

Reproductive Health Practices in Rural Bangladesh: State, Gender and Ethnicity



Runa Laila

REPRODUCTIVE HEALTH PRACTICES IN RURAL
BANGLADESH:
STATE, GENDER AND ETHNICITY

Runa Laila

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Coin on the cover page: This is a Bangladeshi one Taka coin that says: "Bangladesh, Planned Family - Food for All, 1977, 1 Taka".

REPRODUCTIVE HEALTH PRACTICES IN RURAL
BANGLADESH:
STATE, GENDER AND ETHNICITY

REPRODUCTIEVE GEZONDHEID OP HET PLATTELAND IN
BANGLADESH: STAAT, GENDER EN ETNICITEIT

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Dedicated to all women of the Gachhabari village who gave me the opportunity to represent their voices in this thesis.




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Acronyms

AL	Awami League
BARSIK	Bangladesh Resource Centre for Indigenous Knowledge
BIRPERTH	Bangladesh Institute of Research for Promotion of Essential & Reproductive Health and Technologies
BMMS	Bangladesh Maternal Mortality Survey
BMP	Bangladesh Mohila Parishad
BNP	Bangladesh National Party
CHT	Chittagong Hill Tract
CPB	Communist Party of Bangladesh
CPR	Contraceptive Prevalence Rate
D&C	Dilation and Curettage
DAWN	Development Alternatives with Women
DFID	Department for International Development
DG FP	Directorate General of Family Planning
DG HS	Directorate General of Health Services
DSF	Demand-side Financing
EH	Engender Health
ESP	Essential Service Package
EmOC	Emergency Obstetric Care
FWA	Family Welfare Assistants
FWV	Family Welfare Visitors

GA	General Anaesthetics
GAD	Gender and Development
GEM	Gender Empowerment Measure
HA	Health Assistant
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HNPSP	Health, Nutrition and Population Sector Programme
HPNSDP	Health, Population & Nutrition Sector Development Programme
HPSP	Health and Population Sector Programme
HYV	High-Yielding Varieties
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICPD	International Conference on Population and Development
IDA	International Development Agency
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
JI	Jamaat-e-Islami
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCH-FP	Maternal, Child Health -Family Planning
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOHFW	Ministry of health and family welfare
MOHFW	Ministry of Health and Family Welfare

MR	Menstrual Regulation
NIPORT	National Institute of Population Research and Training
NSD	Non-Scalpel vasectomy
PGN	Practical Gender Need
PRA	Participatory Rural Appraisal
PRSP	Poverty Reduction Strategic Paper
PV	Per Vaginal examination
RTI	Reproductive Tract Infections
SAP	Structural Adjustment Programme
SBA	Skilled Birth Attendant
SGN	Strategic Gender Need
SIDA	Swedish International Development Cooperation Agency
SIP	Strategic Investment Plan
SMC	Social Marketing Company
SPSS	Statistical Package for the Social Sciences
SRF	Social Relations Framework
SRHR	Sexual and Reproductive Health and Rights
SSFP	Smiling Sun Franchise Programme
STD	Sexually Transmitted Diseases
SVRS	Sample Vital Registration System
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Tetanus Toxoid
UHC	Upazila Health Complex
UN	United Nations

UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNFPA	United Nations Population Fund/United Nations Fund for Population Activities
UNICEF	The United Nations Children's Fund/ United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WID	Women in Development



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Abstract

This ethnographic study explores an anomaly in the reproductive health situation of poor rural women in Bangladesh, namely the coexistence of significant fertility reduction at the same time as continued high maternal mortality due to dependency on home deliveries in the absence of skilled health professionals and health complications resulting from unsafe abortions. Inspired by the feminist conceptualisation of agency, the study resurrects the importance of considering culture and context in understanding reproductive decisions, as opposed to a rational individualistic notion of agency. Comparison between mainstream patrilineal Bengali and matrilineal-matrilocal indigenous Garos in the same rural location enables the study to demonstrate how complex factors intersect and interact to form gender power structures in shaping reproductive practice.

A combination of the capabilities framework and the social relations framework informed by feminist concepts of gender, agency and empowerment guided the data collection process and analysis of the findings. A village named Gachhabari (Tangail district, Dhaka division), Bangladesh, was purposively selected for its mixed ethnic population of patrilineal Bengali (mainstream Muslims and Hindu minority) and indigenous matrilineal Garo communities. By incorporating women's "voices" articulated through their own narratives, the study aims to show how poor women from different ethnic backgrounds experience and navigate power at the household, community, market and the state level in relation to their reproductive practice.

The study contends that reproductive health policies and discourses are an outcome of existing power structures. Due to donor dependency, national population policies have been articulated in line with the donor discourse. In the mid-1990s the Bangladeshi population policy adopted a comprehensive reproductive health care approach to ensure health equality and reduce the gap between the rich and the poor. However, the findings of the study point to a more nuanced picture. Multiple interest groups and institutional arms of the state exercise forms of covert power via policies, discourses and knowledge produced by disciplinary institutions to govern the reproductive behaviour of the poor.

The depiction of household poverty as a result of higher fertility among the poor, which in turn pushes households to remain in poverty and results in poor reproductive health, interwoven with the national concern about macro-economic development justifies aligning fertility reduction under macro-economic development goals. Knowledge produced by disciplinary institutions that construct a discursive reality of poor women's need for long-acting contraception, fosters the interests of a powerful alliance of service providers, international donor and multinational pharmaceutical companies. By offering long-acting (implant) and permanent contraception (sterilisation) through an Essential Service Package (ESP) under donor supported "safety net programme" in the public health care system to the poor further shapes the reality by shaping reproductive practice.

The ways in which women's subject positions are constructed and normalised in policies and discourses, further explains high maternal mortality resulting from the absence of skilled health professionals during childbirth as "the lack of demand for maternal health care services" by the poor. This depiction of poor women as homogenous and powerless victims of culture justifies female focused Maternal Child Health and Family Planning (MCH-FP) programme to ensure health equality. Such a discourse serves the interest of the health care providers by creating demand and supply of reproductive health care goods and services through dual health care systems, private health care for the well-off and public health care system for the poor. Policy discourse remains silent about how privatisation of health care in combination with market mechanism, class inequality, gender and ethnic differences created existing health inequality.

Despite being critical of the government policy approach, women's organisations realise that the availability of contraception and Menstrual Regulation (MR) services, although inspired by population control motives, could be empowering for women provided that women are not integrated under an oppressive gender system. Women's organisations articulate existing health inequality in relation to women's subordinate position, patriarchal norms and unequal gender power relations. Yet, a major absence in the mainstream women's organisations is the tribal women's voice and in that sense they also treat poor women and their needs as being self-evident and homogenous.

Contrary to the individualistic notion of agency, the study provides insight how a complex interplay between gender, ethnicity and economic forces shape contraception and menstrual regulation/abortion practices. Across all ethnic groups most women take up the contraceptive responsibil-

ity for the greater benefit of the household. A stigma attached to vasectomy and men's role as the breadwinner discourage households to use vasectomy, since households are mainly dependent on men's labour. Men and women both believe vasectomy reduces men's physical power. Although the breadwinners' norm is not equally strong among Garos, they too show reluctance towards vasectomy. A range of concerns including cost, pleasure, safety, gossip, fear of mistrust and rumours create a negative perception towards condoms as expensive, unreliable and inconvenient method of contraception. Ideological restrictions against invasive modern contraception and abortion make Garos more dependent on natural methods and less use of menstrual regulation and abortion services. A more balanced intra-household gender relation is however reflected in proportionately higher condom use among Garos as compared to Bengalis. Older Garo women also showed their agency by using sterilisation, being the only available method in earlier times.

The research findings indicate that the outcome of negotiation does not represent women's autonomous choice, but that notions of masculinity and femininity are linked to different contraceptive methods to make women take on the contraceptive responsibility along with the side effects. This process is reinforced by female focused family planning programmes, which requires minimum involvement from men and further reinforces gender hierarchy by demanding husbands' consent to use MR service.

Women's narratives show they are resilient and deploy resources at their disposal to deal with side-effects of contraception by switching between different methods or sending their husbands to get the pill from private market or to get medicine to treat the symptoms. Women also use existing cultural norms to their advantage to assert their claims to exercise their right to use menstrual regulation services, manoeuvre official rules for the time limit or husbands consent to use menstrual regulation service or use secret abortion practices, although this sometimes puts women's health and well-being at risk. This indicates that even if women are able to negotiate in the household to exercise their choice and agency they face constraints in the health care market. This finding resurrects the importance of looking at gender power relations beyond the boundaries of the household in explaining women's agency in reproductive decisions.

In contrast to the notion of women as ignorant victims of static, rigid cultural norms to explain the low institutional childbirth, the study provided insight how structural factors are enmeshed with cultural factors to render poor women's access to childbirth, after delivery and other reproductive

health care services inaccessible. Women do not mindlessly follow a tradition of home delivery but rather rely on informal Traditional Birth Attendants (TBAs) based on trust, expertise, familiarity, affordability and proximity of the providers. Although cultural norms play a role, hidden cost, doctor's absenteeism and inadequate quality of care in the public hospital remains a constraint on poor women's access to reproductive health care services. Poor women also find it difficult to negotiate between their work responsibilities in the household and outside and biological reproduction in favour of their own wellbeing. This is reflected even in rejecting the option of a Caesarean in a complicated delivery, since it could affect their work capacity. This linkage with women's responsibilities for household reproduction remains largely invisible in policies and discussions in Bangladesh.

The findings of this study suggest that agency in reproductive behaviour is multifaceted. Questioning the conventional indicators of women's empowerment, despite enjoying significant autonomy in terms of intra-household gender relations under the matrilineal system, comparatively higher age at marriage, relatively higher education and no restrictions on mobility, the study found matrilineal Garo women use less contraception, rely on home deliveries and experience higher fertility compared to patrilineal Bengalis. Ethnic differences are not only based on cultural elements, but deeply rooted in the structural system which has far reach political and material implication based on inclusion/exclusion in access to resources in the broader social system. Garo ethnic identity is based on the experience of exclusion from the state authority by banning their traditional livelihood systems, denying access to their ancestral land and forest resources and excluding and marginalising them in forest development projects.

Given that socio-economic and political context, Garo women's choice for relatively high fertility is an outcome of negotiations between their ethnic identity, the desire for daughters to carry on their matrilineal kinship system and the perceived need to increase their numbers due to inter-ethnic tension with dominant Bengalis and political struggle to reclaim their ancestral land. The patronage from the Church which provides security and refuge along with an ideological influence towards larger families contribute to this. Garo women further experience relative economic return from their children due to alternative livelihood opportunities for younger Garo girls and boys created in the NGOs via the Church and other informal sectors. All these contribute to Garo women's practice of raising somewhat larger numbers of living children as compared to their Bengali counterparts.

Interpreting Bengali and Garo women's reproductive decisions as rational individualistic choice detached from the cultural context and existing structures of inequality (as neoliberal policy suggests), ignores the complexities of culturally defined conjugal contracts, differences between patrilineal and matrilineal systems as well as the broader political and socio-economic context which shape gender power relation in reproductive decisions.

*Reproductieve gezondheid op het platteland in Bangladesh:
staat, gender en etniciteit*



Samenvatting

Dit etnografische onderzoek is gericht op een anomalie op het gebied van de reproductieve gezondheid van arme plattelandsvrouwen in Bangladesh: een aanzienlijke fertiliteitsvermindering en tegelijkertijd blijvend hoge moedersterfte door thuisbevallingen zonder de hulp van verloskundigen en complicaties die het gevolg zijn van onveilige abortussen. Geïnspireerd door de feministische opvatting van agency, benadrukt het onderzoek het belang van cultuur en context om beslissingen op het gebied van de reproductieve gezondheid te kunnen begrijpen, in tegenstelling tot een rationele en individualistische opvatting van agency. Door de grootste bevolkingsgroep, de patrilineaire Bengalen, op dezelfde plattelandlocatie te vergelijken met de matrilineaire-matrilokale inheemse Garo, laat het onderzoek zien hoe machtsstructuren op basis van gender ontstaan en in een samenspel van complexe factoren de reproductieve-gezondheidspraktijk bepalen.

Bij de verzameling en analyse van de data is een combinatie van het capaciteitskader en het sociale-relaties-kader gebruikt op basis van feministische opvattingen van gender, agency en empowerment. Het dorp Gachhabari (district Tangail, regio Dhaka) in Bangladesh is gekozen vanwege de etnisch gemengde bevolking bestaande uit patrilineaire Bengalen (meerderheid moslims, minderheid hindoes) en een inheemse matrilineaire Garo-gemeenschap. Door de ‘stemmen’ van de vrouwen, die tot uitdrukking komen in hun eigen verhalen, in het onderzoek op te nemen wordt geprobeerd aan te tonen hoe arme vrouwen uit verschillende etnische groepen omgaan met macht op het niveau van het huishouden, de gemeenschap, de markt en de staat met betrekking tot hun reproductieve gezondheid.

In dit proefschrift wordt betoogd dat het beleid en debat op het gebied van reproductieve gezondheid voortkomen uit bestaande machtsstructuren. Door afhankelijkheid van donoren is het landelijk bevolkingsbeleid in overeenstemming met het discours van de donoren. Midden jaren 90 werd er in de bevolkingspolitiek gekozen voor een allesomvattende benadering van

reproductieve- gezondheidszorg om te zorgen voor gelijkheid op het gebied van gezondheid en de kloof tussen arm en rijk te verkleinen. Uit de resultaten van het onderzoek komt echter een genuanceerder beeld. Verschillende belangengroeperingen en institutionele staatsorganen oefenen achter de schermen macht uit via beleid, debatten en kennis die wordt verzameld door monodisciplinaire instellingen om het reproductieve gedrag van de armen te reguleren.

Het kenschetsen van armoede van huishoudens als een gevolg van grotere vruchtbaarheid van de armen waardoor huishoudens arm blijven en wat tot slechte reproductieve gezondheid leidt, gecombineerd met de nationale preoccupatie met macro-economische ontwikkeling, rechtvaardigt het scharen van vruchtbaarheidsreductie onder macro-economische ontwikkelingsdoelen. Kennis die wordt geproduceerd door monodisciplinaire instellingen die een voorstelling van de realiteit construeren waarin arme vrouwen behoefte hebben aan langwerkende anticonceptie, dient de belangen van een machtige alliantie van dienstverleners, internationale donoren en multinationals in de farmaceutische industrie. Het aanbieden van langwerkende voorbehoedsmiddelen (anticonceptiestafjes) en permanente anticonceptie (sterilisatie) aan de armen door middel van een *Essential Service Package* (ESP) als onderdeel van een door donoren ondersteund 'vangnet-programma' in de openbare gezondheidszorg geeft verder vorm aan de werkelijkheid en de praktijk van reproductieve gezondheid.

Verder verklaart de wijze waarop de positie van de vrouw wordt bepaald en genormaliseerd in beleid en discours dat de hoge moedersterfte door afwezigheid van verloskundigen bij de bevalling wordt toegeschreven aan 'het gebrek aan vraag naar gezondheidszorg voor moeder en kind' onder de armen. Dit beeld van arme vrouwen als homogene groep en machteloze slachtoffers van de cultuur rechtvaardigt het op vrouwen gerichte *Maternal Child Health and Family Planning* (MCH-FP)-programma dat voor gelijkheid in de gezondheidszorg moet zorgen. Een dergelijk discours dient de belangen van zorgverleners door het creëren van vraag en aanbod van goederen en diensten op het gebied van de reproductieve gezondheidszorg door middel van een tweeledig zorgstelsel met particuliere gezondheidszorg voor de welgestelden en openbare gezondheidszorg voor de armen. Dat de bestaande ongelijkheid op het gebied van de gezondheidszorg is ontstaan door privatisering van de gezondheidszorg in combinatie met marktmechanismen, klassenverschillen, gender en etnische verschillen, blijft onbesproken in het beleidsdebat.

Ondanks hun kritiek op het overheidsbeleid leeft bij vrouwenorganisaties het besef dat anticonceptie en menstruatieregulering weliswaar beschikbaar gesteld worden uit het oogpunt van bevolkingspolitiek, maar tegelijkertijd tot empowerment van vrouwen kunnen leiden mits er geen sprake is van een onderdrukkend gendersysteem. Vrouwenorganisaties wijzen erop dat bestaande ongelijkheid op het gebied van de gezondheidszorg te maken heeft met de ondergeschikte positie van vrouwen, patriarchale normen en scheve gendermachtsverhoudingen. In de meeste vrouwenorganisaties wordt de stem van de tribale vrouw echter niet gehoord en in die zin behandelen deze organisaties arme vrouwen en hun behoeften ook als iets vanzelfsprekends en homogeen.

In tegenspraak met de individualistische opvatting van agency blijkt uit het onderzoek dat gender, etniciteit en economische krachten in een complex samenspel de praktijk van anticonceptie, menstruatieregulering en abortus bepalen. In alle etnische groepen zijn het vooral de vrouwen die in het belang van het huishouden de verantwoordelijkheid voor de anticonceptie op zich nemen. Het stigma dat kleeft aan vasectomie en de rol van de man als kostwinner ontmoedigen de toepassing van vasectomie aangezien huishoudens grotendeels afhankelijk zijn van het werk van de man. Zowel mannen als vrouwen geloven dat een vasectomie de fysieke kracht van mannen vermindert. Hoewel de kostwinnersnorm minder sterk leeft onder de Garo, staan zij ook terughoudend tegenover vasectomie. Condooms worden vanwege zorgen over kosten, genot en veiligheid en door roddels, wantrouwen en geruchten beschouwd als een dure, onbetrouwbare en onhandige anticonceptiemethode. Door ideologische bezwaren tegen invasieve moderne anticonceptie en abortus maken de Garo meer gebruik van natuurlijke methoden en minder van menstruatieregulering en abortus. Een evenwichtigere genderverhouding binnen het huishouden komt echter tot uitdrukking in een relatief hoger condoomgebruik onder Garo in vergelijking met Bengalen. Oudere Garo-vrouwen tonen ook agency door gebruik te maken van sterilisatie, wat vroeger de enige beschikbare methode was.

De resultaten van het onderzoek wijzen erop dat het onderhandelingsresultaat geen weerslag is van de autonome keuze van de vrouw, maar dat opvattingen van mannelijkheid en vrouwelijkheid verbonden zijn met verschillende anticonceptiemethoden waardoor vrouwen de verantwoordelijkheid voor anticonceptie op zich nemen en met de bijwerkingen te maken krijgen. Dit proces wordt nog versterkt door op vrouwen gerichte geboortebepalkingsprogramma's die nauwelijks enige betrokkenheid van mannen vergen en die bijdragen aan de genderhiërarchie omdat voor deelname aan het menstruatiereguleringsprogramma de toestemming van de echtgenoot vereist is.

Uit de verhalen van vrouwen blijkt hun veerkracht; ze bestrijden de bijwerkingen van anticonceptie door verschillende methoden af te wisselen of hun echtgenoten te vragen de pil te kopen op de vrije markt of medicijnen te halen om de symptomen te behandelen. Vrouwen maken ook gebruik van bestaande culturele normen om hun recht op menstruatieregulering op te eisen, om officiële regels met betrekking tot de tijdslimiet of vereiste toestemming van hun echtgenoot voor menstruatieregering te omzeilen, of om illegale abortussen te laten uitvoeren, hoewel ze daardoor soms hun gezondheid en welbevinden op het spel zetten. Dit wijst erop dat zelfs wanneer het vrouwen lukt om binnen het huishouden hun eigen keuzes te maken en agency te tonen, ze op beperkingen stuiten binnen de gezondheidszorg. Dit onderstreept dat het belangrijk is om buiten de grenzen van het huishouden te kijken naar de gendermachtsverhoudingen bij het verklaren van agency van vrouwen bij beslissingen op het gebied van de reproductieve gezondheid.

In tegenstelling tot verklaringen van het lage geboortecijfer in gezondheidscentra waarbij vrouwen worden gezien als onwetende slachtoffers van statische, rigide culturele normen, laat dit onderzoek zien dat structurele en culturele factoren ziekenhuisbevallingen en andere vormen reproductieve gezondheidszorg ontoegankelijk maken voor arme vrouwen. Vrouwen houden niet vast aan thuisbevallingen vanwege de traditie, maar maken gebruik van traditionele vroedvrouwen (TBA's) op basis van vertrouwen, deskundigheid, vertrouwdheid, betaalbaarheid en nabijheid van de dienstverleners. Hoewel culturele normen ook een rol spelen, beperken verborgen kosten, absentie van artsen en slechte kwaliteit van de zorg in openbare ziekenhuizen de toegankelijkheid van reproductieve gezondheidszorg voor arme vrouwen. Het is voor arme vrouwen ook moeilijk om hun werk binnen en buiten het huishouden te combineren met hun reproductieve gezondheid. Er zijn zelfs vrouwen die geen keizersnede willen bij een gecompliceerde bevalling omdat ze dan minder inzetbaar zouden zijn op het werk. Dit verband met de reproductieve verantwoordelijkheid van vrouwen binnen het huishouden blijft grotendeels onzichtbaar in het beleid en debat in Bangladesh.

De resultaten van het onderzoek wijzen erop dat er veel kanten zitten aan agency in reproductief gedrag. In tegenspraak met de conventionele indicatoren van empowerment, blijkt uit het onderzoek dat Garo-vrouwen in het matrilineaire systeem weliswaar behoorlijk autonoom zijn binnen het huishouden, relatief later trouwen, hoger opgeleid zijn en niet beperkt worden in hun mobiliteit, maar tegelijkertijd minder gebruikmaken van anticonceptie, vaker thuis bevallen en vruchtbaarder zijn dan patrilineaire Ben-

galen. De etnische verschillen komen niet alleen voort uit culturele factoren, maar zijn diep verankerd in het systeem, wat verstrekkende politieke en materiële implicaties heeft vanwege (het gebrek aan) toegang tot voorzieningen in het bredere sociale stelsel. De etnische identiteit van de Garo is gebaseerd op de ervaring van uitsluiting omdat de staat hun traditionele middelen van bestaan onbereikbaar maakt, hen toegang weigert tot het land en de bosgebieden van hun voorouders en hen uitsluit en marginaliseert bij bosbouwprojecten.

Binnen deze sociaal-economische en politieke context is de relatief hoge vruchtbaarheid van Garo-vrouwen het gevolg van een afweging tussen hun etnische identiteit, de wens om dochters te krijgen om hun matrilineaire verwantschapssysteem voort te zetten en de behoefte om hun bevolkingsgroep uit te breiden vanwege inter-etnische spanningen met de Bengaalse meerderheid en de politieke strijd om het land van hun voorouders. De bescherming door de kerk die een veilig toevluchtsoord biedt en de ideologische voorkeur voor grotere gezinnen komen hier nog bij. Verder bieden Garo-kinderen een economisch voordeel door werkgelegenheid die wordt geschapen door ngo's en via de kerk en andere informele sectoren wordt geboden aan jonge Garo-meisjes en -jongens. Al deze factoren dragen eraan bij dat Garo-vrouwen gemiddeld iets meer levende kinderen hebben dan Bengaalse vrouwen.

Door beslissingen van Bengaalse en Garo-vrouwen op het gebied van hun reproductieve gezondheid te interpreteren als rationele individualistische keuzes los van de culturele context en bestaande ongelijkheidsstructuren (zoals in neoliberaal beleid gebeurt), wordt voorbijgegaan aan de complexiteit van cultureel gedefinieerde huwelijkscontracten, verschillen tussen patrilineaire en matrilineaire systemen en ook aan de bredere politieke en sociaal-economische context. Al deze factoren beïnvloeden de gendermachtsverhoudingen bij beslissingen op het gebied van de reproductieve gezondheid.

1

Introduction

1.1 Women's reproductive health practices in rural Bangladesh

This study adopts a qualitative, intersectional approach to investigate women's reproductive health practices in relation to the unequal gender relations and systematic structures of inequality in rural Bangladesh. Focusing on gendered socio-cultural practices and processes, the study highlights the ways in which state policies, privatisation of health care services, the politics of ethnic identity and intra-household relations in rural Bangladesh impinge on the ways different categories of women can express their agency and abilities to assert their reproductive rights and gain capabilities to ensure their health and wellbeing.

I would like to begin with my personal experience, being born a year before the independence of Bangladesh in 1971. Throughout my childhood, I grew up (like most probably many of the children of my generation) learning that population growth is the main cause of poverty and underdevelopment in Bangladesh. I vividly recall memorising, “*jonoshonkha barey jemetik harey aar khadho utpadon barey ganitik harey*” (population grows geometrically and food production grows arithmetically). The main reasons for population growth, I learned, were son preference, the demand for family labour in a predominantly agriculture dependent country and the lack of urbanisation and modernisation. Later during my bachelor and masters education in Sociology, my academic knowledge regarding the relation between population growth and underdevelopment further elucidated these issues. The implications of population growth were seen not only in terms of more pressure on agricultural land, but also in terms of deforestation, environmental degradation, rural-urban migration, over urbanisation, unemployment and social unrest in the country.

In this historical context, my childhood friend Kabita and I experienced different life trajectories. Due to my father's job in the jute industry, I spent my childhood in a rural setting, where I attended the same school as Kabita, who came from a farmer's family. When I was a teen-

ager, due to my father's new posting, I moved to the capital city of Dhaka. Having the privilege of being born and raised in a middle class educated family, I obtained a university degree and started my career at a public university before getting married and planning to have any children. My childhood friend Kabita however, stayed in the village and was married off right after leaving secondary school at the age of 15. After my university graduation, I went to visit my childhood village and met Kabita. She looked like someone I never knew before. Due to eating "paan" (betel leaf), she looked much older than her actual age with her black spotted teeth. By that time she had become a mother of five children. According to Kabita, she was pressured to bear a son. Although after giving birth to three daughters her fourth child was a son, her fifth daughter was an "accident" (she did not want to bear another child anymore, used birth control pills but forgot to take it regularly). Kabita's situation was not uncommon to many rural Bangladeshi women in the recent past.

The persistent high fertility in Bangladesh in the 1970s and early 1980s had been given competing explanations including the absence of effective forms of family planning, the resilience of pro-natalist values and norms and the existence of material constraints, which led to the reliance on children as economic assets (Kabeer 2001:29). As far as women were concerned, population literature had widely suggested an inverse relationship between female autonomy and fertility, at least when other conditions were favourable (Cain 1993; Amin et al 1994; Balk 1994; Basu 1992; Hashemi et al. 1999). The higher fertility and low contraceptive usage had usually been explained by the low status of women, their lack of access to resources within the household and beyond and their inability to obtain economic security or social acceptance except by bearing many children, particularly sons (Cain et al 1979; Cain 1984; Lindenbaum 1981; Germain 1975; Rahman 1990; Ahmed 1981; Bairagi et al. 1986).

Right after independence, faced with an annual population growth rate of 2.6 per cent, the government of Bangladesh did not wait long to incorporate the family planning programme in the national policy (Mahmud 2003). Recognising population control as a priority concern, the First Five Year Plan (1973-1978) declared that "No civilized measure would be too drastic to keep the population of Bangladesh on the smaller side of 15 crores for the sheer ecological viability of the nation"

(quoted in Demeny 1975: 307). Lowering the birth rate through modern contraceptive supply was the goal of the policy. With support from the World Bank through its International Development Agency (IDA), a large scale service delivery system was created to supply subsidised contraception at the doorstep of the rural population (Demeny 1975). In addition, there was also a motivational change campaign to promote a two-child norm and to legitimise the use of modern contraception (Mahmud 2003). At the same time, traditional methods such as periodical sexual abstinence and withdrawal, which were age-long traditional methods of birth control, were considered ineffective. Therefore any publicity of traditional methods was prohibited in the media (Akhter 2005a).

When the first population policy was unveiled in 1973, there were serious questions about the likelihood of its success. The evidence for the existence of demand for modern contraception was not believed to be sufficient to justify building up a large scale service delivery system anticipating a yet-to-be-proven demand for contraception (Demeny 1975). The motivational change to generate demand was thought to be extremely unlikely to generate behaviour change, in a context where higher fertility was the accepted cultural norm. While several prominent studies have concluded that fertility reduction is not to be anticipated from supply oriented family planning policies, in the mid 1970s, ICDDR,B¹ conducted a pilot project, now known as Matlab model, showing impressive success in fertility decline through a “carefully designed or conscientiously implemented” family planning programme (Phillips 1988). Many elements of the Matlab model have subsequently been incorporated in the government family planning programme (Kabeer 2001) and fertility started to decline since the mid 1980s. Much to everyone’s surprise, the first Demographic and Health Survey conducted in 1993-1994 showed a rapid decline in the Total Fertility Rate (TFR)² from 6.3 to 3.4 between 1975 and 1993-1994 (Mahmud 2003). It has been claimed by some as evidence that the lessons of Matlab had been successfully reproduced at the national level (Kabeer 2001:31). A World Bank publication by Cleland et al. (1994) suggests, “the crucial change that has taken place con-

¹ International Centre for Diarrhoeal Disease Research, Bangladesh.

² The total fertility rate (TFR) is defined as the total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at currently observed Age Specific Fertility Rates (ASFRs) (BDHS 2012: 60).

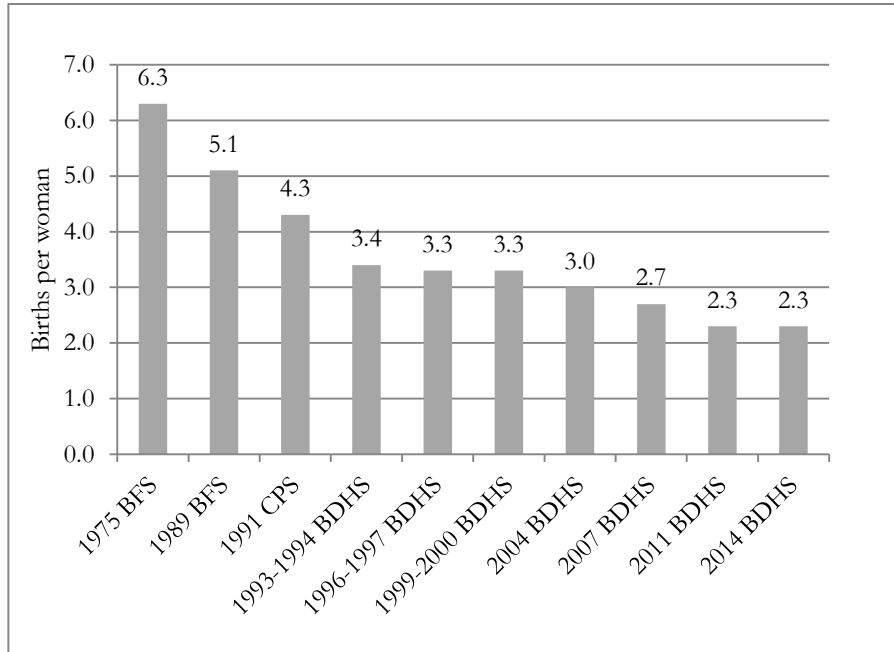
cerns acceptability of and access to birth control and *not* structural change that has driven down the demand for children” (Cleland et al.1994: 134).

Given the long standing interest of the Bangladesh government and external donors, this rapid fertility decline has largely been attributed, firstly to the government family planning programme and the presence of a strong government commitment to reduce population growth (Schuler 1999; Cleland et al 1994; Donovan 1995), secondly to international donors’ support particularly the United States Agency for International Development (USAID) and thirdly to the grassroots based outreach programmes by NGOs (Perry 2005:15; Rohde 2005). However, critics of the family planning programme hold the view that the effects of contraceptive services are a consequence of prior changes in reproductive motives. In this view modern contraception can substitute traditional birth control methods, but it can neither initiate demographic change nor influence reproductive motives (Egero 1998; Caldwell 1999b). Based on demographic surveillance data, Bairagi and others (2001) argued that keeping the desired family size constant, the family planning programme had no major role to play to bring the fertility level down. In the same line Kabeer (1994b, 1999a, 2000) further argued that demand for smaller families is generated by change in the socio-economic context. This leads to differential motives to limit family size in different socio-economic classes.

However, following this rapid fertility decline at the initial stage, the rate of decline slowed down and TFR remained at a plateau at 3.3 since the mid to the end of 1990s. At that stage, many experts argued further decline in fertility required changes in socio-economic conditions which would generate motivational change for further decline in the desire family size (Bairagi 2001).

Irrespective of this debate, following the International Conference on Population and Development in Cairo (ICPD), the government shifted its focus from family planning to a comprehensive reproductive health care approach with emphasis on gender equality and women’s empowerment in its national Health and Population Sector Programme (HPSP) in 1998. After a period of initial stagnation, fertility continued to decline. So far Bangladesh has created almost near universal access to modern contraception with a corresponding TFR decline from 6.3 to 2.3 between 1975 and 2014 (BDHS 2014).

Diagram 1.1
Trends in total fertility rates in Bangladesh 1975-2014



Source: (BDHS 2014:11).

The Bangladesh family planning programme is considered a model for other less developed countries (Bairagi 2001:5). This model suggests that convenient, inexpensive and effective contraceptive services can initiate reproductive change in a poor rural population. According to this model a latent demand exists for effective birth control methods in traditional societies (Cleland et al.1994; Phillips et al. 1988). Therefore, a low cost family planning programme can initiate demand for modern contraception among “couples” in traditional and transitional societies, irrespective of their socio-economic conditions (Phillips et al 1982:137).

Bangladesh is thus seen as an example where fertility change was initiated without significant improvement in socio-economic conditions or standard of living (Adnan 1998; Mahmud 2003; The World Bank 1995). Therefore, Bangladesh departs from the classical demographic transition theory to a diffusion theory which is based on a new understanding of human agency. Where the classical transitional theory relates modern

societies with active agency and traditional societies with passive agency, the diffusion theory assumes that human beings are free to behave rationally in both traditional and modern societies (Carter 1995:55; Schneider and Schneider 1995). Following this theory, the recent fertility decline in transitional societies like Bangladesh is explained by an active concept of agency. As far as women are concerned, declining fertility is associated with improvement in women's status due to increase in education, labour force participation and mobility due to initially NGO-driven micro credit programmes in combination with the easy availability of cheap and effective methods of contraception (The World Bank 2008; Hashemi et al. 1999; Schuler et al. 1997; Planning Commission 2011).

Inspired by feminist scholarship on gendered agency (Evans 2013), this study departs from the standard approaches in explaining fertility reduction where the focus has been given only to the means and goals, ignoring the gendered processes through which fertility has declined. There are three significant aspects and processes that need to be addressed to explain fertility decline among Bangladeshi women:

1. Systematic investigation is needed of the processes through which fertility has declined among women from different socio-economic and ethnic groups. Existing literature shows that in the early 80s a sectoral shift from agriculture to non-farm livelihoods fostered a declining demand for children, particularly among the poor, which was regarded as a cause of rapid fertility decline between 1985 and 1995 (Mahmud 2004). However, it is yet to be examined whether the reduction in fertility has been experienced in the same way among women from different ethnic groups.

2. The use of abortion, as a method of fertility regulation, needs investigation to provide a complete picture of the process through which fertility has declined. Some studies have (Bairagi et al 2001; Haque and Barkat-E-Khuda 1996) indicated that in the absence of effective contraceptive methods, couples rely on induced abortion to obtain their desired family size.

3. The process of fertility decline further requires a more comprehensive gendered analytical approach, taking into account structural and cultural factors. One significant aspect of the fertility decline in Bangladesh is that more than 90 per cent of the contraceptive users are women. In a

Muslim dominated country where the prevailing purdah³ norms keep women outside the power structure (White 1992), the mass use of contraception by women demands an explanation of what changes, if any, have occurred in gender relations (Start 2000).

This study does not intend to discuss fertility reduction as such. It aims instead to broaden the framework of analysis from a narrow focus on fertility to a more comprehensive understanding of women's reproductive health behaviour through real life experiences and variations in rural Bangladesh.

Such a focus is needed since behind the much-applauded statistics of the success in fertility reduction, there are anomalies in other reproductive health components. For instance, in spite of reduction in the Maternal Mortality Ratio (MMR) from 574 per 100,000 live births in 1990 to 194 in 2010 (BDHS 2014), maternal deaths still remain significantly high. The lack of Emergency Obstetric Care (EmOC) during childbirth remains a major cause of such deaths. According to the most recent data, 42 per cent of childbirths are attended by medically trained professionals and the rest are attended by untrained traditional birth attendants and relatives (BDHS 2014). In addition, unsafe abortions remain another significant cause, contributing to 26 per cent of maternal deaths (Rashid et al. 2011).

This raises further issues, going beyond just better provision of services to improving the reproductive health situation of women, requiring an interrogation also of the assumptions and priorities in policies. The study hence takes policy formulation as a part of the problematic, and therefore engages in a critique of macro level policy formulation in the area of reproductive health. Policies are mainly based on macro level quantitative data such as Bangladesh Demographic and Health Survey (BDHS), which do not capture the diversity among women beyond regional and urban rural differences. Feminist scholars (Wilson 2013; Evans 2013; Yuval-Davis 2006) argue that existing health inequality in a society is a result of long term cultural practices, created over time and maintained through different institutional domains. Hence, social norms

³ Purdah can imply a range of practices from covering women's face or head to physical segregation of the sexes, which restricts women's mobility in public spaces. Depending on age, class, religious belief or geography the practice of purdah varies. In Bangladesh, purdah can manifest in three different ways, covering, confinement and personal morality of women (White 2010:322; Hossain and Mashduzzaman 2006a:42).

and values might constrain women's access to reproductive health care services depending on their class, marital status, location and ethnicity, even if services are available. This realisation demands a micro level qualitative study to document the decision making process of individual women regarding their reproductive choices.

In addition, policy interventions are based on a unitary model of the household, where households are seen as a single decision making unit, ignoring intra-household power dynamics. In order to contextualise women's agency, this study sheds light on intra-household power dynamics and its intersection with existing power structures in the market and the community which mediate individual women's access to health care services.

Finally, Bangladesh is not a country consisting of homogenous groups of population. Besides mainstream Bengalis, 1.5 per cent of the total population in Bangladesh are *Adivasi* (indigenous) consisting of 27 different indigenous groups with distinct ethnic, cultural, religious and linguistic background (Minority Rights Group International 2012). Macro data shows disparity in terms of health care access among indigenous groups (Planning Commission 2011:2). To understand the diverse reality of reproductive health experiences of women in Bangladesh, it is important to compare and contrast variations and commonalities between mainstream Bengalis and indigenous ethnic groups.

1.2 Justification of the research problematic

The study is located within current developments and shifts in the ways reproductive health related issues have been addressed in the population and development discourse and policies⁴ since the International Conference on Population and Development (ICPD) in 1994. The way population and development has been conceptualised has underpinned specific population control policies in the recent past. Over the last two decades, it has been realised that "human reproduction" cannot be addressed as a separate entity. It became clear that in the developing countries women's fertility rate will not drop until children survive beyond infancy and young childhood; until men also share reproductive responsibilities; until

⁴ Appendix 1 provides a summary of dominant development discourse and population policies to date.

women have the right to control their own fertility and unless there is a conducive environment to secure that right (Nair et al. 2004:1). The reproductive health status of the present generation has an impact on the health of the next generation, and all these factors are of crucial importance for socio-economic development of a country. This realisation has resulted in the emergence of a multidimensional Sexual and Reproductive Health and Rights (SRHR) approach to address human reproduction. During the World Conference on Human Rights in Vienna in 1993 and the ICPD in Cairo 1994, feminist scholars from the global South and North worked together to replace the old population control paradigm with a broad Sexual and Reproductive Health and Rights (SRHR) approach (Petchesky and Karen 1998). The SRHR approach originated from the idea that women in particular must be able to decide whether, when, and how to have children. The sexual and reproductive health and rights of women are broadly defined as:

Right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence (Nair et al. 2004:3).

To enable women to make informed and autonomous reproductive health decisions this SRHR framework suggests replacing the old welfare approach to improve women's status that advocated female education and employment by broader gender equality and women's empowerment approach (Correa and Reichmann 1994:7).

The International Conference on Population and Development (ICPD) in 1994 is considered a milestone in bringing this SRHR approach into the population and development discourse (Sen et al. 1994). During the conference international commitments were made to establish population policies which will provide reproductive health care services not just family planning. The ICPD Programme of Action defined reproductive health as:

A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. people are able to have a satisfying and safe sex life, that they have the capacity to reproduce and the freedom to decide if, when and how often to do so (Nair et al. 2004:4).

Basic elements of reproductive health include attention to the following: 1) Family planning; 2) Safe motherhood; 3) Safe abortion facilities;

4) Infant and child care; 5) Male participation and responsible behaviour; 6) Adolescent reproductive health; 7) Infertility treatment; 8) Reproductive tract infections (RTI); 9) Sexually transmitted diseases (STDs); 10) HIV/AIDS; 11) Cancers of the reproductive tract and 12) Reproductive health needs of the disabled (UNFPA 2008:6).

However, the incorporation of the reproductive health and rights approach (RHR) in contemporary population policy under the ICPD programme of action has serious conceptual ambiguities and contradictions. The formulation of reproductive health and rights approaches in population policy is a regression from the complex and integrated SRHR approach formulated during the ICPD in 1994 and the fourth World Conference on Women in Beijing in 1995 (UN 1995). In reality, the reproductive health and rights framework continues to explain development as a transition from higher to lower fertility regimes with a neo-Malthusian overtone (Dixon-Mueller 1993a:4; Reddy et al. 2012). Under this framework, women's reproductive rights and empowerment are seen as a pre-requisite to reduce fertility (Smyth 1998:217; Presser 2000). This is a departure from the SRHR approach where gender equality and women's empowerment must be treated as ends in themselves and not merely as means towards the goal of fertility reduction (Petchesky 2003:9).

The incorporation of "right" and "choice" concepts in contemporary population discourse has also been criticised by Southern feminists for its highly westernised and narrow frame of reference. These scholars argue that the conceptualisation of rights and choice in population policies narrowly focuses on fertility control at best and on the single issue of abortion at worst. For example, in the early 1930s the feminist birth control movement that used the term reproductive rights had eugenic premises (Sen et al. 1994:8). Second wave feminists that used the slogan "women's right to choose" with reference to abortion evoked individualistic notions of rights, and had racist and eugenic population control undertones behind "a feminist face" (Akhter 2005a; Hartmann 1995; Sen et al. 1994). Hence, these scholars criticised the narrow notion of rights which are being incorporated in the dominant reproductive health discourse as rhetoric:

Cairo failed to address macro-economic inequities and the inability of prevailing neoliberal, market-oriented approaches to deliver reproductive and sexual health for the vast majority. These failures blocked any real progress

in transforming the reproductive and sexual health and rights agenda from rhetoric into policies and services (Harcourt 2009:50).

Whereas feminists affirm that women's reproductive health choices are determined by a complex interplay between economic forces and its intersection with existing culture and gender systems (Greenhalgh 1995; Harcourt 1997), the contemporary development discourse turns poor women's agency into individualistic strategies of self-improvement detached from the cultural context and structural inequalities (Madhok et al. 2013:5). Population policies remained dependent on the assumption that market strategies are gender-neutral, therefore they do not confront existing structures of inequality. Ultimately women's reproductive health has been subsumed under the neoliberal macro-economic development agenda of trade and economic growth with a market-led health policy logic, that is about creating new areas for investment and expansion of biomedical goods and services, rather than about women's "rights" and "choice" per se. (Bovill 2006; Harcourt 2009:54; Potts et al. 1999; Potts and Walsh 1999).

The current focus on reproductive health and rights does not take into account that many countries have been subject to a "fiscal squeeze", resulting in reductions in expenditures on health, education, welfare and social safety nets which put constraints on women's capabilities and access to resources (UNRISD 2004; Grown 2006; Gideon et al. 2014; Harcourt 2001). In the context of such economic constraints, the "right to choose" makes little sense for women (Menon 1995). In addition, the incorporation of gender in the reproductive health framework not only considers women as reproductive vessels, it is also trapped in a false perception of seeing women as a homogenous group.

Despite these conceptual ambiguities and contradictions, this reproductive health and rights framework was incorporated in the Millennium Development Goals (MDG) during the UN Millennium Summit in September 2000. Although the extent to which national governments adopt the MDG framework and how they are integrated in the national development policies, varies greatly across countries and regions (Reddy and Sen 2012), the MDG framework has been taken by International development agencies to allocate donor aid for development interventions in the underdeveloped countries, including Bangladesh (Kabeer 1994a).

1.2.1 The adoption of MDGs in Bangladesh: current achievements and gaps

As a signatory of the millennium summit, the Bangladesh government incorporated MDGs in its current policy goal. In spite of the commitment of Bangladesh government to provide affordable, assessable and good quality reproductive health care services to all by 2015 (Rashid et al 2011), there is a persistent inequality in reproductive health situations. The following section elaborates on the kind of development interventions initiated by the Bangladesh government focusing on achieving the MDG goal five (to improve maternal health).

Table 1.1
MDG 5: Improve Maternal Health (Targets with indicators)

GOAL	Target	Indicators	Base year 1990	Current status (source)	Target by 2015
Goal 5	5.A. Reduce by three quarters between 1990 and 2015, the Maternal Mortality Ratio (MMR)	5.1 Maternal Mortality Ratio (death per 100,000 live births)	574	194 (BMMS 2010) 209 (SVRS ⁵ 2011) 218 (Sample census, 2011 BBS & UNICEF)	143
Improve Maternal health		5.2 Proportion of births attended by skilled health personnel (%)	5.0	42 (BDHS ⁶ 2014) ⁷ 31.7 (BDHS 2011) 34.4 (UESD ⁸ 2013) 43.5 (MICS ⁹ 2012-2013)	50
	5.B. Achieve by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate (%)	39.7	61.2 (BDHS 2011) 61.8 (MICS 2012-2013) 58.4 (SVRS 2011)	72
		5.4 Adolescent birth rate, (per 1,000 women)	77	118 (BDHS 2011) 59 (SVRS 2010)	-
		5.5 Antenatal care coverage (5.5.a at least one visit and 5.5.b at least four visits) (%)	27.5 & 5.5 (1993-94 BDHS)	67.7 & 25.5 (BDHS 2011)	100 & 50
		5.6 Unmet need for family planning (%)	21.6 (1993-94 BDHS)	13.5 (BDHS 2011) 13.9 (MICS 2012-2013)	7.6

Source: (Planning Commission 2013:62).

⁵ Sample Vital Registration System (SVRS).

⁶ Bangladesh Demographic and Health Survey (BDHS).

⁷ 2014 BDHS data has been added to the MDG progress report published in 2013.

⁸ Utilisation of Essential Service Delivery (UESD).

⁹ Multiple Indicator Cluster Survey (MICS).

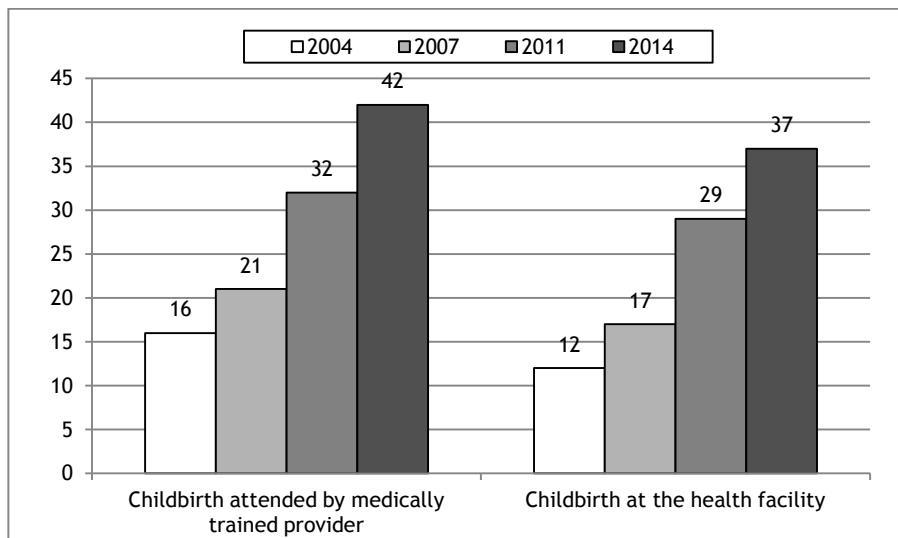
The Bangladesh government adopted a broad-based Health, Nutrition and Population Sector Programme (HNPS) for 2003-2011, in order to improve maternal health and to reduce maternal mortality as part of the commitment to the MDGs. To achieve the MDG Goal 5, emphasis was given to increasing access to obstetrics, prenatal and antenatal services. Table 1.1 shows indicators that have been set to measure the reduction in maternal mortality are (5.1) Maternal mortality ratio and (5.2) proportion of birth attendants by skilled health personnel. The Bangladesh government adjusted its country specific target to reduce the maternal mortality ratio (target 5.A) from 574 deaths per 100,000 live births in 1991 to 143 by 2015 and to increase the proportion of birth attended by skilled health personnel from 5 per cent to 50 per cent between 1991 and 2015.

However, in spite of reductions, maternal mortality still remains high. According to the Bangladesh Maternal Mortality Survey (BMMS), maternal mortality declined from 322 in 2001 to 194 in 2011, a 40 per cent decline in ten years (planning commission 2013; WHO 2012). However, this report further indicated that within the overall 40 per cent decline in the MMR, only 15 per cent decline is due to behavioural change as a result of i) improved access to health care; ii) increase in girl's education and increase in age at marriage; iii) increased awareness among women due to NGO's mobilisation programmes; and iv) improvement in the economic condition (planning commission 2013:59). A major proportion of this reduction in MMR (25 per cent out of 40 per cent) is due to the reduction in fertility rate. The survey indicated that the decline in fertility has a positive implication on the reduction of risks of maternal deaths. Hence, the survey shows that the reduction in maternal deaths does not necessarily indicate improvement in health care access. It should be noted that other surveys found relatively higher mortality during 2001 to 2011.

Moreover, the BMMS 2010 data shows that the maternal mortality due to indirect obstetric causes has somewhat increased, which is related to a lack of access to Emergency Obstetric Care (EmOC) during childbirth. According to the survey Haemorrhage and Eclampsia are the dominant direct obstetric causes of deaths; together they were responsible for more than half of the MMR (Planning Commission 2013:59). These statistics exemplify the significance of ensuring EmOC during childbirth to prevent maternal mortality and morbidities.

However, evidence shows an anomaly between policy priorities and real implementation. In the MDG, the target was to increase the proportion of skilled health providers¹⁰ during childbirth to 50 per cent by 2015. According to the most recent BDHS data the proportion of deliveries by skilled health provider increased from 16 per cent to 42 per cent between in 2004 and 2014 (Diagram 1.2), but didn't reach the 50 per cent target.

Diagram 1.2
Trends in births attended by skilled health attendants & facilities 2004-2014



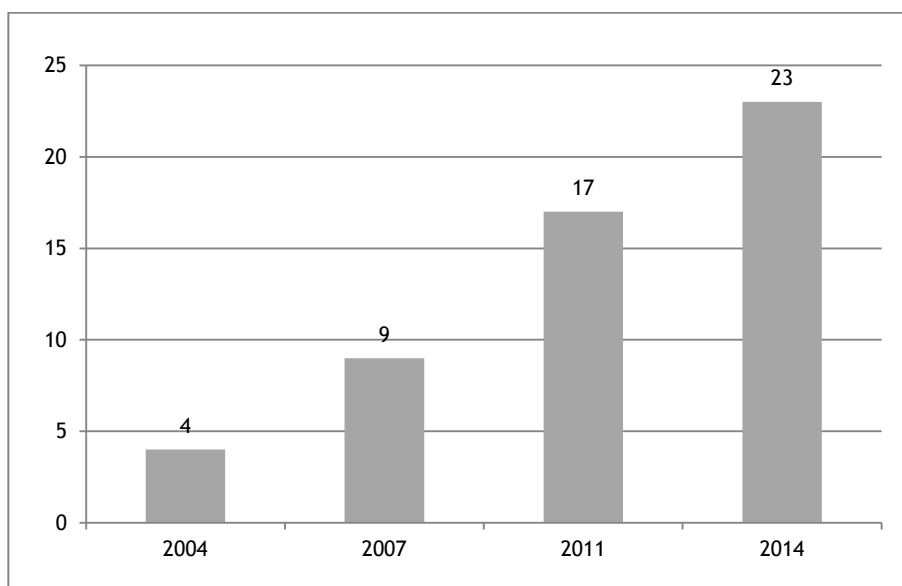
Source: (BDHS 2014:30)

BDHS data (summarised in Diagram 1.2) shows a disparity in terms of access to institutional health care facilities during childbirth. The proportion of births delivered at health facilities has increased from 12 per cent to 37 per cent between in 2004 and 2014. However, 63 per cent of the delivery still occurs at home (BDHS 2014:30), most of which are assisted by untrained Traditional Birth Attendants (TBAs) or relatives in the absence of EmOC.

¹⁰ A qualified doctor, nurse or midwife, family welfare visitor (FWV), or community skilled birth attendant (CSBA)

In addition, there is disparity in terms of access to institutional child-birth across socio-economic groups. According to the most recent BDHS data, 15 per cent of births in the past three years to women in the lowest wealth quintile compared with 70 per cent of births in the highest wealth quintile were delivered in a health facility. This translates to a ratio of about 1 to 5. (BDHS 2014:28).

Diagram 1.3
Trends in births delivered by C-section (percentage) 2004-2014



Source: (BDHS 2014:28)

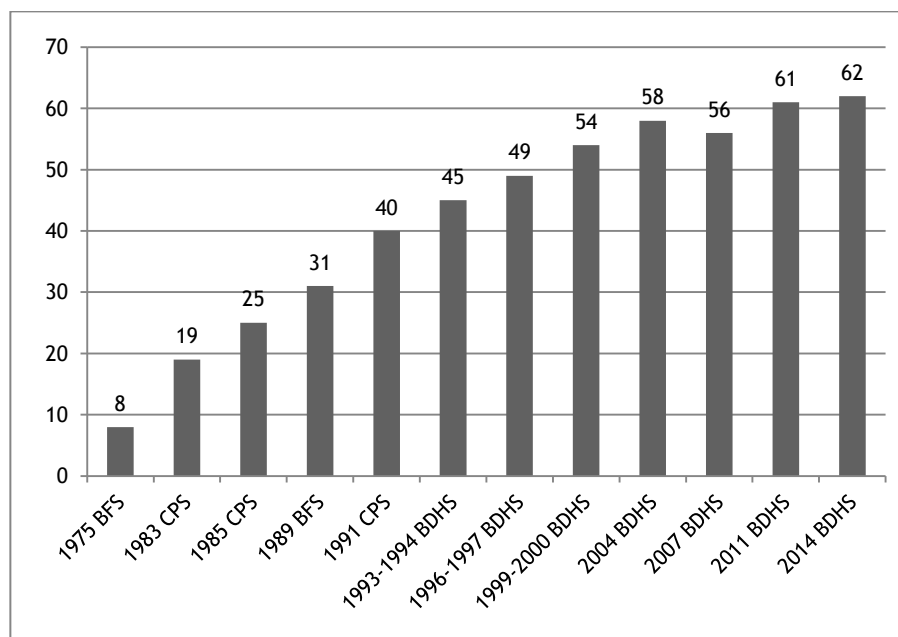
The use of Caesarean section (C-section), which is sometimes considered to be a proxy indicator of women's access to skilled care for complicated deliveries, has increased from 4 per cent in 2004 to 23 per cent in 2014 (Diagram 1.3). Putting the data from Diagram 1.2 and 1.3 together, this implies that six in ten births in a health facility are delivered by C-section. However, there is disparity in terms of access to Caesarean services by location and socio-economic groups. Urban women are twice as likely as rural women to deliver by C-section (38 and 18 per cent, respectively). In addition, half of the births among women who have sec-

ondary or higher education and those who are in the highest wealth quintile are delivered by C-section (BDHS 2014:28). These data are evidence of persistent inequality in health care access during childbirth.

1.2.2 Critical concerns regarding contraception use practice

A major aspect of contraception use practice in Bangladesh is that the great majority of contraception users are women. Since the beginning of the family planning programme, the contraceptive prevalence rate has increased from 8 to 62 per cent between 1975 and 2014 (BDHS 2014) (Diagram 1.4). Although contraception is offered to “couples”, more than 90 per cent of the contraceptive users are women (BDHS 2012).

Diagram 1.4
Trends in contraception use among currently married women (Percentage), 1975-2014

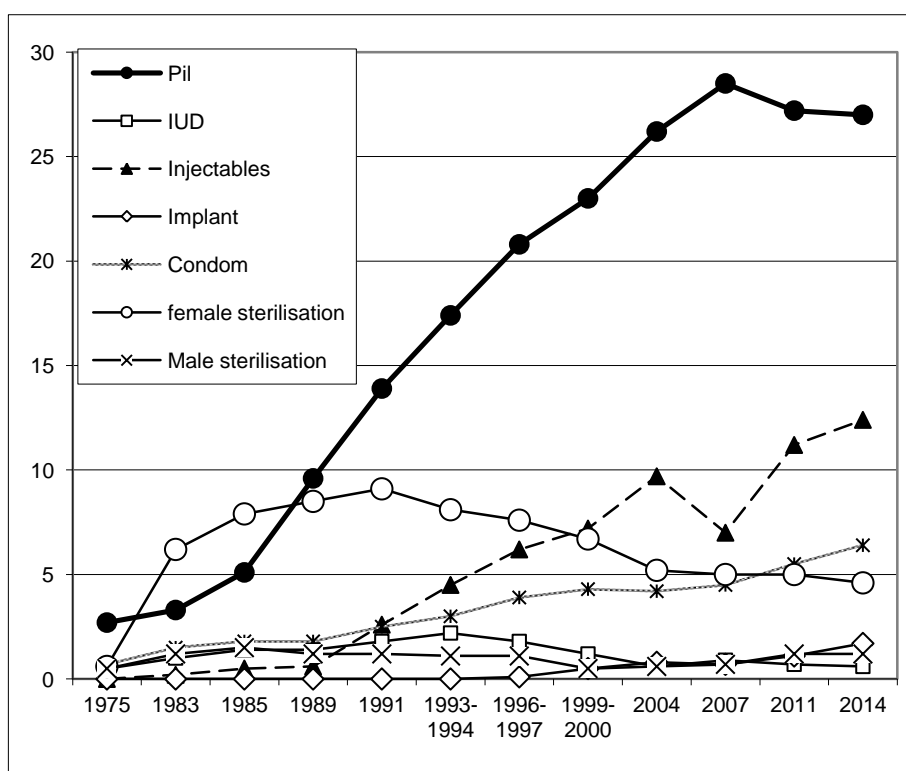


Source: BDHS 2014:17

According to the most recent BDHS data, among the users, the Pill is the most popular method (27 per cent), followed by injectables (12 per

cent). The use of male dependent method is significantly low. While Female sterilisation is 5 per cent, male sterilisation is only 1 per cent and condom use is 6 per cent (BDHS 2014:16) (Graph 1.1). Women thus bear a disproportionate share of the costs of using modern contraception (Mahmud 2004).

Graph 1.1
Trends in contraceptive method use in Bangladesh 1975-2014



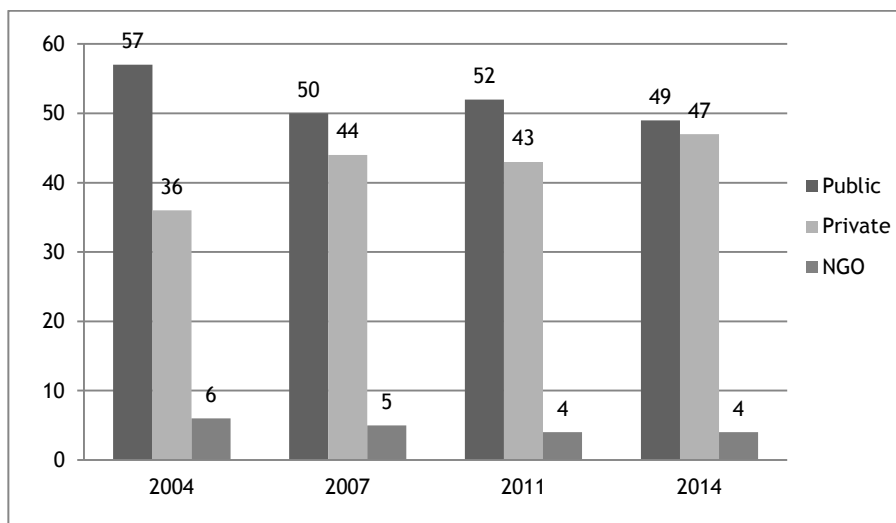
Source: Author generated from (BDHS 2014:14).

Actually, before independence, in the 1960s, sterilisation was geared towards men, because female sterilisation required a lot of skilled personnel. Later in India a parliament fell due to protests against male sterilisation (Kabeer 1994b). In fear of this happening in Bangladesh, the government shifted the promotion towards female sterilisation. Nowa-

days, the non-scalpel vasectomy (NSD) is easier and the safest method and is available everywhere in the country. However, by only making the service available, without encouraging men to use it, the share of male sterilisation remained stagnant at the 1970s level.

This bias is reflected also in the recruitment, from 1973 onwards, of 100 per cent female fieldworkers to motivate “couples” to use contraception. Culturally these female field workers were not expected to discuss family planning matters with men. In reality, the intention of the family planning programme was precisely to target women to change their mind set towards modern contraception.

Diagram 1.5
Source of supply of contraceptive methods 2004-2014.

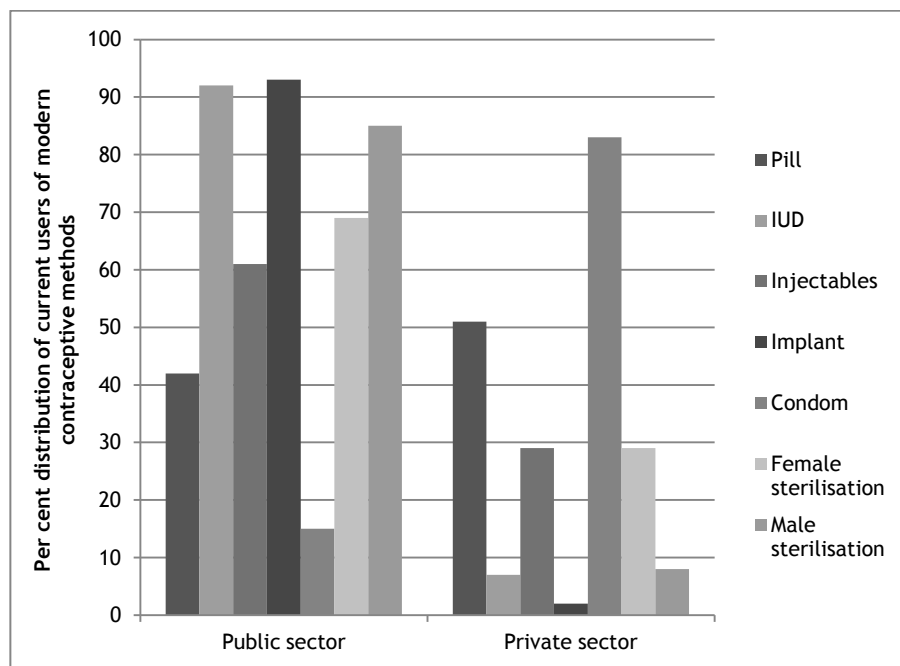


Source: Author generated from (BDHS 2014:20).

Diagram 1.5 shows a shift in contraceptive market from the public to the private sector. Although the public sector is still the most prominent source of contraceptive supply, the share of public sector in contraceptive supply reduced from 57 per cent in 2004 to 49 per cent in 2014 (BDHS 2014:20). Over the years the private sector has become a major player to supply modern contraception in the market. The share of the private sector as a source of contraceptive supply has increased from 36

per cent in 2004 to 47 per cent in 2014. This data shows increasing reliance on the market for contraceptive supply over the years.

Diagram 1.6
Source of supply of contraceptive methods by sector and type 2014



Source: Generated by the author based on (BDHS 2014:19)

A closer look at the BDHS data further reveals that public and private health care sector don't offer the same type of contraception. The public sector is the predominant source of long-acting methods such as IUD (92 per cent), injectables (61), implant (93 per cent), female sterilisation (69 per cent) and male sterilisation (85 per cent). The private sector is the predominant source of supply of the Pill (51 per cent) and condoms (83 per cent) (Diagram 1.6).

The data discussed above suggest that despite success in achieving almost universal access to contraception, the poor's reliance on the contraception supplied by the public sector means that they are largely dependent on long-acting contraception.

Not surprisingly, the data show disparities in methods used by women from different socio-economic groups. After oral pills, rural women are more likely to use injectables while urban couples use condoms. In addition, the poor and less educated women are more likely to use injectables compared to non-poor and higher educated women, while the reverse is true for condoms (BHW 2008; BDHS 2014:15). Methods requiring male participation are much more likely to be used by well-off and educated women compared to non-educated women. Women with no or lower education are also more likely to use sterilisation than educated women. Poor women are more likely to rely on unreliable traditional methods (BHW 2008). This situation further demands attention to look into the use of Menstrual Regulation (MR) and abortions to regulate poor women's fertility.

1.2.3 Abortions/Menstrual regulation as a means for fertility reduction

The approach to abortion in Bangladesh is an interesting example of restrictive laws circumvented by tactful programme planning. Under the British Colonial Law Penal code of 1860, which is still operational in Bangladesh, abortion, self-induced or otherwise is a criminal offence, punishable by imprisonment or fines (Blanchet 1992; Akhter 2000). The only exception is to save the life of the mother. After the Liberation war in 1971, the abortion law was waived for women who were raped during the liberation war (Akhter 2000). Since abortion was illegal, the term Menstrual Regulation (MR) was used by the policy makers, which was considered socially acceptable to get rid of the foetus due to rape during war (Caldwell et al. 1999a).

Later in 1974, the Bangladesh government integrated Menstrual Regulation (MR) services as “an interim method of establishing non-pregnancy” in a few isolated family planning clinics as a public health measure because of high rates of hospitalisation due to complications from induced abortions (Dixon-Mueller 1988; Obaidullah 1996). In 1979, the government incorporated MR in the National Family Planning Programme and free MR services were made available in all government hospitals and in health and family planning complexes (Akhter 1996a; Akhter and Rider 1996).

The Health and Population Sectoral Program (HPSP) for 1998 to 2003 has incorporated MR as one of its reproductive health care pack-

ages. However the MR service remained under the jurisdiction of the directorate of family planning division, and not as a part of the mainstream health care service delivery system. Though MR policy has been incorporated in the family planning policy since 1979, the service is not provided widely (Akhter 2001; Akhter 1996b).

MR is also done in an ambiguous way. It is done for “establishing non-pregnancy” no matter if the woman is pregnant or not. Therefore, pregnancy test is not required. However, the service is only provided to the married women and requires consent from their husbands. Moreover, MR related information is not well disseminated to the population because of the fear of backlash. (Akhter 2001; Amin and Hossain 1995).

Though a difference has been made between MR and abortion in the policy, it is difficult to make a distinction between these two in practice. MR can be performed during the pregnancy up to 8 weeks from the last menstruation period (Akhter 2000) by a paramedics and 10 weeks by a physician. However, the providers sometimes perform the procedures beyond the permitted duration of gestation (Obaidullah 1996; Akhter et al. 1996b; Blanchet and Fauveau 1992; Begum and Jalil 1996). In the absence of a pregnancy test there is an obvious chance to misclassify the duration of pregnancy. Unnecessary health hazards can arise in the case of women with matured pregnancy or women who were not pregnant at all. No systematic research has been done to investigate the impact of legalisation of MR to reduce the number of unsafe abortions.

In 1998 the government incorporated MR in the “essential service package” (Chowdhury and Moni 2004), however in assessing the MDG goals there is no discussion about the number of abortions. Given its illegality there is limited information available on the number of actual abortions in Bangladesh. According to one estimate 653,100 abortions using Menstrual Regulation (MR) provision and 646,600 induced abortions were performed in Bangladesh in 2010, the majority of which were unsafe (Hossain et al. 2012). Another research estimates that unsafe abortion contributes to 26 per cent of all maternal deaths (Rashid et al 2011:21).

A decade long development initiative focused only on MDGs can't explain these anomalies in the reproductive health situation of Bangladeshi women. In this study the links between unsafe abortion and a systematic result of lack of access to MR/legal abortion facilities is explored through the narratives of rural women.

Taking a bottom up intersectional approach this study attempts to understand women's reproductive health experiences at the receiving end of policy intervention. Through capturing voices of individual woman, articulated through their own narratives, this study intends to show how individual women from different socio-economic and ethnic backgrounds are constantly engaged in a process of negotiation in the household, the community, the market and the state level in relation to their reproductive practices.

Taking gender as an organising principle of reproductive life, this study aims to illustrate how both men and women give meaning to their reproductive health practices and participate in the reproduction and contestation of prevailing cultural norms, looking at four interrelated elements of reproductive life: childbirth, use of contraception, MR/abortion and fertility behaviour.

While there are multiple axes of power relations that may shape women's reproductive decision, I take gender as cross-cutting with other dimensions of power such as class and ethnicity. By comparing the real life experiences of mainstream Bengali and indigenous Garo women, this study hopes to provide insight how complex factors intersect and interact to form gender power relations and shape reproductive practices in rural Bangladesh.

1.3 Research Objectives

The main goal of this study is to gain understanding about the anomaly in the reproduction health situation of rural Bangladeshi women in relation to significant fertility decline (which is considered a family planning success story), yet persistent high maternal mortality due to the lack of access to health care services during childbirth and fatal problems arising from abortion complications (although MR has been made legal up to 12 weeks of pregnancy). In doing so, the study goes beyond the surface of success stories and looks into the gendered processes and negotiations in reproductive practice. One anomaly in the success story which doesn't fit the rhetoric is that fertility among tribal population didn't decline in the same way as in the mainstream Bengali population.

Likewise the study aims to go beyond the problems associated with health care access or problem in policy implementation to reach rural

poor and/or tribal women, but to unravel underlying assumptions, silences and hidden areas which are not fully addressed in the policy.

By uncovering the multiple experiences of women, which challenges the notion of homogeneous women, the study aims to contribute to the existing gap in the policy to ensure reproductive health and wellbeing of women. Knowledge produced through this study seeks to contribute to the literature on how the cultural construction of masculinity and femininity come to interplay not only with other structures of power relations such as class and ethnicity, but also the ways in which subject positions are constructed in the policy, in shaping reproductive practice.

1.4 Research Questions

To achieve the aforementioned research objectives, the study explores the following research questions:

1. How are reproductive health and gender equality framed, defined and interpreted in the population/reproductive health policy?
2. In what way do gendered and ethnic power relations shape women's reproductive practices and processes of negotiation?
3. In what way does the socio-economic and cultural setting shape reproductive health practices of women from different ethnic/socio-economic backgrounds?

These questions will be explored through research at the level of three interlinked institutions: the household, the community, and the state.

1.5 Organisation of the dissertation

This Chapter has introduced the study, indicating its importance and introducing its research objective and research questions. Chapter Two describes the theoretical framework and methodology followed to guide this ethnographic study. Chapter Three addresses the first research question. This chapter investigates underlying assumptions and silence areas in the policy. It analyses how reproductive health and gender equality have been framed, defined and interpreted in the policy and in policy discussions. Chapter Four provides a description of the study village of Gachhabari, its socio-economic and ethnic composition, as well as that of the health care providers in and around the village.

Chapter Five addresses the second research question. This chapter illustrates how the complex interplay between gender, ethnicity and economic factors shape women's use of contraception, MR and abortion practices. The chapter highlights how notions of masculinity and femininity are linked to contraception practice, which places the contraceptive responsibility and risks on women.

Chapter Six addresses the third research question, delineating the socio-cultural and economic setting that shape poor women's access to public hospitals during pregnancy, delivery and reproductive health care need. It highlights poor women's dependency on home delivery and informal health care providers during childbirth and other reproductive health problems in the absence of affordable and adequate formal health care services.

Chapter Seven goes further to address a new puzzle that has emerged from the analysis. By focusing on Garos, this chapter illustrates how minority ethnic identity, desire to have daughters to carry on matrilineal system, inter-ethnic tension with mainstream Bengalis and political struggle to reclaim their ancestral land, ideological belief and relative economic return from children shape Garo women's preference for higher fertility. The chapter thus illustrates how complex factors interact, influence and inform each other to shape gender power structure in reproductive practice.

Chapter Eight highlights the main findings drawn from women's reproductive health practices and indicates issues for future research.

2

Analytical framework and research methodology

2.1 Introduction

The introductory chapter discussed the conceptual contradictions and ambiguities in the incorporation of reproductive health and gender equality in contemporary population and development discourses that inform population policy. To frame the examination of reproductive health practices and processes of negotiation of rural Bangladeshi women, in this chapter I put forward a conceptual analytical framework which incorporates and combines the capabilities and social relations frameworks. I also introduce the methodological steps taken to guide the empirical work.

2.2 Integrating the capabilities and social relations frameworks

The capabilities approach developed by Sen provides a powerful broader framework to re-conceptualise women's reproductive health and wellbeing in contemporary population and development discourse, if it is also informed by key concepts in feminist analysis.

The capabilities approach evaluates policies according to their impact on people's lives. This approach covers the full range of dimensions of human wellbeing. It asks whether the resources necessary to exercise people's capabilities are available to them. According to this framework, individual capabilities are transformed by so-called "social arrangements" which either support or deny their capabilities. This framework identifies disaggregated household interests and the different power positions of various members in the household and describes an ideology of altruism in combination with the lack of perception of personal interest and a great concern for family welfare as a reason for existing health inequality (Sen 1991).

After Sen, Nussbaum further developed the capabilities framework with a particular focus on women's capabilities in developing countries. Nussbaum introduced capabilities in plural and made a distinction between "basic capabilities" (innate from birth), "internal capabilities"

(state of a person) and “combined capabilities” (an appropriate political, economic and social environment) (DeJong 2006). Nussbaum gave a list of indicators to compare the quality of life across societies beyond the distribution of wealth and income. For example life expectancy, infant mortality, educational opportunities, access to health care, land rights and political liberties (Nussbaum 2000a; Nussbaum et al. 1993). Acknowledging that existing value systems are highly paternalistic towards women, Nussbaum proposed a set of cross-cultural norms based on legal systems like CEDAW, and covering broadly shared human activities irrespective of time, space and culture. This framework provides citizens with justification and arguments to demand resources from their governments (Nussbaum 2000b:239). The capabilities framework thus enables policy makers to set forth a rationale for spending unequal amounts of money on the disadvantaged groups (Evans et al. 2001).

Given the differences between Sen and Nussbaum’s approach to capabilities, where Sen focuses on the role of policy and public action and Nussbaum on legal constitutions (Gasper and Staveren 2002) based on an ethos of justice (Gasper 2014; Elson 2002), my research adopts the broader notion of capability developed by Sen, and its incorporation of unequal gender relations in the family and the society in explaining existing inequality (Sen 1995; Robeyns and Humphries 2003; Alkire 2002). One major theoretical contribution of Sen’s capabilities approach relevant to my research is the distinction between capabilities and functioning. The capabilities framework expresses the concern that positive trends in female capabilities do not always translate automatically into greater opportunities for women. A distinction between “functioning” and “capabilities” thus helps us to understand the nature and role of the “social arrangements” in translating women’s capabilities into functioning¹¹.

Another significant relevance of the capabilities approach to my study is the distinction between “wellbeing” and “agency”. Sen argues that wellbeing achievements should be measured in functioning. If we add

¹¹ Functioning refers to the “beings and doings” of a person, the set of things that she/he is and does in life. Functioning is therefore directly related to living conditions, an achievement. Whereas capability is merely the ability to achieve, the real opportunities one may have regarding the life s/he may lead (Sen 1987:36). Thus, capabilities are the various combinations of opportunities one may have in life (Robeyns and Humphries 2003:11).

the outcomes of living conditions or achievements, we measure wellbeing, whereas agency is reflected by a person's capability set (Sen 1994).

Despite the positive contribution of Sen's capabilities framework, there are certain conceptual limitations. This framework doesn't challenge existing "social arrangements", but suggests affirmative action by the benevolent state to ensure gender equality and wellbeing of women (Gasper et al. 2002; Truong 2006).

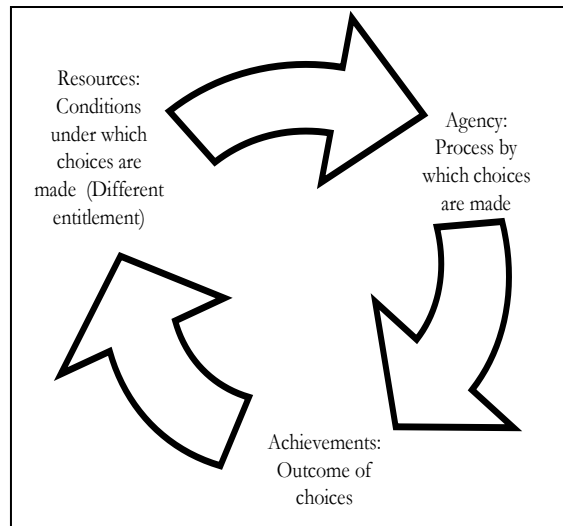
Some scholars argue that the capabilities framework resonates with the neoliberal formulation of agency and either explicitly or inadvertently reinstates liberal assumption of rational individual exercising "free will" and maximising self-interest, albeit within the material constraints (Wilson 2013:85). Such formulations of agency have a tendency to shift focus away from any systematic analysis of gender relations and structural inequality (Wilson 2013:86), which mediate individual women's capabilities into functioning.

To overcome this limitation, my research combines the capabilities approach with the Social Relations Framework (SRF) for its analysis of gender relations in determining the access to and distribution of resources.

According to the SRF, resources are distributed through an "implicit contract" which spells out the claims, rights and obligations of different members to each other which are backed by the norms and rules of the wider society. Taking a dynamic view of gender relations, SRF recognises the conflicting and collaborative aspects of gender relations involving men and women in a constant process of bargaining and negotiation in determining access to and distribution of resources. The outcome of the bargaining will favour the member or members with the largest bargaining power (Kabeer 1999:27).

The centrality of the power dimension of gender relations brings the importance of women's empowerment to the forefront in the SRF approach. Kabeer (1999b) mentioned three inter related dimensions to women's empowerment process: a) Resources: Conditions under which choices are made; b) Agency: Process by which choices are made; and c) Achievements: Outcome of choices (Figure 2.1).

Figure 2.1
Dynamics of empowerment



Source: (Kabeer 1999b:20)

Such a formulation of empowerment helps to make a conceptual distinction between agency and empowerment. According to Kabeer agency refers to the “operationalisation of choice” and there is nothing inherently empowering about the exercise of agency (Kabeer 2011, Wilson 2013). In this study, I take the definition of agency, as:

A reflexive monitoring and rationalization of a continuous flow of conduct, in which practice is constituted in dialectical relation between persons acting and the setting of their activities. In this way both cultural concepts - the values assigned to different behaviours and political economy - the forces creating the setting - become ingredients to, rather than external to, action, and the human agent is placed centre stage (Greenhalgh 1995:19).

This way of defining agency suggests considering culture as a social construct which is constantly under the process of reproduction, negotiation and change. According to feminist scholars, agency can't be determined by looking at the outcome of choices but must instead focus on the process of decision making in everyday practices (Madhok 2013:104). Agency is always exerted in a particular context and within

structures of constraint. This structural constraint is a result of long lasting engagements and negotiations of existing social arrangements (Evans 2013, Yuval-Davis 2006). Therefore, agency is always culture and context specific.

According to Kabeer, for agency to be empowering, it needs to challenge or transform existing inequality rather than reproducing it (Kabeer 2010). I adopt the definition of Kabeer (1999b:437), where “empowerment is the expansion in people’s ability to make strategic life choices in a context where these abilities were previously denied to them”. Thus, empowerment implies a choice made from the vantage point of real alternatives.

The concept of empowerment that has been used within the liberal policy framework is somewhat different. The assumption that no inherent conflict of interest can arise during the process of people gaining empowerment has been a cornerstone of the “equal opportunity” policy in both formal institutes and voluntary sectors (Yuval-Davis 1994). The underlying assumption of such policy is “a non-problematic transition from individual to collective power as if it is always possible for some people to take more control over their lives without sometimes having negative consequences on the lives of others” (Yuval-Davis 1994: 181). Policy based on such assumptions hides internal power differences within social categories.

Discussions of agency and empowerment have to be addressed through an intersectional lens. Although the term “intersectionality” was first introduced by Crenshaw (1997, 1989) to denote the various ways in which race and gender interact to shape the mutual dimensions of Black women’s empowerment, feminist scholars from the South have long argued the internal complex structure of gender which cross-cuts other structures of inequality such as class, race and ethnicity (Miller and Razavi 1998; Yuval-Davis 2006). It also interacts with nationality and global world order (Connell and Messerschmidt 2005:849). Therefore, women’s empowerment strategies must recognise women’s unequal position based on gender and its intersection with other structures of power including the national and the global power structure (Antrobus 2002; Parpart 2010).

A missing aspect in the SRF is the concept of masculinity. Connell introduces a threefold model of the structure of gender relations incorporating i) power (cultural dominance of men and subordination of women

ii) production (based on gender divisions of labour and iii) cathexis (emotional attachment) (Connell 1995:73-74). In Connell's view the main grid that connects these three aspects is masculinity.

Connell's work is useful since it shows how masculinity is not a fixed set of biological determinant or personality trait of individuals, but rather a range of popular ideologies of what constitute ideal or actual characteristics of "being a man" (Connell and Messerschmidt 2005:848). Masculinity is hence a relational concept always constructed in comparison with some notion of femininity. Gender regimes, in Connell's view are the state of play in gender relations in a given institution in a particular cultural context, in a particular point in time (Connell 1987:120).

To understand and explore the complex factors that intersect and interact with each other to form the gender power structure that shape reproductive health practice of rural Bangladeshi women this analytical framework highlights three institutions; the household, the community and the state. Each of these institutions constitutes various types of gender regimes.

2.2.1 The Household

The household is an important concept in my analytical framework not only as a site for reproduction and contestation of gendered identities and conflict of interest but also because of the differing policy consequences implicit in varying conceptualisations of the household. The early unitary conceptualisation of the household as a site for altruistic distribution of resources has been challenged by the feminist scholars that define the household as a complex and deeply contested space (Agarwal 1997; Kandiyoti 1998). In this study I adopt the definition of the household as:

A site of competing interests, rights, obligations and resources, where household members are often involved in bargaining, negotiation and possibly even conflict (Moore 1994:139).

The outcome of bargaining and negotiation determines who does what, who gets what and how each member is treated (Agarwal 1997). A bargaining model thus argues that household members co-operate because co-operation makes them better off than non-cooperation (Sen 1993). Sen (1993) highlighted a) endowment (what a person owns, such as assets and labour), and b) exchange of entitlement possibilities (to use

these entitlements) in explaining bargaining power. However, Sen's bargaining model has been criticised for placing too much emphasis on income/lack of waged work, as being sufficient basis for bargaining.

To determine access to and distribution of resources, feminist analysis has extended Sen's bargaining model with other non-economic factors which can affect bargaining such as perceived contribution (Kandiyoti 1998; Kabeer 1999b). Agarwal further emphasises the role of qualitative factors, such as social norms and perceptions in affecting bargaining processes and their link to extra-household socio-economic and legal institutions within which households are embedded and how these institutions are subject to change (Agarwal 1997:2).

The bargaining model further extends to explain household decisions in relation to context and culture (Agarwal 1997; Kabeer 1994a; Moore 1994), which include power differences; normative understandings and practices; allocation, access and control over resources; and the social processes that perpetuate domination and engender resistance (Chhachhi 2004). Outcomes of negotiations in the household may also be affected by the supra-local discourse about the "right and needs" of a particular group of women, which might be made manifest through the targeted provision of advice or service provided by interventionist programmes (Kandiyoti 1998; Eveline and Bacci 2005; Agarwal 1997).

Acknowledging that resources are distributed through a variety of different institutions in a society, this model expands bargaining from the households to the market, the community and the state. Gender power relations operate in all these institutions in determining differential claims, rights and entitlements of man and women (Sen and Presser 2000). Access to and distribution of resources will be determined by gender regimes in each of these institutions.

While this model provides a useful way of looking at intra-household power dynamics, it is important to also contextualise the model in relation to variations between patrilineal and matrilineal households.

A patrilineal household follows a male-traced lineage, whereas a matrilineal household follows a female-traced lineage system. While the former follows a patrilocal household residence the later follows a matrilocal residence pattern following marriage, which gives a particular dynamics to the household relations and male and female roles in fundamental ways (Mann 1987). In the former women are typically charac-

terised as a “weaker” sex, with no independent claim to property, limited access to the labour market, and little real household decision-making power (Cain, Khanam, and Nahar 1979; Lindenbaum 1981); in the latter, households are typically characterised by mutual co-operation rather than domination (Burling 1963; Playfair 1909; Kar 1982; Sangma 1981; Rao 1985). Jackson (2014) criticises such simplistic binary construction of matrilineal and patrilineal household relations and argues that these modes shadow each other and co-exist to varying degrees. In the context of Bangladesh, where mainstream Bengali households follow a patrilineal system, the co-existence of house-husband (*ghor jamai*) (Hossain and Masuduzzaman 2006:490) is a typical example of a co-existence of matrilineal norms. Similarly among matrilineal Garos, there is also space for patrilocal residence (Nokrek 2013).

Although some authors make an explicit link between matrilineal systems and women’s greater autonomy (Dyson and Moore 1983; Khaleque 1986), studies on matrilineal Garos in Bangladesh show contested views. Most of these studies draw their conclusions on household gender relations based on the gender division of labour. Some authors (Bal 2000; Dey et al 2013; Khaleque 1986; Playfair 1909) argue that Garo women’s work is more restricted to subsistence production, reproduction and care, while males dominate in the public affairs. Another author argues that Garos simply follow a natural division of labour (Burling 1989). It remains overlooked in these debates how the gender division of labour gets reproduced, contested and renegotiated over time in interaction with other social institutions such as the market, the community and the state.

This study looks at how the cultural construction of masculinity and femininity shape reproductive practice in both matrilineal and patrilineal households and the ways in which notions of masculinity and femininity get reproduced, negotiated or contested in interaction with other social institutions including policy.

2.2.2 The Community

In South Asia “community” could be defined with reference to either ethnic or religious differences (Sangari 1995; Chhachhi 1992). This umbrella concept embraces groups or communities defined by colour, language, or religion; it covers tribes, races, nationalities and castes (Chandra 2006:397). Hence ethnicity is not specific to oppressed or minority groupings only (Yuval-Davis 1994). Ethnicity refers to the individual

level of identification with a culturally defined collectivity, the sense on the part of the individual that she or he belongs to a particular cultural community (Hutchinson, 1996:5).

Contemporary construction of community goes beyond fixed and mutually exclusive boundaries between different communities (Yuval-Davis 1994; Hutchinson 1996; Cohen 1996). It relates to the politics of collective boundaries, using any aspect of culture, dividing the word into “us” and “them” (Banks 1995; Vermeulen and Govers 1996; DeVos 1975).

Ethnic identity constructs the collectivity and its interest, not only as a general positioning of the collectivity in relation to others in the society, but also as a result of the specific relations of those engaged in “ethnic politics” with others within that collectivity (Yuval-Davis 1994; Anderson 1991). The politics of identity construction might mobilise all available relevant resources such as political, economic and cultural relating to customs, language, religion etc (Cohen 1996). Since identities shift boundaries and one can belong to multiple identity groups, they might overlap, contradict or reinforce each other. Different historical or political contexts might also reinforce one particular identity over another (Chhachhi 1992).

Even as it is important to look at variations between ethnic communities, contrary to conventional development discourse where community is seen as a harmonious unit, I take the notion of community as a deeply contested space consisting of multiple identities and conflicting interests (Sangari 1995; White 1992). Through an analysis of different religious communities in India, Sangari (1995) has coined the term multiple “patriarchies” which allows for a more nuanced understanding of gender regimes in South Asia. Hence both the external factors as well as the internal power dynamics within a community need to be analysed.

In this study I refer to Muslim Bengalis, minority Hindu and minority indigenous Garos as ethnic communities. I refer to majority Muslims and minority Hindus¹² as mainstream Bengalis. Apart from some cultural differences in terms of language, dress code, restrictions on food, kinship systems there are also religious differences between mainstream Bengalis and indigenous Garos.

¹² In this study I do not go in details about discussing minority Hindus, rather refer to them as mainstream Bengalis.

In this study the differences between the mainstream Bengali and matrilineal Garo communities will be incorporated in analysing existing cultural norms as well as internal diversity and material differences (Bhabha 1990) among Garos and its link to the process through which gendered identities are reproduced, contested and take shape in a particular historical context.

2.2.3 The state

I refer to the state as a regulating, constraining and structuring network of power relations existing in cooperation and also in tension (Rai 1996). Early feminist analysis especially in the 1980s looked at the state either as patriarchal (Kandiyoti 1991) or as reflecting patriarchal and capitalist interests (Wilson 1977; Eisenstein 1979). These feminist theories were functionalist and reductionist and saw the role of the state as “perpetrator of violence”. Contrary to that, in countries with strong welfare orientation the role of the state is seen as an arena of bargaining of interests (Hernes 1987). Some poststructuralist feminists reject the theory of the state as too abstract and argue that the focus of feminist analysis should be micro-level organisations and institutions that affect everyday practice. However, these debates are particular to western feminism, and do not capture the experience of women from Southern and post-colonial countries.

Rai, a Southern feminist (Rai 1995), argues that the legacy of colonialism in post-colonial states has been material, cultural and political. A feature of colonial intervention which is highly relevant here is the simplification of traditional social and economic arrangements in order to be able to extract resources. In order to extract forest resources colonial government labelled the traditional livelihood system of *jhum*¹³ cultivation as environmentally destructive and justified abolition of *jhum* cultivation and customary land rights among indigenous Garos. At the same time Garo masculinity was constructed by viewing Garos as “blood

¹³ The form of land cultivation varies from region to region depending on the variations in the land tenure system, forest clearance process, types of produce, duration of cultivation and the fallow period. The most common form of shifting cultivation follows the slash-and-burn technique which begins with the burning of the forest growths to allow the release of nutrients into the soil. After 5-6 years of cultivation, when the nutrients have been exhausted, the land is abandoned as fallow to ensure the regeneration of the forest (Dey 2007).

thirsty head-hunters” while at the same time romanticising their matrilineal kinship system (Nokrek 2013).

In the broader context of Bangladesh, the role of the state in relation to women is ambivalent. Although the state was founded in 1971 on secular principles, with the advent of military rule in the mid-1970s Islamist political parties came to re-assert themselves in the political sphere. General Ershad (1982-1990) declared Islam as the official religion of Bangladesh in 1988 (White 2010:344). By 1991, when parliamentary democracy was restored after years of de facto military rule, the Islamist party was able to play a pivotal role in electoral politics by forging strategic alliances with the centre-right BNP (Naher 2010:316). Mohsin points out that the state ideology with military and Islamic influences has been increasingly masculine (Mohsin 2010:10).

Conversely a considerable emphasis has been given on the role of the state as legislative power to formulate, legislate and enforce laws regarding equality between men and women (Chowdhury 2006) and as protector of women from domestic violence (Khan 1993). In the context of Brazil Alvarez argues that:

Feminists should neither dismiss the state as the ultimate mechanism of social male control nor embrace it as the ultimate vehicle for gender based social change. Rather, under different political regimes and at distinct historical conjunctures, the state is potentially a mechanism either for social change or social control in women’s lives (Alvarez 1990:273).

In most post-colonial Southern countries the state is characterised as “weak”, which implies a lack of infrastructural capacity in tandem with corruption in implementing state legislation and action (Rai 1996). Contemporary feminist analysis of the state further argues that the state is not homogenous: it is a collection of agencies, institutions, discourses and contested power relations. In post-colonial countries like Bangladesh, it has been argued that the state apparatus tends to get co-opted by the neo-colonial bourgeoisies to pursue their class interests (Alavi 1972).

In this study the focus is not on the state per se but on specific state policies and discourses related to reproductive health and rights and the ways in which these undermine or reinforce unequal gender relations. These are not homogenous and reflect different interests. In relation to this aspect Foucault’s approach to the state and power is particularly useful.

Power, according to Foucault, is not exercised from the exterior; it is not possessed by an individual, nor is it centralised in the law, the economy or the state. Rather it is immanent in everyday relationships including economic exchanges, knowledge relationships, sexual relations, etc. Contemporary feminist reading of the Foucauldian notion of governmentality helps us to understand the link between the micro and macro politics of gender:

Governmentality is simultaneously individualising and totalising. On the one hand, governmentality is simultaneously subjectivising (i.e. it concerns itself with the constitution of individualised subjectivity) and objectivising (i.e. through the operation of bio-power the individual is transformed into an object or docile body). On the other hand, the individual is implicated in large-scale normalising structures and regulatory controls. Governmental analysis, thus, attempts to interlink the micro-effects of power (e.g. self-technologies) with the macro-strategies of power without privileging one or the other (Macleod and Durrheim 2002:45).

This study doesn't deal with bio-power, or how power operates through chain of networks and is dispersed through body politics (Harcourt 2002) as a form of governmentality. My focus is how the power dimension works in and through policies- assumptions and discourses by different actors located within and outside the state. The aspect of governmentality relevant to this study is what Foucault called disciplinary technology. This study shows how knowledge produced through disciplinary institutes regularise and normalise subjects through systematic production of concepts categories and subject positions to construct the reproductive health need of women at the same time shape the reality by enabling or constraining certain reproductive practice. I explore the discourses of need for long-acting contraception among poor women.

Foucault has been criticised for placing too much emphasis on discourse which constructs subjectivity and too little attention to the "messy empirical reality" (Li 2007). The understanding of discursive power has to be balanced by in depth ethnographic study, particularly if we wish to identify possibilities of change and transformation. My study hence deals with the problematic by looking both at discourse as well as the voices of rural poor women.

2.3 Research methodology

Taking a bottom up approach, by capturing the voices of women, articulated through their own narratives, this study hopes to provide insight into how power operates in different institutional domains in shaping women's reproductive health practices in rural Bangladesh.

The following sections describe the methodological steps taken to carry out the research. This includes the following: the research location, the rationale for choosing a qualitative research approach, and a matrix linking the research questions, information needed and methods employed to answer the research questions. It then provides details on methods of data accumulation and steps taken to analyse and synthesise data/information. The last part of this section provides information on research process and reflexivity including ethical dilemmas and questions of reliability and validity of the study.

2.3.1 The research location

To explore reproductive health experiences of women from poor socio-economic and different ethnic backgrounds, I purposively chose a village with a mixed ethnic population to conduct my research. The main ethnic population in Bangladesh is called "Bengali". Bengalis consists of Muslim majority and Hindu minority groups. Besides Bengalis, *adivasi*¹⁴, and *Mandis* were selected purposively for this research due to their distinct matrilineal system which gives them a sharp contrast with mainstream Bengali population. *Mandis* are mostly known as Garos to the international community. In this research I use the term Garos¹⁵ and Mandis

¹⁴ To refer to the indigenous population the Bangla term '*Adivasi*' is generally used. Besides Bengalis 1.5 per cent of the total population in Bangladesh are indigenous. The term *Adivasi* represents a broad category of more than 27 different indigenous groups. Adivasis offer major ethnic, cultural, religious and linguistic distinctions from the mainstream Bengalis (Minority Rights Group International 2012).

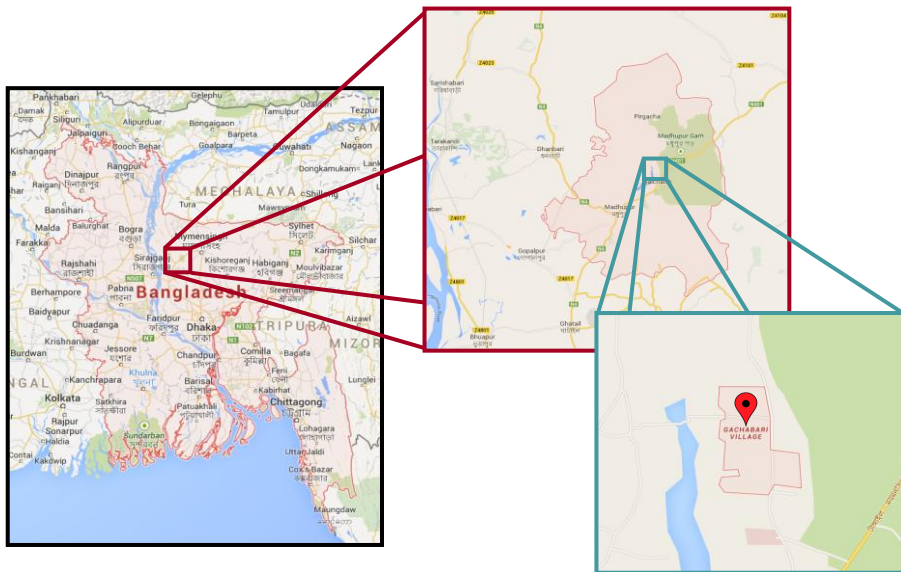
The main *Adivasi* groups in Bangladesh are the Santal, Chakma, Marma and Mandi. Chakmas and Marmas live in the mountains Chittagong Hill Tract (CHT), while Santals and Mandis are plain-dwelling *Adivasi*. Santals live in the north-west and Mandis live in the north-central of Bangladesh (Sherpur, Mymensingh and Tangail district) (Minority Rights Group International 2012).

¹⁵ The term Garo came into being to refer to Mandis in mainstream Bengali writings following colonial writings, which has underlying assumptions that indigenous Garos are originated from the Garo Mountain of India and travelled to current Bangladesh. Such an assumption denies their claim as *adivasi*, which literary means native.

interchangeably. However, I would like to emphasise that Garos prefer to call themselves *Mandis*, which literally means human (Bal 2000).

The village called Gachhabari in Madhupur upazila, Tangail district was purposively selected for this research. Please refer to Map 2.1. (Chapter Four provides detailed information on the study village). To give an idea of the research location, Bangladesh is divided into divisions, districts (jela/zila) and sub districts (thana/upazilas). Dhaka is the central division among 7 divisions and Tangail is one of the 17 districts under Dhaka Division. Madhupur is the largest upazila among the 12 sub districts/upazilas in Tangail district.

Map 2.1
Map of the village



Source: Google Maps

The Madhupur upazila was established in 1951 as Thana and upgraded up to Upazila in 1983. The name Madhupur originated from its availability of *madhu* (honey). This area was known for its jungles and forests with a large number of bee hives. People used to collect honey and sold it at the local market; the area thus became known as Madhu-

pur. Madhupur Sub district/upazila consists of an area of 500.67 sq km. It is bordered by Jamalpur Sadar upazila on the north, Gopalpur and Ghatail upazilas on the south, Muktagacha and Fulbaria upazilas on the east, Sarishabari and Gopalpur upazilas on the west (Bangladesh Bureau of Statistics 2007).

Under the Madhupur upazila, Gachhabari village's mixed ethnic composition made it most suitable to conduct this study. According to the census report Gachhabari village consists of 294 Muslim households, 24 Hindu households and 63 Buddhist households (Bangladesh Bureau of Statistics 2007). In the national census the classification was based on religion rather than ethnicity. Therefore, Garos were classified as Buddhist, due to their old religion: Animism. In fact, almost all the Garos are converted into Christianity.

This composition of ethnic diversity and the presence of public, private and NGO health care services, made Gachhabari an ideal location to explore and analyse women's reproductive health practices in rural Bangladesh.

2.3.2 Rationale for a qualitative research approach

The nature of this investigation required adopting a qualitative approach. It allowed extracting and interpreting the meaning of individual women's reproductive health experiences.

The epistemological stance I adopted is a feminist standpoint approach. Feminist standpoint methodologists consider women's own experiences a valid source of knowledge production which can provide a more inclusive, and less distorted explanation of the reality (Harding 2004; Harding 1991, Wolf 2011). To understand women's real life choices and negotiations, within qualitative research traditions, an ethnographic approach was considered most suitable for offering a holistic rather than a reductionist understanding of the reality (Bloomberg 2008:80).

Many feminist researchers argue that exploring women's "real" life experience means taking real life as the starting point and investigating its subjective concreteness as well as its societal entanglements (Mies 2005:92). To understand the complexities of socio-cultural context under which women perceive their social world and make meaning of their reproductive practices, an "emic" viewpoint (Kottak 2006) was called for.

An ethnographic approach also allowed me long term interaction to build rapport with research participants to provide an “emic” understanding of women’s own interpretation of their reproductive behaviour.

The main data collection technique employed in this research was documenting individual woman’s real life experiences articulated through their own voices through in-depth interviews. Women’s own voices could best portray women’s feelings, thoughts, aspirations, choices and decisions: the realities that women experience in everyday life.

In qualitative research, validity of data is not only a matter of conceptualisation and of the methods used. It involves researchers’ moral integrity and practical wisdom for evaluating the quality of the knowledge produced (Kvale and Brinkmann 2009:248). Detailed and thick description, reflexivity, extensive time spent in the field and the closeness of the researcher to participants are the primary validation criteria in qualitative research (Thomas 2016; Geertz 1973; Creswell 2007).

In qualitative research, triangulation of data implies combining more than one set of insights in an investigation, which can be achieved through combining diverse sources of data, researchers and/or theoretical and methodological aspects (Downward and Mearman 2007:81). In this study triangulation was achieved through combining qualitative and quantitative data collection tools as well as collecting data from diverse sources, to cross-check and verify information throughout.

2.3.3 Matrix: research questions, information needs and methods

The information needed to conduct the research was guided by three main research questions. The link between these research questions, information needs and the combination of different data collection techniques is summarised in the matrix below:

Table 2.1
Matrix of research questions, information needs and data collection techniques

Research Questions	Required information	Methods employed
1) How are reproductive health and gender equality framed, defined and interpreted in the population policy and programme implementation?	<p>Contextual: How reproductive health and gender equality have been conceptualised, framed and interpreted in the population policy and programme implementation.</p> <p>Perceptual: Views, assumptions, biases and silences in the policy document and among key development actors in relation to population policy, reproductive health and gender equality.</p>	<p>Review of official reports, BDHS and other secondary research reports and policy documents.</p> <p>Content analysis and argumentation analysis of policy documents.</p> <p>Key policy stakeholder interviews.</p>
2) In what way do gendered and ethnic power relations shape women's reproductive health practices and processes of negotiations?	<p>Demographic: Reproductive health practices depending on socio-economic and ethnic diversity.</p> <p>Contextual: Explanation of cultural norms and gender relations in the community</p> <p>Perceptual: Individual women's and men's narratives on their decision making process regarding reproductive health practices.</p>	<p>Household survey.</p> <p>Literature review, observation, focus group discussions, service provider interviews.</p> <p>In-depth interviews of individual women and In-depth interviews of individual men.</p>
3) In what ways does the socio-economic and cultural setting shape reproductive health practices of women from different ethnic/socio-economic backgrounds?	<p>Demographic: Access to services depending on socio-economic and ethnic diversity.</p> <p>Contextual: Explanation of socio-economic and cultural setting</p> <p>Perceptual: Description and explanation of individual women's experiences regarding their access to reproductive health care services.</p>	<p>Household survey.</p> <p>Literature review, observation, focus group discussions, service provider interviews.</p> <p>In-depth interviews of individual men and women.</p>

The preparatory phase for the selection of research location and formulation of guidelines for collecting information was between November 2007 and January 2008. The actual fieldwork was between February and November 2008. The field research followed several systematic steps

to collect information from diverse sources. Some of these steps were informed by previous steps and some were done simultaneously. A snapshot of the various steps I took is the following:

1. A continuous review of literature was conducted for a solid theoretical grounding of this research.
2. A content analysis of policy documents was done to understand how reproductive health has been defined and what it implied in terms of policy and programmes available to women.
3. 35 key policy stakeholders were identified, contacted and interviewed following a semi structured questionnaire to explore the underlying assumptions and power dynamics behind policy formulation. (Questionnaire is attached in appendix 2 and the list of key informants in appendix 3).
4. A household survey was conducted to get general information on reproductive health practices among the total 502 households in the research village. (Survey questionnaire is attached in appendix 4).
5. 21 Local service providers/key informants were interviewed to understand providers' attitudes and availability of reproductive health care services in the community. (List of personnel interviewed in appendix 7).
6. Five focus group discussions were conducted among men and women groups separately to explore community perception and attitude towards reproductive health practices and available reproductive health care providers in the community.
7. In-depth interviews of 50 women from diverse socio-economic and ethnic backgrounds were conducted to document individual women's narratives of their own reproductive health experiences and their processes of negotiation in the household and the community. (List of female participants in appendix 5)
8. To understand and explore intra-household decision making processes, 25 men were interviewed to incorporate their attitudes and perceptions regarding existing reproductive health practices. (List of male participants in appendix 6).
9. Observation was used throughout the research while participating in the community or during personal visit to the health facilities or conducting interviews.

2.3.4 Methods of information accumulation

Literature Review

Prior to my fieldwork an extensive review of literature was conducted to ensure a solid theoretical grounding for my research. However, literature review was a constant process to update information or to incorporate new insights into my research.

Content Analysis of policy: documents and discourses

An important aspect of the study was to go beyond the problems associated with issues of access and service delivery of reproductive health care to also critically interrogate the policies to analyse how the issue of reproductive health was conceptualised, framed and interpreted in the state policy. A content analysis and an argumentation analysis of the most recent policy documents was undertaken to systematically explore underlying assumptions, biases and silences in the policy (Reinharz 1992a; Reinharz 1992b; Yanow 2000). There is often a disjunction between what is stated in policies and how these are interpreted and applied by policy makers and other relevant actors. To explore these further, interviews with key policy stakeholders and main development actors were held and principles of discourse analysis applied to the data generated.

Key informant interviews for policy perspectives

Key informant interviews have been a very useful tool to understand and explore the underlying assumptions and power dynamics underpinning policy formulation. The key informants represented a cross-section of donors, government representatives, civil society organisations, academics, research institutes, major political parties and women's rights organisations. Their involvement ranged from direct policy formulation to pure research, health service provision, technical assistance and support, to lobbying, advocacy and awareness-raising. Key informant interviews highlighted the ideologies, resources, power dynamics, agreement and contestation among different stakeholders regarding the conceptualisation of reproductive health and the ways and strategies to ensure health equity in Bangladesh.

I identified a list of 35 key informants to conduct interviews. Political leaders were not initially considered as key informants. However, during several interviews it became apparent that with the change in political

regime there were policy changes in Bangladesh. Therefore it became important to incorporate some representatives of political parties as key policy stakeholders.

Interviews were done in Bangla or English depending on the respondents' preference by two research assistants and by me. The interview questionnaire was sent before the actual interview, to allow the informants to better prepare for the interviews. All the interviews (except USAID) were recorded and transcribed by research assistants in English. Processing and analysing the data based on key informant interviews was done by me. Key informant interviews were analysed using themes that summarised their views and meanings related to policy and programme implementation.

Household Survey

At the beginning of the fieldwork primary data were generated through a household survey conducted in the study village to understand the socio-economic, demographic characteristics and reproductive health care practices in the research village. The household survey questionnaire included information on TFR, infant mortality, place of child delivery, use of contraception, health services used in last six months prior to the survey, and the type of health care providers visited.

A structured questionnaire was developed following the BDHS survey questionnaire to conduct the household survey. Ten research assistants, five male and five female from the studied location from different ethnic background were selected and trained for three days in February 2008. After the training a pre-test was conducted in a neighbouring village called Chunia. The questionnaire was then modified and adjusted for the final survey. The initial survey questionnaire was too long and a part on "knowledge on HIV and AIDS" was taken out from the survey, while new information on the use of contraception was added.

Another adjustment was made in the operational definition of "household". Initially, the household was defined as "where members cook and eat from the same pot and share the income". However, during the pre-test I realised that members from many households migrated to different places, however they share income and other responsibilities. Since my research was interested in fertility behaviour, physical presence in the household was not a necessary criterion to be considered as a household member. Biological children, who have not started a separate

family yet, but live outside the village and share income were considered as household members, even though they did not literally “cook and eat from the same pot” during the survey.

It was difficult to get reliable information on monthly income, as many of household members do not have a fixed monthly salary. Many of them are dependent on agriculture, where they are dependent on harvest twice a year. An estimate of monthly income was generated by combining previous year’s income and monthly consumption and expenditure data. This has to be seen as approximate.

During the survey, the research assistants worked in pairs, conducting the survey in 502 households in 20 days. According to the government population census done in 2001, the total number of households was 382 in Gachhabari village (Bangladesh Bureau of Statistics 2007). According to my household survey, however, the total number of households was actually 517. Out of 517 households, one adult female in the reproductive age group (15-54) from 502 households was interviewed. In 15 households there was no adult female in this age group to take an interview. I focused on women respondents during the household survey and included men in the focus group discussions and interviews.

Focus Group Discussions

Participatory Rural Appraisal (PRA)¹⁶ tools were very useful in focus group discussions to explore the community perceptions and attitudes in determining women’s reproductive health practices and identifying differences between men and women’s perceptions in prioritising reproductive health needs.

The PRA techniques used during focus group discussions included community mapping, mobility mapping and body mapping (shown in Chapter Four, Drawings 4.2 & 4.3 and in Chapter Five, Drawing 5.1). The community mapping provided information on the village’s geographical boundaries, infrastructure, population distribution and environmental setting. The mobility mapping identified availability of reproductive health care providers to the community in terms of childbirth, supply of contraception, MR/abortion and other sexual and reproduc-

¹⁶ PRA approach has received recognition for its usefulness of understanding of contextual, subjective and non-material dimensions of human experience (White 2006). It allows poor people to express and analyse the realities of their live and conditions (Chambers 2005).

tive health care services. The body mapping technique was used to assess the existing knowledge and perception in relation to childbirth and use of contraception on human body (Picture 2.1).

Picture 2.1
PRA technique: Traditional health attendants drawing body mapping



Source: Researcher's photo during FGD, TBAs, 25 April 2008.

The FGDs further provided me with opportunity to be familiar with local terms to refer to different reproductive health matters or events, which made further communication smooth. It also helped me in identifying potential key informants from the community, who were a great support in accessing individual men and women for in-depth interviews.

Prior to conducting focus group discussions a guideline was developed to stimulate discussion among participants to explore shared cultural meanings pertinent to reproductive practice. (The guideline is attached in appendix 8). One focus group was arranged to test and develop the guideline further in the field. However, it did not match my expectation. The setting of the focus group following an open structured guideline, but steering the discussion in a particular direction to explore perceptions of the participants was a disappointing experience. As a

researcher I felt I was trying to explain my own understanding of certain concepts related to reproductive health issues, which seemed not to be familiar to the participants at all. Younger participants didn't feel free to discuss certain issues such as abortion and sexually transmitted diseases openly in front of elder women, while my intention was to maximise diversity in the group discussion by including participants from diverse groups including young and old, educated and uneducated, poor and rich, Bengalis and Garos.

After the test focus group discussion a literature review on qualitative research techniques helped me to apply new techniques for focus group discussions. To get the perspective of younger people, participants between 25-45 age groups from a range of poor to medium socio-economic backgrounds from Bengali and Garo households were selected for the focus group discussions using PRA techniques. Male and female group discussions were conducted separately.

The use of PRA tools immediately changed the atmosphere to a more informal setting which facilitated active involvement of the participants and opened up space to discuss sensitive issues. PRA techniques encouraged participants to engage in the research with confidence by creating a non-hierarchical atmosphere where I became merely a listener and an observer.

PRA techniques help, the analysis of local structures of gender relations and gender divisions of labour (Humble 1998:36). The PRA sessions also made apparent that the reproductive health practices in the village are closely linked to health care services available in and around the village as well as community attitudes and perceptions.

Exploring community perceptions also implied including men. A male research assistant¹⁷ conducted FGDs among men. I did not choose anyone from the community to conduct the focus group discussions

¹⁷A male anthropologist, working with Bangladesh Resource Centre for Indigenous Knowledge (BARSIK) and with long experience of research with indigenous communities, was recruited to conduct focus group discussions with men. He had no prior training on reproductive health issues, but became interested and was generous to help me with the focus group discussions. Despite being long involved with community-level research on "indigenous knowledge on agrarian production systems", after the focus group discussions he mentioned that he was "brought to a new world which he was not aware of" and acknowledged a great deal of learning from the use of PRA techniques in qualitative research.

with men because I realised that participants don't feel free to express their private matters to a person from their own community but are less hesitant to share their views and perceptions to a trusted outsider.

The FGDs involved participation from poor and medium socio economic and different ethnic backgrounds. Two BRAC health workers assisted in organising female participants and a local key informant helped organising male groups. In total, five focus group discussions were conducted. Two focus groups involved 19 and 21 men. Three focus groups involved 18, 19 & 7 (TBAs only) women in each group. The body mapping was organised among seven midwives/TBAs (four Bengalis and three *Garos*). In the previous two focus group discussions it was noticed that those TBAs were more vocal and knowledgeable due to their mobility as TBAs in the community; one of them was also a government field worker, which involved visiting door-to door to supply contraception. Special attention was given to organise the time for focus group discussions. Considering that the best time for the participants could be the worse time for the researcher (Chambers 1998:xvii) preference was given to the participants. The most suitable time for conducting female focus groups, was after lunch between 2.00 p.m. and 5.00 p.m. when participants were relatively less busy with their household work.

Men's focus group discussions were conducted between 5.00 p.m. and 9.00 p.m. Men did body mapping in a bigger group, while only seven female TBAs did the body mapping. The men's group discussions took less time than the women's groups, but provided more details on community mapping and mobility mapping, which suggests that men are in general more mobile than women. It was also easier to access male participants for FGDs.

The application of PRA techniques implied a constant process of assessment and adjustment as new aspects emerged. This process allowed for a rich generation of data.

In-depth Interviews with individual women and men

To achieve a deeper understanding how women from poor socio-economic and ethnic backgrounds articulate and negotiate within the family and community to make their reproductive health choices, open ended in-depth interviews were conducted to document individual women's narratives. The use of in-depth interviews in qualitative research empowers respondents to analyse their own situation (Wood-

house 1998), unlike structured questionnaire interviews in quantitative research, where respondents are considered as passive and merely vessels of answers (Bleek 1987; Brady et al. 2004). Allowing respondents to provide narratives of their own life experiences also helps to redress some of the power differentials women experience in their everyday lives (Camfield 2006) and to explore the meanings women attach to their own reproductive health reality.

Purposive sampling was used to identify information-rich cases for in-depth interviews. Besides informal conversation with numerous women in the village, 50 women were selected from different age groups and different ethnic backgrounds. My research participants are predominantly poor. However, I also included a few participants from better-off households (medium to rich). Although the proportion of mainstream Bengali and indigenous Garos in the village are 82 and 18 per cent respectively, initially I intended to interview 25 women from each ethnic group. The intention of my sampling was not to give a statistical representation of the total population or to generalise the findings to the larger population. Information-rich cases were identified (for example recently delivered women, or women who have had an abortion or are using certain type of contraception across different ethnic groups) to investigate deeper meaning and explanation of their reproductive practices. In the end, 22 Garo women and 28 Bengali women were interviewed until the study reached the stage of “saturation”, when no new insights seem to emerge from further interviews.

In-depth interviews were unstructured and followed a natural way of sharing the respondents’ reproductive health history and the ways they dealt with their reproductive health events and the choices they made. Interviews were taken in their own environment and space. To keep the natural atmosphere and not to interrupt the flow of the conversation interviews were recorded and transcribed afterwards. During transcription new questions emerged which resulted into another follow up interview. The same respondents were visited several times over a period of nine months to follow up the conversation or just to have a private moment to share their deep personal feelings, emotions and experiences.

To fully understand women’s decision making process and intra-household gender dynamics it was also important to incorporate men’s perspective in the research. 25 men (11 Garos and 14 Bengalis) from poor and medium socio-economic backgrounds were interviewed by a

research assistant for this purpose. Interviews were conducted in Bangla. The translation of these interviews and analysis was done by me.

Local level service provider/key informant Interviews

To triangulate information, health care service providers/key informants were interviewed at the local level to understand reproductive health practices and men/women's access to reproductive health care services in the vicinity of the research location. Service provider interviews helped me to understand providers' attitudes and provided information on existing reproductive health practices. At the local level 21 service providers/key informants included doctors and nurses at the Upazila Health complex (UHC) and private medical practice in Madhupur upazila; village doctors at the local pharmacy; Family Welfare Visitors (FWV) and Family Welfare Assistants (FWA) at the Satellite Clinic; Government and NGO field workers in the village; Smiling Sun health care providers in the neighbouring village Kakraid; Pargacha Missionary head father Homrich and two nurses at the missionary maternity centre; Traditional Birth Attendants (TBA), and a religious healer.

Observation

Throughout the research, as an important tool in ethnographic study, observation technique was used to validate information collected through in-depth interviews, focus group discussions and key informants interviews. To understand the cultural context, intra household gender relations and access to reproductive health care services available to the community observation helped me to develop a personal insight. Observing a Garo couple smoking together while taking a break from their work, may reveal more about their intra-household gender relations than several interviews. (Picture 2.2).

Picture 2.2
Garó husband and wife smoking together during a break while working in the field



Source: Researcher's photo.

2.3.5 Data analysis and synthesis

The household survey data was analysed using SPSS showing patterns of reproductive health practices across different socio-economic and ethnic backgrounds. Quantitative information such as demographic, income, land ownership, and fertility and contraceptive use data have been presented in various tables, graphs, charts and diagrams. To analyse policy texts, content analysis was done using ATLAS.ti. An argumentation analysis model developed by Toulmin (1958, 1979), modified by Dunn (1994) and adapted by Gasper (2000) was also used to analyse contents of the policy documents.

To analyse and synthesise qualitative information (Denzin and Lincoln 2003) generated through in-depth interviews, key informant interviews, FGDs and service provider interviews open coding (Strauss and Corbin 1990:61) was used. Following the principle of constant comparison for similarities and differences (Kvale and Brinkmann 2009) information was categorised in different themes that capture the meanings

that participants attached to their world or summarise key informant's views, assumptions and biases in relation to policy priorities. Coding was done manually going through interview transcripts, assigning a code to a specific expression or experience. Coding helped to reduce the complex information in longer interview statements to a few simple categories/themes. These themes provided the building blocks for my analysis of their complex interconnections to one another, which make up the complex social whole within which women make their reproductive decisions.

Since the spoken language and specific terms used by research participants are culture specific and might get lost in the process of translation, coding and interpretation by the researcher (Johnson 2001; Yanow 2000), I tried to maintain authenticity by using quotations in participants' own words.

2.3.6 The research process and reflexivity

In the process of conducting the research, I have learned an important lesson on power dynamics between the researcher and the research subjects in qualitative research. In order to capture the diverse reality of women's reproductive health experiences, my intention was to conduct the research in a mixed ethnic population. I was fascinated by learning about the matrilineal Garos, therefore was interested to include this particular indigenous group in my study. However, the Garo population live in three Districts: Sherpur, Mymensingh and Tangail. The selection of Madhupur upazila in Tangail district was my well investigated conscious choice.

Having lived in the capital Dhaka, growing up with the news items on violence against women every day, and personally being robbed twice, as a woman, before selecting a research location, the first thing that came to my mind was my personal safety. I was looking for personal connections where I could carry on my fieldwork. One of my university friends was posted as a District Commissioner (DC) of police in Sherpur district. I contacted him and he organised a visit to Haluaghat upazila and Jhenai-gati upazila which are known as most Garo populated areas. Haluaghat is the far north sub-district under Mymensingh district and Jhinaigati is the far north sub-district under Sherpur district within the Dhaka Division.

Due to its remote location, in both places there was no possibility to arrange my stay with a family in the village. The most suitable place to stay in those areas could have been at the missionary settlement. My friend tried that option but it wasn't possible to arrange a long term stay at the missionary to conduct my fieldwork. In Sherpur, my friend arranged with an NGO called Caritas, who would have provided me with a room in their office space in a month's time. It was the only possibility to stay close to the community. However, it meant I would be sleeping in an office, where nobody would be present at night. Considering the safety situation I opted against this. Another option was to rent a house in the nearest town, from which I would have to travel every day to reach the community. I tried this option by staying for two weeks in Sadar upazila in Sherpur at my friend's residence and I travelled to a few villages in Jhinaigati upazila, as a tentative research location.

However, my intuition told me this wasn't working. Every place that I visited, people were very friendly and hospitable but I felt there was an invisible wall between me as a researcher and my research participants, which was created by the power difference that was created immediately at the moment I entered into "their" place. In both Haluaghat and Jhenaigati upazila, Garos were living in remote areas. To access them I was dependent on my friend's police vehicle. At the moment I stepped out from a vehicle I was taken as an "outsider". I became aware how physical appearance (clothing, perfume, mobile phone, even a bottle of mineral water) creates a power difference between a researcher and the research subjects. I realised how important the entry point into a community is and how difficult to balance the power difference between the researcher and the research subjects. Even if I were to stay in Caritas office or in the nearest town and would have arranged different transport, I would be entering into the community as an "outsider". After two weeks I returned to Dhaka.

Before investigating my third tentative research location in Madhupur upazila under Tangail district, I looked for a different entry point. My objective was to find a way to live in the community, not to enter the community as an "outsider" just to collect information. I was looking for connections and found that one of my university friends was working with Action Aid, a well-known NGO, who was conducting a programme among indigenous Garos on legal awareness. I contacted my friend and he referred me to a Garo leader Probal Mri. He was kind enough to in-

vite me to stay with his family to explore the area. I visited Chunia, Pirgacha and Gachhabari and after some time selected Gachhabari as the most appropriate site to conduct my research, due to the fact that Chunia and Pirgacha were mostly Garo populated, while in Gachhabari Garos and Bengalis were more mixed. Having selected, I accepted the invitation to stay with the Garo family of Probal Mri as a paying guest until I finished my fieldwork. In retrospect Madhupur was the best choice to conduct my research. It provided not only a proper representation of the ethnic mix between Garos and Bengalis, but also a greater acceptance from the community.

Another important lesson I learned is in gaining trust of the research participants. The intention of qualitative research is to understand a social situation in a particular context and point in time by allowing a researcher to enter the world of “others” (Bloomberg 2008:80). However, before exposing personal life histories in front of an “outsider”, research participants also judge the researcher. As a mainstream Bengali woman I assumed I wouldn’t have any problem to get acceptance among the Bengali population. But I realised that mainstream Bengalis were judging me for staying with a Garo family.

I must acknowledge that without the help of Probal Mri and his wife it would have never been possible to receive such acceptability among the Garo community. I was invited to participate in festivals like weddings, *Wangala* (harvest festival), celebration of indigenous day and all other festivals like an extended member of their family.

However, during informal conversations, a few Muslim participants expressed their curiosity about my food. They asked me whether being a guest in a Garo family, I ate the same food as my host family cooked for them. I realised that in a mixed ethnic community people identify them not only based on ethnic origin or religion but also cultural habit and food. As a Muslim woman, I was not supposed to eat pork meat or crab or drink rice beer, which are the traditional food and drink among Garos. Ajay da and his wife offered me their traditional food, but they always respected my preference what I would like to eat and drink and what not.

Muslim participants’ curiosity regarding my food expressed their concern whether I could be trusted in the Muslim community. After two months of staying at Ajay da’s house, one room with an attached toilet

and shared cooking facility became available in the village. The owner of that room was also a Garo family, but I had a justification that it was the only available place to rent in the village. Soon I started to do my daily shopping in the village market and cook my own meal on fuel-wood in a shared kitchen with my house owner. Soon I came to be seen as a local resident of the village. In this way I was able to maintain a neutral position to both the Garo and the Bengali community.

Picture 2.3
researcher with Garo Participants



Source: Researcher's photo.

Picture 2.4
researcher with BRAC health workers



Source: Researcher's photo.

Being a resident of the village, I was easily accepted in the community (Pictures 2.3 & 2.4). Soon I became a good friend of two BRAC (a well-known NGO in Bangladesh) health workers: one Garo, one Bengali. Their job was to pay house visits, check pregnant women and motivate women to plan small families. They also organised group meetings at different locations in the village to give health and sanitation advice. I became a part of the team of health workers, visiting every household and attending group meetings. In this way I became familiar with my research participants.

Due to my presence with health workers at the beginning of my fieldwork, sometimes participants referred me as family planning *apa* (sister), however, I always conveyed my identity as a researcher and an assistant professor at Dhaka University who is pursuing her research on “women’s health issues”. After knowing my identity many research participants, especially men, compared me with professor Khaleque, a researcher from another University, who conducted an anthropological study in this area a few years prior to my fieldwork.

Being with the BRAC health workers, one of whom was from the *Garo* community, provided me the rare opportunity to learn a few phrases in Garo language. Nowadays the medium of instruction at school is Bangla and Garos don't have any written script. Therefore the young generation Garos are slowly losing their traditional language. My few phrases in local language helped me enormously in building rapport with Garo participants.

Knowing some Garo language further provided me a great advantage in building connections with young generation Garos in the capital city. A number of young Garo girls from the village migrated to the capital to work in the beauty parlours, while their family was living in Madhupur. I visited "Personalia", one of the famous beauty parlours where the majority of the parlour workers are Garo girls. Thanks to my few words of Garo language I immediately had a better connection with them than the common customers of the parlour. It was not only a matter of speaking a few phrases in their language but also about showing respect to and interest in the "other" culture. They were impressed to know that one of their city customers knew the name of their family members who live in Gachhabari. I have met two of these parlour girls when they visited their family in Gachhabari. One of them, Kazoli, went to Gachhabari frequently since she had left her daughter in Gachhabari with her mother. Kazoli said it was difficult to work in a parlour in the city and raise a child at the same time. For me, it was a moving experience. After having lived in Gachhabari for nine months and getting to know these parlour girls who are supporting their family back in Madhupur, I have learned to appreciate them more than before.

Staying long term in the community provided me the opportunity to build trust and rapport with my research participants and key informants, however it also has the risk of establishing a pattern of power relationship.

Socio-economic class rather than gender identity played a major role in how I was perceived in the community. I never helped anyone with money to prevent any false expectation. However I once took a Garo woman to the hospital to do a menstrual regulation, which didn't happen in the end. During my visit to the hospital (Upazial Health Complex), the nurse or the staff (*peon*) would call the duty doctor on his mobile phone to come to his office (while he was busy in private practice during his office hours at the MCH centre of the upazila hospital), while other rural

women would have to wait for hours. As an educated academic I was invited as a special guest during the celebration of the “International Indigenous Day” and received enormous appreciation from both Garo men and women. During my visit to the households, both Garo and Bengali men and women would offer me a bench or a chair to sit on, while other women would stand or sit on the ground and offer tea when I visited them. Rickshaw pullers would give me priority over other customers. Some women also informed me that local shopkeepers and vegetable vendors charged me more than the local villagers, which was understandable and not news to me of course.

I believe I remained a sympathetic trusted “outsider” (Rashid 2010) to the community. However, I didn’t experience this “outsider” status as a serious barrier in conducting ethnographic research. At the beginning of my fieldwork, I was accompanied by a Garo health worker from the community, considering there might be a communication problem and I might need translation. However, I experienced that women were more comfortable sharing their personal stories with a trusted “outsider” than someone from their own community. Language was not a barrier to interview Garos. I found that almost all Garos in Gachhabari speak fluent Bangla (mainstream Bangladeshi language). But they would speak Garo language among themselves when they want to maintain a distance from the “outsiders”. If the trust is gained the barrier of language disappears. Once I felt I was accepted in the community, I decided to conduct the interviews alone. I could even personally interview two men (one Garo and one Bengali) who had undergone vasectomy, which I couldn’t have imagined at the beginning of my fieldwork.

I experienced that power has also a spatial dimension. Due to my previous experience in Haluaghat and Jhinaigati upazila, I preferred travelling up and down from the capital Dhaka to Gachhabari by public transport. Being a woman, I felt quite uncomfortable in the public transport. However, as soon as I arrived at the Jalchata bus stop I had the feeling of comfort and safety.

2.3.7 Ethical dilemmas in qualitative research

Ethical concerns in qualitative research include informed consent, confidentiality and taking into consideration that the consequence of the research does not harm the life of those involved with the research (Kvale

and Brinkmann 2009). However, the idea that a field researcher can fully ensure these requirements in practical situations remains questionable.

The practicality of informed consent: issue of suspicion and mistrust

Informed consent is supposed to ensure voluntary consent of the research participants after receiving prior information about the overall purpose of the investigation as well as any possible risks and benefits from the participation. I was confronted with an ethical dilemma in my efforts to obtain written informed consent from my participants. My initial entry into the village was through my host, a Garo leader of an “indigenous peoples’ organisation”. I was introduced to one of the volunteers in this organisation, an educated young man, Toufiq, who would help me to find ten Garo and Bengali assistants including himself to conduct an initial household survey in the village. I was offered a space in the office to organise training sessions prior to the survey. On the first day of the training, after initial introduction and skimming through the household questionnaire, I presented a consent form (in Bangla) and explained the importance of obtaining it. One of the participants mentioned that some adults in the survey area cannot read. So the idea was that the surveyors would read the consent form to them and ask them to sign it. But the question emerged, what if someone cannot sign? I said, “they can put their figure print” and we moved on with the training. After the day of training while I was about to walk from the training venue to my host family’s house, Toufiq asked if he could join me. He took the opportunity to speak to me alone what he didn’t want to speak in the group because it might offend the Bengali training participants. What he told me is that Garos have a deep rooted fear of signing papers. If one of my Bengali surveyors went and asked for informed consent to a Garo woman it would have created suspicion and mistrust regarding the objective of the survey.

Subsequently I heard stories that many Garos have lost their land to Bengali money lenders. In many cases they had not realised that they had signed land transfer forms. Given the sensitivity in the local context I had to compromise with the idea of a written consent, and settle for a verbal consent.

Participants were informed of the objective of the survey and that they would not receive any financial benefit or compensation for their time invested by participating in the research. Participation in the re-

search was voluntary and it was explained why we would select one woman preferably in the reproductive age group from each household for the interview to document their socio-economic and health situation. Participants were given the freedom to withdraw at any point in time. They were informed that the outcome of the survey would be used for academic purpose only and the information they provided would be confidential.

Confidentiality and negotiated privacy

Confidentiality implies that the identity of participants who have exposed their private life in front of the researcher will not be disclosed (Kvale and Brinkmann 2009: 72). To respect the privacy and dignity of the research participants, participants are given pseudonyms. Parker argues (2005:17) that while anonymity can protect the confidentiality of the participants; it can also deny them the very voice in the research that has been claimed as its aim.

Confidentiality also entails ensuring privacy during the data collection process. I wonder, however, whether a field researcher is able to ensure absolute privacy when the researcher has very little control on the research context, especially in ethnographic research when a researcher literally enters into the space of the “others”.

My experience is that, since ethnographic research relies a great deal on gaining trust of the host (if any) and the community, it may require the researcher to negotiate or even compromise his/her own privacy. Maintaining one's own privacy can be seen as suspicious, something to hide from the “others”. This was highly relevant for me as a Bengali woman wanting to do research on Garos, those who are discriminated, marginalised and even cheated by the mainstream Bengali population and the Forest Department, representing a “Bengali national state”. During my stay with the host family, I always kept my door ajar and never locked my room. If I did, it might have conveyed a message that I don't trust “them”. Since it was an inside room, with no risk of theft from outside, then why would I lock my room?

My host family was my initial contact in the village. They introduced me to two BRAC and one government health worker in the village. My entry point to individual women was through these health workers, who were from the community, which greatly facilitated access to individual women. I never had to ask permission from in-laws or husbands to in-

terview women. In this sense, most women that I interviewed were not under surveillance or monitoring by other adults as is often the case for adolescent married women (Rashid 2007), yet, ensuring privacy during interviews was more nuanced.

One morning, the Bengali health worker, Fatima, took me to visit Anita, who had recently given birth. The idea was she would drop me at Anita's house and go to do her official households visit. As planned, Fatima had left for her house-visit and I started to interview Anita, but in the presence of her mother. After documenting Anita's personal information, at the time I started asking about her pregnancy check-ups, her mother Modhubala, started to dominate the discussion. Being the host and given the fact that senior adults are respected, being a researcher, I did not have the power position to say, "could you please leave us alone for a while"? Considering the fact that Madhubala was a health worker herself and given her interest and experience, I decided to include her as a participant. After I interviewed Madhubala, she left the room to prepare for the cooking, when I could continue my interview with Anita alone. When I went to interview Shobita, a Garo woman, she was alone in her house, giving us absolute privacy. The privacy of my other Garo participant Ambia was compromised by the presence of a Garo BRAC health worker, who was from the same community. In general, I was able to achieve more privacy while interviewing Garos than Bengalis. According to my observation, there are three possible explanations for that: i) Garos live in nuclear-family households, ii) their houses are more spatially scattered, and iii) they have a different notion of privacy. I cannot say for sure whether Garos who I did not interview personally, were more reluctant to come in front of a Bengali researcher.

The notion of privacy as "secrecy" among Bengali participants was the main constraint to ensure complete privacy. When I went to interview Rabeya about her abortion, her sister-in-law from next door came in. By that time I had learned the strategy to show interest in "others" besides the research participant only. I initiated an "informal talk" about how many children do they have, what kind of method they use, etc. and when they realised there is nothing "secret" going on the sister-in-law went back to her "daily routine", giving some privacy. Given the sensitivity of the issue, I had first to chat with her sister-in-law, satisfy her curiosity regarding the research. In several instances, such situations caused frequent interruptions during an interview. During the interview with my

Garó participant Mohua about her abortion experience, we didn't have such interruptions. In most cases, I went back again to complete the interview. In three instances, I decided to drop them from my participants' list; all of them were young, Bengali women.

Privacy was also gendered. My male research assistant reported that privacy was generally ensured while interviewing men, although most of his interviews were conducted in "public" spaces. Given the sensitivity of male vasectomy, although my research assistant was not from the community (but from the capital city), to preserve the confidentiality of Jamal Miah (Bengali) and Shuvas (Garó) I decided to interview them myself. I made arrangement via their wives. At the time I arrived at their homes, in both cases, suddenly their wives disappeared with their children ensuring our privacy. When I interviewed important public figures (Garó leaders and the chief of the missionary in their offices), nobody entered the room without asking permission, although these public figures did not care about confidentiality; on the contrary, they expressed a desire for publicity for their views.

Ethics and moral integrity

Some scholars argue that truly ethical research is impossible, since every research has a political consequence (Asad 1993; Patai 1991; Harding 2004). In the qualitative research process, researchers play the role of convenors, catalysts and facilitators by participating in research and by promoting research participants to reflect and analyse their own social reality (Chambers 2005; Humble 1998). It would be naive to imagine that an ethnographic researcher can be completely detached from the life of those they become a part of. This is even more valid for feminist researches, where the motivation of undertaking such research originates from the deep desire to change the life of marginalised women for the better.

My engagement with research participants and drive to understand their reality once put me in a situation where initially I did not expose my identity. During a regular visit to the UHC, one afternoon I was looking for a nurse, a key informant. She was not on duty. So I was roaming around the hospital entrance. I saw two middle aged women sitting under a mango tree in a large open space at the parking area next to the entrance. Out of curiosity I went to them and asked if they knew any

female doctors around. One of them stood up and asked me to follow her, while she started to walk towards the exit of the hospital.

Before this incident I had learned from several women in the village about their illegal abortion experiences. Although I had heard about abortion brokers, it was a pure coincidence that I encountered one of them, while I thought these women might have come to visit their patients to the hospital. I realised the lady asked me to walk behind her, so that I wouldn't be seen walking with a broker. I immediately understood where I was heading to. On the other side, the broker thought I was a client who could have brought her a good commission. I could have explained to the broker that I was not a client but a researcher, but I followed her blindly. I was directly brought to a female illegal abortion provider's chamber breaking the queue of other general patients. When I entered into the so-called "female doctor's chamber", I saw the female practitioner accompanied by a man in her chamber. Apparently, the man was not a medical practitioner, but he would not leave the consultation room to give me privacy to talk to the female abortionist alone.

At that moment, I felt quite powerless. I experienced two mixed emotions. One was a guilty feeling for the broker that the abortionist, due to her power position, would scold or financially punish her for revealing the illegal abortion practice to me. Secondly, knowing from my research participants how illegal abortions were performed behind her general "maternal health consultation", I could imagine she had a powerful network with local elites and even law and order enforce authority to run her "business". The presence of a man in her consultation room and realising that the abortionist did not have the authority to ask him to leave her consultation room while she was about to talk with a female "client" (me), obviously showed his power position, which made me insecure. The fact that I did hide my identity, it meant that I could be charged as an impostor. But, my determination to know the "truth" made me more stubborn than worried about the consequence of not revealing my identity.

After the man had finally left the consultation room, the lady asked me where my husband is. I replied "abroad". It was the truth. But she could not have possibly imagined that I was married to a man who lives abroad. She thought I might have become pregnant while my husband is away, therefore need an abortion. After some conversation she realised that I would have gone to a "proper" place to do an abortion. I con-

veyed an apology for the misunderstanding and I explained my research objective to her and she co-operated. But she was nervous thinking I was a government secret agent (I have explained our conversation in details in Chapter Five). On the other hand, while I was afraid of the man in her consultation room, as being someone from the local power elite or a law enforcement agent that she maintains a network with, she said, he was a representative from a pharmaceutical company. If I were to arrange a formal interview with this provider, it would have never been possible to get access. The conversation with the provider helped me to validate information that I gathered through interviewing women about their secret abortion experiences. To understand these secret practices that endanger women's lives, I wondered which ethical criteria a qualitative researcher should follow. In this case, my ethical criteria were based on a personal moral judgement.

Ethical considerations in this study have meant more than simply obtaining informed consent of the research participants to fulfil an ethical protocol. They concern moral integrity, in the entire research process from the start of the study to final report writing taking into consideration that the choices I have made should not harm my research participants (Chomsky 1968, Campbell 2006). I tried to be reflexive about the decisions and choices I have made and undertook all possible measures, I could, to preserve the privacy, confidentiality and dignity of my research participants.

3

State, policy and reproductive health discourses in Bangladesh

3.1 Introduction

The introductory chapter of this study discussed the disparity in reproductive health between the rich and the poor in Bangladesh. This disparity partly reflects the disjunction between women's real reproductive needs, how policy interprets and prioritises poor women's needs, and the services made available to women. To understand and analyse the disparity in health care access between the rich and the poor, this chapter highlights how policies conceptualise, frame and interpret health inequality and propose specific solutions to ensure equality in health care access.

The chapter is divided into three sections. The first section provides a brief overview of population policy in Bangladesh and its shift in the mid-1990s towards reproductive health care approach. It also introduces policy actors and their conceptual premises behind that shift. The second section provides a content analysis and an argumentation analysis of policy documents highlighting underlying assumptions, biased and silences underpinning policy formulation and service delivery mechanism. The third section analyses how diverse development actors conceptualise reproductive health and envision ensuring reproductive health and wellbeing of poor Bangladeshi women.

3.2 A Brief Overview of Population Policy and its shift in the mid-1990s

Before analysing any specific policy document, in this section, I provide a brief overview of population policy and health care service delivery approach and its shift in the mid-1990s to set the context.

Population policies in Bangladesh are not articulated in a single document. Historically, the five-year strategic development plans provided by the planning commission, under the Ministry of Health and Family Welfare (MOHFW), are considered to be the most important population policy document (GoB 2006). Since independence, a major focus of these five-year plans has been to ensure increasing access to health care service delivery to the disadvantaged population in rural areas

and to close the health gap between different socio-economic groups (Barket 2006; GoB 2004; GoB 2005). To achieve this objective the country's health and population policy has witnessed two distinct phases in terms of setting priorities and health care service delivery approach.

3.2.1 Phase1: Population policy focusing on family Planning Program

The first phase of population policy lasted till 1997 focusing on centrally managed top-down family planning programmes with the intention to reduce population growth. Bangladesh had inherited an urban based health care system with emphasis on curative services. After independence in 1971, the government realised that the health care system had never been able to deliver even the most basic services to the population living in rural areas. Hence, the objective of the First five year plan (1973-1978) was to create a rural health infrastructure to provide integrated and comprehensive health care services to the rural population (BHW 2007:30).

However, since the mid-1970s, as dependency on international donor assistance started rising, the government began to initiate policy and organisational changes following donor direction (Jahan 2003:184). Keyzers described the role of donors in shaping national policy agenda at this time as follows:

Aid not only serves internally the elites of Bangladesh, it is also a powerful instrument in the hands of donors to exert pressure on the policies of the recipient country. In 1974 when Bangladesh desperately needed food and finance to counter the foreign exchange crisis and the shortage in government food stores, "aid donors" put pressure on the Bangladesh Government to accept the formation of a multilateral Aid consortium. This Aid to Bangladesh Consortium was formed and chaired by the World Bank. Bangladesh was immediately subject to a greater exercise of foreign leverage. Regularising aid commitments in the long run meant immediate concessions outlined in a stabilisation programme of IMF (Keyzers 1982:194-195).

Proclaiming family planning a national priority, along with six other development partners with the help of the World Bank, the government created a large scale subsidised contraceptive service delivery system to supply modern contraception at the doorstep of the rural population.

The programme was geared to the transfer of modern contraceptive technology through a centralised bureaucratic system (Demeny 1975). At this stage the health and family planning services were bifurcated due to the strong belief, especially among donors, that programme effectiveness would be maximised if family planning activities were totally segregated from health activities. This also allowed allocating donor funds exclusively for family planning programmes.

Following the Amla Ata Declaration in 1978, the Second Five Year Plan (1980-85) took a comprehensive community based primary health care approach. The objective was to provide basic public health services with an integrated family planning programme through doorstep service delivery. The private sector was encouraged to share the health care responsibility. However, the government largely failed to translate the Alma Ata commitment into service delivery (BHW 2007:40). With assistance from the World Bank led donor consortium, the government channelled most resources and programme interventions targeted towards family planning through its four consecutive five-year population and health projects (Jahan 2003).

One significant aspect of the population policy during this time was the legalisation of Menstrual Regulation (MR)¹⁸ services within the family planning programme in 1979 (Akhter, Khan et al. 1996, Akhter 2001, BHW 2007).

3.2.2 Phase 2: A shift to Sector Wide Approach to reproductive health care services

The second phase of population policies started in the wake of the ICPD in 1994. This phase marks a transition from target driven centralised top-down family planning programme to a client centred integrated Sector

¹⁸ Under the British Colonial Law Penal code of 1860 which is still operational in Bangladesh, abortion, self-induced or otherwise is a criminal offence punishable by imprisonment or fines (Akhter et al, 2000). The only exception permitted is to save the life of a mother. However, during the nine months long liberation war in Bangladesh (former East Pakistan) with Pakistan (former West Pakistan) thirty thousand women were raped (Akhter et al, 2000). After the Liberation War, in 1972 the first thing that came to the mind of the government is to get rid of the foetus, born out of rape. Since abortion is illegal, medical practitioners used the term Menstrual Regulation (MR) which is considered to be socially acceptable because of the distinction made between Abortion and MR (Caldwell 1999a). Later in 1979, Menstrual Regulation (MR) which is considered “an interim method of establishing non-pregnancy”, is made available at all major public hospitals and health facilities within 10 weeks of pregnancy.

Wide Approach (SWAp). The ICPD programme of action, which the Bangladesh government and the donors endorsed, required supporting reproductive health and rights rather than simply to achieve demographic targets.

The Bangladesh government thus incorporated a conceptual shift in service delivery approach from pure contraceptive delivery to comprehensive reproductive health care approach in its first Sector Wide Approach (SWAp) the Health and Population sector strategy (HPSS) in 1996. The first SWAp, the Health and Population Sector Program (HPSP) was implemented during 1998-2003, the second was the Health, Nutrition and Population Sector Program (HNPS) for 2003- 2011, and the third is the ongoing Health, Population and Nutrition Sector Development Program (HPNSDP) for 2011-2016.

The objective of the first SWAp was to increase access to health services by enabling the community to meet their needs in one single visit. To achieve its objective, in the HPSP, the first SWAp, a number of reforms was outlined such as: a) Transition from a vertically integrated but horizontally segregated project based approach towards a sector wide approach; b) Unification of the health and family planning wings of MOHFW at upazila level; c) Introduction of Essential Service Package (ESP) which included basic services. The doorstep service delivery approach was phased out in favour of services delivered through 16,000 community clinics, each serving a population of 6,000. (BHW 2011:18).

The most significant aspect of the SWAp is the introduction of a client centred ESP delivery through the primary health care system to ensure health care access to the most vulnerable groups - women, children and the poor (Jahan 2003:180). After 2003, when the HPSP ended the second SWAp, the HNPS for 2003-2010 reverted to the unification of health and family planning wings of the MOHFW, with a partial return to earlier practices of domiciliary services to reach underserved poor populations, and suspended community clinics where about 10,000 of the planned 16,000 were already constructed. Instead, the programme adopted the Demand Side Financing (DSF) option for vouchers to pregnant women entitling them to access free antenatal, delivery, emergency and postpartum care services at the upazila level, as well as offered cash transfer for transportation and incentives for delivering with a qualified health provider (BHW 2011:20).

Under the third SWAp, the objective of the ongoing HPNSDP for 2011-2016 is to “improve access to and utilisation of essential health, population and nutrition services, particularly by the poor” (Planning Wing, Ministry of Health and Family welfare 2011:2). Emphasis has been given to revitalisation of community clinics (satellite clinics) to ensure health care service delivery at the community level and make improvements in the health care system to allow the service providers to perform their duties timely and effectively including establishing a sustainable Monitoring and Evaluation System (MES) along with developing Health Information Systems (HIS) (Planning Wing, Ministry of Health and Family welfare 2011:2).

3.2.3 Policy actors, conceptual premises and logics behind the policy shift

The shift in policy and service delivery approach in the mid-1990s was an outcome of negotiation among powerful policy actors. In Bangladesh, broadly, policy formulation is an outcome of negotiation between four types of policy stakeholders: the government, donors, NGOs/civil society organisations and professional organisations. Negotiation between these four types of actors determines the policy outcome. Since these categories are not monolithic, meaning there are variations in interests and ideology within each category of actors, thus the pattern of negotiation varies among and between them. However, generally speaking, the main actors in negotiation are the government and the donors. According to a government representative:

Government is the powerful actor to formulate policies. Government is in the driver's seat and that the role of the donor community is to provide guidance, or to give thrust to certain areas where the government lacks capacity. Most of the time donors speak along the similar lines. There is not really reconciling disagreement among donors and the government (Key informant interview, representative, DG FP, Ministry of Health and Family Welfare, 29 May 2008).

Contested views however existed among different stakeholders in this regard. For instance, a representative from a national research institute said:

Theoretically, the government is the powerful actor, but in reality, most of the population programmes are donor-driven. One of the reasons of do-

nor influence is the lack of knowledge among government employees, not their political weakness. At the Ministry level, government employees are frequently changing between ministries. They don't know much about the programmes, so whenever anything comes up, they become dependent on "expert" knowledge. Though, the donors should never hand over a prescription—this is the medicine, two times a day, five days a week. It is the government and the people of Bangladesh who will adapt according to the national law and international guidelines. However, then the WB comes up, or the donor, or some development partners come up with some proposal that looks good, these ministry people with their lack of knowledge become dependent on the prescription given by the donors (key informant interview, representative, NIPORT¹⁹, 5 May 2008).

Donor influence played a significant part in the shift in policy approach. Following the ICPD, when the government started negotiations with the donors for the preparation of the fifth Five Years Plan in 1995, the donors pressed for policy and structural reforms to provide reproductive health care through an integrated, multi-sectoral Maternal, Child Health and Family Planning mostly known as MCH-FP based service delivery approach (BHW 2007:39).

However, the donors and the government had different logics underlying the shift toward the integrated reproductive health care approach. Along with equity, programme efficiency and long-term financial sustainability was the common and urgent donor concern of the health sector reform (Jahan 2003:185). Expansion of already massive door-to-door service delivery system was not considered to be a viable mode for the future. At the same time reproductive health services were not feasible to offer through doorstep service delivery model. Therefore, service delivery model had to be clinic based (Mahmud 2003; Schuler 1999). Also, an integrated MCH-FP service provided through periodic satellite clinics, were tested in two ICDDR,B projects and appeared to be promising (Phillips et al. 1996). In addition, a shift to sector wide approach was believed to cut down wastage of human and material resources, leading to better coordination among donors and better management of aid at national level. On the other hand the government concern was mainly to incorporate the reproductive health agenda into the existing family plan-

¹⁹ National Institute of Population Research and Training.

ning programme without compromising its success in population control (Mahmud 2004).

A conflict of interest between contraceptive delivery and other reproductive health care services was anticipated as it was believed that withdrawal from the ongoing door-step contraceptive supply would constrain contraceptive use. Around that period, a series of studies conducted by ICDDR,B and the Population Council argued that cutting down on home visits by family planning workers was most likely to result in higher discontinuation of family planning method use (Hossain et al 1996), lower contraceptive prevalence rates (Phillips et al. 1996) and diminished quality of care (Hossain et al 1995).

Despite this conflict of interest, the donors pressed for structural reforms and the government adopted its first SWAp and initiated integration of service delivery. In the first three years of HPSP implementation (1998-2000), the government unified health and family planning services at the upazila level (lowest level of government primary health care service) and below and started to establish one stop community clinics to provide Essential Service Package (ESP) (Jahan 2003).

However, the translation of the broader health sector reform into comprehensive reproductive health care service delivery was compromised by administrative and financial resource constraints (Mahmud 2004). The core strategy of HPSP approach was to allocate 60-65 per cent of the national health budget to be delivered through the Primary Health Care (PHC) system at the upazila level and below (BHW 2011:18). However, MOHFW could not channel the target allocation towards upazila and the lower administrative levels (Mahmud 2004).

Implementing the overall reproductive health agenda also required major reorganisation including service provision, supervision and monitoring (Mahmud 2004). The institutional capacity of the government to implement the reorganisation was weak. For instance, HPSP proposed to establish community groups consisting of MOHFW field workers, members of local government and representatives of primary stakeholders as management committees for the community clinics. However, in most cases these committees were formed by MOHFW without community participation and many of the community clinics remained non-functional (Jahan 2003:189).

The transition from doorstep to clinic based service delivery was also not well planned, which had an impact on the performance of the programme implementation. According to a key policy actor:

After Cairo and at the beginning of the health and population sector program, the government integrated the health and the family planning directorates. And we thought that we had to form community clinics, for each 6000-population. And we thought we would take the fieldworkers out of the field and station them, for some of their weekdays, in the community clinics, and they will go for fewer field visits; only to the difficult clients²⁰, not the door-to-door visits that we had earlier. But later on, what happened? We could not build the community clinics. At the same time, the fieldworkers said, “Oh, I don’t have to go to the field anymore”. So that shift created a lot of supply problems.

Theoretically, it was a good idea to have a clinic for each 6,000 population, but in reality, we could not do any good service delivery there. And another problem is that we had some difficult clients in the community, but we don’t have any information about identifying who are those difficult clients. So this was really a mess. (Key informant interview, representative, NIPORT, 5 May 2008).

The conflict of interest between two implementing wings of the MOHFW was further revealed to compromise the quality of care at the upazila level. According to a policy stakeholder:

To monitor the quality of care in the Health and Population Sector Program, we tried to form a position of Health Manager at the upazila /sub district hospitals. But it created conflict of interest between the family planning and the health directorates. The doctors’ community opposed us and said that the Thana health and family planning official should be the head of the health division. The doctors took the upper hand (used political influence), the family planning people felt that they were being left out, while the doctors were mostly involved in their private practices (key informant interview, representative, NIPORT, 5 May 2008).

As a response to this situation, despite strong support from the donors, three years after implementation the integration was halted and health and family planning directorates were bifurcated again. Donors and some scholars largely blamed bipartisan politics for this reversal of

²⁰ Meaning the tendency to drop out from using contraception.

integration (Jahan 2003). This sentiment was echoed in the following donor representative's statement:

Personally, I think that management improves through integration. There are of course political and power dynamics at play, though. People fear losing their territory when directorates are integrated. And then corruption is always a factor. (People lose chance to collect money when the bureaus are integrated). When HPSP ended, the government was pro-segregation, and the donor community was generally pro-integration. (...) The donors had proved that the one-stop delivery system worked, but the government wanted to shift away from that and go back to door-to-door delivery.

I think it was largely a political decision; it was not evidence-based. Basically, the new party came to power, and they wanted to change things up as a new administration, change the previous regime. Of course, at that time, the clinic based approach wasn't completely in place, so it's difficult to say which approach would be most effective. (key informant interview, representative, USAID, 3 July 2008).

Part of the truth behind the reversal of integration also lies in the fact that programme success was evaluated in terms of contraceptive prevalence rate (CPR) and associated fertility decline (I will come back to this point later in this chapter). In any case, the conflict of interest and the difference in opinions are still there. Since 2001, two directorates are working separately at the upazila level, under the broader umbrella of MOHFW.

To understand the nature of integration between the two implementing wings, representatives from the Family Planning and the Health directorates were interviewed as a part of this study. As expected, both Ministry representatives claimed that the two directorates are adequately integrated, unified in policy vision, and "just implementing the decisions that come down the pipeline". However, the Health directorate interviewee challenged the claim of perfect cooperation, strongly hinting that while the two directorates were united in their policy vision at the ministry level, their cooperation at the upazila level left something to be desired.

Not surprisingly, both government representatives highlighted the lack of human resources to achieve policy targets saying that without skilled "manpower"—gynaecologists, obstetricians, paramedics, and field workers—not even the most uncontested policy measure will be

effectively implemented. As the Health Sector actor admitted, “we will try our best to improve the facility-based services, but even the most modest goal of training and deploying skilled birth attendants remained a long-term and difficult-to-achieve priority for Bangladesh”.

It was revealed that the incorporation of reproductive health agenda in the (1998-2003) population policy was inspired by the change in international donor discourse, “since it was easy to receive money for reproductive health programmes, as long as one doesn’t talk about abortion (Key informant interview, representative, Engender Health, Dhaka, 4 May 2008)”. In practice, there was not much change at the level of programme implementation level. It was implicit in the government representative’s remark:

Policy is important, but if we focus too much on policy, that’s not good. It’s time to go less into policy and go into how to do it. In reality existing family planning programme has been expanded to cover a few aspects of reproductive health components including maternal health, safe motherhood, adolescent’s reproductive health, HIV and RTI (key informant interview, representative, Maternal and New born, reproductive Health programme, DG health services, Ministry of Health and Family Welfare, 13 June 2008).

The conceptual premise behind the shift in service delivery mechanism seemed to be about programme performance and sustainability of the service delivery mechanism rather than embracing a broader reproductive health agenda as outlined in the ICPD programme of action. Instead the policy and programmes adopted a targeted ESP, offering limited health care services to the poor, women and the marginalised population. The switch back and forth between doorstep and community clinic, again a partial return to doorstep, abandoning the community clinics and again revitalising them, and the integration and disintegration of two implementing wings of the MOHFW indicates how policy actors with their diverse power relations give meanings, set priorities and contest the interpretation of evidence to evaluate the success of policies.

Table 3.1
*Selected words and corresponding frequency of Strategic Plan for HPNSDP
 2011 - 2016*

Selected words	Policy document	Executive summary
Health	616	29
Service(s)	481	41
Management / managers / managing	313	8
Development(s)	184	22
System	167	9
Strengthening / strengthened / strengthen	157	10
Programme	125	10
Facilities	114	5
Public	113	5
Improving / improved / improvement(s)	102	9
Quality	102	9
Intervention(s)	83	6
Private	82	5
Priority	76	0
Implementation	69	6
Coordination / regulation	61	0
Budget / Budgetary	60	10
Women	52	2
Poor/poorer/poorly/poorest	43	4
Allocation / allocations / reallocation	34	0
Reproductive	29	1
Gender	21	1
Equity	20	2
Voice	10	0
Adolescents	7	1
Tribal	1	0
Men	2	0

Source: Selected words and corresponding frequency of Strategic Plan for HPNSDP 2011 - 2016

A content analysis of 50 most used words in the policy document represented in the word cloud shows the dominant use of words such as health, services, sector, MOHFW, programme, budget, development, public, facilities, planning, intervention, system, management etc. (Diagram 3.1).

Table 3.1 provides the frequency of some selected words in the policy document and in its executive summary showing the similar trend. For the analysis I also looked at how words are placed in relation to other words. For example women were mentioned in relation to women-friendly services and discrimination and violence against women. Gender was mentioned in abstract forms such as “gender based violence” and “gender mainstreaming”. The term reproductive health was used in relation to service delivery such as “reproductive health services including family planning” and in association with adolescents such as reproductive health and the adolescents. Surprisingly while women were mentioned 52 times, men were mentioned only twice in the 38,698 word policy document. Tribal women were mentioned once in the policy document. However, in the executive summary the term men and tribal women were completely absent.

Table 3.2
Word concurrence in the Strategic Plan for HPNSDP 2011 - 2016

Themes	Service(s)	Health
Target-groups	Nutrition service (1) New-born services (1) Midwifery service (1) MNCH service (1) Family planning services (3)	Reproductive and Adolescent health (1) Health and family welfare centres (1)
Implementation of services	Coverage of health services (4) Priority health services (7) Hospital service (2) The essential service package (2) PHC services (2)	- - Access to health care (1) Health care coverage (1) Health system (1) Health information system (1) Primary health care (2)
Improvement in the service delivery System	Improving health services (2) Improving EmOC service (1) Women friendly services (1)	- Strengthening health systems (2)
Policy and Finance		Health (sector) financing (3) Climate change and health (1) Health strategy (1)
Human resource	Motivation and counselling of service providers (1) Performance of service providers (1) In-service training (1) Service sharing (1)	Human resource for health (1) Health workforce (1)

Source: Word concurrence in the Strategic Plan for HPNSDP 2011 - 2016

Taking the two most frequently used two words, health and service(s), table 3.2 shows how these words are used in concurrence with other words and their frequency in the executive summary of the policy document. These “groups of words” can be categorised under five main themes. They are: target groups, implementation of services, improvement in service delivery system, policy & finance and human resource management. These two words also combine together in “coverage of

health services”, “improvement in health services” and “priority in health services”. These themes provide an idea how policy language tends to be biased towards service delivery. This lead to further close investigation of the policy document.

Given the length of the policy document, as the core of the policy document, the executive summary was selected to systematically analyse the framing, who is actually included and how and what and who is ignored and excluded (Gasper and Apthorpe 1996:6). A tabular format of argumentation analysis model developed by Toulmin²² (2009), modified by Dunn (1994) and adapted by Gasper (2000) is used here. The tabular format of the Toulmin-Dunn model presented in table 3.3, allows a clear presentation of how policy arguments follow specific structures and the types of justification used for the policy claim. The model includes four columns. Starting from the top left corner, the model first looks at the Claim, then the proposed supporting Grounds (Data), then the Warrant, principles that are supposed to bridge the move from Grounds to Claims (including stated or unstated assumptions), then the possible counter-arguments, Rebuttals (Gasper 2000:14). Each row represents a particular Claim.

Table 3.3
The argument structure of the Strategic Plan for HPNSDP 2011 - 2016

<i>[Claims]</i>	<i>Grounds [given data]</i>	<i>Warrant [stated/unsta- ted principles/as sumptions]</i>	<i>Rebuttal [Qualifier, Silences]</i>
(C1R1 ²³) [Main claim] Quality and equitable health	(C2R1) 1. [Previously] Both HPSP and HNPSP focussed on pro-poor essential services packages (ESP)/ESD, which resulted in reducing gap between rich and poor	(C3R1) [Implied as- sumptions] 1. Pro-poor	(C4R1) [Counter argu- ments] 1. Despite expan-

²² Toulmin considers three central elements in an argument: i) the Claim, the proposed conclusion; ii) Grounds or data supporting the claim and iii) the Warrant, a rule or principle relevant to the Claim. Toulmin adds some additional categories for practical argumentation these are: iv) Backing, to justify Warrant v) a Qualifier, to modulate the Claim and iv) a Rebuttal, a counter consideration. (Gasper 2000:5-6).

²³ C=Column, R=Row

<p>care for all citizens particularly for the poor will be ensured by improving access to and utilization of health, population and nutrition services. (Planning Wing, MOHFW 2011:viii)</p>	<p>with respect to outcomes in rural areas. (Planning Wing, MOHFW 2011:viii).</p> <p>2. The strategic plan document specifies strategies to achieve its objectives, of particular ones are: (i) expanding the access and quality of MNCH services, (ii) revitalizing various family planning interventions to attain replacement level fertility, (iii) mainstreaming nutrition within the regular DGHS and DGFP services, (iv) strengthening preventive approaches as well as control programs to CDCs and NCDs at all levels, (v) strengthening the various support systems by increasing the health workforce at Upazila, Union and CC levels, (vi) improving MIS with ICT and establishing M&E system, (vii) strengthening drug management and improving quality drug provision, (viii) increasing coverage and quality of services by strengthening intra and inter-sectoral and private sector coordination, and (ix) pursuing priority institutional and policy reforms, such as decentralization and LLP, incentives for service providers in hard to reach areas, PPP, etc. (Planning Wing, MOHFW 2011:viii).</p>	<p>ESP proved to reduce health inequality between the poor and the rich.</p> <p>2. Pro-poor ESP improves access to services</p> <p>3. Expanding the access and improving the quality of MNCH services is necessary to achieve the policy goal.</p>	<p>sion of ESP services since mid-1990s health inequality persists.</p> <p>2. Although the main objective of the policy is to reduce health gap between the rich and the poor, Family Planning remains as the second priority area to achieve the policy objective to reduce gap between the rich and the poor (see C1R3).</p> <p>[silences]</p> <p>Policy remains silent about how intersection of class, gender and ethnicity created existing health inequality.</p>
<p>(C1R2)</p> <p>[supporting claim]</p> <p>Improving service delivery and strengthening health systems will ensure better access and coverage. (Planning Wing, MOHFW 2011:viii)</p> <p>[main assumption to achieve the policy objective]</p>	<p>(C2R2)</p> <p>1. The major components of the HPNSDP are: (i) Improving Health Services and (ii) Strengthening Health Systems and these are interdependent and mutually reinforcing. The component of improving health services aims at improving priority health services in order to accelerate the achievement of the health related MDGs by capitalizing on and scaling up the interventions undertaken under the HNPS as well as introducing new interventions. (Planning Wing, MOHFW 2011: ix).</p> <p>2. The HPNSDP will have elements that would be different and or add value to the current program (HNPS), particularly in addressing maternal, neo-natal health and nutrition. Some notable ones are: (i) emphasizing MNCH interventions/services in the urban slums through a separate OP,</p>	<p>(C3R2)</p> <p>[Unstated assumptions]</p> <p>1. Availability of services in geographical and socially disadvantaged population will ensure their access.</p> <p>2. Service providers are not women friendly enough.</p>	<p>(C4R2)</p> <p>[Counter argument]</p> <p>Service delivery itself will not ensure access unless other cultural and structural factors are not taken into consideration.</p>

(ii) increasing number of skilled birth attendants, (iii) gradually increasing facility based 24 hour/7 days services for appropriate management of maternal complications, (iv) prioritizing areas of high maternal mortalities, geographically and socially disadvantaged population, (v) women-friendly services at the CCs and domiciliary level and by NGOs (where feasible and appropriate), (vi) sharing of expertise and facilities between DGHS and DGFP for MNH services, (vii) strengthening sick new-born services including home-visit by a trained worker within two days of child birth, (viii) rapid and effective referral systems for sick new-borns, (ix) emphasizing LAPM and unmet needs of FP services, and (x) mainstreaming nutrition services through DGHS and DGFP. (Planning Wing, MOHFW 2011:viii).

<p>(C1R3) [Implied claim] The government and the development partners need to continue investing in the family planning services.</p>	<p>(C2R3)</p> <ol style="list-style-type: none"> 1. Strong investments have led to continuous reduction in the annual population growth rate and the total fertility rate (TFR). (Planning Wing, MOHFW 2011:viii). 2. Family planning services are yet to reduce the TFR at the desired level. (Planning Wing, MOHFW 2011:viii). 3. Diversified and country wide mass scale effective family planning service delivery will be emphasized during the next sector program. Increase in population size is set to impede the achievement of economic development of the country. (Planning Wing, MOHFW 2011:ix). 	<p>(C3R3) [Unstated assumptions]</p> <ol style="list-style-type: none"> 1. The desired level of fertility reduction requires stronger commitment to invest in family planning programme. 2. Higher fertility remains a constant threat to economic development. 	<p>(C4R3) [Rebuttal] Unless the government and the development partners continue to invest in family planning services population growth will impede economic development. [silences] Root causes of economic underdevelopment remains unaddressed.</p>
<p>(C1R4) [supporting claim] Combined public and private resources will strengthen the health system. (Planning Wing, MOHFW)</p>	<p>(C2R4)</p> <ol style="list-style-type: none"> 1. Currently the combined public and private sources of health financing are insufficient to achieve full coverage of health services to all. (Planning Wing, MOHFW 2011:x). 2. To strengthen the health systems, the second major component of HPNSDP, MOHFW will give priority to addressing issues in the areas of stew- 	<p>(C3R4) [unstated assumptions]</p> <ol style="list-style-type: none"> 1. Investment in health care system will improve access. 2. Private health care is 	<p>(C4R4) [Rebuttal] Although there is scope for improved utilization of available funds and achieving greater equity, the HPN sector merits a higher</p>

2011:ix). [Backing, supporting argument for C1R2]	<p>ardship and governance, legal and regulatory framework, mainstreaming gender, equity and voice in the core programs, like MNCH, nutrition and strengthening roles of the parasternal organizations like BMA, BMRC, BMDC, etc including effective use of the NGO and PPP. (Planning Wing, MOHFW 2011:x).</p> <p>3. On an average, about 3.2 per cent of GDP is spent on the HPN sector in Bangladesh, of which about one per cent of GDP is allocated by the public sector. This share is low for ensuring a sustainable development of the sector. (Planning Wing, MOHFW 2011:x).</p> <p>3. This also calls for incremental funding from the Development Partners (DPs), who have been providing support to the development of the HPN sector in Bangladesh. (Planning Wing, MOHFW 2011:x).</p>	<p>effective in service delivery.</p> <p>3. The public sector alone is not able to ensure health coverage without the private sector investment.</p> <p>4. Unless a higher allocation in every fiscal year and an incremental funding from the Development Partners (DPs), who have been providing support to the development of the HPN sector is not ensured, full coverage will not be achieved.</p>	<p>allocation in every fiscal year and an upward rise year by year in the share of HPN allocation to national budget is very much needed.</p> <p>(Planning Wing, MOHFW 2011:x). [Counter argument]</p> <p>Policy promotes dual health care systems private for the well-off and public for the poor, offering limited ESP services.</p>
(C1R5) [supporting claim] ESP service to difficult to reach (marginalized and socially excluded) population through appropriate arrangement with NGOs/CBOs will reduce health inequality. (Planning Wing, MOHFW 2011:ix). [Backing, supporting argument for C1R2]	<p>(C2R5)</p> <p>1. The HPNSDP will give priority to address difficult to reach populations through motivating and counselling the service providers for giving adequate care to the marginalized and socially excluded population, strengthen collaboration with the MOSW, MOCHTA, the CHT Board, the NGOs and the private sector. Planning Wing, MOHFW 2011:x).</p> <p>2. ESP will be provided in the difficult to reach areas through appropriate arrangements with NGOs/CBOs to overcome shortage of public sector human resources. Planning Wing, MOHFW 2011:x).</p> <p>3. To strengthen the health systems, the second major component of HPNSDP, MOHFW will give priority to addressing issues in the areas of stewardship and governance, legal and regulatory framework, mainstreaming</p>	<p>(C3R5)</p> <p>[Stated assumption]</p> <p>Collaboration with the NGOs/CBOs and motivating and counselling the service providers for giving adequate care to the marginalized and socially excluded population will ensure their access to services.</p> <p>[Unstated assumption]</p> <p>The poor,</p>	<p>(C4R5)</p> <p>[Counter arguments]</p> <p>1. Poor are seen as a homogenous group undermining their class, gender and ethnic diversity.</p> <p>2. Instead of providing broader health care services policy offers only ESP services to the marginalised population. What is included in the ESP service is open to interpretation of different development actors.</p>

<p>gender, equity and voice in the core programs, like MNCH, nutrition and strengthening roles of the parastatal organizations like BMA, BMRC, BMDC, etc. including effective use of the NGO and PPP. Planning Wing, MOHFW 2011:x).</p>	<p>women and geographically disadvantaged population are seen as passive, powerless and victims of culture.</p>
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Source: Planning Wing, MOHFW 2011:viii-x.

The main claim of the policy document is its objective. The objective of the policy is “to ensure quality and equitable health care for all citizens particularly for the poor by improving access to and utilisation of health, population and nutrition services”. The main assumption underlying the policy claim is that pro-poor Essential Services Packages (ESP) will ensure health care access to the poor and the marginalised to reduce health inequality. Several layers of claims have been made to achieve the policy objective through expansion and improvement in service delivery to achieve greater coverage through Public Private Partnership (ppp).

The main rebuttal shows that policy has given enough thought about its shortcomings and therefore includes a qualifier arguing, “unless a higher allocation in every fiscal year and an incremental funding from the Development Partners (DPs), who have been providing support to the development of the HPN sector in Bangladesh is ensured, full coverage will not be achieved” (see C4R4 in table 3.3).

Table 3.3 further helps to examine logical arguments, how problems are framed and solutions suggested. Health inequality is framed in terms of problem of access to services. Therefore solutions have been framed in terms of strengthening service delivery through collaboration between public, private and NGOs to ensure access to the poor, women and marginalised population (see C1R5 in table 3.3).

This model further helps to systematically identify biases in the logical reasoning in setting priorities. The tone used in the logic for family planning programme reflects such bias, arguing that “unless the government and the development partners continue to invest in family planning services will impede economic development”(see C4R3 in table 3.3). The use of the language “population growth will impede economic development” reflects an unstated assumption that higher fertility is a constant threat to economic development if not taken care of. Policy language is

also formulated in a pleading way to the development partners to continue their commitment in investing in family planning programme.

Coming back to the point I made earlier in relation to evaluating programme success in terms of Contraceptive Prevalence Rate (CPR) and associated fertility decline, here I provide some evidence from the preceding policy interventions to support my argument. The plateauing of the TFR since the early 1990s gained prominence in the first SWAp, the HPSP to achieve the target of attaining replacement level fertility. The excessive bias in the family planning programme was reflected in the fact that programme success was measured in terms of CPR (Mahmud 2004:8). After three years of integration of health and family planning wings of the MOHFW, an assessment of HPSP's performance indicated that maternal mortality and under-five mortality had declined significantly and antenatal care had doubled (Bates et al. 2003), however, contraceptive prevalence rate remained stagnant and the fertility rate was not near replacement level as targeted. This outcome was used as a justification for the reversal of the integration of two implementing wings (as discussed earlier). This is reflected in the second SWAp, HNPSP document:

It is also crucial that there are no slippages in areas where significant gains have already been achieved as for example in the area of population growth. An emerging concern is the plateauing of the total fertility rate (TFR) since the mid-1990s particularly among the poorer strata. Increased importance of temporary methods over permanent methods in family planning, health sector reform in the late 1990s which promoted a one-stop service centre in place of domiciliary (door-to-door) services may have contributed to the observed TFR plateauing. Any reversal in the population frontier clearly stands to weaken the fight against poverty (Planning Commission 2005:xvii).

The vision and targets outlined in the Poverty Reduction Strategy Paper (PRSP) document have been taken as overarching long-term policy framework and political commitment of the government, upon which the HNPSP developed (GoB 2006:9). Reasserting the priority of fertility decline in order "to fight against poverty" successive five year plans under the second SWAp continued to set narrow time bound targets to achieve replacement-level fertility through progressively high levels of contraceptive prevalence (Mahmud 2003:5). A progressive target up to 70-75 per cent was set in the HNPSP. An integrated infant and child

health care approach was also inspired by the intention to reduce higher fertility among poor households, as reflected in the policy:

One major reason for larger household size contributing to the probability of being poor is the uncertainty arising from a low life expectancy at birth and up to five years of age. It is expected that an expansion of the basic health services aimed at reducing IMR and U5MR will help reduce family size. However, the evidence of TFR remaining on a plateau is a major cause of concern which may have negative impacts on population stabilization, household size and the poverty situation. Thus, attention must be given to reactivate the population programme to attain demographic targets (Planning Commission 2005:9).

With the intention to drastically reduce fertility rate among the poor, long-acting and permanent family planning methods were given high priority in the pro-poor Essential Service delivery Package (Planning Commission 2011). A key policy actor from the national research institute justified the shift to long-acting contraception saying:

If you look at the scenario for the use of contraception, you will see that some users have a preference for certain methods. They prefer sterilization, injectables, these are mostly preferred by the poorer women. It's cheaper, easy to use, easily available and also because many women don't even have a proper place to store the condoms. They're living in one room with their children. So there are a lot of advantages for going for injectables, implant or sterilizations (Key informant interview, representative of NIPORT²⁴, 5 May 2008).

This statement supports a strong emphasis for long-acting contraception among the poor, however misinterprets it as poor women's preference.

In the third SWAp, the current HPNSDP sets an even more ambitious target of CPR of 80 per cent by 2016 (Planning Commission 2011:347). Several studies have documented that target specific programmes have a negative effect on the quality of care and promote subtle pressure or outright coercion (Hardon 1997). The government family planning workers are often poorly trained, callous or careless, and under pressure to meet impossible targets. They also neglect to tell about the

²⁴ National Institute of Population Research and Training.

side effects of the targeted family planning methods (Hartmann 1995). Naripokkho (a women's organisation) further found that in the official discourse of research and dissemination of knowledge, the criteria of "safety" of contraception is determined by the probability of contraceptive failure rather than the effects on women's health (Kabeer 1994a:208). Given the absence of provision of adequate information and medical back-up and low quality care and non-accountability of service providers (Hartmann 1985, Mahmud 2004), this target raises serious concern about violation of women's choice and agency.

What emerges from the analysis is that despite incorporating a comprehensive reproductive health agenda, high fertility continues to be framed as the main cause of poverty among the poor, justifying the alignment of fertility reduction under the imperative of macro-economic development goals even at the cost of women's wellbeing. The root cause of poverty and inequality and its link to the global structure of power remains unaddressed (see C4R3 in table 3.3).

3.3.1 Assumptions underlying service delivery mechanism

Although policy suggests that greater availability of services would ensure access to the poor, especially women and the marginalised, the evidence is thin. To ensure equity in health care during childbirth, acknowledging the importance of skilled health personnel during child delivery in the rural areas, the Bangladesh government initiated a program called Community Skilled Birth Attendant (CSBA) under the first SWAp in the mid-1990s. Development agencies such as United Nations Population Fund (UNFPA) and World Health Organisation (WHO) and IDA collaborate in this programme (WHO 2000; USAID and others 2011). The main objective of this programme was to provide a special nine-months training on pre and post-delivery to Family Welfare Assistants (FWA), those who were primarily responsible for contraceptive method supply and counselling at the doorstep. These community-based FWAs are trained to identify high-risk pregnancies and advise women to give delivery at the public health facility (Ahmed and Jakaria 2009; Murakami et al. 2003).

To provide facility based comprehensive Emergency Obstetric Care (EmOC) services to the rural poor, the government established and upgraded Maternal and Child Welfare Centres (MCWCs) in sub-district hospitals. The Bangladesh government, with the help of UNPFA and

WHO, committed to educate approximately 3,000 midwives by 2015. This new cadre of midwives is proposed to provide twenty-four-hour services in sub-district hospitals (Mince 2011). Despite these initiatives, the utilisation of childbirth services at the sub-district hospitals, on which poor women are dependent, remains low.

To address the low use of institutional childbirth services by poor women, the government, in collaboration with the World Bank and WHO, initiated a “demand-side financing maternal health voucher scheme” for poor pregnant women in the HNPS, the second SWAp. Under this scheme poor pregnant women in 21 sub-districts/upazilas were identified by local committees and provided with vouchers to buy maternal health care services (including treatment for obstetric complications). However, concern has been raised that the incentives (maternal voucher) might have discouraged women from poor households to reduce their number of pregnancies, since the reduction in maternal mortality was not associated with corresponding fertility decline during that period (as discussed earlier). Therefore, this measure has been on hold in the most recent HNPSDP for 2011-2016. According to the policy document:

The demand side financing scheme (maternal voucher scheme) has evidence that this has helped to increase the utilization of safe motherhood service, but there are some concerns [...] the risk that some aspects of the design of the incentives (e.g. cash payment, service coverage) may be changing provider and patient incentives in ways that are not supportive of the maternal health objectives (Planning Wing, Ministry of Health and Family welfare 2011:8).

This indicates a policy priority for fertility control over real commitment to ensure maternal health, if it compromises the former.

At the same time health care continues to be commoditised in Bangladesh (Rashid et al 2011; Sobhan 2005). Since the 1980s the government’s inability to provide quality care in the public health care system has been filled by rapidly expanding private health facilities not only in urban areas but also in rural areas. In the mid-1990s, the shift towards integrated reproductive health care service delivery approach in SWAp was particularly geared towards financial and programme sustainability, which advocated reduced reliance on public financing and greater emphasis on mixed public and private mechanisms (Jahan 2004). Following

this trend, the current policy puts more emphasis on private sector involvement, arguing:

The government recognizes the need for wider involvement of the private sector, including non-state institutions for enhancing effective health service delivery. Public Private Partnership (PPP) in services delivery and in the areas of medical and allied education will be further expanded and strengthened with effective monitoring and regulatory mechanisms. PPPs can help address innovations in service design and management expertise, empowerment of the service recipients, protection of environment, social justice and right based service provision. (Planning Wing, Ministry of Health and Family welfare 2011:33)

While the government is encouraging the private sector for innovative and effective health care service delivery, unfilled posts of medical officers at the Thana level, widespread absenteeism, poor performance and negligence are widely documented in public sub-district hospitals. Other research (Mahmud 2004) supports the conclusion that only the poorest section of the population who cannot afford private services have no choice but to rely on the public health sector.

To ensure better quality of care in public hospitals, Naripokkho, a woman's right organisation has been lobbying with the government since 2001, to revive the so-called "upazila Health Advisory Committee" to make the providers accountable by engaging the local people and resources to set up an effective Monitoring and Evaluation (M&E) system. During a key informant interview a Naripokkho representative mentioned that policy language is strong enough but at the sub-district level there is no accountability and functional monitoring mechanism, saying:

There has been a huge investment: a lot of production of doctors, nurses, there are huge health complexes. At the sub-district level, 31- to 50-bed hospitals, there are 9 doctors, including the specialists. Also the emergency obstetric services, there is a post-operative room; everything is there. All of these investments are going to be wasted, because they are not functioning, the doctors are not available there. To make the system functional monitoring and accountability is the key (key informant interview, representative, Naripokkho, 17 May 2008).

In a baseline study covering a pilot hospital at the sub-district level, Naripokkho showed that the number of visitors rose from 1,500 to 6,000-7,000 per month. This shows that if services are improved, more

people will use them. Naripokkho was thinking to replicate this in other areas. However, Naripokkho expressed concern that to continue the committee is very challenging due to lack of commitment from the doctors, saying:

Doctors are very powerful and they don't want to revive the committee. Because if they become accountable there will be pressure on them and they will lose their private business. So they are not eager, there is a need to constantly push them. (Key informant interview, representative, Naripokkho, 17 May 2008).

The current policy also recognises these limitations, but assumes that better governance in the health care system will solve these problems. This is reflected in the policy document:

Weak governance in the public sector has led to unavailability of designated health personnel, pilferage of drugs and other essential supplies, mistreatment and negligence, unauthorized and illegal payments in public health facilities while internal monitoring and oversight mechanisms remain weak. The poor and the vulnerable members of the society bear the brunt of the weak governance in health sector both in terms of cost and deficient service delivery. (Planning Commission 2011:31)

To make improvements in health care service delivery, the most recent SWAp reasserted the need to establish a sustainable Monitoring and Evaluation System (M&E) along with developing Health Information Systems (HIS) and recruiting health care personnel including midwives to provide 24/7 service at the sub-district hospitals (Planning Commission 2011:2).

Despite acknowledging the problems with quality of care and mismanagement in the public health care facilities, persistent health inequality in terms of access to institutional childbirth continues to be framed as low utilisation of public health care services by the poor:

Utilization of public health facilities by the poor remains low despite the huge expansion/construction of physical facilities for service delivery by both DGHS and DGFP. (Planning commission 2011b:5).

The underlying assumption behind such formulation projects poor women as passive, powerless and victim of culture that lack agency to demand for health care services. Therefore, the solution has been sug-

gested in terms of creating demand for services through targeted programmes to women, reflected in the policy document:

The life-cycle approach will be undertaken to address the need of women for general reproductive health and to ensure reproductive health in phases. The vast network of state facilities will be further strengthened for appropriate women, adolescents and reproductive health. The demand for services will be created through strengthened health product involving community and different stakeholders (Planning Commission 2011b:356).

This proposed solution indicates how the crux of the policy has been to create demand and supply of health care goods and services through fostering a network of public, private and NGO/CBO health care providers. This in turn promotes a dual health care system: private for the well-off and public safety net for the poor (see C4R4 in table 3.3).

It has to be understood that the quality of care in the public health sector is tied to the broader policy that promotes privatisation as a solution to effective health care service delivery, seriously undermining investment in the public health care system. Most of the MCH-FP programmes under the “safety net programme” are not part of the broader health care system, making these programmes unsustainable without donor support.

Instead of a holistic reproductive health care approach as outlined in the ICPD programme of action, lack of resources, a real commitment to ensure comprehensive health care and prioritising family planning services all lead to adoption of a narrow “essential service package”, offering limited health care services to the poor, women and tribal population (see C2R5 in table 3.3).

Gender inequality is also addressed in a limited way. Although the policy document recognises discrimination in terms of gender and ethnicity, the policy frames gender inequality in terms of “difficulty to reach the poor”. According to the policy document:

Discrimination in terms of gender, disability, age, type of disease and cultural differences is found with regards to access, equity and utilization of services. Poor women and children, especially those from tribal populations are poorly served by the current system. (Planning Commission 2011:32).

Policy and discourses further homogenise poor women and their need. This was reflected in policy stakeholder's attitude, when he said:

Actually we are a small country, so we are not so much different culturally, and behaviours are more or less the same. There are some differences in the indigenous (*adivasi*) areas. There may be some problems with the languages, but the fieldworkers will adapt according to the programme needs (key informant interview, representative, Maternal and New born, reproductive Health programme, DG health services, Ministry of Health and Family Welfare, 13 June 2008).

The underlying assumption is that if services are made women-friendly, poor and tribal women will use them. Therefore policies include motivating and counselling the health care providers to offer women-friendly services (see C2R2 in table 3.3). Framing health inequality as a problem of access further suggests extension of services to the hard-to-reach areas through collaboration with NGOs/CBOs. A separate section devoted to "gender, equity and voice" in the policy document further suggests:

Voice and accountability mechanisms will be mainstreamed into the governance and stewardship functions of the overall program. A local level accountability mechanism will be developed in participation with the community people and local NGOs. Representation and participation of the particularly disadvantaged and marginalized groups must be ensured in community planning and management mechanisms to cater to their needs and to improve utilization of health services by such groups. (Planning commission 2011:32).

Again the solution is suggested in terms of decentralisation of health care planning and ensuring community participation to include voices of the poor, women and socially disadvantaged population. But what remains silent in the policy discussion is how intersection of class, gender and ethnicity create the inequality women's access to health services that in turn creates the existing health inequality (see C1R1 in table 3.3).

Above all, what policy means by "reproductive health" and what is "essential" for the poor, women and socially disadvantaged population greatly remains dependent on the interpretation of different development actors.

3.4 Contested meanings of reproductive health among development actors

Since meanings given in the policy might be “read” and interpreted differently by various audiences (Goodwin 2013), this section discusses how different development actors further give meaning to the policy in relation to women’s reproductive health and outline strategies to achieve it.

3.4.1 Donor agencies: UNFPA and USAID

Two representatives from UNFPA and USAID were interviewed²⁵. The UNFPA has the reputation and stated goal of working directly with the Bangladeshi government to uphold international UN commitments to women, while USAID is recognised to be primarily responsible to its constituents in the US and their strict adherence to the Mexico City Policy²⁶.

Meaning of reproductive health

Both donor representatives conceptualised reproductive health in line with the ICPD definition. However, there were also differences in perspective between USAID and UNFPA. UNFPA considers ICPD Cairo as the foundation of a “more holistic” approach to population, reproductive health and women’s empowerment. At the same time, the representative expressed a continued need for a specific population strategy and was wary about diverting donor support and policy attention away from population goals and the “unmet need” for family planning services in the context of Bangladesh.

Although USAID has been harshly criticised by women’s right organisations for emphasising population control at the expense of women’s health and gender equality, the USAID representative claimed that the organisation has shifted its strategy since 2006 to incorporate

²⁵ Representatives from the donor community were difficult to make contact with for an interview, due to their busy schedules and an unspoken understanding that a “gatekeeper” was needed to make an appointment. Unfortunately, this situation precluded an interview with the World Bank, to whom many of the stakeholders refer as the dominant decision-maker in the population sector in Bangladesh.

²⁶ Both of the interviewees seemed to offer very cautious statements rather than candid conversations (the USAID office would not allow a recording of the interview).

more comprehensive reproductive health and rights goals. As a proof, the representative stated that the health budget of USAID this year would be “nearly half-half”—half of the budget would go to family planning programmes, while the other half will go to reproductive health and general health programmes. He saw ICPD Cairo as a paradigm shift, but in his explanation, he inadvertently acknowledged that the donor shift to health care approach was motivated principally by the desire to reduce fertility:

First, we saw family planning as just a vertical activity. [But] after 15 years, people realised that looking only at family planning isn't very successful. So the programme wasn't totally redone, but it was integrated into a broader health strategy (Key informant interview, representative, USAID, 3 July 2008).

The representative redefined the notion of reproductive health and rights in the Bangladeshi context, narrowly referring to family planning:

Reproductive health and rights is about the clients' rights and choices. But the Bangladesh perspective is different from maybe the western perspective. Women have the right to choose any method, even permanent ones, but we are only promoting reproductive rights within the framework of the Government policy. If we wanted to promote sterilisation for women with one child only, for instance, there would be vehement objections from the community. So there is some discrepancy, yes, between a western or international approach and the local cultural context (Key informant interview, representative, USAID, 3 July 2008).

Despite giving reference to the definition of reproductive health in line with the ICPD, the donors seem to adapt a local definition of reproductive health in line with Bangladeshi population policies prioritising family planning. At the same time, the UNFPA representative further rejected any critique of population control objective of the population policy by other stakeholders, especially women's right organisations, saying:

If the government had a strict population control mentality, then there would have been 100 per cent CPR, because the messages have been disseminated. The fact that the CPR is not 100 per cent indicates that the clients have total free choice and will. The gap is in the attitude, which takes time to change (Key informant interview, representative UNFPA, 18 June 2008).

Perceived obstacles/proposed strategies to ensure reproductive health

Donors see cultural barriers as a persistent problem to ensure reproductive health. According to the UNFPA representative “It’s not a question of supply or un-affordability of services, there is still a question of tradition; maybe wanting a son, maybe mothers-in-law are uneducated”. Besides the cultural factors “lack of trained midwives in rural areas” is seen as the main obstacle to ensure EmOC during childbirth.

Given the shortage of human resources in the government health care sector, both representatives supported privatisation of health care services. While encouraging private sector involvement in ensuring health care access (mainly to the middle class), UNFPA was the only stakeholder to bring up the issue of corporate social responsibility and insisted that private sector actors “have an ethical and moral responsibility to the country”. She emphasised the common consensus that the government must continue to provide a strong safety net for the poorest of the poor:

Private sector should be encouraged more to provide health care services. And also I’ve seen the Corporate Responsibility—it’s coming up, but very negligible. It should be more. They are making so much profit selling their products to the clients and to the poor, but they are not feeling debt to the society. They have an ethical and moral responsibility to the country because all the products have been produced here, they have been sold here. If people could take some areas to share the responsibility in the health sector, that will be good. (Key informant interview, representative UNFPA, 18 June 2008).

A major donor of many NGOs, USAID overtly promotes fees-for-service and partial privatisation of the family planning and reproductive health services. The representative considered that access to contraceptives and basic health services was fairly well ensured by the supply-side approach and saw relatively minor rural-urban disparities in health care access.

The real problem to ensure reproductive health according to these donor organisations is not related to policy but to problems in programme implementation. The UNFPA representative considered the internationally-led establishment of measurable, result based strategies, such as the MDGs and PRSP, to be a landmark in the policy process in Bangladesh.

UNFPA viewed the shortage of skilled personnel as a problem. While strongly supporting the Government's strategy to improve community-based health care and train skilled birth attendants, the representative was suggesting an intermediary, semi-professional cadre to meet the human resources shortage in the health care sector. In this case, the representative called for training of a professional midwifery cadre, as this group would require fewer years of training and would be more willing than professional nurses to go out to the rural areas.

The two representatives differed in their perceptions of political shortcomings. According to the UNFPA representative the government's reproductive health and population policies are a successful outcome of the cooperation between donors, NGOs and the government saying:

In Bangladesh, it has always been very development-oriented...I think it's one of the smoothest programmes in the world, if you look at other neighbouring countries. I don't think that politically there are any problems. In fact, there has always been the highest level of commitment, from the highest levels of the government (Key informant interview, representative UNFPA, 18 June 2008).

In contrast, the USAID representative was willing to recognise that political factors—particularly shifts from one government regime to the next—strongly influence the direction and outcomes of health policies and strategies. He believed that the government's cyclical shifts from door-to-door to community-based service provisions were the result of political regime changes, rather than solid evidence:

The quality [of reproductive health services] has been impeded by changes of the government. New approaches are coming with the new employees. For example, rather than emphasising on-going door-to-door family planning, the government is now thinking of training skilled birth attendants for community clinics (Key informant interview, representative, USAID, 3 July 2008).

The USAID representative contended that stability and continuity of political and financial support for a particular policy were far more important than the choice of a particular service-delivery strategy, arguing:

Some are talking about midwifery...Others are talking about creating a cadre of community level health professionals [Whatever it is,] we have to come up with a strategy that won't shift when a new government comes

into office. (...) The bureaucrats are not really a problem, they understand the issue, but ultimately the politicians influence the process. So maybe we need to launch a programme to raise awareness among the politicians. (Key informant interview, representative, USAID, 3 July 2008).

The donor representative's wish seems to have been realised. To ensure programme continuity, for the first time in Bangladesh, the Poverty Reduction Strategy Paper (PRSP) known as National Strategy for Accelerated Poverty Reduction II (NSAPR) for 2009-11, (under which population and health strategy papers are prepared), was placed in the cabinet and in the parliament for people's representation. It was further incorporated in the political manifesto of the political party (Awami League) that was and still is in power.

3.4.2 Political Parties

Representatives from four major political parties²⁷, Bangladesh Nationalist Party (BNP), Awami League (AL), Communist Party of Bangladesh (CPB) and Jamaat-e-Islami (JI) were interviewed.

Meanings of reproductive health

National level political party representatives expressed fluid and sometimes contradictory meanings of reproductive health and rights ranging from welfarist to right based approaches. Despite ideological differences between the four parties, all of them considered population growth as a problem, though there were differences in the way they approached the problem. BNP and Awami League (AL) consider population reduction as a means to achieve development goals. According to the AL representative:

There is a need to control population, because those who can afford, who are able to provide and give proper education to their children and turn them into human resources are limiting their fertility. But those who need

²⁷Among four main political parties, Bangladesh Nationalist Party (BNP) and Awami League (AL) represent the main two ruling parties that were in power. Their political ideology is reflected in the policies they had pursued during their political regime, while the Communist Party of Bangladesh (CPB) and Jamaat-e-Islami (JI) Party provided a template for the policies they would have pursued if they were in power. The Jamaat-e-Islami interview was highly controlled; the questions were requested ahead of time, and the interviewee returned a typed statement in response to the main themes covered. Specific questions about gender equality and/or minority groups' access to services were not answered.

to control are having more children. (Key informant interview, representative AL, 12 December 2014).

In the same line the BNP representative said:

Look, all over the world we are facing food shortages, water shortages. How do you tackle this? I think [whatever may be said against population control], there has to be a way of addressing this. We should have followed the path that China took a long time ago (meaning one child policy). (Key informant interview, representative BNP, 12 May 2008).

The AL representative thus favours fertility limitation policies for the lower classes, while the BNP representative's statement shows a strong support for repressive family planning measures. Looking back to the 1970s and 1980s as the most successful years of reduction in population growth rate and most concentrated political will and resource allocation, the BNP representative argued that:

A few decades ago, population control was a very popular theme among government and among the political parties. The allocation of government resources in this area was also pretty high. But if the government would have [continually] pursued an aggressive policy, it would have worked even better. (Key informant interview, representative BNP, 12 May 2008).

The JI representative specified that "there is no state coercion or religious coercion (in family planning practices) except for some sporadic cases." Nonetheless, the party representative noted that the high maternal mortality rate in Bangladesh is a result of the "anomalous focus of the program, mainly aims at reducing birth rate" rather than ensuring comprehensive maternal health care and wellbeing. He used language of the Capabilities Approach to describe a view of population as a resource, rather than an obstacle, for development.

The JI representative felt that the term "reproductive rights" did not accurately describe the limited claims and understanding of illiterate and underprivileged rural women in Bangladesh. He defined reproductive rights in terms of "a woman's right to motherhood", describing motherhood as a woman's "born purpose". He also sharply criticised the "neo-colonial" influences of multinational corporations for "encouraging a culture of free sex" by marketing emergency contraceptive pills in Bangladesh, saying:

Multinational companies are promoting emergency contraception and post-abortion care, while simultaneously forbidding MR-related services—are “hypocritical” and “the most fundamentalist of all”. (Key informant interview, representative JI, 21 May 2008).

The representative of the left wing political party CPB also criticised the meaning of reproductive health saying:

Reproductive health is considered by most people as something that doesn't need much attention. If a woman gives birth, it's considered her job. If she falls sick, people say she must have done something wrong, that's the mentality. The very idea of reproductive health is absent from the social psychology. In the countryside, there's the tradition of using Traditional Birth Attendants, but their activities aren't organised. Until we can provide enough maternal clinics, we should provide training to these Traditional Birth Attendants. (Key informant interview, representative, CPB, 8 May 2008).

He also criticised the use of the reproductive rights concept arguing that Bangladesh has imported poorly understood concepts of reproductive rights rather than developing concepts that make sense in the country specific cultural context:

The concept of reproductive rights isn't properly understood; it's just being imported wholesale from the west in our efforts to be more modern, and it's creating a cultural divide between the masses and the elite. Eventually, this will create a backlash. (Key informant interview, representative, CPB, 8 May 2008).

Perceived obstacles/ proposed strategies to ensure reproductive health

The Jamaat-e-Islami Party and CPB share a political vision of establishing a social welfare state in Bangladesh to ensure health care for all. Despite radically different ideological orientations, both party representatives identified their goals for the reproductive health and population sector as being part of a holistic picture of improving national health and standards of living. Both argued that the recent population strategies had been geared too much toward family planning and not enough toward ensuring basic health care of the poor. Both parties believe that it is essential to continue restraining population growth, but with greater em-

phasis on improving overall health and (especially for CPB) more equal distribution of national resources.

According to the JI party, the main obstacles to better reproductive health care service provision and policies are corruption and mismanagement at the national level. Specifically, the party representative criticised the high degree of centralisation and corruption in the health sector, the emphasis on hospital care rather than prevention and the shift from field-based services to community clinics. He also urged greater mobilisation of community resources and emphasised several times the need to investigate the potential of alternative and traditional medicines in ensuring people's health.

The CPB representative criticised the donor community (particularly the World Bank and IMF) on the basis of its neoliberal, private-sector orientation, its deference to the interests of "the corporations", and its excessive influence over national policy-making decisions saying:

The policy we have now is piecemeal; we are just trying to respond to international requirements. Actually, donor money is our main source of capital accumulation at the moment. Only it's not being invested in anything productive. The old conservative of "trickle-down" economics is still in place, supported by the donors. Actually, in Bangladesh we have two health care systems now; one for the elite and one for the poor. Health is being turned into a commodity, like purchasing groceries. (Key informant interview, representative CPB, 8 May 2008).

In contrast, the BNP and AL representatives both strongly lauded and encouraged the private sector in improving the quality of reproductive and specialised health services. Described in terms of "trickle-down", the AL representative candidly admitted that the private sector had mainly helped those people who can afford more upscale medical services, and that the government would have to remain responsible for meeting the needs of the poorer segments of the population, resonating his support for a dual health care system:

We are strongly giving emphasis on the public health sector. But, the private sector is providing service to a certain group of population who can afford. It reduces the load on the public hospitals. For example, in the Dhaka medical college hospital we had the capacity for 500 patients but we had to treat between 1,200-1,500 patients. We increase the capacity up to 1,000 patients but we get 2,000 to 3,000 patients. Those who can afford

are going to the private sector. The rest are coming to the public hospital. If the private sector would not be there we would have more than 10,000 patients in the same medical college hospital. There would be a problem to receive treatment. When the private sector is reducing load on the government there is no reason not to discourage the private sector (Key informant interview, representative AL, 12 December 2014).

The BNP representative saw a vicious link between poverty, higher fertility and poor reproductive health suggesting that poor people continue to overpopulate and thereby remained mired in poverty and ill [reproductive] health because they are either too selfish, short-sighted, or poorly educated to restrict their family size to the limits of their household resources, and by extension, to limit their procreation for the greater benefit of Bangladesh. Thus, he argued, a national family planning programme (linked to but distinctly separate from the other health programmes) is essential, reflecting a paternalistic view towards the poor:

First of all we have to educate the poor and motivate them to understand that they should not have children beyond their means. Second, they should educate the children properly. Third, they should think of the nation at large, the number of mouths that the nation can feed. (Key informant interview, representative BNP, 12 May 2008).

Assigning women to their biological reproductive role, he saw women's empowerment (especially through employment) as an essential tool to reduce existing health inequality. The representative offered no concrete strategies for improving women's status. He rather suggested that women have the responsibility to "come up and establish their rights".

Being the political party in power, the AL representative strongly focused on the government's commitment and highly emphasised on proper implementation to ensure health equity for the poor specially women:

Policy is important, but the most important is the implementation. Previous governments also implemented the same policy, but 60 per cent of the government medicine used to be sold in the private market. You can say government medicine used to be stolen from the public hospital and poor people didn't receive proper treatment. We did not only improve proper monitoring, we changed the packaging of government medicine with green and red papers, with big letters we wrote, "not for sale". If someone

steals the medicine and goes to sell them in the private shop, the shop owner will be afraid to buy them, the person will be at risk of being caught with the label on it and the client will be afraid to buy that medicine from a shop. There will be barrier from three sides. Due to these measures now the medicine is available and poor people are getting their treatment in the public hospitals.

To improve maternal health we are giving EmOC training to one doctor and an anaesthetist for each sub-district hospitals and made it mandatory for them to work at the sub-district hospitals at least 2/3 years. Now we don't have shortage of doctors at the sub-district level. These show strong government commitment for policy implementation. You can see the results are visible in the national statistics. Maternal mortality has reduced significantly. (Key informant interview, representative AL, 12 December 2014).

He also gave emphasis on follow-up and programme continuation emphasising revitalisation of the community clinics to ensure care at the "grass-root" level.

All four political party representatives showed a paternalistic approach to reproductive health for women. Their suggestion ranges from effective policy formulation to efficient implementation; from quality services through more resource allocation to access to education, employment and health care services. But none of the state actors mentioned that women should be actively involved in the planning, monitoring and implementation of measures to achieve their own reproductive health agenda.

3.4.3 Production of knowledge on reproductive health: research institutions

To analyse the type of knowledge being produced by disciplinary institutions to represent women's reproductive health need, key informants

from three research institutions NIPORT, BIRPERTH and ICDDR,B²⁸ were interviewed.

Meanings of reproductive health

Among these three research institutions, NIPORT was directly involved in policy forums, while ICDDR,B and BIRPERTH contributed indirectly through their research results. All three research institutes were established in the 1970s and 80s with the objective to control population growth. This ideology was very much reflected in their conceptualisation of reproductive health, overly biased towards fertility reduction. NIPORT and ICDDR,B representatives were critical (in different degrees) about the shift from Family Planning to the Integrated Reproductive Health agenda and showed support for family planning programme priority to sustain the past achievements.

The NIPORT representative deplored the organisational shift from family planning and population issues to reproductive health issues since ICPD Cairo. He called for strengthening and supporting the family planning components of reproductive health programmes and policies:

[Since ICPD], people suddenly started talking too much about Reproductive Health, taking imbalance with Family Planning. We thought it is very important that we don't shift too far away from Family Planning, even though both are very important and should go hand in hand (Key informant interview, representative NIPORT, 5 May 2008).

Similar to NIPORT, the ICDDR,B representative felt that the government should not lose the ground gained over the past decades in population control, stating that:

Before the population policy intervention, the condition of our country was severely dangerous. The government's shift to a broader reproductive health and empowerment agenda had jeopardised the future economic se-

²⁸ NIPORT receives major financial support from the Government of Bangladesh. Some additional funding is provided by donors (including USAID) for specific projects and surveys. *BIRPERTH is also a government-established research institute, which conducts nationwide surveys on contraceptive use and reproductive health behaviour.* The third research institute ICDDR,B was originally established to research on diarrheal diseases. Over the years ICDDR,B expanded its research projects on reproductive health issues, including maternal health, family planning, reproductive tract infections, and HIV/AIDS. It also provides training on STIs, offers baroscopic sterilisation, and has organised at least one workshop for madrassa (religious school) teachers, to encourage them to introduce reproductive health issues into their religious curricula.

curity of the country, by diverting valuable human and financial resources from a still-needed population programme in Bangladesh (Key informant interview, representative NIPORT, 5 May 2008).

Two interviewees at the BIRPERTH centre were reluctant to speak on policy issues, since they considered themselves principally as scientists and not policy actors. Despite strongly supporting family planning programmes, they did specify that women's rights and empowerment need to be incorporated more fully into family planning programs. They added that the burden remains on women (not men) to choose and use contraceptive method, hinting at the lack of male participation in family planning programmes.

Being directly involved in the policy forum, the representative of NIPORT identified male dominated culture as responsible for this contraceptive burden on women:

You know, it is a male-dominated society. If you look at the CPR rate, the use of condoms is increasing. So you cannot say that the men are not coming. But if you look, the sterilisation clients are mostly women, even though the non-scalpel vasectomy is the safest method, and it's available everywhere in the country. Very few males are using it, even though the FP directorate is giving more emphasis on male participation, but culturally, male participation - not only in FP, but also in reproductive health—women are not being helped much to go to ante-natal care. Campaigns are helping, but there is a long way to go (Key informant interview, representative NIPORT, 5 May 2008).

Given the fact that BDHS data discussed in the introductory chapter has shown that condoms are mostly used by educated "couples" and the private health care market provides most of the condoms, this statement highlights that poor men are seen as ignorant about the family planning programme. The representative did not mention the cost of condoms as a barrier for poor men.

One interesting finding among all three research institutions is their positive attitude towards Menstrual Regulation (MR). The NIPORT representative said, "I am a very strong supporter of MR...I think MR is doing a very good role, and we should make it stronger in practice". The BIRPERTH representative mentioned that access to morning-after pill could really reduce unsafe abortion rate.

Perceived obstacles/ proposed strategies to ensure reproductive health

Availability of services and women's economic solvency were seen as a crucial factor in accessing reproductive health care (with an emphasis to family planning) services. The NIPORT interviewee's strongest recommendations were to decentralise government health services and to place a stronger emphasis on improving women's post-natal care-seeking behaviour hinting that it would provide opportunity to give contraceptive counselling after childbirth.

Two BIRPERTH representatives did specify that women's rights and empowerment need to be incorporated more fully into family planning programmes. They added that most women lacked proper information on the choices available to them. One representative suggested, "Women have to be economically solvent before they can have better reproductive health knowledge and claim their rights".

Women's "economic solvency" was cited as a critical prerequisite for improving their reproductive health, health awareness, and health-seeking behaviour. This reflects how women's empowerment is understood in instrumental terms to ensure their reproductive health and well-being. None of these research organisations talked about the privatisation of health services and women's unequal access to the private market for their health care needs, but all research institutes believed that NGOs working for the benefit of the government had been successful in gradually elevating women's awareness and social status.

These research institutes have created a space for systematic production of "evidence" to inform policy. NIPORT is directly involved in policy forums, and provides statistics, survey results, technical reports, and direct advice to the government. One of its important research projects is the Demographic and Health Survey, which is a reliable point of reference for reproductive/population policy makers.

Rural women's reproductive needs constructed by these research institutions become the "truth". They all share a strong bias towards fertility control, conceptualisation of women's empowerment in instrumental terms to ensure reproductive health, and the absence of any recognition of the structural inequalities that create the existing health inequality, thus making a perfect match with the policy discourse.

The knowledge produced by these research institutes on the claimed “need” for long-term contraception among poor women, fosters the interests of health service providers, international donors and multinational pharmaceutical companies. This construction of needs created by disciplinary research institutions further shapes the government policy of offering long-acting (implant) contraception under donor supported essential service package to poor women. Knowledge produced through research institutions thus shapes the reality by influencing the shaping of practice.

3.4.4 Development NGOs

To understand the dynamics of the relationship between the government and NGOs²⁹, a few NGOs were selected on the basis of their important involvement in policy formulation and service delivery. The NGOs that were interviewed can be roughly divided into two groups: the large, national NGOs like BRAC and Grameen, and other internationally funded NGOs like Engender Health (EH), FPAB and Friendship. The NGO category of health provider also includes private companies like the Social Marketing Company (SMC)³⁰. The organisations interviewed provide a variety of direct health care services in the domains of family planning, maternal and child welfare, and emergency obstetric care. Besides service delivery, FPAB and Engender Health are also involved in policy forums, which include advocacy and lobbying, providing technical assistance to

²⁹ The category of NGOs covers a variety of private and civil society organisations. Some of the NGOs are registered with the DG FP Directorate and working in the remote areas, where government services are difficult to reach. Several of these NGOs began with family planning/population services and later shifted their activities to incorporate broader reproductive health and primary health care activities. Besides the big national NGOs like BRAC and Grameen there are other small NGOs like Friendship who is involved in health service provision among outreach population.

³⁰ SMC is the major provider of government-subsidised contraceptives (mainly condoms and pills), as well as some for-profit health products, such as the oral re-hydration therapy “Orsaline” and iron supplements. SMC primarily markets short-term contraceptive methods but has found through market research that there is also demand for longer-term methods (which is of course in line with current Government priorities). SMC’s activities include public health campaigns (through media and in-school presentations) accompanying their health products, market research, distribution of various branded contraceptives in 20,000 pharmacies, and some advocacy campaigns. Recently, the company is calling for government support to allow a corps of unofficial “rural medical practitioners” (people with professional degrees, but not necessarily medical degrees) to be trained in providing clinical services such as insertion of IUDs.

the government, revising policies and guidelines and providing training to different levels of health care providers.

Meanings of reproductive health

Despite divergences, development NGOs conceptualise reproductive health in terms of equitable access to reproductive health care services. As national NGOs, BRAC and Grameen follow all government health and population policies, including MR. The BRAC representative agreed that at one point in the past, health policies had been geared primarily toward family planning rather than population health and wellbeing, but he was satisfied that since the 1990's (particularly since ICPD), the message had improved:

Now we are not saying anymore that “you have to keep your family small, but also that you have to keep them healthy and, to take care of the good health of all of the family members. So this is a shift in our approach” (Key informant interview, representative, BRAC, 21 May 2008).

The Grameen representative referred to the Alma Ata declaration as the foundation for comprehensive, needs-based primary health service provision. Grameen Health claims to be “mainly service-oriented”, and to be the pioneer of micro health insurance programmes in Bangladesh. The NGO also introduced a full diagnostic centre and limited (needs-based) clinical facilities. In the reproductive health domain, the NGO appoints a cadre of Community Health Assistants (who have completed up to 12 years of schooling) to reach the community members with health education and services. The RH programmes attend to safe motherhood and delivery, ante-natal and post-natal care, teenage RH services, and Emergency Obstetric Care. Grameen also began providing MR services in response to the high number of unwanted pregnancies.

In discussing gender issues, the Grameen representative did not speak much on the issue of women's rights, but did mention gender-specific health vulnerabilities (including social causes), such as rural women's higher risks of HIV/AIDS (due to husband's multiple partners), the reluctance of rural women to visit a male doctor, the low skills of traditional birth attendants, and the young age of marriage. In one instance, the interviewee stated that he had refused to provide MR service to one Hindu woman, on the grounds that the man who accompanied her to

the clinic appeared not to be her husband. This reflects that restrictive³¹ MR policy and the moral judgment of the provider took precedence over women's personal claims to their reproductive rights.

SMC representative claimed that they view reproductive health as the right of all women as well as "eligible couples" to have access to a range of contraception. Recently in their marketing campaigns they are trying to encourage male involvement in seeking reproductive health services and products. The reason for this is not inspired to reduce the disproportionate contraceptive burden on women but due to the fact that "men are the primary decision makers in the family and they have the most purchasing power". Given women's low purchasing power, SMC representative viewed availability of contraceptive as a way to empower women, saying, "We are trying to empower women with the availability of contraceptive methods".

The FPAB³² representative acknowledged that policies had generally been geared toward family planning in the past, but appeared satisfied that other components of reproductive health services (including post-partum care, EmOC, and safe motherhood) have been integrated with the support from international donors.

FPAB is one of the few stakeholders that actively supports abortion as a woman's right and actually provides the service to women. FPAB presents its current package of services as the "5 A's: Access (to contraception), Abortion, AIDS, Advocacy, and Adolescent Health". Yet, while the interviewee noted that "it's a woman's body, she obviously should take the decision", she also stated that the organisation required the consent of a male guardian (not necessarily husband) in order to perform an MR.

While many of the USAID-funded NGOs were reluctant to discuss USAID's anti-abortion/ anti-MR stance, the interviewee from Engender

³¹ MR policy demands husbands consent to use the service.

³² Besides service delivery, some of the NGOs are also involved in policy forums. Family Planning Association of Bangladesh (FPAB) and Engender Health (E.H) are two of such NGOs interviewed.

Health (EH)³³ considered it as “a little funny” that USAID don’t fund abortion-related programmes but did fund post-abortion care. He did not feel compromised by donors’ restrictions noting that EH had previously supported a large post-abortion project with USAID funds.

Perceived obstacles/ proposed strategies to ensure reproductive health

The government-NGO collaboration is seen as a unique and successful partnership in Bangladesh to provide health care to the “hard to reach” population. However, co-ordination and monitoring this large number of NGOs to achieve its objective was considered as a problem:

There is NO good mechanism for monitoring the NGO sector. A mechanism is there, but it’s not able to keep up with the actual situation. It’s not set up to provide supervisory support to the large number of NGOs in this sector, which is growing fast. If you look at it from the eyes of the government, it is a problem, because each NGO may have different policies and strategies, which may not be aligned with the national strategy. We’ve been urging the government to have a stronger co-ordination and monitoring mechanism, which has not been happening yet (Key informant interview, representative, Engender Health, 4 May 2008).

While Engender Health strongly supported government emphasis on long-acting contraception, the Friendship representative criticised the “supply ethics” of the family planning programme, saying:

Government told us to address the copper T and sterilisation in each of our 104 *chars* (river bank areas) we’re working. We told the government that we should start with condom, and then we will think about other contraceptives. It sounds nice in the policy. But the field scenario is different from our thinking. Without going to the field, you can’t even realise the problems of the poorest of the poor (Key Informant interview, representative FRIENDSHIP, 6 June 2008).

³³ Engender Health (E.H) another influential actor (representing medical professionals) offers technical assistance to the government on population and health issues. According to the interviewee, a milestone event in RH and population policy formulation, in which E.H played a significant role, was the development of national standards for family planning service delivery. Engender Health has been one of the only NGOs invited to participate in the development of key national strategies in the domain of reproductive health, including the National Strategy for Maternal Health, the Adolescent RH Strategy, and the National Guidelines for Service Delivery on STIs and RTIs. E.H has a couple of projects working on fistula in 20 districts, also providing technical assistance to the Ministry of Health.

A few other NGOs advocated for legalisation of abortion to ensure women's reproductive right. For example the FPAB representative said:

Worldwide movement is going on to legalise abortion law. Though through MR, several lives of women are saved but the government do not want to lobby for this. Besides the word "sexuality" is a mistaken notion. Sexuality is mistakenly refers to have sex with somebody. So making sexual rights a national policy is seen as spoiling young generations (Key informant interview, representative, FPAB, 19 June 2008).

Despite differences in their views and opinions, these development NGOs supported privatisation of health care provided that the government should take care of the poor and strongly emphasises on the availability of reproductive health care services to ensure women's reproductive health and rights. Among all the development NGOs, FBAP was the strongest in favour of privatisation, arguing:

Universal coverage in the health sector was ultimately detrimental to the quality of government care. If free service for all is stopped and ensured only to the poor people, then the primary care for the poor will be better ensured. (Key Informant interview, representative, FBAP, 19 June 2008).

BRAC interviewee tended to emphasise geographic isolation naming isolated areas such as Sylhet and Chittagong and some unspecified "cultural factors" as the main obstacles to better health access. The Engender Health representative further emphasised other social aspects such as education and employment for women to protect their health rights.

Being a development partner of the government, except Friendship, none of them had any major disagreement with government policy directions. In the context of India, some Unnithan and Heitmeyer (2012:307) argued that in the partnership with the state, NGOs are caught within the paradigms of neo-liberalism³⁴ and market ideology, which they seek to subvert. This seems to be relevant in Bangladeshi context as well.³⁵

³⁴ By neo-liberalism I mean, a market-based techniques of government within the terrain of the state itself, where new constructions of "active" and "responsible" citizens and communities are deployed to produce governmental results that do not depend on direct state intervention (Ferguson 2009: 172).

³⁵ Hours (1995) considers that the NGOs in Bangladesh represent a new class of educated elites, holding a neo-liberal discourse of western development.

3.4.5 Women's organisations

Representatives from three women's organisations, Naripokkho, Ubinig and Bangladesh Mohila Parishad (BMP) (three interviews), which are pioneering women's organisations in Bangladesh, were interviewed. This group of women's organisations include both academics and activists. These organisations are amply rights-based, promoting an advocacy agenda of women's empowerment rather than providing reproductive health care services.

Meaning of reproductive health

Women's rights organisations conceptualise reproductive health in relation to women's subordinate position, patriarchal norms and unequal gender power relations. Naripokkho, with other women's right based organisations, actively protested in reaction to the death of a woman due to coercive contraception (Implant) in the 1980s. During that time the issue of health rights and choice gained attention in the public domain. Beside campaigns and protests they started advocacy and lobby with the government to push women's health rights issues on to the policy agenda. Naripokkho was involved in organising and participating in a lot of workshops and seminars at the national and international level to identify the cause of maternal deaths in Bangladesh. Naripokkho with their research and publications started to raise awareness regarding safe motherhood issues. In the mid-1990's, Naripokkho changed its opposition position and became a strategic partner with the Government. A Naripokkho member was invited to be a delegate of the government to the ICPD conference in Cairo. In their realisation:

It is not enough to lobby for policy change. Whatever is said in the meetings and seminars has no impact on women's lives. The main beneficiaries, the women, don't know what there is in the policy. They only know that they have no access to the services. Services must be accessible to women if we want to reduce health inequality and maternal mortality in Bangladesh. (Key Informant interview, representative, Naripokkho, 17 May 2008).

As a civil society organisation, Naripokkho was engaged in the consultation process during the preparatory phase (1996-1998) of HPSP design (discussed in Chapter Three), at the invitation of the donors and the government, although its implementation became a government-donor

driven programme disconnected from civil society participation (Jahan 2003: 183). However, Naripokkho contributed by lobbying with the international donors to make the government committed to safe motherhood programmes to reduce maternal deaths.

In contrast, Ubinig³⁶ took a categorically radical stance against all population programmes, arguing that the government (supported by the donor and pharmaceutical communities) uses women's bodies as instruments to implement a eugenic and Malthusian population-control mission. Ubinig's representative considered that powerful corporate interests are acting through women's docile bodies to market reproductive technologies, whether they be promoting fertility drugs (in the West) or using women as "guinea pigs" to test new contraceptives (such as Implant) in the developing world. Implicated in the corporate/pharmaceutical "conspiracy", the donor community was also accused by the interviewee of having ulterior motives in the areas of reproductive health promotion and making use of women's social inferior position to advance their own agenda. In the opinion of the representative, the term reproductive rights serves the interest of population control:

All the donors are interested in pouring money into women's rights programmes, as long as they're taking care of their fertility. (Key Informant interview, representative, Ubinig, 4 June 2008).

Given the complete rejection of clinical contraception, Ubinig is calling for the promotion of traditional contraceptive practices such as withdrawal and periodical abstinence instead of "imposing clinical methods on women".

Reproductive health was defined by one interviewee of BMP as "the rights of women to protect their own bodies". The interviewees stressed that women remained largely defined by their reproductive capacities:

This reproductive function is creating a barrier for women, physically, mentally, and socially, through the family, society's systems. As a women's rights group, it is our foremost duty to deconstruct these gender ideologies. Reproductive rights are the fundamental issue of our organisation,

³⁶ Ubinig is one of the more radical women's rights activist organisations. Ubinig is primarily a lobbying and research organisation that has from the start strongly opposed fertility control and is currently involved in research and advocacy campaigns against new reproductive technologies. Ubinig receives most of its support from private, international donors with 'feminist agendas' and does most of its advocacy through publishing and attending international conferences.

because every problem for women starts from centring the women reproductively. (Key Informant interview, representative, BMP, 11 June 2008).

BMP strongly feels that the current programme doesn't ensure women's reproductive health and rights and the burden remains on women to use contraception.

All three organisations strongly criticised donor influence over population and reproductive health policies, arguing that most of the pivotal policy changes over the decades had been donor-driven or internationally imported:

Whenever any issues (such as reproductive health) become highlighted internationally, the government goes for implementing those, without cross examination. Does it relate to our cultural context or not? They are fully donor driven. (Key Informant interview, representative, BMP, 11 June 2008).

All women's organisations consciously avoided using the term reproductive health rather used women's health (*narir shashtba*) due to the fear of backlash. To give an example a BMP representative mentioned that the slogan "My body, my rights" that had previously been promoted by Naripokkho experienced backlash, because it had been imported wholesale from Western feminism, which was inappropriate in the Bangladeshi context.

Perceived obstacles/ proposed strategies to ensure reproductive health

Women's organisations perceive aggressive population control policy, unequal access to services and an oppressive culture as barriers to achievement of women's reproductive health and rights. One similarity among these three organisations is their stance against privatisation. All three organisations have been lobbying hard for the past several years against the privatisation of health care (promoted primarily by the World Bank). They think the government should provide the services to ensure women's access to services. Ubinig's representative believed that the donor community, especially the World Bank, dictates the policies of the Government of Bangladesh, leading the government more and more in the direction of privatisation of health services.

Although all three women's organisations ideologically disagree with the government policy approach, all of them have different priorities,

policy stances, advocacy campaigns and different relationships with the government and other development actors.

BMP doesn't oppose family planning services outright, seeing that they could be useful tools for women's empowerment and independence if accompanied by sexuality education, property rights, income independence, and other basic human rights that Bangladeshi women need in order to be aware of and claim their reproductive health rights.

Rather than seeing women's need for a particular contraception, Naripokkho suggests access to a wider range of contraception accompanied by proper information, arguing:

Of course we need to bring down the fertility rate, but the government approach is not the one that we support. Women need to be given the information and the choice. Government should not give the targets, or convince the clients to have permanent contraception. (Key Informant interview, representative Naripokkho, 17 May 2008).

Ubinig demands the incorporation of TBAs in the government SBA training programme, arguing:

In the absence of proper health care access, rural women are dependent on the TBAs for centuries. TBAs have years of experience in helping women during delivery. With proper training and tool kits for delivery they can do a better job than the FWAs after six months of training. To save the life of rural women it is better to train those TBAs until there is a good alternative. (Key Informant interview, representative, Ubinig, 4 June 2008).

BMP's major critique on the national policies was the instability, mismanagement, corruption, male domination, and lack of commitment of each subsequent government. Referring to the abandonment of the community clinic initiative, one interviewee noted, "One of the major problems is that the existing government never finishes the unfinished projects of the previous government".

Despite a moral support in favour of abortion, women's organisations weren't raising their voice because they don't want to lose the MR option, which has already been legalised up to 8-10 weeks of pregnancy. Although this is inspired by population control objectives and requires husbands' consent, women's organisations argue that if services are in place women can have an MR within 10 weeks of pregnancy even at the upazila level, which is already a big advantage for the women. They be-

lieve that with education, information and economic independence, women should be able to demand their own reproductive health rights. The popularity of female foeticide in neighbouring India remains a cause of concern for women's organisations not to lobby for abortion.

Representatives of women's organisations argued for holistic, long-term, and fundamental gender-power shifts to bring about a better environment for women's reproductive health and rights. Their proposed long-term solutions include developing a national sexuality education curriculum, teaching adolescents about their bodies and rights; gender-sensitive budgeting throughout the government and in the health sector in particular; increased representation of women in government policy making bodies; and a greater reliance on Bangladeshi development experts, rather than international consultants, in developing and implementing national health strategies and programmes. None of these organisations however has indicated any attention to the diverse practical and strategic needs of various indigenous groups in their development agenda. In that sense they also homogenise poor and tribal women's practical and strategic needs. The Bengali middle-class-led mainstream women's right organisations seem to fail at engaging with the questions of ethnicity (Guhathakurta 2004).

3.5 Conclusion

Although one objective of population policies has been to ensure access to health care services to the disadvantaged population, especially the poor, women and marginalised groups, analysis of policy discourse shows how policy actors with their diverse power relations negotiate over the meanings, priorities and evidence underpinning policy formulations. The analysis suggests that policy is a product of existing social relations and structural arrangements that provides a discursive construction of the reality at the same time as it shapes the reality by influencing practices. Despite adopting an integrated reproductive health care approach in the mid-1990s, multiple interest groups and institutional arms of the state exercise forms of covert power via policies, discourses and knowledge produced by disciplinary institutions aiming to govern the reproductive behaviour of the poor.

Despite divergences there is an overarching alliance of ideology among diverse policy actors: donors, the government, civil society or-

ganisations and professional organisations in relation to the means and ends of population policy. Higher fertility among the poor is depicted as a matter of national concern, contributing to household poverty and constraining development. The way health inequality has been framed and subject positions are created in the policy discourse becomes instrumental in legitimising fertility reduction under the imperative of macro-economic development goals.

There also exists a divergence between conceptual understandings of reproductive health and discursive practices. Despite incorporating a comprehensive reproductive health care agenda, lack of real commitment and resource constraints have led to adopting a narrow “essential service package” approach, offering limited health care choice to poor women. National and international policy actors have chosen to interpret what is considered essential to achieve macro-economic development, according lower priority to broader health care access.

Policy discourse is also not limited to government texts and documents. Donor commissioned research through disciplinary state institutes constructs reproductive health need of poor women for long-term contraception, fostering the interests of a powerful alliance of health service providers, international donors and multinational pharmaceutical companies.

At the same time, persistent inequality in access to maternal health care services is interpreted as a lack of demand for health care services, depicting poor women as passive, ignorant, victims of culture and lack agency. The way health inequality has been framed, conceptualised and interpreted in the policy, has justified targeted MCH-FP services in the public sector through a safety net programme to reach the poor, women and disadvantaged population.

The state however is not a monolithic unit. An alliance of private, public and CBOs/NGOs health care providers come together to create demand and supply of health care goods and services, reinforcing dual health care systems, private for the well-off and public-NGO safety net for the poor and the marginalised, sustaining health inequality.

Women’s organisations conceptualise existing health inequality in relation to women’s subordinate position, patriarchal norms and unequal gender power relations. Although critical of the population control objectives of the current population policy, women’s organisations recog-

nise that availability of contraception and menstrual regulation services could ensure reproductive health of poor women if accompanied by other means of empowerment. Although women's organisations mobilise a reproductive health and rights discourse, they strategically avoid using the term in public discourse due to the fear of backlash from Islamic groups. They are silently negotiating at the national level with the government and other development partners to create a platform to create collective consciousness of women to claim their own reproductive health and rights.

Given the absence of poor women's voice in the policies and discussions except for the women's organisations (and the absence of tribal women's voice even in these organisations), the chapters that follow will show how women experience, give meaning to, contradict or resist state policies and programmes in their daily life focusing on the village of Gachhabari³⁷.

³⁷ For the validation of data and future comparative study the original name of the village is used in the study.

4

The village of Gachhabari

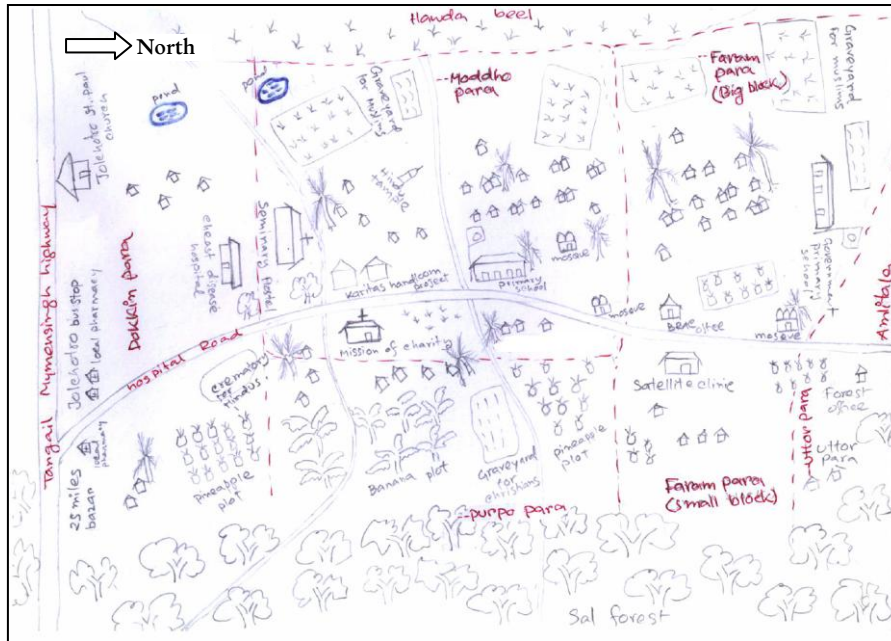
4.1 Introduction

From the centre of the capital Dhaka, the study village Gachhabari is 148 km northeast via Joydevpur on the Tangail to Minensingh highway. The village falls under the Auronkhola union (among 11 unions) of the Madhupur sub-district (among 19 sub-districts) of the Tangail district. On the west boundary of the village close to Chapait is Hawda beel³⁸. On the east boundary is the Madhupur forest area. On the south is the Jalchatra Chest and Leprosy Hospital. On the north boundary is Amlitala village. One main road known as *Boro rasta* (Big road)/Hospital road, running from the south to the north, connects to the main Tangail-Mymensingh highway at Jalchatra bus stop with Madhupur Forest office and “Reserve forest/Eco Park”, splitting the village into two. The larger part of Gachhabari village is on the south side of the hospital road.

As shown in the sketch map drawn by local informants (Drawing 4.1) Gachhabari village can be divided in five main *paras* (blocks): Purbo para (East block), Dokkhin para (South Block), Moddho para (Middle block), Uttor para (North block) and Faram para (Farm block). Faram para is divided in two sub-blocks: small block and big block. Purbo para, Uttor para and small block of Faram para fall on the east side and Dokkhin para, Moddho para and big block of Faram para fall on the west side of the hospital road. The forest office is situated on the east side of the hospital road in Uttor para, which marks the last boundary of the Gachhabari village with Amlitala village.

³⁸ A beel is a Bangla term for a lake-like wetland with static water. In the winter when the water dries out this land is used for rice cultivation.

Drawing 4.1
Drawing of Gachhabari village



Source: Done by participants during focus group discussions (copied in English by the researcher), 17 May 2008.

Official government perceptions on land rights differ from those of village people. The forest department claims most of the land on the east side of the hospital road as state property or *khash* land. Whereas, local residents claim this as their recorded land and live under the fear of eviction.

According to local residents once upon a time Gachhabari was full of Sal trees. That is how Gachhabari was named from *gach* (trees) and *bari* (a cluster of houses). This type of forest land is not suitable for wet rice cultivation. Pineapples, ginger and bananas are grown on this land. On the west side of Moddho para is the Hawda beel, which is the most fertile land for rice cultivation. There are additional rice fields in Dokkhin para and Moddho para. These paras also have two ponds, which are the source of fresh fish in this area. In terms of industry there is a Karitas handloom project producing cotton cloth in the middle block. There is

no village market in Gachhabari village. On the east are Pochish miles bazar and Jalchatra bazar, and on the west are Amlitala and Ghughur bazar.

There are several schools in and around the village. A missionary primary school (Fatema Rani Prathomik Biddaloy) is situated in the middle block and a Government primary school is in Faram para. In the middle block there is also a seminary school for religious (Christian) education. A missionary high school (Corpus Cristi High school established in 1966) is situated in Jalchatra, the neighbouring village.

4.2 Changing population and ethnic composition in Gachhabari

According to the existing literature, before 1964 Madhupur was only inhabited by Garos³⁹ (Burling 1997). However, according to the local residents, Garos and Hindu *Koch* were the original inhabitants of Gachhabari in earlier times and a large number of Bengali Muslim population came in Gachhabari already in 1962. In 1959 under the Bangladesh Agricultural Development Corporation (BADC), the Bangladesh government established the “Madhupur seed production farm” in Kakraid (a neighbouring union). The Government acquired land from local Bengalis in Kakraid and resettled them in Gachhabari; the area where the resettled Bengalis started to live became known as Faram para (Farm block), since they had been displaced by the establishment of the seed farm. Again in the 80s the military government resettled poor landless Bengalis into this area, who were environmental refugees due to river bank erosion, and provided them with five acres of *khas land*, which Garos still claim as their communal property (Satter 2006). Gradually, more Bengalis from neighbouring villages started to migrate into Gachhabari village. Nowadays “outsider” Bengalis make up the majority.

Data from my 2008 household survey confirmed this: the majority of the population of Gachhabari (76.8 per cent) were mainstream Bengalis. The rest belonged to the Garo ethnic group (17.7 per cent) and the Hindu minority group (5.5 per cent) (Table 4.1).

³⁹ The indigenous (non-Bengali) population in Bangladesh is estimated at 15 per cent (Bal 2000). Among the indigenous population are 200,000 Garos (Nokrek 2013), which is 1.25 per cent of the total population. The Garos prefer to call themselves *Mandis*, which means human. I used the term Garos and *Mandis* interchangeably in this research.

Table 4.1
Population distribution based on ethnicity in Gachhabari

Ethnicity	Frequency	Percentage
Bengali Muslims	1,932	76.8
Adivasi Garos	446	17.7
Hindu Koch	138	5.5
Total	2,516	100.0

Source: household survey, 2008.

The multi-ethnic nature of the population is reflected in the spatial location of residents. There are three mosques for Muslims, two churches for Garos, a Hindu temple and separate graveyards for the population of three ethnic communities. The first mosque “Tamiz Uddin Jaame Mondol mashjid” was named according to its founder Tomiz Uddin Mondol in 1975. Shuruz Akanda founded “Gachhabari Kha para Akanda Jaame mashjid” in 1980. In 2001 another big Mosque named “Gachhabari Kweti Jaame mashjid” was established by Samsh Uddin. The establishment of three mosques in one village shows communal competition based on religious affiliation. Every year a *waz Mahfil* (religious gathering) is organised in the winter for religious preaching with loud loudspeakers.

In the middle block there is a temple and a graveyard for Hindus, The graveyard for Christians is in Purbo para and another graveyard for the Muslims is in Faram para. In the neighbouring village Jalchatra, there is a Christian missionary for the Garos. Another missionary is in the neighbouring village Pargacha.

All the Garos in Gachhabari village have been converted into Christianity from their old animistic religion called *Sangsarek*⁴⁰. In the Madhupur area, the first conversion work took place by the Australian Baptist missionary in 1893. Since 1928, the Catholic missionary came in Madhupur. As part of missionary development work the Corpus Christi Parish was established in Jalchatra in 1960. Separating from Jalchatra, St. Paul’s

⁴⁰ Garos believed that the world is populated by spirits (*mite*) that demand periodic sacrifices. The spirit can cause diseases by biting a person. The symptoms of the disease indicate which spirit is causing it, thus allows different kind of sacrifices. Some spirits are too strong and kill their victim no matter what efforts are made to drive them away. Harmony between the people and those spirits is maintained by yearly sacrifices.

Church was established in 1993 in Pirgacha, at the heart of the Madhupur forest area. An integrated human development approach with establishment of schools, hospitals and life skills training accomplished the rapid conversion among Garos. Currently, the Catholics number around 14,000 in the parishes of Jalchatra and Pirgacha (Homrich 2007). Christianity has offered Garos a modern identity and a significant boundary marker in a country overwhelmingly dominated by Muslims (Bal 2000).

Besides a distinct belief system, what makes Garos significantly distinct from the mainstream Bengali population is their unique matrilineal kinship system. The kinship system followed by the Garos, is called *Ma'chong* (motherhood) (Playfair 1909; Sangma 1981). All the members of a *Ma'chong* believe in a common ancestress that bonds them together in a sense of attachment (Marak 1986; Burling 1963). Daughters and sons both belong to their mother's *Ma'chong* and carry on their mother's title.

This matrilineal system originated from Garo customary livelihood systems. *Adivasi* Garo communities had been practicing "shifting cultivation", commonly known as slash-and-burn, swidden or *jhum* cultivation, over several generations in Madhupur. The special characteristic of *jhum* is that it was a community based practice. Each household cultivated as much land as needed to meet their household consumption and the land was usually divided among all the households by the *nokma*, the head of the village (Marak 1986; Richil 1985).

Pictures 4.1 & 4.2

Artwork of God “Misi Saljong” (above) Garo girls in traditional dress (below)



Source: Researcher's photo.

According to Garo mythology, the story of *jhum* cultivation began with a virgin girl (*rai, bima, randi, michik*). Garos believe that a virgin girl used to collect wild fruits in the dense forest with rapt attention. The God “*Misi Saljong*” (picture 4.1) took pity on the virgin girl observing her hardship and asked her to worship him. The virgin girl offered wor-

ship (*puja*) by burning fire and generating smoke with natural incense (*dhup*). God was pleased and rewarded her with seeds of various crops and explained how and when to sow them. Thus the Garos received the seeds of various crops through the virgin girl. Thus, women gained the best knowledge regarding seed selection and preservation (Playfair 1909).

This significant contribution of Garo women in their traditional livelihood system provided them a very distinct status compared to the mainstream Bengali society. A matrilineal system offers Garo women customary land right and ownership and control over resources. Following the customary laws, inheritance is restricted to the female line only. Property is passed on from mother to daughter and never to a son. However, not all the daughters equally inherit property. The most suitable of all the daughters is selected to inherit property. Often the youngest daughter is selected as the heiress (*nokna*) because of her age and ability to take care of her parents in old age. If the parents are wealthy they might consider giving a share of their properties to other daughters as well. If a woman is childless or has no daughter, another woman of the same clan would be appointed to inherit her property. If the heiress dies, her husband cannot inherit any property. *Nokkrom*, the husband of an heiress (*nokna*), is considered merely a custodian and the manager of his wife's property. The nearest male relatives (*chras*) will look after the family property until another heiress is found (Marak 1986).

The Garo community is organised through matrilineal and matrilineal norms. After their marriage men generally move to their wives house. Therefore, Garo women don't have to face the trauma of moving to the house of their newly married husband or in-laws, which is typical for the patrilineal and patrilineal Bengali women (Burling 1997).

Although Garos still follow their unique matrilineal-matrilineal system, the *jhum* cultivation has been banned since 1962 by the state. However, to cherish the memory of *jhum* cultivation, Garos still celebrate the *Wangala* festival, which is a thanks-giving ceremony after harvesting rice in which *Misi Saljong*, the god who provides mankind with nature's bounties and ensures their prosperity, is thanked and honoured (Nokrek 2013).

The matrilineal system among Garos is based on communal rather than individual identity. This serves as a mechanism of social control. If an individual commits an offence, the whole community feels ashamed

of it. Garos usually don't go to a formal court. *Chras* play an important role in conflict resolution in the community. To give an example of such community control on individual behaviour, the case of intra-cultural marriage is interesting here. There are six Garo girls married to Bengali boys and one Garo boy married a Bengali girl in the village, they are neither accepted by the family nor the community. In most of these cases (Garo girls married to Bengali boys) the marriage is arranged according to Muslim rules. Bengalis are patrilineal, therefore after marriage girls move to the husband's house and their children take the father's title, while Garos follow the opposite. For a Garo girl such a marriage is considered a serious breach of custom. To prevent this from happening, a decision has been taken by the elder male Garos (*Chras*) that in such cases Garo girls will lose their inheritance rights and would be expelled from the community. In the case of the Bengali girl marrying the Garo boy, she become part of the Garo family and has been expelled from her Bengali family as well.

Despite the communal division between Garos and Bengalis based on ethnic identity, they participate in economic and social exchange. Bengalis are invited during Garo festivals and marriage ceremonies and vice versa. Separate food is arranged for Bengalis, as Bengali Muslims eat only *halal* food. Garos usually eat pork and drink rice beer which is prohibited among Muslims. According to my observation, not all Bengalis follow the religious restrictions about food or drinks strictly. However at the communal level religious identity plays a significant role as a boundary marker between Garos and Bengalis. Garo women are significantly different in their public appearance due to the absence of *pardah* norms. Garo women have different features compared to Bengali women, and they wear traditional dress called *dokmanda* (picture 4.2) produced by handloom instead of a *shari*, which is the common dress of Bengali women. Garos use a different language called *achick*. However, the young generation Garos also use Bangla, which is the medium of instruction at schools nowadays.

4.3 The class and ethnic structure of Gachhabari

Neither Garos nor Bengalis are homogenous groups. According to the household survey, all groups demonstrate striking internal diversity. The

following tables present the education, occupation, income and land ownership across sex and different population groups.

Table 4.2
Educational level of the household members above 15 years old

Educational level	Male		Female		Total	
	Freq.	%	Freq.	%	Freq.	%
Illiterate	17	1.9	13	1.6	30	1.8
Can only sign	66	7.5	60	7.2	126	7.4
Primary education	689	78.4	677	81.3	1366	79.8
Secondary education	75	5.1	33	4.0	78	4.6
SSC ⁴¹	30	3.4	26	3.1	56	3.3
HSC ⁴²	20	2.3	20	2.4	40	2.3
BA/ Degree	12	1.3	4	0.5	16	1.0
Total	879	100	833	100	1,712	100

Source: household survey, 2008.

The overall educational level is low in the village, as shown in Table 4.2 which shows the education status of household members above 15 years old. According to the survey 1.8 per cent of the population are illiterate and 7.4 per cent can only sign their names. A large number of the population have completed primary education (79.8 per cent). 4.6 per cent have secondary level education, 3.3 per cent graduated S.S.C level and 2.3 per cent graduated H.S.C level. Only one per cent has a graduate degree (Table 4.2). Thus, although literacy rate is quite high in Gachhabari, most of the population have a low level of education. Males are slightly better off than females in education beyond primary level.

⁴¹ Secondary School Certificate

⁴² Higher Secondary School Certificate

Table 4.3
Land ownership

Land ownership	Muslim		Garo		Hindu		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
No land	67	17.0	16	20.0	1	3.4	84	16.7
<10 acres of land	92	23.4	18	22.5	9	31.0	119	23.7
11-50 acres of land	93	23.7	20	25.0	8	27.6	121	24.1
50-100 acres of land	41	10.4	9	11.3	3	10.3	53	10.6
101-500 acres of land	83	21.1	16	20.0	6	20.7	105	20.9
>500 acres of land	17	4.3	1	1.3	2	6.9	20	4.0
Total	393	100	80	100	29	100	502	100

Source: household survey, 2008.

In Gachhabari, land ownership is an important source of livelihood. Table 4.3 shows the land distribution among different ethnic groups. The land distribution pattern shows internal diversity across different ethnic groups. On the whole a number of households (16.7 per cent) don't own any land. The majority of landowning households own below 50 acres of land and only a few households (4 per cent) own more the 500 acres of land. Mainstream Bengali and Hindus are in a slightly better position compared to Garos in terms of land ownership.

Table 4.4
Household Income Distribution

Income in tk per month	Muslim		Garo		Hindu		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
<=1,000 tk	17	4.3	0	0.0	0	0.0	17	3.4
1,001 - 3,000 tk	98	24.9	16	20.0	6	20.7	120	23.9
3,001 - 5,000 tk	130	33.1	22	27.5	10	34.5	162	32.3
5,001 - 9,000 tk	97	24.7	32	40.0	10	34.5	139	27.7
9,001 - 15,000 tk	42	10.7	8	10.0	2	6.9	52	10.4
>15,000 tk	9	2.3	2	2.5	1	3.4	12	2.4
Total	393	100	80	100	29	100	502	100

Source: household survey, 2008.

Table 4.4 presents the distribution of (estimated) household monthly income across different ethnic groups. The data show significant diversity both within and between ethnic groups. The majority (60 per cent) of households earn up to 5,000 tk, which is below 50 euro⁴³ per month. 28 per cent of households earn between 5,000- 9,000 tk (50-90 euro approximately) per month, 10.4 per cent households earn up to 15,000 tk (150 euro approximately), and only a few households (2.4 per cent) earn above 15,000 tk (150 euro) per month. Income distribution shows Garo households are slightly better off compared to Bengalis, with only 47.5 per cent below the 5,000 tk mark compared to 62.3 per cent of Bengali Muslim households. In this research I consider households below the income level of 5,000 tk as poor, 5,001 -15,000 tk as middle income and above 15,000 as rich.

⁴³ During 2008, when the survey was conducted one euro was equivalent to 95 tk approximately.

Table 4.5
Occupations (main source of income) of adults above 15 years old

Economic Sector	Occupation	Male		Female		Total	
		Freq.	%	Freq.	%	Freq.	%
Agriculture/Forestry/Livestock	Farmer (own farm)	212	28.2	0	0	212	24.9
	Farmer (tenant)	31	4.1	0	0	31	3.6
	Nursery	5	0.7	0	0	5	0.6
	Poultry	1	0.1	0	0	1	0.1
	Fishery	1	0.1	0	0	1	0.1
	Agro processing	3	0.4	5	4.9	8	0.9
Construction	Carpenter	7	0.9	0	0	7	0.8
	Welding	1	0.1	0	0	1	0.1
Trade	Business	102	13.6	0	0	102	12.0
	Shopkeeper	10	1.3	0	0	10	1.2
	Hawker	8	1.1	0	0	8	0.9
	Pharmacy	1	0.1	0	0	1	0.1
Manufacturing	Garment	0	0	3	2.9	3	0.4
	Handloom	0	0	1	1.0	1	0.1
	Textile	1	0.1	0	0	1	0.1
Service	NGOs	21	2.8	18	17.6	39	4.6
	Veterinary doctor	1	0.1	0	0	1	0.1
	Land surveyor	1	0.1	0	0	1	0.1
	Barber	1	0.1	0	0	1	0.1
	Teacher	1	0.1	5	4.9	6	0.7
	Mechanic	4	0.5	0	0	4	0.5
	Beauty parlour	0	0	7	6.9	7	0.8
Transport	Tailor	4	1.9	0	0	4	0.5
	Driver	14	1.9	0	0	14	1.6
Labour	Rickshaw/van puller	111	14.8	0	0	111	13.0
	Labour (agriculture)	124	16.5	25	24.5	149	17.5
	Labour (non-agriculture)	86	11.5	0	0	86	10.1
Others	Fuel-wood collection and selling	0	0	33	32.4	33	3.9
	Stitching katha	0	0	5	4.9	5	0.6
Total		751	100	102	100	853	100

Source: household survey, 2008.

According to the survey, among 502 households 751 male members and 102 female members above the age of 15 have a source of income.

The details are shown in Table 4.5. It should be noted that the household survey included only paid labour or self-employed work directly productive of income. Therefore, while observation suggests that large numbers of women help on the family farm and in forestry activities, this unpaid female labour is not captured in the survey.

Agriculture, forestry and livestock sector occupy the major source of occupations (30.2 per cent of respondents, or 47.7 per cent if we include farm labourers). Significant numbers are dependent on transport (14.6 per cent), trade (14.2 per cent) and non-agricultural wage labour (11.5 per cent). The service sector provides only 7.4 per cent of occupations. For those women who report having an income, the main occupations are collecting and selling fuel-wood (32.4 per cent), the service sector (29.4 per cent, particularly employment in NGOs) and agricultural wage labour (24.5 per cent).

Table 4.6
Employment status of employed adults above 15 years old

Employment status	Occupation	Male		Female		Total	
		Freq	%	Freq	%	Freq	%
Self employed	Farmer, Tenant, Nursery, Poultry, Fishery, Agro processing, Business, Shopkeepers, Hawker, Pharmacy, Barber, Tailor, Firewood collection and selling, Stitching katha, Carpenter, Welding, Veterinary doctor, Rickshaw/van puller, Mechanic	503	67.0	43	42.2	546	64.0
Irregular paid worker	Garment, Handloom, Driver, Textile, Beauty parlour	15	2.0	11	10.8	26	3.0
Regular paid employee	Land surveyor, Teacher, NGOs	23	3.1	23	22.5	46	5.4
Labourer	Agriculture	124	16.5	25	24.5	149	17.5
Labourer	Non-agriculture	86	11.5	0	0.0	86	10.1
Total		751	100	102	100	853	100

Source: household survey, 2008.

Table 4.6 shows the employment status of all those reporting having a source of income. For men, the most common status is self-employed (67 per cent) while only 42 per cent of women are self-employed (mainly the firewood collectors) and a larger proportion (almost 60 per cent) are earning wages or salaries. Among the wage and salary earners, a much higher proportion of women have regular salaried jobs compared to men. Among the agricultural labourer proportion of female are also higher compared to men (24.5 and 16.5 per cent respectively), while non-agricultural labour is done by only men.

4.4 Availability of health care services in and around Gachhabari

Community maps and mobility maps drawn in focus group discussions, separately with men and women, provide a general picture of the availability of reproductive health care services in and around the village (Drawing 4.2 & 4.3). Based on this information, health care providers can be divided into three main groups: public health care providers, NGOs and private health care providers including formal and informal sector.

4.4.1 Public health care providers

A Satellite Clinic is the most accessible source of public health care services in Gachhabari village. In November 2004, the Satellite Clinic was inaugurated in Gachhabari (Picture 4.3).

Pictures 4.3 & 4.4

Satellite Clinic in the study village (Above), and Upazila Health Complex in Madhupur (below)



Source: Researcher's photo.

The clinic is open once a month to provide reproductive health care services at the community level. The clinic provides contraceptive pills (SHUKHI) and injections (Depo-Provera). Besides family planning, the Satellite Clinic provides health care service namely, Tetanus Toxoid (TT) injection for pregnant women and immunisation vaccinations (EPI) for children. A Health Assistant (HA) provides EPI service and Tetanus Toxoid (TT) injection to pregnant women and the Family Welfare Assistant (FWA) provides family planning service at the same time. These HA and the FWA are mainly based at the Upazila Health Complex in Madhupur. Under the supervision of FWAs, the field based Family Welfare Visitors (FWVs) pay house visits to motivate couples to use contraception. FWVs also inform women about the opening date and time of the Satellite Clinic, since it has no fixed opening day. Women with complications are referred to the Upazila Health Complex from the Satellite Clinic if needed (Picture 4.4).

While the Satellite Clinic is situated at the centre of the village, the Upazila Health complex (UHC), which is the lowest level of public health care facilities in the rural areas, is within a radius of 10 km of Gachhabari. Besides general health care services the (50 bed) UHC has a maternal and child health unit (MCH) and a family planning unit. The UHC offers safe delivery and free MR services within 8 weeks of pregnancy. At the family planning unit of the UHC, long term clinical methods such as implant and sterilisation services are provided twice a week. The brand of implant that the government is providing is called Norplant, locally known as “*kathi bhora*” (putting five sticks inside upper arm skin).

This long-term contraceptive service delivery is strongly encouraged through offering incentives. Norplant clients receive 75 tk (appx. € 0,75) on the day of insertion, after one month 50 taka during the first check-up and 60 tk (appx. € 0,60) after 6 months during the second check-up. Vasectomy clients receive 500 tk (appx. € 5) and a *lungi* (a piece of cloth for men as an alternative to pants). Female sterilisation clients receive 500 tk and a *shari*.

The public district hospital is situated in Mymensingh, which is 5 hours drive by car from the village, and up to eight hours by bus.

4.4.2 NGO health care providers

As a strategic partner of the government, NGOs play a very important role in providing reproductive health care services in the community. BRAC and Smiling Sun are two major reproductive health care providers in Gachhabari.

BRAC, a NGO, started their health programme in the study village in January 2006. BRAC has five health workers and one health assistant (*Shastho Shebika*). All of them are female. Each health worker covers 300 households. BRAC health workers organise one group meeting each month at a convenient location in the village for about 20-25 participants. Health workers go from door to door and inform about the date, time and place of the group meetings. During these meetings anti natal check-up of pregnant women, family planning and health and hygiene matters are discussed. The main message of these group meetings is “small families are generally healthier and happier”. BRAC also has a pharmacy in the village to sell contraception and general health care medicine.

Since the government health workers aren't sufficient to cover the health care services in the remote areas, as a partnership with the government, BRAC is also providing antenatal health care for women for which the government is responsible (Perry, 2005). On the Satellite Clinic's opening days, BRAC provides maternal health care while the government provides EPI and contraception supply. As a part of antenatal care, pregnant women receive free iron tablets which BRAC receives from the government. BRAC health workers also measure blood pressure, weight, anaemia, diabetes and the position of the child of pregnant woman at the Satellite Clinic. However, this service is not free. BRAC members have to pay 10 tk (appx. € 0,10) and non-members 15 tk (appx. € 0,15) for the antenatal check-up. If the pregnancy is risky BRAC health workers advise women to go to the UHC, a formal referral isn't possible though.

Reproductive health care services provided by Smiling Sun, a USAID funded NGO are situated in the neighbouring village called Kakraid. Smiling Sun delivers pills, IUD and injectables provided by the government to their clients. Although the public family planning services are subsidised, Smiling Sun charges a service cost to the clients. The Government supplied SHUKI Pills cost 2 tk (appx. € 0,02) and contraceptive

pill Femicon costs 12 tk (appx. € 0,12). Injectables, which are given free at the government Satellite Clinic, cost 20 tk (appx. € 0,20) and Condoms cost 10 tk (appx. € 0,10) per pack, which was also given free before, under the government family planning programme. All services are offered to married couples only.

Besides family planning services, Smiling Sun provides general health services which are not subsidised. Smiling Sun offers treatment for lower abdominal pain, STDs and RTIs. Critical patients are referred to the UHC or district hospitals. However, due to the anti-abortion stance of USAID funding, health workers are not allowed to provide any information regarding MR or abortion or advise women to the UHC in case of unwanted pregnancy.

4.4.3 Private health care providers

There are formal and informal private health care providers in and around the village. Among formal private health care providers, in the vicinity of the UHC, there are several private clinics and diagnostic centres, Chowdhury clinic and Khan diagnostic centres are most popular among the villagers. The Jalchatra chest disease hospital, which was established in 1996 by the Damien Foundation under the Tangail TB & Leprosy Control project and the Mission of Charity Hospital which has been build in 2006 in Gachhabari also provides treatment for general health care facilities. In addition, there are more than a dozen pharmacies in Madhupur and three pharmacies at Jalchatra bazar, which is around the corner of the village.

During community mapping a number of informal providers such as Traditional Birth Attendants (TBAs) and local healers were also identified as primary sources of reproductive health care in the community. Among Bengalis local *kaviraj* and among Garos *kamal* are known to cater for most of the reproductive and sexual health problems.

4.5 Patterns of health care service use in Gachhabari

According to the household survey, members of 247 households (of the total 502 households surveyed) didn't visit any health care facilities for any kind of health care services for themselves or for any family members during the last six months prior to the survey (Table 4.7).

Table 4.7
Use of health care services per household

Reproductive health seeking behaviour	Frequency	Percentage
Didn't visit any health facilities for treatment	247	49.2
Did visit different health care providers	255	50.8
Total	502	100.0

Source: household survey, 2008.

Members from 255 households visited health facilities within the last six months prior to the survey. Members of 255 households visited various health care providers depending on the type of health care need with a total of 1,328 visits during the six months prior to the survey. The details are shown in Table 4.8.

Table 4.8
Health care providers visited among the study population

Types of Health care providers	Frequency	Total	Percentage	
Government	Government district Hospital	130	222	16.7
	Sobuz Chata	8		
	Thana Health Complex	52		
	Satellite Clinics	25		
	Health worker	7		
Private health care providers	Private Clinics	262	934	75.9
	Private doctors	236		
	Paramedics	54		
	Pharmacy	382		
	Missionary Hospitals	74		
Traditional Health care providers	TBAs/Kaviraj/Kamal	83	83	6.3
Homeopathy	Homeopathy	8	8	0.6
Home treatment	Home treatment	7	7	0.5
Total	1,328	1,328	100.0	

Source: household survey, 2008.

Given the availability of different types of health care providers, most of the reported visits were to the private health care providers (75.9 per cent of all visits). Private health providers include private clinics, diagnostic centres pharmacies and charitable missionary hospitals. The Government health service covered only 16.7 per cent of the visits. In addition, 6.3 per cent of visits were to the traditional health providers. In a few cases homeopathic or home treatment was also reported.

Table 4.9 shows the reported reason for the most recent visit to a health care provider. Most of the members of the households visited a health facility for children's illnesses (29.4 per cent). 18.4 per cent went for a routine check-up. 14.5 per cent went to the health facilities for general illness for themselves and 12.2 per cent for other family members, mostly elderly people in the household. In terms of reproductive health care services, 14.5 per cent of the households visited a health provider for family planning, 5.1 per cent for postnatal and 2.4 per cent for antenatal care. Members from two households (0.8 per cent) mentioned going to a provider for abortions.

Table 4.9
Reasons for visiting health care providers

Reproductive health seeking behaviour	Frequency	Percentage
Children's sickness	75	29.4
Routine check-up	47	18.4
General sickness like fever, cold, cough, weakness (Counseling)	37	14.5
Sickness of other family members	31	12.2
Family planning	37	14.5
Post natal care	13	5.1
Antenatal care (Pregnancy test)	6	2.4
Delivery	7	2.7
MR/Abortion	2	0.8
Total use of health care services	255	100.0

Source: household survey, 2008.

In summary, this chapter has provided a brief sketch of the ethnic and social composition of Gachhabari village. As we have seen, there is a

clear communal division between mainstream Bengalis and indigenous Garos based on ethnicity. At the same time both communities are highly fragmented in terms of income, land ownership and educational achievements. Hence, the differences in gender relations between mainstream Bengalis and indigenous Garos have to be understood in intersection with their internal diversity.

This chapter has further provided a mapping of health care services available in and around the village. In the chapters that follow, I explore the significance of gender and its intersection with existing structural inequality as well as the space for negotiation within households, community and market to contemplate reproductive health practices in Gachhabari focusing on childbirth, contraception, abortion and fertility behaviour.

5

Gender, ethnicity and contraception and abortion practice in Gachhabari

5.1 Introduction

Focusing on contraception and abortion practices, this chapter discusses how the complex intersection and interaction between gender, ethnicity and economic forces shape reproductive practices in Gachhabari. The chapter illustrates how men and women actively participate in the reproduction and contestation of gendered norms through the use of contraception and abortion practices.

The chapter is divided into two main sections. The first section explores men and women's contraception practice and their meanings and justifications of their contraceptive choice. The second section illustrates women's perceptions and reasons of their unwanted pregnancy. It further explores constraints and possibilities that women experience in terms of using MR/abortion to terminate their unwanted pregnancy.

5.2 Overview of Contraception prevalence and methods in Gachhabari

The household survey shows that the contraceptive prevalence rate among the ever-married women surveyed⁴⁴ is 64.5 per cent (Table 5.1), which is slightly higher than the national average (62 per cent) (BDHS 2014).

⁴⁴ In each household, one ever married female member was interviewed. Preference has been given to women between reproductive age group of 15-49. In the case of more than one married woman belonging to this age group in a household, the younger woman was selected for the interview. Since my interest also concerns fertility behaviour, only if there was no married woman in the reproductive age group in a household, women above the reproductive age group or widows were selected for the interview.

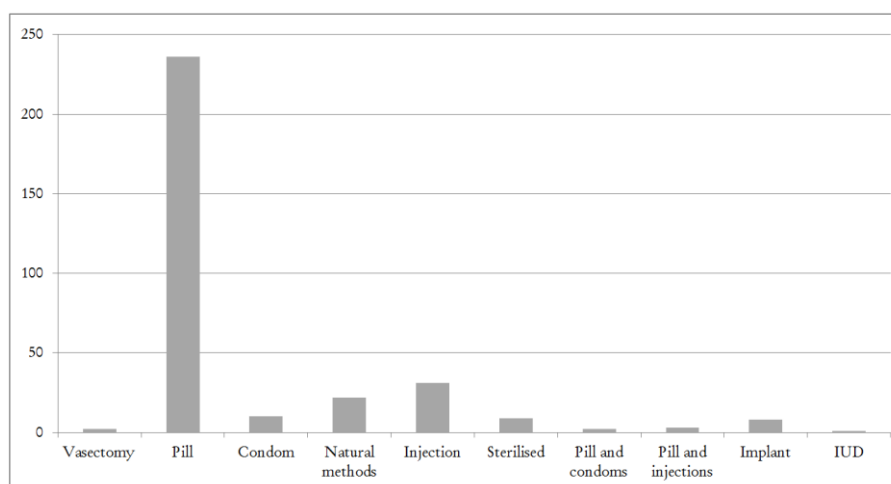
Table 5.1
Contraceptive prevalence rate

Contraceptive prevalence rate	Frequency	Percentage
Use Contraceptive methods	324	64.5
Do not use Contraceptive methods	178	35.5
Total	502	100.0

Source: household survey, 2008

Further details of contraceptive use are given in Diagram 5.1. Among contraceptive users, the majority use birth control pills (72.8 per cent), followed by injections (9.6 per cent) and the natural method (6.8 per cent). Interestingly some women mentioned mixed methods such as the combination of the pill and condoms or the pill and injections. A few women are sterilised (2.8 per cent) and the rest of the female users are using Norplant (2.5 per cent). Condom use is only 3.1 per cent (and some additional combined with pills). Male sterilisation is significantly low at 0.6 per cent.

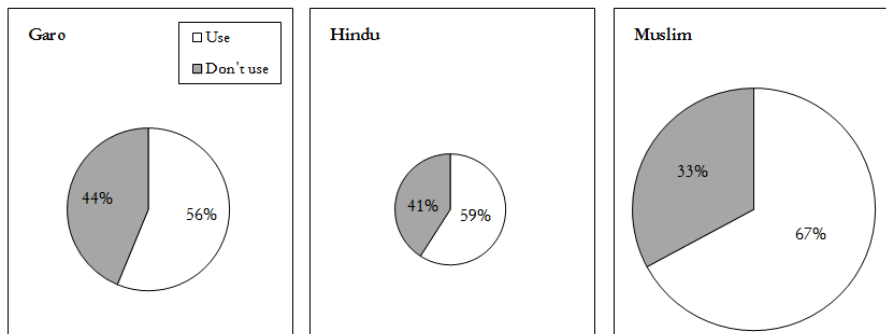
Diagram 5.1
Use of different contraceptive methods in the study village



Source: household survey, 2008.

This pattern of contraceptive use method is quite similar to the national level BDHS data, except that the use of natural methods is higher in the village compared to the national average. Otherwise, this data provides three clear patterns i) domination of female dependent methods; ii) uncontested popularity of the pill and iii) low use of permanent and male dependent methods.

Charts 5.1, 5.2 & 5.3
Use of contraception according to ethnicity



Source: household survey, 2008.

A closer investigation of contraception used by men/women from different ethnic backgrounds (Charts 5.1, 5.2 & 5.3) provides an interesting insight into contraception practice. The use of contraception is lowest (56 per cent) among Garos compared to mainstream Muslims (67 per cent) and minority Hindus (59 per cent).

Table 5.2
Types of contraception use per ethnicity

		Garo		Hindu		Muslim	
		Freq.	Per-centage	Freq.	Per-centage	Freq.	Per-centage
Male dependent method	Vasectomy	1	1.9			1	0.4
	Condom	4	7.4			6	2.3
	Natural methods	12	22.2	2	15.4	8	3.1
Female dependent method	Pill	35	64.8	9	69.2	192	74.7
	Injection					31	12.1
	Sterilised	2	3.7	1	7.7	6	2.3
	Pill & Condom					2	0.8
	Pill & injections					3	1.2
	Implant					8	3.1
	IUD			1	7.7		

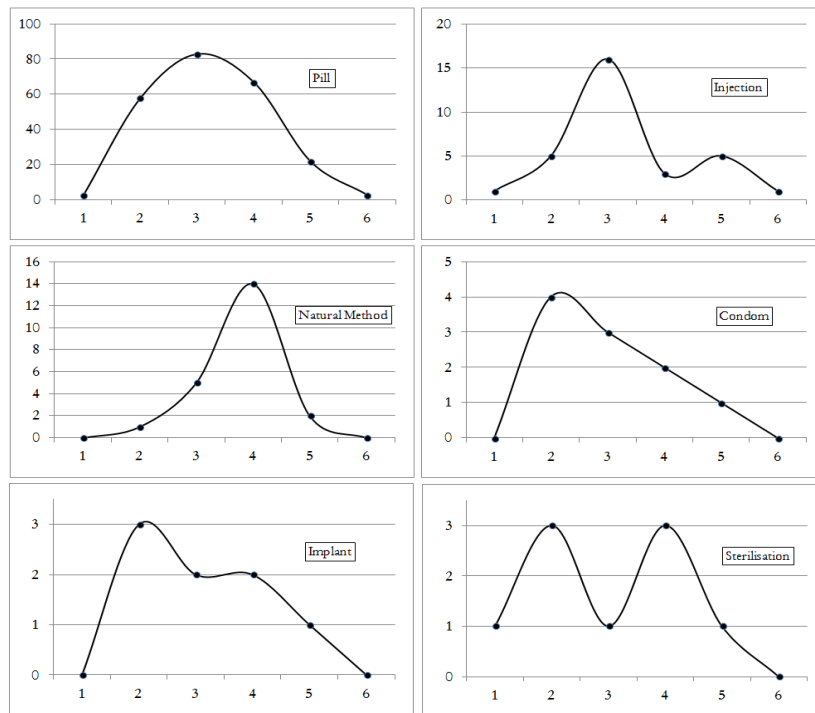
Source: household survey, 2008.

There is also some quite interesting variation in the type of contraception used by different groups, as shown in Table 5.2. Although the birth control pill is the most popular method among all groups of women, natural methods (22.2 per cent) and condoms (7.4 per cent) have the highest use among Garos. Injections (12.0 per cent) and implants (3.1 per cent) are only used among Bengali Muslim women. One Hindu woman is the only IUD user (7.7 per cent). The proportion of sterilised women is higher among the Hindu minority (7.7 per cent) and ethnic Garo women (3.8 per cent), although the number of women using the method is quite insignificant. Despite all groups of women having the same contraceptive supply available, what lies behind this diversity in contraception practice?

Based on the household survey data I have tried to see the different type of contraception use across different income groups of men/women (Diagram 5.2). Although Gachhabari is a relatively poor area, compared to the average per capita income of Bangladesh, disaggregation by household income clearly shows that injections and implant are more frequently used by the poorer group of women. Condom use is also higher among poorer groups, however it should be noted that condom is proportionately higher among Garos. The use of pills is evenly

distributed as pills are available both in private and public sector. However, poor women use government supply pills and richer women buy pills from the private sector. The number of sterilised women was too small to draw conclusions from the fluctuating sterilisation pattern shown in Diagram 5.2.

Diagram 5.2
 Contraception choice per income group (Y-axis: number of users, X-axis: Income group⁴⁵)



Source: household survey, 2008.

⁴⁵ 1<1,000 tk; 2= 1,001 - 3,000 tk; 3=3,001 - 5,000 tk; 4=5,001 - 9,000 tk; 5=9,001 - 15,000 tk and 6>15,000 tk per month.

Interestingly the use of natural method reduces with the increase in income, this suggests that poor households are more dependent on natural methods due to the fact that it doesn't cost money. Another pattern that stands out for almost all contraception types is that the very poorest (group 1) use no contraception at all (only one case of injection and one of sterilisation, no others), which draws attention to the importance of looking at the use of Menstrual Regulation or abortions to regulate their fertility.

The following sections illustrate how a combination of gender, ethnicity and economic factors shape contraception practice in Gachhabari.

5.2.1 Men's Contraception practice and rationales: similarities and differences

Narratives of men and women reveal a complex understanding of the uses and abuses of contraceptives.

One perception about vasectomy is related to masculinity. There appears to be social stigma attached to vasectomy. Due to this stigma men who have undergone the sterilisation operation are looked down upon in the community. This stigma was explicit when a female government health worker shared her own experience during her field visit describing:

One day I was passing by a tea stall next to the primary school building, four to five men were drinking tea at the tea stall and chatting. At that moment one man from the group pointed to a man in the distance and said to the others, look there goes the "castrated" man and all of them burst out laughing (Service provider's interview, Gachhabari, 17 July 2008).

Calling men who have undergone vasectomy castrated⁴⁶ (*Khasha koraichey*) is a matter of shame to their masculinity. There seems to be a belief that those men have lost their sexual power (focus group discussion outcome).

⁴⁶ Castration is a surgical process done among animals (especially among goats) to increase meat production by changing their hormonal balance. Castrated animals do not qualify to be sacrificed as religious offering.

However further discussions revealed that there were additional reasons. It was a hot summer noon when I was interviewing a thirty seven years old Bengali participant Payra Banu, a mother of three children who was suffering from the side effects of contraceptive pills. Normally men are not at home at that time. As usual her husband had left home in the morning with his rickshaw van, but this time he came home to drop some groceries. He overheard our conversation while his wife was talking about her health complaints. He didn't expect me to be present in his house. The atmosphere became a bit uncomfortable to me. To initiate a normal conversation, I introduced myself and politely asked him why he wasn't considering using a method himself in the case of his wife's sickness. He reacted to me saying:

The government gives five hundred tk (appx. five Euros) to get a vasectomy done, but even if you give me five Lac (500,000 tk, appx. € 500,-) I wouldn't do it. Whatever side effects my wife is suffering from, she has to use a method otherwise she can stop it. But I am not going to do a vasectomy even in front of a military gun point (Interview, Hanif Miah, Bengali, 46 years old, Gachhabari, 28 April 2008).

He left the house almost immediately after dropping the groceries. Continuing the conversation, Payra Banu defended her husband for not using contraception saying:

Sister, don't talk about any methods that have anything to do with my husband. I know, my husband is very sincere to me and he has no intention to have a second wife. He only cares for the family (*shongsbar*). My husband is a rickshaw van puller. It is a hardworking task (*porishromer kaj*) to pull a loaded rickshaw van. If he wouldn't be able to do his work anymore after an operation (vasectomy), how will our family survive?

My husband tells me you take the pill or injection or do something else. There are many methods for women. But if I do a vasectomy (he says), I wouldn't be able to perform any hard work to run this family (*shongsbar*) anymore. I also hear from other people that men can't work hard after the operation. I heard from my relatives in another village that young men who work in the NGO did this kind of method. They can rest after the operation. If my husband have to stay at home for 10/12 days after the operation where can we get money from to run this family if he doesn't work? I never worked outside. I can't work as a day labourer or pull a rick-

shaw van like my husband. (Interview, Payra Banu, Bengali, Gachhabari, 28 April 2008).

Picture 5.1
An anonymous man in Gachhabari village



Source: Researcher's photo.

Similar to Payra Banu other women's narratives justified accepting the side effects of contraception for the greater benefit of the household. For example Shewly, a thirty-five year old woman, suffering from severe menstruation and lower abdominal pain since the insertion of Norplant, said:

I am a woman, I can stay at home. I can stay in bed if I am sick due to side effects from contraception. But my husband is a man. He has to work outside and bring money for the family. Do women go in the sun? Do they go to plough land? Do they work as day labourers? It is better for the family if I suffer instead of my husband. (Interview, Shewly, Bengali, Gachhabari, 9 June 2008).

These narratives highlight how notions of masculinity and femininity are linked to different types of contraception. Since households are

largely dependent on male wage work, women take up contraception for the greater benefit of the households, releasing men from contraceptive responsibility.

Despite the availability of the service at the UHC, only two men in the village have undergone vasectomy; Shuvas (Garo) and Jamil Miah (Bengali). Their experience can further illustrate the reason for reluctance towards male sterilisation in the village. Shuvas is a 38 year old community forest guard. He used to work as a day labourer and an occasional van puller in the past. He is a father of two sons and a daughter, his younger child was three years old when he did his vasectomy. In his words:

Garos are generally careless about method. Now they are using different methods at their wives' initiative. I heard about this method from my wife for the first time. She received the information from the female health worker in the village. I talked to the female health worker. She organised three men, two from Gachhabari and one from a neighbouring village to go to the hospital for sterilisation. She told us the government will give a lump sum money and a monthly allowance (*ekkalin taka dibey abar mashey mashey kichu dibey*). Three of us went together and had vasectomy done. The doctor was polite, after the operation he told us (individually) to follow some advice. For example, for a few days we were not supposed to do any heavy work and sexual intercourse. At the beginning I felt some problem. Now I don't feel any problem anymore.

Reflecting back it was a good decision because there is no risk of making my wife pregnant anymore. But sometimes I feel sad thinking that I would never be able to become a father anymore, even if I wish. (Interview, Shuvas, Garo, Gachhabari, 13 October 2008).

Jamal Miah is a 48 years old landless rickshaw van puller, he owns only the plot of land on which his house is built (*Boshot vita*). He has three living children, one son and two daughters. Three children died. In his words:

Due to our poverty, my wife went to the forest to carry firewood even during her pregnancy. Three of our children died after they were born. Couldn't bring them to the doctor, only consulted a local "kaviraj". Being unable to provide for the family once I went to the forest to cut trees. But I was caught and put in jail for six months, which made the situation even worse.

After I got released from the jail, I heard from another van puller that the health worker is bringing people to the hospital for a method. The government will give money for that. I thought I can't even keep my children alive after they were born, it is better to stop having more children. On top of that I will receive cash. Unfortunately, after the operation I became weak and can't pull rickshaw van full time anymore. (Interview, Jamal Miah, Bengali, Gachhabari, 14 October 2008).

It might be that Jamal Miah's physical weakness is due to a combination of having a difficult time in jail, lack of proper nutrition and rest after the operation and aging, however, during discussions other participants often took him as an example of how vasectomy makes men physically weak. A common statement given by many participants was, "we know from those who have done vasectomy that it makes men weak". Shuvas further mentioned that he discussed about this method with others in the village but generally men are not interested in this method.

Despite the stigma attached to vasectomy, neither Shuvas nor Jamal Miah mentioned any cultural norms as a barrier to vasectomy. The motivation of Shuvas and Jamal Miah to accept vasectomy was purely financial. However, Shuvas complained that he was misinformed about a monthly payment, while Jamal Miah complained about the loss of his income after the operation, as he can't work full time any more. Shuvas is comparatively young and he found work as a forest guard which doesn't demand heavy work anymore compared to pulling a rickshaw van which he used to do occasionally before the operation.

In the rural community words spread from mouth to mouth very quickly. The experience of Shuvas and Jamal Miah created more negative attitude towards vasectomy in the community. It also illustrates how the field worker might have manipulated the information about a monthly compensation to get clients, which is not in line with the official document, which creates mistrust in the government family planning programme. Above all, the loss of income after the operation is in no way comparable to the incentives they have received. For Jamal Miah it also implies long term loss of income. The reality of poor men is that their labour is the only capital that they have and if they lose it, their own survival and the survival of their family members is put in danger. During an interview a 38 year old well-off Garo participant Badal said:

Field workers target poor men to convince them to do a vasectomy. They lure them with incentives. Field workers get relief (*khalash*) as soon as the method is done. They don't care what happens with the clients after the operation, whether they follow the restrictions or rest properly. The reality is that if poor people don't work for a day they will not have food on their plates. They work on a daily basis for their survival (*Tara in aney din khay*). Men might have problem after the operation if they don't take enough rest and continue to do heavy work or don't take medicine properly if needed. (Interview, Badal, Garo, Gachhabari, 3 September 2008).

There seems to be another perception among men and women alike that vasectomy reduces men's sexual performance. Badal (the Garo informant just quoted above) also expressed his dislike towards vasectomy saying:

I know a fieldworker in my NGO who took half a day leave from the office to do a vasectomy and continued his work without saying anything to anybody. His vasectomy caused him marital unrest. His wife complained that he couldn't "perform" anymore and got involved in an extra-marital relation. My colleague also regrets saying, "May be I took a wrong decision. I don't feel comfortable. I don't feel pleasure any more". (Interview, Badal, Garo, Gachhabari, 3 September 2008).

The other Bengali participant Jamal Miah also believed that vasectomy reduced his sexual performance.

Another perception about vasectomy is related to its permanency. Those research participants who were using contraception for birth spacing and had not reached their desired number of children were not ready to consider permanent methods either male or female. In addition, poor couples that already reached their desired number of children but have experience of child mortality showed their reluctance to use permanent contraception. Aman Ali, a forty-two year old participant justified his wife using contraception instead of him by saying:

If I perform a vasectomy I wouldn't be able to produce any children any more. If my wife takes Norplant, she would be still fertile. She can have a child after five years again (Interview, Aman Ali, Bengali, Gachhabari, 27 June 2008).

This statement actually demonstrates pragmatism and preference for non-permanent contraception over permanent ones. While vasectomy

causes permanent infertility, most of the female methods such as pills, injectables, IUD and implant are not associated with permanent infertility. By choosing non-permanent methods couples preserve their option to have children in the future if they are not absolutely certain to stop childbearing permanently. Similar evidence was found in another large scale comparative study (Hutter and Sahu 2012) showing Muslim women in Bangladesh prefer temporary contraception, while the opposite is true in India, dominated by Hindu majority.

In general both Garos and Bengalis showed reluctance towards vasectomy due to the perception that vasectomy might cause problems in the future. Although the breadwinner's norm is not as strong among matrilineal Garos like Bengalis, Garo men's reluctance towards vasectomy is linked to their matrilineal system. Following the customary laws among Garos, children belong to their mother's clan. Further conversation with Shuvas reveals that in case of maladjustment, Garo men lose their right over their children and have to leave their wife's house (Unlike Bengalis Garo men generally move to their wife's house after marriage). Therefore Garo men want to preserve their reproductive power for the future. This attitude gets further intensified by a patriarchal mentality which promotes reluctance among Garo men to accept contraceptive responsibility either vasectomy or condoms.

A similar mix of reasons/perceptions emerges about the use of condoms. A focus group discussion organised with men from mixed ethnic groups for this research documented their perceptions about condoms, as summarised below:

- Local people know about condoms from Radio, TV and local health worker and friends.
- Local people are not aware that condoms have an expiry date. Nobody checks it before using it.
- Local people mostly buy Raja condom which costs 3 tk, condoms for 5 tk or even 35 tk are also available at the local pharmacy.
- Men often say condom is not a safe method, it breaks during sex. Sometimes young men claim to their peers that they use double condoms for protection. However, there is not much truth behind such statements. Young men make such claims to show-off their masculinity (*pourusotto phute uthey*).
- Condoms are neither comfortable nor enjoyable.

- 1215 Using condom is problematic (*bhejal*); one has to put it on and take it off in the dark, is it not problematic?
- It creates problem during ejaculation. It feels like sperm can't flow easily, something is blocking the head of the penis.
- Men desire the sperm to flow from free (*unmukto*) penis. Men consider this as a great satisfaction in sex. But using condom spoils this.
- Condom contains "*haram*" (opposite to *halal*, which is forbidden according to religious precept) components.
- Condom creates infection inside women's vagina.
- It is not possible to put a condom without an erection. At the point of erection, the effort of putting a condom in the dark reduces the erection. Ultimately it reduces sexual pleasure.
- It is difficult to store and dispose of condoms. Married couples usually keep them under the pillow or bed, but always wonder where to throw after using them.
- The size of condom is problematic. One size doesn't fit all; it is often loose and creates an irritating noise (*awaaj*) if air gets stuck inside. When couples sleep in the same room with their children, making noise during intercourse is embarrassing. For those who have a fat penis, the rubber of the condom blocks blood circulation and creates pain.
- The criteria to determine whether a condom is good or not depends on whether it breaks easily, thickness, comfort and cost. Generally costly condoms are good.
- Even the poor quality condoms have a cost. Poor people cannot spend money to fuck their wives. Those are for the rich people in the towns.
- Some women don't like their husbands to use condoms. But, some women enjoy sex more when their husbands use condoms. The lubrication of the condom makes it easy to insert inside women and to take it out.

- Men who drink alcohol (*mod*) and go to prostitutes⁴⁷ use condoms more. If men don't take the initiative on their own, prostitutes also put the condom on men. Wives of those men are also afraid of them because they do all nasty things (*ultaplata akam*). "They insert from the front and also from the back".
- Sometimes men are afraid to use condoms. Because if men want to use condoms, their wives suspect them and say, "You might have gone to bad places (having sex with prostitutes), that is why you are putting this thing on". (FGD with men Gachhabari, 17 May 2008)

A combination of these factors ranging from cost and storage problem to fear of creating mistrust, gossip and rumours created a negative attitude towards condoms as an unreliable method of contraception.

A separate focus group discussion conducted with women from mixed ethnic groups further supported these perceptions. The women's group further confirmed that condoms are mostly being used with prostitutes not with wives. Women giggled about seeing used condoms lying around in the jungle when they go to collect firewood. (FGD, female, Gachhabari, 6 March 2008).

Despite the easy availability of condoms in local shops and with BRAC health workers, during a discussion a local pharmacy owner mentioned:

Men don't buy condoms for themselves as frequently as they buy contraceptive pills like Femicon and Nordate for their wives from my shop. (Service provider's interview, Gachhabari, 5 June 2008).

⁴⁷ There is no formal brothel in the village. Men usually go to the brothels in Tangail and Mymensingh. However, floating prostitutes come to the forest area for sex exchange. Their customers mostly come from outside. Some rickshaw van pullers usually work as brokers to bring customers. They can recognise who is a customer and target them and bring them to the destination and promise safety of the clients. These floating prostitutes cost between 40 to 100 taka, while going to a brothel in Tangail and Mymensingh costs more money and extra travel cost. A *hijra* (third gender) was also known as a prostitute in the village. Recently s/he moved to Tangail. Some men from the village also visit him/her. It is considered safe to visit a hijra as there is no risk of pregnancy and provides various ways of sexual act. Men can have oral and anal sex with a hijra in exchange for 10-20 tk. Men learned these from blue films. This is why it is called *English kam* (the English act). There is also a house inside the forest area where sex exchange happens with the backing of local administration. Mostly rich people have access there.

The household survey showed that among 324 contraceptive users only 10 couples were using condoms. In addition, an ethnic difference was found in the use of contraception showing proportionately higher condom use among Garos compared to Bengalis. (I will come back to this point later in this section). An ethnic difference was also profound in terms of the use of natural methods among Garos, which is primarily male dependent. Garo men and women regardless of their economic status and level of education showed their preference for natural methods⁴⁸. Garo couples receive a compulsory training from the Church before their marriage. During this training they receive training about natural methods with a booklet called “*bibaho porichoy*” (Introduction to marriage). This booklet makes a difference between “birth control” and “birth regulation” and prohibits any “unnatural” birth control methods including partial sexual intercourse (*withdrawal*), prevention of conception (*gorvo nirodh*), sterilisation (*bondhakoron*) and abortion (*gorvonash*) (Mohapatro 1975:250). However, it permits “birth regulation” through following the “safe period” due to socio-economic and health reasons. If the menstrual cycle is more or less between 28 to 32 days, counting from the first day of menstruation, the middle 10 to 21 days is considered risk period. Before and after that period till the next menstruation is considered safe period.

However, women’s narratives varied greatly on how they practiced the natural method. For example some older generation women said, “My husband didn’t come to me before 22 days after menstruation”. Other women said, “After 10 days of my menstruation, my husband came to me on uneven days (*bijor diney*), like day 11, 13, 15, 17, 19 & 21, not on even days. After the 21 days have passed there were no restrictions”.

In discussions a number of Garo women mentioned that, “Natural method doesn’t cost anything, it is free. We can save money from contraception. We feel comfortable following this method”. However, this was not a fool proof method. Many women also mentioned about the miscalculation of their safe period leading to unwanted pregnancy. The case of my highly educated Garo participant Godhuli is a good example of this.

⁴⁸ Natural method was also mentioned by older generation Bengali women. Among Bengalis natural method also includes withdrawal.

Godhuli is a high school teacher, and wife of an educated Garo leader. She is 37 years old, a mother of four children. In her words:

We received training from the missionary on natural contraception. We followed that method from the beginning. We planned our second child five years after our first child. We also planned to have our third child five years after the second one. But we did a miscalculation. I couldn't remember the exact day of my menstruation. The third child was born one and a half years after the second one. After the third child was born, I tried pills. But I felt dizzy and gained weight. Since our fourth daughter was born we are combining natural methods with condoms.

We don't use condoms every day. But we follow safe period. We only use it during the risky period. Having the knowledge of safe period made it easy to use condoms and to avoid the side effect from modern contraception. (Interview, Godhuli, Garo, Gachhabari, 6 August 2008).

While the Church rejects modern family planning methods in the form of intervening in the natural functions of the body, condoms seem to be an acceptable form of contraception among Garos. This explains the relatively proportionately higher use of natural method and condom use among Garos compared to Bengalis (although it should be noted that the numbers are small, at only 7 per cent even among Garos). Due to the fact that couples have to attend this compulsory training programme together, both men and women believed in this. However, further discussions revealed that educated Garos are better capable of following the training and keeping track of women's menstrual cycle, while illiterate/low educated Garos often make miscalculations. In addition well-off Garos could afford to use condoms to avoid "accidents" during risky period, but poor Garos mostly relied on natural methods.

5.2.2 Women's contraceptive practice

Focus group discussions and in-depth interviews revealed women's preference for the pill over any other contraceptive methods. The main reason for the preference is due to women's association with regular menstruation. Women anonymously mentioned:

The pill is the best contraceptive method. No other contraceptive method can regulate the menstruation other than the pills. (FDG, female group, 6 March 2008).

However, in discussions a number of women mentioned a quality difference between the government-supplied pills (Shukhi) and the pills that are available in the market. A number of women complained of dizziness and nauseous feeling while using Shukhi pills and felt better when they used pills (such as Nordate and Femicon) from BRAC, or from the local pharmacy. But they have to pay for it.

Trying to understand the difference between government supplied and other contraceptive pills that are available in the market, I found contradictory statements among key informants regarding the quality of government supply free Shukhi pills. One of my key informants explained:

In the Shukhi pill, the Oestrogen and Progesterone level is not adjusted according to the menstrual cycle, rather it contains a constant high level of those components. In the absence of a health check-up prior to the use of contraception, this might cause problems for women having high blood pressure (Key informant interview, representative, Engender Health, Dhaka, 4 May 2008).

In contrast, another key informant mentioned:

There is no quality difference between government supplied pills and the pills that are available in the market. The price varies due to the fact that one brand is subsidised by the government. If it wouldn't be subsidised there would not be any price difference. Different price does not mean that the quality is different. They are produced by the same manufacturer (Key informant interview, representative, maternal and child health unit, Gov, Dhaka, 26 December 2014).

During key informant interview with the representative of Social Marketing Company (SMC), I learned that different kinds of contraceptive pills are available in the market for different groups of women according to their capacity to pay. In the view of the representative:

Actually, for Social Marketing one of our strategies is to segment the population. So we would have a pill for the low-income population, the Femicon pill is for the lower segment of the market. Then we have another pill for the upper segment of the market, the Nordic 28. There is also a pill from the government sector, which is free of cost. All of our products are priced and branded for different segments of the market. We use commercial marketing techniques, but everything is for the benefit of

the population (Key informant interview, representative, Social Marketing Company, Dhaka, 19 May 2008).

Despite these contradictory opinions of different key informants, discussions with women from the three ethnic communities highlighted the side effects from pills provided by the subsidised family planning programme.

Consequences and Use of Multiple methods

During discussions women often mentioned that due to side-effects they would switch between methods. To give an example, Afroza, a thirty-five year old Bengali woman, mother of three children shared her experience describing:

I used free pills for a long time. Since injectables became freely available at the community clinic, I started taking it. I choose to take injections because I couldn't keep my head straight while taking government Shukhi pills. If I can't hold my head straight how can I maintain my *shongshar* (household)? However, after switching to injectables, my menstruation stopped. I feel like a pregnant woman (nauseous). The body has its own rules. If menstruation stops, it creates problem inside the body. At this moment, I am taking pills from BRAC to regulate my menstruation. After some time, I will switch back to injectables again. I will continue like this. (Interview, Afroza, Bengali, Gachhabari, 14 May 2008).

Afroza can't afford to buy pills from BRAC on a regular basis. That is why she decided to switch between free injectables and combine it with pills from the private sector to minimise the cost and the side-effect of injectables.

Convenience was another consideration for several women to switch from pills to injectables. Women have to take pills every day, sometimes they forget to take it. Among my fifty participants, only one mentioned that her husband reminded her every night to take her pills. A reminder could have helped many others to take pills regularly. In any case, injectables for three months seem to be a good alternative to many women. But it comes with side-effects. Similar to Afroza, two other women in the village were creative enough to combine injectables with pills, and a few other women switched to Norplant. The case of Rupali is discussed here as an example.

Rupali is a 28 years old landless Bengali woman and a mother of two children. Her husband is a rickshaw van puller. They decided not to have any children anymore. However, finding the right method and managing the side-effects of contraception is still a struggle. In her words:

I didn't use any method immediately after my marriage. Within a year my first child was born. After that I started to take pills. But sometimes forgot to take it. I became pregnant for the second time within a year after the first child was born. After the second child I took injections for 7 years straight. But injection stops menstruation. I feel sick.

My husband and I do not want to have any children. But my husband is afraid of doing a vasectomy; that is why I inserted Norplant (*Shami pod-hoti doray, tai nijei kathi voira ashlam*). After the insertion I menstruated twice, after that my menstruation stopped for ever. I feel pain in my whole body and can't sleep at night. I feel suffocation (*osbthir osbthir lagey*). A few days ago I felt quite weak and my husband got saline and sleeping pills from the local pharmacy. I talked to the health worker who took me to the hospital to insert the Norplant, she said even if the sticks are removed from my arm, it is not going to solve my complaints. Because once inserted it is already dissolved in my whole body.

I received 75 tk during insertion and 50 tk during a follow up visit. I was told that I would receive 50 tk every month after the insertion. However, a return trip to the Thana health complex already costs 50 tk, it is not worth the effort, so I didn't go to the hospital anymore. (Interview, Rupali, Bengali, Gachhabari, 21 July 2008).

Rupali inserted her implant six months before our conversation. Her story demonstrates that switching from one mode of contraception to the other doesn't necessarily solve the problem of side-effects; women continue to experience similar or even worse type of side-effects.

Narratives of women reveal trying different strategies to deal with side effects. Ramisa's case provides a good summary to illustrate this. Ramisa is a 30 year old Bengali housewife and a mother of two daughters 10 and 4. Her husband is a day labourer. She shared her contraceptive experience:

After my first child was born I took Pills (*maya bori*) for five years straight. Then I stopped and had my second child. I have developed white discharge from using pills for a long time. People say injection reduces

white discharge that is why I decided to switch to injections. But I didn't menstruate for three months. Injections are also not always available at the satellite clinic. Women also had to pay 20 tk for the injections at the satellite clinic.

The health worker told me if I would take Norplant, I didn't have to worry for five years. But after the insertion my menstruation stopped. I tried birth control pills for a month. After finishing all the white pills, I took red pills, but menstruation didn't come. My husband also bought 2 tablets from the local pharmacy describing the symptoms, but didn't help. I am planning on going to the hospital soon with the health worker. (Interview, Ramisa, Bengali, Gachhabari, 29 July 2008).

Women's experience of side-effects of implant varied significantly. Some women complained that their menstruation stopped, while some other women complained of constant menstruation, affecting both their wellbeing, their ability to perform their household responsibilities and conjugal relationships. The story of Boishaki, a thirty eight year old Bengali woman, haunted me for quite a while. Boishaki shared her miserable story:

We are poor. We already have two children. We can't feed them properly. Two years ago we decided not to have children anymore. I went to the UHC and had Norplant inserted. From the first month on, I have constant menstruation. I went to the UHC with the health worker and begged the doctor to remove my Norplant (*kathi*). The doctor told me he will not remove it whether I live or die. We are poor we can't afford to buy sanitary napkins from the market. We use old pieces of cloth during menstruation. We have to wash it, dry it and reuse it. If it rains it doesn't dry properly. It always feels messy and smelly. My husband left me and married a second wife. Private doctors demand money to remove the implant. My husband doesn't bother to pay for the doctor as he already married to a second wife. I'm living my life in hell. (Interview, Boishaki, Bengali, Gachhabari, 7 May 2008).

Boishaki's testimony shows that prolonged menstruation (which was considered a problem by men during FDG) due to the side effect of using hormonal contraception makes women vulnerable in terms of conjugal relationship. Another study found how a woman attempted to commit suicide, in response to domestic violence against her, because of her

inability to provide the necessary post-harvest labour due to excessive bleeding following her contraception use (Kabeer 1994a:235).

In the absence of proper management of side effects, although Boishaki didn't receive support from her husband, Shumi, a thirty seven year old Bengali woman, mother of three children who inserted Norplant five years ago, was supported by her husband for the removal after she has been refused at the UHC. Shumi shared her experience saying:

Right after inserting Norplant, I began to menstruate constantly. It never stopped. Doctors at the Upazila Health Complex told me that it is not possible to take it out before the five years of expiry date. Once inserted it should stay in the body for five years. But our conjugal life was going down the drain and my husband became tired of it. My husband took me to a private doctor and removed the Norplant. We paid five times more to remove it than what I received during the insertion. However, I remained sick for quite a while. It is only recently I feel better after the validity of the Norplant has expired. (Interview, Shumi, Bengali, Gachhabari, 18 May 2008).

In total eight women were using Norplant in Gachhabari for a duration between 2-24 months during this study. All of the five that I interviewed mentioned moderate to severe complications.

Despite experiencing side-effects, the above discussion shows that women are not only passive victims but show their resilience and try to manage their side-effects by using resources at their disposal. They deploy a number of strategies by: switching between contraception, combining different methods, seeking help from the health workers or their husbands and by sending their husbands to get medicine from the local pharmacy to treat the symptoms.

One glaring difference in contraception practice in terms of ethnicity is Garo women's resistance towards injectables and implants. Discussions with a number of Garo men and women reveal that Garos have less trust in government family planning methods. All 31 injectables users and eight implant users were mainstream Bengali women.

Two Garo women accepted permanent contraception in the mid 1970s, since Pills and condoms were not available around that time. The decision to take permanent contraception was linked to the economic condition of the household at that time. A 53 year old Garo woman, Talope's describes that period:

Mandis used to do *jhum* cultivation before. It required clearing the forest for cultivation, which required more family members. Nobody cared how many children they had at that time. After banning *jhum* cultivation, life became difficult. We used to collect potatoes, boil them with salt to eat. We took care of the forest for our own survival. When we collected potatoes we made sure that the plant stays alive so that it grows more potatoes. When Bengalis started to collect potatoes they uproot the plants. Potatoes became less available. We could have something to eat for one meal not for the other (*ekbela khailey arek bela khaite pari nai*). I also collected *hoti* (a kind of corn) to make barley to feed my children. I chopped trees and carried twigs from the forest and sold them in the market. I already had two daughters and a son. Two later children died. One child was born on a Thursday, started to cry and never stopped, died on the following Tuesday evening. The child turned yellow, black and red. His tongue got stuck on the upper pallet. My husband called a Kaviraj (traditional healer), who gave him herbal medicine, closed the house from evil spirits (*ghor bondho korlo*), but nothing worked out. A similar thing happened with the other child as well. I couldn't bear to see the sufferings of my children anymore. I heard about sterilisation operations from a Bengali health worker. I consulted two of my sisters and three of us have had the sterilisation operation done. I didn't even ask permission from my husband. When he found out he was upset. But I made him understand (*ami tarey bujhaichi*). (Interview, Talope, Garo, Gachhabari, 13 August 2008).

Due to the banning of *jhum* cultivation (which I will explain in Chapter Seven in details), elder Garo women faced livelihood constraints. A lack of prospect for the future generation pushed some elder Garos to accept permanent family planning.

Talope worked hard with her husband. Together they cleared up some jungle for cultivation, gradually they have bought some land from other Garos and educated their children. Now her daughters are working in a beauty parlour in the capital and her son is learning carpentry in Madhupur. Talope's case helps to understand how contraception decision is deeply related to the economic and material condition of the households.

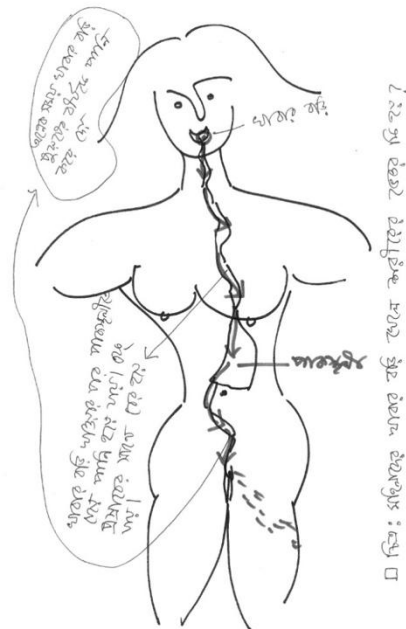
The voices of men and women from the Bengali and Garo communities presented above contradicts the assumptions and interpretations in the policies (discussed in Chapter Three) of poor women's homogeneous need for long-acting contraception. Besides convenience, many women accepted long-acting contraception due to the side-effects of previous contraception.

Women are not only experiencing the similar or worse side effects, since they have accepted implant, but they were also not aware of the side-effects they have encountered. This needs to be realised to interpret women's practice of long-acting contraception as "preference" (which policy claims). Garo women's dependency on natural methods also cannot be interpreted only in terms of ideological restrictions or cultural norms, but also the cost of the pill from the private market and condoms, which they prefer.

Perceived problems in the existing family planning programme

Discussions and narratives of men and women revealed a number of limitations in the existing family planning programme. A focus group discussion of women from mixed ethnic communities revealed that women lack information on how to use pills properly. During a body mapping exercise while women were drawing how pills work as a contraceptive method on women's body, their perceptions were documented. The drawing read: "contraceptive pills turn men's semen (*birjo*) into water" (Drawing 5.1), which prevents women from getting pregnant.

Drawing 5.1
Female body mapping



Source: Drawn by participants during FGD, female, 25 April 2008.

Due to this perception, during an in-depth interview an illiterate woman mentioned taking pills only on the days she had intercourse. When her husband migrated to the cities or to another places to work for a few days as a seasonal worker, she skipped taking the pills. In the absence of any knowledge on how pills work illiterate women couldn't justify taking pills every day, while they aren't having sex. Two other women waited for their husbands to return home after their seasonal work to buy new pills from the pharmacy, while the old strip was finished.

It was further revealed that women's perception about iron pills in the strip of contraceptive pills made women skip those. Women thought the purpose of the iron pills was to regulate menstruation. Normally women should have started taking iron pills from the strip when the white pills were finished and continue taking them until they were finished and then start taking white pills again. However, after taking one or two iron pills if the menstruation starts, women stopped taking iron pills anymore. When the menstruation was over after taking a purifying bath (*pak kosol*), women restarted taking the white pills from a new strip.

The local health worker was aware of such misperceptions of women regarding the use of pills. During a discussion with a BRAC health worker, she said:

Illiterate women do not realise the importance of taking iron tablets. Women also don't have proper information about what to do if they forget to take the pill for a day or two. If they forget to take pills and become pregnant they blame the pills for their unwanted pregnancy (Service provider's interview, BRAC, Gachhabari, 13 July 2008).

Health workers further emphasised that skipping the iron tablets make women anaemic. Women however, put the blame for their lack of information on how to use pills properly on the government policy shift from door-step to clinic based service delivery. During discussions it became apparent that family planning fieldworkers used to go to visit houses to distribute pills and explain how to use them. Now women have to go to the Satellite Clinic to get pills or injectables, which demands extra time. Women are often busy with their household work and forget the opening date, which is once in a month. Family Welfare Assis-

tants (FWAs) at the Satellite Clinic don't have the time to explain how to use pills properly anymore.

During my visits at the Satellite Clinic, the supply of pills was insufficient. Some women received them, some didn't. Three women were even given one packet of pills containing strips for three months. They were recommended to visit the Satellite Clinic in the following month to receive more pills.

In another focus group discussion organised with men of mixed ethnic groups, their perceptions towards family planning programme emerged as summarised below:

- The main problem of current family planning programme is that men or women who are using these methods are never informed about the side-effects.
- Nobody knows what Norplant, copper T or vasectomy is. Men have a vague idea about these methods. Men who have done a vasectomy couldn't explain where/which vein or tube has been removed or tied off. A male participant mentioned that his semen tube (*birjo nail*) is taken away so that semen cannot come out anymore, but men are not well informed before undergoing this method. When men were asked what happens with the semen after vasectomy, their response was that semen turns into water inside the body and comes out during urination.
- Women who were using implant were told that three/four/five thin copper sticks are to be inserted under the skin of the upper arm for three, four or five years which is removable after use. Nobody could explain how these small sticks are going to prevent women from getting pregnant. A general idea was that these sticks are going to destroy female eggs. Other idea was that these sticks turn men's semen into water during intercourse.
- IUD is not used so much in the village and participants had no clue about that method. The government clinic is mainly giving emphasis on Norplant.
- Norplant has health consequences. Women who use Norplant can't do heavy work. They often suffer from sickness. Their health deteriorates gradually.
- To take a permanent method one has to go to the hospital with a health worker, it involves difficulties (*jhamela*).

- After vasectomy men's sexual power deteriorates. They can't enjoy sex like before.
- Those who use Norplant or vasectomy are teased socially. It is believed that they have lost their sexual power.
- Female contraception makes women anaemic, it causes irregular menstruation and women lose their eye sight. (FGD, men, 17 May 2008).

These statements from focus groups suggest that men and women not only lack information how to use contraception properly, they are also not informed about the side effects of contractions they "chose". They also perceive side-effects as a package that comes along with a particular contraception, not being able to realise the possibilities to solve them.

Privacy and confidentiality are not ensured in the way family planning programme operates. In discussions with a number of men and women, going to the upazila health complex for Norplant and vasectomy with a health worker was also perceived as a problem. During discussions it became apparent that to get vasectomy done, men always have to go to the UHC with a government health worker (male health assistant who is responsible for child immunisation programme in the service area). If men go to the UHC alone to keep this a secret, they are rejected. In a discussion in response to the rejection of men in case they are not accompanied by a health worker, the family planning officer at the UHC, said:

In the past some vasectomy clients were never found back. Because of the monitoring and follow-up, clients should always come to the UHC with a health worker from his area (Service provider's interview, Family Planning Office, UHC, Madhupur, 30 July 2008).

Bearing in mind that the FGD among men revealed that vasectomy clients are teased socially, it is quite understandable that those vasectomy clients didn't want to be traced back for follow-up. However, an anonymous Family Welfare Visitor (FWV) further mentioned that these unwritten rules are created to serve the purpose of health workers to meet their targets, saying:

By imposing these unwritten rules fieldworkers get the chance to reach their target. If the fieldworkers can't reach their target their salary is withheld (Service provider's interview, FWV, UHC Madhupur, 30 July 2008).

This shows how setting priorities and targets in the policy are operationalised in practice, which actually works against achievement of the targets. The Family Planning Officer at the UHC was aware of the stigma related to vasectomy, which discourages male clients to accept sterilisation. However, instead of eliminating the barrier of going to the UHC with a local health worker, he tried to emphasise the difference between vasectomy and non-scalpel vasectomy (NSD). Whatever the differences might be between vasectomy and NSD in terms of medical procedures, going to the UHC accompanied by a local health worker puts a man into risk of being the subject of community gossip (seen in the case of Jamil Miah and Shuvas). This situation shows a contradiction between follow-up and counselling and privacy and confidentiality of the “client”.

Another contradiction between the policy priority and men’s need was expressed in terms of the cost of condoms. A policy shift towards long acting contraception (injectables, implant) along with permanent (sterilisation and vasectomy) contraception created dependency on the private sector for short acting contraception such as pills and condoms. For instance, condoms which were previously distributed free from the family planning programme are not distributed free anymore. Condoms are available in local pharmacies. BRAC health workers also sell contraceptive pills and condoms and get a commission on the sale. During an interview, a BRAC representative justified imposing a cost for pills and condoms, saying:

If we would not have taken any money for contraception from the client it would not matter for BRAC. But women would not value the service. Women received plenty of birth control pills and condoms from the government in the past. But they didn’t use them properly. When they buy “Nordate”, which costs them 30 tk (app. € 0, 30) and “Femicon” which costs 16 tk (appx. € 0, 16) and per condom costs 2 tk, then they use them properly. When condoms were given for free by the family planning programme, children used to blow them as balloons. (Service provider’s interview, BRAC field worker, Gachhabari, 13 July 2008).

Despite being no longer free, it seems that small children still play with them as balloons. While two BRAC health workers were promoting small family norm among women in a group meeting, children were busy playing with condoms (Pictures 5.2 & 5.3) a few meters away from them. However, in a context where male use of contraception is already signifi-

cantly low, stopping free distribution of condoms has put a further barrier to pay for condoms on their acceptance. In addition, due to the fact that Garos are more inclined to use condoms, this affects them more.

Pictures 5.2 & 5.3

Kids playing with condoms (above) Health worker promoting FP (below)



Source: Researcher's photo.

We have seen that women highlighted side-effects from government supplied pills; a number of women mentioned their inability to afford pills from the private sector, which they would have preferred. Women also perceived the supply of contraception as a problem in the family planning programme. I mentioned earlier that during my visit to the Satellite Clinic, the supply of pills and injectables was insufficient. In addition, women who came to receive an injection for the first time were rejected. The FWV explained:

Women who do not have any children yet, are not given injections as a contraceptive method, they can only receive pills⁴⁹. Women who have at least one child and wish to start injections as a birth control method should come to the Satellite Clinic to receive the injection while they are menstruating (Service provider's interview, FWV, Satellite Clinic, Gachhabari village, 5 July 2008).

She further explained:

As a side-effect, injectables can sometimes make women infertile. That is why it is not given to women who don't have any children yet. Women who have at least one child should come during their menstruation to make sure that they are not already pregnant before starting an Injection. (Service provider's interview, FWV, Satellite Clinic, Gachhabari village, 5 July 2008).

However, the Satellite Clinic opens once a month. The chance that a woman will be menstruating during the opening day of the Satellite Clinic is small. If women wish to start Injections during menstruation as suggested, and if it is not the opening day of the Satellite Clinic women can get the service from Smiling Sun, another NGO in the neighbouring village and pay 20 tk (2 euro cent). While the service at the Satellite Clinic is supposed to be free, discussions with women revealed that women were also charged 20 tk (appx. € 0.20) for injectables at the Satellite clinic. During an interview with the FWA at the Satellite clinic when I asked the reason for that payment, she informed that due to the shortage of the government supply, FWA had to arrange injectables from an

⁴⁹ However, supply of pills weren't sufficient enough.

NGO and provide those to their “clients”.⁵⁰ Otherwise women would have missed their regular injections. However, women who were not able to pay didn’t receive their regular injectables. In any case women weren’t charged during my visit to the Satellite Clinic. Although women were offering money to the FWA in front of me, the FWA told women they do not have to pay, because government supply has been reassured. I wondered whether women were charged after all in my absence at a later stage. During an interview with a key policy stakeholder, I understood there was a national level problem with the supply of injectables, as they were imported. (Key informant interview, representative AL, 12 December 2014).

Contradictions between health care provider’s and women’s preferences were also evident. The example of Kohinoor can illustrate this point. Kohinoor is a forty-two-year old Bengali woman, a mother of four children from a landless poor family. She was using injections (which are effective for three months only) and wanted to take Norplant and be safe for five years, but she was rejected. She described:

I would have preferred to take Norplant. Then I wouldn’t have to think for five years. I even went to the hospital (UHC) with the health worker. But the doctors refused to give me implant. The doctor told me it is not allowed by the government to give Norplant to any women who already have four children. The doctor insisted that I would accept a permanent method. I left the Upazila Health Complex and continued to take injections from the Satellite Clinic. (Interview, Kohinoor, Bengali, Gachhabari, 14 July 2008).

Kohinoor was afraid of undergoing a sterilisation operation. Therefore, she wanted to use Norplant and be safe for five years. She thinks after five years she might have started her menopause and then she wouldn’t have to use any method any more. However, the health provider didn’t show any respect for Kohinoor’s choice for contraception.

During an interview, the Family Planning Officer responded to this case saying:

I suggest that women who have two living children take permanent methods. If they disagree then I advise them to take Norplant. We are told (by

⁵⁰ In the interview with the FWA and also in the policy document, women are always referred to as clients.

the authority) not to give Norplant to women who have three living children, but still we are giving the method to them. But we don't provide Norplant to women who already have four living children. They can only receive permanent methods (Service provider's interview, Family planning Office, UHC, Madhupur, 20 July 2008).

Referring to Norplant, the Family Planning Officer further mentioned:

These methods are not for the rich. Rich are motivated themselves. Poor clients need to be motivated to use other methods than only pills. Otherwise we will not have clients that use different methods. Everyone would do the same (Service provider's interview, Family Planning Office, UHC, Madhupur, 20 July 2008).

It appears that despite the availability of a range of contraception, they are not accessible to all women. Young, newly married women are given pills. Women at least having one child are given injections and implants. Older women having at least two or more living children are "motivated" to use permanent methods. The above example shows that women may perceive this as contrary to their choice.

The family planning programme was also perceived as gender biased. In discussions, it appears that female field workers are from the community, and therefore share common cultural norms. A common sentiment shared by many women can be summarised in the narrative of Fouzia, a twenty one year old woman, who said:

Fieldworkers also tell us that men's methods are not good. They make men weak. Men are the one who have to do the heavy work. Women don't have to do heavy work like men. That's why fieldworkers motivate only women to use contraception. (Interview, Fouzia, Bengali, Gachhabari, 18 September 2008).

Further discussion with a female field worker reveal that female fieldworkers do not have the mandate to motivate men. In a discussion with the local field worker when her daughter-in-law was suffering from side-effects of pills, when I asked her why her son is not using any contraception the fieldworker with great frustration said, "There is nobody to talk to men and make them understand to use contraception". She further acknowledged that she can't talk about contraception with her own son and convince him to accept male contraception.

BRAC health workers also organise group meetings to encourage family planning, but men are not involved in those group meetings or motivational work either. A BRAC health worker mentioned:

We organise one group meeting every month in the village among 20-25 women. Men are also invited to attend these meetings. But they never come. Men are not motivated to use contraception. They don't care. (Service provider's interview, BRAC, Gachhabari, 13 July 2008).

While the health worker blames men as being ignorant about family planning programme, it is linked to the exclusion of poor men in the way family planning programme has been designed and implemented. These motivational meetings are organised in someone's house or in an open space during noon, when men are not around, which of course allows women to move freely in the village to attend these meetings.

The evidence thus suggests that the contraceptive practice among Bengali and Garo communities in Gachhabari is shaped by the local construction of masculinity and femininity and its link to different types of contraception as well as national policy priorities, providing access to certain types of subsidised contraception and putting barriers to other types by imposing fees and by including/excluding certain members of the households.

5.3 The experience of unwanted pregnancy

Given the constraints and opportunities in the family planning programme discussed above, the following section discusses women's experience of unwanted pregnancy and how women deal with it.

One perception related to unwanted pregnancy is *muta pet*, which means becoming pregnant sooner after giving birth to a child. After the birth of a child, normally women stop menstruating for several months to years. Women wait for the menstruation to start again before starting any contraception to prevent the next pregnancy. But unfortunately many women become pregnant again without starting menstruation following a childbirth. Parboti, a twenty five year old Bengali woman, mother of two children shared her experience of unwanted pregnancy:

After my first child was born, I haven't re-started menstruating, but became pregnant again before planning anything. I wanted to abort the foetus. My husband didn't fully agree, but I went to the hospital anyway with

a health worker. However, the nurse told me that I didn't have enough blood in my body. Even if I could have arranged to transfuse blood, still it would be risky. Later I decided to continue my pregnancy, but I would have preferred not to have another child so quickly after my first child. (Interview, Parboti, Bengali, Gachhabari, 11 April 2008).

Such unwanted pregnancy due to *muta pet* points to the absence of family planning counselling and contraceptive planning after child delivery. This link to the lack of family planning counselling is missing in the policy discourse that links "unwanted pregnancy" with short-acting "contraceptive method failure" and justifies a shift to long-acting contraception for the poor (as discussed in Chapter Three).

Another perception is related to misuse or irregular use of modern contraception. In discussions, women often mentioned they forget to take pills. Women's narratives also considered unavailability of free contraception as method failure. According to Jaigun (a thirty two year old woman, mother of three children), her last child was born due to contraceptive method failure (*podtbotir bhuley*). She explained:

I took pills for a long time. Recently I switched to injections as they became available at the Satellite Clinic. But after a while it wasn't free anymore. Women had to pay 20 tk for injectables. I missed one injection and became pregnant. (Interview, Jaigun, Bengali, Gachhabari, 6 June 2008).

This narrative is interesting since poor women redefine "contraceptive method failure", as a failure of the public health care system to ensure supply of subsidised injectables for the poor.

Another perception was related to pregnancy beyond socially expected norms, which includes not only pregnancy of unmarried women, but also old age pregnancy⁵¹. The case of Phul Banu (a forty nine year old Bengali woman and a mother of five children) can explain this:

I was taking birth control pills for many years. After using the pill for such a long time my menstruation stopped. I thought I might have reached my menopause and not be fertile anymore. As soon as I stopped taking pills, I become pregnant. We had already married off our two daughters. I discussed it with my husband. He said, "at this age we are supposed to play with our grand children. If you give birth to another child, people will

⁵¹ This phenomenon is known as "grandmother complex" among educated people in the cities, I couldn't find a Bangla term for that.

laugh at us". I also felt it would be embarrassing to face our son-in-laws with my big belly. (Interview, Phul Banu, Bengali, Gachhabari, 9 August 2008).

Further discussion with Phul Banu revealed that sexuality at an old age is stigmatised in the community. Therefore, she committed a self-induced abortion (explained later in this chapter).

While official discourse around family planning mainly defines unwanted pregnancy in terms of unmet need for modern contraception, the above narratives provide an alternative discourse of unwanted pregnancy linked to the local cultural context and the absence of adequate family planning counselling after childbirth. The following section explores women's experience of using MR/abortion to terminate their unwanted pregnancy.

5.3.1 Use/abuse of MR services: husband's consent, cost and time limit

Although there is a distinction between abortion and MR⁵² in terms of policy (Akhter 2001), women simply refer to it as removal of a foetus (*pet phela*, *baccha nosto* or *gorvo nosto*). A mix of reasons/perceptions emerges about the use/misuse of MR services in case of unwanted pregnancy. One major reason is related to the time limit. Individual women's testimonies, personal observation and discussions with service providers reveal that although services are legalised up to 10 weeks of pregnancy, in practice the service is not available at the UHC beyond 8 weeks. An anonymous FWV at the UHC mentioned:

We have cannula to perform MR till 10 weeks of pregnancy and our FWVs are capable of doing MR up to 10 weeks of pregnancy. However, due to some unwritten rules at the UHC, MR is not done beyond 8 weeks (Service provider's interview, FWA, UHC, Madhupur, 5 July 2008).

In contrast, in a discussion with the medical official at the UHC, he mentioned:

⁵² To deal with unwanted pregnancy, Menstrual Regulation (MR) service has been integrated in the family planning programme and the service is made available at all major public hospitals and health facilities within 10 weeks of pregnancy in 1989 (Akhter 1996a; Akhter and Rider 1996; Akhter 2001). The MR Service is available at the UHC in Madhupur.

Women beyond 8 weeks of pregnancy are refused because the logistics aren't available at the UHC to perform MR beyond that stage. (Service provider's interview, Maternal Health and Child Care Centre, UHC, Madhupur, 20 July 2008).

Due to this restriction, MR service is not widely used at the UHC. On an average only 2 to 3 women are reported to use MR services (within 8 weeks of conception) in a month. The UHC didn't disclose the information how many women are refused every month due to the time limit. Concerned persons mentioned that mostly poor women go to the government hospital to perform an MR, because due to their poverty another child would be a burden for them. However, illiterate women are often too late to receive a formal MR service.

Further discussions with a number of women and local field workers reveal that although the service is officially free, women are charged a price. Women beyond eight weeks of pregnancy are charged between 500-1,000 tk, (approx. 5-10 Euros) depending on the duration of their pregnancy to get the service. In that case the service is done at home of the health care provider. This shows various sanctioned and unsanctioned ways of service provision where the boundaries between public and private health care provider are blurred. Another study (Rashid 2011) also found a similar trend in health care provision in other areas of Bangladesh.

Husband's consent appears to be a factor for the limited use of MR service. According to the official rules the information that is required to perform an MR is: marital status, number of children, age of the youngest child, LMP (last menstrual period) and the consent of the husband.

Although the availability of MR Service at the UHC provided the opportunity for married women to use the service, women have to negotiate with their husbands to receive permission. The outcome of the negotiation varies depending on women's negotiation power. Two cases (Joy Banu and Shufia) can illustrate the dynamics of such negotiation.

Joy Banu is a forty-eight-years old Bengali woman and mother of four children. She performed MR twice. The first MR was a two months pregnancy and the MR went well. Nine months after the first MR she became pregnant again. Her husband didn't agree with her, to have another MR sooner after the first one. Joy Banu bargained with her husband saying:

You are unable to provide food and education (*khowa pora*) to our four living children. You can't take the children to visit a doctor when they fall ill. Why do you want more children? To let them suffer? My husband kept quiet and allowed me to perform another MR. (Interview, Joy Banu, Bengali, Gachhabari, 15 July 2008).

The narratives of Joy Banu show that legalisation of MR and the availability of the service provided women the opportunity to negotiate in the household. She also used the breadwinner's norm to her advantage to claim her right to use the service. However, not all women have the same bargaining position as Joy Banu.

Joy Banu already had four living children before she went to do her first MR. When Shufia (a twenty two year old Bengali woman, mother of two children) wanted to terminate her second pregnancy, she was not able to negotiate hard. In her words:

I wanted to abort my second child which was conceived due to contraceptive method failure. I was taking pills but forgot to take them regularly. I wanted to have a gap of a few years before having my second child. Initially my husband agreed. He runs a grocery shop; he doesn't have any time to take me to the hospital. He told me if I can arrange with the female health worker to go to the hospital, I can abort the child. Later he changed his mind and said to me, "Why do you want to abort the child? Is it from me or from a secret affair (*jaira ponda*)"? In the end I continued my pregnancy. (Interview, Shufia, Bengali, Gachhabari, 3 June 2008).

These cases highlight how women experience the policy restrictions on MR service differently. The negotiation might be affected by many factors, such as duration of marriage, intra-spousal communication, number of children, reason of MR, health concerns and so on. Husband and wife might have different opinion and logic to do or not to do an MR, and not all men should be labelled as pro-natal or anti-MR.

Unmarried women are also officially excluded from access to the MR service. However, it seems that women who have money can manoeuvre the rules to get the service, albeit at a price. The local fieldworker said,

If you pay extra money you can get the service, it doesn't even matter whether you are married or not. If the pregnancy is within two months, nurses will do it in the hospital. If you develop any problem, you can go back to the hospital. Nurses will check you and give medicine or arrange to perform a D&C if necessary. If it is beyond two months, they will do it

at home. You have to pay more money and the nurses will not take any risk if you face any problem. They will tell you, “I told you beforehand after two months it would be at your risk”. As you took the risk, you would have to pay for any treatment for complications. (Service provider’s interview, field worker, Gachhabari, 10 July 2008).

Due to the restriction on time limit, cost and demand for husband’s consent, many women fall back to back-door or unsafe abortion providers. Those providers neither require any formal registration nor demand any consent from the husband.

5.3.2 Unsafe abortion practices and consequences

In the focus group discussion among women from mixed ethnic groups, illegal abortion appeared to be an open secret. A private clinic and a female private health practitioner’s chamber were mentioned as common abortion providers in the village. Abortion complications can result from abortion done by untrained personal, or abortion done in the hospitals or clinics in an unhygienic way. The boards shown in Pictures 5.4 and 5.5 below read: “Name of the practitioner, specialised in female disease and delivery, Birth Control injectables are available here” (left), “Anonymous Clinic and Hospital” above the Bata (shoe shop) (right).

Pictures 5.4 & 5.5

Unregistered practice (above), poorly maintained private clinic (below)



Source: Researcher's photo.

Discussions with a number of women and health providers made it apparent that women often choose an unsafe provider due to their in-

ability to pay a high cost at the formal private clinics. Women's narratives reveal that unsafe providers seem to be a good deal in terms of cost. The case of Rabeya is a good example to illustrate this. Rabeya is a thirty eight year old poor Bengali woman and a mother of four children. She is a housewife, her husband is a shop-keeper in Jalchatra bazar. In her words:

We have already four children due to our (me and my husband's) ignorance. We can't feed them properly. I started taking injectables. So I was not menstruating (due to injectables). Slowly my tummy became thicker and thicker and I was having symptoms of pregnancy. By the time I realised it, I was already four months pregnant. Then it took me another month to decide for an abortion. I went to the UHC with my sister-in-law with the permission of my husband.

I was refused because my pregnancy was five months old. But a nurse told me that it could be done but it would have cost me 500 tk (appx. € 5). I couldn't afford to pay that much. When we left the hospital a broker took us (me and my sister-in-law who accompanied me to the UHC) to a female doctor's chamber. We agreed for 300 tk and a lady doctor tore my *panipata* (performed an amniotomy) and sent me home. She gave me one pill to take when I would arrive home. As soon as I arrived home, the foetus came out with a heavy flow of blood and severe pain. I became feverish. I was half dead for two days. My relatives found out about my situation and scolded me. Later, they became sympathetic and could not watch me die. My brothers took me to the female doctor's chamber. My brothers told the "lady doctor" to think about the consequences if I would die. The lady doctor then called a big doctor and arranged to clear my tummy. This time she did not charge me any money. My life was saved. I will never do this again in my life. (Interview, Rabeya, Bengali, Gachhabari, 16 August 2008).

Rabeya's story highlights a new form of risk that has been emerged due to side-effects of injectables. Women could not make a distinction between the experience of pregnancy and discontinuation of their regular menstruation induced by the long-acting contraception. By the time they discover their pregnancy it is beyond the official time limit for MR service.

Further discussions with women and health providers further confirm that when women are rejected by formal health care provider, women use back-door services from public health providers. An anonymous

case of a woman in the village shared by the FWV is an example of this. The FWV described:

One patient came to the UHC to perform an MR. I refused her because the duration of her pregnancy was already beyond 12 weeks. Then the lady went to a nurse who works at the UHC. The nurse performed an abortion at her house secretly in return of money. The lady was send back home with serious pain in her abdomen and high fever. After two weeks she came back to me and was begging for her life. While doing her Per Vaginal (PV) examination, to my surprise she appeared two months pregnant after her abortion. The nurse did a partial abortion; half of the dead foetus was still inside her womb which was causing serious cramp and fever. I did a D&C at the UHC to save her life. In addition, I gave her antibiotics that I received as a doctor's sample from a pharmaceutical company (Service provider's interview, FWV, Satellite Clinic, Gachhabari village, 5 July 2008).

The ambiguity around MR policy (discussed in Chapter One) contributes to the misuse of the service. Since MR is incorporated in the family planning programme, the Family Welfare Visitors (FWVs) are officially trained to give MR service in the family planning unit of the UHC. However, women often go to the nurses at the maternity section, who are neither trained nor officially responsible to perform MR services. Nurses strike a deal to do it at home beyond official records. Rabeya's case further illustrates how a network of brokers is active to lead women to secret abortion providers.

Given the official demand for husband's consent, poor unmarried women often fall victim to secret abortion practice. The case of my Garo informant Mohua (19 year old during the interview) is an example of this. Mohua was made pregnant by her boyfriend when she was 16. Mohua's grandmother took her to the UHC. Although pre-marital sex is not a big deal among Garos, Mohua was denied the service. However, a nurse from the UHC agreed to do it secretly at home and demanded 300 tk (appx. €3). The abortion was not done properly and caused Mohua to have serious health problems. She suffers from acute lower abdominal pain and severe blood loss during her menstruation. She became very weak and sick. With the help of her grandmother she received treatment from the missionary hospital and recovered a bit. After a year she was married off with the same boyfriend. She feels pain during intercourse since her marriage. She became pregnant again at the age of 18. Her

pregnancy was complicated. The missionary hospital bore the cost of her delivery. She complains of a bad conjugal life due to the problem related to her unsafe abortion. Mohua's case illustrates how restrictive laws put unmarried women's life into risk of unsafe abortion complications.

During an interview⁵³ with "Dr. Dalia Khan", whose name was mentioned by several women in the village as an illegal abortion provider behind her private practice, the provider mentioned that she doesn't have any registration with the government. She isn't also required to keep any record of her practice for any government monitoring or audit.

She mentioned that poor women often don't keep track of their menstrual cycle (also found in Akhter and Khan 1996a). They count their menstrual cycle according to the moon cycle (*puṛnima and amabosh-sha*). They wait for two moon cycles to confirm their pregnancy. Moreover, poor women need more time to gather money and to use their social network to reach the hospital. Therefore, by the time they arrive at the hospital their pregnancy is often already beyond 8 weeks. She further mentioned:

Some women try to terminate their pregnancy with abortion pills which are now available in the market. But it doesn't work. After waiting for a long time finally they decide to go to the UHC. By that time they are well beyond their time limit to use the service at the UHC. After being rejected from the hospital they come to my clinic. (Service provider's interview, private practitioner, Madhupur, 17 September 2008).

She mentioned that married women who already have a young child of 7/8 months old and become pregnant again are most desperate to terminate their pregnancy. She justified her service arguing:

Women become so desperate that they cry and fall on my feet. They request me so much that I feel pity for them. I just rescue them from their crisis, sometimes without any money. They don't want to have a child at any cost. If I don't do it, they'll go to a TBA or attempt self-induced abortion. They come to me to keep it a secret and I ensure their privacy (Service provider's interview, private practitioner, Madhupur, 17 September 2008).

⁵³ I explained this particular interview in my methodology chapter in the section on ethical reflection.

She also acknowledged some accidents, but defended herself by saying:

It is not something that I can see with my eyes. I have to do it only based on the feeling of my hands (*hater andaj*). That is why sometimes some part of the foetus can still remain inside. Women also can't tell the duration of their pregnancy accurately. That also causes mis-estimation (Service provider's interview, private practitioner, Madhupur, 17 September 2008).

Poor women can't afford to do an ultra-sonogram or pregnancy test from private diagnostic centres to confirm the duration of their pregnancy accurately. Therefore, abortion is done without any diagnostic test, only based on Per Vaginal (PV) examination. If something goes wrong patients can't claim anything because there is no registration, no referral, no witnesses; everything happens behind the curtain.

The provider further admitted that she has neither any medical education nor any formal training or license to perform MR/abortion. Her brother was a medical doctor at the UHC a few years back. She managed to get a certificate from her brother as an intern during his job period. Then she opened her own clinic next to the hospital. She provides the abortion service under cover of maternal health care services. When she can't manage a case her brother who was a medical doctor at the UHC and now transferred to another city comes on an emergency call or helps her out by prescribing medicine over text message.

These findings show although the legalisation of MR saved many women's lives from unsafe abortions, back-door and illegal services are still causing serious damage to women. Many providers are practicing illegally in conditions where abortion is not done properly, without sterile equipment or the providers don't remove the entire foetus, leading to infections and other complications (also found in Azim and Nilufar 1996; Shameem et al 2004)). In the absence of a strong government monitoring system, illegal practices are jeopardising poor women's health and wellbeing. The contradiction in the MR policy that requires husbands consent but it doesn't require a pregnancy test also appear to contribute to abortion complications.

Discussions with a number of women provided evidence of traditional abortion practices in the village. A sharp root of a plant locally known as *aaigga tita* or *rosbotika* or *ubud nengra* (the plant and root are shown in pictures 5.6 and 5.7) is used for this purpose.

Pictures 5.6 & 5.7
Plant and its root used for induced abortion



Source: Researcher's photo.

This practice seems to be in decline and only practiced among poor elderly women. Phul Banu, the forty-nine-year old woman and a mother

of five children who became pregnant at an old age performed this method. In her description:

The plant is uprooted then washed and a straight root is cut into a piece of eight fingers long. The sharp end of the root is inserted into the vagina. The other end of the root is tied with a rope and tied with the upper leg (*thai*) to prevent the root from going too deep inside. After inserting the root women lie in bed. If the foetus is three months old then it will come out in two hours. If the pregnancy is five months old then it will take two days for the foetus to come out completely. (Interview, Phul Banu, Bengali, Gachhabari, 9 August 2008).

She further explains the consequence of this method:

Women will have so much fever that they will shiver and they will grind their teeth after inserting the root. She will need thick clothes and blankets. The pain and fever will continue until the whole foetus comes out. If a part of the foetus remains inside the pain will not reduce. The part of the foetus will be rotten inside and create an infection (*Gha*). The belly will distend (*Pet phula dhorey*) and she will have serious pain in the lower abdomen. At this point if women are not taken to the hospital they will die. (Interview, Phul Banu, Bengali, Gachhabari, 9 August 2008).

Despite knowing the fatal risk, she opted for this method because it doesn't cost any money. Further discussion revealed that this plant is commonly known in the village. Women usually collect this plant from the local jungles and apply it themselves.

According to local gossip, in the last ten years three women died in the village due to using self-induced abortion. Discussion with a senior nurse at the UHC revealed that in the case of several pregnant women who were taken from the study village to the hospital with severe bleeding, herbal roots were detected during ultra-sonogram and Dilation and Curettage (D&C) was done to remove the roots. However the nurse mentioned that the use of this method is decreasing. Nowadays women go to a medical provider (mostly illegal to do it secretly) to terminate their unwanted pregnancy. It is however cynical that UHC provides a D&C to treat the complications due to unsafe abortions but it doesn't provide legal safe abortion services.

An ethnic difference was found in terms of MR/abortion practices. I use three cases (Shantana, Godhuli and Rafiqul Islam) to illustrate this point.

Shantana is 32 years old landless Garo woman. She was allowed to build her house on a piece of land owned by a rich relative of her *ma'chong*. She and her husband work on the land of her rich relative. She had three children and became pregnant for the fourth time. After a conversation at a local tea stall, she asked me to visit her at home. According to our appointment I went to meet her. She was lying down on a mat on the floor in her dark mud house. She told me,

I gave birth to three children before, but I never felt so sick during my pregnancy. I am dizzy I can't keep my head straight. I also didn't want to have another child. It is already difficult with three children. We were following natural method. But something might have gone wrong. (Interview, Shantana, Garo, Gachhabari, 25 September, 2008).

Shantana works as a day labourer. Due to her pregnancy sickness she stopped working for a while. She was thinking of an abortion. She asked advice from her rich female relative, but the relative said, "It is forbidden to kill a foetus (*gorvonash nishedh*). I don't give my consent, but if you decide it is your own risk". She asked for my help. I wanted to talk to her husband. Next day I went early in the morning before her husband left the house. He gave his consent to terminate the pregnancy. We agreed, I would wait for them at Jalchatra bazar, Shantana's husband would bring her there and we would take a tempo (10-passenger vehicle) to go to the hospital. Next day I was waiting at the bazar. Shantana came alone, her husband didn't show up. I was surprised. I took her to the hospital. The nurse already knew me for several months. She checked her and called the doctor. The doctor said to me straight:

She is already four months pregnant we can't perform an MR at this stage. I know you might take her somewhere else and get it done. But she is anaemic. It would be very risky for her. (Service provider's interview, UHC, Gachhabari 27 September, 2008).

The doctor suggested her to eat healthy and give birth to a healthy child and be careful for the next time. I agreed with the doctor and returned home with Shantana.

Godhuli is a 37 year old well educated Garo woman. During a discussion with her husband, he described:

We followed natural method since our marriage. We planned our second child five years after our first child was born. But the third child was born

after one and a half years. We were not prepared. My wife also developed an asthma problem during her pregnancy. She had difficulty breathing. We were in a dilemma whether to save the mother or the child. But how can we do it? According to our religion it is equivalent to killing. I talked to one of my doctor friends. He said, “The reality is that you have to choose between your wife and the unborn”. Finally, I decided to save the mother. I told my wife to get ready to go to a private doctor that my friend suggested in Mymensingh. When we arrived at the doctor I told him, “we are well-educated. We would like to know about the procedure and the effect on both the mother and the child”. The doctor explained about three procedures ranging a cost between 4,000-8,000 tk depending on the level of pain reliever. When the doctor was explaining the three procedures, I was sweating. I told him, “Can we go outside? I forgot my money bag”. In reality I was feeling guilt. I took my wife in a good restaurant, ate *Biryani*⁵⁴ and went back home. My wife was upset with me for quite a while saying, “You chose for the child not me”. But after hearing everything from the doctor it sounded horrible to me. In every procedure the foetus will be taken out by pinching on it (*khocha diye diye ber kore ana*). The pregnancy was also three months old. It also has health risk on my wife. Luckily, my wife didn't have breathing problem anymore and the childbirth went well. After that child my wife gave birth to another child. (Interview, Dulal, Garo, Gachhabari, 6 August 2008).

These two cases illustrate how Garos experience moral restrictions to perform MR/abortion.

Rafiqul Islam is a 38 year old Bengali trader, father of 3 children. He owns two plots under the social forestry project. He describes the situation of his wife's unwanted pregnancy:

Two children are enough in this current time. We have three. We were using condoms but we made a mistake in calculation (*bishabey bhul boiya gechey ga*). If it was within two months it could have been possible to abort the foetus with pills. I took my wife to a doctor. The doctor said the pregnancy was already four months old. It would be harmful to do an abortion. That is why we kept the child. (Interview, Rafiqul Islam, Bengali, Gachhabari, 21 August 2008).

⁵⁴ A famous Bengali rice dish with chicken.

When I asked whether he considered it as a sin his response was, “If you calculate everything is a sin. If you give birth to children and you can’t raise them as a human being with proper education that is also a sin”. He added:

Earning is my responsibility. Looking after the family is my wife’s responsibility. My wife has to tell me what she wants. I will consider whether it is necessary or not. It is my responsibility to take care of her. If I do not have time I will ask my sister or mother-in-law to bring her to the doctor. I also help her after child delivery. Some people tease me. But I think it is also my responsibility to look after the children. (Interview, Rafiqul Islam, Bengali, Gachhabari, 21 August 2008).

In all the above three cases, the pregnancy was not terminated. However, these cases help to illustrate how class and ethnicity shape abortion decisions. Godhuli is from an educated well-off family, she was taken to a private doctor in the district town. But Shantana is from a poor family, she didn’t have the money to go to the UHC until I took her there. Discussions with a number of Garo participants and TBAs confirmed that due to conversion into Christianity, abortion is considered a sin among Garos. Shantana even told me that her husband was afraid that is why he didn’t show up to join to the hospital. No wonder I didn’t find any Garo women except Mohua who had an abortion. While rich Garos can go to a private doctor in another town to do an abortion secretly (although in the case above he changed his mind), poor Garos are mostly dependent on help from the missionaries, therefore afraid to go against the Church rules. Shantana didn’t share the news of her pregnancy and her desire for an abortion except her well-off relative, who eventually discouraged her to terminate her pregnancy.

The Bengali participant however, didn’t consider abortion as a sin, but rather gave a different explanation of what is considered a sin. The Bengali participant was even aware of the abortion pill. In all cases men were convinced that an abortion was necessary. However, none of them took a pro-active decision. Narratives of abortion experiences of women, discussed in the previous section further revealed that women often used the network of female relatives, local field workers or TBAs, and men were often absent during secret abortion practices. Another study (Bhandari et al. 2008) considers this minimal involvement of male partners in reproductive decision as lost opportunities to discuss longer-term sexual and reproductive health needs including contraception needs,

which could prevent the chances of women needing to seek MR/abortion services in the future. A responsive family planning programme that reflects poor men and women's needs and perceptions would certainly help women to prevent unwanted pregnancy. To make the service safe for women who need them requires addressing the fundamental ambiguities in the policy and accountability in service delivery mechanism.

5.4 Conclusion

Contrary to the individualistic notion of agency (suggested in the policy), this chapter has provided insight how a complex interplay between gender, ethnicity and economic forces shape contraception and menstrual regulation/abortion practices in Gachhabari.

There is a widely spread perception among men and women alike that vasectomy reduces men's physical strength. Incentives to undergo a vasectomy are insufficient to compensate the household income loss suffered during the recovery of the operation. Since households are mainly dependent on men's physical labour, vasectomy is not a practical solution. Although the breadwinners' norm is not equally strong among Garos, they too show reluctance towards vasectomy.

A range of concerns including pleasure, safety, gossip, fear of mistrust and rumours inform a negative perception towards condoms as an inconvenient method of contraception. A policy shift that occurred in the mid-1990s, from short-acting (pills and condoms) to long-acting (injections and implant) contraception further implies condoms are no longer available for free. Given the greater preference for condom among Garos they are more affected. Ideological restriction on invasive contraception further leads Garos to be more dependent on natural methods. Interestingly, a few older women used sterilisation since it was the only available method in earlier times. Bengali women are the only user of injectables and implant. The pill remains the most used method among Garos and Bengalis.

While the use of contraception by women has been projected as an indicator of empowerment in the policies and discourses on family planning, the findings point to a more nuanced picture. The analysis of contraceptive practice indicates that notions of masculinity and femininity are linked to different contraceptive methods to make women from all

ethnic groups to take on the contraceptive responsibility for the greater benefit of the household. This process is reinforced by female focused family planning programmes, which require minimum involvement from men, put user fee on condoms and do not ensure confidentiality in vasectomy. Policy further reinforces gender hierarchy by demanding husbands' consent to use MR service.

Based on the evidence given in this chapter it can be argued that women are neither victim of unequal gender relations nor passive beneficiaries of government family planning programme. Women's narratives show they are resilient and deploy resources at their disposal to deal with side-effects of contraception by switching between different methods or sending their husbands to get the pill from private market or to get medicine to treat the symptoms. Women also use existing cultural norms to their advantage to assert their claims to exercise their right to use menstrual regulation services, manoeuvre official rules for the time limit or husbands consent to use menstrual regulation service or use secret abortion practices, although this sometimes puts women's health and wellbeing at risk. This indicates that while women are able to negotiate in the household to exercise their choice and agency they face constraints in the health care market. This finding resurrects the importance of looking at intra-household gender power relations as well as cultural and structural factors in explaining women's agency in reproductive decisions.

6

Culture and health seeking practices in pregnancy and childbirth in Gachhabari

6.1 Introduction

Looking at pregnancy, childbirth and after delivery health care practices, the chapter discusses how a combination of cultural factors and health system factors impinge on women's access to available formal health care services.

The chapter is organised around two overlapping themes. First, it explores cultural factors that shape women's decision for home delivery. Second, it identifies health sector factors that discourage poor women to use public health care services during pregnancy, childbirth and to address other reproductive health care needs.

6.2 Cultural and socio economic rationales for childbirth at home in Gachhabari

In the introductory chapter, I mentioned that the lack of Emergency Obstetric Care (EmOC) during childbirth remains a major cause of maternal mortality in Bangladesh. According to the most recent data only 42 per cent of the births are attended by skilled health professionals including trained TBAs and the rest are attended by untrained TBAs or relatives. In addition, only 37 per cent of the births take place at a health facility. Still the majority of the births (63 per cent) occur at home, most of which are assisted by untrained TBAs and relatives (BDHS 2014).

Despite the availability of childbirth services at the Upazila Health Complex, located within a 10 km radius from Gachhabari village, home delivery was common among Garos and Bengalis. According to the household survey, only twenty-four children were born in the health facility, which is 5 per cent of the total births, while 95 per cent of births occurred at home. What were the reasons, perceptions/rationales and practical considerations behind the dependency on home deliveries assisted by TBAs (locally known as *dais*)?

6.2.1 Birth as “natural”: normal vs. complicated delivery

One major reason for home delivery was related to the perception about normal and complicated delivery⁵⁵. The case of Shobita and Golapi can illustrate this. In the early morning of November 2008, when I went to visit Shobita (Garo participant) who was pregnant, I met a ten year old girl who was carrying her younger sibling in the front yard of Shobita’s house (Picture 6.1). Shobita’s house seemed quiet. I asked the girl whether Shobita was at home. The young girl informed me that Shobita gave birth to a child. Due to the silence in the house I asked whether Shobita went to the hospital for delivery, the girl replied, “Shobita’s husband wanted to take her to the hospital, but it wasn’t necessary. Shobita gave birth at home normally”.

Picture 6.1
The girl in front of Shobita’s house



Source: Fieldwork photos

⁵⁵ Afsana and Rashid (2000) also documented similar perceptions related to childbirth among women in other rural area in Bangladesh.

I didn't expect a ten year old girl to be sharing the childbirth news up-front due to the fact that Bengali women in the village associated childbirth with shyness. The way the girl explained giving birth at home as normal and justified not taking Shobita to the hospital by her husband took me by surprise. I went inside the house and found the new born baby sleeping while Shobita was tidying up her room silently.

Shobita was 24 years old at that time. This was her first child delivery. Her husband was a rickshaw van puller. They got married five years ago. Since her marriage she wanted to bear a child. She neither used any contraception nor visited any doctor for infertility treatment. She believed some women become pregnant later compared to other women. In the end, she conceived four years after her marriage. Despite having a long desired pregnancy, she did not go to any health care facilities for any pregnancy check-up, although BRAC, a NGO, was providing maternal health care services in the village in partnership with the government. She explained:

Dolly *mashi* (maternal aunt) checked me regularly and told me my pregnancy was normal. I didn't feel any problem either. If I went to BRAC for pregnancy check-ups, every time I would have to pay 15 tk. (members pay 10 tk). Going to the hospital means at least 50 tk travel cost. I thought it wasn't necessary. (Interview, Shobita, Garo, Gachhabari, 6 November 2008).

When her labour pain started, Shobita's husband called Dolly *dai* immediately. However, it took her some time to deliver the child. Shobita described the birth experience:

Dolly *mashi* checked me and said it wasn't the time yet. She left and told my husband to call her again if the pain increased. The pain was coming in waves and lasted for one full day and a night. Finally the child was born around 3 in the morning. The child wasn't coming out easily. *Mashi* had to insert her hand to pull the baby out. The pain was so much that it didn't even matter to me if she inserted her hand inside. I was only hoping the pain would be over as soon as I deliver the baby. After the delivery *mashi* cleaned me up and gave me a herbal drink for my comfort. My husband also got some pain killer from the local pharmacy according to her suggestion. (Interview, Shobita, Garo, Gachhabari, 6 November 2008).

Shobita had the support also of her sister during the birth. The residential arrangement amongst the Garos is such that sisters live close to each other. After marriage among Garos, other than the heiress, women move to individual houses and their husbands move to their wives' houses which are in close proximity. If it was necessary to bring Shobita to the hospital her sister would have also supported her financially. However, due to the fact that her delivery was progressing well without major complications, it wasn't considered necessary to go to the hospital.

Women went to the hospital only if there were complications. Golapi (Garo woman) was 19 years old when she gave birth to her first child. She was taken to the hospital when a *dai* failed to assist her to give birth at home. She lived in a well-off Garo relative's house in exchange for helping in the household until her marriage. Coming from a landless poor family, Golapi didn't own any property. She moved to her husband's household after marriage, although this is not a common practice among Garos. Her husband worked as a night guard in a factory in another district. Golapi was living with her mother-in-law in the village. She never visited any doctors after she became pregnant. Her mother-in-law arranged for an NGO worker, who had received training on childbirth from World Vision (an NGO), to assist during delivery. On the day of Golapi's delivery her husband wasn't present, but coincidentally the female well-off relative went to visit Golapi in her in-laws' house. Golapi described the event:

I was so exhausted; I could barely push the baby. The NGO worker pulled the baby out, but he wasn't breathing. The *dai* and my mother-in-law got busy with the child. After oil massage the child started to breath. The *dai* (NGO worker) cut the cord, but my placenta didn't come out yet. The NGO worker asked to get an injection from the local pharmacy. When it didn't work out a local *kaviraj* was consulted to give me *pani pora* (holy water). When the *pani pora* failed, my relative convinced my mother-in-law to take me to the hospital. My placenta was removed by a nurse at the hospital four/five hours after my delivery. Thanks to my relative for saving my life. (Interview, Golapi, Garo, Gachhabari, 7 November 2008).

Golapi's case illustrates also that young women rely on the knowledge of elder family members during childbirth. These elder women often rely on traditional practices to assist with home deliveries.

Discussion with a number of Bengali women revealed that they also perceive childbirth as a natural process not requiring formal medical assistance. For example Parboti, a twenty-seven-year-old Bengali woman, mother of two children, said, “When the head of the child comes on the *mokam* (uterus), *dais* (TBAs) just have to pull the baby out”.

To express women’s preference for home delivery a common sentiment shared by many women was, “by the grace of Almighty God I never had to go to the Hospital during delivery”. “I prayed to God to give birth normally at home”. Both Garo and Bengali women rely on home delivery unless they experience severe complications. As a result women often delay seeking care in the hospitals during complications and that can sometimes be fatal.

6.2.2 Faith and Trust in traditional birth attendants

Another reason for home delivery was related to the views and perception about local TBAs. In the absence of skilled health professionals, women in the village have long been dependent on the TBAs for generations. TBAs are locally known as *dai*, *dhatri* or *dharoni*. They are generally middle-aged or elderly women who are members of the community and have mastered their skills through observing birth events, by assisting senior TBAs and by using their own intellect (also found in Afsana 2005).

The TBAs are cheap, they are from the same community and are readily available to help women at any time during home delivery. After a delivery, TBAs normally receive a new cloth (*shari*) or some cash, according to the capacity of the delivering women’s household, as a gift but they never demand anything beforehand for their service. Among seven TBAs in the village, four have received training on safe delivery from a non-government organisation called Caritas in collaboration with the St. Paul missionary in Pirgacha (a neighbouring village).

All the women expressed faith and trust in the knowledge and expertise of these TBAs. In particular they showed their appreciation and respect for how Shomola *dai* (a senior Garo TBA) was capable of helping women to give birth even during complicated situations such as the delivery of dead foetus or of twins. Fouzia, a twenty-one-year-old Bengali woman, mother of one child, said:

Shomola *dai* helped my mother when I was born, my mother's birth went without any complications. When I became pregnant I wanted her to help me during my delivery (Interview Fouzia, Bengali, Gachhabari, 17 March).

Women in Gachhabari thus make their decisions on child delivery based on the village traditions and depend on the experience, knowledge and resources of the local *dais*.

Even educated women showed their preference for home delivery in the presence of local TBAs. Godhuli, an educated Garo participant, and a high school teacher in Gachhabari, who gave birth to three children at home in the presence of *dais*, stated:

This is a habit (*obvash*) to give birth at home. We believe our *dais* are well trained. They are well capable of assisting during normal childbirth. If the child is stuck or if the placenta doesn't come out on time, *dais* will tell us to go to the hospital. Going to the hospital costs money. Many people cannot afford that (Interview, Godhuli, Garo, Gachhabari, 6 August 2008).

Godhuli's narrative illustrates that while women rely on the knowledge and skills of local TBAs for safe home deliveries they also trust that they would refer them to the hospital during complications. In many instances TBAs also join women in the hospital.

A focus group discussion conducted among seven TBAs further revealed that TBAs (*dais*) possess vast knowledge to deal with complicated (*julum*) delivery. For example, when the cervix does not open up sufficiently *dais* put some coconut oil on the index finger and help to open the cervix (*harer chipi*) by gently pushing on the joint. One *dai* explained, "If someone doesn't open it up, how will the baby come out alone"? *Dais* also help to open the mouth of the cervix (*chala*) by turning it outside for the child to come out easily and help to close it after delivery. They also mentioned the importance of maintaining hygiene while assisting women. During normal delivery, TBAs only wait for the baby to come out naturally. In the case of a breech position, the *dais* explained:

At different months of the pregnancy the position of the child changes. With the maturity of the pregnancy the head of the child should move downwards close to the cervix. If the baby stays in a breech position when labour pain starts, with oil massage the head should bring down first. Only

after that by gently pushing on the belly of the delivering woman the child will come out easily. (FGD among TBAs, Gachhabari, 25 April).

If any other part of the body than the head comes out first (usually one arm or one leg), then *dais* have to push the part inside first, rotate the body and bring the head into the right position, before assisting with delivery. TBAs were also aware that if the placenta (*fuler nari*) doesn't come out after delivery women will die and therefore women should be taken to the hospital to remove the retained placenta immediately.

Each community relies on their own *dais*. Bengalis households generally call a Bengali *dai* and Garo households call a Garo *dai* during childbirth. However, the assistance during childbirth also goes beyond communal boundaries. Due to the expertise of Shomola *dai*, she is also called during the delivery of Bengali women when Bengali *dai* can't manage. Due to the trust in the capacity and knowledge of local *dais*, they seem to be the best option for many women.

6.2.3 Concern about *purdah*/privacy

Discussions with a number of Bengali women revealed that there are additional cultural norms that promote home delivery relying on local TBAs. Bengali women often associated childbirth with the Bangla term *lajja* and *shorom*, meaning being shy or bashful or timid or being ashamed (Dasgupta 1980).⁵⁶ Due to these norms pregnancy and delivery are considered as private matters, which were not discussed publicly. A husband or a family member would refer to a pregnant woman as "sick" while she was pregnant.

Due to these *lajja* norms, many Bengali women prefer to give birth secretly at home and endure their labour pain silently. As Sabiha, a nineteen-year-old Bengali woman mother of one child said:

⁵⁶ *Lajja/shorom* symbolises the shyness of Bengali women, socially constructed as a normative feminine characteristic. It is often said that shyness is the clothing of Bengali women (*lajja Bengali narir bhushon*) (Haque 2000). The opposite of *lajja* is the term shameless (*belaj/beshorom/behaya*). The term *lajja* is also connected to sex. The sex organs of males and females are named "*lajja sthan*" (place of shame). Due to patriarchal norms, shyness regarding body and sexuality is part of the socialisation process of women since childhood (Hossain and Mashuduzzaman 2006b).

I didn't scream during delivery. Because people will realise that I'm giving birth. It is a matter of shame (*shoromer bepar*). People will find it out anyway, after the child is born. (Interview, Sabiha, Bengali, Gachhabari, 29 April 2008).

Some women even mentioned their preference to give birth at night so not to spread the delivery news in public. Due to *lajja* norms, women were not comfortable with the idea of their husbands being present during delivery. Farida, a thirty-five-year-old Bengali woman, mother of three children reacted to the idea of husband's presence during delivery stating:

If husbands would be present during delivery, women would feel shy. They will suffer from more pain. Husbands' presence will prevent women from pushing the baby (*hul dewa*), which will eventually delay the birth. (Interview, Farida, Bengali, Gachhabari, 11 April 2008).

Husbands only wait outside and make themselves available if needed. Otherwise, delivery is considered solely a married women's business and thus confined to the private space.

Pictures 6.2 & 6.3
TBAs demonstrating traditional ways of child delivery: Bengalis (above) and Garos (below).



Source: Researcher's photo during FGD, TBAs, 25 April 2008.

Further discussions revealed that giving birth in the hospital is considered *bepurdah* (violation of *purdah* norms) among Bengali women. The focus group discussion with traditional birth attendants revealed that the traditional way of giving birth is different from a hospital delivery (as demonstrated in Picture 6.2). Traditionally, Bengali women take a squatting position as if sitting on a toilet. A woman bends her body forward, hugging a close female relative, while leaning on her knees. In this process women try to maintain *purdah* by not exposing their private part. The TBA stays behind the delivering woman and waits for the baby to come out naturally. A good TBA is known not to touch or insert her hands into the birth canal during delivery.

In the hospital, women usually have to lie on their back spreading their legs wide open, while other patients are present. The delivery room in the hospital is usually crowded and thus privacy is not assured. Giving birth in the hospital also involves vaginal examination. Sometimes women are also required to undergo an episiotomy (a surgical incision made in the area between the vagina and anus to enlarge the opening of the vagina to prevent uneven perineal tear).

To give a sense of the lack of privacy in government hospitals I will share the story of Shornolota, a nineteen-year-old Bengali woman, whom I met at the Madhupur UHC during the repair of her perineal tear after her first delivery. In the maternity section of the UHC, there were two big wards for the patients. The labour room was next to one ward. There were no doors, only curtains to separate the labour room from the patients' ward. I was looking for a nurse (a key informant) who was busy in the labour room. I could just walk in and found the nurse busy repairing the perineal tear of Shornolota after her home delivery. Next to Shornolota, another woman was screaming in her labour pain, lying on a bed covered with plastic sheet full of stains. Two of her female relatives were accompanying her, while the nurse was busy with Shornolota. I was watching the nurse repairing the perineal tear without any anaesthesia. Shornolota was biting her lips to suppress her pain. When the nurse was making a knot on a stitch, it came off making a tear on the stitched area and Shornolota started to bleed. I felt a serious cramp in my own belly and could not stand there anymore. I left the labour room and went outside to breathe some fresh air. I returned to the hospital after about an hour. Meanwhile Shornolota had been transferred to the maternity ward. I went to her and asked why she did not go to the hospital for delivery,

in which case she might not have to suffer from so much pain from the repair of her perineal tear. Her response was:

How can I decide for myself to go to the hospital when I am in labour pain? My guardians have to decide whether to take me to the hospital or not. A TBA (*dai*) already delivered the baby at home but the head of the baby was so big that I got this big tear. I was bleeding to death and the *dai*, who attended my childbirth, suggested my guardians to take me to the hospital. (Interview, Shornolota, Bengali, UHC, Madhupur, 20 July).

After so much suffering, when women are taken to the hospital, they experience lack of privacy. This situation is compounded by the lack of female doctors at the maternity section.

Garos women's experience is rather different. They neither mentioned any *purdah* norms that prevented them from going to the hospital, nor made a distinction between the private and the public spaces. Garo women also didn't reject the idea of husband's presence altogether, but considered that women have the bodily experience to associate and deal with childbirth naturally. Therefore, in most cases female relatives or TBAs assisted during childbirth. However, some elder Garo women spoke of their husbands assisting during childbirth for pragmatic reasons. Shomola *dai*, the most senior TBA in the village, shared her own childbirth experience:

Madhupur was full of *Sal* and *Gojari* forest. There were only a few Garos living in the dense forest of Madhupur. We used to build our houses 2 to 3 miles away from the *jhum* plot, which was our main cultivation system. Before the liberation in 1971, Garos never build their houses with mud. We used to build houses with bamboos and canes raised from the ground to prevent attack by wild elephants and tigers. It wasn't easy to find someone to help during childbirth like nowadays. Sometimes the labour pain started while working with my husband in the field or in the middle of the night. My husband couldn't leave me unattended to call someone. I asked my husband to help me, he was scared. I cut my cord with a sickle (*kachi*) and he cleaned up and kept an eye on the baby, while I could rest (Interview, Shomola, Garo, Gachhabari, 13 August 2008).

Garos women's childbirth experiences challenge the binary between home vs. hospital delivery. Although Garos don't practice *jhum* cultivation far from the house anymore, during discussions Garo women also

mentioned giving birth in the jungle while they went to collect firewood or wild potatoes accompanied by other women. Younger Garo women like Shobita, Golapi and Godhuli also didn't associate their preference for local TBAs with any cultural norms that restrict their access to the hospital. Their reliance on the TBAs is rather pragmatic. Since the missionary started TBA training to prevent maternal mortality in Madhupur forest area due to the lack of health care facilities, Shomola *dai* and others joined and became trusted TBAs in the community.

During the focus group discussion with TBAs it was further revealed that Garo women take a similar delivery position as done in the hospitals (Picture 6.3). The TBAs stand in front of the delivering women while assisting during childbirth. Garo TBAs believe it provides more visibility and accessibility from the front. Garo TBAs also consider that the position Bengali women take is not convenient and may cause problems. They also claimed, during their TBA training they were trained to assist delivery from the front side. However, Bengali TBAs seem to follow their own customs. Although *purdah* and physical shyness was not a reason for home delivery among Garos, privacy was desired by all women.

6.2.4 Balancing wage/household labour and childbirth

In Gachhabari, most women are busy from dawn to dusk with their household chores. Childbirth occurs in between those activities without too much fuss. As Farida, a thirty two years old Bengali woman, a mother of three children, described her childbirth experience:

During my third delivery I was sweeping the yard in the morning. Right at that moment I felt a cramp in my lower belly. I had experienced labour pain before. I know how it feels. I immediately ran to the toilet. I didn't even have the time to fetch water to use in the toilet. I asked my sister-in-law to give me some water to use in the toilet. I quickly washed myself. As soon as I came out from the toilet I gave birth in the backyard. I could not even reach my room. (Interview, Farida, Bengali, Gachhabari, 11 April 2008).

Rural women's full-time responsibility for household tasks (Chowdhury 2009; Ahmed 2007) seems to remain even during pregnancy and childbirth in their conjugal homes. This naturalised demand on female labour was further reflected in women's stories about the differences in giving birth at the parental house (*maika*) or at the in-laws' house (*sho-*

shural). Traditionally, Bengali women move to their in-law's house after marriage. It is a custom in the rural area that women go to their parent's house during delivery (*naior jawa*), especially during the first childbirth. This custom releases women from performing their household responsibilities for a few days. Anita, a 19 year old Bengali woman, who went to her mother's house during her first delivery, said:

I had to do a lot of household chores in my husband's house during my pregnancy. If I stayed in my husband's house, I would have to do everything till my delivery. Now I can just stay in bed and take rest in my parent's house if I feel tired. I know my mother will do everything for me. She will even serve food for me in bed. After the delivery she will take care of my child until I can take over. (Interview, Anita, Bengali, Gachhabari, 17 July 2008).

However, not all women were as fortunate as Anita to go to their parental house during delivery. Women have to negotiate in order to benefit from this custom. When a woman is away to her parents' house, another member has to take care of her domestic chores. This task inevitably falls on another woman in the household. A fifty-five-year-old mother-in-law, Jamila Khatun, mother of four children, expressed her dissatisfaction in such a situation by saying:

This time I allowed my daughter-in-law to go to her parent's house (*naior*) to give birth. But I will not allow her to go to *naior* anymore. It is a big problem for me. When she goes to *naior*, all the household chores come on my shoulder. I can't take care of all these chores anymore at this age. (Interview, Jamila Khatun, Bengali, Gachhabari, 30 April 2008).

Among the rich households domestic help can be arranged by hiring a poor woman/relative. Therefore rich women can exercise more agency to benefit from this custom. Women in poor households have to stay at their *shoshural* (parent-in-law's)/husband's house and continue their household chores until delivery and resume their responsibility, mainly cooking, often immediately after childbirth.

However, Bengali women also asserted that they do not consider themselves as victims of a traditional ideology of the gender division of labour. They tended to highlight their joint contribution in the household. This was strongly expressed by Afroza, a thirty-five-year-old Bengali woman, she stated:

Women's work is invisible; it's difficult to see them. Women are busy the whole day in the house sweeping the house and the yard (*ghor jharu, uutan jharu*), cooking, washing dishes, washing clothes, feeding the children, cleaning the cow dung (*gobor phela*), filling the vessel with water for the cow (*gorur charite pani dewa*), endless list of things to do. Men work outside, their work is visible. Men take care of the planting, fertiliser (poison), clearing the weeds (*agacha poriskar*), tilling the soil (*khet kopano/nirani*), irrigation (*pani dewa*) harvest and selling crops. My husband leaves the house in the morning and comes back at night, sometimes 10.00 at night. He has to hire labourers to work in the field and pay their bills. He is so busy that sometimes he doesn't have time to eat his lunch. After harvesting in the months of Boishakh/ Joistha (which corresponds to April/May) women's work load reaches the peak. It is women's job to boil, dry and store rice. Husking is done by machine. If husked once it goes for 15 days. I also have two cows and a goat to take care of. (Interview, Afroza, Bengali, Gachhabari, 14 June 2008).

Clearly some women have to perform more work than others. A common impression given by many women was "those who have *shangsher* (agricultural harvest) have more work to do, those who do not have *shongsher* have less work to do". However, since Bengali women do not work as wage labour in the land, their work starts when the harvest comes to the house yard. However, one cannot generalize about Bengali women's experience, since poorer Bengali women do go outside the boundary of their house yard to the forest to collect firewood to sell in the market. This reflects a change in the practice of *pardab* norms among poorer Bengalis. To give an example, Rupali, a 28 years old Bengali woman narrated:

Bengali women didn't go to the forest before. Now it has changed. We learned from Garos. Like me there are many Bengalis who go to the forest to collect firewood and wild potatoes. My husband used to object at the beginning saying other people would criticise him for allowing me to go to the forest. I told him "other people aren't paying to run our family (*shongshar*), why bother what other people say". When men can't provide women are obliged to go outside. He doesn't object to my going to the forest to collect firewood or wild potatoes anymore. (Interview, Rupali, Bengali, Gachhabari, 21 July 2008).

Rupali's narrative reflects the complexity of social reality, and shows how cultural norms are open to multiple interpretations, as opposed to a static notion of rigid culture. Women also use cultural notions and norms to their advantage. The patrilineal Bengali household is built on a notion of male breadwinner, where husband is supposed to take care of the income to justify keeping women under *pardah*. This symbolic notion of masculinity as the protector of female modesty comes in conflict when men are not able to provide enough for the survival of the household. Faced with household poverty, women use this as a patriarchal bargain to challenge and negotiate *pardah* norms. This did lift some of the restriction of *Purdah* norms and increase their mobility, at the same time it also implied an increase in their work.

The experience of Garo women is somewhat different. Garo women are engaged in wage labour along with their reproductive work. Ambia, a 48 year Garo woman, gave an overview of her daily routine:

I get up around five/six in the morning. Sweep the house and the yard, and then prepare for cooking. When the cooking is done, feed and do the dishes. Take a bath and go to work at 8.00 am. I work from 8.00 am to 4.00 pm as a day labourer in pineapple or banana farms. Sometimes I also work in construction of roads. I also work as an agricultural labourer during seasons. Sometimes I go home at noon during lunch time and do a little bit of cleaning up, if it has to be done and if my work is close to my house. Otherwise I take my lunch with me. Coming home after work, I cook again, eat, spend time with children... (laughter)... and sleep. If my husband is at home he also helps me with the cooking and cleaning. If there is no day labour work, then I go to the forest to collect firewood. (Interview, Ambia, Garo, Gachhabari, 28 March 2008).

In this demanding combination of waged work and reproductive work, Ambia shared her childbirth experience:

I give birth easily. I even continued collecting firewood from the forest till delivery. Five or ten days after delivery, I went to the forest again. Once I was in the forest the whole day, collected twigs from the trees and made four bundles. On the way home with my third bundle of firewood my labour pain started. I arrived at home, I smoked a cigarette (*tamak*), laid back and gave birth. I cut the cord and cleaned up. When I came home with my third bundle, other women were still collecting firewood and guarding my fourth bundle in the forest. When I didn't show up anymore

one of them carried my bundle home and found me with my new born child. (Interview, Ambia, Garo, Gachhabari, 28 March 2008).

I wondered whether childbirth was really so easy for some women. The idea that Garo women are stronger⁵⁷ sometimes may even have a racist stereotype undertone denying their health care needs. When I shared my concern with a physician key informant, he said that due to physical work Garo women might have strong pelvic muscles, which helps them to give birth more easily. However, further discussion with Ambia revealed that she had two miscarriages while carrying firewood from the jungle during her pregnancy. Infant and child death was also common among Garos.

In contrast to the Bengalis, the matrilineal system offers Garo women the advantage of living in their parental house or in a separate house close by which implies they can receive help from their sisters and mothers during childbirth. However, due to poverty they go to the forest to collect firewood or work as day labourer during their pregnancy, up to the moment of delivery. This combination of income generating work and reproductive work puts more demand on poorer Garos. Overall however the women's responsibility for household reproduction affects both Bengali and Garo women who find it difficult to abandon these tasks and go to the hospital during pregnancy and childbirth.

6.3 Rural health providers: issues of cost, access and care

The reasons for reliance on home deliveries are also linked to supply factors. Focus groups and discussions with a number of Bengali and Garo women revealed that a combination of health care factors, namely hidden cost, distance and the quality of care in the public hospital further discourage women to seek institutional care during childbirth. The main differences that emerged were due not to ethnic differences but to class.

Theoretically giving birth at the Upazila Health Complex (UHC) is free, but practically it involves several hidden costs besides travel cost. For example, UHC doesn't provide any diagnostic facilities. If women are willing to give birth at the UHC they have to do several diagnostic tests from the private diagnostic centres at the vicinity of the hospital. The UHC is also not well equipped with a blood bank in case of emer-

⁵⁷ This is reflected in the title of the book 'the strong women of Modhupur' by Burling (1997).

gency. Therefore patients have to find blood donors from their relatives or friends if needed. During my first visit to the UHC, I observed the 50 bed sub-district hospital as a ghost building. I wondered whether it was a national holiday! The maternity centre (MCH) of the UHC was being taken care of by two nurses, there was no duty doctor. I learned that the government doctor was performing private practice during his office hour.

It seems like patients are left alone to deal with their problems. While I was looking around in the maternity centre I met a woman, who had a miscarriage. She was admitted to the hospital two days ago. She fell down in her backyard in the rain with her advanced pregnancy and was bleeding severely. She needed A⁺ blood. I talked to her relatives. They said that the doctors refused to do anything until blood is arranged from her relatives or donors. Her relatives couldn't find a match among her potential blood donors and felt helpless. After two days of severe bleeding and without any treatment finally her relatives decided to transfer her to the district (Mymensingh) hospital which is 5 hours away by a car or ambulance from the UHC. I witnessed them leaving the UHC with huge frustration.

The absence of logistical support implies various hidden costs of seeking care in the public hospitals. Due to these hidden costs even a normal child delivery may turn out to be expensive, a factor which contributes to the exclusion of poor women from access to institutional childbirth facilities. During an in-depth interview, Anita, a 21 year old Bengali woman who gave birth to a child a week before our conversation mentioned that she went to the UHC once for her pregnancy check-up with her mother. Anita was told to do an ultra-sonogram in a private lab since there is no such facility at the UHC. One ultra-sonogram costs 400 tk (appx. € 4,-) at a diagnostic centre next door to the UHC. She neither did an ultra-sonogram nor went for a second check-up or for her delivery. Anita's mother Madhubala said:

If poor people were able to spend money for the private diagnostic centres, they wouldn't go to the government hospital in the first place. If a woman is admitted to the UHC with labour pain, doctors will tell the patient to arrange blood, medicine, saline and food, on their own. If poor patients have to pay for everything why should you bring your patient to the government hospital? (Interview, Madhubala, Bengali, Gachhabari, 16 July 2008).

Compared to the cost involved in normal delivery, if there is a need to perform a Caesarean the cost increases significantly. When I enquired the reason for the high cost of a C-section (5,000 tk, appx. € 50) at the UHC, the concerned doctor mentioned:

There is no General Anaesthetics (GA) facility at the UHC. Therefore, a C- section is done with a spinal. These spinal injections are costly, which we have to buy from outside, that makes the Caesarean expensive (Service provider's interview, Maternal Health and Child Care Centre, UHC, Madhupur, 20 July 2008).

During interviews women often expressed their concern about the increasing rate of Caesarean at the UHC. According to the estimate of the medical officer, on average there are 33 normal deliveries and 4-5 C-sections every month in the maternity section. When I asked about the common reasons for Caesareans, the doctor concerned could not provide any convincing answer, rather he replied by saying: "nowadays women are not so strong to push the baby like our mothers and aunts". I was not convinced by his response. However, an increasing trend in C-section is visible at the national level data. The most recent BDHS data shows a large increase in the use of Caesarean section from 2.6 per cent to 23 per cent between 2001 and 2014 (BDHS 2014:28). While there is an increasing trend in the use of C-section, women fear their delivery might turn out to be extremely expensive if done by a C-section.

Reflecting back to my experience when the perineal tear of Shornolota was repaired, there was another woman delivering a baby while two of her female relatives were waiting for the nurse to take over after she is done with Shornolota. The duty doctor was not around. When I was at his chamber he was at his private practice, just outside the hospital building. To give a justification of his absence during duty hours, he said:

Rural women do not want to see a male doctor during delivery. Nurses take care of the deliveries. In case of a Caesarean the nurse will call me. Then everything is arranged in the operation theatre. Caesarean does not involve exposing women's private part (Service provider's interview, Maternal Health and Child Care Centre, UHC, Madhupur, 20 July 2008).

The duty doctor's assumption that rural women don't want a male doctor to be present during childbirth justified his absenteeism during office hours. However, while listening to the doctor's justification, I

wondered whether the increasing number of Caesarean is a result of maintaining *pardah* norms by not exposing women's private part to a male doctor to deal with complicated deliveries, which could have been dealt with differently!

Besides the cost and fear of a Caesarean, the doctors' ignorance was also mentioned by women during a focus group discussion as a reason for not giving childbirth at the public hospital. In this discussion, the death of a pregnant woman at the UHC due to the ignorance of the doctors was mentioned as a factor discouraging poor women from going to the UHC during childbirth. Women mentioned that doctors are powerful; they covered up the case by misreporting the post mortem report (*dhama chapa dewa*) as if poor women's life is not important. This sentiment was also expressed by Madhubala when she said:

Poor people don't get proper care in the government hospital. Doctors don't have any sympathy for the poor patients. Doctors will not bother if patients die. Doctors will not start any treatment before knowing the solvency of the patient (*takar khobor*). Poor patients have to suffer even if they are taken to the hospital (UHC). (Interview, Madhubala, Bengali, Gachhabari, 16 July 2008).

The women were quite vocal about the negligence by the health care providers in the public hospital. Further discussion revealed that doctor's absenteeism further discourages well-off families from using this government hospital. When patients from well-off families go to the hospital and don't find a doctor on duty, they immediately bring their patients to the private clinic. The same doctor from UHC provides service there. Women complained that doctors also refer well-off patients to a particular private clinic. About the referral of certain patients to the private clinics, the medical officer concerned said:

We have to work in very difficult conditions at the UHC. UHCs are not equipped properly. We don't have any GA (General Anaesthetics) in the hospital. If women need a GA during delivery, they need to be referred to private clinics or district hospitals. (Service provider's interview, Maternal Health and Child care centre, UHC, Madhupur, 20 July 2008).

Due to lack of logistics well-off families are referred to the private clinics. But, poor women have no option but to be dependent on public hospitals with their inadequate care or (more commonly) not to use these childbirth services at all. This practice of referring well-off women

to the private clinics is perceived as corruption by poor women. In Madhubala's words:

Doctors are corrupted. Doctors can't take money from the clients if they are in the public hospital. The same doctor who works part time in the private clinic provides better and quicker service than he does at the UHC. Doctors receive commissions for sending the patients to the private clinics and diagnostic centres. (Interview, Madhubala, Bengali, Gachhabari, 16 July 2008).

In summary, despite formally free childbirth services, the costs of diagnostic tests, episiotomy or Caesarean, doctor's ignorance and absenteeism combine to restrict poor rural women's access to childbirth facilities at the sub-district hospitals. While the number of patients in the private clinic next to the UHC is above their capacity, the government hospital turns into a ghost building. This situation is not unique to the UHC in Madhupur, but common in many sub-district hospitals in Bangladesh. As the well-off people start to use the private clinics the quality of government hospital deteriorates (as also found by Chaudhury and Hammer 2004).

6.3.1 Suspicions and insecurity of hospital births

There appears to be a perception among both Garo and Bengali women that Caesarean section is done unnecessarily at the UHC. Since 2001 a NGO, BRAC has been working as a partner of the government to provide maternal health care services. Maternal antenatal check-up is done by BRAC at the satellite clinic once a month. BRAC health workers also have a list of all pregnant women in the village and suggest women with complicated pregnancy should go to the hospital for delivery. However, women showed reluctance to seek care at the hospital due to a fear of Caesarean deliveries.

The case of Anita, who gave birth to her first child at home a few days before our conversation illustrates the suspicions regarding Caesarean delivery as unnecessary and a way of the doctors to earn extra money. She studied till ninth grade. Her family condition was not too bad and her mother is a health worker. However, during my visit to Anita at her mother's house, her mother Madhubala explained the reason for not taking her daughter to the hospital for delivery based on her own experience, describing:

I accompanied a woman to the hospital for delivery. When we arrived at the hospital, the head of the baby already came to the *mokam* (external os of the vagina). If the woman pushed a little bit, the baby would have come out immediately. I requested the doctor to wait for a little longer. Alternatively, he could have used the *pumper* (vacuum) to pull the baby out. But the doctor cut her vagina (performed episiotomy), which was not necessary. When I requested the doctor to wait, he became angry and shouted at me saying, “*bekkel mobila* (stupid lady), what do you know”? I replied to him, “I know as much as you know. But only difference between you and me is that you can cut the vagina and I don’t”. (Interview, Madhubala, Bengali, Gachhabari, 16 July 2008).

Madhubala further mentioned that the woman had to pay 300 tk for the episiotomy, but if it was a normal delivery she wouldn’t have to pay any money. In conversation, women in the village used the term “Caesarean” to refer to both an episiotomy and a C-section. While an episiotomy costs 300-400 tk (approx. € 3-4) a C-section costs 5,000 tk (approx. € 50) at the UHC. It must have been necessary to perform an episiotomy to avoid unnecessary complications. However, the important point here is to highlight that if a health worker is not convinced herself of the necessity of an episiotomy or Caesarean herself, how she can motivate women in the village to go to the hospital during childbirth? In fact she didn’t even bring her own daughter to the hospital during her delivery. Anita was also convinced that it was the best decision to give birth at home, assisted by her mother. As she said, “If I went to the hospital, doctors would have done a Caesarean to me by now which was unnecessary”.

Another perception about Caesarean is related to the fear of physical disability. The case of Fabiha, a 28 years old Bengali housewife illustrates this fear. Her husband is a small land holding farmer. She has two children; one son of 7 and a daughter of 2 years old. She gave birth at home. While giving reason for not going to the hospital for delivery, she said:

I know it is good for me to stay at home during delivery. *Dais* will wait for a day and a night, but doctors/nurses would hardly wait for two hours. After that they would definitely perform a Caesarean. If I went to the hospital, they would have made me disabled by cutting my belly (*Amar pet kaitta pongu koira dito*). (Interview, Fabiha, Bengali, Gachhabari, 9 July 2008).

Fabiha's fear was based on her sister-in-law's childbirth experience, as she explained:

My sister-in-law gave birth to two children at home. There wasn't any problem (*Kono obubidha hoy nai*). During her third delivery she had excessive bleeding. She was taken to the hospital. After examination doctor gave her medicine and advised to do a Caesarean. After the Caesarean she can't do any heavy work at all. She can't pump a tube-well to fetch a jar of water. She can't husk a kilo of rice from the paddy (*bara bana*). My brother has to take care of everything. He runs a business; he can't always stay at home. I am able to perform all my work because I gave birth at home (*barite hoichey boilai etogula kaj korbar partachi*). If I am not able to do these task who would do my work? Nobody would let me eat rice⁵⁸ while sitting (*Amareto keu boiya bhat khaite dibo na*). (Interview, Fabiha, Bengali, Gachhabari, 9 July 2008).

The regular demand on women's labour for household reproduction also seems to create this negative attitude towards Caesarean. Older women from poor households felt that Caesarean is needed only by women from rich households. As of Marufa Begum (a fifty-five-year-old woman, mother of five children), put it:

Those who are wealthy and live a comfortable life (*aramey thaka*), they need a Caesarean. The child grows bigger inside their belly. They have to go up and down to the hospital and spend money for doctors. Those who do hard labour (*porisrom*), deliver normally (*shustho bhabe*). It is a blessing from God that poor women give birth normally at home. (Interview, Marufa Begum, Bengali, Gachhabari, 13 July 2008).

There seems to be a shared understanding among both Bengali and Garo women that doing daily household chores during pregnancy helps to have a smooth delivery different from well-off families. Women from better-off households often rely on hired labour to do the daily household chores. The need for a Caesarean among women from well-off families is seen, particularly by elder poor women, as a failure of a normal event, implying Caesarean wouldn't have been necessary if these women had been used to doing household chores (as also found by Af-sana and Rashid 2000:26).

⁵⁸ In Bangla proverb "eating someone's rice" usually refers to a wife who eats her husband's earnings where men are considered the breadwinner.

For poor women who have to perform their domestic tasks, the doctors' advice to take rest during pregnancy also sounded absurd. As Hoimonti, a fifty-three-year-old woman from a poor household, mother of six children said:

As soon as you become pregnant the doctor will tell, you are not allowed to carry big water jars (*kolosh*) on your hip; you are not allowed to pump the tube well; you are not allowed to sweep your yard (*uthan*); you are not allowed to step on a *dbeki*, (a wooden frame to husk rice from paddy/*bara bana*), what kind of language is this? I did everything. I didn't have any problem. (Interview, Hoimonti, Bengali, Gachhabari, 15 July 2008).

Despite this wishful thinking of elder women, the reality is rather complex. Zakia, a 21 year old Bengali woman from a poor family, was taken to the hospital after considerable suffering and had to have a Caesarian. She shared her experience saying:

We are a farming family (*grihastha poribar*) with unlimited chores. I also have to take care of my old parents-in-law. I have a very little time to myself. When my delivery pain started my sister-in-law called a *dai*. My husband was working in the field. The labour pain lasted for more than 12 hours but there was no sign of delivery. By that time my husband came home and the *dai* asked him to get a saline saying saline will increase the pain and help to deliver the baby. After injecting the saline my pain increased terribly. *Dai* examined me and with disappointment told my husband to take me to the hospital. After waiting the whole night my husband took me to the hospital next morning. The *dai* also accompanied me. Doctors said it wasn't possible to do a normal delivery, therefore had to do a Caesarean immediately. It cost my husband 7,000 tk, which he borrowed from our relatives. (Interview, Zakia, Bengali, Gachhabari, 10 September 2008).

During the interview her child was eight months old and she was two months pregnant again. The doctor already told her that if she conceives for the second time she has to do another Caesarean, but she had not expected to become pregnant so quickly after her first delivery. Considering the cost of another Caesarean she was thinking of doing a Menstrual Regulation (MR) or even an abortion.

During my stay in Gachhabari, another Bengali woman gave birth to stillborn twins. There were different opinions whether the twins were already dead before the labour pain started or died during the delivery process. Perhaps this could have been prevented with a Caesarean if she was taken to the hospital in time. However, the cost of childbirth remains a significant barrier for many women to seek professional care during childbirth.

It seems however that educated women from well-off families are changing their perception towards Caesarean. Laboni a 19 year old Garo participant, who came from a comparatively well-off family chose to do a Caesarean. Laboni's husband has a permanent job in an NGO. Since she became pregnant she went to BRAC regularly for pregnancy check-ups. BRAC health workers promote women to go to the UHC during delivery, since this is the lower level government service available for childbirth by trained health personnel. When she arrived at the UHC, there was no doctor available, but two nurses. She was taken to a local clinic. After examination the doctor recommended a Caesarean. Laboni and her husband were convinced that it might be risky to try a normal delivery and opted for a Caesarean. All together it cost 9,000 tk at a local clinic.

These cases suggest that women's views about Caesarean are contested, and related to class. Poor women perceive it as unnecessary and a means for corrupt medical practitioners to generate an extra income. Women from well-off families perceive it as a medical intervention to avoid risk during complicated delivery. Some women relate it with physical disabilities and fear it might jeopardise their future contribution in the household which demand their labour. Hence, the decision women take is very much shaped by their lived realities depending on their socio-economic context.

6.3.2 Dealing with delivery or reproductive/sexual health related problems

In this context where women mostly rely on home deliveries in the absence of skilled health professionals during childbirth, discussions and in-depth interviews with a number of women reveal that women suffer from long-term and short-term delivery-related complications, such as perineal tear (tears in the perineal tissue between the vagina and rectum), uterine prolapse (the falling or sliding of the womb/uterus from its nor-

mal position into the vaginal area) and obstetric fistula (a hole between either the rectum and vagina or between the bladder and vagina).

Narrative of both older and young women consider perineal tear as inevitable. For example Rupali, a twenty-eight-year-old Bengali woman, mother of two children said:

During the delivery the vagina will tear a bit. Otherwise how will the baby come out without tearing it? After the delivery it hurts to go to the toilet and it burns during urination. This is the pain all women have to suffer even if they go to the hospital for delivery. It is unavoidable, after a few days it will be over. (Interview, Rupali, Bengali, Gachhabari, 21 July 2008).

Among elderly women uterine prolapse was reported as a major childbirth related problem. Khadiza Begum, a forty nine year old Bengali woman, mother of four children mentioned her uterine prolapse (*goraiu neme jawa*) after her last delivery. She explained:

When my fourth child was born, I caught a cold. Two/three days after my delivery, I felt my *nari* came down, while I was coughing hard. If I sit on a low stool/bench it comes out side my body like a *guti* (lump). (Interview, Khadiza Begum, Bengali, Gachhabari, 16 July 2008).

This problem is locally known as *gutir rog*. Khadiza Begum suffers from lower abdominal pain after doing any physical work and it also burns during urination. She was aware of the possibilities of an operation at the district hospital; however, she already spent many years of her life in this misery. She says:

What is the use of doing an operation at this age? It is very itchy and smelly. It would be a matter of shame (*shoromer bepar*) to show this to the male doctors. It is better to die than to live in shame (*shoromer cheye moron bhalo*). (Interview, Khadiza Begum, Bengali, Gachhabari, 16 July 2008).

It is not surprising that as only elder women develop this problem, they were ashamed to speak about these problems and endured silently.

Among young Bengali women fistula was reported as a delivery related health problem. Fistula did not have any local term but was identified with such symptoms as constant urination in drops (*phota phota posrab howa*). Fistula develops due to prolonged labour/obstructed labour more especially among young mothers. During home delivery,

women end up waiting too long in labour pain and women with early pregnancy develop fistula. Among my respondents Bonna was married off at the age of fifteen and had her first child at the age of seventeen. During her delivery she developed a fistula. She suffers from severe lower abdominal pain and burning sensation during intercourse.

Bonna came from a landless poor Bengali family. She gave birth at her parent's house when she developed this complication. A local *dai* in her mother's neighbourhood assisted her during delivery. Due to her poor health condition she stayed two months at her parent's house after her delivery. Her husband and mother-in-law send several messages to her parents to send Bonna back to her in-laws' house. I meet Bonna nine months after her delivery. When I asked her why her husband is not taking her to a doctor, she said:

He doesn't have money to take me to the hospital. He says my parents should pay for the treatment but they are poor, they can't pay either. I have two younger sisters. My parents have to arrange their marriage as well. If they had money they would have sent me to study, not marry me off at that young age. (Interview, Bonna, Bengali, Gachhabari, 31 August 2008).

Although Bangladesh government passed the Child Marriage Restraint (Amendment) Ordinance in 1984, making it illegal for females to marry under the age of eighteen, in practice this law is not implemented. According to UNICEF data, still 74% of Bangladeshi girls are married off before the legal age of eighteen. Poor girls are often married off at an earlier age compared to richer girls, as younger brides require smaller dowries (Al-Mahmood 2012). To explain the reason of early marriage among poor Bengalis in the village, Phalguni Banu, a fifty-four-year-old woman, mother of three daughters and two sons said,

We can see that rich people send their daughters to school and marry them off at a later age but we can't. Poor people have to marry off their daughters earlier. Nobody can say anything against the rich people's daughters. The daughters of the rich family (*ghor*) make *jaira pet* (become pregnant as a result of relationships before marriage) and abort the foetus. Nobody can say anything against them. If their daughters flee away from their parent's house (*palaiya jay*) with a boyfriend, girls are brought back and their parents arrange their marriage (*gochaiya dewa*) with a suitable marriage candidate with a huge amount of dowry. If wealthy girls have an

abortion people will say she had a tumour operation. If our girls have a pimple (*phora*) people will say they made a *pet* (became pregnant due to extra-marital affair). (Interview, Phalguni Banu, Bengai, Gachhabari, 19 July 2008).

Phalguni Banu's statement illustrates how the dowry payment pushes early marriage among poor households, since early marriage requires less amount of dowry. At the same time, with age the risk of being involved in a love affair increases. Marriages are usually arranged by parents. If parents do not consider the man/boy their daughter is having an affair with as a suitable marriage partner, they organise her marriage with a "suitable" man. In such cases the scandal of the love affair might push the dowry payment sky high for the poor households.

Discussion with Phalguni Banu further revealed that due to the mixed ethnic community in Gachhabari, Bengali Muslim parents fear their daughters might get involved in love affairs with Garo boys which would be socially unacceptable⁵⁹. To prevent this, parents arrange early marriage of their daughters. Another study (Rashid 2007) also found that early marriage results from pragmatic reasons among the urban poor. The pragmatic reality of poor households doesn't match with the international/national understanding of legal age at marriage. In the absence of EmOC for young mothers, early marriage and early childbirth thus contribute to develop fistula.

Interestingly, I didn't find a single Garo woman with complication of fistula or uterine prolapse in the village. This might be partly due to the absence of child marriage practice among Garos. The household survey confirms that age at marriage is higher among Garos compared to Bengali women (discussed in Chapter Seven).

A focus group discussion with seven TBAs further revealed that Garos follow food restrictions and adjust their sitting position to prevent these complications. Shomola *dai* mentioned in the group discussion:

From seven months of pregnancy till three months after delivery, women have to keep both legs closed when they sit to keep the baby small and to prevent the uterus to prolapse. After the delivery women have to eat small

⁵⁹ During an interview with the head of St. Paul's Church in Pirgacha it was revealed that although pre-marital relation is prohibited among Muslims, a number of unmarried Bengali girls gave birth at the maternal centre of the missionary. The children that were born are given for adoption.

amounts of food at a time throughout the day. We don't give sour (*chukka*) food after delivery. We also don't give *kochu*⁶⁰ to eat to prevent itching. We advise to eat more vegetables and potatoes with rice. We don't give meat or fish, while Bengalis suggest eating *shing* and *tengra* fish. (Shomola, Garo, Gachhabari, FGD, 25 April 2008).

Given the importance of women's position in Garo households and the role of local TBAs, this knowledge might have helped matrilineal Garos to prevent fistula and uterine prolapse. Their nutrition might have also played a positive role in this. Garo women are not discriminated in terms of distribution of food in the household. Garos believe pregnant women should eat more to be strong to give birth easily and to be able to resume their work after delivery.

In the FDG with TBAs, restriction on sexual intercourse was further mentioned as a reason for complications among Bengali women. A gossip shared in the focus group was:

We (*Garos*) believe women's body stays soft inside for three months after delivery. Our men also know that. We don't have sex for three months after delivery. After three months when everything is back to normal...(laughter)...fun starts again. Nowadays people don't obey those restrictions any more (*bach goch kore na*). Bengalis say they don't have sex before 40 days after delivery. But we see some people don't even wait 11 or 12 days after delivery. (Nibedita, Garo, Gachhabari, FGD, 25 April 2008).

Bengali TBAs showed their tacit agreement with such gossip. One relatively young Bengali TBA even acknowledged with blushes saying, "our husbands don't obey our rejections (*nishedh maney na*) to wait for 40 days". However, these perceptions are no proof of any relationship between fistula/uterine prolapse and the duration of sexual abstinence after delivery.

During the focus group discussion prolapsed uterus (*guti rog* or *shutikar beram* in local terms) was considered to be the worse reproductive health problem (*projonon shastho shomossha*) as husbands often reject their wives because of this disease. Because of the fear of rejection and having a co-wife (*shotin*) women often hide this disease from their

⁶⁰ A particular kind of leafy vegetable.

husbands and suffer silently. With time it becomes worse and impossible to hide anymore. Besides prolapsed uterus and fistula, irregular menstruation and pain during menstruation (*badhok rog*), white discharge (*dhatu rog*) and infertility (*phol dhore na*) were mentioned as common reproductive health problems among women. Vaginal tear was mentioned as temporary, therefore considered as a lesser problem.

Due to the preference for female providers among both Garos and Bengalis, women mostly rely on informal TBAs or home remedies for these complications. For example, women use a heat source (*cheka*) or herbal medicine from TBAs to treat the perineal tear. Local TBAs are also known to give herbal medicine against uterine prolapse, menstrual pain and infertility. Women sometimes consult with village doctor and local *kaviraj*. In that case men (their husbands) mostly explain the symptom of the complication and get medicine. Garo women also consulted *kamal* (religious healer) for infertility problems.

6.3.3 Men's views and perspectives on reproductive health problems

Men's views regarding the persistence and severity of reproductive health problems in the community differed. In a separate focus group discussion organised with men from mixed ethnic communities, they ranked women's reproductive health problem in the following order: prolapsed uterus (*shutika*); white discharge (*shada srab*); pain during menstruation (*badhok*), physical weakness due to thin white discharge (*dhatu rog*) and irregular menstruation (mostly heavy or long duration or several times in a month). Men didn't mention fistula or vaginal tear as reproductive health problems of women, but they identified infertility as a more severe problem for women than men. In men's perception the reproductive health problem of women having the most severe impact on conjugal relationships is prolapsed uterus followed by irregular menstruation.

While women's reproductive health problems were seen in terms of menstruation, delivery related problem and infertility, men's reproductive health problems were mostly seen in terms of sexuality related problem. Men's top four reproductive health problems included: frequent night pass (*ghono ghono shopno dosh*); masturbation (*bat mara*); syphilis (*chiphilis*) and homosexuality (*shomokamita*). The list of reproductive health problem continued with: thin semen (*dhatu patla*), less semen (*kom*

dhatu), took too much time for erection (*derite uttejona asha*), quick ejaculation (*druto birzo shkolon*) and premature ejaculation (*sbamoik uttejonay birjopat*). The most common problem was the shape of the penis (*matha mota gora chikon*) followed by impotency (*dhojobongo*) and premature ejaculation. In terms of impact on conjugal relationship the most severe problem for men was impotency followed by premature ejaculation. (FGD, men 18 May 2008).

According to the participants of the FGD, syphilis is a new reproductive health disease in the village. Unprotected sexual contact with prostitutes in the local towns is the reason for this disease. Homosexuality was seen as a reason related to the problem with the shape of penis (*matha mota gora chikon*) and performance during sexual intercourse (*rog dhila*), when the penis becomes weak, do not stay tight anymore.

Focus groups and further discussions with a number of key informants revealed that men tend to depend on informal sector actors for treatment of these reproductive/sexual health problems. They usually rely on local *kaviraj* (traditional healer). These treatments are done secretly in the village. For the treatment of impotency herbal tonic is available in the form of sticky syrup in bottles, which should be taken every morning on an empty stomach. To make the penis hard and thick different kind of herbal massage oil is commonly available. Four medicinal plants i) *khuirakata*; ii) *ubudnengra*; iii) *ulot combol*; and iv) *shotomul* are also known to increase men's sexual power. During FDG a man claimed success by saying, "It works like magic. It makes the penis so hard that wife can't breathe anymore". While impotency (*dhozobongo*) treatment is done by local *kaviraj*, the cost of treatment for syphilis is much higher. Men usually get Glaisovin tablet from the village doctor to treat this disease. On the local market day (*baat*) herbal medicine is also sold to treat sexual and reproductive health problems. This type of medicine claims some supernatural power that dictates the treatment in dreams (FGD, men, 18 May 2008). The above discussion shows how the absence of formal health care services also makes men rely on traditional and informal private sector providers to treat their reproductive/sexual health problems.

These findings mirror general patterns in the health care system in Bangladesh. Other studies (BHW 2011, Rashid 2011, Rashid et al 2012) have shown that in the absence of adequate reproductive health care ser-

vices in the formal sector, more than 80 per cent of the poor population (men and women) rely on the informal and private sector for their reproductive health care needs.

6.4 Conclusion

Rather than the notion of rigid cultural norms or lack of poor women's agency to explain the low use of public health care services (suggests in the policy discourse), this chapter provided insight how a complex interplay of health system factors and cultural factors shape childbirth practices at home relying on traditional birth attendants in Gachhabari.

Given the fluidity of cultural norms, although some Bengali women's narratives associated giving birth at home with *pardah* norms, at the same time *pardah* norms were lifted a bit when poorer Bengali women had to go to the forest to collect firewood. Garo women on the other hand were neither confined in the household nor experience restriction on their mobility in the public spaces. Yet, they also relied on home deliveries assisted by traditional birth attendants.

Evidence provided in this chapter shows that cultural norms are also entangled with structural elements. A class differentiation was evident with poorer women stressing that doing daily household chores helped in having normal deliveries. By highlighting the household reproduction poor Bengali women asserted their contribution in the household. While these women could not abandon their reproductive work in the household, they also made light of their inability to pay for pregnancy check-ups and child delivery stating that women from richer households need to go to the hospital due to their inability to give delivery at home "normally". Poor women even rejected the need for a Caesarean during complicated delivery, since it might affect their work contribution in the future. Poor Garo women experienced more work burden since they also worked as wage labourer.

Particularly the poorer Garo and Bengali women found it more difficult to trade-off between their reproductive responsibilities in the household and outside and their biological reproduction. This link to women's household reproduction largely remains invisible in the policy discourse and health care service delivery mechanism. A study (Nasreen et al 2010) found that affordable safe childbirth facilities at the community level can reduce maternal death to a great extent. This evidence supports that

bringing the maternal health care services closer to women can ensure better access during childbirth by minimising women's time off from their household reproductive activities.

Women's narratives also suggest that poor women do not mindlessly adhere to the tradition of home delivery. The reliance on TBAs was due to trust and an acknowledgement of their knowledge and skills. Even educated Garo women relied on the expertise on the TBAs to refer them to the hospitals if complications arise. Based on women's voices and meaning of their childbirth practices it can be argued that although cultural norms play a role, the hidden cost and poor quality of care remains the main constraint for poor women to access formal health care services. In the absence of adequate and affordable health care services, poor women continue to rely on TBAs or informal health care providers to deal with childbirth, after delivery and other reproductive health related complications as the best available option for them.

One interesting finding emerging from the exploration of childbirth practices is that in both Garo and Bengali communities, childbirth is seen as women's business; therefore men stay outside the realm of decision making. This finding indicates that understanding women's agency in childbirth practices require reconstructing gender power relations, also beyond intra-household gender dynamics, cross-cutting with class and ethnicity.

7

The politicisation of ethnic identity, matrilineal ethos and fertility among Garos in Gachhabari

7.1 Introduction

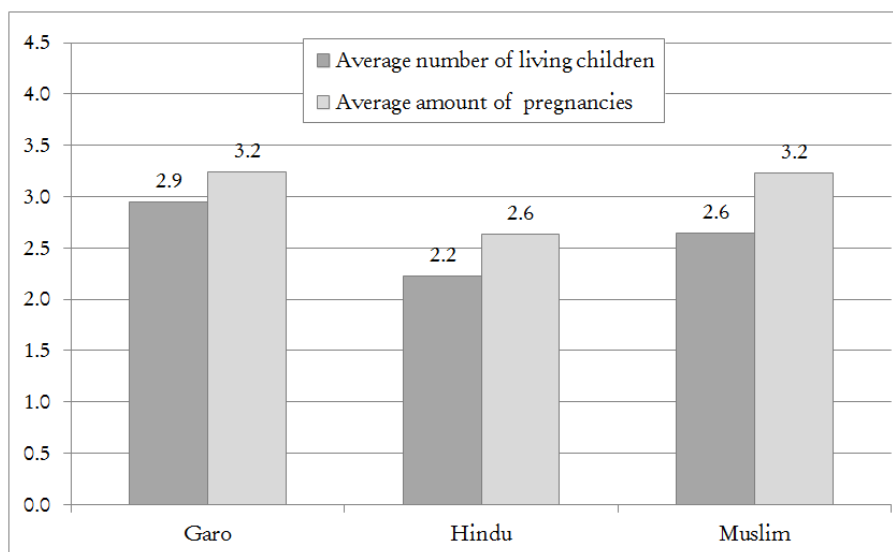
As explained in the introductory chapter, the main reason for the focus on Garos in this study was their unique matrilineal system which offers Garo women land rights, a kinship system followed by mother's lineage and a matrilineal residence pattern, while mainstream Bengalis follow the opposite. Due to their matrilineal kinship system, I expected Garo women would exercise more autonomy in reproductive decision making process in the household as compared to Bengali women and that this would lead to lower fertility. However, as will be shown in this chapter, the household survey found only marginal differences between the two groups, with both groups having the same number of pregnancies and Garo women having slightly higher numbers of surviving children. This finding left me with a puzzle, does ethnicity make any difference, and if so, in what ways?

This chapter delves deeper to explore the ways ethnic and gender power relations intersect in shaping Garo women's reproductive decisions. The chapter is divided into two main sections. The first section presents the results of the household survey comparing fertility among *adivasi* Garos, mainstream Bengalis and minority Hindus. It then presents the views of Garo men and women which suggest reasons why, despite enjoying significant autonomy in their existing matrilineal system, Garo women have similar fertility outcomes compared to Bengali women from a patrilineal system, given the similar socio-economic background.

The second section provides a historical and political perspective to analyse and explore the politicisation of ethnic identity and its link to fertility behaviour among Garos.

7.2 Comparison of fertility among Garo, Hindu and Bengali women

Diagram 7.1
Number of pregnancies and living children per woman, by ethnic groups
(average for all age groups)



Source: Household Survey add year and total sample

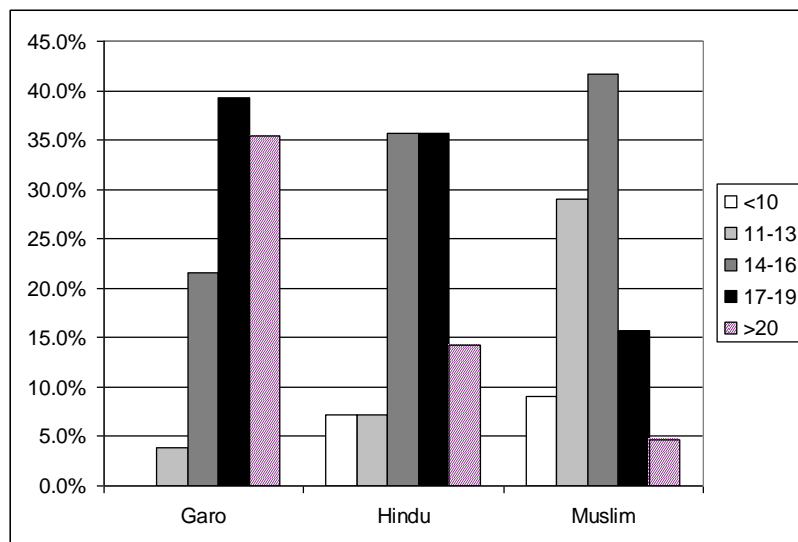
Diagram 7.1 shows the average number of pregnancies and living children in the different ethnic groups, based on the survey of 502 households. While some caution is needed due to the nature and size of the sample of women interviewed,⁶¹ it suggests that while women in both groups have experienced the same number of pregnancies, the average number of living children is somewhat higher among Garos (2.9)

⁶¹ One ever married woman above the age of 15 was interviewed from each of the 502 households. Preference was given to women in 15-49 age group who were married during the interview period. In case there were more than one woman in this age group in a household the younger woman was selected for the interview. In case of no women in that reproductive age group, women above the reproductive age group were selected for the interview. Total number of actual pregnancies and total number of currently surviving children of each woman was documented. Diagram 7.1 shows average number of pregnancies and living children across all women of all age groups.

as compared to the Bengali Muslims (2.6) and minority Hindus (2.2). If Muslims and Hindus were merged within one Bengali category, the outcome would remain the same due to the very small number of Hindu households and a large number of Muslims.

Dyson and Moore's well-known study (1983) used kinship patterns as a locus of women's autonomy in explaining regional fertility differentials in India. These authors argued that if the kinship pattern offers more equitable access to resources, women tend to have higher status and lower fertility. Although the Garo matrilineal kinship system offers Garo women a higher status, it seems to be not a sufficient condition to explain their fertility choice. A previous study done in Madhupur (Harbison et al. 1989) further found that in the 1980s Garo women had similar levels of fertility compared to Bengali women (on an average 3.9 living children).

Diagram 7.2
Distribution of age at first marriage of women⁶² by ethnic groups



Source: household survey, 2008.

⁶² Age at marriage in this study covers actual age during first marriage of 502 women who were interviewed.

Among the many factors which may influence numbers of pregnancies and child survival (not all of which could be systematically explored in this study), one clear difference between the groups concerns age at first marriage. Diagram 7.2 shows a significantly higher age at marriage among Garos as compared to Bengali⁶³ Muslim and minority Hindus. According to convention and other things being equal, a higher age at marriage would result in lower fertility among Garos. In preceding chapters we have seen that Garo women are comparatively higher educated and have more access to wage work. All these suggest that Garo women should have lower fertility when compared to their Bengali counterparts, but the survey found the opposite, at least in terms of the number of living children.

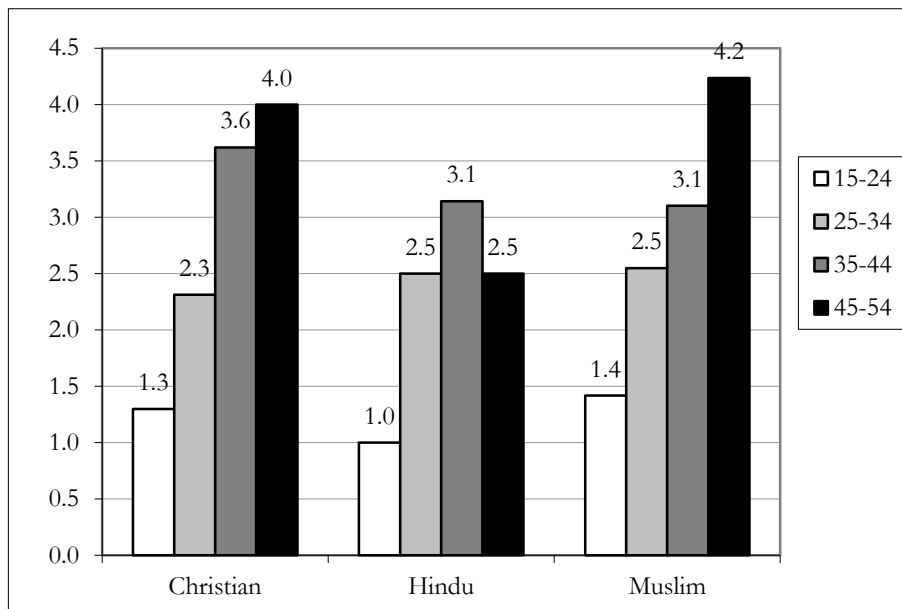
This finding is interesting in relation to the competing explanations of the determinants of reproductive behaviour discussed in the Introduction. Following the argument of Bairagi and others (2001) if the desired family size was the same among two groups of women in the current situation, “couples” would have used different modes of contraception including MR and abortion in the absence of modern contraception to achieve their desired number of children. Following the argument of Phillips et al. (1988) and Cleland (1994) if cheap, available and effective contraception could initiate reduced demand for children and lower fertility irrespective of socio-economic condition, both groups should have shown the same level of fertility (although lower than the 1980s). But the higher fertility in terms of number of living children among Garos indicates that the desired number of children didn’t reduce at the same pace among both groups of women. Given the availability of modern contraception to both groups of women (as discussed in Chapter Five), and higher education and access to wage work among Garo women (as

⁶³ The age at marriage is divided into five groups: Younger than 10, 11-13, 14-16, 17-19 and 20 and older. Early child marriage (younger than 10) is totally absent among Garos. While 7 per cent of the Hindu and 9 per cent of the Muslim women got married before the age of 10, only 3.8 per cent of the women got married in the 11-13 age group among Garos. Many of the Muslim women (29 per cent) got married at this age group (11-13). Most of the Muslim women (41.6 per cent) got married between the ages of 14-16. While only 21.5 per cent Garos and 35.7 per cent Hindus were married at that age. In contrast, most of the Garo women (39.2 per cent) got married between the ages of 17-19 compared to Muslims (only 15.7 per cent). A large number of Garo women (35.4 per cent) got married in their twenties, while among Muslims this number is quite low (only 4.6 per cent).

shown in Chapter Four), the household survey evidence seems to support Bairagi and others (2001). In other words, to explain fertility behaviour, it is the desired number of children that matters most, the access to modern contraception is secondary. The age specific average number of children among both groups of women, as shown below, further seems to support this argument.

Diagram 7.3

Average number of living children by age group of women and ethnic groups



Source: household survey, 2008.

Diagram 7.3 shows lower fertility among younger Garos as compared to younger Bengalis, which it to be expected given the significantly higher age at first marriage. Most interesting is the 35-44 age group, which is the most important age group before ending their reproductive cycle. While Bengali women in this age group reduced their fertility significantly as compared to their elder (45-54 age group) sisters (3.1 and 4.2 respectively), Garo women in the same age group did not reduce their fertility in the same level as compared to their elder sisters (3.6 and 4.0 respectively), suggesting that despite the higher age at marriage they

are ‘catching up’ with their Bengali sisters who married (and started having children) younger. Due to the lower fertility among younger Garo women the average number of pregnancies does not show a significant difference. However, from my observation and conversations with both Garos and Bengalis, I was confronted with a discourse of higher fertility desire among Garos. The interesting question that follows is to explore what are the reasons, perceptions and rationales for having a higher fertility desire among Garos.

A combination of possibly relevant factors emerged regarding high fertility amongst the Garos including the matrilineal ethos, ethnic tensions, a relatively higher return from children, religious belief and norms and the assertion of choice to have a higher number of children. We explore these in turn below.

7.2.1 Matrilineal ethos and the aspiration for daughters/sons

One perception of the value of children was related to daughter/son preference. While son preference (and even its corollary, relative daughter aversion) is commonly reported among Bengalis and many other South Asian communities (Gupta and Bhat 1997; Rahman and DaVanzo 1993; Rahman 1990; Bairagi and Langsten 1986; Chowdhury and Bairagi 1991; Oommen and Ganatra 2002; Belanger 2006; Greenhalgh 1994), Garos expressed a strong desire for daughters (also found in Rao 1985). All Garos desire to have at least one daughter to carry on their motherhood. The narratives of a 47 year old Garo leader, Uzine Sangma can best illustrate this.

We are matrilineal. Daughters are very important for us. After giving birth to three sons my wife gave birth to a daughter. But the daughter died two days after she was born. My wife was crying and became desperate for a daughter. I contacted the “father” (head) of Pargacha missionary. He gave me a three months old daughter to adopt. After adopting that daughter from the missionary my wife gave birth to another daughter. Now we have five children. According to our customary law the youngest daughter will be the heiress (*nokma*). (Interview, Uzine Sangma, Garo, Gachhabari, 7 August 2008).

In discussions with both Garo men and women irrespective of their educational level or socio-economic background, the desire to have

daughters was mentioned as explanation of their having a higher total number of children than desired.

While the desire for daughters was universal, there seemed to be a growing aspiration to have sons as well. The narratives of Elmer, a 40 year old Garo rickshaw van puller, a father of six children can illustrate this, he said:

As *Mandis*, we need daughters. Without daughters who will carry on our motherhood? If we don't have a daughter of our own, we have to borrow daughters to become the heiress. Women do everything in our society. Our women maintain the household (*shongsber*). Nowadays our daughters are going to the parlours and managing the family in the village. We also need sons. Nowadays, I see cultivation, business, shops and markets everything is run by men. Men can go to the court, they can bargain with the police and the forest officers. They can go to the members (local representatives) during disputes. Not everybody gives value to women's voice (*Sobai mobilar kotbar dam dey na*). (Interview, Elmer, Garo, Gachhabari, 29 August 2008).

A number of men from different socio- economic backgrounds and specially educated women expressed a desire for a balanced family. Godhuli, a 37 year old highly educated Garo woman and mother of four children, said:

Two sons and two daughters are ideal. We need both daughters and sons. Brothers and sisters can help each other. There are some places you can't send your daughter at night in case of emergency. We have three daughters and a son. I still have a desire for another son. That is why we (husband and wife) are not considering of doing any permanent method. (Interview, Godhuli, Gachhabari, 6 August 2008).

The desire to have sons was linked to the exigencies of the land struggles in the area (which I will describe in detail later in this chapter). As Garos had to deal increasingly with eviction notices and court cases, the environments in courts and police station were seen as hostile to women, hence the need for sons as well was expressed.

It was not possible however to determine whether the desire to have sons was simply a pragmatic choice asserted by some Garo men and women or also a diffusion of patriarchal ideology from their Bengali neighbours or from the Church.

7.2.2 Religious beliefs and the role of the Church

Another aspect of higher fertility among Garo women was related to religious restrictions on fertility control. During discussions a number of elderly women (45-54) often mentioned, “It is a sin to destroy eggs (*dimbo nosto kora pap*)”. “If God gives many children what to do” (*Bhogoban diley ki er kora*)? Following conversion from their old *shang-sarek* religion to Christianity (as explained earlier in Chapter Four), Garos are given religious training by missionaries. As a part of marriage customs, Garo men and women have to go through an intermediary 21 days, from the first time they announce their intention to marry to the day of the actual marriage ceremony. During this time the marriage partners receive training from the church to prepare them for the marriage, which includes the prohibition on modern family planning.

A rejection of family planning message among elder Garos resonates such sentiment. For example, Priya Chishim, a 55 year old Garo woman from a medium socio-economic background said:

It is only now we hear that it is good to have fewer children. Nobody said this kind of thing before. Those who aspire to have fewer children are those who don't care about *gosthi* (community), they only think of their self-interest. We don't understand how one can form a family (*shongsher kora*) with fewer children. Once children grow up, they wouldn't have enough siblings to consult to take important decisions. (Priya Chishim, Garo, Gachhabari, 12 September 2008).

Bal (2000:191) contended that the missionaries have played an important part in the unification of Garos into a distinct ethnic community which they are today. A strong communal identity rather than an individualistic self-determination, as reflected in the above statement, seems to reject attempts to reduce their fertility.

Local Bengalis had their own explanation for the high fertility of Garo women. Revealing a tension within the village community Abdul Hamid (a 55 year old Bengali grocery shop owner in the village), who seemed to be quite prejudiced, felt that patronage from the Church was a reason. He said:

It is not possible to reduce fertility among *Mandis*. There are many organisations to help them. *Mandi* children get free education from the missionary school. If they are a little bit educated they get jobs at Caritas (a Chris-

tian NGO) and beauty parlours. Nobody knows what would have happened with *Mandis* if missionaries were not here. *Mandis* were illiterate and lived like “beast of Madhupur Jungle” (*boner poshu*). Missionaries made them educated. Now they are more educated than Bengalis in this area. They also get jobs easily. With the same level of education it is difficult to get jobs for Bengalis. (Interview, Abdul Hamid, Bengali, Gachhabari, 29 April 2008).

Abul Hamid used a Bangla proverb, “*ek mukh shona dia bhorano jay, dosh mukh chai dia-o bhorano jay-na*”, (It is possible to fill one mouth with gold, not possible to fill ten mouths even with ashes), to express his concern about growing poverty among Bengalis and the relatively better position of the Garos. This theme was echoed by others, mentioned by both men and women. Akbar, a thirty five years old Bengali rickshaw puller said:

There was no scarcity in old days. Nowadays it is difficult to provide proper food and education for two children. It is difficult to have many children; they will die of hunger. (*Ager jugey ovab chilo na. Ekhon duita baccha hoi-lei thikmoto khawa pora jogar kora mushkil. Beshi baccha newar upay nai, Na khaiya mortey hoibo*). (Interview, Akbar, Bengali, Gachhabari, 20 July 2008).

Similar to Bengalis, Garos also experienced growing economic hardship. This is reflected when Shopon Mrong, a 30 years old Garo man stated:

Previously, Garos used to own huge amounts of land and there were not many people living in the forest. The forest was a treasure, many varieties of grains and edible roots were available, such as cassava and wild potatoes, it was not a problem to have many children and there was always plenty to eat. Now one piece of land has been divided into ten smaller pieces. Even if someone desires to have many children it seems impossible. Nowadays even one child goes hungry. But the decision to have or not to have children ultimately depends on the wife. We believe having or not having children doesn't work by force (Interview, Shopon Mrong, Garo, Gachhabari, 27 August 2008).

These narratives illustrate that both Bengali and Garo communities experienced increasing poverty and scarcity of resources. As mentioned earlier, in comparison with a previous study (Harbison et al. 1989) done

in Madhupur, the household survey suggests that both Garos and Bengalis reduced their fertility. However, Bengalis reduced their fertility relatively more than Garos. The narratives above suggest that Bengalis felt that they had less economic return from children. Although faced with economic difficulties, Garos still find relative economic return from children. This seems to have a mutual interest with the missionary ideology.

7.2.3 Relative economic return from children

Another perception related to desire for children was the relative economic return from children due to alternative livelihood opportunities. At the beginning of my fieldwork when I went to interview a Garo participant Ambia, a 48 year old Garo woman and a mother of 10 living children (two miscarriages) with a Garo health worker, I asked Ambia why she chose to give birth to so many children (in my understanding it isn't good for women's health). Ambia started to talk with the health worker in Garo language⁶⁴. I didn't understand anything of what she was saying but from her expression I could realise that she didn't like my question. After translation from the health worker I understood Ambia thought I was promoting government family planning and her response was:

We have nothing to do with the government. The government doesn't do anything for us. Why do they care if we have many children or not? Is the government going to take care of me when I become old? One of my daughters will take care of me in my old age. (Interview, Ambia, Garo, Gachhabari, 28 March 2008).

When the health worker explained about my research objective and made it clear that I didn't have any government family planning objective, Ambia started to speak in Bangla. Later she became friendly and even shared how she became pregnant with her last child when her husband was completely drunk. She objected but couldn't stop him. Further discussion with Ambia revealed that she used to own a large amount of land but lost most of it due to indebtedness to Bengali money lenders.

⁶⁴ Nowadays all the Garos speak the Bangla language, but to keep a distance from Bengalis, Garos speak their own language among themselves. Due to the fact that Garos don't have a written script, young generation Garos are losing their mother's tongue.

Now she works as a day labourer and depends on the forest to collect fuel-wood to sell in the local market and for household consumption.

Ambia's statement did resonate a strong anti-government sentiment. She also considered that I (as an educated Bengali woman) belonged to the "others" (as I will explain to the next section how ethnic Garos experienced exclusion from the state in a Muslim Bengali dominated country).

Discussion with a number of Garo women revealed that during subsistence economy *Garos* women didn't feel the necessity to reduce their fertility because *jhum* cultivation required family labour. There was no concern about the number of children. A decade ago Burling mentioned that most people continue to feel comfortable, even proud of having produced eight, ten or twelve children, through the infant and child mortality was also high, only a few of them survived (Burling 1997).

Due to the banning on *jhum* cultivation and the loss of ancestral land, poverty and inequality emerged among Garos (which I will discuss later in this chapter). Simultaneously, Garos also experienced other changes in their life. The poor conditions of the Garos were a matter of great concern to the Christian missionaries since the anti-colonial agitations (Bal 2000). Missionary development work provides free education opportunities. With the help of the missionaries several NGOs such as Caritas, World Vision and Action Aid provide employment opportunities to Garo boys and girls. Additionally, since the 1980s Garo girls were able to have access to jobs in the cities, particularly in beauty parlours and garment factories. This situation offers Garos relatively higher return from children, which provided them a favourable condition to keep their fertility high despite their relatively high age at marriage.

7.2.4 Ethnic tensions and the perceived need to increase fertility

Abdul Hamid's statement above suggests a simmering tension between the two communities. A common sentiment expressed by many Garo participants can be summarised in the words of Petric Shimsang (a sixty year old Garo man), he said:

There was not a single Bengali in the Madhupur forest area. Now we have become a minority in our own ancestors' land. If we want to survive we have to increase our numbers. Otherwise there will be no single Garo left

in Madhupur. (Interview, Petric Shimsang, Garo, Gachhabari, 7 August 2008).

This sentiment was shared by Garo men and women alike. Dipti Mrong, a 45 year old female Garo leader of an indigenous social organisation, mentioned that her organisation was conducting yard meetings (*uthan boithok*) among Garo women to motivate them to refuse any family planning method and to produce as many children as they wish. This was despite herself having had a sterilisation operation after her second child. In a discussion she explained,

I became pregnant within a year after my first child was born and my breast milk stopped. I was afraid I wouldn't be able to keep my first child alive. In the end he survived on goat milk. My second child was born one and a half years after the first child. I didn't want my child to suffer again. After the delivery I had a sterilisation operation. After the operation I realised I made a terrible mistake. Now I tell others not to make the same mistake like me. (Interview, Dipti Mrong, Gachhabari, 9 August 2008).

I had this conversation with her, when we were travelling together on a rickshaw through the forest area after celebrating indigenous day while the evening darkness was approaching. She continued the conversation saying,

We need both rich and poor Garos to increase their numbers. As much as we need doctors, engineers and lawyers, we also need rickshaw pullers like this brother who is pulling our rickshaw. I feel safe travelling in the dark because of my *mandi* rickshaw puller *bhai* (brother). I wouldn't feel safe with a strange rickshaw puller to travel through the forest in the dark. This place is not safe anymore because of Bengali outsiders. (Interview, Dipti Mrong, Garo, Gachhabari, 9 August 2008).

The feeling of being marginalised in their ancestral land was very strong. Since mainstream Bengalis were resettled in Gachhabari (as explained earlier), gradually much privately owned land has shifted hands from Garos to mainstream Bengalis. Living on their mainly subsistence-oriented livelihood system, Garos were not familiar with the cash economy. Many Bengalis who came to live in this area bought land from Garos at a cheap rate or grabbed the land while Garos were unable to pay a high interest rate against the money they had borrowed from Bengalis at the time of crisis.

A thirty-five-year old Bengali rickshaw puller Akbar, who used to take me from the village to the sub-district hospital, explained this during our long travel. He stated:

Women used to own land among Garos. During the crisis Garo men borrowed money from Bengali money lenders. Money lenders asked men to give land registration papers as a mortgage. Garo men got the land registration papers from their wives and borrowed money. After a few years Bengali land owners said, “you borrowed that much money and your interest is that much. You pay the money with interest otherwise the land will be mine”. Garos couldn’t pay the 100 per cent interest rate, the illiterate Garo women didn’t have any option but to put their finger print on the land transfer document. Clever Bengali landowners registered the land in their names with very little money that Garos borrowed against the mortgage (Interview, Akbar, Bengali, Gachhabari, 20 July 2008).

In this process many Garos gradually lost their lands and land ownership went into the hands of Bengalis. According to Akbar Garos lost most of their land because they were owned by women, saying, “If men would have owned the land they would have protected them better”. This comment is interesting since it again expresses a negative assessment of the Garos as being female dominated and a general perception that exists amongst most Bengalis and some Garos that Garo men are lazy and aren’t motivated to work. This attitude towards Garo men is not specific to Gachhabari but seems to be a part of broader discourse related to Garo men in general. Given the patriarchal ideology among Catholic missionaries, it is not surprising that Bal (2000:170) also mentioned similar missionary voices, expressing their worries about the impact of matrilineal kinship on the economic productivity and social interest of Garo men and the issue of indebtedness due to money lending from Bengali *mahajans* (money lenders).

Land disputes between Garos and Bengalis sometimes have had serious consequences. Gidita Rema of Jangalia village was stabbed to death by a local Bengali in a dispute over her land in 2001. Linthonas Hadima of Telki village was stabbed to death by local Bengalis who grabbed her land for the construction of a public road (Mangsang 2007).

This doesn’t mean that Garos are systematically marginalised by the mainstream local Bengali population. Nowadays if something happens at the local level it gets media coverage. Adivasi organisations also have

representation in the local government body of conflict resolution. After these incidents the accused persons were put to justice. It is also difficult to say whether the motive was simply economic rather than ethnic domination by the mainstream Bengali population. However, strong communal solidarity among Garos has worked as a control mechanism to keep the local power in balance. Local Bengalis expressed their worry that if a Bengali says or does something to an individual Garo, the whole community from neighbouring villages will come to fight unless the issue is resolved. The inter-ethnic tension expressed by Garos seems to originate mainly from their feeling of becoming the minority in their own ancestors' land. This tension was explicitly putting pressure on the Garo community and women in particular as biological reproducers of the community as well as preservers of the female line to keep their fertility high.

The reasons given by Garos for their higher fertility however provide an immediate explanation of their reproductive decision. To understand the broad intersection of the politics of ethnicity and the desire to have a higher number of children among Garos, it is necessary to trace the changes in the region from a historical and political economy perspective.

7.3 State, politics of ethnicity and collective need for higher fertility

The creation of Garo ethnic identity is a cultural artefact of discrete historical and political processes. In Chapter Four we have seen how the identity of matrilineal Garos was rooted in their customary livelihood system of *jhum* cultivation.

7.3.1 Historical and political economy in Madhupur and its link to the Garo identity

The Garos' *jhum* cultivation was feasible due to the particular land tenure system that existed in Madhupur before and during the British colonial period. At that time, the sub-continent of India was ruled by Mughal Emperors via local zamindars (landlords). Until 1950 forest land of Madhupur and its surroundings was private property belonging to the local zamindars. The Madhupur forest land was under the control of the Hindu Raja of Natore, Shree Jogodindra Nath Ray Bahadur. The Raja

(King) of Natore dedicated the forest lands to the God *Gobinda* and it was called *debottor sompotty* (Gifted Property). The Raja would lease the forest lands to the forest dwellers and received land taxes known as *chang pattan* (Satter 2006). Under the local zamindars, the original Garo inhabitants of the Madhupur *sal* forest cultivated the land with slash-and-burn agriculture for 5-6 consecutive years and then planted *sal* or *gazari* seed before leaving the cultivated plots (Dey et al 2013). The Garos were allowed to live in the fertile lowlands under registered homestead plots, paying a yearly rent or tax (Nokrek 2013; Satter 2006).

When Madhupur forest land was registered in 1878, an exception was made to the Bengal Tenancy Act recognising the Garo Law of Succession and Inheritance from the Succession Act of 1865, No.940. Following this exemption the lowlands along with some of the high land in the Madhupur Jungle were allowed to be registered in the name of female members of the household. A Cadastral survey done in 1914-1918 followed the Garo inheritance law and was updated as an Act of Law in 1925 (Satter 2006). Thus women's right to land was codified in law.

During the British colonial rule, in order to manage and control forest resources, the government of India set up a forest department and the control of the *sal* forests of the Madhupur area went under the state administration in 1925-26. In 1927 the British government passed the Indian Forest Act and proclaimed Madhupur as "reserved forest". The major objective of the law was to generate state revenue from the forest by supplying timber for railway sleepers. Garos were allowed to reside in the lowland areas and practice slash and burn on the higher forest blocks, but they were prohibited from cutting the valuable *sal/gazari* trees. (Dey 2013:8).

Following the division of the Indian sub-continent, the Government of Pakistan passed the East Pakistan Private forest Act of 1947 and the East Pakistan State Acquisition & Tenancy Act of 1950, which made the forests non-retainable under private ownership of zamindars and the management of the forest land went directly to the authority of the regional Forest department (Satter 2006). Subsequently, slash-and-burn cultivation was condemned as environmentally destructive (Chakma 2005) and formally banned by the Pakistani government in 1955 (Khaleque 1986).

After banning *jhum*, the government of Pakistan declared Madhupur forest as “national park” on 42,000 acres or 11 square miles of the forest lands in 1962, where nineteen Garo villages were situated. The government of East Pakistan wanted to evict the Garos from Madhupur Forest and put them in a cluster village at Phulbagchala. Poresh Chandra Mree, who was a Union Parishad (local government body) Chairman and a Garo leader of Chunia village, started various communications with the central government. The government was convinced that the project would cost a lot of legal battle and the social consequence would be enormous, and therefore suspended the project (Satter, 2006:65).

Soon after that the political situation took a different turn. In 1964, a riot broke out and a war began between India and Pakistan. Due to communal violence in India, Garos in Northern Mymensingh witnessed a sudden influx of Muslim Bengali refugees from Assam, India followed by landless Bengali from other places in Bangladesh/East Pakistan. This riot has had much significance for non-Muslim Garo community in relation to their land and identity. Bal (2000) has documented the impact of communal violence on Garos in the border area of Mymensingh:

The arrival of Bengali newcomers coincided with thievery and intimidation of the non-Muslim population and with illegal settlements on the lands of Garos and their non-Muslim neighbours. Rumours rapidly spread throughout the border area that more Bengalis would come to rape and kill. Within one month, almost all the Garos from the border area fled the country. (...) The influx of Bengalis frightened the Garos because they tried to occupy Garo lands and robbed villages, especially at night. At the same time, the houses of neighbouring Hajongs, Dalus, and Banais were set on fire. At night, Garos could see houses burning everywhere around their own villages (Bal 2000:184-185).

Although no refugees were dumped in Madhupur and violence did not erupt, however, a gradually growing stream of Bengalis began to move into formerly *Mandi* areas of Madhupur. The composition of the population began to shift and *Mandis* began to feel like strangers in their own villages. The news from their relatives of Northern Mymensingh also increased their tension and insecurity as a non-Muslim minority group. Some of them decided to flee to India, and others found themselves surrounded by Bengali neighbours (Burling 1997:68).

Communal tension intensified due to the acceptance of the “Enemy Property Ordinance” by the East Pakistan government, whereby property of those residing in India came under the control of the Pakistan government. This law is reported to have been misused by migrated Bengalis to occupy land from Garos (Bal 2000). In Madhupur more land shifted ownership through straightforward purchase. Due to the fear raised by the Enemy Property Ordinance among non-Muslim groups, Garos were not in a position to bargain a fair price for their land (Burling 1997). Those who didn’t sell their land before they had left to India, found their lands had been occupied by Bengali refugees after the war, when they returned; Garos and Hindus claimed their rights to their ancestors’ land. But the act favoured Bengali Muslims and the Garos and Hindus have lost in the court cases (Mangsang 2007). It also involved spending a great deal of money on court cases to get back the land that had been declared enemy property (Bal 2000). There were stories in the village that many Garos spent more money on court cases than the actual value of their land. Some simply gave up.

In most of the writings on Garos, 1964 came to be known as “the first riot”. Before that the struggle of Garos was simply “local” experiencing the banning of a livelihood system that Garos had been dependent on for generations. The “divide and rule” tactics of the colonial government intensified the magnitude of exclusion and marginalisation by categorising them as a non-Muslim minority group (the other) in a Muslim dominated region. The communal insurgencies, intimidation and invasion of Garo inhabited areas by refugee and migrant Muslim Bengalis illegally or under the protection of the state together go far towards explains the “othering” of the non-Muslim Garos based on their minority religious identity.

This ethnic tension continued under the post colonial state of Pakistan. In the Pakistani election in December 1970 the majority of the seats were won by the Awami League, an East Pakistani political movement led by Sheik Mujibur Rahman. Before that the centre of Pakistani party politics had always been in the Western half of the country. Political tension arose when the Awami League advocated for more autonomy for the Eastern half. Tension escalated and the second riot, the independent war of Bangladesh started, which had far worse experience for Garos (Burling 1997:71).

Since Sheikh Mujibur Rahman kept religion out of politics and mobilised Bengali identity as a nationalist discourse of a secular state (Bal 2000:192), many Garo men and women actively participated in the freedom struggle. According to Ball (2000) many Garos chose the side of the Freedom Fighters and dreamt of a country freed from Pakistani domination, which was based on religious ideology. Meghna Guhathakurta (2012) argues that in a state dominated by one religious community, minorities tend to be seen as a “vote bank” for one major political party which is considered to be more secular. Thus, non-Muslim Garos have been considered to be a source of political alliance for Awami League in pre-1971 Pakistan and post-1971 Bangladesh.

After the independence of Bangladesh in 1971, the newly formed government promised that “tribal” people will have full rights over their ancestral lands and will not be evicted (Satter, 2006:33). In fact, the constitution of independent Bangladesh was written at Dukhola Rest House near Chunia village in Madhupur forest. Dr. Kamal Hossain, a freedom fighter and a powerful political leader at that time, who was the minister of Law in 1972-73, was close friends with the family of Garo leader Pores Chandra Mree (UP chairman, introduced earlier). When the Prime Minister, Bongo Bondhu Sheikh Mujibur Rahman was assassinated on the 15th of August 1975, many Garo young men also took part in the protest. Later the Government of Bangladesh, then the President Ziaur Rahman appointed many Garos in the BDR (Bangladesh Rifles), police and army. On February 14, 1976 President Ziaur Rahman declared publicly at Mymensingh town public hall that “No Garo will be evicted from Madhupur Jungle” (Homrich 2007).

Non-Bengali Garos, however did not fit into the nationalist discourse of independent Bangladesh (Bal 2000). The process of “othering” and exclusion of non-Bengali Garos continued by categorising them as “tribal” population in the constitution of Bangladesh.

Although having a friendly relationship with the political party in power favoured Garos until Ziaur Rahman’s regime, this situation began to change with the onset of the military government in 1982, and “the re-emergence of religious identity as a marker of Bangladeshi nationalism, which was used by successive ruling regimes as a tool to offset the more linguistic-based Bengali nationalism (Guhathakurta 2012: 298)”, which was already problematic to embrace non-Bengali Garos in a Bengali nation state. A Forest Gazette Notification was issued in 1984 by the

military government. According to this notification the total area of the “reserved forest” was declared as 42,767.27 acres of land which included many areas of the personal land of the Garos. When this was challenged in the court and in the Land settlement office, the Bangladesh Government refused to recognise tenancy rights and stopped collecting taxes on these lands (Homrich 2007). Since 1984, the Forest Department claims that many Garos are squatters (even though it is their traditionally owned ancestral land) and successive governments have issued eviction notices and filed cases under the Revised Forest Act. In 1990 at the end of rule of the National Party of President Ershad, the government of Bangladesh amended the Forest Act of 1927. The amendment raised the punishment from 6 months to 5 years imprisonment plus a tk 5,000 fine for entering into the reserve forest area with the intension to “destroy” forest resources and included a sub-section making the verdict non-bailable (Satter 2006:69).

According to local estimates, at least 6,000 cases have been filed against local Garos for violation of the Forest Act. Those who have been arrested suffered in jail for years without any trial. Some people have been accused several times for the same incident (Interview, Eugene E. Homrich St. Paul’s Church, Pirgacha, 25 October 2008).

At the same time, the process of eviction continues under the name of various development projects. To generate revenue from the “reserved forests” a number of forest development projects were set up. In 1985 the government handed over 15,000 acres of forest land to the Bangladesh Forest Industry Corporation (BFIDC) for rubber plantation and 50 acres of forest land has been given to a project called Charaljani Silviculture. These development projects included *Khas* and registered land from Garos. Due to conflict between the Forest Department and local people the forest department could hand over a total of only 10,647 acres of land for the proposed projects. The Forest Department was also alleged to have evicted local people from land occupied and used by them from the project area without any compensation (Satter 2006:45; Mangsang 2007).

The historical evidence provided above shows how the shift in forest land management from local zamindars to the Forest Department and the subsequent declaration of “reserve forest” denied Garos right over their ancestral land, and this struggle to retain and reclaim their land continues today. This process also reflects a shift from tension between

Muslim and non-Muslim communities to a tension between the tribal Garos and state agencies, the Forest Department in particular.

In the following section, I explore how Garos experience exclusion or marginalisation in various forest development projects based on their ethnic identity.

7.3.2 Exclusion from the forest development projects

In 1990, the government of Bangladesh introduced a 25 million dollar “Social Forestry project” funded by the Asian Development Bank and the World Bank (Gain 2002; PROSHIKA 2000). My respondents remembered this project and the way in which they were excluded:

In the beginning of the project the Forest Department followed the Social Forestry policy imposed by the ADB and World Bank by including some Garo households. Later in the second round in 2000, the Forest Department did not follow the policies. According to the official rules plots were supposed to be distributed among local inhabitants living within a one km radius of the plantation area. The idea was that local households who receive these plots have to take care of the woodlot plantation for 10 years. Seven years after the plantation they would have received two third of the turn over from the sale of the trees. Three years after that, they would receive another two third of the turn over from the second round of sale. They made contracts with outsiders in exchange for bribes violating the policy. They received Tk.10,000 to 30,000 per plot (one hectare). But the local poor Garos could not pay bribe so they were deprived of participation in the Social Forestry projects. Garos are given less than five per cent of the plots as a token gesture, even though there were more Garos living close to the plantation plot. The rest is given to Bengalis, even those who don't live in and around the area. (Interview, Badal, Garo, Gachhabari, 3 September 2008).

A Bengali trader told me he received two plots, one on his name, and the other on his wife's name. He even acknowledged bribing forest officers to receive these plots. He further justified the decision of not distributing plots among poor Garos stating:

If plots would be distributed among poor Garos, they wouldn't be able to protect the plots against thieves. If plots are distributed among well-off people they can better take care of their plots. They can invest to clear the undergrowth in their plot and buy fertilisers to make the trees grow faster. Trees would grow taller and yield a better price when sold. Thieves would

be more afraid to cut tress from powerful Bengali plot owners than poor Garo women (Interview, Rafiqul Islam, Bengali, 38 years old, Gachhabari, 21 August 2008).

Again it is interesting that the perceptions of Bengalis place the blame on the fact that women own the land and there are rumours among local residents that Garos who were given plots in the first round couldn't yield good profit.

In addition to exclusion, Garos experienced restriction on their access to forest resources on which they are dependent on for generations. In 2001, the Government declared the establishment of an Eco-Park in the Madhupur Forest area and proposed to build a brick wall enclosing 3000 acres, with 3 watching towers, 13 picnic spots and 10 guest houses. This development intervention not only included the land that Garos claim as ancestral, but it would also block the roads that Garos have used for centuries to access non-timber products such as food, medicine and household supplies. Suspicion was expressed by Garo leaders:

The Eco-Park will isolate all Garo villages and will block the roads we have used for centuries. In the near future we will have to pay to enter and exit our villages by paying fees at the gates of Eco-Park. The tourists from outside would come to pass their leisure times. They will play loud music with mikes. If it happens then the mikes will be played from 13 picnic spots and 10 guest houses at the same time. Will not the wild birds and animals be scared? How long can the forest dwellers stand it? Moreover it will affect our social lives and the peace in the forest cannot be maintained. Who knows if the guest houses will turn to ghost houses! (Interview, Ginet Nokrek, Garo, Gachhabari, 12 December 2007).

Garos have already paid a high price due to the declaration of reserve forest and felt that making a wall around the forest would make their life even worse. A number of Garos from neighbouring villages had lost their lives in the hands of forest guards for entering into the reserve forest. Bihen Hagiok of Joynagacha was shot to death while he was collecting fuel-wood in April, 1996. Adhir Dopu of Sataria village was shot to death while he was helping his wife to collect edible roots in November, 1999 (Mangsang 2007).

Garo men and women from all Garo villages protested against the established of the wall around Eco-Park, under the leadership of Piren Snal. On January 3, 2004 a shooting on a peaceful demonstration killed

Piren Snal⁶⁵ and 25 were wounded (Mangsang 2007). The Eco-Park project was stopped temporarily after that incident. However, again Cecilia Snal of Sataria village was shot while she was collecting fuel-wood in the jungle in August 2006. In addition, many Garos had to suffer in jail for trespassing the Forest Law by extracting forest resources. Local Garos complained that many of these cases are false. They alleged that right before forest officers moves to a new post by rotation, they file many false cases. It shows their good performance and helps to get promotion in the new post. I did not investigate whether these allegations were right or wrong. However, this allegation resonates the growing tension between Garos and the forest department.

Garos also rejected the “social forestry project” initiated by the forest department in 2007. The Forest Department took initiative to plant trees on *khas* land under the project, which was meant to be based on voluntary participation. The Forest Department with the help of the Bangladesh Army started planting trees on crop land and even on homesteads that Garos claim as their registered land. My respondents suspected it was a way to take control over the contested land and evict Garos, saying:

The local forest officer promised that 40 per cent of the benefit would go to the participants but there were no written contracts. This was a way to capture “our” land by the forest department (Interview, Dulal, Garo, Gachhabari, 21 August 2008).

Narratives of Garos show they share a common history of communal violence, banning of their traditional livelihood systems, loss of land ownership and exclusion from forest development projects and restrictions on access to the forest resources. Mistrust and suspicion expressed by Garos reflect not only their exclusionary experience but also their self-identification that unifies them as an ethnic community based on a shared history of exclusion and resistance.

⁶⁵ Since 1962 under the leadership of Poresh Chandra Mree Garos are organised for their land rights. To protest against Eco-park project Garos were mobilised in 2004 under the leadership of Piren Snal.

7.3.3 Collective Action to preserve land and identity

Garos in Madhupur have been formally organised since 1962 through the “indigenous peoples’ association” established by Poresh Chandra Mree. After his death Cholesh Ritchil took the leadership. Under his guidance, Garos have protested against the Eco-park project since 2001. Garos were again mobilised against the “social forestry” project in 2007. In several villages, when the Forest Department went to plant trees, Garo men and women resisted together. In the description of Shuninda, a 35 year old Garo woman:

When the Forest Department came with the army to plant trees on our banana plots or homestead garden, they hired day labourers from other neighbouring villages. We women went in front of the army to resist them planting Eucalyptus and other foreign trees. We asked our men to stay behind because the army would have arrested our men. The army would not easily arrest and torture women. The Forest Department hired some of the poor Hindu female day labourers from another neighbouring village. I recognised some of them and said to them, “The Forest Department is using you to work against us. The Forest Department don’t plant trees themselves. Without your help they wouldn’t be able to do the work. You are elderly women, it wouldn’t be pleasant if you are beaten by our men, so please leave”. Due to our protest the Forest Department had to stop planting trees but they destroyed our banana plots before we knew it. (Interview, Shuninda, Garo, Gachhabari, 5 September 2008).

Later on, the Forest Department used legislative power to stop the resistance by arresting their leader. Cholesh Ritchil⁶⁶ and Protap Jambil (another Garo with whom Cholesh was on a motor bike) were arrested on a charge of conspiracy against the state department. They were taken to Kakraid Army Camp and tortured. Protap was treated in Madhupur Hospital and dumped in his home village at night. Cholesh was tortured terribly; his whole body had black and blue bruises. He was sent to the Madhupur Hospital where he was declared dead from high blood pressure and a heart attack, while it is widely known that he died as a result

⁶⁶ At the time the movement against the National Park started Garos were organised under *Joyenshabhi adivasi unnayan shomiti*. The chairman of this *shomiti* was Benedict Mangsang. He was also one of the members of the Eco Park Committee. Cholesh Ritchil was general secretary. When the movement against Eco Park started all indigenous communities united under the name of *Adivasi songram Oikko parishad*.

of torture by the Army (Homrich 2007:6; Human Rights Watch 2008:53; Ramakrishnan 2013:240).

These instances show the political struggle of the Garos to assert claims over their ancestral land and resistance against eviction. This political struggle is another factor motivating Garos to increase their numbers to strengthen their communal power. This sentiment was reflected when John Dafo, a 33 year old Garo leader vividly stated:

Sister, there are three types of power in the world: power of money, power of knowledge and power of the majority. We Garos don't have money; we don't have access to higher education, so we can't gain the power of knowledge either. We need power of the majority for our survival. We need to increase our numbers. (Interview, John Dafo, Garo, Gachhabari, 12 September 2008).

This sentiment was also reflected in Shuninda's opinion when she said:

If we were smaller in numbers the Forest Department would have easily planted trees on our land and later would have claimed as Forest Department's property. We were higher in numbers, Forest Department didn't succeed to capture our land easily. But many Garos have already given their lives in the hands of forest guards. Many young Garos are moving to the cities for a better life leaving their ancestors' land. If we don't have enough people to resist gradually the Forest Department will take over. We are sure the forest department will come back soon, next time may be with more army. (Interview, Shuninda, Garo, Gachhabari, 5 September 2008).

The political struggle for their rights over ancestral land and resistance against eviction have fostered the self-identification and categorisation of Garos based on a collective ethnic identity, highlighting their matrilineal kinship system, which encourage Garos to increase their numbers for group survival. This is however, does not mean that Garos are a homogenous group. The next section will explore the internal diversity and the dynamics of gender power relations among Garo households.

7.3.4 Changing livelihoods: class differentiation and changing gender power relations

Garos can no longer be characterised as a semi-egalitarian (Bal 2000) community, as they used to be during subsistence economy. The transfer

of forest land from private ownership of zamindars to state authority and the banning of *jhum* cultivation created internal diversity among Garos. After banning *jhum*, households with more active labour force were able to secure control over some lowlands close to their homestead for permanent agriculture and private ownership of land emerged, while the majority of the Garos became landless. This process of acquiring land created new categories of poor and rich division in a relatively egalitarian Garo community (Mohsin 1997).

Subsequently, the subsistence livelihood system of *jhum* cultivation has been replaced by commercial agricultural production. Cash crops such as pineapples and bananas were introduced in Madhupur with the influence of Bengali migrants. In the view of local residents, extensive use of chemicals and introduction of exotic plants has damaged local biodiversity and different species of honey bees for which Madhupur was famous for have disappeared. The head of the St. Paul's Church said:

Do you know that the name Madhupur came from *Madhu* which means honey and *Pur* which means place? Several species of honey bees were found in Madhupur forest. Now they are extinct. Now many Garos say we better rename Madhupur as *Bishpur*.⁶⁷ (Interview, Eugene E. Homrich St. Paul's Church, American, Pargacha, 25 October 2008).

Entry into the labour market was on unequal terms for Garo women and men. One third of the Garo households were landless in the village. Men didn't have a fixed income. Landless Garo men mostly worked as van/rickshaw pullers or day labourers. Sometimes they might earn just enough for daily consumption, sometimes not. A shift from subsistence to commercial economy and private ownership of land also changed Garo women's position in the production system. Landless Garo women do work in the plantation plots as day labourers. During discussions with a number of Garo participants it was revealed that female workers received 100 tk and male workers received 120 tk as a daily wage, although women performed tedious and more time consuming tasks in the plantation plots. Most of the plot owners are Bengalis. A Bengali plot owner justified unequal payment for Garo women working on his plot, saying:

⁶⁷ The local term people use for pesticide is *bish* (poison).

Women have less physical power to work. A man can do more work than a woman given the same amount of time. Women are also less intelligent. A man will think what to do next, organise and plan accordingly. A woman will wait for the instruction. They cannot plan and manage independently. When I hire women I always have to be around to give them instructions. (Interview, Rafiqul Islam, Bengali, Gachhabari, 21 August 2008).

The statement of Bengali plot owner indicates how women's unequal pay and discrimination as a day labourer is justified based on an essentialist gender bias.

At the same time, since the Forest Department has put restrictions on entering into the forest for the preservation of natural forest and conservation of bio-diversity, Garo women face specific vulnerabilities and risks while collecting fuel-wood. There were rumours that Garo women had to pay a bribe to enter into the forest and women were also intimidated by the forest guards when they went to collect fuel-wood. In a discussion with Orchita, a thirty two year old Garo woman when I expressed my interest to join her inside the forest, she refused, stating:

Sister, there are leeches (small tropical animal that sucks human blood) in the forest. We carry salt with us against leeches (she even showed me salt folded in a piece of plastic that she was holding in her palm). But, there are also human leeches in the forest. We are familiar with all the tiny routes inside the jungle. We can run away faster from those human leeches. But how are you going to escape from them? We can't take you with us and leave you behind in the jungle. (Interview, Orchita, Garo, Gachhabari, 23 October 2008).

To avoid the potential risk of abuse and rape, women never go alone inside the forest. They always go in a group of three or four. They never send a child in the forest to collect fuel-wood. I also heard about the rape of a Garo woman by the forest guard, which has been covered up. One Bengali man in the village told me, "Good women never go to the forest". But for the poor landless Garos there is no alternative. Orchita and her husband are landless and work as daily wage workers. The days when she is not hired for labour work, she goes to the forest to collect fuel-wood. As Orchita explained:

I don't have any alternative. If I don't go to the forest and bring fuel-wood to sell, my children would be hungry. When my children are hungry they

come to me and cry. Men don't stay at home; they stay outside to look for work. They will not see when the children are crying, when men return home children are asleep. (Interview, Orchita, Garo, Gachhabari, 23 October 2008).

Therefore Garo women have no option but to carry heavy bundles of fuel-wood from the forest even during their pregnancy. When I met my 42 year old Garo participant Shulekha, carrying a heavy bundle of fuel-wood I didn't even realise that she was pregnant. Six months later when I have met her again I was surprised to see that she had given birth to a child recently. She said:

I'm considering going to the forest to collect fuel-wood soon. I can't stay at home anymore. Now I need more money for the child to buy food and clothes and to take him to the doctor if he falls sick. If I don't go to the forest, how can I take care of my child? My husband is old he can't do physical work anymore. He will stay at home and look after the child while I go to the forest. (Interview, Shulekha, Garo, Gachhabari, 1 November 2008).

Due to my urban gender bias I assumed that it was women's role to collect fuel-wood from the forest. But during conversation with Shulekha I understood it is not due to the gender division of labour but due to the restriction from the forest department. Shulekha mentioned:

Men aren't allowed to enter into the forest by forest guards. There are thousands of court cases against Garo men for entering into the forest. Men don't go to the forest because of the fear of court cases by the forest department. (Interview, Shulekha, Garo, Gachhabari, 1 November 2008).

The notion of femininity as being the preserver of the nature privileged Garo women to still enter into the forest, since the forest guards seem to believe women would not destroy forest resources as Garo men would do. This change in the gender division of labour due to the shift in livelihoods led to an intensification of women's reproductive work and an increase in labour time since women also have to cover a long distance to collect fuel-wood for their household consumption due to massive deforestation.

The meagre sources of income and support from forest resources are now under threat due the ongoing deforestation process, despite vigilant forest guards (also documented in Gain 1995; 1998 and 2002). Priya

Chisim, a 55 year old Garo woman, a mother of eight children recalls the changes:

The rice Garos used to produce during *jhum* is called *mimandi*. We used to make holes in the soil and put seeds of *mimandi* rice mixing with different types of vegetables, ginger, papaya, mustard and melon. When *jhum* was banned we started to produce rice on the lowlands⁶⁸. But *mimandi* rice doesn't grow on the low lands. We learned to cultivate "hybrid" rice from Bengalis. With hybrid rice one can't grow vegetables and fruit anymore, one can only produce rice. Many wild potatoes, vegetables and medicinal plants used to grow under the shade of big trees. We were still able to get them from the forest. Now the big trees are gone. Many vegetables and medicinal plants don't grow anymore. The number of people living in the forest area has also increased significantly. The forest has been completely plundered (*bon ujar hoye gechey*). (Interview, Priya Chisim, Garo, Gachhabari, 12 September, 2008).

The forest department and Garos blame each other for the deforestation. Garos have a saying, "*beray bagan khay* (the fence eats the garden)". Garos consider the forest as their motherland, which needs to be taken care of and allow for its regeneration for their own survival. While the forest department blames Garos for extracting the forest resources and put restrictions on their access to the reserve forest, Garos blame the corrupt forest guards, saying:

Forest guards are thieves themselves. They are vigilant at day time and restrict Garos to enter into the forest, at night they allow thieves to load big trucks by cutting valuable trees and get their share. A forest officer was caught with a huge amount of cash money under his mattress. Where this money comes from? How can the forest guards blame Garos while they are the one selling the trees at night? How can the thieves enter into the forest with their trucks and leave the forest loaded with trees without forest guards noticing them? (Interview, John Dafo, Garo, Gachhabari, 33 years, Gachhabari, 12 September).

The point here is not to prove who is to blame, but to highlight the shrinking forest resources. Given the influx of Bengali population, Garos also realised that they can no longer rely on the forest resources for their survival.

⁶⁸ Although not everyone could acquire lowlands.

This realisation has further pushed young generation Garos to migrate to the cities and look for alternative livelihoods. Unlike elder Garos, nowadays young Garos are involved in non-agricultural activities such as garment manufacture, poultry farming and working in beauty parlours. Since the 1980s beauty parlours and the garment industry became popular sectors in the cities in Bangladesh. Garo girls have managed to get access in the parlour sector due to their loyalty, hardworking attitude and fair complexion. One renowned parlour owner in Dhaka city mentioned that 90 per cent of her parlour workers are Garo girls. The parlour owner characterised Garo girls as “trustworthy”, “hardworking” and “less demanding”. However, the entry of Garo girls in the city parlours is based on a vertical relationship of Bengali parlour owners and Garo girls as informal workers. Garo girls are working at the lower strata in the parlours, while managerial work is performed by the educated mainstream Bengali girls. (Pictures 7.1 & 7.2).

Picture 7.1
Three generation Garos



Source: Researcher's photo.

Picture 7.2
Garó girls at a beauty parlour



Source: Researcher's photo.

The subsequent shift from subsistence livelihood system to commercial monoculture and beauty parlour and other informal sector changed Garó women's position in terms of gender relations in the production system. Their intra-household gender relations appear to be under constant negotiation and change as well.

7.3.5 Changing matrilineal-matrilocal norms and intra-household dynamics

The idealistic construction of matrilineal Garos, where household relations are typically characterised by mutual cooperation rather than domination (Harbison et al. 1989; Burling 1968) portrays a static and timeless gender-power relation among Garó households. However, the prevalent matrilineal system followed by Garos appears to be under a constant process of contestation and change. The discourse around the attributes of Garó men and women represents Garó women as hardworking and Garó men as lazy and not motivated to work. These attributes (women as hardworking and men as lazy) appear to be linked with their matrilineal kinship norms. For instance, Tutul Shimsang, a thirty-seven year old Garó man said:

Our women have to work hard because it is their household (*shongshar*). We can't possess any property; we have to move in to our wives' house after marriage; if my wife dies today, I will be immediately thrown out from her house; I even do not have any right over my children. What is the use of working hard? (Interview, Tutul Shimsang, Garo, Gachhabari, 3 August 2008).

Liton Shimsang was articulating a rationale for why Garo men feel discouraged to work. However Burling (1997) criticised the argument that matrilineal kinship in general or the matrilineal residence in particular can be blamed for the somewhat passive behaviour of some Garo men. Rather than pointing to the kinship system as explanation, Burling mentioned the lack of their traditional role and livelihood alternatives as a reason for such attitude. Once Garos were characterised as "worriers" and "blood thirsty head hunters" (Playfair 1905). Their matrilineal system wasn't considered a limitation in those days.

The underlying resentment in the statement above seems to arise also from the interaction with the majority mainstream Bengalis in Gachhabari. Being the majority, Bengalis project their patrilineal, patrilocal norms as an ideal norm. I have witnessed Garo marriages during which men move to their wife's house and heard members of the Bengali community saying this is ridiculous and "less civilised" than their patriarchal kinship system. Due to confrontation with these "ideal" mainstream patrilocal norms, Garo men have started to blame their matrilineal system, and a process of assimilating the patriarchal values of the Bengali society that surrounds them has started. Some, especially educated Garos are now shifting to patrilocal residence. This could have some impact on Garo women's freedom and autonomy. Some wealthy Garos are also giving a share of their property to their sons. However this depends on the parent's voluntary wish, it is not a rule. A Garo leader, Uzine Sangma, explained:

Following our matrilineal customs only daughters inherit property, but we are also Christians. In Christianity both daughters and sons inherit property. We discriminate our sons from property rights. Nowadays Garo girls are becoming more educated than Garo boys. Educated girls don't want to marry less educated boys. Our girls are also going to the cities and taking jobs in the beauty parlours and garments industry. We are afraid if our girls marry with boys from other communities, Garos will lose their land. Now we are thinking of making amendments in our inheritance law, to give land

also to sons and if our girls marry in a different community they will lose their right on their property. (Interview, Uzine Sangma, Garo, Gachhabari, 7 March 2008).

A Garo author further argues that although a female heiress (*nokna*) owns the property, if she isn't capable of managing it, the *chras* (male kin from mother's clan) have the right to take her property away and hand it over to another heiress (Nokrek 2013).

The influence of patriarchal norms and the ideal of the male breadwinner is also entering into Garo women's perceptions. As 32 years old Garo participant Orchita said:

Bengali women are privileged. Whatever their husbands buy from the market they can just cook those. Among Garos, we can't demand anything from our husband. My husband would say, "What do you expect from me? This is your family (*shongshar*), why don't you go and get it"? If I ask him to buy anything from the market he will ask money from me. I will have to go out and borrow money from others. I have pain in my heart but can't say anything. (Interview, Orchita, Garo, Gachhabari, 23 October 2008).

There also appear to be contested views regarding the gender division of labour among Garos. Although Burling (1997) argued that Garos followed a natural division of labour, other authors argue that since *jhum* cultivation there is a gender division of labour among Garos (Playfair 1909), where women's work is more restricted to subsistence production, reproduction and care (Dey et al 2013; Khaleque 1986), while men dominate in the public spheres (Bal 2000; Dey et al 2013). Discussions with a number of Garo participants reveal that Garo men and women perform different tasks, however they don't attach any value to their tasks as superior or inferior rather see them as complementary. Ginet Nokrek, a 75 year old village head explained the division of labour among Garos, saying:

We *mandis* do not make a distinction between men and women's work. Everyone can do everything. There are some tasks like cooking, taking care of the children and cleaning the house usually done by women. And some tasks such as taking care of the cattle, guarding the fields and shopping are done by men. But we don't have any restrictions (*badha dhora niyom*) that men shouldn't perform women's work or vice versa. *Mandi*

men also cook and take care of the children and wash their wife's clothes whenever necessary. There is no shame in doing women's tasks. Women also go to the market and do shopping according to their preference whenever they want to. (Interview, Ginet Nokrek, Garo, Gachhabari, 12 December 2007).

Despite the different interpretation of division of labour among Garos, Garo men surely dominate in public affairs. At the same time the matrilineal system offers Garo women freedom of mobility in public spaces, a total absence of *purdah* norms. The owner of a beauty parlour in the capital city mentioned that Garo girls could make their space in the beauty parlours due to the fact that they do not have restrictions on their mobility. Bengali girls wouldn't be allowed to move alone to the cities to work in the parlours.

Discussions with a number of Garo men and women reveal a paradox in women's position in the matrilineal Garo household. Women are seen as head-worker, confident, moving alone in public spaces without any hesitation and can work in the field as wage labourers. At the same time they are also expected to show respect to their husbands. This is reflected in the fact that during my household survey women mentioned their husband's name as household head except for the households with no adult male. In a discussion, a 40 year old educated female Garo participant Khushi Machi said,

Nowadays I see husbands manage everything. They only ask for our permission. Without our signature they wouldn't be able to sell our land. Husband will say, there is no other option but to sell the land. What do you say? We have no option but to say "yes". We are matrilineal, women have more power on paper. But we show respect to our husbands. If we don't give them permission they wouldn't be able to sell the land. But we think what he is doing, is doing for the best interest of the family. (Interview, Khushi Machi, Gachhabari, 26 October).

Although the general impression is that Garo women have more power in decision making than their husbands, the narrative above shows how women's decision is taken in a symbolic sense. Analysis in the previous chapters further showed Garo men showed reluctance towards vasectomy. Although condom use was proportionately higher among Garo than Bengali men, more women than men take the contraceptive responsibility. Despite no restrictions on mobility Garo women

hardly used hospital services during pregnancy check-ups and child delivery.

A paradox was also reflected in the discussion around wife-beating among Garos. There were rumours in the village that Orchita's husband is alcoholic and he beats her occasionally. This did not match my pre-assumption about Garo women's autonomy and the strong role of *ma'chong*⁶⁹. I asked Orchita why she didn't complain to her *ma'chong* against her husband. Her response was:

When he makes a mistake I think OK this is the first time, he might not to do it for the second time. When it happens for the second time, I think OK give him another chance. If I complain to my *ma'chong*, my relatives will call his relatives and both parties will decide to give him a punishment and ask me if I would still be willing to be married to him. If I decide to break the marriage then my children will lose their father. He will have to leave this family. I am still having patience. Let's see how it goes. If he doesn't change at all I have to bring it up to the attention of my *ma'chong*. (Interview, Orchita, Garo, Gachhabari, 23 October 2008).

To give the other side of the story, when I asked Orchita's husband, the reason he gave me was, some days he goes out to look for day labourers' work but finds nothing. When he comes home with frustration his wife starts to complain based on the suspicion that he might have earned something and spent on alcohol, which he claims not to be true. Unless he beats her she would not stop complaining.

Contradictory views were also expressed by local Bengalis reporting that Garo husbands get beaten and kicked out from the house by their wives, fabricating and ridiculing Garo men's weak masculinity.

During conversations with Garos when I asked for the reason of wife beating despite having a strong matrilineal system, the common answer I received was, "there are good and bad men among Garos and Bengalis, only bad Garos will strike their hands on their wives like bad Bengalis, it is not a matter of patrilineal or matrilineal system".

We cannot generalise the experience of Orchita to the situation of all Garo women. However, it does indicate the need for some nuance in our understanding of the intra-household gender regime among Garos,

⁶⁹ Among matrilineal-matrilocal Garos, maternal kin (*ma'chong*) regulate all public affairs including family disputes.

which is often portrayed as “pure” harmony. The slow shifts in terms of patrilocal residence and inheritance rights to sons (although voluntary), as well as the changing discourse about men as household heads challenge a fixed, timeless romantic idea about matrilineal kinship system among Garos. Despite all these changes that have been going on, based on my observation, I would like to emphasise, the Garo matrilineal system still offers women a higher status. *Ma'chong* does play a significant role. If Orchita's husband is found guilty, he will be punished impartially. Garo women's higher autonomy (compared to Bengali women) is certainly reflected in terms of their ownership of household resources, higher education, freedom of mobility and access to wage work.

In reference to the study of Dyson and Moore (1983) and Harbison et al. (1989) mentioned earlier in relation to the influence of kinship patterns on women's status and its link to fertility, the evidence of Garo women's experience suggests that kinship pattern alone cannot explain women's agency in reproductive behaviour. The complexities and combination of multiple factors - the politicisation of ethnic identity, erosion of matrilineal norms, changes in livelihoods, influence of the Church and intra-household power dynamics – all shape the gender power relation to inform fertility decision among Garos.

To preserve the Garo community which is seen under threat Garo women “choose” to have more children. Although this choice is made under political and economic constraint it would be wrong to characterise this as implying community control over women. Garo women's agency has to be understood as intersected with ethnic identity and is reflective of a relational (Joseph 1993; Mahmood 2001; Evans 2013; Wilson 2013) rather than an individualistic notion of agency.

However the story does not end here. Despite the choices made there are indications also of younger Garo women who are taking reproductive decisions for smaller families. Among the young generation Garos, as a result of access to education and especially employment opportunities in the cities the desired number of children has declined. The ideal family size was two among younger women. Younger Garo women don't see the need to have higher fertility anymore and relate lower fertility with the notion of modernity. Kazoli, a twenty year old Garo woman, who finished her secondary school education, working in the most popular beauty parlour in the capital city, represents the sentiment of younger generation Garos:

We are educated; we earn enough money to support our families. We can afford to buy mobile phones and nice clothes nowadays. Our parents were disadvantaged; they lived in the forest, they didn't have access to education. They were also not aware of family planning methods. (Interview, Kazoli, Garo, Dhaka, 5 June 2008).

Kazoli has one daughter. She thinks having two would be enough. She looks forward to providing her daughter with higher education and a better future. Many educated Garos mentioned that with the increase in education Garos are becoming self-aware. In Kazoli's words, "Education makes us aware of raising children properly and giving them higher education. It would be hard to raise children properly if we had many". Like Kazoli, many other younger generation Garos are becoming educated and moving to the cities. They might experience less control from the Church over their lives. At the same time they are also confronted with new challenges. The cost of raising children in the cities seems to be a concern. As the preserver of their ethnic identity they face the risk of loss of their property right should they choose to marry outside their community. Education and migration to the cities certainly increase this possibility. As the biological reproducer of the matrilineal community would they prefer daughters over sons, given the cost of raising children in the cities? Or would they subscribe to the mainstream norms and son preference would take over?

Since the younger Garos have not yet crossed their reproductive age what their fertility choice would be depends on how the intersection of gender power relation in the household, the community, the labour market and their relation to the state take shape in the years to come.

7.4 Conclusion

Given the distinct position of Garo women in their matrilineal system in terms of access to household resources, freedom of mobility to wage work, higher age at marriage and relatively higher education compared to Bengali women, I expected it would provide them more autonomy in terms of reproductive decision making to such an extent, that they would have a lower fertility in comparison to the patrilineal Bengalis. However, this was not the case.

Garo men and women's voices presented in this chapter suggest that ethnic differences in reproductive behaviour are not only based on cul-

tural norms and values, but deeply embedded in the structural system which has far reaching political and material implication based on inclusion/exclusion in access to resources in the broader social system. Ethnic categorisation based on cultural difference and matrilineality does not capture the political dimension of ethnicity.

The historical evidence provided in this chapter shows that Garos have historically been marginalised by their “othering” by the colonial, post colonial and contemporary Bangladeshi state. Earlier Garo identity was rooted in their *jhum* cultivation, which was banned by the state authority and Garos were denied their rights over communal land and forest resources. Gradually, Garos became a tribal minority group in their own ancestral land surrounded by a majority migrant Bengali community.

Relatively high fertility among Garo as compared to Bengali women may be partly due to their strong desire for daughters due to their matrilineal norms. Despite experiencing poverty that pushed Bengalis to reduce their fertility, alternative livelihood opportunities for young Garo boys and girls, Garo women had relatively higher return from children. The emphasis on high fertility was also triggered by religious injunctions from the Church against contraception. However the most interesting finding regarding the reasons for the relatively high fertility of Garo women was linked to the politicisation of ethnic identity. As a response to dispossession, exclusion, and displacement by a migrant majority Bengali community, and state repression Garos have organised and launched numerous struggles to reclaim and retain their land and identity. In this highly charged political context the threatened Garo community valued and promoted high fertility.

The analysis in this chapter has suggested that Garo women’s relatively high fertility compared to the majority Bengali community is an outcome of their perceived need for group survival, and their preference for daughters to carry on their matrilineal system is to ensure claim and reclaims for land which has been codified and registered in women’s names. Sons were also welcomed to increase the force of their struggle and resistance.

Although the Garo ethnic political identity does enforce a collective consciousness to increase their numbers, which can be interpreted as a subversion or subsumption of individual women’s choice and agency, Garo women asserted their ethnic gender identity in making a “choice”

to have a higher number of children. Other studies among minority groups (Sahu, Wissen, Hutter and Bosch 2012; Kulkarni 2002; Gangadharam 1999) show similar findings, arguing that high fertility amongst minority groups is the result of vulnerability due to their socio-economically disadvantaged position.

Based on the evidence presented, it can be argued that considering Garo women's fertility as rational individualistic choice would divert attention away from the multifaceted aspect of the context where a complex combination of politicised ethnic identity based on exclusionary experience, inter-ethnic tensions, religious ideology and matrilineal norms and relative economic return from children all intersect and interact to inform reproductive decisions.

8

Conclusion

This study set out to question aspects of the Bangladesh “success story” of significant fertility decline coupled with persistent abnormally high maternal mortality. To provide insight into this anomaly I examined the existing discourses used by a variety of development actors namely donors, government bureaucrats, research institutions, development NGOs, and political parties as well as women’s organisations based on interviews, along with a content and argumentation analysis of policy assumptions and health care service delivery mechanisms and most importantly, the voices of rural poor women (both mainstream as well as tribal). Underpinned by a feminist standpoint approach, I have tried to bring women to the centre of my analysis by documenting the ways in which they subjectively constructed meanings and explanations of their reproductive practices and choices. This allowed for the expression of multiple interpretations shaped by the subjective experiences derived from the distinct position that rural women occupy as members of a household and an ethnic group. The findings hopefully have provided a counter point, a different perspective on the Bangladesh success story on fertility decline.

In this concluding chapter, I first summarise the key findings, and conclude with reflections on the implications of this study for policy and further research.

8.1 Main Findings

8.1.1 The state: Policies and discourses

Although reproductive rights are enshrined in the national population policy documents, the reality of rural women’s experiences in this regard are rather complex. While Sen suggests (1992) affirmative actions by the state to ensure women’s health and wellbeing, this study hopefully provides insight into how the multiple actors and institutional arms of the state contain forms of covert power through policies, discourses and knowledge produced by disciplinary institutes to govern reproductive behaviour of women to ensure macro-economic development goals.

Concern about “high fertility” as the main cause of poverty among the poor, interwoven with the national concern about macro-economic development, leads the Bangladeshi state to align fertility reduction with the broader imperatives of development goals. Analysis showed that the national population policy is subject to global power structures. Due to donor dependency the government incorporated reproductive health in the population policy in the wake of ICPD in 1994. However, the incorporation of the reproductive health agenda, although progressive, was underpinned by an intention to mobilise greater acceptance for fertility control. This is reflected in the continuous setting of progressive targets for fertility reduction in the post ICPD policy documents.

At the same time, lack of real commitment and resource constraints have led to a shift away from a comprehensive reproductive health agenda to a narrow “Essential Service Package” approach, offering limited choice for poor women. National and international policy actors have chosen to interpret what is essential in order to achieve macro-economic goals even to the detriment of poor women’s health and well-being. As elaborated in Chapter Three, to operationalise the ICPD commitment to provide integrated reproductive health care services, the Health and Family planning wings of the MOHFW were integrated in 1998. Despite positive evidence emerging in terms of maternal mortality decline after three years of integration, two implementing wings were separated again partly because the decline in maternal deaths was not accompanied by the targeted level of fertility decline. Following the same logic, despite having positive results, the maternal voucher programme to ensure EmOC during childbirth has been withdrawn in subsequent policies. The overall determinants of the population policy reflect neo-liberal principles proposing public-private partnerships to ensure health equity in which access to broader reproductive health care for all sections of the rural population remains less of a priority.

The state however is not unitary in its intentions and involves and influences a range of different interest groups and actors. Analysis of the discourses and meanings associated with reproductive health of donors, government bureaucrats, NGO service providers, and political parties show, despite some variations, there is an overarching alliance of ideology that support family planning programmes as a means to achieve fertility reduction for macro-economic development. Women’s reproductive health was seen in instrumentalist terms to achieve the fertility goal

and little attention was paid to the existing structure of inequality and unequal gender relations that result in the poor reproductive health of women.

In addition, despite variations amongst these policy actors there was also a common assumption that rural women in particular were homogenous, powerless, and ignorant victims of culture. Policy and discourses paid little attention to men's role in biological reproduction and male responsibility, thus family planning programmes remained mainly female focused.

Policies based on "evidence" such as the Bangladesh Demographic and Health Survey produced by official research institutes, interpreted data in a limited way. Data from the large-scale surveys do not delve deeply into gender, class, and ethnic differences and power relations. For example the use of long-term contraception by rural poor women is interpreted to mean that they prefer this method rather than the safer short-term methods. Since these researches are conducted to provide evidence to inform policies, the construction of rural women's reproductive needs by these research institutions becomes "truth". This justifies the policy shift from short term to long-term contraception and fosters the interests of a powerful alliance of health service providers, international donors and multinational pharmaceutical companies. Provision of long-acting (implant) and permanent contraception (sterilisation) under donor supported Essential Service Package (ESP) in the public health care system through offering incentives to the poor further shapes the reality by shaping contraceptive practice of the poor.

In contrast it was seen that the evidence, production of knowledge, discourses and strategies of women's rights organisations are different. Reproductive health is conceptualised in relation to women's subordinate position, patriarchal norms and unequal gender power relations. In terms of strategies these organisations argue against privatisation in the health sector and advocate for a universal access approach. Rather than seeing women's need only for one type of contraception, they advocate for a wider range of contraceptive choices as well as reproductive health care services.

Although critical of the population control objectives of the policy, at the same time women's organisations recognise that availability of contraception and menstrual regulation services, even if currently not a free choice, could be empowering for women. There are variations in how

they see the pathways for reproductive health ranging from total opposition to the policy to advocating for improvements within the policy; a welfarist approach. Strategies towards the state follow an “in and against” approach. From the discussions with these organisations a certain ambiguity emerges; despite a strong critique of the policy, they do not use the language of women’s reproductive rights. This strategy is similar to other South Asian context, where some women’s organisations choose to use the language that has greater resonance with their localised struggle for gender justice (Unnithan and Heitmeyer 2015). A major absence in their strategies are the concerns of tribal rural women and in that sense they also treat women’s needs as being self-evident and homogenous.

8.1.2 Intra-household dynamics in use of contraception

The deconstruction of the multiple discourses of actors discussed in Chapter Three revealed the assumptions underlying the policies and pathways towards women’s reproductive health and rights. The ways in which women’s subjectivities are constructed and normalised in policies and discourses, projects the use of contraception by women as an indicator of women’s agency and empowerment, however the findings of the study point to a more nuanced picture.

Voices of poor rural and tribal women provide insight into how a complex interplay between gender, ethnicity and economic forces shape contraception and menstrual regulation/abortion practices. There is a widely shared perception among Bengali men and women alike that vasectomies reduce men’s physical and sexual power. The local cultural construction of masculinity and men’s role as the breadwinner therefore discourages households to use male vasectomy. It is important to note that although the conventional male breadwinner norm is not strong among Garos in the same way as Bengalis, Garo men also showed reluctance towards male sterilisation. At the same time, condoms seem to be perceived negatively due to a range of concerns including cost, pleasure, reliability, gossip and fear of mistrust. Nonetheless more equal gender relations in the household seem to be reflected in a proportionately higher condom use among Garos as compared to Bengalis. Ideological restrictions against invasive modern contraception methods such as implants, vasectomy and abortion partly made Garos more dependent on natural methods and less on menstrual regulation and abortion services.

However it is interesting that older Garo women mentioned when they encountered livelihood insecurity due to the abolition of their traditional cultivation system and scarce forest resources because of the pressure from the mainstream Bengali population, they resorted to sterilisation in the mid-1970s. This was due to sterilisation being the only method available in the village in earlier times.

The adoption of contraception by both Bengalis and Garos shows that women in both communities take on the major responsibility. This is not the result of women's autonomous choice, but is the outcome of negotiations within the household where notions of masculinity and femininity are linked with different contraceptive methods. A range of perceptions come into play in the choice of methods such as loss of masculinity, diminishing of male sexual pleasure, suspicion, preference for temporary methods as well as the cost of condoms for poorer men, which all combine to influence women to take on the burden and risks of contraception.

This process is reinforced by the way family planning programmes have been designed, focusing mainly on women, requiring minimal participation from men, hence reproducing existing gender inequality. The assumption that contraceptive use equals women's empowerment is based on an individualistic understanding of agency and does not capture the dynamic gender relations in patrilineal and matrilineal households and the process of negotiations that shape the outcome of contraception choice.

Strategically or inadvertently, the neoliberal orientation of this policy is reflected in targeting women as clients – soft targets in a marketing strategy which does not challenge intra-household gender power relations. Other studies also point out that intra-household spousal communication for contraception use and husband's participation in the management of side-effects and complications of contraception remains overlooked in the policy (Choudhury, et al 2012). Indeed the policy shift in the mid-1990s further legitimises the focus on long-acting contraception for poor women, which reduces their choice to withdraw in case of side-effects. The shift also implies the imposing cost of condoms, which puts pressure on poor men to use contraception since condoms are no longer free. Given the voices of poor men in Gachhabari and their preference for temporary contraception, particularly among the Garos, their choice is not reflected in the policy.

Similar dynamics enter into the use of Menstrual Regulation (MR) services (included under contraception in the policy documents). Although MR is legal, requirements of consent from the husband (or a male relative) reinforces a gender hierarchy. Due to the stigma associated with the sexuality of older women, rather than using MR, these women resort to self-induced abortions to maintain secrecy, while married women who cannot meet the official requirement or manoeuvre the system by paying a price, resort to cheap, illegal dangerous services. This evidence shows that while women are able to negotiate to exercise their choice and agency within the household to regulate their fertility, they also face constraints in the health care market. This suggests the importance of looking at health care constraints that shape women's reproductive practice.

8.1.3 The question of access to health care services in rural Bangladesh

The deconstruction of underlying policy assumptions underpinning the health care service delivery mechanism (Chapter Three) portrays an individualistic notion of agency, detached from the cultural context. The assumption is that if health care services are made available in rural areas women will access them without any problems.

Despite the availability of the services, voices of poor women in this study have provided insight why the majority of the poor Garo and Bengali women gave birth at home in the presence of Traditional Birth Attendants (TBAs) or relatives. Both Bengali and Garo women spoke of the cultural and structural constraints which render access to formal health care services difficult for them.

Rather than a static notion of rigid cultural norms constraining women, evidence shows that cultural norms are fluid and subject to reproduction, transformation and change. Although some Bengali women spoke of giving birth in the hospital as *bepurdah* (violation of purdah norms), at the same time *purdah* norms were lifted a bit when they, especially poorer Bengali women, had to go to the forest to collect fuelwood. Garo women on the other hand were neither confined in the household nor experience restriction on their mobility in the public spaces. Yet, they also rely on home deliveries assisted by Traditional Birth Attendants (TBAs).

The reliance on TBAs was due to trust and an acknowledgement of their knowledge and skills. This was reflected in the distinctions made between normal and complicated delivery. Only in cases of severe complications did women use hospitals. A class differentiation was also evident with poorer women stressing that doing daily household chores helped in having normal deliveries. Cynical and slightly mocking statements saying women from rich households need to go to the hospital due to their inability to deliver at home “normally”, was also an expression of the fact that poor women could not afford to go for pregnancy check-ups and institutional care.

As other studies also pointed out significant changes have occurred in Bangladesh in terms of women’s education, labour force participation and change in cultural norms related to sexuality (Siddiqi 2014; Hossain 2012; Rashid 2007; Aziz and Maloney 1985) and the idea that cultural factors are inflexible, can no longer be considered as a constraint to women’s access to institutional childbirth services.

The issue of access to health care services is also linked to the productive and household reproductive tasks of rural women. Particularly for the poorer Garo and Bengali women there is a trade off between the responsibility and labour time required for household reproductive tasks and getting better health care for biological reproduction. For Garo women it also means calculating the loss of income from wage labour. Even if services are made absolutely free and available in the sub-district hospitals, these women’s work responsibilities in the household and outside are difficult to negotiate in favour of their own well being. This is reflected even in rejecting the need for a Caesarean in a complicated delivery, since it could affect their work capacity.

This linkage with women’s responsibilities for household reproduction is rarely acknowledged in policies and is invisible in discussions on family planning policies in Bangladesh. For instance, in the wake of ICPD, the debate around the shift from doorstep service delivery to community clinics in the integrated health care approach used a different logic arguing that women’s mobility to the community clinics will facilitate greater empowerment of women which was constrained during doorstep service delivery (Schuler 1999). The tacit assumption underlying such a policy shift, is the notion that women’s time is “infinitely elastic” (Elson 2002) and assumes a causal link between women’s mobility and empowerment.

The problem of non-utilisation of formal health care services, however is also due to the quality of the services in rural areas. The study has revealed some of the hidden costs due to the lack of diagnostic facilities and other logistics, doctors' absenteeism, lack of privacy and inadequate quality of care in the public hospitals. In the absence of affordable and adequate quality services in the formal health care system, poor men and women continue to rely on informal networks and private providers with uncertain, even harmful practices. The quality of care in the sub-district hospitals as expressed by poor women, is tied with the neoliberal policies that discourage investing in public health care systems and advocate dual health care systems, consisting of a private system for the well-off and a public "safety net" for the poor. Despite government commitment, policies and discourses (discussed in Chapter Three) show that public health care service delivery has been compromised due to resource constraints. This situation mirrors the broader health care situation in Bangladesh where more than 80 per cent of the rural population are dependent on private and informal providers for health care need including sexual and reproductive health (Rashid et al. 2011).

In policy language, persistent health inequality is interpreted as "low use of public health care services" due to "lack of demand for maternal health care". Framing health inequality in this way, justifies confining intervention only in terms of improvements in service delivery, leaving unequal gender power relations unaddressed. One hidden/silent area in the policy discussions and discourses is how multiple levels of gender power relations come to interplay in creating existing health inequality.

One interesting finding on childbirth practices is that in both Garo and Bengali communities, childbirth is seen as women's business, therefore men stay outside the realm of decision making. This suggests that the problem of not availing formal health care services during childbirth is not due to women's subordinate position or less bargaining power in the household, but linked to other aspects of inequality such as class and ethnicity.

8.1.4 The intersectionality of women's agency

This study has provided insights into the multifaceted aspects of agency in reproductive decisions. Despite constraints and controls, women from both communities want to have control over their bodies and full access to quality health care service. In the prevailing context they show resil-

ience and use different strategies at their disposal to deal with side-effects of long-term contraception, switch between different contraception methods or seek help from their husbands to buy contraceptive pills or to get medicine to treat side effects from their local pharmacy. Women also use cultural norms to their advantage to negotiate for MR or manoeuvre official rules to use MR services or use secret abortion services, although this jeopardises their bodily health and wellbeing.

I started this study on the premise that given the differences between the matrilineal Garo community and the patrilineal Bengali community, Garo women would have more autonomy and opportunities to express their own agency in relation to reproduction as compared to the Bengali women. However, the voices of tribal Garo men and women demonstrate how ethnic differences are not only based on cultural elements, but deeply rooted in the structural system which has far reaching political and material implications, which shape their reproductive decisions.

As elaborated in Chapter Seven, Garo women's subjective identity is based on the experience of exclusion from the state authority by the banning of their traditional livelihood systems, the denial of access to their ancestral land and forest resources and their exclusion and marginalisation in forest development projects.

Garo women still enjoy considerable freedom and autonomy in their matrilineal kinship system compared to mainstream patrilineal Bengali women. They have rights to ownership of land and household resources, have choice of marriage partner, practice mainly matrilocal residence, enjoy freedom of mobility in public spaces and have access to independent income from wage labour. As elaborated in Chapter Seven there have been changes over time eroding some of these features. While earlier, Garo women could engage in pre-marital sexual relations without stigma, now with the influence of the Church this is not sanctioned. There are also shifts towards patrilocal residence and restrictions on divorce and abortion. Although the Garo household today is not patriarchal in a classical sense, an erosion of women's fallback position (particularly the loss of communal land) and the emergence of new gender hierarchies have given men more bargaining power. Men still need to ask for agreement from women on various issues and cultural norms of gender equality still exist but there are significant changes.

The evidence suggests that Garo women's decisions on fertility and other reproductive health choices are less rooted in intra-household

power dynamics than in broader socio-economic and political factors. First of all, due to their matrilineal kinship system Garos desire to have daughters to carry on their lineage. Secondly Garos have become a minority group on their ancestors' land due to the influx of migrant Bengalis in the area. This has created pressure to preserve a collective identity as a community and the need to increase the Garo population for group survival. Thirdly is the role of the Church which provides security and refuge along with an ideological influence towards larger families and avoidance of modern contraception. A fourth factor is linked to their ethnic political identity. *Jhum* cultivation, which was the subsistence livelihood system among Garos has been banned and Garos have lost their right over communal land and control over forest resources, on which they were dependent for generations. The political struggle to regain communal land rights puts unspoken pressure on the Garo community to increase its numbers. To maintain the boundaries of the community and a communal identity Garo women who wish to marry outside the community are threatened with expulsion and loss of property rights. The combination of these factors has meant that Garo women want to have more children which is reflected in the surprising finding that they have not lower, but slightly higher fertility outcomes as compared to the Bengalis in the village.

It has been documented that different historical situations can enforce certain ethnic projects that benefit members within a community in different ways (Chhachhi 1992). The Garo ethnic political project does enforce a collective consciousness to increase their numbers. Rather than seeing this as a subversion or subsumption of individual women's choice and agency, Garo women asserted their ethnic gender identity in making a "choice" to have a higher number of children.

Understanding Garo women's fertility choice calls for, what Saba Mahmood (2001: 225) stated, a particular openness to be aware of the diversity of women's needs and interests, which are profoundly mediated by different capacities and desires that are historically and culturally specific. Garo women's articulation of their desired number of children reflects constant negotiations between their ethnic identity, matrilineal norms, ideological belief and livelihood reality. This finding challenges any drawing of a simple linear equation between low fertility and women's agency based on conventional indicators of empowerment

which is embedded in official policy assumptions and discourses and in many studies on population, as well as in some feminist positions.

Interpreting Bengali and Garo women's reproductive decisions as rational individualistic choice detached from the cultural context and existing structures of inequality (as neoliberal policy suggests), ignores the complexities of culturally defined conjugal contracts, differences between patrilineal and matrilineal systems as well as the broader political and socio-economic context which shape gender power relation in reproductive decisions.

The structure of the Bengali household is closer to that of a classic patriarchy and intra-household relations are negotiated often around men as breadwinners. Women's strategies in this context tend to be covert, without openly challenging the gender hierarchy. The pattern is similar to that mentioned as characteristic of South Asian households where women negotiate a "patriarchal bargain", keeping up the notion of men as breadwinners and protectors versus abandonment, insecurity and possible violence that may ensue with open confrontation (Kandiyoti 1988; Kabeer 2011; Feldman 2001; Unnithan-Kumar 2000).

Women's real life experiences articulated through their own voices indicate the need to deconstruct the conceptualisation of agency in policy and development interventions. The evidence provided in this study, firstly challenges the notion of Bangladeshi women as a singular monolithic subject (Mohanty 1991a). Secondly it reiterates the importance of considering context and culture in understanding agency. Thirdly, it shows how multiple layers of power relations such as economic factors, gender and ethnicity intersect and interact to shape agency in reproductive practice.

8.2 Policy Implications

The findings of this research have a number of implications for future policy formulation and health care service delivery. In order to create an enabling condition for poor men and women to exercise their reproductive choices a number of issues demand attention.

First, there is a need to revisit underlying assumptions, biases and silences in the policy. Policy analysis (discussed in Chapter Three) shows how poor reproductive health has been conceptualised, defined and interpreted as a result of poverty and higher fertility, which legitimises a

policy approach prioritising family planning over ensuring broader health care. Policies, in fact, need to revisit the very assumption of the household. The underlying assumption in policy is a unitary model of the household, where family planning is offered to “couples”, while more than 90 per cent of contraceptive users are women. Since the beginning of the family planning programme the government has recruited only female family planning workers to motivate women to use contraception. Interviews with service providers showed that they assume it is easier to motivate women rather than men to use contraception. The tacit assumption that the use of contraception equals women’s agency and empowerment, justifies female focused family planning programmes, keeping men outside. Despite the availability of male contraception, its use has remained almost static at the 1970s level. Ensuring gender equality also requires men to share the contraceptive responsibility. Among Asian countries, Thailand has achieved significant success in male participation in contraception use. The Bangladesh family planning programme could learn from their experience.

Second, the findings of this study indicate the need to deconstruct the notion of women and their needs as homogenous. This study provides insight into how the choice of contraception is shaped by notions of masculinity and femininity and their complex interaction with access to various types of contraception in the public and private sector as well as religious ideology. Another comparative study (Hutter and Sahu 2012) found that Hindu women prefer long-term contraception, which is reflected in the popularity of sterilisation in India (Saavala 1999), while Muslim women prefer temporary contraception. My study yields similar findings, indicating a mismatch between women’s preference for the pill and the supply driven family planning programme that promotes long-term (implant and sterilisation) contraception for poor Muslim women. The fact that women with four living children can be denied an implant and persuaded to use sterilisation reflects this mismatch.

The preference for the pill among most women of all ethnic groups and the fact that some women complained of side-effects from government supplied contraceptive pills, indicates that the cost of contraception remains a concern to access short term contraception (the pill and condoms), since the policy shifted its focus to long-term contraception along with permanent contraception. This could explain the fact that more poorer women did not use any contraception. Besides the preference for

the pill, my research further found a relatively greater preference for natural methods and condoms among tribal Garos. If condoms were free, it could reduce the dependency on natural methods and the risk of unwanted pregnancies among the poorer Garos. These findings have implications for policies to address reproductive health needs among tribal populations. As Kulkarni (2002) points out when there is diversity (cultural, ethnic or religious) between various population groups, a population policy might give priority to the concerns of dominant groups at the cost of the disadvantaged and minority groups. In such cases South Asian scholars have suggested that health care systems need to be responsive to context, gender and age specific health needs of the local population (Unnithan-Kumar 1999).

Third, privacy, confidentiality and informed consent need to be ensured in the service delivery mechanism. Men's narratives confirm how stigma attached to vasectomies puts a constraint on men to choose this method. The unwritten rule of going to the health facility with a health worker from the community puts men at risk of being exposed. Informed consent implies providing proper information and management of side-effects, counselling and health check-ups. It also implies men and women should be given the freedom to withdraw from contraception at any time if they wish to do so.

Fourth, MR services need to be made available to reduce the risk of illegal and harmful abortion practices. Women's experiences revealed that although MR has been made legal up to 10-12 weeks of pregnancy, it is not possible to receive the service beyond 8 weeks due to the lack of adequate medical supplies in the sub-district hospital in the research area. If the MR service were used properly it would offer women the opportunity to reduce the risk of illegal and back-door services, during the period from 8 to 12 weeks to terminate unwanted pregnancies.

Fifth, ensuring health equality and providing emergency obstetric care (EmOC) during childbirth require a stronger government commitment to provide adequate and quality health care to all. It implies real commitment to strengthen the public health care system. As compared to other South Asian countries Bangladesh is far behind in investing in the public health care system (Nazneen 2001; BHW 2010). Countries like Sri Lanka and Malaysia (The World Bank 2009) are examples where maternal mortality has been reduced significantly by strengthening the public health care system. Kerala in India has shown that even with modest fi-

nancial resources it can have a huge impact on reducing maternal mortality by strengthening the health system (Freedman 2003, Freedman 2005, USAID and others 2012). Bangladesh can learn lessons from these countries.

The quality of care in the public hospitals remains a constraint for women. Poor women still continue to be dependent on the TBAs and other informal providers for childbirth and other reproductive health care needs, due to the absence of adequate and quality care for the poor. Women's narratives show how their household reproductive work responsibility remains a constraint to go to the hospital (which is approx. 10 km away). The provision of "normal" delivery services at the community level would reduce the opportunity cost of poor women by reducing their travel time. Only in case of complicated deliveries women need to be referred to the hospital. Re-introducing the maternal voucher programme could contribute positively to the reduction of the amount of maternal deaths.

Sixth, the role of the local TBAs as a catalyst needs to be acknowledged in the formal health care system. This study highlights how TBAs play an important role during home deliveries, including in many instances recommending women to seek professional care and even joining them at the hospital. By integrating TBAs in formal government training schemes, they can act as a catalyst between the community and the formal health care system. Above all, women's unequal access to services due to their class, gender, labour demand, location and ethnicity has to be taken into consideration in the policy to provide women with a conducive environment to exercise their right to safe childbirth practices.

Seventh, policies need to ensure male participation in maternal health care services. One of the findings of this study is that childbirth is seen as women's business, therefore men stay outside the realm of decision making. Hence, many men may not understand or recognise the symptoms of complications. This study also found that elder women play a significant role in both communities during childbirth. In addition, where women's position in the in-laws' house is often considered as a barrier to seek care during childbirth, this study shows women also move to their parental house before delivery as a tradition in rural areas. Following the matrilineal custom, Garo women live close to their mother and sisters and never move to their in-laws' house. Therefore awareness

training among men and elderly women that have influence in decision making might positively contribute to seek care in time.

Finally, my research findings raise some questions regarding the “Framework for Tribal Peoples Plan (TPP)” (upgraded in September 2015) adopted under the Health, Population and Nutrition Sector Development Programme (HPNSDP) for 2011-2016. The underlying assumption of this framework is that higher fertility among the “tribal population” is a result of the under-serviced and under-funded health care system (Planning Commission 2012:2). The solution was suggested only in terms of improving service delivery by extension and renovation of existing facilities and building new ones in tribal areas (Planning Commission 2015:1).

The assumption that poor rural/tribal women lack demand for maternal health care service also is contradicted by my research findings. My study suggests that the low use of public health care services is not mainly due to women’s ignorance, but rather due to the poor quality of care, hidden cost, opportunity cost and doctors’ absenteeism and negligence. One major area in which the policy discourse urgently needs to better reflect reality is to recognise how class inequality, market mechanism and ethnic differences create the existing health inequality among tribal population.

8.3 Contribution to the literature and implication for further research

As already noted, my research hopes to have provided an alternative perspective to the family planning success story of Bangladesh. Scholarly debate around fertility reduction in Bangladesh mostly revolves around the question of whether fertility reduction is directly linked to family planning programmes or whether other socio-economic factors contribute to a motivational change towards adopting smaller families, in turn creating a demand for contraception. This micro level study places women in their local context and cultural setting. Men and women’s voices provide a deeper understanding of how complex social factors interact, intersect and inform each other to shape women’s agency in reproductive behaviour. Based on voices of Bengali and Garo women how they experience and navigate power in the household, community and the market in relation to their reproductive practice, my study con-

tributes to the literature on agency showing the multifaceted aspect of agency, contrary to the rational individualistic notion of agency.

However, it is not possible to cover all aspects of reproductive health practices within the scope of a PhD dissertation. Several crucial issues for future research can be mentioned here.

Sexual rights are an integral part of reproductive rights (Germain 1996) and most of the policies related to reproductive health are based on publicly accepted notions of sexuality (Menon 2007; Karim 2012). Sexuality is one of the major silence areas in policy discourse, but deserves proper research and policy attention in its own right. I recommend, as a matter of urgency, future research to investigate how unspoken assumptions around sexuality issues play a role in population policy formulation and how that in turn affects the access to reproductive health services for those who do not fit within the conventional definition of a “unitary family”, particularly among adolescents.

My study focuses on three components of reproductive health listed in the ICPD programme of action, namely access to contraception, access to safe delivery and access to safe abortion. Similar research is required covering other reproductive health components to broaden the understanding of the reproductive health situation of Bangladeshi women. These components are infant and child care, male participation and responsible behaviour, adolescent reproductive health, infertility treatment, reproductive tract infections, sexually transmitted diseases, HIV/AIDS, cancers of the reproductive tract and reproductive health needs of the disabled.

While this study contributes to an in-depth understanding of women’s agency in a rural setting, further research is needed to cover urban areas. Studies have indicated that reproductive health conditions among adolescents both in urban areas especially among slum dwelling urban poor (Rashid 2007; Rashid 2012), and in rural areas (Bosch 2005), require serious attention.

Another area for further research is how women adjust, cope and deal with their reproductive health needs in their new circumstances due to displacement and migration. As the study shows, some women return to their parental home before giving birth especially during the first childbirth. Usually women also move from an urban area with more health care facilities to a rural area where health care facilities are poor or ab-

sent. These women also face problems due to the loss of their usual network and become dependent on older women, usually their mothers. Bangladesh is a disaster-prone country with a high risk of floods, cyclones and river bank erosions, where displacement and migration are a common phenomenon and these women face great risks.

Another important aspect which requires further research, is the effectiveness of different service delivery approaches. My review of population policies showed that over time, the health care service delivery practice has switched back and forth, between door-to-door and community clinics, or a combination of both. A comparative study between consecutive implementation strategies at the national and cross-country level is required to establish a plausible recommendation. However, it has to be noted that the health outcome is not only determined by service delivery as this study shows. It requires addressing other socio-economic and cultural factors that constrain health care access as well as the criteria (fertility decline or reduction in maternal deaths) against which the success of the programme implementation is assessed.

My study raised serious questions regarding the increasing numbers of Caesareans at the national level. Is this because access to the service has improved? Does the commercial interest of private doctors play a role? National data shows that six in ten births at the health facilities are now done by Caesareans, of which two thirds are done in private health facilities. Macro level data further shows a difference in terms of urban versus rural areas as well as among rich versus poor women. The question is whether the difference is due to the varying access to the services or due to a difference in perception. My study found that poor women reject Caesareans because it might affect their ability to perform their household work, they also find it unnecessary. However, the study is very context and culturally specific. It is not possible to draw any general conclusion upon these results. It is very important to conduct further research at the national level, to find out both why the frequency of Caesarean sections has increased so dramatically, and also why poor women less often choose (or are offered?) Caesareans.

8.4 Concluding remarks

I started this dissertation by introducing my 1970s childhood school friend Kabita from a farmer's family, who married early, experienced in-

laws' pressure to bear a son and gave birth to five children. Although after giving birth to three daughters her fourth child was a son, the fifth daughter was born due to irregular use of contraception.

I started the journey of this research out of curiosity to understand how the family planning success story has changed the life of many rural women like Kabita in this millennium to enable them to give birth to two children only. During my journey I took a different epistemic lens that tries to capture rural poor women in the complexities of their social reality. I observed and listened to the voices of rural women like Anita, Bonna, Parboti, Boiskaki, Fouzia and Kohinoor among others. I also came across Ambia, Orchita, Godhuli, Shobita and Mohua, tribal Garo women adding another dimension to their reality, speaking in a different voice. These voices of Bengali and Garo women sometimes joined together, and sometimes differed. These women conveyed a message that they were neither victims of cultural norms nor passive beneficiaries of a family planning success story.

As discussed in the introductory chapter, the tremendous fertility decline has been explained by some as a success of family planning programme by ensuring cheap, available and effective forms of contraception in combination with increase in women's status (The World Bank 2008). There is no denying the tremendous achievement of the family planning programme in providing diverse contraceptive methods to those with unmet need for such methods and also by bringing the possibility of fertility control within the calculus of conscious choice for many women (Kabeer 2001:65). There is copious evidence in favour of the argument that the significant fertility reduction from 6.3 to 2.3 children per woman is due to the increase in contraception use from 8 to 62 per cent between 1975 and 2014. However, drawing on the evidence from women's real life experiences, this study provides an alternative explanation of the family planning success story.

Real life negotiations around contraception practice documented in this study challenge a simplistic linear relation between the use of contraception and women's higher status and agency. Men and women's narratives provide insight into how different types of contraception are linked to the notion of masculinity and femininity. Men and women do not challenge prevailing gender norms rather reproduce the notions of masculinity and femininity through contraception practice, sustaining gender inequality. A family planning programme based on an individualistic no-

tion of agency which suggests a female focused programme to achieve gender equality, does not capture this gendered process in explaining contraception use. Similar to the national level, among my research participants it is mostly women (more than 90 per cent) that use contraception. I argue, the Bangladesh family planning programme is carefully designed to focus on women without confronting existing gender norms and hierarchies. In fact, the requirement of husbands' (or male relative's) consent to use an MR service reflects reproduction of gender hierarchy in the policy. The availability of cheap or free (or even through incentives) contraception, legalisation of MR and women focused family planning programme provided poor rural women the opportunity to use contraception. However, it would be a mistake to draw a simple causal relation between contraception use and women's higher status, exercise of autonomous choice, and agency.

Despite the availability of a range of contraception and MR services, both Garo and Bengali women spoke of constraints within the household, the community and in the health care market. However, women showed resilience and adopted various ways available to them in relation to their contraception and MR/abortion practices, although sometimes women put their bodily health and wellbeing at risk. This suggests that women's agency in reproductive practice has to be seen in a relational way. Realising full capabilities of agency in the sphere of reproductive decision making, requires transformation of persistent unequal gender power relations in the household, the community and the health care market.

Both Garo and Bengali women's narratives showed it is not a matter of ignorance or fatalistic behaviour of poor women but hidden cost and inadequate quality of care in the public hospitals remain major constraints for poor women to ensure their access to safe childbirth services, sustaining their dependency on home deliveries in the presence of traditional birth attendants. This finding contradicts the policy approach that suggests dual health care systems - private for the well-off and public safety net for the poor - to ensure health equality. Women's experiences indicate that the public health care system, on which poor rural women are mostly dependent, is not able to provide adequate quality of care. This finding suggests that a persistent high maternal mortality is the manifestation that equality in health care access is not ensured.

To make significant progress in the reduction of maternal mortality, policies need to take into consideration how privatisation of health care, market mechanisms, class, intra-household and ethnic power dynamics all combine to create the existing health inequality. Unless women's right to life during childbirth is ensured the national and international commitments to reduce maternal death remain hollow.

Finally, while the mainstream policy and discourse project a linear link between women's empowerment and lower fertility, the experiences of Garo women contradict this. Garo women's voices provide insight into why despite showing a higher status in all conventional indicators of empowerment, they choose to have slightly higher number of living children compared to Bengali women which does not fit into conventional policy assumptions.

Based on empirical findings, this study contributes to our understanding of the complex interaction of the household with class and ethnic dynamics that impinge on the ways women from different communities can express their agency and access health care services. Irrespective of patrilineal or matrilineal household structures, both Garo and Bengali women experience diverse, but similar outcome. These findings indicate that women's class and gender identity in the broader system put women in a position where it does not guarantee their access to formal health care services to ensure safe childbirth, safe abortion, and treatment of other reproductive health complications.

Drawing on these findings, this study suggests that a dynamic gender, class and ethnic relation should be central to our understanding of how women take reproductive decisions and access health care services. Well informed policies need to be aware of and recognise women's diverse needs, interests, constraints and capabilities, (which are shaped by their mutually interlocking gender, class and ethnic positions), to enable women to exercise full control over their body and reproductive rights.



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Appendices

Appendix 1: Policy Approaches to women in the dominant Development paradigms

This section provides a summary of dominant development paradigms and its approaches to population policy and integration of women/gender.

Modernisation paradigm

After the World War II the modernisation paradigm based on liberal positive economic theories became more influential in the development discourse. The modernisation theory envisioned a progressive continuum of economic development and growth that would bring social and political benefits for all citizens of all the countries with a 'trickle-down effect'. It explains the transition of fertility from higher to lower fertility regimes, ushered by socio-economic development and a concomitant increase in income, urbanisation and industrialisation via the reduction of fertility rate.

Within the framework of this development paradigm, policies on women and development took a welfare approach. As Moser (1993) has shown, the purpose of the welfare approach is to bring women into development as better mothers. Women are seen as the passive beneficiaries of development. The UN conventions⁷⁰ based on this liberal welfare approach, identified women solely in their reproductive roles. Population policies within this paradigm offer birth control and nutrition programmes for women and lactating mothers. It is non-challenging and, therefore still widely popular. As Rai (2002) notes this welfare approach focused on the sexual division of labour and individual negotiation within family often left the gender relations of a society unchallenged.

⁷⁰ In the first UN decade of development, major international institutions of development took shape within the liberal capitalist framework. Aid became an important mean to integrate third world countries into the existing international capitalist trade regimes.

Esther Boserup (1965) argued that women are not only engaged in reproductive roles, but they are also engaged in the productive roles. Boserup had been criticised by Beneria and Sen (1981) for her presumption that modernisation is beneficial for third world countries and ignores the effect of the processes of capital accumulation on women and not to take into account the stratification of women along with the lines of class. Boserup has failed to capture the new forms of subordination created by the modernisation process (Rai 2002; Elson and Pearson 1981; Elson 1999).

The crucial issue at the heart is the question of power relations among women and men, but also the power differences between women occupying different socio-economic spaces (Rai 2002). The framework does not question the status quo.

Another criticism of the “modernisation theory” came from the dependency theorists. In 1963, Raul Prebisch articulated the “dependency theory”. A.G. Frank argued that the liberal development model was in fact the development of under-development. His argument shows that all colonial countries were underdeveloped before western capitalist penetration. The third world countries became underdeveloped after their incorporation into the international capitalist system. International capitalism depended upon the exploitation of the cheap resources of the third world; the opening up of the post-colonial states to the international capitalist world is criticised not to enhance development, but to increase the dependency and exploitation. Feminists have made a broader critique as well on the modernisation paradigm, arguing that within this system, women are seen as ‘the last colony’ (Mies and Bennholdt 1988). Men often benefit from the oppression of women and that they play an active role in prolonging it, both within the private domain of the home but also in the purportedly neutral arena of the market place (Kabeer 1994a). A patriarchal dominance was maintained through the agencies of the state within marriage and through work legislation. It has been argued that it is not the men who keep women at home, though they may appear to be the most direct oppressors, but the structure of the capitalist system, which benefits from the unpaid labour of the housewife (Kabeer 1997). The inequalities between men and women could not be understood in isolation from the polarisation of the capitalist mode of production between centre and peripheral countries. The situation of women resulted from two intersecting conditions: “the con-

tradition between social classes” which is dominant in capitalist social formations, and “the contradiction between sexes” which is subordinate in the same type of “social formation” (Kabeer 1994a).

Basic Needs Approach

In the 1970s, the basic needs approach initiated alternative ways of envisioning development, which sought to shift the focus of development from growth to fulfilment of basic human needs. The basic needs approach put forward the idea that poverty is not an end that can be eradicated by ‘means’ of a higher income (Kabeer 1994a). It was also proposed that development planning should include the explicit goal towards the satisfaction of an absolute level of basic needs. In that context, poverty was conceptualised as an indication of the inability of people to meet basic needs. The basic need theorists thus shifted the focus from the growth politics to income distribution politics (Rai 2002). This approach emphasises on certain minimum requirements of a family for private consumption of adequate food, shelter and includes essential services provided by and for the community at large, such as safe drinking water, sanitation and public transport and health and educational facilities. Finally the Basic needs approach focused on people’s participation in the development. The basic needs approach is further developed by Amartya Sen in his human development and Capabilities framework (Sen 1984).

Within the basic needs framework of the development paradigm, policy approaches to women and development took an equity and anti-poverty approach. These views are epitomised in the equity approach used in the 1975-85 UN Women’s Decade. It challenges women’s subordinate position. Its purpose is to gain equity for women, who are seen as active participants in development. The main idea of equity approach was to remove the inequality in the division of labour between men and women (Kabeer 1992). It recognises the triple role and seeks to meet SGNs⁷¹ through top-down state intervention giving political and eco-

⁷¹ Strategic gender needs (SGNs) are “the needs women identify because of their subordinate position in society. They vary according to particular contexts, related to gender divisions of labour, power and control, and may include issues such as legal rights, domestic violence, equal wages, and women’s control over their bodies. Meeting SGNs assists women to achieve greater equality and change existing roles, thereby challenging women’s subordinate position (ILO 1998:1)”.

conomic autonomy, and reducing inequality with men. This approach is considered threatening to, and is unpopular with governments (Moser 1993).

Another approach which fits under the basic needs paradigm is the Anti-poverty approach, which is also a WID approach, a toned-down version of equity, adopted from the 1970s onwards. Its underlying premise was that women are members of the poorest of the poor. Moreover, women's poverty was seen as a problem of underdevelopment, not of subordination (Moser 1993). Anti-poverty approach geared to meet PGN in productive role, to earn an income, particularly in small scale income generating projects (Moser 1993). This approach is most popular with NGOs. However, the basic needs framework did not take into account that women are already overburdened.

The politics of the needs based development approach was one of the liberal critiques, of persuasion, information and education rather than any fundamental challenge to the prevailing social relations.

Some scholars (Rai 2002, Said 1978) argued that women's visibility in the development discourse is not accidental. After the colonial period, while the nationalist movements of many third world countries had created an optimism based on the discourse of equality, the language of development and the modernisation theories ensured that they were constantly characterised as "underdeveloped" and essentially a "problem", which is named as "Orientalism" (Said 1978) that need addressing and managing. Women occupied a particular place within this oriental discourse (Mohanty 1991b). The portrayal of women as poorest of the poor allowed the orientalist to rescue the oppressed women through new development interventions.

Population policies within this development framework remained based on the welfare approach, which offers birth control and nutritional programmes for lactating mothers to enable them to participate in economic activities.

In the context of the failure of equity and anti-poverty approach, Southern feminists, such as Development Alternatives with Women (DAWN), have challenged the assumptions of the neutral goals of such development interventions.

Human Development Framework

The Human development framework represents a powerful critique over many years of prevailing utilitarian approaches to measure welfare in development studies and economics. Amartya Sen has examined sex bias in India and elaborated the evidence of gender differences in the health condition. Females show to be in worse conditions than males for a number of functions, such as age-specific mortality rates, malnutrition and morbidity (Robeyns and Humphries 2003). Sen's quantitative applications based on aggregated data have become widespread, especially in development studies. The most famous one is undoubtedly the concept of human development, which has resulted in the construction of a number of indices, such as human development index (HDI), the human freedom index (1991), the gender-disparity-adjusted HDI (1993), the income-distribution-adjusted HDI (1993), the gender related development index (1995), the gender empowerment measure GEM (1995) and the human poverty index (1997) (UNDP 2011). The functions that are incorporated in these indices are life expectancy at birth, education (measured by adult literacy and educational enrolment rates) and adjusted real GDP per capita which is taken as a proxy for a number of functions with material preconditions, such as being sheltered and well-fed. These indexes clearly show that GDP/capita is an imperfect indicator of human development and that the ranking of countries according to GDP-based indicators and the human development indicators are different (UNDP 2011). These approaches have had a large impact on policy making. According to this view, lack of reproductive health constitutes a significant deprivation of wellbeing in the developing countries and yet the field is not central to mainstream development policy.

Sen argued that in social evaluations and policy design, the focus should be on what people are able to do and to be, on the quality of their life, and on removing obstacles in their lives so that they have more freedom to live the kind of life which upon reflection, they find valuable (Sen 1993). The human development approach also stressed on the fulfilment of non-material needs as a part of the development process. Participation of people in decision making that affect their lives and self-management of development projects became an important part of this framework (Rai 2002). Freedom, equality and dignity came into the core of the development paradigm as fundamental human rights (Truong 1997).

Although Huq, Amartya Sen and Murtha Nussbaum provide an important perspective on reproductive rights in human development framework, population policies continue to be based on basic needs approach.

Within the broader development paradigm, parallel to the Basic needs approach, neo-liberal policies emerged at late 1970s.

Neo-liberalism

Since the late 1970s, neo-liberal macroeconomic policies and associated policies of domestic regulation have been pursued widely in the developing world. Many countries have been subject to a fiscal squeeze, resulting from reductions in trade and finance related taxes and from declining tax rates on capital. In several instances, expenditure cuts have been concentrated in capital expenditures affecting infrastructure, and in others, expenditure on health, education, welfare and social safety nets have been eroded (UNRISD 2004). The neo-liberal development policy continued to focus on economic growth and modernisation.

Within the neo-liberal development framework policies on women and development took an efficiency approach. The “efficiency approach” is the third and now predominant approach to incorporate women in development. Its purpose is to ensure that development is more efficient and effective through women’s economic contribution, with participation often equated with equity. This is the most popular approach. This approach focuses to meet PGN⁷² in the context of declining social services by relying on all three roles of women and elasticity of women’s time.

Population policies within the efficiency approach encourage the reduction of fertility to enable women to participate in the productive work on the basis of efficiency. However, the efficiency approach assumes that women are able to extend their working days to a large extent.

⁷² Practical Gender Needs (PGN) are “the needs women identify in their socially accepted roles in society. PGNs do not challenge, although they arise out of, gender divisions of labour and women’s subordinate position in society. PGNs are a response to immediate perceived necessity, identified within a specific context. They are practical in nature and often concern inadequacies in living conditions, such as water provision, health care and employment (ILO 1998:1)”.

DAWN has criticised the negative impact of the structural adjustment policies on the family, and the disproportionate burden of privatisation that women are forced to carry. As a result of the fiscal squeeze, constraints on public spending have particularly negative effects on women. This burden was further intensified by the increased time women were forced to spend on income generating activities (Rai 2002). The evidence of the negative outcome of structural adjustment policies on women further emphasised the importance to scrutinise macro-economic and sectoral development interventions from a gender perspective (Miller and Razavi 1998). Household rights and obligations between husband and wife are asymmetric, where the burden of reproduction often a demand on women's health and time. Rao (2002) further argued that in a neo-liberal context, the rights of the vast majority of women to access resources, the most basic determinant of health, are being denied.

Despite limitations, within the broader neo-liberal development paradigm the Millennium Development Goals (MDG) came as a bench-mark of development for this decade.

Millennium development Goals

In September 2000, the UN Millennium Summit committed motivation towards achieving fundamental human rights. At the 2000 summit the UN General Assembly came up with 8 Goals, 18 targets and 48 indicators. The Goals are benchmarks of progress towards the vision of the Millennium Declaration-guided by basic value of freedom, equality, tolerance, and respect for nature and shared responsibilities. Moreover, it prescribes the purpose of development as the improvement of people's lives by expanding their choices, freedom and dignity (UNDP 2003). Thus, the human rights approach provides an opportunity to fulfil basic human needs, where, denial of basic human rights puts human dignity itself at risk (Gasper 2005; David 2002). These commitments received additional backing during World Summit on Sustainable Development in Johannesburg, South Africa in September 2002. Under the MDG framework, a life cycle approach emerged (Datta 2003).

However, critics say (Rao 2002, Rao 2004) beneath the rights language, lays a developmental goal which are fertility reduction and population control rather than ensuring women's reproductive health and wellbeing. The Millennium Development Goals (MDG) remains hollow

unless reproductive services are available and accessible for all. The extremely low level of resources allocated to the health sector in some of the poorest countries mean that it is not possible to provide even basic universal coverage of essential health services. The health sector reform has contributed to slow progress on the broader commitments towards human rights and gender equality (Standing 2004).

The basic limitation of population policies within MDG is its neo-liberal orientation which put reproductive rights out of their context and considers women as rational decision makers. Feminist authors (Keyzers 1994) argue that the reproductive rights of women should be placed in a broader human rights and macroeconomic policy framework.

Within the broader development framework, as an alternative to neo-liberal approach Gender and Development (GAD) approach emerged from feminist scholars.

Gender and Development (GAD) approach

The extent, to which macro-economic policies can ensure women's well-being, does not depend on their ability to enhance growth. The effects of economic growth are gender-differentiated, as growth operates through various types of markets, through inter family and intra-household resource distribution, and through public spending. Each of these elements is subject to the pervasive influence of social norms regarding the roles and rights of women. Hence, women and men's capabilities, their access to resources such as time, land, credit, income, and their ability to obtain social insurance or health facilities differ widely (UNRISD 2004).

In many societies women have traditionally minimal control over resources (Agarwal 1988) or decision-making power within the household and the community. The resources and the range of options women have, affects their ability to exercise their rights (Correa and Petchesky 1994). In some regions those inequalities have taken such extreme forms that they result in markedly higher levels of maternal mortality, malnutrition and ill health among women and girls. Such inequalities are difficult to explain simply in terms of differences in tastes and preferences suggested by Neo-liberal thinkers.

Feminist scholars have argued that a focus on the gender relations that position women within society must be at the core of all development initiatives (Young 1989). To describe women's subordinate situa-

tion within a society, Young made distinction of women's "condition" and "Position", which Molyneux (1985) called "practical" and "Strategic" interests (Moser 1989). Molyneux (1985: 232-233) Suggested "analysis of women's subordination and [...] the formulation of an alternative, more satisfactory set of arrangements to those which exist [...] such as the abolition of the sexual division of labour, the alleviation of the burden of domestic labour and child care, the removal of institutionalised forms of discrimination, the establishment of political equality, freedom of choice over childbearing and [...] measures against male violence and control over women".

Within the GAD paradigm, feminists articulated the policy approach to women, which is empowerment. Its purpose is to empower women through greater self-reliance. Within this approach, women's subordination is experienced not only because of male oppression but also because of colonial and neo-colonial oppression. It recognises the triple role, and seeks to meet SGNs indirectly through bottom-up mobilisation of PGNs). It is potentially challenging, although its avoidance of western feminism makes it unpopular except with Southern women's NGOs (Moser 1989:1808).

Whereas, in SRHR approach, feminists affirm that women's health and empowerment must be treated as ends in themselves and not merely as means towards the (Petchesky 2003:9) goal of fertility reduction vis-a-vis population control.

While gender and development remains a powerful development framework, population policies remain to continue in a liberal framework. The next section provides a brief review of development paradigm in relation to population policy and its incorporation of gender and its limitations.

Dominant Development paradigms in the field of population policy

Population Control Paradigm

Over four decades, Neo-Malthusian and Eugenic ideologies driven by population control paradigm dominated the population policies.

Initially the population discussion has received attention in the development discourse in 1798, when an English clergyman and economist Thomas Robert Malthus published his book "An Essay on the Principle of Population". The main objective of his essay was to explain the nature and origin of poverty in a way which would favour capitalist economy. His explanation of poverty as a natural product of higher fertility provided justification to implement profound structural changes, which further put more pressure on the poor and created new opportunities to accelerate growth. Although, Malthus acknowledged the unequal distribution of wealth contributing to existing poverty, however, he believed that redistributing wealth would only make poverty worse (Ross 1998). Malthus argued that redistribution of property through charity would have encouraged the poor to breed and increase the supply of labour which would further contribute to more unemployment and low wages among the poor (Lohman 2003:9). Therefore, he recommended privatisation as a solution to existing poverty and inequality. The way in which Malthus explained the relation between poverty and fertility became a leading ideology in the population and development discourse for several decades.

Subsequent Malthusian scholars and activists established the Malthusian League, which was the first international forum to discuss the population problem formally and explained poverty and inequality as a consequence of population pressure on resources. There were two schools of thought within the Malthusian paradigm, the "Malthusians" and the "Neo-Malthusians". Although Malthus viewed population growth and competition among workers as a necessary stimulus to industrial growth (Ross 1998:5), therefore his intention was not to reduce population growth. However Malthusians considered fertility control through war or disaster or delayed marriage and the Neo-Malthusians favoured birth control as the main solution to reduce the pressure on resources.

A century later Malthusianism found an intellectual ally in eugenics. The eugenicists believed that the ‘unfit’ should be weeded out and the affluent, or “gifted”, be encouraged to breed, so that the human “stock” could be improved (Akhter 2005b:98).

Eugenicists were not limited to academic exercise only. They were organised, particularly in Germany, England and the United States, in implementing policies consistent with their theories (Gordon 2007). The development and promotion of birth control was a major eugenic success. Besides being one of the pillars of Nazism, eugenics influenced the birth control movement⁷³ which retained the racist premises of its origin. A key programme of the eugenicists was to purify the human race by sterilising the “unfit” (Davis 1990:21).

After World War II, the eugenics movement continued to thrive under the International Planned Parenthood Federation (IPPF). When IPPF was founded in 1952, it was housed in the office of the Eugenics Society. From 1952 onwards, a major part of the eugenics movement continued under the birth control movement, with the same people doing the same things, but with a new public rationale. One of the organisations that promoted eugenics under the new public rationale was the Population Council. At the time of the creation of the Population Council, Rockefeller echoed the “Malthusian belief” (Mass 1976:37).

In the population and development discourse, Malthusian, eugenics and birth control movements thus became intertwined and almost indistinguishable (Akhter 2005a:100).

Reproductive Health and Rights: A Paradigm shift!

Since the International conference on Population and Development (ICPD) in Cairo 1994, this population control paradigm has been replaced by a ‘new’ reproductive health and rights paradigm. During the conference, the population control paradigm has been replaced by a reproductive health and rights Paradigm. To enable women to make informed autonomous reproductive decisions this framework advocated replacing the liberal approach to improve women’s status that advocated

⁷³ Marie Stopes, who was the pioneer of the birth control movement, was promoting her writings with accompanying love Songs to Adolf Hitler. (The Free Encyclopedia 2012).

female education and employment by the promotion of gender equality and women's empowerment (Correa and Reichmann 1994).

However, the reproductive health and rights paradigm continues to explain development as a transition from a higher to the lower fertility regimes with a neo-Malthusian overtone (Dixon-Mueller 1993a:4). Under this framework, women's reproductive rights and empowerment are seen as a pre-requisite to reduce fertility (Smyth 1996:217). In addition, despite sexuality being an integral part of reproductive health (Dixon-Mueller 1993b), this aspect is missing in the way reproductive health has been used in the population policy. Feminist scholars emphasised on the separation of these two because it challenges the control and non-recognition of women's sexuality outside their reproductive roles (Sen et al. 1994b:23). Feminist scholars argue (Young 1989:102) that any discussion of the management of human reproduction involves a complex set of issues concerning ideas to do with sexuality (especially female sexuality); interconnection between sexuality and procreation; the nature of socially permitted relations between men and women; and stereotypes of womanhood and manhood.

The ability of women to control their sexuality and fertility further depends on the gender system of a society (Sen 1994a; Harcourt 1997), wherein the gender systems are usually constructed to exploit women (Correa and Reichmann 1994:9). Women's sexuality is often the symbol of honour and status of the family, the clan, the caste and the ethnic group, therefore the subordination is often being achieved through the subjugation, exploitation, and control over women's sexual lives (Kitts and Roberts 1996:10).

Addressing women's sexual rights is important, because even in circumstances where women enjoy some control over economic resources, they still might be sexually submitted, to the male power (Fabros 1998). Addressing women's sexuality further requires understanding the dichotomisation between "public and private spheres" (Petchesky and Sonia 1994:1007), which perpetuates women's unequal access to the market. In most societies, women's activities are confined to the reproductive domain in the private sphere, while the public sphere, where the economy, politics and public affairs occur, is considered a masculine domain (Correa and Reichmann 1994:105; Elson 1991).

While feminists affirm that women's reproductive decisions are determined by a complex interplay between economic forces and its inter-

section with existing culture and gender systems, the reproductive health and rights framework adopted in the population policies during ICPD, fails to offer an analysis of existing culture and power structure. The rhetoric of the reproductive health and rights discourse is also linked to the global politics of population discourse (Ginsburg and Rapp 1991).

Politics of poverty and population policy discourse

The population policy discourse revolves around the issue whether high population growth rate is related in a direct, casual way to underdevelopment (Coontz 1961; Ehrlich 1990, Young 1989). Acceptance of a causal relation between population growth and underdevelopment, lead international development agencies to suggest development interventions through population control. In the context of the Southern countries, even global warming became an argument for population control (Chamie 1994; Ehrlich 1968). By 1968, curbing population growth became central to the World Bank's development policy, and has remained so ever since (Akhter 2005a). To address population problem, UN established United Nations Population Fund (UNFPA) (formerly United Nations Fund for Population Activities). The UNFPA sponsored three ICPD meetings, in Bucharest in 1974, in Mexico in 1984 and in Cairo in 1994, bringing together the heads of state from most of the world to develop a global population strategy to solve the population problem. No other global issue drew as much attention as population problem.

These international conferences are of a great importance, because they display dominant views that shape development strategies of International donor organisations (Smyth 1998). Besides policy directions, these conferences also display international power imbalances, where national policies are a response to international donor pressure. This pressure is reflected in the conditionality for loans imposed by international financial agencies in countries with large populations (Smyth 1998:224).

However, this development discourse through population control has been criticised for its narrow focus on fertility reduction. Just to mention a few of them, critiques from a number of third world and socialist countries considered development as the best contraception (Kabeer 1994a :189). A number of scholars also argued that the real cause of poverty was not population growth at all. Henry George (1879) argued

that poverty caused population growth, not the other way around. Paul Harrison (1992) further argued that India was plagued by famine not because of “overpopulation” but due to the oppressive rule by the Mughals and the British. Also, the great famine of 1844 in Ireland which was often cited by Malthusians as a proof of their theory was in fact an inevitable outcome of land extortion by the landlords. According to these critics the politics of population discourse was to distract attention from the underlying inequality in the international economic order, which is the root cause of poverty and inequality in the third world countries (Escobar 1995). Instead, this reproductive health and rights discourse provides solutions which sustain the global structure of power (Cornwall 2010).

It has been documented that increasing interest of the states and powerful institutions such as multinational and national corporations, international development agents, western medicine and religious groups construct the context within which local reproductive relations are played out in reproductive decisions (Ginsburg and Rapp 1991:312).

This process is relevant to many Southern countries. It is important to see how these national and international gender power relations are played out in the context of reproductive health situation in Bangladesh.

Appendix 2: Guideline for Interviewing the National level policy actors

Guideline for interviewing government actors:

Themes	Topic guide to be probed	Interviewees
Policy Design	<p><i>Could you kindly share your knowledge and experience on the formulation of population/ reproductive health policy and its successes and challenges in Bangladesh?</i></p> <ul style="list-style-type: none"> • Which year did you find the most important in relations to the formulation of population policy since the independence of Bangladesh in 1971? Why? • What do you think are the major international or national events that shape the current health / population policy in Bangladesh? • Does the International Conference on Population and Development (ICPD) in 1974 have an impact on the current population policy in Bangladesh? In what ways? Is it a reproductive health policy? • What were the major concerns of the government while deciding on the reproductive health / population policy? What socio-political, ecological, economic, and global factors did you think of play important roles for the policy formulation? • Who were the policy designers (Their professional background, Knowledge and expatriates, information providers, financial, materials) • In the process of policy formulations– what ideology of GO policy makers or donors or the interest of political leaders or professionals played a significant role? • Do we have an integrated health and population policy or an isolated health, population and family planning policy in Bangladesh? What are the co-ordination mechanisms among all those ministries? How effectively are they working towards ensuring health for all? • What is your definition of reproductive health? 	Population/ health Policy makers: DG, Family planning & DG, HS,
Do	<ul style="list-style-type: none"> • Was there any donor involvement during policy formulations? 	

<p>nor involve- volve- ment</p>	<p>Who are the donors that were involved during policy formulations? What was the role of the donors in the policy making process?</p> <ul style="list-style-type: none"> • Each donor has different approach to support the population program. How did you feel about the diversity of working approaches between donors? How easy or difficult it is for different ministries to deals with different donors with different interests and approaches? • Which donors are more sensitive towards the reproductive health needs of men, women and Adolescents of different socio-economic, ethnic and religious origins? How? • To what extend a need assessment of men, women and adolescents was conducted before the policy formulation? • How did class, ethnic, gender or religious issue get into the policy agenda when designing the health/population policy? 	
<p>Re- sponse on pol- icy and pro- gram</p>	<ul style="list-style-type: none"> • What are the main characteristics of the current population/ health policy in Bangladesh? What are the major components under the current population policy in Bangladesh? Are there any class specific or gender specific family planning/ health, nutrition programme? What are those? • Is family planning programme subsidised? Do you deliver doorstep contraceptive service delivery system now? • Did the government stopped providing doorstep services for a while? What was reason to stop doorstep service delivery system? Who took the decision? What was the consequence of the decision? When did it start again? What is your opinion about the decision? • The TFR have been reduced significantly from 6 to 2.8 in Bangladesh since 1971. But the Contraceptive prevalence rate (CPR) did not increase proportionately. What do you think is the success of the reduction of Total fertility rate (TFR) despite of slow increase of CPR? • What could be the other causes behind the fertility reduction rather than only effective contraception use? • Is MR legal in Bangladesh? From which year. What was the assumption behind the legalisation of MR (Menstrual Regulation) in Bangladesh? Is the MR service free? Where can women get the MR services? What is the time limit to perform an MR? Who is authorised to perform an MR? Being a Muslim country, how easy or difficult was to legalise MR in Bangladesh? 	

<p>Access to services</p>	<ul style="list-style-type: none"> • It was expected that the access to contraception and the legalisation of MR would bring down the unsafe abortions in Bangladesh, what is your experience after the legalisation of MR? • What is the current maternal mortality rate (MRR) in Bangladesh? What do you think is the cause of maternal death in Bangladesh till now despite the success of family planning programme? 	
<p>Budget and implementation</p>	<ul style="list-style-type: none"> • If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards family planning and fertility control, some are towards maternal and child health, awareness raising and motivational work. There are differentiated health needs among different social groups like married and unmarried, urban and rural, educated and uneducated, young and adult, ethnic and Bengali groups. Do you think that access to contraception and MR is available for all groups? How? Or why not? • Some Critics say that population policy has been towards family planning rather than ensuring health. Access to basic primary health care by the poor is limited. Do you agree with this? If yes, how? If not, why not? • What is the total health Budget in Bangladesh? Where the budget comes from? How much of the budget goes to general health? How much is allocated for family planning? How much is for awareness rising and how much is for reproductive health services like safe motherhood, MR or Abortion, prenatal and ante natal care or infertility treatment? • Many NGOs and private organisations are also providing health services in co-ordination with the government. Do the NGOs and private sectors have different health policy or do they implement government policies? Are there any co-ordination mechanism to integrate GO and NGO services? • What do you think about the success and challenge of the existing population/ health policy in Bangladesh? • What is your suggestion to make the population/ health policy more effective? 	
	<p><i>Thank you for your kind co-operation and for sharing the valuable information with me.</i></p>	

Guideline for Interviewing development NGOs

Themes	Topic guide to be probed	Interviewees
	<p><i>Could you kindly share your knowledge and experience on the successes and challenges of the implement of the policy in Bangladesh?</i></p>	Marie Stopes, FPAB, BRAC,
Organisational introduction	<ul style="list-style-type: none"> • When did your organisation start working in Bangladesh? How did it establish; where the idea came from? What are the main objectives of your organisation? Who are the beneficiary group of your organisation? How big is your working area by geographic area and by the scope of work and budget? • How long has your organisation been involved in implementing health programme? What motivated your organisation to participate in the health program? • Which kind of services does your organisation provide in the health sector? (Training, research activity, policy lobbying at local, national and international level, strengthening activities at local level, awareness on health rights, service delivery?) 	GANO SHASTHO KENDRA, FRIENDSHIP, Engender Health
policy making	<ul style="list-style-type: none"> • How often does your organisation participate in the policy forums organised by the Government at district or national level? • You perhaps attended many policy forums where the decisions on new policy making or policy implementation are discussed and decided. Could you kindly explain me which year did you find the most important in relations to policy development and change since 1971? What were the major events in different years during this period? • Have you ever experienced a circumstance where the government, donors, civil society organisations and professionals used to debate/contest for a decision regarding any health related issues? How was it solved? • Based on your experiences, which are the influential actors in policy formulations? Why? • Do you think the power relations between donors, Government, NGOs and women's group make difference in policy formulations? Could you please share your experiences in relation to the policy formulation in Bangla- 	

	<p>desh?</p> <ul style="list-style-type: none"> • There are unequal power relations among men and women according to gender, class, and ethnicity. How do you feel about the population policy to address the reproductive health needs of men and women regardless of their age, class, marital status, geography, religion and ethnicity? • From your experience, what are the policy problems for making the sexual and reproductive rights issues as prime policy agenda in Bangladesh? 	
Funding	<ul style="list-style-type: none"> • What are the sources of income of your organisation? Who are your major donors for implementing the health services you are offering? How did you find the role of donors/their projects in implementing the health policy? • Each donor has different approach to support the population program. How did you feel about the diversity of working approaches between donors? What are the advantages of diversity? What are disadvantages of diversity in terms of co-ordination and implementation of the policy? • Which donors are more sensitive towards the reproductive health needs of men, women and Adolescents of different socio-economic, ethnic and religious origins? How? 	
Reproductive health policy and services	<ul style="list-style-type: none"> • Do you think that the current population policy is successful to bring down the TFR among women from different class, ethnic and religious population? What are the underlying reasons behind the fertility reduction other than access to service delivery among all social groups? • Are there any mechanisms with the government to monitor the health services provided by the NGOs? • According to you what is reproductive health? What are the reproductive health components you are providing in your health programme? • Does your organisation have a reproductive health policy? Or do you implement government policy? If no then to what extent your policy is different than the government health programmes? • How would you describe the relationship between your organisations with the Government in terms of policy implementation? 	

	<ul style="list-style-type: none"> • Do you experience any problem in implementing the government policy? (Co-ordination, Fund, Training, Accountability)What are those? • Some Critics say that population policy has been towards family planning rather than ensuring health. Access to basic primary health care by the poor is limited. Do you agree with this? If yes, how? If not, why not? 	
Response on programme	<ul style="list-style-type: none"> • If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards fertility control and some are towards women's empowerment. Which approach does your organisation follow? Is it reproductive health and rights approach? • According to you what is reproductive health? • What are the reproductive health care services you are delivering? Is your programme subsidised? Or is the service free? Which services are free of cost? • Are you delivering any contraceptive methods? What are those methods? Where do you deliver contraceptives? What are the other reproductive health services you are providing? • Do you provide MR services? How much does it cost to have an MR? Do women have to go for a pregnancy test for an MR? What is the time limit to perform an MR? Who is allowed to perform an MR at your service? Is MR done under GA? Clients have to pay for MR services? How much is the service charge? Who are mainly your clients? (Unmarried, married. Widow, women with 1/2/3/ more children or no children? How frequently do women come for a MR? How many times do you perform MR to women? • It was expected that the access to contraception and the legalisation of MR would bring down the unsafe abortions in Bangladesh, what is your experience after the legalisation of MR? • What do you think is the challenge and constraints for women to avail safe contraception and safe abortion in Bangladesh? 	
	<i>Thank you for your kind co-operation and for sharing the valuable information with me.</i>	

Guideline for Interviewing Women's (right) organisations:

Themes	Topic guide to be probed	Interviewees
Organisational affiliation	<ul style="list-style-type: none"> • Could you kindly share your knowledge and experience to work with health and rights issues in Bangladesh? • How long have you/ your organisation been involved with the health and rights issues in Bangladesh? What motivated you/ your organisation to participate in the reproductive health issues? • What is your definition of reproductive health? • What is the main agenda or issue of your feminist movement or activism in relation to reproductive health and rights? • Do you also incorporate men's right in your agenda? 	Naripokkho Ubinig Bangladesh Mohila Parishad
policy making	<ul style="list-style-type: none"> • How would you evaluate current population policy to ensure women's reproductive health and rights in Bangladesh? • What would be the ideal health/ population policy according to your criteria? • You perhaps attended many policy forums where the decisions on new policy making or policy implementation are discussed and decided. Could you kindly share your experience in relations to policy development and if there is any major shift in the policy since 1971? • What do you think is the basic motivation/ assumption/ logic of the government, donors, civil society organisations, academics and professionals on deciding the current population/health policy? • Have you ever experienced a circumstance where the government, donors, civil society organisations and professionals used to debate/contest for a decision regarding any health related issues? How was it solved? • Based on your experiences, which are the influential actors in policy formulations? Why? • Do you think the power relations between donors, Government, NGOs and women's group make difference in 	

	policy formulations? How?	
The roles of donors	<ul style="list-style-type: none"> • What are the sources of income of your organisation? Who are your major donors for implementing the health or rights issues in Bangladesh? • Each donor has different approach to support health, rights and empowerment issues. How did you feel to deal with different donors with different interests and approaches? • Which donors were more sensitive towards the reproductive health and rights issues of men, women and Adolescents of different socio-economic, ethnic and religious origins? How? 	
Perception towards reproductive health and rights	<ul style="list-style-type: none"> • Does your organisation have a reproductive health policy? To what extent your policy is different than the government policy? • How would you describe the relationship between your organisations with the Government in terms of perception towards health need of men and women? • Some Critics say that population policy has been towards family planning rather than ensuring health. Access to basic primary health care by the poor is limited. Do you agree with this? If yes, how? If not, why not? • If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards fertility control and some are towards women's empowerment. Which approach do you think more effective? Why? 	
Response on programme	<ul style="list-style-type: none"> • Do you think that the current population policy is successful to bring down the TFR among women from different class, ethnic and religious population? What are the underlying reasons behind the fertility reduction other than access to service delivery among all social groups? • It was expected that the access to contraception and the legalisation of MR would bring down the unsafe abortions in Bangladesh vis-à-vis the maternal mortality rate in Bangladesh, what is your experience after the legalisation of MR? • What do you think is the cause of maternal death in Bangladesh despite the success of family planning pro- 	

	gramme and the legalisation of MR?	
	<ul style="list-style-type: none"> • What is your suggestion to reduce the maternal mortality rate? 	
Response on policy	<ul style="list-style-type: none"> • There are unequal power relations among gender, class, and ethnicity in Bangladesh. The needs of the poor are different from those of the well-off members; women's needs are different from men's. I would like to know from your experiences, how do you feel about the population program to address the reproductive health needs of men, women regardless of their age, class, marital status, geography, religion and ethnicity? • From your experience, what are the problems and constraints to incorporate sexual and reproductive health issue into policy agenda? 	
	<i>Thank you for your kind co-operation and for sharing your valuable information with me.</i>	

Guideline for Interviewing Academics/ Research institutes:

Themes	Topic guide to be probed	Interviewees
Organisational affiliation	<p><i>Could you kindly share your knowledge and experience to work with health and rights issues in Bangladesh?</i></p> <ul style="list-style-type: none"> • How long have you been working on population, health and development issues in Bangladesh? • How long have you/ your organisation been working on reproductive health issues? • What is your definition of reproductive health? • What is your major work in the field of population, health or development? • Would you please share your major research findings with us? • In what ways your work helped/ can help the policy makers to formulate future population or health policy in Bangladesh? 	Department of population sciences ICDDR,B NIPORT BIRPERT
policy making	<ul style="list-style-type: none"> • You perhaps attended many policy forums where the 	

	<p>decisions on new policy making or policy implementation are discussed and decided. Could you kindly share your experience in relations to policy development and shift in the policy since 1971? What were the major concerns for this shift in the policy?</p> <ul style="list-style-type: none"> • What do you think is the basic of the government, donors, civil society organisations, academics and professionals on deciding the current population/health policy? • Have you ever experienced a circumstance where the government, donors, civil society organisations and professionals used to debate/contest for a decision regarding any health related issues? How was it solved? • Based on your experiences, which are the influential actors in policy formulations? Why? • Do you think the power relations between donors, Government, NGOs and women's group make difference in policy formulations? How? • There are unequal power relations among gender, class, and ethnicity in Bangladesh. The needs of the poor are different from those of the well-off members; women's needs are different from men's. I would like to know from your experiences, how do you feel about the population program to address the reproductive health needs of men and women regardless of their age, class, marital status, geography, religion and ethnicity? • From your experience, what are the policy problems for making the sexual and reproductive rights issues as prime policy agenda in Bangladesh? 	
Research Funding	<ul style="list-style-type: none"> • Is your research funded by any local or international donor? Who sponsors your research on population and health issues? • Each donor has different approach to support health, rights and empowerment issues. How did you feel to deal with different donors with different interests and approaches? • Which donors were more sensitive towards rights based approach? • What is your definition of reproductive rights? 	

Response on policy	<ul style="list-style-type: none"> • Some Critics say that population policy has been towards family planning rather than ensuring health and rights. Access to basic primary health care by the poor is limited. Do you agree with this? If yes, how? If not, why not? • If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards fertility control and some are towards women's empowerment. Which approach do you think more effective why? • The TFR have been reduced significantly from 6 to 2.8 in Bangladesh since 1971. But the Contraceptive prevalence rate (CPR) did not increase proportionately. What do you think is the success of the reduction of Total fertility rate (TFR) despite of slow increase of CPR? • It was expected that the access to contraception and the legalisation of MR would bring down the unsafe abortions in Bangladesh, what is your experience after the legalisation of MR? Are there any mechanisms with the government to monitor the MR services provided by the NGOs? • What do you think is the cause of maternal death in Bangladesh despite the success of family planning programme? • What do you think is the success and Challenges of women to have access and to access contraception and safe abortion in Bangladesh? • What is your recommendation to the policy makers for future policy formulations 	
	<p><i>Thank you for your kind co-operation and for sharing your research experience with me.</i></p>	

Guideline for interviewing donors

Themes	Topic guide to be probed	Interviewees
Policy Design	<p><i>Could you kindly share your knowledge on the successes and challenges of population policy programme in Bangladesh?</i></p> <ul style="list-style-type: none"> • Which year did you find the most important in relations to the formulation of population policy since the independence of Bangladesh? Why? • What are the major international or national events that shape the current health / population policy in Bangladesh? • Does the International Conference on Population and Development (ICPD) in 1974 have an impact on the current population policy in Bangladesh? In what ways? • Who did you think the influential actors in policy formulations in the light of ICPD? What was the role of donors in the policy decisions? • What do you think are the major concerns of the population policy in Bangladesh? What socio-political, ecological, economic, and global factors did you think of play important roles for the policy initiative? • How did cultural identify and value of actors shape the decision of implementation of particular intervention approach? • Did you remember any event where contestation between the government and donors/project did take place with regard to deciding population programs? Or dispute on any decisions in policy implementation stage or new health policy design? 	UNFPA AUSAID
Perception towards reproductive health	<ul style="list-style-type: none"> ▪ How would you definition of reproductive health and reproductive rights? ▪ What is your opinion about the reproductive health and rights situation in Bangladesh? ▪ If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards family planning and fertility control, some are towards maternal and child health. Which programme do you find effective? Why? ▪ What do you think is the success and challenges of the existing population/ health policy in Bangladesh? 	

	<ul style="list-style-type: none"> ▪ Some Critics say that population policy has been towards family planning rather than ensuring health. Access to basic health care is limited by the poor do you agree with this statement? Why? Why not? ▪ What can be done to make the reproductive health services more available and affordable? 	
Pro-gramme implemen-tation	<ul style="list-style-type: none"> • For how long have you been supporting population programme in Bangladesh? (5year term, ten year term) • What is the total budget you are spending per year in Bangladesh on health sector? What are the main components of health programme you are funding? (family planning, MR, Condoms, sae motherhood, Education, motivation, awareness raising) • Many NGOs and private organisations are also providing health services. Do you also support NGO services? Which are those NGOs that provide health services under your funding? • How do you co-ordinate GO and NGO programmes? • Do you think that the current population policy is successful to bring down the TFR among women from different class, ethnic and religious population? What are the underlying reasons behind the fertility reduction other than access to service delivery among all social groups? • It was expected that the access to contraception and the legalisation of MR would bring down the unsafe abortion rate in Bangladesh, what is your experience after the legalisation of MR in Bangladesh? • What do you think is the cause of maternal death in Bangladesh despite the success of family planning programme? • What do you think is the constraints and possibilities for women to have access to contraception and safe abortion in Bangladesh? 	
	<i>Thank you for your kind co-operation and for sharing your views and experiences with me.</i>	

Guideline for Interviewing Political parties

Themes	Topic guide to be probed	Interviewees
Political agenda	<ul style="list-style-type: none"> ▪ What are the health and population issues in your political agenda? ▪ What is your opinion about the current population/ health policy/ programme in Bangladesh? ▪ What do you think is the success and challenges of the existing population/ health policy in Bangladesh? ▪ Some Critics say that population policy has been towards family planning rather than ensuring health. Access to basic health care is limited for the poor do you agree with this statement? Why? Why not? 	BNP Bangladesh Awami League, Communist party, Jamaiti Islami
Perception towards reproductive health	<ul style="list-style-type: none"> ▪ How would you definition reproductive health and reproductive rights in the context of Bangladesh? ▪ What is your opinion about the reproductive health and rights situation in Bangladesh? ▪ If we look at the nature of population program in Bangladesh, they are heterogonous in terms of approaches. For example, some are towards family planning and fertility control, some are towards maternal and child health. Which policy do you think more effective for Bangladesh? Why? 	
Response on population Programme	<ul style="list-style-type: none"> • It was expected that the access to contraception and the legalisation of MR would reduce the unsafe abortion rate in Bangladesh, what is your opinion and experience regarding the legalisation of MR in Bangladesh? • What do you think is the cause of high maternal death in Bangladesh despite the success of family planning programme? • What do you think is the constraints and possibilities for women to have access to contraception and safe abortion in Bangladesh? • After your political party came in power are you changing the population policy or are you continuing to implement the same policy? • If you are changing the health policy of the previous government what changes are you going to make? 	
	<i>Thank you for your kind co-operation and for sharing your research experience with me.</i>	

Appendix 3: List of Key informants interviewed

No .	Type of stakeholder	Institutional Affiliation	Number of respondents
1	GOB	Ministry of Health and Family Welfare (MOHFW)	1
2		DG, Family planning, MOHFW	1
3	Research institutes	NIPORT	1
4		ICDDR,B	2
5		Bangladesh Institute of Research for Promotion of Essential & Reproductive Health and Technologies (BIRPERTH)	2
6	Donors	UNFPA	1
7		USAID	1
8	NGO/Civil society or organisations/service providers	DMCH	1
9		Marie Stopes	1
10		FPAB	2
11		BRAC, health section	1
12		Engender Health	1
13		Gano Shastho Kendra	1
14		Ad Din Welfare Centre	1
15		Smiling Sun Franchise Program	1
16		FRIENDSHIP	1
17		Grameen Kalyan, Grameen Health	1
18		Social marketing company	1
19	Women's organisations	Ubinig	1
20		Bangladesh Mahila Parishad,	3
21		CWFD	1
22		Naripokkho	1
23	Political party	Communist party	1
24		BNP	1
25		Awami league	1
26		Jamaat-e-Islami	1
27		Advisor, Care taker government	1
28	Academics	Dhaka University (Population Sciences and Women and Gender Studies Department)	3

Appendix 4: Household survey Questionnaire

REPRODUCTIVE HEALTH AND RIGHTS: STATE POLICY, AND GENDER INEQUALITY
REPRODUCTIVE HEALTH OF WOMEN IN BANGLADESH
HOUSEHOLD SURVEY QUESTIONNAIRE

Serial No: _____

A. IDENTIFICATION:

1. NAME OF THE RESPONDENT _____ 2. ADDRESS OF THE HOUSEHOLD: NAME OF HOME (like talukder bari) _____ VILLAGE: _____ WARD NO: _____ UNION _____ UPAZILLA: _____ DISTRICT _____	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>						

	1 ST VISIT	2 ND VISIT	3 RD VISIT
DATE	_____	_____	_____
INTERVIEWER NAME	_____	_____	_____
RESULT	_____	_____	_____
RESULT CODE: 1= COMPLETED, 2= NO HOUSEHOLD MEMBER AT HOME OR NO COMPETENT RESPONDENT AT HOME AT TIME OF VISIT, 3= ENTIRE HOUSEHOLD ABSENT FOR EXTENDED PERIOD OF TIME, 4= POSTPONED, 5= REFUSED, 6= OTHERS (SPECIFY _____)			

Good morning/evening or namaste/ Assalamualaicum!

My name is _____, I am working as a research assistant for a PhD research on women's reproductive health (access to contraception, safe delivery and safe abortion) and well-being in Bangladesh. We are conducting a survey about the health and well-being of women, men, and their children in this area. We can confirm, whatever information you provide will be kept strictly confidential and the result of the survey would be used only for academic purpose.

Participation in this survey is voluntary and you can choose not to answer any question or not to participate at all. However, we would very much appreciate your participation in this survey since your participation is important. Would you be willing to participate in this survey?

If you would like to know more information regarding the survey you can ask.

ANSWER ANY QUESTIONS AND ADDRESS RESPONDENT'S CONCERNS.

In case you need more information about the survey, you may contact the researcher.

May I begin the interview now?

Signature of the interviewer: _____ date: _____
 RESPONDENT AGREES TO BE INTERVIEWED.....1, RESP. DOES NOT AGREE TO BE INTERVIEWED..2
 BEGIN INTERVIEW

DEMOGRAPHIC INFORMATION

Line No	Usual Residents	Relationship To Head Of Household	Sex	Residence		Age	Marital Status	Age At First Marriage (8)	Religion (9)	Eligibility	
				Does (Name) usually live here? (5)	If no (5) Where does she/he live (5a)					How old is (Name)? (6)	What is the current marital status of (Name)? (B) (7)
(1)	Please give me the names of the member of this HH (Starting with the head of the household) (2)	What is the relationship of (Name) to the head of the household? (A) (3)	Is (name) male or female? (4)	Does (Name) usually live here? (5)	If no (5) Where does she/he live (5a)	How old is (Name)? (6)	What is the current marital status of (Name)? (B) (7)	(8)	(9)	Circle line number of all women are 15-49 (10)	Circle line number of all women are 15-49 (11)
01			M/F 1 /2	Yes/ No 1 2		Years				01	01
02			1 2	1 2						02	02
03			1 2	1 2						03	03
04			1 2	1 2						04	04
05			1 2	1 2						05	05
06			1 2	1 2						06	06
07			1 2	1 2						07	07
08			1 2	1 2						08	08
09			1 2	1 2						09	09
10			1 2	1 2						10	10
11			1 2	1 2						11	11
12			1 2	1 2						12	12

12. Total Number of Children: Boys Girls.....

Code for Ethnicity	Code
Muslim	1
Garos	2
Hindu	3
Others	4

Code: Q.3. Relation to head (A)		Q.7 Marital Status (B)	Q. 11 Education Level (C)
01= Head	08= Brother or Sister	1= Currently married	(Write only digit like 1, 2, on the basis of level 99= Illiterate 98= can sign 97= can read and write (never go school))
02= Wife or hunsband	09= Brother-in-Law or Sister-in-Law	2= Married, Gauna not performed	
03= Son or Daughter	10= Niece/Nephew	3= Widowed	
04= Son-in-Law or Daughter-in-Law	11= A dopted/Foster/Ste p-child	4= Divorced	
05= Grandchild	12= Domestic Servant	5= Separated	
06= Parent	13= Other not related	6= Never Married	
07= Parent-in-Law		7= Don't Know	

Line no	Education (If age 5 years or older)				House Work division	time spend	Birth registration	
	School going (13)	What is the highest (Name) has completed (C) (14)	Level of last attended school (in case of dropout) (15)	if dropout What is the reason (16)			Does name has a birth certificate (19)	Where was he/she born? At home=1 Hospital=2 (20)
01	Yes No 1 2						Yes No 1 2	
02	1 2						Yes No 1 2	
03	1 2						Yes No 1 2	
04	1 2						Yes No 1 2	
05	1 2						Yes No 1 2	
06	1 2						Yes No 1 2	
07	1 2						Yes No	

							1	2	
08	1	2					Yes 1	No 2	
09	1	2					Yes 1	No 2	
10	1	2					Yes 1	No 2	
11	1	2					Yes 1	No 2	
12	1	2					Yes 1	No 2	
Code: Q. 15 Domestic work (D)									
1= Cooking 2= Taking care of young siblings 3= Fetching water for household use 4= Collecting fire wood					5= House hold agricultural work 6= Shopping 7= Helping business 8= Others (specify _____)				

TICK IF CONTINUATION QUESTIONNAIRE USED

21. Just to make sure that I have a complete household listing:

a) Are there any other persons such as small children or infants that we have not listed? Yes No

b) Are there any biological children who may not be present in this household but lives with your other wives? Yes No

c) Are there any infant death/stillbirth/miscariage/MR/Abortion in your family? Yes No

d) If yes, then how many? _____ at what age?

e) Did any of your family members died because of pregnancy related causes? Yes NO

f) If yes, who died? at what age?..... How did she die?

Q. 22 What are the sources of water use

Purpose	Source code	Source code	Code: Sources of water	
Drinking			1= Piped inside dwelling water, 2= Piped outside dwelling, 3= Tube well, 4= Surface Well/other well, 5= Pond/Tank/Lake, 6= Rain water, 7= others (specify _____)	
Cooking				
Dish washing				
Bath				

Q. 23. Do you treat water in any way to make it safer to drink? Yes 1 No 2 Don't know 3

Q. 24. What do you usually do to the water to make it safer to drink? (Tick on code)

Techniques	Code	Techniques	Code
Boil	1	Use water filter (ceramic/sand/composite/etc.)	4
Add bleach/chlorine tablets	2	Others: specify _____	5
strain through a cloth	3		

Q. 25 What kind of toilet facility does your household have?

Techniques	Code	Techniques	Code
Septic tank/modern toilet	1	Hanging latrine	5
Water sealed/Slab latrine	2	No facility/Bush/Field	6
Pit latrine	3	Other :specify _____	7
Open latrine	4		

Q. 26. How many household use this toilet? _____

Q. 27. When members of your household get sick, where do they generally go for treatment?

	Code		Code		Code
PUBLIC MEDICAL SECTOR		PRIVATE MEDICAL SECTOR		OTHER	
Hospital/Medical college	1	Private Clinic	6	Home Treatment	11
Family Welfare Center	2	Private Doctor/clinic	7	Traditional healers(Ozha, Boidda, Kobiraj, Jharr, fue, holi water etc)	12
Upazilla Health Complex	3	Private paramedic	8	Dai (TBA	13
Satellite/EPI/Shobuz chata/clinic	4	Medicine shop/Pharmacy	9	Homeopathic	14
FWV/FWA	5	NGO or Trust Hospital	10	Other (specify)	15

	If do not go to the Government Hospitals,	Otherwise go to the next Question	Code
Q. 28	Why don't members of your household generally go to a government facility when they are sick?	No nearby facility	1
		Facility timing not convenient	2
		Health Personnel often absent	3
		Waiting time too long	4
		Poor quality of Care	5
		Other (specify _____)	6
Q. 29	During the last six months why did you / your household members go to any health facilities?	To accept family planning methods	1
		To give birth of a child	2
		Post natal care	3
		MR/Abortion	4
		Counseling	5
		STD	6
		Children's sickness	7
		Household member's sickness	8
		Pregnancy test	9
		Routine check up	10
		Others (Specify)	11

30. How far is the nearest health facilities from your house?.....KM

31. Do your household have the following assets or animals?

	Yes	No		Yes	No
1. Electricity	1	2	11. An electronic Fan	1	2
2. A mattress	1	2	12. A Refrigerator	1	2
3. Almirah (wardrobe)	1	2	13. A thresher	1	2
4. A table, chair or bench	1	2	14. A tractor	1	2
5. A watch of clock	1	2	15. Cows/Bulls/Bufaloes	1	2
6. A cot or bed	1	2	16. Goats	1	2
7. A radio that is working	1	2	17. Pigs	1	2
8. A television that is working	1	2	18. Sheep	1	2
9. A bicycle	1	2	19. Chickens/Ducks	1	2
10. A water pump	1	2	20. Mobile phone	1	2
			21. Others		

32	What types of fuel does your household mainly use for cooking?	Electricity	1
		LPG/Natural gas	2
		Biogas	3
		Wood	4
		Straw/Grass	5
		Agricultural crops waste	6
		Cow dung	7
		Others: specify _____	8

33	In your Household, What kind of stoves do you use to cook food in your household? (stove, a chullah, heater etc.)	Stove	1
		Chullah	2
		Open fire	3
		Others: specify _____)	4
34	Is the cooking done under a chimney?	Yes = 1, No = 2	
35	Is the cooking usually done in the house, in a separate building, or outdoors?	In the house	1
		In a separate buildings	2
		Outdoors	3
		Others: specify _____	4

36. What are the materials of your house?

	Roof	Walls	Floor
Code			

Code of materials: 1 = Bamboo/batch, 2 = Tin, 3 = Brick/Cement/concrete,
4 = Wood, 5 = Mud/Earth

37. How many rooms in this household are used for sleeping? _____

38. Does this household own any land? 1 = Yes 2 = No

39. If yes, please give me the following descriptions:

SL	Types of land	Amount in acres	Who is the owner?
1	Agricultural land		
2	Homestead land		
3	Garden		
4	Pond		
5	Total		

40. How much expense do you need in a month for the maintenance of your household on ?

1. Food (Monthly)	2. Treatment (Monthly)	3. Education (Monthly)	4. cloths (yearly)	5. house repair(yearly)	6. Guests/relatives	7. Accidental	8. Total (yearly)

41. What are the sources of income to maintain this expense?

Sl.	Major Occupation	Amount	Secondary Occupation	Amount (in tk)Year
1				
2				
3				

Monthly income:

42. Do your household have any savings after all the expenses at the end of the year?

Code	1= Surplus	2= No savings, no deficit	3= deficit (borrowed money from money lenders)
------	------------	---------------------------	---

43	Do any of your household members have a bank account or a post account?	1= Yes 2= No 3= Don't know	If yes then who have it?
44	Do any of your household members have a health card?	1= Yes 2= No 3= Don't know	If yes then who have it?

45. How many times do your family members take meals per day? ____ Meals per day

46. Please mention the food items that you have taken last night at home?

1= Rice, 2= fish, 3= Meat, 4= Eggs, 5=vegetables, 6= Dal, 7= potato, 8= Milk or milk products, 9= Others(specify)

47. Do your family members have enough warm cloth for the winter? Yes No

48. Which class do you think you belong to?

1= Rich	2= Upper Middle	3 = Middle	4= Poor	5 = extreme poor
---------	-----------------	------------	---------	------------------

49. How is the health condition of your household members?

	Code			
Your health	Very good= 1	Good=2	Not so good=3	Bad= 4
Your Spouse's health	Very good= 1	Good=2	Not so good=3	Bad= 4
Children's health	Very good= 1	Good=2	Not so good=3	Bad= 4
Elder member's health	Very good= 1	Good=2	Not so good=3	Bad= 4

50. Do you / your spouse use any methods of contraception to avoid pregnancy? Yes = 1, No = 2

51. If yes, which method?-----

52. If no, Why not?-----

Thank you for your participation in this survey by providing valuable information and time.

Appendix 5: List of female participants for in-depth interviews

No	Name	Age	Ethnicity	Number of children	Education	Occupation
1	Orchita	32	Garo	3 (Vasectomy)	No Education	farmer
2	Shuninda	35	Garo	3	5 th grade	housewife
3	Jamila Khatun	55	Muslim	4+ 2 miscarriage	No education	housewife
4	Joy Banu	48	Muslim	4(2 MR)	5 th grade	housewife
5	Payra Begum	37	Muslim	3 (Pill user)	5 th grade	housewife
6	Madhubala	53	Muslim	6	No Education	housewife
7	Kazoli	20	Garo	1	10 th grade	Parlour worker
8	Anita	19	Muslim	1	10 th grade	housewife
9	Phul Banu	49	Muslim	5 (self induced abortion)	No Education	housewife
10	Sabiha	19	Muslim	1	5 th grade	housewife
11	Nilima Sangma	24	Garo	3	5 th grade	farmer
12	Ambia	48	Garo	10+2 miscarriage	10 th grade	farmer
13	Parboti	25	Muslim	2(unwanted pregnancy)	5 th grade	housewife
14	Phalguni Banu	54	Muslim	5	5 th grade	house wife
15	Fabiha	28	Muslim	2 (pill user)	5 th grade	house wife
16	Mohua	19	Garo	1+ (1 abortion)	8 th grade	house wife
17	Shobita	21	Garo	1	H.S.C	housewife
18	Afroza	35	Muslim	3 (injection user)	3 rd grade	housewife
19	Fouzia	21	Muslim	1 (injection user)	5 th grade	housewife
20	Bonna	18	Muslim	1(Fistula)	5 nd grade	housewife
21	Moyna Mazhi	22	Garo	1	10 th grade	Parlour work
22	Sulekha Chishim	45	Garo	7	No Education	farmer
23	Shufia	22	Muslim	2(unwanted pregnancy)	5 th grade	house wife
24	Ramisa	30	Muslim	2(Norplant)	5 th grade	housewife
25	Shumi	37	Muslim	3 (Norplant)	5 th grade	house wife
26	Farida	32	Muslim	3+ 1miscarriage	5 th grade	Field worker
27	Rabeya	38	Muslim	4+ unsafe abortion)	no education	house wife
28	Shewly	35	Muslim	3 (miscarriage)Implant	no education	house wife

29	Natasha	25	Muslim	2	4 th grade	housewife
30	Kohinoor	42	Muslim	4(Injection user)	5 th grade	house wife
31	Laboni	19	Garo	1 (Caesarean)	H.S.C	house wife
32	Zakia	21	<i>Muslim</i>	1 (Caesarean)	8 th grade	house wife
33	Khushi Machi	40	Garo	3	H.S.C	teacher
34	Priya Chisim	55	Garo	8	5 th grade	farmer
35	Jaigun	32	Muslim	3 (1 miscarriage)(unwanted pregnancy)	5 th grade	house wife
36	Hoimonti	53	Muslim	6	No education	house wife
37	Talope	53	Garo	3 (3 died)	no education	farmer
38	Munni Mankhin	23	Garo	1	H.S.C.	NGO worker
39	Sapna Chisim	35	Garo	2 (Natural method)	H.S.C.	NGO worker
40	Dipti Mrong	45	Garo	2	10 th grade	Activist
41	Shulekha	42	Garo	3	no education	farmer
42	Godhuli	37	Garo	4	H.S.C	teacher
43	Shantana	32	Garo	3 (unwanted pregnancy)	5 th grade	day labourer
44	Khadiza Begum	49	Muslim	4 (UP)	5 th grade	housewife
45	Boishaki	38	Muslim	3 (Norplant)	10 th grade	housewife
46	Golapi	19	Garo	1	5 th grade	housewife
47	Ketuki Nokrek	50	Garo	6	no education	farmer
48	Dipali Mrong	40	Garo	6	no education	farmer
49	Rupali	28	Muslim	2(Norplant)	5 th grade	housewife
50	Marufa Begum	55	Muslim	5	3 rd grade	house wife

Appendix 6: List of male participants for in-depth interviews

No	Name	age	ethnicity	Number of children	education	Occupation
01	Patric Shingsang	60	Garó	6	10 th grade	Agriculture
02	Riaz Miah	35	Muslim	3	No education	Day labourer
03	Shopon Mrong	30	Garó	3	9 th grade	Carpenter
04	Jamil Miah	48	Muslim	3 (Vasectomy)	5 th Grade	Rickshaw Van puller
05	Akbar Ali	35	Muslim	2	8 th grade	Rickshaw van puller
06	John Dafo	33	Garó	1	4 th grade	agriculture
07	Antaz Ali	87	Muslim	9	No education	agriculture
08	Mr. Sabor Uddin	27	Muslim	No children	No education	agriculture
09	Hafiz Miah	35	Muslim	2	No education	Day labourer
10	Elmer Sangma	40	Garó	6	No education	Agriculture labour
11	Md. Hanif Miah	46	Muslim	6	No education	Van puller
12	Gonendra Nakrek	61	Garó	3	H.S.C	Service, agriculture
13	Rafiqul Islam	38	Muslim	2	S.S.C	Agriculture business
14	Shurjo Sangma	55	Garó	4	2 nd grade	agriculture
15	Dulal	37	Garó	3	9 th grade	NGO service
16	Md. Aman Ali	42	Muslim	2	No education	Day labourer
17	Md. Nasir Uddin	36	Muslim	2	HSC	Agriculture business
18	Md. Malek Miah	46	Muslim	3	2 nd grade	Agriculture, NGO service
19	Uzine Sangma	50	Garó	4	s.s.c	Job at Demiel foundation
20	Md. Akter Hossain	42	Muslim	3	4 th grade	Service agriculture

21	Md. Julhas Uddin	47	Muslim	2	No education	Van puller
22	Abdul Hamid	55	Muslim	4	10 th grade	Grosary shop owner
23	Ginet Nokrek	75	Garo	6	5 th grade	agriculture
24	Badal	38	Garo	4	Masters	Teacher
25	Shuvas	38	Garo	3 (Vasectomy)	5 th grade education	Community forest guard

Appendix 7: List of local level service providers for interviews

No	Name	Organisational affiliation	position
01	Dr. A.M Parvez Rahim	Madhupur Thana	Union Parishad Nirbahi Officer (UNO)
02	Dr. Narayan Chocroborti	UHC	Medical officer, Maternal health and Child care centre , UHC
03	Abdur Rahman	UHC	Family planning Officer
04	Morium	UHC	Nurse
05	Nurun Nahar	FWA	Satellite clinic, Gachhabari
06	Krisna Machi	FWV	Satellite clinic, Gachhabari
07	Rohima Akter	HA	Satellite clinic, Gachhabari
08	Johura Begum	Government health worker	Community health worker
09	Dr. Fatema Jahan	Private practice	Private practitioner, Madhupur
10	Father Uzin	Father	Pirgacha St Paul's Church
11	Father Homrich	Father	Pirgacha St Paul's Church
12	Aanna Dalbot	Nurse	Pirgacha St Paul's Church, maternity unit
13	Feluchita Nokrek	Nurse	Pirgacha St Paul's Church, maternity unit
14	Najma	BRAC	Programme officer, health
15	Shonchita Mankhin	BRAC	Health Assistant
16	Gonendra Nokrek	Local pharmacy	Pharmacist
17	Shochita	Shurjer Hasi	Local NGO
18	Shomola Azim	TBA	Community member
19	Asia Bewa	TBA	Community member
20	Zainul Abedin	Local journalist	Local representative Gachhabari area
21	Hornath Mankhin	Religious healer	Community member

Appendix 8: List of focus group discussion topics

To understand existing knowledge about reproductive health, I will conduct FGDs among men and women separately. Participants will be given the following topics and statements to share their opinion.

Reproductive health issues

- Family planning;
- safe motherhood;
- safe abortion facilities,
- infant and child care,
- male participation,
- adolescent reproductive health,
- infertility treatment and sexually transmitted diseases (STDs)
- HIV/AIDS
- polygamy and VAW

General

- Women should give birth of her first child at the age of 20
- Women should remain a virgin till her marriage
- Unmarried women shouldn't become pregnant
- It is easy to understand/know whether a woman is virgin or not
- It is difficult to understand/know whether a man is virgin or not
- Every couple needs at least one son
- Poor people need more children for their old age security
- Parents shouldn't discuss sex with adult children
- Sexual health education in the secondary schools will encourage boys and girls to experiment with sex
- Masturbation makes a man impotent

Menstruation and pregnancy

- Menstrual blood is impure
- Couples shouldn't have intercourse during menstruation
- Women can become pregnant during menstruation
- Women should eat less during pregnancy to give an easy delivery
- The husband should be present during the delivery of his wife

Contraception

- Condoms aren't as effective for contraception as pills or injections are
- Condoms reduce the pleasure during Sex
- Women who use contraception may become promiscuous
- Condoms are made of impure (Napak) elements
- Men should use condoms with prostitutes not with their wives
- Contraception is women's business and man shouldn't have to worry about it
- Women shouldn't hide the use of contraception from their husbands
- Amount of intercourse have consequence on reproductive health
- Women can prevent pregnancy by not having intercourse during certain period in her menstrual cycle.

Abortion

- If an unmarried women becomes pregnant due to a love affair she shouldn't go for an MR/Abortion
- If an unmarried women becomes pregnant of a rape she shouldn't go for an MR/Abortion
- Unmarried women should have access to legal and safe MR/Abortion
- Women have the right to have an MR/Abortion even if the husband disagree
- If abortion is not done in the hospital women can have serious health problem or die.

Men's group

- Women should be married off maximum at the age of 18
- Working women aren't obedient to their husbands
- Housework is women's responsibilities even if they have a job
- Women aren't good at financial management
- Higher educated women can't be a good wife
- Daughter's should get more education than sons
- Husbands can beat a disobedient wife
- Men become inactive after vasectomy
- Condoms reduce the pleasure during Sex
- Women should do an MR if she has an unwanted pregnancy even if husbands don't agree.

Women's group

- One's husband can't be one's friend as well
- Women should refuse to have intercourse if husband has an STD or if women don't want to be pregnant and the husband doesn't want to use condoms
- It is a shame to discuss about sex with one's husband
- Men don't want to use condoms
- women should use contraception secretly if their husbands don't allow them to use contraception
- Women should be married off as early as possible to save the honour of the family
- Adolescent girls shouldn't mix or play with boys before marriage to avoid any unwanted pregnancy.
- Adolescent girls should stay at home for their safety
- Women should give their income to their husbands if they ask
- Women shouldn't do a job if their husbands don't like it
- Women shouldn't leave her husband even if he marries another woman or goes to prostitutes
- Sons should get more education than daughters

Give me your opinion regarding the following statements:

Gender roles

- Men should earn money to maintain the family
- Men should not cook or do household works
- Women should stay at home to maintain purdah
- Women should give birth of her first child right after her marriage to prove her fertility
- If women delay marriage after the age 20 then there is a possibility that she can become infertile
- Polygamy is against women's rights

Women's Rights

- Woman should decide how many children she wants to have
- Staying at women's house (in-law's house) after marriage is not prestigious for man
- State laws ensures women's equal rights to man
- Kinship system should be determined according to father
- Existing customary laws do not protect women's rights (dower, inheritance, alimony)
- Women have right to divorce and right to choose partner
- Women have the right to control over her income
- Women have the right to education, health care, security
- Women have the freedom of mobility
- Women have control over own body and sexuality.
- women are privileged to have a Maternal leave
- In case of rape perpetrator should give alimony for the child
- It is the best solution to arrange marriage between the rapist and the victim of rape

Nutrition and hygiene

- Parents should teach their children about personal hygiene during puberty, menstruation, pregnancy, delivery and their daily life
- Money can give access to a doctor but can't ensure good health

- Women should eat less during pregnancy to give an easy delivery
- Women should give birth at home to maintain purdah
- Breastfeeding can protect women from going pregnant during lactating period.

Body and sexuality

- Women should remain a virgin till her marriage
- It is easy to understand/know whether a woman is virgin or not
- Adolescent girls shouldn't mix or play with boys before marriage to avoid any unwanted pregnancy or premarital sex
- Adolescent girls should stay at home for their safety after their puberty
- Parents shouldn't discuss sex with their adult children
- Sexual health education in the secondary schools will encourage boys and girls to experiment with sex before marriage
- Women should not masturbate
- Women do not have climax
- Women should not show interest of sex
- Unmarried women shouldn't be pregnant
- Masturbation makes a man impotent
- The use of alcohol affect men's potency
- Promiscuity is allowed for man
- Children from unmarried women should not consider as illegal child
- HIV is a sexual disease
- AIDS patients do not look healthy

Thank you for your participation.

Appendix 9: Background information of the population in the survey

This section provides an overall idea on the population and sex structure of the study population based on the household survey conducted in the study village over 502 households.

Ethnic diversity in the study village

The research village consists of a population from different ethnic groups. Majority of the population are (76.8 per cent) Muslims. The rest belong to Garo ethnic group (17.7 per cent) and Hindu minority group (5.5 per cent) (Table 9.1). Though, Hindus and Muslims are mainstream Bengalis, in this research Hindus are kept as a separate group to see the diversity due to their minority position.

Table 9.1 (Appendix)
Population distribution based on ethnicity in the studied village

Ethnicity	Frequency	Percentage
Muslims	1,932	76.8
Garos	446	17.7
Hindus	138	5.5
Total	2,516	100.0

Source: household survey, 2008.

Total numbers of the households interviewed were 502 and the total population is 2,516. In 502 household total male members are 1,281 and female 1,235 which is 50.9 per cent male and 49.1 per cent female household members (Table 9.2).

Table 9.2 (Appendix)
Sex composition of the total population

Sex	Frequency	Percentage
Male	1,281	50.9
Female	1,235	49.1
Total	2,516	100.0

Source: household survey, 2008.

It is interesting to see the male female ratio according to the age structure of the population in the study village. In the 1-4 age groups there are more girls than boys. The number of girls decreases sharply in the 5-9 age groups. Then the number again increases in the 15-34 age groups. Again the number of female decreases significantly in the 35-64 and 65 onwards (Table 9.3).

Table 9.3 (Appendix)
Age Group according to Sex composition

Age Group	Sex		Total
	Male	Female	
>4	103	118	221
5-9	156	143	299
10-14	142	142	284
15-19	130	137	267
20-34	350	403	753
35-49	227	195	422
50-64	111	78	189
65+	61	19	80
Total	1280	1236	2516

Source: household survey, 2008.

The reproductive age group (15-49) covers 706 Men among which 546 are Muslims, 125 are Garos and 36 are Hindus. Among 735 Women in the same reproductive age group 564 are Muslims followed by 129 Garos and 42 Hindus (Table 9.4).

Table 9.4 (Appendix)
Sex composition of the reproductive age group according to Ethnicity

Religion	Age Group (15-49)		Total
	Male	Female	
Muslim	546	564	1,110
Garo	125	129	254
Hindu	36	42	77
Total	706	735	1,442

Source: household survey, 2008.

Above table shows more female than male in the reproductive age group.

This thesis explores the intricate factors that play a role in women's lack of access to reproductive health care services, causing continued high maternal mortality in Bangladesh over the last decades. In the same period of time Bangladesh has achieved a significant fertility decline, which is commonly attributed to the government family planning programme in combination with an increase in the status of women due to better education, labour force participation and mobility. But why is this improved status not reflected in the maternal mortality trends? Why do women lack access to health care services during childbirth and suffer from complications arising from unsafe abortions?

By comparing the real life experiences of mainstream patrilineal Bengali and indigenous matrilineal Garo women, in the same rural location, this ethnographic study provides insight into how poor women from different ethnic communities experience and navigate power in their households, communities and on the health care market, in relation to their contraception, menstrual regulation, abortion and childbirth practices.

Given the distinction between the position of women in patrilineal and matrilineal households, the findings indicate that it is not enough to understand women's agency by only looking at household dynamics. The reality is that intra-household gender dynamics, class and ethnic positions all impinge, in complex interaction, on the ways women from different communities can express their agency and access health care services in order to ensure their reproductive health and wellbeing.



Runa Laila was born in Dhaka, Bangladesh. She completed her Bachelor and Master's degrees in Sociology at Dhaka University in 1993 and 1995 respectively. She began her academic career as a lecturer at the University of Rajshahi in 1996 and was promoted to Assistant Professor in 1999. After pursuing an MA in Development Studies with a specialization in Women, Gender and Development at the International Institute of Social Studies (ISS) in the Netherlands in 2003, she joined the department of Women and Gender Studies at Dhaka University as Assistant Professor from 2004 to 2014.

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