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Bangladesh's Family Planning Success Story: A Gender Perspective

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Working within the constraints of a social system in which women are subordinated and secluded, the Bangladeshi family planning program uses village-based female workers to deliver contraceptive information and supplies to women in their homes. In-depth interviews conducted with 104 women and 92 men (including 85 couples) as part of an ethnographic study in rural Bangladesh suggest that this strategy, despite its success in increasing contraceptive prevalence, often fails to provide adequate information and support to contraceptive users and may actually reinforce women's isolation and powerlessness by accommodating existing gender norms. In addition, the program has placed the costs of fertility control primarily on women by emphasizing female methods and failing to involve men. (International Family Planning Perspectives, **21:**132–137 & 166, 1995)

Bangladesh has received considerable attention lately, in international development circles and in the media, as a country where a "reproductive revolution" is occurring in the absence of significant improvements in economic indicators. The dramatic increase in the prevalence of contraceptive use (from 3% to 45% among married women since the country gained its independence in 1971) and the declining fertility rate (from about seven births per woman in the mid-1970s to 3.4 births per woman in 1993) have been attributed in large part to massive efforts made, particularly over the past 15 years, to expand access to family planning methods and services and to motivate people to use them.[1] The reproductive revolution that has begun in Bangladesh is particularly remarkable when seen against the backdrop of persistent poverty, high mortality, low literacy (particularly among women) and such patriarchal social norms as early marriage for girls, seclusion of women and adolescent girls and preference for sons.

The national family planning program could be described as "culturally sensitive" (or pragmatic) in that it uses strategies that acknowledge and accommodate gender inequality. Its central strategy, delivery of family planning information and methods to women in their homes, was launched between 1976 and 1980, when 13,500 female family welfare assistants were hired and trained.[2] Currently, there are about 28,000 such women working in their own or nearby villages; about three-quarters of them are employed by the government. The majority have had some secondary schooling. Their primary functions are to inform women about various methods of contraception; to motivate women to use contraceptives; to supply condoms, pills and (in some cases) injectable contraceptives; and to refer women who want clinical methods to appropriate sources such as government clinics. The initial training period is 48 days, after which some workers receive follow-up training.

During the 1970s and early 1980s, when sterilization was the main focus of the family planning program and compensation was provided for accompanying sterilization clients to clinics, the village-based workers spent much of their time promoting sterilization and assisting female sterilization clients. Even now, it is not unusual for a family planning worker to take a client to a clinic for sterilization, keep her company before and after the procedure, and provide other assistance, such as watching the client's children or bringing water, food or medications. However, because direct compensation for this service was discontinued in the late 1980s and nonpermanent methods are receiving more emphasis in the program, most of the village workers' time is now spent in promoting and supplying contraceptive pills.

In 1992, Simmons and colleagues published the results of focus-group interviews with village-based family planning workers and other residents of villages in the Matlab subdistrict, where an intensive nongovernmental program had been under way for over a decade. They suggest that, by providing employment opportunities for women in an environment where professional employment opportunities are scarce, the family planning program has not only transformed the lives and improved the status of the outreach workers themselves, but has transformed community perceptions of women's roles, making social boundaries less rigid for other women.[3]

The workers Simmons and her colleagues interviewed had gone through a difficult period but had ultimately gained community acceptance of their nontraditional roles. Visiting households, attending training sessions and meetings, and initiating discussions about reproductive health and contraception were initially perceived as violations of traditional standards of female modesty. According to Simmons, the project (and the workers) succeeded in gaining social acceptance by conforming as far as possible to traditional definitions of gender.

Although the Matlab project was run by

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a nongovernmental organization, in certain ways it became a model for the government program. In particular, it produced data demonstrating the effectiveness of community-based workers, which influenced the government's decision, backed by international population donors, to expand the cadre of community-based female workers in the national program. Although the Matlab workers may provide services of consistently higher quality, the government program's family welfare assistants provide the same basic services, work in much the same way and seem to have adopted similar strategies for gaining acceptance in their communities.

In this article, we use case-study data from ethnographic research to make the argument that the program's accommodation to gender-based social inequality has been its weakness as well as an important factor in its success; although the program has succeeded in reaching Bangladeshi women and persuading them to use contraceptives, it often fails to support contraceptive users and to meet women's other reproductive needs. By removing the need for women to leave their homes, this strategy deprives them of the opportunity to avail themselves of a wider range of services. Moreover, instead of attempting to engage men, the program places the responsibility for family planning disproportionately on women, who lack the resources to deal with its costs and risks.

Methodology and Data

Our observations are based on ethnographic research conducted by resident researchers in six villages in two regions of Bangladesh between 1990 and 1994 as part of a larger study of transformations in women's status and reproductive norms in Bangladesh.[4] Three of these villages are in northern Bangladesh, in Rangpur District, and three are in the west—two in Magura District and one in Faridpur District. At the time of the interviews, one village had a worker from a nongovernmental family planning program, one had both a government and a nongovernment worker who visited occasionally and the other four were served by government family planning workers.

Each male-female team of researchers selected a stratified random sample of 20 households in their village for intensive case studies. They limited the sampling frame to households that owned less than one acre of land. (Roughly half of the rural population of Bangladesh falls into this category.) To maximize the number of potential users of family planning in each sample, they included only households with a married woman aged 35 or younger who had at least one living child.

The researchers conducted in-depth interviews with 104 women and 92 men (including 85 couples) from these villages about reproductive decision-making and experiences with contraceptive methods and services. In addition, they interviewed 47 women and 47 men (including 46 couples) who lived in hamlets near the ethnographic sites; all of these respondents, who belonged to the same socioeconomic group as those in the six-village sample, had adopted a contraceptive method during the year preceding their interview. Men and women were interviewed separately by an interviewer of their own sex.

The 151 women had a mean age of 27 years and an average of 2.8 living children. About 77% had one or more living sons. Only 5% said they wanted another child in the near future, while 21% said they wanted another child after some years and 72% said they did not want any more children; 2% (three women) gave ambiguous answers. About 63% of the women in the six-village sample and all of the women in the supplementary sample were using a contraceptive method at the time of the interviews. In all, 13% of the women said they had aborted at least one pregnancy, and 41% of those at risk of pregnancy said they would have an abortion if they conceived again in the near future.*

A semistructured interview guide was used to elicit a fertility history and a chronicle of each couple's family planning decisions and practice, starting from the time of marriage. The interview guide was designed to help the respondents remember what they had known and thought about family planning at various times in their lives, whom they had talked to, who had been involved and who had dominated in family planning decisions, what factors had played a role in their decisions and behavior, and who had helped or hindered them in finding out about contraceptive methods and in obtaining and using methods.

Some of the underlying themes that emerged from the women's interviews were: the evolution of the respondents' awareness that fertility can be controlled; their growing sense of a need to control it; the decision-making processes, fears, conflicts and other barriers facing women who want and need family planning services; and their experiences in getting access to and using contraceptive methods. The interviews with men tended to be much briefer, probably reflecting their more limited interest in the topic. The women's interview transcripts were compared with their husbands' transcripts, and follow-up interviews were conducted to clarify inconsistencies and probe for additional information.

The experiences described in these interviews might be considered the subtext of the family planning "success story" that has been unfolding in rural Bangladesh. The quotations we present are not intended to be representative or to illustrate the full range of situations encountered in the study. Rather, they have been selected deliberately to illustrate key themes that emerged from the analysis, and to elucidate patterns and principles underlying the behaviors described.

Findings

Worker-Client Interactions

The style in which the family planning workers interact with clients has several traditional aspects, the most obvious of which is that the workers are women interacting with women in a sex-segregated society. Another is the way the workers are described and addressed: Many people use kinship terms to address and refer to the workers in their village because they are related to them in some way. People who are not related generally refer to their village family planning worker as "mother of (the name of one of her children)" or "wife of (her husband's name)" or "Sister" (*apa*).

A worker who comes from outside the village typically is called "Sister" and referred to as the "pill-giving Sister" or "pill-bringing Sister." Thus, at least in the way they are named, workers fit into the pattern of traditional life, in which women do not deal with outsiders. Recruiting women to work in their own villages and labeling outside women as insiders makes it more acceptable for them to interact directly with women.

A central aspect of the "inside/outside" dichotomy in traditional Bangladeshi society is that women need intermediaries—typically, husbands, sons or other male relatives—to interact with the outside world. On occasions when women are allowed to go out (e.g., to visit their natal home, attend a wedding, see a movie or seek med-

*This calculation excludes 25 cases in which the husband or wife had been sterilized and 20 women who did not give clear responses to the question. However, 13 of those who did not give clear answers had already made some attempt to abort a pregnancy or said that they had wanted to but were prevented by their husbands. Several women who indicated that they were against abortion, but did not say directly that they would not have one, were included with those who said directly that they would not have an abortion if they became pregnant in the near future.

ical care), men almost always accompany them. In many rural areas, it is virtually unheard of for a woman to go alone to a health facility or family planning clinic. Given her status as both insider and outsider, the family planning worker can act as an intermediary in arranging for clinical services and accompanying women on visits to family planning facilities.

Rural Bangladeshi society is quite hierarchical. A decade or two ago, family planning workers were usually recruited from elite rural families, and most of the more recently recruited workers come from the rural middle class. Women from poor rural families rarely become fieldworkers because few can meet the educational requirement (in most cases, a minimum of 10 years). In addition, most poor families cannot afford to pay bribes to secure government jobs. Although the tone of interactions between the village-based workers and their clients suggests benevolent concern, it is also hierarchical, both because of the status of the job itself and because of the difference in social class between the family planning worker and most of her clients.* This status difference may help indirectly in reducing male opposition to women's use of contraceptives.

In the six study villages, the family planning workers rarely initiated conversations with men unless they were related to them through kinship ties. Although the workers did engage in discussions with unrelated men who initiated a conversation, they usually talked to men indirectly, through their wives. As one village woman recounted:

> R's wife [the family planning worker] asked me, 'Why have more children when you already have four? Why don't you have the operation? It's time you did something. Besides, your health is not good. We have our hospital in Faridpur. There will not be any problem having it done. Besides, you have no land, how will you feed them properly? How can you give them a proper life?'

After the family planning worker came a second time, the woman presented these arguments to her husband and added,

> 'R.'s wife is very logical. If we have more children, what will we feed them? And by the grace of Allah, we already have two sons.'

Following traditional ideas of proper behavior, the wife usually does not make a direct request or suggestion to the husband. Rather, she mentions that the family planning worker (who has a higher status) has suggested that she practice contraception. If the husband expresses reservations, the wife explains what the family planning worker has said.

> I said to my husband, 'Your brother's wife, the Sister from [the family planning clinic], told me that I should not have any more children, because we already have a son and a daughter. She advised me to adopt some method and warned me that my health will deteriorate and the harmony of the family will be destroyed if I have too many children.' After hearing all of this, he became interested in family planning and told me to adopt a method.

Even when promoting nontraditional behavior, the village-based workers tend to help their clients continue to behave traditionally in other ways. By providing information and services in the home, the workers remove the need for women to go to a clinic or other outside source for family planning services. Although they sometimes suggest that their clients speak to their husband or seek their husband's permission to adopt a contraceptive, they do not encourage open confrontation with husbands who are opposed. In some cases, they assist women in using contraceptive methods secretly—secrecy being a much more traditional form of behavior for women than confrontation.

Men's Role in Family Planning Decisions

In Bangladesh, men often give their wives permission to practice contraception in a noncommittal way, without actually making a decision themselves; if anything goes wrong, they can blame their wives. Men have authority, but often they are reluctant to take responsibility.

> I asked my husband whether I should take the pill. He didn't say anything.…He won't disapprove, nor will he tell me to do it. He is very quiet.
>
> [The family planning worker] came to my house on many occasions and talked to me about family planning.…I told this to my husband. He didn't oppose it. He told me to do what I thought best, but warned me that if I got sick [from the contraceptive] he would not pay for my treatment.… Twelve days later I told my husband that I was going to the Sister's house to get the injection. He said there was no need to tell him about all of this. 'That's your business,' he said, 'there's nothing to tell me about.'

One of the men explained:

> After the fourth child, my wife told me that she didn't want to have any more babies. She wanted to take pills. [The family planning worker] had told her not to have any more children. I told my wife that I didn't know anything about that and said she should do what she thought best.…I was indifferent because I thought that whatever was to happen would happen. I did not talk to anyone about it.

Another said:

> My wife doesn't talk about family planning with me. I only know that the Sisters gave it to her and that she's taking it. I don't want any more children. My wife is taking the pill regularly, so I don't ask her anything about that.

In some cases, men do get directly involved in discussing and making family planning decisions, bringing their wife contraceptive pills from the market, taking the initiative in getting their wife to use a contraceptive method, or even getting sterilized or beginning to use condoms. We would argue, however, that the family planning program in its current form does little to promote men's involvement in family planning and that this is a problem for women.

Weaknesses of the Home Delivery System

Household delivery of family planning services by village-based female workers has been very effective in transforming reproductive norms in rural Bangladesh. Changes in reproductive norms, however, do not constitute a transformation in gender relations. (Indeed, such a transformation is not the family planning program's objective.) Women's social subordination and economic dependence, combined with the family planning program's woman-centered, door-to-door service delivery approach, leads to or exacerbates many problems—overreliance on the village-based workers, a lopsided method mix, misinformation about methods and about availability of safe abortion services, unavailability of services when needed, fear of methods and side effects, and inadequate assistance with side effects. Thus, many women who use contraceptives feel isolated and frustrated.

• *Overreliance on village workers.* Many women have contact only with the village-based family planning workers who visit them, and never have the opportunity to consult a doctor, nurse or trained midwife

*The experience of the Matlab Project suggests that the credibility of village family planning workers is compromised if clients perceive them as socially inferior or less knowledgeable than themselves. (See: M. Rahman et al., "The Matlab Contraceptive Distribution Project," Scientific Paper No. 32, International Centre for Diarrhoeal Disease Research, Dhaka, Bangladesh, 1979.)

about reproductive health and fertility control. Of the 91 women in the six-village sample who had ever used a contraceptive method (including traditional methods), 33 had had contact only with a village family planning worker and one had had no contact with any trained family planning service provider.

Of the women who had visited clinic-based or hospital-based family planning facilities, 21 had done so only once, 17 for surgical sterilization and four for an abortion, and one had done so twice (once for an abortion and once for sterilization). Just 26 of the 91 women who had ever used family planning had received a reversible method or been given treatment or counseling for contraceptive side effects from clinic-based family planning service providers.

Many women perceive the village-based family planning worker as their only source of support and assistance in practicing contraception. While the majority of the women interviewed in our study appeared to be grateful for the services they received, those who did not like or trust their local worker expressed a sense of bitterness and frustration.

> After my second child was born I had a Copper-T inserted at Sister's house. But I had terrible pains in my belly and I couldn't do the housework. One day I told my husband that I had a Copper-T inserted three months earlier. He told me to take it out immediately, but I kept it in for another three months, and then had it removed [at a clinic]. Sister was really angry with me for having the Copper-T removed, and she didn't give me advice about using any other method. If she had helped me, I would not have had two more children. My husband was angry with me too. And I was angry, so I stopped visiting Sister.

Using village-based workers and bringing family planning services to the household restricts the technical quality of services that the program can offer. There is a limit to what can reasonably be expected of a rural woman with only 10 years of formal education, a few months of technical training and little or no technical supervision. Moreover, the family planning worker often is not there when needed, particularly if she does not live in the same village.

•*Method mix.* In Bangladesh in 1993–1994, only 4% of married women younger than 50 were protected from pregnancy by vasectomy or the condom, while 32% were using a modern female method.[5] The male-female method mix in the six ethnographic study villages was similar, with fewer than 5% of married couples in which the wife was younger than 50 using modern methods for men and 37% using modern methods for women. Given the relative safety and the negligible side effects of male methods, this method mix suggests biases among both family planning clients and service providers.

•*Misinformation.* Misconceptions about contraception were common among the women we interviewed. Some of the most prevalent misconceptions were that using the pill for a long time causes sterility or other problems; that it is sometimes helpful to "rest" by taking the pill intermittently or alternating with condoms; that it is inappropriate or dangerous to use the pill before the birth of the first child; that it is inappropriate or even dangerous after having a child to start a contraceptive method before the menses resume; that rich, expensive foods are needed to protect the body from the pill; and that sterilization causes long-term physical weakness in men and women and that it makes men impotent. Women frequently reported that family planning workers were the source of this information.

In addition, many of the women who had at some time wanted to have an abortion were unaware that menstrual regulation (early pregnancy termination) procedures have been available free in government facilities since 1975.[6] As one interviewer reported:

> R. realized that she had too many children. [After her eighth child she got pregnant again and went to an aunt in the village who was known as an abortionist. The respondent did not explain what method was used.] She did not charge any money, but the abortion was not successful. The neighbors told her that she would have an abortion if she took Mayabori [contraceptive pills]. So she took one and one-half strips, but this did not work. She got weak and dizzy.

Village women recounted the following experience:

> At that time, I could not buy pills because we were short of money. After awhile I got pregnant. After discussing it with my husband I had my four-month pregnancy destroyed through Ayurvedic treatment [a traditional medical system based on herbs]. I nearly died because of the heavy bleeding. With my husband I visited a lady doctor in Rangpur and [had a D&C.] It cost us 800 Taka* and we had to sell two decimals of land to pay for it.

In the interview transcript it is not clear why she and her husband were buying pills instead of getting them free from the family planning worker. They may have been told that the free pills were inferior, a notion that came up in many interviews, or the worker may have run out of pills. (There are periodic supply problems in the Bangladeshi family planning program.) Or, the family planning worker may have been selling the pills rather than distributing them without charge.

"Even when promoting nontraditional behavior, the village-based workers tend to help their clients continue to behave traditionally in other ways."

•*Services not available when needed.* Even with 28,000 family planning workers, it is virtually impossible to make regular and frequent visits to all women who may need family planning services. In 1994, 65% of the married women younger than 50 in the six ethnographic study villages reported that they had been visited by a family planning worker during the year preceding the interview, but in one village only 28% had been visited during the previous year.[7] In a similar survey in 1993, 48% said that they had been visited during the previous three months.[8] Three of these villages have resident family planning workers, and three have workers who visit periodically. When the workers fail to visit, women often have no one to turn to for family planning information and services. As one woman explained:

> The Sister used to bring pills to me at my home. She advised me to use pills, and I started doing it without letting my husband know. My husband doesn't approve of my taking pills. He says, 'I will provide food and clothing—there is no need for all that.' Then the Sister stopped coming.

The woman became pregnant and went to a clinic with her sister-in-law, but she lacked the 90 Taka to pay for an abortion, so she resigned herself to having the baby.

In one group of hamlets, the women depended on the family planning worker to take them to a nearby family planning facility for contraceptive injections, but she came at very irregular intervals.

*In 1993, $1 US was equivalent to about 35 Taka.

> The family planning worker advised [R.] to take injections. R. agreed to this, but three months have passed, and the family planning worker has not come back.

Given the extreme dependence of contraceptive users on the often unpredictable visits of family planning workers, it is remarkable that 45% of married Bangladeshi women younger than 50 use modern contraceptives. The encouraging statistics documenting the family planning program's success hide the problems that women often face in trying to control their fertility.

•*Fear of methods and side effects.* Fear of contraceptive technologies and procedures (e.g., IUD insertion, sterilization) and bad experiences in using contraceptive methods often inhibit adoption of contraceptive methods, contribute to sporadic use and discontinuation and create ongoing anxiety among contraceptive users.[9]

> I forbade [my wife] to take pills.…I think family planning is bad because one person died from taking pills, and there are many cases in which the woman becomes ill.

In some cases, the fears and apprehensions about various contraceptive methods that affect method choice and continuation are not unrealistic. One interviewer described how a respondent had selected her method:

> She saw that one or two women had severely swollen arms after taking injections for birth control. Those who used the Copper-T had excessive bleeding during menstruation. Even though everyone told her that pills make one's head spin, she thought that this would cause her less difficulty than the effects of other methods of birth control.

Both men's and women's fears about contraceptive technologies often relate to their perception that harmful side effects may result in economic losses. They often feel that their lack of economic resources makes contraceptive use more risky for them than for people who are better off. One woman explained her husband's reasoning:

> [He] says, 'If I get some illness because of the operation, then I won't be able to drive my van (bicycle-driven cart). Who will support the family? I heard that one man died from the operation.'

Another woman expressed similar fears:

> I'm scared of the operation. If I get seriously ill, how will I do heavy work? I'm too poor to get someone else to do my work.

•*Inadequate assistance with side effects.* Often, when women need to consult a family planning worker because they are experiencing contraceptive side effects or believe that physical problems they are having are being caused by their contraceptive method, the worker is not available. Even when she is available, the family planning worker often does not provide any assistance. And, women typically do not go to clinics to consult paramedics or doctors about contraceptive side effects.

> The worker came to remove J.'s stitches seven days [after the sterilization procedure]. She took J.'s card [that she had received from the clinic] and left and did not return to find out how she was feeling. J. had severe pain in her abdomen after the stitches were taken out, and she had to buy medicine.

> I took the pills for a year. I felt dizzy and lost my appetite. I told the Sisters about it but they didn't say anything. So I stopped taking it, and then I felt better. Then I got pregnant for the third time. I wanted to abort it, but people told me not to do that.

Women's Dependence

The family planning program's woman-centered approach motivates women to take responsibility for family planning. In using contraceptives, however, as in most of what they do, Bangladeshi women are extremely dependent and vulnerable. This was poignantly expressed by two of the respondents in the ethnographic study village where women are least economically active:

> How can I disobey my husband? What they bring, we cook, and if they don't bring anything, we don't cook. What is the use of my thinking unless my husband thinks the same way?

> I keep quiet. My husband is all I have.…He buys me a saree when the one I'm wearing is torn to shreds.…I don't dare ask him for anything because we're so poor. He brings medicine when the children or I get sick, but I don't ever ask him for medicine. I'm a woman.

In some cases, contraceptive use is opposed by husbands and other relatives. Even when there is no direct opposition from the husband or family, women fear they will be blamed if something goes wrong. Divorce or desertion is the repercussion most feared by women who use contraceptives without their husband's consent. More commonly, women are subjected to verbal and physical abuse. In addition, many women perceive contraception as risky because they have heard about or experienced side effects. They know that they are dependent on others to pay for, arrange or provide treatment, and they feel uncertain that such treatment would be forthcoming if needed. Because women are not perceived as economically productive, their husbands and in-laws often feel that it is wrong for them to incur expenses:

> There were some expenses when I gave birth to the stillborn child. Everybody blamed me for this, as if I had intentionally killed the child just to cost them money.

> My husband doesn't object to my taking pills. But when I get ill and he has to spend money, he snaps at me, 'You squander my money by taking these (pills). Have I piled up money to spend on you?'

One husband explained his reaction:

> My wife took pills for six months. Then one night she said to me, 'I think my health is deteriorating because of taking pills. Everybody says that women who take pills need to drink milk.' What my wife said made me feel bad. I don't earn enough to buy milk for my wife. I said to her, a little angry, 'Then stop using pills if they cause you inconvenience.'

When they experience side effects and problems with contraceptive methods (or unrelated problems perceived as side effects) that require out-of-pocket expenditures, women expect and receive little assistance from their husbands or from community-based workers and other service providers. And women are unlikely to have access to the milk and other expensive foods they believe they need to physically withstand the effects of the most accessible method, the pill. Many women in rural Bangladesh do not keep any cash of their own, and those who do keep cash often would not dare to spend it—particularly on themselves—without their husband's permission. The following case illustrates this problem:

> After I had given birth to two children…I had a Copper-T put in with the fieldworker's help. I didn't ask my husband's permission, but I revealed everything to him when I started having sharp pain in my belly and difficulty in walking 15 days later.…My husband would not have allowed me [to obtain an IUD] if I had told him.…When he found out, he was very angry and he told me to have it taken out right away.…My husband was really angry and scolded me a lot after I became sick from using the Copper-T. He said to me, 'I won't take care of you if anything bad happens. I won't

provide any treatment for you.'…But I waited, hoping that gradually I would get used to it. I endured the Copper-T for six months. I told the fieldworker of my problem and she assured me that the problems I was having were common for a new Copper-T user and that in time everything would be all right. I didn't take any medicine and she didn't give me any. When I couldn't bear it any longer, I had it taken out.

Later, this woman tried the pill. But whenever she was ill (not necessarily from the pill), her husband became angry.

The man of the house never likes it if the woman can't work. He says, 'Did I marry you to keep you as a pet? I married you to work in my house! If you sit around, who will look after the children and who will do all of the chores?' This is why I stopped taking pills.

Such problems frequently lead to unwanted pregnancies and unsafe abortions. Of the 104 women in the six-village sample, 52 said that they had had an unwanted or mistimed pregnancy. Thirty-five women* said that at one time or another they had wanted to abort a pregnancy; of this group, 12 were prevented from doing so (in most cases by their husband or family planning worker) or lacked the necessary funds. The other 23 underwent some type of traditional or modern medical procedure or took herbs or drugs to bring about an abortion; only 13 were successful.

When Hamidul was three years old, my periods stopped. I was upset. I didn't want any more children; I had so many already. One night [following the instructions of a homeopathic doctor who lived in the village], I smeared a long root with ghee [clarified butter] and stuck it inside me. It had a rope tied to the end so that it wouldn't disappear. The woman dies if the root gets loose in her body. The baby inside of me was four months old. I started bleeding and it continued for eight days. Then the baby came out. No one knew about it. Three days later, my arms and legs started convulsing. Everyone thought that I had encountered an evil wind. My husband said to the others [in the family]: 'Tell her to get up and cook the rice!' My husband's love for me meant nothing but having sex…. Then his younger sisters called the doctor, and he said that I had tetanus. I was taken to the hospital. The doctors said that it would cost 9,000 Taka to cure me; otherwise, I would not survive. One of my distant cousins, a civil surgeon at the hospital, helped us to get the treatment for less. We had to sell a cow to pay for injections that cost more than 4,000 Taka.

*Two women were not asked this question.

Conclusions

The Bangladesh family planning program's accommodation to prevailing gender norms was not necessarily a mistake. Directing information and services through women, to women, may have been the best option available. Clearly, this strategy met a considerable latent demand for family planning services, and much has been accomplished by working within the patriarchal system. The reproductive revolution that has started in Bangladesh is important not only for economic reasons but also because it gives women the potential to control their own lives in a new way, as well as enhancing women's and children's health and well-being. Many women who previously perceived that they had no reproductive choices have been presented with options and assisted in choosing among them.

In its intensive focus on family planning services for women, however, the program fails to disturb and may even reinforce the patriarchal structures that keep women isolated and vulnerable. Our findings illustrate some of the situations in which women become trapped, both because of their economic dependence on men and because of the larger system of gender inequality in which that dependence is rooted. Contraception cannot solve the larger problem of women's subordination, which we believe should be addressed more directly.

Programs that provide economic opportunities and resources to women can reduce their economic dependence on men and draw them into the public sphere. Micro-enterprise credit programs have been used for this purpose on a relatively large scale by nongovernmental organizations in Bangladesh. In earlier analyses, we demonstrated that two credit programs, Grameen Bank and the Bangladesh Rural Advancement Committee (BRAC), have increased contraceptive use and helped empower women economically and socially by augmenting their contributions to household income.[10] Case studies from our six-village sample suggest that similar effects can be achieved through direct employment programs for poor women—for example, road maintenance or irrigation projects or market-based employment. In urban areas, the garment industry is a fast-growing source of nontraditional employment for women.

We suggest as well that this is an appropriate time to reassess family planning program strategies in Bangladesh. New approaches are needed to influence men to bear greater responsibility for the costs of fertility control, both through greater use of male contraceptive methods and by helping rather than hindering their wives in obtaining reproductive health care. In addition, the role of the female family planning worker should be modified, with more emphasis given to drawing women out of their homes so that they can avail themselves of a broader range of information and services.

Perhaps, based on the long-standing custom of accompanying women to clinics for sterilization services, the female workers could take groups of women to clinics for educational sessions, selection of contraceptive methods and treatment of problems and side effects. For this to be successful, an effort to improve the services offered at clinics would also be needed. Although complex organizational, social and financial constraints will make the present family planning service delivery system difficult to change, the time is right for a new model.

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Resumen

Para funcionar con las restricciones de un sistema social en el que la mujer está subordinada y recluida, el programa de planificación familiar de Bangladesh utiliza trabajadoras que residen en el pueblo para distribuir a las mujeres en sus hogares información y anticonceptivos. Entrevistas detalladas realizadas a 104 mujeres y 92 hombres (incluidas 86 parejas) como parte de un estudio etnográfico llevado a cabo en la región rural de Bangladesh sugieren que esta estrategia, a pesar de su éxito en incrementar el uso de anticonceptivos, frecuentemente no ofrece a las usuarias información adecuada y el apoyo necesario. Además, el programa ha puesto la carga del control de la fecundidad básicamente en la mujer, utilizando principalmente métodos femeninos y no ha involucrado al hombre.

Résumé

Travaillant dans les contraintes d'un système social dans lequel les femmes sont subordonnées et retirées, le programme de planning familial du Bangladesh a recours à des travailleuses habitant dans le même village pour fournir des informations sur la contraception et des contraceptifs aux femmes dans leurs maisons. Des entrevues approfondies menées auprès de 104 femmes et 92 hommes (y compris 85 couples) dans le cadre d'une étude ethnographique en zones rurales du Bangladesh suggèrent que cette stratégie, malgré son succès dans l'accroissement de la prévalence des contraceptifs, ne réussit pas, dans bien des cas, à fournir des informations et un appui adéquats aux personnes faisant usage de contraceptifs. En outre, le programme a imposé principalement aux femmes les coûts de la contraception en mettant l'accent sur les méthodes féminines et en ne faisant pas engager les hommes.