

Promoting Women's Reproductive Health: Why Autonomy Matters

by © Biplab Kumar Halder

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Table of Contents

ABSTRACT	I
ACKNOWLEDGEMENTS	II
CHAPTER 1 INTRODUCTION	1
1.1 OUTLINE OF THE THESIS	3
1.2 THE COMMUNITY HEALTH CLINIC SYSTEM AT A GLANCE	6
1.2.1 THE HISTORY OF THE COMMUNITY HEALTH CLINIC SYSTEM	7
1.2.2 MAJOR FEATURES OF COMMUNITY HEALTH CLINICS SYSTEM AS HIGHLIGHTED BY RESEARCHERS	9
1.3 PERCEIVING THE COMMUNITY CLINIC SYSTEM THROUGH A PUBLIC HEALTH LENS	11
1.4 WHY IS IT NECESSARY TO COMPREHEND THE SYSTEM THROUGH AN “ETHICS LENS” THAT IDENTIFIES MICRO-LEVEL ISSUES?	14
1.4.1 THE TENSION BETWEEN PUBLIC HEALTH AND MEDICINE	14
1.4.2 PATH TO CONVERGENCE	15
1.5 OUTLINING THE PROBLEM: 1	23
1.5.1 A LACK OF APPRECIATION FOR WOMEN’S AUTONOMY IN THE COMMUNITY HEALTH CLINIC SYSTEM	23
1.6 OUTLINING THE PROBLEM: 2	29
1.6.1 HOW THE DENIAL OF WOMEN’S AUTONOMY LEADS TO THE CREATION OF A WEAK SENSE OF REPRODUCTIVE HEALTH	30
	30
CHAPTER 2 THEORETICAL FRAMEWORK	35
2.1 INTRODUCTION	35
2.1.1 SOCIAL JUSTICE	36
2.2 THEORIES OF VULNERABILITY AND AUTONOMY	44
2.2.1 VULNERABILITY	44
2.2.2 AUTONOMY	45
2.3 APPLYING THEORIES	48
2.4 THE INTERRELATIONSHIP OF THE CONCEPTS OF SOCIAL JUSTICE, RELATIONAL AUTONOMY, PERSONHOOD, AND VULNERABILITY	49
2.5 METHODOLOGY	52
CHAPTER 3 THE COMMON GOOD: WOMEN’S REPRODUCTIVE HEALTH AND SOCIAL JUSTICE	54
3.1 INTRODUCTION	54
3.1.1 WHAT IS REPRODUCTIVE HEALTH?	54
3.2 THE SPECIAL MORAL IMPORTANCE OF HEALTH	55
3.2.1 THE SPECIAL MORAL IMPORTANCE OF REPRODUCTIVE HEALTH CARE	57
3.3 HOW COMMUNITY CLINICS PROMOTE WOMEN’S REPRODUCTIVE HEALTH	58
3.3.1 REPRODUCTIVE HEALTH CARE IS MORALLY IMPORTANT BECAUSE IT ENHANCES WOMEN’S CAPABILITIES, A MAJOR REQUIREMENT FOR SOCIAL JUSTICE	59

3.3.2 HOW COMMUNITY HEALTH CLINICS ENHANCE WOMEN'S CAPABILITIES THROUGH REPRODUCTIVE HEALTH CARE	60
3.3.3 WOMEN'S CAPABILITIES AND HEALTH EQUITY	63
3.4 WHY WOMEN'S AUTONOMY MATTERS	64

CHAPTER 4 THE WAY AHEAD: REPRODUCTIVE HEALTH AND THE IMPORTANCE OF RECOGNIZING WOMEN'S RIGHTS AND AUTONOMY IN HEALTH CARE **67**

4.1 INTRODUCTION	67
4.1.1 THE LEGAL FOUNDATION OF THE RIGHT TO HEALTH CARE	68
4.1.2 THE MORAL FOUNDATION OF PEOPLE'S RIGHT TO HEALTH CARE AND WOMEN'S RIGHT TO REPRODUCTIVE HEALTH CARE	70
4.2 WOMEN'S RIGHT TO A BASIC MINIMUM OF HEALTH CARE SERVICES AND HOW REPRODUCTIVE HEALTH CONSTITUTES A 'MINIMUM OF HEALTH CARE'	70
4.3 TELEMEDICINE: AN EXAMPLE OF HOW WOMEN'S AUTONOMY CAN BE RECOGNIZED AT THE MICRO-LEVEL	73
4.3.1 HOW DOES THE RECOGNITION OF WOMEN'S AUTONOMY REQUIRE THAT PROFESSIONAL CONDUCT AND RELATIONSHIPS ARE MAINTAINED IN PROVIDING REPRODUCTIVE HEALTH CARE THROUGH TELEMEDICINE MECHANISMS?	74
4.3.2 HOW DOES PROMOTING TRUST CONSTITUTE THE PRECONDITION FOR AUTONOMY?	75
4.3.3 WHY IS IT IMPORTANT TO INVOLVE PATIENTS AND PROMOTE THEIR AUTONOMY?	76
4.3.4 SHOULD CONCERNS FOR BENEFITS OVERRIDE CONCERNS FOR WOMEN'S AUTONOMY?	76
4.4 CONCLUSION	77

CHAPTER 5 THE WAY AHEAD: WOMEN'S VULNERABILITIES AND THE IMPORTANCE OF RECOGNIZING WOMEN'S AUTONOMY IN HEALTH RESEARCH **79**

5.1 INTRODUCTION	79
5.2 WOMEN'S VULNERABILITIES AND REPRODUCTIVE HEALTH RESEARCH WITHIN THE COMMUNITY CLINIC SYSTEM	79
5.3 WOMEN'S VULNERABILITIES TO EXPLOITATION AND INFORMED CONSENT AS A WAY OF MITIGATING WOMEN'S VULNERABILITIES	88
5.3.1 INFORMED CONSENT: A CRUCIAL STEP TO RECOGNIZING WOMEN'S AUTONOMY AT THE MICRO-LEVEL	89
5.4 CONCLUSION	93

CHAPTER 6 CONCLUSION **94**

<u>BIBLIOGRAPHY</u>	98
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Abstract

Community health clinics in Bangladesh are well known for their reproductive health care services such as maternal health care and counselling on contraceptive methods. However, since women's reproductive health conditions determine their overall well-being, community clinics' reproductive health care services require a critical analysis. Within a social justice framework, this thesis argues that women's autonomy should receive adequate attention in providing reproductive health care for them, and that it currently does not. I analyze community clinics' activities in the areas of both reproductive health care and health research. While acknowledging the positive aspects of the system at the macro level, I conclude that community health clinics lack an appreciation for women's autonomy in promoting women's reproductive health, despite the strong moral reasons for considering women's autonomy as a paramount concern.

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Chapter 1 Introduction

In 1981, the clinical trial of Norplant began in Bangladesh among other developing countries, namely Brazil, Sri Lanka, Philippines, the Dominican Republic, Chile, and Nigeria (Sherwin, 1998, p, 244). Norplant is a contraceptive device that is surgically implanted on the arm under the skin of a woman. Bangladesh's national family planning and biomedical research organization promoted Norplant by labelling it as "a wonderful innovation of modern science" (Raymond, 1995, p, 16). However, the organization did not disclose that Norplant was still in an experimental phase. The trial neither fulfilled the informed consent procedures adequately, nor did it value women's rights to know the risks and side effects of the product (Raymond, 1995). The participants were merely being used as tools for accomplishing the purpose of what was in fact research. Although, later on, Norplant appeared as one of the most effective birth-control methods, the study created a massive controversy in Bangladesh because of its unethical attributes.

This case provides some useful lessons for policymakers, researchers, health care professionals, and care receivers. Even though a public health initiative benefits a population as a whole, the concerns for individual rights and autonomy are important as well. The above situation is a clear example of the denial of women's autonomy that leads to exploitation, oppression, and injustice. The case also demonstrates that the denial of women's autonomy perpetuates marginalization, exclusion, and the violation of women's rights to control their bodies and reproduction. This thesis argues for the importance of the recognition of women's autonomy in the promotion of their reproductive health.

I illustrate this through analyzing how the community health clinic system in Bangladesh, a network of community clinics for delivering health care services to the rural populations, offer reproductive health care to women. In this thesis, I argue that community health clinics lack an appreciation for women's autonomy in promoting women's reproductive health despite the strong moral reasons for considering women's autonomy as a paramount concern. Put another way, this thesis acknowledges that the community health clinic system as a public health endeavour contributes positively to the health sector of Bangladesh, but it is essential to address women's autonomy at the individual level.

Community health clinics in Bangladesh are well known for their reproductive health care services such as maternal health care and counselling on contraceptive methods. However, since women's reproductive health conditions determine their overall well-being, community clinics' reproductive health care services require a critical analysis. By acknowledging the positive aspects of the system, this thesis conducts a critical examination of community clinics' reproductive health care. Within a social justice framework, this thesis investigates why women's autonomy should receive adequate attention in providing reproductive health care for them. I argue that in promoting women's reproductive health through community health clinics, their autonomy must be recognized at the individual level. In developing this argument, first I provide an overview of the community health clinic system that includes the background of establishing community clinics as well as a description of the functions and services of these clinics. I narrow down the analysis to community clinics' activities in the areas of both reproductive health care and health research. By acknowledging the positive aspects of the system at the macro level, I conclude the thesis by claiming that community health clinics lack an appreciation

for women's autonomy in promoting women's reproductive health at the micro level despite the strong moral reasons for considering women's autonomy as a paramount concern.

1.1 Outline of the Thesis

Chapter One provides a background to the research and an overview of the community health clinic system with an emphasis on reproductive health care. It also discusses how the system has received extensive attention from health researchers its innovation in delivering health care services and for contributing to improving reproductive health. In this chapter, I describe the tension between public health and clinical medicine in terms of their goals, methodologies, and prevailing moral theories in these disciplines. This chapter problematizes community clinics' reproductive health care services with regard to women's autonomy. Finally, this chapter provides the rationale for conducting a moral analysis of the reproductive health care within community clinics.

Chapter Two discusses the theoretical foundation of the thesis. I discuss social justice framework that explains why each person is entitled to enjoy their basic liberties. I provide an overview of the concept of social justice theory advanced by John Rawls, Amartya Sen, Martha Nussbaum, and Norman Daniels to analyze how the community health clinic system promotes health equity. Norman Daniels (1985; 2001) suggests that health care is of special moral importance. His view strengthens my claim that the special moral importance of women's reproductive health entails that their autonomy must be recognized. This chapter also presents theories of autonomy and vulnerability that navigate the discussions of this thesis.

Chapter Three describes the contexts of Bangladesh in which women are situated. It discusses how community health clinics promote social justice by valuing health as a special social good and by promoting health equity in Bangladeshi society. In doing so, this chapter explains why promoting women's reproductive health is morally important. This chapter explains the community health clinic system's public health goal for the common good. I discuss how community health clinics contribute to enhancing women's capabilities, a major requirement for social justice. Nevertheless, this chapter also points out that the community clinic system lacks the acknowledgement for women's autonomy in the promotion of their reproductive health.

Chapter Four argues for women's autonomy from the perspective of women's rights. This chapter argues that women not only have the right to access reproductive health care but also they have the right to exercise their autonomy in accessing it. In conducting the analysis, I endorse John Rawls' approach to social justice that implies that an individual has the right to access health care. I extend Rawls' concept of social justice to analyze the importance of women's liberty in the promotion of their reproductive health. I argue that women's disadvantages must be acknowledged. I explain why women's reproductive health should not be used as a tool and how the concept of human dignity requires that women are treated with dignity. In this chapter, I argue that there are moral implications for women's autonomy if reproductive health is being used as a tool for achieving further goals such as population control. Finally, this chapter illustrates community health clinic system's telemedicine services to show how women's autonomy and rights can be acknowledged at the micro level.

Chapter Five deals with several micro-level issues that arise in the area of health research. In Chapter Five, I argue that although the community health clinic system promotes social justice, women in Bangladesh are vulnerable to exploitation and oppression. While women's autonomy as moral agents must be recognized, the existence of women's vulnerabilities require that social structure and institutions are arranged in a way that they promote and recognize women's autonomy. This chapter also acknowledges that the analysis of vulnerability poses problems if it is overly broad. Accordingly, Chapter Five presents an investigation of the importance of addressing the context-specific vulnerabilities of women within the community health clinic system. I argue that an overly broad categorization of women as a vulnerable group often leads to designing paternalistic health interventions for them. For example, Martin, Tavaglione, and Hurst (2014) argue that a vague categorization of vulnerability can result in "undue overprotection of some individuals as well as stigmatizing attitudes towards the vulnerable" (p. 52). Within the framework of Tavaglione et al. (2015), I propose an analysis of the vulnerabilities of women in Bangladesh. In a like manner, I argue that while women should not be subjected to undue *overprotection*, their autonomy should be protected when they participate in health research. I illustrate the importance of women's autonomy by providing an analysis of how a meaningful informed consent policy and practice can uphold their autonomy as well as protect them from possible exploitations.

I conclude the thesis by emphasizing that community health clinics must recognize women's autonomy in providing reproductive health care for them. Each chapter strengthens the major claim of this thesis- by providing support for the recognition of women's autonomy in the promotion of their reproductive health.

1.2 The Community Health Clinic System at a Glance

As recent as three decades ago, Bangladesh had the highest maternal and child mortality rates among its neighboring countries. By 2010, the maternal mortality rates decreased to 178 per 100,000 live births, as compared to 583 per 100,000 live births in 1990. Over the same time, the child (under-5) mortality rates decreased to 33 per 1000 live births by 2011; this decreased from a child mortality rate of 133 per 1000 livebirths in 1990 (Ahmed, 2015). Bangladesh has also demonstrated remarkable achievements in maintaining a low prevalence of HIV/AIDS and Sexually Transmitted Diseases. These achievements in its health sector, while dealing with limited resources and multiple challenges such as poverty, corruption, poor resource-setting, and a vast population, have also surprised the global community. Scholars, researchers, and health professionals repeatedly refer to the community health clinic system as an innovative health care delivery system because of its contribution to Bangladesh's substantial progress in its national health care sector.

The community health clinic system in Bangladesh is termed as a pro-people health care delivery system since it has brought health care services to the doorstep of the rural people in Bangladesh ("Health care Services for All," 2014). Previously, it was difficult to provide health care services to the rural zones and hard-to-reach areas of Bangladesh. To deal with this challenge, the community health clinic system has made it possible to offer health care services to the people who were previously left out of the health coverage due to geographical location. The government of Bangladesh and its development partners (local and global NGOs and donor countries) allocate necessary funds and offer technological and logistic support to ensure the proper functioning of community health

clinics. For example, USAID (a USA-based NGO) and DFID (a Canada-based NGO) are currently funding a project through community clinics titled “NGO Health Service Delivery Project” (Azad, Shamiul Bashar, & Anwar, 2015). This is the largest health care project in Bangladesh. Because of its achievements and promises, the community health clinic system is the top priority of the government of Bangladesh within its health care sector.

1.2.1 The History of the Community Health Clinic System

The story of the community health clinic system in Bangladesh began in 1998 under the *Awami League* government which had the vision to establish eighteen thousand community clinics throughout the country. Initially, 10723 community clinics were constructed between 1998 and 2003. Eight thousand of these clinics started to function immediately. However, with changes in political circumstances and a new government, the functions of the community health clinics were completely shut down in 2001. In 2009, the *Awami League* government took an initiative to revitalize the community health clinic system as a priority project which was titled “Revitalization of Community Health Care Initiatives in Bangladesh”, under the Ministry of Health and Family Welfare (Azad et al., 2015, p, 32).

It appears that different factors worked as motivation to establish the community health clinic system by the *Awami League* government from 1996 to 2001. One such motivation was the Bangladesh government’s family-planning program which achieved remarkable success in reducing the fertility rates through supplying contraceptives and providing reproductive counselling to rural people in the 1980s and 1990s (Arifeen et al., 2013). However, the achievement of the family-planning program was not sustainable enough to make a substantive change in the health sector of Bangladesh. The government

of Bangladesh wanted to extend its free health care services to more people in a cost-effective manner.

The government set a goal to construct one community health clinic for every 6000 people, in order to provide integrated primary health and family-planning services to the rural people of Bangladesh. This package of integrated primary health and family-planning services was known as the Essential Services Package (Sarker et al., 2002). An essential service package is comprised of maternal and neonatal health care services, reproductive health and family-planning services, vaccination services, supplying micro-nutrients, the treatment of common diseases, and the screening of non-communicable diseases (Sarker et al., 2002).

At present 13136 community clinics are functioning all over the country, and the number of clinics is proliferating (Ahmed, 2015). For each clinic, the government has recruited one Community Health Care Provider who periodically receives training from the public and nongovernmental organizations in order to provide up to date health services to the rural people through the community health clinics. Community clinics work as primary health care centers which provide one-stop, convenient services to the rural people of Bangladesh. The *Awami League* government has taken the initiative to set up a trust fund for the community clinic system in order to ensure an uninterrupted function of this system even in the event of a change in the government (Bangladesh, n.d.).

Ahmed (2015) provides a brief overview of how the community health clinics function through a public-private partnership at the grassroots level. As he points out, each clinic consists of a Community Group which comprises of a government representative, community leader, community representative, and land donor. The Community Group is

responsible for the management of the respective community clinic. The government with the help of its development partners, local and international NGOs, and the donor organizations provide the support to build infrastructure, recruit and train the community health care providers, supply drugs, and monitor the function of the community health clinics (Ahmed, 2015). Thus, the community health clinic system involves NGOs and donor organizations as significant actors in the functioning of the system.

As stated above, the community health clinic system involves non-government organizations (NGOs) in delivering health care services, conducting research, and providing technical support for the clinics. Sixteen NGOs have signed MoU (Memorandum of Understanding) to collaborate with the community clinic system. These NGOs work closely with government representatives and local people in various nutritional and community health projects, which creates a public-private partnership.

1.2.2 Major Features of Community Health Clinics System as Highlighted by Researchers

A number of key features of community clinics have attracted the attention of scholars and researchers in recent years. In 2013, the *Lancet* published six research articles in their series on the health system of Bangladesh (Adams et al., 2013; Kaosar Afsana & Wahid, 2013; Ahmed et al., 2013; Arifeen et al., 2013; Bhuiya et al., 2013; Tavaglione et al., 2015). The journal also published several commentaries on these research articles by distinguished scholars such as Amartya Sen, a Nobel laureate economist, and Sir Fazle Hasan Abed, the Chairperson of BRAC (Building Resources Across Communities), the largest non-government organization in the world (Abed, 2013; Sen, 2013). These authors and commentators have critically examined the health system of Bangladesh and expressed

their opinion on the advancement of the health care sector in Bangladesh. Most of the papers have explored the innovations in the health system of Bangladesh.

Amartya Sen (2013), in his commentary *What's Happening in Bangladesh?*, focuses on four striking features which have contributed toward a health transition in Bangladesh: (1) reducing gender inequity and the liberation of women; (2) the collaborative initiatives between the government, NGOs, and private enterprises; (3) a community-based approach in the delivery of health services and medical care; and, (4) Bangladesh's improved ability to face natural disasters (Sen, 2013).

Bangladesh has made remarkable improvements in reducing gender inequity in its various sectors. As such, Sen (2013) mentions that the participation of females in different areas including health and education has increased rapidly. He points out that the number of girls in the primary education system is more than the number of boys. A substantial number of females are working in different NGOs and are contributing to the improvement of health, livelihood, and education. Sen (2013) also argues that the participation of women in various sectors has not only empowered them but has also reduced the gender inequality within society. In Sen's (2013) view, the reduction of gender inequality has contributed to a rapid social change in Bangladesh.

Amartya Sen (2013) also explains how the community-based approaches in the health service delivery and the collaboration of multiple actors (public organizations, NGOs, and global health organizations) have contributed to Bangladesh's rapid advancement in its health sector. As discussed earlier, the community-based approach has established a public-private partnership. The government provides financial and logistic support to local communities in functioning community health clinics. The community

participation has also promoted community-empowerment by placing decision-making authority in the hands of the local communities. People in the local communities participate in decision-making about their respective community clinics. This community-engagement has contributed positively to the national health system of Bangladesh.

As noted, the health system of Bangladesh engages multiple actors from both the public and private sectors, and this has practical implications. Sen (2013) observes, “the pragmatism that Bangladesh came to accept through a complex political and social process has yielded noticeable success, which has impressed—and to a considerable extent surprised—the world” (p, 1967).

1.3 Perceiving the Community Clinic System Through A Public Health Lens

Many scholars have branded the success story of the public health system in Bangladesh as “one of the great mysteries of global health” and as a “near miracle” (Das & Horton, 2013; Huq, 1991). In the *Lancet* series, many authors identified the contribution of community-based health clinics as an innovative health care delivery mechanism in providing health care services to the rural people of Bangladesh.

The first paper of the *Lancet* Series, *The Bangladesh Paradox: Exceptional Health Achievement Despite Economic Poverty*, presents a picture of Bangladesh’s health system with several success stories (Chowdhury et al., 2013). This paper states how the country was once labelled a “country without hope” by Henry Kissinger, former United States Secretary of States. Now, however, Bangladesh is applauded as an example of “good health at low cost” (Chowdhury et al., 2013, p, 1734). The authors (Chowdhury et al., 2013) emphasize,

“exceptional performance might be attributed to a pluralistic health system that has many stakeholders pursuing women-centered, gender-equity-oriented, highly focused health programs in family-planning, immunization, oral rehydration therapy, maternal and child health, tuberculosis, vitamin A supplementation, and other activities, through the work of widely deployed community health workers reaching all households” (p, 1734)

The authors (Chowdhury et al., 2013) in this paper point out that community health workers deliver essential health care services such as reproductive health care services, limited curative care services, and health care services to control communicable diseases through outreach programs.

The majority of the services provided by the community health clinics are targeted toward women, and this has also brought health equity in society. Previously a large number of women could not access essential health care services. Chowdhury et al.'s (2013) paper also focuses on how Bangladesh has shown exceptional health achievement in many fields, especially when compared to its neighboring countries such as India, Pakistan, and Nepal. The coverage of vaccination and oral rehydration therapy are tremendous. In Chowdhury et al.'s (2013) paper, the authors note that “Bangladesh achieved relatively improved gains in equity in health services, particularly in family-planning services and treatment for childhood illness” (p, 1739).

In *Harnessing Pluralism for Better Health in Bangladesh*, another research paper in the *Lancet* series, the authors explore how Bangladesh has made considerable advancements in health and human development in spite of “a health system that is frequently characterized as weak, in terms of inadequate physical and human infrastructure and logistics, and low performing” (Ahmed et al., 2013, p, 1746). This paper argues that the pluralism of the health system, with multiple stakeholders, has created the conditions

for a rapid change within Bangladesh's health sector. In defining the pluralism, the authors point out the various stakeholders and interest groups involved in the health system of Bangladesh (Ahmed et al., 2013). In simpler terms, this pluralism refers to the involvement of public and private organizations in Bangladesh and international donor organizations such as the World Bank, the World Health Organization, UNICEF, and USAID in the national health sector of Bangladesh. While this pluralism could have made the health system more complex, it has contributed positively instead.

Shams El Arifeen and his colleagues have explored how the innovation in health service delivery has contributed positively to the health advancement of Bangladesh (Arifeen et al., 2013, p, 2012). Their analysis shows that the community health clinic system is an innovative health care delivery system which has improved both the health service coverage and health outcomes. Arifeen and his colleagues (2013) present some of the success stories of the community-based approaches in Bangladesh that include: (i) the Bangladesh family planning program; (ii) the oral rehydration therapy program; and (iii) the expanded program on immunization (Arifeen et al., 2013). It should be noted here that all of these programs have been adopted in the community health clinic system. Currently, community health clinics are providing these services with the help of its partner organizations such as NGOs and international donor organizations.

In order to establish and maintain community clinics, the Bangladesh government has established partnerships with communities, NGOs, and donor organizations. These partners of the Government of Bangladesh provide sufficient funds for securing a sustainable health service delivery to the people of Bangladesh. From a public health perspective, the community health clinic system has contributed positively to the health

care sector of Bangladesh. However, there are some micro-level issues that need to be addressed.

1.4 Why is it Necessary to Comprehend the System through an “Ethics Lens” that Identifies Micro-level Issues?

1.4.1 The Tension Between Public Health and Medicine

Public health as a discipline has its aims, methodologies, and theoretical frameworks which are different from those generally established in medicine. For example, in terms of goals, public health is concerned about the health of the entire population rather than individuals. Conversely, in medicine, a patient’s well-being is regarded as paramount. Accordingly, interventions are designed for individual patients.

Public health is dependent mainly on epidemiological data and the appropriate methodologies for analyzing the data. Thus, we often find different public health mechanisms for improving or protecting the health of a population by designing different sorts of interventions. Public health is multidisciplinary that incorporates, amongst others, sociological, biological, and psychological aspects of health and well-being. On the other hand, medicine is centred mostly on the biomedical model of health that focuses on disease and diagnosis of the human body through a molecular biological lens.

In the contemporary literature on public health and medicine, scholars are often in widespread disagreement on whether ethical frameworks that are common in the practice of medicine are suitable for public health as well. For public health, many scholars offer theories such as social justice, communitarianism, and utilitarianism that uphold the value of the common good. As such, in the utilitarian tradition, it is customary to estimate the

overall outcome or consequences of an action. On the other hand, rights-based approaches that value individual autonomy and rights are predominant in clinical medicine.

The contemporary development of public health ethics as a separate area from medical ethics bears the mark of this difference. In “Public Health Ethics: Mapping the Terrain” (2002), Childress and his colleagues outline some general moral considerations, “clusters of moral concepts and norms that are variously called values, principles, or rules - that are arguably relevant to public health” (p, 171). These moral considerations include (i) producing benefits; (ii) avoiding, preventing, and removing harms; (iii) producing the maximal balance of benefits over harms and other costs (often called utility); (iv) distributing benefits and burdens fairly (distributive justice) and ensuring public participation, including the participation of affected parties (procedural justice); (v) respecting autonomous choices and actions, including liberty of action; (vi) protecting privacy and confidentiality; (vii) keeping promises and commitments; (viii) disclosing information as well as speaking honestly and truthfully (often grouped under transparency), and (ix) building and maintaining trust (Childress et al., 2002, p, 171-72).

1.4.2 Path to Convergence

The above discussion shows the tension between public health and medicine. Such tension raises the question of why the community health clinic system as a public health initiative in Bangladesh should take the issue of individual autonomy seriously. Lisa M. Lee (2012) describes the tension between individual freedom and community well-being in several disciplines and how scholars offer ways of convergence. She writes, “in 1988, Dan Beauchamp foreshadowed the 2000s by bringing together health, equity, political

philosophy, and democratic theory to root public health ethics as a balance of, as opposed to a struggle between, individual freedom and community well-being” (p, 86).

Although ethical theories often stand opposed to one another, there is a tradition of viewing opposite theories as complementary to each other. One example of such convergence is the interpretation of utilitarian and deontological perspectives in Beauchamp and Childress’ *The Principles of Biomedical Ethics* (2013). This book sketches out the Principles of respect for autonomy, nonmaleficence, beneficence, and justice that represent both the utilitarian and deontological traditions. The following is an excellent example of how different moral theories (which are often represented as contrary to each other) can be translated into the efficient policymaking process.

In one of the reports to the Canadian Agency for Drugs and Technologies in Health (CADTH), Pullman (2018) outlines macro, meso, and micro level considerations for assessing Composite Resin and Amalgam for Dental Restorations, two health technologies in dental and oral medicine. The analysis of macro-level issues such as public health policy and environmental concerns draw on utilitarian and similar perspectives that value the common good. Pullman (2018) also identifies meso-level issues that are related to professional bodies and institutions. The micro-level issues include the concerns for personal autonomy of patients and physicians. The analysis of the micro-level issues incorporates the deontological approach, among others, in moral philosophy that values human dignity and autonomy. The following figure presents how macro, meso, and micro

considerations may incorporate theories like utilitarianism, social justice, and deontology.

Macro, Meso, and Micro Considerations

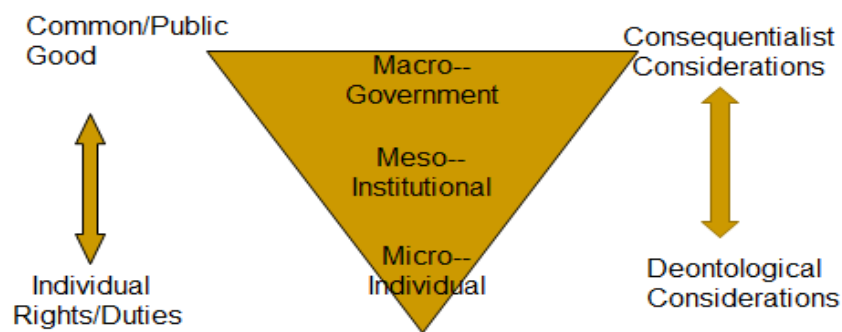


Figure: Adapted from the report “Composite Resin versus Amalgam for Dental Restorations: A Health Technology Assessment”. Ottawa: CADTH; (Pullman, et al., 2018, p, 91).

Drawing on the above example, this thesis strives to articulate that while the community clinic system promotes the common good for society, women’s autonomy should be regarded as paramount. Several moral theories can be put together in pursuing the answer to the question of why women’s autonomy should be regarded as the paramount concern to promote their reproductive health.

In fact, the *Lancet* series illuminates the macro-level issues within the community clinic system while paving the way for reviewing micro-level issues such as women’s autonomy and individual rights. The primary goal of the *Lancet* series was to highlight the innovations in the Bangladesh health sector which includes, among other things, health service delivery, community-involvement, and pluralism. It is noteworthy that the community health clinic system has developed an awareness among the Bangladeshi people that their overall well-being is an important issue. To this end, researchers call for a plan to

create a “second wave of innovation” which will steer the country toward universal health coverage (Das & Horton, 2013, p, 1682).

In “What’s Happening in Bangladesh?”, Amartya Sen emphasizes that “Bangladesh’s path of development will demand critical examination over time, since substantial overall advancement can coexist with persistent inefficiency and inequalities in the sharing of the benefits of health transition” (Sen, 2013). Drawing on Sen’s suggestion for a critical examination of Bangladesh’s national health system, I point out that reproductive health care delivered through community health clinics also requires a critical examination that problematizes reproductive health from a moral perspective. Accordingly, I conduct a moral analysis of the provision of reproductive health care services within community health clinics, one of the major components of the national health system of Bangladesh.

The authors in the *Lancet* series have applauded the innovations in the delivery of health care services. However, while the innovations in the delivery of health care services might improve overall health outcomes, the innovations themselves do not guarantee an equitable and just health care system. The innovations are merely tools to improve health outcomes. It must be analyzed whether these innovations in delivering health care services are morally satisfactory. Put another way, the innovations in the area of health care delivery mechanisms must not be granted uncritically. An excellent example of this is the use of mobile phones to reach patients. Using mobile phones in reaching people might be an effective innovation in terms of health care service delivery, but this innovation must be reconciled with the privacy of the patients. It is equally important to analyze whether the

innovations are responsive to ethical considerations such as health equity, patients' autonomy, privacy, and confidentiality.

The Lancet series makes the case that Bangladesh has demonstrated extraordinary health achievements through several innovative strategies. It is important to address the micro-level ethical issues that emerge from the initiatives of the community clinic system in Bangladesh.

An analysis of the micro-level issues that persist in the community health clinic system is crucial for several reasons. Firstly, Bangladesh, with its numerous obstacles, has become an example of health advancement in the world. The community health clinic system has become a role model for many developing countries; as such it is especially important that the system treats individual patients in general, and women patients in particular, in an ethically defensible manner. Secondly, since the community health clinic system is gradually expanding its services and coverage, it is crucial for the government to find any loopholes before advancing the program to the next level. A moral analysis of the community health clinic system would help the government to take any necessary steps before further developing the system.

Community clinics were established in Bangladesh in order to promote good health of the citizens. If we observe the motivating factors of establishing community clinics in the rural areas in Bangladesh, we find that the government wanted to ensure: (i) a sustainable integrated primary health care program comprising of family planning services and primary health care services; (ii) that reproductive health care reaches the doorstep of rural people; and, (iii) the reduction of the total fertility rate to control the population growth and to lower the maternal mortality ratio (National Health Policy, 2011). It is noteworthy

that 80% of the total population of Bangladesh are the beneficiaries of the community clinic system. Although the government wants to satisfy this majority of the people, women's reproductive health is being used as an instrument for controlling the population growth rates.

Community health clinics' reproductive health care services are targeted toward women at their reproductive age. However, there are also minority groups of women such as postmenopausal women and adolescents whose reproductive health is equally important. Community clinics' reproductive health care is less concerned about these groups. This implies that the community clinic system is more concerned about women's *reproduction* than about their reproductive health in general. The focus on women's reproduction, in particular, creates an impression that women are instrumentally valuable for the society because of their reproductive ability. Such an impression could be interpreted to imply that women's reproductive health can be used as a tool, which is contrary to the concept of human dignity. From the Kantian deontological perspective, individuals should not be used merely as tools. As persons, individuals have intrinsic moral worth. Each deserves to be treated with dignity.

Women's reproductive health contributes to the overall advancement of the health sector of Bangladesh. The neonatal health care services, vaccinations, and nutrition supply programs of the community clinic system contribute to ensuring a healthy generation who will lead the country toward a prosperous future. These programs are directed toward the common good, toward a better society for the future. Such 'common good approach' to reproductive health creates an image that women's reproductive health is instrumentally valuable since this contributes to the creation of a healthy generation.

In the case of community health clinic system in Bangladesh, the common goods, e.g., creating healthy generations or reducing population growth rates, are to be achieved through reproductive health care services and women are being used as the stepping stones to accomplish this common good. Simply stated, women are being targeted mostly through the government and non-government reproductive health intervention programs such as contraceptive distribution programs. Men, however, remain excluded (Kamal, 2000). Women constitute the highest users of contraception, which also demonstrates the fact that women are mostly reached and targeted comparing to their male counterparts. Although these programs generate an overall benefit for the country, women pay the larger price for this.

Since women are frequently reached by the female Health Assistants or Family Welfare Assistants of the community clinic system, this creates an assumption that women's reproductive health is the instrument of achieving greater goods. The female health workers provide counselling to married women of reproductive age on the available options of different contraceptive methods and how to use different contraceptive methods such as birth control pills. Presumably, men are excluded from this counselling and do not receive information on contraceptive usages. It is highly unlikely in the Bangladeshi culture that a female health worker would talk about sexuality and reproductive health with a man. Since the health workers are almost always females, it is more likely it will be women who receive information and counselling on contraceptive usages. Indirectly, this policy pushes women to use contraceptive methods and to be responsible for the success or failures of the chosen contraceptive method. This also excludes men from the conversation of

contraceptive usages placing a disproportionate responsibility on women to use contraceptives.

Often, women are used as tools, which is also evident in the goal of population control through reproductive health care services. Population growth has become one of the major public health concerns in Bangladesh in the last few decades. Donor organizations pressure the government to take initiatives to reduce the population growth rates. Thus, family-planning has become a major tool to fulfill the goal of reducing population growth rates. The reduction of the population growth rates thus satisfies both the majority of the people of Bangladesh and the donor organizations.

The primary purpose of the reproductive health services offered by community health clinics is to enhance the common good of the society, to control the population and to reduce the overall maternal and infant mortality and morbidity rates. While it is true that because of the government's initiatives through community health clinics women's fertility rates have been reduced, this does not necessarily mean that women's reproductive health has improved. The donors, development partners, and international health organizations also support the Bangladesh government's initiatives for reducing women's fertility rates. Nevertheless, while the community clinic system generates the common good for society, it is important to address the micro-level issues within the system.

There was a time in Bangladesh when the family-planning program was so aggressive that women were given incentives to use permanent contraceptives or for being sterilized. In the 80s and 90s, the government spent 20% of the donations of the US Agency for International Development (USAID) to provide incentives in the forms of money, food, and clothing for acceptors of contraception, particularly sterilization, and for health workers

who would recruit new clients (Anderson & Cleland, 1984). Still, the practice of providing incentives for adopting and continuing some permanent family-planning methods persists in Bangladesh.

Presently in Bangladesh, NGOs and government health agencies cannot legally offer incentives to their clients for simply accepting any permanent contraceptive method. However, the practice of using indirect incentives to promote some permanent contraceptive methods still exists. If anyone chooses a contraceptive method which causes financial loss, for example, loss due to the absence in work or transportation cost, the government offers remedial incentives to fulfill the loss. Put another way, the incentives are not offered for accepting a contraceptive method *per se*, but rather an incentive is disbursed for the time one spends for a procedure. Of course, this sounds a good and just initiative for the individuals who choose to use certain contraceptives, but at the same time, this initiative also reveals the government's boldness to control the population growth of the country through its reproductive health services. Is it ethical to use women as tools in order to achieve the demographic goals of the government? The next section problematizes the reproductive health care services provided by the community clinic system.

1.5 Outlining the Problem: 1

1.5.1 A lack of appreciation for women's autonomy in the community health clinic system

Although community health clinics are contributing to the well-being of rural Bangladeshi women, the system does not adequately acknowledge the importance of women's autonomy in promoting their reproductive health. For instance, a lack of appreciation for women's autonomy persists in an important policy document titled the

Health Information System and eHealth Revised Operational Plan (Directorate General of Health Services, 2013). This document (2013) outlines how a population health registry will be created by obtaining data from community clinics. However, the document does not sketch out how the concerns for women's privacy and autonomy will be addressed. Nevertheless, implementing an operation plan to a health care system requires that various concerns for privacy and autonomy are properly addressed. Before beginning the discussion of how community clinics lack an appreciation for women's autonomy, it is crucial to explain the concept of autonomy first.

In the literature on medical ethics, autonomy refers to one's capacity to make decisions regarding health care interventions that allegedly benefit him or her. For example, if a patient consciously prefers to have a knee replacement to improve their quality of life, the patient is considered to be autonomous. However, in this thesis, I adopt the concept of relational autonomy that originates from a feminist tradition in bioethics. The relational concept of autonomy not only explains an individual's capacity to make decisions but also analyzes the conditions for autonomous choices (Stoljar, 2014). In general, a woman is considered autonomous if she is capable of making her own health care decisions, such as preferring home birth to hospital birth. From a relational perspective, the concept of women's autonomy encompasses an understanding of the contexts that influence a woman in making her health care decisions. The relational concept of autonomy acknowledges that women's social and historical contexts affect their decisions regarding health and well-being.

A relational approach to autonomy explains the concept of autonomy by considering how external conditions undermine women's autonomy. For instance, from a

relational perspective, if a woman chooses not to take contraceptives to satisfy her male partner, her choice may not be regarded as autonomous. In this example, her male partner's influence could effectively curtail the woman from making an autonomous decision. In biomedical ethics, the standard literature on informed consent acknowledges that informed consent should be voluntary in the sense that the person who is giving the consent is free from both internal and external controlling influences such as persuasion, coercion, and manipulation (Nelson, R. M., Beauchamp, T., Miller, V. A., Reynolds, W., Ittenbach, R. F., & Luce, M. F., 2011). However, the relational perspective of autonomy emphasises that women, by virtue of being women, are more susceptible to being influenced by external and internal forces such as social and religious norms, husbands and in-laws, and so on.

In explaining women's autonomy, Natalie Stoljar (2018) reflects on the prominent feminist literature on autonomy. I formulate Stoljar's view in the following three questions:

- [1]. Do women invalidate their interests and needs for the sake of others' wishes? (self-abnegation)
- [2]. Do women adapt to oppressive norms and regulations due to a lack of alternative options? (adaptive preference formation)
- [3]. Do women internalize practices of oppression? (normalization of oppression)

Natalie Stoljar (2018) explains that there are 'autonomy-undermining' external conditions that influence women's choices. Drawing on Stoljar's (2018) work on the concept of autonomy, I demonstrate in the following section that the community clinic

system lacks plans to address the external conditions which undermines women in exercising their autonomy while receiving health care services from community clinics.

Self-abnegation

One significant features of a community clinic in Bangladesh is that it involves the local community in the maintenance of the clinic. However, the community health clinic system lacks plans for involving women who would actively participate in the decision-making processes. Each community clinic consists of a community group with 13 to 17 members who are responsible for the daily operation and the long-term planning of the clinic (Azad, Shamiul Bashar, & Anwar, 2015). According to the government's guideline for founding community groups, at least one-third of the members of a community group must be women, even though about 80% of the service seekers are women and children (Directorate General of Health Services, 2017). Since the community group of a clinic decides how a fund is utilized and what health care services are included in the clinic, the presence of women's voices in a community group is important.

Mahmud (2004) identifies several structural constraints for women to express their concerns in the meetings of community groups. For instance, due to the existence of power inequalities between men and women in community groups, women are less likely to participate in community group meetings. Similarly, women's educational status determines their active participation in community groups. A lack of education discourages women from expressing their concerns. Mahmud (2004) cites a landless woman who is also a community group member, 'I am poor and ignorant, what will I say? Those who are more knowledgeable speak more [at meetings]' (p, 16).

The above discussion shows that constraints such as power inequalities, poverty, and a lack of education undermine women's participation in community groups. Mahmud (2004) writes, "...implementing initiatives for community involvement in health such as the CGs [community Groups], without adequate attention to these questions [regarding power, hierarchy and exclusion], carries the risk of simply reinforcing existing power hierarchies and generating further frustrated expectations among the poor and marginalised (p, 17).

Adaptive preference formation

One of the major goals of establishing community health clinics was to replace domiciliary visits for delivering family-planning services, such as distributing contraception and counselling on contraception. However, women prefer family planning services delivered to their homes since they "feel shy to tell their problems in the presence of elders at the CCs. They prefer to get FP services as before through home visit and satellite clinics." (Normand, Iftekar, & Rahman, 2002, p, 38). In practice, even though women do not want to visit community clinics for availing of family-planning services, they must seek services at these clinics due to a lack of alternative options. This scenario reflects how women make choices that do not represent what they actually want.

From April 2009 to September 2017 in Bangladesh there were 560.85 million visits by rural people to community clinics (Bulletin, 2017). An implicit message in the bulletin is that the figure represents how these service recipients (irrespective of their gender) choose to visit community clinics. This massive figure does not necessarily represent women's autonomous choices. In the Bangladeshi society, women's choices are often heavily influenced by their husbands and family members. A woman may visit a

community clinic simply because her husband wants her to do so. Thus, even though a substantial number of women visit community clinics each year, their visits do not mean that they would otherwise choose to visit those clinics.

The conversation of the importance of recognizing women's privacy and autonomy is crucial especially in the context of Bangladesh. Although Bangladesh has made substantial improvements in obtaining gender equality, there a culture of undermining women's autonomy still persists in Bangladeshi society.

Normalization of oppression

While Bangladesh has remarkably achieved gender equity in the areas of education and income, the persistence of oppressive norms and practices in the area of health is one of the major barriers to women's autonomy. A good example of an oppressive norm is the practice of treating women as passive and less capable than men in making decisions about health care. The Japan International Cooperation Agency (JAICA) is one of the donor organizations that works with the government of Bangladesh for improving women's health. A JAICA report on Bangladeshi community clinics states that "They [community leaders] organize male gathering and provide information on safe delivery and newborn care. Pregnant women and their family members also receive orientation on birth planning (Islam, 2009, p. 37)." Note that in the above report, males are in charge of birth planning whereas women merely receive orientation on birth planning. This is a gendered norm that reinstates male dominion over women. While men can certainly play an important role in improving women's health, the assumption that men can better take care of women than women themselves is morally problematic. Such an assumption is paternalistic in a way

that denies women's agency. The community health clinic system has institutionalized male domination by treating women as passive and as an intrinsically vulnerable group.

Another example of internalizing the practice of oppression is the normalization of abuses. An evaluation report of the community clinic system says that 20% of the service recipients (during their visits to community clinics) reported rude attitudes of service providers (Normand, Iftekar, & Rahman, 2002). This being said, although most Health Assistants and Family Welfare Assistants are women (who work at the field level), a substantial number of men work as Community Health Care Providers who are stationed at the clinics. Since a large share of CHCPs are men, the incidents of abuse due to the persisting power gap between male and female cannot be ruled out. Presumably, considering women's disadvantaged social positions in Bangladesh, women are primarily the victims of these abuses. However, those same women seek health care services from these service providers and internalize that it is normal to tolerate abuses. The community health clinic system has not taken any initiatives in addressing the incidents of abuses in health care services.

1.6 Outlining the Problem: 2

Another key problem of promoting women's through community clinics is that the system has adopted a weak sense of reproductive health that is not responsive to women's interests. The next section discusses what the strong and weak senses of reproductive health are.

1.6.1 What are the Weak and Strong Senses of Reproductive Health?

A sense of reproductive health is weak if (i) it excludes the comprehensive health care needs required for maintaining the overall reproductive well-being of women, and (ii)

it is founded upon a narrow ethical perspective overlooking the issues of other broader moral aspects of reproductive health such as women's reproductive rights, protecting the rights of the vulnerable women, gender equity, and women's autonomy. On the other hand, the concept of reproductive health is strong if it includes women's concerns for their overall reproductive well-being.

1.6.1 How the Denial of Women's Autonomy Leads to the Creation of a Weak Sense of Reproductive Health

The concept of reproductive health has evolved over the last few decades and is now considered to be a basic human right (Dudgeon & Inhorn, 2004, p, 1389). Several new components have been recently included in the comprehensive concept of reproductive health. The following four components are notable among them: (i) an emphasis on reproductive and sexual rights by feminists in developing and developed countries; (ii) the denunciation of population control as a motivation for contraceptive research and distribution; (iii) the need to address the HIV/AIDS pandemic and the increasing incidence of heterosexual transmission; and (iv) the failure of family and maternal-child health programs to address complex reproductive health issues such as sexuality (Dudgeon & Inhorn, 2004, p, 1389).

It is noteworthy that some of the emerging issues surrounding reproductive health have been incorporated into the concept of reproductive health due to the different public or political movements such as feminism and human rights. These new movements highlight the importance of the overall well-being of women's reproductive health.

In addition, a consensus has emerged that women must exercise their autonomy in receiving reproductive health care. Put another way, failing to recognize women's

autonomy in the promotion of reproductive health, leads to a sense of reproductive health that is weak and narrow.

Drawing on the discussion above, I maintain that a broad and strong conception of reproductive health must include the concerns of equity, rights, and women's overall well-being. However, the concept of reproductive health can also be described in a narrow and weak sense that does not include the concerns of equity and rights of women. The question still prevails whether the concept of reproductive health within the community health clinic system adequately comprises the broader aspects of reproductive health or not.

I now discuss how the system adopted in the community health care clinics in Bangladesh relies on a weak sense of reproductive health while excluding the broader area of reproductive health. I then describe some moral implications of adopting a weak sense of reproductive health.

1.6.3 How the Community Clinic System Adopts A Weak Sense of Reproductive Health that Excludes the Concerns for Women's Overall Well-being

The above discussion explicitly indicates that reproductive health is both comprehensive and complex. The concept of reproductive health includes the broader well-being of the agents involved in the concept of sexuality and reproduction. At the same time, women's autonomy constitutes an integral part of the concept of reproductive health. Since it is the female who is at the center of reproduction and who bears the utmost responsibility of reproduction, the concept of reproductive health mostly centers on women. Thus, the concept of reproductive health must emphasize both the overall sexual health of women as well as the health issues of women involving their reproductive activities.

A key issue of a weak sense of reproductive health is that it perpetuates exclusions. The journey of the community clinic system began with the objective to ensure equitable health service for all. However, a closer observation of the services offered by the community clinic system reveals that there is a considerable gap between the system's commitment to equitable reproductive health and the services it provides presently.

The system is overly concerned about the reproductive health of women who are at their reproductive age. However, the reproductive health of postmenopausal women has not received enough attention from the community clinic system. Postmenopausal women in the age group 40 to 65 are suffering from postmenopausal health complications like uterine prolapse, benign diseases, cervical carcinoma, and uterine leiomyoma, the most common gynecological tumours (Ferdous, Jahan, Begu, Hassan, & Shahnewaj, 2013). The reproductive health of postmenopausal women is significant for several reasons. Firstly, women between the ages of 40 and 64 constitute 20.1% of the total female population of the rural area of Bangladesh. Secondly, these types of reproductive health problems are, in general, medically neglected problems in Bangladesh. Postmenopausal women have different reproductive health care needs than the women who are of reproductive age. However, the community clinic system's reproductive health care services exclude the concerns of postmenopausal women. As such the community clinic system adopts a weak sense of reproductive health that is not responsive to women's overall well-being irrespective of their ages.

Additionally, the reproductive health services of the community clinic system inadequately include the mental health aspect of the concept of reproductive health. It is crucial for all women and especially those in younger age groups, to have access to mental

health supports. For example, adolescent girls are at risk of developing mental health problems during their pubertal transitions, many women need mental health support during their pregnancies and after childbirth, and many women need mental health support to overcome the trauma of sexual violence. The community health clinic's reproductive health services are only concerned about the physical health of women, and even the physical health services are limited. Again this indicates that the system relies upon a weak sense of the concept of reproductive health.

Family-planning has received special attention in the community health clinics under the services of reproductive health. However, several other important components of the concept of reproductive health such as curative and preventive measures for reproductive diseases and improving the reproductive health of women are not considered in the community clinic system's reproductive health care service package. So, the community clinic system adopts a weak sense of reproductive health by over-focusing the family-planning services and underestimating the reproductive disease prevention services in its reproductive health policy.

The community health clinic system's reproductive health policy is inequitable for the women who are already affected by single or multiple reproductive health conditions. In Bangladesh, rural women with lower socioeconomic status are at risk to be affected by sexually transmitted diseases, urinary tract infections, reproductive tract infections, and sepsis and pelvic infections, which can cause infertility (Nahar, 2012). Unfortunately, these women struggle to afford the treatment of these types of diseases in private clinics. Since community clinics are well known as the health centers for the people with the lower socio-

economic condition, women with lower socio-economic conditions deserve to receive these services in these clinics.

It is important to maintain equity between males and females as it relates to contraceptives and sterilization. South Asian countries reveal a discriminatory picture of sterilization. The Center for Reproductive Rights, a USA-based non-profit organization which studies the reproductive rights of women, has written about this inequity:

Bangladesh, India and Pakistan have relied heavily on sterilization to meet their demographic goals. Female sterilization is the most common method of modern contraception adopted by women in South Asia. This is consistent with global trends. Rates of male sterilization, however, remain extremely low throughout the region. The provision of female sterilization in the South Asian context raises important human rights concerns. (Center for Reproductive Rights, 2004, P. 14).

The above quotation states that an inequity between men and women persists in the area of reproductive health. Such injustice also leads to the creation of a weak sense of reproductive health that excludes men's role in the promotion of women's reproductive health.

The community health clinic system promotes social justice by providing essential reproductive health services to women. However, persistent inequities exist in the system in terms of providing a comprehensive reproductive health care service. It is important to address women's rights, equity, autonomy, and overall well-being through improving their reproductive health. In order to promote its agenda of social justice, the community health clinic system must adopt a comprehensive sense of reproductive health. Otherwise, the sense of reproductive health in the context of community clinics system in Bangladesh would be incomplete, and the system's mandate of social justice would be unaccomplished.

Chapter 2 Theoretical Framework

2.1 Introduction

This Chapter discusses the theoretical framework of this thesis. There is a lack of literature that conducts a moral analysis of reproductive health care within community health clinics in Bangladesh. This thesis strives to fill this knowledge gap through a moral analysis of reproductive health care within Bangladeshi community health clinics. In conducting a moral analysis of the reproductive health care, I draw upon a number of authors to develop a comprehensive notion of social justice that helps illuminate some of the issues that arise in the context of the system of community health care clinics in rural Bangladesh. The authors I draw upon mainly include John Rawls, Amartya Sen, Martha Nussbaum, and Norman Daniels (Daniels, 2007; Nussbaum, 1997; Rawls, 1971; Sen, 2009). I discuss their perspectives in the thesis to explain why women's autonomy should be acknowledged in the promotion of their reproductive health. The scope of the research contained in this thesis includes both the theoretical underpinnings of social justice as well as a moral analysis of the reproductive health care within community health clinics in Bangladesh.

Reproductive health is one of the most referenced services by the government of Bangladesh in the community health clinic system. Researchers and health professionals often claim the success of the health system in Bangladesh by citing the achievements in the field of reproductive health. I problematize women's reproductive health care as it is offered by community clinics in Bangladesh. More specifically, this thesis demonstrates why, in promoting reproductive health, an appreciation of women's autonomy is necessary.

I demonstrate this through the framework of social justice by contextualizing it in the health care system of Bangladesh.

2.1.1 Social Justice

A social justice approach to health addresses health disparities between members or groups of society. Such approaches show that there are moral reasons to reduce health inequity among the groups or individuals in a community. For instance, the capability approach to health, within the tenet of social justice, argues that society has a moral obligation to reduce health inequity since health contributes to enhancing capabilities of individuals (Ruger, 2004). Furthermore, an individual's capabilities contribute to his or her overall well-being. A great deal of discussion in this thesis concerns John Rawls' concept of social justice that explains why basic liberties and opportunities should be distributed equally among the members of society (Rawls, 1971).

John Rawls and the Principles of Justice

John Rawls, as a successor of the contractarian tradition of Locke, Rousseau, and Kant, is concerned with the basic structure of social institutions. He thinks of justice as the first virtue of social institutions and presents two principles of justice as fairness (1971). The first principle which is also known as the 'liberty principle,' articulates that equal rights and basic liberties such as freedom of speech, freedom of conscience, and freedom of thought must be ensured for every member of society (Rawls, 1971, pp. 52-53). The second principle is known as the 'equality of opportunity' principle where Rawls disseminates the idea of a fair share of opportunity among the members of the society (Rawls, 1971, pp. 52-53). The second principle includes what Rawls refers to as the 'difference principle' which asserts that social and economic inequalities must satisfy the condition that the inequalities

benefit everyone, and in particular, the inequalities benefit the least advantaged members of the society (Rawls, 1971, p, 53).

Rawls' two principles of justice serve as the moral rule in the distribution of five primary social goods: liberty, opportunity, income, wealth, and the bases of self-respect (Rawls, 1971). However, Rawls (1971) treats natural goods such as health, vigour, intelligence, and imagination as morally irrelevant to the discussion of justice since these natural goods are unearned and hence fall beyond the purview of distributive justice. This invites an obvious question: if Rawls does not provide any account of justice concerning health, then how is it possible to extend the discussion of justice to a narrower concept of women's reproductive health?

My response to this and similar questions invokes the very moral principles (liberty principle, equality of opportunity principle, and difference principle) that are foundational to Rawls' concept of justice. This thesis applies a social justice approach to health because of the persistent inequalities between men and women, urban and rural women, and between women at different age groups in the Bangladeshi society. As such women in general and rural women in particular lack both liberty and equal opportunity to pursue their life goals. In short, I maintain that unequal access to the means by which to preserve health, and reproductive health in particular, is a social justice issue. Women's unequal access to the means by which to preserve and promote their health effectively runs counter to the difference principle in that the unequal distribution of and access to health care services further disadvantages women.

One example of such inequalities is gender-based discrimination against women. Bangladeshi women still have minimal opportunities to make decisions about their health

comparing to their male counterparts (Senarath & Gunawardena, 2009). The persistence of these inequities between men and women demonstrates that a social justice approach to health is useful in this thesis. An excellent example of applying Rawls' theory of justice to health care is observed in the writings of Norman Daniels. Daniels outlines "how one general theory, Rawls' theory of justice as fairness, might be extended in this way to provide a distributive theory for health care" (Daniels, 1983, p.19).

Norman Daniels: Extending Rawls's Social Justice Theory to Health

Before starting a discussion of the extension of social justice theory to health, it is essential to discuss the distinction between health and health care. Health does not mean the absence of diseases only; it also includes the physical and psychological well-being of a person. It is regarded as a special good for having both intrinsic and instrumental value (Anand, 2002). Health is both intrinsically and instrumentally valuable.

Norman Daniels extends Rawls' social justice theory to health care by claiming that health care is a special social good. Health care refers to the services provided by health professionals to aid in maintaining or restoring good health to a person. The concept of health care also includes the allocation of health care resources, the financing of health care, and the quality of health care services (Braveman & Gruskin, 2003). Health is a broader concept than health care, and includes the social and economic determinants of health such as living conditions, income, social class, ethnic and gender identity, and even health care itself. Why should health care then be treated as a special social good?

Norman Daniels (1983) illustrates how health care is a special social good. The term social good indicates common well-being that should be promoted by society. For example, a culture that values people's intellectual aspirations can consider education a social good.

Norman Daniels' (1983) account of just health care includes the rationale for perceiving health care as a special social good. He (1983) also provides a list of health care services with their moral weight, for example, why a right to access a lifesaving drug is morally more important than a right to access dental treatments.

Daniels also emphasizes that health care is a different type of social good than some other kinds of goods, for example, education, technologies (e.g., internet), and transportation. The former type of social good is essential for extending, improving, and saving lives, whereas the later are not essential. However, these non-essential social goods may improve the quality of lives as well. Secondly, further classifications can be made regarding the moral importance of different health care services. Some health care services are essential for improving the quality of lives and restoring normal health, while some are not required for sustaining lives. A good example of this latter kind of social good may be cosmetic surgeries.

To illustrate the moral importance of health care in a theory of justice, Daniels introduces the idea of *normal species functioning* in his account of just health (Daniels, 2007). The concept of 'normal species functioning' explains that there are certain 'species-related' competencies. These 'species-related' competencies determine the regular functioning of the members of a species or genus. An individual requires certain competencies to sustain a regular lifestyle that is compatible with the general characteristics of the human species. A good example of this is an individual's abilities, e.g., intellectual and physical capabilities that enable him or her to earn a decent wage. A disease can limit an individual's regular activities. Daniels (1983) argues that since a disease limits the

normal functioning of an individual, it also obstructs an individual's opportunities. Daniels (2007) explains,

One central question dominated Just Health Care: What is the special moral importance of health and health care? Connecting the answer to that question to prominent work in the general theory of justice was a first step toward articulating a population view since it pointed to the grounds for our social obligations to promote population health and distribute it fairly. Specifically, health is of special moral importance because it contributes to the range of exercisable or effective opportunities open to us. I understand health to mean normal functioning – the absence of significant mental or physical pathology. Maintaining normal functioning through public health and medical interventions thus makes a limited but significant contribution to the range of exercisable opportunities open to people (p, 2).

Access to health care largely contributes to enhancing equality of opportunity. So, health care as an important institution of society should be treated as a primary social good (Daniels, 1983).

Daniels' (1983) 'normal species functioning' thesis is also important in classifying certain morally important health care services. A health care service is morally important if it helps an individual, as a member of the human species, to maintain his or her normal functioning. Similarly, I argue that reproductive health care services in community health clinics in Bangladesh should help women maintain their normal health.

Amartya Sen's Capability Approach to Social Justice

The capability approach to social justice is a theoretical framework that outlines the importance of an individual's freedom and its value in realizing one's capabilities. For example, within the capability approach to social justice, one would argue that an individual must have the freedom to realize what constitute his or her well-being and what opportunities are essential for him or her to achieve the well-being goals. This line of reasoning can also be extended to argue that society that values justice would provide its

members with the opportunities to realize their physical, social, and psychological well-being. Thus, the capability framework can be used as an evaluative tool to examine how enhancing certain human capabilities contributes to achieving justice in society.

In the rural areas of Bangladesh, nutritious foods such as eggs, fishes, meats, and vegetables are mostly available. These types of foods are critical for the health of pregnant women. However, the availability of such nutritious foods does not bring any benefits to pregnant women if they do not have access to these foods. Many women cannot afford to buy such foods. Moreover, certain religious norms prohibit women from taking meat and fish during their pregnancies. Even though specific options are available for women, they are not capable of making their own choices. This entails that an individual's capabilities matter in conjunction with the availability of resources.

The capability approach in health acknowledges the importance of an individual's capabilities whereas traditional choice-based approaches in health identify how an individual makes a rational choice in terms of their health. For example, from the choice-based perspective, the activities or decisions of an individual, such as eating healthy food, availing of medical care, and doing physical exercise, determine his or her health status.

The shifting focus from people's choices to improving people's capabilities has important implications for health. Many health programs now focus on developing individual's capabilities or empowering them to flourish in their lives. For example, in order for the athletic capabilities of the community to thrive, the community must have a conducive environment which may include playgrounds and running tracks.

Amartya Sen (2002) considers health equity, while also acknowledging "the larger issue of fairness and justice in social arrangements, including economic allocations, paying

appropriate attention to the role of health in human life and freedom” (P 659). Thus, the concept of health equity endorses the broader context of equity in the distribution of health and health care resources with the consideration of justice and fairness. Now, it is crucial to discuss how community clinics promote health equity, and how health equity leads to the promotion of social justice in the society of Bangladesh. Sen's (2002) concept of justice is useful to explain how community clinics promote health equity by providing reproductive health care for women.

Sen's (2009) perspective of justice contrasts with that of John Rawls' (1971). Rawls' concept of justice is ideal in nature. It analyzes the structure of just institutions in society. On the contrary, Sen is not interested in the ideal structure of the just institutions. Rather, Sen's (2009) idea of justice focuses on human capabilities. As such, Sen (2009) argues against defining the just set of institutions but rather argues for reducing “manifest injustices” from the society (p. 263). In my opinion, Sen provides a human-centred view of justice, which is more practical than the approach of Rawls. Sen's human centred view is useful to explain why women's micro level autonomy, as opposed to focusing primarily on macro level social institutions, is essential to a complete understanding of social justice.

Martha Nussbaum: A list of Capabilities

Martha Nussbaum provides a fundamental list of ten human capabilities: (i) normal lifespan, (ii) bodily health, (iii) bodily integrity, (iv) senses, imagination and thought, (v) emotions, (vi) practical reason (vii) affiliation, (viii) other species, (ix) play, and (x) control over one's environment (Nussbaum, 1997). In practice, an individual must have the capabilities of leading a normal life span, in order to promote his or her physical health and physical integrity, and so on. A more careful look into the capability list provided by

Nussbaum shows that community health clinics in Bangladesh help to advance most of these human capabilities. An excellent example of this is the *Safe Motherhood Programme* that allows mothers to have normal lifespans (Berer, M., & Ravindran, T. K., 1999). The capability approach to health argues that social justice requires that the members of a society receive an opportunity to improve their capabilities.

Why does society have a moral obligation to promote human capabilities?

Nussbaum (2000) explains the importance of human capabilities in promoting social justice, particularly as it pertains to women, as follows:

Women all over the world have lacked support for central human functions, and that lack of support is to some extent caused by them being women. But women, like men — and unlike rocks and trees, and even horses and dogs — have the potential to become capable of these human functions, given sufficient nutrition, education, and other support. That is why their unequal failure in capability is a problem of justice. It is up to all human beings to solve this problem. I claim that the capabilities approach, and a list of the central capabilities, give us good guidance as we pursue this difficult task (p, 242).

Society must provide a congenial environment for women so that their potential or capabilities can thrive. Enhancement of women's capabilities in the areas such as health, education, nutrition, and employment is also the determinant of promoting justice in a society.

One of the main reasons for adopting a social justice perspective in this thesis arises from the fact that a social justice perspective values the importance of autonomy. Social justice perspectives uphold that equal basic liberty among the members of a society is essential. Since this thesis also argues for the recognition of women's autonomy, a social justice perspective that advocates for individuals' basic liberty is helpful for strengthening

the claim of this thesis. In addition to the social justice approaches to health, this thesis discusses several theories of vulnerability and autonomy.

2.2 Theories of Vulnerability and Autonomy

2.2.1 Vulnerability

In discussing vulnerabilities, I endorse the theoretical framework of vulnerability articulated by Nicolas Tavaglione and his colleagues (2015) explaining (i) physical integrity, (ii) autonomy, (iii) freedom, (iv) social provision, (v) impartial quality of government, (vi) social bases of self-respect and (vii) communal belonging. Using this theoretical framework, I argue that women within the community clinic system in Bangladesh are vulnerable because of paternalism in the health care system and social institutions, a persisting gender gap, and women's social position.

The issue of vulnerability is discussed from many perspectives. A wide range of research is now exploring Bangladeshi women's vulnerabilities to pregnancy-related mortality, disasters, climate change, and sexually transmitted diseases. In the community health clinic system, women constitute a substantial part of those who participate in reproductive health research. Angela Ballantyne and Wendy Rogers (2016) argue that women are considered vulnerable because they have a greater chance of being exploited (Ballantyne & Rogers, 2016). However, in order to locate the vulnerabilities of women, a context-specific discussion is necessary. The following part of this chapter discusses how women within the community clinic system in Bangladesh are vulnerable and why their autonomy must be recognized.

Nicolas Tavaglione and his colleagues (2015) have made the case that most of the research about vulnerability has been conducted on the issues of research ethics and

“vulnerability in health care has been comparatively neglected” (p. 2). In their paper (2015), they have analyzed the concept of vulnerability exclusively in the contexts of health care. This implies that it is necessary to discuss the vulnerabilities of women in terms of their access to health care as well. However, a blanket categorization of women as a vulnerable population jeopardizes their health and well-being. If women are too broadly categorized as vulnerable, they might be excluded from significant research projects. For example, pregnant women are excluded from many clinical trials because they are generally treated as vulnerable. Consequently, clinicians and researchers miss the opportunity to gather invaluable data for producing new drugs or designing new health interventions for pregnant women (Baylis & Ballantyne, 2017). Furthermore, women themselves are deprived of numerous benefits of health research projects. Thus, an in-depth investigation of the contexts and types of women’s vulnerabilities can contribute to making research more efficient.

2.2.2 Autonomy

The concept of autonomy in moral philosophy has been well-established through Immanuel Kant’s deontological theory that values human dignity and rights. From the perspective of Kantian deontological theory, everyone’s rights and dignity must be respected (Melden, 2008). The deontological theory states that each human being’s autonomy must be respected. The Kantian concept of autonomy presumes that each individual, by virtue of being a human, is an autonomous being. This concept of autonomy can be called moral autonomy that recognizes the fundamental moral worth of each human being. There is also another sense of autonomy that emphasizes that the social circumstances must be arranged in a way where each person would be able to exercise his

autonomy without any impediments. This thesis acknowledges the distinction between moral and practical autonomy and argues that both are important in the promotion of women's reproductive health.

One can act autonomously while being influenced by other external parties such as the state or religious authorities. For example, a woman may refrain from using contraception simply in order to satisfy her husband. Should such actions be regarded as autonomous? From a Kantian perspective, an individual is autonomous if he or she acts by his or her own will and not influenced by an external authority. One acts autonomously if one is free from all external influences in making one's choices. This implies that it is morally important that women can exercise their autonomy without any external influences. In addition to the Kantian concept of autonomy, I discuss a relational concept of autonomy that has emerged through the works of several feminist writers.

The following is the concept of women's autonomy from a relational perspective. Some of the significant indicators of women's autonomy are: (i) whether women have control over finances; (ii) whether they have decision-making power; and (iii) whether women have freedom of movement (Bloom, Wypij, & Gupta, 2001). Even though women may have decision-making power, their decisions can be influenced by numerous external forces such as the government, health care professionals, and family members. Moreover, women's economic and social conditions also can affect their decisions. For instance, a woman's decision regarding her maternal care plan is profoundly influenced by her economic conditions and her position in the family. Similarly, women's freedom of movement and control over finances can also be influenced by social and cultural norms. Since women's reproductive health is the central aspect of this thesis, my take on the

concept of women's autonomy concerns whether women have control over their bodies, and how free they are from the external influences in making reproductive health care decisions. An excellent discussion regarding women's control over their reproductive health is found in the works of feminists such as Patricia Hill Collins. She writes,

Family planning comprises a constellation of options, ranging from coercion to choice, from permanence to reversibility regarding reproduction of actual populations. In the case of individual families, decision-making lies with family members; they decide whether to have children, how many children to have, and how those children will be spaced. Feminist scholars in particular have identified how male control over women's sexual and reproductive capacities has been central to women's oppression. (Collins, 1998, p, 75)

A substantial body of literature in the area of feminist philosophy explains how women make choices that do not reflect what they actually desire. Anita Superson terms it 'deformed desires' as opposed to 'informed desire' (Superson, A., 2005). Women often form deformed desires because of the persistence of oppressive norms in society. For example, a common norm in the Bangladeshi society is that a woman must not resist any decision of her husband. Due to the existence of such norms, even though women make decisions regarding their health, their decisions are often deformed, induced, and manipulated.

If a woman internalizes an oppressive norm, it works as a barrier to her autonomy. Natalie Stoljar (2014) argues that "the inculcation of oppressive norms damages autonomy in a particularly insidious way. Agents who are oppressed come to internalize their oppression: they come to believe in the ideology of oppression and to make choices, and form preferences and desires, in the light of that ideology" (pp. 227-228). Stoljar's view emphasizes that the concept of autonomy must consider whether an individual internalizes

oppressive norms. To put it otherwise, this thesis endorses the concept of autonomy that acknowledges that women are more likely to be influenced by oppressive social conditions in making their choices which may not represent their actual desires. Thus, I understand the concept of women's autonomy in a sense that explains how oppressive norms obstruct women from making autonomous decisions regarding health care.

2.3 Applying Theories

As mentioned previously, this thesis offers a moral analysis of the reproductive health care offered by community health clinics within the theoretical framework of social justice. I have used several moral principles drawing on the work of the following key authors: John Rawls' (1971) principle of equal liberty and the difference principle; Amartya Sen's (2009) capability principle; Norman Daniels' (2007) normal species functioning principle; and, Tom L. Beauchamp and James Childress' (2013) principles of respect for autonomy, nonmaleficence, beneficence, and justice.

Inasmuch as social justice theory has emerged largely from Western social contexts there may be challenges when attempting to apply Western ethical theory to the issue of women's reproductive health within the context of the Bangladeshi health system. One might argue that since Bangladesh presents a different social context, applying a Western social justice perspective is not helpful. My response to such an objection draws attention to the fundamental constituents of social justice theory. Although social justice theory bears the great tradition of ancient Greek philosophers and social contract theorists in Europe, the major components of social justice theory such as rights, equality, equity, and fairness are equally important for both Western and Eastern societies. Hence, while contemporary theories of social justice may be articulated largely from a western perspective, the

fundamental values underlying these notions transcend any particular philosophical tradition and are applicable to all societies both east and west.

Amartya Sen (2009), who is himself Indian, has demonstrated the usefulness of applying ostensibly Western conceptions of social justice in several Indian Sub-continental contexts. A good example is his analysis of the wealth distribution patterns during the Great Bengal Famine, a famine of 1943 which caused the death of ten million people (Sen, 2009). Using the social justice framework, Sen (2009) contends that the famine occurred due to distribution patterns, not due to the lack of food. In the same way, I concede that social justice theory is instrumental as a theoretical framework in discussing the moral issues that emerge from the Bangladeshi health system. Now it is crucial to explain why Bangladeshi community clinics' provision for women's reproductive health care needs a critical examination.

2.4 The Interrelationship of the Concepts of Social Justice, Relational Autonomy, Personhood, and Vulnerability

This thesis consists of several interrelated concepts such as social justice, personhood, autonomy, and vulnerability, which are interpreted through a relational lens. Figure 1.0 shows the interrelationship between a relational perspective, social justice, and the concepts of autonomy, personhood, and vulnerability. I discuss these concepts while analyzing the promotion of women's reproductive health through the Bangladeshi community health clinic system. In other words, the discussion of social justice necessitates that we address how individuals or groups are vulnerable to systematic disadvantages and how to make remedies for those disadvantages.

Ethicists Dan Beauchamp (1976), Lawrence Gostin and Madison Powers (2006) argue that social justice should be the core ethical value of public health. This thesis works from a similar perspective, namely that Bangladesh's public health goal of improving women's reproductive health can also espouse social justice as a cardinal value. Social justice requires that community health clinics in Bangladesh acknowledge women's autonomy when promoting their reproductive health. A social justice perspective urges that systemic injustice among different groups must be corrected. The concept of social justice used in this thesis explains the systematic disadvantages that Bangladeshi women encounter in receiving reproductive health care. Moreover, social justice works as a concept that guides the discussions of this thesis, and this thesis acknowledges the concept of social justice as an underlying value in public health scholarship and policy work.

This thesis also adopts a relational perspective that "appreciates the social nature of persons and recognizes the moral significance of social patterns of discrimination and privilege as they affect different groups," as Françoise Baylis and her colleagues explain the perspective (Baylis, F., Kenny, N. P., & Sherwin, S., 2008. p, 206). By acknowledging the social nature of individuals and by identifying the systematic disadvantages that individuals encounter, a relational perspective focuses on the concept of social justice as opposed to the concept of distributive justice. Distributive justice concerns the analysis of the general pattern of just institutions and "the fair distribution of quantifiable benefits and burdens among discrete individuals," whereas social justice is concerned with how individuals are socially situated and how individuals are constituted by their relationships with others (Baylis, F., Kenny, N. P., & Sherwin, S., 2008. p, 203). This thesis conjoins the concept of social justice and a relational perspective.

I argue that the acknowledgement of women's autonomy is crucial to the promotion of their reproductive health. Throughout the discussion, I adopt a relational perspective in analyzing the concepts of autonomy, personhood, and vulnerability. For example, in understanding the concept of personhood, the self is not analyzed as an independent, rational, self-interested individual who can freely make choices. Rather, the self is understood as a being who is socially constructed by its relationships with others and whose decisions are influenced by various social circumstances. Joel Anderson and Axel Honneth (2005), in "Autonomy, Vulnerability, Recognition, and Justice", discuss how the concepts of vulnerability and autonomy are central to the discussion of social justice. I uphold a similar perspective to the authors (2005) that "autonomy can be diminished or impaired through damage to the social relations that support autonomy" (p, 127).

The concept of vulnerability discussed in this thesis relates both the notions of autonomy and social justice. Janet Delgado (2019) argues that "vulnerability and relational autonomy are two intimately related terms: it is the same human being that is vulnerable and autonomous at the same time, but it is necessary to understand vulnerability and autonomy as relational terms" (p, 52). In this thesis, I describe why it is important to identify women's autonomy-related vulnerabilities (e.g., compromising their choices due to external influences) and to foster a social change that respects the value of women's autonomy.

In Chapter Five, I demonstrate how the discussion of social justice also demands that the concept of vulnerability is explained. Social justice requires that vulnerable groups or individuals of society receive adequate opportunities so that they can recognize their potential and capabilities. Françoise Baylis and Nuala P. Kenny observe that "a

commitment to social justice requires us to recognize the special disadvantages that face members of social groups who are subject to systematic discrimination and reduced power” (p, 204). This thesis encompasses these interrelated concepts.

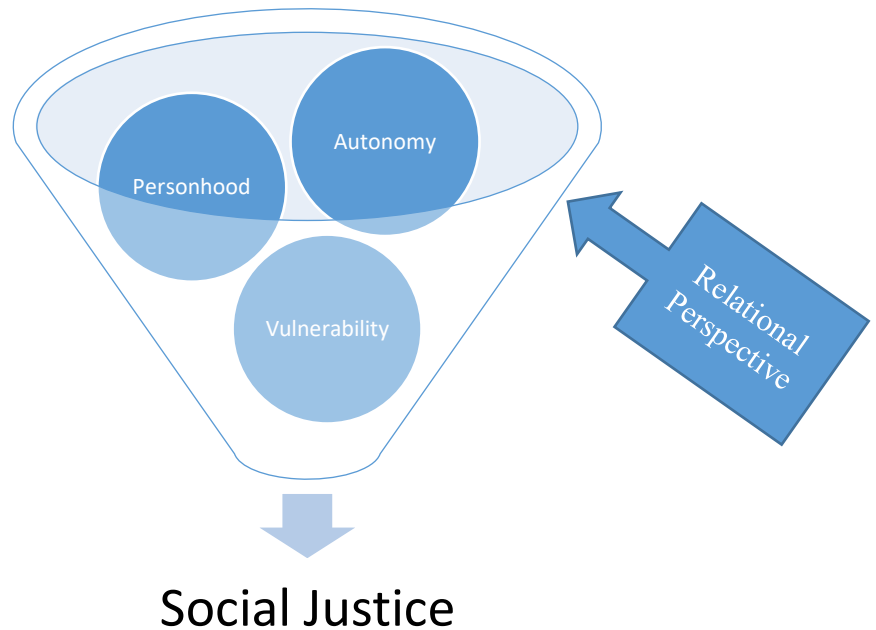


Figure 1.0: The interrelationship between a relational perspective, social justice, and the concepts of autonomy, personhood, and vulnerability.

2.5 Methodology

The methodology of this thesis is conceptual in nature. A social justice framework guides the discussions of this thesis. I have used secondary resources such as journal articles and books to support the arguments that appear throughout the thesis. Data regarding the community health clinic system is obtained from secondary resources such as journal articles, annual reports of the Ministry of Health and Family Welfare, Bangladesh, and country reports of the NGOs that are currently collaborating with the Government of Bangladesh.

In presenting the case of women's reproductive health within community health clinics in Bangladesh, I endorse the view of Arras (1999) when he recommends that we "avoid schematic case presentations. Make them long, richly detailed, messy, and comprehensive. Make sure that the perspectives of all the major players (including nurses and social workers) are represented" (p. 49). Likewise, I have incorporated the views of the beneficiaries of the community clinic system as well as the opinions of researchers, ethicists, health professionals, and journalists regarding women's reproductive health care offered by community health clinics in Bangladesh. In the following chapters I draw on the theoretical perspectives and ethical principles described above to unpack relevant aspects of this complex situation. The next chapter discusses how the community health clinic system promotes the common good through its reproductive health care services to women.

Chapter 3 The Common Good: Women's Reproductive Health and Social Justice

3.1 Introduction

The central claim of this thesis is that community clinics should recognize women's autonomy in promoting their reproductive health. This invites an obvious question in the first place as to whether reproductive health carries any special significance that requires the recognition of women's autonomy. By discussing the positive aspects of the community health clinic system, this chapter claims the special moral importance of women's reproductive health which entails that women's autonomy must be recognized in the promotion of their reproductive health.

3.1.1 What Is Reproductive Health?

According to the Pan American Health Organization and World Health Organization, sexual and reproductive health means "the experience of the ongoing process of physical, psychological, and socio-cultural well-being related to sexuality (Cook, Dickens, & Fathalla, 2003, p, 175)". In the broader concept of reproductive health, an individual's overall physical, psychological, and socio-cultural well-being are included (Hansen, Mann, McMahon, & Wong, 2004).

In May 2004 the World Health Assembly adopted five core aspects of reproductive and sexual health. These are: (i) improving antenatal, perinatal, postpartum and newborn care; (ii) providing high-quality services for family-planning, including infertility services; (iii) eliminating unsafe abortion; (iv) combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynecological morbidities; and

(v) promoting sexual health (De Francisco, Dixon-Mueller, D'Arcangues, & Global Forum for Health Research, 2007, p, 10).

The above description specifies that the concept of reproductive health must involve the medical care of women in the gestational period and post-pregnancy period. This implies that strategies of eliminating the risks associated with different sexually transmitted diseases as well as eliminating the risk of unsafe abortions should be included in the concept of reproductive health. The definition also includes family-planning as a protection of women's reproductive health and the treatment of infertility as a protection of the reproductive rights of women. However, the reproductive health of men, as the counterpart of women, is also a part of reproductive health. Many argue that women's reproductive health can be influenced profoundly by their male counterparts in the area of contraceptive use, childbearing, and abortions (Dudgeon & Inhorn, 2004).

3.2 The Special Moral Importance of Health

Recently, I watched a speech given by a man who has become an independent person by producing his food, clothing, shelter, and similar materials that are required to meet his basic needs ("Life is easy. Why do we make it so hard?," 2014). The speaker (2014) described how he escaped a busy urban life and returned to his village to find peace. He explained how people are overly concerned with luxuries that diminish their happiness. I agree with the speaker's point of view that people can independently live their lives. One can grow one's food that is required for survival. An individual can build a shelter that would protect him or her from harsh weather conditions.

However, I also contend that some necessities require assistance from others. For instance, even though a person can acquire the necessary skills to sustain his basic health,

he cannot avoid seeking support from professionals when severe medical conditions appear. Such interdependencies among individuals bring people together to form a society. People create a 'social contract' stating terms and conditions that outlines the obligations of individual members to and those of society to its members. Society, in the form of a government or other social institutions, takes the responsibility of providing some primary resources to its members. This raises the question: what sort of resources should a society provide for its members?

Many argue that health care resources should be provided by society because health constitutes a category that can be termed as a special social good (Norman Daniels, 1983). The concept of social good designates that some goods are necessary for the overall well-being of a society. Accordingly, society has a moral obligation to promote such social goods. Some social goods may be more important morally than some other goods. Some health care services, lifesaving treatments, for example, are regarded as morally more significant than some other health care services such as cosmetic surgeries. Such moral importance of certain health care services also implies that society has a moral obligation to provide such 'morally important' health care services for its members. This prompts questions such as: (i) why is women's reproductive health morally important, (ii) who should determine the well-being of women's reproductive health, and (iii) how does the moral worth of women's reproductive health imply that women's autonomy must be recognized? I pursue answers to these questions with relation to women's reproductive health issues as they emerge out of community clinics' reproductive health care in Bangladesh.

3.2.1 The Special Moral Importance of Reproductive Health care

Several reasons demonstrate the special moral importance of women's reproductive health. For instance, women's opportunities are often contingent upon their reproductive health conditions. A woman cannot avail of her regular opportunities in the workplace when she is pregnant. Moreover, there are structural constraints that prohibit women from enjoying opportunities that they deserve. A good example of such structural constraint is the criminalization of abortion. Dudgeon and Inhorn (2004) argue that "structural constraints range from asymmetries in pay and work opportunities, to legal systems that allow for domestic violence and rape yet criminalize abortion, to the comparative lack of research on and development of male contraceptive technologies" (p.1380). The persistence of such structural constraints in many societies also emphasizes the importance of women's reproductive health.

As stated previously, the *normal species functioning* thesis of Norman Daniels (1983) refers to the range of needs, activities, and opportunities of an individual which must be fulfilled in order to perform as an average person. Daniels' thesis entails that there are some basic needs such as the need for having proper shelter as well as the need for access to basic health care. These are the prerequisites in order to function as a normal species. Some opportunities must be maintained, or barriers to opportunities must be removed so that individuals can function as normal species. For example, a person must be healthy enough so that his or her opportunity to earn a fair wage is retained. The 'normal species functioning' thesis is contingent upon fulfilling some basic health care needs. Daniels (1983) mentions five health care needs: (i) adequate nutrition, shelter; (ii) sanitary, safe, unpolluted living and working conditions; (iii) exercise, rest, and other features of healthy

lifestyles; (iv) preventive, curative, and rehabilitative personal medical services; and, (v) non-medical personal (and social) support services (p, 158).

3.3 How Community Clinics Promote Women's Reproductive Health

A recent study reveals that improved menstrual health contributes to women's better functioning in the areas of health and education (Hennegan & Montgomery, 2016). Menstrual health, as an integral part of women's reproductive health, determines how women function in their daily lives. The inclusion of reproductive health care services in community clinics in Bangladesh demonstrates that these services are required for women to function as healthy persons.

Some of the primary services of the system of community health clinics in Bangladesh include: (i) maternal and neonatal health care services; (ii) treatment and integrated management for childhood illness; (iii) reproductive health and family planning services; (iv) vaccination services; (v) health education and counselling services; (vi) services to identify and treat severe illnesses like tuberculosis, malaria, and pneumonia; and (vii) emergency obstetric care services and outpatient services to treat minor diseases (Ahmed, 2015, p, 67). Many of these health care services are required for rural women in Bangladesh to carry on their regular activities. For instance, community clinics' counselling service on contraceptive methods helps women avoid unwanted pregnancies. Thereupon, women can sustain normal lives by continuing their regular activities.

It is worth noting that while community clinics are providing the above-mentioned health care services, the community clinic system does not acknowledge women's autonomy as a paramount concern. For instance, the system emphasizes that it is important for pregnant women to take nutritious foods, but, the system lacks a plan that addresses the

economic and social barriers that prohibit women from acquiring nutritious foods. Instituting a health policy at the macro level will have limited positive impact micro level efforts are not made to enhance women's ability to act autonomously.

3.3.1 Reproductive Health care is Morally Important Because It Enhances Women's Capabilities, A Major Requirement for Social Justice

A randomized control trial was conducted in two Bangladeshi villages in the 1970s to study the long-term impacts of making contraceptives available to married couples (Joshi & Schultz, 2007). Contraceptives were made available to the experimental groups in one village. After several years, the study demonstrated that the families of the experimental group were better off than the families in the control group. Families who had access to contraceptives became financially well off, and women in those families could limit their pregnancies which in turn contributed to their children's health and education. Such studies also tell us that improvement of women's reproductive health contributes to not only their overall functioning but also such improvements determine the well-being of their families and children.

Women in Bangladesh face several challenges regarding their reproductive health. However, community health clinics lend a hand to these women through several health and awareness programs in improving their reproductive health. One such program is the community health clinic system's Safe Motherhood Program. The World Health Organization applauds this program by expressing,

“Community clinics have positively contributed to improvement of the health status of Bangladeshis. This is a great innovation in the Bangladesh health sector as most health indicators are now showing positive trends, especially those addressed by the Safe Motherhood Programme. This can be attributed to these clinics,” says Dr. N. Paranietharan, the WHO Country Representative in

Bangladesh. “WHO has been providing financial and technical support since the Revitalization Project started,” he adds (WHO, n.d. ¶, 16).

Community health clinics offer reproductive health care services through its Essential Service Package (ESP), a package of integrated health and family-planning services. The five core components of ESP are: (i) reproductive health care, (ii) child health care, (iii) communicable disease control, (iv) limited curative care, and (v) intervention programs for behavioral change to promote healthy lifestyle and to prevent diseases (Sarker et al., 2002). Among these five core components, reproductive health care service is considered as one of the most significant parts of the ESP.

The government also sets the Sustainable Development Goal (SDG) of ensuring universal access to sexual and reproductive health care services by the year 2030 through community health clinics (Azad, Shamiul Bashar, & Anwar, 2015, p, 30). Thus, reproductive health care services have become one of the most emphasized services of the community clinic system in Bangladesh. Consequently, the system promotes social justice by providing reproductive health care services to women. The next section discusses how the system promotes social justice.

3.3.2 How Community Health Clinics Enhance Women’s Capabilities Through Reproductive Health care

In the 1980s and 1990s, female health workers in Bangladesh would visit women by going door to door in order to distribute contraceptives and to provide counselling to married couples. This dramatically decreased the fertility rate and improved maternal and infant health. These success stories surrounding family-planning and population control in Bangladesh have grabbed the attention of international communities. It was applauded in

the 1994 International Conference on Population and Development Program (ICPD) in Cairo. International health organizations such as the World Bank also highly applauded the family-planning program of Bangladesh with a partnership between the government of Bangladesh and NGOs. However, the World Bank, one of the major donors in the Bangladesh health sector, recommended that the family-planning program should also include a broad range of high-quality reproductive health services through a sustainable health care delivery system (Kantner & Kantner, 2006, p. 77).

The World Bank specifically recommended a community clinic-based system to carry out the family-planning program with an ‘essential service package’ (ESP) comprising of child care, reproductive health (including family-planning), communicable disease control, and limited curative care (El-Saharty, Ahsan, Koehlmoos, & Engelgau, 2013, p. 71). Thus, providing a high quality of reproductive health services became one of the major commitments of the community health clinic system. Community health clinics offer prenatal and maternal health care services to a large number of women, thus contributing substantially to reducing the maternal and infant mortality and morbidity rates. Consequently, the system advances its mandate of social justice by providing reproductive health care services. The next section discusses how the system’s reproductive health service enhances women’s capabilities which, according to Nussbaum (2000), is a prerequisite for social justice.

The system offers some limited reproductive health care services through its ESP to the rural women of Bangladesh such as family-planning services, the distribution of temporary contraceptive methods, Tetanus vaccinations, etc. (Normand, Iftekar, & Rahman, 2002, p. 33). However, in a limited manner, the community clinics also offer the

following services: (i) counselling services and health education to the married women of childbearing age before pregnancy; (ii) antenatal care services of pregnant women; (iii) emergency obstetric care of pregnant women; (iv) post-delivery health care services to mothers; (v) services to treat reproductive tract infections or venereal diseases; and (vi) nutritional supplementation services in order to ensure maternal nutrition and safe motherhood.

There are at least three capabilities, among the capability list of Nussbaum (2000), which are advanced by the community health clinic system's reproductive health care services:

(i) Life. Being able to live to the end of a human life of normal length; not dying prematurely or before one's life is so reduced as to be not worth living.

(ii) Bodily Health. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter.

(iii) Bodily Integrity. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction (p, 231-232).

Community health clinics in Bangladesh save lives and prevent maternal mortality through their intervention programs. Community clinics provide support for women in retaining their basic physical health. The system also promotes awareness about the adverse impacts of the discrimination against women. Through the system's awareness programs, people are now raising their voices against domestic violence and sexual assault. Thus, the community health clinic system enhances women's capabilities in life, bodily health and bodily integrity.

The concept of health equity also implies that women's reproductive health is of special moral importance. The conditions of women's reproductive health determine their capabilities in the other areas of life. The special moral importance of women's reproductive health is revealed if we examine the concept of health equity.

3.3.3 Women's Capabilities and Health Equity

Many women in Bangladesh are victims of domestic violence by their partners (Koenig, Ahmed, Hossain, & Mozumder, 2003). Domestic violence is often expressed in the form of gender-based violence. In other words, women endure different types of domestic violence simply because they are women. From a social justice perspective, any sort of gender-based violence hinders health equity in society. In the example of gender-based domestic violence, women are unjustly deprived of their normal life because of their gender identities. Society must resist such gendered-based oppression. At the same time, health equity also requires that society provides a congenial atmosphere for promoting women's reproductive health. Accordingly, society should allocate health care resources equitably so that women can protect themselves from violence.

As noted previously, health is a broader concept than health care. Health is instrumentally valuable as other goods such as income, freedom, and quality of life are not achievable without the possession of good health. Because of the intrinsic value of health, scholars consider health as one of the central features of the concept of social justice (Sen, 2002). This brings up the question, how does health equity contribute to social justice?

The phrase *health equity* means an equal distribution of health care resources among the members of society. The discussion of health equity is often accompanied by questions such as: why is it important to ensure an equal distribution of health care resources; should

any state take affirmative actions toward the disadvantaged groups of the society so that health equity can be attained; how does health equity contribute to a positive social change and economic development; and how does improving social determinants of health contribute to health equity?

When I came to Canada for higher study, I found that the Canadian Provincial and Federal governments created several job opportunities for international students through different programs such as the ‘graduate work experience program’, ‘Canada summer jobs’ and so on. However, at the same time, I discovered that most of those jobs required certain skills or capabilities such as language and communication skills. Even though there were many jobs available, one would not be able to obtain any of those jobs if one did not have the required capabilities. This example demonstrates that apart from creating job opportunities it is important to enhance the capabilities of international students in many areas including language and other soft skills. Similarly, a society must enhance the respective capabilities of its members so that they can avail of different opportunities in life. The capability approach to social justice argues that society has a moral obligation to enhance the respective capabilities of its members. Since promoting women’s reproductive health contributes to enhancing their capabilities, society has an obligation to promote reproductive health. The above sections discuss the moral importance of women’s reproductive health. Now it is crucial to discuss why women’s autonomy matters.

3.4 Why Women’s Autonomy Matters

Due to the raising awareness against numerous types of exploitation that women usually face, women’s situation in Bangladesh has developed. Yet, concerns such as the use of high-risk contraceptive devices and poor informed consent scenario remind us that

the promotion of reproductive health in Bangladesh should be critically assessed. This also demonstrates that often women's well-being can be misrepresented by other interest groups.

Even though reproductive health enhances women's overall functioning, promotion of reproductive health requires that women are autonomous enough in improving their reproductive health. The above discussion shows that reproductive health is morally important because it enhances women's capabilities. Equally important, since reproductive health concerns women's capabilities, is that women themselves must have a better understand their well-being.

The major aim of the capability approach is to use normative principles to assess individual well-being and social arrangements. From this perspective, a person is judged by his or her capabilities and by the actions he or she is able to do. Sen (2009) holds a broader view of "human capabilities" and emphasizes opportunities and freedoms which constitute the concept of well-being (p, 225). For example, an individual's freedom contributes to his or her physical and psychological well-being. The capability approach to health emphasizes that a society must extend the opportunities and freedom to its members so that they can realize their physical, mental, and social well-being. In Sen's perspective, opportunities and freedoms are the two essential constituents of the concept of well-being. The promotion of women's reproductive health enhances women's opportunities. However, at the same time, their well-being requires that women make the decisions about their reproductive health and that they have opportunities to choose among alternatives. The next chapter points out some micro-level issues that prevail in the health care activities

within the community health clinic system that negatively impact women's individual autonomy.

Chapter 4 The Way Ahead: Reproductive Health and the Importance of Recognizing Women's Rights and Autonomy in Health Care

4.1 Introduction

In an interview with a researcher, a rural woman in Bangladesh described how she could not afford to buy contraceptives and how she ended up being pregnant (Schuler, Hashemi, & Jenkins, 1995). After four months of her pregnancy, she had an abortion by using a traditional method that caused heavy bleeding. The woman almost died. Even though many women have access to contraceptives, they do not have the freedom of accessing safe abortions because of the existing criminal laws against abortion. Such stories are common in Bangladesh, and they demonstrate how women's reproductive health is jeopardized due to the lack of access to reproductive health care, persistent discrimination against them, and their lack of autonomy.

Equally important, the above scenario shows that many rural women in Bangladesh face social and economic disadvantages that create health inequity in society. However, women are entitled to the right to access the basic minimum of health care such as access to contraception and safe abortion. A good example of exercising a woman's autonomy is the freedom of choice whether she will terminate a pregnancy or not. This chapter argues that in substantial ways Bangladeshi women cannot exercise their right to access reproductive health care such as accessing safe abortion services, which implies a lack of recognition of their autonomy as well. Nevertheless, there are strong moral reasons that substantiate women's autonomy.

4.1.1 The Legal Foundation of the Right to Health care

Many international conventions, declarations, treaties, and constitutions of states uphold a right to health care of individuals as one of the supreme human rights which forms the legal foundation of a right to health care.

A right to health care is articulated in a number of international human rights documents. For example, the Universal Declaration of Human Rights (UDHR) was adopted by the United Nations in 1948 (Assembly, U. G., 1948). Article 25 of the UDHR states: “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care...” (Assembly, U. G., 1948, p. 4). The International Covenant on Economic, Social and Cultural Rights (ICESCR) states that a country must recognize the right of everyone to the enjoyment of the “highest attainable standard” of physical and mental health (Hunt & Backman, 2008, p, 84). The member states of these international organizations have ratified these human rights documents that protect the right to health care for every individual.

Furthermore, the domestic legislation and policies of a country in accordance with the international treaties and conventions protect its citizens’ right to health care. For example, the constitution of the People’s Republic of Bangladesh (Habibullah, 1996) recognizes the provision of the necessities of life, including food, clothing, shelter, education and medical care in its article 15(a). Article 16 of the Bangladesh constitution states that necessary measures must be taken to reduce disparity in the health care sector (Rahman, 2006, p, 12). According to the constitution of Bangladesh, necessary laws must be put into force by the state so that peoples’ right to health care is protected, and that people enjoy a favourable situation which will allow their health to flourish.

Global and bilateral health organizations such as the World Health Organization (WHO), World Bank, United Nations Children’s Fund, United Nations Human Rights Council (UNHRC) and the United States Agency for International Development (USAID) have established treaties with various countries across the globe in order to improve the health condition of the people in those countries (Muller, 2005). These treaties often include clauses that uphold the health care rights of the people.

The constitution of the World Health Organization includes the *availability*, *accessibility*, and *acceptability* clauses which mentions health care as a right of the people (McLaughlin & Wyszewianski, 2002). The *availability* clause obliges the member countries to ensure “a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programs” (Desierto, 2015, p, 62). The *accessibility* clause states that health facilities, goods and services must be accessible to everyone. The *accessibility* clause has 4 overlapping dimensions: (i) non-discrimination; (ii) physical accessibility; (iii) economic accessibility (affordability); and (iv) information accessibility (Desierto, 2015). The *acceptability* clause also protects the health care right of the people by ensuring that all health facilities, goods and services of the member countries are respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements. The member countries of the United Nations are legally obligated to abide by these clauses. Thus, the treaties also serve as legal documentation of the right to health care of the people.

Philosophers, ethicists, and economists in the field of health have discussed why people have the right to health care from a moral perspective. In the next section, the moral foundation of the right to health care is discussed.

4.1.2 The Moral Foundation of People's Right to Health Care and Women's Right to Reproductive Health Care

As described previously (see Chapter 2), many philosophers, ethicists, and economists in the modern period considered health as one of the special social goods. They argue that health is one of the basic requirements for achieving social justice.

Although women's rights to reproductive health care is recognized by the global organizations such as the United Nations, Bangladeshi women are still struggling to secure their rights to reproductive health due to political and religious reasons. While women face a number of barriers in accessing contraception in Bangladesh, abortion is prohibited by the criminal law. Amin and Hossain (1994) observe that "in the ensuing struggle over women's rights, rival interpretations of Muslim laws, reformist and anti-reformist, are enlisted by each of the parties for their own aid. What is forgotten in the process, however, are women's own experiences, and the struggle to bring those experiences to bear on the formulation of standards by which to secure women's rights" (p. 1319).

4.2 Women's Right to a Basic Minimum of Health care Services and how Reproductive Health Constitutes A 'Minimum of Health care'

The right to a basic minimum of health care is dependent upon the context of the health care system and society. The rights claim is stronger in a non-insurance-based health care system where citizens have access to health care according to the affordability for the citizens. In a public insurance-based health care system such as Canada, some basic health care services are accessible to all of its citizens regardless of citizens' ability to afford it. However, in a non-insurance-based health system like Bangladesh, for some people, access to some basic health care services is contingent on their affordability. There are some free health care services available in public hospitals for people who live in the urban areas,

however, prior to the development of the community clinic system people who live in rural areas of Bangladesh had access to no publicly funded health care services. The establishment of the community clinic system has reduced the inequity between the urban and rural people. Now rural people have access to basic health care services through the community health clinic system free of cost.

The citizens in a non-insurance-based health care system have to compete with their counterparts for access to health care. In a non-insurance-based health care system, the unhealthy people do not get to benefit from the unused resources of healthy people. In most cases, the least affluent members of society end up with very limited or no access to health care. They depend on unscientific health measures. Bangladesh has a non-insurance-based health care system and provides an example of how people are sometimes helpless and have only limited access to the basic health care needs such as maternal care and childbirth care. In the absence of a public health insurance, the government has an obligation to support its citizens in accessing the basic health care services. The community health clinic system provides this support for the rural people in accessing necessary health care services.

The context of socio-economic conditions and resource settings are also important for an individual to make the claim that she or he has a right to a basic minimum of health care. One's right to health care is stronger if the individual faces restrictions in accessing adequate income, education, and housing. If a country's social determinants of health (e.g., income, education, and housing) are weak, it will also reduce the capability of its citizens to access health care facilities. For example, a person of low income would not be able to pay the cost of medical care out of his or her pocket and would have, as a result, limited

access to health care. Therefore, it is the state's responsibility either to improve the social determinants of health or to ensure a minimum level of decent accessible health care. The question now arises, as to what is meant by a 'decent minimum' in the context of health care?

Many authors have attempted to explain what should be included in the package of a 'decent minimum'. A decent minimum can be understood as a level of health care which preserves the minimum capabilities of a person to have an education, to seek or hold a job, or to raise a family. It also extends to the affirmative actions for individuals who, because of ill health, are unable to meet any of the goals mentioned earlier. The goal of ensuring a decent minimum is to provide the opportunity for a person to live with dignity and comfort (Schneiderman 2011, p. 8).

The concept of decent minimum incorporates the idea that the most basic health care services should be included in a service package. These health care services are normally adequate for maintaining good health. In other words, they are adequate for a decent or tolerable life (Buchanan 1984, p. 59). Reproductive health care is required for women to preserve the opportunities for them. These opportunities are necessary in order to live with dignity and comfort. This implies that women's reproductive health care must be included in any discussion of the decent minimum health care service which they deserve to receive from the state.

A decent minimum of health care may also help some physiological and psychological capabilities to flourish. Some of those are: thinking and emotions, senses, circulation, respiration, digestion and metabolism, movement and balance, immunity and excretion, fertility, and hormonal control (Ram-Tiktin, 2011, p, 24). One of the major

services of the community health clinics is maternal health care. It includes counselling, educating about the danger signs during pregnancy, providing nutritious food supplements, and childbirth services. The maternal care services help to decrease maternal morbidity and mortality rates substantially. Women are healthier than before because of the services provided by community health clinics. Women can realize their opportunities and capabilities if they maintain good health. However, while community health clinics' reproductive health care services meet the basic minimum health care services, they fail to acknowledge women's individual autonomy in providing those services. The next section discusses this through the example of telemedicine services offered by community clinics.

4.3 Telemedicine: An Example of how Women's Autonomy can be Recognized at the Micro-Level

The community clinic system has provided telemedicine services since 2012 ("Health care Services for All," 2014). The system has expanded its service both in terms of coverage and nature of services. Now the telemedicine service includes mobile phone-based health service, advanced telemedicine, and Skype-based teleconsultation (Azad, Shamiul Bashar, & Anwar, 2015, p, 198). Community health care providers are instructed to use their mobile phones to provide services to their respective areas. Bonnie Kaplan (2016) has explored the implications of telemedicine for its users. I draw on Kaplan's work to demonstrate how women's autonomy could be recognized in promoting their reproductive health through telemedicine mechanisms. In particular, Kaplan's work demonstrates the importance of recognizing women's autonomy by posing the following questions: (i) how does the recognition of women's autonomy require that professional conduct and relationships are maintained in providing reproductive health care through

telemedicine mechanisms; (ii) how does promoting privacy, patient safety, and human values constitute the preconditions of autonomy; (iii) why is it important to involve patients and promote their autonomy; and (iv) should the benefits of the telemedicine services override women's concerns for autonomy?

4.3.1 How does the recognition of women's autonomy require that professional conduct and relationships are maintained in providing reproductive health care through telemedicine mechanisms?

Providing reproductive health care through telemedicine mechanisms often poses threats to women's privacy. The community health clinic system's transition to the eHealth brings with it new actors, activities, and norms. It is not only the physicians who provide the health care services, rather several other providers are directly involved in delivering health care services within the community clinic system in Bangladesh. The CHCPs (Community Health Care Providers) provide a significant part of the health care service to the pregnant women within their respective locality. They use their mobile phones to contact the respective pregnant women to provide the necessary supports. However, this also poses a significant risk to the privacy and confidentiality of pregnant women who are in the contact list of a CHCP, since a personal phone usually does not fulfill the security requirement as much as an official database does. In case of a loss or stolen phone, all of the women's contact details might be exposed to others.

Once the privacy is breached, the trust relationship becomes fragile. Women who seek the reproductive health care services through the telemedicine services in the community clinic system must be assured that her health information would not be disclosed to anyone else other than the physician or the CHCP. Enough safeguards must be ensured so that the women feel confident to trust their health care professionals. Above all,

professional conduct is a key issue in telemedicine. However, the community clinic system lacks plans that address the micro-level issues of women's privacy and confidentiality.

4.3.2 How does promoting trust constitute the precondition for autonomy?

While patients trust that health care professional will always serve the best interest of their patients, health care professionals should promote the autonomy of their patients as well. Telemedicine services through video conference must be compatible with the value of trust. Physicians are morally obligated to treat their patients fairly even if the relationship is virtual. There must be specific guidelines to ensure that health care professionals are aware of the privacy and confidentiality issues of women. Due to the sensitive nature of the reproductive health services, it is crucial to be aware of the relevant ethical issues. All of those responsible for initiating and maintaining telemedicine, including not only the higher authorities but also every actor in the process, must understand the importance of the privacy and confidentiality issues of women.

The introduction of telemedicine service also affects the patient-physician relationship. Since women constitute a significant part of the users of telemedicine service, ultimately women bear the negative impacts of this service. Trust has been considered as one of the enduring features of the patient-physician relationship throughout the history of medicine (Kalliainen & Lichtman, 2010, p, 2128). Patients trust that physicians would ensure the quality of care and minimize the risk during the course of a treatment. A patient also trusts that her privacy and confidentiality would be protected by the physician (Voerman & Nickel, 2016). The increasing prevalence of E-health to provide reproductive health services in the community clinic system poses challenges to the physician-patient

relationship. It is a challenge for both physicians and patients to build a trust relationship through a virtual interaction such as telemedicine.

4.3.3 Why is it Important to involve patients and promote their autonomy?

One of the main features of the community health clinic is to involve the relevant communities in delivering health care services. By involving patients in the telemedicine service, the community clinic system promotes the autonomy of the patients as well. Through the telemedicine services, patients can take charge of their health. Kaplan and Litewka (2008) argue that telehealth empowers patients by enhancing their autonomy.

These new developments seem to provide what people want: personalized relationships with providers, information targeted to their concerns and needs, and interactive tools for health and disease management. It is thought that patients and others needing health care services will benefit from use of these technologies in several ways commonly considered “empowering” (P, 402).

4.3.4 Should Concerns for Benefits Override Concerns for Women’s Autonomy?

Most of the literature, annual reports, health bulletins, and government and non-government publications focus on how women are benefited by the telemedicine services (GIZ, 2014). The telemedicine service has gained support among stakeholders because it has reduced the geographic barrier of providing health care services to the hard-to-reach areas, as per the government claims. Benefiting these communities is the major reason for implementing the telemedicine services through the community health clinic system in Bangladesh. Dr. Bonnie Kaplan observes,

Telemedicine is becoming more widespread. This is care at a distance, where patient and clinician are connected by information technology that may include video, audio, and monitoring equipment linked by computer. Telemedicine has many advantages. It can bring expert care and support to people in remote locations. It can help empower patients by giving them more independence and letting them stay where they are comfortable while still getting good care. It can lower health care costs while providing service that may be even better than

what would be available in person. It is convenient—freeing both patient and clinician from in-person visits for routine follow-ups or simple cases in which the diagnosis and treatment are clear (¶, 1).

Telemedicine services do in fact bring advantages to the women in the rural areas of Bangladesh in meeting their reproductive health needs. However, in the community health clinic system, the benefits of the telemedicine service are somewhat unduly exaggerated while its associated risks are not properly addressed. Overemphasizing the benefits of the service might encourage a crude paternalism toward women who seek reproductive health care services through the telemedicine services.

Even though the goal of a health care service is to benefit its users, the benefit should not be brought to the patients at the cost of their privacy and confidentiality. It might seem worthwhile, for the sake of beneficence, to ignore the privacy and confidentiality concerns in providing the telemedicine services to women in Bangladesh. But, in the long run, this practice would jeopardize their other health care rights as well.

4.4 Conclusion

In this chapter, I have demonstrated that social justice requires that women's right to access reproductive health must be recognized. Moreover, their autonomy must be acknowledged in accessing reproductive health care through community health clinics in Bangladesh. This chapter establishes the fundamental claim that there are good reasons to value women's right to access reproductive health and their autonomy. At the same time, through the example of community clinics' telemedicine services, this discussion shows how women's autonomy can be acknowledged at the micro level. An important area where women's autonomy must be recognized is the area of health research within the community health clinic system. The next chapter discusses how women are vulnerable to exploitation

when they participate in health research, further establishing the case for why the recognition of women's autonomy is crucial.

Chapter 5 The Way Ahead: Women's Vulnerabilities and the Importance of Recognizing Women's Autonomy in Health Research

5.1 Introduction

Promises in Reproductive Health Research

Community health clinics have already shown remarkable progress in improving maternal and reproductive health through its *Maternal Health Voucher Scheme and Emergency Obstetrical Care Services* (Koblinsky, Anwar, Mridha, Chowdhury, & Botlero, 2008). This advancement has been possible because of the development of a vast knowledge base through research.

The community clinic system in Bangladesh has created opportunities for conducting biomedical research in the area of nutrition and reproductive health of women. Several research programs were running through the community health clinic system after its commencement (Millat et al., 2011). At present community health clinics include research activities that involve women as participants. Donor agencies and different global health organizations are involved, directly or indirectly, in these research studies. Thus, the system has a numerous promise in the area of reproductive health research. Despite these promises in reproductive health research in the community health clinic system, women in Bangladesh are vulnerable to exploitation when they participate in reproductive health research. The next sections discuss women's vulnerabilities in the society of Bangladesh.

5.2 Women's Vulnerabilities and Reproductive Health Research Within the Community Clinic System

In Bangladesh, women are considered as vulnerable subjects when they participate in health research. However, a blanket categorization of women as a vulnerable population

jeopardizes their autonomy. Women are most likely to face undue paternalism if they are generally categorized as a vulnerable group. One of the main issues in our knowledge of vulnerability is a lack of research that addresses the context-specific vulnerabilities of women. While a context-specific analysis of women's vulnerabilities avoids a vague and general categorization, it also helps to locate the actual vulnerabilities of women.

As has been indicated, this chapter aims to discuss the vulnerabilities of women within the community clinic system in Bangladesh, a system that involves women both in terms of conducting research and delivering health care services to them.

The seven determinants of vulnerability formulated by Tavaglione et al. (2015) are credible since it can also be justified from some of the dominating principles of bioethics, such as the principle of non-maleficence, the principle of beneficence, and the principle of autonomy (Tom L. Beauchamp & Childress, 2013). Moreover, John Rawls' principle of liberty and the hypothetical concept of "the veil of ignorance" also serve as the moral foundation of some of the determinants of vulnerability (Rawls, 1971). These indicators of vulnerability are helpful for locating the specific vulnerabilities of women who are living within the coverage of the community clinic system's health care services.

Physical Integrity

Protecting physical integrity

An individual can be vulnerable due to the absence of adequate protection of his or her physical integrity. The underlying moral principle of the right to bodily integrity is the principle of non-maleficence (Beauchamp & Childress, 2013). The principle of non-maleficence, one of the fundamental principles of bioethics, requires that an individual should have adequate protection from society to be free from bodily harm. Furthermore, if

any social provision situates a threat to the physical integrity of an individual or a group of individuals, the individual or the group of individuals can be considered vulnerable. The following section identifies some major components of vulnerability and discusses how women within the community clinic system are vulnerable in terms of protecting their physical integrity.

From the capability approach of Martha Nussbaum (2011), the physical integrity of women means, “being able to move freely from place to place and having opportunities for sexual satisfaction and for choice in matters of reproduction” (Nussbaum, 2001). In her view, physical integrity is essential in order to realize one’s fullest capability. In the following two paragraphs, I argue that the practice of paternalism in the health care system and in the social institutions prevent women to retain their physical integrity intact.

In determining the vulnerability of women within the community clinic system, it is crucial to ask whether women in Bangladesh have control over their bodies. I present the example of pregnancy and childbirth. Paternalistic practice exists both in the health care system and in social institutions such as families and communities. In rural Bangladesh, women have very limited control over their physical activities. Many women must continue risky household activities during their pregnancies. Often in-laws, husbands, and elderly members of the family decide a woman’s activities within a household. Thus, a paternalistic approach to women threatens their control over their bodies.

However, health care professionals alone cannot be blamed for this situation. The entire health care system has not addressed this issue adequately. It is a systemic issue within Bangladeshi culture. Very few health care professionals in the rural area of Bangladesh receive training on the importance of patients’ autonomy. Thus, paternalism in

the health care system and in social institutions hinders the physical integrity of women in Bangladesh.

Promoting physical integrity

Society must protect the physical integrity of its members; positive initiatives must be taken so that an individual's physical integrity can thrive. The principle of beneficence, a widely held moral principle in bioethics, requires that society must provide the opportunity for an individual to sustain his or her complete physical integrity (Tom L. Beauchamp & Childress, 2013). The capability approach pioneered by Amartya Sen also explains the society's positive obligation to its members. He (2009) emphasizes that each should receive the opportunities for flourishing his or her physical integrity (Sen, 2009).

In Bangladesh, society has minimal provisions which directly promote the physical integrity of women. There is an inequitable power relationship between patients and health care providers. A physician or a health worker's knowledge puts him or her in a dominant position when compared to his or her patient. This inequitable power relation creates a threat to the physical integrity of women. In developed countries, interest groups and relevant stakeholders work together to reduce this power inequity. However, in Bangladesh, very few positive steps have been taken in order to empower the voice of patients. Women in Bangladesh are not empowered enough to control their bodily integrity. The Bangladeshi society is reluctant to take positive actions to reduce the inequitable power relationship between women and health care providers. In a like manner, social norms and practices contribute negatively to keep their bodily integrity intact.

Autonomy

In exploring the nature of vulnerability of women in Bangladesh, one must discuss how autonomy is respected when women make their own health care decisions. The principle of respect for autonomy requires that an individual should be self-directed in making his or her health care decisions (Tom L. Beauchamp & Childress, 2013). Women are vulnerable to exploitation in providing meaningful consent when researchers conduct clinical research with them within the community clinic system. Moreover, several external factors often influence women's decisions. The social constructions of certain norms affect women to limit their autonomy. For example, in Bangladeshi society, a woman who raises her voice to claim what she deserves is considered a 'shameless' woman (Rozario, 1998). Most women would rather tolerate an unjust decision of her family members than portray herself as a shameless woman. Thus, women themselves negotiate their autonomy in order to comply with social norms.

Furthermore, women's autonomy is also at stake in making health care choices and decisions. In the rural areas of Bangladesh, women have an insignificant control in preparing their antenatal and postnatal care plan. A woman's husband and other elderly family members decide her care plan. In general, women's concerns are not properly addressed. Thus, their autonomy is not protected in terms of receiving health care services.

Freedom

An individual's vulnerability can be determined by recognizing the degree of his or her freedom and by identifying the obstacles to his or her freedom. Society has a negative obligation to its members so that coercive and oppressive policies do not limit women's liberty arbitrarily. The society also has a positive obligation to its members so that

individuals can get an opportunity to exercise their freedom, which includes freedom of expression, freedom of conscience, and freedom of association, etc. The underlying moral principle of freedom as a determinant of vulnerability can be derived from the liberty principle of John Rawls that he outlines in his “Justice as Fairness” (Rawls, 1957). The first principle of justice formulated by John Rawls describes the rationale for individuals’ entitlement to freedom or liberty (Rawls, 1957). Rawls (1957) argues that society must ensure the basic liberty for its members in order it to be a just society. The section below explores how freedom constitutes a significant determinant of vulnerability for women in Bangladesh within the community clinic system.

The community clinic system has a top-down approach in addressing the reproductive health of women. Although the community clinic system is a public-private partnership program, policy decisions are generated from higher officials at the ministry level. The community health care providers who provide health care services to women at the grassroots level follow direct orders from their superiors at the district level. In this process, authorities and the representatives of authorities, CHCPs for example, have greater authoritative control over women than the women themselves. Women play a passive role in the process of receiving maternal health care services from community clinics as well as in creating health care policies.

Social Provision

Society has an obligation to provide some basic needs for its members. These social provisions include food, housing, education, and protection against unfortunate events such as unemployment, illness or disability (Tavaglione et al., 2015). Each of these social provisions determines an individual’s health and well-being.

In rural Bangladesh, women often lack access to nutritious foods during their pregnancy. The community clinic system runs educational programs for pregnant mothers to make healthy food choices. However, many women cannot afford healthy food during their pregnancy. Moreover, in rural areas of Bangladesh, one of the major causes of food insecurity among women is the scarcity of nutritious food.

The community clinic system in Bangladesh addresses the health care needs of women. However, there are many social deterrents such as housing, education, and economic condition that impact women's health. No existing policy in Bangladesh determines the requirements of a healthy living condition for its citizens in the rural areas. Many women pass their gestational period in unhealthy and unhygienic houses. Despite the government's effort, these social determinants of health are still unmet for many women.

Many women in Bangladesh are victims of domestic violence while government and NGOs work toward reducing domestic violence. However, the social and state provisions are still inadequate to protect women from domestic violence. The World Health Organization's Multi-Country Study on Women's Health and Domestic Violence against Women reveals that Bangladesh is one of the highest rated countries where domestic violence and induced abortion or miscarriage are common incidents during pregnancy (García-Moreno & Organization, 2005). The study also shows that in some countries pregnancy is a time of relative protection from physical violence. However, in Bangladeshi society this is not the case. Unfortunately, women are more vulnerable to physical violence during their pregnancies.

Impartiality

Several health authorities exercise their authoritative powers over women to improve women's health and well-being. However, this exercising of power needs to be impartial so that nobody is discriminated against arbitrarily. John Rawls' concept of "the veil of ignorance" explains the importance of having a neutral position in order to apply the principles of justice (Rawls, 1971). From this perspective, in order for there to be a just distribution of wealth and primary goods, the social institutions must maintain a neutral position so that nobody is benefited unjustly, and nobody is deprived of his or her due. The question arises, are the health authorities in Bangladesh impartial in exercising their authoritative power?

The health system of Bangladesh is biased toward the biomedical approach to health. Sometimes it ignores alternative approaches to health as well as the importance of improving social determinants of health. One of the examples of a bias toward the biomedical approach is its medicalization of the pregnancy and childbirth. The local midwives who once constituted the major care providers in the period of pregnancy and childbirth in rural areas have become powerless (it should be noted that rural midwifery is also controversial in Bangladesh for practicing unhygienic and unscientific techniques during childbirth). Consequently, obstetricians are facing a considerable workload to provide health services to pregnant women who could otherwise receive health care services from trained midwives. However, although the community clinic system is currently providing training to midwives in their respective localities, it is not adequate to serve the vast population in rural areas of Bangladesh. Thus, the health system is facing many implications for its bias toward the biomedical approach to health. For instance, such

bias can also put women under the undue pressure of accepting medical interventions during their childbirths and pregnancies. In other words, women can be vulnerable to facing unnecessary medical interventions regarding their reproductive health.

Social Bases of Self-respect

One can understand one's vulnerabilities by assessing his or her social bases of self-respect. Norman Daniels states John Rawls' explanation of the social bases of self-respect and how this primary good needs to be distributed fairly (N. Daniels, 2001). The concept of self-respect includes an individual's sense of his or her value. It also includes an individual's secure conviction that his or her conception of good and his or her plans of life are worth carrying out. 'The social bases of self-respect' is also one of the important determinants of vulnerability in Tavaglione et al.'s (2015) list. The inclusion of the social bases of self-respect in this list also indicates that vulnerability can be generated from a non-material source.

Communal Belonging

Women's sense of belongingness into the community is connected to their vulnerability. However, women cannot develop a sense of community because of the social norms that restrict them from participating in the local community affairs. The Bangladeshi society constructs certain norms for women to follow in order to be considered a *good woman*. It is generally accepted that a woman should not participate in communal activities and disobey her husband and other elderly male members of her community. A woman's role in the community is limited due to this gender gap. The social construction of the *good woman* prevents women from realizing their position in society and in their families. A

woman tends to be a *good woman* at the cost of her self-respect. Consequently, women develop an insignificant sense of community belonging.

As the foregoing demonstrates, there are multiple sources of vulnerabilities for rural Bangladeshi women. The social, economic, and cultural context can put women in vulnerable situations. Because of the existence of these vulnerabilities, women's autonomy must be recognized. The following section discusses how informed consent can be one way of recognizing women's autonomy.

5.3 Women's Vulnerabilities to Exploitation and Informed Consent as a Way of Mitigating Women's Vulnerabilities

There is a lack of understanding about the importance of informed consent in both parties, researchers and participants. Such a knowledge gap regarding informed consent also contributes to perpetuating women's vulnerabilities.

In the context of Bangladesh, the involvement of the multinational research organizations in the community health clinic system poses further risks for women to be exploited. Because of the persistence of women's vulnerabilities to exploitations, they need special protection. Recognizing women's autonomy is a crucial step to the procedures of special protection. Ruth Macklin (2003) nicely summarizes women's vulnerabilities in developing countries:

The type of multinational research likely to raise the most ethical concerns is that in which the investigators or sponsors are from a powerful industrialised country or a giant pharmaceutical company, and the research is conducted in a developing country (the 'host' country). Two main ethical concerns are prominent in this type of research. The first concern is that research subjects in the host country might be vulnerable by virtue of their low educational level or lack of familiarity with modern scientific concepts, their poverty or powerlessness, and therefore open to exploitation in some manner. The second concern is that large numbers of people in many developing countries lack

access to good health care or even any medical services. Such individuals may be eager to enroll in biomedical research that holds the prospect of some benefit to them, despite the risks of experimental procedures. Because of their unfamiliarity with scientific research, they may also fall prey to the 'therapeutic misconception', the belief that the purpose of research is to benefit the research subjects rather than to gain new knowledge.

The above stance on vulnerability points out the power relations between the researcher and the researched. Women in rural Bangladesh are vulnerable to exploitation because of their powerlessness. Conversely, researchers hold powerful positions because of their educational background, scientific knowledge, and institutional support.

5.3.1 Informed Consent: A Crucial Step to Recognizing Women's Autonomy at the Micro-level

In 1998, Niels Lynøe and his colleagues conducted a study among 105 pregnant women who were participating in a community-based study of iron supplementation (Lynøe, Hyder, Chowdhury, & Ekström, 2001). The paper (2001) indicates five core problems in the community-based research in Bangladesh: (i) most of the participants did not understand that they could decline to participate in the study; (ii) very few women understood that they could withdraw themselves from the study; (iii) half of the participants considered the study as a part of the routine health care; (iv) eighty seven percent (87%) of women in the study thought that participating in the study would bring great advantages in terms of medical treatment for themselves and their child; (v) the presumed medical advantages put the participants in a position not to refuse to participate in the study (Lynøe et al., 2001, 460-461).

The above study shows that even though informed consent is obtained, women's autonomy can still be jeopardized. For example, many women do not have a clear understanding of the distinction between health research and health care service. This lack

of understanding often places women in vulnerable positions to be exploited. Thus, women's awareness about their rights (when they participate in research) is necessary. Likewise, researchers also have an ethical obligation to protect their subjects from possible exploitation.

Informed consent has become one of the central concerns of biomedical ethics at present in the era of individualism in Western societies. It is the fundamental prerequisite for conducting any biomedical research that involves human subjects. Proper informed consent from the participants must be obtained before commencing any biomedical research. The problems of informed consent are discussed within both the legal and moral framework (Faden & Beauchamp, 1986, p, 3). Informed consent is regarded as a practical application of the principle of respect for autonomy, one of the foundational principles of biomedical ethics (Beauchamp & Childress, 2013). Moreover, an informed consent document can be crucial for the participants of any biomedical research in the event that they pursue compensation for experiencing harm due to the investigation.

Informed consent can also refer to an agreement between the patient and physician to conduct certain types of medical treatment. A physician can administer a medical procedure only if the patient is capable of deciding and agrees to the procedure. However, alternative procedures regarding informed consent are practiced in case of incapable patients such as demented patients, children, and patients with severe mental disorders. Usually, informed consent is obtained from the guardians or from the Substitute Decision Maker (SDM) in the above cases. Researchers and clinicians must respect the self-determination of individuals and obtain meaningful informed consent from the patients or

participants of any research so that the rights and responsibilities of both parties are protected.

Although informed consent is widely practiced within the field of biomedical research in Western developed countries, the issue of informed consent is also crucial in developing countries. However, informed consent is one of the major issues that steers moral controversies in developing countries especially when global organizations and the developed countries are involved in these researches (Emanuel, Wendler, Killen, & Grady, 2004, p, 930). In Bangladesh, several factors, such as literacy, socioeconomic conditions, cultural context, and power relations, work as obstacles against obtaining meaningful informed consent (Hossain Talukder, 2016; Lynöe et al., 2001). Hence meaningful informed consent is crucial for the recognition of women's autonomy and how it can mitigate women's vulnerabilities in rural Bangladesh.

The literature on informed consent in the context of Bangladesh is rarely available. But, in general, the practice of informed consent is disappointing in Bangladesh. Clinicians and researchers obtain informed consent from the patients as a routine work and as a legal safeguard of their research rather than respecting the autonomy of the patients (Hossain Talukder, 2016). The situation of informed consent in the community-based research in Bangladesh demands the discussion of the importance of informed consent.

Due to the existence of power gaps between women and researchers, recognition of women's autonomy is important. For example, if a researcher acknowledges that a woman's autonomy is important, the researcher would obtain meaningful informed consent from her before involving her in the research. Now the question arises, how informed consent can be a crucial step toward the recognition of women's autonomy? With a

discussion of some limitations of informed consent, the next section presents whether informed consent can be a crucial step for the recognition of women's autonomy in promoting their reproductive health.

Meaningful informed consent can be a crucial step for acknowledging women's autonomy. *Meaningful* informed consent is a must for any research project in order for it to be ethically sound. I emphasize on the meaningfulness of informed consent because, in general, informed consent merely is routine work for many researchers without comprehending its importance. Any vagueness or deception within the informed consent process would jeopardize the autonomy of the participants. History has witnessed unethical health research such as the Nazi experiment, the Tuskegee syphilis experiment, and the Willowbrook Hepatitis Experiment (Resnik, 2012). After seeing the ill effects of these incidents, a consensus was created among researchers, ethicists, and human rights activists to conduct health research in a way which respects the complete autonomy of the participants. International codes of conduct in ethical research such as the Nuremberg Code and the Declaration of Helsinki were adopted in the health research community. The main purpose of the informed consent process of a research project is to respect the autonomous choices of the participants. Unclear informed consent does not serve the real purpose of the informed consent in research.

As stated previously, many women do not understand that they can refuse to participate and that they can leave a study any time they want. The vagueness surrounding the informed consent in the study was an obstacle to the choices of the participants. It is the researchers' responsibility to ensure the freedom of the participants to be or not to be enlisted in the study and to leave the study at their own will. Moreover, the researchers

must clarify the objective of the study to the participants. However, sometimes health literacy of the participants of any study can create an obstacle to the meaningful informed consent process. The researcher must communicate through a lucid and easy language so that the participants understand the risk and benefit of participating in the study.

Any human subject, literate or illiterate, possesses the right to be informed about the objectives, risk-benefits, possible consequences to the respective community, the provision of withdrawing from the research without any harm, and the safeguards of their privacy and confidentiality. I recognize that this basic information, which is key to any research, must be communicated in an easily understandable language to the participants before recruiting them so that they can understand everything and then participate. Although informed consent procedures are crucial for women's autonomy, there are some limitations of informed consent.

5.4 Conclusion

The crucial claim in this thesis is that community health clinics do not acknowledge women's autonomy in promoting women's reproductive health at the micro level in the areas of both health care and health research. Through the discussion of reproductive health research, this chapter explains how the community health clinic system lacks plans that acknowledge women's autonomy. Women's social positions in the Bangladeshi society make them vulnerable to exploitation when they participate in reproductive health research. Women's vulnerabilities in the Bangladeshi society also necessitates that their autonomy is recognized. Women in Bangladesh deserve special protection and meaningful informed consent is necessary for mitigating women's vulnerabilities. At the same time, a meaningful informed consent mechanism can serve as a crucial step in recognizing women's autonomy.

Chapter 6 Conclusion

Despite all of its significant contributions to advancing public health in general, nevertheless, the community clinic system is failing to recognize and promote the autonomy of women in general, and rural women in particular. Such failure is evident when women are considered merely as passive service recipients. They are not actively engaged in the decision-making process of how a clinic would run or what kinds of health care services should be included in a clinic. Needless to say, treating women as passive service recipients undermines their choices and preferences. At the same time, by considering women as passive, the community health clinic system fails to recognize women as autonomous agents.

This thesis makes a case for the importance of recognizing (i) women's moral autonomy that explains their fundamental moral worth as human beings, and (ii) women's practical autonomy which requires that the circumstances that either promote or else undermine an individual's ability to live and act autonomously must be addressed. The recognition of women's moral autonomy is especially important at the macro-level such as in health care policies and guidelines that reflect women's fundamental moral worth. At the meso level, institutions such as community clinics and the associations of health care providers must reflect the value that the moral autonomy of women is significant. The community health clinic system at the micro level must create a congenial atmosphere where each woman would be able to exercise her autonomous choice (practical autonomy) without any obstacles.

In favour of recognizing women's autonomy, a social justice perspective explains why women have the right to access reproductive health care, to be treated with dignity,

and to exercise their autonomy. A social justice approach to health recognizes that each woman should receive the freedom to develop an ethical self-understanding and realize a personal concept of her well-being regardless of her social position.

This thesis indicates that while the community clinic system positively contributes to Bangladesh's rapid advancement in the health care sector, the system must address the moral issues related to the promotion of women's reproductive health. Establishing the community clinic system is one of the innovations which has brought better health outcomes in Bangladesh. The research papers of the *Lancet* series applauded this innovation as well. However, the community clinic system demands a critical examination of its goals, innovations, and achievements. This thesis critically examines the accomplishments of the community clinic system with regard to its reproductive health services. I examine why women's autonomy matters. More specifically, the major claim of this thesis is that while promoting women's reproductive health, their autonomy should be regarded as paramount. I forward the arguments of the thesis within a social justice framework that explains why women's rights, health equity, and autonomy are important.

Within a social justice framework advanced by authors such as John Rawls, Amartya Sen, and Norman Daniels, this thesis conducts a moral analysis of women's reproductive health care provided by community health clinics. By discussing the concept of health equity, that is prevailing in social justice framework, this thesis argues that women in the rural areas of Bangladesh deserve the same right to access reproductive health care as much as the urban women do.

Although the community health clinic system contributes positively to the health sector of Bangladesh, a substantial lack of addressing the issues of research ethics exists in

the system. Women are still vulnerable to exploitations when they participate in health research within the community clinic system. This thesis conducts an in-depth analysis of vulnerability to argue that women in Bangladesh deserve special protection when they engage in health research conducted by national and multinational organizations. At the same time, I acknowledge that a broader categorization of women as a vulnerable group imposes undue paternalism on them. The community health clinic system must promote women's autonomy so that those who are vulnerable to exploitation are protected, and nobody is subject to undue overprotection.

One of the crucial reasons for valuing women's autonomy originates from women's vulnerabilities to exploitation and oppression. The recognition of women's autonomy can protect women from possible exploitation. One practical example of such recognition of women's autonomy is the practice of informed consent in health research that involves women as participants.

I analyze how Bangladeshi women's vulnerabilities demand that their autonomy should be protected and promoted. The community clinic system must clearly distinguish between research and a health care service. Many of the participants who seek health care services in the community clinic system do not know whether they are enrolled in research, or they are just receiving a health care service. If women are receiving a health care service as part of any research, they have a right to know about the nature of the study. They also have a right to withdraw from the study without encountering any negative consequences. Furthermore, the principle of respect for autonomy requires that women's autonomy must be respected when they are enrolled in a study.

Even if the concept of informed consent emerges in Western societies in the age of individual freedom and autonomy, it is also applicable in Eastern societies like Bangladesh. The community clinic system has an excellent opportunity to exercise meaningful informed consent in conducting any research with its beneficiaries.

Moreover, the transition of the health care system from the traditional paper-based system to an information technology-based system in Bangladesh is positive. In the age of modern technologies, the blessings of information technologies can be integrated wisely into the health care system. However, several precautions must be taken in the process of transition so that women's equity, privacy, and confidentiality are respected. This is important in providing health care services for women through telemedicine.

Finally, despite the presence of several moral pitfalls, the community health clinic system in Bangladesh promotes social justice through its health care services. The reproductive health care services of the community clinic system need to be critically analyzed. I firmly believe that the recognition of women's autonomy is crucial for promoting social justice in the Bangladeshi society. This thesis makes a case that acknowledging women's autonomy in the promotion of their reproductive health is morally significant. Accordingly, women's autonomy must be regarded as a paramount concern in the promotion of their reproductive health through community health clinics in Bangladesh at the macro, meso and micro levels.

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