COMMUNITY BASED HEALTH CARE THE NGO WAY: AN ANTHROPOLOGICAL STUDY OF A MATERNAL-CHILD HEALTH AND FAMILY PLANNING PROGRAMME IN RURAL BANGLADESH

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ABSTRACT

This is an anthropological study of a rural Maternal-Child Health and Family Planning (MCH-FP) project and the community in which it worked, in Bangladesh. It analyses the Non-Government Organisation's (NGO's) approach to rural community-based health care and integrated development, using the health programme as a framework. Beginning with an examination of the NGO's relationships with its donor-funding and technical support organisations, it moves on to a critique of population policy from a socio-cultural perspective, focusing on issues of gender and poverty. Following this, it examines contraceptive use and experience of side-effects from the perspective of village women. The subsequent chapter focuses on the MCH programme, highlighting contradictions between local cultural beliefs and the premises of modern medicine, concerning pregnancy and maternal care, and explores the use of trained local Traditional Birth Attendants.

The study then turns to examine the objectives of women's empowerment and analyses the development of a women's group formation programme, identifying an increasing problem of NGO competition and 'encroachment' in villages. This was a growing trend amongst grass-roots NGOs, and specific cases involving the Bangladesh Rural Advancement Committee (BRAC) and Grameen Bank are scrutinised. Fuelling this activity is a target-driven quest for rapid programme expansion, motivated by pressure and competition for donor funds and influenced by current global development trends. It is questioned whether, under these pressures, organisations are able to retain their participatory empowerment ideologies whilst undergoing extensive expansion. The analysis reassesses the impact of these changes on achieving women's empowerment through credit. The verdict is one of more restrained optimism than opinions expressed in most of the literature.

The main conclusions call for an expansion of the MCH agenda to adopt a more holistic perspective on the social context of women's health. This involves recognising the role of men in women's health care and actively including them in programmes. It also necessitates recognising the heterogeneity of female needs, beyond those of the conventional MCH reproductory focus, and the recognition of domestic violence as a significant cause of female morbidity and mortality. The principal conclusion is, therefore, the need for a gender perspective in the formulation of health policy and the design and implementation of health programmes, and more active participation in these processes, not only of women, but all members of the community, particularly men and influential leaders.

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DECLARATION

I declare that this thesis has been composed by myself and that the work presented herein is my own.

Rosamund Ebdon

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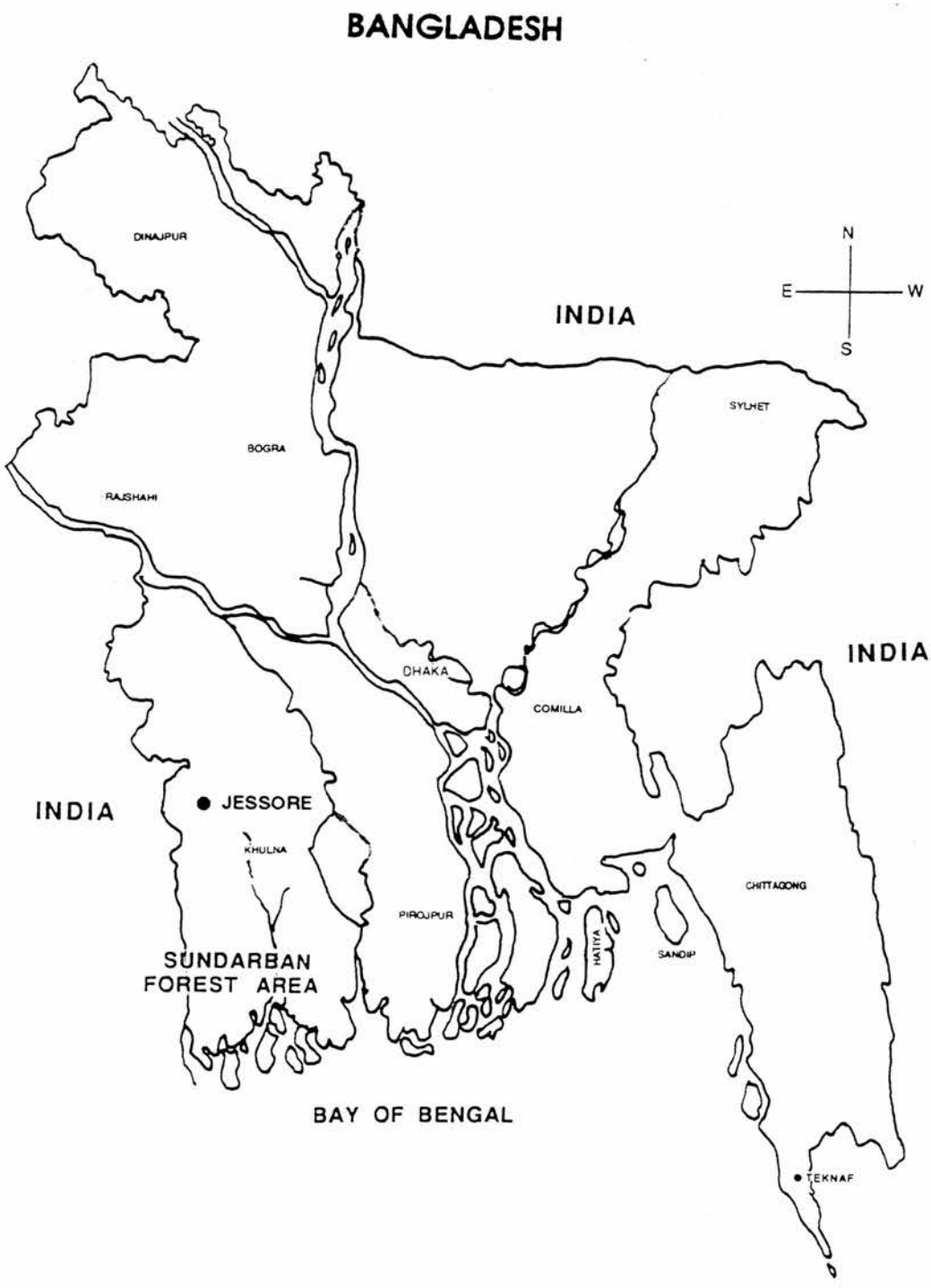
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CHAPTER 1
INTRODUCTION

I pondered long and hard over how to describe this piece of research. Should it be called a study of systems of rural health care in Bangladesh, or more accurately of rural development, since it covers wider issues than simply those relating to health? I thought perhaps 'an ethnography of a Non-Government Organisation (NGO) rural health project', but then decided against this because of the all-encompassing nature of the term 'ethnography'. I had not spent sufficient time conducting the research to brashly claim an intimate knowledge of every nook and cranny of the organisation and its programme. Anyway, this would imply that my enquiring eye was focused on the organisation, when in fact it was the interaction between the organisation and its beneficiaries that I was interested in. I did not study the machinations and structure of the organisation itself, but rather its philosophy, and its approach to health care and development within a small rural community. Thus, I have taken the organisation's programme as my starting point and my guide for the course of the research. I feel that the thesis is therefore best described as an anthropological study of the interactions and interrelations between a rural health care NGO and the community in which it worked. The focus has been to look at the interaction of the different cultures of the organisation, largely based on the premises of modern scientific or allopathic medicine, and of the community based on local systems of belief and practice, norms and social relations.

The scope of the research is therefore primarily delimited by the 'boundaries' where these two cultures overlap, and this is principally defined by the different aspects of the NGO's programme. This bounding is of course only hypothetical and difficult to do, since it is no simple task to prioritise which aspects of the local culture are relevant to the programme and the processes of development, and which are not. Essentially, of course, everything is since the different aspects of life interact to form a complex whole; I need elaborate this point no further as it forms the fundamental basis of anthropological discourse. It has, however, been the error of development interventions to assume that culture can be carved-up into relevant aspects and examined in a dislocated way, and I have been concerned that taking a

development perspective, I too should not fall into this trap. However, within the restrictions of time and practicality set by the criteria of a PhD thesis, and a limited period of funding, I decided that using the framework of the organisation's programme to mark the scope of the thesis was the most logical way to contain the size of the research task. I have, however, used this as a flexible framework, and gone beyond the specific micro focus that it describes, to explore a wider context of village life, and to trace up to macro issues of development. The diversity of subjects covered is consequently very great, each chapter addressing something different, but at the same time related to the root concept of the thesis - approaches to rural community-based health care and integrated development.

Structuring the thesis in this broad way has meant that the depth with which I have been able to tackle the different issues addressed in each chapter is limited. Some chapters could easily be expanded to form theses in their own right, such as that on the highly controversial debate concerning population policy (Chapter 5), or that on maternal health care and childbirth (Chapter 7). However, since much of this has been extensively covered by other authors, I have chosen, at the expense of achieving their detailed analytical depth, to try and show how these different issues are interrelated within the experience of a small health project, and how they relate to, and are perceived by, the people with whom they are ultimately concerned; rural villagers. In a sense then, this **is** an ethnography of an NGO project, but a rather incomplete one, and one which attempts to represent the perspective of both the project and its beneficiaries.

THESIS STRUCTURE

Following this introductory chapter which addresses theoretical issues and pertinent literature, I begin with a methodology chapter (Chapter 2) discussing how I conducted the research, and my relationships with the NGO, and the villagers with whom I lived. For the sake of anonymity I shall call the NGO Muhilar Shasto (meaning Woman's Health), and point out that all the names I have used for people are pseudonyms. In Chapter 3 I give a brief ethnography of the research village, which I shall call Shundurgram, although again this is not its real name. The different chapters in the main body of the thesis then explore various aspects of the NGO's programme and subjects relating to these. I have divided these into distinct sections according to the programme's structure, but it should be recognised that they are both overlapping and interdependent, forming the overall integrated

Maternal-Child Health and Family Planning (MCH-FP) programme. I discuss the nature and structure of the programme as a whole in Chapter 4, and look at the NGO's relationship with the technical support organisations based in the capital city, Dhaka, which fund Muhilar Shasto and give them guidance. In Chapter 5 I look at family planning policy and contraceptive use from a socio-cultural perspective. This essentially forms a critique of population policy, focusing on gender and poverty, and the socio-cultural factors influencing decisions concerning family planning. In Chapter 6 I examine village beliefs and experiences of using different contraceptive methods, particularly the implications of side-effects on people's decisions to use contraceptives.

Chapter 7 looks at local beliefs concerning pregnancy and appropriate care of mothers and children during antenatal, intrapartum and postnatal periods. I examine how local food restrictions and behavioural norms contradict advice given by the MCH programme, and how, for example, these effect attendance at clinics for check-ups, and the use of trained Traditional Birth Attendants (TBAs). I also look at the TBA programme in more detail to identify certain problematic areas and important issues. The chapter ends by briefly discussing the role of existing local allopathic health practitioners in the village and asking whether these village *daktars* represent a threat to local health care or are an important local resource. I discuss their prominent role in the village, their mismanagement of allopathic medicine and their need for training, and the possibility of involving them in the activities of the MCH-FP programme to increase its support in the community.

Chapter 8 looks at women's empowerment and analyses in detail the development of Muhilar Shasto's women's group formation programme, from the perspectives of the members of four particular groups which I studied closely for a year; the Family Health Visitors (FHVs) who organised them; and the NGO itself. This provides useful lessons about how expectations can differ between the NGO and the intended beneficiaries, and the consequent dangers of relying on assumptions.

Chapter 9 follows on from this, identifing what appears to be a growing trend of competition amongst grass-roots NGOs, and examines specific case studies of the political relations between Muhilar Shasto and two national development

organisations, the Bangladesh Rural Advancement Committee (BRAC)[1] and the Grameen Bank. The discussion draws on a macro analysis of the processes of scaling-up development programmes and questions whether it is possible for small grass-roots organisations to retain their founding ideological approaches while undergoing extensive programme expansion. I move on to question the effectiveness of these organisations', and the general development forum's, currently favoured approach of 'empowering women' through provision of credit for small income generating businesses. I use case studies to support my scepticism over the way these programmes have been almost invariably presented as positive examples of achievements in women's empowerment. In the light of my experience, my expectations of women's credit programmes in positively changing the social and economic status of women are perhaps more restrained than the current opinion expressed in most of the literature.

Chapter 10 brings together the main conclusions of the study. These call for the reassessment and expansion of the MCH agenda, to adopt a more holistic perspective on women's health care, taking into consideration the social context of their situation. This involves widening the definition of reproductive care beyond the narrow focus on maternal needs, to address the heterogeneity of female needs and the role of men. The predominance of domestic violence as a health issue should be recognised and stronger emphasis placed on addressing this at the institutional level and through empowering women with self-esteem, confidence and knowledge of legal rights. The principal conclusion encompassing all of these is the need for a gender perspective in designing and implementing health programmes, and the more active participation, not only of women, but all members of the community, particularly men and influential leaders.

THEORETICAL UNDERPINNINGS

The above outline indicates the diversity of subjects covered in the thesis, and hence the difficulty in associating any one particular theory to the arguments and analyses presented. By necessity the theoretical analyses in different chapters are, therefore, specific to the particular issues under discussion. However, the guiding threads which run throughout and form an underlying theoretical framework, are based on

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[1] BRAC is one of the largest indigenous NGOs in the country. More details on it are given in Chapter 8.

several theoretical concepts in common use in development discourse. The fundamental one, which hardly needs mention or explanation in the context of a social anthropology PhD, is 'social development', i.e., applying a social perspective to the analysis of the processes of development; in other words, 'applying anthropology'. In the context of my research, this meant analysing the primacy of people and their roles in the processes of grassroots development and rural health care. I take the trouble to specify it here for the reason that the other concepts I shall deal with are, as Mark Nichter (1984:237) argues, largely meaningless rhetoric in the absence of such a sociocultural perspective. These concepts are 'community participation' and 'empowerment' in the context of rural community-based health care, with an underlying gender perspective, and will now be looked at briefly in turn.

COMMUNITY PARTICIPATION

Use of the term 'community participation' has become increasingly popular within development dialogue over the last decade[2], but its meaning has remained vague and ambiguous. The complex nature of 'participation' is such that it cannot, as commonly happens, be regarded as a separate programme component to be added onto a project, or a method which can be simply applied to address the social aspects of development. As is apparent from the vast amount of literature on the subject (e.g., Apthorpe & Conyers 1982, Cohen & Uphoff 1980, Constantino-David 1982, Lisk.F. 1985, Oakley & Marsden 1984, Chambers 1983, Rahman, A. 1993, Burkey 1993) there is no universal meaning or understanding. 'Community participation' is essentially used as a blanket term with a whole range of meanings (see Oakley and Marsden 1984 for a detailed discussion on this), but in its most basic sense it encourages the active participation of the people in any development activities proposed or undertaken (Oakley 1989:1).

In general terms, two different types of interpretation can be identified. One is result oriented, where participation is seen as a means to an end; the involvement of local people is intended to ensure that the project will be appropriate, acceptable and effective. People's involvement in this sense tends to be 'passive' in nature, where decisions are made by others, the planners and policy makers. The **results** of

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[2] For example, the Overseas Development Administration (ODA) are preparing a technical note on Participation in British aid programmes, for use at policy level.

their participation - the successful achievement of programme objectives - are more important than the **act** of their participation. In this interpretation, 'participation' is describing a **state**, or an input into a development programme (Oakley and Marsden 1984:27). This is the more common form of participation found in rural development projects and was the predominant strategy for participation in Muhilar Shasto's programme.

The second interpretation has a more political objective, where participation is not only a means to an end but also an end in itself, based on the conviction that people have the right to influence decisions which affect them (Ladbury 1991:2). This involves a process of 'empowerment', where formerly powerless groups acquire the power to make decisions and assume responsibility for their implementation. The following statement illustrates this more radical school of thought:

> power is the central theme of participation and... participatory social action entails widely shared, collective power by those who are considered beneficiaries. The people become agents of social action and the power differentials between those who control and need resources is reduced through participation (Fernandes & Tandon 1981:5, cited in Oakley and Marsden 1984:26).

In this interpretation the process of participation is seen as a dynamic and permanent feature of rural development, outliving the span of the project and enabling people to take a more active role in determining their future. Oakley states that "the critical elements in the process are to enhance awareness and build up organization" (1989:11). Although Muhilar Shasto's overall strategy was more akin to the former interpretation, they began to adopt a more 'empowerment' focused philosophy, particularly regarding the participation of women through group formation and awareness-raising. Their interpretation and strategy for 'community participation' might, therefore, be seen as a convergence of the two.

Who or What is the Community?

Before I examine the concept of 'empowerment' it is necessary to ask who or what is the community; to whom are we referring when we say participation of the community?

The community development approach, which became popular around the 1950s and 1960s, treated communities as homogeneous wholes, living as egalitarian harmonious units, with shared interests and concerns. However, this failed to

recognise the underlying complex social structure of a community, which comprises many different contradictory and conflicting interest groups. The assumption based on this misunderstanding was that the benefits of development would be equally shared amongst community members, or villagers, and that community leaders represented the voice and concerns of all - rich and poor. This harmonious model was in time proven wrong when community development projects, for example, set up to distribute the benefits of the Green Revolution, failed to reach the poorest members of the community and benefits instead fell predominantly into the hands of the richest and most influential. The main example of this in Bangladesh is the 1960s agricultural cooperatives programme in Comilla, where access to, and benefits from the programme went to richer members (Abdullah et al 1976).

The use of the term 'community', in reference to 'participation', still often fails to recognise and identify the different groups which make up this complex social structure. The concept of the 'community' as a whole rather than disaggregated on class, gender, religion and so on, is typical of primary health care programmes. The term is often used in reference to a geographical area with physical boundaries, rather than socially defined or symbolically constructed boundaries (Cohen 1989), for example, in describing a village as a 'community', with the implicit assumption that it is a socially cohesive unit.

The term 'community' can, therefore, only be used generally, to describe a complex collection of overlapping and interacting social groups each with their own specific agendas and interests, but who share a system of values, norms and moral codes which provide a sense of identity within a bounded whole (Cohen 1989). The terminology most recently used in development discourse (e.g., by the Overseas Development Administration, ODA) refers to these different interest groups as 'stakeholders'. These may be groups of political and religious leaders, elders, landowners, landless, small landowners, traders, moneylenders, and so on. In this list is often included the group 'women', the assumption being that all women have the same interests and priorities. However, this is of course not the case. Although women's interests and needs are often quite distinct from those of men and therefore need to be identified separately, they are not a homogeneous group. White's study on gender and women in Bangladesh argues that:

> It is not something out there, but the discourse itself, that constructs women as a group with common features and interests more significant than those which divide them (1992:144).

'Women' constitute different social categories and interest groups: the rich, poor, elderly, young, newly married, married, unmarried, widowed, divorced, mothers-in-law, mothers, childless, and so on. Thus, like communities, women are also not a harmonious cohesive group, although this fact is all too often not recognised.

When talking of community participation it is, therefore, necessary to identify which particular social groups, or stakeholders, are being referred to, and to recognise that their reasons for wishing to participate may be very different from those of other groups. It is also important to understand the priorities and expectations of the different groups, and to include the development organisation in this analysis, since it will have its own set of priorities related to its own organisational culture; in this sense it too is a stakeholder. An example of the problems which arise when these differences in expectations are not identified is given in Chapter 8, in the discussion of Muhilar Shasto's women's group formation programme. It is, therefore, important to state that when I refer to the 'community' in this thesis, it is in full recognition of the inappropriateness and ambiguity of the term.

EMPOWERMENT

'Participation' as a process of 'empowerment' is in rhetoric, if not in practice, becoming very much the standard rural development strategy, particularly by NGOs in Bangladesh where structural change or redistribution of common assets are fundamental objectives. These implicitly require enhancing the political and economic strength of the poor, or 'target group', such as women. Thus, like 'participation', 'empowerment' is now a key concept in development discourse, to be found in most NGO literature on women, rural development, poverty alleviation, and so on. But just as 'participation' has gathered an exhaustive collection of interpretations, 'empowerment' is also an ambiguous concept.

In its very basic sense 'empowerment' means people "gaining the ability to do things, to set their own agendas, to change events, in a way previously lacking" (Young 1993:158). Looking at 'empowerment' with regard to gender relations and women's status (as has been the empowerment-focus of Muhilar Shasto's programme) from a feminist perspective, the meaning is more political and "involves the radical alteration of the processes and structures which reproduce women's subordinate position as a gender" (Young 1993:158). This requires a historical and holistic analysis of the past and present contexts creating and

reinforcing this position. The central argument is that subordination is founded on the "control of female sexuality and procreation, and the sexual division of labour which allocates women a heavy burden of responsibilities while denying them control of valuable social resources" (Young 1993:158). These structures of male dominance are internalised by both men and women, and until they are identified and changed, Young argues, they will continue to reproduce this subordination. Collective empowerment of women, rather than individual empowerment, is necessary to bring about these changes; only the force of collective action by women can effectively shift the focus of policy and development to respond to women's needs.

Muhilar Shasto's programme demonstrates this point well. Their approach used the formation of women's groups to address local issues concerning health and women's social status, through developing a sense of shared experience and collective solidarity. The women expressed a need for economic assistance in the form of credit and work, and made demands on the NGO to provide this. It had not been part of the programme plans but the degree of pressure which their collective solidarity within the groups exerted on the organisation eventually led to the introduction of a credit programme. This process involved a number of complex problems, including pressures from parties external to the groups (i.e., other NGOs and male influences), which created internal conflicts within the groups, threatening the future of some and creating difficult relations with Muhilar Shasto's staff. However, the final result was a notable example of the power of women's collective action over development planning. The processes involved are analysed in detail in Chapters 8 and 9.

Young (1993) presents 'empowerment' as a radical alternative to the more common economic, individualistic, self-reliant approach, which concentrates only on drawing women into the local economy through self-employed income generating schemes. Within the context of Bangladesh, advocating empowerment of the poor and women in an approach which combines collective action through institution building, with enhanced economic status through credit assistance, has come to be a popular approach amongst NGOs. This approach is espoused in the development rhetoric of some of the largest and best known NGOs in the country, like BRAC and Proshika (see Montgomery, Bhattacharya and Hulme n.d., and Hashemi 1990 for critical analyses of the effectiveness of these programmes). The theoretical underpinnings of such an approach, as elucidated by Kramsjo and Wood (1992) in their study of Proshika, are based on recognition that the 'chains' of patron-client

dependence characterising the socio-economic structure of rural Bangladesh, are extremely strong and resilient to challenges. Kramsjo and Wood argue that this rural structure of vertical dependence makes it difficult to build a sense of class amongst the poor and hence it is difficult to develop a programme of action leading to structural transformation. They state that

> the problem, then, is not the awareness among the poor of their exploited condition, but the degree of sophistication in that awareness together with the objective capacity to act on it (1992:8).

From this theoretical perspective, institution building to develop collective solidarity amongst the poor is, therefore, an essential element in the process of developing the poor's capacity to break the chains which bind them in poverty. Kramsjo and Wood's study shows how Proshika's work has led to some significant impacts on local structures; however, research by Hashemi (1990), and more recently Montgomery et al (n.d.), shows that this is not always the case. In practice, the outcome of attempts to empower the poor through institution building is not always as positive as the rhetoric implies. Montgomery et al discuss this in detail with respect to BRAC's programme. Their findings show that in the process of rapid expansion which the organisation has undergone its priorities are more centred on institutional self-preservation and credit-orientation than their participatory rhetoric implies (n.d.:78). Montgomery et al conclude that, with expansion and consequent changes in approach which inhibit active participation, the likelihood of BRAC's programme facilitating empowerment of the poor is significantly reduced (n.d.:78). This supports my own analysis of BRAC's programme, based on my experiences of their grass-roots level activities in the Jessore area. In Chapter 9, I discuss this divergence between rhetoric and practice from the perspectives of villagers in my research area, and Muhilar Shasto and their field workers.

Participation in Rural Health Care

There is a large amount of literature on community participation in health care, particularly the works by Peter Oakley (1989) and Susan Rifkin (1990) for the World Health Organisation, Rifkin's other publications (e.g., 1981, 1983a&b, 1985, 1986), and the works of Twumasi (1981), Nichter (1984), Askew (1989), Hye & Quddus (1990), Ladbury (1991), MacCormack (1992). I shall therefore merely outline the basic theoretical premises before moving on to look at this more critically from a gender perspective. This perspective has surprisingly been somewhat overlooked in the literature.

There has been a strong emphasis on community participation in primary health care since the immediate post war period, when it was recognised that the curative, hospital-based, technological approach to health was inadequate for improving the health of the majority of the world's population. It was realised that rather than a 'top down' health service dominated by medical expertise, a 'bottom up' community-based preventative approach would be more effective and appropriate in reaching the poorest and neediest in rural areas. This approach recognised the need to consult and involve consumers of the service - client communities, or 'beneficiaries' - in order to prioritise and address their differing health needs. They, therefore, needed to be active in decision-making, planning, and implementation of services. The recognition of the potential of the population in developing effective health care culminated in the concept of 'primary health care', defined in the declaration at Alma Ata in 1978, by the World Health Organisation (WHO) and the United Nations Children Fund (UNICEF). Primary Health Care was defined as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford" (Rifkin 1990:2).

In the primary health care approach the community is seen as the key to successful health improvement and disease prevention; it is recognised that there is great potential in both the human and material resources within a community which members can utilise and contribute towards their own health and development, rather than depending on external resources and medical professionals. There is also an emphasis on broadening the definition beyond just health services, to a more integrated concept of primary health care and development, including improvement of water supplies and sanitation, nutrition, functional education and income generation. The detailed activities of a primary health care programme are discussed in Chapter 4 using the example of Muhilar Shasto's programme. For the present I shall concentrate on the varying nature of community participation in such programmes.

Rifkin (1990:11-15) identifies five levels of community participation in health programmes: The first is a very passive form where people participate in the benefits of the service. Participation involves merely accepting the services offered, such as immunisation or contraception, and attending community-based clinics. Participation can be equated with simple acceptance. Secondly, there is participation in programme activities which may involve contributing resources such as land, labour and money. Community health workers who may be paid or

voluntary, play an active role in the programme but their activities are defined by the planners, not by themselves or the community. Participation therefore takes the form of agreement to carry out the decisions and priorities of others. Thirdly, there is participation in implementation, whereby community members run different activities, for example, nutrition clinics or group discussions, and take on managerial responsibilities. They make decisions about how to run the activities but these are still initially planned and decided on by others, who also define the objectives of the activities. Village committees set up by a project to manage local activities have this type of role; they have a certain amount of decision making responsibility but the project's staff supervise this. In this sense participation is active but the community still do not have control over the programme.

Fourthly, there is participation in monitoring and evaluation. This is a less common participatory role but with the current emphasis on 'participation' in all aspects of programme development, it is becoming more popular. It involves the community's participation in evaluating whether the programme has achieved its objectives, and analysing the reasons for successes and failures. Community members are trained to carry out surveys and basic evaluation techniques (Feuerstein 1986) and are able to suggest modifications to objectives, but not to actually determine them. Finally, there is participation in the planning process, which is considered the ideal, and which is again uncommon and most difficult to achieve. This occurs generally when the inspiration for a programme comes from members of the community itself, usually leaders or influentials, who perceive a local need for health services and seek assistance, expert knowledge, resources and so on, from government, or other sources. Community members design and plan the programme with outside assistance, and control the decision making processes. In this type of programme the levels of participation are very broad, such that some community members may still only receive the benefits, whilst others may participate in greater degrees up to the planning level. The latest trend in programme planning, known as Participatory Rural Appraisal (PRA), is intended to involve the community at this level (Chambers 1992, IEED 1991).

This framework for analysing levels of participation in a health programme is not hard and fast, and not all programmes can be neatly fitted into the different categories defined. Indeed, in all programmes there will be people who participate to differing degrees by choice as well as by programme design. As Rifkin's research (1986) found, there is a tendency for people to regard health programmes as the domain of medical professionals and not to want to get involved or take

responsibility for them. She says, "[health] planners assumed that communities wanted a much larger role in programmes than many community members actually did want" (1986:161), and the reason was that they did not see health as a main priority. Their motivation to participate was much greater in activities for housing, food production and income generation, to which they gave higher priority. Her findings, therefore, strongly support integrating health care with other community-based development activities. I examine the nature of community participation in Muhilar Shasto's programme in Chapter 4, on health care intervention. Here I wish to deepen the analysis and look at an aspect of participation which this framework does not address. This is the issue of gender, particularly the relations between men and women which determine the level at which women can participate in, and benefit from, the health programme.

A Gender Perspective on Participation in Health Care

Health planners speak of empowering women to improve and maintain their health status through education and knowledge of preventive and curative measures, improved health skills and enhanced adeptness in dealing with family health care (MacCormack 1992:831), and developing the power to make real choices concerning health care programmes. MacCormack argues that by teaching women primary health care skills "their legitimacy to command technologies and 'produce' health in the community is enhanced" (1992:831), and that this is a process of social empowerment, having an impact beyond merely addressing women's health status. However, in considering these claims and analysing the activities of Muhilar Shasto's MCH programme, I found that the solution to improving women's health status is far more complex than these strategies imply. Being aware of women's specific health needs and designing a programme of service provision to address them without taking into consideration the wider context of factors which influence women's health and social status, such as gender relations, ultimately fails to have a long-term impact. This has basically been the short-coming of the Women in Development (WID) approach of development agencies; i.e., exclusively focusing on women and assuming that they can be the sole agents of their destiny, without corresponding changes in, or reactions from, men (Young 1993:130). 'Gender' has

'Gender' has been used to refer to 'sex' rather than the social appropriation of biological 'sex' (Rathgeber 1990, cited by Young 1993:129[3]).

Hence, although the MCH approach focuses on and involves women, often as staff members or even managers (as with Muhilar Shasto), this does not mean that there is an inherent sensitivity to, and awareness of, gender issues in programme design and implementation. For example, Muhilar Shasto, despite being predominantly female staffed, did not have a clear gender perspective in its programme. The project was planned as an integrated MCH programme with the aim of addressing women's health status, primarily through 'targeting women' as the main beneficiaries. Men were not taken into consideration or actively included in the programme, mainly because they were seen to play an insignificant role in female health needs and the welfare of children and the family. It was also implicitly assumed that health advice and education, particularly regarding family planning, would reach the male population through their wives. However, because of cultural restrictions on social relations between husband and wife, this is often not the case: women are not expected to advise their husbands or challenge their opinion, particularly on sensitive issues such as birth control and contraceptive use.

Family planning and promotion of contraception are major aspects of Muhilar Shasto's programme, and so became a prominent subject of my research. Living amongst village women, who were the main targets of family planning motivation, it became obvious that there are many more factors at play concerning women's adoption of contraceptives than simply being 'motivated'. The slogan used by family planning agencies, 'children by choice not chance', implies that people, i.e., women, need to be given the choice to prevent pregnancy and that this is dependant on the availability of contraception. However, the choice equation is not this simple, there are many more factors which have to be added; socio-economic considerations, cultural beliefs and norms, perceptions of side effects, religious proscriptions, gender relations and power hierarchies in the family, patterns of decision making, and so on. All these factors are outside the control of women but programmes often do not recognise these restrictions. Within the household a wife's decision making power is very restricted and major decisions such as the acceptance of contraception and the method used, are dependent on the attitude of

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[3] See Young (1993), Kabeer (1994) and Moser (1993) for discussions on the appearance of women in development policy.

her husband and very often her mother-in-law (if according to custom she is living in her husband's home). The wife's opinion may play little or no part in the final decision. This, therefore, emphasises the importance of widening the focus of family planning programmes from exclusively targeting women of reproductive age to recognising the roles that men and other influential figures (mothers-in-law) play in controlling women's sexuality and fertility, and recognising the need to actively involve them in the programme. This gender perspective on family planning policy and programmes is presented in Chapters 5 and 6.

This same argument is relevant to all aspects of the Maternal Child Health approach, as discussed in detail in Chapter 4. For example, women's access to health facilities, such as community-based clinics, is dependent on the granting of permission by those having authority over women, their husbands and/or mothers-in-law. Even when clinics are held in their own village many husbands refuse to allow their wives to attend because of the cultural restrictions of *purdah* (seclusion) which limit a woman's social and physical mobility[4], as a form of maintaining family status. For women in higher status families, or those with religious influence, attendance at a clinic, unless right on their doorstep, may be impossible. This was the case for the married women in the household in which I stayed.

Targeting women in this way not only excludes men but also tends to address women solely in their reproductive role as 'mothers', preventing a wider perspective which recognises their heterogeneity as a group. Not all females fit into the maternal category; young girls and elderly women also play important roles in health care and family welfare, e.g., looking after children, cooking and collecting water. Within female hierarchies, elderly women may have authority over decisions concerning other women in the household, particularly young wives, and they also need to be included in education on antenatal and postnatal care, safe deliveries, child care, sanitation and hygiene, nutrition, etc. These different categories of females also have their own specific health requirements and interests which are not usually addressed by MCH programmes[5].

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[4] For detailed discussions of *purdah* see, e.g., Papanek (1973, 1982), Jeffery (1979), Abdullah and Zeidenstein (1982), White (1992), Gardner (1994).

[5] The Bangladesh Population and Health Consortium (BPHC), which funds Muhilar Shasto and various other NGOs, recognises that adolescent girls have particular needs and has

Another important issue related to women's health status which is overlooked by the MCH approach is domestic violence. In my research area, and Bangladesh in general, it is very common. Although I did not specifically address the issue in my research I was constantly aware of the extent to which it occurred, from horrific articles in the newspapers and incidents reported in the village, often resulting in suicide or murder. During June and July my diary became full of stories of 'suicides', some real, some cover-up murders, often, I was told, the culmination of an unhappy marriage, or the failure of the bride's family to pay her dowry. These cases were very rarely followed up by the police and were treated almost as a matter of course in village life. Sometimes women would be beaten as an indirect result of the programme, for example, for taking contraception without their husband's permission, attending the satellite clinic without permission, or not receiving a loan from the credit programme. Although Muhilar Shasto recognised violence as a problem and discussed it in the women's groups, there was no specific project policy on how it could be addressed at the organisational level. Garcia Moreno and Piza-Lopez (undated) call for a review of the primary health care model, which analyses more thoroughly the factors impinging on women's health status and recognises domestic violence as a women's health issue (see also Heise 1993, Fauveau and Blanchet 1989, and Blanchet 1991).

I therefore argue throughout this thesis that empowering women to have greater control over their health, fertility and life does not concern women alone, but involves a change on the part of both women and men; if women are to gain more power and control over their lives men have to be prepared to relinquish some (Young 1993). Like women, they need to perceive personal benefits in doing so, such as a reduction in maternal and infant death locally, reduction in local population growth and consequent pressure on scarce resources, better nutrition and general family welfare, reduced doctors bills from illness, and so on. This means having a gender perspective which recognises the roles of both women and men in health care, rather than narrowly focusing on women alone. Rather than remaining with the exclusive focus of the Women in Development approach, MCH-FP programmes need to broaden their perspective to a Gender and Development (GAD) perspective which analyses the structures and processes giving rise to women's disadvantage (Young 1993:135). There is a growing body of literature on

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designed a programme to try and address these, but at the time of my research it was only in the early stages of experimentation in a few NGO programmes.

the gender and development debate which I am unable to cover here, but which underpins this (for example, Boserup 1970, Afshar 1985, Young 1989, Tinker 1990, Ostergaard 1992, Moser 1993, Cleeves Mosse 1993).

SELECTED LITERATURE ON HEALTH AND GENDER IN BANGLADESH

Since a number of different subjects are covered in this thesis, ranging from local health practices and beliefs, modern health interventions, population and family planning issues, women's empowerment and credit, to the impact of scaling-up development programmes, it is extremely difficult to give here a comprehensive review of the literature relating to my work. What I shall therefore do is refer selectively to those texts which I have found most useful, and in relation to which my research can in some way be situated, as a contribution to knowledge on the subject of health and community-based development in Bangladesh.

The work of Mark Nichter in India was, in fact, the first inspiration for this research. His PhD thesis, *Health Ideologies and Medical Cultures in the South Kanara Areca-Nut Belt* (1977), subsequent publications in journals (e.g. 1980, 1983, 1987; latter two jointly with Mimi Nichter) and his book *Anthropology and International Health* (1989), cover many subjects which this thesis also addresses. His works concentrate on socio-cultural aspects of health care and the implications of these for the implementation and effectiveness of health services. In my research there is much overlap with his findings in India and Sri Lanka concerning, for example, local perceptions of contraceptive methods and how they work (1987, 1989), and contradictions between medical health advice emphasising the desirability of large birth-weight babies and local preferences for small babies (1980, 1983). His work therefore provides very valuable comparisons with ethnophysiological and ethnomedical systems in Bangladesh. *Labour Pains and Labour Power* (1989) by Patricia and Roger Jeffery and Andrew Lyon has also provided initial inspiration and comparative material. It examines the socio-cultural aspects of health, in particular childbirth, in India, locating these in the wider socio-economic and political environment of rural society.

A number of studies specific to Bangladesh have helped shape the main ethnographic foundations of this research. Therese Blanchet's *Meanings and Rituals of Birth in Rural Bangladesh* (1984) is one of the most detailed anthropological studies on women and fertility and the role of traditional birth attendants (*dais*). My own

research follows on from this, looking at how traditional concepts and practices accommodate modern maternal-child health care interventions, and vice versa, how these interventions utilise the existing skills of local *dais*. Blanchet's subsequent studies on savings and credit (1986), violence (1989) and maternal nutrition and birth practices (1991) have also provided valuable inputs to the different subjects in this thesis. Maloney, Aziz and Sarker's book *Beliefs and Fertility in Bangladesh* (1981) has also been a major contributor of comparative ethnographic data, particularly concerning contraception and attitudes towards family planning. Their extensive research, based on anthropological methodologies and survey data, is rich in quotations and details of villagers' attitudes and beliefs concerning fertility, and was conducted primarily for the use of those involved in population policy and planning. Aziz and Maloney's subsequent book, *Life Stages, Gender and Fertility in Bangladesh* (1985) adds to this study of fertility, an understanding of different social roles at different stages in the life cycle. It focuses on socialisation processes relating to sexuality during childhood, adolescence and adulthood, and achieves surprisingly detailed insights into the culturally sensitive subject of sexual behaviour, such as I have not read in other research.

Another influential author on the socio-cultural aspects of health in Bangladesh is the anthropologist Sushila Zeitlyn, who has produced detailed studies for the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and other development agencies (e.g.,1993) and journal publications (e.g.,1991). Her most helpful work in relation to this study is *Feeding Practices in Bangladesh With Special Reference to Pregnant, Postpartum and Lactating Women and Infants and Children: A Review of the Literature* (1993). It provides a very useful overview of a wide range of studies conducted at household level, and identifies some of the social factors, such as preference for boys, which determine a characteristic difference in nutritional status between males and females. It also analyses important beliefs and practices related to dietary restrictions on pregnant and postpartum women and the implications of these for low birth-weight babies and neonatal deaths. Perceptions of breastmilk and colostrum, weaning practices and feeding during child-illness, are other crucial areas of research covered by the review, which finishes with practical suggestions for future research. The work of Mahmuda Islam, *Folk Medicine and Rural Women in Bangladesh* (1980) and *Women, Health and Culture* (1985), adds to these qualitative studies in the area of indigenous health practices and treatments, and beliefs of illness causation.

Many studies have also been done with a more demographic focus using quantitative methodologies, particularly through the ICDDR,B research programme in Matlab, on a variety of subjects related to maternal and child health, most notably contraceptive use (e.g., Bhatia and Kim 1984; Seaton 1985; Phillips, Simmons, Koenig and Chakraborty 1988; Mahmud 1991; Cleland and Mauldin 1991; Caldwell & Caldwell 1992; Koenig, Rob, Khan, Chakraborty and Fauveau 1992). The strong emphasis on statistical data of, for example, Amin, Mariam & Faruqee (1987), does however, limit their contribution to furthering knowledge on the socio-cultural aspects of health, and hence their utility for this thesis.

Finally, I shall mention the literature on women and gender in Bangladesh which I have found most useful, and some basic ethnographic works. Sarah White's study *Arguing With the Crocodile: Gender and Class in Bangladesh* (1992) examines the significance of women's work and power with regard to gender relations and argues that it is not what women do but the relationships within which they do it that is important. Thus, she challenges the apolitical framework within which women have been represented in academic studies and development discourse, the latter of which she argues, has significant influence in shaping the gender debate. She presents gender as a contested image which is constantly being defined and redefined by context and negotiation, and aims to breakdown the separation of the focus on 'women' from the broader community, looking instead at the ways in which activities of men and women relate to class and gender divisions. She states: "What is important, is to distinguish the fact that people in society are always gendered - male or female - from any assumption about what the significance of their gender might be" (1992:144). This and her other work on poverty alleviation programmes in Bangladesh (1991) have been useful, particularly in analysing the empowerment approaches of women's credit programmes, as discussed in Chapter 8. I should also mention the work of Abdullah and Zeidenstein (1979 and 1982) for their contribution to studies on village women and the implications for development programmes. Finally, I will mention in particular Arens & Van Beurden's *Jhagrapur; Poor Peasants and Women in a Village in Bangladesh* (1977), Van Schendel's *Peasant Mobility: The Odds of Life in Rural Bangladesh* (1981), Hartmann and Boyce's *A Quiet Violence: View From a Bangladesh Village* (1990, [1983]), and Jansen's *Rural Bangladesh: Competition for Scarce Resources* (1990, [1987]) as important ethnographic village studies of rural Bangladesh. There are, of course, many more works which I have not had space to include in this brief review, but which will be referred to within the body of the thesis where appropriate.

CHAPTER 2
REFLECTIONS ON THE RESEARCH PROCESS

EARLY DAYS AND FIRST IMPRESSIONS

I received funding to do this PhD from the Overseas Development Administration (ODA) of the British Government under the Associate Professional Officer Scheme (APOS). The scheme provided a total of three years and four months funding, from October 1990 to January 1993, and approximately eighteen months of this time (October 1991 to April 1993) were spent in Bangladesh on fieldwork, attached to an ODA project, called the Bangladesh Population and Health Consortium (BPHC). Previous to this I had only visited Bangladesh for two weeks as a preliminary visit to acquaint myself with the country. Therefore, when I arrived in Bangladesh in October 1991, I had very little idea of what I was about to embark on.

My knowledge of the country was based on extensive reading, horror scenes of natural disasters presented by the media and experiences of the brief visit in March of that year, just before the devastating cyclone. If I had had only the former two sources to prepare me, I would have been extremely anxious about surviving the year without being washed away by a cyclone, tidal wave or flood, being caught in the cross-fire of a military coup or civil uprising, or wasting away to nothing due to lack of food - images the media feeds to the rest of the world as representative of normal events in Bangladesh. Thankfully my brief visit sketchily filled in the huge vacuum remaining in the picture of 'daily life' that these images exclude: people going about their business in bustling, noisy Dhaka; the beautiful panorama of the green patchwork countryside; country boats sailing calmly down the river; the laughing of women in the village as they sit chatting whilst preparing a meal; men in the fields tending to the paddy - pictures of normal, everyday life. The warmth and hospitality I was shown by NGO staff and village women made the sight of bullet marks on the walls of the university and stories of violence towards Westerners during the Gulf War, fade into unwarranted paranoia; the country endeared itself to me instantly.

A fear that never left, however, as I visited an NGO on the island of Hatiya in the Bay of Bengal, was the possibility of being caught in a cyclone. I had heard so many tragic stories in Dhaka and these were told again by women I met on the island who had lived through numerous disasters, many losing members of their families and some losing their homes up to seven times over the years. I was taken to the end of the island and shown the incredible erosion that occurs as a result of frequent severe cyclones and annual tidal bores. This seemed hard to believe as the weather was calm and sunny, the island quite beautiful, bursting with vegetation and the attitudes of the people so apparently unconcerned about the constant threat to their lives. The only thing that stood as a reminder was the large, angular, concrete cyclone shelter towering above the little house I slept in. On the two nights I stayed I dreamt about tidal waves, but always survived, waking with absolute terror at the vividness of the experience. Two weeks after I returned to England I switched on the news only to see that my nightmares had become a reality; Hatiya had been hit by the worst cyclone in its history and my little house had been washed away, I had survived. I was shocked. The images on the screen were no longer just 'typical pictures of life in the third world'; images that people in the west find so hard to relate to and can only really comprehend as tragic, but stereotypical of poor countries far away. Had I not visited I too would have felt this superficial sympathy for the victims, and been further convinced that Bangladesh was a dangerous country to live in and had second thoughts about going.

However, my personal experience of the place gave me a different perspective. I knew the people who had been affected, it was all very real and very horrific, the stories of their plight and strength and determination to overcome it, echoed in my head. They had only just rebuilt their lives after the last disaster and now they had been destroyed again. This time had been particularly severe, but these events were actually a matter of course in their lives and they had developed their own strategies to cope and carry on. They were not the helpless, pathetic, poor portrayed in media coverage, reliant on invoking sympathy and cash donations from other countries. They were victims of circumstances out of their control, both natural and political, but were working with the aid of an indigenous NGO to change this. Media coverage showed only images of helplessness but I was instead provoked into feelings of respect and admiration for their struggle to survive and courage to overcome their circumstances, rather than sympathy for the hoplessness of their poverty. My experiences in the eighteen months of my following visit to Bangladesh reinforced this respect; there is so much to be learnt from the resilience

and resourcefullness of people who have so little and live such difficult lives, and yet this is rarely recognised by those more fortunate.

FINDING A RESEARCH AREA

So, despite nearly being caught in one of Bangladesh's worst tragedies since the floods in 1988, I returned willingly and enthusiastically, if somewhat apprehensively. The morning after my arrival I found myself in language classes and spent the next six weeks in Dhaka and Pirojpur, a rural area in the south, learning Bengali and becoming acquainted with the country. On my return to Dhaka in December, and eager to try out my new skill, I began the difficult task of selecting a field area for study. I was to be based with an NGO funded by BPHC in Dhaka, and the problem of deciding which was not easy. Some were eliminated by their location in areas which had distinctive dialects requiring another few months to learn; time I didn't have. This eliminated all projects in the northeast and southeast (Sylhet and Chittagong districts), leaving the west open to possibilities. With the help and advice of the BPHC coordinator, Fiona Duby, and a vague set of criteria prioritising a rural-based MCH programme with an ethos of community participation, we narrowed the choice down to seven and I set off around the country to visit them.

The selection process was very much based on gut-feeling but some were quite obviously inappropriate, for their large size or semi-urban location. The final choice was, however, very tough indeed and I felt for a long time afterwards that I had made the wrong decision, despite feeling happy with it initially. On my first meeting with Shameem, the project manager of Muhilar Shasto, I felt a great sense of trust and honesty which I had not felt in other places and the closeness of fit to my criteria, with the added interest of being a female-run project (which was unusual), convinced me that it was the correct choice. Community participation was not a strong element but I felt that it would be just as interesting to examine why it wasn't and see how the programme developed over the year. It was, in fact, the last project I visited and time was running away, I had been granted twelve months fieldwork with extra time for language training, and it was now January. I finally left on 4th February 1992, to join Muhilar Shasto in Jessore, near the Indian border in the southwest.

One of the main bonuses of chosing Jessore district was that people spoke very clear Bengali, as I had learnt it. Village language was slightly colloquialised but still very similar and decipherable. The question of having an interpreter-come-research assistant was raised but I was very unsure of the wisdom of this. I felt, based on advice and my own instinct, that it would be more of a problem than a help, making me reliant on their language rather than my own and adding another tier of interpretation to the translation. Besides, there weren't too many suitable people available (female, good English speaker). Who wants to spend a year living in a village when they have strived through gaining a good education, to distance themself from it? I chose, therefore, to go without and rely on developing my own language skills and it was a choice I never regretted.

My Role as Anthropological Researcher

I decided it was best to shirk my ODA connection and explain that I was a 'PhD student', to try and distance myself from the connotations of working for a donor agency, i.e., money and power, neither of which I had. However, because I was unavoidably introduced to Muhilar Shasto by BPHC, my association was known. I was greeted at Jessore airport by Shameem, the project manager, with garlands of flowers and a hired car, at great expense. Fearing the 'honoured guest' treatment would continue and feeling most uncomfortable with it, I explained I too was in fact a recipient of donor's funds, rather than a disperser of them, and certainly not a *boro lok* (literally 'big person'), merely a student. It would have been quite understandable for Shameem to disbelieve my words of assurance and view me as a 'spy' from the donors, and insist it would be too difficult for me to conduct my research in that area, but she didn't. Having just graduated with a Masters in management she was able to relate to me as a student quite easily and with great interest in the fact that I wanted to do research. This was her first job after graduating, she was the same age as me and spoke very good English. We hit it off instantly. In our first meeting she was very open about the difficulties of her work and of the project, such that the foundations of honesty and open discussion were laid from the beginning. It seemed almost too easy to be true.

Finding a Home

Once I had settled on the NGO I would work with, the next problem was finding a suitable place to live; would I stay in the little *upazila* (now called *thana*, meaning

sub-district) town of Amhat[1] and travel to and from the different villages that made-up Muhilar Shasto's working area, or would I select one particular village to stay in? My preference was the latter, I wanted to live under the same circumstances as the 'beneficiaries' of the project, who lived in villages rather than the little town. In fact, I decided to live in one of the most isolated of Muhilar Shasto's working areas, to experience the types of problems women (who are the main target of their MCH programme) have in utilising the locally available health facilities in Amhat.

Another criterion in looking for a village was the presence of women's *samitys*[2] (women's groups started by Muhilar Shasto). I felt the most evident form of community participation in the programme was the women's group formation and so decided it would be important and insightful to follow the development of some of these groups. They were initiated as savings groups and met on a weekly basis with the Family Health Visitor (FHV) to discuss various issues, primarily concerning health care. This was a relatively new element in Muhilar Shasto's programme and had not been started in every working area, thus eliminating quite a number of villages.

The other important criterion was that the FHV should live in the village. Due to difficulties in recruiting women from the villages with sufficient education (class 10, or 8-10 years), it was necessary to recruit from the general area. This meant that FHVs would come and go, often staying with a family in the village during the week and going home at the weekend (Friday). I wanted to be somewhere where the FHV was herself a village member by birth or marriage, and so always available for me to accompany her on daily house-to-house visits when I chose and also because she would be a good source of information on the village.

Shundurgram, the village I finally selected, had all these factors: it was isolated, being about six miles from Amhat without any proper road or electricity. There was therefore no public transport; the nearest bus was over an hour's walk and it took about an hour to cycle to town, depending on the weather. The FHV had married

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1 This is not its real name.

2 *Samity* is pronounced shomity, but is written as the former by BHPC, Muhilar Shasto and most other development organisations. It means association, society or organised group.

into the village from Jessore town. There were three *samitys* formed and another in the neighbouring village served by a different FHV.

I felt the development of the women's groups would become a primary focus of my research and so requested to stay in the house of a member and was very fortunate to find one whose *bari* ('homestead') had a spare room - a very rare occurrence indeed. I had expected to need to build a mud hut in someone's yard and so was delighted to be offered a rather nice little brick room in a predominantly brick *bari*, which indicated the higher economic status of the family. The *samity* member was in fact a sister in the house. She had been divorced by her husband about six years before and so returned to her father's home. His first wife had died and he had remarried and moved into another house, leaving this to the oldest brother and other siblings.

The *bari* therefore consisted of: the oldest brother (*boro bhai*), his wife (*bhabi*, used to refer to the senior 'sister-in-law') and three daughters (their 10 year old son was at school in Jessore); the third brother (*shezer bhai*), his wife and two sons; the *samity* member, who was the third sister (whom I refer to as 'my sister' and whom I became quite close to); and a sister (about 18 years old), the youngest child of the first wife, who was married in the last month of my stay. I took on the role of another sister, and was called 'sistar' by *bhabi* and *appa* (meaning 'sister') or *Rose appa* by everyone else except the children. Those in my *bari* called me 'anti' (as in auntie, an Anglicised term *bhabi* taught them) and others used *kala ma* (meaning 'mother's sister'). My 'father' and various other older men, including my *boro bhai*, called me Rose, a fitting first name address from a senior male to an unmarried female, or daughter.

WHO AM I?

After a few months, when I became settled in my new environment, my relationship with Shameem began to develop into one of work acquaintance, friend and confidant. This could have meant rather distanced relations with the rest of the staff. However, the fact that I spent the majority of my time in the field with them and chose to live in a village rather than Jessore town, helped to erode the social distance between us and to create good friendships. I spent a much greater amount of time in the village with the fieldworkers than I did in the office and sometimes found myself in an awkward but interesting situation of middleman, receiving grievances, complaints and secrets from all sides. FHVs would complain to me

about problems with a supervisor and vice versa, and Shameem would discuss with me problems relating to particular staff that she could not share with anyone else. I was a willing and interested ear to all.

In the village my role and purpose was much less clear to people. I was automatically associated with Muhilar Shasto since I spent so much time with the FHV, and many people logically thought I was part of their staff. I tried hard to deny a formal connection because of my intention to explore the relationship between the NGO and community, and felt that if people thought I was part of Muhilar Shasto they would not speak openly and truthfully to me. However, no matter how much I insisted I was just a student come to learn about Muhilar Shasto's work, many remained unconvinced. It was very difficult to try and explain what 'research' was, let alone the meaning of 'anthropology', so I told people I was interested in health care and medicine. This automatically lead to the conclusion that I was either a *daktar* (meaning any kind of trained or untrained medical practitioner), or learning to be one. This assumption concerned me to begin with because I did not want people to think I was more knowledgeable on the subject than the FHV and somehow usurp her authority. Or that I was more knowledgeable than they and so make them feel intimidated to talk about their own perceptions. I therefore claimed complete ignorance but expressed a strong desire to learn. I came to realise, however, the term *daktar* was attributed to anyone with a connection to modern medical practices, such that the FHV and Traditional Birth Attendant (TBA) were both called *daktar*, as were the local untrained village allopathic practitioners. Consequently, my mere attendance with the FHV at people's houses qualified me, in their eyes, to be called a *daktar*. The label was applied so freely had I identified myself as one it wouldn't, as I initially assumed, have changed many people's perceptions of me, but would simply have helped them slot me into an existing social category, which befitted my social status. *Daktars*, by definition of their connection with 'modern' technology and income earning capacity, are generally of high status.

Denying my attachment to Muhilar Shasto and my status of *daktar* but expressing a desire to learn about these things, left me an anomaly in local experience. If I wasn't going to become a *daktar* why was I learning about it, and if I didn't have a job, where did I get my money? My broken, waffley explanations of 'doing research' were rarely satisfactory and I found that by far the easiest way to be introduced was by leaving it up to others to explain who I was and what I was doing. This they did according to their own understanding and in terms easily comprehensible within

village experience. It also proved to be quite an informative way of discovering how I was known and perceived in the community and amongst my friends. The most common answer given was "a student come to learn about life in Bangladesh", or "to learn Bengali". For most people these answers sufficed without causing too many suspicions or problems, the less satisfied would enquire, "but why do you want to learn this when you are rich and live in a rich country, why come and stay in a poor village like this?" The reply would often be made for me, "ah, if she stays here for one year and learns these things, she will be given a degree and get a good job!". Any kind of academic credit is highly coveted, particularly for girls, since it provides access to the best paid jobs. Their logical conclusion was if I was well educated I would attract the best husband; the attainment of a rich husband and a high status job, e.g., a government post, needed no further explanation. The fact that I was so old, at the grand age of 25, and still unmarried, was also a great mystery, but this explanation served perfectly to justify my spinster status: "Is it possible to study and be a good wife and mother at the same time?" I would ask. "I shall get married once I have finished my studies." The reason, although the reverse of village priorities, i.e., where studying would be forsaken for marriage, made perfect sense for a person of my economic standing. If my family could afford a good education and then marry me to an equally rich and educated husband, the benefit would certainly be worth the delay.

NOT A 'WOMAN' BUT A 'FOREIGNER'

I was the first foreigner most villagers had ever seen, the first *shada manush* ('white person') to come to the village and most definitely the first woman to be seen riding a bicycle. The village was so isolated the only practical way for me to be mobile between there and the office, six miles away, was by bicycle. The stir I created by doing this only marginally reduced over the twelve months. Cries from surprised onlookers or excited children would continually exclaim "look, look, a girl riding a bicycle!" My behaviour was a total breach of the fundamental norms of *purdah* to which women were subject, and it concerned me greatly that my inconsistencies with 'correct' behaviour might create a bad and damaging impression. Such a public display of immodesty, hair and *orna* (a scarf covering the head and chest) flying all over the place, face flushed and unveiled for all to see, would almost certainly have caused a scandal if it hadn't been for the fact that I was a *bideshi* ('foreigner'); an anomaly within the social system. I was a *bideshi* first, and a woman second, which

permitted me, to a certain extent, to step outside these norms and behave in an otherwise unacceptable way, without public criticism (to my knowledge).

In fact, whilst riding my bike, I took on an almost 'token-male' role, entering into an exclusively male sphere. For example, I would suddenly find myself sandwiched in the middle of a snake of men on bicycles making their way to the weekly *hat* ('bazaar'). Comments would be made, heads turned and speeds adjusted so as to ride along side me, or within conversational distance. I would then be trapped in conversation with a total stranger until our paths divided, answering time and again, the same old questions: "Where is your country?", "What do you do?", "How much do you earn?", "Have you a mother and father?". To begin with these inquisitions simply made me feel embarrassed by the amount of attention I attracted, and sometimes angered at the invasion of my privacy. However, as time passed and I became more familiar with social norms, particularly regarding the taboo of associations between women and strange men, my discomfort and occasional anger at these inquisitions took on a different form. I began to feel directly approaching me with questions and engaging in conversation was an intrusion not on my privacy but my 'modesty'. I felt that no-one seemed to treat me with the proper respect afforded a 'woman', as dictated by social conventions, (although on reflection such public performances made this not very surprising). According to these our interaction was unacceptable and quite shameful on my part. If I refused to speak, as an expression of modesty, they would simply persist until I did. I felt annoyed and angered in the belief that their behaviour (not mine) was ruining my reputation and tried my hardest to behave as modestly as possible. Since I was so blatantly contravening the norms of *purdah*, it was obviously felt that other norms could also be contravened.

However, the tone of voice, polite choice of words and nature of questions, indicated respect rather than contempt in men's attitudes towards me. I would be implored to stop and drink tea in the bazaar, a place where no self-respecting woman would ever want to be seen, including myself. But this was regarded by the offerer as perfectly acceptable and an insult to decline, which, however, I frequently did with apologises of "no time!". Hence, I was treated with a different set of rules to 'normal' women. I wasn't treated disrespectfully, on the contrary it was quite the opposite and to have been ignored by a person (man) of high social standing would have been rude. To be seen with me, particularly drinking tea in the bazaar and therefore socialising, was a tremendous status symbol. It was my status of *'bideshi'* (rich, powerful, educated) and not 'female' that, in this context, was of primary

importance, and it was a status appropriately attributed to men rather than women, hence the cross-over of gender norms which were applied to me. This ambiguity actually proved to be very helpful in the course of doing research as it allowed me access into situations where as a local woman, I would never have been permitted to go, and I used it to my advantage.

During my year in the village, I never encountered a rebuff or unpleasant word, nor caught wind of 'bad words' (*karap kota*) said about me, despite my unconventional behaviour. My *bhabi*, who observed very strict *purdah*, reassured me my walking around the village to visit others' houses was perfectly alright because everyone understood it was necessary for my studies. She said when it was first learnt I wanted to live in the village, one of the old women, with whom I later became very friendly, had been very disapproving, saying that white women were bad and shameless. But once she had met me her mind was changed. On the contrary, everyone said how modestly I behaved when in the company of men, such that I did not disgrace myself, or my new family. This talk eased my anxieties tremendously; I knew that my attempts to avert eye contact with men, turn aside on the road and hide my face with my umbrella were pathetic and minimal, and was relieved to have been allowed these freedoms without criticism.

Acceptance of my behaviour was, in fact, very much the result of the presence of Rohima, the FHV. She had been working in the village for three years, and had married the son of one of the richest families, thus becoming a 'village bride' (*gramer bou*). When she first began visiting people's houses, as a stranger from the town, her behaviour was severely criticised and she was considered an immoral woman. However, as she persevered and people came to understand the nature of her work and her intentions, she gained great respect within the community as an educated and skilled woman, who provided an important service[3]. Consequently, she brought about a change in attitude which was tolerant to breaches of *purdah* under certain conditions (i.e., her status instead being symbolised by her education and job) and which paved the way for me.

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[3] Simmons et al (1992) have studied how employment in family planning affects the status of female field workers, bringing social influence, a professional reputation and prestige.

A Growing Involvement

As time passed and my command of Bengali improved, my relationships quite naturally developed and I found myself wanting to become more involved in the activities of Muhilar Shasto, not just as an observer. However, at the same time I felt it was important to remain an 'outsider' as much as possible to preserve the unique view point I had from sitting on the dividing wall between being a 'villager' and being a 'Muhilar Shasto worker'. I was very much immersed in village life, which gave me the ability to understand how villagers perceived Muhilar Shasto's work, but at the same time my close association with the staff and project manager, gave me intimate knowledge and relations with them too.

In a sense my situation could be likened to Rohima's who, living and working in the village also saw both sides through playing the dual role of FHV and village wife, trying to balance out the priorities and obligations that both demanded. I, on the other hand, had no obligations to either side, I was independent and could manipulate my position to experience different perspectives more clearly. As time went on, this became harder as I became more settled in the village and developed a 'village' way of talking, looking and behaving. I underwent a visible but unconscious transition. People in town would comment on how my attitude and physical appearance were becoming more and more like a village woman, although I was largely unaware of it at the time. Shameem could always tell when I had come straight from the village, she said I had different characters, one for in the village and one for in town, and probably another for when I went to Dhaka amongst my foreign friends. This was very much emphasised by the different style and quality of clothes I wore, but my character also changed. In the village I was one person: ignorant, naive and incompetent, like a child going through the process of socialization, I felt foolish and frustrated at my inability to communicate properly. In the NGO office I was another: more comfortable and in control because of the familiarity of the surroundings and greater ease in communicating. And in Jessore town another: more relaxed and normal, protected by the privacy of my own room and ability to speak English with other foreigners. The difference between the first and the last was quite extreme and only I knew both. No-one from the village went to my house in Jessore and no-one from Jessore went to the village.

As I grew in confidence, experience and knowledge my involvement with Muhilar Shasto also began to change. I began to see things which they were unaware of, for example, problems developing in the women's group formation programme, and

began to share my observations with Shameem, through informal chats and discussions. She was as much an informant as she was a friend, and I learnt a tremendous amount from her by discussing my experiences in the village. She too learnt a lot from our discussions. Although I attended meetings my role still remained formally an 'outsider' and I played no active part in discussions or decisions made by project staff. I was aware that if I did, whatever I said would be considered 'correct' because of my educated foreign status and so I acted only as a provider of information. I was a new resource for them to utilise and could offer a different perspective, an outside view, on various aspects of the project.

GATHERING INFORMATION

My research method could more appropriately be called an 'approach', since method implies the application or observance of specified rules, the parameters of which one must remain within. There were no rules or parameters to my research approach as such, other than my loose interpretation of the principles of participant observation. In short, this meant keeping my eyes and ears open to what was going on around me and trying to balance out the best way to be in ten places at once so as not to miss anything! This involved tagging on to people as they attended various events, such as weddings, births and funeral preparations; listening and contributing to conversations and asking ignorant (often stupid) questions in order to be given the basic information that everyone else knew and took for granted; participating in various household activities; planting and watering the vegetable garden with *bhabi*; washing clothes and utensils; sitting-in on *samity* meetings, etc. There was no way of planning this type of data gathering, it was mostly gleaned from spontaneous events and passing conversations, things which simply happened in daily life. When I didn't understand something or wanted to verify a piece of information I would ask my most reliable and patient sources, *bhabi* and Rogina (the TBA). I passed many hours sitting in their cooking huts questioning them on the basic and finer details of things I was trying to understand, and they in turn questioned me endlessly on life in my country. They, more than anyone, put colour in the black and white pictures I was forming and were my main teachers and closest friends.

I did, however, develop a routine based on the daily activities of Rohima, the FHV, and the weekly staff meetings at the office. During the working week (Saturday to Thursday) I stayed in the village and based my days on Rohima's work schedule.

She would visit twenty *baris* every day, giving general health education, family planning advice and methods (pill and condom), education on antenatal and postnatal care, nutrition, and so on. Information concerning the health of household[4] members was recorded on files and cards. These records also held detailed information on the household structure: e.g., how many members, males, females, children between 0-1 years, 1-6 years and women between 15 and 49 years old; monthly household income; number of pregnancies; number of live and dead children, etc. This was very helpful because it saved me from having to do a basic household survey to get an idea of average household size, average number of children, income[5], etc. She also conducted a more detailed socio-economic survey on household assets, such as land ownership (both cultivated and homestead land) and ownership of cows, goats, ducks and hens, which assisted her in categorising households into socio-economic groups, depending on level of annual per capita income[6].

In addition to providing detailed information on individual households, more importantly, these visits also gave me direct access to discussions and local attitudes and perceptions about various health issues. Particularly to more sensitive subjects such as family planning and contraception, which were difficult to broach otherwise, especially with strangers. I learnt a huge amount from sitting, listening and observing the interactions between the FHV and women, my presence rarely causing any problem to women's openness. By visiting so many different

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[4] A 'household' is defined in academic literature as those people who eat from the same cooking hearth.

[5] It is debateable how accurate information on income was because it is a difficult thing to calculate, fluctuating tremendously from month to month, season to season and not being calculated only on cash from productive labour but also earnings from crops, land tenancy, business, payments in kind, non-monetary exchanges and so on. FHVs were told to take all these things into account for the period of a year, work out their monetary value, add them up and divide them by twelve to reach an average monthly household income. This is a very complicated calculation indeed, not least because of the amount of guessing and estimation involved both on her part and that of the informant. However, it was undoubtably a more accurate estimate than if I had attempted to find out for myself, having no knowledge of peoples landownership, etc. The FHV was at least in a postion to know if the information being given to her was true or approximately correct.

[6] Socio-economic categories of households were as follows:
A - less than Tk 2000 per person per year
B - Tk 2000-2500
C - above Tk 2500

In 18 months the exchange rate fell from approximately Tk67 to £1, to Tk55.

households (346 in Shundurgram in February 1992), some only once, some perhaps twice and others more regularly, it helped me to gain an impression of the variety of attitudes, perceptions and experiences people had concerning Rohima and her work. In this way it was possible to test things I had learnt from one encounter, on a number of other people, to establish their generality and my correct understanding.

My contact with men was, not surprisingly, far less than that with women, particularly amongst strangers. However, being very conscious of the need for male as well as female perspectives, I tried as much as possible to engage men who were around during our house visits in the discussions. In this official context this intercourse was acceptable and they were usually willing to talk. However, on a more casual level, when I was visiting houses alone, it was far more difficult to engage in conversation because of the social boundaries between men and women. It was impossible for me to approach men, other than those in my *bari* with whom I had close 'kin' relations. I had to be invited to sit and talk and this would invariably involve **them** questioning **me** with all the usual enquiries about my family, wages, education, eating habits and farming in my country. Rarely did I have the chance to return fire, and even then it was difficult to ask the types of questions I really wanted to know their opinions on, like family planning and contraception.

Consequently, I only really got the opportunity to discuss things at length with men whom I knew well through daily or regular social contact, i.e., the men in my *bari*, the labourer who worked for the family and ate in the house, my neighbour (the *samity* cashier's husband) and Muhilar Shasto's male staff, particularly Mahmud, Rohima's supervisor. It was also acceptable for me to sit and talk to 'professional' men, such as the local (unqualified) village doctors, or *daktars*, of whom there were several in the area. Three in particular served my *para* ('neighbourhood') and I often arrived at a house to find them treating a patient. The oldest and longest established was the one with whom I had most contact. The government EPI worker (Expanded Programme of Immunisation) also visited the village once every four to six weeks and presented yet another perspective on village health care.

Samitys met every Wednesday, usually led by the FHV, and my day was spent attending as many as possible, there being four locally, some with overlapping meeting times. Weekly staff meetings were held in the office on Thursdays, and on the last day in each month TBAs also attended a monthly meeting. I found these meetings extremely informative and insightful since the feedback from other staff enabled me to compare the problems and issues arising in Rohima's field, with

those in other areas. This was also a good time to sit in on consultations with the paramedic and clients in the office clinic. Every other day the clinic staff, consisting of a paramedic, councillor and *aiya* (cleaner-come-clinic assistant) would operate a satellite clinic, rotating on a monthly basis around the more isolated working areas[7]. Thus, once a month, I would also attend the satellite in Shundurgram and my neighbouring village.

After the Thursday meeting I would usually travel to Jessore with Shameem and we would discuss the week's events over tea at her house. There, I stayed with one of the few other foreigners in town, enjoying the luxury of a shower, privacy of my own room and the ability to lie-in in the absence of squawking ducks and children hammering on my door at 6am. Rejuvenated, I would return to the village on Saturday morning.

I would also visit Dhaka for a few days about every six weeks and discuss with Fiona, my ODA contact at BPHC, and other friends working in the development field, the progress of my research. Having no-one with an objective interest to discuss it with in Jessore, I found their comments and advice very helpful and they were also able to put me in touch with other useful contacts. The wealth of foreign and indigenous NGOs in Dhaka harboured another important source of information on NGO activity in general, and primary health care activity in particular. Some of those I visited included CONCERN, CARE, Save the Children Fund, GTZ, BRAC, WIF, UNICEF and Grameen Bank. I found 'networking' amongst these different organisations very helpful in forming a wider perspective on development issues in Bangladesh.

BPHC were very interested in my observations, particularly regarding the development of women's groups, and invited me to give a presentation at their annual workshop in September 1992. This was attended by representatives from all 39 NGOs receiving BPHC funding and was an extremely valuable experience enabling me to discuss these issues with other NGOs. Through these contacts I was able to visit other field areas, which helped in gaining a comparative perspective with that of Muhilar Shasto. Again, the wider experience was very important in preventing me from forming an image of MCH programmes based exclusively on

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[7] This system changed towards the end of my stay when a second clinical team was recruited, enabling satellite clinics and the main clinic to run daily.

the example of Muhilar Shasto, although ultimately their's is the only example I shall use extensively in this thesis.

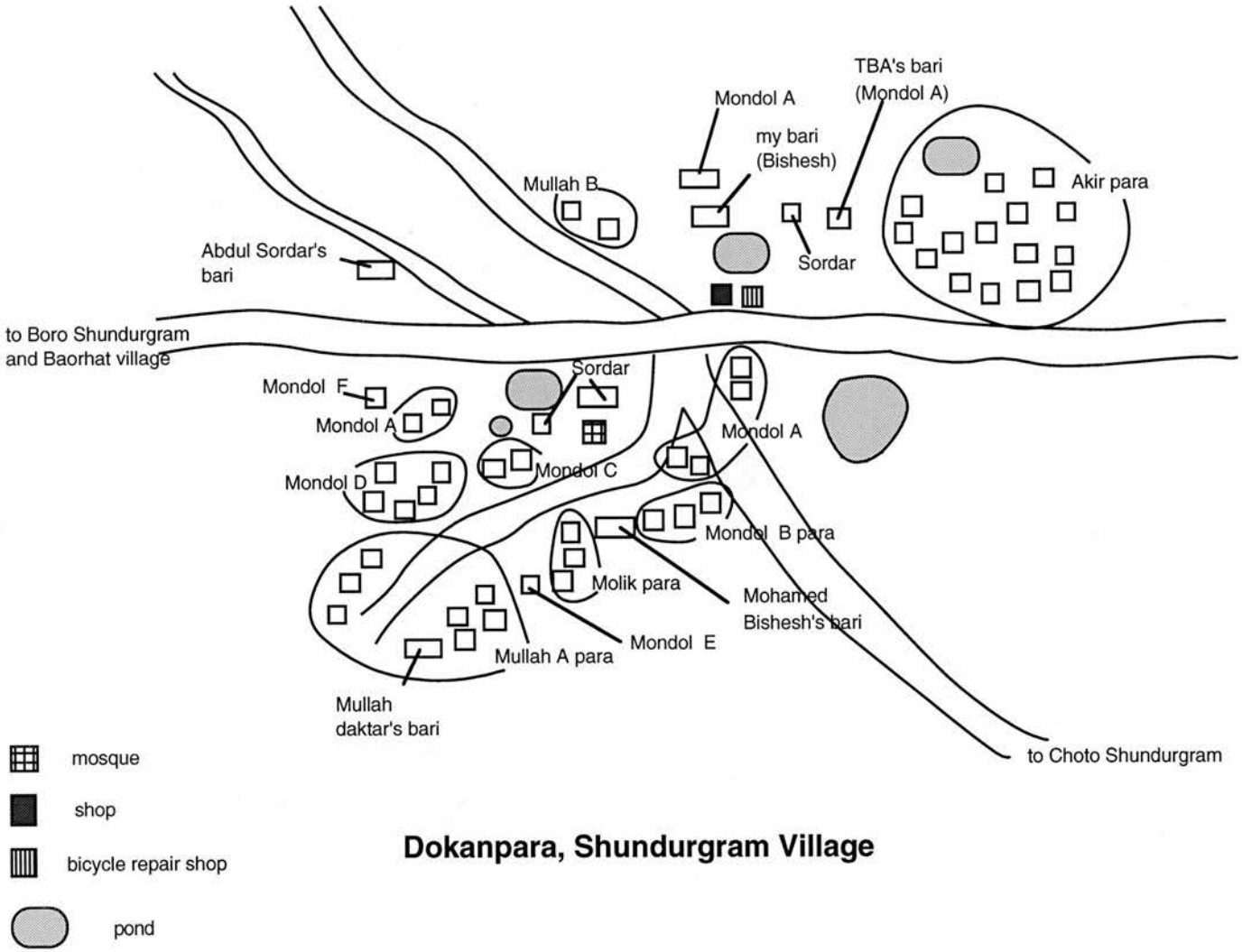
I have talked only briefly here about Muhilar Shasto's programme, and Shundurgram, my research village. In the next chapter I shall discuss the ethnography of the village in greater detail and follow this in Chapter 3 with a detailed look at Muhilar Shasto's programme.

CHAPTER 3
THE VILLAGE OF SHUNDURGRAM

This chapter presents an ethnographic outline of Shundurgram, the village upon which this study is based, and describes the main families in the neighbourhood where I stayed. The purpose of the ethnography is to set the context for the rest of the study, which forms the main body of the thesis.

It took a month for me to finally settle on Shundurgram as the village in which I wished to stay. Muhilar Shasto worked in 35 villages and I visited many of them, but there was something about Shundurgram and the friendliness of its people that attracted me. I distinctly remember my first visit. I had gone with the supervisor and Shameem to see the women's group. We went by rickshaw van and it seemed to take for ever. Turning off the herring-bone brick lane that ran from Amhat town, we headed out into the fields along a winding dirt track. It was February and still reasonably cool, but the rickshaw wala was sweating under the strain of hauling his passengers through the deep loose sand ruts. The path began to find its way into trees and small mud houses popped-up between the vegetation, still very sparse with leaves due to the lack of rain since October. After what must have been half an hour of riding through an almost continuous trail of scattered houses, we finally reached a large junction, where a brick school building stood out in the middle of the paddy field opposite; I was informed that this was the start of Shundurgram. How anyone could have known this, unless they were a local, was impossible, for there was no obvious physical boundary marking a distinction between house number 1 in Shundurgram and their neighbours in Chatagram, a few feet away.

From this starting point the village seemed to sprawl for a couple of miles, alternating between densely inhabited areas of vegetation and uninhabited expanses of paddy fields. The *bari* of the FHV, Rohima, was a very large, grand brick building with huge pillars and large stone steps leading up to the verandah. It looked quite old, the white plaster discoloured and falling off in places. Rohima's father-in-law was in fact one of the richest members of the community and this was very evident from the number of smaller houses around the sides of the yard, the



Dokanpara, Shundurgram Village

large grain store, out-houses for animals, pond and rough land surrounding it. Two other brick houses we visited a little further on were still sparkling white and modern in design, surrounded by high walls, preventing the penetrating gaze of outsiders into the internal life of the household. Plaster on bricks symbolises wealth, high walls symbolise status; they protect women's vulnerability by maintaining their *purdah* - their seclusion - and upholding the honour of the family. This was clearly a relatively wealthy neighbourhood for it was uncommon to see new plastered houses in villages.

When we finally arrived at our destination, the neighbourhood of Dokanpara, the scenery had changed again. Here the landscape looked parched and trees were much less abundant than a mile down the road. The few houses I could see in front of me were far more modest and had very little protection from the rays of sun, only isolated patches of trees stood around them. Sitting on the ground in the yard of one of these houses was a group of women - the *samity* - and they welcomed us warmly. I was impressed by their openness and willingness to talk, unlike some other groups I had visited. When Shameem explained I was looking for a village to stay in, there was great enthusiasm amongst them and several women said they had room to build me a house. My first impression of Dokanpara was, therefore, one of contradiction: the landscape was exposed and unwelcoming but the people friendly and hospitable.

As the seasons changed the landscape also changed. The area was intensely farmed and the patchwork of fields that spread for miles, changed colour as the different crops appeared. The area was relatively dry, and required irrigation between the rains, which lasted from about June to October. The year I was there the rains were particularly light and this had serious consequences for the autumn rice. Those who could afford it, irrigated the paddy during the rains, but this was a very expensive option and not possible for the majority of small farmers and sharecroppers. Rent for a diesel pump cost Tk40-50 per hour, plus diesel at Tk20 per kg, and a day's labour only paid between Tk32 and Tk50. Consequently, the harvest in October yielded only about half the usual crop. Ironically, Bangladesh as a whole had a bumper crop that year, despite the low rainfall, because of intensive irrigation practices in the north. Low production in the Jessore area was compensated for by

government measures to keep the price very low (Tk8.5 - 9 per kg of *chal*[1]). Despite this, villagers said they still didn't have the money to buy it and those who had managed to produce a cash crop, received lower prices for it. For many of the poorest families it was uncertain when and from where their next meal would come. The Traditional Birth Attendant's (TBA) family was one of these and on several occasions her daughter, aged about 10 years old, became very sick from bad stomach pains and cramps. I suspected this was caused by lack of food because I was well aware of the fact that she and her mother sometimes missed meals. Only on one occasion, in total despair, did her mother admit to me that she was crying because she was hungry and there was no food in the house to feed her. Hartmann and Boyce's study (1983:19) of rural life also found many in this position, unable to guarantee their daily meals.

The agricultural year was very busy, with three rice seasons, jute during the rains, two seasons of *dhal* varieties (pulses), wheat, mustard, *hollud* ('tumeric') and a wide variety of vegetables during the winter (see Appendix 3: Table of Agricultural Year). Farming households were, thus, constantly engaged in year-round agricultural productivity, both for domestic consumption and income. The sexual division of labour prescribed by Islamic norms of *purdah* predominant in Bangladesh society, restrict women to the socially prescribed boundaries of 'inside' (*bhitore*), confining their productive activity to within the physical representation of this; the homestead. Thus, their work is characterised by domestic activity, their access to productive resources 'outside' (*bahire*) being severly restricted and dependent on males. Women's opportunities for economic activity, and hence economic independence, are therefore very limited and small scale, e.g., selling eggs, milk, fruit and vegetables grown around the homestead, rice husking on the *dheki*[2], share-tending of animals and domestic labour. These generally occur within the boundaries of the 'inside'; amongst women in neighbouring households and through social networks of female relations[3]. 'Outside' represents the public domain

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[1] Hartmann and Boyce (1983:18) state that "rice dominates the landscape, the villagers' diet and often their thoughts". The importance of rice in Bengali culture is demonstrated by the number of different words used to describe it: *dhan* is unhusked rice, I also refer to this as 'paddy'; *chal* has been processed and husked; *bhat* has been cooked. There are also many different varieties, each with their own name, e.g., *11 dhan, Iri dhan, IT dhan*.

[2] Foot-operated wooden rice husking device.

[3] For detailed studies on women's economic and productive roles in the household see Abdullah and Zeidenstein (1982) and White (1992).

of men and they are therefore the sole agricultural labourers and main economic providers for the family.

Geographically the village of Shundurgram spread for about two miles, but within this, three distinctive, separate communities could be identified, divided by large expanses of fields. The fact that they formed the same 'village' was arbitrary, since social, political and economic relations between them were no more significant than between any of the other neighbouring communities, in other 'villages'. This was particularly the case when the next 'village' was simply the next house.

The apparent random and illogical division of areas into villages stems back to the British Colonial era, when for purposes of censuses and tax collection, the countryside was divided up into village units called *mauzas*. These still exist today for official purposes, but are quite impractical divisions, since homesteads have moved and residential patterns have changed. The imaginary boundaries cut up neighbourhoods and lump together communities which in practicality, have no particular relation (Hartmann and Boyce 1983).

The interactive social units of daily activity are these smaller neighbourhoods, called *paras*. The term is also used to refer to smaller units within these neighbourhoods, which are usually inhabited by members of the same patrilineal kin group (*gushti*). The three distinctive communities, or *paras*, in Shundurgram were called Choto Shundurgram, Boro Shundurgram and Dokanpara, where I lived. Dokanpara was itself divided into several different smaller *paras*, but geographically this was not evident. My research focused primarily on life in Dokanpara, since in practical terms its size was more manageable than the village as a whole, which consisted in total of 335 households, 78 of which were in Dokanpara. It also seemed logical to concentrate on what constituted the traditional socio-political unit, rather than the officially imposed 'village' construct. I did, however, spend a lot of time in the other *paras* on visits with Rohima and attending *samity* meetings, and visited every household in the village at least once, most two or three times.

Of the 335 households in the village, only two were Hindu, neither of which were in Dokanpara. House number 1 in Shundurgram was one of these and in practicality belonged to the neighbouring Hindu village. The other was new to the village whilst I was there. The extended family of three brothers, their parents, wives and children, settled on rented land belonging to a wealthy Muslim beside

the *baor* ('lake'), where they continued their traditional occupation of fishing. There were no other Hindu families in the vicinity, but at the far end of the next village, which formed part of the same stretch of houses, there were a few other *baris*. In another village served by Muhilar Shasto about a quarter of a mile away, the population was nearer 50-50 Muslim to Hindu and I visited this village on a couple of occasions, one being in the middle of the night to attend a delivery. It wasn't however, part of my focused research area.

Shundurgram was, therefore, almost exclusively Muslim. I was told there had never been Hindus in Dokanpara, but there had been a Hindu *para* of about twenty families in Choto Shundurgram, until that year, when the final family left. They arrived from India during the late 1960s, and bought relatively large holdings of land. However, relations with their Muslim neighbours were strained and those with land gradually sold-up and returned to India. I was assured by the Muslims who had moved into the *para* that there was no hostility between them and the remaining Hindus, and this was interestingly qualified by the comment: "they wouldn't have said anything anyway because they were too small in number." These last families were the poorest and were obviously without a strong enough support network to withstand the social pressures of the growing Muslim occupancy in the *para*. They finally left for India around the time I arrived in the village, in March 1992.

SOCIAL ORGANISATION IN THE VILLAGE

As I have explained, a village in rural Bangladesh often represents an arbitrary geographical unit, rather than a socially defined community of people. The village does not act as a corporate unit, it is made-up of smaller neighbourhoods, *paras*, within which social, economic and political relations are strongest. However, neither the boundaries of the village nor those of the *para* mark a cut-off point for social relations. Patrilineal, and more specifically matrilineal ties extend beyond these, maintaining an important network of social and political associations in other villages. These can be called upon in times of particular need, for example, they can be particularly useful in seeking-out suitable marriage partners, providing agricultural labour during harvest and female domestic labour.

On a day-to-day level, however, cohesion is strongest amongst the patrilineal kin group (*gushti*) and within the *para*, identity is expressed in terms of membership of this. On a wider social level, such as that of the village, a person is identified by the

particular *para* in which they live - such as Dokanpara, Boro Shundurgram and Choto Shundurgram. It is only within this smaller geographical and social boundary that a sense of 'community' exists, and where activities beyond those of the kin group take place; for example, communal Friday prayer in the local *para* mosque. Within a large *para*, or one of mixed religion, communities may be more specifically defined according to membership of a particular *gushti*, or whether they are Hindu or Muslim. In this respect, Dokanpara could be regarded as a single community[4], made-up of the different kin groups I will outline later.

Domestic Units and Household Structure

Kinship is organised on the principles of patrilineality and patrilocality, such that the basic residential unit - the *bari* ('homestead') - is an extended kin group of parents, unmarried daughters and the families of sons. The *bari* may be a single household or it may be made up of a number of different households. The standard definition of a household consists of those people who eat from the same hearth. In many instances this is a joint production-consumption unit, but the degree of variation is great[5]. Sarah White therefore states that:

> While other resources may be separate, those within a single household will share the same rice: it is the minimum statement of shared identity (1992:40).

This definition of the household as a 'consumption unit', is the basis on which Muhilar Shasto's socio-economic survey was conducted and the definition I refer to when using the term.

Household composition is very varied and constantly in flux as people come and go. However, certain types of household structure can be identified. White (1992) categorizes four: separate, joint, extended and single. The separate, 'nuclear' or 'elementary' (Jansen 1987) family is the basic unit from which the others arise - husband, wife/wives and children. A joint household is the economic union of two or more such families. An extended household is an 'elementary' family with

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[4] I have discussed the ambiguity and inadequacies of this term in Chapter 1.

[5] There is extensive academic discussion on the definition of a household, since however it is defined, there are many cases which do not fit. For example, the wage labourer in my *bari* ate two of his three daily meals with us, but lived with and economically supported his wife and baby. He, therefore, belonged to two consumption units. For further discussion on this see 'Appendix 2: Defining and Delimiting Households in Bhaimara' in Jansen 1987.

additional kin members, typically a widowed mother or a sister. In Dokanpara it was also quite common to find other relatives, such as unmarried brothers and sisters-in-law, living in households for prolonged periods of time. In 'my' *bari*, the brother of the youngest *bou* ('wife') joined her household in return for giving his labour on their land. The final type refers to a household headed by a single person, more often than not a widowed woman. Although strictly there were no single female headed households in Dokanpara, there was one that verged on this - the husband spending several months at a time with his second wife in a different village, and leaving his first wife to provide single handedly for their young son, during his absence.

The characteristic feature of these domestic units, and hence of village composition, is their flexibility. Year round there is a constant flow of people in and out of the village: labourers hired from other areas to do seasonal work; women visiting their *baper bari* ('father's home') for several months, e.g., during pregnancy and child birth; men leaving for work in other areas, the town, or overseas; visiting relatives, etc. In this flux, political and economic relations are formed, manipulated and exploited as households struggle to negotiate their position and survival in the community.

Hierarchies of Authority in the Household

Authority within the household is based on male patrilineal hierarchy. The head of the household is usually the most senior member - the father or oldest son - and he generally has the decisive say in the economic and social activities of the household. He will be responsible for agricultural operations, the buying and selling of land, hiring of labour, and so on, and will allocate labour tasks amongst the male members. The degree of his authority will depend on the composition of the household and economic standing of different members. Once a son breaks from his father and sets up his own household, usually within the same *bari*, he becomes responsible for making these decisions within his own family. His father's authority over him is thus greatly reduced.

Within the *bari*, individual households and 'elementary' families have their own *ghor* ('room' or 'house'), arranged around a central communal yard, where domestic activities take place. Each individual household will have its own kitchen (*rana ghor*), organised and controlled by the senior female - the *shashuri* ('mother-in-law') or wife of the oldest brother. Within this female hierarchy, the newest in-married

wife, called the *notun bou*, is ranked at the bottom. She is expected to obey not only her husband but also her *shashuri*, who has control over her labour. The work load of a *notun bou* is often much heavier than that of other women in the household and she is commonly subjected to criticism, torment and abuse by her female in-laws.

Decisions concerning her welfare are often made by her *shashuri*, rather than her husband, particularly if they are domestic or 'female' issues, e.g., her ability to take rest from work if she is ill, the amount of food she is given to eat, the use of modern health facilities during pregnancy and delivery, etc. The female head is also largely responsible for the maintenance of the family's respect and therefore the degree of observance of *purdah* by female members of the household. She will grant permission for movement outside the *bari*. In the position of a 'new bride' in a household, a woman has very little control over her life; all decisions are made for her by others. It is only as she progresses up the female hierarchy, on arrival of the next 'new bride', when she has children, and when she herself becomes a *shashuri*, that she begins to gain some kind of control and power over her own and other females' lives[6].

THE SAMAJ

At community level, the *samaj* is the traditional unit of social control and community decision making. It is an exclusively male body of locally respected men, who take on the role of community leaders - *matobars*. Each particular community in the village has its own *samaj*, the members of which are usually leaders of the most influential kin groups (*gushtis*). Thus, they are also generally relatively wealthy. They are responsible for enforcement of social norms, and for determining appropriate punishments for those who breach them. They must, therefore, be respected for impartiality in judgement and possess particular skills in mediating and negotiating between conflicting parties. A hearing of this nature is called a *shalish*. The position of *matobar* is often hereditary, passing down from father to oldest son. In Dokanpara there was one *samaj*, with representatives from each of the main *gushtis*.

A *matobar* may be called upon to settle any dispute or breach of conduct that cannot be solved or dealt with by the individuals concerned, the family, patrilineage, or

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[6] See White (1992) for an analysis of women's social and political relations.

whatever is the smallest unit to which the disputants belong. A well respected *matobar* may also be called upon to solve inter-village disputes. This method of adjudication is still, in many cases, preferred to the outside intervention of the police. Only when an issue cannot be satisfactorily solved are the police involved. The following is such an example:

> One afternoon I was sat gazing out the window towards my *boro bhai's* little shop in front of our house, when a commotion began. A large group of men quickly gathered to observe the heated argument as it rapidly culminated into jostling and a blow to the head of one of the disputants. It turned out that the man who had been hit was from the neighbouring village, and the assailant someone I knew from Dokanpara - Pakhi. Immediately a discussion ensued as to what should be done and the most respected local *matobar* was called to settle the dispute. However, Abdul was Pakhi's older step-brother, and because of this relationship he felt that he could not pass judgement. The other *samaj* leaders, although from different *gushtis*, had similar reservations and so finally the police were called and arrived the next day with a warrant for Pakhi's arrest. True to his name, meaning 'bird', he had however, taken flight and disappeared. After some time, without success in finding him, the issue quietened down and was forgotten. Pakhi then reappeared, with no further repercussions.

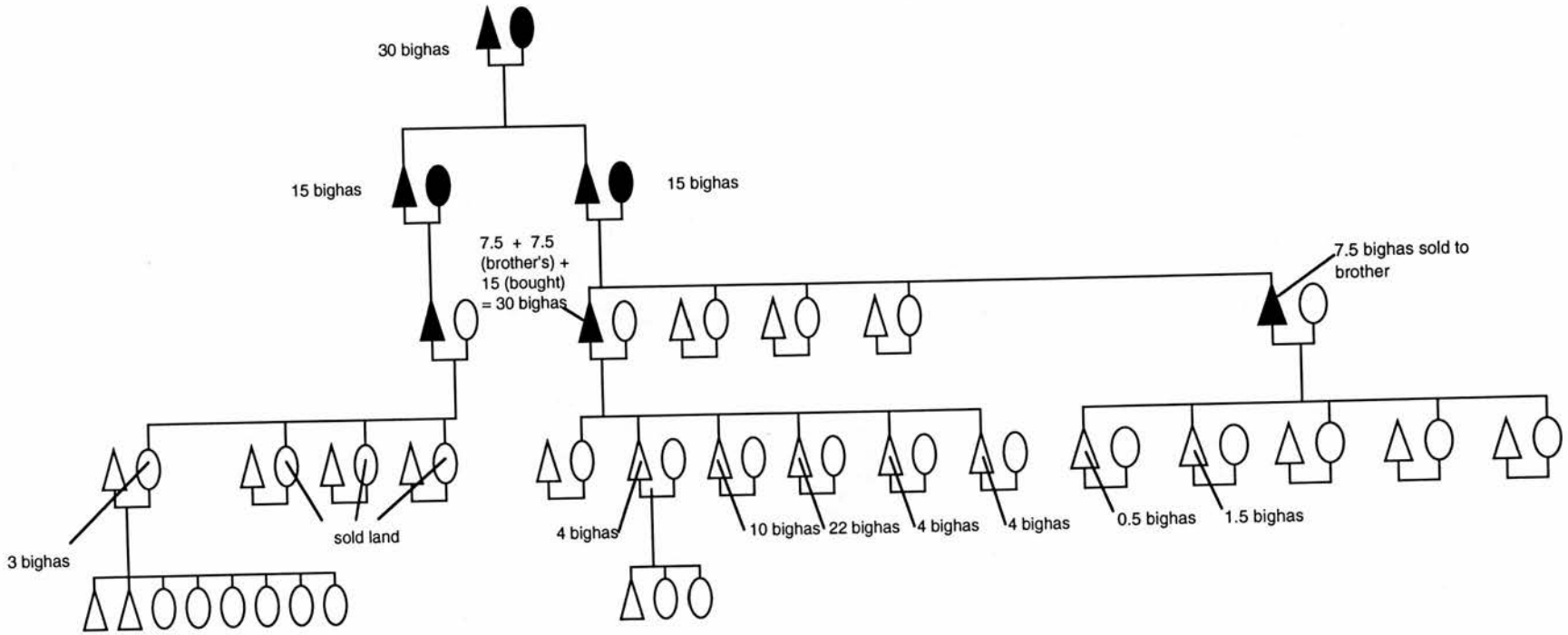
SOCIAL AND POLITICAL RELATIONS IN DOKANPARA: NETWORKS OF KINSHIP

Only fifty years ago the whole area was thickly covered with forest, extending up from the mangrove swamps of the Shundarbans, lining the south coast along the Bay of Bengal. In those days tigers were said to roam the area and cautionary tales were told to children to avoid attacks. The population was very small. Some estimated only about 20 people lived in Dokanpara then. Slowly land was cleared of trees to increase cultivation and families from other areas of the country and other villages moved in. In the Jessore area there seems to have been an influx of people from the district of Noakhali, in the south, around this time (1940s-1950s) (Crawford 1993).

One such family came to Dokanpara, the Mondols, and purchased 30 *bighas* of land, a *bigha* approximating 1/3rd of an acre. This represented a substantial amount and established them as a wealthy and influential family. The Mondols are now a large and relatively wealthy *gushti* in the *para*, with new land purchases adding to the original land, which has been divided many times according to Islamic laws of inheritance. These state that when a man dies his property is inherited by his wife and children. His wife is entitled to an eighth of the property and daughters receive a share half that of their brothers. If he dies childless his widow should inherit one quarter and the rest will be passed to his closest relatives. However, the women's share is often foregone in favour of male inheritors, in order to retain their right to economic support from male kin, in times of crisis, for example, at early widowhood or divorce (Jansen 1987; Z.R. Khan 1992). Aziz (1979) and Jansen (1987) observe that this is in fact the common practice: the 'tradition of daughters' to avoid straining relations with their brothers and thus jeopardise the possibility of turning to them for support.

Inheritance patterns have meant that generally, individual land holdings have become smaller and smaller as they are divided up through the expanding generations. This can be seen in the kinship diagrams of the Mondols and Sordars (p.47 and p.50). Land ownership amongst the Mondols now varies from 1/2 to 22 *bighas* per household, the average in Dokanpara being 4.22 *bighas* (see Appendix 4: Socio-economic Survey). In total, the *gushti* (kin group) owns about 46 *bighas*, but each holding is farmed by the individual household. Land is not farmed communally unless a son remains joint with his father or brother and they pool their resources, such that they eat from the same hearth. Their families are then defined as a single household. The most influential male member of the Mondol *gushti* has also inherited from his father, the traditional role of a *matobar*. In Dokanpara, each main kin group is represented by a *matobar*, who together form the local *samaj*.

Mondol Gushti (indicating land ownership)



1 bigha = 1/3 acre

The two most influential kin groups in the *para* can be traced back to the same apical ancestor, Sordar. Sordar was also wealthy, owning about 80 *bighas* of land which was divided equally between his two sons. The oldest had only one daughter, who was married into another village but on his death received this land. She returned with her husband, who farmed it and was able to purchase another 40 *bighas*, making them the largest land owning family in the *para*. According to patrilineal descent the family took the name of the husband - Bishesh, and are recognised as being a different lineage to the Sordars, but still closely related. It was the oldest son of Mohamed Bishesh with whom I stayed.

Mohamed Bishesh is now in his 70s, and considered an important *matobar* in the *para*. His first wife died after having eight children (four boys and four girls), and her land was divided up between them. He remarried a much younger woman with a daughter by her first husband, and has had another two daughters. He still owns 15 *bighas* of land and is consequently considerably wealthy. His oldest son, my host, owns 7 *bighas* and runs a small shop, selling everything from soap, tea, rice and *dhal*, to diesel and pesticide. Since it is the only one in the *para* it does good business and has also made him wealthy enough in local terms, to be able to send his only son to a private boarding school in Jessore town and help support two of his younger brothers through university. These are the only two people in the village to have gone to university.

My host was educated to class 10, matriculation, which is an uncommonly high level for villagers. Suitably, his wife is also educated, having studied to class 5 before being married at 13 years of age. She is one of the few women in the village to have continued past primary 1 or 2; most have not even done that. Her status as a wife in an important, wealthy family means that she must observe strict *purdah* in order to maintain the family's honour and prestige.

In total, Mohamed Bishesh and his offspring own a small business and 43 *bighas*, one of the largest land holdings retained within a kin group, in the *para*. Despite being only a small *gushti* - the lineage extending only three generations, from Mohamed to his grandchildren - they are politically and economically very influential members of the community and wield substantial power.

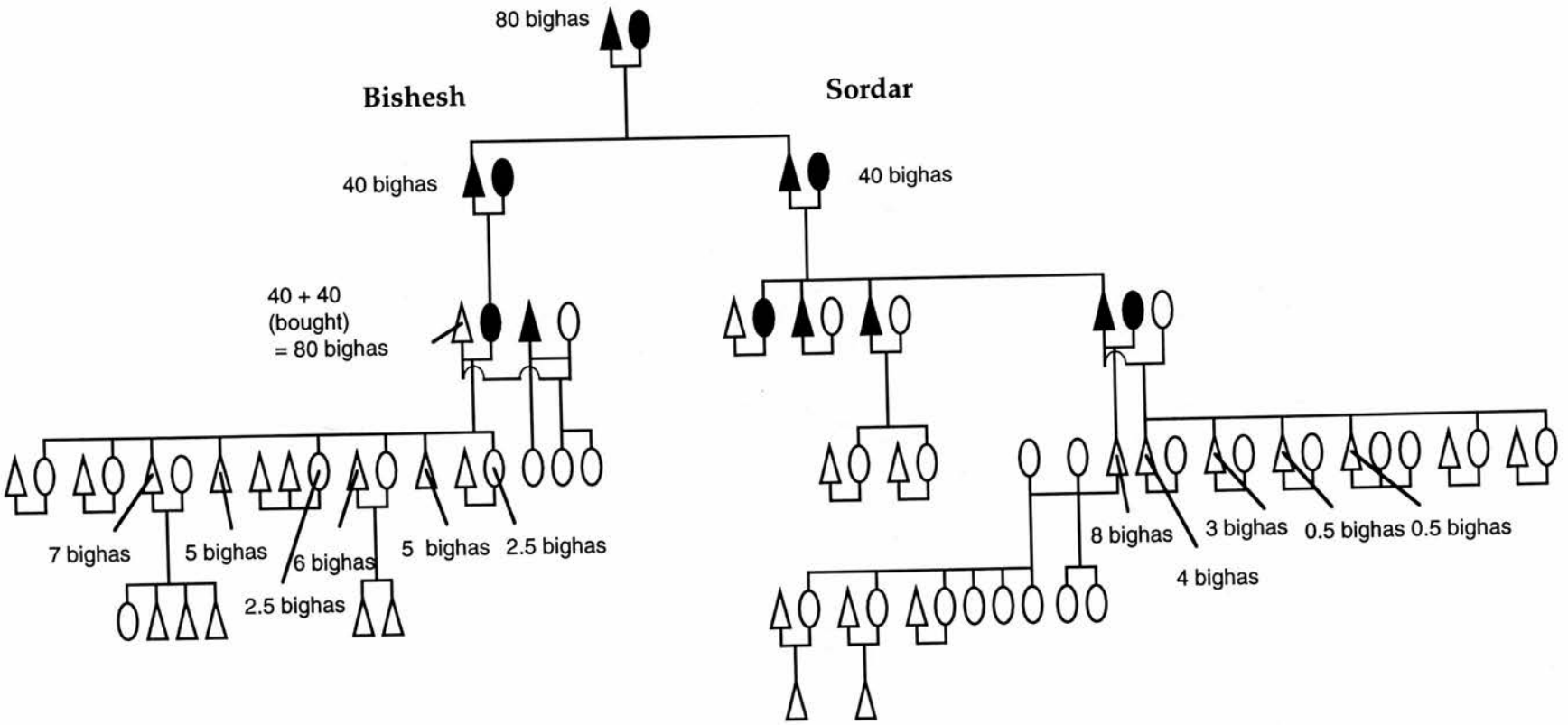
The Sordar lineage has thus primarily descended through Sordar's second son, who had four children. The only descendants from these siblings to remain in the *para* are those of the youngest son. He had seven children by two wives, the second of whom is still alive and lives with her sons, three of whom have remained in the family *bari*. The youngest has established his own *bari*. The only child - a son - by the first wife has left the family *bari* and built a new home at the side of the fields, on the outskirts of Dokanpara and away from other households. Thus, his family no longer remain within a small *para*, and are isolated from other members of their *gushti*. This has significantly restricted the social lives and movements of the female members.

His oldest daughter separated from her husband and lives back in her father's house (*baper bari*). She has her own small sewing business and therefore her own income and spends every hour of daylight slouched over her machine, running-up clothes to order. Her income enables her to be financially, although not totally, independent of her father and to send her young son to the village school. She wishes for him to go to a better school in Amhat but the distance is too far. In return for food and a room she contributes to the family's resources, supplementing the lone income of her father, the only male in the thirteen member household!

Her father is in the 'unfortunate' position of having only daughters, eight in total, by two co-wives. Without sons he is left to maintain his family on an income from farming 8 *bighas* and running a small bicycle repair shop. According to Rohima's socio-economic survey, this brings in an average monthly household income of Tk1500 per month. This is higher than the average, of Tk1250, but calculated on an annual per capita basis is actually very low - only Tk1325. Muhilar Shasto uses this calculation as a basis for categorising socio-economic status, and according to this they belong to the lowest group: defined as those having an income of less than Tk2000 per person per year.

Abdul is one of the most respected and influential members of the community and regarded as the most important *matobar* in the *para*. This is predominantly by virtue of his status as an ex-member of the local Union *Parishad*, an administrative council below the *upazila* level. This consists of ten elected male members, including the chairman. Z.R. Khan (1992:140) states that the official Local Government Ordinance of 1977 includes two nominated female members on the council, however, I was

Sordar Gushti (indicating land ownership)



1 bigha = 1/3 acre

unaware of there being any in Amhat since they were never mentioned. Amhat *upazila* is made-up of eleven unions, each union having a constituency of three wards, between 15-20 villages. Only the Chairman receives an 'official' remuneration but election onto the council has significant economic and political advantages. There are opportunities for material benefit from council funds and projects, bribes, corruption, etc., and increased local political support and respectability. Thus, failure to be re-elected has perhaps lost Abdul a valuable source of additional income, but he retains his reputation and high social status as an 'ex-member'. In total, the Sordar *gushti* now own only about 13 *bighas* of land compared to 40 *bighas*, four generations back.

MULLAH *GUSHTI*

The other prominent kin group in Dokanpara is the Mullahs. This descends from one of the original families in the area and all members reside in a neighbourhood, known as Mullah *para*. Unlike the other main *gushtis*, however, they were not originally wealthy land owners. Their wealth and importance has grown over the years as they have worked hard to slowly increase their land holding from 5 to 30 *bighas*. The prominent members of the kin group are seven brothers, two of whom are *matobars*. This is the only *gushti* to be represented by two leaders on the *samaj*. The oldest is the village *daktar* and a highly respected *matobar*. He was the only brother to receive an education, and so despite failing his SSC Matriculation exam, was the pride of the family. He is the oldest practising *daktar* in the area, with a very good professional reputation built up over some twenty-five years.

Being a *daktar* is very lucrative since there is no shortage of clients and his success is exhibited by the fact that he lives in one of the few brick houses in Dokanpara. He also owns the only motorbike, using it to ride between the village and Jessore, where his wife and children stay. His aspirations are to leave the hard village life behind and start a practice in Jessore town where he could make 'easy' money and branch-out into more prestigious - and lucrative - types of medicine, such as surgery. He now considers village life to be beneath him and like many, believes that real opportunities for prosperity lie within the realms of urban society. He is however, one of the few people in the village who could afford to make this desired break.

AKIR *PARA*

The final *matobar* on the *samaj*, Tokel Ali, comes from a distinct and separate *para*, known as Akir *para*, in which the households are essentially unrelated to the other *gushtis* in Dokanpara. There are only one or two affinal links. This is the poorest neighbourhood, in which nine of the fourteen households are landless.

The families in Akir *para* are somewhat regarded as outsiders by others, having come from the neighbouring village in more recent years. Consequently the lack of kinship ties between this *para* and the others means that social relations between them are weaker. This 'social' isolation is also expressed by its geographical separation to the rest of the community. Social behaviour also demonstrated this: women from this *para* very rarely visited the other neighbourhoods and vice versa. Consequently, I also spent far less time there. It should be explained here that observance of *purdah* in one's own *para* is much freer and women do move between neighbouring *baris* and those belonging to their *gushti*. However, even the most mobile females - young unmarried girls and *buris* ('old women') - who would happily wander between the different neighbourhoods of the main *gushtis*, would not be found socialising in Akir *para*. Their main lineage connections, and therefore social and economic alliances, are with the neighbouring village, from whence they originally came.

OTHER LINEAGES

As previously mentioned, there are also a number of smaller, less politically significant lineages in Dokanpara, all of whom, with the exception of one, are named Mondol. My map of Dokanpara identifies another five Mondol *gushtis* (B,C,D,E,F), varying in size from a single household to four or five *baris*; another Mullah *gushti* (B) of three brothers; and Molik *para*, consisting of three brothers, one of whom is a *munchi* who leads pray in the *moshjid* (mosque). The location of the different *paras* can be seen on the map at the start of the chapter.

ZIA RAHMAN'S VILLAGE GOVERNMENT AND VILLAGE EDUCATION PROGRAMME

During the early 1980s the Bangladesh Nationalist Party (BNP) Government of Zia Rahman (1975-81) embarked on a programme to decentralise administrative and judicial power down to the village level. This was done through establishing self-

governing village bodies called village governments, or *gram shorkar*. They were conceived as a strategy to develop grass-roots self-reliance, local problem solving, and full utilization of local material and human resources, as part of the government's national development initiative. Members were selected by villagers, with representatives from different interest groups - the landless, youths, women, farmers, other occupations - headed by a chief and secretary. Their main tasks were to "increase production, mobilise the villagers towards controlling population growth, combat illiteracy and ensure law and order in the rural areas"(Z.R.Khan 1992:146).

Part of this initiative involved a rural literacy programme, with teachers selected from those in the community who could read and write. The programme ran for a year or so in Dokanpara and was well remembered by the older generation. They told me that during this time everyone had to learn to read and write - up to the age of 80! It was compulsory for men, women and children and attendance was enforced by the *gram shorkar*. If they didn't attend class every day a fine would have to be paid or they would be taken to the *thana* ('police station'). The government announced that offices would no longer accept thumb prints as 'signatures' on official papers; in order to buy and sell land people would have to be able to write their name. Villagers were therefore frightened of the consequences of not learning and they said that as a result, attendance was good.

Women met after cooking the midday meal, children in the morning and men in the evening after returning from the day's work. Since this meant it was then dark, men would have to study by kerosine lamp and a typical fine for not attending was the cost of oil for the next day's class. A husband would have to pay the fine if his wife did not attend and so there was incentive to ensure that women, as well as men, went to the classes. However, the system came to an end with the assassination of Zia in 1981. The new government of General Hossain Ershad abandoned the *gram shorkar* system and without anyone to enforce the unpaid teaching or attendance, the classes stopped.

EDUCATION AFTER ZIA RAHMAN

Educational opportunities in villages, particularly for females, are very limited. Few children attend school beyond primary level, the reason being a complex of factors relating to poverty, culture and insufficient infrastructure. The 1991 National Census (Bangladesh Bureau of Statistics 1992) shows a national literacy rate of

24.82%; for Jessore District it is 26.01%. It found a 94.6% Participation Rate for Primary level (5-9 years), 27.6% for Secondary (10-14 years) and 4.2% for Higher (15-24 years). Since these are national statistics they do not necessarily accurately reflect the situation in different parts of the country, particularly those most isolated from infrastructural resources. In Dokanpara the numbers would not have been as high, although Shundurgram does have two primary schools and one secondary school. Unfortunately the statistics do not differentiate for sex and so do not reflect the significant imbalance between male and female attendance, particularly beyond primary. The 1975 statistics measured literacy at 29.9% amongst males and 13.7% amongst females and the Ministry of Social Welfare and Women's Affairs (Ahmad,Q.K., Khan,M.A., Khan,S., & Rahman,J.A. 1985 referenced in White 1992:30) found that at every level of education, enrolment was lower for girls than for boys and the drop-out rate was higher.

Although education is highly valued it is generally reserved for the priority of males, since it is regarded as the key to economic opportunities and these can only be exploited by men. Reading and writing skills are not considered necessary for the domestic role a girl is destined to fulfil when she becomes a wife and mother. In Dokanpara girls (far more than boys) tend instead to go to religious classes at the *madrasa* in the neighbouring village, for a couple of hours a week. White (1991) and Maloney, Aziz and Sarker (1981) also note this. The latter account for it as being the religious duty of parents to raise their children well so that they may undertake their 'worldly and religious duties'. If they fail to do so the parents will be answerable to Allah and they state that: "for this reason parents take the initiative to support the system of *maktab* (Islamic primary education) without government help" (1981:100). Since females are primarily responsible for raising children, it therefore makes sense that if priority has to be given, they should attend religious classes rather than school.

The cost of keeping a child in school is high even though primary education is free to all. Books, pens, exams, uniforms etc,. have to be paid for and the potential labour of an older child within the household is lost, so there must be some perceived benefit from doing so. Boys who have basic literary skills may be able to start their own small business or shop. If a family can afford to educate their son to matriculation (class 10) or higher, this is seen as a future investment as it is expected that he will then be able to get a well paid job (*chakri*) in town and send money back to the family. Maloney et al's detailed research (1981) also found this to be a widely held expectation amongst rural people.

This is certainly the expectation of the family I lived with, who from the incomes of the father and oldest brother were paying large sums of money to put two of the brothers through university to master's level. It was expected that they would either become university lecturers or get a secure and well paid government job. The fact that jobs in Bangladesh are in incredibly short supply, even for people with master's degrees, did not seem to affect this expectation. The thought that they might not find a job was never entertained by the family, suggesting a naive view about the golden opportunities of urban life and an ignorance of the poverty of a large proportion of the urban population.

Talking to women who had been involved with the village literacy programme, I found much enthusiasm amongst them about women learning to read and write, and they felt it would be good if the classes could be started again. Only one woman, ironically one of the teachers, had less enthusiastic things to say about the old system and felt it would be pointless to start it again. Her 12 year old daughter had never been to school and her mother saw no reason to send her: "what is the point in her learning to read and write if she is not going to get a job? There are no jobs here [in the village] so why does she need to learn - what will be the benefit?" This was an attitude I was surprised to hear from someone who was educated to class 5 herself and had been a women's teacher. She clearly did not put much value on the benefits of her own learning. However, other 'educated' women in the *para* felt very differently and were insistent that their daughters be well educated, despite the expense. The *samity* cashier's two girls were the only ones in the *para* to still regularly attend school beyond primary level. In fact, they were the only children to do so, with the exception of my *bhabi's* son who went to boarding school in Jessore. In general, those women who had received an education themselves seemed to place great value on educating their children, both girls and boys. This did not necessarily mean that they expected their daughters to get a job, rather it was seen as a qualification for getting a good, educated, rich husband who would be able to look after her comfortably and respect her more, because of her educated status. The function of education was, therefore, more important as a symbol of her social status and 'worth' as an addition to her dowry, than for her personal development.

Having described social relations in Dokanpara I shall finish by looking briefly at the findings of Muhilar Shasto's socio-economic survey.

SOCIO-ECONOMIC SURVEY FINDINGS

The survey conducted in August 1992 was undertaken by Muhilar Shasto in order to gain more detailed socio-economic data for the field area, and was extremely helpful since it meant I did not need to conduct my own. The information collected included details of household assets, i.e., ownership of animals, homestead and cultivated land, access to a tube well, use of a pit latrine, number of members in the household, and monthly household income. This was a complicated calculation based on estimates of cash earned from labour, sale of produce, small business activities, etc., over a year within the household. Seasonal fluctuations and unpredictability of the local agricultural economy, upon which the majority of people depend for income earning activities, make this a very rough figure. It was, however, the indicator used by Muhilar Shasto to categorise socio-economic status in the village. Considering, in particular, the insecurity of income for the landless, this figure does, however, misrepresent the economic stability of these households and I shall look at their situation in relation to the survey findings, in more detail.

An annual per capita income was calculated for the members of each household[7]. On the basis of this, the household was then categorised as 'A' 'poor', 'B' 'middle income' and 'C' 'rich', according to ranges set by the World Health Organisation (WHO). These are as follows: below Tk2000, Tk2000-2500 and above Tk2500 respectively. The results classified 18 households as 'poor', 11 as 'middle income' and 49 as 'rich'. The average income - Tk3190 - was found to be above the minimum income level of the highest range, such that the majority of villagers were seen to be well-off. Looking specifically at the 22 landless households, many of which are in Akir *para*, 10 are categorised as 'C' and 3 are categorised as 'B'. Only 9 are considered to be 'poor' and, hence, the most 'needy', despite the fact that most of these landless households are dependent on others, largely for wage labour, and therefore are extremely vulnerable. Several of them embarked on smuggling small amounts of goods, such as vegetables, rice, oil, diesel, saris and material, across the border from India as either their regular income or a supplement to wage labour. Prices were often much lower there and so the demand for cheaper goods was high - particularly for saris. It was, however, a risky business involving bribing the border guards and goods were regularly confiscated. Although at times quite

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[7] Annual per capita income is calculated by multiplying the monthly household income by 12, and dividing by the number of household members

lucrative, particularly when diesel became expensive during the peak irrigation season, it was very unpredictable. Half way through the year of my stay the border guards clamped down and brought the activity almost to a halt, thus cutting off an important source of income for several of the poorest, landless households. Representing these as 'well-off' households based on a very unstable and fluctuatig income is therefore deceptive.

At the other extreme, one household owning 10 *bighas* of land is categorised as 'poor' because the large family of 9 members, means that their per capita income is only Tk1600. There is, however, a big difference in long-term security between this household and the landless households, but this is not reflected in the social classes of the WHO system based only on estimated yearly income. In rural Bangladesh the currency of wealth, power and social status is expressed, not in terms of *taka*, but in terms of land and material assets (Hartmann and Boyce 1983; Jansen 1987; White 1992, Maloney 1986; BRAC 1986). For this reason, socio-economic surveys generally tend to categorise households according to land ownership rather than income. BRAC (1986) and Jansen (1987) use 5 landholding categories, White (1992) identifies 4 according to strength or vulnerability, determined by both material assets and social support networks. In all these categorisations the landless belong to the lowest socio-economic groups in the society, reflecting far more accurately, patterns of rural social stratification. Maloney and Ahmed's study of 'Rural Savings and Credit in Bangladesh' (1988:12) points out that it is, however, misleading to assume that the landless are necessarily the poorest:

> many of them do not try to earn from land but have another occupation, and their income is also higher than those day laborers having only a little homestead land...their income is more reliable because it is diversified.

It is certainly the case that some of the people in Dokanpara who smuggled as their main occupation earned as much or more than those who depended wholly on day labour. One could earn Tk1000 per month or more doing 'black' (smuggling) at peak times, but as soon as the borders were tightened up during clamp-downs on illegal trading, their income was cut severely. More significantly, they were also subject to market fluctuations. Whilst one week there may be an abundance of items at a price that will make a profitable sale in the local Bangladesh market, the next week there may be nothing or the demand may have changed because of local availability. Whatever was available and brought in the most money was smuggled. During the lead-up to the Eid celebrations in June, cows became a major smuggling commodity in the area. This was particularly foolproof because they could not be identified by

the police as illegal - there were no 'made in India' labels. However, they were much harder to smuggle across the border in the first place, without being caught! Smuggling was, therefore, a very precarious source of income and during hard times the families suffered greatly. Quite frequently the *buri* ('old woman') from the neighbouring *bari*, whose son was a smuggler, would come and beg rice from our house; they rarely ate a nutritious meal. The husband of the leader of one of the *samitys* also relied on smuggling to suppliment his income from transporting goods to and from market on his rickshaw van, when it was operational[8]. They too suffered hungry periods, particularly during the rainy season, when meals had to be reduced to two a day.

The isolation of the village meant that other forms of non-agricultural employment were rare and so opportunities to diversify one's income were limited. Thus, the landless households in Dokanpara were, on the whole, a very vulnerable group. Kramsjo and Wood (1992:22) estimate that as a result of agrarian fragmentation some 70% of rural households do not have sufficient land for subsistance and rely on wage labour in agriculture, rural works and out migration. They state:

> poverty is a function of access: first to cultivatable land and second to employment opportunities in the countryside (1992:21).

The choice of indicators in Muhilar Shasto's socio-economic survey therefore reflects a rather different picture of economic status to that experienced by the villagers. As is characteristic of rural Bangladesh, the social order in Dokanpara revolved around power and wealth, determined primarily by ownership of material assets - i.e., land - those without any came way down at the bottom of the social pecking order.

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[8] A rickshaw van has a flat wooden platform behind the rider upon which goods and people can be carried. They are the main form of transport in rural areas but are often made immobile after heavy rain on the dirt tracks. During the rainy season bullock carts are frequently the only form of transport that can negotiate the mud.

CHAPTER 4

COMMUNITY BASED HEALTH CARE : THE MATERNAL-CHILD HEALTH AND FAMILY PLANNING (MCH-FP) APPROACH

Muhilar Shasto's Mother-Child Health and Family Planning (MCH-FP) programme began in March 1989, with funding from an ODA project based in Dhaka, originally called the ODA-NGO Project. This was established in 1988, as part of the Bangladesh Government's Third Population and Health Project (Pop 3), to provide support to indigenous NGOs involved in health and family planning activities. This is now in its second phase, as part of the Government's Pop 4 Project, and is funded by a consortium of four donors; ODA, CIDA, SIDA[1] and the Netherlands under the overall supervision of the World Bank. In accordance with this, the office has changed its name to the Bangladesh Population and Health Consortium (BPHC).

In 1992 BPHC was funding 39 NGOs, some of whom received funding directly and some, like Muhilar Shasto, who received it via another indigenous NGO, which provides support and networking services to local partner organisations. The objective of this intermediate level organisation is primarily to provide greater technical support and training to small, local NGOs, as a means to achieving a higher quality of skills, management ability and project performance and hence to contribute to their long term sustainability. BPHC also gives funds to this support NGO, called the Centre for Development Services (CDS), with the aim of building-up in-country, local development expertise, skills, technical support and training facilities.

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[1] CIDA - Canadian International Development Agency

SIDA - Swedish International Development Agency

BPHC has devised an MCH model which proposes a basic strategy for integrated primary health care at the community level. The aim is to provide appropriate and affordable health services to people, particularly the poorest and most vulnerable, in areas otherwise unserved by government (or NGO) facilities. The model is designed to complement the government's own health system, which has been decentralised with 400 *Thana* (*Upazila*) and Rural Health Complexes across the country. However, this still leaves much of the population unserved, since about 78% of people live in rural areas, many of which are geographically isolated by the immense river network that covers the country, and poor roads and infrastructure. The priority is on targeting women and children who, due to their specific health needs (e.g., women's reproductive health needs and special neonatal and infant care) and vulnerable social and economic position in society, are those most at risk and in need of health care. Most women, particularly in rural areas such as those served by Muhilar Shasto, are unable to travel the long distances to utilise the nearest health facilities. The aim of an integrated primary health care programme is to bring these facilities to the community, using local staff and resources to address basic health needs. The Alma Ata Declaration of 1978, made at the first International Conference on Primary Health Care, held in the then Soviet Union by the World Health Organisation and UNICEF, states that these facilities should provide promotive, preventive, curative and rehabilitative services which include:

> education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (Gish 1979:203),

with the overall global objective of achieving 'Health For All by the Year 2000'.

It also states that primary health care should require and promote

> maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources [and develop the] ability of communities to participate (Gish 1979:203).

The BPHC strategy, as set out in their '*NGO Project Manual*' (n.d.) stresses that participation of the community is essential in identifying local needs: "community participation is the central point around which projects evolve...Only when community people are actually involved and working together can major problems

be overcome" (*NGO Project Manual,* page 5). They suggest that a 'starting point' for integrated community health programmes is addressing the status of women, since it is upon them and their well-being, that future generations depend. They describe a vicious circle that females in Bangladesh are born into:

> The female child is less valued then the male
> She is fed less, and grows less
> She is not sent to school so she cannot be economically independent
> She is married early to avoid financial dependency
> She becomes pregnant when she is small and malnourished
> She produces a small baby
> She does not give her baby colostrum because she thinks it is 'bad'
> She thinks her breast milk is too weak and gives the baby bottle feeds
> She does not have enough money to mix the milk properly
> The baby falls sick and dies
> The mother gets pregnant quickly
> Her body is still weak from the last pregnancy
> She has a small baby...
> (*NGO Project Manual*, page 7)

Their strategy is focused on breaking this circle and, therefore, on changing the social situation of women, through 'empowering' them "with good health, knowledge and income" so they may have control over their own fertility.

BPHC perceives the community based primary health care approach to be 'a process of empowerment'; empowering people, often poor and disadvantaged, to prevent illness and disease and to manage their own health needs, rather than being dependent on the curative services of hospitals, clinics and medical practitioners - whose treatment is often inappropriate, unnecessary and expensive. The focus is very strongly on prevention and treatment in the home because many of the causes of morbidity and mortality can be easily dealt with by individuals, if attended to early enough. Diarrhoea, for example, is the most pervasive cause of mortality amongst children under five years of age, causing 30.4% of deaths. However, it can be prevented by observing hygienic practices and easily treated with homemade oral rehydration solution (ORS). The FHVs teach mothers how to make this out of locally available ingredients, and educate them on preventive care. The FHV's relationship with the community and the work that she does in educating, motivating and raising their awareness is the key to this approach.

THE ROLE OF THE INTERMEDIARY ORGANISATION, CDS

In most cases, BPHC monitors and evaluates the performance of the projects it funds; however, Muhilar Shasto is also supported by an intermediary NGO, CDS,

which has a similar role. CDS is a Dhaka-based, national level organisation, established in 1983 by a group of social workers with an interest in providing support services to self-starter local NGOs. It has its own direct projects in three different areas and supports another eighteen partner NGOs scattered around the country. Of these eighteen, five are BPHC-funded MCH-FP programmes. CDS receives the funding and dispenses it to the 'partner' NGOs with close guidance and technical assistance. The partnership is intended to nurture the NGO until it has sufficient capability to 'graduate' and go it alone.

Interestingly, in the 1992-3 CDS Annual Report these five organisations are refered to as both 'partners' and as 'CDS projects', identified by numbers, e.g., Muhilar Shasto is CDS unit No. 019. From these descriptions it is, therefore, difficult to ascertain whether the projects are seen as autonomous organisations or as part of CDS. The choice of language in the report indicates a strong sense of ownership over the projects and their achievements:

> CDS with the assistance of Bangladesh Population and Health Consortium (BPHC) introduced a project known as 'family planning, community based contraceptive distribution, health care and integrated development' in five different areas of the country...CDS has been providing maternal/child health (MCH) and family planning (FP) services through four partner organisations including one direct project to promote health awareness amongst mothers (*1992-93 CDS Annual Report*, page 18).

When Muhilar Shasto decided to start the health programme in 1989 they applied to CDS for funding, who in turn obtained finances from BPHC. CDS helped draw-up their first project proposal and have continued to play a major role in design and development of the project, perpetuating a parental ownership. Symbolic of this is the sign board outside Muhilar Shasto's clinic, identifing them as 'MCH-FP Project, CDS unit no.019', there is no mention of their name, by which they are identified locally. CDS makes regular monitoring visits to the project and monthly reports on performance, collated centrally by BPHC for all projects, are also closely monitored by CDS.

My observations were that Muhilar Shasto's performance was primarily judged by their attainment of set targets, for such things as Contraceptive Prevalence Rate (CPR), number of IUDs and ligations, number of safe deliveries by TBAs, etc. They had to complete eight different monthly reports for the government and BPHC/CDS detailing these statistics, with justification for low performance rates. This placed a lot of pressure on the project manager and took up a lot of her time, time that she also needed to spend on more practical aspects of running the

programme. The strong focus on quantifiable indicators and attainment of set targets for performance determination, led me to question whether these monitoring priorities restricted Muhilar Shasto's freedom to focus on their own project-specific problems[2]. To effectively recognise and address them required a more qualitative analysis of the situational context and hence a more qualitative perspective on 'performance' and project development. For example, not just stating how many people had purchased pit latrines, and thus that sanitation had improved, but asking how many were installed and who used them - this type of questioning presented a rather different picture, since in my neighbourhood several slabs and rings were piled at the side of houses untouched.

My point here is not to analyse the effectiveness of the monitoring and reporting system per se, but to suggest that because it played such a central role in determining the project's performance and progress, it inhibited the NGO's ability to set its own goals and priorities according to locally perceived needs. Thus, to refocus the question, my intention is to examine the degree of autonomy Muhilar Shasto had to determine their own priorities and development direction, given the parameters of their relationship with CDS.

During my research period CDS provided several training sessions to Muhilar Shasto and advised certain changes and additional elements to the programme in accordance with their own project design, such that all five MCH projects had basically the same structure. Muhilar Shasto were 'obliged' to adopt these new aspects, e.g., village volunteers, community meetings, adult education programme, community workshops, and a model village, which were intended to increase the amount of community participation in their programme. Ironically, they were however, planned and decided upon in a top-down manner by CDS, with little participation from Muhilar Shasto in determining whether they were indeed appropriate strategies for the project. Muhilar Shasto were sent a plan detailing the months by which they should have implemented the different elements, but since they were not involved in the planning process some of the targets had already been achieved, while others were inappropriate in relation to their own plan. A particular case in point was CDS's sudden decision that an adult literacy

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[2] In Chapter 9 I discuss more fully the emphasis on targets for measuring achievement with respect to some other development programmes.

programme should be completed by members of the women's groups before the start of Muhilar Shasto's planned credit and loan programme, which was already very delayed. Not surprisingly the prospect of a further, and much lengthier delay, caused great problems at the field level, particularly for the FHVs coordinating the groups. Eventually Muhilar Shasto's project manager, Shameem, was able to reverse the decision and the credit programme went ahead, albeit some seven months after it was first planned! I shall discuss the issue in detail in Chapter 8 on group formation, and it is sufficient here to use the incident in demonstration of the hierarchical relationship between the 'support' organisation and Muhilar Shasto, in which decisions were ultimately controlled from above.

However, this is not to infer that Muhilar Shasto or Shameem were resentful of the relationship. On the contrary, Shameem maintained a very close liaison with CDS and was appreciative of the amount of support she received. A BPHC evaluation of the project at the end of their first 3 year phase, felt they were ready to graduate from CDS and become independent. However, Shameem felt that Muhilar Shasto still had a lot to learn and wanted to maintain the close affiliation; she explained she didn't feel confident to run the project without support. She found the network created between BPHC-CDS projects very helpful, particularly because the regular coordination meetings held for project managers established a forum for problem sharing and discussion amongst fellow NGOs. Shameem was a very competent manager and had developed a very good secondary management level amongst her supervisory staff, who were capable of running the office effectively in her absence. Her technique was delegatory and participatory at all levels; main decisions about the project were made through discussion with the supervisors and FHVs in weekly and monthly meetings, and they were encouraged to come up with ideas on solving problems, sustainability, etc. Despite this, much of the direction for the project's future development, such as the shift to a more participatory approach, came from 'above', according to CDS's own development plan. Shameem had many ideas and plans which she discussed with me, but at times had to await the advice and approval of CDS before acting on them. I therefore felt that although Muhilar Shasto needed to rethink its approach and greatly develop the participation of the community in its activities, the imposition of CDS's own plan to do this to a large extent inhibited Muhilar Shasto's own innovation and encouraged Shameem's dependence on CDS for guidance.

My overall impression was that although CDS described Muhilar Shasto as their 'partner', which would imply a relation of equality, they did in fact regard them as a

CDS project within the organisational hierarchy. The degree of control they exercised over Muhilar Shasto's programme planning and finances - which they dispersed four or five times a year rather than six-monthly - meant that Muhilar Shasto could not operate as an autonomous organisation. Anything that required extra finances (such as a credit fund for the loan programme), a change in budget expenditure, or a major change to the programme had first to be approved by CDS. The external evaluation team, contracted by BPHC to evaluate Muhilar Shasto, stated that they felt CDS had too much control which constrained the management capabilities of the project's Implementation Committee. This was a committee set up to manage the project and make decisions about its future, recruitment of staff, control of funds, etc. They also had an Executive Committee whose role was very similar. The evaluators found that instead these roles were being fulfilled by CDS. The general feeling of the team was that the main line of communication existed between Shameem and CDS, and missed out these 2 voluntary bodies, thus undermining further the NGO's independence. They recommended the Implementation Committee members should be given technical assistance to perform their role more actively and retain control of the project's management. In fact, the committee has since been disbanded and the Executive Committee has assumed all responsibility. Whether this has been accompanied by a change in lines of communication and an actual decentralisation of decision making power from CDS I am unable to say, since it occurred after my departure. However, my feeling was that if Muhilar Shasto was to develop into a sustainable NGO with effective and capable management, this needed to happen in order to lessen their reliance on others for decision making and direction.

MUHILAR SHASTO'S MCH-FP PROJECT

Muhilar Shasto was established in 1985 as an education programme for children in the district town of Jessore and some surrounding villages. A small school was set up in town and female volunteers trained in villages to teach groups of children in their homes. In response to village women's requests for health care provision, the project decided to start a community-based health programme and sought assistance from CDS for funding. Although under the same directorship and General Body Committee, the MCH-FP project was set up separately from the education programme, with its own office and clinic in Amhat *upazila*, 20 miles from Jessore town. New staff were recruited, including a Project Manager, to run the project essentially as an autonomous organisation, with its own management

system and source of funding. Hence, when I talk about Muhilar Shasto, I am referring exclusively to the MCH project.

STAFF

An unusual feature of the project is that it employs mostly women - 28 of the 35 staff members. This includes the senior positions of project manager, accountant and paramedic, with Muhilar Shasto's directorship also being held by a female. It is also interesting to note that all these women are only in their mid-twenties and hold at least graduate degrees; Sharmeem, the project manager, has a master's degree in business management. This represents a highly qualified and quite unique management and organisational structure, for although it is one of eleven female-run BPHC-funded projects, the other female managers are significantly older and tend to be supported by male senior staff. The other senior-level staff member of the project, recruited in the fourth year, is the male Development Officer, also a graduate in his twenties.

The paramedic heads the clinic staff of two counsellors and two *aiyas*. The project was looking to recruit another female paramedic to complete a second clinical team, but had very little response, even on a national scale, because of the distinct lack of appropriately trained women. Consequently, there was tremendous demand for them within both NGO and government sectors, resulting in a high turnover. The impermanence of paramedics was a problem shared by many NGOs, since it disturbed the continuity of projects and incurred the expense of continually training new staff. This was so acute that during the last few months of my stay Muhilar Shasto was actually left completely without a paramedic, due to the resignation of the current one in favour of a government post. Two new recruits were finally found and began the month after I left.

The body of staff is made up of those working in the field: Family Health Visitors (FHVs) and supervisors. The project covers 35 villages, widely dispersed over a large geographical area, and is divided into 18 working areas, each served by an FHV. There are 18 FHVs in total, all female, and 6 supervisors - 3 female and 3 male. Each supervisor is responsible for 3 working areas and hence 3 FHVs. Their role is primarily to oversee the work of FHVs through regular field visits, which they make on about 4 days a week; the remaining two are spent in the office attending to large amounts of paperwork associated with the various reporting systems. All the supervisors live in either Amhat or Jessore and travel to and from the working areas

on a daily basis. This is considerably easier for the men, who ride bicycles and are therefore independently mobile. For the female supervisors the job is harder because they have to rely primarily on using rickshaw vans to visit villages, the majority of which are unevenly scattered in very remote areas, and unserved by proper roads and public transport. During the rainy season reaching these areas by rickshaw often proves to be impossible and they are forced to walk long distances through the mud. Thus, large amounts of their time are taken up travelling to and from the working areas.

Each FHV works with a trained Traditional Birth Attendant (TBA) from her field locality. These are women selected from and by the community because of their previous experience in performing deliveries. In many developing countries TBAs have come to be recognised as an essential resource in extending the effectiveness of mother and child health programmes. In Bangladesh, an estimated 95% of births take place in the home, assisted by local birth attendants or female relatives, and hence TBAs are very important indigenous health care providers. Under the government and NGO collaborative programme they are given training on safe delivery, antenatal and postnatal care, and the recognition and referral of risk mothers, and are provided with basic delivery kits. They are not employed as members of staff but form a voluntary cadre within the rural health team. As such they do not receive a wage for their work, but are given a monthly travel allowance, which in Muhilar Shasto is Tk300 (about £5.50). This covers the costs of attending a monthly meeting in the Amhat office and any other work-related travel. I shall discuss the programme in more detail in Chapter 7.

In addition to the aforementioned staff, the project also has a male office assistant, peon and guard.

COORDINATION WITH LOCAL GOVERNMENT HEALTH SERVICES

All health projects intending to run a family planning service must be registered with the local Family Planning Department. Their working area is then allocated by the local Deputy Director of Family Planning to ensure no overlap with government services, and observing the map in Muhilar Shasto's office, it is rather noticeable that many of the allocated areas are very isolated villages and quite difficult to reach. The system, it appears, is to allocate to others the least accessible places in the *upazila*! The village I lived in might be classified as one of these. The result has been to create a totally random working area for Muhilar Shasto, spread across five of the

eleven unions in Amhat, such that many villages are served in isolation from their neighbours. The lack of geographical continuity obviously hampers the efficiency and effectiveness of the programme since much time is wasted travelling to and from different places on a day-to-day basis. It also means the existing local mechanisms of communication and social networks can not be fully exploited to facilitate involvement of the communities and spread awareness of the project. Due to the randomness of villages the rationale for dividing up field areas is based on population size, each FHV being given a similar number of households to cover, totalling about 350. This means some FHVs have widely dispersed field areas and have to walk several miles to cover them, while others work only in one large village. Another disruptive element in the system is the fact that every so often the government decides to re-allocate villages, claiming for itself areas where Muhilar Shasto have become established and well known, and giving them in return, a previously unserved area. This obviously creates tremendous logistical problems for Muhilar Shasto, but also causes dissatisfaction in the communities, which have become familiar with the FHV and her work.

Affiliation with the government and necessity to complete regular reports for the Deputy Director of Family Planning means the project maintains a close association with local government health facilities. In the small *upazila* town of Amhat, where Muhilar Shasto's office-clinic is based, these constitute a hospital and Family Welfare Centre. Both are used by Muhilar Shasto as referral centres for clients requiring medical care beyond the expertise of the paramedic. The Family Welfare Centre can perform sterilisation and menstrual regulation (MR)[3] but delivery complications and emergencies must be referred to the hospital. The term 'hospital' is a rather optimistic description of what in actuality is a collection of five dirty, poorly maintained rooms housing little more than paperwork and frustrated, uninspired doctors. In many instances the situation is such that anything requiring

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[3] Under the 1860 Colonial Penal Code, abortion is permitted in Bangladesh only in extreme circumstances where the mother's life is considered to be at risk. However, in 1979 the government declared that Menstrual Regulation was permitted as a method of inducing menstruation in a woman who has missed her period, and may or may not be pregnant. The Bangladesh Institute of Law (1979) describe MR as an "interim method of establishing non-pregnancy for a woman at risk of being pregnant", whether or not she may in fact be pregnant (Begum 1993:30). Essentially, MR is a euphemism for abortion, but the technical ambiguity of the physical state of the woman soon after missing a period, allows the method to be a politically and culturally acceptable health measure (Dhal and Mazumdar 1993, Dixon-Mueller 1988, Coyaji 1993).

more than minor treatment has to be referred to Jessore town because of the dire lack of facilities, equipment and drugs. They are not able to deal with any serious cases, and this includes problematic deliveries such as caesarians. There are no wards, or even space except on the verandah, where patients can be kept over night. Surprisingly, however, staff is one thing that is not lacking. There are six qualified doctors plus several nurses, none of whom can actually practise properly because of the lack of medicine and equipment. One doctor told me they even had to buy their own stethoscopes because the hospital couldn't afford them! On one occasion I was there a woman was rushed in on the back of a bicycle, having tried to commit suicide by drinking poison. The doctor I was talking to paid no attention at all and the nurse simply stood outside on the steps watching, while what appeared to be the peon and husband forced a tube down her throat and proceeded to wash out her stomach. This all occurred on the grass in front of the hospital, but not a single medically trained person attended to the emergency! A new large, modern hospital complex had been under construction for a long period but still remained incomplete after my departure, despite being well past the official opening date. Consequently, the government health facilities in Amhat leave a lot to be desired and many people prefer to use local unqualified practitioners, rather than be turned away by the hospital staff.

THE COMMUNITY HEALTH APPROACH

Muhilar Shasto's programme is based on the BPHC model, and has the primary objectives of achieving a reduction in maternal, neonatal and infant mortality rates, increased acceptance of family planning, improved sanitation and safe water use, increased immunisation coverage, and improvement in the general health status of the target population. Within the project's programme there are various elements that address these objectives. Obviously the health goals are targeted through the MCH activities and TBA programme, and these are integrated with family planning activities, all of which are focused at the household level. Discussions on safe water use, hygiene and sanitation are incorporated into health education and given quite a central importance, since the majority of illnesses, particularly amongst small children, can be related to unhygienic practices and polluted water sources. Although there are a number of deep tubewells in the area of Shundurgram, with good quality water, the preferred custom is to use water from ponds or the river to cook with, particularly for rice and certain vegetables. Most people also prefer to bath in a pond, for which there is a multiplicity of other uses, such as washing

clothes and utensils, watering animals, fishing and so on. The lack of a cultural concept of hygiene makes it difficult to change people's attitudes and behaviour concerning this. For this same reason, the use of pit latrines is also not common in rural areas. Quite the opposite to defecating in one protected location, the practice is to use the vegetated *bagan* ('garden') areas or rice fields, where the faecal matter is spread over a large area. To combat the consequent spread of disease and worm infestation that this causes, and to try and change local habits, Muhilar Shasto started a latrine distribution programme through its women's groups, which has now been expanded to the client community in general.

Muhilar Shasto do not give immunisations as part of their activities, since the government's Expanded Programme of Immunisation (EPI) covers their entire working area. They do however, work in coordination with government workers, motivating people to take their children along to monthly sessions held in the villages. Muhilar Shasto have tried as far as possible to synchronise their own satellite clinics with these EPI sessions so as to provide a comprehensive service all in one go. Even when this is not possible, the FHV accompanies and assists the EPI worker, often recruiting the local TBA to help round-up clients.

Muhilar Shasto's community health approach has three stages in service delivery, the first two being the most fundamental and the levels at which the majority of activities take place:

1. Community/household level: FHV provides advice and education on general health care, mother and child health, screening for and provision of contraceptive pills and condoms; TBA provides antenatal and postnatal care and safe deliveries.

2. Satellite clinic held in the community: counselling and health education, screening for and provision of contraceptive pills, injectables and condoms, immunisation, antenatal and postnatal care, growth monitoring, general treatment.

3. Static clinic in *upazila*: service as satellite clinic plus screening and IUD insertion, referral to government clinic and hospital for Menstrual Regulation (MR), IUDs, sterilisation, deliveries, problem cases and emergencies.

Thus, service delivery is primarily community based and is provided by FHVs, who are ideally local village women. The intention is to utilise existing local human

resources so that, as members of the client community, they are able to act as 'brokers', representing both parties in the relationship. This is also very important in establishing trust and reliability, and the roots of community participation and ownership of the project. They are, therefore, the most important and essential members of the community health team. In practice, however, there is a problem with recruiting women from villages in which they work because very few have the educational qualifications required (at least 8-10 years schooling), and those that do come from higher status families who are often reluctant for them to work. Consequently, only a few FHVs are actually from their working areas. Most travel to them daily from neighbouring areas, or stay there during the week and go home at weekends. Thus, many of them are 'outsiders' to the communities. The FHV I worked with was from Jessore, but after working in Shundurgram for a year and renting a room in someone's house, she married the son of a wealthy family in the village and consequently became a permanent resident.

FHVs work on a daily house-to-house basis, visiting around 20 households each day, and covering their entire field area, of around 350 households, every month. Their roles are primarily those of educators and motivators, and they are the main links between the community and NGO. They are supposed to spend about 20 minutes in each house, identifying the individual needs of the household and its members, but typically the time spent is much shorter. The FHV I worked with had a tendency to cover everything at top speed, with little opportunity for feedback or discussion. Her technique was very non-participatory and more like a lecture than a dialogue or exchange. Consequently, she used to finish her day's work quickly, sometimes we would have covered the 20 households by around lunchtime, and she would then go home to tend to her new baby (born in June 1992) and her domestic duties. FHVs complete a Family Health Card for each household, regularly recording the health status of the whole family, including illness episodes, pregnancy, contraceptive methods used (if any) by 'eligible couples', side-effects, births and deaths, etc. Thus, the card maintains a detailed health history of the family.

They give education to women on maternal, child and primary health care issues, e.g., a priority is the treatment of diarrhoea with homemade Oral Rehydration Solution (ORS). They teach mothers to use the MUAC (Middle Upper Arm Circumference) tape to detect malnutrition in children and tell them about local nutritional vegetables and how to make *kechuri*, (a rice, *dhal* and vegetable dish) which is high in nutritional value and also used as a weaning food. The MUAC

measurement is recorded monthly on a card kept by the mother, in order to plot the child's nutritional history between the ages of 1 and 5 years. Most mothers understand the significance of the three different colours on the tape and are able to say that red means *karap* ('bad'), yellow means *beshi bhalo na* ('not very good') and green means *shasto bhalo* ('their health is good'). However few, if any, use it themselves to monitor their children. It is seen as something the FHV does on her monthly visits. 'Red' children, i.e., those at risk, are referred to the satellite clinic for growth monitoring by the clinic staff.

The child health programme includes the distribution of vitamin A tablets half-yearly, to combat the pervasive national problem of nightblindness. FHVs also used to distribute de-worming tablets to children on a house-to-house basis, but this was changed so that children suspected of having worms now have to be referred to the paramedic for treatment, and greater emphasis is placed on educating mothers about preventive measures. This, of course, ties in with the water and sanitation programme, emphasising the need to use water-sealed pit latrines, to wash hands thoroughly with soap and water after defecating and before eating, to keep nails short and clean, and wear shoes, particularly when going to the toilet.

Women's health issues are predominantly concerned with reproductive health care: prevention of pregnancy, care during pregnancy, safe delivery and care after delivery. FHVs primarily target their main work at married women of reproductive age, although they are urged to involve mothers-in-law in discussions as much as possible, and husbands, if they are home. Motivating women to use contraception is central in their work - I specify women because men are usually out at work during visits and therefore not available for inclusion in discussions. Even when men were at home, Rohima, the FHV I worked with, only tended to talk to them directly if they objected to using contraception and prevented their wife from doing so. In general, she only actively approached men when they represented a barrier or obstacle. She did not routinely target them with health education. One of the reasons for this being that most men weren't interested in what she had to say about children, or nutrition and health care. They saw these as the responsibility of women and were therefore not prepared to sit and listen.

The consequent focus on **women's** reproductive responsibility is in accordance with the cultural gender division of labour, in which child bearing and rearing are female responsibilities. However, this ignores and excludes the predominant role men play in household decision-making processes, and the ultimate power they have over

their wives' bodies. Consequently, their lack of 'motivation'[4] concerning birth control can prevent their 'motivated' wives from using contraception. The imbalance between female and male awareness concerning family planning therefore needs to be addressed, so that both are in a position to make informed decisions. The subject of family planning policy is complex and contentious and I explore it in more detail in the following chapter. The point of practical importance here is that motivating people to use contraception can be hard work, especially with objections from the most influential members of the household and community. Since FHVs' performance is, to a large extent, judged on the contraceptive prevalence rate (CPR) in their field areas and their ability to achieve set targets, it is understandable why so much affort is put into family planning motivation.

This is not the only indicator used to assess the quality of their work, but is sufficiently significant to warrant public commendation and a prize for the health worker (government or NGO) with the highest CPR in the *upazila*, at the Annual Population Day celebration. Muhilar Shasto also decided one month to give a prize to the FHV with the highest number of new IUD and ligation acceptors, in recognition of their successful work and as an incentive to the others.

FHVs are trained to screen for suitable users of contraceptive pills, a supply of which they carry with them, and they also distribute condoms, although they are not very popular. Women wanting to use another method, such as the contraceptive injection, must go to the clinic, or satellite clinic for screening by the trained paramedic. FHVs are not trained to give injections or medicine.

Their other primary responsibility is care of pregnant mothers and supervision of the local TBA. When a client becomes pregnant the FHV gives advice on dietary requirements and special care, such as reduced work load, rest, hygiene and so on, and refers the woman to the satellite clinic or clinic, for regular antenatal check-ups. The TBA should also make regular antenatal visits to the woman and record her progress on a TBA Card. Since the majority of TBAs are illiterate, a pictorial card has been specially designed for their use by BPHC. The FHV is responsible for

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[4] I am using the words 'motivation', or 'motivate', rather than possibly more approriate terms such as 'interest', 'desire' or 'support' because they are constantly used by staff in reference to improving contraceptive acceptance. Strong emphasis is placed on good 'motivational' techniques to 'motivate' people to change their attitudes and behaviour.

promoting the skills and importance of the TBA within the community, and for convincing people of the need to call her when labour starts. In order to enhance community respect and recognition of her skills, the TBA in Shundurgram would often accompany myself and Rohima on house visits, and explain her training and techniques to other women, particularly the *buris* (old women), who were sometimes sceptical of the need to call her if they themselves had experience of deliveries (see Chapter 7).

SATELLITE CLINICS

All working areas are visited monthly by the mobile satellite clinic, staffed by one of two clinical teams. When I first arrived there was only one team, which worked alternate days in the field and office clinic, such that not all working areas could be covered in the monthly cycle. Those nearest Amhat had to come to the office and eleven of the field areas were visited. However, when the project went into its second phase of funding Muhilar Shasto received money to increase the number of staff, and nine new members were recruited, including a counsellor (trained as a staff nurse and therefore able to administer injections) and *aiya* for a second clinical team - as previously mentioned, there was some delay in finding a suitable paramedic. This made it possible to expand coverage of clinical services to all working areas, in addition to having a daily office clinic. The satellite team, usually including the supervisor as well as clinical staff, travels to villages by rickshaw van, with the equipment stored in a large tin trunk. Most destinations require travelling at least part, if not all the way, along dirt tracks, and are also a significant distance from the office. Some sites take a couple of hours to reach by rickshaw van, making satellite visits physically demanding for all involved, especially the rickshaw wala, who pulls the weight of three or four people plus the trunk! The hot rainy season is the worst. At this time of year roads are often deep in mud and rickshaws cannot pass, meaning that the trunk has to be carried on foot. During this season the regularity of satellite clinics is very much dependent on the weather, and sometimes certain areas can not be reached.

The satellite clinic situates itself in the house of a respected community member. The selection of location is dependent on accessibility for all people in the area and this, as I learnt, is not a straight forward issue of geographical centrality. Originally, in large field areas such as Shundurgram, the clinic rotated every few months between neighbourhoods. But this was then changed to a relatively central, static

location, with the rationale that people would always know where to find it and become accustomed to going there. However, as I will discuss later, the change actually prevented many women who had previously utilised the facility from doing so further because of a number of constraints that existed: the culturally prescribed boundary, defining the paddy fields they had to cross as an area of great vulnerability for women, particularly when pregnant; the physical constraint of the distance (which was only about a 15 minute walk); and the social boundary demarcating an unfamiliar neighbourhood. As a result the satellite clinic in Shundurgram was often quite poorly attended.

The satellite clinic lasts for about 3 hours in the morning. The counsellor holds group health education sessions for those waiting to be seen by the paramedic, and organises women in the surrounding houses to contribute ingredients to cook, *kechuri* for children who have been referred with malnutrition. This is given as a practical demonstration to mothers on how to rehabilitate the nutritional status of their children, without wasting money on the magical 'syrups' and other medication given by local '*daktars*'. Growth monitoring of children is done by the supervisor, and the FHV and TBA visit houses, rounding-up those who need to attend, e.g., antenatal and postnatal mothers, contraceptive injection users, and 'red' (malnourished) children. The paramedic also provides general treatment using essential drugs.

Although the satellite clinics are community based, they are not community owned or controlled. Management and organisation is done by the staff and community involvement is very passive. This is an aspect the BPHC evaluation picked up on and felt needed enhancing, by handing over responsibility for organisation and management to the community. CDS also felt this to be necessary and suggested a female volunteer, perhaps from the women's groups, should be recruited to keep the client register and collect the service fees. However, finding somebody literate enough to do this, and with spare time to give up a whole morning, is not easy, so the system has not been successfully implemented.

SAMITY PROGRAMME

In the second year of their programme, Muhilar Shasto also introduced the formation of women's savings groups, known as *samitys*, into several of the working areas. These were started in June 1991 as a means of helping to implement the health programme more effectively within the villages. The main aim was to

encourage women to become actively involved in the MCH-FP activities to help increase their awareness of primary health care issues, and hence try and combat malnutrition in a vast number of children. Members were also encouraged to save small amounts of money on a regular basis to build-up savings in order to help improve their economic status, and some groups were given *tut gach* (mulberry trees) for a future income generating sericulture programme. It was also felt that involving women in this way, would increase local support and strengthen the project.

In the third and fourth years Muhilar Shasto began to expand their programme with a more integrated perspective on development. This has meant that groups have begun to address wider issues, such as gender relations, legal rights in marriage, polygamy and divorce, domestic violence and payment of dowry, in addition to health care. These weekly meetings are intended to create a sense of unity and support amongst women, and to provide a forum in which they are able to talk about their problems and tackle them with the help of others. This is seen as a process of empowerment, and as part of this process a loan and income generating programme was started in February 1993, with the intention of helping to improve women's economic status and reduce their financial dependence on men. I discuss the development of the *samity* programme, its empowerment aims and the loan programme in much greater detail in Chapters 8 and 9.

THE MISSING AGENDA: DOMESTIC VIOLENCE AND WOMEN'S HEALTH

An important issue which is directly related to the objectives of the MCH programme, i.e., improving women's health status and welfare, but which is overlooked by the MCH approach, is the issue of domestic violence.

In Shundurgram incidences of domestic violence were common but not recognised by Muhilar Shasto to be of primary concern to their health agenda. In policy terms, domestic violence is usually categorised as a women's empowerment issue and concerned with women's legal rights, rather than their health status. Muhilar Shasto broached the subject in informal discussions within the women's groups, but outside this forum the issue of domestic violence was rarely brought-up in contacts between health workers and women. The relationship between husband and wife was considered to be a private matter and FHVs did not regard it their business or

part of their job to discuss this. Physical abuse was very much taken for granted as a fact of life.

However, there was a connection between the programme and domestic violence which was not openly acknowledged by Muhilar Shasto. In the village I often heard women say they couldn't use contraception, they couldn't attend the clinic, they couldn't take a rest from work, or eat more nutritious food, because their husband would beat them. Some women were frightened to have an IUD because they thought they wouldn't be able to do heavy work and their mother-in-law would chastise them with physical or emotional abuse. Side-effects experienced by many women from taking the pill, such as dizziness, headaches, nausea, lack of energy, aching and painful limbs, also made it difficult to do this. A woman who is unable to maintain the household and look after her children properly is not a 'good wife' and worthy of criticism and punishment. Many women on the pill also experienced irregular and prolonged menstruation, during which time sexual relations with their husbands were strictly taboo. Some women said that when this happened over long periods their husbands beat them in anger.

Many women's lives seemed to be characterised by this painful but quiet violence which took place behind closed doors. It was often unseen or ignored by others, and nearly always went unquestioned or unchallenged. The emotional and physical suffering was a taken-for-granted part of being a female. Reports in newspapers and stories from women indicated that in many instances the unbearable abuse leads to suicide and murder; I was aware of several cases in the Shundurgram area. Such cases are looked upon almost as a matter of course in village life and are very rarely followed up by the police. Often the victim will be blamed for her own death and the offending party regarded as free from guilt.

I illustrate this with an example:

> On 18th June I went to view the body of a young woman who had allegedly hung herself. She had been married for 9 years but had failed to produce a child and consequently was regarded as an inadequate wife. Both her husband and mother-in-law were dissatisfied with her and she was frequently beaten and abused. The husband was in fact, in love with another woman whom he wanted as a second wife, and this upset his first wife badly. They had argued and he had beaten her, ripping a handful of hair from her

head. That night she had become so desperate she hung herself from the beams inside her room.

The talk amongst the local women was, however, more macabre. They believed that he had in fact beaten her to death, and in an attempt to hide it, had put the rope around her neck to make it look like suicide. The truth was never discovered because the police, after receiving a bribe from his family, failed to investigate. In the eyes of the law her life was not worth the effort.

Even when someone is known to be guilty social circumstances often fall in their favour. The woman's family is often powerless to question the truth since they can not insist on an inquiry because of the expense of a court case. This would also require an autopsy, which for a number of reasons, is culturally unacceptable: in terms of the traditional Ayurvedic and Unani medical systems, which do not involve surgical operations, the idea of an autopsy is quite repulsive (Blanchet 1984:129); revelation of the woman's naked body to strangers is unthinkably shameful; and cutting open and dismembering it would mean that it could not be properly purified according to Islamic funeral rites. The sinful act of suicide also brings dishonour to the family and, therefore, it is better quickly forgotten than dwelt upon. Thus, a complexity of factors - patriarchal dominance, cultural norms, the low value of a woman's life and the expendable nature of a wife - ensures that such female suffering remains a silent and invisible issue; a private matter concerning only those involved.

Although Muhilar Shasto recognised violence to be an important issue and discussed it in the women's groups there was no specific project policy relating to how it could be addressed by the programme. This again reiterates the need for MCH programmes to adopt a gender perspective on health issues and to analyse the underlying causes of women's poor health and social subordination.

DEVELOPMENTS IN THE PROJECT: AIMS TO INCREASE COMMUNITY PARTICIPATION

Over the 12 months I spent with the project, which covered the transition from the first 3 year plan and funding period to the second, Muhilar Shasto's perspective changed to one of a more integrated development approach, with wider objectives beyond those of primary health care. This was instigated by two factors: 1) the introduction by the support NGO, CDS, of a number of new elements into the

programme to develop a more participatory approach, and 2) as a result of experiences and problems encountered by the project, particularly with women's group formation, and a recognition that a wider section of the community needed to be involved in the project - principally men, and women with authority in the household, i.e. mothers-in-law. It was realised that although a mother or wife has 'responsibilities' in maintaining the household and welfare of children, she does not necessarily have 'control' over what is done and so mothers-in-law, in particular, need to be more involved in health discussions during the house visits.

Overall decision-making power in a family is, however, held by men, such that they ultimately have control over the extent to which their wives are able to act on the education and advice they receive. Many problems experienced by the project can be accounted for by the fact that the structure of local power relations has been ignored. The most influential decision-makers and power holders in the community - men, male and female elders, political and religious leaders, who are often also the guardians of traditional values and norms of behaviour - have not been actively involved in the intended process of change. Participation of the community was limited to a passive role played by women, participating in the programme simply by accepting the service, the most minimal form of participation identified by Rifkin (1990) (see Chapter 1).

In response to these experiences and information fed back by field staff, changes were made in the programme that tried to encourage greater participation of the community. In the last few months of my fieldwork village committees were formed by FHVs in each working area. These constituted eight members, four men and four women, ideally made up of local and religious leaders, teachers, women from the groups and other men and women from a cross-section of the community, but the meetings are open to everyone. Women's attendance and participation at the few initial meetings I was able to go to was poor, but this is only to be expected early on, since such public forums are traditionally exclusively the domain of men. The FHV and supervisor guided the discussions, which were intended to cover general health issues, such as sanitation, specific health issues relating to the community, such as low contraceptive acceptance, village problems and future development plans, etc. The aim was to increase awareness of health issues at community level, particularly amongst community leaders and men, and hence gain their support in bringing about changes in attitudes and norms of behaviour. The forum was not explicitly intended to give the community a decision-making role in the overall planning process, but to allow them to contribute to different

community activities and take on responsibilities in, for example, encouraging use of pit latrines and organising satellite clinics. In this sense the form of participation would be active but the community still would not have control over the programme.

In addition to this, as part of CDS's own development plan, a village volunteer programme was also planned but had not begun before I left. The objective was to select certain women to help FHVs in their motivational work, with the running of the satellite clinics and act as local holders of oral rehydration solution (ORS) and condoms. The intention was that these women would create a closer link between the NGO and the community. CDS also wanted to start a women's literacy programme within the *samitys*, where the volunteers would be trained to be teachers. There was some dispute as to whether this should be implemented before Muhilar Shasto's own plan to start a loan programme, and eventually it was agreed to postpone it until the loans were well under way. On my departure in February, it had still not been planned when the literacy programme would actually start, since selection of village volunteers was incomplete. Again, this measure to encourage participation in the programme would only allow a contributory role in activities planned by the project, rather than enhancing women's ability to participate in the planning process itself.

My departure from Jessore in February 1993 was unfortunately badly timed as all these changes only began to take shape early that year. As a result of their relationship with CDS and learning from their experiences, Muhilar Shasto was moving into a new phase that encompassed a more holistic approach to community health and its interrelatedness with other development priorities. It would have been interesting to have stayed longer to observe the implementation of the new programmes and the impact of the measures to increase community participation, but unfortunately time, my sponsors and my funding would not allow it.

CHAPTER 5

POPULATION, POVERTY AND PATRIARCHY: A SOCIO-CULTURAL PERSPECTIVE ON FAMILY PLANNING POLICY AND CONTRACEPTIVE USE

> For the Indian woman, fertility is the path to power. She must procreate to establish an identity and status. But few women have control over their fertility (Dhal and Mazumdar 1993:25).

This is also true for their female neighbours in Bangladesh, and for women in many other developing countries. They see the 'population problem' from a very different perspective to that of many demographers, policy makers and politicians, who set the global agenda to 'control' the so called population explosion. Rapid population growth, many have claimed, is the main cause of economic crisis in developing countries[1], leading to deepening poverty and environmental crisis in the future. Kate Young (1989:104) quotes R.McNamara, President of the World Bank, expressing the World Bank's attitude in the 1970s; "To put it simply: the greatest single obstacle to the economic and social advancement of the majority of the peoples in the underdeveloped world is rampant population growth" (cited by Pradervand, in L. Bondestam and S. Bergstrom 1980). Hence the need for stricter regulation of women's fertility, which, it was reasoned, would lead to a decline in poverty and growth in the economy since pressure on limited resources would be reduced. Although Young credits the World Bank with a later change in attitude, fertility reduction remains the priority of population programmes. Factors such as hierarchical power structures, social relations, inequalities in wealth distribution, income and resources, and gender inequality are still not prioritised as pertinent factors because, it is argued, population growth rates in The Third World are so high that we cannot wait for a spontaneous reduction as a result of developmental progress (Kabeer 1992:8). Teresita de Barbieri, in reference to Latin America, criticises those ignoring the underlying causes of poverty, and the maintenance of

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[1] Mamdani (1972) cites Paul Ehrlich as a major populariser of the 'population problem' during the 1960s, through his best selling book, *The Population Bomb* (1968).

the existing status quo. She argues that blaming population growth alone for economic failure means that other key aspects of social differentiation are over looked, particularly in relation to gender.

> The inequality between men and women socially, at family level and in interpersonal relations has not been seriously challenged. Every indication is to the contrary, that population policies aim to preserve the existing order, its hierarchies and its inequalities (1993:87).

Women in developing countries have received a disproportinate amount of attention in population programmes, compared to other spheres of development, based on the evident fact that they are the bearers of children (Kabeer 1992:3). As the poorest and most powerless members of the world community, they have the finger of guilt pointed at them, as perpetrators of a heinous crime. They are performing their biologically determined and socially prescribed roles as the reproducers of humankind, too well! The accusation, if interpreted in terms of the pessimistic assumption that there are too many people for the world to maintain, ultimately suggests that women, the reproducers of these people, are to blame for the resulting civil disorder and demise of the planet. It seems somewhat ironic that such powerless individuals could be blamed for such dramatic events, so how does the finger come to be pointed at them? Does it have something to do with women's relations with members of the opposite sex, who at the same time as ensuring that women remain subordinate in their reproductive role, are also, by and large, the owners of the finger and the critical tongue?

De Barbieri thinks it does. She argues that population policy is dominated by patriarchal politics, and that

> in the drawing up of population policies and in family planning programmes, a particular masculine perspective has predominated, cut from a technocratic cloth, that displays a limited knowledge of many of the complex processes present in the phenomena it seeks to control (1993:87).

Mira Shiva (1992) is also critical of population policy and the North's preoccupation with reducing fertility rates through technological fixes. She alerts us to the fact that corporate politics is central in population policy, with many of the world's corporate giants having representatives on the board of the International Planned Parenthood Federation, including Dupont Chemicals, US Sugar Corporation, General Motors, Chase Manhattan Bank, International Nickel, Marconi, Xerox, RCA and Gulf Oil. The question must then be asked, whose interests do these policy makers (most likely men) have at heart? Is it the interests of the global family, the

national or corporate family, or do they actually think of Bangladeshi women and their poverty stricken families? I somewhat doubt that the latter is their main priority.

This should not be read as a radical feminist attack, nor as a challenge to demographic and population policy - this has been done by a number of authors with greater authority and knowledge of population and demographic theories (e.g., Hartmann 1987, Shiva 1992, Kabeer 1992, Berer 1993, de Barbieri 1993). Instead, my intention is to attach a human face to the inanimate numbers that statisticians crunch when calculating, for example, the volume of new human bodies added to the earth every day[2]. Quantitative studies are useful for hypothesising about people's behaviour and predicting trends, but what about what people actually do, and really think? Who are the individuals behind the statistics making up the national Contraceptive Prevalence Rate (CPR), and what are their individual experiences and opinions? How well do national surveys reflect these? I want to refocus the lens through which 'the population' is viewed, from its wide-angle global and national settings, to the micro focus of the perspectives of the people who are most significantly affected by, and are the targets of, population policies - women. More specifically, I wish to view the issue from the perspective of women and their families in my research area in rural Bangladesh.

Before going any further I must point out that in presenting a women's perspective I have not ignored men, but as a female researcher in a *purdah* society it is difficult to gain access to male perspectives and attitudes, because of the strict norms of male and female segregation. These apply even when, as a foreign female anthropologist, you are considered a social anomaly with an almost androgynous identity that allows a certain gender ambiguity in social behaviour! Consequently, my experiences and relationships were primarily with women, in their private world of domestic seclusion. Of course, wandering from house to house with the health worker meant entering the public domain of men and brought me into contact with many men whom I did not know, but because of my presence with the familiar and respected female health worker, was able to talk to. Within the household where I stayed, I was able to talk quite freely with certain male members: i.e., my 'brothers';

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[2] According to an article entitled 'Birth Pangs' in an Indian news paper called *The Week* (1992 22 Mar:28), India adds 45,000 new human lives to the planet every day, which the author warns is 'well above the danger mark', leading to an 'ecological crisis' (quoted in T.K.Sundari Ravindran 1993:26).

male 'in-laws', e.g., the brothers of my 'sisters-in-law', and husbands of my 'sisters'; and the day labourer who worked for the family. I was also socially comfortable with the husbands of some of my closer female friends and with the 2 or 3 local *daktars* (unqualified allopathic practitioners) living in the area. I also spent a lot of time with the male supervisors and other male members of staff. Thus, while my experiences and research data are certainly not devoid of male opinions, attitudes, beliefs and so on - in such a male dominated society it would be impossible to ignore or avoid them - the nature and depth of my understanding of male perspectives is, as one would expect, limited.

I want to present an alternative picture to that of the rural Bangladeshi woman who, through ignorance and superstitious belief, fails to comply with the desires of politicians and population planners to 'control' her fertility, and irresponsibly continues to reproduce.

In this and the next chapter I explore local opinions and attitudes towards the concept of family planning, village women's experiences of using contraception and the perceptions they have about different methods, and how these are formed by, and relate to cultural norms, religious beliefs and notions of ethnophysiology. Through gaining a better understanding of the local cultural context into which family planning programmes are introduced, it becomes easier to understand why people have reservations, anxieties or objections to using contraceptive methods to limit the size of their families or practise birth-spacing. Non-compliance in family planning programmes is not due to ignorance or lack of education among the client community, but is bound up in a complex of social, cultural and economic factors. Planners and implementers, usually from an urban background with little experience and/or knowledge of these factors in rural communities, argue that people don't understand and need to be 'educated', but in many instances it is they who need to listen and learn in order to provide a service that meets the needs and priorities as defined by the people they are targeting[3].

THE FAMILY PLANNING PROGRAMME AT VILLAGE LEVEL

The promotion of 'family planning' through discussions on ideal family size, birth spacing and use of modern birth control methods is a main element of Muhilar

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[3] See Lipton (1977) and Chambers (1983) for discussions on urban bias in development.

Shasto's programme. A comprehensive service is provided at village level on a house-to-house basis by the Family Health Visitors (FHVs). In December 1992 the Contraceptive Prevalence Rate (CPR) of their working area was 58.2%, compared to 46.78% when they began in 1989.

Shundurgram, my research village, had never been served by the government's community-based family planning programme, so the arrival of Rohima, the project health worker, one morning back in 1989 marked the first time many villagers had heard about contraception, and been given the opportunity to use it. Some women had taken the pill bought from the market by their husbands and a few had had ligations and IUDs at the government clinic in town, but the number was not high.

Rohima explained to me that when she first came to the village she was met with suspicion and distrust. Local religious leaders were particularly strongly opposed to contraception. People described her and her work as 'bad' and said that she was not needed in the village. Other health workers had similarly unwelcoming receptions and one told me how she was chased out of a house by an irate old woman with a broom! However, Rohima persevered and slowly, after several visits, she began to win the trust of some of the women, who became interested in what she had to say about their children's health and the need to use contraception to prevent pregnancies[4]. She believed that the main reason why many women had not previously used contraception and were slow to respond to her, was that advice and methods had not been readily available. Since most village women observe some degree of *purdah*, many quite strictly, and few have been educated beyond primary level, they had never before had the opportunity to learn about contraception, and have direct access to it. The few that had used the pill did so only with the motivation of their husbands, who had to purchase them in the market at varying cost (prices ranged from about Tk6 to Tk35 per packet). Initially, many people expressed religious objections, but she found that younger women were quite easily convinced that these were unjustified, given a more liberal interpretation of Islam that supports having small families. This states that in actively doing so, parents are better able to feed and educate their children properly, and bring them up to be good Muslims: a quality rather than quantity argument (Obermeyer 1994:43). Practising birth control, Rohima argues, is being a

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[4] Simmons et al (1988) have written an interesting article on the role of female family planning workers in 'empowering' rural women in fertility decision-making.

responsible Muslim. Then and now, the main problems she has with motivating people to use contraception, lie not so much with the wives, but their *shashuris* ('mothers-in-law') and husbands, whose decisions on the matter are very influential. A few women secretly take the pill or contraceptive injection, but it is not easy to hide this under the circumstances of village life, where individual privacy simply does not exist.

Shashuris are generally elderly women who, by virtue of age and status, command considerable respect from and power over other women in the household. They sit at the top of a strict female hierarchy consisting of both their unmarried daughters and their son's wives (*bous*). At marriage *bous* enter the household at the bottom of this hierarchy and as they demonstrate their worth to the patrilineage through their fertility, preferably by becoming mothers of sons, they gain respect and status. Control over their domestic and reproductive role within the household, however, still remains with their *shashuri* until their husband breaks from the paternal household to set up his own, or until the *shashuri* dies and the most senior *bou* takes on her role, or indeed, when the *bou* becomes a *shashuri* herself. In all these instances the husband (and in a more general sense, other senior males in the household, such as the father-in-law), retains ultimate control over his *bou*.

Shashuris tend to have the most traditional attitudes towards family planning, often objecting to their daughters-in-law using any form of contraception, and are regarded by FHVs as among the main barriers to wider acceptance. However, quite a number now say they realise it is important and wish it had been available in their day, so they could have been spared the difficulties of perhaps 15 pregnancies, with 10 or 11 surviving children. Consequently, these women actively encourage their *bous* to use contraception and have only small families of 2 or 3 children. For example, one old woman lamented to me that had modern contraceptive methods been available when she was young she would not have suffered 19 pregnancies, 9 miscarriages, 10 births, and had 9 surviving children to feed!

I encountered one Hindu woman, who after giving birth to her second child, a girl, was told by her *shashuri* that she didn't need any more and should have a ligation. Her husband objected, however, but considered that an IUD might be permissable. Although their attitudes were positive from the viewpoint of fertility control, the wife's opinion was not significant, in that the power to control her own body was still being usurped by others. This demonstrates a very important point for planners, implementers and deliverers of family planning services to consider - a

woman can rarely make the decision to adopt a contraceptive method on her own; she does not have the reproductive freedom to choose.

So who does the ultimate decision lie with?

Invariably the husband must give his agreement. If he objects, the wife's opinion is of little consequence. In Shundurgram, I found that of non-acceptors, the explanation was more commonly an objection by the husband, than by the woman. For example, one woman who had been pregnant 13 times and had 9 living children, wanted to take the pill because she didn't want any more, but her husband (educated to class 5) objected on religious grounds, and said he would leave her if she did. There were, however, some cases where the woman was the objector and the male was in favour.

Depending on the type of household structure and the influence of the *shashuri* within it, her opinion may also be an important factor, particularly in extended households where sons remain in their parental household. As explained, within the household the *shashuri* wields the power in the female hierarchy, controlling the lives of the *bous*. Any decisions that concern them will be made if not exclusively by her, then in consultation with her. This is not so in the *baris* of sons who have split from the *shashuri's* household, as was common in the area of study. When the couple become economically independent the *shashuri's* power over the *bou* is greatly reduced, if not severed, as the *bou* is no longer responsible for household work, chores and cooking in the *shashuri's bari*. She has her own *bari* to maintain and the process of making decisions concerning her personally passes to her husband.

Thus, the wives in a household have very little control over their own fertility and sexuality. Shiva states about Indian women that "the freedom not to conceive is not in their hands: they do not have the right to say 'No'" (1992:83). Her comment is just as appropriate for women in Bangladesh.

WOMEN, MEN AND FAMILY PLANNING: THE NEED FOR A GENDER STRATEGY

Gender relations and women's status in society are, therefore, crucial factors in the control of women's fertility, and hence the 'success' of population programmes. Why then is it that, as de Barbieri (1993) bemoans, population programmes do little

or nothing to address female subordination and gender inequality? Women's empowerment is fundamental for them to be able to take control of their own fertility. Shiva, in reference to Indian population policies of the 1950s, argues that this is a major reason why they failed: if only they had listened to the people, to the women, they would have realised the need to strengthen women's position in society through education, economic opportunity and social change, to enable them to make choices about 'conception and contraception'. As it is, she contends, the situation of women in India (and it is equally true in Bangladesh) makes the concept of 'choice' a myth.

> In a society where a woman has no choice about when and to whom she should get married, when and how many times she would like to conceive, or even how much she should eat while she is pregnant or lactating, and where she is in no position to avail herself of minimal rest from strenuous work in the terminal stages of her pregnancy, does she really have any choice regarding contraceptive methods? Can she be expected to make an informed decision when she has no access to information, when often the only alternative open to her is sterilisation? (1992:86)

The issue of women's empowerment is absolutely fundamental to every aspect of maternal health care, particularly reproductive health care, but it is not necessarily included as a policy priority, or even an objective, in MCH-FP programmes. The BPHC does recognise its importance and in its NGO Project Manual, actively encourages NGOs to develop a gender strategy; indeed, it encourages an integrated community development approach combining primary health care with group formation, literacy, conscientization, skills training, credit, gender education and legal aid. However, it is not actually within its scope or mandate to provide training or technical support for these other activities, although financial assistance is available to set up credit schemes. NGOs requesting technical assistance in, for example, gender awareness or group formation, are referred to a number of experienced local training organisations. That BPHC recognise the primacy of women's empowerment in relation to health and women's welfare is significant and very positive, but their scope to actually integrate a gender strategy into their programme has been limited by the policy makers funding the project, namely ODA. ODA wrote the policy to cover the duration of both POP3 and POP4, i.e., the World Bank and Government of Bangladesh Third and Fourth Population and Health Projects, by which BPHC is bound[5]. The POP3 project (1985-1990) made no mention of a WID (Women In Development) strategy; one does appear in POP4

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[5] See ODA 1986, 1988, 1989, 1990, n.d.(a), n.d.(b).

(1993-1995), although a 'mention' is all it seems to get. It is written with reference only to recipient NGOs, and simply states that they are required to develop a 'gender strategy'. It does not explain what this strategy might involve or what its objective is, neither does it outline or consider what this might require from BPHC, in the way of technical support, training, finance, monitoring and evaluation. It is rather difficult to expect NGOs to do this when BPHC does not have its own clear gender strategy or appropriate in-house expertise to advise on it. No guidelines were given to them on how to implement a 'gender strategy' or monitor and evaluate impact on gender relations and women's empowerment. BPHC were unable to recruit new staff to cover this within their allocated budget, and the donors (ODA) would not allocate more for this purpose. Some senior staff did attend a 3 day Gender Training course (which I also attended), but this was of limited use to the overall project in isolation from any other assistance or inputs. Consequently, a gender strategy was not prioritised within the BPHC project mandate, rendering the emphasis on developing a gender strategy within NGO programmes more rhetorical than practical.

It is not that 'women' are overlooked (I am purposely using this rather than 'gender' for reasons that will become evident in a moment), but it is the superficial attention and marginalised position they are given at the policy and planning level, that is important. This demonstrates a more common trend in population planning, that women's status, subordination and sexual inequality are not central to 'population' issues, in the same way that supply and demand of contraceptives, quality of service, non-compliance of use, economic costs of child raising, and so on, are. 'Women's empowerment' is not regarded as intrinsic to their ability to adopt fertility control methods. Enhancing the status of women is, in BPHC's own words "a good starting point" for a community based health programme (*NGO Project Manual*:5). "A fundamental priority is to empower women with good health, knowledge and income. Part of this empowerment process is in enabling her to have control over her fertility" (page 10). But as Shiva has argued, provision of contraceptives is not sufficient to do this; a woman's status determines her control, such that programme activities to change her status must be part and parcel of the health programme, and not marginalised as separate 'women's programmes'. The integrated health approach recognises the importance of safe water and sanitation as non-health sector priorities; it also needs, as a fundamental requisite, to include activities related to women's empowerment and gender awareness at household,

community and project levels, addressing both women and men, landless and leaders.

The maternal health focus has brought attention to the need to involve women in health programmes, both among staff and within communities, in order to improve programme effectiveness and acceptability. Most NGOs recruit local women to become community health workers, thus opening up new opportunities of employment for more educated village women. This not only improves women's access to health services, but also helps to establish confidence in them and makes women visible in the public sphere. However, the emphasis is very much on 'women' rather than 'gender'. Men are not actively targeted and involved in commuity-level programmes in the same way as women are, since their reproductive and domestic responsibilities are seen as insignificant (Blanchet 1991:60). However, as is evident from the above discussion, and demonstrated by the ethnographic detail of the following chapters, the relationship between men and women is fundamental in defining and reinforcing these gender roles. Women-focused family planning programmes place reproductive responsibility solely on female shoulders, emphasising women's contraceptive methods and targeting education and motivation at women. Little attention is paid to the role of men in decisions relating to contraceptive use or to promoting 'male' contraception, i.e., condoms, vasectomy and withdrawal (Kabeer 1992:18). Men play a crucially important part in determining the health status of women and children in their family by virtue of their economic control over household affairs and overall decision making power. Therefore, although they are least in need of priority health care this does not mean they should, or can be ignored by health programmes.

Their political, economic and social superiority acts as a controlling power over women which cannot be side-tracked by exclusion. The only way for changes to occur so that women gain control over their own fertility, is to tackle these underlying causes of their powerlessness. This means a change in male attitudes and pervading social opinion, on for example, female mobility outside the household, stimulated through male-focused motivation and discussion groups, joint discussions with couples and (if necessary) the *shashuri*, and community level meetings attended by both women and men. Rather than a 'women in development' (WID) strategy there needs to be a 'gender aware' strategy that moves away from placing the blame and onus of reproductive responsibility on women, to a shared responsibility with men, and which takes account of existing structures of power and social relations.

> They should thus incorporate...discussion of the relations of both mother and father to the care and rearing of their children. In other words, the political dimension of the topic has to be recognised...That is to say, that it should be recognised that women have rights and needs *as women* and not just as mothers (Young 1989:117).

Population and health programmes cannot be apolitical if they are to have long-term beneficial effects.

FACTORS INFLUENCING FAMILY PLANNING DECISIONS

ECONOMIC PRESSURE AND GENDER PREFERENCE

As the title of this chapter implies, two of the most crucial underlying causes of high fertility rates are poverty and patriarchy. I have discussed the relationship of patriarchy with the 'population problem'. I would now like to turn to the issue of poverty and the chicken-and-egg tautology of, which came first? The neo-Malthusian 'population control' protagonists give a resounding 'p' for 'population explosion'. However, Mahmood Mamdani argues from the other direction:

> To talk...of 'overpopulation' is to say to people: you are poor because you are too many...[but] people are not poor because they have large families. Quite the contrary: they have large families because they are poor (1972:14)[6].

Even the World Bank's 1984 Report (p.184) claims to have changed its perspective, to recognise the rational decisions behind poor parents' choices in having many children (Kabeer 1992:7). A number of other studies in the agrarian societies of India and Bangladesh also support this argument (e.g., Jeffery et al 1989; Hartmann and Boyce 1983; Jansen 1987; Maloney et al 1981). Since the unpredictable nature of agrarian existence allows no assurance of security from one day to the next, let alone in old age, the most valued assets a poor family can have are human resources. Material assets such as land, a homestead and animals are fluid currency in rural society, slipping progressively from the hands of the poor to the powerful, as people struggle to survive the unpredictable odds of natural and economic catastrophe. There is no guarantee that a plot of land owned one day will not have to be sold the next, since the cost of merely living can be prohibitively high. The

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6 Mamdani's study has since been critised for being methodologically flawed and inaccurate (e.g. Nag & Kak 1984), but his argument that the poor have large families due to economic vulnerability is still valid.

illness of a family's male income earner is, for example, a major reason for having to sell one's assets, in order to pay the extortionate medical bills of the local *daktar*[7]. My village neighbours had become landless in this way, their only remaining real assets being the health of the father, who was quite elderly, and the son. When the father became ill they had to sell the small plot of land they owned because the son was still too young to work, and it became very tough to feed the family of three girls and a boy. Rogina, their mother, recalled that life only really began to improve when her son, a pious young boy of about fifteen, started working in the fields to earn an income of around Tk20 to Tk30 a day. In her household, he was without a doubt the most valued member. For many similar small landholders in the village, landlessness lingered just around the corner.

Thus, a large family represents some form of future security for parents in their elderly years, that is, when children have grown into adolescents and adults. However, small children are also economically productive, performing important tasks around the household, like minding goats, caring for younger children, helping in the kitchen, carrying lunch out to men in the fields, running messages, and so on. Girls tend to perform more of these tasks, starting at a younger age than boys, in training for their domestic roles as wives and mothers. Boys generally have more freedom to play, starting work in the fields at around 10 years of age, partly because they are more likely to attend primary school until this age. However, children's productive value is regarded by many in Shundurgram as outweighed by the cost of bringing them up. This was reflected in numerous comments made to me about the difficulty of feeding and clothing children. Thus, as Patricia Jeffery et al (1989) found in Uttar Pradesh, the benefits of a large family are realised in the long-term, when children become economically productive adults, rather than earlier, as a result of their labour when young.

Without children, preferably sons, there is no guarantee of being looked after once one becomes old and unable to earn an income. The situation is particularly acute for widows whose husbands, upon whom they have been totally dependant, die leaving them without any economic security. Patrilocal living arrangements mean that sons remain within the family *bari* and take over the responsibility of maintaining their parents once they are old, and they are also the perpetuators of

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7 Pryer's study (1989), '*When Breadwinners Fall Ill*', is an interesting examination of the implications of men's illness on the household.

the lineage. Daughters, on the other hand, leave the family home at marriage and become the 'possession' of their husband, and hence another lineage. They are, therefore, a less valuable source of future security, since their ability to provide support is dependent on the sympathy of their husband, and his family. This lesser economic and social value is reflected in the way girls are treated from birth and throughout their lives. Despite their contribution of household labour from a young age, girls represent a considerable economic burden. A dowry, usually costing several thousand *takas* cash, plus gifts of clothes, a watch and often a bicycle for the husband, must be raised for a daughter's marriage. The longer she remains at home the more of an economic burden she is to the family (Kramsjo and Wood 1992:22), and the greater the social stigma of her spinster status. Few can easily raise this amount of money and it often means borrowing, or selling land or animals. The neighbours on the other side of my *bari* were extremely poor and landless. The family was headed by a widow, whose three sons smuggled goods across the Indian border to earn an income. The daughter, in her late teens-early twenties, had been married for a short time but was now divorced and living back with her mother, who simply could not afford the expense of feeding and clothing her any longer. She was desperate to marry her off again but barely had enough money to survive. She sobbed to me "that it would cost five or six thousand *taka* because she cannot read or write", and there was no way she could find money like that; looking after her daughter was a terrible burden.

The pressure to have sons is therefore very great. Jeffery et al state about India:

> A son's labour power is considered more valuable than a daughter's... Sons are the best - if not the only - way of dealing with the hazards of old age in a society without pensions, life insurance, or substantial personal savings. Women's and men's security alike is bound up in their sons (1989:182).

Other studies in Bangladesh (e.g. Maloney et al 1981; Choudhury et al 1987) have looked at sexual preference and desired number of children, with the similar conclusion that sons are considered more important. The opinions expressed vary, but there is general agreement that at least one son is necessary, and two desirable. The social pressure to achieve this is enough to motivate many couples to reproduce until a son is conceived. Maloney et al found that the most common reason given for wanting more children was sexual preference for a son, and that this was stated more by females than males. They found that "if there are no living sons, more people want more children than if there are no living daughters" (1981:109). I often heard village women, who only had daughters, saying that

although they did not want a large family, they would continue to conceive in the hope of having a son. The pressure exerted on a woman by her husband and *shashuri* to produce a son or grandson can be very great, since she does not prove herself a worthy wife and perpetuater of her new lineage until she does so. Failure can result in severe criticism, abuse, abandonment, taking of a co-wife, and a generally unhappy existence for the woman in her husband's home.

I remember the story of my young female friend: she was pregnant for the third time, having lost her first two children in miscarriages, and was under close scrutiny by her *shashuri*, who desperately wanted a grandchild. Her own concern was the attitude of her husband. In her previous two pregnancies, when she had been extremely ill and remained recovering at her father's home for many months, he had not even come to see how she was. This time he told her that if she had a girl he would leave her, because all he wanted was a son. She therefore lived in fearful anticipation of the child's sex. When she gave birth to a girl in her father's village my own concern was raised. However, after speaking with her husband it seemed that the threats were forgotten, for his joy at finally becoming a father could not be hidden, even if it was a daughter's birth he was celebrating!

Another important factor that must be taken into consideration is the extremely high infant mortality rate in Bangladesh. In 1990 this was 94 deaths per 1000 live births (Bangladesh Bureau of Statistics 1992). Some more alarming figures that highlight the situation include the following: every 90 seconds a neonate (baby less than 28 days) dies; every year 400,000 infants (less than 1 year old) die, or almost 1 every minute; every year 200,000 children under 5 years of age die from diarrhoea (UNICEF February 1991, cited in BPHC *NGO Project Manual*). Under these circumstances, there is a high possibility of losing a child before or during delivery, and throughout infancy, so if a couple desire three children (the average number stated in Choudhury et al's study, 1987) with at least one son, it is very likely that the woman will need to endure more than three pregnancies before she is assured of having three live children, all of whom will reach adulthood. The unpredictable future of a young life and fatalistic attitude that rationalises this uncertainty, and supports a pro-fertility ethos, makes 'planning' a family an almost nonsensical concept. This uncertainty is part of the reasoning behind BPHC's approach of combining maternal and child health services with family planning programmes. If the chances of child survival can be improved through healthy mothers, safe deliveries, immunizations, home diarrhoea treatment, accessible clinical services,

and so on, people will feel less need to have so many children from fear that some will die.

RELIGIOUS ARGUMENTS 'FOR' AND 'AGAINST' CONTRACEPTION

Religious proscriptions are also important in influencing decisions regarding the use of contraception. The traditional interpretation of Islam pervasive in rural areas and upheld by many *munchis* and religious leaders (but not all), is a pronatalist, anti-contraception one. It asserts that humanity is dependent on Allah to provide new life and that only Allah has the power to determine if, and when, this should happen. Interfering with this process by preventing conception is deliberately challenging and changing Allah's will and committing a serious sin, punishable both on earth and in the after life. It is believed to be a person's fate to have a certain number of children, and that Allah will provide them with food and not allow them to go hungry. In other words, one can not use poverty as an excuse to thwart God's will. In largely illiterate communities where few can read the Quran or Hadith (teachings of the Prophet Mohammad) themselves, the view held by religious leaders is predominant and generally shared by the rest of the community. These men represent the local authority on religious doctrine and norms of morality; their opinions are therefore very important in the judgement of acceptable behaviour, and hence the acceptability of contraception.

I was given a very interesting exposition of the relationship between sex, family planning and poverty in Bangladesh by an elderly *fakir* (healer), whilst sitting in on a women's group one afternoon. He explained to me that his country was so poor because young men had only one interest, sex, and expended all their energy thinking about it. "When they see a young girl (*juboti*) they desire her and their bodies become hot, they are not interested in work and have no energy to do it. Foreigners, however, put their energy into work rather than sex, and for this reason have developed and become rich." He felt that it was the responsibility of the educated to educate others that you had to 'work' for your food and living, not be fatalistic and depend on Allah to provide this. This fatalism was, he said, the reason why many people did not use contraception. They did not worry that their baby would not eat because they believed Allah would provide for it. Even the rich and educated did not understand. "They buy meat and fish and good food to fuel their sexual drive, rather than to invest in their energy for work," therefore, even they do not contribute towards development of the country. He believed that through

people like health workers coming to rural areas to educate others on health issues, they had learnt something about this, but only a little. His argument, therefore, blamed the poor for their predicament, due to their ignorance, inordinate lust and laziness, and saw education as the only way to bring about development. Providing this was the responsibility of the better off and better educated, who up until now had themselves failed to understand properly and were as guilty as the poor. This explanation of the interrelatedness of the causes of poverty and the population issue is unusual, particularly in the context of village perspectives, although the *fakir* told me that he often met other *fakirs* of like mind. His analysis left an admirable impression on the project supervisor I was with, who commented that he had a far more intelligent and 'conscious' attitude than most villagers.

Since the government's family planning programme began in the mid 1960s, however, an increased awareness of contraception has led to a creeping change in attitudes and a corresponding rise in contraceptive use, particularly as a result of improved access to temporary methods. As one woman who had been using the contraceptive injection for a year told me, "I did not use family planning before because it was not available, but I had a desire (*icha*) for it." In recent years both governmental and non-governmental agencies have promoted contraceptive methods widely across the country through a variety of mediums, such as radio, T.V. and a social marketing campaign. The programme has been based on a more liberal interpretation of Islam. The main premises are that contraceptive use is not inconsistent with Islam, but on the contrary, is supported by it, since it is a sin to have children whom one can not properly educate and provide for. Mohammad condoned coitus interruptus and this, by analogy, has been taken to support all nonterminal contraceptive methods (Obermeyer 1994:43).

This view was relatively widely accepted within Shundurgram and other areas in which Muhilar Shasto had been working for up to 3 years. This did not necessarily mean that people therefore adopted contraception, merely that they did not object to it on religious grounds. There were, as discussed above, below and in the following chapter, a complex of other reasons for not using it. Those who maintained a traditional conservatism against contraception tended, on the whole, to be the *munchis* and elders (*shashuris* and *shoshurs*; 'fathers-in-law') and in general, more commonly men. Young women in particular, but also some older women, were far more willing to liberalise their views than their male partners, and realised the benefits of limiting the size of their families. Schuler and Hashemi's research (1992) in another rural area of Bangladesh found a similar situation; objections to

contraceptive use and dependence on the will of Allah are more commonly expressed by men.

GENDER AND REPRODUCTIVE RESPONSIBILITY

This 'traditional' male objection is strongly grounded in the gender relations between husbands and wives, men and women, which underpin the social stratification of rural society. In objecting to their wives' use of contraceptive methods, men are maintaining their position of power, by retaining control over women's fertility and preserving the state of *purdah*. Schuler and Hashemi state:

> "Traditional" opposition to use of contraception, on the grounds that it is against the religion, frequently is interwoven with opposition to women's increasing presence in the public sphere. When the ideological struggle between traditional and modern views of Islam and contraception is played out through social interactions, there is often a subtext involving women's gradual emergence from domination by men, and a patriarchal backlash (1992:4).

Within the patriarchal family, men generally reap the benefits from having a large family while women of reproductive age bear the costs (Kabeer 1992:9), so their interests in contraception will be different. Male reproductive responsibilities are different to women's; they do not feel constraints on their time, resources and opportunities in the same way that women do[8], and so do not perceive the need to contain the size of the family in the light of the same experience as women. They do not directly suffer the consequences of repeated pregnancy, ill health and problematic deliveries, or the physical burden of being pregnant for nine months whilst continuing an exhaustive workload. Men's concerns focus more on economic constraints. A woman's experience of having a large number of children is, therefore, very different from that of her husband, and the physical and emotional strains of bringing up the family are, one might argue, more pronounced for the wife. It is she who remains at home all day with the children; she who has to stretch meagre food resources to provide a dinner for them, soothing their hungry cries when these are not adequate; she who shoulders the main responsibility for their physical and emotional welfare and cares for them when they are ill, and she who washes and purifies their bodies when they die. It was, therefore, not unusual to meet women who, knowing of the existence of contraception, were desperate to

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[8] This was also found in a study on the reproductive motivations of wives and husbands, in Maharashtra, India, by Jejeebhoy and Kulkarni (1989).

control their fertility and prevent the birth of another child, because of the physical and emotional hardship involved.

CONCLUDING DISCUSSION

My sister-in-law, who had two young sons, expressed the opinion of many others when she told me that "two children were enough. Young babies are a lot of trouble because you have to feed and clothe them." In comparison to many others in the village, she was in a relatively comfortable position, the family belonging to one of the wealthiest lineages in the *para*. Despite this, both she and her husband (educated to about class 5 and class 10 respectively) were in firm agreement that they did not want any more children because they would not be able to look after them properly[9]. This sentiment was echoed by another man with two daughters. Even though he did not have a son, he wanted a small family and felt that if he had any more children he would not be able to feed them. Although poverty and lack of long-term financial security are the main reasons for the rural poor's dependance on children and large families, the changing nature and severity of poverty resulting from the disintegration of small subsistence farms and greater landlessness, are inducing a change in survival tactics. Economic reasons also seem to be the pragmatic force behind the changing attitudes and family size norms taking place in Shundurgram, and this has also been Schuler and Hashemi's finding. They conclude that::

> The main factors driving the normative changes that we have attempted to describe have nothing to do with religion; they are a growing poverty-driven demand for contraception, active promotion of a small family norm by state and other agencies, and improved access to contraceptive methods and services (December 1992:17).

Local availability and wider awareness of contraceptives are clearly positive factors in the increasing utilisation of modern birth control methods in Shundurgram, but religious objections to their use are still significant. However, an interpretation of Islam can be adopted to support either argument. The modern interpretation espoused by Muhilar Shasto, the media and so on, which supports contraception, reinforces the need to improve the family's economic circumstances - a need widely

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[9] Unfortunately, this research has not had the scope to examine the importance of factors such as socio-economic class and education, on decisions concerning family size, although the significance of these relationships is recognised. Research addressing these issues includes, for example, the forthcoming publication by Jeffery and Basu (1995?).

felt by most villagers - in order to fulfill parental responsibility. Thus, this Islamic economic-moral duty argument can provide the necessary justification, allowing people to follow their essentially pragmatic economic needs. This could be an explanation for the relative speed with which many young Muslim women in Shundurgram became interested in what Rohima had to say, and showed willingness to try taking the pill (whether or not their husband or *shashuri* shared their enthusiasm and actually allowed them to).

As is evident from this discussion, there are a complex of economic, social and cultural reasons for wanting children which, in addition to a dislike of certain methods (e.g., condoms because of their inconvenience and interference with sexual enjoyment), act for and against choosing to adopt a contraceptive method, in order to achieve minimum fertility goals. This perhaps implies that couples perform some sort of calculation to see how many children they need to have in order to attain their 'desired' family size. However, this is not the case. Few husbands and wives in rural Bangladesh sit down and discuss how many children they want to have, and when, let alone the reasons for wanting them. It is more demographers who analyse these 'reasons', construct variables relating to them, and make complex calculations concerning how many children people want, need and/or can afford to have[10]. Maloney et al conclude that it is unreasonable to expect people to summarise why they want children, in one, or any more, 'reasons':

> Those in favour of a large family are commonly those who say they depend on God for this, meaning that in their life experience this is not a matter about which an individual can or should exercise control. Those who give answers that they want few children often do cite economic reasons. But we feel that most people want several children for undefined personal fulfilment, which is couched in terms of moral duty, family prosperity, or future support (1981:112).

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[10] A good example of this is a study discussed by Khan et al (1993), called "Costs of Rearing Children in Agricultural Economies: An Alternative Estimation Approach and Findings from Rural Bangladesh". The study ignores all cultural aspects of reproductive behaviour, such as *purdah*, patriarchy, son preference, status, prestige, etc., and looks solely at a hypothetical calculation of the monetary cost of raising children, concluding that fertility decline would result from structural changes in the economy, and the satisfaction of, and an increase in, the demand for family planning services.

Whatever the reasons for wanting children, it is clear that social factors relating to population programmes go much deeper than mere decisions about family planning. Poverty and patriarchy are central issues concerning the players in the fight for fertility control, but are often disguised or ignored by those in positions of power whose premise is the need to reduce population growth rates. Without addressing the economic precariousness of the lives of the majority of the population who live in villages, and the inequalities in gender relations which are both reinforced by poverty, and help perpetuate it, the family planning perspective remains one of top-down 'population control'. The social goals of improved health status, improved standards of living, better educational opportunities, women's empowerment, and so on, remain only the rhetorical sweeteners of marketing campaigns, aimed at motivating the masses towards achieving the national economic goals of curbed population expansion. Sundari Ravindran (1993) calls for a redefinition of the 'population problem' which necessarily takes into account the complexity of the issues and moves away from the ideological stance that a reduction in the birth rate is intrinsically good and should be pursed for its own sake.

NGOs are in a better position to adopt the necessary holistic perspective on family planning than a national programme and Muhilar Shasto are attempting to do this through slowly expanding their MCH programme and including women's group formation and income generation. However, a pervasive observation throughout my research was the lack of attention paid to gender relations and the subordinate relationship between husband and wife, which was expressed in the frequency with which women were subjected to abuse by their husbands as a direct or indirect result of using contraception. Family planning programmes tend only to address women's rights as far as providing them with the option to prevent pregnancy, but it is clear that the issue actually goes far beyond this. Women can only make choices if they are able to openly voice their opinions and this will require dramatic changes in attitudes, and institutional support for women from outside. Simeen Mahmud concludes:

> In order for a couple to socially accept modern birth control technology, to adopt contraceptives, and to remain effective contraceptors, other favourable conditions are necessary over and above the existance of a contraceptive delivery service and an articulation for smaller desired families. These conditions have to do primarily with improvements in the overall status of women in society, and their relative position in the home (1991:36).

Family planning programmes, therefore, need to be part of an integrated development approach incorporating education and skill development, income generation, women's empowerment, legal rights and gender awareness into a wider perspective which challenges the existing status quo. Technological fixes alone will not bring about effective changes in women's reproductive control.

Having looked at the social and economic reasoning behind family planning decisions, in the next chapter I will go on to examine local perceptions of contraceptive technology and women's experiences as contraceptors.

CHAPTER 6
LOCAL PERSPECTIVES ON MODERN CONTRACEPTIVE TECHNOLOGY

"You can't be sure about any family planning, even *kobiraj* medicine" (village woman in Dokanpara).

In addition to the economic, social and cultural reasons for not using contraception, as discussed in the previous chapter, one of the main reasons why villagers were unwilling to adopt, or stopped using, contraceptive methods, was because of a widely felt dissatisfaction with the way they affected women's bodies. A large number of women complained of side effects, such as irregular and heavy periods, dizziness, headaches, aching and painful limbs, nausea, lack of energy and general ill health, which they associated with the contraceptive method they were using. Complaints were particularly acute from pill users, but many women taking injectable contraceptives (Depo-Provera or Noristerat) also experienced some of these side-effects. Interpreted within local cultural perceptions of health and well being, these experiences meant that using contraception was not only physically unpleasant for many women, but also provoked great anxiety because of the cultural implications of, for example, prolonged menstruation. Furthermore, there were practical considerations relating to the economic and productive losses of ill health, inability to work and the expense of treatment.

The ambiguity of many women's feelings towards contraception - i.e., it is good because it allows them to have fewer children, but bad because it has adverse effects on their mental and physical well being - is expressed in a conversation I overheard between a young woman and a *buri* ('old woman'). The *buri* was of the opinion that all contraceptive methods were "nothing but trouble because they made women *oshanti* ('unsettled', 'unhappy')". They caused a paucity of blood (*rokto kom hoy*) which, she said, leads to weakness, tiredness and inability to work. The young woman agreed, adding that women suffer many different illnesses (*rog*) from using them: "some women have no period, some very little, and some will bleed for 30 days." She was speaking from her own bitter experience and was typical of many

women who neither wished to suffer the discomfort of such side-effects, nor wanted more children. In this situation, what could she do?

My observations on the predominance of contraceptive side-effects are far from unusual; almost every study I have read on contraceptive use identifies this to be a highly significant factor in family planning decision-making processes. However, the perspective taken is usually that of medical professionals, planners and implementers, attempting to identify the 'barriers' to contraceptive acceptance and the reasons for high drop-out rates and 'non-compliance'. This commonly results in categorising side-effects as 'rumors' and 'fear based on unscientific knowledge', perjoratively minimalising and trivialising the physiological consequences felt by individuals, and resorting to blaming the victim for their ignorance of the dominant medical culture.

The following two examples illustrate this. Martha Ainsworth's World Bank study of the client's perspective on family planning programmes states that:

> Programs have been undermined by widespread rumours of rare or unproved side-effects. (1985:16)

Brian Seaton's study of non-compliance among oral contraceptive users is more blatant in its finger pointing:

> The effects of non-compliance on the incidence of side-effects among oral contraceptive users has not, in general, been given adequate attention. Breakthrough bleeding is known to be caused by irregular use of oral contraceptives...Human nature being what it is, the majority of noncompliant users are unwilling to acknowledge or are unaware of their part in method failure, and they may tend to place the blame for failures and side-effects entirely on the inadequacy of the oral contraceptive. This brings oral contraceptives into unwarrented disrepute. (1985:52)

Nichter (1989), however, challenges this categorisation in a study of the rhetoric of rumours and side-effects relating to family planning programmes in Sri Lanka. He identifies what outsiders describe as 'rumours' to be the "popular interpretive understanding of experience and potential experience" (1989:59) based on cultural perceptions of physiology, health, illness, food, etc. He argues that it is necessary to question the assumptions of health planners, which presuppose that literacy, improved access to contraception, and an increased family planning workforce leads to increased contraceptive acceptance, given economic circumstances favouring birth control. These assumptions ignore the quality of service (i.e.,

contraceptive technology) and perceptions of its effectiveness and appropriateness, based on local premises about health, physiology and pathology.

It is from an analytical view point couched in these terms and based on these premises, that I wish to examine local perspectives on contraception and side-effects in Shundurgram.

THE 'CATCH-22' DILEMMA

If a woman suffers from side-effects regularly, be it daily when she takes the pill, or at certain times in the month, for example, during menstruation, her already heavy work load is made harder by her sense of ill health. She then finds herself in a difficult position, her options of changing contraceptive methods being limited by a complex set of social, cultural, practical and economic factors. For example, social and cultural restrictions may prevent a woman observing *purdah* from visiting the clinic in town, or even the satellite clinic if it does not come to her *para*. The practical restrictions of distance and time, or economic restrictions of travelling costs may also prevent her from doing so. Thus, the only options available for her are those methods that can be delivered to her *bari*, namely the pill and condoms, but as the table indicating 'method use' on page 105 shows, condoms are not very popular. Religious beliefs about the use of an IUD, or sinful act of sterilisation may eliminate these options, as might the opposition of her husband, on grounds that these require the revelation of her body to a stranger (male or female). Or, it may be the advice of other women, based on bad experiences, that puts her off certain methods. Depending on these factors, she may or may not be in a position to change her method. If she has tried all the options these limits allow, she is left with the choice of either dropping-out altogether and risking another pregnancy, or putting-up with the complaints and suffering from anxiety and ill health.

The process of contraceptive decision-making is, therefore, not simple. Few husbands are willing to take on the 'practical' responsibility of fertility control, i.e., using condoms or having a vasectomy, this aspect they regard as the woman's responsibility (if they are not fatalistic and dependent on Allah). They do, however, maintain 'political' responsibility over decisions to practise birth control and to a lesser extent, the contraceptive method which is acceptable. Consequently, once a woman has received consent from her husband and/or *shashuri* to use contraception the process of deciding which method to use is not simply based on her own preference or physiological suitability. It is influenced by many factors out

of her control, and is a matter of great concern and anxiety. Different methods promote differing degrees of anxiety or satisfaction within users, based on personal experiences and the experiences of others, interpreted within the context of local knowledge and belief. It is therefore important to explore the connotations and meanings embodied by different methods and by the side-effects they cause.

To indicate the number of people using modern contraceptive methods in the project area, and the types most commonly used, I provide the summarised details of a monthly Family Planning Report below.

Muhilar Shasto Family Planning Report, December 1992

Method	No. users	% of users
Pill	1669	46.6
Injection	574	16.0
Condom	492	13.7
Ligation	408	11.4
IUD	308	8.6
Vasectomy	131	3.7
Total Users	3582	100.0
Total EC	6155	
CPR	58.2%	

EC Eligible Couples , CPR Contraceptive Prevalence Rate

The most widely used form of birth control is the contraceptive pill - 1669 users out of a total 3582 acceptors, or 46.6%. The main reason for this popularity is that it is most easily available to the majority of village women, who under the constraints of *purdah*, rarely leave the confines of their *bari* or *para*. The pill is distributed by FHVs during daily door-to-door visits and can also be bought in the local markets - of the total, 221 women use bought pills.

Religious acquiescence of contraceptive use often operates on a continuum of acceptability rather than being based on a clear-cut 'for' or 'against'. While some supporters of birth control believe all contraceptive methods are acceptable, far more believe certain methods are more 'sinful' than others, in particular, IUDs and sterilisation. Whilst the pill is not one of these, there are a number of other important issues relating to its use and giving it the ambiguous position of being the most popular method, yet that with possibly the worst reputation for causing side-effects.

PERCEPTIONS AND BELIEFS ABOUT THE PILL: THE SIGNIFICANCE OF SIDE-EFFECTS

Before a woman is given the pill there are several precautionary checks that should be made by the FHV for contra-indications, which if present, indicate the method to be unsuitable. Some are extremely difficult, or impossible to diagnose in the context of the village delivery setting, such as diabetes and a history of heart and circulatory disease, since these conditions are not understood in terms of local health culture and very unlikely ever to have been diagnosed. However, other indicators of risk, such as high blood pressure, varicose veins, migraine, pregnancy and age over 35 years can be assessed by the FHV. I never actually observed Rohima, the FHV, checking for varicose veins or migraine before giving a new client the pill, but she did screen for blood pressure as an indication of possible heart and circulatory problems, and continued to do so regularly on her monthly visits.

However, despite these precautions for detecting unsuitable clients, many women suffer bad headaches, aching limbs, stomach pains, fatigue, dizziness, and irregular and extensive bleeding when they take the pill. If a client shows signs of an adverse change in blood pressure, or is suffering badly from other side-effects, Rohima would usually advise her to try another method, such as an injectable contraceptive (Depo-Provera or Noristerat) or an IUD. For those women who, for example, due to cultural restrictions of *purdah* or practicalities of time and distance, are unable to attend a clinic to receive these, this presents a big problem. An alternative is to try a different variety of pills with a lower hormone dosage which reduces the incidence of some side-effects[1]. The problem is, however, that these are not available through the project and must be bought in the market. The project's stock is limited to two higher-dose varieties supplied by the government, i.e. Combination-5 (C-5) and Ovral, on bilateral agreements with the governments of Germany and Canada. The important point about this is that it has been recognised in the west, since the mid 70s, that there are risks of serious side-effects from taking high-dose oral contraceptives, such that they began to be discontinued in the USA, with the Federal Drug Administration's approval of lower-dosage regimens in 1974. To quote Djerassi, author of *The Politics of Contraception* (1981):

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[1] See Guillebaud (1989, [1985]) for a medical discussion on side-effects.

> Generally speaking, the severity and incidence of undesirable side-effects of a drug are directly proportional to the dosage; accordingly, it is desirable to use the lowest effective quantity of any active drug. Obviously this principle should apply to pill dosages (1981:63).

However, in the 1990s we find that the government of Bangladesh, either through choice, ignorance, or 'persuasion' by the bilateral partners, is still only providing women with the option of high-dose pills. The issue at stake here is, at what cost and at whose benefit are women suffering unnecessarily by taking pills known to cause unpleasant side-effects? One is led to question the political implications of the government's decisions. According to a World Bank source, a lower dose pill is destined to be introduced[2] into the government's stock, however, the question is, how long will this take? Family planning is not about enforcing any old contraception on people but about offering them a variety of safe choices. For how much longer will poor Bangladeshi women suffer the side-effects of drugs which have been considered inappropriate for use by many western women since the 1970s? Blanchet (1991:60) and Jeffery et al (1989:209, with reference to India) raise the same point. Why the massive time lag in equating the safety of Bangladeshi women's health, with that of women in the United States and Britain? These are questions which need to be answered on behalf of those Bangladeshi women who are passively accepting drugs which could at worst be causing them serious problems, and at least, causing them anxiety and discomfort.

Of the two government-supplied varieties, Ovral is generally less popular in the health project's field area, receiving more complaints of side-effects than C-5. Interestingly, the chemical composition of both these varieties is the same, although C-5 has a sugar coating making it taste better; only this and their physical appearance and packaging differ. A study by Kamal et al (1989) on oral contraceptives in Bangladesh found exactly the same preference, with both users and health workers favouring C-5, despite there being no significant difference in the pattern of side-effects reported. For both varieties, about four-fifths of users complained of dizziness, weakness and sickness. The researchers concluded that the preference was, therefore, based on the more attractive packaging and better taste of C-5 pills.

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[2] Personal communications from World Bank and ODA sources.

Other brands of pill available in the market include Ovostat and Lyndiol costing Tk25 and Tk35, both of which are made in Bangladesh (by foreign companies), and Ovocon which costs only Tk6 and is an American product. However, buying even the cheapest of these pills is a very expensive and unfeasible option for the majority of village women, who rely on their husbands to go to market for them. It is also an unreliable and ineffective method of transferring important contraceptive information. Since pills are generally bought by a male over the counter without prescription, the female taking them does not receive counselling on how they work, which brand is most suitable (e.g., which are high or low-dose), how to take them correctly, when to start them in the menstrual cycle or what side-effects might occur. The quality of instructions and information on packets varies but even this can not be read by the majority of people. Hence, there is great potential for misinformation and incorrect use, and greater likelihood of side-effects or pregnancy[3].

'CHEAP' AND 'EXPENSIVE' PILLS

Complaints about effects of the pill are very common and a main reason for women 'dropping-out'. From the point of view of the project they therefore represent another problematic factor to overcome in increasing contraceptive acceptance. The Muhilar Shasto counsellor believed the symptoms of side-effects are to a certain extent psychological, brought on by women believing exaggerated stories they hear, or heightened by the belief that the symptoms are caused by the pill, when really the cause is something else. She also relates this phenomenon to the popular belief that the 'government *bori*' (i.e. those distributed by Muhilar Shasto) is a 'cheap' *bori* and not good for one's health. This conforms with the popular opinion that all free or low cost medicine given by the government is low quality. Expensive pills, which one buys (*dami bori, kina bori*) are believed to be fine for everyone because they are 'good quality', the cost of the medicine being symbolic of its quality and efficacy. This belief is exploited by government doctors and paramedics who charge for medicine even though it is supposed to be provided free through the government health system. Patients are told that if they want 'good' medicine they must pay because it is expensive, otherwise all they can have is the free variety which is not as effective. The village *daktars*, who generally have no official medical training, also

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[3] See Rees (1994:41-45) and Price (1994:51-54) for a discussion on the pros and cons of contraceptive social marketing.

exploit this to the full, charging inflated amounts for injectable and intravenously administered medication because they are perceived to be the best, most powerful forms of medicine.

As a technique for easing anxieties caused by side-effects, during clinic sessions the counsellor explains to women that there is no connection between the pill and the symptoms they are feeling. She points out the physical distance in the body between the *tolpet* or *nari* (stomach area) where the pill works, and the areas where the problems are felt, such as the head and limbs, arguing that the action of the pill in the stomach cannot effect these other areas. She explains why else the symptoms might be caused and how to prevent them, e.g., the need to drink lots of water when it is hot to prevent dehydration and headaches, take rest when feeling tired, eat more nutritious food and take the pill regularly after meals to prevent nausea. In this way she distracts the association of the symptoms away from contraceptive use and on to other health issues, and maintains that when a woman's attitude changes, the symptoms sometimes disappear or are eased.

Psychological reasons may well be influential in bringing on these symptoms but in using this explanation it is all too easy to mistake or ignore real side-effects, or trivialise and devalue the experience of the woman. No doubt strenuous work, lack of nutritious food, irregular eating and extreme heat, combined with exhaustion are also very influential factors in these health complaints. However, the sheer number of women who experience these when on the pill, seems to indicate that there is a strong connection between the two. Therefore, the sooner a more appropriate low dose pill option is available to women through the government health system, the less compromised women will be having to decide between risking their long-term health status and daily sense of well-being due to side-effects from contraception; and childbirth, which although medically a more life-threatening health risk, has fewer social and cultural 'risks' because of its accepted place within the local world view.

Intrinsic Qualities of the Pill and Their Effect on the 'Hot' and 'Cold' Balance in the Body

Some side-effects experienced by women can be understood in terms of the pervasive South Asian belief system of balance in the body between 'hot' and 'cold'. Indian Ayurvedic medicine and Muslim Unani medicine (see Leslie 1976, Obeyeseker 1978), which form the basis of Bangladeshi village medical belief

systems, are both based on concepts of 'balance' and are similar to that of ancient Greek and Chinese systems. In ancient Greek ethnomedicine, which influenced Unani, the body was believed to contain four humours which had to be kept in balance (Maloney et al 1981). In Ayurvedic medicine the balance must be maintained between three 'dosa', and in both systems there is an emphasis on balance between 'hot' and 'cold', 'wet' and 'dry'. In my research area, the concept of this dichotomy is very pervasive and associated with good health and sexuality, 'health' being culturally defined in terms of not only one's physiological or physical state, but also one's social and psychological state. "In this sense, 'health' and 'illness' are cultural features, as distinguished from disease, which is medical" (Maloney et al 1981:134).

Balance is conceptualized in the intrinsic qualities of different substances, e.g., food, water and medicine, and certain activities and bodily functions, e.g., sexual intercourse and menstruation. Food substances are dichotomised into several sets with different qualities which affect health: 'hot' and 'cold', 'wet' and 'dry', 'sweet' and 'sour'. Most foods are defined as either 'hot' (*gorom*) or 'cold' (*thanda*) although some are considered neutral. Consuming too much 'hot' food, such as meat and chilli, causes the body to overheat, and in the same way, too much 'cold' food, such as vegetables and plain water, causes it to become cold. Ingesting the correct balance of 'hot' and 'cold' food is therefore very important in maintaining ones physical and social health, and in equalising an imbalance causing illness. Conversations relating to a person's health often refer to the state of balance in the body and quality and quantity of one's blood, which is determined by this balance. For example, someone with a headache would explain that their head had become 'hot' (*mata gorom*), or that their stomach ache was caused by over heating (*pet gorom*) and that they therefore needed to avoid 'hot' food and consume only 'neutral' or 'cold' substances until the balance was regained. A young child with a cold or cough would be described as being 'cold' (*thanda*), perhaps from ingesting its mother's breast milk after she had bathed, when her body, and hence milk, had been cooled too much. Many people complain of weakness and tiredness which they relate to the quantity and quality of their blood. Strong blood is produced from eating 'good' food, such as meat, eggs, milk, fish, most of which are 'hot', thus a diet lacking these causes one's blood to become weak and reduced in quantity (*rokto kom hoyeche*), so that the body is without energy and vitality. This, it is believed, can be rectified effectively by the various bottles of 'tonics', 'syrups' and 'vitamins' available in the market, which supposedly strengthen blood.

Local perceptions of intrinsic qualities of the pill are interpreted within this ethnomedical belief system. Modern, allopathic medicine, *alopathi*, is regarded as being very powerful and strong, giving it excessive 'heating' properties and hence the pill is considered to be very 'hot'. These excessive heating powers dry-up the quantity and quality of blood causing fatigue and general weakness. This is apparently the most commonly reported negative effect of the pill worldwide (Nichter 1989). Many women in Shundurgram complain of it, associating headaches, nausea, aching limbs, burning sensations in their hands and blurred vision, which often accompany it, with over heating caused by the pill. The FHV, herself socialised in the cultural ideology of balance advises them to counteract the action by taking something 'cold', such as coconut water, to cool the body down. Maloney et al (1981) found that Bangladeshi women believed that through weakening the blood in this way, the pill prevented conception. This perception of the pill as a heating substance was also found in Sri Lanka (Nichter 1989) and Iran (Good 1980) where it was used to explain the way in which the pill works through drying up the body. Women who are suffering from an illness, or already believe their blood to be 'weak' and reduced in quantity, therefore perceive themselves as very vulnerable to the 'harshness' of the pill and are reluctant to take it because of the worsening effect it will have on their health.

The pill is also sometimes blamed for causing 'infertility' in women. If a young girl is given the pill before having her first child and then fails to conceive when she stops taking it, the pill is often considered the cause of her infertility and the blame for this placed on the FHV who gave it to her. This is a very serious accusation to be made against someone since child birth is the primary means of proving a woman's worth as a wife. The expectation placed upon a new bride is to conceive as quickly as possible to establish respect for her in the new family. If she does not do so within the first year or two, there is a strong fear of possible divorce due to the dissatisfaction of her in-laws. Good and Nichter identify similar associations amongst women in Iran and Sri Lanka. Women in both countries feared the long-term 'heating' effect of the pill on the uterus causes it to become dry and over time, unable to accept male seeds. They compared this to a field without water, where the seed is unable to take root, and this analogy of infertility is also common in rural Bangladesh.

> ...many Sinhalese believe that they cause permanent damage to the body and are, in effect, a permanent method. A concern voiced by many young women wanting to space their children was that after taking the pill for some time,

their chance of conceiving when they once again wished to was diminished (Nichter 1989:61).

Rohima consequently explained that the reason why she was reluctant to give a new bride the pill as her first contraceptive method, was to avoid negatively affecting both her own reputation and that of the pill. Instead, she tried to encourage condoms as a first form of birth control.

PHYSICAL QUALITIES OF THE PILL

The physical qualities of the pill, as interpreted in the local health ideology, are also considered by some women to cause problems. Tablets are generally perceived to be hard to digest and some women believe that if they take the pill it will not be properly digested and will build up to form a hard ball in the stomach. Various stories were related to me about women becoming seriously ill from this and dying, the ball being found in an 'autopsy' afterwards. Some fear that if a woman who has used the pill becomes pregnant the undigested pills will become attached to the baby, which forms in the stomach area sharing the same space as food, and cause harm to it. Nichter and Nichter (1983) found a similar belief amongst pregnant women in South Kanara, India, who showed considerable reluctance to receive certain types of medicines, such as ferrous sulphate and multi-vitamin tablets. These medications were viewed with great suspicion because of their physical characteristics as tablets, which they considered inappropriate medication for pregnant women because of the difficulty in digesting them and the harm they could do to the developing foetus.

RITUAL PURITY

Excessive menstrual bleeding for long periods of time, or spotting between menstruation is quite commonly experienced by women taking the pill and causes problems with their attainment of ritual purity. For many, this is a very perturbing situation. When a woman is menstruating she is in a ritual state of pollution such that she must observe certain strict taboos. She should not touch clay vessels or cooking utensils without washing beforehand, she should not touch the rice store for fear of ruining the harvest, she cannot have sexual intercourse, she must not touch the Quran, and most importantly for many of the women I knew, she cannot perform *namaj*, the ritual praying which should be performed five times a day. If, as appeared to be quite common, a woman bleeds for a week at a time, or off and on

for several months, she is unable to pray satisfactorily and this can cause tremendous anxiety, particularly if it occurs during the time of Ramadan, the month of ritual fasting and prayer.

Not all women observe daily *namaj* to the same degree, but for many, praying is an important ritual which must be performed as often as the practicalities of a heavy work load will allow. In performing *namaj*, women derive a great deal of spiritual comfort. If they pray regularly they can hope to be rewarded for their sufferings on earth by a happy existence in the afterlife, and to a certain extent, their faith in this heavenly destiny helps in coping with the stresses of their physical existence, over which they have little control. Just as praying brings reward in the after life, it also brings spiritual relief and peace-of-mind in the present. However, failing to perform *namaj* properly results in severe punishment after death, and from this perspective it is then understandable why women experiencing irregular periods from taking the pill, suffer such great distress and anxiety.

This state of ritual pollution not only impinges on the woman's life but also on those around her, due to the taboos which must be observed, particularly that of sexual abstinence. A husband may become very impatient if his wife is unable to fulfil her sexual obligations to him for prolonged periods and women commented that this sometimes results in being punished or beaten. This is clearly a very important social aspect of the side-effects of contraceptive use which may not be obvious to those removed from the village context but is an issue of great concern to village women.

It is also necessary to consider the practical implications of irregular and heavy bleeding, since village women rely on pieces of old material which must be washed regularly and hung up to dry. Menstruation is a terribly shameful and polluting state, it is therefore very embarrassing and inconvenient to have to continually go through this process, particularly when it is so difficult to hide from others.

The nutritional implications are also important. When the majority of village women are already malnourished and anaemic, heavy menstruation and continual spotting can do nothing but worsen the extent of this.

In the light of these practical problems and cultural beliefs, it can be better understood why some women feel so disturbed by the irregularity of their menstruation. Clearly, a deeper sensitivity to local cultural belief systems is required by health programmes if they are to understand the reasons behind the

'fears' and anxieties of women who experience these side-effects when taking the pill.

THE PILL AS A TECHNIQUE FOR ABORTION

A rather concerning use of the pill which health programmes should be made aware of, is as a technique for inducing abortion. Women who suspect they may be pregnant attempt to abort the foetus by consuming large numbers of pills in one go or over a short period of time, with apparent varying degrees of success. I am unsure how common the practice actually was in my research area, but I heard on various occasions of women who had tried it or wanted to try it, and a woman with whom I was very close confided that she too had once attempted it. The technique is to take two or more pills a day with hot water, presumably to add extra heat to their intrinsic heating property, until the packet is finished and bleeding starts. My friend had not been successful. She had surreptitiously taken the entire packet in five days, but it only resulted in her becoming extremely ill from severe bleeding. The child, her third, was born without any problems. She explained that when taken normally the pill works because it has poison (*bish*) which destroys a baby before it has developed; *bacha noshto hobe*, 'the baby will be destroyed'. Therefore, she reasoned, if taken in large doses it will be strong enough to destroy a more developed baby and cause an abortion.

She told me of another incident in which a woman had tried this and actually died from hemorrhaging. Of the stories I heard, it would seem that most attempts ended-up with the woman suffering severe bleeding and in need of medical treatment. Interestingly, both Nichter (1989) and Good (1980) report the same abortive use of the pill in Sri Lanka and Iran. Nitcher states:

> A common notion we encountered is that if contraceptive pills are powerful enough to weaken the *dhatu*[4] or in some other way prevent conception from occurring, then taking several pills at once should effect the body sufficiently to heat, dry, or push out the fetus (1989:66).

It would, therefore, seem to be an 'internationally' common and dangerous misuse of the pill. High dose pills can actually be used as a clinical 'morning after' pill in certain circumstances (Guillebaud 1989, [1985]), but this must be done under medically supervised instruction and not in the random and risky way reported

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[4] *Dhatu* is a substance in the body associated with vitality and strength.

here. The consequences of uncontrolled hemorrhage in the setting of a rural village do not bear thinking about, particularly when qualified medical help is unlikely to be sought because of the secrecy involved.

Cultural understanding of how the pill works, for example, as a poison, or by heating and drying the blood, can logically be followed through within the ethnophysiological idiom, to the conclusion that magnifying the pill's action by taking multiple doses, leads to a more powerful result and actually destroys a developing foetus. Hence, it is possible to see how this practice could have come about. However, another practice, encouraged by the 'official' medical authority of the health programme, could be interpreted by women as reinforcing this belief. I frequently heard both the FHV and TBA advise women concerned about experiencing amenorrhoea for prolonged periods, usually after using injectable contraceptives, to take the pill to 'start up' their 'closed' menstruation. It would seem possible that a correlation has been made between using the pill for this function and using it to induce abortions, i.e., to induce menstruation which flushes out the *nari* (womb). It is, therefore, important to recognise how information given in one cultural idiom (that of western medicine) can be reinterpreted in another to bring about an unintended outcome, which could, as in this case, be potentially dangerous.

Another, rather amusing use of the pill I came across, was as a general medicine used by my *bhabi* for treating her sick chickens, and by her husband when he was ill, in the belief that the 'red' pills (placebos) contained lots of vitamins (in fact they contain iron)! This of course meant she was not taking the full course properly and so not 100% covered from pregnancy. She also said she frequently forgot to take the pill everyday and often missed the 'red' row, the last in the pack, during her period. Although missing this row doesn't actually matter, missing the 'white' pills does and put her at risk of becoming pregnant. The incorrect and irregular taking of pills is common, but few women are properly aware of the risks from doing this. Some stop taking them for a week or so whilst they are visiting a relative's house, or their husband is away, or if they are not feeling well, and many forget. However, most women believe that if they take two the next day, or however many they have missed, they will be safe. If they then become pregnant they may well blame the pill for not working, misunderstanding how this is related to their incorrect usage. There is obviously also a possible causal link between this and the irregular periods that many women experience.

Again, this is an example of how misuse of the pill is associated with the health idiom within which it is understood and Nitcher cites several similar examples from Egypt, Sri Lanka and Peru (1989:65-66).

INJECTABLE CONTRACEPTION: DEPO-PROVERA AND NORISTERAT

The injectable contraceptive is the second most popular method in the project's field area, and used by 16% of clients. However, since its development as a contraceptive method in the early 1970s, its use has been surrounded by a controversial debate concerning safety, and one which continues to cause contention both in the west and developing countries, where it is widely used. It was introduced in Bangladesh in 1974, a decade previous to a 1984 USA Federal Drug Administration Board of Inquiry stating that it had not yet been proved safe and therefore could not be used in America. Hartmann and Standing (1989:42) state that despite this, the World Health Organisation and International Planned Parenthood Federation approved and heavily promoted its use in developing countries. Since then it has been approved for use in Britain and is available through the NHS. Enthusiasm for the drug is based on its effectiveness and simplicity of use. One injection covers against pregnancy for two or three months at a time and in the context of Bangladesh, can be given at village level at satellite clinics, making it ideal from the point of view of population control. This is also seen by planners as an advantage for women who use it, freeing them from the need to be continually responsible for birth control and making it possible for those whose husbands object to contraception, to surreptitiously use it. As positive as this may seem, Hartmann and Standing argue that these advantages can also turn into disadvantages:

> Freedom from responsibility can also mean loss of control. If a woman suffers adverse effects from an injectable, there is nothing she can do until it wears off. For some women this can mean months of misery, since the side-effects of the drug can linger beyond two or three months (Hartmann and Standing 1989:43).

This was the case for many women in my research area.

Side-effects are mainly weakness, headaches, dizziness and menstrual disorders. Most commonly this means prolonged amenorrhoea, but some also experience heavy and intermittent menstruation, as with the pill. This extreme irregularity has been described as 'menstrual chaos' by the medical profession (Guillebaud 1989:189, [1985]). Interpreted within the local health ideology, injectable contraception is

perceived to work in a similar way to the pill, heating and drying the body. However, its intrinsic qualities as an 'injection' are considered to be even stronger, this being regarded as the most powerful form of modern medicine, based on an association with 'miracle' medicines such as vaccines and antibiotics. The injection is considered to be so strong, *shokto*, that it causes the blood circulating in the body to dry up and become thick, resulting in a paucity of both this energy giving blood and the separate, polluted menstrual blood (*mashik*). Women may go for a couple of years without menstruating and this is considered quite dangerous because of the consequent build-up of *mashik* blood inside the body. This blood is believed to be a different type to that which circulates around the body and is highly polluting, both physically and ritually. Therefore, if it is not expelled regularly the build-up of pollution in the body is perceived to be very dangerous to one's health and spiritual well being, and can lead to ruined eyesight. Good describes a similar belief amongst Iranian women who fear that "if it moves throughout the body, instead of being discharged through free-flowing monthly periods, it can cause darkness of skin and aches and pains of the body, especially in the joints and head" (1980:149).

Although there is no medical cause for concern with the condition of prolonged amenorrhoea (it can be regarded medically as a health benefit, Guillebaud 1989:187, [1985]), culturally it is very worrying. The health workers were told it was not a serious problem but Rohima and Rogina (the TBA) were not wholly convinced, since they did not understand why this happened and could not explain it to other women. Consequently, at the same time as transfusing information from the 'modern medical' belief system that the condition was not dangerous, the TBA would also give advice reinforcing the 'ethnomedical' belief system that the polluted blood needed to be eliminated, and would recommend women to take the 'white' pills to induce menstruation. This is an interesting example of how the different belief systems are used one to explain the other, though in contradiction with each other. The contraceptive pill, a medicine from the modern system, can be utilized within the discourse of the ethnomedical system for positive ends; i.e., to alleviate a condition caused by modern medicine but which is culturally perceived to be very dangerous.

LOCAL BELIEFS AND PERCEPTIONS ABOUT IUDS

Provided there are adequate screening and follow-up services, from a medical perspective, Intrauterine Devices (IUDs) are considered to be one of the safest

available methods of contraception in Bangladesh because they cause 'minimal' side-effects, are reliable and provide cover against pregnancy for up to 8 years without removal. The side-effects are generally initial stomach cramps and heavier menstruation. The popularity of IUDs within the government health system is such that there is a heavy promotional strategy, with set monthly targets for new clients at both government and NGO clinics. Targets are expected to be achieved primarily through the motivational work of community level government family planning workers and NGO health workers. In Muhilar Shasto, the responsibility to achieve the government's required number of new clients was shared between the five supervisors, who passed the responsibility on to the FHVs. A similar situation existed for achieving set numbers of sterilizations each month, and put a considerable amount of pressure on FHVs to heavily motivate women to adopt these two methods. This was a situation with which the staff and project manager felt very uncomfortable, since their performance in the eyes of the local Family Planning authority was being judged by their ability to meet these targets. This in practice, reflected back on the FHVs' personal achievements and meant that to a certain degree, their work was judged on their ability to motivate IUD and sterilization clients - a situation Rohima was unhappy with because of their lack of local popularity.

In Muhilar Shasto's project area IUDs were used by only 8.6% of contraceptive acceptors (December 1992), making it the least favoured method, next to vasectomy at 3.7%. What then is it about IUDs that makes women so reluctant to use them? The following discussion of local attitudes and beliefs helps to shed light on the issue.

Much of their unpopularity is founded on a sense of fear: fear of religious punishment and social sanctions; fear of something which is not understood and cannot be seen; fear of having to go somewhere unfamiliar, i.e. the clinic, and be examined by a stranger; fear of the method of insertion and pain; fear of side-effects. Most of these are fears caused by uncertainty.

Fears of Religious Penance

Many women are frightened of what will happen to them if they die with an IUD inside them. It cannot be removed by the woman herself, she must visit a clinic to have this done and so the chances of the IUD remaining inside her if, for example, she were to suddenly die from an illness or accident are very high. The fear is that if

the IUD is not removed the body can not be properly purified by the washing ritual performed at a Muslim funeral (*janaja*). This ritual is like that of *ozu*, the washing ritual that must be meticulously observed before praying. It prepares a person to meet Allah in a state free from impurities of the profane world, transferring them from the state of being *napak* ('polluted') to being *pak* ('pure'). Approaching Allah in anything other than this state is a sin, and therefore women are very fearful that if they retain part of the profane world within their body they will be rejected or punished after death.

This reason was given more than any other, for the complete dismissal expressed by many women when asked why they would not consider using an IUD. However, it is not the sole reason mentioned. Fear of religious castigation is interwoven with a number of other concerns rationalised within the cultural belief system and often founded on misconceptions.

Fears and social constraints concerning the process of insertion

It is believed to be very shameful and embarrassing (*khub lojja lagbe*) for a woman to see her own naked body, especially her genitalia, such that the idea of allowing another stranger to see it is out of the question for many women. This is felt even more strongly by many husbands, who feel their wives' *purdah* will be infringed and hence their own *shonman* ('honour') affected. The process of receiving an IUD is also very alienating. The woman must go to a clinic she has probably never visited before, possibly on her own, and is confronted with a totally unfamiliar environment. She is given only a very limited explanation of what is about to happen and possibly will not even see an IUD, let alone understand how it actually works inside her body. The manner of the medical staff can also add to this alienation. I often found Muhilar Shasto's paramedic very brash and aloof with clients, spending little time explaining things in terms they could understand, thus reinforcing the passive doctor-client relationship and mystic surrounding modern medicine. Once the IUD has been inserted and the woman returns to her village there is little she can do if she wishes to change her mind, or suffers pains and heavy bleeding, as is quite common to begin with. To reverse her decision she must also reverse this humiliating and alienating process, returning to the clinic to go through the whole thing again. For many women the thought of this experience is enough to deter them from even contemplating trying the method.

Many also believe that a 'machine' is used to implant the IUD and are scared of this technology, fearing it will be painful.

Fears of side effects and the social implications of these

There is a general belief that IUDs adversely effect the body causing permanent ill health. This, in addition to obvious reasons, is a matter of great concern for women because of the implications for their future ability to perform their role within the household. If a woman is ill it impedes her ability to maintain the household and look after her children, and she will be subjected to criticism by her husband, *shashuri* and others for not being a good wife. This can lead to the threat of possible divorce, or the taking of a co-wife. As well as causing general ill health, more specifically it is believed that an IUD will make one weak and unable to do heavy work, and this is reinforced by the paramedic's advice to take plenty of rest for seven days and refrain from too much physical activity. Women are also told they may experience heavy bleeding, which in local health ideology means a loss of energy through the depletion in quantity of blood. However, the reverse might also happen. One woman reported not having a period for 10 months. She had the IUD removed because she had become ill and extremely thin. The fear of illness is particularly acute during harvest seasons when a woman's work load is greatly increased and involves hard labour. At these vital times of year it is therefore particularly inappropriate for a woman to receive an IUD because of her difficulty in heeding advice to take rest. A strategy to reduce the severity of side-effects, such as stomach pains and heavy irregular bleeding, might be to seasonally promote IUDs during the months of less productive activity. This would allow women's bodies a better opportunity to accommodate the device with less severe side-effects and hence reduce, to a certain extent, the social penalties that they cause.

I heard from women in several different places that IUDs are believed to cause 'cancer', although the definition of 'cancer' is rather unclear. Most people are familiar with the term, having heard it in the media and from local *daktars*. However, it is used in a very liberal sense to refer generally to chronic illnesses inexplicable within local health ideology. The belief is largely founded on stories of women who have used IUDs and become ill, and then been diagnosed as having cancer, most likely by local untrained medical practitioners. Nichter (1989) reports the same belief amongst women in Sri Lanka. He also notes a commonly held misunderstanding, shared by women in Bangladesh and many other parts of the

world including Botswana, Kenya, India, Tunisia, Mexico and Peru, that the IUD can travel within the body, moving up to the heart, lungs, brain and other parts of the body, causing serious harm and possibly death.

Another cause of concern for women is that they are advised to abstain from sexual intercourse for seven days after receiving an IUD. However, it is a punishable breach of a wife's role to turn down her husband. This means that if she refuses he may simply ignore her requests and force her, causing complications and bleeding, or beat her for her disobedience. I heard of one very unpleasant case like this.

The important point to discern is that the social implications of advice may not be obvious to health staff, or they may not consider them to be their concern, but for the woman they are very significant. Advising a *bou* to take seven days rest is asking her to do the impossible without consent from those who have control over her - her *shashuri* and husband. Advice and discussion must be had with them as well, to prevent punishment and critiscism for her breach of social norms.

A practical problem with IUDs from the clinic's perspective, is the difficulty in ensuring women receive regular check-ups. This often means that adverse reactions are only treated when reaching extreme conditions, and hence intensifies the promotion of gory stories. To counter these negative stories, women who have had no problems could be encouraged to discuss their experiences during sessions at satellite clinics or samity meetings, so that more positive accounts enter local communication networks. It is also important that health staff speak with local religious leaders, particulalrly those who support contraception, to encourage them to allay women's fears of religious penance if they die with an IUD in their body.

BELIEFS ABOUT STERILIZATION *(ISTEY PORDHOTI)*

Sterilisation is a very unpopular form of contraception in the project area, more so for men than for women, with 11.4% ligation clients and 3.7% vasectomy clients. Many people who support the use of contraception still vehemently object to this, predominantly on religious grounds. As I previously explained, religious acquiescence of contraceptive use often operates on a continuum of acceptability, with pills and condoms at the 'most acceptable' end and sterilization at the 'grave sin' extreme. In liberal interpretations of Islam nonterminal methods can be accomodated within the same 'acceptable' category as withdrawal, but the justification is not so easily extended to sterilisation. There is a general feeling, also

reported by Schuler and Hashemi (1992) in other parts of Bangladesh, that sterilization is 'worse' than any other method, promoting the greatest amount of opposition. It is believed that supernatural punishments are most severe against those who have had 'the operation', effecting not only the individual but bringing misfortune upon the community as well. Consequently, the social sanctions of stigma, criticism and ostracism can be very severe and lead to serious social and economic implications, such as the severing of important social and economic relationships.

Ligations and vasectomies are considered to be so sinful because they challenge and oppose the immortal powers of Allah. These powers allow him to bless someone with children when he so chooses, but, if a person permanently prevents this from happening by having an operation, this is challenging his will. Such an action causes him to become greatly angered, *khub ragi hobe*, and those who have consented to sterilization are believed to pay dearly for these sins when they die. I was warned by my *bhabi* that even if a woman prays, her *namaj* will no longer be of any worth: *"namaj porte parbe kintu kono kaj korbe na"*, "*namaj* can be performed but it will have no effect". Essentially, once the sin has been committed there is no 'repentance', unlike with other methods whose effects can still be reversed. For this reason there is still great opposition.

I was told, those who believe sterilization to be a breach of religious proscription 'will not eat food cooked by the hands of a woman who has had the operation', and the social implications of this can be very serious. The stigma can lead to ostracism by family and neighbours, and refusal to touch the woman's body when she dies, for fear that her sins will be transfered. If the local *mullah* shares this belief, he may also refuse to perform *janaja namaj*, the funeral prayer. If this is not performed, it is believed the rites of passage from this world to the next to be incomplete and salvation is not attained, causing eternal sufferance in the fires of hell - a fate few would wish upon themselves. Vasectomy is considered to be equally sinful, with the same religious punishment and a man who has committed such a sin will not be allowed to pray in a mosque with others. Thus, the social and religious penalties can be very high.

Those who undergo the operation are said to suffer not only in the afterlife but also in the present. There are many stories of women who have had operations followed, as punishment, by the death of their children - childlessness being a woman's worst fate - and there was one woman in Shundurgram to whom this had

happened. Both her children had died quite unexpectedly in their early and mid teens and this was seen as her penance for sins. I was told of another woman who died after the operation because her insides had gone bad where the *nari* ('reproductive tubes') had been cut.

Thus, for Muslims, the cultural implications of sterilisation are very serious, affecting not only their spiritual relationship with Allah but also their social relationships with those around them. The irreversible nature is also of great practical concern because of the uncertainty of young life and the possibility of one's only children dying, leaving the parents without future security. The combination of these factors are the main reasons for its unpopularity amongst Muslims. Hindus, on the other hand, do not have the same religious objections and although they are subject to the same threat of losing their children, they are much more open to sterilization. For this reason, FHVs were always pleased to be working in Hindu villages because it made achieving set targets for new sterilization clients a lot easier.

I do not intend to analyse the government systems of sterilization targets and compensation payment (whereby clients receive clothing and money in compensation for their period of convalescence), since this has been subjected to critiques by others, such as Hartmann and Standing (1989) and Cleland and Mauldin (1991). The former argue that "incentives and disincentives have distorted the provision of sterilization in Bangladesh and have undermined informed consent, contraceptive choice, basic medical standards and the delivery of other health services" (1989:17). However, Cleland and Mauldin's research, commissioned by the government and World Bank in 1987, argues that this is not the case,

> the decision of Bangladeshi men and women to undergo sterilization is a considered and voluntary act, taken in knowledge of the nature and implications of the procedure, and in knowledge of alternative methods of regulating fertility...Money may be a contributing factor to the decision to become sterilized in a large majority of cases, but a dominant motive for only a very small minority (Cleland and Mauldin 1991:1).

In the context of my research area, the government's financial incentive of Tk200 plus a sari or lungi, is one thing which may well sway people's uncertainty, particularly during the periods of shortage before harvests, when money is very scarce. Shameem spoke of distinct seasonal peaks at these times and referred to *Kartik* month as 'sterilization season', when the rice crops have finished and people are particularly hard-up and tempted by the money and free sari. A specific

example of this springs to mind during one of my house visits with Rohima in Shundurgram:

> Rohima had spent some time talking to a couple about the possibility of the woman having a ligation and had left them to discuss it, when the husband called her back agreeing that it should be done. On questioning him as to his decision, he replied that he would give his consent as long as Rohima gave him a further Tk500 because the government's Tk200 was not enough, and added that he did not want the sari! Rohima marched away in annoyance moaning that he, like most other people, thought she was paid more for successful referrals, and didn't believe her when she denied this, because the government workers did receive money. She was forced to concentrate on motivating for sterilizations because if she failed to reach her monthly target she would be reprimanded by her supervisor. She felt the system of 'targets' was very unfair because some FHVs worked in predominantly Hindu areas where motivation was easy, but in her area nearly everyone was Muslim and it was a much harder task.

How Do You Eat a Condom?

The problem of cross-cultural misunderstandings, assumptions and poor communications is wonderfully demonstrated by the story of the woman in the village who found herself completely perplexed by the condoms she was given to prevent pregnancy:

> Rohima and I arrived at the woman's house for her monthly visit and sat ourselves down on the verandah to talk. After some discussion concerning family planning and different contraceptive methods Rohima delved into her bag and surreptitiously slipped some condoms into the woman's hand without anyone but myself seeing. She leant over and quietly told her that she would give her more if she needed them. The woman nodded, swiftly hid them inside her sari and we left. As we walked away I asked Rohima why she hadn't explained how to use them, thinking that perhaps it was too embarrassing to discuss, but she told me that it was because there was no need to do so, her husband would know. The next time we visited, a month later, the woman's neighbour was at the house and began laughing when we arrived and an embarrassed look appeared on the face of the other woman. "What's wrong?" Rohima asked. "Oh", the neighbour replied in fits of giggles,

"when you gave her those condoms last month she was so confused she came to me and asked 'how am I supposed to eat these?'!" Sitting at the side, I had to hide my amusement at the thought of this poor woman chewing away and wondering how on earth this was going to stop her from getting pregnant.

Of course she was now aware of her error in assuming that the condoms should be swallowed like the pills she had previously been taking, and felt suitably foolish, however the fault did not really lie with her. An assumption had also been made by the FHV that the woman or her husband would know how to use them, and she had not bothered to find out if they actually did. In assuming this she also failed to explain how the method worked, leaving the woman to make her own assumptions based on her own very limited experience of contraception and physiological knowledge. The incident demonstrates that what may seem completely obvious to the trained FHV, can be interpreted in a different way or misunderstood by someone else when the language of communication is in the discourse of a foreign belief system which they are not familiar with.

This leads me to question why it is that condoms are not a terribly popular method of contraception in the project's area (13.7% of users). Is it because of misunderstandings and they are being used incorrectly, as in the case of this woman? I suspect that most people do have a more accurate idea of how to use them, but that is of course my assumption. However, their unpopularity is reportedly mainly due to 'interference with sexual satisfaction' on the part of the husband. Although this may be referring to a loss of physical sensitivity, one needs to question whether men do understand properly how they should be put on. 'Inconvenience' and 'awkwardness' are, after all, major reasons why they are disliked in many other parts of the world too. Another problem is that of disposal; although this was never mentioned, it was my observation. There is no such thing as a 'rubbish dump' and very few households in the village have a latrine down which condoms can be thrown, so discreetly disposing of them is not terribly easy. Perhaps this is why it is not uncommon to see children in villages using condoms as balloons! This problem of disposal is not generally considered by health planners.

TRADITIONAL METHODS OF BIRTH CONTROL *(PRAKITIK)*

A small number of women in the village, generally older, or the wives of religious leaders who objected to modern contraception, claimed to be practising 'natural' methods of birth control. However, on gazing through their family record cards the

effectiveness of their 'methods' appeared to be somewhat questionable, considering the generally large number of children they had. The *huzur*, who claimed he did not need to be told about it because he already knew, was clearly making some mistakes, for his wife (39 years old) had been pregnant twelve times and was now pregnant again! Where was he going wrong?

The FHV told me that *prakitik* means withdrawal (*azul*), the method advised by the Prophet Mohammad, but the way it was being practiced here did not seem to be very effective. On discussions with women about fecundity one possible reason for this emerged. Women had differing degrees of knowledge and opinions on the menstrual cycle and when the fertile period was, but it was generally agreed that it started just after bleeding had stopped. One said straight away and for only seven days, after that it was impossible to become pregnant. Others said 3-5 days after menstruation and from then on was infertile. People's knowledge was therefore varied, but nothing was consistent with a biomedical explanation of the menstrual cycle, such that if *azul* is consciously practised only during the times perceived to be most fertile, the chances are that this would in fact coincide with the biological reverse, and leave the woman without precautionary measures during the middle of the month - the most fertile time. It is, therefore, very important that health staff understand these local ethnophysiological explanations so they are able to explain to people why *azul*, the way they are practising it, is not effective.

When I asked a group of women if they practised traditional methods (meaning *azul* and abstention) they said that they couldn't because their husbands wouldn't observe the restrictions and they would beat them if the women wouldn't comply. They explained that women in the town could, however, because if they were beaten they could pay the police to take their husbands away and put them in jail, but the police wouldn't do this in the villages. They said this very lightheartedly but at the same time it was spoken with seriousness - this was the kind of treatment to expect if they refused their husbands and there would be no protection given by the law.

HERBAL CONTRACEPTION (*KOBIRAJ PET BURA*)

Local traditional health practitioners, *kobiraj*, use herbs, esoteric incantations and spiritual powers as forms of treatment[5], and their herbal contraceptive pills, known as *pet bura*, are quite commonly used by women. The availability of modern contraception has meant that some previous users have changed to modern methods, however, the herbal variety still remains an option for those who are unwilling to use them. Generally, those who take *pet bura* are reluctant to try modern contraception because they are fearful of the side-effects they may suffer and the consequences these would have on their health and ability to work. *Kobiraj* herbal pills are perceived to be 'safe' and have no undesirable effects on the body. How effective they are is of course another question, although the women I knew who used them believed them to work well, in fact perhaps too well! One young woman with two boys had been given *pet bura* secretly by her mother to prevent her from becoming pregnant again, but she now wished for another child and was failing to conceive. As a result her *shashuri* had begun to suspect that she had secretly used something and had become very angry. Another woman had taken six *kobiraj* pills and she told me they had worked for two years (I'm not sure how she knew that they had ceased to be effective since she had not then become pregnant), although she had now changed to using a modern oral contraceptive supplied by the FHV.

HERBAL FERTILITY MEDICINE

If, as in the case of the young woman mentioned above, conception does not happen of its own accord when desired, all is not lost since *kobiraj* medicine is also available to make one conceive. My young friend who gave birth to a daughter during my fieldwork had taken this and believed that it had indeed caused her to become pregnant again, three months after the death of her second child, the first being lost in a miscarriage. She told me that the pills (*boris*) must be taken in a specific way if they are to work:

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[5] Gupta (1976) provides an interesting account of the history of indigenous ayurvedic medicine, practiced by 'kaviraja', in Nineteenth and Twentieth Century Bengal. These practitioners were orthodox Hindus and masters of Sanskrit texts, and in the Nineteenth Century there were several leading schools of traditional ayurveda in East Bengal. For studies on more current *kobiraj* practices see M.Islam (1980 & 1985).

> On the third day of menstruation the woman must bathe and remaining in her wet clothes, go into her room, sit in the middle of the floor and eat one of the herbal *boris*. She must then move to sit in the middle of the doorway and eat another *bori* and then move outside to the middle of the verandah and eat the last *bori*. Finally she should leave the house and change into dry clothes.

These movements, she explained, are symbolic of the process of pregnancy. The room symbolises the stomach, and the woman's position in the middle is where the baby will develop. Sitting in the doorway is symbolic of the baby's passage out of the womb, and coming out of the house is symbolic of the birth. Wet clothes must be worn throughout to keep the body cool because the pills are very 'hot'. Once the ritual is complete and she has left the room the woman can then change into dry clothes.

For my friend the ritual had been successful but another young woman a few houses away had not been so fortunate. She had been married for years without becoming pregnant and had tried every local method available. The FHV advised her and her husband to go to the hospital for tests to see if there was anything that could be done to help them but they had never gone. It was unusual in these circumstances that her husband had not taken another wife and both he and her in-laws seemed to treat her well, but despite this she was always very quiet and melancholic.

As another friend explained to me, the plight of a young childless *bou* is not enviable: "what can a woman do, how will she feel if she does not have a child?" In her situation women are sometimes forced to take desperate actions and 'steal' the life of another child. My *bhabi* told me that through jealousy barren women will secretly steal a lock of hair from a child and put it in a *manli* ('locket') around their neck. The child will then become ill with fever and vomiting and if it dies the woman will conceive, if it survives she will not. Barren women may, therefore, be regarded with a certain amount of suspicion by other women with young children.

TRADITIONAL ABORTION PRACTICES

Although I was aware that traditional abortions occurred in the village I never actually experienced an incident during my stay; this may be because none were done or just that I did not know about them. Since I worked closely with Rohima, the FHV, who would almost certainly have known, I suspect that the former was

the case; however, the absolute taboo nature of such practices meant that the upmost secrecy was necessary and it may have been that I was simply not told. Consequently, in the privacy of an empty *bari* where no-one would overhear, women could be drawn to talk about it and tell anonymously of people who had had them, but the conversation was usually very guarded and awkward. No-one would divulge the names of the women practitioners who made the devices used, even the village *daktar* brushed swiftly and embarrassedly over the subject when queried. Only one woman with whom I had a very open relationship spoke quite frankly to me about it the first time I touched on the subject, but the next time, for some reason, even she closed-up.

What I understood out of these various tacit discussions was that a small, long, thin stick about the length of the span of a hand and with special herbal plants bound to the tip, is inserted into the vagina and the uterus by the woman herself and kept in place with a cloth. After about 2 or 3 days this causes haemorrhaging and the contents of the uterus to be flushed out. Not surprisingly, the result can be very serious indeed with uncontrolled haemorrhaging and infection leading to death. I was told that no-one had died from an abortion in the village, but that some had been very ill. When this happened the village *daktar* was called in to give them medicine to make them better. When I doubtingly asked if the local *daktars* were actually always able to do this, my friend confidently replied that they were - such were the powers of modern 'miracle' medicine. This was, however, a last resort because of the expense and dishonour and shame involved, and I suspect that the true cause of the illness was often disguised, especially when the *daktars* are respected local males. The mere fact that the *daktar* could (sometimes) make them better seemed in the eyes of the woman who was my main source of information, at least during our first discussion, to significantly reduce the risk, such that she considered it neither dangerous nor bad. When I next spoke to her about it again sometime later she changed her attitude completely and denied ever saying these things to me, insisting that it was "*khub karap*"; "very bad".

It is, therefore, difficult to know how she and other women truly felt, but it was clear that although women were aware of 'safe' abortions at the government clinics they were not prepared to go all the way into town to have them, mainly because of the expense. Although they are supposed to be free as part of the national family planning service, the staff who perform them generally make a charge which increases for every month into the pregnancy. I was told, but do not know how true it is, that they will perform an abortion up to 6 months, but for a very high price

because of the risks involved. One woman who wanted an abortion told the FHV that she could not go to the clinic because at three months it would cost Tk1000! For this reason, whether based on accurate information or not, most village women seeking to abort a child choose the local traditional method and thus put themselves at considerable risk.

CONCLUDING POINT

The physical side-effects of contraception are obviously of great concern when it comes to deciding what type of method to use. However, socio-cultural factors, such as beliefs about health, social control and spiritual destiny, are also very important and play a significant role in shaping people's attitudes and choices. In the words of Ravindran and Berer:

> People who use contraception, especially women, make jokes about it, cry about it, get frustrated and enraged by it, find it terrific or a pain in the neck, love it and hate it in turns. For most people, contraception is a 'good thing' and fear of unwanted pregnacy is a powerful motivator. But that doesn't mean people like contraception or always deal with it rationally - often it is merely tolerated and barely so, at other times it is just too much to cope with, and sometimes it is the last thing on people's minds (1994:10-11).

If people are to be given a properly informed freedom of choice it is, therefore, important that the information provided by health workers and their communication techniques are based on an understanding of these factors, and that the existing local perceptual framework is used to explain new ideas and concepts. The examples I have given, such as the woman with the condoms, serve to demonstrate how it is not possible to base advice and education on assumptions, for this is destined to lead to misunderstandings and confusion, and possibly heighten people's fears about contraceptive methods that they do not fully understand. The examples have also demonstrated that the health workers are also not totally understanding of, or in agreement with, the advice they give, since they too are grounded in the local belief systems. Staff training, therefore, also needs to take these factors into consideration.

CHAPTER 7
MATERNAL AND CHILD HEALTH CARE

> The ideal wife and mother is a person who produces and reproduces but does not consume (Zeitlyn 1993:16).

A central part of Muhilar Shasto's rural health care programme is concerned with providing health facilities to mothers and children. Their specific health needs and dependent social position make them the most vulnerable members of society. UNICEF estimate that in Bangladesh every year 23,000 women die from causes related to pregnancy, or 3 every hour, and that every year 400,000 infants (under 1 year) die (cited in BPHC 1993:6). The goals of the Government's Fourth Five Year Plan 1992-1996 are to try and improve this situation and include:

> Reduce Maternal Mortality Rate from 5.7 to 4.7 per 1000 live births.
> Reduce Neonatal Mortality Rate from 80 to 65 per 1000 live births.
> Reduce Infant Mortality Rate from 110 to 80 per 1000 live births.
> Increase coverage of prenatal care services to 50% of pregnant women.
> Reduce Total Fertility Rate from 4.3 to 3.4 per woman.
> (BPHC 1993:9)

In this chapter I explore the meaning of these objectives from a cultural perspective of life in Shundurgram, and examine the ways in which Muhilar Shasto's programme attempts to improve and change the factors which contribute to the poor health status of women and children. The primary focus of this work is concerned with the health of pregnant women.

The maternal and child programme is largely based on providing education and raising awareness about the necessary care of mothers and children, through the Family Health Visitors' (FHVs) house-to-house visits and monthly satellite clinics. At these satellites and the main clinic in Amhat, the councillor holds education and discussion sessions with the women present on various health subjects, from general issues such as vaccination, management of diarrhoea, sanitation and nutrition, to issues specifically related to the needs of pregnant women and the health of their babies. During the year I attended many of these sessions; they were informal and relaxed, and often very entertaining, due to the skillfully animated and jokey manner of Ambia, the councillor. Unlike the paramedic, who tended to be

rather dismissive and behaved with an air of superiority towards her clients, Ambia had a wonderful way of relating to village women, although she was herself from Jessore town. She sat on the floor of the verandah with the women, addressed them with the informal terminology used in a close relationship - *appa*, *chachi ma* ('sister', 'paternal aunty') - and used the vernacular of the village in her explanations. She had collected a variety of pictures, posters and flip-charts to assist her and often caricatured examples of village life in a lighthearted but effective way, illustrating the common problems experienced by women. Hence, she was very well liked, and my sister in particular, enjoyed listening to her sessions.

At satellite clinics the paramedic gives antenatal and postnatal check-ups in the privacy of a room off the verandah, where the rest of the clinic activities are held. When necessary, she also visits postnatal women at their houses, since for the first 40 days after giving birth both the mother and child are perceived to be extremely vulnerable to illness and supernatural attack. Consequently, they observe strict seclusion and are unable to move outside the confines of their *bari*. If the paramedic is unable to visit, the TBA will do so, to check there are no complications which require medical attention.

Training Traditional Birth Attendants (TBAs) to perform safe home deliveries, and to provide ANC and PNC to mothers at the household level, is a predominant element in the MCH programme. TBAs are recruited based on their previous experience in performing deliveries in their villages, having learnt their skills from observation and practice. They tend to be older women, who are often poor, but well respected in the community. The local term for a woman who performs the role of a mid-wife is *dai*, but as I discovered, once given training, the women preferred to call themselves by the official title of TBA, or 'delivery daktar', to distinguish themselves from other, untrained *dais*.

Each working area of the project has a TBA who works alongside the FHV, making regular house visits to pregnant and postnatal women. She provides homebased antenatal and postnatal care, identifying and referring risk mothers to the clinic or hospital, accompanying them to a clinic if necessary, performing deliveries, giving advice on breastfeeding and maternal nutrition, and attending monthly office meetings and training sessions in Amhat. For each pregnant woman in her care, the TBA is required to fill out a record card with details of the woman's pregnancy, any problems she may have, when her expected delivery date is, and so on, and if the delivery is performed by the TBA, a section is also completed on the details of the

birth. The card has been specially designed in pictorial form so that it may be understood and completed by TBAs, the majority of whom are illiterate. In Bangladesh the training of TBAs as part of a rural health service is common, both in government and non-government programmes, and they are recognised to be a valuable local health resource. However, such programmes have experienced certain problems, a major one being under-utilisation of their services by the community, and I shall go on to examine some of these issues later.

Health care provided by this MCH programme is considered by the medical profession to be an essential aspect of the management of pregnancy, and the healthy development of a child. However, in the local cultural framework of health care and pregnancy these priorities are not necessarily shared, and it is the divergence between the two differing health ideologies ('local' and 'scientific') that I would like to explore in this chapter. Since the broad research emphasis has not allowed an all-encompassing ethnographic study of birth and fertility, I have used a number of other anthropological works on the subject in Bangladesh[1], in particular that of Therese Blanchet (1984), to supplement my own knowledge and experiences. I shall use these sources as a foundation from which to examine the practical implications of these differing ideologies with respect to achieving the MCH objectives of Muhilar Shasto's programme.

Some of the main problems encountered by Muhilar Shasto's MCH programme are to do with low utilisation of facilities by pregnant women. The satellite clinic in Shundurgram, for example, suffers from low attendance for antenatal and postnatal check-ups. In the overall project area the use of TBAs for safe deliveries is generally low (30%), and there is poor use of referral facilities, such as the *upazila* government clinic and hospital, by risk mothers. Continued under-use of services which attempt to address the restrictions of distance, time and travel costs by bringing facilities to the village, and even to the door, indicates that the problems go deeper than can be accounted for by these practical considerations. My experiences of living in Shundurgram amongst women for whom these facilities were intended, shed light on why the community-based health system was still not meeting the needs of pregnant women.

As suggested, the root of the problem lies in the divergent ideologies of the

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[1] Studies on birth and fertility include Blanchet 1984 & 1991; Maloney, Aziz and Sarker 1981; Aziz and Maloney 1985; Bhatia 1981; Khan et al 1981.

interacting medical and cultural systems in the village. In the local cultural system, the condition of being pregnant imposes on women specific norms of behaviour which conflict with the tenets of the intervening scientific medical system. At times these are in direct opposition to advice given by health workers. Under these circumstances the messages received by pregnant women can seem confusing, or have little meaning within their own world view. Consequently, they may not feel the advice to be of any value, or may not be able to respond to it even if they should wish to, because of the restrictions of the pervading cultural system. I shall begin examining these contradictions with regard to the lack of a culturally perceived need for special antenatal and postnatal medical care.

CULTURAL RESTRICTIONS ON PREGNANT WOMEN

In the local cultural system pregnancy is a condition which is not publicly proclaimed, it is regarded with great shame and secrecy, and is something which should be hidden, and not talked about. By way of example, one of Muhilar Shasto's staff was pregnant but it wasn't until she was in her ninth month that I discovered this from overhearing a conversation. She had effectively hidden her pregnancy by constantly draping a large shawl over her head and body, even during the extreme summer heat. Pregnancy is a very vulnerable state for both the mother and developing foetus, and causes women to be particularly susceptible to attack by supernatural spirits, *bhut*[2]. An attack may cause abortion, illness and misfortune, such that antenatal care in the local cultural system is predominantly concerned with preventing this from happening. This in practicality, means a closer and stricter observance of *purdah* - *purdah* of a secondary nature to that of the Islamic tradition (Blanchet 1984). This involves keeping women inside the confines of the *bari*, and restricting any necessary movements outside it to avoid certain times of day and places perceived to be particularly dangerous. *Bhut* are believed to live in bamboo groves and trees and move around the paddy fields, and tend to be most active at sunrise, midday and sunset (*shokal*, *dupor* and *shondhe*). Hence, these are the most inauspicious times and places to be, for a pregnant woman. Seclusion is also prescribed to maintain the woman's modesty and family honour (*shonman*),

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[2] Mahmuda Islam (1985) discusses illness causation due to spirit possession and the different kinds of *bhut* that exist. In Kuriagram I found that *bhut* were believed to attack only the weak and vulnerable, and never heard reference to attacks on men; women and children were their targets. Islam also found this gender preference. However, Blanchet (1984) says that men are also attacked but that it happens far less frequently.

for pregnancy is a cause of great shame and embarrassment (*lojja*), particularly a first pregnancy.

For these reasons of vulnerability and shame, very little preparation is made in advance of giving birth, so as not to attract undue attention to the woman. Her behaviour is restricted to increase her seclusion, and this may be strictly enforced by her *shashuri* ('mother-in-law'), but otherwise she is treated in the same way as normal; she is expected to continue to work as before and the quality of her diet remains unchanged, but with some food avoidances. I discuss the latter two aspects in greater detail below, but concentrate here on the increased restriction of movement and the consequences of this for utilisation of antenatal care facilities at the satellite clinic.

Let me illustrate using Nurjahan's story:

> It was the 23rd May (1992) and the satellite clinic had come to Shundurgram but only two of the *gorboboti mas* ('pregnant women') had visited, both from Choto Shundurgram *para* where the clinic was held. The other pregnant women had been visited the previous day by the TBA, and that morning by the supervisor, but all had said that they would not go because it involved a long walk across the fields. Their *shashuris* would not allow this for fear of being attacked by *bhut*, which live in the trees and out in the paddy fields, and their husbands would beat them if they went.
>
> I was interested to know more about these reasons, so I asked the labourer who worked for my family why his pregnant wife had not gone. He replied to the effect that it was a long way away and it was not good for her to wander around in public. I asked if he objected to the paramedic seeing her and he said that he didn't, he thought it was a good thing, so I enquired that if she only went to the clinic and came straight back would it be acceptable? He said it would, it was wandering around from one *bari* to the other that was not. It therefore appeared he had no objection to her visiting the clinic and having a check-up, the problem was the location and breach of *purdah*.
>
> Four days later Nurjahan, his wife, was in our *bari* making *chira* (a crushed rice snack) with some other women so I broached the subject with her. 'Why didn't you go to the clinic?' I asked. She said that she had gone once before, when she was 4 months pregnant. She had been having problems with pains in her stomach and the *daktar* had checked her over but hadn't given her any

medicine. She said that after seeing the *daktar* the pains went away and she was fine - *shere gieche*. Her *shashuri*, however, took a different view on the matter and claimed that the pains had started after Nurjahan had gone to the clinic, asserting that she could not go again. She said that she had not seen a doctor when pregnant and had had 7 children, therefore, Nurjahan didn't need to see one either.

Nurjahan explained that although she wanted to go, she wouldn't without permission from her *shashuri* because she would be very angry and argue with her; *amake bokbe*. 'Why would she be so angry?' I enquired. Nurjahan suggested that I ask her myself, and the other women present explained that *shashuris* are always jealous of their *bous*, and are therefore very strict with them.

Later that day I asked Nurjahan's *shashuri* the same question, 'why hadn't Nurjahan gone to the clinic?' She repeated what they had told me she would say: Nurjahan had gone before and developed pains in her stomach; it was dangerous to walk through the trees and paddy fields at *shokal, dupor* and *shondhe* because she might be attacked by *bhut* and become ill. I asked if the clinic was nearer, in her own *para*, could she go then? She replied that it would be alright.

She then told me that Nurjahan had been pregnant twice before, but both babies had died. The first had died 3 days after birth, and the second had miscarried. This, she said, was Nurjahan's *dosh* ('fault'), she had been careless and not observed the appropriate behaviour, and as a result had been attacked by *bhut*. Her *shashuri* was not going to allow this to happen again, since theirs was a childless marriage of 5 years, and she desperately wanted a grandchild. She explained that when someone suffered from *bhut* it could only be treated by a *kobiraj*, the *daktar's* medicine would not be of any use if Nurjahan became ill again. She was very dismissive of the need for medical care and allopathic medicine during child birth. In a later discussion on the same subject she became annoyed and walked away, mumbling something about 'soon women will be making babies with their own hands!'

Let us now examine this in the context of Muhilar Shasto's programme.

PROVISION OF ANTENATAL AND POSTNATAL CARE WITHIN THE VILLAGE

In the overall working area less than half of the pregnant women referred by the FHVs and TBAs for antenatal check-ups at the satellite clinics, actually went. Attendance at the satellite clinic in Shundurgram was even lower. As described in Chapter 3, the village was geographically widely spread, and divided into three distinct neighbourhoods - Choto Shundurgram, Boro Shundurgram and Dokanpara - themselves made up of smaller neighbourhoods, or *paras*. The satellite clinic had originally rotated around these three neighbourhoods every few months. However, not long after I arrived the policy was changed as Muhilar Shasto decided that it would be better to establish one permanent location for the clinic, so that people would always know where to find it. A central place was therefore selected, in a *para* midway between Choto Shundurgram and Dokanpara (where I lived), at the house of a local wealthy *kobiraj*. The distance from this house to Dokanpara and Boro Shundurgram was spanned by some large paddy fields, and it was about a 10 or 15 minute walk along winding paths through this open space. It was therefore not surprising to find that the regular visitors to the clinic were women from the same, and neighbouring *paras*, who had greater social and physical mobility within this neighbourhood than those from Dokanpara and Boro Shundurgram. In order for women from outside the neighbourhood to attend the clinic, it was necessary for them to transgress the social boundaries of their own *para* and pass through the symbolically dangerous areas of the paddy fields. The importance of these cultural boundaries therefore represented a strong deterrent against women attending the clinic, particularly pregnant women, and they were effectively enforced and manipulated as instruments of authority by husbands and *shashuris*.

In general, the control exerted by a *shashuri* over the wives (*bous*) within her *bari* is very significant, particularly regarding their welfare during pregnancy. The *shashuri* is often the one who imposes most pressure upon a *bou* to conceive and perpetuate the lineage by producing a grandson. She is also the guardian of female respectability within the *bari* and responsible for maintaining the honour (*shonman*) of the family. Hence, she has a strong interest in the behaviour and welfare of a pregnant *bou*, and enforces strict observance of the appropriate antenatal cultural norms. In the practical experience of Shundurgram, this meant that there was a lot of resistance from *shashuris* like Nurjahan's, to allowing their *bous* to attend antenatal check-ups at the satellite clinic: not only did it mean breaching *purdah* by leaving the *bari*, or *para*, and being seen in public by strange men, but the necessary

journey through the open paddy fields also exposed women to the risk of attack by *bhut* and *batash* (bad wind which causes illness), and hence threatened the health of the baby. Within this cultural framework it was therefore very difficult for many women, and not just those who were pregnant, to attend the satellite clinic unless it was on their doorstep in their own *para*.

The more obvious restriction of time was also an important reason why women from Dokanpara were unable to attend the clinic. The clinic team usually arrived around 10am and stayed until about 1pm. A visit took over an hour with the 10 minute walk either way, and time spent listening to health education, counselling discussions and waiting to be seen by the paramedic. Since this invariably covered a large part of the morning, most women could not afford to give up the time away from their busy schedules; dinner had to be prepared and ready for the return of their husbands at midday. Those with young children and no-one to leave them with also complained, since they then had to be taken along too.

Many women commented that they would go given the opportunity, but that their husbands objected and they would beat them if they did. Interestingly, I found that husbands often said that they did not object to their wives seeing the doctor (female paramedic) but would not allow them to go out of the *para* to do so. The issue for them was therefore more related to the maintainance of their own honour and prestige, through their wife's observance of *purdah*, than based on a fear of attack by supernatural influences.

REST AND REDUCED WORK LOAD

Pregnant women are advised by Muhilar Shasto to take care of themselves by doing only light work and avoiding heavy tasks, such as carrying heavy water containers and working the *dheki*[3]. However, as Nurjahan explained, this is in direct contradiction with traditional beliefs of appropriate behaviour for a *gorboboti ma* ('pregnant mother').

She said they have a belief: if a woman does not continue to work hard whilst pregnant, she will have a problematic delivery. Sitting around all day sewing and chatting is very bad, she should work as hard as she can to remain *shokto* ('strong'),

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[3] A *dekhi* is a heavy wooden device operated with the foot, used for husking rice.

and continue to fulfil her role as a wife without slacking. Allah will then look kindly upon her and give her an easy delivery. Since pregnancy is a shameful condition and should be hidden and denied as much as possible, this reinforces the need to continue work as usual. She told me that town women, however, are different. They do not work during pregnancy and this is not good. They are considered to be weaker than village women. This, my *bhabi* ('sister-in-law') said, was demonstrated by the fact that many of them give birth in the hospital; the hospital being considered by village women, to be only a last resort for those with complicated deliveries. She reasoned, therefore, that they must be weak and this was because they didn't work, they had maids to do this for them.

In terms of maternal health, this belief is a great threat to a mother and her unborn child, especially to women identified as at risk[4]. It is however, deeply rooted in traditional attitudes towards women and their reproductive role in society. Let me take the case of Mahmuda as an example:

> Mahmuda was a middle-aged woman, seven months into her thirteenth pregnancy. Her husband was a *huzur* (religious leader) who refused to use contraception and she also felt no need for it. She had believed that she would not become pregnant again because of her age, about 40 yrs, and the fact that she had so many children already - 6 dead and 6 alive, the youngest being only 1 year and 9 months. When Rohima (the FHV) and I visited she was busy boiling *rosh* ('date palm juice') and cutting mud to make a new house. She looked very weak and tired and Rohima told her that she should be resting and eating more nutritious food to give her strength. She replied that she had been doing so much work all day that she didn't have time to eat properly, and anyway, if she ate *bhat* she couldn't work because her stomach felt heavy now that the baby was big: '*bhat kele, kaj kora jae na*'. She added that she also hadn't had time to wash the day before because of the amount of work she had had to do. It was lunch time and whilst we were sat there her husband returned and demanded to know where his dinner was, causing her to stop everything and serve him.

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[4] Risk mothers are defined as women: of height less than 4'10" (measured with a plastic strip); who weigh less than 46kg; with an arm circumference of less than 20cms (measured with a tape); above 35 years of age and less than 18 years; with previous obstetric problems; with high blood pressure and oedema; who are severely anaemic; and who have had more than four pregnancies.

She had intended to go to the satellite clinic the day before for a check-up, but had been prevented from doing so because of the arrival of a sick relative. (It is debatable whether her husband would have allowed her to go anyway, being that it was in a distant *para* and she had not been before.) Foremost in her mind were her duties as a wife, mother and woman, to look after others before herself. Her own personal care came a poor second, if there was time. Her social circumstances, and as a product of these, her attitude, would not allow her to heed Rohima's advice.

Her example is typical of the situation of many pregnant women under the cultural constraints of the village social system. At the same time, it is also a consequence of the circumstances of poverty under which the majority of rural families live. These demand a heavy burden of labour from both men and women. The processes of maintaining a household on a hand-to-mouth existence, where every available resource is vital, allow little respite for tiredness and ill health. A pregnant woman who is still physically able to perform her domestic and productive tasks is, therefore, unlikely to be able to reduce her work load significantly even if she feels she should.

Food Restrictions and Preference for Small Babies

Traditional antenatal care is predominantly concerned with prevention of and protection from attack by supernatural powers, in the form of proscriptive behaviour regarding women's mobility, and the use of amulets (*tabij*), prepared by a *kobiraj* (traditional herbalist) containing esoteric words and substances[5]. However, certain other precautions are also deemed necessary, involving dietary practices and restrictions on the types of food that can be eaten. In general, as in Zeitlyn's literature review (1993:2), I found that the latter applies more to the period after birth than to that during pregnancy. However, some taboos do exist; for example, women with water retention, or oedema, are supposed to avoid certain 'wet' foods such as *mishti kumra* (pumpkim), *pepe* (papaya) and *kola* (bananas) because they are believed to make the condition worse. It is interesting to note, however, that this condition does not cause undue concern, since it is regarded as a state of normal pregnancy. Blanchet (1984:72) found that some fish were also forbidden, particularly those with ugly features, fearing that they might cause malformation of

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[5] See M. Islam (1980 & 1985) for studies on traditional health practices and *kobiraj* medicine.

the child. Bhatia (1981:69), Zeitlyn (1993:2) and Maloney et al (1981:173) have noted other foods, particularly other protein sources, which people have suggested should also be avoided, and these include duck eggs, milk and meat. On the other hand, there is no agreement on this and some say these are important to the mother's diet. Zeitlyn's study (1993:2) of the literature on this subject concludes that most authors agree that pregnancy is a 'hot' condition, and so in general heating foods should be avoided; these include the sources of protein mentioned above.

In Shundurgram, I found that restrictions were applied more to the quantity rather than the type of food eaten. There was a general belief that pregnant women should reduce the amount they eat. This is usually associated with the perception that a reduction in food will lead to a small baby, which is desirable for an easy delivery. However, opinions seem to vary, and some women say that this will lead to a large baby because there will be more space for it to develop in the stomach; the belief being that the womb and stomach are combined and so food and the baby share the same space. This has also been noted by Nichter and Nichter (1983) elsewhere in the sub-continent[6]. One old woman supported this, saying that she had reduced her food intake and her twelve babies had been large. Nurjahan, on the other hand, had also done this but her baby was very thin. According to this train of thought one should therefore eat more food to have a small baby, but I didn't come across any women working on this premise. Several women felt that big babies were better because they were more healthy, but still worked on the principle of reducing food. The advice given by FHVs, that 1) large babies are best and 2) this requires an increase in the amount of food eaten, is therefore almost the reverse of popular belief.

In fact, I heard several complaints that on following this advice women had had difficult deliveries because the baby was so big. I also heard women relate these complaints to the vitamin A and iron tablets given to them whilst pregnant. The FHV in the neighbouring village to Shundurgram confided that she was worried

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[6] Nichter and Nichter (1983) identify the same 'big baby/small baby' dilemma in South Kanara, India. They found a tendency for the preference of smaller babies, which contradicted the modern medical concept of a 'healthy' baby, as expressed in health education. This preference related to the dietary behaviour of pregnant women determined by cultural taboos prohibiting valuable sources of protein. These taboos were related to ethnophysiology and concepts of 'baby space' within the woman's body, believed to be the same space as the stomach and hence shared with other substances; and 'baby strength', a small muscular baby was perceived to be more healthy than a big baby.

about the advice she was giving because she had noticed an increased incidence in difficult deliveries, due to babies being bigger. This brings to light a possibly important opposition in the MCH objectives, if not significant in medical terms, then certainly significant in local ethnophysiological terms: increasing birth weight of babies through an improved maternal diet may actually cause women to have a more difficult delivery, particularly if they are small, and/or young mothers, as many are. Clearly, I am speculating on the concerns expressed by village women and the FHV, and in medical terms the threat to the mother may be insignificant in comparison to the benefit of improved nutritional status. However, it is certainly an issue requiring consideration when addressing the general problem of increasing low birth weight, which is a main cause of the high neonatal mortality rate.

BIRTH PRACTICES AND MATERNAL-CHILD HEALTH

The large majority of women in Bangladesh give birth in the confines and privacy of their own home, without any assistance from medically trained personnel. Under these conditions they are at great risk should a complication in birth arise, and as the national statistics show, many mothers and babies die as a result. As a reminder, the Maternal Mortality Rate for 1990/1991 was 5.7 per 1000 live births - in Britain it was 0.07 (1991 statistic from Central Statistical Office 1994:38) - and the Neonatal Mortality Rate was 80 per 1000 live births (BPHC 1993:9). To try and improve the life chances of mothers and their children during this vital period, much focus has been placed on traditional birth practices, and the training of traditional birth practitioners in safe delivery techniques. Blanchet's study, *Meanings and Rituals of Birth in Rural Bangladesh* (1984), is the most detailed ethnographic exposition on birth practices, and has been used by health programme designers to highlight some of the most important cultural and medical aspects of this ritualised and symbolic process. The focus of education and training programmes has therefore been to build on the role of traditional birth attendants in rural communities, improving their skills, and modifying and changing certain aspects of traditional practice which could increase risks to the health of mother and child. Emphasis has also been placed on improving the quality and availability of referral facilities in rural areas, to deal with life-threatening complications. Using mainly Blanchet's work (1984, 1991) and my own research experience, I shall therefore examine Muhilar Shasto's programme approach with respect to these issues, in particular their use of Traditional Birth Attendants. To do this it is necessary to provide an ethnographic background concerning the rituals of birth, particularly those aspects

identified by the medical profession as being 'dangerous'. I shall therefore use an account of one of the three births I attended with the trained TBA, Rogina, and then discuss how this differs from the traditional practices of *dais*.

The following account is taken from my diary on the 30th September, 1992.

> Last night I had quite the most magical experience. I was woken at 1.30 am by a quiet voice calling my name - "*Rose appa, utben, delivery hobe, Ampure, apni jaben?*" "Rose, get up, there will be a delivery in Ampur, are you coming?" I couldn't make out what it was to begin with. I had been in a world of deep slumber and dreams, but after coming round I realised it was Rogina, the TBA. She was outside my window on her way to the neighbouring village to perform a delivery and needed my Savlon lotion. She asked if I would like to go - how could I turn down such an exciting opportunity, and on such a beautiful night?
>
> The moon was a thin sliver in the darkness of the sky and just bright enough to cast light across the scenery. The stars, for the first time in several nights, shone brightly in their thousands - the world stood silent and magical. Quickly our figures hurried through the darkness, along the winding road. Skirting the paddy fields, through the shadows of the *narikel* trees, we went one behind the other, led only by the dim orange light of a hurricane lamp. Only the sound of a dog barking and a baby crying pierced the silence. *Bhut*, the spirits of the trees, were the only ones to witness this curious scene. I covered my head with my *orna* to prevent them from attacking me, my white skin, so I am told, being a great temptation to them.
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> We arrived some twenty minutes later in a little village, the blackened outlines of the *baris* rising out of the ground. The only sign of life was marked by a small light in a doorway, silhouetting the figures of two elderly women sat crouched on the ground. They talked quietly to a young woman sat next to them, clutching at her stomach and moaning. She had been in labour since *shondhe* ('sunset'), but the pains were worse now, it might be any time...they were waiting in anticipation for our arrival.
>
> Rogina asked them to prepare a blade and some cotton in boiled water, these would be the only instruments she would use. We then sat down to wait. The village *daktar* arrived a little behind us, carrying his large black bag - the identity tag of his trade - in which are kept the all-powerful *alopathi oshud*

(allopathic medicine). He remarked casually about the trouble of being called from his sleep and jested that they already had a *daktar* present, Rogina, and of course myself. The comment was subtle but sufficiently patronising to establish Rogina's lower status; he was of course the real *daktar*, the knowledgeable one, the one who was seen to control the situation, and for his bother he would be well paid. Rogina, however, would receive at most Tk20 or some food for her skills, and ultimately, more vital expertise. Although he was one of the few local *daktars* to have done the Government's *pallichikitshok* training course twenty years ago, he knew little about the physiology of birth.

In fact, all he would do, all he could do given the cultural restrictions, would be to administer unnecessary, and possibly dangerous medicine. On all three occasions I have witnessed a delivery, he has given the mother an injection to speed up the birth (Cyntocin) and a saline drip. The paramedic told me that these measures are only meant to be taken in serious cases of prolonged labour under trained medical supervision; they are not appropriate for village conditions. I suppose, however, there is little else the *daktar* can give in order to earn his fee; the combination adds up to around Tk100. There is also the other plus point as far as he is concerned; it speeds up the waiting around, so his job is over and done with much more quickly. On this night the magic worked within about 40 minutes. I was sat steadying the young woman's arm, into which the drip was inserted, when suddenly her waters broke in the most incredible gush, breaking the anticipation on all our faces. A few seconds later her baby came spilling out onto the mud floor, which was covered only by a dirty plastic sheet. Rogina made no effort to catch the new arrival, but allowed it to fall unassisted into the puddle of expelled liquid. I couldn't help thinking what an abrupt beginning it was, and how if she hadn't been lying but squatting, as was more usual, it could have caused all sorts of damage to the baby's head!

The *shashuri* stood looking anxiously over my shoulder, struggling to make out what was happening in the dimly lit space where we sat. She immediately implored Rogina to *foo*, or gently blow, into the baby's mouth, over and over again until it showed clear signs of breathing life. The little mite began to wriggle and open his eyes, this was his first glimpse of the world outside his mother's protective womb. Rogina squeezed some milk from the mother's breast, put it in the baby's mouth, and a few minutes later

out came the placenta, a neat package more white than red in colour. It was left untouched on the ground in a small pool of blood, symbolising the contradiction between its powers of defilement and its powers as a life-giving source.

Rogina passed a glance down the tiny body and exclaimed to the few of us awaiting the news, that it was a boy! The response was quite unlike the other births I had seen, both of girls. Then, nobody showed the remotest signs of joy or gratitude at the sight of the new babies, including the mothers. At one, the young woman, no older than about eighteen, had sat exhausted and emotionless on the floor, this being the birth of her first child. She barely looked at the baby and did not hold it for quite some time. I thought perhaps her blank expression reflected the knowledge that her *shashuri* and husband would be disappointed it wasn't an heir. Even her own mother, in whose house she sat, made no comment about the arrival of her granddaughter. There was no cause for public celebration. But this time the atmosphere was quite different, everyone was delighted. The mother smiled quietly as she sat watching Rogina tie and cut the umbilical cord, dab the end with Savlon, and rub the baby with mustard oil. He was given a drop of sweet water, wrapped in some old scraps of cloth and placed in my arms, no-one else offered to hold him. Babies are considered to be incredibly 'dirty' and polluting (*napak*) when they are first born, and only someone as ignorant as myself would be openly willing to hold one.

The boy's father immediately began to pray out loud, standing in the yard calling praise to Allah. Allah had been generous and sent them a son this time, their first child was a girl. The *shashuri* sat gazing at her grandson, the look of joy expressed on her aged face in a large smile. She talked to him and played, although never actually touched him. The men sat outside on the porch, peered in to grab a glimpse of this blessed child. There were smiles all round. Someone was sent to bring biscuits for us in celebration but we hastily declined, the hour now being nearly 4am.

In these situations the mother never receives any attention, in fact, during labour she is severely reprimanded for crying out in pain. It must all be kept inside, she must keep silent - a woman is not supposed to express her emotions or the pain she may be feeling in any event of her life. It is a sign of a weak woman and everyone would mock her for it, bringing shame to the

family.

Once the placenta, called the 'flower' *(phul)*[7], and all traces of blood had been cautiously scraped from the mud floor by Rogina, and put into a broken earthenware pot to be buried, her job was over. The *shashuri* would bury these under a tree, or at the side of a field with great care, for their powers of pollution are very strong. Rogina put the baby to its mother's breast but it wouldn't suckle, so the effort was abandoned. She went off to bath thoroughly, to purify her ritually impure, *napak*, state, and the mother was also bathed and dressed in a clean sari. We then made our way back home, guided once again by the dim glow of our hurricanes.

Back in my *bari* no-one had noticed my absence. Kasheem and Hameed were still sound asleep on the verandah. Only the dog watched me from the kitchen door as I made my way across the yard to the tubewell, to rinse my hands and feet, I couldn't face bathing fully to remove the ritual pollution of my experience. No-one stirred at the cranking of the pump's handle, no-one stirred at the springing of the large padlock on my door. I climbed into bed, tucked in my mosquito net and joined the others in a shallow sleep until morning...it had been quite an unforgettable night.

I asked Rogina how she had changed the way she performed deliveries after receiving training from Muhilar Shasto, and she told me she had learnt that many of the things *dais* do were 'bad'. For example, since childbirth is perceived to be highly polluting the *dai* does not bother to wash her hands before delivering the child - it is after the delivery that thorough cleansing is necessary.It is therefore the *dai* and others present, rather than the mother, who are subject to the intrinsic dangers of the birth process, and can be ritually 'infected' by it. The scientific concepts of disease causation and hygiene are absent, and so cleanliness is not a consideration. The mother is sat on the bare mud floor of the birth room so that the polluting fluids can easily be scraped-up and removed, and the child is allowed to fall on to this and lie there. Old cloth is used to wrap the child and the umbilical cord is cut with an unsterilized blade, or perhaps a bamboo sliver (Bhatia 1981:67, Blanchet

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[7] An elderly woman explained to me that a woman is like a tree, *gach*. "If the tree has no flowers will it have fruit?" she asked. "If the woman has no flower she will not bear children". Thus, the placenta is the source of life, from it develop the fruit of humankind, and in the rituals of birth this is richly symbolised. Blanchet (1984:89) elaborates on this in great ethnographic detail.

1984:95). Cow dung is put on the stump of the umbilical cord to stop it from bleeding. Interestingly, my 'sister-in-law' who studied to class four, told me that for her two sons she used dung to stop the bleeding, and savlon and talcum powder to keep the stumps clean. The risks of infection and tetanus as a result of these practices are clearly very great.

The threat to mother and child is perceived to be supernatural in nature rather than pathological, so protection and treatment utilize the local healing system. Tetanus, characterised by clenched fists and a jerking stiff body, and eclampsia characterised by shaking, are in cultural diagnoses recognised as signs of attack by *bhut*. A cure is therefore sought using *kobiraj* medicine, such as a *tabij* containing holy words, or sanctified water, known as *pura pani*, over which a *mullah* has blown and whispered esoteric holy words. For this causation of illness, resort to allopathic medicine is not deemed appropriate.

It is believed that if not prevented, during pregnancy the growing baby will move upwards inside the woman's body to the lungs and heart, causing serious problems. Hence, women tie their petticoat strings very tightly around their waists throughout the course of pregnancy. At the onset of labour this fear is heightened and so a thick cord may be tied above the stomach to block the child's movement in the wrong direction. A delayed delivery is a cause for concern, so the child may be helped to move downwards by the application of pressure on the woman's stomach. Some *dais* use their feet to do this. The fear is that either the baby will move upwards to the lungs and heart, or that it has a problem and is likely to die. It is quite likely that for this reason the attendance of the local *daktar* at births was common in the area, i.e., so that he was on hand to administer Cyntocin to alleviate the threat caused by delay. This is another interesting example of the complementary use of the two different local medical systems. In the same way that women use the contraceptive pill to induce menstruation and so prevent the harmful effects of a build-up of polluted blood in the body (see Chapter 6), they also utilise labour-inducing drugs from the allopathic system, within an overarching ethnomedical framework of birth. I am not sure how common the incorporation of village *daktars* into the rural birth setting is outside the catchment of this particular *daktar's* area. It is obviously partly dependent on the availability of a *daktar*, and their knowledge of Cyntocin, amongst many other factors such as the cost of calling them, but from the limited mention in other literature, it would seem to be a

relatively new phenomenon[8]. This clearly requires further research, since the unqualified use of Cyntocin could cause serious medical complications, possibly leading to maternal and neonatal mortalities[9]. An important issue which obviously arises here concerns the availability of the drug in the market place, and this also applies to numerous other potentially dangerous drugs. The mismanagement of allopathic medicine by unqualified local *daktars* is indeed a very serious issue, encompassing, for example, the development of antibiotic-resistance through administering inappropriate dosages - I observed this on several occasions - but this important subject is unfortunately outside the scope of the thesis. I will however, discuss the social function of village *daktars* and their potential as a further resource for health programmes, at the end of this chapter.

Some *dais* insert their hands (Blanchet [1984:87] notes that it is usually the left hand since this is used for defiling tasks) into the mothers vagina to check the position of the baby, and some use mustard oil to lubricate the passageway to facilitate the birth. They are taught in their TBA training that these techniques are potentially dangerous and that they should refrain from doing them. The delivery position of the woman is usually squatting with the support of another woman either in front or behind her; however, I noticed that in the delivery described, Rogina made the woman lie down, as taught by the paramedic. The paramedic subsequently underwent refresher training and was taught that the traditional squatting position was far better, and so changed her advice to the TBAs, to revert back to their old way.

After birth the baby is assisted to breathe by the *dai* gently blowing in its mouth. If as in the first birth I saw, the baby doesn't respond immediately, the *dai* may chew on some spices, such as cardamom and cloves, to hotten her breath, causing the baby to gulp air from the heat (*jhal*). This is, in essence, a form of resuscitation

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[8] Blanchet mentions the role of village doctors and their use of Cyntocin in her study on birth for SCF, (1991:52). Jeffery et al (1989:219) also briefly mention the undermining of *dais* by the "encroachment on childbirth" of male practitioners using modern drugs, such as Oxytocin to stimulate contractions.

[9] Oxytocin, a drug of the same generic class as Cyntocin, is a hormone given to stimulate uterine contractions in the induction of labour. Reynolds (ed) (1993:960) *Martindale, The Extra Pharmacopoeia*, states that conditions of use should involve the monitoring of contractions and feotal heart-rate, and warns that: "Administration of oxytocin in high doses or to those hypersensitive to it may cause violent uterine contractions leading to uterine rupture and extensive laceration of the soft tissues, foetal bradycardia, feotal arrhythmias, and feotal asphyxiation, and perhaps feotal or maternal death."

which in the case I have cited, had the desired effect of bringing to life the baby girl. The next concern is for the rapid expulsion of the placenta, which if retained, is also believed to move upwards inside the body. The umbilical cord is not usually cut before this has occurred and is often tugged to pull the placenta out; a practice which can cause damage to the uterus, or leave fragments of the placenta behind, inviting infection. If this does not work, the *dai* may use her hands or feet to apply pressure to the mother's stomach, and sometimes the mother's hair is pushed down her throat to make her vomit[10], which is said to contract the stomach and force out the placenta. Nurjahan, in the case study I used earlier, told Rogina and I that her mother had done this to her, when she gave birth to her daughter. Rogina replied that the paramedic had taught her a much better way which she now always used. She had learnt that the initial thick yellow breast milk (colostrum) was not 'bad' as everyone thought (this belief is discussed in detail later), and if it was given to the child immediately after birth, and before cutting the umbilical cord, the placenta would very quickly come out. She hadn't believed this at first but when she tried it, it had worked and she was very impressed. She appeared quite proud of her new technique.

A medically trained person explained to me that this is due to an interaction of hormones, stimulated by the initiation of lactation. In order for it to happen, the baby therefore needs to suckle. However, I found it interesting to discover when next observing Rogina at a delivery, that she had interpreted this information differently. When the baby was born she squeezed a small amount of colostrum from the mother's breast and put it in the baby's mouth. She then turned to the old woman present, informing her that the placenta would now quickly be expelled, and sure enough it was; thus was the proof of her new knowledge. The interesting point is that, although she had not actually put the baby to the breast, as was intended by the training as a way of encouraging immediate and exclusive breastfeeding, she had refrained from pulling on the umbilical cord, and shown that her attitude towards the qualities of colostrum had changed. Thus, in this regard, the training had had a positive impact.

In the three deliveries I attended the mothers continued to bleed quite heavily after birth, but as Blanchet notes (1991:51) this was not considered to be a matter for concern. In fact, it is seen to be a necessary process to rid the body of the remaining

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[10] Blanchet (1984:85) and Bhatia (1981:68) give accounts of these same practices.

polluted blood, and thus this can have serious consequences for a mother suffering from hemorrhage. It may be several days before assistance from a *kobiraj* or *daktar* is called to treat continued bleeding, if at all. For example, Kaleda was delivered by her elderly *shashuri*. She told me she had not bled straight after the birth but started later in the day, continuing heavily all night (*onek sirup bangche*), and was still bleeding when I visited at 11a.m. the next day. She said she was feeling very weak and had eaten large amounts of rice, *bhaji* ('fried food') and *simay* (a sweet wheat-flour dish) to stop the bleeding, but it hadn't worked. She complained of pains in her stomach, which she thought was *thandar*, cold; to my inexperienced eyes it still looked very big. Her *shashuri* arrived and began to explain that the bleeding was from a round ball of blood in her stomach - she formed her hands together to demonstrate - which comes out when you give birth, after the placenta (*phul*). She called it the *sap*, made up of *sirup* blood, and emphasised that it was different to the *phul*. It should have come out after the birth but a day later it still hadn't, and she was now becoming worried, although she didn't appear to be doing anything about it. As far as I was aware, no treatment was given and she finally stopped bleeding, but continued to complain of feeling extremely weak.

POSTPARTUM RITUALS

For the first seven days after birth the mother and child are perceived to be still highly polluted and particularly vulnerable to *bhut*. Consequently, various precautions are necessary to ensure their safety, and the safety of those around them. During this period they remain strictly confined to the room where the birth took place, called the *atur ghor*. The mother is allowed to rest and care for the child. She has no duties, her food is cooked for her according to special dietary restrictions (which I discuss below), and she only leaves the room to relieve herself. I was told that a small fire is burnt in the doorway to keep roving *bhut* at bay, but I actually only saw this done twice, out of a number of new babies I visited[11]. One was a Hindu house in the neighbouring village, where an animal's jaw bone was being burnt - the paramedic who I was with (a Muslim) found this quite revolting and reprimanded the mother severely for causing the baby to breath the unpleasant fumes. I could not establish why she was using a jaw bone, rather than other fuel, since she was too intimidated to speak. However, Blanchet (1984:102) mentions that

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[11] Blanchet (1984:88) discusses the significance of this in Bangladesh and its commonality across the South Asian continent, as do Maloney, Aziz and Sarker (1981:181).

the bone of an animal killed in sacrifice, along with a broom and old shoe may be placed next to the child's head for protection from *bhut*, and so there is perhaps a connection between these two ritual practices. The other instance was at a relatively wealthy Muslim household, where anyone entering the room had to hold the soles of their feet and hands to the fire to chase away *bhut* that may try to enter with them. I was also told that the mother should keep with her an iron object to fend off the spirits, particularly if she had to leave the room. Blanchet (1984:100,102) also details these, and a number of other ritual precautions.

I was informed by my *bhabi* that on the sixth day a ritual is performed to bring good fate to the new child. A special meal is prepared for the mother of male chicken meat, *shol* fish, seven vegetables cooked together, milk and *mishti* (sweets). In slight variance, Bhatia (1981:70) found that this occurred on the fifth night and that five vegetables were given. On the sixth night, Allah is said to write the child's fate. The mother writes the child's name on a palm leaf and on the seventh morning she bathes and the leaf and some of the food is thrown into the pond or river. Gifts are given by relatives, to be kept for when the child is older. The seventh day marks the end of the strict seclusion period and the dietary restrictions, and after this the mother is able to come out of the *atur ghor*. However, according to Islam she is regarded as being ritually polluted for a total of forty days and so must remain within the confines of the *bari* for this period. Her vulnerability to *bhut* also means she must be particularly vigilant of her movements outside the birthroom at inauspicious times of day - dawn, midday and sunset.

For these forty days Islam states that a woman should refrain from sexual relations with her husband, although I heard from several women that their husbands were unwilling to observe this. It is believed to be bad for the woman's health because her body is still not fully healed, and it is also thought to reduce the husband's life expectancy because of her pollution (Maloney et al 1981:182). During this time the TBA is supposed to pay regular visits to check the progress of mother and child and to advise on a nutritious diet. She is also expected to discuss contraceptive measures to prevent what is locally termed a *muro bacha*; a baby conceived without the prior return of menstration. I was surprised and alarmed at how often women appeared to conceive in this way, or within only a short period after giving birth. Women like Mahmuda in the earlier case study, who was seven months pregnant for the thirteenth time, her youngest child being only one year and nine months old, were not uncommon. The FHV who was also expected to visit, told me that this represented a problem because the pill, which was the most widely used method

because of its convenient availability, was not appropriate for a new mother. It inhibits lactation and therefore should not be used by a breastfeeding mother. The method she was advised to encourage was condoms, but they were not popular. The contraceptive injection is also considered medically appropriate but requires the woman to attend the satellite clinic for it to be administered by the paramedic. IUDs are also safe but require a visit to the office clinic. With the even stricter norms of seclusion applied to new mothers, these were also not popular. At the end of the forty days the rites of passage are complete and the mother bathes thoroughly, washing her clothes and all things she has used, to assume a state of ritual purity. She is then able to return to her usual role and behaviour.

After the forty days the TBA refers the mother and child to the satellite clinic for a postnatal check-up, Tetanus Toxoide injection for the baby, and birth spacing advice. However, motivating *shashuris* to allow their *bous* and grandchildren to attend the clinic, with the blatant exposure to *bhut*, was, as discussed above, a problem, and so postnatal check-ups at the satellite in Shundurgram were few.

FOOD RESTRICTIONS ON POSTPARTUM DIET OF THE MOTHER

Blanchet (1984:113) states that, unlike during pregnancy, in the postpartum period women observe rigidly controlled diets which are restricted to certain types of food only. Whereas pregnancy is a 'hot' state, after giving birth the body is believed to be 'cold' (*thanda*), so 'cold' foods should be avoided, and this includes many vegetables. The womb is then 'wet' and like a sore (*nari gha ache*) needing to be healed, and so for the first seven days the parturient woman should eat only fried food. This is categorised as 'dry' (*shukno kaoa*), helping to dry up the bleeding wound inside the body. *Jento mach* (stored live), e.g, *jiol mach*, should also be eaten because these promote the production of blood to replace that which was lost. Zeitlyn's study (1993:4) found this to be mentioned by several other authors too. Chicken meat, particularly young chicken, is also believed to be very good because of its blood-producing property. I was told that *kupothi kaoa*, harmful food, which should be avoided (*kaoa jae na*) included certain other fish, bought when dead, e.g., *illich mach*, *chingri mach* (shrimps) and *puti mach*, and cow and duck meat because they make the wound worse. Duck is particularly taboo because it is very 'strong' and causes the body to produce *rosh* ('juices') which will not allow the wound to heal. *Narikel* ('coconut') is also avoided for this reason because it is 'oily' (*teler jinnish*). Also vegetables such as *lau* ('marrow'), *begun* ('aubergine') and *poishak* (green leafy

vegetable), should be avoided because they are 'cold' and cause the mother to suffer from *shutika* ('post-partum diarrhoea'), and the baby to suffer from *patla paikhana* ('diarrhoea') and *shordi* (a 'cold'), passed through the mothers milk[12].

The food taboos are applied not only as a form of healing and restoring the mother's health, but also to protect the child. The mother and child live in symbiosis (Blanchet 1984:116)[13], the quality of the food (i.e., 'hot', 'cold', etc.) eaten by the mother being transferred to the child through her breastmilk. Thus, great care must be taken in observing the taboos, so as not to upset the vulnerable balance of 'hot' and 'cold' in the child's body, and cause it to become ill. If illness does occur, the mother is blamed for her negligence. Her diet is scrutinised and adjusted appropriately, and any treatment is given to her rather than the child. An example of this system of etiology is given in the case of Hamida's baby, who at several weeks old, contracted *ham*, the local term for measles. When I asked if the baby had had any treatment, Hamida replied that she had restricted her own diet to avoid fish and *moshari dhal*, and that she should not wash the baby for a few days. She was confident that this was all that was necessary, it was not a matter for undue worry. These etiological beliefs have important repercussions in, for example, the use of Oral Rehydration Solution (ORS) to treat diarrhoea in babies[14]. Treating the child is in direct contradiction to the local ideology; it does not tackle the cause of the illness, the mother's milk, which has become 'bad' due to another cause, e.g., her diet or *bhut* attack. This association of causation is symbolised in the name given to diarrhoea in babies, which is *dudh haga* (milk diarrhoea).

Interestingly, however, attitudes and behaviour about appropriate food for mothers did seem to be changing, with increasing awareness amongst villagers of the need for lots of vitamins in their diet. This was learnt from a variety of different sources, including Muhilar Shasto's health education, school and the radio, on which programmes about nutrition were quite common. A number of the mothers I spoke to said that they now ate vegetables and fish which they had previously avoided.

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[12] Blanchet's study (1984) explores postpartum taboos in detail and identifies various other prescribed and proscribed foods. She also explores the concept of *shutika*, and the causes of it.

[13] Nichter (1989:160) notes a similar symbiosis and transfer of food properties from mother to child via breast milk, in Sri Lanka.

[14] Nichter (1989) explores this issue in the context of Sri Lanka, examining Sinhalese perceptions of diarrhoea and ORS use.

BREASTFEEDING

The issues of breastfeeding, 'bad' milk, and insufficient milk are important in the context of rural Bangladesh, where breastfeeding is the main, and generally only source of nutrition for a baby during its first year of life. It is, in fact, common across the country to find mothers breastfeeding their children up to as old as three years of age (Zeitlyn 1993:7). The effect of the mother's diet on lactation is therefore very important, as are the perceptions regarding the attributes of breastmilk, and in particular, colostrum. This has been widely researched in conjunction with the pro-breastfeeding/anti-bottle feeding campaign in Bangladesh, which uses the slogan 'mother's milk is best', and so is not dwelt upon in detail here[15]. My aim is to reinforce the findings of others, with observations from Shundurgram.

In regard to perceptions about colostrum, it appears to be a widely held practice to withhold the breast from a new born child for the first few days, in the belief that the initial thick yellow milk, *shal dudh*, is 'bad' and *moila* ('dirty') - "it should be thrown away". I was told this by many women, old and young, and noted that in the three deliveries I attended, the mother was very reluctant to breastfeed, despite the advice of the TBA. Whilst normal breastmilk is regarded as having positive qualities because it is believed to be made from blood, the health-giving substance, colostrum is considered 'bad' because it is made from the polluted blood of pregnancy, and hence is harmful to the child. It is therefore expelled. This is a practice which the breastfeeding campaign has tried to change, since it denies the newborn of the necessary nutritional requirements provided by colostrum, in particular vitamins, minerals and protein, and vital antibodies for the immune system. Instead of this *shal dud*h, the mothers in Shundurgram fed sweetened water and/or heated diluted and sweetened cow's milk to their babies for the first three days, until the 'good' milk began to flow. After this they began breastfeeding. Immediately after birth they put a small amount of honey, or sweetened water (*misri pani*), in the baby's mouth. This was to make the child speak 'sweet words' (*mishti kota*) and be a 'sweet' person. I was also told that it was to wash down the mucus in the babies throat, so that it did not become blocked. This practice has been commonly reported by others (VERC 1992:1, Blanchet 1984:113, Zeitlyn 1993:6). If a mother felt she did not have enough milk, as was a complaint (also noted by

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[15] Useful references are Zeitlyn's literature review on maternal nutrition (1993), Zeitlyn and Islam (1989), VERC (1992), and Blanchet (1991). Interesting new perspectives on breast-feeding as a social construct are presented in Maher (1992).

Blanchet 1991:46), she would supplement breastfeeding with cow's milk if she could afford it, or a sweetened watery ground-rice mixture called *shabu*, a similar ground-rice dish called *sugi*, and/or *misri pani*.

Even if breastmilk was not in short supply, after a few weeks when the child's appetite was seen to increase with growth, cow's milk, *shabu*, etc., were given as regular supplements. The lack of hygiene in the methods of feeding was extremely worrying; often an old medicine bottle was used, with a dirty rubber teat stuck on the top. The bottles I saw generally looked as though they had never been washed! They would be dropped, left around for the flies to sit on, and then stuck back in the child's mouth. It was no wonder that babies I saw being fed in this way were generally suffering from diarrhoea. One child in the *para* next to mine, whose mother had died in labour, was being cared for by his young sister and fed only *shabu* from a revoltingly filthy bottle. At six months he ressembled a tiny withered old man, and tragically, but not surprisingly, he died not long after. The use of powdered milk is quite widespread nationally because of its promotion through hospitals and medical establishments, in the form of free samples from multinational companies[16]. This was uncommon in the village, however, since it is very expensive and only those with surplus resources could afford to buy it. In fact, the only person in Shundurgram I saw doing this was, rather ironically, the FHV, Rohima! She said she was forced to do so because her work didn't allow her to breastfeed her baby during the day. This was an awkward example of not practising what you preach: Muhilar Shasto staff were told to be very vigilant about the use of bottles and milk powder because of the high incidence of neonatal death caused by diarrhoea. Using an unsterilised bottle and unsafe water sources to dilute the powder are instant access routes for diarrhoea-causing pathogens.

The significant point here is the irony of Rohima's situation. She is encouraging women to be good mothers by caring for their children properly, and to become more responsible for their own lives by being less dependent on their husbands and having greater freedom outside their houses. However, her own example actually highlights a contradiction in this advice: by being 'free' and taking a job outside her home she is in fact preventing herself from fulfilling her responsibilities as a 'good

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[16] A national 'baby-friendly hospital' campaign was started to try and prevent this, one of the main instigators being the coordinator of BPHC. A 'baby-friendly hospital' is one where there are no bottles used for feeding, and free samples of milk powder for mothers, provided by multinational companies, are not accepted or promoted.

mother', by being unable to breastfeed her baby! At the same time, this contrasts with the symbolic status of feeding expensive milk supplements to a child. Since their cost, packaging and availability in shops and hospitals associates them with 'modernity', high status and allopathic medical care, they are seen to be superior to breastmilk, and so a family that can afford it might feel it to be a worthwhile expense as a source of prestige, particularly if the child is a boy. (Rohima's baby was a girl.)

WEANING FOOD

The weanling child, who is being breastfed but also receiving regular additional food, is identified by Zeitlyn (1993:9) as being particularly susceptible to morbidity and mortality. The common early supplementation of breastmilk with *shabu* etc., is seen by Blanchet (1991:41) to represent a 'worrying trend', since, as I have pointed out, it increases the child's vulnerability to illness immensely. This is clearly a crucial stage in the child's life, and the type of food given, quantity and quality, and so on, are very important. Muhilar Shasto's programme has a specific focus on the nutritional requirements of children at this stage. They advise women to exclusively breastfeed for the first four or five months and to introduce weaning food after this, in the form of *kechuri*. This is made from a mixture of rice, *dhal* and various different vegetables, cooked together in one pot, and practical demonstrations of how to make it are given at the satellite clinics, with mothers from the locality donating the ingredients, and cooking. It is then fed to the undernourished children who have been brought to the clinic for growth monitoring - and to any other children present.

Local perceptions regarding weaning, however, do not necessarily recognise this type of food as being the most appropriate for young children. Many women believe that if they give foods like rice to a young baby, its digestive powers will be inadequate and they fear it will make them ill. Some mothers explained that babies could not eat it (*khete parbe na*) because they did not have the *obesh*, habit, yet. Others said it would cause the child to develop a fat belly, which was not desirable; Zeitlyn (1993:11) also reports this complaint. Another woman with a nine month old child told me she fed only breastmilk, cow milk, rice with salt, and *shabu*. She was frightened of giving vegetables because she thought the baby wouldn't be able to digest them. She was particularly worried that the *jhal* ('chilli') with which they are cooked (they are never cooked without some kind of spices to give flavour), would

burn the child's mouth preventing it from eating. Another mother said that she would be pleased if her eight month old baby ate vegetables but he wouldn't, he just spat them out because "he couldn't eat yet". She fed him *shabu* and breastmilk only. Although beliefs concerning suitable food varied, there was a general agreement that *bhat* (rice) was not suitable for young babies of four or five months in age, and hence, that *kechuri* was also inappropriate as the combination of rice and vegetables would be too difficult to digest. Thus, although breastfeeding is prolonged, it is often accompanied with delayed supplementary feeding of solid, nutritious foods, such that the child lacks a sufficient source of nutrients beyond its first few months (Bhatia 1981:71).

Zeitlyn (1993:9) cites the work of Rizvi (1979) regarding popular weaning foods, and appropriate stages at which to introduce solids into a child's diet. Rizvi found that certain milestones in the child's development were seen as indicating that it was ready to eat solids, for example, cutting its first teeth or starting to walk. This occurred around fifteen months. Rohima informed me that generally women felt children should be about a year old before receiving rice, when they were able to feed themselves. Maloney et al (1981:185) mention mothers using similar indicators as first teeth, although there was a difference between Hindu and Muslim practice. The average age for breastfeeding without solids amongst Muslims was nine months, whereas amongst Hindus it was sometimes younger, after a traditional feeding initiation ceremony called *annaprasan* or *mukhebhat*. They found this to be held at the sixth, ninth or twelfth month, whereas Blanchet (1991:44) found it to be at the ninth month. Interestingly, the Muslim women in Shundurgram also talked of the *mukhebhat* ceremony, saying that it was a joyous (*anondo*) occasion of thanks to Allah, when they feed the child with its first *bhat* and *mangsho* (meat), of goat and chicken. No vegetables or *dhal* are given. At what month this was said to occur, however, differed between women; Rohima said seven months, whereas my *bhabi* said it was five months for a boy and seven months for a girl. The reason she gave for this difference was as follows: "if a girl goes to her in-law's house, her mother-in-law will feed her rice last, and so women say that she should learn the habit early". She said she had not actually observed these rules, however, because she had had insufficient milk to fill her babies' stomachs and so had fed small amounts of rice, egg, potato, vegetables and milk, when they were about five months. It is significant to note that she is married into a relatively wealthy family compared to most, and so had the economic resources to do this. If she had not, perhaps she too would have fed *shabu*. It may also be a significant fact that she had been educated to class

5, unlike the majority of women in the village.

One other interesting perception concerning *kechuri* which *bhabi* drew to my attention was the attitude that it symbolises poverty. If you ate it people would think you were poor because it was commonly only eaten when there were inadequate quantities of food to cook dishes separately. It was therefore perceived as low status food. In this form, it was also usually only rice and dhal, the addition of vegetables was new and I wondered if this would discourage mothers from cooking it for their babies. However, I did not hear this given as a specific reason against feeding it. Most mothers said that although they understood how to make it, it was the extra effort and time needed which put them off, since they did not usually cook separate food for their children. Another problem was that the ingredients, particularly *dhal*, were not always available in their homes, and out of season, they couldn't afford to buy it specially. Malnourished children up to the age of five, identified by growth monitoring done by the FHV, were recommended to be fed *kechuri* for a week or so to improve their weight. Many mothers said that they made it once or twice, but few seemed to do so on a regular basis because of the above reasons. I knew only one woman, my 'step-mother', whose two young daughters were constantly malnourished, who cooked it regularly, because she had seen how well it improved the girls' health. The counsellor at the satellite clinic had demonstrated how to make it and so the girls gave it the name *doktar bhat*, doctor's rice. Despite its traditional low status, there seemed to be a general growing awareness in its nutritional value; people would say that it had *beshi vitamins* (lots of vitamins) and was good for your health (*shasto bhalo hobe*), and many people found it very palatable.

THE TRADITIONAL BIRTH ATTENDANT (TBA) PROGRAMME

"In Bangladesh, it is estimated that approximately 95% of deliveries, especially those in rural areas, take place at home, assisted by female relatives or traditional birth attendants" (VHSS n.d.:2), the latter commonly referred to by health organisations as *dais*. *Dais* have been recognised by WHO, UNICEF, the Government of Bangladesh and NGOs alike, to be a valuable existing local health resource, who can be utilized by the formal health services, to provide essential maternal and child care at village level. A major focus of BPHC has been the development of TBA programmes, training and appropriate record cards for use by TBAs who are illiterate. BPHC has also played a supportive role in helping to

develop the government's TBA programme, in addition to the MCH NGOs it funds. Internationally there has been a lot of interest in the training of TBAs since the 1970s, marked by the WHO's official document on *"The Traditional Birth Attendant"* in 1979, following the Alma Alta declaration (Roskell Payton n.d.:8). Roskell Payton (n.d.:10), in her PhD research on midwifery in Tanzania, cites Landy (1974), Williams (1986) and MacCormack (1982) as positive proponents of the training of TBAs.

Her own experience in Tanzania, however, has led her to be more sceptical about the effectiveness and cost of the national TBA programme there. Jeffery et al (1989:218-19) are also less positive about the government's TBA training programme in India. They criticise the quality and effectiveness of the training and the poor institutional support system for TBAs in the field. One point they make, also relevant to Bangladesh, is that the majority of *dais* are middle-aged so that benefits of training individuals may be only short-lived. The continual 'turn-over' of *dais*, as old ones die and new ones begin to practise is, they suggest, a principal reason why most deliveries are still handled by untrained women despite the efforts of the national training programme. They argue that "even trained *dais* are not necessarily the best route through which to enhance the quality of care for childbearing women" (1989:219) because of the highly restricted social network within which Hindu *dais*, and even Muslim *dais*, are able to operate due to the cultural barriers of caste and social status. They state that the basic problem of the programme in northern India has been the failure "to comprehend *dais* and birthing practices in a wider framework of childbearing" (1989:219) and that the solution lies beyond simply the provision of training; there must be a wider programme of education for young girls and mothers-in-law, in order to have an effective impact on the conditions of childbirth.

This is perhaps the most significant reason, given the cultural similarity to India, why TBA programmes in Bangladesh, conducted nationally through both NGOs and a Government-NGO TBA Task Force, have not suffered the same scepticism. That is to say, they have largely been integrated within wider community-based MCH programmes. The Task Force was set-up in October 1989 to coordinate Government and NGO activities, with the aim of achieving the Government's goal of training 68,000 TBAs, or one for every village. This has involved in part, the standardisation of selection criteria and training of TBAs in order to establish a standard level of quality, and ensure adequate supervision, reporting mechanisms and support. The statistics on births performed by TBAs amongst the BPHC-funded

NGOs show a good average of 51% over 30 projects (1991-92), although Muhilar Shasto's was only 30% (calculated from BPHC 1993:25-26). Thus, there is great potential in training local *dais*, when they are part of a comprehensive MCH programme. As Blanchet states:

> In spite of the numerous difficulties in identifying and reaching the "right" kind of village *dais* in Bangladesh the training of these traditional practitioners must be encouraged and developed for one important reason. *Dais* are, and most likely will remain for a long time, the only birth attendant available to village women (1984:150).

THE EXPERIENCE OF MUHILAR SHASTO

I hope that the previous section of this chapter will have demonstrated that the TBA training had been of benefit to Rogina in, for example, improving her delivery skills and practices, changing her attitude towards the value of colostrum, and teaching her new skills and knowledge concerning antenatal and postnatal care. These aspects of her training were also passed on to mothers and other women attending births, as she demonstrated her techniques. The training also built-up her self-confidence in management of the birth situation, and her professional reputation locally.

She told me how after receiving an intensive 5-day training course in Jessore, she was called to a delivery in the neighbouring village by the local *daktar*. The girl, in her first pregnancy, had been brought back to her *baper bari* (paternal home) by her mother for the delivery. Labour pains had started at 3am but by midday the child had not come and so her mother called the *daktar* from my *para*, for assistance. When he arrived he realised that there were problems and so he called Rogina. In a previous conversation with this *daktar*, he had told me that he did not usually respect *dais* because their practices were unscientific, he only believed in allopathic treatment. However, he had changed his mind about Rogina when he heard that she had training from Muhilar Shasto's clinic and saw that she did a good job. Rogina said that he had given the girl a 'delivery' injection (Cyntocin) and saline injection because there seemed to be problems, but she had done the delivery without any trouble. She was positively beaming as she told me how well it had gone using her new skills. I asked what she had done differently, and to my surprise she replied that she had "taken charge of the situation". With confidence she had checked the position of the child to see if it was coming, and had then told the women in the room to step back and allow her to work. She told them to "keep

quiet and just watch, they could learn how to do a safe delivery". She was clearly very proud of her performance and said that everyone had praised her and asked where she had learnt her techniques, such as feeding colostrum to the child to remove the placenta.

Although there is much room for exaggeration in her account it seemed quite evident to me that she had learnt not only technical skills, but also to have confidence in herself. I had known her for ten months and had never seen her so proud and self-confident before. The interesting thing about this conversation was that it was held in front of her husband, who was sat in the yard, and at times, joined in. Usually this subject would not be discussed in the presence of men, but this did not appear to be an issue at all. In fact, he jokingly told us how the young boy sent to call Rogina had mistaken him to be the *delivery daktar* rather than her! He clearly supported her work, most likely because of the Tk300 she was given by Muhilar Shasto each month for travel and equipment costs. This was not supposed to be a *beton* ('wage'), but everyone called it that. He asked what she had been given for the delivery but passed little comment on the Tk20 sum. The *daktar* told her if it had taken any longer he would have added another Tk50 on to the bill and given it to her. As it was he hadn't done so, but had no doubt earned himself over Tk100 for his trouble.

Rogina's example is not, of course, representative of the other seventeen TBAs in Muhilar Shasto's programme, and although she clearly had a lot of respect in the village, she still did not perform even half the deliveries that occurred. The overall TBA delivery rate was less than a third in all the working areas and the average number of antenatal visits made by them to pregnant women was 4.5 rather than the target of 10. It is therefore necessary, as Jeffery et al (1989:219) have argued, to take a broad perspective on the role and performance of TBAs in the cultural context of the village environment. This is what I shall now turn my attention to, focusing on the practical implications for the health programme. I do not feel it necessary to analyse in any detail the traditional symbolic and ritual role of *dais*, since the various studies previously cited (primarily Blanchet 1984 & 1991) have done this thoroughly.

PROBLEMS OF DEFINING A *DAI*

The WHO has defined a *dai* as "a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by

working with other Traditional Birth Attendants" (cited by VHSS undated:4 without a reference). The selection criteria of *dais* according to the TBA Task Force is based mainly on their previous experience of deliveries - they should have performed at least eight in the last year - and their reputation in the village. On the whole they tend to be elderly women who are either married, divorced or widowed with children of their own. Blanchet (1991:50) found that the busiest are usually widows and poor, although this is not always the case. A couple of Muhilar Shasto's TBAs were from relatively wealthy families and there were also several women who were relatively young, in their early thirties. Rogina was, however, very poor and in her early forties, married, and had five children. Blanchet has found that the majority of *dais* are over forty, and this is around the time that they stop having children, either because of the physical onset of menopause, or because this is the 'social' age at which their status changes (Blanchet 1984:140). They gain greater authority within the household and greater freedom of movement outside it because the restrictions of *purdah* are greatly reduced, as they are no longer considered sexually attractive. Those who are widowed also no longer have their husband's honour to maintain (Blanchet 1984:142). This life stage also grants them a certain degree of respect as elderly and wise.

However, as 70% of deliveries in Muhilar Shasto's working area were still done by women other than those trained to be TBAs, there are obviously many more women who also perform deliveries. In Shundurgram, Rogina was in fact the second *dai* to be nominated for TBA training, the first having proved unreliable and so dropped by Muhilar Shasto. Thus, there were at least these two women who were publicly known to have the skills, and many more *buris* ('old women') who said they delivered their daughters' and daughters-in-laws' babies. On several antenatal visits *shashuris* said they did not need to call Rogina because they could do deliveries themselves. However, in the event of labour they did sometimes change their minds, and the case of the *kobiraj's* daughter is a notable one. The girl's mother had insisted they did not need Rogina, but with the father's persuasion she was finally called, and received Tk10 and a sari as an honorarium.

The definition is therefore unclear and ambiguous, and Blanchet in fact identifies three different types of Muslim *dais*, categorised according to the frequency of deliveries, social relationship of clients, geographical area covered and

motivation[17]. She does however, use as a decisive criterion, whether the woman handles the polluting blood of birth or not (1984:138). This may merely involve cutting the umbilical cord, the most polluting but essential task of all. The defiling nature of this job means that generally only women of low socio-economic status, or of close relation such as mother or mother-in-law, are willing to do it. Some parturient women also perform the task themselves, such as my sister-in-law. For this reason the culturally defined status of a *dai* is low, and may bring embarrassment to the family. This may of course, also lead women to hinder their identification as *dais*, disguising the number of women who do regularly perform deliveries. Let us look at the issue of status in more detail.

DISTINCTION BETWEEN *DAIS* AND TBAS

In Shundurgram area the term *dai* was understood to refer to a woman who performed only the task of cutting the umbilical cord, and was considered to be an occupation of very low social status. I was, however, not aware of the stigma attached to the job for quite some time since Rogina and the other Muhilar Shasto TBAs appeared to be well respected in their villages where everyone knew about their work; it did not seem to be a matter of shame to them or their families. However, one day whilst walking with Rogina I asked her how she had learnt the work of a *dai*, and to my surprise, she denied the title vehemently. I didn't understand her response since her birthing skills were publicly known and advertised by the FHV and satellite clinic staff. Why was she denying being a *dai*? After a few awkward moments of silence, she finally drew a very serious look upon her face, and told me that there was something she wanted to tell me. She and the other TBAs were very unhappy about being referred to as *dais* by Muhilar Shasto. Mahmud the supervisor, and the staff from CDS (the supporting NGO) had called them *dai mas* and they were very annoyed about it because it implied that these *boro lok* ('big people') considered them and their work to be of low status, and this stigmatised their name in the villages. She told me that the term was not used locally, but refers to a woman who "simply comes at the time of delivery and cuts the umbilical cord, puts ash or dung on it but does nothing else, and then asks for rice, oil, a sari or money for her work". She told me "*daier kaj kub niche hoy, shonman*

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[17] For details of these three categories of *dais* see Blanchet 1984:147-149, and for a detailed discussion on the role and status of *dais* see Part 3.

kub kom", "*dai's* work is very low, with little respect" and so if people thought they were *dais* they would have trouble marrying-off their children because of the social stigma. She was adamant that she had not been a *dai* before, she "just did deliveries when people called her". If her son, who was unmarried and about fifteen, knew that Muhilar Shasto called her a *dai* he would not allow her to do the work anymore.

Apparently, after one monthly meeting in the office, all the TBAs had said amongst themselves that they would stop their work if Muhilar Shasto continued to call them *dais*. However, they did not actually say this to Muhilar Shasto. Rogina wanted me to say something for them. The distinction that they made between their work as TBAs and that of *dais* was their training and association with the clinic. Any kind of training or knowledge of modern medicine qualifies a person to be termed a *daktar* (I was often called a *daktar*). They therefore deemed themselves to be above *dais* because of their modern knowledge and skills, and wanted to be called TBAs or 'delivery *daktars*'. This, and 'TB *daktar*', were the terms Rogina used to refer to herself. On the pictorial record cards used by TBAs to record pregnancies it asked for '*dai's* name' and they wanted this to be changed to 'TBA's name'. When I mentioned the issue to Sharmeem, Muhilar Shasto's manager, she said they were unaware of the social implications of the term but agreed to use only TBA in the future. Doing this would help to raise their status in the villages and clearly distinguish their work from that of other untrained *dais*.

THE MIGRATION OF PREGNANT WOMEN

Muhilar Shasto's target for safe deliveries performed by TBAs was 50% of all women registered, but they only appeared to be achieving a third, at most. One reason was the common practice in the Jessore area, for women to go to their paternal home, or *baper bari*, in the last few months of pregnancy. This was particularly the case for the birth of a first and second child. A young woman, once married, is treated as a guest in her father's house and so it is here that she is likely to receive the best treatment during this important stage in her life. In Shundurgram most young *bous* left for their *baper bari* in about their seventh month of pregnancy and did not return until several months after giving birth. This consequently meant that the TBA was only able to give her limited care; she could not complete the ten antenatal visits she was supposed to make, perform the delivery, or make postnatal visits. However, the office's recording system did not

allow for this custom so TBAs' performance in achieving the targets always appeared to be low. In fact, the extent of the migratory custom was quite significant. In the six month period between July and December 1992, 32% of total deliveries registered occurred outside the TBAs' working areas, at the women's *baper bari.*

As a result of this practice, there was also a flow of girls coming into the working area to deliver at their *baper bari*, who may also have been attended to by the TBA. However, these deliveries were not counted in the office records. This was also the case for deliveries performed in neighbouring villages which were outside the official NGO working area, but not the locality covered by the TBA. In January-December 1992 121 deliveries were done by TBAs outside the working area but were not accounted for in the official records. Consequently, the number of safe deliveries being performed by TBAs was higher than the records gave credit for.

PAYMENT FOR A DELIVERY

Traditionally payment for the service of a *dai* is given as a gift of some food, a sari or small sum of money. However, it has been found across the country that with the training of TBAs, people have begun to stop traditional forms of honorarium in the belief that they are paid a wage (VHSS n.d.:11). However, this is not the case, since it would be too expensive to encompass them as staff of health services; they constitute an unpaid cadre of health providers. Their training is seen to improve the benefits of an existing local resource and it is expected that the community will continue to support them in the traditional way. Muhilar Shasto gives a monthly sum of Tk300 to cover their travel costs to meetings, the office clinic, and so on, and FHVs are told to explain clearly that this is not a wage. However, since the sum is quite significant in local terms, most people, including the TBAs, regard it as such.

The converse of this was that some people did not call the TBA to a delivery because they feared they would have to pay her a lot due to her training. On visits to pregnant women the FHVs would therefore take time to explain that there was no charge, but that the TBA was not receiving a wage and so should be shown the same gratitude as was traditional. Rogina complained to me that despite this, people still often didn't pay her anything.

INFORMAL TRAINING OF OTHER BIRTH ATTENDANTS

A solution to increasing the number of safe deliveries performed in villages points

to the need for a wider awareness and understanding amongst women other than just the nominated TBAs, of the dangers involved in childbirth. We have seen that there are often many women who perform deliveries to varying degrees of frequency and who may feel it unnecessary to call the TBA. The custom for women to go to their paternal home for the birth also means that they will most probably be delivered by someone without training. Hence, it is important that the pregnant women themselves have an understanding of the dangers and safe practices, and should be encouraged to take with them at least a new blade and cotton to be boiled and used. Traditionally young girls have no knowledge of childbirth since they are not allowed to attend births and so are totally unprepared for what to expect. There is therefore a great need for health programmes to expand their education to target young girls so that they will be more aware of their needs and requirements later on. However, this will have limited effect if as young *bous* they are dominated by their *shashuri* and unable to make decisions themselves. Thus, education also needs to be aimed at *shashuris* and other women who perform deliveries.

Based on this need, Muhilar Shasto decided to extend their programme and begin informal training on safe deliveries for other women who were known to perform them. They planned to do this through holding a workshop and then asking the TBAs to give further advice, casual follow-up training and support in the village. At the time of my leaving the details had not been thoroughly thought through, but the idea had two potentially positive outcomes: wider awareness of knowledge on safe deliveries, and further respect for TBAs, not only as trained service providers, but also as teachers.

VILLAGE 'DAKTARS': A THREAT TO LOCAL HEALTH CARE OR AN IMPORTANT LOCAL RESOURCE?

I feel it necessary here to comment on the role of local *daktars* in the village health care system, since their involvement in deliveries, in addition to other practices, is cause for some concern. As already mentioned, their liberal use of the drug Cyntocin to induce contractions is worrying when they have no knowledge of, and are not in a position to manage, its potentially powerful effects. I was told by medical professionals that the threat to both mother and child can be very great when contractions are induced without proper dilation of the cervix, and of course, the *daktar* certainly does not check this before administering the drug. On the three occasions I saw it used, the *daktar* gave a different dosage in different methods,

once injected into a drip, once in a single injection and once as a double-dose injection. I am not qualified to interpret the potential seriousness of these practices but believe that there is an urgent need for research to be done on this, such that some measures may be taken to curb a possibly growing trend. This *daktar* liked to use it, he said, because it made his job easier and quicker. He explained that he particularly liked deliveries for this reason, and of course because they brought him a good income, an injection and saline drip costing in the region of Tk100 or more. I doubt, however, if he was aware of the potential risks from his actions.

This particular *daktar* came to learn of the training the local TBA had received and the excellent reputation she had and began to call her to deliveries he attended. On several occasions he took her to other villages on the back of his motorbike. Despite the fact that he was then financially benefiting at the TBA's expense since he got paid and she did not (or only very little), there is a positive side to this relationship. It meant that the area covered by the TBA would increase, and her intervention may help to reduce his use of Cyntocin. She was aware that the injections were unnecessary, that for a first pregnancy labour could last a long time, and that after 48 hours the woman should be referred to hospital. However, she told me that she felt too shy to tell the *daktar* this because he would be angry, he was the knowledgeable one. Her association with him, as a highly respected local *daktar*, would however, greatly benefit her reputation and recognition of the professionalism of her work. On the other hand, she would have to be careful not to promote his role in childbirth, and continue to advise people that only the hospital could deal with serious problems. Consequently, the relationship needed careful management.

I found the practices of village *daktars* in general to be of great concern, the majority of them only being educated to SSC level, and receiving their 'training' from apprenticeships with compounders or other practitioners. The *daktar* referred to above had been on the Government's 12 month Pallichikitshok course[18] back in the 1970s, but had received no training or follow-up since. He considered himself to be above the average village *daktar* because of his training and had hopes of moving to

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[18] This was a course aimed to train local men and women (with 11-12 years of education) to be community health practitioners, as a means to improving the quality and accessibility of health care for the poor in rural areas. Feldman (1983) argues that rather than doing this, it served to increase unequal social access to medical care, as it led to an increase in charges, leaving the poorest to resort to cheaper unqualified practitioners. For further discussion in support of the programme, see Claquin (1981).

the town and performing surgery, which he claimed to have learnt by observation during the training period. My own experience of regularly observing the work of three local *daktars* and hearing about treatment given by many more, leads me to conclude with confidence, that malpractices by them are vast, and quite possibly responsible for worsening a significant percentage of illnesses, sometimes leading to death.

Monitoring their activities is an almost impossible task for the Government because of the locations in which they live and their vast number. However, the problem can not be ignored; they represent the primary health service at the village level and are highly respected by their clients. As such they are an important and valuable resource which does have potentially positive uses. If, as in the example of Rogina, they could be encouraged to promote the use of the TBA, or give advice on family planning and contraception, good nutrition, etc., in addition to their usual service of, for example, administering a *vitamin fial* for weakness, these would be positive steps. NGOs and the Government programme could offer one day work-shops on diarrhoea management, first aid, sanitation, safe delivery, family planning, etc., as a non-confrontational and participatory way of discussing these issues and learning more about their degree of knowledge and practices. At the same time, this would also help to gain their influential support in the community. There are obviously problems with persuading confident and successful *daktars* that they should attend training without offering them incentives, so the tactics would have to be carefully thought out and the invitation presented in a way that plays on their respect and status. The *daktar* I have been discussing throughout attended such a course in Jessore arranged by a drug company, and was very proud to tell me that he had achieved a score of 18 out of 20 in a test; he was clearly open to such opportunities to further his knowledge and show off his skills.

CONCLUDING COMMENTS

Local health ideology attributes little significance to the role of modern allopathic health facilities in maternal care, particularly antenatal, intrapartum and postnatal care. These are regarded by many, and in particular older women who are responsible for the care of pregnant *bous*, to be an inappropriate and unnecessary intervention, because the predominant threat to mother and child is supernatural. Consequently, there is a lack of a perceived need to utilize the services of the satellite clinic for antenatal and postnatal check-ups. Visiting the satellite clinic also

requires that women breach their *purdah* and leave the confines of their *bari* or *para*, and hence there is often considerable male objection to using the facilities as well.

Although individually attitudes were changing, it is difficult to expect this to bring about significant changes on the scale necessary to improve the general health status of mothers and children. There is therefore a great need to expand the audience for health education beyond the household and satellite clinic level, where contact is generally with women, and particularly 'mothers'. Although I have said that young *bous* need to be more aware of their bodies and the processes of childbirth, they have little power over them, and so those with the power - their *shashuris* and husbands - also need to be aware of their specific needs. One way of reaching this wider audience, particularly men, is through the village committees which were set-up by Muhilar Shasto towards the end of my stay. If, in this forum where village leaders and both men and women are present, the importance of this kind of care could be openly discussed and recognised, it might make some headway towards liberalising the local norms concerning female mobility and access to the satellite clinic. The essential thing is that awareness of the special needs of mothers and children is shared by all members of the community, particularly those who enforce cultural norms, and does not remain a matter concerning women only.

CHAPTER 8
THE PROCESS OF WOMEN'S GROUP FORMATION

When I set out on field work my main interest was 'community participation' in rural primary health care. Thus, when I finally decided upon Muhilar Shasto as the NGO to study, I was distraught to discover that it was not in fact a very good example of a 'participatory' approach, or at least how I had perceived one to be. There were no community members on the project's committees - they all seemed to come from Jessore 20 miles away - and no mention of 'the community'[1] on the project's organogram on the office wall, i.e., on the hierarchical diagram of the organisation's structure, with committees and staff arranged beneath each other according to their positions of authority. The community did not seem to play any role in the project other than as passive beneficiaries of a health service. I toyed with the idea of finding another project with greater participation but after a few days realised that perhaps I was being a little naive in thinking that the ideal participatory project, as I perceived it, actually existed. It was, I decided, necessary to look more practically and less idealistically for this elusive 'participation'.

Thus, I homed-in on what I thought was the most obvious example of community activity in the programme, the formation of women's groups, or *samitys*. In Bangladesh this 'target group' approach has become the fashion amongst NGOs in reaching prioritised groups considered most needy (Chapter 9), such as the landless, and poor women. It is also a popular approach among NGOs elsewhere (Riddell and Robinson 1992) and given a high premium as a means of promoting participation in the design and organisation of programmes, awareness raising, promoting class and gender - particularly female - solidarity and empowerment of the poor, and developing self-reliance and sustainability. However, it also functions more practically as a means of facilitating the distribution of inputs and resources, such as credit (Chapter 9). Like many other NGOs, Muhilar Shasto began to incorporate this target group approach into their programme primarily as a more

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[1] I have acknowledged the inaccuracy of this term to describe the residents of the vastly dispersed villages covered by the project in the introductory chapter.

effective means of raising local awareness of health issues, particularly amongst women.

I decided to follow the development of one or more of these groups throughout my twelve month research period and chose to live in an area where there were several I could spend time with. Dokanpara in Shundurgram was a good location because it had two *samitys* in one neighbourhood, another in Choto Shundurgram and a fourth in the next village, Baorhat. I felt that the most suitable thing would be to live with a group member so that my experience would not be limited only to weekly meetings but would extend to unofficial out-of-meeting discussions and events. When I visited the *samitys* and enquired about the possibility of this, I was flattered by their response and the offer of a spare room (unheard of in a village) in one of the member's households. Hence, I found myself in a good situation to follow in detail the progress of four women's samitys.

The first groups were started in June 1991, two years into the project, as a means of helping to implement the health programme more effectively within the villages. The aim was to encourage women to become actively involved in the MCH-FP activities of Muhilar Shasto, primarily to help increase awareness of local health issues, improve the nutritional status of the vast number of malnourished children and enhance the socio-economic conditions of local families through savings. It was felt that actively involving women in health education and awareness raising would give strength and support to the project, and be a way of stimulating the community (or more specifically women) to participate in the programme. The original objective for forming the groups was, therefore, as an extension to the health programme; Muhilar Shasto described them as 'MCH groups', as opposed to groups aimed more generally at social awareness raising and women's empowerment, or credit and income generation.

The groups met once a week, usually on a Wednesday, and were led by the FHV who would discuss various topics concerning health care. The idea was that if a few women understood these issues well, they would begin to incorporate this new knowledge into their daily lives and pass it on to others. For example, one of the main issues covered was the treatment of diarrhoea with home made Oral Rehydration Solution (ORS), known locally as 'selline' (i.e., saline). Although every woman visited by the FHV was taught how to make this, many still did not do so when a family member became ill with diarrhoea. The role of the *samity* women was to advise the family on treatment with 'selline' to rehydrate the body, and

demonstrate how to make it. Another subject covered regularly in the meetings was the use of safe water and sanitation. Many people in the area used pond water and *baor* ('lake') water to cook with despite having access to safe water from tube wells. It was hoped that after discussing the dangers of this in the group meetings, *samity* members would be able to persuade others to stop using such sources. A sanitation programme was also started within the groups with slab latrines made available to *samity* members on a six month instalment repayment system. One member from each group received training on their use and how to build them, so they could then pass the information on to other members. Again, the intention was that they might be exemplars for the rest of the community.

Other intended group activities included monitoring the nutritional status of the member's children using the MUAC (Middle Upper Arm Circumference) tapes; learning to cook *kechuri*[2] for undernourished children; taking children to the clinic or satellite centre for monthly growth monitoring; encouraging pregnant mothers to attend regular check-ups at the clinic or satellite centre; encouraging pregnant mothers to utilise the TBA to ensure safe deliveries; motivating others to use contraception.

The other main activity of the *samitys* was as savings groups, each member putting Tk2 (about 3 pence) weekly into a group account which was recorded in individual pass books and in a group register. The account was held and maintained on behalf of the group by Muhilar Shasto in a local bank. The intention was for each woman to build up her own financial resources which she could use later, for example, to start a small income generating scheme, or as a fund for family needs, etc., so that she was not totally dependent on her husband or other males. Eventually, this savings element grew into a credit and loan programme, albeit through a somewhat tenuous chain of events which I cover in detail later in this chapter.

Over the year, the rather narrow objectives and activities of the groups became both uninspiring and unsatisfactory to many *samity* members causing discontentment and several major problems for the future development of the *samity* programme. Reflecting on these events, it emerged that Muhilar Shasto staff were not actually very clear about the aims and objectives for forming women's groups beyond that of health discussion forums, and were unclear as to the groups' long-term aims and

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[2] This is a highly nutritious food made of rice, vegetables and lentils, cooked together.

future developments. Consequently, the aims and expectations of the *samity* women and of the organisation diverged significantly, bringing to a head the need to reassess the programme to see how it could be improved. (I shall analyse the problems this entailed in a following section.) A fundamental problem was the lack of staff training on group formation and community development. The staff freely admitted that they had understood very little about the empowerment objectives of women's group formation, i.e., as a forum in which women could discuss their problems and work together to bring about changes. They had regarded the groups as belonging to Muhilar Shasto and thought that 'they' were responsible for organising and running them. They had not interpreted the process of group formation as one of 'solidarity building' amongst women so that they might address the specifically gender related aspects of their poverty, beyond those of their specific 'gendered' health needs, i.e., reproductive health needs. They clearly had a very limited understanding of the potential role of group formation in bringing about social change and lacked a gender perspective on development. Finally, in November 1992 a training programme was arranged by CDS, the intermediary NGO responsible for providing the project with technical support, and the Muhilar Shasto staff expressed a great deal of satisfaction from doing it. The training introduced a new perspective, with FHVs taking more of a back seat in the organisation and control of *samitys* and widening the agenda of the groups to discuss topics such as women's rights in marriage and divorce, domestic violence, and local mechanisms and structures which reinforce poverty, such as dowry.

The groups I was living with found the new discussions interesting and inspiring since these were subjects they could closely relate to and express opinions on. As a result, meetings tended to be more participatory than before. However, many women still felt dissatisfied since the credit activities of the national development organisations BRAC and Grameen Bank[3] were widely known, and they demanded that Muhilar Shasto provide loans so that they might start their own income generating projects. Some threatened to leave or join another organisation. Many felt they had benefited little from the activities of the groups so far, valuing the perceived advantages of credit over the knowledge and support they had gained from membership. It was not until Muhilar Shasto finally distributed the first loans

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[3] The details of BRAC and Grameen Bank's credit programmes are discussed in the following chapter.

in February 1993 that women's enthusiasm grew again, and threats to leave the groups declined.

THE PROCESS OF GROUP FORMATION

I feel it would be interesting and revealing to trace the developments outlined here in more detail, to analyse why and how the problems which the groups experienced arose, and why, until the disbursal of loans, their future continuation and development looked very unpredictable. My close relationships with the members of the groups, the FHV Rohima, and the project manager, allow me to consider the situation from the perspectives of the different parties involved - i.e., the *samitys*, the health worker and Muhilar Shasto - and to piece together a wider understanding of the group formation process. I have already outlined the official perspective of Muhilar Shasto on the role of the *samitys* in the programme. Through case studies of meetings, and events during the year I stayed in the village, I shall attempt to illustrate how the NGO's perspective diverged from that of the *samitys'*.

CASE STUDIES

I begin by describing the composition and characteristics of the four *samitys* and their motivations for coming together to form groups. The three groups in Shundurgram were organised by Rohima, the FHV, and the fourth group in the neighbouring village, by another FHV, Kobita. The size of the groups varied, the maximum number of members being twenty, who ranged in age and socio-economic status: unmarried, married, widows, divorcees, young, old, landowners and landless.

Torulata *Samity*

Torulata is the *samity* with which I had most involvement since I stayed in the house of a member. It had been running since July 1991, and was therefore eight months old when I arrived. On my first visit to Shundurgram with the project manager I took an instant liking to the women in this group. They were very friendly, and I found them more outward going and easy to talk to than other *samitys* I had visited. They seemed very keen and enthusiastic. They expressed great trust in Rohima with their savings money, despite having had bad experiences in the past with a phoney NGO which had collected money from villagers with promises of loans and never

returned. There were fifteen women in the group of very mixed age, from an unmarried fifteen year old school girl to the middle aged TBA. The group also included members from all socio-economic backgrounds; some were from households with several *bighas* of land, and some were exceptionally poor with no land at all. Thus, it was a very heterogeneous group but most members knew each other very well because they lived in close proximity and were related in some way; for example, five were *zars* in the same *bari*, i.e., wives married to five brothers in the same house.

As specified by Muhilar Shasto, they had three elected roles of responsibility - chairman[4], cashier and secretary - which were held by the same women throughout the year. They were nominated for the roles basically on the grounds that few could actually read and write well enough to keep the attendance register and accounts. At the beginning only six members were able to write their names and several more had learnt by the end of the year (taught by myself), the rest gave thumb prints in the register in place of their signatures. Interestingly, however, the TBA was elected chairman despite being illiterate, and the poorest member of the group. This is significant because of her low social status in comparison to some of the other members from more influential families. She was nominated because she had close communication with Muhilar Shasto as a TBA and went regularly to the office, and so could deposit their savings, attend training, etc., more easily than most. In other regards she seemed an unlikely candidate since she lacked the confidence to lead the meetings and, for much of the time, barely said a word.

The most educated member of the group, who had studied to class seven, took the role of cashier, in charge of keeping the accounts of weekly savings. Although this was her responsibility it was, in fact, usually done by the FHV. Instead, the cashier tended to take on the role of leader and did most of the talking and decision making. The FHV also wrote the resolution after each meeting. This was supposed to be the responsibility of the secretary but she also played a very back-seat role, and wasn't really good enough at writing to do this. Some other members complained to me about her inactivity and said she only wanted the position for the status but would never admit this and allow someone else to take on the role. There were, therefore, some undercurrents of tension within the group which led, at one

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[4] This is the title they use for the group leader.

stage, to the secretary threatening to leave. Generally, however, relations between the women were good.

Notably, there were seven or eight members who constituted the body of the group and regularly attended the weekly meetings. These included the three elected women. Although this demonstrates their generally greater interest in the group, there is also the practical consideration that the meetings were held in, or near their *baris* and so were more convenient to attend; the location being the neighbouring houses of either the chairman or cashier. These women also included those from the more socially influential families. The other women were less regular attenders, often because they were unaware that it was 10am and time to meet - having limited access to clocks or watches in their homes - or that the FHV had arrived and called the meeting. They also lived in a different *para*, which although not physically very far, put restrictions on their social mobility, and made it harder to give up an hour of their time when workloads were heavy. Poor attendance was particularly noticeable at certain times of year, such as the fasting month of Ramadan and harvest seasons, when the women were at their busiest processing crops.

I asked how the group had started and the cashier provided the following explanation: Muhilar Shasto's office, she said, had heard about *samitys* from somewhere else and thought they would start some because they would be good to 'help the poor'. Rohima had described them as savings groups, where women saved a couple of *taka* each week so that they had their own money to use in times of need, for example, if their husband fell ill, or for their daughter's marriage. The women reasoned that, since poor women did not usually have money of their own it seemed a good idea to join.

There was some debate over whether Rohima had said they would receive loans but the consensus was that she had. Most women hoped to receive money and work from joining the group and also mentioned getting tube wells, something greatly needed by many members. They therefore had clear expectations of material and economic benefits, in addition to learning about health.

Taposhi *Samity*

This group started later than Torulata, in January 1992, and had fourteen members made up of women from a different *para* who were on the whole, more homogeneous in age and class, and overall less educated and poorer. They formed

independently after seeing and hearing about the other group and approached Rohima for her help. Their motivation seemed predominantly to be a desire to share in the perceived potential material benefits of group membership. These looked promising since Torulata had received some *tut gach* ('mulberry trees') for future silkworm income generating projects, as well as slab latrines on a six month repayment system. They also wanted these things, and more importantly, the loans which they believed would follow. It appears that Rohima actually said at the start that they would be given loans, despite this not being on the project's immediate agenda, although she neither categorically admitted nor denied this. The women, being extremely poor, prioritised their economic needs above the benefits of health awareness, sanitation and solidarity. They, therefore, latched on to expectations of receiving loans (*rhin*) and work (*kaj*) and improving their economic status. They, like most villagers, were aware of the existence of different development programmes in the Jessore area that provided these to women in *samitys*, and therefore made the association that '*samity*' equalled 'credit'.

The group's chairman was an outspoken, sometimes extremely fierce, woman who took her role as leader very seriously and tended to rule the group autocratically, stifling and often silencing the others in the group by her tendency to burst into a rage and assert her opinion regardless of what others thought. Her attitude was that it was her group. Attendance at meetings, which were held at her *bari*, was very poor. Generally, women would come to deposit their savings and then leave; they always said that they were too busy to sit down. If they didn't come, they would send the money with someone else because failing to pay meant risking the wrath of the chairman who took pride in the regularity of the group's savings. They did, in fact, have the best record of latrine repayments out of the three groups in Shundurgram with no outstanding debits, which is quite significant considering how poor most of them were.

The chairman's strictness and domination was, rather surprisingly, not resented but respected by most other members, although perhaps more through fear of her temper than anything else. As with the other group, they all knew each other well and were intricately related through marriage and lineage ties. Despite her domination over the group, I never heard anyone actually complain about her; it seemed to be generally felt that she was the best person for the job - and frankly, I can't imagine anyone else challenging her for the title! One member commented, "Have you seen the way she is if we don't pay-up, she is very strict and gets very angry if we don't attend a meeting". When I asked if this was a good thing, she

replied that she thought it was. She said that even if the FHV did not turn up, as was the case for several months when Rohima was pregnant, they attended the meetings and discussed "what they wanted to do, how everyone was, if someone was ill what they should do, what food they should eat, how to make saline...". These were the types of things that Rohima talked about and constituted the agenda for the groups as set by the project.

This description of group meetings was, however, very interesting because although she clearly knew what they were intended to be like and the sorts of topics they should be discussing, this was not representative of what they actually involved. Very rarely did all members turn up at the same time and sit down to discuss something, or listen to what Rohima had to say. She usually talked on a subject for a few minutes, for example, the prevention of worms and use of latrines, capturing the attention of a few who had generally heard it numerous times before, and then collected the savings, filled in the register with a rather imaginative account of the meeting and left. There were a couple of interested women, the chairman being one, but most seemed uninspired by the same old thing each week and used the group simply as a means of saving and receiving some kind of material benefits, whatever they might be - they hoped loans. On the whole, the women were quite complacent and happy about the way the group was going, and thought it was a 'good thing' but that 'it would be better when they got loans'. As time went on, and loans and other material benefits didn't materialise, their complacency turned to disinterest and annoyance. One of the things they expressed a great need for over and above latrines and hadn't received, was tubewells. They claimed that Rohima had said they would be given them, but the programme had no allocation for this at all. Their feeling was that if Muhilar Shasto wanted to help them because they were poor why didn't they give them the things they needed; tubewells, loans and work? By July, with the non-appearance of loans, tensions between the group leader and Rohima and her supervisor, who visited the group occasionally, rose to a fever pitch culminating in a nasty confrontation, a refusal to deposit any more savings and a threat to disband the group. These bad relations continued for about six months, with all the members becoming annoyed. The atmosphere between Rohima and the *samity* was not really defused until the following February when the first loans were distributed, one not surprisingly going to the chairman.

Bilashi *Samity*

The third *samity* in Choto Shundurgram was the last to form, in March 1992, with twenty members. When I first visited the group it was only a couple of months old and the members seemed very unsure of the purpose of meeting in such a manner. Rohima didn't turn up for the meeting and so there was not a proper gathering of all members. Those who had come didn't really have any idea what was supposed to happen at meetings, Rohima having led the sessions previously, and immediately looked to me for guidance. It reminded me very much of a class awaiting the teacher for instruction, and didn't really seem as if the women felt any possession over the group - they gave the impression that they regarded it as another part of Rohima's work and somehow more for her benefit than theirs.

The chairman explained that Rohima had told them about *samitys* and that it would be good if they started one because they were poor. She told them they would be given latrines, tubewells and loans, and so they decided to join. Thus, as in the other groups, the motivations for joining hinged on perceived economic and material gains rather than improved health status and female solidarity. She said that many women were interested in joining, and Rohima chose who would actually belong to the group and who the chairman, cashier and secretary would be, they didn't elect them. On my subsequent visits I got the continuing impression that the women didn't really have any aims or objectives for the future of the group, other than to collect savings and receive loans. I rarely attended a meeting where they all came and sat down to talk about problems or discuss something other than the topics brought up by Rohima.

They expressed no personal 'empowerment' objectives and clearly didn't place much value on the sanitation programme, for although everyone had bought a slab latrine from the project, only a few were actually being used. The rest were either still not installed or installed but never used. When asked about this, they replied that they felt repelled by using them because everyone going in the same place was dirty and it would smell. Their habit was to go in the garden (*bagan*) and they preferred this. The interesting thing is that they knew the theory of why they should be used to prevent the spread of disease and worms very well; Rohima had talked about it on numerous occasions as it was a main priority of the programme. The women, however, did not view it with the same importance and openly said they did not consider the latrines to be a 'benefit' gained from being in the group. The singular focus of the group was on loans. This was the only thing people had an

opinion on, and even then it was difficult for Rohima to get everyone together at the same time to discuss the issue properly. One meeting I attended, and understood very little of, was so heated with raised agitated voices coming from all directions, including some husbands standing at the side, that Rohima finally left, planning to return later when things had quietened down.

Over the months members' interest and enthusiasm never really grew beyond this, and the group as a whole did not mature. There was little sense of group unity, and only one or two women showed any sense of conviction in what the group could do. Their lack of enthusiasm and direction was exacerbated by their lack of guidance, particularly between May and June when Rohima was on maternity leave. All three *samitys* in Shundurgram were left unsupervised during this time. The chairman of this group also suffered personal problems with the arrest and imprisonment of her husband, and the *samity* didn't meet for another two weeks because of this. Consequently, this newest *samity* was the most inactive of them all.

Polash *Samity*, Baorhat village

This *samity* was started in August 1991 and had twenty members, including both Hindus and Muslims, unlike the other groups which were exclusively Muslim. They met on Wednesdays at the same time as Taposhi in the neighbouring village, so I could not spend so much time with them and, consequently, didn't get to know the internal dynamics of the group so well. This was the field area of a different FHV, Kobita, who had only one group to work with and so was able to give it much more time and energy than Rohima. Although Kobita was better at 'motivating' and inspiring enthusiasm and interest than Rohima, when she had covered everything on the agenda of an MCH group for the umpteenth time the women, and myself, began to get bored. They also had a strong leader who was the local TBA, but individually the women were more outspoken with their opinions than those in Taposhi.

In the first meeting I attended they defined their group's rules (*niom*) and set them down in the resolution so everyone would remember them. All groups had sets of rules but they were generally suggested by Muhilar Shasto rather than formulated by themselves. They were as follows:

1. Weekly meeting on Wednesdays at 10am for approximately 2 hours.

2. Everyone must deposit Tk2 each week. If they miss a week because they are not at home it will be collected the next week. If they are in trouble and cannot pay the other members will collect Tk2 from amongst themselves to pay for that week.

3. If a member wants to leave the *samity*, she will be bought out by the other members, so that her savings remain in the *samity's* bank account.

4. The chairman, secretary and cashier are elected and can be changed.

5. Members must be of low economic status, no *dhoni lok*, ('rich people').

The group did, however, define their own aims, which were: to save money and earn interest on it, and in the future they wanted work.

During my stay this was the group which had the most problems, with members leaving and others threatening to leave to join the groups of two other NGOs (one being BRAC) which wanted to move into the village. The arrival and aggressive approach of these new NGOs caused considerable problems for all involved. Not only did it upset relations within the group and amongst villagers in general, but it also caused friction between Muhilar Shasto and the other NGOs. I will discuss the dynamics of these events and the growing trend of NGO encroachment, in the following chapter.

Several important things come to light as a result of looking at the different groups closely, and are paramount to understanding the problems involved in developing the *samity* programme. These relate to group ownership, decision making and setting priorities for group activities. I discuss these in detail below.

OWNERSHIP OVER THE GROUP: WHOSE PRIORITIES AND OBJECTIVES?

Firstly, the reasons for starting *samitys* differed for Muhilar Shasto and for *samity* members. The groups' priorities and objectives were set by Muhilar Shasto to achieve a very restricted set of aims, which concerned improving and spreading health awareness in the communities and encouraging some kind of 'community participation' in the project. The objective of the latter, as discussed in Chapter 4, was very ambiguous and intended more as a means of effectively implementing the MCH programme than for 'empowering' members to play more active roles in the

programme. The role of group formation as a development approach aimed at strengthening and empowering the poor through shared identity and unity, was not properly understood by any of the staff, from the project manager down to the FHVs. They seemed to have adopted the group approach without fully understanding 'why', and 'how'. They had received no training on the theory and processes involved, or on the motivational techniques and group discussion skills vital to stimulate interest and enthusiasm. Consequently, FHVs were led to believe that groups belonged to 'them' and that 'they' were responsible for organising and running them; they saw it as just another aspect of their work, about which they were very unsure. The women in the groups therefore allowed them to take control and sat back, passively answering questions and handing in savings, believing that Muhilar Shasto was benefiting from the groups in some way. They had little or no sense of ownership over the groups themselves.

The groups' activities, discussions and so on were focused primarily on health and health-related issues, such as safe water, sanitation, worms, nutrition and kitchen gardening. Sanitation and the use of slab and ring pit latrines, which were not traditionally used in villages, were considered high priority by Muhilar Shasto and targeted as a main focus of group discussions and activities. The provision of latrines on a payment by instalment basis was intended to make it possible for the poor to buy them. However, those without convenient access to a safe water supply placed a tubewell far higher up their priority list than a latrine, even when they were aware of the risks of spreading disease by not using one. In several meetings women expressed the need for tubewells as a priority when asked by Rohima what their main problems were. This priority, however, was not necessarily health related, since many used both pond water and tubewell water. It was more of practical importance, to help save time and labour by reducing the burden of collecting water several times daily.

The reasons given by women for forming the groups were very different from those of Muhilar Shasto, and, as the tubewell case indicates, based primarily on practical needs. Above all, what most people expressed a need for was work, or *kaj*, to enhance their income and credit so they could start their own businesses. Whatever they may have been told by Rohima about benefits from being in the *samity*, the women clearly hoped these would be economic and material, rather than the non-measurable, non-quantifiable benefits of knowledge and awareness about health.

Thus, the imposed group priorities and objectives did not reflect members' practical, and often urgent needs for daily existence, and this soon led to loss of interest and disillusionment. The failure to let women choose their own priorities ultimately meant that there were not enough immediate benefits to make group membership seem worth-while. As Stan Burkey (1993) points out:

> Members must set their own priorities. This choice must be based on their own analysis of their reality [...] Our priorities are often directed towards health, sanitation, childcare or ecology rather than finding enough money to buy seed and fertiliser for the next planting season which begins two months from now!...[T]he poor must have a foundation to stand on before they can invest in their long-term future. Their first priority is their immediate needs (Burkey 1993:149,160).

GROUP ACTIVITIES: THE NEED 'TO DO SOMETHING'

The second important point leads on from the above: the groups were little more than classes led by the FHV on topics which, for want of a wider agenda, tended to cover the same things over and over again, and thus became uninspiring and tedious for all concerned. The sessions were totally led and dominated by her, in the belief that it was her job to do this rather than the chairman's. In groups where the secretary and cashier could read and write, they were supposed to keep the attendance register and resolution and fill out savings records, but Rohima mostly did this too. The format of meetings was such that there was very little discussion or dialogue, or participation by most members. Rohima and a few outspoken women would usually talk; the rest took a very passive role in meetings and rarely volunteered opinions or suggestions. Burkey (1993:160-162) refers to this as 'non-constructive participation', where control is taken over by a dominant figure or figures, and the remaining members begin to lose interest and no longer attend, or leave. These kinds of dynamics make group decision making very difficult.

Group activities, that is, things undertaken and achieved by the groups, were very limited. The 200 mulberry trees (*tut gach*) given to Torulata were supposed to be for a group sericulture programme, but in practice only two women maintained them and therefore felt that they should be the beneficiaries when silk worms were given. One example of a successful group activity was, however, a session given by Rohima on how to cook *kechuri*, where all the women contributed some ingredients and participated in cooking. I was away at the time and so didn't attend this meeting but heard all about it on my return; the women enjoyed it tremendously and such was their enthusiasm that they planned to have a picnic and do it again

(although this never actually occurred). Unfortunately, there were not enough enjoyable occasions or group activities like this to maintain women's enthusiasm without any other form of material or economic benefit. They complained of there being no profit from being in the group; *kono lab nei*. They didn't regard their new knowledge on health care as a tangible gain or achievement. No value was given to this knowledge. When asked what the *samity* had done, no-one mentioned these things, and they frequently forgot the latrines and *tut gach*.

Discussing group formation, Burkey suggests that,

> The need 'to do something' is central to the existence of the group. A group will lose all reason to exist unless it directs its attentions within a reasonable time to some type of collective social or economic activity, or to collective assistance to individual members. Unless members realise a tangible personal benefit within a reasonable time, they will leave the group or become inactive. Groups consisting of the poor must eventually improve the economic situation of their members otherwise they cannot be sustained. Normally, economic activities will be the first priority of the poor (1993:148).

This is exactly the situation in the four *samitys*.

SAVINGS PROGRAMME

The savings element was an important aspect of group formation. Even when the women lost interest in coming to the meetings many still continued to save Tk2 each week, sending the money with someone else if they didn't attend. Regularity of payments varied between members and groups, Bilashi being the most behind, but generally savings in other groups were quite good, with most members maintaining the same level of money. If a member left they would be bought out by other members or a new member, to keep the level of savings amongst members the same. In theory, this made it quite difficult to enter the group at a late date because the sum of money to be deposited would be relatively large. In practice, I'm not sure this was actually done, since the new member to join Torulata halfway through the year did not, as far as I know, make this payment. Saving was an aspect of groups that most members were pleased with and considered advantageous. They expressed a feeling of reassurance in knowing they had a small amount of money set aside which could not be pilfered by others in their family, or themselves in times of shortage. The money was set aside for the future, for emergencies, childrens' education and marriage, illness, small business and so on. Although not large sums, it represented some form of security. Many had informally saved before, putting a handful of rice aside each day or selling eggs and vegetables, but it

did not have the regularity and discipline of group saving and was not secure. The objective of Muhilar Shasto was to encourage women to save as a habit (*obesh*), and this was mentioned as a good thing by many women. Surprisingly, few women mentioned interest on their savings as a positive aspect and only one group, Polash, included this in its overall objectives. In fact, a couple of women in Torulata objected to earning interest on savings and paying it on loans, arguing that it was an Islamic rule (*niom*) that you should neither pay nor receive interest.

Muhilar Shasto's intentions were that women would save for a prolonged period until they had significant sums to start small income generating activities. It was not planned to provide credit to the groups, at least not at this stage in the project, because 1) they did not have the funds to do so; and 2) they felt the groups needed to mature first. The savings programme was, therefore, intended to help improve the economic status of women and their families in the long-term, but plans were rather vague. The money could not be withdrawn by members as and when they wanted, as the signature of several people in the group and NGO were needed before this could be done. Consequently, the money was not easily accessible to women should they decide to leave, or to use it.

Other savings programmes I was familiar with, such as those of CARE and CONCERN, and several others in Bangladesh evaluated by Sarah White (1991), allowed groups to utilise their savings to provide small loans to members, setting their own interest rates, repayment conditions and so on. This was an effective way of boosting the group fund and enabled income generating activities to be undertaken by individuals much earlier on, without dependence on credit from the organisation. In this way members had greater control over their group's activities and a greater sense of unity and ownership.

White observes that:

> Savings are generally made as insurance for the future, rather than for a specific purpose, and most samiti members do not keep close tally of the sums they have deposited (1991:101).

Interestingly, this was also the case with most women in the *samitys* I knew: few were actually able to say exactly how much money they had in their own savings or the group savings, but this did not seem to matter; the sense of future security was the important thing.

A BROADER AGENDA FOR GROUPS: SOCIAL AWARENESS RAISING AND WOMEN'S EMPOWERMENT

As I have explained, the groups were set up by Muhilar Shasto with a narrow MCH agenda, and little understanding of the processes and dynamics of group formation. The FHVs responsible for organising the groups had no experience of the communication and motivational skills required to stimulate and direct group discussions and encourage participatory dialogue within groups. This was reflected in the unenthusiastic attitude of not only *samity* members, but also some FHVs; Rohima was sometimes as bored and frustrated with the way things were going in her groups as members were. There was evidently a great need for training, both for staff and *samity* members, and finally in November 1992 CDS, the intermediary technical support organisation, held a 4-day training course on group formation for staff.

The training gave a very good background on the main issues of development, particularly at village level, and how these could be addressed by the process of forming groups amongst the most vulnerable members in society, i.e., poor women, with the aim of developing a shared identity and a sense of mutual support. It was explained that together, as a united front, a group had the strength to challenge and change situations which powerless individuals could not. Through belonging to groups, women could be instilled with the confidence to take some control over their lives, rather than always being dependent on others, particularly men. The groups should therefore not be passive classes, as with many *samitys*, but a forum for mutual problem sharing and discussion, and for social awareness-raising on issues directly concerning members (e.g., women's legal rights in marriage, divorce and desertion, perpetuation of inequality through the dowry system, unacceptability of domestic violence, importance of female education, and so on).

The training also located the objectives of primary health care within the development process and explained the inter-relationship of health with poverty, powerlessness and disease. Although one would assume that as health workers in a development programme this would not be new to them, the staff responded very much as though it were. There was great enthusiasm for what they were learning and they were pleased to finally understand their role in the development process more clearly. There was also a tremendous sense of relief and satisfaction to be told, finally, what groups were all about. Everyone admitted that they hadn't had much idea about why they were forming groups, what they should have been doing with

them and, more importantly, that they had misunderstood their roles within them. One FHV confessed:

> Before, we thought that the *samity* was ours, we were doing it. Now I've learnt that the group is theirs and I am only helping them.

They thought that groups belonged to the project and that they were responsible for them and in charge of them. They had not realised that the groups were meant to be owned and directed by the women themselves. Their role was simply to stimulate and facilitate discussions and give guidance and support, assuming a back seat role in organisation, running and decision making. As the trainer explained:

> Your role isn't to develop them, but to help them develop... You cannot solve their problems, their problems are endless. What you can do is help them to understand, you have to ask, 'Why are you in this condition?', and they will begin to think about the reasons themselves.

The issue of participation in group meetings and discussions was also addressed, emphasising the need for the FHV to ensure that everyone was involved and that no-one dominated the meetings, preventing others from speaking and airing their opinions.

At the end of the four day course, everyone felt they had learnt a lot and their satisfaction was reflected in the new perspective and enthusiasm they expressed. Rohima felt more confident about how meetings should be run and shared her new perspective on the role of the groups with *samity* members. She explained that they were 'their' groups and how, by supporting each other, they could address their own problems and bring about changes. She talked about their legal rights in marriage, the necessity of officially registering a marriage to assert these rights and the rights of women to bring court cases against their husbands for divorce. All this was new to the women. She also discussed the evils of the dowry system and how it perpetuated poverty and inequality, and members decided that they would no longer accept or pay this, and that, if need be, they would marry their children to the families of the members of other *samitys*, on the same agreement. Both Rohima and the *samity* members showed greater interest in the new topics of discussion because of their relevance to their situations and many women who usually kept quiet contributed to the conversations.

One particular area which struck a deep chord with many women was the issue of their rights in marriage and the ability of women to bring court cases against their husband for divorce, due to maltreatment and abuse. Usually women would not

dream of this, men being the initiators of divorce often for totally unjustified reasons, leaving their wives without any form of support, and often failing to pay the amount agreed in the marriage contract. The women in Torulata found the discussions on their rights a revelation and began to question their own situations and their complicity towards their treatment by their husbands. They agreed that they would no longer tolerate being beaten and abused, and would together go to the house of a man and challenge him if he beat his wife. I heard the women in several other groups also say this and was told of one or two instances where they had gone and told the husband he was wrong to do this and that his wife could bring charges against him if he continued. On each occasion that this was told to me, I asked the women if they had ever done this before, and they all replied that they would never even have contemplated it. They said that now they understood their rights, and had the support of other women in the *samity*, they felt they had the strength to challenge a husband's attitude that he could treat his wife as he pleased and beat her.

I was impressed by village women saying this, especially because it was often said within hearing distance of their own husbands and other men, but was very sceptical about whether it would actually go beyond 'words' into 'actions'. I could not imagine the group of timid women in Torulata challenging a man towards whom they usually behaved in a respectful and subordinate manner, and telling him he was wrong to act in such a way! It seemed so incredibly against the expected and acceptable norms of behaviour for women, but I was proved unjustly cynical by an incident recorded in my diary, which occurred in Dokanpara one afternoon in February 1993:

> The TBA, Rogina, with whom I spent much time was also the leader of Torulata *samity*. When I first arrived she was a very non-participatory member of the group, keeping quiet throughout most of the meetings and never expressing her view. However, during the year her character slowly began to change as she became more involved in the project's activities, attending meetings at the main office in town and receiving various different types of training. She gradually became more confident and outspoken, and gained a very good reputation for her TBA work. Stimulated by a training session and some *samity* discussions, she began to consider her situation as landless and poor in relation to the other richer families in the village, and the situation of women within this.

When the husband of a *samity* member, who had badly beaten her and from whom she had been separated for 8 years, returned out of the blue to take her back, Rogina headed a group of women who marched over to challenge him and point out the legal rights of his wife. Unfortunately, I was not around to witness the confrontation but heard from several women how impressive and assertive Rogina was; quite surprisingly no-one, including her husband, spoke badly of her behaviour. She told me she would never have done anything like that a year ago, but having been made aware of a woman's rights to make a case against her husband for abuse and to divorce him, her attitude had changed. Hearing that he had returned she had become extremely angry and as a united group she and the other *samity* women had gone to support their fellow member. The member was very pleased, although her husband still refused to divorce her and hence pay the Tk 20,000 divorce agreement. She refused to return to him and said that she might decide to divorce him herself. The husband, not expecting this, left in a rage without her.

Although this was only one small incident it was a very significant event in the context of the development of the *samity*. It represented the beginnings of a change in women's attitudes and a consciousness that they were not second class citizens, that they had rights and that together they could actually do something to change their lives. It marked the first sign of a sense of empowerment from belonging to the group.

Despite the revitalised interest and enthusiasm in the groups that resulted from the new agenda and new approach of the FHVs, the old problems did not go away; in fact, they were becoming more and more acute. Women still measured the achievements of the *samitys* in terms of quantifiable things like tubewells and money, neither of which they had yet received, and thus, their dissatisfaction was still very evident. Consequently, complaints to the FHVs got more and more problematic, culminating in Muhilar Shasto having to redesign their programme. I shall now examine the issues that led to this.

DEMAND FOR LOANS

From very early in my involvement with *samitys*, it was evident that women had expectations for gaining something tangible out of them. Back in April 1992 when I attended a meeting with Torulata and asked how they hoped to benefit from their

samity, their reply was that they wanted work. This became a more and more common request in later months, not only from this *samity* but also most others I visited. They complained that *beka meyera* - young girls without the responsibilities of marriage and a family - had little to do and needed work to earn money to contribute to supporting their families. In Torulata the main pleas seemed to come from the secretary's *bari*, which had four unmarried daughters, and the cashier's *bari*, which at the time had three. These girls assisted with the work of the household: tossing *dhal*, rice husking on the *dheki*, cooking, looking after younger children, cleaning utensils, washing clothes, etc., but generally had more free time than other women, and spent much of the day visiting other houses to chat, sew and make leaf mats.

My 'sister' was in a similar situation because she was divorced and without children, and her poor health prevented her from doing many heavy tasks in her oldest brother's house. Without a husband to support her, and therefore reliant on her brother, she also wanted to provide her own source of money. There were a number of young women in the same situation as she, who would have benefited from such opportunities. Their single status also made them less restricted by *purdah* norms than married women, so they were freer to move around the neighbourhood and therefore could embark on income generating activities outside their homes.

The most popular request was for sewing embroidered article like bed covers, because most women knew how to do this and believed it would be easy for Muhilar Shasto to sell them in town, since other NGOs appeared to do this (e.g. BRAC). They did not realise, however, that it was not as simple as this, and that these organisations actually marketed the goods through established channels in Dhaka and overseas, the local demand being negligible. They also wanted to start up small *hash-morgi* ('poultry') businesses with loans. There was some debate over whether Muhilar Shasto had ever promised to give loans, but the general opinion was that they had, which surprised me because of my understanding that it was not their plan to do so in the immediate future.

From this time on, the main issue raised at meetings and in conversations with me was loans. Members seemed to become more and more disillusioned with the *samitys*, and this appeared in part, to be based on their knowledge of BRAC *samitys* in neighbouring areas. BRAC had large income generating groups within a 10 mile radius of Amhat *Upazilla* and most people had heard of them. They gave large loans

from Tk1000 upwards to individuals to start small businesses in addition to providing work, such as sewing, and those in nearby areas were receiving these within only a few months of forming the groups. Thus, this was the basis upon which most people's concepts of *samitys* were formed, and they therefore began to feel hard done by because they had not received anything from Muhilar Shasto, except latrines and mulberry trees, which they did not greatly value.

By June 1992, after constant requests for loans from *samity* members and the threat of BRAC moving into some of Muhilar Shasto's working areas offering loans[5], Shameem, the project manager, found her hand being strongly forced and finally decided that they would start a loan programme. This was a rather reluctant decision, however, since as there were no plans for such a programme there were also no funds, and they had no knowledge or experience of what it would involve. This being the case, it was decided, in consultation with CDS, to provide loans from the *samity* savings, as a type of revolving fund, but this meant that the amount that could be given would be very limited. For the first year, only two women from each group would be able to receive loans of Tk500, which would be paid back in weekly instalments of Tk11.5, at 16% interest. The selection of women would be left to the groups, according to brief criteria: they must be knowledgeable about the groups' rules, attend meetings regularly, contribute to the sharing of ideas and have a good record of savings. They must also have a feasible idea about what type of business they would start with the loan, and be sure they could pay it back. Recipients would be monitored carefully to see how well they managed the money and how successful their ideas were, before the programme could expand to give more loans.

The problem with this was, however, glaringly obvious from the start. It was virtually impossible to expect a group of twenty poor women, all in need of money, to decide without friction who the two lucky recipients will be, or to be satisfied with such a small amount. The response of the women was as I expected; anger at Muhilar Shasto for failing to provide everyone with a loan and arguing amongst the members over who should take the money. The internal frictions were quite heated and groups were told to meet without the presence of any project staff, to sort out their differences and decide who would receive the first two loans. Much to my surprise, out of the factionalism and rivalry came a united reply from most groups that, on principle, they would not accept any money unless everyone was a

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[5] The encroachment of BRAC into Muhilar Shasto's area is discussed in Chapters 8 and 9.

recipient, preferably of a larger amount. They were all very angered by Muhilar Shasto's inadequate offer and sounded-off to me about it on various occasions. The general feeling was that they were being cheated or denied something they had been promised, and they felt the *samitys* had achieved very little, such that the gains had not been worth the effort they had put in.

Members' husbands played a significant role in all this, based on their wider awareness of things on offer from other NGOs operative locally, e.g., BRAC and Grameen Bank. The husband of the chairman of Polash *samity* was particularly angry. He blamed Kobita, the FHV, for the internal fighting and jealousies caused by the loan business, and said he wanted to break-up the group, if it didn't dissolve itself. He disliked her work in the *samity*, although he thought her MCH and family planning work was very good and needed in the village. He and the TBA told me that Kobita had made all sorts of promises when the group started a year before, such as loans, work, sewing machines and training, but they had not received any of these and saw no advantage in having the *samity* any longer. In fact, the husband described the *samity* as a 'loss'. When I asked about latrines, they replied, "Yes, we have received those but we paid Tk115 for them and we also had to pay to have the *tut gach* delivered!" Obviously, they felt they should be receiving free gifts from the project.

The event which brought many of these feelings to a head was the arrival of BRAC in the village a few days before. BRAC had claimed not to know that Muhilar Shasto worked there, and had offered to start a new *samity* and provide Tk1000 loans to all members within a very short time. They also said they would start a school and pay the teacher Tk700 a month. Naturally, the women, and men to whom they also offered loans and a fishing project, were very keen to turn their loyalties to BRAC, and many women said they would leave the Muhilar Shasto *samity*. Only the chairman and a few others faithfully stuck by it, saying they would not disband the group. The chairman's husband mocked her for this, saying she would be the only remaining member. I was impressed by her loyalty considering the apparent anger she felt towards Muhilar Shasto, and even more surprised that the group still insisted they would not accept the two loans, despite the fact that members who left for BRAC would be able to receive large sums of money. She said that Tk500 was not enough money to start a business, pay back the loan in weekly instalments, eat

and make a profit, and therefore it was not feasible. Two *maunds*[6] of *dhan* (unprocessed rice) cost Tk600, and if the women were to make a profit from dehusking it, this was the minimum amount needed.

When Muhilar Shasto's project manager, Shameem, heard about BRAC's activities she was furious, as they blatantly contradicted the NGO ethic of working in coordination rather than competition. She paid a visit to the local BRAC office in Amhat. The manager insisted he had not known Muhilar Shasto was working in the area, even though Shameem had sent him a list of the villages covered to prevent any overlap. The BRAC field worker also admitted to knowing Kobita, and actually told the village women they would have to leave the Muhilar Shasto group if they wanted to become BRAC members. The manager insisted that it was not their policy to interfere with other NGOs' field areas, despite the fact that this was not the first time it had happened to Muhilar Shasto, and that I had heard of similar incidents in other parts of the country. Shameem explained that they already had a *samity* in the village that was a year old and that they were going to be giving them loans in the near future. She requested that BRAC withdrew from the area predicting that their presence would cause great problems for the project not only within Baorhat, but also in the surrounding field areas. After some discussion the meeting was finally settled on BRAC's agreement not to return to Baorhat.

The resolve of Polash and Bilashi *samitys* remained; they were not prepared to accept loans on the set terms. In fact, Bilashi said that they would rather wait for a couple of years until their savings had built up. However, the two groups in Dokanpara, Taposhi and Torulata, finally agreed to the conditions - although Taposhi only did so because they were told Torulata had - and set about deciding who would be the first two recipients. This wasn't done in a terribly democratic manner, the most outspoken members basically deciding on behalf of everyone else, and not surprisingly there were undercurrents of dissatisfaction within the groups. Despite their acceptance they still complained bitterly about the small amount and the method of repayment, which was to be on a weekly, rather then monthly basis. They felt this would be too difficult and preferred to pay monthly, as with the latrines.

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6 One maund equals approximately 37kg.

The unhappiness within the groups was strongly felt by Muhilar Shasto through feedback from the FHVs, many of whom were having a difficult time. In office meetings it was clear that most *samitys* had similar bad feelings about only two people being able to take loans, and also felt that TK500 was too small. The NGO found themselves in a difficult position; they could not increase the amounts because of lack of resources but understood that the plans for the loans were not going to work the way they were. They also began to feel greater and greater pressure from the threat of encroachment into their field areas by other organisations such as BRAC, Grameen Bank and other local NGOs. They therefore felt very pressurised to expand the programme further and applied to BPHC for some assistance with a credit fund. However, even when this was granted they still had to wait for final 'permission' to go ahead with implementing the programme from CDS, which for various reasons I shall discuss later, caused several months further delays. These changes and deliberations at the level of project management left the programme in a type of limbo where field staff didn't really know the internal details of the planning problems or when loans would be available. Consequently, they found it very difficult to answer people's questions with truthful and straight replies, which only aggravated the situation further.

In November a training session was organised for *samity* representatives on social awareness, inequality and development in the villages, and the loan arrangements were also discussed. The one piece of information which everyone wanted to hear but was missing, was of course the date on which they would be given loans. However, Muhilar Shasto still could not say when this would be. Although many appeared relatively satisfied with assurances that they would be given very soon, the chairman of Taposhi was furious and as a stand, decided to withhold the group's savings from Muhilar Shasto until loans were given.

Back in the groups, decisions over who would get loans had to be confirmed and certain aspects of the arrangements went towards determining who would be the most 'appropriate', rather than 'worthy', members to receive them. Regular repayment was particularly important with these first loans because it would determine whether others would be given them in future. Some of the poorest women feared they might not be able to manage this, so did not want to take the

risk[7]. Therefore, the decision was based to a large extent on who it was felt would be best able to use the money to ensure repayment, i.e., those who had access to some kind of business activity, perhaps their husband's or son's, and were consequently, by definition the 'less' poor members. This was the logic behind the selection of my 'sister' as a recipient in Torulata. She had by now purchased a sewing machine (with earnings from the crops on her own land) and had started making clothes for people but did not have the money to buy a small stock of cloth. She intended to use the loan for this and was almost certain to be able to make the repayments because of the existing demand for clothes. However, other members in the group were far poorer, and much more needy, but less confident of their abilities and too shy to speak out. Though they did not openly say it, they were still resentful of her getting the loan and one approached the local *munchi* (religious leader) to complain. I was surprised to hear this since I thought he disapproved of the *samity*, but he intervened, judging it to be unfair since my 'sister' was already wealthy, and stated that a poorer member should be given the money. This was not done publicly but was accepted by my 'sister' without question, and she did, in fact, cover up that this had happened, telling me she had changed her mind and decided not to take the loan after all. She was not aware that I had been told differently by others.

DIFFERING PERSPECTIVES

As a mobile observer I could view the situation from different perspectives and appreciate the difficulties and frustrations felt by everyone involved. However, others' perspectives were not so obvious to the different parties - *samitys*, project management and FHVs - and each felt the others were being unreasonable. *Samity* women felt that Muhilar Shasto was being unfair and tight-pocketed, believing it to be a very rich organisation which in some way was part of the government and received money from foreigners (i.e., the British government). For most villagers that period (particularly August, September and October) was extremely tough because the rains were unusually light and insufficient to water the new rice. As a result the crops were dying from water shortage and those who could afford it were having to buy water for irrigation, a great expense normally only necessary during the dry season. The physical environment had serious repercussions on the

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[7] Montgomery et al (n.d.) and Goetz and Sen Gupta (n.d.) also note resistance of the very poorest to taking loans because of the risk of being unable to make the weekly repayments.

economic environment, with a lack of demand for agricultural labourers and failed crops leaving the poor in desperate need for money to feed their families. Hence, it was a period of great need and the opportunity of loans was seen as a blessing, if only they would materialise! Looking at it from this perspective, it was perfectly understandable that *samity* women should feel so exasperated by the constant delays in receiving loans.

Muhilar Shasto viewed the women's singletrack preoccupation with loans somewhat differently, regarding them as unappreciative and ungrateful for all the other benefits *samitys* had brought, which they considered important, such as latrines, kitchen gardens, greater health awareness, savings and group support. They saw their readiness to leave the *samitys* for another organisation as disloyal and a rejection of the hard work and respect they had striven to achieve over the last three years. They had developed a good relationship with the communities, particularly because most FHVs were from the same villages or the local area. But now the arrival of competitors (e.g. BRAC) had started to create friction and a sense of 'them' (Muhilar Shasto) and 'us' (villagers). The loan issue was proving to be a big problem not only because it threatened the future of the *samitys* but also possibly the future of the whole programme in these villages. The FHVs' respect and credibility was being called into question by the arguments and accusations of failed promises made by some of the *samitys*, resulting in their loss of face. The behaviour of the encroaching organisations exacerbated this disillusionment through their tactics of one-upmanship, boasting to the villagers that their projects were better than Muhilar Shasto's because they could offer more things, and that they should leave and join them.

Those in the most awkward situation were the FHVs. They were caught between understanding and sympathising with the *samity* women's need to receive loans, being village women themselves, and the confusion and uncertainty in the office over the final details of the arrangements, these being dependent on receiving a credit fund from BPHC and getting the 'go ahead' from CDS. Thus, being very much in the dark about what was going to happen, they were unable to tell *samitys* what they wanted to hear, i.e., exactly when they would be given loans. Consequently, they were forced to give evasive answers and since they worked daily in the villages, were constantly being criticised and accused of lying or being untrustworthy, causing much anxiety and tension. For instance, women began to stop listening to Rohima during meetings and told her that her words were worthless, *'apnar kota kono mulo nei'*. Though Rohima and Kobita had no control over

when and how loans would be dispersed, they were taking most of the blame for the perceived inadequacy of the project. The two male supervisors who should have been giving them support and guidance rarely visited the *samitys* and Rohima complained to me of not having enough help to deal with the situation.

The most notable thing to emerge from this overall view is that people's perspectives on loans were quite different because of their differing sets of priorities, and the different structural positions in which they found themselves. This represented a main cause of the problems. The line of control and communication was too vertical with too much decision making power held at the socially removed level of the project management upwards, i.e., with CDS, and too little understanding of what was going on at the field level.

Between November 1992 and February 1993, when loans were finally disbursed, the situation worsened as threats of women leaving the groups became more common. In three *samitys* I visited women had left because of pressure from their husbands, who were angered at the non-appearance of loans. In one of these areas Grameen Bank had moved in and immediately given loans to nine women from the Muhilar Shasto *samity*. This created great problems which appeared to be caused more by their husbands than the women themselves. They said their husbands were forcing them to leave the group and join Grameen Bank because they gave loans instantly. One woman told me, "Our husbands will beat us if we don't get loans". Such was the men's influence over the women's actions. Many of those remaining in the group said they were satisfied with the way things were and appreciated what they had learnt and the sense of support they felt from other women, and were pleased they would be getting loans soon. They said that before Grameen Bank arrived in the area there was no trouble within the group, but since its arrival it had created many problems among members and their husbands[8].

During this period NGO activity in the area began to intensify and BRAC moved into two of Muhilar Shasto's field areas and began giving loans. Two more local NGOs also appeared on the scene and began visiting villages trying to stir up interest. Much to my surprise, in some places such as Choto Shundurgram, they were sent away by the *samity* saying that they were not needed because of Muhilar Shasto's presence. In other areas, however, such as Baorhat where BRAC had

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[8] I discuss the events around this in more detail in Chapter 9.

previously visited but not returned, when the local NGO Bashta Shekha visited with offers of loans, work and a school they were warmly welcomed and recruited thirty women to form a *samity*, although none were initially from the Muhilar Shasto group.

By the end of the year, Muhilar Shasto had been granted Tk200,000 from BPHC as a loan fund, allowing them to rethink and redesign their programme. Although communication channels between villagers and decision-makers were weak and inefficient, the management had learnt from the FHVs' feedback that certain changes were necessary for the programme to meet the demands women were making. These were, in particular, that the amount of money needed to be greater for any profitable activity to be possible, and that more women in the groups should receive them. In consultation with some other local NGOs and CDS it was finally arranged that each month three women would be able to receive loans of Tk2000 with a 10% service charge[9], and that this would be repaid weekly over 10 months, starting two months after receipt of the money to allow the income generating activity time to become productive.

It all looked as though the loan programme could finally get underway when a new spanner was thrown into the works with the intervention of directives from CDS. These stated that all *samitys* would have to do a literacy training course, involving several months of classes, before receiving the loans. This was based on their previous experience that credit programmes ran into difficulties in the long-term if *samitys* were unable to keep their own books. Sustainability was deemed to be far more likely if women were able to read and write beforehand. Thus, without consultation with Muhilar Shasto, CDS decided it was necessary to delay the loans until the *samitys* had undergone literacy classes, which would first involve finding suitable teachers and training them. This would take time, since very few women had enough education and would be willing to do so, especially if they were expected to teach without payment when other NGOs, like BRAC and Bashta Shekha, were offering to pay women to become teachers. I thought this a very inappropriate decision, imagining the response of the *samitys* in Shundurgram when they heard that loans were to be delayed yet again! From the women's perspective, it would almost certainly have seemed another tactic for stalling the loans, and would have caused even worse relations with the FHVs. Shameem was

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[9] They used this term to avoid Islamic objections to 'interest'.

extremely annoyed but felt it difficult to contradict the advice given by CDS, even when she knew that in Dhaka, they were unaware of the serious consequences that might ensue should she follow it. The ground was tested with FHVs informing *samitys* at the following meetings, and their responses were as expected; anger and resentment. Shameem notified CDS that it would cause all kinds of further problems for the project if they were to delay loans any further, and it was finally agreed that the literacy programme would be started as soon as possible, after the first loans had been disbursed. The incident was a good example of the inappropriateness of the control that CDS had over Muhilar Shasto's decision making process and how disruptive this manner of top-down intervention could be.

The new arrangements were made official in the office meeting at the start of January 1993, and the first loans were finally disbursed in mid-February, after I had left the village. This was very unfortunate because it meant I was unable to observe the reactions of women in Taposhi, Torulata, Bilashi and Polash, when their bargaining and demands finally paid off and they received their loans. This, of course, also meant that I was unable to observe how they used them, if they were able to repay without problems, and so on. These issues, particularly how the money was used and who used it - the woman or her husband - require important consideration since they have significant consequences on the objectives of poverty alleviation and women's empowerment through the provision of credit. I analyse these implications in the following chapter.

SOLIDARITY AND WOMEN'S EMPOWERMENT

Despite the objectives of the *samity* programme, for most of my fieldwork period there was little sense of solidarity displayed within the four groups with which I spent most time. A growing sense of mutual support did not become evident until towards the end of my stay, when a couple of incidents within Torulata *samity* (including the one described previously concerning the abusive husband) indicated this happening. Even so, the complaints in this group over the secretary's idleness and the change in location for meetings due to this, the arguments and disagreements over who should get the loans, the irregular attendance by half the group and domination by a few, the general level of dissatisfaction and apathy felt by all members, and so on, demonstrated that the underlying sense of unity was still weak. Disputes over loans did, in one sense, draw group members closer together in challenging Muhilar Shasto, but the amount of 'unity' and agreement in their decisions and actions was, in most cases, relatively superficial, particularly in

Taposhi, where the chairman dominated the group and members passively supported her. She said that she spoke on behalf of others but I was aware that her stand against Muhilar Shasto in withholding the group's savings was very much out of personal interest - she was extremely poor and at times struggling to feed her family of seven three times a day, and therefore had great need for financial assistance.

The lack of group activity and group social action or participation in local issues made it difficult to build a sense of solidarity and shared identity amongst the women. The staff group training in November helped change this somewhat, widening the agenda for discussions to cover issues about which the women could share their own experiences with others, and helped stimulate a greater sense of shared identity and group strength. However, the difficulty in building solidarity was partly a reflection of the orientation of Muhilar Shasto, which itself lacked a clear vision of where enhanced solidarity would take the women. White (1991) identifies the same problem in several of the NGOs she studied in Bangladesh.

CONCLUDING COMMENTS

This account may give the general impression that little was achieved by the groups as far as women's empowerment is concerned, but this is not wholly the case. Certainly, if Muhilar Shasto had had a clearer objective when they started the groups, some of the problems would not have arisen and they would have been able to give more effective support. However, to expect great changes in such a short period of time is to expect the impossible, and one has to look more subtly for positive indications of change.

The coming together, discussing, learning and increased mobility required for attendance at meetings, office training, satellite clinic sessions and so on, helped raise the self-confidence and self-respect of many *samity* members. When I arrived in March 1992 very few women living in Dokanpara would attend the satellite clinic only a ten minute walk away in the neighbouring *para* because they said it would ruin their respect (*shonman*) and their husbands would chastise and beat them. Throughout the year Rohima tried to motivate women to attend because many said they would like to try the contraceptive injection, but it could only be given by the paramedic at the satellite clinic. The *samity* women asked if the clinic could be moved into their *para* but were told that this was not possible because it was already in the most central place in the village. They insisted that their husbands would

never allow them to go and they would be too embarrassed to walk that far in the open where people could see them. For months they never came, and then, on the morning of the last clinic I attended in Shundurgram, a small group of about ten women could be seen walking together through the paddy fields from Dokanpara and down the path towards the *para* where the satellite was held. I could hardly believe my eyes; amongst them were some members of the *samity* whom I had barely seen outside the boundaries of their own *baris*, let alone their own *para*, as well as a young pregnant woman whose husband had told me only a few days before that he would never allow her to come. Even more surprising was the presence of the wife of one of the *munchis*. She had come to receive a contraceptive injection without her husband's permission to leave the house, and said that if he came back from the fields to discover her gone he would be very angry indeed, for although in private he was not against contraception, he did not want other people to know they used it. The courage it must have taken for her to come was, therefore, quite astounding. The women had decided to come together in a group so that they would not feel so ashamed and embarrassed; the others' protection gave them a sense of support and confidence. This was for me one of the most memorable and significant occasions during my stay. It represented a very significant step for those women towards gaining greater control over their own lives. Whether stimulated by being in a *samity*, or from Rohima's motivation on her house visits, this was a very positive example of changes resulting from the fruits of her and her project's hard labour.

The overall attitude of women towards the groups which this analysis has highlighted has been one of dissatisfaction and disillusionment, but, it is neither accurate nor fair to say that this was the opinion of everyone, or that even those who for the most part felt this way, did not feel the occasional sense of pride at belonging to their group. This was demonstrated by the fact that each *samity* bought a sign-board with their name on it, to hang outside their meeting place, to identify themselves to anyone passing by. The contradictory comments and attitudes expressed by individuals on different occasions and in different contexts - either deriding or lauding the groups - demonstrates the difficulty in representing their opinions. Women did not express a clear-cut perception of the groups to be either 'advantageous' or 'a waste of time'. Their opinions represented more of a continuum, swinging to the negative extreme in certain situations and issues, such as material benefits, and to the positive extreme in others, such as group support. The issue around which I have chosen to discuss the process of *samity* formation, i.e., loans, and the fluctuating attitudes expressed by different women concerning

them, illustrates very clearly this point. What is also quite striking when standing back and looking at the whole loan episode, is the degree of power and strength demonstrated by the women's groups in pressurising Muhilar Shasto to provide them with credit on terms acceptable to them. Manipulating an organisation in this manner is a significant achievement and indicative, in an ironic way, of Muhilar Shasto's success in stimulating the processes of women's empowerment within the groups. To balance-up the positive side of the picture further, I close the chapter with a little case study of Rogina, the TBA and chairman of Torulata *samity*, as representating an individual's positive experiences and attitudes towards belonging to a group.

During my year in the village I became a close friend of Rogina, spending many hours sitting in her house talking about anything and everything that caused us curiosity - from the skills of delivering babies, to what snow was like to touch. She was a very shy and quiet person, very unassuming and timid, and very reluctant to give her opinion on matters when in the company of others whom she regarded as above her. Thus, in the *samity* she remained quiet allowing others to take the lead and make the decisions, at least when I first met her. However, over the year she began to change, growing in self-confidence, speaking out in meetings and travelling the six miles to the office for monthly meetings alone. When I first arrived in the village she did not have the confidence to do any of these things. For her the experience of belonging to the *samity* had been very positive and she expressed this clearly one day in a conversation with a visitor from another village, who belonged to a Grameen Bank *samity*. She asked what they discussed in their meetings and when the woman replied that they did not discuss anything, they were just for giving loans, she retorted, "But what is the point if you do not learn anything?" She asked a number of further questions and finally concluded that her *samity* was far better. Although it had not yet provided them with loans, it had, she said, taught them many other things which were in her mind, valuable enough to make it worthwhile.

CHAPTER 9

NGO POLITICS, WOMEN'S CREDIT AND THE FIGHT TO REACH THE POOR: ENCROACHMENT AND COMPETITION AT THE GRASSROOTS

The previous chapter highlighted an important issue which only came to light towards the end of my research and dominated many of my observations and interactions with villagers and staff of Muhilar Shasto. This was a growing sense of competition between NGOs working in the same geographical areas. In particular, the last four or five months of my stay in the village were constantly occupied by people's discussions, mostly within *samitys*, of the arrival of fieldworkers from new organisations, offering bigger and better benefits than Muhilar Shasto - namely, loans and schools. Muhilar Shasto did not have either of these elements in their programme, since their primary focus was on health, and health-related issues. Consequently, as my analysis of processes of women's group formation has shown, the competition offered by new organisations caused various problems for Muhilar Shasto's programme, and its relationships within the villages and with these organisations. In this chapter I focus on the politics of this 'encroachment' trend from the perspective of villagers, Muhilar Shasto and the 'encroaching' organisations, analysing its implications for the development process, from grassroots level up. I shall broaden the focus of the discussion from the specifc, micro level of some case studies, to analyse on a more macro level, the possible institutional motivations and influences behind the trend. This requires examining the pressures exerted on NGOs by, for example, donor organisations, to expand their programmes, and, therefore, brings the focus of the discussion to the level of pervading national and global development ideology. I shall, however, begin with my own experiences, drawing on events discussed in the previous chapter.

When I first arrived in Jessore I was unaware of these problems, assuming that overlaps in the working areas of different NGOs would not happen, since there were, quite evidently, many areas in need of some kind of assistance. It did not occur to me that NGOs would actually resort to competing with each other, in order to work in the same villages! On the contrary, I imagined they would be making

every effort to avoid this, by communication and coordination of their local activites. However, by the end of twelve months fieldwork, my visions of a friendly, supportive local NGO community were well and truly lost; relations between a number of NGOs had turned quite sour, due to what appeared to be a rapidly growing trend of NGO 'encroachment'[1]. This trend involved an increasing number of incidents whereby NGOs, in the quest for expansion into new field areas, moved into the working areas of others, without any form of communication or coordination. This behaviour, not surprisingly, caused great annoyance to the NGO already working in the area, and created significant problems for their field operations. The competitive, and often aggressive behaviour of the incoming organisations towards the established NGO was reflected in the reactions of villagers. Their relationships with each other and with the established NGO became quite heated and problematic. Arguments began between group and committee members in the villages over the offers and enticements made to them by the new arrivals, testing their loyalties to the established NGO, and causing factions and jealousies, leading in some instances, to a loss of faith in the existing NGO's staff and programme (Chapter 8).

These competing activities were generally embarked on by national organisations, or larger local level NGOs with plentiful resource bases, and hence the ability to 'go one better' than others. They could, therefore, afford to ignore the general NGO philosophy of working towards a common goal, through mutual support and coordination. Their consequent ruthless behaviour had a very significant, and generally negative effect, on the programmes of smaller, less powerful NGOs such as Muhilar Shasto. I will use case studies of the activities of the two largest protagonists in Jessore district - the national development organisations of Grameen Bank and BRAC - to illustrate the effect that this increasingly common mode of activity was having on grass-roots level development.

At the organisational level, this was an interesting situation to observe, for it demonstrated their need for the continuation of a patron-client type relationship of dependence between villagers and organisations. This was necessary in order to maintain villagers' loyalties and allegiances in the increasingly competitive environment. It was, however, particularly interesting because of the implicit contradiction between this, and the general NGO philosophy of building self-

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[1] Montgomery, Bhattacharya and Hulme (n.d.:36) also found this a significant problem.

reliance and empowerment amongst the poor. Considered within the context of the rapid development and expansion that several large NGOs and organisations, such as BRAC and Grameen Bank, have been undergoing, a conceivable pattern in this expansion process emerges. This suggests that as such programmes grow in size, influence, and power, an accompanying breakdown, or 'dilution', in ideology occurs, particularly at the lower echelons of the organisational structure. This can be seen overtly manifested in the approach, attitude and behaviour of some field staff, for example, the non-cooperation, and at times aggressiveness, of staff in the local offices of BRAC and Grameen Bank in response to complaints made by Muhilar Shasto.

I shall explore what I believe to be some of the reasons behind this a bit later on, but it would first be helpful to locate these organisations in the overall picture of NGO activity in the country. I therefore begin with a brief historical outline of the appearance and proliferation of NGOs in Bangladesh.

THE PROLIFERATION OF NON-GOVERNMENT DEVELOPMENT ORGANISATIONS

Sarah White (1991) and Syed Hashemi (1990) have documented and analysed the dramatic 'mushrooming' of NGO activity across the country over the last twenty years. It is mainly from their work that I sketch-out a brief history of this phenomenon, which although not unique to Bangladesh - NGO activity is also very intense in certain parts of India, such as Tamil Nadu - has become a distinctive characteristic of development activity in the country. To illustrate the extent of this, various estimates of the number of NGOs, i.e., societies, clubs, voluntary and local organisations receiving funds from local and government sources and registered with the Social Welfare Department, range from 12-15,000. Those receiving foreign funding and registered with the Foreign Donation Registration of the government's NGO Bureau exceed 600 (Rain 1992:11). Thus, the NGO population is vast.

The appearance of NGOs really began in the early 1970s after the war of Independence in 1971. The first foreign NGOs came in with relief and rehabilitation programmes in response to the resulting crisis, and slowly began to widen their perspective towards a variety of development approaches. At the same time the strong sense of nationalism resulting from the winning of the war stimulated local leaders to form their own organisations with the aim of reconstruction and self-reliant development. Out of this initial period two pre-eminent NGOs were

founded: the Bangladesh Reconstruction Assistance Committee, now known as the Bangladesh Rural Advancement Committee, or BRAC; and a people's health centre, Gono Shasthyo Kendro, or GK.

In the next stage of the process, as identified by White, international organisations began to withdraw, some transferring the running of their activities to locals who had been working with them. Out of this were born organisations with a different philosophical approach to those which had arisen during the initial excitement and idealism after liberation. These had a less autonomous vision of their future direction and took on a more poverty focused perspective, inherited from their 'parent' agencies. Friends in Village Development (FIVDB) was one such organisation, taking over from the International Voluntary Service, and around the mid-70s Proshika was launched by a Canadian NGO, as a service NGO intended to provide training and logistical support to other NGOs.

The result since then has been an increasing number of small local NGOs, providing a new form of employment for graduates and educated people, as their managers and staff. The favoured career for such individuals was, and still is as civil servants, as this brings status and job security. However, as the number of graduates increases and the number of opportunities diminishes, competition for these positions becomes extremely fierce. The NGO sector provides an alternative career route, often better paid and without the bureaucratic drudgery of government jobs, but with the drawback of an unpredictable future, largely dependent on external donors for financial sustainability. The aims and objectives of this vast collection of NGOs therefore differ greatly depending on the philosophy and commitment of the founders and management. Certainly, it can not be denied that some are set-up purely to tap the overflowing funds and benefit from the perks this can bring, such as a nice new Pajero jeep, or motor bikes and a smart office, but I hope it is fair to say that this is the motivation of only a minority.

White (1991:11-15) traces certain broad trends in the type and focus of different programme approaches, beginning after the reconstruction phase with an emphasis on agriculture and integrated community development programmes. However, by the late 1970s the popularity of this approach had declined as it was realised that the benefits were not going to the poorest but to those already better off. The concept of 'poverty' was then refocused from that of a situation caused simply by inequality in income, to one which realised the complexity and significance of power relations in rural society. The emphasis was then placed on 'consciousness

raising' and the formation of class-based cooperatives, an approach adapted from that popularised by Paulo Friere in Latin America. This type of 'rural politicisation' has been the favoured strategy of some NGOs, such as Gono Shahajjo Shangstha (GSS), who receive part of their funding for health awareness raising from BPHC. Their attitude towards service provision and income generation programmes is one of disdain; they perceive such NGO activities as reinforcing the government's lethargy in providing basic services and resources, and therefore maintaining rather than challenging the status quo. The provision of credit for individual income generation activities, they argue, serves to prevent and destroy solidarity amongst the rural poor through encouraging individualistic attempts at economic welfare, and hence avoids challenging the root causes of inequality (Hashemi and Schuler 1992:12).

This is, however, the approach of only a minority of NGOs, and a more integrated approach with 'conscientization' as one element in a wider strategy of development is more common. In this context the 'political' content is lost and it is perhaps more appropriately described as 'awareness raising', becoming part of a programme including literacy, health education, safe water and sanitation, income generation and skills training (White 1991:13). Not all organisations choose, or are able to cover this wide programme of elements and therefore have a narrower scope, such as the health focus of Muhilar Shasto, but it is widely recognised that the most effective results are achieved with a holistic approach to change. The most popular trend in implementing these community-based programmes, like the 'conscientization' approach, is based on the building of mutual support and solidarity through the process of group formation.

A coordinating body known as ADAB - Association of Development Agencies in Bangladesh - exists as a means of establishing communication between NGOs and has branches around the country, known as 'chapters' to which local NGOs can subscribe. The meetings provide a forum where small and large organisations can formally communicate and coordinate with one another, discuss solutions to local problems, and so on, and on a national scale can represent themselves in a unified way to the Government. Other smaller organisations which perform a similar coordinating function; the Centre for Development Services (CDS) which acts as an intermediate support agency to Muhilar Shasto and several other small NGOs, is one example, Samaj Progoti Parishad (SPP) which coordinates five NGOs in the northern area of Dinajpur, is another.

The sprouting of this multitude of small indigenous NGOs has been significantly accelerated by the influx of donor aid in response to various disasters experienced by the country, notably the floods in 1987 and 1988, and the cyclone of 1991. Progressively there has been a strong preference by donors for channelling aid via NGOs rather than through state initiatives, both as a means of avoiding the formidable bureaucratic processes of government, with their inherent opportunities for mismanagement and corruption, but also White asserts, as a consequence of World Bank and donor emphasis on privatisation. She believes that the figure of US$85-100 million in foreign aid given to NGOs each year (White 1991:11, cited from D'Rozario 1989) is a modest estimate, but even so it represents 6% of Official Development Assistance to Bangladesh in 1988, consisting of US$1,592 million (White 1991:11, cited from World Bank 1990a). Increasingly, NGO activities are contrasted favourably with those of the state. The World Bank review of "Poverty and Public Expenditure " (1990b) in Bangladesh, recommended the expansion of NGOs to supplement government efforts and encourage improved delivery of services through competition. Wood's paper on the franchise state (1994) discusses this, looking at NGOs taking over the role of the private sector for service provision. This preference for NGOs has in part contributed towards fostering an increasing tension and antagonism between NGOs and government (Sanyal 1991). As some of the larger national NGOs, such as BRAC, grow in size and influence government officials find it difficult to accept without suspicion, the accompanying economic and political power that senior NGO leaders wield. Their view, as Rain (1992:11) states, is that "by pledging unconditional loyalty to the donors, and by involving in political activities, the NGOs are posing a challenge to the government".

This fear of insurgency reached a head in 1991-2, when the government's NGO Bureau - set up in 1990 to register NGOs in a more efficient way than the previous system which required applications to 5 separate government departments - approached the Prime Minister, Begum Khaleda Zia, with a chronicle of allegations against a large number of NGOs, both foreign and indigenous. Accusations included controversial anti-state activities, the issuing of political statements and production of journals with political content, financial corruption, irregularities and conversion of illiterate poor people to Christianity (Rain 1992:11). The Salvation Army primarily based in Jessore, my research area, was a major target of the last accusation and had severe attacks made against it in the national press and was threatened with cancellation of its registration with the NGO Bureau. There were

also accusations that NGOs were breaching the government stipulation that a limit of 20% of project costs can be allocated to administrative expenditures, and were instead spending from 40-60% on high salaries and the benefits of a comfortable standard of living for NGO officials. The Bureau also claimed that large amounts of money (about 138 million taka) had been accepted by NGOs from foreign donors without going though the proper government channels, between 1988 and 1990 (Rain 1992:12, Hashemi 1994).

In an attempt to regulate NGOs' activities the Bureau formulated recommendations to make them more accountable to government, a move which attempts to constrain the existing freedom of their status as 'non-government' bodies. The proposal, not surprisingly, did not go down well with the NGOs, or with the donors.

However, as White (1991:17) points out, the government has little to worry about where threats of subversion from the NGO community are concerned. The majority are, she argues, working towards the same aims as the government, helping to prevent rebellion rather than stimulate it: very few work with the philosophy that the poor must pressurise the government to provide better public resources. Many consider this an unrealistic expectation and attempt to provide the services themselves, thereby complementing the existing government structures. This is, in essence, the aim of the structural adjustment policies of the World Bank. Fowler (1991:79) explains that:

> structural adjustment promotes a division of tasks between institutions - commercial, governmental and non-profit - according to their perceived comparative advantage in market-led, equitable development. Free enterprise is the economic engine, governments provide the infrastructures and a regulatory apparatus, and NGOs secure equity by targeting and assisting groups that are marginalised by the adjustment process.

ENCROACHMENT TACTICS: THE LOCAL POLITICS OF NGO EXPANSION

As I explained, 'encroachment' by organisations into the working area of others became an increasing problem during my research, not only for Muhilar Shasto but also for other NGOs in the Jessore area. With a 'free-market' perspective one might argue that this kind of competition would provide villagers with a variety of options from which they could chose the most advantageous - giving them the upper hand in picking and chosing to whom they bestowed their support and loyalties. Picking and chosing is in effect what happened in Muhilar Shasto's field

area, but whereas the above view gives the impression of villagers benefiting from this competitive activity, the reality did not seem so positive; in some villages it created a lot of problems, arguments and divisions amongst people who had previously supported each other as members of Muhilar Shasto's *samitys*. It also led to severe disagreements between some husbands and wives. Those who 'benefited' most, it might be argued, were actually the encroaching organisations. Through their tactics of making more tempting offers to villagers than the existing NGO - for example, large loans and promises of schools - they were winning support for the expansion of their programmes by playing on, and reinforcing, a 'hand-out' mentality which perpetuated a patron-client type relationship of allegiance, and to an extent actually served to undermine the development of an independent 'self-determining', 'self-reliant' perspective. They were also improving their performance statistics - area covered, number and amount of credit given, etc. - in the eyes of donors and other external bodies and so building-up their reputation, status and support base.

Before discussing this further, I will give two examples of the kinds of incidents that occurred during the year, to illustrate the 'tactics' and their impact on the targeted community. These examples involve the two largest rural development organisations in Bangladesh - BRAC and Grameen Bank - and so I shall begin with a very brief outline of their programmes. I will not go into any detail since there is a wealth of existing literature on them[2].

BRAC was started in 1972 and Grameen Bank in 1976. BRAC began as a relief and rehabilitation programme in response to the devastating effects of the War of Liberation. After the initial emergency they branched out and developed into a wider multi-sectoral community development programme. The approach however, experienced various problems since the 'community' focus failed to address the needs of the poorest members; most benefits went to land owners and local power holders. A major review of the programme was undertaken and a new strategy evolved, specifically targeting the poorest of the poor - the landless, small farmers, artisans and women. The programme has continued to develop based on the

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[2] Grameen Bank has published various books, papers, and note series, see for example: Gibbons 1992; Shehabuddin 1992; Yunus 1982 (March), 1992 (March); Shams 1992; Hossain 1986. Other works exploring the success of Grameen Bank include: Ray 1987; Soltan-Mohammadi 1981, Fuglesang and Chandler 1986; A.N.Chowdhury 1990; Hossain 1988; Haque 1989; Madeley 1991. For accounts of BRAC see for example: BRAC 1990; Chowdury, Mahmood and Abed 1991; Streefland 1993; A.N.Chowdury 1990; Chen 1986.

philosophy of people's participation to achieve the goals of poverty alleviation and empowerment of the poor. Their main strategies are consciousness raising and capacity building through group formation, human development and skills training, credit and income generating, and non-formal education. The cornerstones of their interventions are the Rural Development Programme and Rural Credit Project, now known as the BRAC Bank Project. The following discussion refers primarily to the credit programme. The founder and Executive Director is F.H. Abed.

Grameen Bank was begun by Professor Mohammed Yunus as an action research project aimed at extending unsecured loans to the landless poor to enable them to undertake income generating activities. It began as an experiment in one small village in Chittagong and increasingly expanded from there with the support of the government and the International Fund for Agricultural Development (IFAD). It became a fully fledged bank in 1983 with 75 branches and by 1991 had expanded to 894 (Rahman and Wahid 1992). At its outset it was foremost a 'bank', with objectives of poverty alleviation. Over time it has developed more formalised programmatic elements to address socio-economic change and 'empowerment' of the poor.

In recent years BRAC and Grameen Bank have come to resemble each other, as BRAC focuses more heavily on credit and both strive to involve women as central participants in their programmes. By providing credit opportunities they claim to be stimulating and facilitating women's 'empowerment'. The organisations have similar strategies based on community level activity guided by large numbers of field staff, who are based at the local office and make regular visits to the surrounding villages. They work on the principle of forming groups, which meet regularly for discussions and the collection of weekly savings. Loans are disbursed through the group mechanism, group members providing the 'guarantee' for repayment in place of collateral. Both organisations have expanded at rapid rates and are now present in most parts of the country.

CASE STUDIES OF NGO ENCROACHMENT

These are just two of a number of cases (some discussed in the previous chapter); in November FHVs reported to the office that Grameen Bank had given loans to Muhilar Shasto group members in two field areas and that BRAC and MSS had moved into two other areas. By January Bashta Shekha had moved into Baorhat village (see Chapter 8) and BRAC had approached another 4 areas offering to start

schools and pay teachers Tk500 per month. The incidents therefore increased as the amount of NGO activity began expanding in the area.

Case Study of Grameen Bank activities in Muhilar Shasto's working area (from fieldnotes)

Grameen Bank moved into Tala village in September 1992, where Muhilar Shasto has been working for the last three and a half years. There are two women's samitys here which are just over a year old. As yet Muhilar Shasto has not started a loan programme with these groups but has plans to do so in the future. When Grameen came to the village offering loans to women immediately, this began to cause problems amongst the members of the samitys. Four women were tempted away from the group at first, receiving Tk3000 loans, and by December the number had increased to ten recipients, nine of whom were Muhilar Shasto samity members. As a result, the husbands of those who were staying with Muhilar Shasto became angry that they were not receiving money, and began demanding that they left the groups and joined Grameen. The husbands argued that they saw no profit from their wives being in the groups for the last year and half, but the women themselves felt that this was not so. They said they had learnt many things about caring for their families' health which they regarded as a benefit. They also had begun to recognise the value of sitting with other women to discuss issues and building support amongst themselves. They had on a couple of occasions collected money to help two other women who had had problems, and thus the general opinion of most members was that they wanted to stay in the groups. Pressure from visits by Grameen, anger from their husbands who were beating them for not getting credit, and growing jealousies and conflicts amongst the women themselves led to four members visiting Muhilar Shasto's office with an ultimatum.

They said that Grameen Bank were freely offering loans and that if Muhilar Shasto could not do the same very soon, they would be forced to join Grameen. They demanded to know the exact situation, so a meeting was arranged between the Muhilar Shasto Development Officer, Supervisor and members, for the 19th December. The meeting was very heated, mainly because Muhilar Shasto were unable to provide a satisfactory answer to the problem, i.e., confirmation that loans would be given quickly. It had recently

been decided by Muhilar Shasto that before credit could be disbursed the women would have to do a functional literacy course, which would take six months and hence delay the loan programme significantly. This advice came from Muhilar Shasto's supporting agency, CDS, based in Dhaka, who believed that the loan programme would be more effective if women were literate before they received credit. Not surprisingly, however, the staff found it very difficult to persuade the women that this was the best thing for them.

The women explained that until this time they had been happy with the group and there had been unity and agreement amongst them, but when Grameen Bank came on the scene this changed things dramatically. They began to argue and fight about leaving or staying and their husbands became very angry that they were not taking credit when it was offered to them. The groups were divided and nine women joined Grameen, although they continued to come to Muhilar Shasto meetings as well. In fact one of these women was the Muhilar Shasto cashier. She said that she wished to remain a member of both because although she had received material benefit from Grameen, in the form of money, she also valued the learning and support of the Muhilar Shasto group. The supervisor of Muhilar Shasto didn't believe that other women would share this view and once they received a loan from Grameen, would discontinue coming to the Muhilar Shasto meetings. For this reason she did not believe it would be possible for a woman to belong to both groups, and of course did not want the Muhilar Shasto groups to dissolve. She was extremely angered at Grameen's behaviour and visited their local office to complain but was received with disinterest and an attitude of non-cooperation.

The women expressed a great sense of concern; they said that the samity had a lot of problems at the moment but that they would be corrected if only Muhilar Shasto would give them loans. They were also frightened of the reactions of their husbands, and repeated over and again that if they didn't receive loans they would be beaten. (Domestic violence by frustrated husbands is also reported in Goetz & Sen Gupta's research [n.d] on BRAC women's credit groups.)

The situation was to some extent eased with the disbursal of Muhilar Shasto's first loans in February 1993. These totalled Tk 6000 per samity; Tk 1-2000 per

woman. Most women who had shown loyalty to Muhilar Shasto and stayed with the group were then satisfied by this.

Case study of BRAC's activities in the field area of AD-DIN in Jessore, (from notes on a discussion with the project's director)

In the previous chapter I showed how Muhilar Shasto's *samity* programme was affected by the competitve behaviour of BRAC and other local NGOs. Therefore, I shall use here a case study from another Jessore-based NGO with which I was very familiar and which also received BPHC funding.

> Several other NGOs in the Jessore area have experienced BRAC's encroachment into their field areas; AD-DIN is one example. This project has a similar MCH programme to Muhilar Shasto but is already disbursing credit amongst some of their *samitys*. In several areas BRAC has moved in and tempted their *samity* women away with the offer of larger loans and the distribution of wheat. This has consequently caused great problems for AD-DIN because women now expect to be given wheat in addition to credit and are not happy that AD-DIN does not provide this. AD-DIN have approached BRAC about the fact that they are working in their field area but BRAC has made no attempt to retreat or change their programme. They state that their policy is not to start *samitys* where others exist, but on the contrary, they have worked very hard to convert AD-DIN *samity* leaders to join BRAC in the knowledge that they are influential women and if they join other women will follow. They have done this with the promise of larger sums of credit and wheat. This puts the women in a very difficult position because although they feel loyalty to AD-DIN, they are still poor and in need of money and food, so BRAC's offer is a very hard thing to turn down.

These are just two out of a number of cases of 'encroachment', which was becoming increasingly common in the Jessore area, a district with a relatively large number of NGOs of varying size and origin. Foreign presence included a massive food-for-work CARE programme, a DANIDA fisheries programme, the Salvation Army, a hospital run by Italian priests, and VSO. Indigenous NGOs were plentiful, with branches of large national organisations like BRAC and Grameen Bank (this is not technically an NGO but operates along similar principles, so it is regarded as a quasi-NGO by many); larger NGOs with projects in other parts of the country such as Concern Women, Manub Sheba Shongsta (MSS), Bangladesh Association for

Voluntary Sterilisation (BAVS); large local NGOs such as Bashta Shekha, Jagaroni Chakro, and AD-DIN; and several smaller locally-based NGOs like Muhilar Shasto. Relations between some of these organisations were rather tense due to previous acrimonious disagreements, organisations splitting off and setting up on their own, and other complicated 'local politics' with which I never really got to grips, and the 'encroachment' issue further irritated some of these relationships. Far from them being a harmonious, coordinating, cooperative NGO 'community' the undercurrents flowing between different NGOs meant that, in general, it was wise to be careful what you said to people about different organisations, not knowing what their relationships were like or to whom they were related. I was rather surprised to discover that the amount of communication was very limited and generally restricted to those local NGOs who were 'allies' or had close connections. There was a local chapter of ADAB but it did not seem to meet regularly or arrange any communal NGO activities, so the effectiveness of its coordination was minimal. The situation therefore appeared to be one of small united factions rather than an overall feeling of NGO unity and the sense of 'competitiveness' was therefore already present between some local organisations.

The case studies used give an idea of the kinds of problem such competitive behaviour can create not only for NGOs and their staff, but also in villages, particularly for the women who are the primary targets of the NGOs' activities. For a small local NGO like Muhilar Shasto this trend created a tremendous problem and added a new dimension to their work; trying to negotiate agreements and compromises with supposed political 'allies'. Not having the financial backing or power base of the 'superpowers', a small NGO is unable to compete. As 'encroachment' by other organisations became more common, this took up more and more of the project manager's time and distracted the field staff from their work, in dealing with the resulting frictions that were caused in the villages. Relationships between organisations which were previously comfortably neutral or nonexistent became quite unpleasant and aggressive. Material symbols of status, such as BRAC staff arriving on motorbikes[3] rather than on foot or bicycles (as Muhilar Shasto's staff did) were important influences on villagers' decisions to change allegiance, and a lot of energy was expended by Muhilar Shasto fieldworkers in trying to convince people to stay with them. Many difficulties created at this level remained unacknowledged or unimportant to the managerial

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[3] BRAC also has large impressive red-brick offices in nearly all *upazilas*.

and office-based staff of the encroaching NGOs. The gender implications of this behaviour, i.e., the way in which repercussions in villages actually hindered the attainment of the objectives of bringing women together and improving their social status vis-a-vis men, did not seem to concern the management.

The activities of Grameen in Tala village, for example, not only undermined the objectives of the NGO already working there - which were similar to their own regarding provision of credit - but ultimately did so by compromising the existing unity and welfare of the women they were professing to help. Their arrival and contentious approach caused friction and fighting amongst group members who had previously been happy, destroying the unity they had begun to feel. Their sense of loyalty to the group was taxed further by increasing pressure from their husbands to leave Muhilar Shasto and take the Grameen loans, and the threats of abuse if they didn't. I asked the women what they attributed the problems in the group to, and they said the arrival of the Grameen Bank; they felt that the groups would not have been divided if Grameen hadn't come. Grameen justified their activities in Tala by arguing that all poor women should be given the opportunity to receive loans[4], and that their actions in providing credit in this village were therefore upholding the women's rights. In the words of Professor Yunus, the founder of Grameen Bank, "priority should be assigned on the basis of a person's location on the economic ladder. If a person is below another person, he/she will get higher priority than the other person" (1992:7 March). Theoretically speaking then, the fact that the existing NGO, Muhilar Shasto, already planned to start a loan programme for women in this area, should have actually led Grameen to feel it unnecessary to begin work there and to seek villages in which the same opportunities were not available to women. Despite the presence of quite a few NGOs in Jessore District, there were only three or four others (BRAC, CARE, and more recently MSS and Bashta Shekha) in addition to Muhilar Shasto working in Amhat *upazila*. Thus, of the 165 villages in the *upazila* only a fraction were adequately served by government services and/or NGOs, leaving plenty of areas untouched by NGO activity. Those newly arriving in the area could easily have sought to work in these places and avoided those already covered, complementing the existing work of others, but this was not their apparent rationale.

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[4] The founder of Grameen Bank, Professor Muhammad Yunus, believes that access to credit is a human right of everyone, including the poor, and particularly women, such that they must be given specific priority in access. For his statement on this see, for example, "*Steps Needed to be Taken for Poverty Alleviation*", March 1992.

This type of behaviour contradicts the NGO philosophy of cooperation and coordination with the common interests of empowering the poor. Instead, as I suggested earlier, it creates and perpetuates factions and conflicts at all levels. Attitudes of dependence and expectation are heavily reinforced by the 'hard-sell' approach of competitors, nurturing patron-client type relationships, in which the NGOs become the new 'patrons' offering access to new and valuable resources and seeking allegiance from their 'clients'. Hashemi and Schuler identify this relationship as one of the problems arising out of the expansion of NGO programmes[5]; they state:

> in keeping with the system of patron-client relationships NGOs are considered as new patrons bringing with them access to external resources. In a pervasive political situation where accelerating aid dependence has meant that governmental successes are measured according to the quantum of aid each government brings in, NGO resources are zealously sought after. Rather than promoting self-reliance, the NGO presence reinforces the patron-client relationship; either NGOs replacing old patrons or colluding with old patrons (1992:8).

The attitude which began to develop amongst villagers was therefore that NGOs 'give away' money, schools, tubewells, etc., and this was the bench-mark used to judge a good organisation. One which did not offer these, such as Muhilar Shasto, therefore did not fare so well.

The tactics of larger NGOs were to play on this attitude, offering bigger and better loans to tempt villagers away from Muhilar Shasto's *samitys*. With increasing pressure from the *samitys*, Muhilar Shasto had planned to start a credit programme later in the year but wanted to develop the *samitys* as savings groups first to ensure a degree of unity and solidarity amongst the members before distributing credit, otherwise it was feared that problems with repayments and commitment to the group might result. However, this approach was undermined by BRAC and Grameen Bank who offered initial loans within a very short period of time, despite having their own official policies contrary to this. Grameen visited Tala village only

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[5] An interesting and different perspective on this relationship is expressed in an article by Rahman and Wahid (1992) on 'The Grameen Bank and the Changing Patron-Client Relationship in Bangladesh'. They argue that Grameen Bank has "brought about a silent revolution in the century-old patron-client relationship in rural Banladesh" (p19), concluding that the overall influence of the patrons has been reduced by the intervention of Grameen. They recommend that until mature leadership has developed amongst the poor, Grameen should play an active role in maintaining a 'judicious balance' between conflicting groups. They do not equate their current role as replacing that of the patrons they have 'overthrown'.

once to take names before disbursing loans and the only criteria set for recipients was that they learnt by heart 16 'rules' - the Sixteen Decisions[6] - by which they were then supposed to live their lives. Their arrival and quite different approach consequently caused great problems for Muhilar Shasto's field workers, with *samity* women's husbands demanding loans, or instructing their wives to leave and join Grameen (see previous chapter). Grameen made it very plain to Muhilar Shasto that they were not an NGO but a business, and therefore quite prepared to compete for clients.

Interestingly, Grameen also began to move into BRAC's working area and 'steal' members from their groups to receive Grameen's loans. In the instance described to me by the BRAC programme officer, they had disbursed money within 5 days of entering the village and without any form of communication with BRAC. When she went to discuss the situation with them she received a similar uncooperative response, thus laying the ground for a potential war between the two national credit 'superpowers'.

TARGET ACHIEVEMENT: THE GOAL POSTS OF EXPANSION

A significant factor encouraging this competitive behaviour is that Grameen and BRAC workers are given loan distribution targets to achieve. The BRAC programme officer in Amhat informed me that she is given a certain amount of money to disburse as loans each month and can go a little above or below this but if

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[6] The 'Sixteen Decisions' are as follows: 1.We shall follow and advance the principles of Grameen Bank - Discipline, Unity, Courage and Hard Work - in all walks of our lives; 2. Prosperity we shall bring to our families; 3. We shall not live in dilapidated houses. We shall repair our houses and work towards constructing new houses at the earliest; 4. We shall grow vegetables all the year round. We shall eat plenty of them and sell the surplus; 5. During the plantation season we shall plant as many seedlings as possible; 6. We shall plan to keep our families small. We shall minimize our expenditures. We shall look after our health; 7. We shall educate our children and ensure that we can earn to pay for their education; 8. We shall always keep our children and the environment clean; 9. We shall build and use pit latrines; 10. We shall drink water from tubewells. If it is not available, we shall boil water or use alum; 11. We shall not take any dowry at our sons' weddings, neither shall we give any dowry at our daughters' weddings. We shall keep the centre free from the curse of dowry. We shall not practice child marriage; 12. We shall not inflict any injustice on anyone, neither shall we allow anyone to do so; 13. We shall collectively undertake bigger investments for higher incomes; 14. We shall always be ready to help each other. If anyone is in difficulty we shall all help him or her; 15. If we come to know of any breach of discipline in any centre, we shall all go there and help restore discipline; 16. We shall introduce physical exercise in all our centres. We shall take part in all social activities collectively (quoted from Schuler, Meekers and Hashemi 1992).

she is way out she will be reprimanded. This basically means that her performance is judged according to her ability to meet targets for disbursal and recovery of money in whatever way it may be effectively done. Other BRAC staff have also complained of this (Montgomery et al n.d.). Under such pressure, a village in which women have already been motivated by an NGO to form groups and receive loans, may seem far easier to try and 'convert' with competitive offers of larger and quicker loans, than beginning initial awareness-raising and motivation in a village having no previous contact with NGOs. The temptation to facilitate achieving these targets is, therefore, to seek out the members of other organisations' programmes. The quality of work and intensity of coverage in one particular area becomes unimportant; impressive figures are what matter - high recovery rates and wide coverage are the goals (this is also Montgomery et al's [n.d.] finding). Both BRAC and Grameen work on the principle of covering a field area of a particular radius around the local office to begin with. However, when working to this radius principle it is quite likely that areas around the small *upazila* towns will quickly be covered and overlap will occur. If the general NGO priority is to provide resources and opportunities to those without them, one would assume that it would be considered a waste of time and money to begin work where these are already available. Sadly this is not the case.

Both organisations are world renowned for their achievements in grassroots level development and particularly for making loans available to poor village women, something that was never available through government and banking systems. The innovative nature of BRAC's work caused great interest abroad and brought huge financial support, enabling it to expand to a national scale. The Grameen Bank's loan distribution system has provided a paradigm for initiatives in numerous countries, e.g., United States, Malaysia, Burkina Faso, Philippines, Indonesia and Malawi. The success of these organisations is to a large extent measured in terms of their impressive repayment rates - both have a national rate of 98% - and the quantity and coverage of loans: to the end of January 1992 Grameen had distributed "almost US$270 million to 1,091,802 very poor rural households" with 93% of borrowers being women (Gibbons 1992:11); from its inception in 1972 to December 1990 BRAC had disbursed a total of Tk686,138,162 to 264,378 group members, 62% of this sum going to women (BRAC Report 1990).

Both 'superpowers' pride themselves in 'covering' large proportions of the country; Grameen claims to work in more than 25,000 out of 65,000 villages, (by the end of January 1992, Gibbons 1992:11) while BRAC claimed a coverage of 3,664 villages in

1990 (Annual Report 1990). Consequently, there are both personal and organisational incentives for moving into new areas and starting groups; i.e., securing one's job, and reinforcing the reputation of the organisation through maintaining their impressive performance statistics. Mahabub Hossain (1988:77) highlights this clearly in his identification of the need for enthusiastic and dedicated midlevel officers as a constraint to Grameen Bank's expansion, he states: "Incentives for hard work have been maintained through quick promotions and transfers based on performance in the field."

However, as I have suggested, the quest to maintain these achievements and continue to expand seems to have had a price; a dilution in the organisation's vision and ideology at the field level, such that addressing the objectives of empowerment and poverty alleviation of the poorest have become almost the secondary goals of improved 'performance'. An example of this might be seen in the fact that both Grameen and BRAC threw their policies of group maturation and solidarity-building out of the window when they entered Muhilar Shasto's field area. Both immediately offered loans without any of the preliminary activities they give importance to in their literature, for establishing group commitment and cohesion. The project officer in BRAC told me they did not give loans until groups had been formed for three or four months, but this was clearly not the case in the instances I was aware of. In fact, the official guidelines for granting loans specify that before receiving a loan a borrower must complete functional education training, regularly participate in weekly meetings and savings deposits, have minimum savings equal to a percentage of the loan, and have made deposits in compulsory group and insurance funds (BRAC 1990:14). None of these criteria were met by the new loanees in the Muhilar Shasto field areas. Through word of mouth and brief discussions with members I heard that meetings of BRAC groups in the villages around Amhat basically consisted of collecting savings and making loan repayments; the workers didn't seem to spend much time holding women's group discussions, directing their energies towards raising awareness on social issues, or nurturing a sense of solidarity amongst group members through group activities. I was told by one BRAC member that the worker came, collected money and then left, however, I never actually attended any meetings and so am unable to verify this with my own experience.

In Tala village, the women who had attended the first Grameen Bank meeting said that the main thing the worker had done was to teach them 16 rules - the 'Sixteen Decisions' - which they had to be able to recite before they would be given a loan.

This was all that the initial stages of setting up the programme in the village involved. The Sixteen Decisions are the basis of what Grameen terms their 'social development' programme. This 'programme', i.e., list of rules, is intended "to imbue members with discipline, unity, and hard work and to improve their living standard." (Hossain 1988:27) They include certain 'codes of conduct' by which members are encouraged to live their lives, although observance is not compulsory. This 'social development' programme also includes participation at group meetings, in physical training (exercise) and parades, and chanting the Sixteen Decisions as slogans. Grameen regards the introduction of this programme in 1984 as the organisation's move into an overall development programme for the poor (Hossain 1988)[7].

Hashemi and Schuler's research in the north found that the compulsion to maintain high repayment rates meant that selection of membership to groups actually worked against the very poorest. Schuler, Meekers and Hashemi (1992:6) found that the target was more the slightly better-off section of the 'very poor' (also Goetz & Sen Gupta n.d., and Montgomery et al n.d.). Only those with an existing income or assets would be chosen because these could be used to make repayments if the income generating enterprise did not make a profit. This was reportedly the case with Grameen Bank in Tala village; one old man told me that "you won't receive a loan if you don't have the 'capacity'", meaning assets which could be claimed by Grameen in the case of default or death. He said that they visited houses to check this before giving the money. Thus, if you were very poor and had very few assets, despite being the supposed target beneficiary of Grameen Bank's programme[8], you were in reality 'ineligible' to receive a loan.

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[7] Describing the 'Sixteen Decisions' as a social development programme is, I feel, artistic license for what appeared in Tala village to be simply rote learning of a list of rules. The fact that this programme involves observing these rules as 'codes of conduct' clearly indicates that the intentions are not those of 'empowerment' and self-determination. The idea of women saluting the Grameen worker, marching around, chanting and doing physical exercise gives the whole thing a rather unpleasant militaristic tinge. Hossain actually decodes the rhetoric by admitting the Bank's self interest in the programme. I quote: "The managing director, (however), emphasises the bank's interest in the social development program. In the long run, better housing and sanitation, and increased consumption of vegetables and friuts improve the health of the borrower, increase his productivity and income, and hence ensure better recovery of loans...Dowry constitutes the greatest risk of default in repaying loans, as the poor borrower is under compulsion to use capital to finance it" (Hossain 1988:27), hence their emphasis on doing away with the system.

[8] Grameen Bank's target population is officially those withless than 0.5 acres of cultivated land, or assets with a value equivalent to less than 1.0 acre of medium-quality land.

How does this discrimination with regard to assets and the targeting of women belonging to other organisations square-up with their claims to provide credit to 'the poorest of the poor'? If someone is already in possession of a loan from another NGO, or has the opportunity to receive one, then surely they are no longer the 'most needy' since there are still many others without this opportunity. The irony of the situation is, therefore, that it actually reinforces an unequal distribution of resources to particular people in a particular area, at the expense of others. How can this be reconciled with the organisations' individual ideologies and those more generally, of non-government organisations?

Hashemi and Schuler argue:

> NGO expansion therefore proceeds extensively (covering newer and newer villages) and not intensively (ensuring that all the target group members in a village have been accounted for). That is why even with NGO membership running in the millions one does not discern a dent in rural poverty in any region (1992:8).

Examining the relationship between NGOs and donors to see how this affects 'the evolutionary cycles of NGOs', as Avina (1993) has done, one can identify a close relationship between donor priorities and the pattern of expansion observed here. He points out that donors are also under pressure to 'perform' and "to maintain institutional credibility to their funders, [such that] they must demonstrate a record of orderly disbursements and quantifiable outputs" (1993:464). They therefore use disbursement levels to evaluate their own institutional performance, and may target specific priority areas or interventions to increase their disbursement levels.

> It should be noted that many large donors are not set up to target small NGOs. Instead they prefer to work with government agencies or other agencies who can absorb large disbursements and development projects. Increasingly, however, more large donors are recognising the value of NGOs as effective microtargeting disbursement vehicles (Avina 1993:459).

This is not to say that efficient disbursement is the main reason why donors are funding NGOs, but it could be fair to argue that the emphasis placed on 'disbursement targets' and 'performance rates' by larger NGOs is heavily influenced by donors. Edwards and Hulme's (1992) analysis of NGO expansion emphasises the inevitability of this influential donor relationship. They argue that successful grassroots development is not possible in isolation from the macro-level influences of national and international political processes. NGOs must therefore be fully aware how these will affect their expansion ambitions. In the process of NGO organisational growth and operational expansion the need for increased capacity to

raise material and human resources invariably requires that they seek grants from official donors. In doing this they become subject to upward accountability, which Fowler warns may lead them to be increasingly "driven by the procedure" (Fowler 1991, quoted by Edwards and Hulme 1992:19). BRAC receives huge sums from foreign donors - 68.2% of its income in 1990, which totalled Tk16,344,670, 24.55% of which was from ODA (BRAC Report 1990) - and has an international reputation to maintain as one of the largest and most innovative Southern NGOs. Pressure to fully utilise this funding with the greatest 'impact', which of course will determine funding in the future, means that more money must be disbursed in loans, with high repayment rates, to produce impressive performance indicators. The result of this in practical terms is that the focus moves from development of 'others', i.e., the poorest of the poor, to development of 'selves', the institutions.

PROFESSIONALISATION: LOSING SIGHT OF 'EMPOWERMENT'?

An integral part of this expansion process is the increasing commercialisation of NGO enterprises, which White (1991) relates to their increasing professionalisation and growth as an alternative career path. For example, since its inception in 1972, BRAC's programme has over the years evolved into a highly professional and commercialised organisation; the Rural Development Programme with which many are familiar is only part of their expansive activities, which include: the establishment of the BRAC Bank in 1990 as part of a self-financed rural credit programme; handicraft production and marketing through a number of their own shops and export links; income generating and commercial enterprises, such as BRAC Printers and BRAC cold storage; Training and Resource Centres and a Management Training Centre used by internal staff and other development agencies. Personnel involved in these enterprises comprised over 4,200 in 1990 and during that year, 31.8% of total funds were raised through these income generating enterprises. The remainder came from donors' contributions. The aim of this commercial expansion is, ultimately, to achieve self-sustainability (information from BRAC Report 1990).

'Sustainability' is a key concept in development discourse at present, addressing the practical aspects of the long term perpetuation of projects. In the context of large and small NGOs alike, the availability of future financial resources is a paramount consideration, so the concept of 'sustainability' is often largely equated with institutional income generation and profit making enterprises. As a result, the

selling of training services, facilities, specific technical skills and advice, and other services, in addition to commercial activities such as producing and marketing handicrafts and other products, are becoming more common elements of NGO programmes. GK was a leader in this, establishing its own pharmaceutical factory as a commercial enterprise to undercut the high pricing of multinationals. White (1991:14) also sees this trend as an outcome of the current international climate favouring privatization and the establishment of entrepreneurial enterprises, which encourages self-reliant funding.

She states that "typically, NGOs regard these activities as quite separate from their development work, and as not changing the kind of agencies they are, except in allowing them more autonomy from donors" (White 1991:14). However, the case studies and examples given seem to indicate that this is not representative of the general situation in, for example, the Jessore area. The 'commercialisation' and 'professionalisation' which has accompanied the vast expansion of, for example, BRAC's programme does appear to have changed the nature of its development strategy (Montgomery et al [n.d.] and Goetz & Sen Gupta's research [n.d.] also indicate this) whether intentionally or not, and whether institutionally acknowledged or not. Billis and MacKeith's (1992) examination of the organisational dimensions of 'scaling-up' demonstrates the dramatic impact such changes can have on organisational culture; in particular, the search for "professionalism subordinates commitment and 'mission'-related values" (Edwards and Hulme 1992:19). One might interpret the case studies as indications that this is happening. As Fowler (1990:11, cited by Edwards and Hulme 1992:14) points out, the roots of NGO comparative advantage over government programmes are in the quality of the relationships they develop at the local level, not the volume of resources they command. However, "some NGOs appear to have lost sight of this fact in a headlong rush for growth, influence and status" (Edwards and Hulme 1992:14). Edwards and Hulme warn that the danger from doing this is that the hallmark of NGOs - 'human concern for others' - will go out-of-fashion in the growing concern for 'impact' and 'strategy'.

Grameen Bank and BRAC are not typically given as examples of NGOs or organisations to whom this has happened. In fact, they are used as models of how successful 'scaling-up' can be achieved. Many studies have been done on Grameen

Bank[9], but the tendency is to highlight quantitative details as indicators of 'success', e.g., the accelerating numbers of loanees, maintained high repayment rates, high percentage of women recipients, different business ventures and geographical area covered, without focusing sufficiently on the finer micro-details of the social impact and effects at village level. Individual case histories are often used but are always positive 'success stories'; I have read only two other accounts (Goetz & Sen Gupta n.d., and Montgomery et al n.d.) which mention a less than ideal picture of field level activities, group meetings, economic achievements, and so on. Goetz & Sen Gupta's research (n.d.) reinforces my belief that aggressive competitiveness and resultant problematic field relations - factions and fighting, conflict and abuse between wives and husbands, non-cooperation with other NGOs - are not restricted to Jessore.

The other focus, represented in the papers collected by Edwards and Hulme (1992), has been to analyse the processes of expansion in order to establish a conceptual framework with which to make sense of the numerous different models and strategies of scaling-up that have been embarked on. The chapter by Howes and Sattar examines the scaling-up strategies of BRAC using this framework, and focuses on the processes and typologies of its 'organisational' growth strategies. The attention is therefore on successful capacity building to maintain the innovative nature of the original programme, and they conclude that: "Where attention is given to building organisational capacities to support programme expansion, there is no inherent contradiction between quality and scale. Bigger can also be better" (1992:110).

Whilst I do not question the incredible achievements of these organisations in reaching the rural poor with credit, and the positive economic impact this has had for many, my (admittedly limited) experience of both Grameen Bank and BRAC's programmes leads me to question the social impact of their acclaimed 'successes' in scaling-up their programmes. From the qualitative facts of what appeared to be an increasingly common pattern in Jessore and other parts of the country, I re-pose the question of whether they have been able to maintain their innovatory enthusiasm and founding philosophies. That is, whether as NGOs (or quasi-NGOs) they have retained their characteristic value-bases which prioritise "human concern for other

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[9] Much literature has been produced extolling the success of Grameen Bank's expanding programme, see footnote 1 for references, and Hulme, D (1990) for an examination of the replicability of the Grameen Bank model in other countries.

people as individuals" (Edwards and Hulme 1992:14) and whose driving goal is the 'empowerment' of the poorest of the poor[10].

The authors I have cited regarding BRAC and Grameen's expansion have concluded that it is possible for an NGO or quasi-NGO (such as Grameen) to continue to operate as such, providing adequate attention is paid to the inevitable changes which will occur, for example, in the organisational structure and in their relationship with the macro-development environment. Bureaucracy and extended hierarchy are inevitable, increasing the distance along channels of communication between those who manage field activities at the 'bottom' and those managing the organisation at the 'top' (Edwards and Hulme 1992) - thus those at the top become out of touch with what is happening at the grassroots, and vice versa. In this process, enthusiasm and dedication as embodied in the organisation's philosophy and proudly upheld by the founders seated in directorial chairs in Dhaka, is not necessarily translated into the attitudes of new recruits at the field level; they, however, are the 'public face' and ultimately determine the effective implementation of the philosophy. In this regard, BRAC have themselves admitted that they believe only about a third of their staff to be highly motivated, while the rest regard their work as they would any other job in a bank or government service (White 1991:14, cited from Sen 1988). Under these circumstances, and with increasing institutional complexity, it is possible to see how organisational values can change, or become 'diluted', and how the approach that may have been successful on a small scale, loses its vision and impact once scaled-up.

My main objective in raising these questions is then, to stimulate a more critical micro-level 'social' analysis of the grassroots activities and achievements of these

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[10] Some people in the development community argue that it is wrong to accuse Grameen Bank of losing sight of their 'social' objectives because they do not claim to be a 'development' organisation; they are a bank. However, I disagree with this since Professor Yunus' writings make clear that he sees it as more than just a 'business' institution. He describes the main aims as 'poverty allieviation' and 'empowerment of the very poorest and explains that he conceived of the idea after becoming disillusioned with 'textbook economics' which did not face the problems of 'the real world' around him; the rural villages of his country. He speaks of his own vision of development and of the bank's social development programme - the Sixteen Decisions - of the need to target women to empower them and to improve the lives of their children; the country's future. His vision is clearly one of social and economic change, 'development', stimulated by the activities of Grameen Bank. For a detailed and passionate exposition of his conception of the idea of the Grameen Bank see his publication *"Grameen Bank: Experiences and Reflections"*, January 1992, or any of his previously cited writings.

'superpowers', in order to draw a more representative picture - warts and all - of their current 'good guy' images and widely heralded successes in empowering the rural poor. They are, after all, internationally regarded as role models for rural credit and empowerment programmes, but the unintended effects of their 'expansion strategies' within the targeted communities, and upon the programmes of smaller NGOs over whom they carelessly trample, highlights the need to draw attention to the seriousness of this emerging 'encroachment' trend. Roland Hodson argues that NGOs should not be fearful and shy of expanding and encourages them to 'aggressively pursue' growth (1992:128), advising that "In the medium term the harm done by the problems engendered by aggressively pursuing growth will be greatly outdone by the additional good achieved." In fact, he says they have a 'moral obligation' to do this. I am unclear as to the manifestation of aggression he is recommending; however, if it is the type of competitive 'one-upmanship' exhibited in the incidents I have here referred to, then I disagree strongly with his advice, for reasons I hope will by now be clear.

He uses the Grameen Bank as a 'classic example' of how the risks and negative aspects of growth are outweighed by the benefits:

> While the quality of its work may have suffered in some respects due to a remarkable pace of growth, who would argue that this cost has not been worth paying to achieve its remarkable outreach across Bangladesh? (1992:128)

This is countered by Hashemi and Schuler's (1992) observation that because of the tremendous pressure to increase disbursal levels of credit, the expanding 'outreach' of a project is 'extensive' rather than 'intensive', having only a minimal effect on overall levels of poverty in a specific area. Having a 'remarkable outreach' is, therefore, no indicator of having a greater impact on poverty alleviation. Against Hodson's claim I would argue that his acknowledgement of the drop in the quality of work is a far more important issue for consideration.

He completes the paragraph with the question: "If the additional poor who have been served had been consulted, would they have argued for slower growth?" The answer is that it depends on who you would have asked; answers from husbands might well have been different from those of their wives. And what about the opinions of those who were overlooked because they were 'too poor' to be given loans?

The threat that such domination and monopolisation by larger NGOs poses to the overall goals of grass-roots empowerment and the general ethics of NGO development should not be ignored. Their aggressive striving for influence and status within the local political arena rather taints the shining image they have as humanistic pioneers of 'effective', 'empowering', rural development programmes. Perhaps there are negative as well as positive lessons to be learnt from them, which highlight their less desirable characteristics as the 'uncooperative dinosaurs' of the NGO/rural development community.

The gender implications of this expansion process are particularly important, since as I have shown, the repercussions at village level have, for example, led to incidents of domestic violence by husbands, angered by the terms of women's credit programmes. Also, the emphasis on 'credit-worthiness' of recipients and the resultant exclusion of the very poorest women need to be examined from a gender perspective. In the following section I shall, therefore, scrutinise the 'empowerment' objectives of these programmes, since in the quest for expansion and high repayment rates, it appears that women's empowerment is more rhetoric than reality.

GENDER ISSUES AND WOMEN'S CREDIT PROGRAMMES: SOME IMPORTANT CONSIDERATIONS

The centrality of credit as the currently favoured means of poverty alleviation and 'empowerment' of the rural poor in Bangladesh, is strikingly evident in the strategies of many NGO programmes. Those who have not yet incorporated credit into their strategies are likely to find themselves doing so sooner or later, as demand amongst the rural poor is heightened by increasing levels of landlessness and hardship, and a spreading awareness that 'this is what NGOs do'. Grameen Bank were the pioneers in this approach, and along with NGOs like BRAC, have been the role models for the formation of new credit programmes.

As the discussions above and in Chapter 8 demonstrate, in the Jessore area they have also been role models for forming local expectations of what NGO programmes should provide. As we saw, pressure from the women's groups eventually forced Muhilar Shasto to embark, rather blindly, on a credit programme, for fear of losing local support. (This is an interesting example of how the groups

actually turned what they had learnt about the power of unity, back on those who had taught them about it - the NGO - with great effect[11].) The programme, consequently, had a very rocky conception and after several months of trial and error, was finally initiated in February 1993, with the disbursal of the first loans. Unfortunately, the long gestation period meant that I was unable to observe its full implementation. However, my discussions with group members in the initial stages before any loans were given, brought to light some very important issues concerning women's credit programmes, which I feel need consideration.

Before addressing these issues, it is important to understand the ideology behind targeting the poor, particularly women, with credit as a means to alleviating their poverty. I therefore begin by looking at this.

THE THEORY OF CREDIT AS A MEANS TO POVERTY ALLEVIATION

The main objectives of this strategy for poverty alleviation are to provide the very 'poorest of the poor', who have few or no assets as collateral, and have, therefore, previously been denied access to official sources of credit from banks, with the economic resources to engage in self-employment. This releases their dependency on others for the provision of work, and also their dependency on the exploitative rates of local money-lenders. Hence, the provision of small amounts of credit addresses the immediate economic needs of the poor with a medium-term solution, i.e., local individual and small group income generating activities. The strategy is, therefore, one of self-reliant development, which encourages individuals or small groups to find their own solutions to improving the situation of their poverty. Whilst provision of credit is clearly important and effective from the perspective of addressing the immediate economic needs of the poor, it is also a step towards achieving a locally sustainable means of poverty alleviation.

As a cautionary note, this does, of course, assume that there is an adequate and appropriate local market to cope with a swell in petty production and trade. Hashemi and Schuler (1992:8) highlight the importance of this point, in their discovery that in one village in the northern area of Rangpur, some Grameen Bank

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[11] Montgomery et al (n.d.:79) suggest that BRAC's reduced emphasis on 'empowerment' aspects of the credit programme is due to their fear that more active representation by members might lead to pressures from below to change their policies and provide different services, as happened with Muhilar Shasto.

clients were actually gambling their loans away because the limited capacity of the local economy could not absorb new productive avenues! However, as White (1991) argues, the credit strategy is also an intervention which supports the general policy of the donors. In the macro-frame of development, the increasing number of small-scale businesses are part of the overall global trend towards privatisation and the creation of a nation of small entrepreneurs. The emphasis on credit can also "implicitly present poverty as a temporary 'cash-flow' constraint, which is relatively simply remedied, without need for social or political action." (White 1991:10). By encouraging the poor to solve their own economic problems it might, then, be argued that the government is being let off the hook in not having to provide rural employment opportunities, or face the structural causes of poverty. Credit is, however, generally accepted by most NGOs as one of the most practical ways of tackling rural poverty, given the current economic and social environment.

The increasing awareness of the need to empower poor women, as bearers of a 'double burden' of poverty - due to their double exploitation through class and gender relations - has led programmes to specifically target women with credit facilities. In the context of Bangladesh, the double burden upon women is particularly acute due to their virtually total economic dependence on men, reinforced by their cultural subordination through the *purdah* system, and the pervading social discrimination against them from birth. The provision of credit to women through the system of group formation is seen as a way of empowering them, both economically and socially. The premise upon which this is based is that women's low social status is related to their economic worth in the household, such that if they are perceived to make little or no contribution to household income, and, therefore, are considered an economic burden, their status is very low. If, however, they are enabled to earn a cash income through self-employment, their contribution to the family income is believed to enhance their status. This, then, improves their bargaining position within the household and allows them greater involvement in family decisions. Having their own source of money also reduces their economic dependence on their husband, in the event of his illness, death or desertion. The social dimensions of forming groups, awareness-raising and building solidarity amongst women, also contribute to this 'empowerment' process. Women's increased mobility outside their homestead or neighbourhood, for attendance of meetings and training, also improves their access to information and resources, and their general interaction in public spheres. Studies have also shown that increases in women's income improve the effectiveness of their welfare

functions within the household (Goetz and Sen Gupta n.d.:5). The anticipated implications of providing credit to poor women are, therefore, very optimistic.

Various studies and articles have been written on the successes of empowering women through credit programmes in Bangladesh[12], and whilst I am impressed by the incredible stories and achievements they depict, my personal experiences cause me to question whether these successes typify the general experience of women receiving credit through NGO programmes. My query includes members of Grameen Bank and BRAC. As I have explained, my experience was limited to the lead-up of Muhilar Shasto's credit programme, and does not cover what actually happened after loans were given. My experience is, therefore, largely based on what I was told people would do with their loans, not what they actually did with them. This is, of course, an important factor to take into consideration, but was one of the constraints my fieldwork imposed over which I had no control. However, Goetz and Sen Gupta's unpublished recent study of BRAC's credit programme has provided further empirical data to reinforce my arguments.

I shall use this and my own ethnographic data to illustrate and explain my scepticism in the following section.

DOES 'CREDIT TO WOMEN'='EMPOWERMENT'?

Muhilar Shasto's general objective in providing credit to women was, as defined above, to facilitate economic development of the poor at the household level, but with a gender specific objective of empowering women in the process. The reasons women wanted loans, as expressed in their demands during group meetings, were, not surprisingly explicitly related to the former; "we are poor, we need money to feed our families", they would say. The latter objective, their own 'empowerment', expressed in terms of personal benefit, was however, rarely explicitly mentioned. It, therefore, seemed to be an objective imposed by the NGO, rather than expressed by women themselves, even though in the context of group meetings, women's subordination and rights were discussed. Thus, the general sense I felt concerning the women's attitudes was, that the personal benefits of receiving loans were secondary, or even not considered. The need to increase the overall income in the

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12 A specific example of a study on the Grameen Bank is Rahnuma Shehabuddin's (1992) '*Empowering Rural Women: The Impact of the Grameen Bank in Bangladesh*'; and on BRAC is Martha Alter Chen's (1986) '*Quiet Revolution: Women in Transition in Rural Bangladesh*'.

house and to feed, cloth and educate their children were primary motives. The social awareness-raising and discussions on women's rights were very new elements in group meetings[13], so the challenge they posed to the accepted norms of women's roles, were still very daunting to members. The women's own desires for social change, greater independence, greater economic control, and so on, had, therefore, not had time to develop and mature. Their attitude was still very much that others - men, family and children - came first. Consequently, on reflection, it was perhaps rather premature, or naive, to expect women to prioritise, in receiving a loan, the objective of their own 'empowerment', when pervading social norms were against this, and the practicalities of their poverty so acute.

The first consideration is, then, to establish which of the interested parties involved - i.e., the women, their husbands and their families; referred to as 'stakeholders' in current development discourse - share the NGO's objective of giving credit as a means to empowering women. The likelihood is that, at most, the NGO and the women will prioritise this, and at the least, only the NGO. It should, therefore, never be assumed that the organisation's objectives are clear to, and the same as, those of the women and other interested parties. For example, husbands are quite unlikely to agree that the primary benefit of credit should go to their wives rather than to them, in order to reduce their wives' dependence on them. The power relations between men and women also make it unlikely that women will prioritise this, since their husbands play such an influential role in decision making. Montgomery et al (n.d.:86) reinforce this point, arguing that women's interests are not sufficiently divergent from men's and others in the household to wish to controvert existing divisions of labour and distribution of privileges.

The premise that giving women credit will directly improve their social and economic status, by providing them with their own financial resources over which they have personal control, is, therefore, highly problematic. Providing credit alone does not automatically open up avenues to women's participation in the market place. Although women do play an economic role in productive processes (White 1992) and do have their own petty sources of income, for example, from selling eggs, vegetables and fruit grown around the house, or saving handfulls of rice to sell, these are not 'perceived' as economically significant within the household. For a

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[13] See Chapter 8 for details on the development of the groups.

household to socially recognise and permit a woman's involvement in economic activity, therefore, requires a significant breach of pervading social norms.

Since women's role in the household economy is perceived to be negligible, their role in the control of family finances is not significant (although they do control the finances in cash and kind of their own endeavours) and they are often considered incapable of doing so by their husbands. Consequently, when Muhilar Shasto began discussing the possibility of giving loans to women in the groups, the automatic assumption on the part of many group members' husbands, and often members as well, was that the husband, or son, would utilise the money. They were regarded as the household income earners, the woman was merely the source of access to the credit. For many women the security of their future depends on the security of their marriage so as a survival strategy they transfer the loan to their husband (Goetz & Sen Gupta n.d.:17). In order to ensure effective use of the loan and regular repayment, Muhilar Shasto required that the loan be used only by the woman receiving it, for the stated activity. BRAC and Grameen Bank also stipulated this. However, under the circumstances described, it appeared quite common for the stated use of credit, as written on official documents, to be quite different to the actual intended use.

Several points come out of this observation.

Firstly, the implications for women's empowerment objectives have to be considered. In the discussions I had with women already receiving loans from Grameen Bank in Tala village (see the first case study above), and in another village where Muhilar Shasto had women's groups, it appeared quite common for women to hand over loans to their husbands, who used them for their own income generating activities, such as: buying fertiliser for crops, buying a cow or plough so they could sell their labour ploughing other people's fields, buying *mal* ('goods'; often smuggled) that could be sold locally at a profit, or buying a rickshaw van which they would ride. In these cases the woman receiving the loan had no control over her money; it went straight to those controlling the existing finances in the family, and, therefore, she did not directly benefit from the loan The benefit went to her husband and the general family income. She may have been given some of the profit, but since she didn't do any of the work and would not usually have had control over finances, it is more likely that the profit would remain in her husband's hands, and that he would simply give her the money to cover the weekly repayments. Hence, her economic status was not improved. In fact, if her husband

failed to provide repayments for whatever reason - illness, death, used on something else - the repercussions would fall on the woman, because the loan was taken in her name and, therefore, the legal obligation to repay rested with her (Montgomery et al [n.d.:45] and Goetz & Sen Gupta [n.d.:1] present the same problem[14]). It might be argued that under these circumstances, with the threat of losing the few assets she, or they, had because of her husband defaulting on the loan, the woman was even more economically dependent on him. The BRAC officer in Amhat informed me that of their 80% repayment rate on loans to women, she thought about 60% was met by earnings from husbands using the loans. "What can we do?", she commented, "we have a lot of problems with the loan programme". One husband was adamant that it was his decision whether his wife took a loan and what would be done with it, because, to quote him, "she was only a house servant (*bari bandi*) who had to obey his command". When told by the Muhilar Shasto supervisor that it was actually his wife's decision, and only she could use the money, he became extremely angry.

Goetz and Sen Gupta (n.d.:6) argue that targeting women is, in fact, an instrumental strategy in the management of credit programmes since it is a well recorded fact that women repay at consistently higher rates than men, and are more reliable and tractable. With increasing pressure on fieldworkers to meet targets and therefore assess credit-worthiness of borrowers, they were prompted to 'screen' the likely productivity of the husbands of female borrowers. Some men were implicitly promised loans for their own use if they allowed their wives to join the groups. The use of women's loans by men is therefore, it seems, not an altogether unintended consequence of credit managers' strategies.

White's study of NGO credit programmes in Bangladesh (1991) noted the same tendency; loans given to women were used by men, particularly when the sum increased (Montgomery et al n.d.:83, Goetz and Sen Gupta n.d.:13). "This is understandable, both because of male dominance which prescribes that larger amounts of money tend to pass into male hands, and because men are able to undertake higher productivity activities" (White 1991:29) because of their access to the public domain, and most importantly, the market place.

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[14] Montgomery et al (n.d.:45) found 10% of women receiving loans were not in control of the money and had no personal income or benefit, and Goetz and Sen Gupta (n.d.:12) found this to be the case for 20% of women in their survey.

This leads to the next point, that even when women do utilise the money themselves and begin their own income generating activities, in most cases they are still dependent on men for access to the market. This dependency limits the scope of their productivity. It also means that ultimately, they still hand over financial control to a man, since they must trust him to buy and sell their produce at the best price, and return the full profits to them. When I mentioned this to some women, they replied that they trusted their husbands and close male relatives to do this, but would be more cautious about others outside the family. I wondered if it was necessary to pay a husband or son a fee for their part in transporting produce and their negotiations, and was met with a bemused expression: "of course not, they are family" was the retort. This would only happen if an 'outsider' was hired for the work, and the women said they would avoid doing this. However, since men can demand to take the loan money to use to their own ends, with very little dispute from women, I found it hard to believe they would not exert the same power over the women's earnings, if they so desired. White (1992:127) quotes a wonderful example of this relationship of apparent trust: "When I asked whether he gave his wife the full price of her goats which he had sold, Bolai...laughed and said: 'If I ask you to bring something from Rajshahi and it cost Tk30 and you said it cost Tk50, then won't I believe you?!" I did not encounter any women who had broken free of the culturally prescribed boundaries to the extent they, themselves, went to the market place to buy and sell goods. Only activities which centre solely around the neighbourhood avoid the need for male labour, and these tend to be very marginal, such as selling small quantities of home grown vegetables and eggs to neighbours.

Thus, even when women are able to mobilise their own labour and move around outside the confines of their *bari* ('homestead'), or *para* ('neighbourhood'), the limited extent of this mobility still restricts many from being totally independent in their productive activities. However, the increased mobility they experience, and the wider network of non-kin social relations and contacts they make, are significant aspects of the overall process of 'empowerment'.

As the BRAC officer said, it is very difficult to enforce a rule that only women can use a loan, mainly because women may not actually, practically, be able to do so. The dominance of males in their household, the impracticality that restricted mobility enforces on their access to the market, or a lack of confidence in their ability and a preference for their husband to use the money, are all constraints to achieving this. In this regard, credit programmes can, therefore, actually maintain and reinforce the existing status quo in gender inequalities in the household, rather

than challenge them. This point is strongly emphasised by both Goetz and Sen Gupta (n.d.) and Montogomery et al (n.d.).

An important issue which does not seem to have been properly acknowledged in women's credit programmes, is how constraints, particularly those discussed above referring to male dominance over loan use, differ depending on the social and marital circumstances of a woman, and her stage in the lifecycle (Goetz and Sen Gupta n.d.). White (1991:97) notes that NGOs have a tendency to regard class differences as less significant amongst women, such that when forming women's groups, membership can be markedly heterogeneous. The heterogeneity of their social status and social experience is reflected in the varying strictness of the social constraints by which their behaviour is bound. Hence, the very poorest, most destitute women (whom White found were largely excluded from some of the credit programmes she reviewed), become largely freed from the rigours of social norms restricting female behaviour and mobility. Women who are widowed, divorced or deserted and without a kin support network to look after them, i.e., are heads of their households, typify this categorisation of the 'very poorest of the poor', and not only experience much greater physical mobility in public spaces, but also have quite different relationships with men. In a female headed household there is no male to dominate decisions over the use of a loan, or take away financial control from the woman, and there is likely to be less dependence on men's labour to move in public spaces. The woman may well be forced to do all this herself. Hence, the potential economic benefits for a woman not subject to male domination in her household, are much greater than for a woman with a husband, since the former is able to retain direct control over her credit without male interference. The impact of credit can also, therefore, be much more empowering for women in this economic and social category, compared to other women. The findings of Goetz and Sen Gupta discussed previously, which indicated programmes targeting married women so that their husbands could invest the credit, have important implications for female-headed households and access to credit.

I mentioned above that a number of implications resulted from the difference between the officially stated use for a loan and the actual, or intended, use for it. I have discussed the gender dimension of 'diverted' use, but there is also the more practical fact that for many households consumption needs are so acute that all or part of the money is diverted into purchasing food, or used to invest in an essential non-productive item, such as a tin roof for a house (Montgomery et al n.d.:45). Using the loan in this way, of course, means that it is not bringing in any income or

profit, and repayments have to be found from other sources. For the very poorest, this can cause considerable hardship, perhaps even resorting to a local moneylender to repay[15]. It is not only consumptive use that uses up the money in a non-profit making way, such that the loan does not pay for itself. Some income generating activities proposed by women in Muhilar Shasto's groups also took the form of investments without immediate returns, rather than productive 'running' businesses, as Muhilar Shasto intended[16].

For example, a very common suggestion was to buy young livestock in order to sell it a year or so later at a profit. One woman in Muhilar Shasto's Golap *samity* was nominated to receive a loan of Tk1000, with which she intended to buy two young goats. In two years time she planned to sell them for a handsome profit of Tk2000 each. However, this does not constitute a running business bringing in a regular income, so she would have to find the weekly loan repayments from somewhere else. In this instance she hoped to repay the weekly instalments of Tk22 from her husband's labour ploughing other people's fields. The problem with this, however, was that he did not own his own plough and would have to rent one at a cost of Tk40 per day. I was told that you could earn around Tk50 per day from this work, which would leave an income of only Tk10. In addition to this, he had, of course, first to get the initial day's rent from somewhere, and this they said, would come from the crops on their 5 bigha plot of land. They were clearly not the poorest of families and it is questionable why the woman was given one of the first loans, but this aside, if she had been without the asset of land and a varied source of income, she might have found meeting repayments very difficult. In certain instances, drawing weekly repayments from already meagre earnings actually **reduces**, rather than increases the family income, and possibly makes life harder than it already is. This also illustrates that tracing the use and impact of a loan is not a straightforward process.

It might also happen that if a man uses his wife's loan and embarks on a totally new form of income generating, for example, if he has been a day labourer but buys a

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[15] Montgomery et al (n.d.:65-66) conclude that credit can be more of a burden than a benefit to the poorest. In particular, the weekly repayment criteria necessitating a reliable regular income is problematic. They argue that households need to have reached a minimum economic level in order to successfully use loans and maintain a sustainable income.

[16] Montgomery et al (n.d.:64) found that use of loans for 'fixed' investments on livestock was popular because of the relative security (excepting illness) in profit, but that the income was sporadic and low in the short term.

rickshaw and gives up labouring, there is not actually any financial improvement. If the new form of earning is not significantly more profitable than the previous one, it may be that the loan has simply replaced one form of income with another.

It is, therefore, vitally important for women (and men) embarking on income generating activities to have a long-term perspective when thinking about the business they intend to start, and to plan it well so they are aware of possible problems and drawbacks. However, the uncertainty and insecurity of rural life, characterised by the constant threat of natural or economic disaster, prevents most people from being able to adopt such a long-term perspective. The precarious nature of mere existence therefore inhibits a rationale to plan for the financial future, such that training for illiterate women on planning and money management would be very useful, to help them develop in an area where their skills and experience are extremely limited.

CONCLUDING POINTS

The preoccupation with impressive performance indicators, particularly extensive field coverage and high loan repayment rates, demanded by the processes of scaling-up rural development programmes, has, it appears, resulted in a dilution of participatory and empowerment objectives. The quest for target achievement imposed by this expansion process has also caused a new and growing trend of NGO 'encroachment' and competition, with largely negative consequences at grassroots level. Not only does this behaviour contradict the NGO philosophy of coordination and cooperation, leading to bad relations between local organisations, but it has negative effects on the implementation and running of programmes, usually to the detriment of smaller NGOs. The gender implications of this process also require important consideration, particularly regarding the women's empowerment objectives of loan programmes. The greater emphasis placed by field staff and management on credit-worthiness rather than poverty alleviation, means that the very poorest women, i.e., those heading their own household, are seen as high risks and are overlooked. Goetz and Sen Gupta (n.d.:30) go as far as to say that they are discriminated against in favour of married women, because of the greater economic potential of these women's husbands. They suggest that women are targeted with credit because of their effectiveness at repayment and cost-recovery, as opposed to a concern with the quality and meaning of their participation.

From this analysis and the experiences of Muhilar Shasto, the issues to be considered when planning credit programmes for women therefore include the following.

It is essential that the organisation is clear about its objectives in specifically targeting women with credit. Are the objectives generally to raise the economic status of the family, or are there also more specific aims at addressing gender inequalities? When gender objectives are prioritised, it is important to be aware of the extent of local support for this objective. That is, an understanding is needed of whether loan recipients also regard this as one of their own objectives, or whether it is imposed upon them and the programme, by the NGO. If the women themselves don't share the vision of achieving their own economic independence from their husbands, then the development objectives of achieving women's empowerment through credit are limited. Positive changes to their social and economic circumstances will be much slower and more subtle when they are not willing or able to challenge the major constraints currently subordinating them, primarily the dominance of males and pervading gender norms. As I have said, providing credit alone does not automatically change women's access to mechanisms of the local economy, so the potentially positive impact that credit can have, in terms of women's empowerment, can be severely obstructed by male objections, and the prerequisite of their labour for access to the market place. In fact, specifically targeting women with 'empowerment' programmes has been one of the key reasons behind the rise in fundamentalist criticisms of NGOs during 1994, and attacks made on BRAC schools and other NGO prgrammes across the country[17]. Their rationale is that working with women threatens the 'family', i.e., patriarchy, and furthers christianisation.

With regard to the more general objective, Hashemi and Schuler have more positive findings (1992:7):

> Though control of funds by male family members remain and utilisation of loans in activities other than that intended is fairly common, NGO credit has definitely meant less dependence on moneylenders, and in quite a few cases the difference between having food and going without in the lean period.

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[17] This also includes the fundamentalist death threats to the feminist author Taslima Nasrin, for her alleged heretical comments that the Quran needed to be revised.

NGOs therefore need to be aware of the constraints they face when implementing women's credit programmes, and be prepared and able to provide women with the training, support and guidance necessary to enable them to plan and utilise loans effectively. However, my findings and those of Goetz and Sen Gupta (n.d.) and Montgomery et al (n.d.) indicate that it is probably unrealistic to assume that any form of monitoring, training or awareness raising will ensure that credit remains with the women and is not redirected to the uses and pockets of loanees' husbands. It is also likely that under these inevitable circumstances the empowerment objectives of women's credit programmes are overly optimistic; they may, in fact, reinforce or exacerbate existing gender relations. Much greater attention needs to be paid to the social development aspects of credit programmes and constraints which inhibit women's effective use of credit.

CHAPTER 10
DRAWING CONCLUSIONS

In the introduction I explained the difficulty of outlining the subject matter of this thesis, because of its greatly varied nature. For the same reasons, it is difficult to end it with any one major conclusion. I have moved from the specific example of the village and Muhilar Shasto, to the general policy level, trying to show how individuals in different positions in the development 'framework' experience the 'development process'. The focus has mainly been on the perspective of the grassroots, to reflect the experiences of one particular development project and its intended 'beneficiaries'. The restrictions of *purdah* imposed on me as a female researcher, and the fact that Muhilar Shasto's staff are predominantly female, like the targeted beneficiaries of their work, has meant that the perspectives represented are primarily those of women. Even so, the influence and opinions of men have been strongly apparent because of their dominance in the lives of these women. A central theme throughout this study has therefore been that of gender and its significance in the attainment of maternal health care objectives.

The premise in attempting to distribute health resources through a community-based MCH approach is that the benefit to women will be greater, since they will be better able to utilise services and participate in the programme. Specifically focusing on women in this way, however, does not automatically mean that the programme has an implicit gender perspective, and as I have shown, this often leads to failure in recognising constraints imposed by the wider context in which women live. As Kabeer has argued:

> The problem with relying on 'women' as the analytical category for addressing gender inequalities in development was that it led to a focus on women in isolation from the rest of their lives and from the relationships through which such inequalities were perpetuated. The implication was that the problem - and hence the solution - concerned only women (1994:xii).

The tendency to exclude men from MCH-FP programmes clearly demonstrates this, for it fails to acknowledge the nature of power and gender relations within the household. Hence, the centrality of men in decisions which relate to the welfare of

women and the family is overlooked. There is an assumption that, particularly in a *purdah* society, maternal health and reproductive decisions and responsibility are the domain of women and have little to do with men. This places responsibility concerning family planning and contraceptive use squarely onto women's shoulders, failing to recognise that fertility control is not a matter of women's individual choice or to emphasise the joint responsibility of husband and wife. It is essential that priority is given to educating women about choices concerning birth control, and to making contraception easily available. But at the same time, it is an unavoidable fact that many are prevented from making these choices by uncooperative husbands, who are not privy to the same information. Thus, providing women with birth control education empowers them with knowledge but this is not sufficient to combat the constraints of their social circumstances. It is, therefore, important for planners to recognise who has control over women's fertility, i.e., their husbands and in-laws, and to include them actively in family planning programmes.

The impact of other aspects of MCH programmes, such as community-based clinics for antenatal and postnatal care, are also reduced by male reluctance to grant permission for women to attend, for reasons of prestige. Targeting only women with nutrition education fails to reach the men who actually go to market to buy food. Educating women about sanitation is not sufficient to make men change their habits too, or convince them of the need to purchase a slab latrine. They also need to be motivated. Primary health care and MCH objectives are therefore not achieved by ignoring the presence and influence of men.

Some might argue that including men as well as women in health programmes is turning back feminist progress in achieving recognition of women in development. But this is to misunderstand the importance of a gender perspective. It does not mean the denial of women's specific disadvantages and hence the need for specific measures to address them, since it does not necessitate symmetrical treatment for men and women. Like class analyses of rich and poor, the most oppressed can still be prioritised (Kabeer 1994:xii), but in ways which recognise the causes of their oppression and enable these to be challenged. Including men does not jeopardise women's empowerment but assists it. Gender needs to be 'factored into' family planning (Kabeer 1992:18) and MCH programmes. Men need to play a greater and more active role in programmes to improve women's health, which should not be seen as solely the responsibility of women.

This is, of course, easier to say than to actually achieve, for reasons discussed throughout: men are not at home when FHVs visit during the day; cultural norms make it difficult for FHVs to discuss topics like family planning and contraception with men; family welfare is perceived along gender divisions of labour, defining women as the carers and male responsibility as economic rather than social; etc. Muhilar Shasto faced these problems in trying to gain male support and approval but their programme was not really designed appropriately to tackle them. The introduction of village committees was aimed at increasing male awareness and participation but these were held only on a monthly basis, and depended on men voluntarily attending. Such a forum is important for raising community-level awareness and discussion since local opinion manipulates social norms, and these are enforced and sanctioned by village influentials and leaders. Their support is therefore very important.

However, men need also to be involved at the smaller scale, more personal household and group or *para* level. A CONCERN project in north Bangladesh ran health awareness-raising groups for men in the evenings, which received a very good response when started in parallel with women's groups, as part of a wider integrated programme. The ability of Muhilar Shasto's female FHVs to run night groups is hindered by practical and cultural restrictions on their movements after dark. However, organising such groups might be something which male supervisors could do. Like the female village volunteers recruited and trained to act as community representatives, motivators and depot holders of condoms and ORS, it is important that men should also be trained to act as motivators of the male population. In the evenings in Dokanpara many men gathered for several hours to socialise at the little tea shop; such regular meeting places could be appropriate locations for male volunteers to hold formal or informal discussion groups.

Men also gather for Friday prayer at local mosques and this could provide a good opportunity to discuss subjects like family planning with religious leaders. AD-DIN in Jessore, run by a well-respected local Muslim figure, held workshops for religious leaders from the surrounding area as a way of changing conservative local attitudes. The fact that the director was himself a very pious man, helped give legitimacy to the pro-birth control perspective.

The decision-making processes involved in women's health and family planning are, thus, very complex and based on intricate networks of social relations and these have to be understood when determining the appropriate audience for health

education and awareness-raising and the content of the information. The essential thing is that all community members, particularly decision makers and leaders, are aware of the special needs of mothers and children and actively participate in the programme.

Another issue highlighted by the research is the homogeneously narrow focus through which women have been viewed. The traditional approach of MCH programmes is to define women's health needs within a limited agenda concerning their reproductive role as 'mothers', with the emphasis on safe pregnancy and birth. However, other aspects of reproduction are not dealt with, such as infertility - the consequences of which are very significant for a woman's status - reproductory tract infections and sexually transmitted diseases (STDs), most importantly AIDs. In an area so close to the Indian border and only about 60 miles from Calcutta, this is something which should be of grave concern to health programmes in Jessore, and of course all over Bangladesh.

Reproductive health concerns are also not limited to those of reproductive age, they include problems of adolescence and puberty, and menopause. The specific needs of young girls and elderly women are often completely overlooked. They also play important roles in health care and the welfare of the family, e.g., looking after children, cooking and collecting water. Within female hierarchies, elderly women and mothers-in-law wield considerable authority over decisions concerning other women in the household. Without their awareness of the needs of women in their charge, particularly pregnant *bous*, traditional attitudes and personal experiences remain the sole basis of their knowledge and can act against these women's health needs. For example, the preference for a small baby and easy delivery often dictates an inadequate diet and continued heavy work load. Thus, the heterogeneity of women needs to be recognised and specific health services and education targeted at these different groups.

Expanding the health agenda means seeing women not as reproductive beings but as individuals, and hence giving value to the quality of their lives. In this regard the prominence of domestic violence - defined as gender violence by Heise (1993) and Timyan et al (1993) since it is committed against women due to their sex - is of foremost concern. It is an aspect of women's lives across the world and for those in Bangladesh it looms large in their experience of being women. I have commented that during my stay in Shundurgram I was startled by the number of female suicides and attempted suicides I heard about, mostly as final responses to

prolonged abuse and suffering. Similarly, Counts (1987; cited by Heise 1993:174) found that suicide in Oceania was a culturally accepted way for the politically powerless to take revenge against those who had made their lives intolerable, since suicide brought great shame upon the family. Fauvaeu and Blanchet (1989:1124) state that in Bangladesh the underlying causes of violent death in women of reproductive age are social, and that "many of them may be seen as a consequence of the strict control enforced by males over the sexual life of women and reproduction". Stewart (1989; cited by Heise 1993:177) claims that in Bangladesh assassination of wives by husbands accounts for 50% of all murders. This is difficult to substantiate since the large majority of cases go unreported, but is a powerful indicator of the extent of the problem. Another study of rape (Shamim 1985, cited by Heise 1993:177) found that 84% of victims suffered severe injuries, unconsciousness, mental illness or death following the incident, most likely inflicted by the family because of the dishonour that rape and an illegitimate pregnancy brings. Faveau and Blanchet (1989:1125) show that death from such injuries (suicide, homicide, assault and induced abortion) is much greater for unmarried teenage girls than for married, emphasising the intentionality of this violence.

I have shown throughout how the threat of violence affects women's ability to utilise health services and represents a significant factor in their non-use or discontinuance of contraception. I have also shown how it impinges on their participation in women's groups. Gender violence is evidently responsible for a considerable amount of female morbidity and mortality, yet is not given the attention it urgently requires in the health agenda.

In the stark words of Heise (1993:174): "Through both forced suicide and murder, gender violence kills".

Society's tacit acceptance of this needs to be challenged not only through forums such as *samitys*, but at the public level through active campaigns and mass education, denouncing such behaviour and giving value to women and their rights. Violence undermines women's self-worth, reinforcing the societal attitude that they are second class citizens; they need to be instilled with the confidence and self-esteem to challenge these abuses themselves, and be assured of emotional, institutional and legal support from NGOs and official structures, as well as from fellow women.

Muhilar Shasto's *samity* programme had begun to build this sense of confidence amongst members and to change women's perceptions of themselves, through discussions about women's rights. The example of Rogina, the TBA, and her leadership in confronting the abusive husband of a *samity* member demonstrates this. Her involvement with the *samity* and training as a TBA had instilled in her a self-confidence and self-respect which she had not felt before. As Timyan et al (1993:227) argue, lack of knowledge and awareness is linked to women's low self-esteem, and the belief that suffering is a woman's lot. The women amongst whom I lived regarded their constantly tired and physically exhausted state as a taken-for-granted aspect of their life, not worthy of attention. Although taught how to improve their health and that of their children, many women lacked the assertiveness to do so, especially if it meant challenging decisions made by others. It was in instilling the belief that their actions could bring about change, that Muhilar Shasto's *samitys* benefited members most. The groups made women aware that they could make decisions and choices concerning their lives. Despite all the problems the programme experienced, this was a positive step towards achieving the objectives of women's empowerment. I shall reassess these further, below. The link between enhancing women's self-esteem and giving them the confidence to adopt new health practices and concepts is a strong argument for including women's groups and functional education classes in health programmes, and for actively encouraging the general education of girls, to enhance their overall status in society.

In improving the effectiveness and appropriateness of health programmes it is clearly important to understand how the medical premises and concepts upon which they are based relate to local health ideology and practice. In Bangladesh, pervading concepts of traditional health care attribute little significance to the role of modern allopathic health services in maternal care, particularly during antenatal, intrapartum and postnatal periods. Beliefs concerning supernatural forces, balance of body humours and spiritual destiny are important in shaping attitudes and health seeking behaviour. The role of traditional practitioners - *kobiraj* - during these periods is seen as more important since the perceived health threats to mother and child take the form of spirit attack and bodily imbalance, rather than illness treatable by *alopathi oshud* (allopathic medicine).

Ethnophysiological beliefs also shape peoples understanding of how medicines and contraception work inside the body and give meaningful explanations to the occurrence of side-effects. The local system of belief therefore influences the value people place on contraceptive methods and other preventive and curative allopathic

treatment. Hence, it is important that the information provided by health workers and their communication techniques are based on an understanding of local ethnophysiology and perceptions of health and illness, and that explanations of new ideas and concepts utilise these.

The issue of family planning and contraceptive use is highly complex and entwined in the differing objectives of population control, fertility control, reproductive choice and women's empowerment. In rural Bangladesh, poverty and patriarchy play an important role in decisions concerning the practice of birth control. In particular, the economic precariousness of people's lives and the importance of male children as a source of income and support in old age, are motivations for many to have a number of children. At the same time, however, the increasing pressure of poverty due to growing landlessness and lack of alternative economic opportunity, is causing the poor to change their perceptions about the benefits of large families, and think more of limiting the number of children they are able to look after. The relationship between poverty and ideal family size may therefore be changing for some in support of population control objectives, but this should not mask the urgent need to address poverty alleviation and incorporate family planning into a wider, integrated development approach.

The objectives of Muhilar Shasto's programme were therefore to improve women's status and 'empower' them, but what did this mean in terms of women's daily lives? Listening to the conversations and opinions of the women with whom I spent most of my time, I became aware of just how ambiguous and complex this notion of 'empowerment' is. In *samity* meetings Muhilar Shasto's staff spoke of decision-making (*shidhanto*), unity (*unayon*), strength (*shokti*) and change (*poriborton*), and of aspects of personal development; gaining confidence and belief in oneself, overcoming the sense of isolation in ones oppression and being aware of a shared experience with other women and the right to a better life. Kabeer (1994:245) describes this as 'power within'; raising women's consciousness by giving them the opportunity to review their lives from different vantage points, based on reflection, analysis and assessment of what has otherwise been taken-for-granted. Male power is, she argues, exercised through the mobilisation of biased norms, rules and procedures, established by their 'power to' make decisions and 'power over' which issues will be excluded from the 'decisionable' agenda (1994:225). That is, demarcating which aspects of life are flexible and negotiable, and which, such as the household division of labour, are so deeply entrenched in the social order that they appear to be 'naturalized' and are, hence, taken-for-granted.

'Power within' involves understanding how social norms, values and practices can conceal the reality and pervasiveness of male dominance and defuse gender conflict by shaping people's wants, needs and preferences. Thus, women's goals and priorities are shaped in such a way that they accept their role in the existing order either because they can not imagine an alternative, or because they believe it to be divinely ordained (Kabeer 1994:227).

This concept of power and empowerment strikes a strong resonance with my experiences in the village. For example, the saying 'heaven is under a husband's feet'[1] was offered by women in explanation of their submissive relationships. It wasn't that women weren't aware of the circumscribed nature of their lives, but that they took this as given rather than reflecting on why it was this way. Thus, it became clear that their 'empowerment' did not simply involve providing them with the resources of power - good health, education, skills, knowledge or even credit - but far more intangible changes related to their own perceptions of their situation. 'Empowerment' is not something which can be given or done to someone else, it has to come from within people themselves, and this involves 'transforming their consciousness' so that they can 'reinterpret their needs' (Kabeer 1994):

> New forms of consciousness arise out of women's newly acquired access to the intangible resources of analytical skills, social networks, organisational strength, solidarity and sense of not being alone (Kabeer 1994:245-6).

This is the process I observed in Torulata *samity*, once they began discussing issues like domestic violence, women's rights, dowry and so on. When the focus was solely on health issues, members had not discussed the shared nature of their hardship, but when the agenda was widened they began to view their lives from a different perspective which enabled them to see how their apparently individual problems were, in fact, socially constructed and socially shared (Kabeer 1994:245). It was after these discussions that I began to observe a change in their assertiveness and self-esteem and was told, for example, of challenges to husbands for abusive behaviour towards their wives.

The important point which Kabeer (1994:256) vocalises and I was very aware of, is the need for these changes to come from the initiative and priorities of the women themselves, so that the organisation does not remain the agent of change, thus ultimately defying the empowerment objectives. In practical terms, the process of

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[1] Hartmann and Boyce 1983:88 and Gardner 1994:8 also note this saying.

empowerment is extremely slow and cannot be enforced or hurried. The discussions I had with women regarding their intentions for utilising their loans demonstrate this. Muhilar Shasto, like the other NGOs discussed, intended loans to be a vehicle for women's empowerment by providing them with their own financial resources for greater economic independence, but this was not the objective expressed by the women. They did not mention their own personal betterment, but spoke of the family and giving the money to their husbands. The 'empowerment' objective of loans was therefore imposed by the organisation. I have explained how gender relations between women and their husbands impinged on their freedom to decide whether to take a loan and how to use it, and have pessimistically concluded that because of the inevitability of these social constraints, women's control over loans will always be dependent on their relations of power with men. However, had the process of transforming women's consciousness been more mature before they received the loans, they might have formed their priorities differently, based on a new perspective and new assertiveness. They might then have felt a stronger desire to retain control, and been in a more empowered position to do so.

When talking about women's empowerment and enhanced social and economic status, it is therefore important to understand that these may not be objectives immediately prioritised by the women they are aimed at. Feminists and the development forum may perceive a need for women to have greater social and economic control and greater independence from men, but it can not be assumed that these ideals of gender equality and individualism are also shared by village women. It is important to establish at an early stage what such concepts mean in terms of women's own objectives and ideals, since these will be defined by priorities based on the social context of their lives and may be quite different to those of the development organisation. The argument is, therefore, for much greater attention to the social development aspects of women's credit and empowerment strategies and for an emphasis on developing women's 'power within'.

The final conclusion to be drawn from this study concerns the development process itself, and the effects that pressures to expand and scale-up programmes can have on the impact of grassroots development. The preoccupation of BRAC and Grameen Bank with impressive performance indicators, particularly extensive field coverage and high loan repayment rates, provides a warning to all NGOs. The obsession with development of the organisation itself has resulted in dilution of participatory and empowerment objectives and turned the focus away from development of 'others', i.e., women, to development of 'selves'. Thus, the beneficial

impact of their rapidly expanding women's credit programmes has to be questioned and analysed from a gender perspective. Not only does their quest for growth and target achievement cause domestic violence and aggravation in gender relations, and serve to exclude the very poorest and most vulnerable women, but it also leads to a growing trend of NGO 'encroachment' and competition. As I have shown, this has largely negative consequences for the development of smaller NGOs and causes many problems at field level. It is important that the impact of this behaviour is recognised by the NGO superpowers and curtailed, before it has irreversibly negative effects on the valuable work of smaller NGOs like Muhilar Shasto.

The final point to be made is the importance of a more active form of participation in Muhilar Shasto's programme involving different members of the community. Men, women, young and old, religious leaders, influentials, etc., need to have much greater input into deciding the future developments of the programme and in overcoming the problems I have outlined. Many of these result from divergent priorities, due to a lack of shared understanding of the different cultures involved. Their participation needs to be of a nature which treats them as partners of Muhilar Shasto rather than clients.

The main objective of this research has been to study applied anthropology in the context of development, hence the policy-related focus in the conclusions drawn above. However, the material from which these analyses have been drawn also constitutes a contribution towards the general body of ethnographic literature on rural Bangladesh, in particular, local health culture. In this context, the works amongst which this study can best be placed include those by the authors Therese Blanchet, Clarence Maloney, Ashraful Aziz, Profulla Sarker and Sushila Zeitlyn, to whom I have continually referred throughout. All their studies look at local health ideology, particularly reproductive health, and have provided useful comparative sources. Much of the ethnographic detail in this thesis accords with the findings of these studies from different parts of Bangladesh, suggesting a similar rural health culture across the country. Some of these studies have contrasted the differing Hindu and Muslim beliefs and practices (e.g. Blanchet 1984) within this rural world view, whilst others (Maloney, Aziz and Sarker 1981) have focused predominantly on Muslim culture. This has unaviodably been the case here because of the almost exclusively Muslim population in my research village.

The ethnography has looked at popular interpretative understandings of different aspects of 'modern' health care, based on cultural perceptions of health and illness, relating to ethnophysiology, disease causation, concepts of balance, food categorisation, psycho-social wellbeing, and patterns of resort to appropriate care. It has been interesting to observe how these interpretations have fitted allopathic medicine, such as contraception, into the local health ideology, bestowing upon them the intrinsic qualities (usually 'heating') associated with the systems of balance found in Ayurvedic and Unani medicine. Within local health ideology, formed predominantly by the combination of these two medical systems, the action of such medicine on the body can be meaningfully understood.

The intrinsic 'power' of the pill and contraceptive injection gives them excessive heating properties which can lead to seriously detrimental effects on the body, such as drying-up the blood, reducing both its quantity and quality, causing fatigue and weakness, and it is interesting to learn that this is also commonly reported as a negative effect of the pill worldwide (Nichter 1989). This perceived somatic effect can be rectified by ingesting appropriate strength-giving foods and locally available 'tonics' to build the blood back up, but as noted in other parts of the world (Iran [Good 1980] and Sri Lanka [Nichter 1989]), and across Bangladesh (Maloney, Aziz and Sarker 1981), women fear that the long-term effects can cause infertility, drying the womb so that it is no longer able to nourish the male seed. It would therefore be interesting to further examine this, looking at the relationship between these transcultural interpretations of the pill and the similarity in physical side-effects experienced by women across the world, by comparing concepts of ethnophysiology and illness causation. In this way, a greater knowledge could be gained on the cross-cultural understanding of reproductive technology.

Related to this subsuming of allopathic medicine into local health ideology, is the way in which negative effects of some allopathic medicines, e.g., injectable contraceptives, are seen to be mitigated by other allopathic medicines, e.g., the pill, to alleviate culturally perceived potentially dangerous conditions. I am referring here to the culturally perceived dangers of 'closed' menstruation caused by injections, and the way in which the pill is used to bring on menstruation, to rid the body of polluted blood. In this way the 'powers' of allopathic medicine are utilized within the discourse of the ethnomedical system to counteract their own negative effects. Allopathic medicines therefore have their place within local health ideology. The two do not operate only as parallel systems of care but can be selectively utilized within the discourse of one system, to act in complementarity. Another

example of this is during childbirth, when both systems of care are utilized; traditional delivery practices and Cyntocin medicine from the *daktar*, are employed at the same time to induce delivery, to alleviate the culturally perceived danger of a delayed birth. Other conditions, such as spirit possession, are clearly categorised as appropriately treated only by the local health system, but patterns of resort can also utilise the systems in parallel. For example, conditions of severe dehydration, where the reason for the illness may be accounted for in supernatural terms, require *kobiraj* treatment to exorcise a spirit, but the actual symptoms of vomiting and diarrhoea may be seen to be best treated with an allopathic saline injection or drip. There are clearly different levels of perceived causation, which Maloney et al (1981:8) describe as 'ultimate and proximate causation', and correspondingly appropriate care. Thus, they state, "seeking assistance simultaneously through medical, herbal, ritual, and moral means is not irrational" (1981:8). Patterns of resort can therefore be quite complex and constantly in change, as different elements of allopathic medicine and 'modern' health care become interpreted and subsumed within the ethnomedical system.

Another aspect of local ethnophysiology at which this research has looked is that of fecundity and the menstrual cycle. Although there appear to be differing opinions on detail amongst village women, the general notion seems to be one of contradiction with biomedical explanations. This coincides with the opinions given in Maloney et al's study (1981). It would be very insightful to gain further understanding of local concepts of the body, its internal appearance and functions, using different research methods, such as women's expression of these ideas through drawing pictures. Similarly, the concepts of 'baby space' shared with food in the stomach, and separation of menstrual blood and freely circulating blood, appear to contradict biomedical explanations of physiology and it would add to the ethnographic knowledge of local health systems to understand these in more detail.

There is therefore great scope for further analysis of the ethnographic data in this study, and for further research into the areas outlined. However, these unfortunately lie outside the practical and theoretical limits of the main thesis, as has been presented here.

APPENDIX 1
GLOSSARY

abar	father
aiya	cleaner, assistant
alopathi oshud	allopathic medicine
annaprasan	ceremony of first food
anondo	joyous
appa	sister
atur ghor	birth room
azul	withdrawal
bacha	baby
bagan	garden
bahire	outside
baor	lake
baper bari	father's home
bari	homestead, household
bari bandi	house servant
batash	wind
begun	aubergine
beka meyera	unmarried girls
beton	wage
bhabi	sister-in-law
bhaji	fried food
bhalo	good
bhat	cooked rice
bhitore	inside
bhut	spirit, ghost
bideshi	foreigner
bigha	land measurement, 1/3rd of an acre
bish	poison
bondho	closed
bongsho	lineage
bori	pill, tablet
boro bhai	big brother
boro lok	big, important person
bou	bride/wife
buri	old woman
chachi ma	paternal aunt
chakri	job
chal	husked rice
chingri mach	shrimps
chira	crushed rice snack
choto bhai	little brother
dai	traditional birth attendant
daktar	doctor
dami	expensive
dhal	pulses
dhan	unhusked rice

dheki	foot operated wooden device for husking rice
dhoni	rich
dosh	fault
dudh	milk
dudh haga	milk diarrhoea
dupor	midday
fakir	healer
foo	blow
gach	tree
gha	sore
ghor	room
gorboboti ma	pregnant mother
gorib	poor
gorom	hot
gram	village
gushti	patrilineal kin group
ham	measles
hash	duck
hat	bazaar
hollud	turmeric
huzur	religious leader
icha	desire
illich mach	type of fish
istey pordhoti	sterilization
janaja namaj	funeral prayer
jento mach	live fish
jhal	hot, chilli
jiol mach	type of fish
juboti	young girl
kaj	work
kala ma	maternal aunt
kaoa	food
karap	bad
kechuri	rice, vegetables and pulse mixture
khub	very
kina buri	bought pills
kobiraj	traditional herbalist
kola	banana
kolaiy	pulse variety
kom	few
kosu shak	spinach
kota	word
kupothi kaoa	prohibited food
lab	profit, benefit
lal shak	red spinach
lau	marrow
lojja	shame
madrasa	Islamic school
maktab	Islamic primary education
mal	goods
mangsho	meat
manli	amulet, locket
manush	person
mashik	monthly, menstrual blood
mata	head

matobar	leader
maund	measure of weight = 37kg
mauza	village unit
mens	menstruation
mezer bhai	second brother
mishti	sweet, desert
mishti kumra	pumpkin
misri pani	sweetened water
moila	dirty
morgi	chicken
moshjid	mosque
mukhebhat	ceremony of first food
mullah	religious leader
mulo	value
munchi	religious leader
mushari	pulse variety
namaj	pray
napak	ritually polluted
nari	stomach area, womb, reproductive tubes, umbilical cord
narikel	coconut
niom	rule
noshto	spoilt, ruined
notun	new
notun bou	new bride
obesh	habit
orna	scarf
oshanti	unsettled, unhappy
ozu	ritual cleansing
pak	ritually pure
para	neighbourhood
parishad	council
pata kophi	type of vegetable
patla paikhana	diarrhoea
pepe	papaya
pet	stomach
pet bura	herbal contraception
phul	flower, placenta
phul kophi	cauliflower
poishak	leafy vegetable
poribar	family
poriborton	change
pukur	pond
pura pani	sanctified water
purdah	curtain, seclusion
puti mach	type of fish
ragi	angry
Ramadan	Islamic festival
rana ghor	kitchen
rhin	loan
rog	illness
rokto	blood
rosh	juice, date palm juice
samaj	village council
samity	group, association

shabu	ground rice mixture
shada	white
shal dudh	colostrum
shalish	hearing in local council
shashuri	mother-in-law
shasto	health
shere	heal, cure
shezer bhai	third brother
shidhanto	decision
shim	beans
shokal	morning
shokti	strength
shokto	strong
shondhe	sunset
shongsha	nuclear family
shonman	honour
shordi	cold
shorkar	government
shoshur	father-in-law
shukno	dry
shutika	post-partum diarrhoea
simay	sweet wheat flour dish
tabij	amulet
taka	money, national currency
thana	police station, sub-district
thandar	cold
tolpet	stomach area
tut gach	mulberry tree
unayon	unity
upazilar	sub-district
ustey	type of vegetable
zars	wives of brothers

APPENDIX 2
ACRONYMS

ADAB	Association of Development Agencies in Bangladesh
ANC	Ante-Natal Care
APOS	Associate Professional Officer Scheme
BAVS	Bangladesh Association for Voluntary Sterilization
BPHC	Bangladesh Population and Health Consortium
BRAC	Bangladesh Rural Advancement Committee
CDS	Centre for Development Services
CIDA	Canadian International Development Agency
CPR	Contraceptive Prevalence Rate
DANIDA	Danish International Development Agency
EC	Eligible Couples
EPI	Expanded Programme of Immunisation
FDA	Federal Drug Administration
FHV	Family Health Visitor
FIVDB	Friends in Village Development
GAD	Gender and Development
GB	Grameen Bank
GK	Gono Shasthyo Kendro
GSS	Gono Shahajjo Shangstha
GTZ	Technical Cooperation - Federal Republic of Germany
ICDDR,B	International Centre for Diarrhoea Disease Research, Bangladesh
IFAD	International Fund for Agricultural Development
IUD	Intrauterine Device
MCH-FP	Maternal Child Health and Family Planning
MR	Menstrual Regulation
MSS	Manub Sheba Shongsta
MUAC	Middle Upper Arm Circumference
NGO	Non-Government Organisation
ODA	Overseas Development Administration
ORS	Oral Rehydration Solution
PNC	Post-Natal Care
PRA	Participatory Rural Appraisal
SCF	Save the Children Fund
SIDA	Swedish International Development Agency

SPP	Samaj Progoti Parishad
STD	Sexually Transmitted Disease
TBA	Traditional Birth Attendant
UNICEF	United Nations Children Foundation
USA	United States of America
VHSS	Voluntary Health Services Society
WB	World Bank
WHO	World Health Organisation
WID	Women in Development
WIF	Worldview International Foundation

APPENDIX 3

TABLE OF AGRICULTURAL YEAR

Months of the Year			Seasonal Crops						
			Dhan	Dhal	Mustard	Vegs	Turmeric	Jute	Wheat
Season:	*grishshokal*	(summer)							
boishakh		April/May							
joishtho		May/June	*						
Season:	*borshakal*	(rainy)							
asharh		June/July							
srabon		July/August						*	
Season:	*shorutkal*								
bhadro		August/September	(late)						
ashshin		September/October	*						
Season:	*hemontokal*	(autumn)							
kartik		October/November	*	*kolaiy*		*			
oghrohon		November/December	*			*			
Season:	*shitkal*	(winter)							
poush		December/January	*		*	*	*		
magh		January/February				*			
Season:	*boshontokal*	(spring)							
falgun		February/March		*mushari*		*			*
choitro		March/April							

Vegetables: *begun, ustey, shim, lal shak, kosu shak, phul kophi, pata kophi*

APPENDIX 4

SHUNDURGRAM SOCIO-ECONOMIC SURVEY: AUGUST 1992

Total no. households	335	
Total no. tubewells	83	
Total no. pit latrines (with/without ring and slab)	58	
Total no. ponds (with water all year)	6	
Total land ownership (bighas)		
homestead	100	
cultivated	1,529	(4.56 average)
Animal ownership		
ducks	985	
chickens	1675	
cows	795	
goats	609	
Occupation of head of household		
job/salaried	3	
small business	12	
farmer	320	
Schools		
Primary	2	
Secondary	1	
Madrasa	0	
Mosque	3	

1 *bigha* = approx. 1/3 acres

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