Governing Empowerment: "Second-Wave" Feminism and Population Control Post-1971 War of Independence in Bangladesh

By

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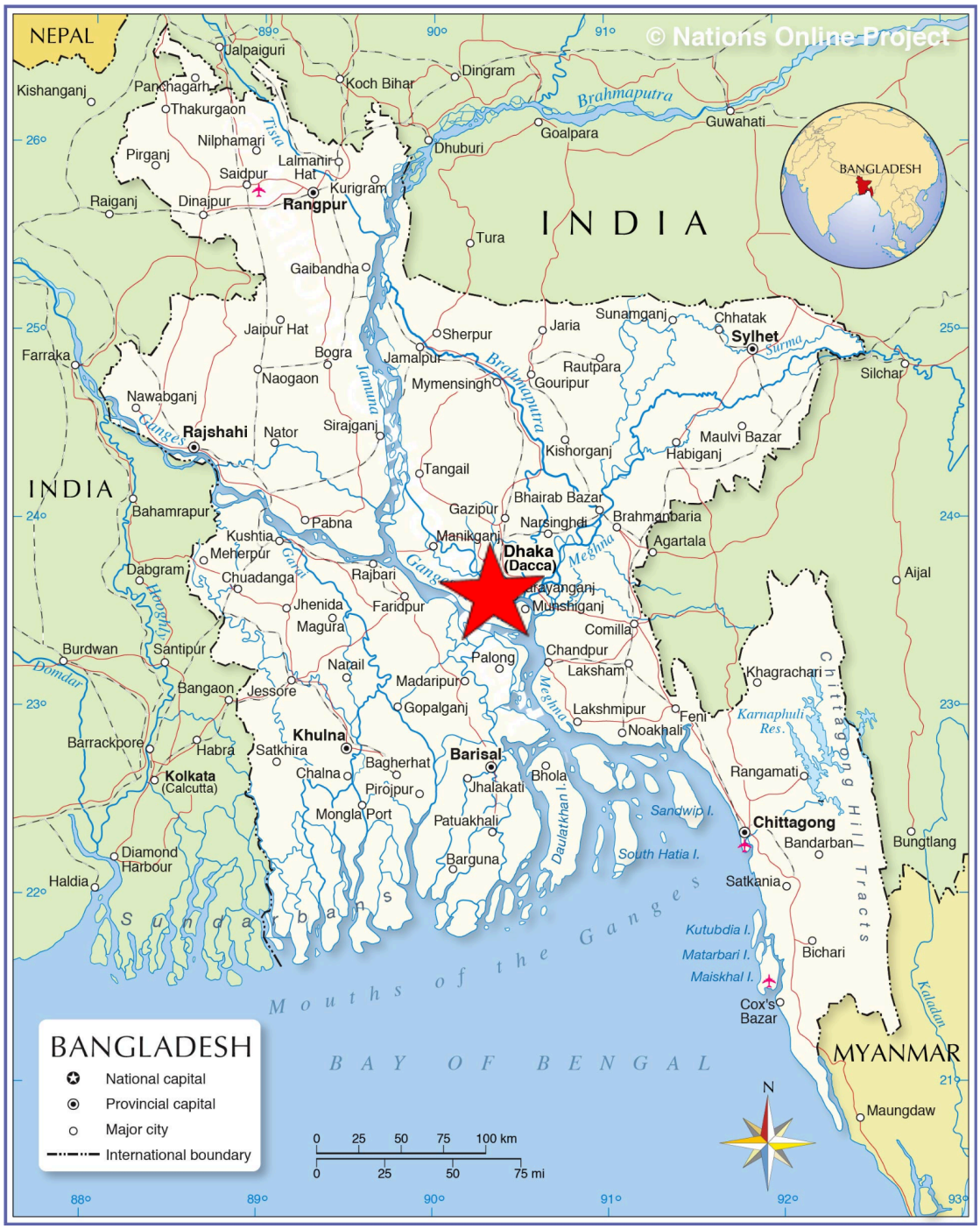
ABSTRACT

Following the Liberation War, Bangladesh's declaration of independence from Pakistan led to the rape of 200,000 Bengali women by West Pakistani forces and local collaborators. In a mission to 'purify' the nation, and re-establish Bengali identity, the government decided to put an exception to the abortion ban Penal Code 1860. This allowed private and state-controlled American population control experts and so-called "Second-Wave" elite white feminists to set up abortion clinics in Bangladesh. The United States government spent millions of dollars on abortion in Bangladesh during the neo-Malthusian era of development, which believed that poor people should not reproduce, while women in the United States had no such access. While most women did voluntarily seek abortions, especially right after the war, it is not clear that all women understood what the abortion entailed or gave informed consent. There is evidence that despite seeking abortion, many left clinics, sterilized, without their consent, and many had no idea of this. While we know that American reproductive rights activists were rallying for access to abortion in the United States, the United States government and other Western development began enforcing unsafe contraceptives and abortion methods through so-called family planning. This research seeks to address the overlap between the demands of Western "Second-Wave" feminism in the United States and the desire to "empower" women in the Global South and neo-Malthusian population control.

Keywords: Second-Wave, Feminism, Bangladesh, Women, Abortion, Contraceptives, Sterilisation, Reproductive Rights, Population Control

Map of Bangladesh



Source: Nations Online Project.

*Primary field work site: Dhaka capital city

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CONTENTS

INTRODUCTION 7

METHODOLOGY 10

CHAPTER 1: BIRTH OF A NEW NATION 11

1.1 Women's Rehabilitation Center
1.2 Private and State-Funded Abortion Clinics and Abortion Technology
1.3 American Feminist Discourse on Super Coil

CHAPTER 2: SO-CALLED FAMILY PLANNING 19

2.1 Transitioning towards Family Planning Development Strategy
2.2 Bangladesh Government's Role in Forced Sterilization

CHAPTER 3: BODY AS A SITE OF EXPERIMENT 24

3.1 Modern Contraception and Its Use upon Bangladeshi Women
3.2 Depo-Provera Controversy

CHAPTER 4: FORCED STERILIZATION 34

4.1 Compensations: Wheat in Exchange for Sterilization
4.2 Saris and Sterilization
4.3 Free Will or Population Target?

CONCLUSION 40

WORKS CITED 43

BIBLIOGRAPHY 45

APPENDICES 49

Appendix 1 Abbreviations and Acronyms
Appendix 2 Timeline of Reproductive Rights Events
Appendix 3 Women's Rehabilitation Center Inauguration at Bailey Road
Appendix 4 Manual Vacuum Aspiration
Appendix 5 The Philadelphia Story: Another Experiment on Women

Appendix 6 National Women's Health Coalition Archive Collection
Appendix 7 Women of Bangladesh: A Photo Essay
Appendix 8 Karman Threatens Suit
Appendix 9 Distribution of Trained Physicians and Paramedics
Appendix 10 Menstrual Regulation Procedures
Appendix 11 Use of Private Doctors, Pharmacies for Side Effect Treatment
Appendix 12 MR (Menstrual Regulation) Technique Can Help Check Population Boom
Appendix 13 Good News for Women
Appendix 14 Another Shot at Women
Appendix 15 Sterilization Card for Wheat
Appendix 16 Food, Saris and Sterilization
Appendix 17 The Poverty of Population Control

INTRODUCTION

After the *Liberation War* of 1971, Bangladesh became a newly independent state. During this deadly nine-month war between the Pakistani colonial military personnels and Bengalis in former East Pakistan, about 200,000 women were raped and about 25,000 attacks resulted in pregnancy (Brownmiller, 1975). Children who were born or conceived as a result of sexual violence from the Pakistani army began to be referred to as 'war-babies.' As the new state harbored sentiments of Bengali nationalism separate from its previous Pakistani identity, the existence of 'war babies' would have meant living under constant reminders of the violence by the Pakistani state (Mookherji, 2007:339). Thus, women had to be both physically and psychologically 'purified' to remove any traces of 'Pakistani-ness' out of Bangladesh and ensure national honor. Sheikh Mujibur Rahman gave women the title of *Birongona*, which translates to "war heroine," to honor them. However, it furthered the stigma surrounding female victims of sexual violence, and deprived women of receiving war compensations, in contrast to their male counterparts: while men benefited from compensation as freedom fighters, female freedom fighters and *Birongona* had no recognition nor benefits. (D'Costa, 2011) Even though abortion had previously been banned, the new government decided to put this law into a 'state of exception' that neither legalized nor criminalized abortion (Mookherji, 2007:339). The exception of the law allowed women to have mass abortions who were raped during the war. The result of this 'state of exception' not only successfully aborted "war-babies" on a large scale but also led to a dark period that turned Bangladesh into an 'aid lab experiment' (Hossain, 2017). Large private and state-funded development organizations such as USAID, The International Planned Parenthood Federation, (IPPF) Rockefeller Foundation, and The United Nations

Population Fund poured millions of dollars into setting up abortion and "Family Planning" clinics (Mookherjee, 2007; D'Costa, 2011; Hartmann, 2016; Hossain, 2017; Shehabuddin, 2021).

After its independence, Bangladesh had the reputation of being an 'international basket'[1] case, famously stated by both Henry Kissinger, the Vice President, and U.S. under Secretary of State for Political Affairs Ural Alexis Johnson. By 1975, Bangladesh had suffered a massive number of deaths from famine, cholera, typhoon and war (Murphy, 2017:84). However, Bangladesh's population size was largely blamed for predicting the nation's economic failure and poverty. Thus, international development actors had begun enforcing unsafe contraceptives and sterilization on Bangladeshi women. Population control development agencies set up "Family Planning" and "Maternity clinics" that often forcefully sterilized women (Shehabuddin, 2021; Murphy, 2017; Connelly, 2010; Mookherjee, 2007; Akhter, 1992). While this event rapidly took place post-1971, independently, "Second-wave"' feminism in the United States was campaigning for women's "social equality" (Maxwell et al., 2018) which included sexuality and reproductive rights, as well as the choice for women to have control of their bodies. At a time period in which women in the United States were fighting for access to contraceptives and abortion, women in Bangladesh were already given access to this through the state of exception. Since "Second-Wave" feminism and pro-choice is associated with a progressive agenda, the fact that Bangladesh, a newly developed war-torn country, had given women access to such reproductive services could have been considered much ahead of its time. While the American reproductive rights movement was separated from the American population control development agencies such as USAID, UNFP, IPPF or Rockefeller Foundation, their goals to allow for access to abortion and contraceptives coincided with the goals of population control agencies who aimed to reduce the Bengali population with neo-Malthusian intentions. On the other hand, Bangladeshi

[1] A term when used to describe a country means economically incapable of functioning.

reproductive rights activists had a much different outlook in regards to the state law exception, especially with regard to the sea of contraceptives and abortion that was forced upon Bengali women that fundamentally changed their lives. While some agencies paid the Bangladeshi government to incentivise women to receive sterilization surgery and meet quotas, others refused food relief without sterilization cards. In some cases women would be sterilized without their consent after waking up from giving birth. In the US abortion rights are discussed in binary terms such as “pro-choice” and “pro-life” (Connelly, 2010), yet political ideological goals and their implications gave Bangladeshi women no bodily autonomy and rather politicized women’s bodies for nationalistic aspirations. The focus on this study is analysis of perception regarding issues of women in the West vs the Global South. The significance of this study is to understand the fundamental biases, orientalism and neo-malthusianism against women in the Global South in the backdrop of the Western feminist movements that often excluded ethnic and racial minorities. Even though ‘Second-Wave’ feminism and neo-Malthusian development has been extensively studied, their convergence of the two is rarely studied in the context of the Bangladeshi women post-1971.

METHODOLOGY

I am using qualitative mixed-methods of research: historical archival research and interviews. During December 2023, I traveled to Bangladesh and conducted 9 interviews. Upon my return to the US I interviewed 8 American reproductive rights workers and activists. Interviews were conducted both on Zoom and in person. These were in-depth interviews that delved into personal experiences, work experiences, and opinions regarding what was taking place post-1971 till the 1980s. I used a content analysis and discourse analysis approach on the basis of McNabb's chapter of *Analyzing Texts, Documents, and Artifacts*. Using both of these methods allowed me to fill gaps left by qualitative interviews by cross-checking narratives I find within my interviews. Content analysis of archival materials such as written texts, mass media (magazines and newsletters), pamphlets, posters, articles, and books as evidence to understand views of reproductive rights activists and their influence of opinions upon their audience. I visited the *Naripokkho*[2], *Ain o Salish Kendra*[3] and the UBINIG[4] offices to collect archives.

[2] *Naripokkho* is a women's rights organization in Bangladesh founded in 1983. It is known for executing campaigns, lobbying and advocacy for policies surrounding women. In the 1980s, they were at the center for fighting coercive family planning funded by USAID.
[3] *Ain o Salish Kendra* is a legal aid human rights organization that provides legal support for disempowered people. The organization has an extensive warehouse of archives that include collected research testimony of war-rape victims, interviews with international doctors who worked in Bangladesh post-1971, international human rights trial records and court cases surrounding sexual war crimes.
[4] UBINIG is an NGO founded in 1984 for policy research for Development Alternative. In the 1980s, UBINIG's main goal was campaigning against unsafe and non-clinically approved hormonal contraceptives such as Depo-Provera (injection) and Norplant (arm implant) on rural Bangladeshi women.

CHAPTER 1

BIRTH OF A NEW NATION

1.1 Women's Rehabilitation Center

On 7th of January 1972, the Women's Rehabilitation Center was formally inaugurated at Bailey Road with Sufia Kamal, famous poet, feminist and activist as the Chairperson **(Appendix 3).** The primary purpose of these Rehabilitation Centers was to rescue and rehabilitate *Birongonas* separated from their family and provide them with medical aid, and reintegrate into social and family life. (D'Costa, 2011) After independence, women were rescued by teams of both Bengali freedom fighters and Indian Soldiers who were fighting as allies with Bangladesh. These women were both physically assaulted and deeply traumatized (D'Costa, 2011). The initial role of the rehabilitation center was to help women return to their families. However, in most cases, after contacting their families, many no longer wanted their daughters to return (D'Costa, 2011). Those working at the rehabilitation center after the war described how women in the center could no longer return to their village; women's honor had long been embedded in sexuality, and thus the stigma for women being victims of rape led to some famillies disowning their daughters while others did not allow their daughters to come back from the risk of being ostracized within their villages. (Personal interview, December 2023 & January 2024; D'Costa, 2011). Soon after the rehabilitation center had realized that the majority of the women had nowhere to go, it became an organization that transitioned to helping women independently reintegrate back into society.

Even after victims of rape were given the title of *Birongona* (war-heroine), the term began to be used as an insult within Bangladeshi society. Abortion was the last resort for women because neither their families nor society would accept them and their children. There was still a

dire need for abortion within the Rehabilitation Centers and overall within the country. The Rehabilitation Center brought doctors to perform clinical abortions. Prior to this time period, women had relied upon traditional practices of terminating pregnancy. According to Dr. Davis Geoffrey, an Australian doctor who worked in the abortion camps in March 1971, around 5,000 women had already had an abortion prior to the establishment of the abortion clinics; some used traditional methods while others who could afford to travel to India had clinical abortions (Geoffrey, Interview archive with D'costa).[5] Dr. Geoffrey Davis conducted about 100 abortions per day during the 6 months that he worked in the abortion camp. Dr. Malcolm Potts who, similar to Dr. Geoffrey Davis, working under the patronage and training of the IPPF in Bangladesh, mentioned conducting a similar number of daily abortions during this time in the camps (Personal interview, February 2024). There are discrepancies regarding the number of women who had abortions within the Women's Rehabilitation Center. While some mentioned that no personal data was collected on the women in order to protect their privacy, others mentioned that all evidence was destroyed to protect anonymity after the Women's Rehabilitation Center merged with the Ministry. Given that there are no written records, only the women who had lived within the rehabilitation center and had gone through abortion, the social workers, journalists, and doctors from the time period hold the institutional memory of what transpired.

Based on fieldwork, there were contradictions regarding the locations of the abortions. For example, Khushi Kabir who worked in the Women's Rehabilitation program said that doctors who came from abroad performed abortions within the Women's Rehabilitation Center. Dr. Potts mentioned that these abortions took place in local hospital clinics where women arrived

[5] যুদ্ধ অপরাধ [Yuddha- aparādha] (War Crimes). Dhaka: 2008. Loaned by *Āin o Sāliśa Kendra*.

in small groups to get abortion. There is contradictory information within the interviews regarding how consent was collected within the center before abortions took place as no such record has been found by researchers in this field. According to Dr. Potts and Dr. Davis, verbal consent and consultation was given to women regarding receiving an abortion. But according to a social worker, written consent of women was also taken (Personal Interview, February 2024; Bina D'Costa, 2014). Even if there had been a written record of the name, signature and background of the woman, it is vital to note that most women seeking abortion in the center were illiterate, meaning that rather than a signature, they were required to put their fingerprint in replacement of a signature. This also meant that since they could not read or write, their signature or fingerprint were not fully informed consent. Thus, how much information was provided to the patients is unknown. When interviewing doctors who performed the surgeries, they stated that all abortions taking place in the Center were voluntary and there had been no form of resistance nor hostility by the women as they went into the surgery. Contradictorily, volunteers and workers at the Center stated that even though most women wanted safe abortions, there are many stories of unwanted abortions and adoptions that the Women's Rehabilitation Center facilitated. Maleka Khan, a significant member of the rehabilitation centers and social worker in the 1970s, said in an interview, "There was this girl who gave birth. She said before the delivery that she wanted to give her baby for adoption. However, when the time came she had been crying so much! No one offered to help … no one said 'Let us take care of the baby and the mother.' I have not seen any such thing!" (D'Costa, interview, 1999) Many women also did not know what was happening to their bodies (Personal interview, January, 2024). While the majority of the women did voluntarily seek abortions, for many there was no alternative other than abortion.

1.2 Private and State-Funded Abortion Clinics and Abortion Technology

The most well-known figure was Dr. Harvey Karman, a doctor of physiology. He was a very notable figure in pioneering abortion technology and committed to abortion work in both the United States and Bangladesh. After the war in 1971,the founder and former president of the National Women's Health Coalition, and a feminist, Merle Goldberg, had arranged for Dr. Harvey Karman to go to Bangladesh under the sponsorship of the IPPF. He was most-well known for this invention of the Manual Vacuum Aspiration (MVA) **(Appendix 4)**, a low-cost abortion kit that performed menstrual regulation (after 12 weeks of the last period date). MVA is known as a non-painful and safe method of abortion. MVA became a revolutionary technology in the field of abortion due to its safety and painless method of terminating first trimester pregnancies and effectiveness in reducing uterine perforation (Tanfer, 2008). Dr. Karman invented the MVA technology. Dr. Potts was the one who pioneered and promoted its widespread use in medical abortion across the world.

In order to advance his abortion technology to terminate second trimester pregnancies, Dr. Karman invented another method of abortion which was the *super coil* method. Alongside MVA, Dr. Karmen used the the super coil method on rape victims in Bangladesh after the war (Goldman, 1974). The super coil is a 40cm long and 4.6mm wide super coil [6] made up of plastic strips. Then it becomes attached to a string, which is later inserted into a woman's uterus using an IUD. About a dozen super coils are inserted into the uterus and left for 12-24 hours. The sharp plastic coil is left in the uterus so the fetus can detach from the placenta and slice any contents left within the uterus. Afterwards, the coil is carefully removed from the uterus using forceps. Unlike the MVA, the super coil method was actually an incredibly dangerous method of abortion. Before the usage of super coil on rape victims in Bangladesh, the super coil was not an

[6] CDC, "Medical Complications From Induced Abortion by the Super Coil Method" (1974).

accepted method of abortion in the United States. The infamous case of the *Philadelphia Story: Another Experiment on Women*[7] **(Appendix 5)** where Dr. Karman illegally attempted to test the super coil on 20 women from Chicago with the help of National Women's Coalition and Chicago's Jane Abortion Collective. The women were brought to Philadelphia from Chicago by Merle Goldberg and without their consent filmed for the New York Based Net-TV. [8] However, Phyllis Ryan, from a local abortion referral clinic named *Choice* had found out about Dr. Karman's activity in Dr. Baron Gosnell's clinic. He reported to the media and the District attorney who later asked the CDC to investigate (Tune, 2008).

In a 1974 study, the Centers for Disease Control and Prevention (CDC) did a study on effects of super coil on 15 women who had used the super coil method as they were unable to receive an abortion in their home state in 1972. Among the 15 women, two women did not follow up with the doctor (the study assumes they did not have complications), nine women returned with complications, and two women returned with major sustained complications that required surgery. According to the study one woman was hospitalized for "suspected acute inflammatory disease," while another bled so much they had become anemic (CDC, 1974). The study done by the CDC conflicted with reports by Dr. Karman of the success of the super coil.

Unlike Dr. Davis and Dr. Potts, who were medically trained professionals, Dr. Karman was not only terminating pregnancies without a medical license but also trained paramedics in Bangladesh to conduct abortions (Tanfer, 2008). Even though Dr. Karman claimed that his super coil method was effective with no side-effects among Bangladeshi women, he had no concrete evidence to support his claim [9] **(Appendix 6)**. He attempted to validate his results by doing a

[7] Position paper circulated at National Women's conferences written by members of the feminist movement describing their opinion of the controversy between Dr. Karman, the women in Philadelphia seeking second trimester abortions

[8] *The New York Times Archive*. "Coast Psychologist Sought in Abortions Filmed by TV Crew (Published 1972).

[9] In his book *The Paramedic Abortionist* and Medical World news Dr, Karman mentions the validity of the super coil testing. May, 1972

super coil trial on 56 women. However, he did not mention any side-effects and only cited 3% morbidity rate of the super coil method. However, a study by Drs. B. Mullick, W. E. Brenner and Gary Berger reported that coil abortions in the Central Clinic in Dacca[10] resulted in multiple cases of peritonitis, excessive bleeding and much more. The CDC study stated that there are risks associated with the super coil method. Despite this, Karman claimed that 'doctors don't like them because they find them inconvenient'[11]; Karmen said that there was 'virtually no chance of perforation' and any uterine laceration of the woman who had a hysterectomy took place at the hospital, not in the clinic where the abortions was performed (Off Our Backs, 1973).

One of the interview participants was trained by Dr. Karman on how to terminate second trimester abortions. When asked if there had been side effects of abortion technology, the participant explained that they viewed having side effects to any medical procedure as common, which did not pose a serious threat (Personal Interview, 2024). While side-effects to any abortion or contraceptive method may be true, the acceptance of negative-side effects without follow-ups, especially rural villages without healthcare infrastructure can be incredibly dangerous.

Despite Dr. Karman's revolutionary invention of the MVA and its use to safely terminate first trimester pregnancies, both in Bangladesh and world-wide, his invention of super coil has been extremely controversial in the media, and are highly contested, especially within feminist and medical discourses.

1.3 American Feminist Discourse on Super Coil

Various "Second-Wave" feminists have responded to Karman's super coil in various ways. While some feminists (especially White mainstream feminist media such as *Ms.* Magazine were either in support of or uncritical of Karman's role in Bangladesh following *The*

[10] A study by Mullick B, Brenner WE, Berger GS. Termination of pregnancy with intrauterine devices.
[11] Quote taken from an archive article of a feminist magazine publication in 1973 called Off Our Backs quote

Philadelphia Story (**Appendix 5**). In reference to **Appendix 7**, *Ms*. Magazine publishes a photograph of Harvey Karman performing an abortion. “Second-Wave” feminists such as Joyce Goldman and others in *Ms.* Magazine celebrated the use of unsafe abortion methods such as the super coil. Goldman even made the comparison of methods of abortion in the US versus Bangladesh to be “safer and easier than some other methods available to women in the United States.” This comparison is not only false, but also demonstrates a lack of criticism of the US developmental organizations by Western feminists who viewed ‘Third World’ abortion rights from a place of ethnocentrism and eurocentrism where this is a dichotomy between “pro-choice” and “pro-life” rather than a choice to have abortions unsafely vs choice to not have abortions at all. Feminists such as Merle Goldberge are also on the same page where the criticism of Karman’s unsafe abortion methods are responded with threats. In reference to **Appendix 8**, when Sister Magazine wrote about the *Philadelphia Story*, Goldberg and Karman threatened Sister’s Magazine with legal action. Under the National Women’s Health Coalition, Merle Goldberge used the pretext of feminism to protect and uplift Karman as a ‘Hero’ despite his unethical action within the abortion safety measures.

Other more radical feminist groups were very critical of the sheer racism, double-standards and ethical violation regarding testing abortion technology on poor Bangladeshi women. In September 1973, "Her-Self: Community Women's Newspaper" published Karman's infamous *Philadelphia Story*, “unlawful” abortions and described Karman as “sexist.” Even more importantly, the article says,

> “*Time was when feminists in the abortion reform movement didn’t dare to publicly criticize their reform allies. Fighting against the anti-abortionists had been long and bitter, and the years had molded us into embattled solidarity with strange bedfellows. We only whispered our doubts to other feminists, fearing that our objections might be proof of some everlasting truth in the rabid press of the right-to-fetal-lifers.*”

This article demonstrates that within feminist circles, there were ranges of narratives and concerns, which some feared voicing due to mainstream “Second-Wave” feminists largely being uncritical of figures like Harvey Karman, who abused women’s bodies to test medically unsafe technology. Another magazine, called *Science for the People Magazine,* published an article in March 1973 condemning Karman's abortion experiment. The author of the article boldly said, “THAT MAN IS NOT A FEMINIST.” Given Karman’s history of unethical abortion, testing abortion technology on Bangladeshi women and poor women of color in the United States, radical feminists within the “Second-Wave” actively opposed his actions.

CHAPTER 2

SO-CALLED FAMILY PLANNING

2.1 Transitioning towards Family Planning Development Strategy

The rape of 200,000 Bengali women prompted the IPPF, UNFPA, the Ford Foundation, Rockefeller Foundation, and many others to extensively set up abortion services and family planning clinics in Bangladesh. As the post-war period transitioned from the need to assist women in aborting unwanted 'war-babies' to focusing on poverty reduction by limiting births, these organizations and their impact became integral and enduring. In 1978, *Pathfinder Fund* initiated MR training services to government and private doctors and paramedics to perform MR (Akhter 1987). Prior to this, MR services were only performed by medically trained doctors. But as there were very few doctors in the 70s who could perform abortions, training non-medically trained paramedics became a priority to replace medically trained doctors. By 1981, there were significantly more paramedics than doctors **(Appendix 9)**. This was especially important in rural areas where there were no doctors, hospitals or clinics where surgeries were generally performed.

> *"*[By] *[t]he use of a paramedic[s] for MR* [...] [with MVA is] *an example for Bangladesh* [where][...] *you can use a simple method with a simple device, and help so many women. And you do not need doctors to do that, you know, if apparently doctors don't go to the rural area, whereas the women in rural area needed more"*
>
> —- Personal Interview, January 2024

As the newly established war-torn country, the international donor sector became increasingly concerned of Bangladesh's booming population; among the $844 million fund allocated to women by international donors, 55% went to family planning, 2% to health, and 8% to education (Jahan, 1995). After the Second Five-Year Plan 1980-1985, public-sector development funds began targeting women within the social sectors through population control,

family planning, and women's affairs. Direct allocation of funds for women was less than 0.3% of the government's development budget (Jahan, 1995). The mid 1970s-early 1980s marked the beginning of a dramatic transition to Bangladesh becoming an "aid lab," when international donors poured money into both private and public funds to enforce population control measures (Hossain, 2017). The "aid lab" meant that Bangladesh became a state where foreign development agencies enforced a variety of development theory and projects. By 1984, an estimated 2,100 doctors and 2,200 paramedics were trained to perform MR (Akhter, 1987). In **Appendix 10** *Table of Menstrual Regulation Procedures* shows the dramatic change of MR procedures reports. Between Around 1979-80 to 1982-83, the number of MR procedures rose from 10,479 to 58, 579. By 1983, there was a 19% increase in the use of regular contraceptives among married women in Bangladesh (Amin et al., 1993). International agencies such as USAID did not work independently in Bangladesh; in fact, funds were often allocated to governments for reproductive services. IUD, vasectomy, tubectomy, condoms, oral pills, emko (phial), injection, and MR according to the Bangladesh Bureau of Statistics in 1985 were considered contraceptives (Hartmann et al., 1989). Between 1979 and 1984, the number of IUD insertions grew from 22,000 to 301,000, tubectomy from 171,000 to 334,000, oral pills from 6.2 million to 9.7 million, and hormonal injection from 26,000 to 121,000. While there was a range of contraceptive options available to women, IUDs, hormonal injections, and sterilizations were given more emphasis as they were more long-term than pills. While pills needed to be consumed daily, IUDs were effective for 5 years, injections effective for 3, and sterilizations were permanent. Other methods, such as an arm implant that would last 5 years, were also long-term. Such long-term and permanent methods allowed little or no room for reversal, which meant women could not change their minds. This became particularly concerning in rural areas, where women did not

have access to follow-up appointments. In many cases, certain doctors refused to remove IUD insertions when women wanted them removed. **Appendix 11** is data from an UBINIG [12] showing private and non-governmental institutions that are present within the study sample locations: Dhaka, Savar, Sherpur, and Tangail. Among the 4 regions in which the study was done, only 6 government facilities were available for side-effect treatment —- where they would have either been free of cost or low-cost. While the side-effects of Depo-Provera (injection) and IUD could be treated at a government facility in Dhaka and Tangail, there were no government facilities in Savar or Sherpur where side-effects of the injection could be treated. This was similar for other contraceptives such as Norplant, Oral Pills, and sterilizations where barely any government facilities are available to treat side-effects.

> "*Most of the community [have] community clinics[.] The community clinics don't have paramedics though[,] they have short trained workers who understand these [contraceptive or abortion] methods. So if [the women] cannot manage the minor side effects, they will send them to the [...] Family Welfare Center. [...] And then I think two days a week or three days a week the paramedic comes to the community clinic and to support them with the clinical aspect. So, they can [tell] the woman that [...] 'after tomorrow, our paramedic will be coming. So, you [can] come in to get the consultation.'"*
>
> —Personal Interview, January 2024

This can not only be costly for villagers who would need to travel far lengths to access doctors; wouldn't receive compensation for follow-up care and loss of wages; sickness from sterilization and IUD and failure to remove caused disability to work (Akhter, 2005). This exacerbated the unhealthy conditions of poor rural women relative to what they had been before the war.

[12] UBINIG, and Narigrantha Prabartana Study. *"Supposed to be Happy?"* Economic losses after contraceptive use by women in Bangladesh. 2005. This study demonstrates how, even though some (not all) contraceptives and sterilization were done free of cost with "compensations," the economic loss women faced from consistent side-effect treatment became a huge financial burden for women.

2.2 Bangladesh Government's Role in Forced Sterilization

The dedication of Bangladesh's national government and international development agencies towards fighting the population "boom" was received very positively by the international community. An archive of a *Times* article from 1980 [13] reported,"The five year plan […] will be able to achieve a target of more than 50 percent of couples of child-bearing age who regularly use some kind of contraceptive." This meant that the family planning strategies that were introduced by development agencies were positively embraced by the Bangladeshi government. Minister of Health and Population Control Dr. Mohammad Matin stated, "Create 50,000 strong field force of official workers" where villagers will be offered what he describes as 'cafeteria type' service of contraceptives as well as voluntary sterilization [...] the minister is also advocating for menstrual regulation (early abortion), with sterilization after the third child" mainly targeting rural villages (Wigg, 1980). Rural villages were particularly higher targets as there was widespread poverty, famine and natural disasters. President Zia expressed that he would encourage one-child families if it is realistic within conservative Muslim families (Wigg, 1980) . An archive in the *Bangladesh Observer* in 1975, indicates the Bangladesh Association for Voluntary Sterilization was holding a seminar for the purpose of teaching Bangladeshi doctors techniques of MR. Previously in 1972, MR was used to perform an abortion on victims of rape, but in the transition period during 70s, there was a obvious shift towards the use of abortion technique towards to control the population of Bangladesh. As previously stated, While MR is an abortion technique, it can still be performed on anyone, including non-pregnant women, for the sake of "regulating" menstruation. This "regulation" then transitioned to becoming a method that was going to "regulate" the population. This shift can be seen in

[13] Wigg, Richard. "Another five-year plan for family planning." Times, 16 June 1980, p. III. The Times Digital Archive,

Appendix 12 where MR starts to be referred to as a method of controlling the "population boom." It is significant that the article in **Appendix 12** is a Bangladeshi newspaper article which demonstrates how much the neo-Malthusian ideology had become a part of Bangladesh. While this article did not indicate whether it viewed MR as only an abortion method or birth control method, the archive captured how MR had begun to transition to a method that would reduce the booming population of Bangladesh.

While both the Bangladeshi government and international donors viewed Bangladesh's rising population as a threat to poverty solution, the reality through which family planning was implemented in the 1980s was radically coercive. The neo-Malthusian ideology is central to understanding the perception of poverty. The ideology was that if a country like Bangladesh does not reduce their population, there simply would not be enough resources for the entire everyone. Because international donors poured money into family planning it had been their responsibility to evaluate the effectiveness of their donorship. The Bangladeshi government also, however, had significant responsibility in the coercive nature of so-called "family planning." In June 1983, in the district of Mymensingh, villagers with more than three children were rounded up by the military and taken to local clinics by a truck. There they were forced to sign "consent" papers and sterilized. As this took place over some weeks, an estimate of over 500 women, mostly poor Bangladeshi or indigenous minority tribes, were forcefully sterilized. (BIAG, 1985) (Hartmann, 2016) When this incident had taken place, USAID eventually pressured the Bangladeshi government to cease the use of the army to enforce sterilization. The news regarding the army campaign and sterilization incentive reached donors, many had refused to provide aid until there was assurance that women would no longer be forcefully sterilized.

CHAPTER 3

BODY AS A SITE OF EXPERIMENT

3.1 Modern Contraceptives and Its Use upon Bangladeshi Women

> *For me, my view is, yes, women need to have control over their bodies and talk about whether or not they want to get pregnant and have a child, they have every right. But it should not be done in a hide and seek manner, forced upon them where there is no full access to information or tools given to them, which would help them make the correct decision.*
>
> —Khushi Kabir, human rights activist (Interview, 2024)

Amongst all the modern contraceptives that were introduced to Bangladeshi women in the 1980s, Depo-Provera remains one of the most controversial methods of contraceptives not only in Bangladeshi but across many developing nations as well. Depo-Provera is an injectable contraceptive that needs to be taken every three months. During its initial approval in 1959, the FDA recommended this only as a short term contraceptive (less than two years). While use of Depo-provera was widely encouraged in the Global South, in the Global North it was recalled by the FDA in 1978 and discontinued following lawsuits over the side effects. What makes Depo-Provera and many other new hormonal contraceptives controversial is not only their harmful side effects, but rather the double-standard in their geographical application. While both USAID and IPPF promoted this contraceptive in Bangladesh, they rarely paid close attention to the side effects of these contraceptives among rural women. Family planning workers under the government and Midwives were paid by USAID to visit women door-to-door to distribute contraceptives. After pills were distributed door-to-door, there was little medical follow-up in rural areas. According to (Akhter, 2005), about 70% of family planning workers never followed-up with clients. Despite the lawsuits and complaints in the West (Petchesky, 1990), the

contraceptives were unsafely forced upon women for population control measures. (Akhter, 1982; Akhter, 2005) Even with the acknowledgment that some contraceptives may be harmful, population control agencies continued providing them because they considered health side-effects to be minor in comparison to the population control goals.

Among the many contraceptive methods provided to women, the main ones were Depo-Provera (injection), Norplant (arm implant), Copper T 380A (IUD), and Nordette (Pills). These brands were distributed to women by health care workers, social workers, and midwives called *Poribar Porikolpona Apa* (Family Planning sister) (Hartmann et al. 1985; Hartmann et al. 1989; Akhter, 2005). When family planning workers visited families door-to-door, the goal was not to merely inform women of the availability of contraceptives Rather, it was to convince them to adopt a regular method of contraceptive. When contraceptives were given to women, they were provided very little information about the side-effects; in many instances, advertisements targeting women lied to them about not having side effects at all **(Appendix 13)**. Recipients did not choose which contraceptive they used; rather, the healthcare workers did. (Akhter, 2005) Firstly, unlike the United States where oral contraceptives require prescription, women in Bangladesh were offered oral contraceptives without prescriptions at local corner stores or pharmacies. Pharmacies in Bangladesh, whose primary goal is to make sales, are generally unable to privately communicate and provide information on side-effects. Not only that but pills purchased from pharmacies are mainly purchased by husbands who relay little information to women (Hartmann et al. 1989), making the process of learning about contraceptives very limited. The UBINIG study documents cases of women who were refused contraceptives of their choice. Maria, [a person of this description/qualification] from the small town of Savar, had taken oral pills but suffered from side-effects and thus intended to switch to an injection. However, instead

of the injection she was given an implant (Akhter, 2005). One woman named Momota was visited by the family planning workers several times to persuade her to take oral contraceptives. Once she did, she experienced side-effects. When she informed the FP worker, they suggested that she get sterilized. Similar to Momota, many other women in the case study expressed that they were visited by FP workers multiple times before they accepted a method of contraception, but afterwards they hardly returned to follow-up, especially in rural areas (Akhter, 2005). UBINIG's study demonstrates how the majority of the women who took up contraceptives did so by persuasion by frequently visiting FP workers, leaving women little room for choice. Women were told things like "you should not have any more children as you are poor," or "You have enough children so you must get sterilized." This took place alongside a surge in slogans and advertisements for family planning in Bangladesh and the larger Global South. Yasmine Ahmed who worked as a lead at the Marie Stopes Clinic (a UK-based organization) in Bangladesh providing family planning recalled, "There would be leaflets, physical demonstrations, posters on the wall. If you had a TV, maybe something going on in the TV regarding contraceptives. So a lot of communication activities were in place to promote contraception" (Ahmed Interview, 2024).

However, false advertisement within the family planning department of Bangladesh was a significant part of its success. For example, a Nordet advertisement not only claimed to be "almost 100% effective," but it also stated that "there is no problem such as vertigo, vomiting, or others." According to UBINIG case studies on injectables that were used on Bangladesh women, there were various side-effects: some had excessive bleeding, others had irregular menstrual cycles, still others had side-effects that made them switch from one method to another.

Specifically, contraceptive pills were advertised in Bangladesh by the Social Marketing Project (SMP), funded by USAID. Using existing business channels, pharmacies and shops, and modern media technology of its time period, SMP advertised contraceptive pills and other contraceptives. The annual budget for SMP was over $3 million, of which "almost a third [...] was devoted to advertising" (Hartmann et al., 1989). However, the media was not only used to promote family planning within health clinics but also within visual mainstream media through comedy. Having more children became associated with "stupidity" in mainstream media (Church et al., 1989). Even when there was fear among Bangladeshis about the effects of pills, there were media campaigns to suppress those fears by ridiculing them. An advertisement agency named Manoff International [14] made a campaign on Bangladesh Radio to trivialize side-effects of the pill. Richard Manoff, head of Manoff International describes the advertisement as

> *"A mini drama in which the protagonist (always male), accepted as a wise man, confesses to behavior as a fool. The reason? He had believed family planning (methods) to be unsafe. Why? Because he has been listening to ignorant tales told by ignorant people. By realizing his foolish error in time, he looks into family planning (the condom, the pill, and other safe methods), finds it safe, discusses it with his wife, and with her selects a method, his self-esteem as a wise man thankfully restored."*
>
> —Pamphlet "The Poverty of Population Control: Family Planning and Health Policy in Bangladesh." Written by Hartman et al., 1989

Campaigns such as this used men's self-esteem and patriarchal notion of being the family "decision-maker" to persuade women to adopt regular contraceptive use. Promotion of family planning went beyond the scope of a clinic. It became part of an ideology that shaped personal values and family life. It became a way of thinking.

[14] Betsy Hartmann and Hilary Standing quotes Richard Manoff in their pamphlet "The Poverty of Population Control: Family Planning and Health Policy in Bangladesh." This advertisement specifically targeted men who were the primary buyers of contraceptive pills on behalf of women in the pharmacy. The purpose of this ad was to use male masculinity and self-esteem ideals to persuade buying oral contraceptives

"চেলে হক, মেয়ে হক, একতি শোনতান যথেষ্ঠ"

(Translation: Boy or Girl, one child is enough)

—Popular Slogan during the 1980s by Family Planning agencies

Immense pressure from media, healthcare workers, and the government to adopt family planning left the burden of fertility control on the bodies of women, especially when the motivation to control men's fertility was little compared to women. Even though condoms were encouraged initially, family planning workers have found little success in enforcing them. Often unused condoms in the trash or used as balloons, because they were considered to have ruined men's "pride" (Kabir Interview, 2024). There was also a belief that enforcing male sterilization would "offend sentiments of men in a predominantly Muslim society." (Hartmann et al., 1985) Primarily based on oriental perspective, foreign family planning workers found it easier to control women's fertility. Consequently, family planning agencies largely aimed to control women's fertility. Thus, even though many of the contraceptives, such as Depo-Provera and Norplant, were recalled and discontinued in the U.S. by the FDA, they were promoted in the Global South for many years through family planning agencies, including USAID, IPPF and WHO.

3.2 Depo-Provera Controversy

Depo-Provera was founded by Upjohn Co. in the 1950s, and was approved by the FDA in 1974. However, in 1978 the FDA recalled its approval due to major concerns of cancer. Even during its initial stages in 1959, the FDA used two control case studies[15] by WHO in New Zealand to find that women who had used Depo-Provera were at relative risk for breast cancer.

[15] Initial stage of approval. It was found on a Depo-Provera prescription information

One of the main warnings by the FDA regarding Depo-Provera was that it reduced serum estrogen levels and was associated with significant loss of bone mineral density (BMD) among women. This was especially the case if used in young adulthood — a critical period for bone accretion. While the initial stages of approving the injection did not have the information regarding the severity of Depo-Provera, it did conclude that Depo-Provera still showed significant bodily risks to consumers. Based on clinical studies the FDA demonstrated that "after discontinuing Depo-Provera CI in adolescents, mean BMD loss at total hip and femoral neck did not fully recover by 60 months (240 weeks) post-treatment [...]. Similarly, in adults, there was only partial recovery of mean BMD at total hip, femoral neck and lumbar spine towards baseline by 24 months post-treatment." (Gold and Willson, 1981) By 1978, Depo-Provera had been banned in the U.S., but the World Health Organization and International Planned Parenthood Federation continued to supply Depo-Provera to countries in the global south (Gold and Willson, 1981).

In June 1979, the National Population Policy of Bangladesh was established. This policy meant that family planning measures were now going to be integrated into the healthcare sector. This also led to the training of healthcare workers on how to motivate and persuade couples to come to the clinic (Akhter, 1992). Through door-to-door training, oral contraceptive pills were distributed, as well as advertisements for contraceptives such as Depo-Provera. *Gonoshyastha Kendra* (People's Health Centre) introduced Depo-Provera in Bangladesh. This organization alone had gotten 7,358 women to start using Depo-Provera. Within *Gonoshyastha Kendra'*s Progress Report No.7, it states that "this was to test the suitability of the drug for Bangladeshi women" even though the FDA had halted clinical trials due to the severity of Depo-Provera's side effects (GK, 1980). While *Gonoshyastha Kendra* was testing the hormonal injection upon

women, they had soon realized the detrimental health consequences of the injection, including extreme bleeding, weakness, headache, etc. In a single study in Chiang Mai, there was an increase in cervical and breast cancer, an area where 56% were using or had used Depo-Provera (ACAR, 1981-1982). Yet, in this time period the Bangladeshi Government had officially announced the drug to be used on a national scale (Akhter, 1992). Even though *Gonoshyastha Kendra* had eventually ended the use of Depo-Provera in their family planning programs, other healthcare providers still largely provided Depo-Provera.

In an interview with Farida Akhter, she described encountering American magazines discussing the dangers of Depo-Provera while she was living in Bangladesh where Depo-Provera was being promoted. As she recalled,

> *"By [19]81, I got some information on Depo-Provera. [...] So [...] there was this article on Depo-Provera [on Mother Jones magazine], [...] which really talked about very serious effects of Depo-Provera in other countries. [...] But in Bangladesh it is promoted as a miracle solution to fertility. At that time, [...] nobody would talk against population control. And it was also a military government [with General Ershad] [...] so they were very keen to have [a] population control program even before that [General] Ziaur Rahman also used to have sterilization camps. And these were seen as a good thing. [...] they did not look at the ideological aspect of that. So, I started writing, firstly, to create an awareness about [...] contraceptive technologies, as a technology, how is it for a woman[.] [...]I found that they were shifting from pills, to these methods, which are provider controlled [rather than] woman control, like pill, if you give it to a woman, she will have to take it by herself every day. But here, the provider comes every three months or six months, and just pushes an injection and she can decide on her behalf. So that was something that struck me that I mean, this is not right."*
>
> —-Akhter Interview, 2024

After receiving several articles about Depo-Provera's negative side-effects in Latin America, she realized that there were racist implications to the promotion of this injection in Bangladesh given that it was solely promoted in the Global South, while people within the U.S. had banned Depo-Provera. The promotion of Depo-Provera as a safe contraceptive method despite the study

on Beagle Dogs,[16] which proved its carcinogenic properties. Despite this Upjohn Co. still wanted to seek other markers to approve the drug. The persistence to have Depo-Provera clinically approved was a burden put upon women in the Global South—especially Bangladeshi women. After the FDA halted clinical trials due to its alarming carcinogenic level and cancer causing side-effects, this resulted in "clinical trials of Depo [...] [being] exported to [...] Third-World countries" (Akhter, 1992). While there was a huge debate among family planning leaders in the West about the advantages and disadvantages of contraceptives such as Depo-Provera, it was promoted in Bangladesh where women had no idea that this same injection was not used by the US countries that were funding them.

In the case study by UBINIG on rural and urban women on economic losses after taking contraceptives, it shows that despite the FDA warning that Depo-Provera should not be used for more than two years, the majority women in Bangladesh used Depo-provera for much longer (Akhter et al., 2005). Even though dropout rates for Depo-Provera were very high due to side-effects (ACAR, 1981), many women used Depo-Provera for four to ten years (Akhter et al., 2005). According to this study, some women also opted for multiple methods of contraception, such as pill and IUD, Depo-Provera and IUD, or Depo-Provera and pill. While the study itself does not address the side effects of using two methods simultaneously, there was a risk of overdosage of hormones. Contraceptive pills, injections, and implants are all hormonal contraceptives which include progestin, estrogen, or a combination of both.[17] Thus, using mixed hormonal methods can potentially harm women even more, especially when they lack clinical testing or medical safety. About 55% of Depo-Provera users complained about side effects, such as extreme bleeding, menstrual irregularities, discharge, and extreme body discomfort. In one

[16] By testing Depo-Provera on Beagle dogs, studies showed the injection was carcinogenic in a high dosage. After this study, the FDA halted all clinical trials of the Depo-Provera.
[17] CDC website: https://www.cdc.gov/reproductivehealth/contraception/index.htm

case study, a rural family had to sell their ducks to be able to afford medical treatment for the side-effects. (Akhter et al., 2005) The minimum cost range for side-effect treatment ranged from 40 taka to 5,575 taka (which today would be valued at $0.59 to $127.28) (Akhter et al., 2005). The cost was higher in rural areas and an immense burden on lower income rural families whose income is an estimated $100 annually (Hartmann et al., 1985). Despite making contraceptives available for free to women in Bangladesh, the health and economic costs associated with the side effects negatively impacted household income as there was little to no assistance from the same international organizations. In fact, the concern for safety of Bangladeshi women was secondary. The advisory panel to USAID in July 1980 suggested Depo-Provera be made available to any country that requests it, despite the fact that it would violate the Foreign Assistance Act of 1961 under The Helms Amendment, which promptly states, “No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions” (USAID). The desperation to provide women with any contraceptives by the international development agency mimicked a sense of false urgency that without the availability of contraceptives there would be rampant poverty; with IPPF and USAID being its biggest endorsers of Depo-Provera. Empowering Bangladeshi women was secondary to the population control mission. Female ‘empowerment’ was often used to justify the promotion of clinically non-safe contraceptives. In fact, during a meeting debating health risks and population control missions, the USAID advisory board agreed that “ the benefits of Depo use in the Third World outweigh its risks” (Gold and Willson, 1981). Whether in Bangladesh or the Western world, women desire to take control of their own fertility and family planning, yet providing Bangladeshi women with safe and clinically approved contraceptives was compromised by the population control fallacy that unless all Bangladeshi

women adopted regular or long-term contraceptives, Bangladesh would fail. Bangladeshi women, however, were not the only victims of the Depo-Provera controversy. In Thailand, Colombia, and Mexico, 10% or more of married women used Depo-Provera (Singh, 1995). But in Australia, Depo-Provera was also given to Aboriginal women and refugees to promote short-term infertility. **Appendix 14** is an example of a poster protesting against the use of Depo-Provera on minorities and indigenous women in Australia (Coombe et al., 2020). Even though USAID and other developmental organizations justified the use of non-clinically approved modern contraceptives on the population "boom," the case of Depo-Provera used upon minorities and women of color also exhibits principles of eugenics; eugenics meaning that even if the contraceptives create bodily harm they should still be given to Bangladeshi women because their bodies had lesser priority over developmental goals.

CHAPTER 4

FORCED STERILIZATION

4.1 Compensations: Wheat in Exchange for Sterilization

> "*Voluntarism is based on the idea that couples should have the right - the basic human right - to determine the number of its children. But what is a human right in one country may not be a right in another. If couples in Bangladesh decide to have a big family they endanger the well-being of their compatriots and threaten the very existence of the next generations of Bangladeshis. Thus, having a large family in Bangladesh is anti-social and contrary to the common [wealth] and hence, a matter that deserves drastic Government intervention*."
>
> —-Walter Holzhausen; UNFPA representative in Bangladesh; *STRICTLY CONFIDENTIAL* Letter to Dr. Nafis Sadik, Assistant Executive Director of UNFPA in New York, 18th January 1984

In Bangladesh, the line between "voluntary" and "coercive" family planning has become incredibly vague when incentives are added as part of the family planning scheme. These incentives were given in the form of payment or wheat/rice to those who agreed to sterilize. Even though USAID, the main organization participating in incentivized sterilization, referred to these as "voluntary" sterilizations, these practices were actually coercive, especially when considering that women's bodies became a mode of income for healthcare workers, social workers, and midwives. The very goal within family planning was not to "empower" women, but rather to reduce population numbers (Akhter, 1992). Sterilization as a method of contraception meant a permanent inability to have children–the perfect solution to the mission of population control agencies. Thus, "voluntary" sterilization campaigns and organizations had begun, mainly funded by USAID within rural areas of Bangladesh. Healthcare and social workers in family planning

were required to reach a specific quota for sterilization of both women and men. As discussed before, family planning agencies in Bangladesh viewed sterilization as a way to cheaply and permanently regress the growth of the population of Bangladesh. While USAID funded sterilization through incentives advertising it as "voluntary," the Bangladesh military government took this far enough to carry out armed raids in villages forcing sterilization operations in 1980. Many women were sterilized in hospitals without their consent, even when they had gone in for surgeries unrelated to reproductive health (Akhter, 1992). Sterilization was consistently advertised to women, if not outright done to them without any consent or information. The quote above is from a leaked confidential letter by Walter Holzhausen describing the nature of population control in Bangladesh. While it might seem that forced sterilization is an obvious violation to one's bodies, Western foreign development agencies tweaked the definition of voluntarism and the right for Bangladeshi women to make a choice as the very ability to choose would risk poverty within Bangladesh. They believed that the right to control one's own fertility is a human right that cannot be extended to Bangladeshis. It is through this kind of discussion of confidential exchanges, discussions and meetings that population control policies both by international agencies and the Bangladeshi government were determined.

4.2 Saris and Sterilization

As part of an incentivized program funded by USAID, the Bangladeshi government promised payment incentives to sterilization patients and healthcare workers. Until 1985, social workers were required to meet a quota of 2 sterilization surgeries per month in order to be paid their salaries, and they were rewarded TK 15 for every sterilization. If they failed to meet these expectations, they risked losing their jobs (Akhter, 1992). Alongside payment, wheat was also withheld from rural communities unless they decided to get sterilized by being given a

sterilization card **(Appendix 15)** (Hartmann, 1987). The most controversial incentive measure was the government promising both Bangladeshis women and men free Sari or Lungi (commonly worn clothing by Bangladeshis) and TK 175 if they agree to be sterilized (**Appendix 16**). Incentive payments of TK 5-15 taka were also given for IUD referrals to healthcare workers and midwives who bring women **(Appendix 17)** (Hartmann et al., 1989).

Both payment and free clothing were huge incentives within the rural communities most impacted by cyclones, flooding, and famine with minimal income and resources. USAID funded 85% of the incentives and referral fees with its $25 million annual contribution to Bangladesh for family planning alone. Even the doctors and staff within the clinic received special payment for every sterilization surgery. And anybody such as midwives (Tk. 45) or general public (Tk. 20-35) were able to earn money by "motivating" or "referring" sterilization to a patient (Hartmann et al. 1985; Hartmann, 1987; Hartmann et al. 1989) even though this incentivized sterilization measure violated Section 104(f) of the Foreign Assistance Act of 1982, which reads, "No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions" (USAID). But the loophole USAID used to respond to this criticism was by calling the incentive payments "compensation payments." Jack Thomas, USAID's deputy chief of family planning in Bangladesh, said, "Just look at these people. They're so dirty," [18] making the argument that rural communities, especially consisting of peasants, were unsanitary and would lead to unsanitary conditions at the clinic. Therefore, the use of the free saris or lungis was to justify providing sanitary 'surgical apparel' (Hartmann, 1987).

The case study interviews, however, showed the reality of the loophole undertaken by USAID: a majority of the time, the free saris and lungis were actually given to people after the

[18] Quote was collected by Betsy Hartman through J. Hughes in Dhaka.

surgery. In some cases, many women did not even receive payments or wheat that were promised to them. There are many case studies that exemplify how much the incentive system was based upon false promises, a lack of informed consent, and an absence of concern for hunger and starvation. One participant said,

> "*I am 30 years old. My husband is a day laborer. [...] He earns Tk.8.00 to Tk 10.00 per day [...]. For the last three years we have not been able to grow any paddy because of floods. [...] I have three children. My eldest son is 15 years old and the youngest 5 years old." Promised money, sari and a sterilization card "I agreed to undergo the sterilization operation, but I was given only a saree and Tk. 100. No card or wheat was given. When complained to the chairman, he said, 'let's give wheat to the new clients first. If there's extra, then we will give you some.' [...] Nausea, weakness and pain in my abdomen are very frequent.*"
>
> —-Hartmann et al.. 1985

While the majority of sterilization cases targeted women who already had families and children, in other cases the desperation of food and hunger led young women to seek sterilization. This led them to be unable to get married again, as it was taboo for women to be sterile (Hartmann, 1987; Akhter, 2005). As one sees, not only did sterilizations take place by force—in the sense that hunger had forced women to take-up sterilization—their lack of hygiene, proper sterilization method, and informed consent left women economically and bodily disabled. Hunger compelled them to take up sterilization. It was the lack of alternatives provided by the "humanitarian organizations" that backed these women into a corner, limited their options, and made sterilization the easy way out when they were the most vulnerable. About 66% of women had felt side-effects from sterilization, and the cost to treat these side-effects varied from TK 400 to TK 25,000 (Akhter, 2005). Hartmann et al.'s study showed that "in more than 40% of the centers observed, clients were 'not adequately informed about the permanent nature of the operation' or surgical procedures" (Hartmann et al., 1985). The manner in which forced

sterilizations had physically and psychologically left women traumatized had not been taken into account by international population control agencies nor the national governmental family planning agencies who mercilessly enforced population by any means necessary.

4.3 Free Will or Population Target?

If sterilization measures in Bangladesh had truly been voluntary, or if incentives were actually "compensations", then neither million dollar advertisements campaigns nor wheat cards would actually be necessary. When the USAID, World Bank and other donors of family planning were informed about the horrors of forced sterilization, some donors were genuinely mortified learning about what their funds had been used towards while other donors felt that they were not responsible for its coercive nature. The World Bank's Population Health and Nutrition Department's senior adviser, Dr. K. Kanagratnam, argued that "it's not the donor's responsibility to supervise the government programs, if you buy a car from me and then run someone over, is it my fault?" [19] But this argument does not have validity when there are clear establishments of statistical targets meant to be reached. As of 1987, 34% contraceptive users (1.6 million people) in Bangladesh were sterilized. By the start of the following decade the Bangladeshi government aimed to reach 41% (Hartmann, 1987). The knowledge of the Bangladesh government's population control goals were well acknowledged by international development organizations within the confidential 1985 World Bank Report [20]. The report acknowledged Bangladesh's goal as "achievable," given that incentives are still on the table.

When news of forced sterilization had reached people, international organizations were quick to withdraw their name and position within the whole ordeal. However, USAID, World Bank and UNFPA had all agreed to position papers that call for 'drastic' reduction in population

[19] Quote taken from Betsy Hartmann's book "Reproductive Rights and Wrongs" (1987)
[20] 1985 World Bank Report. (Confidential) Found by Hartmann, 1987

control. These position papers included “creation of an autonomous National Population Control Board with ‘emergency powers’ and frequent visits by ‘high ranking government and Army Personnel’ to promote family planning in villages [...] [and] increase sterilization incentives.” (Hartmann, 1987) Population control leads such as Walter Halzhausen continued to send stronger letters to endorse family planning. As Bangladesh was highly dependent upon foreign aid, the national government had no choice but to heed to the commands and donor funds. The influence of this foreign aid was so crucial that even Bangladesh’s own leaders firmly relied on population control to solve poverty. Amidst population demography, and poverty predictions, Bangladeshi women had fallen victim to population targets, despised being flaunted by population control organizations as women who are able to make a “choice” now. But where women’s “choices” are forced upon them in the name of free will, women no longer have free will nor control of their body.

CONCLUSION

The conversation surrounding reproductive rights today remains incredibly controversial, especially within the United States. June 2022 marked the overturn of Roe vs. Wade after nearly 50 years of its groundbreaking Supreme Court decision. The Supreme Court law that allowed abortions for American women in all states has now become obstructed. The conversation surrounding abortion has become deeply controversial again and brings the opportunity to rethink reproductive rights from a transnational feminist perspective. It provokes the question of how access to abortion in the United States has historically been limited and unreliable, while access to abortion in the Global South was largely abundant with little to no regulations. It becomes facilitated by the same government agencies who either previously or continue to fund abortion technology and contraceptives in the Global South. Whether discussing American or Bangladeshi women, a majority of women desire family planning, access to abortion and contraceptives for women, and the choice to control their own fertility. But when the intention to provide access to reproductive rights is plagued with coercive strategies, then it is no longer a reproductive "right." A "right" is what one can exercise at free-will unmotivated by hunger, starvation and poverty.

The nationalist movement stemming from the Liberation War movement, "Second-Wave" feminism, and population are three independent movements that overlap beginning in the 1970s. As the newborn nation of Bangladesh grappled with immense poverty, the neo-Malthusian ideology motivated Western development agencies took the opportunity to experiment with development strategy upon Bangladesh; women faced the significant brunt of this aid experiment through family planning. In the 1970s, the main focus of bringing reproductive rights services

and contraceptives was on helping women rehabilitate from the war. But by the 1980s, concern for women was no longer based upon empowering them from their trauma; rather, their bodies became a mechanism to reduce population and poverty. The overlap of Western "Second-Wave" feminism and population control was central for coercive family planning to be executed within Bangladesh.

When the Women's Rehabilitation Center allowed several development agencies, doctors and feminists from the West, it introduced modern abortion and contraceptive technologies. While these modern technologies such as the MVA were crucially important in providing women voluntary abortions, this same access also took away the rights of women to make decisions regarding their own bodies. Bangladeshi women's bodies become a lab 'experiment' when new abortion technology was tested by Harvey Karman. Despite its danger and lack of regulation, the abortion technology safety was neglected. When Karman's actions became largely publicized, it showed very different reactions from feminist discourses within the United States. This demonstrates how even within "pro-choice" empowerment for Bangladeshi women, the opposite was taking place. This also illustrates how for Bangladeshi women the choice given was not between having an abortion or not having an abortion; rather it was having an unsafe abortion or not having an abortion at all.

When the international development organizations begin to permanently set up Family Planning Programs, the transition to coercive contraceptives, sterilization and population control begin to take place. Alongside the funding from USAID, IPPF, World Health Organization and many others, the government of Bangladesh embraced the neo-Malthusian population control as a solution to poverty. This created a detrimental effect upon the bodies of rural women on whom the contraceptives were forced upon by taking advantage of their hunger and low income. Most

Western feminists or feminists trained in the West viewed this as “empowering” the reality of rural women being more brutal. Thus, the overlap of “Second-Wave” feminist ideals and population control intimately work with each other to serve their own agenda.

This thesis attempts to contribute to a greater understanding of how the independent ideologies of Western “Second-Wave” feminism and population intimately work one another to fulfill their agenda. While “Second-Wave” feminism seeks empowerment for women, it uses ideas of population to make a case for itself. Population control on the other hand pretends “Second-Wave” ideals are present within population control strategies but with the underlying goal of reducing population. The most adverse impact of this overlap was left upon the bodies of Bangladeshi women.

The limitation of this study is partly due to the lack of a Bangladesh Archival Collection at UC Berkeley and the scarcity of English translation of the Bengali language archives. It is my hope that there will be institutional funding support to help digitize one of a kind of archives that I discovered in Bangladesh for open access in the future.

The study of the overlap of “Second-Wave” feminism and population control in Bangladesh is a field that is yet to be explored even more deeply. There is very little academic literature that extensively touches upon the transnational feminist experience in the Bangladesh context where “Second-Wave” feminism overlaps with population control. Thus, this thesis is making a significant contribution to the body of literature that demonstrates that “Second-Wave” feminism played a huge role in launching population control in Bangladesh in the context of a post-war period.