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# Beyond Supply: The Importance of Female Family Planning Workers in Rural Bangladesh

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*Using participant observation data on worker-client exchanges from Bangladesh, this article examines the interface between a government family planning program and the rural women it serves. Case material focuses first on the program function typically identified in the literature: meeting unmet demand for contraception by providing convenient supply. Functions that have been less recognized are then illustrated: (1) the worker's role in reducing fear of contraceptive technology; (2) her effort to address religious barriers, child mortality risks, and high fertility preferences; and (3) her role in mobilizing male support. The range of functions performed by the female family planning worker in the cases discussed here demonstrates that her role transcends the boundaries of what is conventionally implied by the concept of supply. She acts as an agent of change whose presence helps to shift reproductive decision-making away from passivity, exposing women long secluded by the tradition of purdah to the modern notion of deliberate choice. (STUDIES IN FAMILY PLANNING, 1988; 19, 1:29-38)*

Family planning programs do much more than serve unmet demand by providing a point of convenient access for users. However, the tendency in the population literature to refer to program activities as the "supply side" ignores their significant sociological role. Programs may be logistically and administratively complex as well as costly, requiring careful attention to design, management, and implementation. The scientifically interesting issues of family planning, however, are perceived to lie elsewhere, in questions about the level and composition of demand and its societal determinants. The nature of

complex organizations, especially client relations, is generally ignored in these pursuits, precisely because the sociology of programs is not adequately appreciated. This article moves beyond conventional notions of supply by portraying the female outreach worker within the institutional setting, of village society in Bangladesh. Using participant observation data on worker-client exchanges from rural Bangladesh, we take a direct look at the interface between a government program and the population it serves. The purpose is to elucidate the meaning and significance of that relationship through a qualitative analysis of the actual interactions between the program's field agents and their clients.

A recent analysis of panel data for a large sample of rural women in Bangladesh has demonstrated that worker-client exchanges can constitute a net determinant of contraceptive use. The influence of contact remained strong even when measures of demand were controlled for (Phillips et al., 1986). These results corroborate earlier findings from another study (Phillips et al., 1984a), which also showed a consistent relationship between worker contact and contraceptive adoption. These findings stand in contrast to the view that institutional and structural variables exert such overriding influence in the direction of high fertility in settings such as Bangladesh that service programs cannot succeed (Cain, 1977; Arthur and

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McNicoll, 1978; Demeny, 1975). By portraying the broader context within which worker-client exchanges occur, this paper provides insights into the question of why such contacts lead to contraceptive use.

We argue that in a social system characterized by strict patriarchal controls and extensive female seclusion, the presence of a female family planning worker acts as a link to modern ideas about reproductive choice in which the role of women shifts from passive toward more active modes of decision-making. By mobilizing demand for family limitation, mediating familial and religious conflicts with regard to contraception, alleviating fears of an alien technology and delivery system, and facilitating access to family planning methods, the worker's presence contributes to contraceptive use. The data analyzed here warrant an interpretation of the worker's role as one of emergent institutional significance.

## Background and Methodology

Where demand is weak, outreach is a crucial element in a successful supply strategy. In the Bangladesh government family planning and maternal/child health (MCH) program, a female field-worker is responsible for an average population of 7,500. She lives in her work area, has at least an eighth-grade education, and has received training for approximately four to six weeks. She is responsible for regular household visits to all women of reproductive age in her area. Given the size of a worker's area, she can, in theory, visit each eligible woman once every three months; more typically such visits occur an average of 1.5 times per year (Clark et al., 1986).

The interactions at the interface between workers and their clients reflect much about the realities of program implementation, but detailed information on this dimension is almost nonexistent in the population literature. This paper analyzes data based on translated transcripts of conversations and field notes from 65 actual encounters between 22 workers and rural women of reproductive age. Observations were conducted over a period of 18 months between February 1984 and August 1985, during the workers' regular village routines.<sup>1</sup>

The data were collected in the four sub-districts of the Extension Project, an ongoing action-research project of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).<sup>2</sup> All four study areas are rural. The two areas located in the northern part of the country are in a region that is subject to regular flooding, and characterized by the absence of industry and low literacy rates (19.5 and 21.5 percent, respectively). Study areas in the southwestern part of the country are located near two major cities, have some industry, and have higher literacy rates (26.1 and 35.2 percent, respectively).

The principal objective of this project is to utilize insights from the successful experimental maternal and

child health and family planning project in Matlab<sup>3</sup> in order to strengthen service delivery in the government program. Research is guided by a mixed-method paradigm with quantitative and qualitative methods providing complementary perspectives on the complex issues of program dynamics and service effects. Statistical analysis of longitudinal survey data from this project has provided support for the hypothesis that changes in reproductive behavior are significantly related to the clients' contact with workers (Phillips et al., 1986), posing multiple questions about the social context within which these effects arise. These questions can be at least partially answered with a qualitative approach. The contribution of qualitative research in this respect is threefold: (1) it lends perspective to a gross effect as measured by statistical coefficients, rendering a personal and explicable interpretation of an effect that is otherwise enigmatic; (2) qualitative research permits analysis of invariant attributes of the study population, which are a major focus of the present analysis; and (3) qualitative research permits exploratory investigations, allowing not just refinements in analysis but expanded scopes of inquiry.

To highlight the real-life quality of the data, seven cases are presented for detailed analysis, with extensive citations of actual dialogues. These dialogues provide access to the program-client interface, which is often blocked due to linguistic and gender barriers, social and cultural distance, or the difficulties of unobtrusive observation. The cases discussed here were purposefully selected, guided by the endeavor to elucidate the sociological significance of the worker's role, not to portray a picture of average or representative performance. Variations in length, content, and quality of exchanges do exist but are not discussed in this paper. In fact, given the emphasis on sociologically relevant functions, this analysis portrays the worker's best rather than average or weak performance. It should also be noted that some of the workers had received special training and guidance from the Extension Project. Field-workers were familiar with project staff from previous activities, a fact that contributed much to reduce anxieties about the observer's presence. Care was also taken to explain the non-supervisory nature of the observations, and workers were followed to several households in the expectation that this would be more likely to capture normal behavior. Nonetheless, it must be assumed that the observed behavior reflects the worker's best performance.

This article focuses first on the function typically identified in the literature on programs: meeting unmet demand for contraception by providing convenient supply. Functions that have been less recognized are then illustrated: (1) the worker's role in reducing fear of contraceptive technology; (2) her effort to address religious barriers, child mortality risks, and high fertility preferences; and (3) her role in mobilizing male support. A final section summarizes and interprets the worker's role within the institutional setting of rural Bangladesh.

## Meeting Unmet Demand through Convenient Supply

While debate persists about the magnitude of unmet need, some demand for family limitation and modern contraception in Bangladesh is generally acknowledged, even though it has been argued that social and economic institutions nurture high fertility norms. When clients express interest, it is the female worker's role to provide instruction about contraceptive methods, to deliver contraceptive services to the woman in her home, or to facilitate access to services at the nearest appropriate health facility. Her role in these situations closely follows the designated purpose of programs defined in the population literature:

[Programs are] designed to provide the information, supplies, and services of (modern) means of fertility control to those interested. Such programs frequently have a persuasive component as well, advocating the small-family norm, but that element is not strong. Usually the programs more or less accept existing levels of motivation and seek to meet the existing 'need' by minimizing the cost of fertility control not only monetarily but personally, by legitimizing the idea and by providing services through trusted sources (Freedman and Berelson, 1976:3).

Several of the observed encounters between the female outreach worker and her clients fit this conventional concept of the worker's supply function well. Three such cases are now illustrated.

### Case One

The worker approaches a poor household where she is obviously well known; the women of the household and several neighboring women gather around her inside the house. She inquires whether everyone is well and asks for the household registration cards, which she recently brought to this house. A young woman brings the cards and the following conversation takes place:

*Worker:* See, Apa [sister], I have sewn all these cards together so that none will be lost, but where has the string gone? . . . Get a needle and thread, I am sewing it again. How many times do I have to put it together?

*(The woman of the household looks as if she wants to say something. Eventually she speaks.)*

*Woman:* Do you people give the pill to stop birth?

*Worker:* Oh, yes, we do. Why? Do you want any?

*(The woman covers her face with her sarce in a gesture demonstrating culturally appropriate modesty.)*

*Woman:* Yes, I want some. Give me some pill.

*Worker:* Does the baby's father know about it?

*Woman:* Yes. He asked me to take some.

At this point the husband returns from the field, and sits next to the worker.

*Worker:* What is the news?

*Husband:* We are fine. How are you?

*Worker:* Do you want your wife to take the pill?

*Husband: (laughing)* Yes I want to. I do not want another baby soon. She is only one year old.

The worker begins to instruct the woman in the use of the pill after the husband has left the room to spare his wife the embarrassment of discussing the details of contraception in his presence.

In this case, both husband and wife clearly want to limit their family size; the husband appears to have initiated the decision-making process leading up to the adoption of contraception. When asked for the pill, the worker responds willingly with supplies and instruction.

### Case Two

This is the case of a woman who wants to use a Copper T IUD and has just secured her husband's approval for doing so. As she and the worker discuss the date for the insertion, which will take place at the nearest subcenter staffed by a female paramedic, the woman insists, "But you [i.e., the worker] have to take me, and bring me back."

This is a typical request when services cannot be provided in the home. In a society that values the principle of *purdah*—the physical and cultural seclusion of women—it is highly unusual for a woman to leave the immediate vicinity of her house. When she must do so, cultural norms and her own security require that she does not leave unaccompanied. Because she is known and trusted, the worker can serve as a link to an unfamiliar delivery system. It is generally the worker who takes the woman to the nearest subcenter for IUD insertion or to the health center in the case of tubectomy, often incurring transportation costs out of her own pocket. She stays with the client until services have been completed and accompanies her back to the village.

### Case Three

A major activity of the worker is the resupply of pills or injectables.<sup>4</sup> In one such case the worker has come to the household of a poor mother of four children who uses injectable contraception. The woman explains that the use of injectables has alleviated her menstrual problems:

*Woman:* Listen, Apa, I had so much trouble with my period before that I cannot express it to you. The bleeding was so much—just like a woman who delivered a baby recently. I had to change so many times a day I was not able to do my housework. . . . But after taking the injection my bleeding is normal now. I think it is because of the injection. It is very good.

*Worker:* You people became angry at me at the beginning when I asked for family planning. But you didn't want to understand what it is. Sit down, the injection is ready.

The worker administers the injection to the slightly nervous woman. Two other women are present, and the

atmosphere is friendly and relaxed. The mother then proudly shows her four little boys to the observer:

*Worker:* Pray to Allah so that they remain healthy.

*Woman:* Apa, it would be better if I would not have him (*she hugs the baby*), if I would have known about this injection before. (*After a pause*) He [the baby] is now one and a half years. It would be time for me to get pregnant if I did not take the injection.

This, then, is an example of contraceptive services made conveniently available in the home. Without the visit of the female worker, this woman is unlikely to continue contraceptive use. She wishes her last child had not been born—a genuine indication, it would appear, of strong demand for family limitation. She recognizes that without the services of the worker, she might find herself pregnant once again.

Distributing the pill and facilitating access to services and resupply are characteristic situations in which the worker performs the supply functions defined in the literature on programs. Follow-up visits to check IUD insertions and tubectomies, so essential in assuring continued confidence, fall into this category as well. In the cases presented above, services were delivered in a context where the worker had established trust and credibility. Without these, the function of meeting unmet demand through convenient supply could not be performed.

### Fear of Contraceptive Technology and Ambivalence toward Additional Births

Many women contacted by the worker appeared quite willing to contemplate the possibility of limiting childbearing, but expressed fear about contraceptive methods and the delivery system itself. The profound fear and anxieties associated with contraceptive technology and its delivery system are tied to the position of women—that is, to their status and life experience in a traditional culture that values female dependency and seclusion. Exposure of a woman's reproductive organs, necessary for IUD insertion, violates the profound sense of modesty and shame regarding anything associated with sexuality—"women's special sense of vulnerability" (Papanek, 1973: 296). Tubectomy, referred to in the village as "operation," evokes the horror of death for people who turn to the local healer when they are ill. They expect the events of the reproductive cycle to occur within the home environment. Pills and injectables, although more acceptable because of their dissociation with sexuality or the hospital, have a reputation for side effects that many women find intolerable. As is illustrated in the following cases, the worker attempts to provide reassurance and support in the face of these fears, while at the same time emphasizing the need to limit childbearing.

### Case Four

The worker is in a household where the husband has three wives. Two of the wives are present during the exchange; the husband and oldest wife, who has no children, are away. The youngest wife has just lost her first-born. The second wife has four sons and one daughter.

Most of the exchange occurs between the second wife and the worker. When the worker had met the husband some time before, he asked her to speak to his second wife about family planning. After an initial discussion about the death of the youngest (third) wife's child, the worker addresses the second wife:

*Worker:* Did you have your period in time?

*Second wife:* Yes. If I would have one more child, then I would go. (*After repeating this sentence two or three times, she looks at the third wife.*) She does not have any certainty of staying here. If the man dies, then she has to go to marry someone else. That man will need some children. But if she stays here, that is a different thing. If she gets some children, that is alright.

Later she agrees with the worker that five children are really enough for her, and most of the conversation focuses on her fear of contraceptive methods.

Here is a woman who is quite ready to agree that five children are enough when confronted by the worker with the importance of family planning for health and economic reasons. However, when considering the fate of the childless third wife and the insecurity implied in childlessness, she expresses the wish to have another child. This ambivalence about the preferred number of children does not appear to be the only barrier to contraceptive use. The woman's fears of the operation and the IUD are extensive, and she is apparently unsuited for the use of pills.

She fears tubectomy because, she says, women could become pregnant in spite of the operation. The worker counters this by pointing toward a nearby house:

*Worker:* All of them had the operation. I took them for the operation. Did any of them get pregnant? Did you hear it?

As the conversation continues, it becomes evident that the woman is profoundly afraid of the operation itself:

*Second wife:* I don't like cuts, stitches and all that.

*Worker:* You will not feel them.

*Second wife:* No, that is not right. Babu's wife felt them and shouted at the doctor, "What are you doing to me?"

*Third wife:* I know three or four women who cried in the operating room.

*Worker:* Now they don't make the patient unconscious—only the part of the body becomes senseless. But you will not feel anything about the operation.

*Second wife:* I am afraid of the operation.

The fear of contraceptive technology and of aspects of the delivery system emerge as strong themes in this encounter. They must be considered an influence on contraceptive use that is independent of, though interactive with, reproductive preferences. Abdullah and Zeidenstein have argued that the perceived risks of side effects are so extensive that they often outweigh a woman's desire to limit childbearing:

If a young village woman uses contraception and has problems with it, she is in a very difficult situation. The person who speaks for her if the outside world is involved is her mother-in-law who will hear from her son that there is a problem. The young woman must therefore have their prior approval in order to go to them, and even then there is likely to be embarrassment. If there were no problem within the household, the woman in difficulty is still faced with the real problem of getting adequate attention because there is likely to be no one really knowledgeable about family planning in the village; because travel to a clinic is culturally and physically difficult or costly; because dependable health care relevant to family planning needs may not be available at all. In addition, going out for help reveals the problem to the whole village and the men of the family are subject to ridicule for allowing such a situation to occur. It is not hard to understand why, in this setting, many women who may be motivated or interested in contraception, will not take the risk of trying it, or if they do, will stop as soon as they encounter difficulties. It may be genuinely less difficult and even less costly to have another child (1982: 187).

The worker's role here is to provide reassurance and support, which works well when she can point to successful contraceptive users within the neighborhood. At times, though, this is not sufficient to alleviate the fear evoked by counter-examples of women who experienced severe complications. Since these experiences, in fact, reflect lapses in the quality of care or follow-up within the government program, the worker's role is not an easy one. Ultimately it will be her standing within the community and the credibility she establishes through her interactions with the client that guarantee high quality care and persuade women to take the risk of trying an unfamiliar and alien technology.

### Introducing the Calculus of Choice in an Environment of High Fertility Norms, Mortality Fears, and Religious Opposition

Bangladesh has been described as a society in which high fertility is the norm. Children provide welcome extra hands in an agricultural economy; moreover, sons provide status and security to women in a patriarchal society and an environment constantly fraught with the risk of calamity. From the perspective of parents in a Bangladesh village, Cain concludes, "... high fertility and large

numbers of surviving children are economically 'rational' propositions" (Cain, 1977: 224).

The family planning worker is required to visit all women in their reproductive years, not only those who are actively seeking contraceptive methods. The following cases illustrate the nature of her role and influence in households where the fear of child mortality and religious opposition dominate the conversation.

#### Case Five

The worker and observer have come to this house accompanied by the client who was present at the visit next door. A family dispute in another part of the house has left everyone feeling slightly uncomfortable. An elderly man and an elderly woman are present as the worker begins to ask the client whether she has ever practiced family planning:

*Woman:* How can I stop birth when I don't know whether they are going to die or not? All the children will not survive.

*Worker:* Now you have three. Three is enough. The excess fourth one came but died. Actually two is enough nowadays. But you have one more.

*Woman:* Allah will decide how many will survive. If he wishes then all of them might survive, otherwise they will die. I cannot do anything over Allah.

*Worker:* This is not true that all of your children will die or Allah will take them away. All of them will not die anyway.

*Old man:* What you said is the order of the government and what we believe is the rule of God. He will decide everything. If he can give the mouth, he will provide the food as well. People do not have anything to do with it.

*Worker:* People have four, five, or more children. But you can understand easily that having two children is better. You can raise the children very comfortably. And it is less expensive too to give them food and clothing. Most of our people don't have enough money.

*Old man:* You don't have to think about children's food. God will provide you that.

The conversation continues along these lines, ending with the old man stating, "Government people invented all these medicines and now they have to sell it—that is why—" The worker, though, does not allow him to finish his sentence, countering, "People would not be able to invent anything if God did not wish that. God gives us the knowledge. Man cannot make anything without God's wish."

Is religion a pretext, the vehicle through which people articulate high fertility norms or express ambivalence about fertility limitation, or is it the real reason for the unwillingness to practice contraception? The old man dwells on the religious position. Would the woman have reacted similarly without his presence? Evidence that religious arguments are quite often used by men to oppose

a woman's wish to practice contraception is presented below. Fear of child mortality and religious prohibition against contraception are recurrent themes in the cases we discuss in subsequent sections as well. The worker attempts to counter religious opposition to family planning while at the same time referring to the value of smaller families for health and economic reasons. In this case, the worker's arguments did not persuade the client or her older male relative of the need to limit childbearing or of the legitimacy of contraceptive practice within Islamic law, certainly not during this particular visit. Nonetheless, if interpreted within the context of female seclusion and patriarchy, which define sex roles for women in Bangladesh, her visit was far from meaningless.

The system of *purdah* prescribes that women must be sheltered from what is perceived to be a threatening "outside" world. They are expected to remain within the confines of their own compound; mobility beyond this area is to occur only on special occasions and with appropriate company. Limited female education, an additional consequence of patriarchal systems that establish women's complete dependence on men and the dictates of female seclusion, has kept women in rural Bangladesh isolated from innovation and change. Their behavior in most spheres of life continues to reflect the norms of a traditional, rural, Islamic society. With respect to fertility, a high value is placed on large families, especially sons, and husband-wife communication on issues related to reproductive functions generally does not occur. With strong norms about what constitutes appropriate fertility behavior, individual decision-making is passive in nature. What Hollerbach has written for Latin America holds for Bangladesh as well: "In such situations the relative costs and benefits of childbearing are not consciously weighed nor are alternatives to childbearing; or the consequences of childbearing are defined *a priori* as positive and socially reinforced" (1980: 5).

It is in this context that the household visits by female field-workers assume special significance. Women's seclusion implies separation from innovation and change occurring in society at large (Maloney et al., 1980). In addition, women have limited access to formal and informal learning outside of the home. This is the environment into which the female family planning worker enters. She articulates new ideas about childbearing, representing the voice of someone from outside of the family—a worker of the government program—but at the same time she is a woman from the community who is more educated and generally also of higher social status than her clients. She acts as an intermediary, connecting traditional women to the wider ideas of a modern and changing world in what is the most central, role-defining dimension of women's lives: childbearing. While arguing for change, she respects and emphasizes conformity with tradition and the institutions of rural life.

The worker's arguments introduce the possibility of

choice into a cultural context where childbearing represents a learned, unquestioned response to the very definition of what it means to be a woman. Many of her clients will continue to believe that any tampering with reproductive functions violates Islamic law and represents unsound insurance against the risk of child mortality. Their world has changed nonetheless. They now know, and will hear the message again, that some women, not so different from themselves, believe in the legitimacy of alternatives.

Notable also in these encounters is the fact that it is the worker's message, but not her role, that is frequently rejected. Her role is validated when men allow their women to engage in conversation with the worker and when they themselves participate in the exchange. As long as the worker is allowed to enter the household and talk with her clients, the cultural barriers that segregate women from the outer world have begun to crumble, and reproductive norms, long sheltered from influences of change, are exposed to growing cross-pressures.

### Mobilizing Male Support

The institution of patriarchy shapes most facets of village life in Bangladesh. Patriarchy has been defined as "... a set of social relations with a material base that enables men to dominate women" (Cain et al., 1979: 406). Women are dependent on husbands and sons for status and security, and therefore desire high fertility. A point less emphasized is that when women do decide to limit childbearing, patriarchy once again exerts itself. The decision to adopt contraception does not rest only with the woman herself.<sup>5</sup> Given her dependency on men and her limited power to act independently, husband's consent and approval of other male elders is usually required. Sanctions against women who defy these norms can be extreme.

As will be seen from the cases discussed below, the worker's role in such situations is to facilitate husband-wife communication, to mobilize support for the woman's decision, or at times to arrange and support surreptitious contraceptive use. In each case she acts as an ally for the woman and expands her power base to make reproductive decisions, while simultaneously persisting in her efforts to weaken the desire for additional children.

#### Case Six

The worker approaches the house of a poor woman, who is eating while she nurses a baby. Three naked children share the food with her; her saree is torn. The worker asks the woman to finish feeding her children. After a moment the conversation begins:

*Woman:* What should I say? My man is not home.

*Worker:* How many children do you have this time? Three or four?

Woman: Four.

Worker: (Addressing the observer) I have been trying to convince her since she had only two. Now she has four. I could not convince her in any way. She is rigid like a stone. She is not ready to take any pill, or use something or to go somewhere to do something. (Addressing the woman) I (the woman starts laughing) have to send some angel, perhaps he can do something to you.

Woman: I am afraid of those things. (After a while) it would be nice if you would come in the morning. His father (pointing to the little boy) would be home then.

Worker: It is quite early in the morning. Now tell me what is your decision?

Woman: Can I say anything without his permission?

Worker: You are giving the same excuse for a long, long time.

Woman: So what can I do? . . . He can give the decision. I cannot give the decision.

Worker: Listen to me. Have you ever tried to convince him? Try to convince him nicely. Tell him that you have only this piece of land. You have no extra space to make houses for your sons when they will grow up. Where will you make houses for them? Look at your clothes and blankets. They are all torn. You were not like this before. You used to wear nice sarrees but now you are using the same sarree and it is all patched. Your condition will deteriorate if you get any more children.

Woman: I do understand it. I need one *seer* of rice every day.

Worker: How much money does he get each day from day labor? Ten or twelve *taka*. You need nine *taka* to buy one *seer* of rice. What will you buy with the remaining one *taka*? Salt, chili, or kerosene? What do you eat and what do you give to my brother [i.e., the woman's husband]? Children do not understand your economic condition. They will eat as much as they need. (The woman agrees with each point.)

Woman: You are right, children do not understand. They are immature.

Worker: You have no chance to get some rice or any other produce from the field. You don't have any land. You are poor people. If you would have one or two children, you could share the food in a better way. I am suggesting this because you are poor. Even rich people are using family planning methods.

The woman begins to talk about the children who died during her first marriage, when she was pregnant 11 times. All but two of those 11 children died; she subsequently had four more during her second marriage. She believes she is at the end of her childbearing period and will not become pregnant again. The worker disagrees, arguing that she is perfectly capable of having several more children.

The worker recounts to the observer how she had previously convinced the husband that the wife should have a Copper T IUD inserted; she even advanced them some money (presumably the compensation acceptors receive for IUDs) and she treated the husband when he

was ill. But this couple changed their minds, giving religious excuses. The dialogue continues:

Worker: Your old man is very difficult.

Woman: If he does not agree, I have no way to do anything.

Worker: That was a very good chance for me. But I failed. Even though I was not successful, I am not giving up hope. My hope is that today or tomorrow I must give you some kind of method. When I go to him he says you do not agree; when I come to you, you give his excuse. (The woman laughs.) Truly speaking, this is not our way of giving people family planning. We never force people to do that. We like to convince people by regular visit, by behaving very well and loving them. You are my own people; I am your well-wisher. That is why I am asking you so many times and for so long.

Woman: That is true. But I have a brother and sometimes I visit his house. I have no other place to go. But if I accept a method, then that door will be closed for me. I will not be able to walk near his house. My younger brother's wife had the operation and my elder brother said that he will not arrange her *zanaza* [last prayer after death] and he will not bury her. He said that she should be isolated from society.

Worker: Is he your own brother?

Woman: Yes.

Worker: You did not tell me this before.

Woman: This is what I am afraid of.

During most of this conversation it seems that the woman might be willing to limit childbearing but that she cannot act without the consent of her husband. The experience of child mortality that overshadowed her first marriage has not been forgotten, though; her reference to the nine children who died during that marriage signifies a nagging fear about the fate of her current offspring. Thus, while the dominant theme is the husband's opposition, the woman implicitly acknowledges her own hesitancy to accept a method.

The worker directs her arguments both at the adverse economic consequences of continued childbearing and at the need for persuading the husband of the urgent need to limit births, so that they can provide for the children they already have. Her previous efforts with this family were almost successful, but a last minute change of mind obliged her to start from the beginning.

The relationship is friendly and casual, and the worker jokes frequently. It is not until the end of this lengthy conversation, however, that the woman reveals who might be the real barrier in this case: her brother, who objects to family planning on religious grounds. He has threatened another sister-in-law with social sanctions and the refusal to give her the last prayer at the time of her death. Both husband and wife seem to fear these religious sanctions more than anything else. The worker is surprised that she did not know this before, but undaunted in her readiness to deal with these fears. She

obviously recognizes that success is not likely during this visit but cheerfully states that she will keep trying.

Social and religious sanctions from a husband if a woman acts without his consent, and more importantly in this case, the fear of such sanctions from other family members, predominate over what appears to be considerable readiness to limit childbearing. The worker's task is a formidable one.

No matter what the sanction, though, women do seem at times ready to follow the advice of the worker rather than abide by the dictates of male relatives. Such is the example discussed next.

#### Case Seven

The worker is in a house where the husband's older brother, a religious leader, vehemently argues that Islam does not permit the practice of family planning. The worker contradicts him point by point, arguing that family planning is not forbidden by Islam and is quite widely accepted by other religious leaders. When the older brother leaves, the worker turns to the woman's husband and asks for his opinion. He meekly declares, "What should be my opinion? My opinion is what my brother thinks about it."

Other women who are present throughout the conversation emphasize that this man's wife would not be allowed in the house if she had a tubectomy. Eventually the woman whispers to the worker:

*Woman:* I can feel that I am not yet pregnant. But you have seen everything. What can I do, tell me? My husband does not have any voice in this family. My brother-in-law is everything.

The worker decides to conclude the visit:

*Worker:* It is not possible to discuss anything confidentially. All these are confidential matters. Anyhow, we have to go now.

The wife follows her to the next household where she begins talking to her. She wants to accept a method but is afraid of her brother-in-law. She seems at first to want pills, but when the worker offers them to her she does not accept them after all—yet she continues to follow the worker while she visits the next three households. Here we see an indication that cross-pressures might not always be resolved in favor of religious norms as interpreted by male relatives. The worker is becoming an ally of women who choose to use secrecy in order to bypass the opposition of their husbands and other male relatives."

Why would men object to their wives' use of contraceptives? Male opposition to women's practice of contraception is not limited to Islamic societies, but part of the explanation may nonetheless be seen in the institution of *purdah*. One aspect of *purdah*, Papanek argues, ". . . allocates to women in segregated societies a greater responsibility in the moral sphere. . . . Women's

proper behavior as sheltered persons becomes an important source of the status of their protectors" (1973: 317). Practice of contraception, through its association with sexuality, violates fundamental moral taboos. Several of the references in these worker-client exchanges convey the impression that family planning use is associated with a loss of status for women. Following Papanek's reasoning, one might suggest that this loss of status is not limited to women but affects their husbands as well. This concern with status must, of course, be considered along with the possibility discussed above that religious concerns themselves are both genuine and profound.

The combined forces of patriarchy and *purdah* imply that women in traditional Bangladesh society have no support system outside the family. In addition, given the nature of patriarchy, the woman's interests, especially when she is young and must establish her worth, are always secondary to those of others in the family (Chen, 1983). The presence of the female family planning worker constitutes a remarkable departure in this institutional setting. Not only does she articulate alternatives to traditional, high fertility norms, but she assists women in overcoming male opposition, an unprecedented phenomenon for these traditional rural women.

#### Conclusion

The range of functions performed by the female family planning worker in the cases discussed above demonstrates that her role transcends the boundaries of what is conventionally implied by the concept of supply. She acts as an agent of change whose presence helps to shift reproductive decision-making away from passivity, exposing women long secluded by the tradition of *purdah* to the modern notion of deliberate choice. This, it might be argued, is a prerequisite for eventual fertility control. The worker defends the practice of contraception as legitimate within the principles of Islamic law and attempts to alleviate child mortality fears by reference to new trends. She also makes relevant MCH recommendations and acts as a general family friend, providing advice on marriage and economic matters. Her credibility acts as guarantor for the safety of contraceptive technology and for an alien delivery system. She provides support in familial conflicts when the views of other family members and the woman's own interests concerning the practice of contraception clash. The provision of convenient access to the means of fertility control are part of the worker's function, but this role has broader social and cultural significance.

When the worker talks to clients she is rarely alone; groups of neighboring women, young girls, children, and sometimes men gather around her. Often lengthy conversations ensue, providing women with the opportunity to discuss contraception and related family

matters. It is not only the worker who lectures women on these occasions; other women explore openly the pros and cons of family planning. At times, satisfied users proudly describe their experience. Social diffusion has obviously occurred and is continuing to spread as the worker proceeds from house to house.

The worker's presence in the village is beginning to show institutional potential, although the incipient stage of this phenomenon must be emphasized. Not all workers perform the various dimensions of this role with equal competence, nor with the formally required regularity. Some of the observations, including those cited here, reveal glaring inadequacies and missed opportunities for meaningful exchange, and it is known from our close association with the field and other Extension Project research that the overall quality of care—especially screening of patients, attention to side-effects, and follow-up—must be improved. Moreover, it is recognized that support systems and requisite facilities to assure full effectiveness of the field staff are lacking, that quota systems—especially in the absence of effective supervision and support—may blur the line between authoritative guidance and undue pressure, and that worker-to-population ratios are too low to assure a steady presence in the village. In fact, the overall administrative and operational context within which the field-worker functions is generally so weak that the strength of her presence and obvious influence in the village are almost a surprise. The intent of this paper has been to focus on the significance of the field-worker as an ideal type. This does not imply her performance is always exemplary but that the "crucial instances" (Gerth and Mills, 1958) reported here amount to a type of influence that is in fact operative in rural Bangladesh.

While the institutions of traditional society continue to shape the lives of rural women in Bangladesh, forces of change are also visible, creating greater responsiveness toward the worker's role. Radios are a common household good and even television sets are occasionally available in the village. The media reinforce family planning messages and provide indirect access to a wider, modern world, even though most women remain restricted in their physical mobility. Female education, while still low, is increasingly accepted as desirable. Growing landlessness and economic adversity, coupled with aspirations for a better and more modern life, may also create a more responsive climate for the worker's message of family limitation (Freedman and Freedman, 1986).

On methodological grounds, it might be argued that the situations observed overrepresent the normal performance of a worker. This is undoubtedly so. Workers knew they were being observed and it can be assumed that they gave their best performance. Nonetheless, there is much evidence in the data that what was observed was not simply the result of a "Hawthorne effect." Workers were, on the whole, well known and well received, even by families who opposed the practice of contraception. They were repeatedly invited for a meal

or asked to stay longer with a family. Individual conversations revealed evidence of long-standing relationships and motivational efforts.

Bangladesh has been described as a society lacking in local institutional mechanisms to assure collective action for the benefit of communities. Villages are deficient in social cohesion, factional alignments are strong, and local administration is weak (Arthur and McNicoll, 1978). In the context of such institutional weakness, the role of the field-worker as a representative of the deliberately constructed governmental mechanism to affect population growth assumes special significance. In spite of relatively low worker densities and variability in individual performance, the notion of the worker's role as one with emergent institutional relevance is persuasive. It can be hypothesized that the presence of the female worker is beginning to amount to an institutional innovation counteracting those elements in the system of patriarchy and *purdah* that render women passive in decisions about their fertility.

## Notes

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- 1 Observations were made by one of the authors and two other female researchers.
- 2 For the design and initial findings from this research see Phillips et al., 1984b and 1986; Simmons et al., 1984; Koblinsky et al., 1985; and Yunus et al., 1985.
- 3 The Matlab project is described in Bhatia et al., 1980; Phillips et al., 1984b; and Phillips et al., 1984c.
- 4 Following the Matlab example, the Extension Project has introduced the delivery of injectables through field-workers on an experimental basis.
- 5 For a more general discussion of this point see Koenig and Foo, 1985.
- 6 That women sometimes use secrecy to protect their personal interests and that of their children against household or other relatives has been noted by Abdullah and Zeidenstein (1982) who report instances where women accumulate savings without the knowledge of other family members.

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