rishyasinga (2001) who found that some women blame tension and overwork for their experiences of white discharge. See also - Dawson, M.T; Gifford, S and Amezquita, R (2000) in their study on Chilean women, found that many believe stress can weaken the immune system and leave women vulnerable to other illnesses in the body.
discharge, normal and abnormal are referred to locally as dhatu bhangah [white discharge]. In some cases, conditions overlap with biomedically-defined problems; in others they do not. When probed further, young women had separate cultural frameworks to understand chinta/poverty/weakness model of white discharge which only became problematic and abnormal, if discharge persisted and was left untreated.

Understandings of abnormal discharge are closer to the biomedical model and young women blame too many pregnancies, miscarriages, abortions, unhygienic practices, unfaithful partners, and so on, for various reproductive health problems, including infertility. The more specific experiences of this type of discharge, which affect the reproductive health experiences and practices of married adolescent women are discussed in the next chapter [refer to earlier diagram and table].

It is apparent from young women’s understandings that local notions and experiences of the body are at odd with rigid biomedical models of white discharge, which clearly
demarcate it as ‘reproductive health.’ As Thomas Ots points outs, the main difference in perception and labelling the experience of illness is in understanding the phenomenology of the lived body (1990). For married adolescent women in the urban slum, this illness condition has many levels of meaning, influenced by subjective experiences, and linked to the broader social, political and material realities of their lives.

When speaking of reproductive illnesses experienced in the last three months in the survey interview, out of the 106 responses given, 86 percent (n=91) young women complained of experiencing white discharge. Many of the adolescent women blame a number of factors, including excessive worrying and poverty for their experiences of white discharge [See table above]. As illustrated in the previous chapter, married adolescent women are powerless and often remain under the social and economic control of others, mainly males and family members, and live in an extremely patriarchal dominated and hierarchical society. Extreme destitution means that young women struggle under extremely difficult conditions. These harsh realities of life are a repetitive theme in the discussions of adolescent women’s experiences of illnesses, including white discharge.

Case study 1: Asma’s Story

While I collected a number of case studies of the experiences of white discharge, I will concentrate on one particular case here, which is typical in many respects and serves as a good example of how poverty, marginalization and strained relations impact on young women’s lives, and shape illness experiences. Below is a partial excerpt of a discussion that took place in Asma’s household, regarding her experience of white discharge and increasing weight loss. Asma was briefly introduced in chapter two. Her husband does not work and is a heroin addict and she is very dependent on the support of her natal family to manage. She has a baby girl who is only 3 months old and she is not in a position to work. Her husband often disappears for months, leaving her to cope alone.

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126 When asked if any of married adolescent women suffered from any health problems in the past three months, out of 105 young women, 44 complained of suffering from chinta roge, 22 claimed to be suffering from ‘sadness in their heart,’ and 20 spoke of losing weight and ‘wasting away.’ The rest of the young women complained of gastric ulcers, fevers, bodily aches and headaches and so on.

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Asma declares: I am weak because of my chintas. I am constantly worrying that my husband is getting into bad habits and going on the wrong path. He takes heroin and he does not like to work. Sometimes he just disappears from time to time and I don’t know where he has gone. After my father died my chinta has increased much more. Now I can’t eat food. I cannot even swallow my food because of chinta.

Asma’s mother interrupts to state: Asma is weak and her body is losing all the nutrients. She suffers so much.

Nasima states: When women have this problem, it comes outs like foam, little by little, white. But if too much comes out then it is bad for the body.

Sabina: What do you mean?

Nasima: ...Let me tell you about Asma. Asma was not like this before. Now she has chinta and she is becoming so weak. Asma does not eat less. If there is no food in her home, she eats in my home or my mother’s home. What is in her home? Unhappiness! He [her husband] does not work properly and he takes heroin. If she mentions anything about heroin he slaps and hits her on the face. If the husband runs the household for 10 days it is Asma who runs the household for the rest of the 20 days sewing bags on the machine. When she cannot eat or has no money to eat, she comes and eats at our mother’s home. What is she going to do, you tell us? Today her husband works and tomorrow he does not work. Then why won’t she have discharge and weakness? Her body is becoming khoi [wasting away inside]!

Sabina: Can you explain a bit more about what khoi means!

Asma’s mother says: One’s body has so many nice and good things. But from chinta (worry), the good things inside Asma’s body are all drying up inside of her. She does not eat less. But her insides are becoming khoi! She is having syrup loss [discharge].

Then Nasima replies: I have heard a lot of women say that they lose ‘syrup’ and they feel very weak when it happens...
To add to her sorrows, her father, whom she relied on for support, recently died of a heart attack, which was blamed on his excessive worries. After the eviction of the slum, the family lost their homes and they have had to relocate to a new place. The family is under severe financial constraints, and Asma feels extremely vulnerable. During the conversation, Asma’s sister Nasima [married adolescent] and her extended family blame Asma’s continual worries and the sad state of her married life for her illness condition and weak body:

Nasima responds [to my question on discharge]: The white syrup that women have coming out of their bodies is *dhatu bhanga* [white white coming out].

Sabina: Is there any other name for this?

Nasima states: This is called *shada srab* [white syrup]

Sabina: Why does this happen to women?

Nasima replies: I don’t know. But this happens to women if they don’t have *pushti* [nutrition] in their bodies. *Apa* [sister], listen in my home if there is lack of food and unhappiness then how can one have *pushti* [nutrition] and a healthy body? Then the mother responds, ‘from *chinta* [worry] white syrup comes out and from *chinta*, all sorts of illnesses get created in the body.

Sabina: What about you Asma? What do you think?

Asma (looks upset) remarks: I don’t know if *chinta* is an illness. I don’t have any of this! I have nothing to say! [She looks embarrassed].

Sabina: I didn’t say you have any of this. I just want to know what you think of white discharge and that why do you think it happens to women.

Asma [after some hesitation] replies: I only have *chinta* and now my body is becoming weak. All I know that I am getting weaker and I don’t look that nice any more!

Sabina: Why do you think your body is becoming weak?
After a few minutes, a neighbour informs them that the water has come into the piped taps and everyone rushes out of the room to collect water, except for Asma who remains sitting on the bed, breast-feeding her baby daughter. After they leave, she appears more eager to talk to me. She says:

Now my brother’s wife cooks for everyone but she does not keep rice for me! She refuses to cook rice for me. [Asma looks like she is close to tears]. No one gives anyone anything for free! Because my husband is bad and that is why I have to walk outside people’s doors. I have to hear people’s comments and criticisms! What will I do, tell me? If my father were around then I would not have so much suffering in my life. I have no strength left in my body anymore. Before I could go to my father. My father would say, ‘work and I will look after you. Don’t worry I will feed you.’

Sabina: You miss him a lot don’t you?

Asma states: No one in the family has given anything to my child since it was born. My power and strength has gone. When my father was alive he would work and he would look out for me.

Sabina: But what about your sisters? They want to look out for you and they care for you.

Asma responds: My sisters eat someone else’s rice [they are dependents on others]. Nasima’s husband is someone else’s son. How long will they look out for me for? How long will they feed me? One day they will say something, Nasima’s husband already makes comments and so does my sister-in-law. At meal times, Nasima’s husband has often said to me, “What are you doing in my room again? Go to your room.” My mother has no money, so how will she help me? My father always gave me everything. Now my father is gone and I am alone! My husband is good for nothing. Once my child is bit
The preceding account illustrates how social, cultural and political-economic realities are embodied and incorporated into explanations of vaginal discharge by adolescent women and their families. Kielmann suggests that the body is not merely a site of suffering 'but the space and medium through which one can articulate the experience of the self' (2002:2). The family focuses on Asma’s worries and miserable married life as explanations for her weight loss and white discharge. Private discussions with Asma reveal that strained intra-personal relations with husband and family and hunger anxiety are also blamed for her illness condition. Nasima claims that Asma does not have to go without food, but the reality is that Asma often remains in her room, avoiding the family at mealtimes because Nasima’s husband and her elder brother’s wife have made her feel unwelcome and made it clear they are tired of supporting her. There are incidents when extended family members have insulted her and she feels like she is a burden. The human body is not only an object but also part of a symbol system functioning both in the microcosm of self and in the macrocosm of social world (Schepker-Hughes and Lock, 1987).
Although Asma’s sister and mother do try to provide her with whatever support they can, she feels extremely vulnerable. She obliquely refers to this in the discussion, when she speaks of being unable to swallow her food, thereby highlighting her marginal status and powerlessness. She refers to her loss of well-being by speaking about food, ‘the substance from which health is derived and social relations constituted’ (Nichter, 1989:270). For many of the women in the slum it is believed that discharge is made up of blood as well as other essential nutrients of the body. For some, loss of discharge is conceived of as red blood, which has become pale and weak, an indication of the body’s lack of strength. Studies in rural Bangladesh have found men and women believe that the body needs to have sufficient amounts of blood to remain balanced and healthy and only certain foods can produce good rokto (blood) in the body. The healthy body is believed to maintain a balance between hot and cold, and eating the right kinds of food can help to keep the body healthy and strong (Aziz and Maloney, 1985). While adolescent women do speak of meat, eggs and milk as blood strengthening foods, very few are able to purchase these items. In reality most of the adolescent women in the slum are lucky if they are able to eat at all, and maintaining humoral balance in the body is a low priority as most of them are concerned with satisfying basic hunger. Young women are extremely malnourished, often surviving on water with rice and chillies or dry flat bread for days.

To make sense of their distressed conditions of life and their increasingly thin and emaciated bodies, Asma, like other married adolescent women in the slum speak of white discharge as ‘the loss of calcium’ and pushti [nutrition], the ‘body’s syrup’ [strength]. Discharge is viewed as the actual loss of nutrients/essence from the body, which leaves women weak and ill. I argue that such understandings are also influenced by nutrition campaigns, and this is discussed in greater detail later in this chapter.

For many young women in the slum, the family unit provides the basis for survival and a breakdown of support can trigger an enormous amount of stress on the individual. In her narrative, Asma communicates how her marginal position is being embodied and mirrored in her weak and worried body, which is losing essential discharge and becoming thinner and thinner.

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127 Some women refer to Shutika illness to explain their weak and thin bodies, with some perceiving Shutika and white discharge as the same illness, but with different names.
Asma is expressing the gradual degeneration of the integral body, which is as much social, structural as well as physical. Increasingly strained relations with her husband and other family members; recent events, such as the eviction from the slum, her father’s death, husband’s continuing heroin addiction, the pressures of looking after a young baby, and food insecurity are literally wearing her body down and depleting it of energy. She uses the term khoi, which was commonly used by adolescent women in the slum, to explain the ‘inner wasting away’ of the body. Similar to the South Indian women in Nichter’s study, so too in Asma’s case, the loss of discharge reaffirms what she already feels her ‘vitality and well-being slip away’ (1981:391). In a meaning-centred interpretive framework, loss of discharge is an ‘idiom of communication’ and the wasting of the body speaks metaphorically to a loss of one’s essential strength and power (Trollope-Kumar, 2001:264). Asma, like most other young women who speak of weak bodies and white discharge, is conscious of the social, personal and economic context, which has made her ill, and like the nerves sufferers of Brazil, is unable to ‘effect structural change or to alter’ her immediate circumstances (Rozemberg and Manderson, 1998:178).

Subjective experiences & differing understandings of white discharge

The circumstances of Asma’s life are broadly representative of the experiences of adolescent women living in the slum. However, for Asma and many of the married adolescent women in the slum, meanings of white discharge differ and change in response to the physical, emotional and social conditions of the sufferer. Below is an excerpt of the discussion between the three female health providers at the local clinic and a patient, which illustrate the complexities of the understandings of white discharge.

Sabina: Can poverty and chinta roge cause discharge in the body?

Rosie – health provider 1, states: Discharge cannot happen from chinta. Chinta roge can cause heart attacks and strokes and even blood pressure, but not white discharge. White discharge [dhatu bhangah] happens right before menses and after menses [menstruation]...and it is normal for women to have it [she looks at me questioningly]?

Sayeeda - health provider 2, looks very annoyed by Rosie’s answer, retorts angrily: Oh you know everything, do you? Wait till Apa [the paramedic who is their boss] comes and we can ask her. I know for a fact that chinta can also lead to white discharge.
Sabina [researcher]: Why do you say that?

Sayeeda – health provider 2, responds: When Shaheen my daughter was healthy and fat then she didn't have dhata bhangah [white discharge]. But now look at her, she is so thin now and she is getting thinner. She has lost her job in the garment factory and she has so many worries. She has chinta roge. I know that she worries a lot about money. There is no peace at home for her [they live with Sayeeda’s older sister and her family, who treat Sayeeda and her children very badly. There are constant arguments and fights in the household between the two sisters and the children]. Everyday Shaheen is getting weaker and more and more discharge is coming out. Now it comes out like water. So I know okay. So, don't you tell me [looking at Rosie] that discharge does not happen from chinta, okay! I know it does!

Sufia - health provider 3, interrupts to state: Maybe it can happen because of chinta roge...but what I have heard is that discharge happens because of lack of food in the body. Due to poverty one does not eat properly and then from the bones calcium leaves the body [everyone nods]. I know someone who had this experience...

A female patient standing nearby interrupts: I have white discharge time to time. One loses vitamins from the body if this comes out, and a person will not live very long if they lose all the strength and calcium from their bones...Apa [sister], a person because of worries and poverty loses their iron [strength] from their bones and their body. Under a lot of constraints I bought a land in my name in my father’s home. I have two ruined kidneys and I could die at any time. If I die, then my husband will marry again. If I had kept the land in my husband's name, then my daughters would not get anything and he wouldn't give them anything. I worry for their future. I am so weak now, look at me...I can't even stand from the weakness!

Two more patients and the paramedic enter the clinic, bringing an end to the discussion.

The above account on white discharge illustrates how shared knowledge of an illness condition is incorporated and shaped by subjective experiences, which affect the meaning and construction of the discharge experience, with meanings negotiated in specific social, political and economic contexts. Among the women, there was a lack of consensus as to the cause of Shaheen’s experiences of white discharge. This is because individuals construct their own explanatory model of risk factors to particular illness conditions, based on their lived experiences, which are dynamic and uncertain (See 163
Gifford, S, 1986). Sayeeda’s explanations of her daughter’s illness experience make references to the political economy, her daughter’s [and her own] powerless position, and inferior position within the extended family. Sayeeda is a widow who lives with her three children in her elder sister’s home. Her brother-in-law was a well-known leader of the slum. Sayeeda and her children are treated badly by her elder sister, who is suspicious of her husband’s affections for Sayeeda and is convinced they are having an affair. Sayeeda relies on her children’s monthly income to pay for rent and food and uses her salary as savings for the future. Her daughter’s income is used to pay for part of the rent every month. Shaheen lost her job because the garment factory she worked in shut down and she had not been paid for the past two months. She lost a lot of weight during this period and was suffering from white discharge. Sayeeda feared that she might be suffering from jaundice as well. During this period, Shaheen did not receive any care or special treatment from her aunt. Instead she was scolded and asked to quickly look for another job. Food was increasingly rationed at home. Sayeeda grumbled that her children were given stale rice, bones and gravy while her elder sister’s children were given larger, choicer and meatier portions. Sayeeda and her two daughters washed all the clothes, cooked and cleaned, while her elder sister’s daughters went to school and did no household work.

After the eviction in the slum, financial pressures increased because both of the families had moved into a flat nearby and the rent in the flat was Taka 4000 [AUS $100] per month, whereas previously they lived for free in their own home in the slum. Sayeeda’s elder sister was pressuring Sayeeda to increase her monetary contribution to the household. After Shaheen lost her job, she became morose and very thin, and began to spend most of her time away from the flat. When she was at home, she was very quiet and usually sat alone and ate separately in the kitchen. When I asked Shaheen the reason for her white discharge, she shrugged her shoulders and made no comment. For Sayeeda, the insecure political economy, unequal social and power relations in the household are seen as the root cause of her daughter’s suffering and illness conditions. For young women like Shaheen, who sell their labour for less than AUS $20 a month, socio-economic, political contradictions may take shape in ‘the “natural” contradictions of sick and afflicted bodies’ (Scheper-Hughes, 1992:186). In her explanations Sayeeda makes symbolic references to Shaheen’s [and her own] structurally and socially weak and trapped position as an outsider in the household and in the wider society. In the cases of Asma, the patient in the clinic and Shaheen, the construction of white
discharge/weakness are generated by a shared cultural framework with illness meanings emerging in situated discourse (Farmer, 1994).

**Gender, weakness & discharge: hungry and malnourished bodies**

The perceived relationship between *durbolata* [weakness] and discharge is so close that adolescent women in the slum use them interchangeably. A reason for this is that most young women in the slum are ashamed to use the term *dhata bhangah* [white discharge] openly, because of its multiple meanings, it can also imply that the young woman may be suffering from abnormal discharge or sexually transmitted illnesses. In addition, there is shame, guilt and stigma attached to this illness condition. Most women prefer to employ the term weakness to explain their condition. One pharmacist informed us how women were reluctant to openly use the term *dhata bhangah* [white discharge], because of its various sexual meanings: ‘Most women come to see me for weakness problem. Then I ask them, “Does your discharge come out?” The women have never come out and said that they have white discharge. They say, “I can’t work and I can’t sleep. I feel very weak!”’ In addition, weakness in the body is seen as both a cause and an effect of white discharge. This is similar to findings from other studies in Bangladesh and India (See Mahbub and Ahmed, 1997; Ross James L et al 2002; Bang and Bang, 1994; Patel et al, 1994). Yet there is no analysis of the phenomenon of weakness in the literature, with a few exceptions (Nichter, 1981; Trollope-Kumar, 2001; Ramasubbhan and Rishyasringa, 2001).

After much probing, some of the adolescent women admitted to experiencing white discharge. They blame its root cause on the pressures of poverty, stressful conditions of life, childbearing, miscarriages and malnutrition. Adolescent women referred to the ‘white, light, watery’ discharge as the loss of calcium/nutrients. Calcium/nutrients are understood to be crucial for body’s energy and any loss weakens the person. The perception that white discharge drains off body energy and leads to ‘weakness/thinness’ can be attributed to the beliefs in the Ayurvedic medical system. It is believed that *dhatu* [discharge] is an essential body humours are associated with vitality,

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128 In many cases, young women believe forced and regular sex can lead to discharge and they may feel ashamed to openly share their condition.
129 This is discussed in detail in the next chapter.
130 Obeyesekere gave the example of anorexic women who ‘may attribute their state to semen loss’ [loss of vaginal discharge] (1976:423 cited in Edwards, JW, 1983).
the regulation of body processes, the control of heat, strength and a positive source of health. Women as well as men are believed to have semen (Nichter, 1981). According to Ayurvedic ethnophysiology, the body is perceived to be in state of ‘ceaseless flux within the natural and supernatural environment.’ The body’s boundaries are permeable and a body in flux that loses too much semen can become sick (Trollope-Kumar, 2001:262).

Most of the adolescent women view long-term loss of discharge as damaging for their health and some of them perceive it as the loss of blood from the body. One health provider explained, ‘One drop of dhatu is equal to three drops of your blood. If one loses too much, then the body becomes very weak.’ These understandings are influenced from the Ayurvedic and Hindu belief system, which states that ‘one drop of semen is equivalent to one cupful of blood’ (Bang and Bang, 1994: 84), and ‘any loss connotes loss of power, control and productive power’ and strength (Nichter, 1981:390, 1989). These ideas shape understandings in South Asia and the way in which men and women view their bodies and self (Kakar, S, 1982).

As explained earlier, the general literature on understandings of discharge and weakness have focused primarily within the biomedical health framework and on sexual elements to understand the meanings of white discharge, with a few exceptions (See Nichter, 1981; Trollope-Kumar, 2001; Ramasubbhan and Rishyasringa, 2001). In the case of married adolescent women in the Dhaka slum, I argue that although the underlying model of white discharge/weak bodies is based on the Ayurvedic system, it is not solely associated with sexual and reproductive health. If one were to critically examine past the biomedical framework, it is apparent that young women’s interpretations of white discharge/weak bodies can be understood as a way of expressing distress over poverty and the manifestation of hunger in their bodies. Similarly, Scheper-Hughes (1992) shows how in the poverty-stricken shantytowns of Brazil, nervos can gloss both physical symptoms of hunger and anxiety. An adolescent woman, Shohagi explained:

White discharge is the kind of illness that makes a standing person sit down [makes a healthy person unwell]. If the body is empty and without food then won’t discharge happen? How will my body stay okay? If I can’t eat one meal then I can’t afford to eat the

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131 Slightly different versions are reported in other studies, depending on the region in South Asia.
second meal so how will my body stay okay? Slowly the body becomes weak and thinner.

Shohagi speaks of hunger anxiety as well as indirectly refers to the ‘structural weaknesses’ of the social, economic and moral order (Scheper-Hughes, 1992:195). A large number of the married adolescent women also complained of experiencing the following symptoms, loss of energy, nausea, giddiness, burning sensation in the hands, feet and body, fever, dizziness, aches and joint pains, backaches, loss of appetite, weakness of eyes and diminished vision. This makes it difficult for many to complete their household tasks quickly, which are physically demanding and exhausting. These include, cleaning the home, standing in a queue to collect water everyday in large heavy pots from public taps; going to the market, cooking in the hot sun and washing clothes and utensils, as well as looking after children. Some young women lamented of ‘wanting to sleep and never waking up again.’ Many of them said that they felt tired all the time, and shared feeling of helplessness and powerlessness. Nichter found that in South India when women suffering from discharge spoke of ‘dizziness,’ they were symbolically speaking of the loss of balance both physically and psychosocially (1981a). Other research has found that women speak in symbolic language to refer to ‘weakness’ when speaking of discharge (Bang and Bang, 1994), and refer to range of mental and emotional meanings. While this is true, the experience of discharge/weakness is more than just symbolic for young women in Bangladesh. It is physiologically experienced for poor married adolescent women in the slum who are extremely malnourished and often forced to live on meagre, irregular meals, frequently going without food for days, relying on scraps and managing on stale rice, water and chillies. Remaining hungry and weak is an inexorable part of their lives. One particular story below highlights poignantly the effects of food deprivation on individuals. Roshonara said:

132 See also Oomman’s study, she found that women blame poverty and the lack of foods and nutritious foods in their bodies for their weakness (1996).
133 See for similar findings, Ramasubban and Rishyasringa, (2001).
134 Bangladesh suffers from one of highest malnutrition rates in the world. The impact of deprivation is evident in the findings of the Bangladesh National Nutrition Survey, which reveals high levels of both stunting and thinness among poor adolescent girls aged 10-17 years (UNICEF report, 1999). Thinness was found to affect a quarter or poor urban girls and more than a third of rural girls and eighty two percent of urban ten-year old girls were found to be thin. Adolescent women were found to suffer from deficiencies in iron, vitamin A and iodine. An anemia survey carried out included a sample of 200 poor adolescent girls aged 11-16 years, found up to 43 percent of them to be anemic, with 12 percent suffering from vitamin A deficiency (UNICEF Report, 1999).
The landlady fed my sister rice, but I saw a rat came out of that rice before it was cooked! She saw it too. Who would tolerate and let their sister eat that rice? I am telling my sister don’t eat that rice, she is giving you free rice out of which rats lived in. What does my sister do? She ignores me and gobbles the food down her throat.

Unpredictability and a feeling of limited control mark the day-to-day lives of married adolescent women. When young women speak of their experiences of white discharge/weakness, it is within the context of a difficult political economy, disparate gender, class and power relations, and injustices in the household and in the wider society. The strain and suffering young women experience in trying to fulfil their role expectations beyond their years is wearing their bodies down, making them weak and tired. Married adolescent women in this way weave into their illness perceptions the experiential side of the oppression of everyday life (Good, 1977).

**Incorporation of biomedical understandings into folk models**

**Medicalization of white discharge & weak bodies: nutrition campaigns**

Paul Farmer asks, ‘how do illness representations and the realities they organize and constitute come into being…? How are nascent models related to the history and conditions of the people who endure the suffering and elaborate the models?’ (1994:806). The shift in reinterpreting white discharge as semen loss to it being a loss of calcium or *pushti* [nutrients] can be attributed to the synergy of Ayurvedic understandings of white discharge; chronic poverty and hunger in the lives of the women and the promotion of nutrition and health campaigns by the government and NGOs. The nutrition messages have in turn led to the proliferation of vitamins/tonics in the health sector, further sustaining the local discourse of body and illness.

In the past few decades, the media, development agencies and the government via billboards, messages on the radio/television and health workers speak of poor diet as the main reason for various illnesses. The overwhelming message is that *pushti* [nutrition]

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135 Common understanding in the Ayurvedic medical system.
is necessary for healthy bodies and bones [calcium]. The poor are constantly urged to increase their strength and health and avoid illnesses by eating nutritious foods, such as, spinach, meat, milk and eggs, which they can rarely afford. The common treatment prescribed is to eat rich foods, which further de-socializes the nature of the problem (see Scheper-Hughes, 1992). These institutions that promote the nutrition messages overlook the political-economic reality of poor people's lives, preferring to blame poor diet and ignorance, rather than the glaring disparities and asymmetrical power relations, which is the root cause of the problem. In response to this, are young women then covertly transforming hunger anxiety into an illness condition and thereby indirectly expressing 'disallowed feelings and sensations' through the idiom of white discharge/weak bodies? (Scheper-Hughes, 1992:195)

Marketing of tonics and herbal drinks as treatment

Sabina: When a woman suffers from white discharge do they need to take treatment?

Nasima replies: No, you can just drink cooling drinks at home...[she looks at the other young women]

Nasima’s sister-in-law, Lisa interrupts: One can buy special tonics from the healer and pharmacy that replenishes the body of the loss of fluids, from loss of calcium. But it costs money to buy the tonics. Not everyone can afford to buy tonics...but the pharmacy doctor said that one should take these syrups to reenergize the body, otherwise the body is losing and losing vitamins and the woman becomes very weak...

Nichter and Vuckovic (1994:1510) maintain it is important to analyse the link between the political economic conditions of life, healing systems and consumer demands. In addition, social transformations change the needs of a population, resulting in shifts in the type of therapies accessed, and the emergence of 'new forms of medicines.' They suggest an investigation into pharmaceutical behaviour in relation to its ability to negotiate 'between coexisting health ideologies as well as shifts in lifestyle, work and

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136 A study done by the author in rural village of Tangail in 1998, found health workers regularly promote eggs and milk as foods to eat to maintain one's health and to avoid weakness from contraceptive use. Many complained that these expectations were unrealistic, as they could not possibly afford such food on a regular basis (Rashid, SF, 1998).
consumption behaviour. The impact of aggressive nutrition campaigns in poverty-stricken areas has played a role in influencing understandings of white discharge and weakness among poor women in the slum. Weakness has physical, social and moral dimensions, ‘in need of medications and doctoring’ (Schepert-Hughes, 1992:174). Local healers, pharmacists, and doctors/chemists in response to these cultural concerns market new forms of therapy to influence treatment options. Married adolescent women are advised to drink cooling liquids and to purchase tonics and vitamin syrups to treat white discharge and or weak bodies. Healers, pharmacists, street vendors and unqualified doctors/chemists, are basically ‘de facto medical practitioners,’ and serve as health care alternatives for the population (Logan, K, 1983:69). They actively encourage the link between white discharge, weakness and nutrition/vitamin loss and the use of tonics, and thus sustain local discourses about the self, body, illness and health, causes, meanings of sickness, vulnerability and need (Nichter and Vuckovic, 1994).

A popular street vendor, Montoo Mia, [48 years old, male] explained, ‘If white discharge happens then the body loses vitamins and to stop this women need to drink my special medicine – Shalsha syrup to restore energy in the body. One phial [bottle] costs Taka 90 [AUS $2.10].’ A healer who is known for selling herbal shokti [strengthening] pills said, ‘If white discharge happens then it is the khoi roge [wasting away illness] and the body loses all its strength. It can be fatal if the women don’t drink cooling drinks and take vitamins... appropriate treatment needs to be sought.’ The new forms of medicines promoted by local healers highlight how indigenous medical systems are dynamic and adapt in local and social contexts to the needs of their clients (Singer, Merrill et al, 1988). Despite advocating the use of particular products by the de facto medical professionals, some of the married adolescent women did not purchase tonics, and some accessed homeopathy and other medicines instead, with a few opting for cheaper therapies, such as drinking starchy water and lemon juice at home. If white discharge persisted with other symptoms, including those of weakness, or if young women experienced severe ‘weakness, dizziness,’ they did not hesitate to buy tonics and syrups. Most of the women purchased their bottles of herbal tonics from the pharmacy

137 See also – (Van Der Geest S and Whyte SR, 1989).
138 Chemists are often addressed as doctors by the poor.
139 Nichter (1989:287) also found in his study in South India, that 15percent of all medicines sold for women were tonics associated with weakness with an additional 5percent of medicines sold for leucorrhoea associated with weakness.
and in a few cases from [unqualified] doctors and local healers. Time spent in the field with young women [from the surveys, in-depth interviews, case studies and observations] revealed that 23 of them had purchased tonics to alleviate experiences of white discharge and/or for weakness in the body. The young women spent Taka 45-80 per bottle [AUS $1.00 - 2.00], equivalent to almost two days of food for the household. In two cases, young women who needed immediate curative results bought intravenous saline drips, administered by pharmacists and even doctors [unqualified] to replenish their bodies with energy [nutrition], hoping it would maintain their health. The use of saline offers a quick option to compensate for extremely poor diets.

As discussed in the chapter two, in Dhaka City, pharmacies are run by unqualified men, who have no formal training and are often consulted by the local population for diagnosis and advice on treatment (Rahman S et al, 1999). Poorly educated and insufficiently trained, a few of the pharmacists appear to believe in the 'potency' of the tonics and syrup products promoted by the pharmaceutical companies to treat 'women's health' problems. It was well known in Phulbari slum, that many of the pharmacists recommend particular brands of tonics for treating discharge/weakness, but knowledge from other women in the slum also guide the decisions of the young women, with 'health ideologies reproduced through the act of taking medicine' (Nichter and Vuckovic, 1994:1509). A pharmacist gave the analogy of land and fertilizers to explain the need for tonics to replenish the body:

Those people in the slum have no end to their suffering. From this suffering and poverty comes worry illness and from the worries the body starts breaking down. The body is like land, if you need to reap crops then you need to fertilize it and sow seeds. You have to take care of the land otherwise you will not get any rewards [or good health]. You need to give your body shar

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140 Nichter (1989:271) argues that the appeal of medicine is not simply caused by heavy promotional activities of these companies, but also influenced by larger phenomenon of other quick fixes, such as alcohol, movies, romance magazines and television.

141 The number could be higher because this information came out later on in the surveys, in-depths and case studies.

142 Nichter and Vuckovic (1994) suggest that there needs to be a documentation of the profit margins and chain of incentives offered by pharmaceutical companies to 'stockists' and by 'stockists' to wholesalers and by wholesalers to retail pharmacists. Also in need of documentation is the role played by pharmaceutical representatives in educating practitioners about new medicines and emerging diseases.
[fertilizer] and then you can get something in return like good health. There is so much poverty in our country and that is why women's discharge comes out…

In fact often when treating cases of abnormal discharge, pharmacists sell tonics and vitamin syrups as health supplements along with the required antibiotics. In the selling of tonic/vitamin syrups, pharmaceutical companies underscore the cultural concerns and social insecurities of the local population and market particular products which address these symptoms, concerns and associated cultural meanings (Nichter, 1989). Similar to India, in Bangladesh, advertisements abound for food supplements, nutritious drinks, tonics and purifiers which are linked to a world determined by extreme poverty, increased competition and an unpredictable worsening environment (Nichter and Vuckovic, 1994).

\[143\]

\[\text{In discussions, the paramedic at the slum clinic and two of the employed pharmacists admitted that they are often overwhelmed and felt powerless by the chronic poverty in the lives of the women and offering tonics/vitamins is their response to their patient's difficult life circumstances.}\]
### Table 5. Tonics Sold as Treatment for Discharge/Weakness

<table>
<thead>
<tr>
<th>1. CINKARA [foreign product] - herbal formula sold in pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Label reads - for vigour, vitality and freshness – (nervous debility, general weakness, weakness of stomach and liver, anaemia fatigue, vitamin A and C deficiency states) – HAMDARD Lab, Pakistan, Taka 60-80 [AUS $1.50-2.00] – sold as cure for weakness and discharge</td>
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<table>
<thead>
<tr>
<th>2. SENA VIT – [local pharmaceutical company] – sold in pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Label reads - tonic for vital organs and appetizer (cardiac weakness, mental and general weakness, anaemia, anorexia, hepatic debility, vitamin A and C states) – Seena Lab, Bangladesh - Taka 80-90 [AUS $2 - 2.25] – sold as cure for weakness and discharge</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Glucose Salines – Intravenous drips – sold in pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs vary from Taka 250 to 400 [AUS $6.25-10] – sold to cure weakness in the body</td>
</tr>
</tbody>
</table>


| 5. Traditional healers – sell Shokti ‘strength’ tablets – Taka 20 [AUS $ 0.50] -- to cure weakness/discharge |

Pharmaceuticals in Bangladesh come from three main sources: from domestic manufacturers, from approved imports and from illegal imports. There are about 200 registered pharmaceutical manufacturers in Bangladesh, but only 50 are active and ten dominate the market [70 percent of the combined market share] (World Bank, 2000).

A majority of the misleading advertisements which appear in the newspapers and periodicals are placed by the manufacturers of Ayurvedic and Unani medicines, claiming 100 percent success in curing a wide range of illnesses from sexual problems, to weakness, cancer, mental illnesses and white discharge and so on. As the advertisements do not mention any names of drugs, the advertiser cannot be prosecuted under the Drug [Control] Ordinance 1982. Due to loopholes in the law, it is difficult to

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144 Each has to obtain a license, renewable every two years. Government laboratories produce infusions and some vaccines. Import licenses are issued for pharmaceuticals on WHO Essential drug list that are not produced in Bangladesh and the Drug Control Committee may approve of others if it is convinced of their efficacy (World Bank, 2000).
prosecute these companies. In 1993, there were 76 cases pending in the drug court against 17 traditional medicine manufacturers for illegal adverts. Punishment is imprisonment of up to five years or a fine of up to Taka 100,000. Often drug officials supplement their low income by taking bribes from these smaller companies which manufacture substandard drugs, allowing them to continue their false promotion and production of deceptive drugs (Chowdhury, Z, 1996:108; 115).

The variety of tonics and syrups sold in the pharmacies claim to remedy conditions of 'nervous debility, general weakness, weakness of stomach and liver, anaemia fatigue, vitamin A and C deficiency states' of individuals [see table above]. The medicinal contents of such tonics do not match what they purport to offer. Despite this, in Bangladesh, like India, herbal and Ayurvedic supplements are perceived as improving one's health and negating the effects of harsh foreign medicines, poor diets, and illness conditions as well as the deteriorating situation of 'defective' modernization (Nichter, 1989a; 2001:102). Drug advertising are influenced by 'hybridity' that is, these tonics claim to be Ayurvedic, while retaining an English name. This represents modernity and quality, and being Ayurvedic implies it is traditional and therefore humorally compatible with the body, with no fear of side effects. Thus 'ancient solutions to modern problems are available at a cost.'145 Van der Geest and his collaborators suggest that the secret of medicines and their attributed power is in their concreteness. Medicines are tangible and 'practicing medicines...is the art of making disease concrete' (Van der Geest, Whyte and Hardon, 1996:154).

Reliance on falsely advertised medicines to treat conditions, which are constant among poor married adolescent women, means a cycle of 'disease-treatment-disease' and profits for quasi-professional medical practitioners and especially for the pharmaceutical industry (Nichter, 1989a: 285; 292; Nichter and Vuckovic, 1994:1512). The danger lies in that the treatment of discharge/weak bodies with tonics/syrups and vitamins leads to the medicalization of married adolescent women's suffering and hunger anxiety. Attention is diverted from the complexity of their experiences and the factors involved in the maintenance of this illness disorder. The focus on the individual tends to 'de-socialize sickness and displaces its historical, political and economic

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145 In South India, the local population viewed English medicine as powerful but dangerous if used long term, whereas Ayurvedic medicines effects on the body was seen as neutral; although individual medicines within each system had heating and cooling properties (Nichter, 1989:196).
determinants’ (Young, 1982:268). Scheper-Hughes points out a hungry body exists as a powerful critique of society, whereas a sick body implicates no one, it is a ‘neutral social role’ (1992:174). Just as in Espanto Brazil, where nerve pills/injections are bought to relieve social and economic distress, so to in the slums of Dhaka, young women buy tonics and syrups to purchase their health, in the hope of reclaiming their vitality and energy. Public health is transformed into an issue of ‘health consumption’ where the ‘only way of being healthy is consuming health.’ This means ‘consuming medicines, consultations, examinations and a wide range of other merchandise that symbolize health’ (Rozenberg and Manderson, 1998:177). Medicines can also serve the function of controlling and subduing the will of the population to ‘produce docile bodies by taking the hard edge off hunger’ (Talcott Parsons (1972) in Scheper-Hughes, 1992). The local population silently accepts capitalist ideology through their appropriation of ‘commodified health,’ the ideology being ingested with the medicines [tonics] that embody it (Nichter, 1989a).

Poor families struggle and compete with one another over scarce resources, and the buying of tonics instead of food is cruel irony. However we must not be so quick to overlook the psychosocial importance and meanings the purchase of tonics, syrups and salines have for poor married adolescent women in the slum. The medicines provide the only temporary solution in the context of extreme scarcity in their lives and their inability to change their material and structural conditions. Unlike the meagre quantities of food that young women are forced to ration and share with others, bottles of tonics and saline drips don’t need to be shared with anyone else. If one buys a glucose saline drip or two bottles of Cinkara syrup, they can afford to indulge in, without fear of retribution or guilt. Furthermore, the buying of tonics/syrups serves as ‘nonverbal markers of life problems’ for young women (Nichter and Vuckovic, 1994:1516). The complaint of weakness allows for a legitimate complaint to symptomatic relief and tonics may even be seen as empowering in that they offer users a means of short term control (Whyte SR, et al, 2002) and allows them to register their discontent (Scheper-Hughes, 1992). Young women are aware that tonics ultimately will not take away the root cause of their problems: ‘when I drink this [tonic] I feel better, but my worries will not go away. There is no cure for that. Those who worry [chinta] can never be well and healthy.’ Oths writes, an ultimate cure for distress remains as ‘illusive as social justice and the amelioration of centuries-long oppression by the powers that be’ (1999:308). In some ways, accessing tonics and syrups by married adolescent women are an effort to
cope with the oppression, 'the hidden and overt injuries' of class and other forms of social inequality. The use of such tonics may 'function as a form of self medication for the psychosocial injuries of oppression' (Baer, Singer and Susser, 1997).

**Conclusion**

A harsh political economy, rapid social transformations, persistent poverty in the slum and the cultural construction of illness converge in the meanings, interpretation and treatment of white discharge and weak bodies. In the case studies of Asma and Shaheen, we see the contextualization of the experience of general deprivation, insecurity and deteriorating social relations as embodied in the individual, social and body politic (Scheper-Hughes and Lock, 1987). The general literature on white discharge in South Asia associates it primarily within the biomedical framework of reproductive health, except for the work of Nichter (1981) and Trollope-Kumar (2001). Nichter found that loss of discharge was often brought up in the context of social vulnerability and powerlessness (1981). In the slum, married adolescent women's narratives of white discharge speak of political, social and economic marginalization, of gender pressures and unequal power relations, and poverty and hunger distress. In the discussions, married adolescent women present themselves as powerless and vulnerable, coping in difficult circumstances, which manifest in illness conditions in the body, making them more fragile in health. Their courage, however, in surviving strenuous conditions contradicts their self-description as weak.

The social, political-economic environment determines cultural understandings of illness conditions. Farmer suggests that to understand illness representations, requires a moving back and forth between individual and collective experience, between macro and micro, ‘between shifting narrative structures and enduring frameworks that, while subject to change, nonetheless serve as grid’ helping to support the illness experience (1994). Interpretations of the chinta/poverty/weak bodies model of white discharge incorporate distress about economic deprivation, gender suffering and actual hunger, thus reflecting the reality of the lives of young women in the slum. It is important to point out that the worsening conditions of life, the nutrition campaigns in the past few decades and local marketing of vitamins and tonics have influenced this new emerging model of white discharge. Nichter suggests that when one investigates a particular idiom of distress/expression as well as the emergence of new ‘forms of medicines,’ it is
necessary to locate it historically, with respect to changing social conditions (1981, Nichter and Vuckovic, 1994:1510). The Ayurvedic model speaks of loss of discharge as 'semen loss,' and the new model of discharge has incorporated nutrition/calcium, food and hunger into its meaning structures. Like the shantytown dwellers of Brazil described by Scheper-Hughes, married adolescent women in Dhaka city are poorer, more hungry and feel weak (1992), overwhelmed by the pressures of life, this they articulate in the form of white discharge/weak bodies.

Health culture is evolving constantly and interactions between local and global source of knowledge, the political economy and medicine impact on the lives of the poor. The use of vitamin tablets and tonics by adolescent women for white discharge represent an local-global interface, where local pharmacies, vendors, medicine-sellers and healers use local forms of knowledge about the body and illness and reproduce it through the global voice of medical authority (Boonmongkon, P et al, 2002). It is important to point out that pharmacists and local practitioners are not simply 'agents peddling products of dependency' but this commercialisation takes place by responding to playing upon existing 'deep-seated cultural concepts and practices' and social insecurities (Nichter, 1989a: 271). The local quasi-health professionals are in a position to reproduce an aura of authority associated with commercial medicinal products (Boonmongkon P, et al, 2002). Local pharmaceutical companies encourage this deception and market the association between white discharge, weakness and tonics and salines. Boonmongkon and her collaborators (2002), point out that the success of various medicines is as much about marketing as it is about cultural perceptions of what they can do. Thus pharmaceutical companies actively produce tonics, with local pharmacists promoting and selling these syrups, intentionally and unintentionally misleading women into thinking it will improve their energy, well-being and health. The availability of tonics and syrups have both medicalised and provided poor young women the short term relief from the miserable conditions of life, while never quite alleviating the real causes of their misery. However, married adolescent women are fully aware that this relief is only transient. While medicalization can be harmful as it obscures the power relation and inequalities (Scheper-Hughes, 1992), some young women use medicalization to legitimise their suffering, although they admit that the effects are temporary, and they remain tired, weak and hungry.
As discussed earlier, women perceive excessive white discharge from *chinta* [worrying] and tension, if left untreated, can lead to a range of reproductive complications, such as abnormal 'smelly' discharge to ulcers in the uterus, and more serious problems, such as pelvic inflammations and prolapse and even infertility. In the next chapter, I shift my focus to specific reproductive illness experiences and I demonstrate how structural and social inequalities contribute to risky reproductive health experiences for young women in the slum.
Chapter Six

Reproductive and sexual negotiations: constructing a 'political economy of the body'

Introduction

Naila, 16 years old, said: 'I didn’t realize married life would be like this. Life was carefree before and I had less tension. Now I have a child and not enough money to eat...he wanted the baby, but I was too young and not ready and scared. Now I remain tired and feel weak all the time after having the baby. My body feels feverish...but my husband comes home and wants to have his fun [sex] with me, and how many times can I say no? If I deny him, won’t he go elsewhere to satisfy himself? Sometimes I suffer from discharge, which is itchy and smelly...I think it is because of the sex...I know he notices other women...we end up fighting a lot because he is always roaming about ...Apa [sister] men are dogs! I don’t trust men. In front of their wives they behave nicely and suck up to them but behind their backs they shit all over them.

For many young women in the slum, it is evident that it is not just culture, but structural factors, the political economy, gender and class inequalities, which impact on power relations and shape behaviour, risks and experiences of reproductive illnesses (Ginsburg and Rapp, 1995; Farmer et al, 1996; Parker, 2001). In this chapter, I discuss how married adolescent women find it difficult to negotiate their reproductive and sexual bodies. I discuss their experiences of a range of reproductive illnesses such as abnormal discharge, weakness, pelvic inflammation, and uterine prolapse, which they blame on factors outside their control, such as being subjected to frequent and forced sex, family planning use, and too many pregnancies and miscarriages.

In their negotiations, poor married adolescent women construct a 'political economy of the body' and pragmatically acquiesce with decisions made by others, even though they may violate their sense of bodily integrity and well-being (Petechsky, 2001:285-287). Brutal poverty and powerlessness means that many are forced to be practical, often putting their health at risk, but it gains them advantages and limited power within their social situation.
This chapter illustrates young women’s traumatic experiences of forced and risky sex after marriage and coping with discomfort, itching and ‘severe discharge’ problems as a consequence. Young women speak of men as a resource, someone they need to hold on to in the unpredictable, crime-ridden and poverty-stricken environment. Married adolescent women have limited support, and are willing to tolerate their husbands’ behaviour. They share fears of losing their desirability as they get older and worry about their husband’s fidelity. They speak of the effects of childbearing, too many pregnancies, and miscarriages, which leave their bodies ugly and their vaginas ‘loose’ and unattractive.

Since the seventies, the State has been actively promoting family planning in both rural and urban areas of the country and poor women are rigorously targeted in the interventions. While many married adolescent women do want to regulate their fertility, they speak of experiencing severe side effects after family planning use. Often they do not receive counselling or support from the health workers and the clinic. Many of the women remain anxious that long-term family planning use may lead to infertility. This is the primary reproductive health concern of all the young women interviewed in the slum, and I discuss infertility understandings in detail in the next chapter.

Cultural and social expectations mean that young women are expected to bear a child soon after marriage. Young women complain that as a consequence, many of them are left with blood loss, and are weak and tired. In addition, young women cope with emotional and physical abuse. Young women spoke of the harsh urban environment, high unemployment and substance abuse, which lead to regular incidents of domestic violence in the household. Four women confessed to miscarrying after a particularly violent episode with their spouses.

The government and NGOs promote maternal health interventions. However, government hospital care is costly and often extremely inadequate. Young women turn to cheaper alternatives for delivery care, such as local traditional birth attendants [TBAs] and nearby pharmacies for complications. Young women are encouraged to visit local clinics for antenatal check-ups. Observations found young women spending money on ultra-sonogram procedures, which are promoted by both private and local NGO clinics, which poor women often do not need, cannot afford and do not understand. While many adolescent women access antenatal care, ultimately, in most
cases, my survey shows that delivery took place at home and not in the hospital. Poverty, cultural norms and expectations, high costs required for maternity care at hospitals, and lack of decision-making role of young women were some of the main factors for the home births.

Young women remain extremely concerned that the consequences of early and frequent childbearing will lead to reproductive complications, such as pelvic infections and uterine prolapse. Although all reproductive illnesses are viewed as a social stigma, young women are particularly reluctant to admit they suffer from infections or prolapse. The three cases I uncovered after 14 months of fieldwork highlight the sensitive nature of these health problems. Therefore, young women who suffer from these illnesses tend to remain quiet, but two of them spoke of experiencing extremely painful sex with their husbands. Many worry that if they are unable to have sex they will be viewed as failures, unable to fulfil their wifely duties. Rumours abound in the slum of men leaving their wives because of these conditions, with the women blamed.

Finally, this chapter will show the interaction of a range of factors, structural, social, and economic, which critically affects young women’s responses to reproductive illnesses. Deprivation, insecurity, worries about food and meeting other basic needs, usually overrides ‘reproductive health’ concerns. While young women may worry about their reproductive health illnesses, this loses priority in the face of coping with oppressive burdens of poverty facing urban poor women and their families.

**Desires, discomfort & abnormal white discharge**

‘He wants sex all the time and I cannot say no!’

For married adolescent women, poverty, unfavourable power and gender relations, social and cultural pressures make them vulnerable to risky reproductive health experiences. In their discussions, they associate the onset of abnormal discharge and other gynaecological problems to early marriage, becoming sexually active at a young age and having sex frequently with demanding husbands, who refuse to back down.\(^{146}\)

\(^{146}\) ME Khan et al (2002) also found that forced sex is relatively common phenomenon within married life. Out of their 54 informants, 32 reported experiencing forced sex on a regular basis.
Discussions with young women reveal that forced sex is a common occurrence within married life. Rosina, 14 years old, had a love marriage. We became quite close to her during our fieldwork. She confided that her husband would often get high on drugs and come home and demand rough sex, which was uncomfortable and painful and resulted in her suffering from episodes of severe abnormal discharge. She said:

The days he is high on drugs, which is often... he wants to have sex with me and I have a lot of difficulties then. Then I don't feel good at all. He does not listen to me at all and even if I say no he just does not listen. My body aches after the sex. He is very forceful and does not want to take no for an answer. He just grabs me and pushes me down. I don't scream out of shame. My mother-in-law sleeps next door to us. If I tell him later on why did you this to me, he hugs me and holds me close and says, 'Look I won't ever do this again to you,' but then again when he is high on drugs he does it again. After one really bad incident, I was in pain, and he warmed up water and brought it for me to wash myself. I had discharge as well later and it was smelly and sticky. I put powder there to get rid of the smell... sometimes it gets so itchy and I scratch it like crazy and the skin comes off.

The 'extremely smelly, whitish/yellowish or brownish and sometimes reddish in colour, thick, heavy and sticky fluid' is labelled as abnormal discharge. Married adolescent women perceive abnormal discharge as extremely worrying and accompanying conditions of vaginal itching brings about boils and sores in the genital region, which they believe will eventually cause cancer in the uterus. As one young girl explained, 'when it itches and it is smelly, we cannot help ourselves and end up scratching and scratching sometimes taking the skin off. All that scratching causes boils in the area [vagina] from which more boils happen, which I have heard leads to cancer in the jorayu [uterus]!' While many of them did not mention a direct link between abnormal discharge and infertility, they remain anxious about the consequences of ulcers and tumours in their uterus.

While frequent sex was seen as major cause of abnormal discharge, adolescent women were reluctant to reject their husband’s advances, fearing that they would go elsewhere to meet their needs. This highlights the role of gender and sexuality structures in

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147 This is documented elsewhere in the literature women are caught in the dilemma of trying to please their husbands and meet their sexual needs against their own wishes (See also Stark, Norris, 1993; Khan ME et al, 2002).
promoting the vulnerability of young women. Social and cultural expectations are such that women are expected to be sexually available and compliant for their partners. When some of the young women complained to their mothers and aunts about their predicament, they were admonished and told to bear the pain and ‘everything would get better with time.’ However, a few young women continued to reject the sexual advances of their husbands despite earning regular beatings from their husbands.148

Sexual Attractions Equals More Power

Reproductive health complications are an uppermost concern for young women, but their narratives also reveal worries about their long-term desirability and sexuality in their married life. A few adolescent women frankly shared their anxieties of having ‘loose vaginas’ from too much sex and from bearing children, and their husbands rejecting them later for younger females. A young woman explained:

A man wants good mal [tight vagina], and if you have sex too much then the place becomes too big. My ‘thing’ [vagina] is okay; it is neither too big nor too small. It is just right. Men don’t have any problems. They have more power, because their bodies are not affected but women’s bodies are affected. A rich woman can get that place sewed and tightened. But if a woman’s thing [vagina] becomes big, then the men don’t find enjoyment! That is why these men marry so many times.

Arguments and fights in the slum were normal because of infidelity and polygamy, which bred jealousy, suspicion, and hostility among women, who often accused each other of attempting to seduce their husbands. There were always stories of women who flirted with other men, and those who had betrayed their neighbours, friends and even sisters and eloped with their partners. Older and married adolescent women worry all the time that their husbands will fall in love with a younger woman and leave them. A married adolescent woman, Roshonara, 19 years old explained, ‘All men are dogs, they are all the same. Wherever they see a young [kochi] girl they go running.’ Much of the existing literature finds that a woman’s autonomy and decision-making varies with age and position in the family, and generally, prestige and influence increase as a woman

148 Although rare (considering that young women are expected to be shy and modest), there were a few adolescent women who spoke of having enjoyable sexual relations with their husbands, and a few also complained that that their husbands left them unsatisfied and despite their hints for more sex, their partners used weakness and physical exhaustion as an excuse.
becomes older, with newly married women lowest in the hierarchy (Norris-Stark, 1993:110; Aziz and Maloney, 1985, Blanchet, 1996). However, research in the slum indicates that paradoxically, young women because of their age and youth are also advantaged, as they are able to manipulate their only assets, their bodies, to gain power.149 Younger women are aware that they were perceived as more desirable to men because of their 'attractive tight bodies.' In contrast, some of the married adolescent women who have been married for longer, and older women spoke of men's attraction to young adolescent girls. Often during conversations, they would point to their bony arms and pull at the skin and remark, 'He does not enjoy having sex with me anymore because I am so ugly and haggard. Apa [sister] give me some fat pills, or give me some vitamins so I can become beautiful and fat and my body will be tight [body and vagina]...like I was when I first got married.'

Younger women are accused of using their sexuality to ensnare men [lovers, husbands], and in this way gain advantages over older co-wives and in-laws. A common statement was men were like animals attracted to young girls, who only had to spread their legs and men became their pawns. Shehnaz, 15 years old, married and shares her husband, who is 40 years old, with an older co-wife. Her husband spends most of his time living with her and she explains why she has the upper hand in the marriage:

My husband is older than I am. His first wife has big saggy breasts and because she is older he does not like her anymore [sexually] and that is why he has married again. It does not matter that I am his second wife I have much more pull over him and he has more affection for me. All I have to do is to tell him and he will come running to me. If a woman were to spread her legs a man comes running like a dog for meat. That's how stupid men are...he can never ever say no to me! He gives me two thirds of his income but he gives her so much less.

In the context of poverty and competition for scarce resources, men, young women can mark their superiority over older women through their youth, and their attractiveness [sexuality] becomes an important source of power.

149 In a poverty stricken environment, women with access to money also have more status, irrespective of their age or looks.
Bad husbands and sexual illnesses

As discussed earlier in chapter four, the competition between women for men, which is aggravated by patriarchy, poverty and insecurity, means that no woman can afford to be complacent if she wants to hold on to her husband. Young women speak of the lack of control over their lives, coping with high marital instability and husbands who are serially unfaithful and remarry. Social and cultural pressures of maintaining respectability and unequal power relations in the slum are often the reasons for enduring such relationships. Many of the married adolescent women admitted to overlooking their husband’s behaviour and tolerating their extra marital relationships with other women and co-wives, in exchange for marital security and respectability. Some of the young women recognize their husband’s sexual relations with co-wives and other women as risk factors for the onset of severe abnormal discharge and other ‘bad’ illnesses.

Discussions on sexual health are whispered and most of the married adolescent women did not want to talk openly. The social stigma surrounding this disease is one reason for their silence. Another reason is a form of denial, which is a way of coping with reality of living with unfaithful husbands and a lack of ability to change the social and material conditions of their life. A few were frank and mentioned stories of other women who had experienced *jonno roge* [sexually transmitted – ‘bad’ abnormal discharge] and only one adolescent woman shared her own suffering from this condition. Ten married adolescent women\(^\text{150}\) shared stories of husbands suffering from discharge, boils and sores on the penis and itching. Joshna was recently abandoned by her husband and had left her with a sexual illness. She said:

I didn’t know he was sick. We had sex as normal and then after a few weeks, one day he had sores all over his penis and even on his balls. It itched like crazy. And pus and watery stuff came out. Soon after, I was suffering from severe smelly discharge, and itching and I went on saw this woman doctor with my mother for treatment. I didn’t want to go to the local clinic in the slum, as they will only talk.

Rumours were rife in the slum that after Joshna’s husband had abandoned her, she was having sexual relations with a well-known drug dealer in the slum, who paid for her

\(^{150}\) The information came from ten women, which include 2 from the survey, 1 from a key informant who referred us, 1 from clinic observation, and 6 from in-depth interviews/case studies.
expenses and took care of her, showering her with expensive gifts. Towards the end of my fieldwork I heard that he had married her. She became his third wife.

In Bangladesh, family planning has traditionally been separated from other services, including sexually transmitted illnesses (STIs) and maternal and child health facilities, which has influenced its acceptability in the community, and led to the stigmatisation of sexual health. Public health messages aimed at particular low-status groups [prostitutes] have further increased the stigma. Joshna is unusual; as most women are reluctant to share their own experiences of suffering from sexually transmitted illnesses. Conversations reveal that women appear to have a network of close family and friends that they can turn to for support but the fear always remain of backstabbing and gossiping by other women in the slum. This is the common reason given for keeping silent about such illnesses. She said:

*Apa* [sister] you must be careful what you share with whom, because once a fight breaks out they will shout out all your secrets to the world. If people hear that I have discharge problems then they will say I have a bad character. If I tell someone else then that woman will tell someone else. Then they will discuss amongst themselves, 'look this is what she talks about? She has no shame. She must have been up to no good. Then there is all this bad talk.'

Having a sexually transmitted illness is associated with promiscuity and reflects negatively on the person. Not surprisingly, very few women were forthcoming about this topic, and none except for one, shared her condition, whereas the few, who did, spoke reluctantly of their husband's illness. Young women are hesitant to share personal experiences, as they will be viewed with suspicion, accused of sleeping around by their husbands as well as others in the community. It was common for older and younger men to get jealous and suspect their wife's fidelity. Although some of the married adolescent women are aware that condoms are an effective barrier to sexually transmitted illnesses, the reality of their lives make it difficult for them to demand their partners use condoms or abstain from sex. Almost of all the ten young women said that they did not use condoms when they had sex with their husbands when they had been suffering from

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151 For young newly married adolescent women the shame and taboo associated with sexually transmitted illnesses means that they will probably refrain from seeking care and delay sharing their predicament with anyone else.

152 See Dawson MT et al, (2000) for similar discussion on how Chilean women find it difficult to negotiate condom use with their partners.
episodes of severe discharge and other sexual health problems at the time. In some cases, young women said that their husbands insisted on having sex with them but did not inform them of their illness, until much later.

Marriages are unstable in the slum, and observations reveal that some men shared their living and sleeping arrangements with different wives and women, and a wife insisting on condom use may imply that she was unfaithful while he was away. Men are expected to be unfaithful and by nature ‘have uncontrollable urges’, but young women are expected to be loyal and faithful. Thus there exists the sexual double standard of permitting polygamy for men, while women’s sexuality is controlled. In reality, slum women alluded to young women who were abandoned/separated or in polygamous marriages sleeping with other men in exchange for food, cash and other rewards. The prevalent discourse of sexually transmitted illnesses and HIV has made prostitutes the main vectors of disease. While there is logic to the public health campaigns, it has an unfortunate side effect. Condom use continues to be associated with promiscuity and something husbands and wives do not need to use. As Sobo points out in her study of poor inner cities in the US, for women, cultural ideals dictate, a healthy relationship [marriage] ‘involves a healthy disease free partner.’ She argues that women use unsafe sex as part of a psychosocial strategy of preserving an image of having the conjugal ideal, what she refers to as the ‘monogamy narrative.’ The use of condoms indicates that the partners are not sexually exclusive and signals a lack of mutual trust. Thus in some ways, condom use denotes a failed relationship, and inversely unsafe sex implies a close relationship (1998). These understandings make the awareness of and acceptability of condom use with one’s husband exceptional.

Moreover, most men were averse to using condoms and in the survey of 153, only 2.6 percent (n= 4) of adolescent women’s husbands took responsibility for fertility control and agreed to wear condoms during sex, but temporally or inconsistently. Condom use in this case was seen as related to fertility control rather than for safe sex. In addition, practical constraints make condom use nearly impossible for young couples sharing living in congested spaces with other family members in the slum, with rooms no bigger than 35 square feet. One young woman explained:

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153 This involves the claim of having an excellent and monogamous relationship.
We are poor. We all stay in some room. You have the luxury of having separate rooms. We all stay in the one room – mother, brother, daughter, son and husband. So when my husband and I want to do it [sex], it is very quick. When we get a chance we steal time together. I don’t even have time to think about what he has been up to or anything else. All that goes through my head is that I hope no one sees us [having sex]. Do you think anything else even enters my head? She laughs and then she says, ‘Apa [sister] I am just glad when it is quickly done because I am so worried that someone will see us.

Poverty, cultural ideals and unequal gender relations make it difficult to negotiate condom use, and young women do not want to alienate their husbands by insisting. The marital bed is a place where a woman’s status as a desired wife (and therefore her security) is acknowledged. A husband by sleeping with his wife communicates to her that she is secure within the household (Norris Stark, 1993). In the context of poverty, and the absence of material resources, a young woman’s sexuality is what she can offer and manipulate to hold on to her husband’s [or other men’s] affections. Although young women do recognize that symptoms of abnormal discharge can be extremely serious, the dilemma for most young women is the lack of power and control in their lives. Young women behave pragmatically, which may result in greater risk to their bodies and reproductive health, but it is in exchange for some sort of status and social respectability. These decisions are taken as a survival strategy, but this strategy may become eventually a ‘death strategy’ for young women (Schoepf, 1998:107).

Adolescent women do recognize that frequent sex with unfaithful and demanding husbands makes them vulnerable to reproductive and sexual illnesses.

Poor married adolescent women experience contradictory roles in the local systems of power in which their lives are embedded. Without economic independence and social autonomy, most are compelled to agree to painful sex as well as risky sexual relations. While gender relations are open to negotiation, they are still shaped by structural and social conditions outside their control.

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154 A study by ME Khan et al (2002) in a rural area of Bangladesh, found that with contraceptive use, particularly condom use, it was the husbands who made the final decision on whether to use a condom or not.

155 Those who do avail of clinic care find it difficult to bring their husbands along. The paramedic at the local clinic also said that one of the major difficulties was asking women to bring in their husbands for treatment as well.
Biomedical interventions: family planning in the slum

Fertility control, side effects and poor quality of care

Public policy regarding contraceptive services is to provide a wide range of choices, such as pills, condoms, sterilization and IUDs. The mainstay of the program is oral contraception, followed by sterilization, mainly female sterilization and since 1985, an increase in the availability of longer-term methods such as injectables and Norplant. Bangladesh has long been considered successful in decreasing fertility rates in the country through the intervention of family planning activities, which started soon after independence, in early 1976 and 1980. Decreasing fertility rates from more than 7 children to 3.3 children per woman are attributed to social economic changes taking place and the large efforts over the past twenty years in increasing access to methods and services and in motivating people (Schuler et al, 1995; Larson and Mitra, 1992).

The encouraging statistics documenting the family planning program, however, hide the problems married women often face in trying to control their fertility. Schuler et al (1995) suggest that the family planning program falls short of meeting women's needs. Sustaining rates of continuation of modern family planning methods has become a challenge, and recent indications are that levels of use have stopped rising. National figures show that only 30 percent of married adolescent women use a method of contraception, compared to the figure of 49 percent for all women.

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156 A 1996 study of 542 men and 993 women in five Dhaka slums recorded levels of current syphilis of 11.5 percent for men and 5.4 percent for women, and of hepatitis B of 5.8 and 2.9 percent respectively, while gonorrhea and chlamydia were below 1 percent for both sexes (Sabin et al, 1997).
157 IUD is an intra-uterine device contraceptive.
158 Norplant is a non-conventional birth spacing method in which six capsules are implanted in the inner side of the upper arm of a woman through a minor surgical procedures which is provided free of cost. The capsules deliver a constant low dose of progestine, which causes infertility for up to five years. Injectables refer to progestin depotmedroxyprogesterone acetate (DMPA) available in Bangladesh, usually sold under the brand name Depo-Provera. The normal injection of 150mg is administered every three months (Rashid, SF, 1998).
159 More than 45 percent of married women use modern contraceptives in Bangladesh (BDHS, 1999-2000).
160 The Bangladesh Demographic Health Survey of 1999/2000 indicates that total fertility rate has stopped falling and increase in contraceptive prevalence rate has slowed.
161 The Bangladesh Demographic Health Survey (BDHS, 1993-94, 1996-97) found the discontinuation of modern methods such as injectables, Norplant, IUD and sterilization is increasing. It is reported that more than half of users cease using a modern method within the first 12 months of starting use. Out of all the family planning programs in Asia, Bangladesh has the highest discontinuation rate. This is extremely worrying for the program (Piet-Pelon, 1996:39).
A large number of married adolescent women in the slum spoke of the need for methods of family planning but expressed concerns about the terrible side effects. Out of the 153 married adolescent women surveyed, 42.4 percent (n=65) were using a method, particularly the pill and injectables, which are heavily pushed by health workers at the local NGO clinic, located inside the slum.\(^{162}\) In the context of poverty and other insecurities, practical necessity may be given priority, yet adolescent women remain anxious of the consequences of using contraceptives long term. Adding to women’s dilemmas, very few men agree to use condoms and complain of side effects of condom use,\(^{163}\) thus revealing existing gender tensions and power inequalities. Therefore, young women are left with the responsibility of fertility control. The State reinforces this ideology, by promoting female methods, with the central strategies of the program being delivery of family planning messages by women to women.

Twenty-two percent of young women (n=34) did not use a method at all for fear of side effects. Particularly newly married adolescent women, who had not borne any children, did not dare use contraceptives. Only in two cases, newly married young women who did try to work within these constraints and accessed methods, had to contend with the resistance of their husbands. Both husbands threatened not to treat any illnesses - future infertility problems, arising from family planning use. This means that financial, emotional, and other resources would not be provided to the adolescent women. Young women remain unsure of the kinds of side effects brought on by family planning use, and do not want to risk losing family/spousal support, in case they are unable to bear children.

Observations and discussions with young women found incorrect use of the pill, some were not taking it regularly, and in one case, a young woman was taking two a day. Some of the young women also believed that after using a method for sometime they have built up protection against pregnancy and do not need to use the method, leading to pregnancy. Some young women also switched between methods, dropping out and restarting a method. Side effects are one of main reasons given for dropping out, switching and taking breaks between methods. Young women are chronically malnourished, tired and hungry, and spoke of the ‘powerful,’ almost ‘toxic’ effects of family planning methods on their already weakened bodies. They complained of

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\(^{162}\) After the demolition of the slum, the clinic was relocated nearby.

\(^{163}\) Women also shared their concerns of hearing rumors of male impotence because of condom use.
constant dizziness, nausea, headaches, menstrual irregularities, abnormal bleeding, and tingling sensations in the hands and feet, swollen and bloated stomachs and white discharge, which left many of them feeling anxious about their health. Many of the young women said that the constant side effects made it difficult for them to function daily, making household tasks extremely arduous to carry out.

Problems with methods are aggravated by the inadequacies in health care, with lack of information, poor counselling of side effects and no follow up care (Bruce, 1990). In the slum, observations reveal that in many cases, health workers tend to remain quiet when adolescent women share their fears of the negative effects of family planning use, or they just reject adolescent women’s concerns. Health workers feel inadequate about counselling, as they do not receive enough training on the management of side effects or counselling, instead they are trained to promote methods and recruit acceptors (Salway, S et al, 1993).

**Childbirth: pregnancies, miscarriages & reproductive illnesses**

**Birth and death: no joy in pregnancy**

Pregnancy and childbirth profoundly affect young women, particularly if they are unprepared for the event (Doyal, 1995). Soon after marriage, the dominant expectation is that married adolescent women are expected to fall pregnant and bear a child within the year. In most cases, young women said that they were pressured to bear children, before they are even ready, and this is discussed in more detail in the last chapter. Out of the 153 adolescent women in the survey, 83.6 percent (n=128) said that they had already experienced a pregnancy, of which 85 percent (n= 108) already experienced one to two pregnancies, and 10 percent (n= 13) had experienced 3 to 4 pregnancies, with 7 non-responses. Out of the 128 young women who had experienced pregnancies, 16.4 percent (n= 21) had experienced miscarriages.

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164 Bruce (1990:78) states that many programs are designed with recruitment of clients more in mind than the maintenance of contraceptive use. She argues that side effects are not taken seriously and most programs are interested in the number of acceptors rather than women's satisfaction. Contraception has been dominated by a male medical model, rarely taking into account how women actually feel about their bodies, their perceptions on methods being offered and the implications of their use (Raikes, 1992:52).
Sixty-one married adolescent women gave multiple responses and said they suffered from health problems during pregnancy. These include: 22 percent (n=13) complaining of experiencing nausea and body aches, 21 percent (n=13) also said weakness, 21 percent (n=13) said their feet swelled with water, 9 percent (n=14) experienced fever and were bedridden and four women said that they suffered from ‘eclampsia.’

According to the young women, their conditions are aggravated by the lack of financial and social support and long working hours carrying out household chores. If abdominal aches and pains persisted, some of the married adolescent women did seek care, fearing a possible miscarriage, but the quality of care is inadequate and discussed later in this section.

Most of the young women in the slum are barely more than 13 or 14 years old when they experience their first or second pregnancy. Pregnant adolescent women spoke of feeling anxious about the impending birth, especially after hearing rumours of long and painful labour, blood loss and even death. Their fears are not surprising considering the high levels of maternal mortality in Bangladesh. The maternal mortality ratio is one of the highest in the world with estimates of 320 per 100,000 live birth, with as many as 100 morbidities for every maternal death. About 15,000 poor women die annually during childbirth (Huq, N, 2004). Moreover, maternal mortality is estimated to be 3-4 times higher in adolescents [15-19 years]. The primary cause is attributed to complications during childbirth (Akhter, 1994; Jahan, R, 2003).

However, the experience of giving birth is seen as a natural phenomenon and not one requiring medicalisation, except if there are perceived to be complications (Afsana and Rashid, 2000; Rozario, 1998). In the slum, a majority of the births took place at home, in the tiny mud floors of the room, or in the adolescent woman’s natal village.

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165 Women mentioned the biomedical term ‘eclampsia.’ They said that the doctors diagnosed them as suffering from this illness condition.

166 In rural areas, we found that the concepts surrounding ‘normal’ and ‘complicated’ childbirth are constructed in the context of culture and social practices. Women’s notions of ‘normal’ versus ‘complicated’ childbirth were similar in all the villages. The rural women perceived the act of childbirth, locally known as bachcha khalash as a normal and natural phenomenon. This was referred to as ‘kono oshubidha hoi nai’ - or as having no difficulties. They, however, expanded their definition of ‘normal’ childbirth to include a number of other signs, such as (i) birth process is smooth without any prolonged pain, (ii) membrane has not ruptured before the beginning of labor pain, and (iii) the baby is born with an intact phul or placenta. On the other hand, bekaidai or ‘complicated’ childbirth was defined as having the following symptoms (i) prolonged labor pain without further progress, (ii) membrane rupturing without
with conditions not much better. In the 104 responses recorded in the survey, 89.5 percent (n=93) of young women relied on traditional birth attendants [TBAs, referred to locally as dais]. Dais tend to be very poor, elderly widowed women with no education or formal training (Rozario, 1998; Blanchet, 1984). Twenty-nine percent (n=34) relied on a close female relative. Only 10 percent (n=12) relied on a doctor/nurse during delivery and had their babies delivered in a private clinic or hospital. This coincides with other research that has found traditional/untrained birth attendants conduct about 85 percent of all deliveries in the country (Barkat et al 1998).

Chronic shortage of cash means that most of the women and their families in the slum are reluctant to spend money on something that is perceived to be a natural event, and has essentially been practised for decades at home with negligible expenses. Usually, dais or female relatives assist the woman in delivering the baby in poor conditions, with many of them lacking basic knowledge on hygienic and safe delivery practices (Rozario, 1995, 1998; Fauveau and Chakraborty, 1994; Stark, 1993). Dais are compensated with a meal or a sari, but sometimes with nothing, if the family is extremely poor. Families and women only feel the need to access care if there is an emergency because of the costs involved. When Jobeda, (15 years old) was suffering from complications during delivery, on the advice of neighbours, her husband and family rushed her to a government hospital. However, although most government services are reportedly free, extra hidden costs for medicines, travel and other costs, such as bribing attendants for patient entry, discourage the poor from accessing care:

They took me Dhaka medical hospital but they wouldn't admit me. My husband pleaded... but the system works like this, if you know the doctor or someone inside then you can get admission – but most of the time brokering takes place... you know a ‘dalal system’ where there are middle man who will let you in after you pay them. Who are these middlemen I ask? The ward boys [peons – bring the tea/coffee and run small errands] are 4th class employees [low in the hierarchy]. Then my family took me to Mohakhali medical and they didn't keep me. They didn't think I would live and no one wanted to admit me. Then we had no choice. Finally my husband and my relatives took me back to another government hospital. They had to pay Taka 2,400 [AUS $60] bribe to get me admitted. They paid the money. In 11 days they spent Taka 35,000 [AUS $875] on me. The doctor told my husband that if he wanted me to live he would have to do an

labor pain, (iii) nari (cord) coming out beforehand, and iv) becoming pregnant after a long interval of 6 years or more (Afsana and Rashid, 2000).
operation [caesarean]. More money was spent, and in the end, we owed a lot of money and interest to some people [moneylenders] in the slum.

Jobeda and her family's harrowing experiences are exacerbated by a poorly prepared and corrupt medical system where employees in the 'free' government hospitals admit poor women only after a payment. A study in Dhaka points to the high costs involved for poor people in accessing maternity care from government hospitals. They found that 'hidden' costs are a determining factor contributing to low utilization of medical facilities. On average, the mean cost of a normal delivery was close to US$ 32 (Taka 1275) which was 25 percent of the average monthly household income; and the costs of a caesarean section were quadruple and 95 percent of the poor household's income. More than 51 percent of poor households did not have enough money to pay for maternity services, with 75 percent having to borrow money from moneylender or relative to manage (Nahar and Costello, 1998). Thus, institutional inequalities maintained in the medical system only perpetuate poor people's miseries in the slum and discourage many from seeking care outside from hospitals and encourage home births. This shows how the medical complex within its encompassing political-economic framework is shaped by unequal power relations and domination, and reproduces social inequalities in society (Baer, Singer and Johnsen, 1986). In addition to these factors, cultural and social practices, delayed referrals to medical care, diet and mobility restrictions, and finally, husbands/in-laws who tend to be the main decision-makers as to whether care is accessed, result in risky pregnancy experiences for young women.  

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I discuss some of the cultural and social restriction on young women's mobility once they are pregnant in the next chapter. Young women fear miscarriage or harm to themselves and the baby from black magic, sorcery and the spirit world if they venture out at certain times of the day/night.

Structural factors tied to political and economic power are also to blame for high maternal mortality rates. These include among others, poor infrastructure, mediocre government health services, costs of delivery, absent doctors, shortage of nurses, drugs and equipment, understaffed clinics, unhygienic conditions in the health centers and a class system which ensures discrimination and disparity in the levels of care given (Afsana and Rashid, 2001; Rozario, S, 1995; 1998). More recently, there has been the introduction of small fees for family planning and reproductive health services in response to conditions set by leading international agencies to recapture costs are just some of the problems, which just adds to the economic burdens of the poor (See Abbasi, 1999).
Medicalization of the birthing experience - awareness of risky births

With the advent of hospital and clinics, and NGO messages on pregnancy care and safe childbirth practices, adolescent women and their families are aware that complications can occur during delivery and the limitations of dais skills in the slum. While traditional birth attendants (dai) are praised for their expertise in managing deliveries and heavily relied upon in the slum, they are no longer considered the sole authority on birthing care (Afsana and Rashid, 2000). Young women in the slum, particularly those born in Dhaka city, prefer to be close to medical facilities and pharmacies so that they are able to seek care if there are complications during delivery and if the dai is unable to manage.

Nasima, a Dhaka born slum girl, was in the village living with her in-laws when she had her first baby. She spoke of her fears because of the absence of clinics in the village:

I became so weak and I took vitamin tablets. I didn’t really have any problems but I was worried because with the first pregnancy I was in the village and there were no clinics to do any antenatal check ups or for treatment... I gave birth, but the placenta would not come out. She (dai) stepped on my stomach and put hair in my mouth...it [placenta] tore coming out and I lost consciousness. I nearly died. The second child was born in the slum but then the dai from the Medical College came for this delivery. My husband paid for the costs.

The difference for Nasima in the second birthing experience is that she gave birth in the slum with the assistance of a dai who works as an ayah at the Dhaka Medical college. The young women view the government dais as superior and better skilled than the traditional dais in the village or slums. The ayahs gain prestige and status because of their association with the biomedical environment of the hospital and take on the role of the nurse/doctor. In reality, these ayahs are not trained at all but merely observe doctors and nurses in the hospital and are hired to clean the labour room and patients’ rooms. Financial constraints force many of them to do this type of work both in the slums as

169 Since 1987 – under the international health banner of ‘Safe Motherhood’ declaring pregnancy is special, public health has focused on educating poor women about appropriate pregnancy care.
170 In recent times, the TBAs find themselves gradually displaced from their traditional base of authority. This is a result of many influences - the modern community-based TBA training programs, increased community awareness about the risks of pregnancy by NGOs and government health workers, and the availability of modern health care facilities. Even some of the TBAs have become aware of their own limitations when conducting complicated cases of childbirth, and realize the importance of having referral linkages with the medical health facilities (Afsana and Rashid, 2000).
well as in the government hospitals. As they offer a much cheaper alternative than hospitals, some young women prefer to rely on them. A study in rural areas, similarly found that doctors tend to be absent in government hospitals and poor women often rely on these untrained female attendants, ‘ayahs’ in the labour room, who earn a sizeable amount of money. Many of them manage complicated cases, thus endangering women’s lives (Afsana and Rashid, 2000).\(^{172}\)

For young women who were born in the slum, giving birth in the village was perceived as risky and they feared being stuck in a remote village\(^{173}\) with no immediate clinical care available if there were complications. Although in the city most young women prefer to give birth at home, surrounded by familiar female relatives and a traditional birth attendant, they are aware of the numerous pharmacists, doctors, clinics and hospitals, they can access quickly in the event of an emergency.

Narratives indicate that usually during complications, pharmacists and quack doctors are brought in by the birth attendant to give saline drips and injections to induce births. Injections and saline are seen as ‘miraculous agents of cure’, complementary to but more than the remedies provided by traditional healers, and uncertified doctors sustain this understanding (Rozario, 1998: 158).\(^{174}\) Most women prefer not to go to hospitals unless the situation is perceived to be dire. When Hameeda, 18 years old, experienced prolonged labour, she sought care from a pharmacist, who gave her an injection to induce the birth. Hameeda informed us that after the delivery she was very ill, and had lost a lot of blood. She said:

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\(^{171}\) Ayah is a local term used to describe a female cleaner/worker.

\(^{172}\) The qualitative study on childbirth in a rural village in Bangladesh found that nurses tend to remain busy keeping accounts and administrative tasks and doctors are not always available because most are reportedly busy with their private practices. The only people available in the labor room are usually female ward attendants (ayahs) who usually end up managing child delivery, often employing dangerous methods. By doing this, the ayahs earn some money from the clients, and for the families it is cheaper than being treated by a doctor. The under-utilization of skilled persons in the district hospital reflects not only an administrative failure but also a lack of accountability. This is frightening and paints a depressing picture of the state of government hospitals.

\(^{173}\) Due to poor infrastructure access to formal health care services is hindered. Roads do not provide access to many remote villages. During the rainy season, communication and services become even more difficult. Many women never manage to get to a doctor or hospital even in emergencies. A study showed that in spite of five health facilities in the area, 75 percent of women dying in childbirth did not see a doctor before their death and 89 percent did not go to a modern health facility (Caldwell, J., & Caldwell, P. 1992).

\(^{174}\) Bazaar based health care tends to be a large selection of medicine shops and practitioners, including cosmopolitan doctors, homeopaths which women seek care from – especially for injections and salines to induce births (Laston et al, 1996; Rozario, 1998).
Everyone feared for my life. I was feeling very unwell, very restless and my body was burning. My mother took me to Muslim bazaar [next to Phulbari slum] and the [pharmacist/ ‘doctor’] gave me an injection, which cost Taka 100 [AUS $2.50]. After that, my breathing difficulty stopped but I started vomiting. Then the baby came out…but I was so ill after the delivery. I could not walk or sit or do anything properly...

Such stories were not uncommon in the slum. It was typical to hear young and older women speak of their own or others ‘obstructed labour’ and other ‘near death experiences’ during delivery and the rescue and in some cases, harm done by ‘quack doctors/pharmacists.’

Medicalization of pregnancy care: ultra-sonograms in urban slums

There is literature on the social, cultural and economic factors and institutional gaps in services that shape pregnancy care. However, little is known of the role biomedical technologies, such as ultra-sonograms, play in crucially shaping young women’s reproductive behaviour and practices. The significance of ultra-sonograms was inadvertently revealed when I analysed the data and found at least 6 out of the 50 women in my in-depth interviews had been told to get an ultra-sonogram done by the paramedic, when they complained of lower abdominal pains during pregnancy.175

Poor, inaccessible and costly government-run hospitals have resulted in the mushrooming of commercial clinics and unqualified doctors all over the City. They fill the gap as well as make their money from getting the middle class and the poor to pay for treatment and for various diagnostic tests and x-rays, regardless of their efficacy (World Bank, 2000). While in India ultra-sonograms are done to discover the sex of the baby and then terminations are carried out if the foetus is a girl,176 in Bangladesh, ultra-sonograms are not used for this purpose. Many young women in the slum view this procedure as an important part of antenatal care, in order to check if there is something seriously wrong with the foetus. As mentioned earlier, young women in the slum are

175 Observations reveal that older women are recommended for ultrasonograms if they suffer from stomach aches. As I didn’t pursue this information in-depth, I don’t know if the paramedics make extra money or a commission from other NGO clinics or diagnostic centers if they send women to get ultrasonograms done. I know that they do get money if they refer patients for terminations [legal abortions] to private clinics – this is discussed in the last chapter.
176 This is a common practice in India (Archarya, A, 2004). In Bangladesh although sons are valued, girls are also desired.
barraged with public health messages about the dangers of early marriage and pregnancies. Newly married adolescent women are extremely anxious about their first pregnancy. Bearing these health messages in mind, young women pregnant for the first time and suffering from abdominal aches/pains, tend to rush to the clinic because they fear a miscarriage. In the survey, out of 113 young women, 58.4 percent (n=66) said they sought antenatal care during their pregnancy. As discussed earlier in chapter two, the NGO clinic in the slum provided basic maternal health care, such as antenatal care (provision of iron tablets, injections, taking blood pressure and weight) and other basic health services.

In all six cases, when the young women shared their concerns regarding their pregnancy and lower abdominal aches, the paramedic asked them to do an ultra-sonogram. An ultra-sonogram costs nearly Taka 400 [AUS $10], a lot of money for poor families in the slum, who live on the margins of extreme poverty. Fears of challenging the paramedic, who was treated with immense respect in the clinic, and unable to afford the ultra-sonogram procedure, discourage poor young women from returning to the clinic for further pregnancy care, but leave them worried about their health.

Shaheeda was 16 years old and this was her second marriage and her first pregnancy, after one year of desperately trying to fall pregnant. Her husband was a heroin addict and did not like to work and fights in the household were common. She was five months pregnant when her husband kicked her in the abdomen during one of their arguments. Since then she was experiencing abdominal aches. She went to visit the paramedic in the clinic in the slum who asked her to do an ultra-sonogram and then return to the clinic. Shaheeda admitted that she did not have the money to pay for the test and she decided to visit the traditional healer instead for treatment. She said, 'I am waiting...I think I will go and see a kabiraj [traditional healer]. Where is the money to do an ultra-sonogram? If I don't do the test, I don't want to return to the clinic, she [the paramedic] will get angry with me.' The uncertainty of not knowing and not being able to afford the procedure left Shaheedaanguishing about her pregnancy and health. She kept worrying that she might lose the baby. Luckily for her she gave birth to a premature but healthy baby girl, some months later.

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177 Interestingly, after the birth of a child, out of 105 responses in the survey, only 22 percent (n=23) of young women sought post natal care, with the rest not seeking any care.
Rehana, 19 years old, had been advised to have an ultra-sonogram after she continued to lose weight despite being 4 months pregnant. She was worried about her weight loss, as she had terminated 3 pregnancies in the past. Luckily for Rehana, her husband had a job running his own grocery store in the slum and was supportive and agreed to pay for the first ultra-sonogram. We accompanied her to another NGO clinic for the procedure. Although Rehana was anxious to know the results of the test, the health worker just handed her the report and indicated there was a problem. When she returned to the clinic, the paramedic looked at the report and said it was not clear what the problem was and she needed to do another ultra-sonogram. Rehana was upset because she had already spent so much money and the paramedic refused to provide her with any information about her pregnancy and dismissed her concerns. She was left with many unanswered questions about her health and the pregnancy. Her encounter with the paramedic reinforced her apprehension about her pregnancy and made her distrust the clinic staff. Her anguish increased because her husband refused to do another ultra-sonogram because of the costs involved. Rehana became very distressed during this period because she did not know what was going on inside her body. She remained concerned about her previous abortions and guiltily wondered if the procedures had damaged her uterus or her foetus. She was concerned about her lack of weight gain for this pregnancy. A week later, she visited a traditional healer and illegally terminated her pregnancy, as she feared that something was wrong with the foetus.

In another case, a young woman, Seema, experienced bleeding for two weeks after the termination of a pregnancy at the clinic, and she was asked to do an ultra-sonogram by the health staff. She did not understand why she needed the procedure. She said, ‘Why do I need an ultra-sonogram for this. I don’t understand any of this? I ate so many medicines after the termination and still I am not better. I don’t have anymore money to spend…’ She could not afford this procedure, as she was a single mother bringing up two children on her own and her husband had remarried.

Poorly informed women pay for ultra-sonograms because they are taken in by ‘the power and cultural hegemony of biomedicine’ (Singer, 1987:260). Thus extremely poor young women will spend money for an ultra-sonogram since a ‘doctor’ recommends it, and believe it is especially important to ensure a health pregnancy. Moreover, young women are too scared to confront the paramedic if they have doubts, and most tend to unquestioningly accept the diagnosis of the practitioner. When women walk into the
local clinic, they automatically enter into a process of institutionalisation, and in this encounter, power is located in the hands of the biomedical professionals (Whittaker, A, 2000). The reality is that young women may be exploited by the clinics and pay for procedures, which they cannot afford, may not require, which just increases their mental and economic burdens. Furthermore, those young women, who are unable to afford this procedure such as Shahana, or are left uninformed like Rehana, are filled with doubts and emotional distress. My findings are based on 6 case studies and general observations in the slum, but I would argue that ultra-sonograms are commonly and indiscriminately prescribed for young women suffering from abdominal pains during pregnancy, general abdominal pains and even for post-abortion complications. Although this procedure might be appropriate in some cases, in the absence of adequate care it is unhelpful and only increases poor women’s distress.

Reproductive complications during pregnancy: miscarriages & violence

Nearly 90 percent (n=138) of the 153 married adolescent women in the survey shared experiences of regular domestic violence. Further probing in in-depths and case studies, found that four had miscarried because of violent assaults by their husbands, and in one case, miscarriage took place because the young woman was a victim of gang violence in the slum.\(^\text{178}\) The root cause of most of the domestic conflicts was blamed on poverty, husband’s remarriage and husband’s drug use, and high unemployment. Shehnaz, 16 years old, explains how she lost her first baby when she was four months pregnant, after a fight with her husband. She said:

All I had eaten was rice and water. When I asked him for money for bazaar he became very angry and he kicked me so hard that my stomach hurt for 2 days...that is why my first baby did not survive. Then I had blood coming out of the jorayu [uterus] where I

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\(^{178}\) Gang violence in the slum also impact on adolescent women’s reproductive experiences. One particularly tragic story is that of Shilpi [16 and a widow] whose husband, Jonnie, was murdered in front of her by a rival gang. She said, ‘At around 10 am as we were inside chatting when some boys suddenly surrounded our household compound. One of them walked into the room and said, ‘Jonnie bhai come outside we have something to say to you.’ The man pulled out a gun and grabbed him by the collar and dragged him outside.’ They beat him – kicked him and punched him. I ran outside and so did my mother. I kept crying out, ‘please let Jonnie go...please let him go.’ Then one of the guys turned around and kicked me twice in the stomach. I was four months pregnant at the time...they killed my Jonnie.’ Shilpi miscarried soon after. She said, ‘I felt a sharp pain and I fell on the ground. I fell unconscious and lay on the road. Later, I lost my baby.’
urinate! Twice like this, blood came out. Soon after, I lost the baby. Since then, occasionally my lower abdomen aches. The ache stays for an hour and then it becomes all right on its own. It is difficult for me to urinate. I don’t know what is wrong with me. He kicked me in the stomach and killed the child. I was so upset. That is why when Pinky [her second baby] was in my stomach he never beat me even once. He was scared after I lost the first baby. If my mother lived close by do you think he could ever beat me like this? When I told my mother-in-law, she said to me, ‘do any good women get this sort of problem?’

Shehnaz does not receive much support from her husband or in-laws and is vulnerable because her immediate family does not live nearby. Shehnaz like many young women is oppressed by institutional, structural and social inequalities, which shape conditions at a micro-level in the slum, and direct impact on young women’s lives. Worsening poverty, eroding social networks and support structures force young women to tolerate physically abusive marital relationships, which impact on their bodies and reproductive health. Moreover, young women who end up suffering from gynaecological problems because of domestic assaults, are often ashamed, and remain fearful that the condition may progress to cancer or some terrible tumour, if left untreated. However, they remain constrained, and feel they neither know what to do, nor are they in a position to speak freely about it or do anything anyway.

Reproductive complications after pregnancy

Fears of blood loss & ‘protrusions from the vagina’ - prolapse

For those who do manage to carry the pregnancy to full term, there are constant worries about giving birth for the first time and the potential for reproductive health complications. Married adolescent women made links between pregnancies, miscarriages, spontaneous abortions and various reproductive illnesses. Monsura, a married adolescent with a 10 month old son [introduced in Chapter Three] and her mother discuss her pregnancy experience and the resulting complications she experienced:

179 Uterine prolapse is a condition in which the female reproductive organs fall to a greater or lesser degree from their normal position. Prolapse is likely to occur because of: over stretching of the perineum; obstructed labor; delivery of a large infant; delay in episiotomy; and/or imperfect repair of the perineal injuries (Earth and Sthapit, 2002).
Monsura’s mother looks at me [the researcher], ‘Take a child now, don’t wait. Why are you waiting to have a child?’

Monsura says, ‘Apa [sister], if you take a child it is a lot of suffering. I was so nervous. The stomach becomes very big and one can’t walk and do anything properly. Let your health become a bit better and then you take a child!’

Monsura’s mother responds, ‘Her body [researcher] is fat now; let her take the child now, why are you trying to scare her? If she does not take a child at the right time then her nari [uterus] loses its vitality.’

Monsura replies, ‘Don’t take a child, don’t take a child. You are better off without a child. If you are pregnant it is a lot of suffering and you lose a lot of blood and then you fall sicker.’

Her mother snaps at her angrily and says, ‘What rubbish. Of course she has to take a child. You don’t lose any blood at all, only a little bit.’

Monsura interrupts and states, ‘If you are pregnant you can’t walk properly, you can’t eat properly and you can’t even sit properly.’

After a long pause, Monsura leans over and whispers that because of the birth she is suffering from abnormal discharge, ‘it smells like urine, strong and it comes out chunky and yellowish’ and now something sticks out from my vagina. You know when I sit down to piss or shit or even if I sit for long periods, the [vagina] area gets swollen and sticks out. It really hurts me. This has been happening for awhile...I think since the birth of Joy the pain is getting worse now.

Her mother replies, ‘listen, when a woman has a child then all women have this ‘thing’ coming out. A kabiraj [traditional healer] cannot do anything, and a doctor gives an injection and pushes it up...’

Monsura then whispers, ‘Apa [sister] it feels like something is swollen and coming out...I am so scared...’
Young women constantly worry about discharge, weakness, and blood loss and most importantly about ‘protrusions from the vagina’ as a consequence of childbearing. There were stories circulating in the slum of women suffering from ‘protrusions’ finding sex incredibly painful, and facing difficulties with urinating, defecating, sitting and carrying out daily chores. A traditional healer ranked this illness as one of the worst things to happen to a woman: ‘May God forgive them, but this is a very bad illness. I hope to God that this does not happen to any woman. Women suffer a lot with this illness.’

Observations in the slum reveal that this is major concern among older women and young women fear prolapse very much. There is an absence of information in the literature on perceptions or treatment of this reproductive illness, as most research in Bangladesh has focused on family planning and birthing. Adolescent women are reluctant to speak of it because of the shame and stigma surrounding this condition and worry it may reflect on their moral and social status. As Farmer explains regarding rural Haitian culture, ‘certain bodily states, ‘serve as moral barometers that submit private problems…to public scrutiny” (1988:62). Monsura’s case illustrates this, and it was only after spending more than one year with her, that she admitted to suffering from this problem. She explains how she finds sex unbearable but tolerates it, ‘I don’t want to have sex with him [husband]. If I have sex with him it really hurts so much. I try and put him off for as long as I can and I told him about my health problem but who will listen to my words? But his work [sex] he will have to do.’ I encouraged her to seek care and we went to see a female doctor outside the slum. Monsura, like many poor women in the slum, is embarrassed about being examined physically, which appears to be another deterrent to seeking care for this condition. She was informed that her condition was pelvic inflammation, and not prolapse, but young women in the slum appear to be unclear about the difference in symptoms between pelvic inflammations and prolapse.

Young women’s main fear is that pelvic infections or prolapse will lead to the end of sexual relations and one’s marriage. They also worry about their reputation being

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181 At a charity clinic that provides free services for only Taka 20 [AUS $ 0.50]. I accompanied her to the clinic and covered the basic fee of Taka 20 [AUS $ 0.50].
182 Lenore Manderson writes that the social control of women’s sexuality, and as a result the constraints on their mobility and autonomy, hinder treatment for sexual and reproductive illnesses, severely impacting on their health and well-being (1999).
tarnished. They want to be viewed as ‘normal and healthy’ and do not want to be viewed as having ‘defective bodies’. This was apparent during fieldwork, when I came across Jharna, a married adolescent woman, who was taunted by the health workers and her sister-in-law about her ‘condition.’ Her story will give you a sense of the stigma and shame associated with this reproductive illness. Rumours in the slum were Jharna’s husband had remarried because she was suffering from prolapse:

When we walked in to talk to her, Sayeeda [health worker] said to her, ‘don’t feel embarrassed, we know you have an illness. There is nothing to hide and there is nothing to be ashamed of. You can tell the Apa [sister].’ Jharna defensively said:

What illness? I don’t have any illness. I am well. Who is saying that something is coming down or sticking out from my vagina? All I have is a boil in my anus. I am fine.’ She became angry and retorted, ‘What have you heard? What illness do I have? What you have heard is not true. It is not true. I am fine. If I had problems then I wouldn’t have had children... [she became very upset]. And if I had a problem then how did that man do shongsar [family life, marriage and sexual relations] with me for so long.’ Yes I have problem, ‘I have urinary tract problems, but it has not caused any problems for me. What you have heard is not right. What the other women were talking about me is not true... if I had some bad illnesses or something very wrong with me then how did I have a child? Why would my husband have a sexual relationship with me for so long in the past? He still comes to visit me.

Adolescent women believe that they are at risk of this illness condition from having sex too often with their husbands, because of prolonged labour, and rough pulling and probing by traditional birth attendants during delivery. Further, their social and economic position results in heavy workloads and household chores, which they have to carry out soon after giving birth, which aggravates the condition. Young women acknowledge that only rich women can afford to rest, but as they are poor, they have no choice but to carry on being productive. To add to their dilemmas, the local NGO health clinic, like most health services in the city, are inadequately equipped to deal with this health problem. As a consequence, most young women remain misinformed, as one girl

183 See for similar findings on the experiences of uterine prolapse among women in Nepal – Earth and Sthapit (2002).
184 Studies which have explored traditional birth practices by traditional birth attendants, have often found that potentially harmful procedures are carried out during delivery. These include, increasing frequent
explained, 'Till it completely comes down one cannot do any treatment.' Many also perceive this health problem as 'normal,' a fact of life, and they constantly hear whispered stories of older women suffering from this condition and tolerating it. As a result, young women suffering from pelvic infections or prolapse suffer in silence.

**Larger factors that impact on the lives and health care of young women**

**What is more important - surviving, eating food or spending money on an illness?**

We discussed briefly some of the constraints in Monsura's life previously in chapter three. According to Monsura, she was unable to seek care for her 'prolapse' condition because they did not have any money. During this period, her husband did not have a job because of the government ban on the older model baby taxis [for causing pollution]. They were barely managing on his unstable income while he was working odd jobs. In addition, after the eviction they had to pay double the amount of rent in their new home regularly, whereas in the slum they had a close relationship with their landlady and delayed payment for weeks if income was irregular. Her husband was also suffering from hernia for the past 8 months. He had recently spent Taka 500 [AUS $12] on a chest x-ray, completely unnecessary for his condition, but recommended by a commercial clinic.

When Monsura shared her illness condition with her husband, he was sympathetic but suggested they wait till he saved up money to operate on his hernia, and then he would pay for her health condition. For Monsura, her husband's health takes priority over hers, and she herself admits that if anything were to happen to him she would be left a widow, reduced to begging on the street, saddled with a young child. She would prefer that his illness be dealt with first, which would relieve her mentally and emotionally. The costs of paying for a hernia operation is close to Taka 3000-5000 [AUS $150], more money than they can ever hope to have. Her father-in-law has remarried and is not interested in helping his son. Her husband's younger brother is married to a rich girl and

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vaginal examinations, asking women to push during the first stage of labor, pulling and manipulation of the infant and forced delivery of the placenta (Muna, L et al, 2002, also see Chowdhury et al, 2001).
has his own rickshaw business. Due to her husband’s bad track record of drinking and smoking marijuana, his brother was not interested in hiring him or lending him any money. His older brother had lent them Taka 1000 [AUS $ 25] for the operation, but that money was already spent on food and rent costs for the previous month. Monsura’s mother is extremely poor and survives by earning an income as a traditional healer. In the meantime, Monsura’s husband continued to look for work and complained of increasing discomfort.

Dire poverty and competition over scarce resources among families means that there is less financial and emotional support. Daily life is a struggle and living on insecure minimum wages ensures that there is no cash to plan for minor or major crisis in the household. The situation of all of these young women demonstrates how crucial it is to acknowledge the interaction of a myriad of factors, structural, social, and political-economic, which shapes their lives, affecting their experiences and responses to reproductive health problems. Married adolescent women’s lives are consumed by the burden of poverty and reproductive illness is just one of many other sicknesses in their lives.

Conclusion

The chapter demonstrates how structural and social inequalities result in particular reproductive health experiences for married adolescent women in the slum. Young women explain and interpret abnormal discharge and other reproductive illnesses within the context of social and sexual relationships with their husbands, and emphasize male behaviour as risk factors. Men increase a woman’s risk through engaging in rough, forced sex and marital infidelity. Cultural ideals and pragmatism make young women willing to have sex as men want and when they want, to narrow the competition from potential rival women. Thus, young women tolerate frequent and even risky sexual

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185 In the context of seriously limited resources, some studies suggest that there is a rank order in the perception of problems relating to their health. Sudden problems with menstruation [signs of infertility], pregnancy and delivery, basically anything related to childbearing are perceived as important and requiring immediate care (Ramasubban and Rishyasringa, 2001). However, I argue that in reality, whether they are able to do so is often influenced by many situational circumstances, including, resources, support, and power and politics in the household, as evident in the situation of many of these young women.
relations with their husbands, to maintain their social status and respectability, but in doing so; put their health and bodies at risk.

The government encourages women to use family planning methods to control their fertility. However, women remain ambiguous about using methods, and many complained of side effects, aggravated by poverty and hunger. The lack of counselling only adds to their dilemma. The cultural and social ideals surrounding childbearing force many to have children soon after marriage, resulting in miscarriages and reproductive illnesses. Young women experienced a range of illnesses during pregnancy, such as weakness, nausea, feet swelling, fever and so on. Most of them remain anxious about their health and the baby’s health throughout the pregnancy. Public health interventions to promote awareness of risky childbearing practices have made young women aware of the dangers of pregnancy. Biomedicine and technologies are increasingly accessed/used to manage women’s bodies and health, with beneficial as well as adverse effects. Poor quality and expensive care in government facilities has resulted in range of cheaper alternatives, such as, uncertified pharmacists/doctors, ultrasonograms and government ayahs masquerading as skilled attendants. Therefore, in Bangladesh, growth of private clinics, diagnostic centres and badly run government hospitals has led to a growing ‘medical-industrial complex of profit seeking operations,’ with services and health care determined by profit making (Singer, 1987:262). Poor young women are exploited and in many cases, their lives endangered.

The effects of a harsh political economy, class, and unequal gender and power relations are evident in the slum, where frustrated males turn to domestic violence to cope, which impact on young women’s reproductive health experiences. Four young women miscarried because of domestic abuse. Moreover, pregnancies and miscarriages leave married adolescent women vulnerable to gynaecological complications, such as discharge, weakness, pelvic inflammation and prolapse, which increase their anxiety and impacts on sexual relations and marriage. Social stigma associated with uterine prolapse, lack of information and poor quality of care result in women coping on their own. Finally, the experiences of Monsura, Shaheeda, Seema and Shehnaz are broadly representative of poor married adolescent women in the slum and demonstrate that to truly understand their experiences and responses to reproductive illness, we cannot separate it from the broader context. Reproductive health experiences and responses do
not occur in isolation, but are shaped by structural, social and cultural realities, and economic conditions.

In the next chapter, I focus on understandings of infertility, within this broader context, which is a primary reproductive health concern of married adolescent women in the slum. I demonstrate how infertility understandings among women in the slum are not static, but shaped by the conditions of life and the presence of biomedical interventions, which offer new medicines and modern technologies.
Chapter Seven

Infertility understandings: impoverished wombs, blocked uteruses & stolen babies

Introduction

Aisha is 15 years old and married for three years. She has been suffering from infertility for almost two years. She said, ‘When I fell pregnant...we were staying in Agargaon [another slum], with my mother-in-law. I was three months [pregnant], and I went and stood outside in the evening and a dog came and stood outside, ready to bite me. I got so scared that I lost consciousness. Everyone gave me water and I felt better. That night when I slept, I saw three hujurs [religious preachers] who showed me gold ornaments and asked me to go with them. They were taking me with them but as soon as I opened the door my husband stopped me. My husband asked me, ‘where are you going?’ I said, ‘why did you stop me.’ I was very angry. Why did he stop me? I still wanted to go. My husband started shouting and others came forward to stop me from leaving. They forced me down so I couldn’t leave.’ She believes that the hujurs were bad spirits who had come to steal her baby. She continues, ‘I became unconscious when they stopped me from going. My husband brought a kabiraj [traditional healer] and did treatment [blew prayers on her].

The spirits [referred to as Bhut/Jinn] can come in many forms - there are good, bad and all kinds. Some women dream that they are eating fruits but it is the bhuts [spirits] that come to suck the babies and take them away. Before I fell pregnant I went to my father’s place and got a hold of a kabiraj and she gave me an amulet for closing my body from the bad winds and spirits to keep my baby safe. After the dream, for 15 days I was okay and then after that my whole body swelled up like when water comes and fills up inside you. My husband took me to Midford, a government hospital, but I lost the baby...soon after I was told to take a method, the pill to avoid falling pregnant, which I did. But after some months, I experienced severe body aches, and bleeding and then I stopped taking the method after 6 months... but that was almost two years ago and since then I have not been able to conceive...

Sabina: Why do you think you lost your baby?

Aisha said, ‘I think it is the spirits who made me fall ill and took my baby, that night when I saw the dog and then the dream but sometimes I think the bori [pill] has made me
infertile. I think when I used it, it must have burnt my uterus or done something to it because since then, I have not been able to conceive at all... I hear of women who took the pill and then they cannot have children. It has been two years since I have not been able to have a child. If my husband remarries then where will I go? Who will I stay with? If I have a child then I have a future. In the household if there is no child, then I have no value in my household. Power increases for the woman as she negotiates with the family, her in-laws and outsiders. If a woman does not have a child, then no matter how much your husband loves you - one day he will turn around make a dig at you about being childless. My husband always grabs other children and walks around with them - plays with them. He loves children and so do I. Sometimes my husband says to me, 'if you can’t have children then what use have I got for you?' People say things to us. Apa, [sister] how long will my husband support me or put up with me? My husband has helped me a lot. Till now I am still okay. Sometimes I test him. I say to him, 'I can’t have children so why don’t you marry someone else?' Then he replies, 'in one person's life how many marriages does one do? Who knows if I remarry whether I will be able to have a child?' In the slum, there are lots of bad people who give him the wrong advice - they tell him, 'leave your wife, marry again and you will have a child!'

A predominant concern for married adolescent women is infertility as childbearing is so central to the female role and sense of self. Young women's sexuality and reproductive health and their ability to reproduce define their identity and gender role in Bangladesh. As Aisha's case shows, for poor women in Bangladesh, children traditionally provide them with a great source of symbolic value, as well as social and economic security. By giving birth, adolescent women are respected as useful and worthy members of society. Everyone in the slum advocated that children are the main reason for marrying and establishing a family, and bearing children is one of the main duties of a wife, thus reproducing the social order. Thus, structural subordination of women is reinforced, and as Ortner points out, distinct feminine aspects 'centering on biological reproduction' is promoted (1981:400). Lock and Kaufer argue that these 'culturally constructed gender and age related behavioural norms' are often legitimised as natural, thus women must conceive and reproduce to be considered "real" women (1998:20).
In Bangladesh, a report in the seventies found the infertility rate to be 6.9 percent (WHO report in Nahar P, et al, 2000). Since the State health agenda is primarily on fertility control, infertility studies remain absent in the review of literature and demographic materials till now. Fertility and concerns about reproduction dominated the conversations of young women in the slum. Observations and discussions with young women reveal that infertility can result in marital insecurity, ridicule, and abandonment, and low status in the household and in the community. Particularly in a harsh urban environment, where young women have very few support structures, children can provide them with future security, both socially and economically. This is discussed in detail in the next and final chapter of the thesis.

Aisha’s understandings of the causes of her infertility reveal a juxtaposition of folk models and biomedicine. Constructions of infertility meanings are not fixed and there is continual incorporation of new forms of cultural knowledge added on to older strands of existing knowledge, with production, ‘mediated in the realm of experience’ (Singer et al, 1988:374). In this chapter, I show how infertility is attributed to the spirit world, but newer constructions of infertility exist now, with cultural beliefs integrated with incoming reproductive technologies and biomedicine. Newer constructions of infertility blame it on long-term family planning use, which is perceived to ‘burn the uterus’ or cause blockage in the uterus, making women infertile. Young women remain concerned with high infant mortality rates, miscarriages and spontaneous abortions and always want to remain fertile. They fear that using a method for long periods might make them barren. However, extreme poverty in the slum also means that they are caught in a dilemma. Thus, many young women who have given birth to one or more children, are willing to tolerate contraceptives, because they believe that smaller families brings prosperity. However, they remain anxious, because they want to always be fertile, in case they lose a child.

Another popular reason given for infertility is the ‘build up’ of fat in the stomach. This is primarily attributed to long term family planning use. Women and men believe that contraceptives deposit toxins and fatty substances in the abdomen and uterus. In addition, eating the wrong kinds of foods, fatty or oily foods can also cause the ‘build

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186 This is to point out little importance is given by international and local policymakers to infertility concerns. The last study carried out on this reproductive condition was in the seventies and since then the entire focus of health research and policy has been on fertility control and maternal health in Bangladesh.
up of fat' inside the stomach and uterus, leading to blocked uteri and infertility problems for young women. The influence of biomedical technology is evident, and many women in the slum believe that the only way to get rid of the 'fat' is to undergo a medical procedure referred to indigenously as 'wash' [literally wash out and remove] the 'build up of fat' from the stomach or uterus. This illness concept of 'wash' refers to the medical procedure of dilatation and curettage [D&C -procedure to clean out the womb], borrowed from biomedical culture. Only a physician can cure this problem and carry out this procedure. Private clinics take advantage of poor women and promote links between infertility and the procedure of 'wash' however, very few poor young women can afford this procedure, and it is mainly lower and middle class women who access such services (See also Nichter, 1981). The reality is that the absence of a medical discourse on infertility results in the thriving of local cultural beliefs that largely continue to attribute the cause to the spirit world, and poor young women tend to rely on healers for a cure.

Local cultural beliefs largely link infertility to the spirit world. Infertility meanings associated with the spirit world symbolically mirror existing gender and power relations (Stark, Norris, 1993:79; Blanchet, 1984), and the disruption of social relations within the harsh political economy. Young women are seen as more vulnerable to spirit attacks because of their sexuality, which needs to be controlled through restricted movement and pardah. Young women who break pardah are said to increase their chances of spirit attacks and miscarriages. There are widespread stories of increased black magic and 'evil eye,' directed at individuals in the slum, with pregnant women and babies the most susceptible to harm. The narratives of aggressive spirits 'stalking young women' in their dreams at night and during the day, who 'suck and steal' babies from their wombs, metaphorically speak of the theft which both 'impoverish both young women's wombs' and their lives (Feldman-Savelsberg, P, 1994:470). The underlying cultural model of spirit world and infertility provides an insight into the wider forces shaping the lives of the urban poor.

This chapter is divided into four main sections. In the first section I discuss more recent understandings of infertility, which blame this condition on family planning use. In the

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187 See also Nahar P, et al, 2000 – for similar findings.
188 Older women who already have children, but believe that they have build up of fat in their uterus from long term family use also resort to this treatment to clean out their bodies.
second section, I explore the presence of biomedical technologies such as dilatation and
curettage, which are reshaping infertility meanings and care practices for women. In the
third section, I discuss models that attribute causality to the spirit world, for many of the
miscarriages, pregnancy mishaps and infertility problems experienced by young women
in the slum. Finally I discuss some of the gaps in health services in addressing the
needs of the young women and the policy implications of these understandings on
young women's lives and on health policies in the country.

Infertility understandings: incorporation of biomedical
models into folk models

Family planning: ‘burns the uterus’

It is understood that contraceptive use will ‘dry out the uterus’, and in some cases, lead
to the ‘build up of fat’ in the stomach, and obstruct fertility. These understandings are
often reinforced because of the disruption in menstruation brought on by contraceptive
use and the poor quality of counselling of these side effects. Married adolescent women
in the slum are in a terrible predicament, as they want and need methods to control their
fertility but worry that long-term family planning use will lead to menstrual
irregularities, and more dangerously, ‘dry out the uterus’ and make them infertile.

Shoma, 15 years old explained the ‘poisonous effects of the pill’ on the uterus:

Inside the bori [pill] there is something with a lot of powerful chemicals, and because of
this the child is not born. If you take this medicine, the pill enters your uterus directly and
all its chemicals are directly deposited there and thus it can do a lot of damage directly to
the uterus. Apa [sister] why won’t it be powerful? Only God can decide how many
children we have. But once you take this medicine it stops you from having a baby. So
you can imagine how strong it is and what it must be doing to your body. That is why a
woman feels sick and dizzy after using a method.

Embodied female experience is important to the shaping and content of ethno-
physiological notions, but it is also linked to the broader context. As Sobo points out,
‘social and moral order and pathology find homologous expression in

Young women spoke of rumours in the slum of women who refused to use a method being forcibly sterilized when they go to the hospital for an operation or when they had a hospital birth. These rumours are loosely based on experiences of poor women in hospitals, who are sometimes asked by doctors/nurses if they want to have any more children and if they would like to be sterilized. Women and men in the slum appear to distrust medical facilities and fear that they will be deliberately sterilized, because of State policies on fertility regulation, which are targeted towards the poorest in the country.\(^{190}\) In the slum, men, older women and traditional healers warn of the damaging consequences caused by frequent use of the pill and injectables, which are understood to not only stop flow, but more dangerously, 'dry out of the uterus' and 'build up fat in the stomach,' leaving women barren. In this, they promote resistance toward the State ideology of fertility control. Nichter suggests that rumours are 'social facts' and consist of local health knowledge which is counter to the propaganda of the State health authorities, and 'indexes power relations between a dominant medical system and popular health culture...' (1989:75). Gossip was rife in the slum with stories of female relatives unable to have children because of extended use of the pill and injectables. These cultural promoted fears of illness [infertility] have a 'social function insofar as it motivates individuals to avoid the danger [disease] by conforming to the dictates of the social code' (Sobo, 1993:64). The negative comments concerning family planning use are partly influenced by religious proscriptions, but also by difficult political economic realities in life, which make the urban population even more wary of State interventions into their health.

### Infant deaths: ‘a woman always wants to be fertile!’

It appears that married adolescent women who already have more than one child were more willing to tolerate contraceptives, and out of 104 responses recorded, 52.9 percent (n=55) initiated use of a method, but remain extremely wary of its consequences. This is not surprising considering the poverty and deplorable living conditions, which

\(^{190}\) Similarly Whittaker (2000) found the people of Isan in Thailand are critical and sensitive of the relations of power inherent in the implementation of the family planning program, which target them for reform.
contribute to illnesses and deaths among infants in the slum. In Bangladesh, 56 percent of poor infants suffer chronic malnutrition, and the nutritional status of children in poor urban households is much worse than that of poor rural children, from a similar socio-economic status. Nationally, the infant mortality rate is estimated at 71 to 82 per 1000 live births and one in nine children dies before reaching the age of five (BBS, 1997). In urban poor households, the mortality rate of under five-year-olds is three times higher than of children from well off households (HKI, 1997; BBS, 1997). These fears of child deaths are reflected at a micro-level in the slum and shape family planning behaviour. Farida, 17 years old, had given birth to her second child some months ago and was debating whether she should start using injectables immediately. Her sister-in-law remarks demonstrate the dilemmas poor young women have to face. She said, ‘Of course bhabi [Farida] will think about her decision [to use family planning]. She wants to make sure she can always have kids. Which mother doesn’t in this slum? A child can die suddenly - then don’t you need to have another one? No one wants to close the option of ever having a child.’

These fears meant that young women relied inconsistently on the pill and injectables, sometimes switching methods, taking breaks from using a method and even dropping out. To further add to young women’s anguish, the reluctance to use contraceptives, as well as misuse of methods, results in unintended pregnancies, which are then terminated. Often young women worry about reproductive complications, including infertility, brought out by repeated terminations. However, it is strongly believed that taking breaks in between method use gives the body a chance to ‘balance’ itself internally, and undo the harm from long term use of contraceptives.

To ‘wash’ or not to wash the fat off the uterus: d&c and infertility

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191 An analysis of fertility and mortality data in Bangladesh suggests that the occurrence of an infant death greatly increases the risk of a subsequent pregnancy (Rahman and DaVanzo, 1993), and the general fear of child loss appears to have a strong impact on subsequent fertility (Islam, A et al, 1996).

192 In Bengali culture one refers to their older brother’s wife as bhabi.

193 Abortion, unlike family planning use provides evidence of one’s fertility, an advantage for young women in marriages [more discussion in next chapter]. Many poor adolescent women prefer to use abortion or menstrual regulations as method of birth control.
Curing infertility by cleaning out the womb

Another popular reason given for infertility is the ‘build up of fat’, which can happen for numerous reasons such as family planning use, eating certain kinds of hot or oily foods, or because one’s menstruation has stopped. A way of curing this problem is to ‘wash’ [literally wash out and remove] the ‘build up of fat’ from the stomach and/or uterus. As discussed earlier, ‘wash’ appears to be a newer folk concept, borrowed from biomedical culture, and refers to the procedure of dilatation and curettage [D&C].

Afflictions of infertility caused by the spirit world require a local healer but only a physician can fix the build up of fat. These operations are performed for the cost of Taka 2000-2500 [AUS $60] in many of the private clinics mushrooming all over Dhaka City. These beliefs are maintained despite the high costs, and this is because many health workers and physicians continue to promote this link between ‘wash’ and infertility. A health worker explains how she took her sister in for a ‘wash’ after the doctor had advised her to do so, because her abdomen had become heavy from build up of menses. Often health workers are paid a commission, a small amount of money for referring patients to these private clinics, ranging from Taka 100 or more [AUS $2.50]:

For 13 months her periods [menses] was shut. That is why I took her to the clinic and they did ‘wash’ [D&C]. The doctor said, ‘she has fat in her stomach because of the menses being shut and that is why she had become fat. When they did an operation on her kidney stones at ANWARA [private] clinic about three years ago they had told her that she had a lot of fat build up. They said, ‘your menses has shut so let us do the D&C and remove the fat. It will cost Taka 3000 [AUS $75] and your periods will clear out.’ My sister did not have that kind of money to spend so she didn’t go ahead with the operation. Recently I took my sister to this other [private] clinic and they carried out the operation for less, for Taka 2000 [AUS $50].

Although the term ‘wash’ is used to also refer to pregnancy terminations, this procedure ‘to wash’ is seen as distinct from an abortion, and is viewed purely as the ‘washing out of fat,’ which is seen as obstructing the uterus and affecting fertility. I show below a discussion that took place between Ronnie, a young woman and her female neighbours who live in her complex, about her infertility problem. Ronnie is 19 years old and has been trying for a baby for the past 6 years and is contemplating a ‘wash,’ as a last resort:

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194 This allows for considerable ambiguity regarding abortions as well.
195 This is very similar to the illness concept of fibrom in Haiti, which requires abdominal surgery and costs US $500.
Ronnie explains, 'Apa [sister], all I want is to have a baby. Wash is an option, I cannot have children at all.

One woman disagrees and pipes up, 'She needs to show a fakir [traditional healer].

Then someone else comments, 'She has done a lot of things and spent a lot of money on all kinds of healers and now she has one last wish. She is trying to save up money to do a 'wash.' They will clean out the area.

Sayeeda apa [health worker] interrupts to say, 'What they mean is that she will do a D&C.

Ronnie says, 'With the wash they clean out the uterus, and if there is any fat or dirt build up, they clean it out once and for all making it easier for the woman to have a baby. 'Wash' is done to clean anything that is obstructing the woman from conceiving...and if a woman cannot have a child, her marriage will not last.

Some months ago, Ronnie had visited the health workers at the local clinic who advised her to take the pill for a few months to regulate her menstrual cycle. That is all health workers can do, in the absence of any biomedical training or official policy on infertility treatment. Although Ronnie is not sure whether she has 'fat build up' in her uterus, the failure of local healers to cure her has made her explore other possible explanations for her infertility. Ronnie makes no direct links between her severe discharge and her infertility problems, but she suspects that there is something not right with her uterus, however, she does not blame her husband. A few months later when we spoke to Ronnie she had given up on her plans for a 'wash' and said that she was going to try local healers again. As she did not have the money for the operation, her only option is to go back to the local healers, who are cheaper and available. In contrast to her, Shahana is 16 years old, and her mother paid for her 'wash' treatment, after numerous disappointing visits to local healers. According to her mother, Shahana fell pregnant soon after the 'wash' treatment.

Ronnie, like many of the married adolescent women in the slum, desperately wants to avail of biomedical technologies. For Ronnie, the only option is to wait and visit more traditional healers, as other alternatives are limited. On the other hand, for Shahana, her mother's financial help ensures that she is able to access a D&C - 'wash.' Out of 153
young women in the survey, 35 claim to have suffered from infertility [in the past as well currently]. Of this, 23 percent turned to prayer, and 39 percent went to visit *kabirajis* [traditional healers]. In reality, resorting to ‘wash’ as treatment for infertility is rare and only one young woman paid for this treatment. This situation is what Lock and Kaufert (1998) refer to when they argue that the process of medicalisation is not a monolithic enterprise, and reactions to it vary, depending on the perceived needs of the women, and I would add depending on the resources available. Young women actively reflect on their health and condition and resources, when determining a course of action.

**Spirit world causes infertility in women’s bodies**

The spirits steal and suck babies out of our wombs!

Inadequate formal health care for infertility problems has encouraged the continued existence of folk beliefs, remedies and practices, which offer young urban women sources of meanings, comfort and treatment for infertility problems. This in some ways reduces their dependency on an inadequate formal system unwilling to meet their needs. In Bangladesh, the lack of biomedical discourse on infertility has encouraged young women to depend on local healers and practitioners and elder women in the community for advice to seek care. Local healers and older women commonly attribute pregnancy complications, miscarriages, and infertility to the presence of the *jinns* and other spirits who live in the cosmic universe, and can give *drasti* [evil eye] to women, men and children. These understandings of the spirit world are an integral part of Bangladeshi culture and the belief in *jinns* has its roots in Islam, but a mixture of pan-Hinduism and local cultural folk beliefs embellish these understandings.

Young observed that some kinds of sickness episodes ‘perform an ontological role, communicating and confirming important ideas about the real world,’ and illness

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196 While the Quran states that there are *jinns*, this actually refers to the inner demons of the soul – anger, envy, jealousy etc. These versions have been created and now refer to *jinns* as independent beings living in a world parallel to our world. According to the slum dwellers, they are known to physically harm women and cause miscarriages and other health problems for women. *Bhuts* are not Islamic but have been melded onto the concept of *jinns*, who are thought to possess women. However, this is open to debate, depending on whether one takes the literal or metaphorical interpretation of the meaning. However, the existence of sorcery and witchcraft is recognized in the Quran, and there are numerous stories of attempts by the enemies of Islam to harm prophets through witchcraft. Plus there are some often recited prayers in the Quran to ward off harm from ‘evil’ eye, jealousy and witchcraft. The knowledge of witchcraft and sorcery is well known among all classes [poor and richer sections of society].
episodes validate ideas about hierarchy and power relations (1978). Understandings of the spirit world held by both men and women mirror the social and cultural structure and existing gender and power relations (Stark, Norris, 1993; Blanchet, 1984) and I would suggest also speak of disruptive social relations and the political-economic environment. Men and women believe that a jinn/bhut or pore can give dristi or najar [evil eye] or can alga batash [travel through the wind] and harm a human being. Incidences of Dristi and alga batash seem to occur mainly among females. Dristi and alga batash are used interchangeably to explain the destructive force of the spirit world. A jinn/bhut by giving dristi or alga batash can cause serious harm to menstruating, pregnant or parturient women, who are most susceptible. They catch hold of women who venture into the fields, near drains, latrines, and at certain times of the day and night (See also Blanchet, 1984). Newborn children are vulnerable to the powers of this spirit and any illnesses in the early months are blamed on batash. Jinnsl/bhuts are particularly active at daybreak, sunset, at noon and at midnight. Unlike jinns, which can be good and bad, bhuts are seen as completely unrestrained and immoral and not bound by the rules of human living society.

Infertility is blamed on kal dristi, which refers to abdominal pains and the passing of 'clotted black, blood' during menstruation, and treatment requires the skills of a kabiraj [local healer]. This affliction is blamed on jinns/bhuts who are attracted to the 'polluting' smell of dirty menstrual cloths, which if thrown carelessly on the ground, will result in the invasion of young women's bodies, causing infertility. Thus women's inherent pollution from menstrual blood attracts not only jinns, but also especially bhuts, who are regarded as the lowest of all spirits. The jinn or bhut is believed to eat or suck the baby/baby out of the womb. In the survey of 153 young women, 23 percent...

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197 Spirits and ghosts are categorized under a general heading known as bhut (Blanchet, 1984). Bhut are viewed as the lowest and most malevolent of spirits deceased who are unable to enter heaven. Often aborted children come back as bhuts, and remain restless souls wandering the earth and taking revenge on humans.

198 Sometimes pore and jinn are used interchangeably or to signify the male and female of this spirit form, with jinns viewed as males. Jinns can be both good and bad. These notions are not confined to only the poor and prevalent among the middle and some of the upper class.

199 There are also stories of jinns marrying humans and sexual relationships taking place.

200 Babies are kept indoors as much as possible and when carried outside, they are kept bundled up and not handed to strangers or childless women out of fear of the 'evil eye.' Infants are especially vulnerable to the 'evil eye' because they are so highly desired.

201 The literature on pollution and menstrual blood of women, identifies menstrual blood with energy and fertility, as well as with uncontrolled sexuality, which the spirits are attracted to (See Blanchet for further discussion, 1984: 64).
(n=35) admitted that they have been trying to become pregnant but not succeeding, with 67 percent (n=24) of them blaming their infertility on kal dristi.

Local healers refer to two types of kal dristi, mild and severe; in the mild case, young women may conceive but miscarry soon after, and in the severe form they are unable to ever conceive a child. The spirits are known to travel with the wind and prefer young and pretty girls, those who are adolescent, and particularly pregnant young women. An older woman explains, ‘as a girl grows up, the way the people notice her is the same way she comes under the gaze of the bad jinns. If a jinn looks at a particular girl, then kal dristi happens. The jinns tend to give dristi when the girl is young [in puberty].’ Thus the onus is on the adolescent women to restrict their movement and behave modestly, to avoid attracting the bad spirits. If she breaches the rules of proper conduct, the spirits will invade her body. Taussig writing of North America (1980:7) has observed that ‘behind every reified disease theory’ in society there is an underlying ‘organizing realm of moral concerns.’ This is also true in the urban slum, where infertility is linked not only to a modernist discourse, but also to moral concerns and the disruption of social relations. Many of the people in the slum blame the lack of pardah, immodesty and the transgression of social norms by young women for the increase in miscarriages and kal dristi incidents. A local healer shared her comments:

Not all jinns/bhuts can attack a mother. A mother has three rules she has to follow. If a pregnant mother goes to the bathroom and does not cover her head she will be attacked by the bhut. Secondly, if she sits in an indecent way exposing her left breast when she is in the toilet then a bhut can attack her and finally a woman who goes to urinate but does not wash her hands and feet properly then the bhut will attack them. You know it is the fault of the young women these days - why do they go outside the home to work or at wrong times to the bazaar and openly here and there? It [jinns] will get a hold of the women then, won’t it? Then a woman’s body also stays open [when she is pregnant].

Women have to be careful about where they walk and what they do.

Young women’s behaviour are seen as challenging the sacred role of motherhood, and disrupting the ‘perpetuation of the body politic’ (Marcia Inhorn, 1994:459), thereby threatening the reproduction of the moral and social order. Underlying these narratives are accusations of young women giving priority to other areas in their lives, such as, work, delaying childbearing by using contraceptives and thus undermining their primary
roles of being a mother. Older women often commented on how adolescent women like to flaunt their pregnant bodies, and attract envious eyes of the evil spirits. By behaving ‘immodestly’ young women were seen as rejecting ‘traditional’ Islamic behaviour, which according to orthodox views requires women remain secluded in *pardah*, and adhere to a moral code of behaviour. Increasingly now, adolescent women work outside the home in garment factories and in domestic work, earn their own income, while men remain unemployed. These understandings reflect inter-gender tensions, and validate important features of gender roles, which link women to pollution, restrict their movements, and in some ways access to income earning opportunities and economic resources (Stark, Norris, 1993). There is an implicit critique of urbanization [modernization], which has led to the disruption of gender roles and behaviour, and is seen as jeopardizing the social and moral order.

Jealousy and hostility are rife in the slum. Polygamy and competition over men and scarce resources leads to heightened awareness of enemies, and young and older women spoke of wearing amulets and shutting their bodies from spells cast by bitter co-wives, ex-lovers, jealous mothers-in-law and infertile women. A local healer in the slum explained a cure for infertility: ‘A mother who has no children and wants to conceive, can steal another child’s clothes and I tear a bit of the cloth and make a *tabij* [amulet] out of it. The child may be harmed but if one takes this *tabij* [amulet] then the menstruation will become all right and then the person will have a child. Even if the woman has been infertile for 12 years, she will have a period and have a child.’ Such stories only serve to heighten the tension and insecurities with accusations of witchcraft common, and stress the micro-politics of social relations in infertility narratives. A local healer explains how *jinns* can be conjured up to attack women and harm them:

> *Jinns* cannot just come like that they have to be called in by the *kabiraj*. Once a *jinn* comes they must possess the person. They take over the person. One must shut the body down and that is why women shut their body for their own good. Those women who have a child who passes away at birth or if they lose a child when they are three months pregnant child then they should wear a *tabij* [amulet] for their own safety. People wear this *tabij* [amulet] for their own safety. You can call them *bhut, jinn, petni*, they are all the same and they wander around with the wind. So when the mother is pregnant and

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202 Sometimes young women face accusations of being a sinful person or not wanting a child hard enough – but the onus of infertility falls on the woman and not the man.

203 These rules are relaxed as women age, become postmenopausal and assume mother-in-law status.
carrying the child then the desire for the *jinn* to eat the child is the greatest. Whatever they want to take they will make sure they have it. Only a *kabiraj* can get rid of them, not a doctor! They want to eat the babies and steal it from the mother’s stomach. When a mother is sleeping at night and she is dreaming she is eating fruits, it is the *jinn* that is eating her baby, sucking it out of her...

For young women, danger can come from anywhere, from infertile women, rivals and from malicious and greedy spirits, who are ‘eager to suck the baby from her womb’ and come at night in her dreams, or push her in the field, to destroy the child through miscarriage. Young women first reaction to these threats is to hide her pregnancy till it is no longer possible to hide it. Usually early on in the pregnancy, young women will visit a healer for an amulet to bind their bodies for protection from the ‘evil eye,’ and malevolent spirits from harming them and their foetuses. Healers provide amulets for protection as well as medicinal preparations for a positive pregnancy outcome for young women. Analogies are constantly made that pregnant women’s bodies are like ‘a delicious fish with eggs so everyone is eager to look at it.’ It was common to observe young women and pregnant women wearing amulets around their necks and even arms, and men also wearing amulets to protect themselves from harm. An amulet is basically a tiny cylindrical casket that is filled with a scroll of paper on which Sanskrit or Arabic words are inscribed and then tied to the body (Stark, Norris, 1993).

These discussions symbolically speak of the cultural and social disruption, expressed in comments about increased black magic and evil eye, wrought by worsening political-economic conditions. Similar to Cameroon, in the slum the balance of an ideal community is disturbed by individuals who use sorcery to harm others and for personal advancement (Feldman-Savelsberg, Pamela, 1994: 465). Young women fear manipulation and trickery from co-wives and others, mothers-in-law and sisters-in-law, who can cause conflict and disrupt their relationship with their husbands. The metaphors of ‘sucking and stealing’ of babies figure prominently in the narratives. Young women link their fears of infertility with concerns over being stigmatised and other women being suspicious of them. Increasing poverty, child loss and infertility position young women at greater risk of becoming socially and economically poorer, thus causing disruptions in social relationships and long term material and emotional...
support from their husbands and the community. With such concerns in mind, it is not surprising that the language and symptoms employed to explain illness conditions is replete with the experiences of life, ‘into illness we pour out experience of life, filtered as always through collective representations’ (Singer et al, 1988:380). Although, most slum dwellers cast their analysis in terms of the spirit world, these constructions of infertility meanings are dynamic and are continually subject to revision by newer illness models.

State policy: implications for the family planning program & poor women

Health systems and policy makers internationally and nationally have consistently neglected infertility. The international and national agenda is focused on overpopulation - controlling fertility and more recently on maternal and child health, with other aspects of women’s health neglected, creating a large gap in services and increasing poor women’s vulnerability. If the Bangladeshi government continues to focus on fertility control without providing counselling services for family planning side effects and infertility, contraceptive use will not increase among poor married adolescent women. Failure to address infertility concerns undermines the family planning program, as young women continue to make links between family planning method use and infertility, resulting in low contraceptive use or discontinuation of methods, as evidenced by the national indicators.

One of the other effects of the absence of a public health policy on infertility results in men not being blamed, and women continue to be viewed as the problem. Men are believed to contribute to the child’s conception, but women are seen as responsible for infertility (Stark, Norris, 1993:iv). The reality of men’s behaviour in the slum such as widespread substance abuse and as potential carriers of sexually transmitted illnesses contribute to infertility and yet are not addressed. Not only are young women vulnerable to sexual illnesses from their husbands, but they are also blamed for resultant infertility, which leaves them emotionally, socially and economically marginalized.

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204 Young women also sought care from the clinic – if they experienced abdominal aches and pains or any other symptoms, or if they were concerned about their pregnancy. By accessing more than form of care,
Conclusion

Infertility profoundly affects young women’s moral and social identities and the ‘local moral worlds’ in which they live (Inhorn, Marcia C, 1994:459). Women are seen as responsible for infertility, and men are rarely blamed. Guilt, blame accusations and mistreatment are among the common experiences of childlessness. Married adolescent women suffering from infertility problems have to contend largely with an indifferent formal health sector, which is more concerned with the global and local ideology of limiting births of an already ‘overpopulated’ State, rather than assisting with infertility concerns. This means that female bodies continue to come under scrutiny both at the local, cultural, social level as well as at the national, political and demographic level; but the same does not apply to men (Upton, R.L, 2001). Moreover, the absence of State services to address infertility concerns has implications for contraceptive use among poor adolescent women in the slum.

Despite the absence of widespread medical services for infertility, there has been a transformation of the folk health culture. Transformations in local cultural understandings of infertility brought about by the new and medicalised urbanized environment of slums, is apparent in the re-labelling of infertility from spirit world afflictions to something that is also attributed to family planning use and ‘build up of fat’ in the uterus and stomach. Young women in the slum remain anxious, as they need to control their fertility but worry about long term family planning use. There exists a divergence between the global discourse on population control, which is not interested in infertility experiences of poor women, and in the local discourse it is a predominant concern for all women. Poor women lack the political and economic resources to demand particular health services and are forced to turn to local healers for assistance. Thus, for many women the experience of infertility is one of anxiety and fear, pressures to conceive, social stigmatisation, and the constant search for therapies (Inhorn, Marcia C, 1994).

Infertility is also blamed on ‘build up of fat’ in the stomach or uterus and according to the women in the slum this can be cured by the medical procedure of dilatation and curettage [D&C]. Thus, there is a shift in local understandings of infertility, from which

in this way, young women ‘maximize protection’ for their pregnancy (Jacob, A Adetunji, 1996:1565).
only could be cured by local healers to one that requires the treatment of medical professionals. Singer et al point out in their discussion of changing illness symptoms among urban Haitian migrants, that there is ‘creative reconstruction’ of reproductive illness beliefs under changed social circumstances…and under conditions of biomedical hegemony’ (1988:380). However, for most poor women like Ronnie, the medical procedure of ‘wash’ is not affordable, and in the absence of other affordable medical treatments available, young women are forced to rely on folk meanings and seek care from healers. Local cultural beliefs continue to largely attribute the primary cause of infertility in young women to the spirit world. These understanding symbolically reflect gender ideologies and inter-gender tensions of urbanization, as well as material anxieties of female poverty brought about by childlessness.

In this chapter I examined how infertility is a primary concern for young women and their understandings of this illness. In the next and final chapter, I examine the contradictions and dilemmas of the fertility experience for married young women, which is embedded in the political economic structures of slum life. The last chapter illustrates how a dynamic urban landscape, competition for scarce resources and chronic poverty create tensions and struggles over fertility decisions, which have both beneficial and adverse consequences on married adolescent women’s lives, bodies and impact on their reproductive behaviour.
Chapter Eight

Disrupted reproduction: chronic poverty & fertility
dilemmas for married adolescent women in the slum

Introduction

Destitution and increasing marital instability in the slum mean that children are a necessity, a practical requirement, as well as a burden for married adolescent women. Children can trap young women in bad marriages, sometimes making it difficult for them to leave or to remarry, but the birth of a child can strengthen relations between the couple and offer young women status, power and security later in life. Ginsburg and Rapp (1995) have shown that reproduction itself is a potentially contested domain and one should focus on the structural and cultural processes, which shape conflicts surrounding reproduction. This is evident in the slum, where married adolescent women are forced to bear children before they were ready, and some are also forced to terminate their first and subsequent pregnancies. Despite the pressures, married adolescent women recognize that a baby can provide autonomy and encourage the separation of the household from hostile in-laws. The most common reason given to have a baby was to salvage one’s marriage. Young women and their families hope that a child will soften in-laws who are opposed to the marriage, improve their husband’s behaviour, make him more responsible and make the marriage stronger, making it less likely for him to stray. Thus, reproduction is an ‘ongoing social and political construction that can begin long before and continue long after’ the biological fact of childbearing (Greenhalgh, 1994: 4). In this final chapter, I will illustrate how a dynamic urban landscape and competition for scarce resources create dilemmas and contradictions for young women which have both advantageous as well harmful effects on their reproductive health experiences, their bodies and their lives.

As discussed in the previous chapter, for a married adolescent woman in the slum, her reproduction is not only tied to her power base and has symbolic value, but also has

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305 Recent work by anthropologists and feminists both within and outside of demography have brought new perspectives to the study of abortion. The ‘political economy of fertility (Greenhalgh, 1990:90) and the ways in which the meanings, beliefs and practices surrounding reproduction are structured historically and culturally by local and global forces (Ginsburg and Rapp, 1995, Greenhalgh, 1995) are some of the influential studies which have shaped greater understanding of the reproduction process.
economic and social consequences. As family support structures crumble and marital insecurity increases in the slum, poor young women hope that they can rely on their children later in life for their security but also to support the household, in the absence of a male figurehead. Although very few young women verbally stated that they preferred giving birth to sons instead of daughters, observations and informal conversations reveal that sons are valued. However, many older and younger women admit that nowadays it was the daughter who worked outside the home and supported families in old age rather than sons. Despite this, sons still bring in dowry [cash] to extremely poor families through marriage, whereas girls require payments of dowry, which is a burden for any distressed family. Further, religious and patriarchal structures ensure males have greater inheritance and legal rights and access to a public domain, offering women security as well as networks with influential people in the public arena, which is absolutely crucial for survival.

Infertility is a predominant concern for married adolescent women who were expected to have a child soon after marriage. A failure on the part of adolescent women to make a successful transition from status of daughter to mother often can result in the end of a marriage. But as discussed earlier, urbanization and increasing poverty means that there is tension around fertility and young women are not only forced to have children but are also forced to terminate their pregnancies. The major reasons given for forced terminations are chronic destitution, unpaid dowry, desertion, and rivalry among family members, in-laws or co-wives, all of which are aggravated by limited resources. Thus, women's bodies are not only vehicles for reproduction but also sites of struggle over control over reproduction (Greenhalgh, 1994:8). In circumstances where families relied on their son's earnings to manage the household, they did not see any personal gain from the adolescent bride having a child in the near future. Instead the birth of the child is seen as a burden on the family, and in-laws fear that the son's emotional ties and income may be diverted to the new bride and baby. Some males, who had more than one wife and already had children, were reluctant to support any more children and encouraged their second wives, who were usually younger adolescent women to terminate their pregnancies. In some households, young wives who did not bring any dowry money at the time of marriage were discouraged from becoming pregnant. Some were forced to terminate and instead asked to work and provide an income for the family. Thus, young women bodies are 'highly contested arenas over which a variety of individuals and groups fight to maintain control' (Doyal, 1995:94).
As the narratives in this chapter will depict, political economic conditions in the slum are restructuring ideas about motherhood and fertility. Kabeer suggests that many women in making fertility decisions find themselves in the paradoxical situation of making decisions, which may risk their own well-being as part of a survival strategy for themselves and their families (in Doyal, 1995:95). Poverty, uncertain existence and asymmetrical gender and power relations mean that poor married adolescent women have limited options and construct a rational ‘political economy of the body’ in their reproductive negotiations (Petechsky, 2001: 285). Petechsky argues that often women pragmatically submit to choices and decisions, which may violate their sense of bodily integrity, but do so in order to gain advantages under conditions of extreme poverty and limited options (2001).

In a large number of cases, the terminations of pregnancies are carried out illegally and increase risks to young women’s health and their bodies. In Bangladesh, abortion is legally restricted; there is the option of menstrual regulation which is the interim method of ensuring non-pregnancy for a woman at risk of being pregnant. The official policy is the resumption of menstruation and it is not regulated by the Bangladesh Penal Code, which restricts abortion. Menstrual regulation (MR) services are available at all major government hospitals and health facilities, as well as by local NGOs and private clinics, sometimes-clandestine private services, which are provided by untrained workers. The government provides support in the form of clinic space, salaries and equipment for MR training and services. However, after 1983-84, with funding assistance halted due to the US government stance against abortion, almost all non-government programs supported by the USAID (donor agency) stopped providing MR services (Akhter, H.H. 2000). This has impacted negatively on the quality of care and services provided for poor women in the country. A report estimates that there are over 400,000-500,000 performers of MR services, including traditional practitioners and medical personnel who have no formal training. Menstrual regulation costs almost Taka 400 [AUS $10], while termination services in private clinics if the woman is over 3 months pregnant are more expensive. In addition, poor services compel many young women to turn to cheaper illegal and dangerous methods to end their pregnancy (Ali et

206 In reality this is more ambiguous and in all cases observed at the clinic, poor women undertook a urine test to determine if they were pregnant, before they decided to terminate the pregnancy.
Induced abortion constitutes one of the major causes of maternal mortality and morbidity in the country (Akhter, H.H. 2000). These factors shed light on the relations of global and local processes and power relations, which impinge on married adolescent women’s lives, and shape their reproductive experiences.

Having a baby

Reproductive gains and their costs

In the slum, reproductive practices particularly child bearing is shaped as much by social and cultural ideals, as by the reality of poverty, high marital insecurity and gender and power inequalities, which govern young women’s lives. Browner (2001) notes that much of the literature assumes that men and women share similar reproductive interests, which is not the case, in fact reproduction is a potentially contested domain. In the slum, reproductive interests differed between young women and their husbands, in-laws and their mothers. Although many adolescent women value children, 72 percent (n=123) out of the 153 surveyed, said that they were coerced into childbearing soon after marriage, when they were not ready. As discussed in the previous chapter, there are strong pressures to prove one’s fertility as soon as possible after marriage. Having a child provides a young woman with social acceptance and ability to achieve social adulthood. Children are valued for bringing happiness to a household and increasing the emotional bond between a husband and wife, and ensure marital and economic security for young women (See also Cain, 1978, 1981, & 1986).

In the context of slum life, the reality of poverty and marital instability means that young women and their family hope that the birth of a child will improve the marriage and rectify their husband’s behaviour, and give women more power and room to

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207 Clandestine abortions are widely practiced in Bangladesh. Approximately half of the admissions to the gynecology departments of major urban hospitals are due to complications of abortion. A large portion of the poor women admitted were suffering from sepsis, temperature and pelvic infection, a direct consequence of procedures used in inducing abortions, such as using roots and or a stick into the uterus. However, in 37 percent of the cases, MR equipment was used for the induction of abortion (Akhter, H.H. 2000).

208 In a country wide national survey between October 1996 to March 1997 in health care facilities of different levels in the country and at the community, overall 28,998 deaths of women of reproductive age were identified [reported]. Of the 8,562 deaths associated with pregnancy or postpartum, 1,476 deaths were attributed to abortion. In a national maternal mortality study the ratio of abortion related death and reported morbidities of abortion were (1415:30668); 1:22 (Akhter, H.H. 2000).

209 See - (Doyal, 1995; Ginsburg and Rapp, 1995).
negotiate. Shohagi [14 years old] and her mother explain how her relationship with husband and in-laws improved considerably after the birth of the baby:

Shohagi: My husband and I had a love marriage. Soon after the marriage he started talking about children but I didn’t feel ready but he really wanted a baby. I was working in the garments. I wanted to work for longer, save up some money and then have a child. But he said, ‘you don’t need a job, you take a child.’ My mother convinced me to have a baby to make him happy.

Her mother interrupts and states: ‘My son-in-law would not work and they were always fighting. Also his parents started taking advantage of this situation and said, ‘we won’t take such a dark skinned girl and started demanding dowry money. Her husband would gamble and beat her up. He wouldn’t feed her rice properly. But after the birth of the child, things improved…her in-laws love her now and her husband’s whole world is his baby.

Shohagi replies, ‘My mother said that it was the only way to make him more responsible and make the marriage stronger... After my first daughter was born his maya [affection/love] increased for me. I am young I know but when I didn’t have a child in my home, it wasn’t a shongshar [no family life or marriage] in my home; it felt like we were dolls playing a house. Then once I had a child it became a household. He is pleased with me and he gives me whatever I need. Before he would give his brothers and sisters his income, but now he gives me his income. If one has a child, Apa [sister] you can exercise your rights but if you don’t have a child then you have no rights.

Once a woman has produced a child, perhaps, a son, but even daughters, she enters a new phase in her life. She can often initiate the separation of the joint household, and possesses greater domestic power and decision-making in the household (Stark, Norris, 1993). This was the situation for Lima, who is 18 years old, had a love marriage and was married for four and half years. She admits that it was after the birth of her second daughter Rina that her relationship was cemented with her husband. She fell pregnant soon after the birth of her first child and wanted to terminate the pregnancy, but her husband insisted she continue her pregnancy and she listened to him because she didn’t want to anger him. In the past four years, she was been subjected to mistreatment from her in-laws. According to her, her husband became more responsible after the birth Rina, who is the first female grandchild in the family and her husband’s favourite. Lima admits that as time went on, she became tougher and less willingly to put up with abuse.
from her mother-in-law, especially after the birth of her first and second baby. The separation of the household happened in the past year, when Lima had yet another fight with her mother-in-law. Her mother-in-law gave her husband an ultimatum, and he sided with Lima and they moved out soon after. Lima said:

He was usually out all day, either at work or roaming around and when he would come back he would hear the neighbours talking about how his mother had given me a hard time. I think things changed for me once I had my children. My son was born and my strength increased. My husband had affection for me, but it was really after my daughter was born that my husband became very happy. Although I was not ready for the second child my husband was keen so now I am glad. You see, in their family they are three brothers and one sister but none of them have any daughters. This was the first [grand] daughter to be born in this family. She is the first girl of the family...slowly things just came to a head we fought so much. I am not saying it is their entire [in-laws] fault; sure some of it is also my fault. Maybe I have faults as well. I guess I would answer back. I wouldn’t listen to everything they ordered me to do. After taking abuse for so long, I started replying back and I would say, ‘why don’t you work and let me sit around instead. Why should I do all the work?’ After hearing so much rubbish over the years you just burst one day and just say something back. I had worked hard enough for too long with no appreciation. One night at midnight when we were screaming at each other, they [in-laws] said to my husband, ‘will you live with this cunt or will you live with us?’ He replied, ‘I married the cunt and I will live with her.’ So we became separate. The kicked us out in the middle of the night. we became a separate household... She smiles and says, ‘once you have a child, there is more maya [love] and a woman’s power automatically increases. I realize that now. Once you have a child, then there is evidence. If anything happens you can get a hold of the man.

Thus young women are caught in a dilemma, emotionally and physically not quite ready to bear children, but they are aware of the positive advantages of children. Married adolescent women spoke of their children as ‘evidence’ [proof] of an obligation fulfilled, which ideally should ensure them greater rights over their husbands. Shohagi and Lima, like many young women, hope that the birth of a child can improve relations with the husband and also with disapproving in-laws, particularly if no dowry is paid at the time of marriage. A child tends to strengthen the marital relationship, and women hope that the husband becomes increasingly attached to his children and spouse. Some of the men appeared to have extremely close and loving relationships with their children, and continued to play an important role in their lives, even when they moved
out and remarried. Thus, young women hope that children will ensure continued emotional ties and financial support for the household, even if the marriage broke down.

Value of sons in a harsh urban environment
Married adolescent women realize that social acceptance and security in the marital home are established largely through fertility, particularly through the birth of a son. The preference for sons is evident in the dynamic and unpredictable urban landscape, where vicious poverty, crime and female vulnerability is widespread, and having a son can ensure, social, political and economic security for adolescent woman. Thus, for women, sons are valued not only because of social prestige and fulfilling cultural ideals, but linked to more pragmatic concerns. With more job opportunities available for males, sons can provide income as well as provide a degree of social protection in the absence of other male guardians. In contrast, young women have opportunities to work in a narrow range of occupations; garment factory or as domestic servants, and brick-breaking work, which is common among older women and is extremely low status and low paid work. Moreover, unlike adolescent females, young males are not restricted by ideologies of pardah and can work at a relatively young age, without fear of rape and harassment in and outside the slum. Younger and older women spoke of the burden of worrying about guarding a daughter’s izzt [honour] whereas boys are free to do as they pleased. As one woman explained, ‘a woman who gives birth to a son does not worry about a bad reputation. But if a woman has a daughter then she has more worries. She will always get a bad name if she does not watch her carefully.’

The extremely gendered nature of the labour market provides insight into the high value placed on the birth of sons in extremely poor households, where wage employment is crucial for survival. While females are also contributing to the household and have

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210 Studies in rural areas of Bangladesh have found sons are valued above daughters for their economic value in providing help to the family, working on the farm and land, providing security for parents in old age and in carrying on the family line (See Cain, 1977, Khuda, 1977; Caldwell, J.C. et al, 1984).
211 Although very few adolescent women verbally admitted that they preferred sons to daughters, observations in the slum indicate otherwise.
212 Women are excluded from a range of jobs open to males. These include: the transport sector [rickshaw pulling, baby taxi driving etc], most skilled craft-work [carpet work, mosaic work] and the majority of the service industry and retail sector jobs [shop/restaurants, hotels, grocery stores, barbers and cooks], and working in certain markets which involved movement at night (Salway, Rahman and Jesmin, 2003).
213 Cain (1978, 1981, 1986) similarly found in rural areas that since young girls were confined to mainly household work, families wanted sons as an effective way of investing into their future. Lack of real assets meant that sons could work and support rural parents in old age.
greater decision-making roles, they continue to still have limited scope for economic and social independence. This is because local power and patriarchal structures remain weighed against females (Salway, Rahman and Jesmin, 2003). This was apparent when the sudden evictions resulted in large numbers of families becoming homeless overnight in late July 2002. A few families decided to return to the village with their young daughters, and their only recourse was to leave their young male sons behind in the city to continue working and send money back to the village. To find appropriate accommodation and remain in the city is not as difficult or as worrying for young males, but young females are far more vulnerable to harassment and threats of sexual violence.

A patriarchal organizing society means that the slum is a male dominated environment and men tend to have more authority within and outside the household. The following narrative illustrates how men play a decisive role in the private and public arena, and use their masculinity and networks with others in the community to flex their muscles, assert power and control. Shuli’s [married adolescent woman, 13 years old] was forcibly sent back to her natal home by her mother-in-law, who constantly mistreated her. An unplanned meeting took place a few days later, when her mother-in-law visited her natal home to take Shuli back to the in-laws home. Shuli’s father had remarried, so it was her elder brother, being the only male guardian, who intervened and mediated the dispute. After some initial comments her elder brother refused to negotiate with the mother-in-law in the absence of the father-in-law and taunted her for taking on a ‘man’s role’:

He looks at the mother-in-law and says, ‘My sister got married on her own. I gave her in school to study but she did prem [love affair] and got married on her own. Listen, I live in a society and I am a Mirpur boy [name of locality] and I maybe a ‘wrong baj’ [thug] myself but I have not brought my younger sister up to be rude or bad. She can be at fault at times but she is a good girl...we want to know what happened. Now even if I want to call anyone, a thousand people will come running to our aid [showing off their power and strength]. We are 2 brothers and I have 5 uncles in this area. We are a well-known family and we know everyone. Ask about me in this area. Does anyone say anything bad about me? About 90 percent of the people will say good things about me. What will I talk to you about? Listen, sister, the men of your household let them be men. Give them a chance to speak. Why have you come? Where is your husband? He adds [after a pause],

214 There were quite a few families who returned to the village and left their sons behind in the slum to hold on their homes, continue to work and send money to the village.
‘it seems that in the 90s I left the arms [weapons] behind me but I will have to start taking up arms [criminal activity] again.’ The woman friend who accompanied the mother-in-law said, ‘no no, brother, let’s not talk like that…

During the discussion, Shuli’s brother did not directly attack the mother-in-law’s mistreatment of his sister. More significantly, during the discussions Shuli’s elder brother makes references to his tough image and reputation and his wider links in the community. He stresses that they can count on a large number of male kin who ‘will come running to our aid’ and even threatens to ‘take up arms’ [weapons] again, to intimidate Shuli’s mother-in-law and her family. This is deliberately to boast of the power and strength of his male network. His approach wavers between aggressiveness and conciliatory, and towards the end, he softens slightly and states that he will allow his sister to return to her in-laws home, but only after he meets the father-in-law. What is apparent in the discussion is a culture of violence and aggression, and the need for the presence/network of male guardians, be it, husband, sons, or uncles [fictive and non-fictive kin]. This provides a stronger power base for the family and for young women to negotiate. 215 Unlike females, males are socialized to congregate outside the home, and in this way they are able to develop relationships with other male peers in the community. In the context of a patriarchal dominated society and an insecure and crime-ridden environment, sons/males can provide a degree of protection for women, where violence is a socially sanctioned means of dealing with conflict. 216

While sons are important, many older and adolescent women realize that having sons does not necessarily ensure long-term security. There were many stories circulating in the slum of sons who neglect their parents and set up separate households after marriage. Some of the women argue that often it was daughters who support their

215 For example, when Moni’s [married adolescent and separated from her husband) salary was withheld for three months, she turned to her brother and his group of close male friends for assistance, who threatened the manager at her garment factory to pay her as soon as possible. Rani, was a leader’s wife, and after the eviction of the slum, a rival leader threatened her and accused her of continuing to extort money from the slum dwellers. Her husband had gone into hiding and in his absence she relied on her eldest son [17 years old] and his network of gang friends to confront the leader and sort out the situation. Shaheeda, [16 years old] is an unmarried adolescent woman, who works at the garment factory, seven days a week till late at night. She informed us that unlike some of the other females, she was never harassed and did not have her pay packet robbed by gang members, because her brother was well known in the slum and had close relations with many of them.

216 In addition to this, families who retain a rural base in their village of origin, need sons because they can be sent back to the village to purchase land or cattle, look after family land, or settle disputes over property matters. Some sons are left behind to take care of property in the slum, while parents return to the village.
families in old age rather than sons, working hard in the factory or at home in income
generating activities. Despite this, the reality is that sons may bring in dowry [cash] into
extremely poor families through marriage, whereas girls require payments of dowry,
which is a large burden. A young woman explained why girls were such an
cumbrance on families, ‘to get a daughter married off, one needs Taka 20,000 to
50,000 [AUS $500-1250] these days. This is pressure by the daughters on her parents.’
Further, religious and patriarchal ideologies ensure males have greater property and
legal rights than females. A male has the right to unilateral divorce, the right to
guardianship and custody of children from a marriage, and a double share in the
parental property. One man is equated to two women in legal testimony (Mansoor, T,
1999). In the context of destitution, marital instability and increasing vulnerability for
married adolescent women, the presence of men, particularly sons, means both
economic and social protection. Men provide links to local and social networks and
power relations, which women are excluded from, but are crucial for survival in the
slum and in the city.

Reproductive micro-politics of fertility behavior in the
slum

Poverty and insecurity: resistance to childbearing

Although there are pressures to bear children, growing poverty, disruptions in family
life and limited material resources also discourage some female adolescents from
having children. Majeda, [married adolescent] claims she was suffering from infertility,
kal dristi, and refuses to seek treatment despite her husband and mother-in-law offering
to cover costs. Other women in the slum claim that Majeda was using contraceptives to
avoid conceiving. Majeda explained:

My husband gave me money to go see a kabiraj [local healer]. But I didn’t bother to go.
This husband of mine is not very good. I think he has a relationship or wife elsewhere. If
I say 10 things to him he says about one thing. Sometimes he goes out and then he does
not return. Then it is very difficult for me to manage. Often my father and my aunt give
me food and some money and that is how I manage. Sometimes people say that they have
seen my husband talking to this woman or that woman. Now if I do treatment and take a
child then how will I manage? Don’t I have to manage? If women don’t have children it’s
a problem men want to go and marry someone else. But then again also if you have children men go off and you are left to look after the children, so you don’t really win either way. That is why I don’t give much importance to having a child. I don’t know if this shongshar [marriage] will last, so I don’t want a child.

Majeda, 16 years old, is married to a man who she suspects has another wife. This is her second marriage, as her first husband left her. She is not sure whether this marriage will last and does not want to try for a baby. For now, being childlessness is a source of independence and flexibility. Majeda’s narrative reveals how the wider social and economic oppression in her life makes her rethink her reproductive role. She consciously chooses a life beyond reproduction, through paid work outside the home, while still hoping for a better life. By resisting reproductive control over her body and ignoring gender pressures to conceive, Majeda remains paradoxically less vulnerable if her husband leaves her as she will not be saddled with a young baby. However, this manoeuvring has contradictory effects as continued childlessness will lead to the inevitable breakdown of her marriage and she becomes stigmatised, and can expect to receive little sympathy and support from the slum community. ‘Reproductive strategies are in flux’, (Sargent and Cordell, 2003:1964) and Majeda and her husband do not share similar reproductive goals. The situation in the slum reflects what Sargent and Cordell (2003:1964) refer to as reproduction ‘gone awry,’ and men and women’s reproductive interests appear at odds.\textsuperscript{217} The difficult economic conditions and social circumstances have resulted in a continual process of re-examining the value of childbearing, and young women like Majeda, reconsider the traditional gender expectations.

\textbf{Forced terminations: gains and losses for young women}

Although Majeda chooses not to have a child, some married adolescent women who do want to have children are compelled to end their pregnancies because of extreme economic conditions and tensions in the household.\textsuperscript{218} The survey of 153 married adolescent women, including probing in-depth interviews and case studies, found 18 percent (n=27) young women had terminated their first or subsequent pregnancies, of which 48 percent (n=13) had sought menstrual regulation services and 52 percent

\textsuperscript{217} See also – (Browner 2001; Browner and Sargent, 1996; Ginsburg and Rapp, 1995).

\textsuperscript{218} Similarly, a study by Ganatram and Hirve (2002) in India, found that 25 percent of adolescent women in rural Maharashtra, felt pressured into having an abortion by their mothers-in-law and husbands, when they wanted to continue the pregnancy.
(n=14) had illegally aborted the pregnancy. While many young women in the slum value children, they are not keen to have large families because of the poverty and suffering in their lives. Some of the young women spoke of the difficulties of feeding and looking after more than one child and preferred to terminate. Many of the young women have incorporated the discourse of family planning campaigns, which link smaller family size to better economic conditions and hope to improve their quality of life. In the general discussions, only a few women revealed moral or religious concerns with termination; instead young women prefer to keep it quiet from others, because they worry neighbours would assume the abortion was because the pregnancy was a product of an extra marital affair. As one young woman explained, 'They say to women, why don’t you want to keep the baby? Is it not your husband’s?’ A common justification for termination used by many of the young women and their family is the risk of early childbearing. They employ widespread public health Safe Motherhood messages, which depict early childbearing as extremely dangerous. They argue that it is safer to terminate the pregnancy rather than endanger the life of the adolescent girl. Ironically, the means to regulate fertility is through illegal or menstrual regulation, rather than family planning use.

Available literature demonstrates that often values, ideologies and concepts related to abortion, or legal terminations of a pregnancy are culturally and historically constructed and definitions of motherhood and pregnancy change over time (Rylko-Bauer, B 1996; Greenhalgh, 1995). While fertility and childbearing remain important, against the backdrop of hunger and deprivation many young women experience contradictory pressures regarding reproduction. As discussed earlier, 11 married young women said they were coerced into terminating their first pregnancy, except for one case, where both the young husband and his adolescent wife ended the pregnancy because they

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219 I would say the number is higher but because abortion and menstrual regulation is a sensitive topic, it is difficult to gather the actual number of terminations and many women underreport or do not mention it at all. However, observations at the clinic reveal that young and older women regularly come to the clinic to carry out urine tests and many end their pregnancies either through abortions or menstrual regulations.


222 Data gathered from – 2 adolescent women in the 153 surveys, 2 adolescent women from long term clinic observations, 2 adolescent women who were referred us by the health workers, and 5 adolescent women spoke of this in detail in the 50 indepth interviews. For example, in the indepths, Rosina [14 years old] and her husband [17 years old] revealed she was embarrassed because she was pregnant so soon after their marriage. Her husband felt that they were too young to have children. Her husband was worried about being teased by his friends and uncles who were the same age and older, and did not have any children as yet. However, she did admit that she would have preferred to keep the baby but he did not agree, so she was forced to terminate.
worried about the stigma of early childbearing. The forced regulation of pregnancies is not only about a 'gendered divergence' of reproductive goals (Sargent and Cordell, 2003:1961), because both males, husbands and fathers-in-law; and females, mothers-in-law and co-wives, pressured young women to end their pregnancies in the slum. Extreme deprivation and rivalry over resources and asymmetrical relationships ensure that adolescent women have few options to resist such demand.

**No dowry, no baby: ‘stratified’ reproduction**

Bina, (a 17 year old adolescent woman) fell in love and married her co-worker in the garment factory, Bulbul, who is 20 years old. The marriage took place despite her parent’s anger and protests. They were unable to stop the marriage as they lived in the village and Bina was independent, earning her own income and living in the city with her uncle. After one year, Bina and Bulbul decided to get married. Although her in-laws did not protest about the marriage she knew that they were not happy because she had not paid any dowry at the time of marriage, but her husband insisted that she did not have to pay any dowry. They settled comfortably into married life and lived in her in-law’s home in the slum. After 6 months of marriage, Bina fell pregnant. However, when she fell pregnant her relationship quickly soured with her father-in-law who pressured her into terminating her pregnancy. She was extremely disappointed that her husband did not defend her and chose to go along with his father’s decision:

A couple of months after my marriage I went to the local healer [to exorcise her from evil eye and spirits] but I still felt weak and tired all the time. My husband forced me to go to the doctor who did a check up and informed me that I was pregnant. When we were leaving the clinic, my husband said, ‘Let’s not keep the child, you are not well at all. You look so sick.’ My grandmother-in-law brought medicine [abortion medicine] from the local healer ... [her voice starts shaking now] my father-in-law wants me to work and bring money for the household. If I fall pregnant I cannot work, can I? She brought the indigenous medicines the very next day after our visit to the clinic, but when nothing happened, then my father-in-law went and spoke to health workers about a possible MR [menstrual regulation]. I overheard them speaking about the costs of the MR. What did you think? I thought to myself what is the point of me saying anything. My father-in-law has no intention of letting me keep the baby. If I don’t listen to him, I will have to suffer and hear words. Then who will feed the baby if no one wants the baby in the household I felt very sad initially. It was our first child and I thought that he [husband] would also
want to keep the child, but he is too scared of his father. He didn’t want the child but then again he did. He said, ‘If you want to really keep it then keep it’ but his heart was not in it and I didn’t want to have a child and give it suffering. If there are costs for the child I will always have to hear about it. [She starts crying – we stop interview… and then she starts after five minutes] …when I got married and I came to this home my father-in-law said to me, ‘You have to work for two years and then give me all your earnings.’ Why did he say that? Well if he had got his son married he could have got Taka 50,000 [AUS $1250] for him in dowry money so I have to make up for it. Were you upset with your husband because he didn’t support you? I was upset but what can he do as well. We live at my father-in-law’s place and he provides us a roof over our heads. I have married him now and my parents have nothing to do with me. It is better that I keep quiet and do as my in-law thinks is best… a lot of garments are shutting. They are not paying us and many women have not been paid for some time. I was sick for 12 days and I lost my job at the garment factory. When you don’t have money in your hands then you have tension… you have tension about the future about what will happen to our future. If one has money in their hands then they have everyone else in their hands but if someone does not have money, then your strength is less. My husband gives his entire salary to my father-in-law. If I need anything I have to ask my father-in-law… so for things I like, such as for earrings or clothes, I cannot really ask for money. Things are different now that I am married…

Bina, like many poor adolescent women in the slum, is not in a position to negotiate her situation. However, married adolescent women who can afford to pay dowry and have strong natal and spousal support, are likely to face less pressure and be allowed to reproduce. This situation is what Ginsburg and Rapp (1995) refer to, as ‘stratified reproduction,’ where power relations decide which categories of people are empowered to nurture and reproduce while others are unable to do so.

Although, some young women were forced to terminate their pregnancy, a few of them resisted such pressures. Rashida [16 years old] lived with her husband in her in-law’s home. Like Bina, she also had a love marriage and did not pay any dowry at the time of marriage. When her in-laws found out she was pregnant, they insisted she terminate her pregnancy but she refused.223 Rashida’s husband did not work regularly and her in-laws

223 It is difficult to know whether Rashida was given contraceptives by her husband or in-laws to stop her from conceiving. It could be that Rashida secretly stopped using them in order to fall pregnant or her fears of infertility stopped her from using a method. It was not clear from the discussion whether she had ever used a method or why her husband did not take responsibility for fertility control and left it up to Rashida. It could also be that although her husband or in-laws did not want her to use a method, [because of
wanted her to continue working at the garment factory and provide for the family. Her husband and in-laws relied on her income, which meant that they saw little gain personally from her becoming pregnant. Instead the birth of the child was seen as a burden. To her in-laws dismay, Rashida stopped working five months into her pregnancy. When she suffered from serious labour complications during her pregnancy, her in-laws refused pay for treatment or intervene. Eventually, her mother and brother took her to the clinic and paid for the costs, which were close to Taka 5000 [AUS $170]. Although Rashida gave birth to a baby boy, she continues to be subjected to verbal and physical abuse from her in-laws and her husband. In this case, Rashida productivity is given priority and valued, instead of her reproductive capabilities. However, Rashida and Bina, like most married adolescent women are in a dilemma. They are expected to produce an income for the family at present but in the near future they will also be expected to reproduce for the family. Thus, the political economic conditions have worsened the situation for young women, where their reproductive abilities do not necessarily have the same value and status it once had, and instead they are expected to work and earn an income and contribute to the household.

**Marital insecurity, co-wives: jealousy, manipulation & fertility**

As I discussed earlier in chapter four, it was found that 11 percent (n=17) of married adolescent woman said that they were divorced/separated or abandoned. Furthermore, 5 percent (n=7) of young women claimed that they were previously married and this was their second marriage, and another 4.5 percent (n=7) claimed that their husbands had a co-wife and spent time in both households. In polygamous households, competition for resources is more than compared to other households and is likely to affect young women’s health even more. Most young women tolerating their husband’s relations with co-wives realize that there are sparse resources, which must be distributed to a variety of family needs. The rivalries with co-wives over finances as well as the insecurity of wanting to strengthen emotional and sexual ties with husbands can compel young women to assume they would terminate if she did fall pregnant, which is not uncommon behavior in the slum. The discussions surrounding family planning use is difficult to find out because some young women initially do not want to admit that they do not want to use a contraceptive, for fear of reprimand or being viewed as ignorant. They would often nod their heads in agreement and list the names of contraceptives available. However, long term participant observations revealed that very few used a method before the first child for fears of infertility, which is a real concern. As I stated in the earlier chapter, young women often prefer to terminate their pregnancy rather than use a method before they their first child, and at least with menstrual regulation, there is proof of their fertility. This situation is definitely under reported.
some co-wives to try and have a baby soon after marriage\textsuperscript{225} (See Bledsoe, C et al, 1998). This was the case of Dolly, [15 years old] who wanted to have a baby and strengthen her relationship with her husband, as she was his second wife. He was previously married and had two children and continued to maintain close relations with his first wife and children. Below is a discussion that takes place between Dolly and her husband, over her pregnancy. Dolly claims to be four months pregnant\textsuperscript{226} but her husband wants her to abort the child. She claims that she is too weak to abort the child:

Dolly angrily comments [looking at her husband]: ‘See, I am nothing to him. But if I have a child he will have to buy it milk. He buys those children [from first wife] milk but he does not make a big deal of it, but when it comes to me it is a different story! I am not going to get rid of this child.’

The husband said to me [researcher]: ‘Apa [sister] I can only pick up two mounds on my head but if someone gives me more than 3 mounds can I lift it then? Tell me Apa [sister] I told Dolly to abort the child. I will suffer, as this child is also mine. But if the child is born then I won’t be able to take care of it and I won’t be able to manage. This child is still in the stomach so I have no maya [affection] for it but once it is born then won’t I have a different kind of affection for the child. Then will I be able to do anything? But this I cannot explain to her.’

Dolly responds angrily, ‘I will keep the baby and if I take this child you will have to give milk for it. I know why you don’t want me to keep the child; it is to keep her happy [first wife]. He already has children so why would he be interested in having any more children.’

A few weeks after this discussion, Dolly ended her pregnancy. She was extremely upset that her husband did not support her and decided there was no point in continuing the pregnancy. She initially purchased some pills from the pharmacy but when that did not work, she asked her husband to pay for her menstrual regulation from the local clinic.

\textsuperscript{225} Sargent and Cordell (2003:1970) refer to ‘pregnancy rivalry’ among co-wives, proposed by Fainzang and Journet [1988] in their book, La femme de mon mari [the wife of my husband]. See also Bledsoe, Banja and Hill, (1998) - they refer to rural women in Gambia, if divorced with children, need to build up their base by having more children with their new partners. See also, Ratcliffe, A.A., Hill A G., and Waller G. (2000) for similar discussion on polygynous households and its affects on reproductive dynamics. See also, Barthelemy Kuate Defo, (1997) who discusses how polygamy disrupts and negatively affects women’s health.

\textsuperscript{226} Young women often are unsure and guess their pregnancy stage, so she could be under four months rather than over four months. However, private clinics do terminate pregnancies over three months, beyond the safe period of 10-12 weeks allowed legally.
She was so upset after the termination that she moved out of her husband’s home and moved in with her elder female cousin, Shehnaz who also lived in the slum. Since then, her husband has been pleading with her to return to him, but she refused. The discussion between Shehnaz, (who herself is a first wife and shares her husband with a younger second wife) and Dolly below, highlight the politics and power relations that exist between co-wives:

Shehnaz states, ‘The second wife does not have strength and power as long as the first wife is alive.’

Dolly scowls and says, ‘It depends on the husband...I am fed up and I don’t want to eat his rice [remain married to him]. He has a wife and children already.’

Shehnaz interrupts to say, ‘The first wife always remains the first wife. A first wife’s presence [morjada] a second wife can never fill. A husband gives priority to the first wife always.’

[Dolly makes a face] and then interrupts to remark: ‘A second wife’s presence a first wife can never fill either! A husband gives priority to the second wife.’

In the case of Dolly, the fact that her husband already has children meant that he was not interested in supporting another child. Dolly is concerned that her husband’s behaviour and indifference to her pregnancy may actually reflect his sentiments towards her as a new wife and reveals the stronger ties he may have with his first wife. Dolly was eager to have a baby as soon as possible to hold on to her husband’s affections long term and to mark her position in the household, improve her status and power. The existence of co-wives aggravates jealousy and insecurity among the women, shaping their responses. As such, gender and power inequalities and access to scarce resources, exacerbated by polygamy, impact on reproductive health behaviour.

For example, in Maliya’s case, [14 years old], she was married for less than one year and was caught in the politics between her two mothers-in-law and suffered the consequences. Maliya’s husband’s stepmother arranged their marriage, but soon after the marriage, Maliya moved in with her husband to his own mother’s home. However,

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227 At the time of the interview and in the next few weeks when we carried out repeated visits we found her still with her cousin sister, Shehnaz. But a few months later, Dolly returned to her husband.

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Maliya continued to remain close to her father-in-law’s much younger second wife. Her mother-in-law constantly harassed her. Maliya admits that the jealousy between her mother-in-law and the much younger co-wife, and her close relationship with the co-wife, was the one of the main reasons for the tension between them. When Maliya fell pregnant, her mother-in-law insisted that she terminate her pregnancy, using the discourse of public health campaigns and cited her young age as a great risk factor. In addition, Maliya’s husband did not support her decision to continue the pregnancy and sided with his mother. Since Maliya lives in the first mother-in-law’s home, the father-in-law and his second wife did not interfere for fear of antagonizing the first wife and sons. Maliya’s parents live in the village and did not want to interfere. Private discussions with Maliya’s mother-in-law, Sharmeen, reveal underlying tensions about her co-wife, daughter-in-law and her insecurity about losing control over her son:

...Maliya had a wash [legal abortion] about 3 months ago. Did Maliya want to abort the child? Did your son want her to abort the child? Maliya did not want to abort the child but my son was not agreeable to this. I thought she was too young. He felt he was too young and it was too soon for them to have children. This son of mine did not want to get married even. He did not like her. That woman [second wife] picked her out for my son. Why did she want a child immediately? She wanted to take a child immediately. Then she would trap my son. Why do you say that? Then she would trap us and she would just do what she wanted to do and go wherever she wants and then we wouldn’t be able to say anything. This is what she wanted. You see that woman [co-wife] also immediately gave birth to a baby, she couldn’t even wait long before she was producing a baby for my husband... Why would Maliya be able to trap you? She would be able to hold on to my son. If she gave him a baby boy, he would listen to her and she could do what she wanted. But it didn’t quite work out like that and I told her she must get rid of the child and she was too young. Do you know what Maliya tells me, ‘you didn’t bring me here. My father-in-law and choto [second] mother-in-law did; this is the way she speaks to me!’

Interpersonal conflicts between co-wives can impact on young women’s reproductive health choices. In this situation, Maliya’s mother-in-law, Sharmeen, fears her position is shaky, as her husband has remarried a much younger woman who has already given birth to a baby boy. Sharmeen only has her two sons to rely on for her future economic and social security. Despite the fact that her husband owns numerous small grocery stores in the slum and land in the village, under Islamic law, a mother can only inherit one eight of her husband’s property if she is widowed. Her two sons and any children
the second wife bears will inherit almost all of her husband’s property. Widowhood and women without sons to rely on, are at greater risk of illnesses, poverty, with their only recourse being begging and death (See Abdullah and Zeidenstein, 1982; Lindenbaum S, 1974; Rahman et al, 1992). Sharmeen is anxious that if Maliya has a baby then her son will shift his affections to her and the newborn baby. This will automatically result in the transfer of his finances to the needs of his own family. Sharmeen recognizes that she is very dependent on her sons and needs them for her future protection. While she still has the power to dictate over household matters, she will continue to act in her own best interests, even if it harms her daughter-in-law.

Struggles over termination of a pregnancy provide an insight into the complex inter-relationships between structural conditions of poverty and gender and power inequalities, which shape the nature of relationships between husbands and wives, brides and in-laws, and among co-wives, and shape reproductive behaviour. Married adolescent women’s bodies become sites of struggle and manipulation, and they are forced to make a trade-off between long-term support and security and risking their reproductive bodies. As Petechesky said, women may go along with decisions not of their own, but in the context of limited options, they hope to gain some advantage under extreme conditions (2001).

**Biomedical interventions & poor quality of care**

**Termination of pregnancies: ‘it’s a business for the health workers!’**

Pregnancies are terminated, either through menstrual regulation, which is legal and expensive or through crude and illegal means, which is often the preferred option, as it is much cheaper. However, young women also worry about reproductive complications and even infertility, from too many terminations. Termination methods range from using herbal pills, roots and liquid drinks purchased from local healers and even packets of birth control pills from the pharmacy and local slum clinic. In the case of Dolly, Bina and Moni, they ingested indigenous methods at first but when that

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228 Due to the sensitivity of the issue, the precise number of pregnancy terminations performed both legal and illegal is unknown in Bangladesh. According to the Bangladesh Demographic Health Survey (BDHS), 2 percent of the sample of 9,640 currently married women said that they had terminated an unwanted pregnancy (1999-2000).
didn't work, they resorted to menstrual regulation services from the local clinic. The cost of a menstrual regulation at a local NGO is approximately Taka 350 [AUS $8], which does not include the costs of medicine or transport to the clinic. This explains the preference for cheaper options from the local informal sector. In addition, although the government officially claims to provide free procedures, in reality, women have to pay from Taka 30 to as high as Taka 550, [AUS $0.75 - $13.75] with the average amount spent Taka 290 [AUS $7.25] (Hossain A et al, 1997).

As discussed earlier, Bina, was forced to end her pregnancy because her father-in-law wanted her to work for two years and contribute to the household. She explains how scared she was when she went with the health worker to a private clinic for the termination. After the termination, which took about 15-20 minutes, a woman worker at the clinic made Bina lie down in the rest room. Usually, there appears to be inadequate post-operative monitoring and most young women are expected to leave immediately after the procedure. Although Bina was asked to rest for half an hour, we left ten minutes later when the health provider became impatient to return to the slum. Bina was sobbing quietly. She said:

I didn't want to abort this child. But because today I am poor so I had to get rid of this child. When they did MR (menstrual regulation) I felt that they were pulling out my liver, my heart and my soul. I cannot explain it but it was like they were ripping out my soul. I was so scared. It could be that there is suffering inside my heart because I had to destroy this baby... When the daktar [nurse] walked in the room with the syringe I was just praying inside and my whole body was shaking. The daktar [nurse] became angry and said, 'Why do you keep screaming out God? What has happened to you? Why are you behaving like this?' Apa [sister], I will never ever do this again. I will never do MR [menstrual regulation] again. I won't let anyone ever do this again to me...

Bina was also concerned whether the menstrual regulation would result in any reproductive health complications. She said, 'I have heard that if they put their hands inside me for the MR [menstrual regulation] then the place [uterus] gets spoilt. Then what is a woman left with? But I don't have a choice, do I?' A widespread understanding is that termination, particularly if it requires the insertion of hands or

229 See Caldwell B et al, (1999) for more information on this topic.
230 Women are dependent on health workers for information, dates and locations to access menstrual regulation services.
anything else inside the vaginal area, is invasive and believed to disturb the body's natural balance, harming one's health, womb and fertility.

Economic considerations of health workers overshadow quality of care. There is no counselling of young women's health concerns about menstrual regulation and rarely any follow up care of patients after the procedure takes place. The workers in the slum remain overworked and underpaid in the present health system. The main concern for poor and marginalized health workers, who earn only Taka 1300 per month [AUS $32.50], is to gather as many clients as possible as there is a large amount of money to be earned from menstrual regulation services. Female health workers and even the local paramedic thus become brokers for private clinics and compete with one another, always scanning the slum and in the clinic for potential clients. There is a system of referrals where numerous private clinics which employ trained or untrained workers, have linked up with field health workers, including the paramedic, promising them cash in exchange for clients. The incentive for health staff to take poor women to private clinics is that they are paid half of whatever the client pays for the costs of the termination, earning close to Taka 100-150 [AUS $2.50 - 3.75] per client, a substantial amount of money for poor women and their families. In contrast, they only earn a fixed amount of Taka 50 [AUS $1.25] from their local NGO clinic. As a consequence, health workers are more inclined to take adolescent women to private clinics for menstrual regulation, and as a result, quality of care is severely compromised. Private clinics are more willing to conduct the procedure beyond the safe period [more than 10-12 weeks], and there is no responsibility for post abortion complications. If there is an incomplete menstrual regulation, poor young women are expected to cover the full costs for a repeat termination.

In contrast, the local NGO clinic did not provide termination services beyond the safe period and provides free repeat procedures, in the event of an incomplete one. However, attitudes of staff and the quality of care remain poor, which is documented in other studies (see Hossain A et al. 1997). After Dolly had a menstrual regulation at the local NGO clinic, she suffered from abdominal aches and bleeding for 14 days. She returned to the clinic to complain. Initially the NGO health providers dismissed her concerns, but

231 Observations and discussion reveal that clinics link up with health field workers from all the NGOs operating in the slums and nearby areas.
after she persisted they took her back to the NGO clinic for a second procedure. Although she did not have to pay for the second termination, she had to pay for the costs of the transport and medicines bought, which cost her close to Taka 50 [AUS $1.25] [the cost of one/two days of food]. After the second procedure, her bleeding persisted, so she returned to the clinic anxious for advice, but the health staff blamed her for the complications. This is the interaction that took place between Dolly and the health staff in the local NGO clinic in the slum:

Dolly said to the health worker: The bleeding is still happening. It has been one month already. I have gone and done wash [menstrual regulation] twice at the NGO clinic. Even then I am not getting any better. Tell me what you want to do with me.

Dolly was brought in front of Rashidah [a senior health worker who was visiting the slum clinic] who was quickly informed of Dolly's situation.

Rashidah said: Have you done an ultra-sonogram? Then we will understand if you still have something inside you or not [incomplete procedure]?

Dolly said: What is an ultra-sonogram? I don't understand any of this. I need help for the bleeding...

Then Mahmuda [the local paramedic] informs the visiting doctor: Apa [sister], she has had wash [menstrual regulation] twice and she is still bleeding.

The doctor scolds Dolly: Listen, doing an MR [menstrual regulation] is not good for your health. If a girl does this, then it does a lot of damage to her body.

Dolly replies, Apa [sister] I didn't do it on purpose. I got into a situation where I had to do it I didn't have a choice. Does anyone do this on purpose?

The doctor continues in a scolding tone, ... Are you having sex with your husband? If you are, then this can happen and then we can't do much to help you.

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232 Physicians use the term incomplete procedure when parts of the products of conception have been expelled and part has been retained (Lane SD et al, 1998).
233 A study in Bangladesh found that out of 53 clients, more than half of the women ended up with incomplete procedures and complications and many providers conducted the procedure beyond the 10-12 week period (Hossain A et al, 1997).
234 I observed this interaction in the clinic.
Dolly remains quiet. She is asked to return on Wednesday morning and once again needs to return to the NGO headquarters for a check-up. As she leaves the clinic, she mutters to herself, ‘If I am not going to stay with my husband [have sex] then what else will I do?’

Dolly is extremely concerned about the loss of blood and that her body is becoming weaker and will eventually waste away. The clinic does not want to take responsibility for the post abortion complications and instead Dolly is asked to pay for an ultrasonogram, a procedure she does not understand; which is expensive, costing approximately Taka 400 [AUS $10]. Her husband has already spent Taka 350 [AUS $8.75] for the menstrual regulation. The doctor is reluctant to empathize with Dolly’s socio-economic circumstances and powerless situation, and instead she is made to feel guilty about her decision to have a termination and also accused of continuing sexual relations with her husband. Thus, Dolly’s suffering is multiplied; not only is she pressured into terminating her first pregnancy by her husband, but the health staff are dismissive of her complaints and instead blame her for the health problems.

However, the slum clinic came under fire recently, after an anonymous phone call was made about the behaviour of health workers to NGO headquarters. Sufia, a health worker informed us in November 2002, ‘Do you know what happened not too long ago? Someone called up our manager and said that we take them to a private clinic and one of the girls said that she was still bleeding. The manager called up Mahmuda [paramedic] and confronted her and informed her about the phone call. The paramedic called a meeting and asked us to be careful. She also said, “I told you not to take the patients and you need to be careful so why are you doing it?” But Mahmuda apa defended us.’ This resulted in a temporary stop in referring and taking young women to private clinics, but not for long.

In general, young women often tolerate poor services at the local NGO slum clinic because of the absence of alternative and affordable options for their health needs. The quality of care was inadequate and insensitive to the needs of poor women. Women waited for long periods at the clinic to meet the paramedic, but they rarely misbehaved or complained. Only once I observed outright anger from one of the slum women. She was woman in her late 20s, and had become furious after waiting for over thirty minutes to see the paramedic. The woman screamed out, ‘How long will we have to sit and wait? We have work at home and then they just keep us sitting and sitting. All the time it is the same thing either there are no medicines available or the doctor is away. How
long can we wait like this?' The other women were watching her [some smiling and others nudging each other, but most of them didn’t join in and preferred to keep quiet]. The paramedic had been away the entire week on training and personal leave. When she arrived this particular morning, she was busy sorting out her files in her room. It was 10 a.m. and most of the women and their children had been waiting for services since 9 a.m. Sufia, a health worker was very angry by the woman’s outburst and replied, ‘Listen you, the government doesn’t care about you, has the government given anything in Phulbari slum? It is the NGOs who have come and helped you all! ...Go where you want to go! We can’t do anymore...’ This explains the predicament of urban slum dwellers who tend to neglected by the State and forced to rely on services from NGOs and the private sector. The lack of options available means that many women have to tolerate rude behaviour. However, the situation was also difficult for the health workers who were often ill treated by the paramedic235, and remained overworked, underpaid, and bore the brunt of dissatisfaction from poor women in the slum.

Conclusion
This final chapter of the thesis illustrates how the micro level politics of reproductive behaviour has a strong connection to larger socio-cultural, political and economic inequalities (see Greenlagh for overview, 1990). Young women’s reproductive aspirations appear to be at odds with others and they remain vulnerable to control and manipulation of their reproductive bodies. Although many married adolescent women were forced to bear children even when they were emotionally unprepared, they recognize the practical advantages of having children. Particularly in the context of dire poverty and marital insecurity, children can strengthen a marriage, can improve the husband’s behaviour and provide power and room for negotiation for young women. Thus, as much as children are loved for personal, social and moral reasons, the birthing experience is also a political act for young women (Handwerker, 1990).

235 The paramedic often made disparaging comments about the health workers in the clinic. She viewed them as inferior because they were poor, uneducated and slum dwellers. The paramedic lived in a slightly better neighboring area, (which was not a slum) and she had received basic paramedic training. She was often rude to the health workers and the female patients. Many of the patients were too scared to complain or voice their anger towards the paramedic and reserved their dissatisfaction with the health workers, who were constrained and often unable to satisfy disgruntled clients.
Young women's status is changing in multi-directional ways, as traditional norms and behaviour break down and they lose ground in this new urbanized environment of uncertainty. The high incidence of desertion and polygamy leave young women vulnerable. Social and cultural norms control the sexuality of young women and structures of the market economy limit their access to employment opportunities in the city. The gendered structures of jobs, which favour males, reinforce the value of sons in poor urban households. However, increasingly young females are praised for contributing to the household, whereas sons are accused of neglecting their parents, not working and setting up a separate household soon after marriage. However, religious, institutional and patriarchal structures are biased towards men. This means that having supportive sons, or male guardians, creates a stronger power base for married adolescent women for their survival.

Women gain status and security by bearing children, but there is a tension around fertility as many young women are not only pressured into giving birth but also compelled to end their pregnancy. The economic value of children is increasingly questioned in the light of constant poverty and one of the main reasons given for termination. Health ideologies of ‘Safe motherhood’ are employed by mothers-in-law, husbands and even by the young women themselves to justify this procedure and to sway any moral opinion. Although many of the young women actively decide to terminate their pregnancy, some of the married adolescent women also admitted that they were forced to end their first pregnancy, against their wishes. Economic constraints, politics, asymmetrical gender and power relations in the household between husbands and wives, and young women and their in-laws and relations between co-wives have implications for young women bodies and their reproductive behaviour. Although adolescent women do rely on the traditional role of motherhood to elevate their status, political economic conditions in the slum are reshaping these cultural ideals and economic concerns are taking precedence over childbearing capabilities.

Gender tensions, unequal power relations and related economic pressures mean that husbands and in-laws attitudes towards childbearing are sometimes in sharp contrast to married adolescent women. Majeda’s situation exemplifies the paradox for adolescent women, namely that they may be empowered by not choosing to have children, but may face desertion or divorce and no sympathy from the community. In contrast, both Bina and Rashida had love marriages and are eager to have children. However, in their case,
unpaid dowry and present political economic conditions in the household have created tensions and influence their in-laws and even husbands’ attitudes, and greater stress is placed on their productivity in the market economy, rather than on motherhood. Polygamy exacerbates insecurities among women and shapes their reproductive behaviour. This is also evident in both Dolly and Maliya’s case, where tension and jealousy impacts on their reproductive health choices. Thus, the relationship of seemingly unrelated events, such as polygamy and fertility behaviour underscores the wider inequalities shaping the reproductive lives of married young women. These cases also demonstrate how poor women of a similar socio-economic background, but from different age groups are affected contrarily, with different personal gains and losses.

The varying situation of the married adolescent women is evidence of how traditions and cultural ideals of fertility and childbearing are constantly shaped, challenged and reshaped by political economic conditions, to fit the particular needs of individuals. Thus for many young women, socially acceptable roles of mother and child-bearer are crumbling and they face greater insecurity and loss of identity in this new, changing and unpredictable environment. Young women’s anxieties about reproductive bodies and health are aggravated by inferior quality of care provided by health care services, and workers who are overworked and underpaid. Terminations are about making money for poor health workers rather than about quality of care. To supplement their monthly income, poor field health workers turn to private clinics for menstrual regulation services, which may be run by trained or untrained staff. Private clinics tend to carry out terminations beyond the safe period and there is inadequate post-operative monitoring. Overall, the level of care, counselling and assistance provided by both NGOs and private clinics to married adolescent women remains extremely inadequate.

What is evident is that married adolescent women’s reproductive health behaviour and outcomes need to be set in the context of larger political and economic hardship and survival, where less food, insecurity, and the uncertainty of everyday life, means making choices that put their bodies and reproductive health at risk (Petchesky, 2001). Definitions of reproductive health continue to be linked to mainly biological reproduction, moving away from subjective experiences of health and illness as well as the lived realities of women’s everyday lives (Kielmann, 2002a). I demonstrate in this chapter that the situations in which poor urban adolescent women make reproductive
health decisions are within the wider socio-cultural, political and economic constraints that surround them, and the larger structural conditions that govern their lives.
Conclusions

At the heart of my thesis is an attempt to raise awareness and an understanding of the complex, interrelated and contextual factors – political, economic and social and cultural that critically shapes the lives of the poor and contribute to particular health experiences. This thesis has important implications for public health, which often rely on simplistic models [one size fits all] to improve the health of local populations in a country. In the chapters, I illustrate the kinds of multiple oppression and constraints operating in the lives of the urban poor, which dictate many of their decisions and choices. Married adolescent women’s reproductive experiences are embedded in larger political economic conditions, and structural and social inequalities. Baer, Singer, Farmer and other scholars, have pointed out that we need to recognize that structural and social factors may be of far greater importance than the nature of pathogens which infect bodies (Singer, M and Scott, S, 2003; See Farmer, 2003; Baer, Singer, Susser, 1997). There needs to be a shift in the way we conceptualize disease as inside the body to a more holistic approach which emphasizes the links between macro and micro forces, social conditions and inequalities, which would ‘make social of disease’ (Singer M and Scott, S, 2003; Frankenberg 1980: 197).

Recently on January 2, 2004, the health ministry in Bangladesh announced that they were launching a ‘three year ambitious Health, Nutrition and Population Sector Programme [HNPSP]’ to reduce malnutrition, maternal and child mortality, [but without a specific budget or deadline] (Daily Star, 2004). The following day, a leading English newspaper carried a report on the continuing dismal health situation in the country. The headline read:

‘Giant health plan, so little success.’

The giant Health and Population Sector Programme (HPSP) has fallen short of achieving its major goals, including curbs on high rates of maternal and child mortality, in its five year life span… The maternal mortality rate is still the highest in the world with about 15,000 women dying annually during childbirth. More than 95 percent of the deliveries still take place at home aided only by untrained birth attendants… The level of malnutrition in the country is also the most severe in the world, with 600 to 700 children dying from malnutrition related causes every day. More than 50 percent of them suffer from chronic energy deficiency and studies suggest there has been little improvement in
women's nutritional status over the past 20 years... Even now 50 percent of the couples do not practice FP [family planning] in Bangladesh... Experts say that the overall HPSP [health] mission and vision failed largely due to mismanagement and lack of enthusiasm...’ [Huq, N, 2004].

The recent report criticized the health ministry for its failure to improve the overall health and reproductive health of poor women and children in the country. What is noticeable in the response is the absence or recognition of poor men who also suffer from poor health indicators. Moreover, in the news report, the blame for the lack of success is placed on fragmented and poor service deliveries and mismanagement. However, this is only partly true. Among most health researchers and policymakers locally and globally, there continues to be a tendency to obscure questions of how health in general and reproductive health in particular can be at all obtained by the poor in the context of oppressive conditions which greatly disable them.

The social and political economic conditions in slums necessitates a critical exploration of the how the injustices of a harsh political economy impacts on lives and crucially affects health experiences, behaviour and responses. In Chapter Two, I illustrated the insecurity of the urban poor, who were suddenly evicted from their residence after living in the slum for more than twenty years. The urban poor do not have access to land, housing and any legal rights. I explored how global and local processes shape local employment conditions for poor men and women in the slum. Permanently juggling temporary insecure jobs urban poor males remain displaced, leading to substance abuse, high homicide rates, and gang violence in the slum. Most of the urban poor live precarious lives, and cope with many forms of intimidation, including extortion of money from criminal leaders, rival gangs as well as the police, and general lawlessness, including sexual harassment and rapes. The State and the police, which maintain links with criminal slum leaders for their own interests, neglect the urban poor. Being socially and economically segregated, the poor are left with no legal access to land, housing, education, basic services and social mobility, and extreme destitution. This destitution creates a hostile environment in the slum forcing individuals, including family members to compete with one another to meet their basic needs. Social and political conditions and entrenched inequalities maintain disparities that work against the urban poor and push them deeper into poverty, ultimately impacting on their health.
As described in Chapter Three, the urban poor speak of their suffering and the advent of a ‘folk ailment’ *chinta roge* [worry illness], which is seen to cause a range of illnesses in the body. *Chinta roge* is blamed on poverty, urbanization, increasing powerlessness, corruption of the State and its indifference to the needs of the poor, the lack of adequate housing, jobs and the general breakdown of religious values, family and society. Thus, as circumstances deteriorate for the urban poor in an unpredictable slum environment, with poverty constraints and breakdown in social and economic relations, suffering is embodied and illnesses are experienced (Lock and Scheper-Hughes, 1996; Ots, 1991).

The folk idiom of *chinta roge* has multiple meanings, and is metaphor and narrative for all kinds of social and political-economic distress, poverty and hunger anxiety, including various related emotional and physical illnesses in the body. While everyone is vulnerable to *chinta roge*, women claim to experience *chinta roge* more often, as a result of the patriarchal environment of the slum and unequal gender and power relations that exist. Through the narratives of Shoma [an older woman] and Monsura [married adolescent woman], I showed how *chinta roge* comes to be embodied, creating various illnesses - cancer, heart attacks, nervous shakes and weakness in the body. All of the narratives speak loudly of suffering, pain and distress brought on by economic and social insecurity and hardships, affirming the assertion by Scheper-Hughes and Lock (1987:20) that ‘to a great extent talk about the body...tends to be talk about the nature of society.’

In Chapter Four, I brought the lives of married adolescent women into focus, and illustrated how factors of poverty and insecurity shape their reproductive lives. For these young women, the slum is a harsh urban environment, beckoning constant crime, gang violence and poverty. These conditions result in a high percentage of early marriages as families worry about costs of dowry and having unmarried daughters raped or sexually harassed. Urbanization and poverty have reshaped marriage practices, created disruptions in family life, and diminished parental control over children. As more young women work outside the home to earn an income, many elopements and love marriages have ensued. I demonstrated how difficult social and political-economic conditions are leading to alcoholism, drugs, and marital insecurity and family breakdowns, indicative of how painful the transition to urban life has been for many of the poor. Frustrated by their inability to support their wives, many poor men turn to substance abuse, infidelity, abandoning their wives or indulging in polygamy. In addition, extreme poverty, patriarchy and cultural pressures force many adolescent...
women to tolerate their husband’s behaviour, as marriage is the only acceptable means of social protection, acceptance and identity. The structural and gendered nature of the job market means that young women who are deserted by their husbands find that they are worse off due to limited work options, low wages and discrimination in the workforce as well crime in the slum. Parental, spousal or in-laws support is crucial in shaping adolescent women’s vulnerability, but destitution and competition for limited resources means that support is rare and in most cases, absent. Power relations, patriarchy and scarcity all impact profoundly on married adolescent women lives, which directly and indirectly shape their reproductive health [which is discussed in detail in Chapters Six, Seven and Eight].

After detailing the insecure, unpredictable and tense lives that married adolescent women live, in Chapter Five, I examined how these conditions frame young women’s understandings and embodiment of their illness conditions. This is exemplified in married adolescent women’s descriptions of chinta roge; manifesting itself in conditions of white discharge and weakness in their bodies. Married adolescent women spoke of the pressures of economic hardships, poverty and hunger, early marriages and marital disruptions and how this impacts negatively on their already weak and malnourished bodies. They perceive the material conditions of their lives to causally impact on the internal state of their bodies and health, resulting in particular gender specific illness conditions. Constructions of chinta roge and white discharge/weak bodies in the slum demonstrate that the reporting and experience of symptoms of white (vaginal) discharge is significantly different to what is taken to be universal. This reveals the body to be an ‘unstable and contested object,’ thereby contributing to the end of a ‘biomedically defined body, stable in time and space’ (Lock, 1993:145).

In Chapter Five and subsequent chapters, I discussed how life experiences, cultural factors and the presence of biomedical interventions modify understandings and experiences of illnesses among married adolescent women in the slum. Lock and Kaufert argue that biomedical knowledge is ‘complex and not standardized and open to contestation from both within the profession and outside’...with enormous variations existing in different countries (1998:16; See Singer and Baer, 1989). In Chapter Five, I described how poor young women’s harsh lives, health nutrition messages, and the illness discourse circulated by healers and pharmacists have influenced understandings of the experiences of white discharge/weak bodies. In the past decade, nutrition
campaigns and health promotion messages both by the government and local non-governmental organizations have reinforced links between poverty and lack of food and ill health. This has altered young women’s explanations, as they interpret white discharge and weakness as a result of scarcity in the body from hunger, which is believed to result in the ‘loss of calcium’ [nutrition/strength] from the body. Furthermore, indigenous healers, street sellers and pharmacies also market various tonics as replenishing bodies from loss of white discharge and to restore strength to weak bodies. Some young women spend whatever little money they have to purchase tonics, which means that often-scarce money is spent on useless medicines. Baer, Singer and Susser (1997) suggest that the sickness of the modern world creates a powerful source of pluralism, where the popular health sector emerges to fill the gaps, and often biomedicine and its patrons in the formal health sector also rise to the occasion. Young women hope to gain short-lived relief from dizziness/weakness [hunger], yet are fully aware of the larger structural conditions which restrict their lives and therefore perpetuate illnesses. At a micro-level, the sufferer’s experiences also reshape and reinforce the role of biomedicine at a macro-level, as international and local drug companies in Bangladesh, India and Pakistan increasingly produce, market and distribute herbal tonic drinks in pharmacies to sell to poor women.

In Chapter six and subsequent chapters, I explored the nature of ‘structural violence’ and the devastating impact oppressive conditions have on young women’s reproductive experiences. In many cases, married adolescent women cannot afford to be concerned with their bodies and their ‘reproductive health,’ as they struggle to cope with overwhelming burdens of chronic deprivation. I have shown how the harsh political economy, gender and class inequalities position poor married adolescent women at risk for adverse reproductive health experiences. These young women in the slum are vulnerable to forced sex and unsafe sex, early and excessive pregnancies, miscarriages and abortions, which contributes to reproductive tract infections, sexually transmitted illnesses, pelvic infections and other reproductive complications. Widespread public health messages and interventions to promote awareness of risky childbearing practices have made young women aware of the dangers of pregnancy, resulting in both beneficial and adverse consequences. Poor, costly and insufficient care in government facilities has resulted in a range of less expensive accessible alternatives, which have mushroomed in the city. For example, thousands of uncertified pharmacists/doctors, the
promotion of procedures like ultra-sonograms, and government *ayahs* masquerading as skilled birth attendants, which young women access, often endangering their lives.

In Chapter Seven, I focused on infertility, a predominant concern for young women, due to social and cultural pressures to bear children. Fertility is extremely important for their identity, marital security and for social acceptance in the community. Infertile women fear divorce, desertion and ridicule and ostracism from the community. I demonstrated how local constructions of infertility are also being reshaped by conditions of life and biomedicine. Although much anxiety exists about infertility there is an absence of infertility treatment by the State. Influenced by global health ideologies, the State is more concerned in family planning and fertility regulation of poor women. This has implications for infertility understandings and contraceptive use. Many women older and younger situate long-term family planning use to infertility problems as linked, conceptualised as causing blockages and ‘burning the uterus.’ A lack of monitoring of the private health sector in Bangladesh means that those who can barely afford to are taken advantage of by private clinics to undergo technological ‘D&C’ procedures, which are promised as a cure for such problems. However, this procedure is usually too expensive for poor women to access. Young women are keen to avail themselves any biomedical interventions, which can cure their infertility. Poor women living in slums lack the political and economic resources to demand particular health services from the government. In the absence of affordable and available treatment, poor young women usually rely on indigenous healers and the spirit world as explanations for infertility. These understandings of the spirit world speak metaphorically of the marginalization of their local world, as young women realize that childlessness often leads to divorce, desertion and even social ostracism from society. For many women the experience of infertility continues to be one of anxiety and fear.

In the final Chapter, I demonstrated how the pressures of brutal poverty are impacting on the dynamics of fertility behaviour in the slum. Cultural and social expectations mean that a large number of married adolescent women were forced to bear children before they were ready. Young women recognize that children are a necessity, a practical requirement as marital breakdowns are increasing and many rely on their children, particularly sons, later in life for financial support. I have shown how the unsafe environment of crime and violence in the slum reinforces the need for males/sons for protection of young women, yet males are also the cause of many of the
women’s problems. Institutions reinforce this gender bias, as religious law and inheritance rights favour males with greater property, legal and marital rights and men have greater freedom and visibility in the public domain. However, dire poverty and competition for scarce resources also means that there is anxiety around fertility and several married young women in this study are forced to terminate their first pregnancies, against their wishes. Some of the reasons for forced terminations by young women are pending dowry payments, desertion, and husbands having more than one wife, rivalry among family members, in-laws and co-wives. The case studies show that it is not only poor men - fathers-in-law, husbands who coerce young women into terminating their pregnancy, but also mothers-in-law, daughters-in-law and co-wives who turn against each other. This demonstrates that notions of power and oppression are complex. Lock and Kaufert (1998) argue that one cannot minimize economic and power relations between women, and gender is crosscut by other categories, such as personal gain, class, hierarchy, or age, at the local level (Lock and Kaufert, 1998). Forced terminations of first pregnancies demonstrate a shift in traditions and cultural ideals of fertility and childbearing, which are being constantly challenged and reshaped by scarce resources. Thus, for many young women, socially acceptable roles of wife, mother and child-bearer are changing and they face greater insecurity and loss of identity in this new, changing and unpredictable environment. Extreme deprivation and powerlessness force many young women to be pragmatic and submit to decisions, which put their lives, reproductive bodies and health at risk. Chapters Six, Seven and Eight underscore how structural disparities intersect with class and gender inequalities to reveal the real causes of many reproductive illness experiences.

Finally, in Chapter Eight, I discuss how health services and a medical hierarchy operating in Bangladesh replicates the class and gender hierarchies at the level of services. Health workers [at the lower level] in the slum are underpaid and over worked, but ironically are the ones who come into the most contact with urban poor women. Economic considerations result in health workers treating married adolescent women who want pregnancy terminations poorly, often viewing them purely as a business venture to supplement their low incomes. As a result, married adolescent women pay a lot of money for terminations, and remain at the mercy of private health practitioners and health workers, who are concerned with earning an income, rather than providing appropriate counselling or post termination care.
All of this is exacerbated by the government’s neglect of the situation of the urban poor. As the population of slum residents increase in Dhaka city, efforts from the government and from donors to strengthen primary health care services for this population greatly lag behind efforts for the rural population (MOHFW, 1998a). The government is also influenced by international aid agencies, which only spend a tiny portion to directly address the needs of the urban poor, compared to the overall international support for the rest of the country (UNICEF, 1993). Therefore, a majority of the slum residents experience a government health care system that is often fragmented and ill prepared to sensitively treat many of the health problems of poor women and their families. Many of the urban poor turn to NGO clinics, and an unrestricted private health sector, as well as traditional healers for their health needs, and remain vulnerable to bad services and financial exploitation. As the discussions in the chapters illustrate, biomedicine creates ‘unresolvable tensions’ among young women, who are marginalized in multiple ways, not only by traditional expectations, but also by worsening political economic conditions, and the presence of medicines and ‘power of technological innovation.’

While biomedicine may give them increased options, improve health by providing access to contraceptives or medicines to treat a particular ailment; these interventions can also open the door to new forms of power and domination (Lock and Kaufert, 1998:22-24), further increasing poor families social and economic burdens. Singer states that the role of biomedicine has increasingly become ‘as an agency for social control’ but he asks, ‘control in whose interests?’ He argues that increasingly, in a capitalist system, health care services are determined by the business of profits rather than needs of the patients (1987:262).

Particular international health ideologies shape policies, influencing the direction of Bangladeshi health services and research. This contributes to the maintenance and formulation of particular discourses and ideologies of health in the country, irrespective of the actual needs of the poor. This thesis attempts to shed light on the larger questions of why Bangladesh continues to have extremely poor reproductive health indicators in the country, despite the millions of dollars of aid. I clearly outline how political economic conditions and large scale social forces lead to suffering and multiple injustices and difficult life conditions for poor families, which shape their health experiences, and contribute to harmful reproductive practices for young women in the slum. However, these broader structural risk factors which are significant in young
women lives are not included and do not form the basis of international and national health policies.

We need to acknowledge that to truly bring about changes in the health and well-being of the poor may require more attention to be given to poverty, unequal power relations and the lack of economic resources in their lives, which are the actual risk factors to better health. Petechsky argues that to bring about improvements in reproductive health, we need to recognize that human rights, reproductive health and economic justice are indivisible (2000). Basu states, that to improve health requires shifts from the ‘piecemeal medical interventions that dominate many policy prescriptions’ to a radical reconceptualization of health and development strategies, with broader societal reform, and egalitarian distribution of economic resources, and prevention rather than just relying on curative medicine. One needs to acknowledge the limits of biomedicine in its ability to improve health (2000: 26). While better and sensitive health services may ease some of the suffering of the poor, for young women and their families the fundamental constraints to improving their lives and [reproductive] health are structural and social inequalities, which force them to remain an underclass, unable to realize their health potential. Their poverty is part of the global and local economic system and an unequal class structure. I argue that their situation will remain unchanged unless there are fundamental changes to alter these inequalities. Farmer argues that one cannot separate inequality of power in different forms which are central to poverty and destitution and one cannot separate social and economic issues if one wants to improve the health of a population (2003: xvii). He stresses that poverty and powerlessness are the ‘strongest pathogens on earth’ and maintains that the integration of social and biological approaches to illness ‘is easy to demand but harder to produce,’ yet the failure to do so is costing countless lives (Farmer, 1999, 2-5).

A woman in Phulbari slum bitterly exclaimed [a sentiment echoed among the majority]: ‘Under our feet we don’t even have land [forcible eviction] and we have no roof over

236 An initial step in the right direction would be if the government does the following: provides fixed tenure of land, creates employment and develops the technical skills of the urban poor, provides access to better housing, clean water, sanitation, and free education and health services for men, women and children. The government needs to ensure a safe and crime free environment for the urban poor, who need to have their legal rights respected and they need to have access to free legal aid. The government and NGO could provide safety nets for the poor, by providing low interest larger loans so the poor are able to invest and plan in times of crisis. In addition, many of the inequalities are also shaped by larger global processes; the relationship between richer and poorer countries and the global market economy which also need to be addressed.

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our heads. Just to hold on to our place we went everywhere for help but received nothing...No one has ever helped us. See, in every house there is a child. If they fall sick we can't treat them because we are poor. We can't even educate the children because we don't have any money. The government and NGOs are always talking about health and rights but what are we getting? Nothing! What has the government given us? They have not even given us one piece of cloth over our bodies. All these NGOs just come and go. But our situation remains the same. We are poor. We don't know what we will eat, whether we can eat. We have nothing! Look at us, look around, we have nothing!' Her statement speaks volumes of the distressing situation for the urban poor, who remain powerless and suffer from insufficient food, shelter and job security. With worsening social, political and economic conditions for the poor, it is not surprising that after millions of dollars spent on health interventions, their overall health and reproductive health remains deplorable in Bangladesh. I argue that social and economic justice needs to be an integral part of medicine and public health, if we truly want to see improvements in the health of poor women [and men]. My rallying cry has been echoed in the work of numerous researchers, such as Farmer (2003) and Baer, Singer and Susser, (1997). Farmer points out that medicine has much to learn from reflecting on the lives and struggles of the poor (2003).

Anthropology is a kind of witnessing. Scheper-Hughes (1992) so rightly points out, that as anthropologists, we are accountable for what we say and for what we do. Scheper-Hughes suggests that if we can make our writings available to the larger audience and to public policy, it is a form of intervention for those, whose voices have traditionally been silenced (1992). I hope this thesis is useful in representing the voices and needs of the urban poor and encourages a critical rethinking of concepts such as 'health' and 'reproductive health' in Bangladesh.

237 Exploring the links between health and social justice is one of the main goals of critical medical anthropology.
238 Farmer points out that many of the current concepts popular in health – such as 'cost effectiveness', 'sustainability' (now also being advocated in Bangladesh by the World Bank and other donor agencies to improve health of the poor), will be hindered unless social justice becomes central to public health and medicine (2003:18).


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