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Abstract

In Bangladesh family planning and health programmes were the first major employers of rural women in outside paid work. Thus, women community health workers became the pioneers in bringing rural women into outside formal employment in a social/economic context that not only discouraged women's participation in paid outside work but also actively restricted their mobility in the public domain. Although for women today, working as community health workers is no longer a departure from the norm, this was not always the case. This paper looks at contemporary women health workers in Bangladesh to explore how they have re negotiated purdah and social norms to emerge as valued members of their families and respected members of their communities. While the work of a health worker was itself an extension of women's traditional care roles and was conceived precisely because norms around women's visibility and seclusion were so strong at the time that women were difficult to reach with male health workers, this job has been able to negotiate norms to make women's breadwinner roles and mobility in the public sphere more socially acceptable. It is noteworthy that in this process of change and continuity, women's trade-offs have been more difficult within the sphere of family and their individual lives, and relatively easier in the sphere of community life. There was some evidence that the specific organizational context in which women worked had bearing upon these changes.

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LIST OF ABBREVIATIONS

BIRDEM	Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
BRAC	Bangladesh Rural Advancement Committee
CHRWs	Community Health Research
WorkersDPS	Deposit Premium Scheme
FGD	Focus Group Discussions
FWA	Family Welfare Assistant
GK	Gonoshasthya Kendra
HA	Health Assistant
HSC	Higher Secondary Certificate
HW	Health Worker
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
II	In-depth Interview
KII	Key Informant Interviews
MBAs	Master of Business Administration
NGO	Non-Governmental Organization
SK	Shastya Kormi
SS	Shasthya Shebika
SSC	Secondary School Certificate

1. Introduction

Health is traditionally considered an appropriate sector for women's employment as it is consistent with their caring role. However,in the 1970s when women field workers were first employed by family planning programmes, patriarchal structures of women's seclusion were such that the extent of women's employment in the public domain was negligible[1]. Only two types of women worked in the public sphere: either very poor women with no male breadwinners in the family, who engaged in informal casual waged employment (domestic service, post harvest work, earth work); or highly educated and well off women in formal salaried employment. In Bangladesh family planning and health programmes were the first major employers of rural women in formal salaried outside paid work, and in those early years women community health workers had to challenge various social norms and stereotypes by being engaged in regular employment, coming out of their homes and being visible in the public sphere, moving freely in their communities and fulfilling a socially valued role. Thus, women community health workers became the pioneers in bringing rural women into outside formal employment in a social/economic context that not only discouraged women's participation in paid outside work but also actively restricted their mobility in the public domain.

One of the earliest studies documenting the effect of such work on women and their communities was on women community health workers of the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) in Matlab, a rural area of Bangladesh (Simmons et al, 1994). The analysis at that time put a great deal of emphasis on purdah, the tradition of female seclusion and the strict segregation of the sexes. The study had found that "Accepting employment …places community workers in conflict with established social and cultural norms. Instead of adhering to the principle of female seclusion within the private sphere of the home, the community worker transgresses into the public or male space. She leaves her home without the guardianship of her male kin and interacts freely with all segments of the local community in pursuit of a set of tasks that violate existing norms of social decency and morality" (Simmons et al,1994: 324).

Although there was a potential for a loss of status because of breaking social norms, women's performance of new roles led to "marked improvements in their standing in the community" (Simmons et al,1994: 324). The authors used the concepts of "prestige" (respect the community accords to a women who adheres to the standards to honour and morality), "professional status" which is "the trust and influence the community worker has gained as a result of her expertise in the field of health and family planning, her access to special resources and the quantity and quality of services she delivers", and "social influence", which is to do with the worker's ability to influence other matters beside family planning such as settling disputes, giving financial advice and helping with family decisions (Simmons et al,1994: 325).Over time, however, women's new roles actually led to "marked improvements in their standing in the community". They concluded that the "old rigidities of purdah have been transcended, and women can more freely avail themselves of employment opportunities requiring entrance into male space" (Simmons et al., 1994: 329).

[1] In 1983 the female labour force participation rate was 8 percent compared to 78 per cent for males (BBS 1984).

Although for women today, working as community health workers is no longer a departure from the norm, this was not always the case. The rationale for the study lies in the fact that since community health work has become a socially acceptable employment option for rural women with some education, it is important to ascertain whether gains in women community health workers' social position captured in the early Matlab study have been sustained and perhaps even consolidated over time. It is also important from a policy perspective to demonstrate whether the job of community health work can provide pathways to women's empowerment across several dimensions of women's lives: enhance women's position in their communities, increase women's self esteem and independence in their own personal lives and make family relationships more egalitarian. The latter two aspects were not explored in the early Matlab study.

To do this the paper examines the lives of contemporary women health workers in rural Bangladesh employed by four of the major health provider organizations in rural areas, to explore to what extent this work has been instrumental in bringing positive change into their own lives and the lives of other women in their communities by negotiating pathways of empowerment within their families, communities and the workplace. We want to evaluate the transformative potential of this type of women's paid work outside the home, both from women's own perspective (as agents of change in their individual lives) and from the perspective of women in general and broader social relations (as agents of change in society and in other women's lives).In addition, we will briefly examine whether the specific organizational context in which women work have any bearing upon the changes women health workers experience.

The paper is arranged as follows: Section 2 presents the background and analytical framework. Section 3 provides a brief history and approach of each of the four organizations. Section 4 presents the research objectives and locates them in an analytical framework; Section 4-7 presents findings changes in personal lives, family relations and community status of health workers. Section 8 presents the processes of negotiations around work and purdah while Section 9 draws some conclusions.

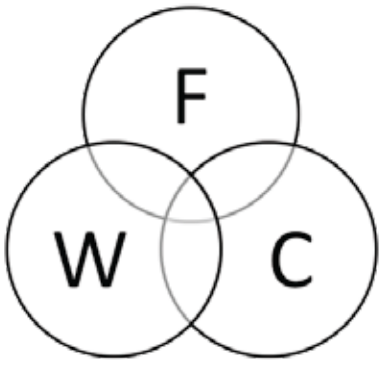
2. Background

In the early 1970s Bangladesh had just emerged from a devastating war of independence and a horrific famine that had disrupted the society and economy massively. These changes represented forces that destabilized old ways of economic and social organization and gender relations. At the same time the newly independent government identified high population growth rate as one of the major development problems facing the country, in keeping with international development thinking. Since the early 1960s, the international development community, fearing a population explosion, actively promoted population control as essential for economic development especially in South Asia, which was home to the greatest numbers of poor people in the world (and still is). It was in this context that community health work by women was introduced with strong organizational support, initially by the government family planning programme and by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B, formerly Cholera Research Laboratory) for the purpose of reaching family planning services to rural women in their homes. The altered social and economic environment in which this initiative was taken may explain why large numbers of women were able to respond to these new and unconventional employment options.

A comprehensive review by Kabeer (2008) highlights the considerable academic and policy interest in the transformative and empowering potentials of women's paid work. Kabeer (2008) noted "Context is critical to research on the relationship between women's paid work and empowerment because context helps to shape both the availability as well as the acceptability of different kinds of work for women." The importance of the rules, norms and practices associated with kinship and family institutions in shaping the gender division of roles and responsibilities in production and reproduction is particularly relevant in the Bangladesh case. Additionally, in the case of Bangladesh these norms and practices, while rooted in the social relations of the domestic domain, spill over into the wider community and even the public domain of the workplace. We want to add that there may be several pathways (routes) that lead to these transformative journeys originating from the context (reality) of women's lives, namely from the family, the community and the workplace. Kabeer emphasized that this "requires us to explore the circumstances under which access to paid work leads to progress or setbacks along one or other of these pathways as well as the circumstances under which the two pathways might intersect, progress in one leading to progress in the other.

The early empirical study of ICDDR,B women health workers documented the intense social resistance the health workers had to face because of breaking traditional roles. Hence, the programme chose women who had strong personality characteristics that would help them withstand such pressures[2]. The women negotiated the social restriction imposed by purdah by defining the concept of 'internal' purdah as being a frame of mind rather than physical. The article argues that maintaining or regaining prestige was closely associated with the professional and social activities the workers performed in the village, which led to the acquisition of new dimensions of status. The workers were also able to facilitate access to curative health at the sub-centre or even the hospital. As gradually the community experiences the benefits of the family planning and health activities of the workers, their position became stronger and enabled them to have social influence and community respect (Simmons et al.,1994: 330). "Their physical mobility within the village and their role as professionals have vastly expanded the scope of their role as social leaders" (Simmons et al.,1994: 333).

Drawing upon the conceptual issues raised above and the early empirical findings we propose the following framework for analyzing the experience of women health workers in rural Bangladesh and the effect of their work in creating pathways of empowerment and social change.



[2] By selecting women with the type of social background and personality characteristics that gave workers the strength to break with traditions and function as innovators in the community, the project made it possible for women to establish new social norms whereby women could maintain their prestige and gain professional status and social influence. (Simmons et al.,1994: 326).

The individual woman community health worker is situated in the confluence of three overlapping spaces: the family, community and the work place or organisation. Each of these spaces is governed by distinct but related norms (rules) and practices (behaviours) that determine gender relations in that space, and that generally put women in a subordinate position to men. By causing a relaxation or weakening of these unfavourable norms women's paid work creates pathways of women's empowerment and social transformation, resulting in changed gender relations in each of these spheres. Depending upon the rigidity of norms and practices operating within a particular space it is possible for women to also become disempowered in some situations along any of these pathways. Moreover, while women may experience empowerment in one space and along some pathways in that space, they may experience disempowerment in another.

For this analysis we select the following pathways to assess the empowerment process in the three spaces. Within the family women we examine: a) health worker's (HW) ability to negotiate taking up outside paid work and purdah; b) whether she had a supportive family (husband for married women); c) whether HWs' women's contribution to family income was given recognition, d) through women's roles as the main income earner, e) through the absence of her husband a de-facto household head, and f) through a supportive family.

Within the community women's empowerment takes place through: a) community status and prestige, b) more flexible purdah norm and mobility practice, c) participation in mediation and conflict resolution in the community, d) influence on other women in the community or being a role model and e) demonstrating the value of girls' education.

Within the workplace or organisation the pathways of empowerment are: a) the image of the organization and its status in the community, b) recognition accorded to HWs within their organization and c) satisfaction and sense of fulfillment from the work of serving others.

It is hypothesized that women health workers (HW) become agents of change and negotiate these pathways to bring about empowering changes in their own lives and in the lives of other women in their communities.

3. Brief History of Programmes and Organizational Approach

Government Programme:
Although begun in the 1960s, the government family planning programme was strengthened and scaled up with international aid for population control in the mid-1970s. By 1975 the programme went through significant changes in recognition of the limitations of past delivery systems and attempted to innovate new strategies in rural areas. At present the rural public health system is organised around the Upazila Health Complex at sub-district, which is well supported by qualified allopathic doctors and trained staff with in-patient and basic laboratory facilities; At the lower level Union Health and Family Welfare Centres are supported by two or three sub-centres at the lowest administrative level and a network of field-based staff consisting of family welfare assistants (FWA) and health assistants (HA), whose job is to reach family planning and maternal and child health services to women at their doorsteps, Within a four tier system these workers are in the third grade and require an education level of SSC (Secondary School Certificate) for FWA and HSC (Higher Secondary Certificate) for HAs. Although earlier HAs were generally men, since the late 1980s more women HAs were being recruited as they were seen as more acceptable in the

community. Also, there is implicit preference for married women over unmarried ones.

HAs jobs are transferable and they may get promoted to higher posts on the basis of vacancy, service length and performance evaluation. By virtue of their posts, HAs are members of the Upazila Parishad standing committees on health, which gives them the opportunity of interacting with the local government representatives and being known in their professional capacities. FWAs do not have the same scope for promotion and work in their own community. One important point to note is that while HA jobs are transferable it is only in exceptional cases that FWAs are likely to be transferred (if unmarried).As permanent government employees their work is valued socially because of the recognition, better salary and benefits (See Annex Table 1).

ICDDR,B

ICDDR,B has been working in Matlab since the early 1960s. It has earned a good reputation both locally and internationally, and become very much a part of the Matlab community, with many families having members employed in ICDDR,B. The community health programme is delivered by Community Health Research Workers (CHRWs) in 67 villages in Matlab[3], who are educated and married local women. In 2002 ICDDR,B decided to upgrade their status and integrate them within the main staffing structure (at level 2), changing their designation and raising their salary. The required educational qualification is SSC (See Annex Table 1).

There is no scope for transfer for ICDDR,B HWs, but they can respond to vacancies for higher posts and compete if they have the required qualifications. Upon joining, CHRWs receive one month basic training at Matlab after which they are attached to a senior CHRW for practical training. Once they can work independently, they are assigned their own field areas. Strong community management and supervision has characterized the programme from the beginning. The CHRWs are backed by a cadre of resident female paramedics in the subcentre clinics. ICDDR,B HWs have to give an undertaking that they will not accept payment for any service (like deliveries) or fees. They are forbidden to participate in local groups or *shalish* on the grounds that this may undermine their neutrality.

BRAC

BRAC, the largest NGO in the world, has a community health programme that started in 1986 as a primary health care programme, was scaled up in 1995, and is now spread all over Bangladesh (31 million persons). BRAC HWs draw considerable support from the wide range of development programmes that BRAC is involved in the areas in which it works. BRAC employs two categories of community health workers: Shasthya Shebikas (SS) who are volunteers and Shastya Kormis (SK) who are paid a minimal salary and are supported by SSs whose work they have to supervise. Our study has chosen to look at SKs as the front-line workers interacting with the community although their educational qualification is lower than the other programme health workers, and their professional skills are also lower. Selected SKs receive basic training of 15 to 20 days at regional training centres and 15 days field based practical training with an older SK. There is no scope for promotion to a higher position.

[3] In another 75 villages that are served by the government programme ICDDR,B runs only the Health and Demographic Surveillance System to collect data.

BRAC supports women HWs to challenge purdah norms by encouraging HWs to use bicycles to travel in rural areas and by stipulating the wearing of a white coat (apron), both to distinguish SKs from other field workers and discourage the wearing of *burkha*.

As Annex Table 1 shows, salary structure and benefits of BRAC HWs are lowest compared to other HWs, especially in comparison to HWs from ICDDR,B and Government. They have to supplement their incomes by selling medicines, condoms and sanitary napkins to women in the communities. However, they are allowed to carryout other income-generating activities such as poultry rearing and "kantha" (quilt) sewing to supplement their earnings.

Gonoshashthya Kendra

Gonoshasthya Kendra or the People's Health Centre, is considered a leader in the area of people oriented community health. It took on the challenge of making health accessible for the rural poor by going beyond the traditional constraints of scarce doctors and nurses. To do this GK trained health workers and paramedics in a wider range of skills than was the usual practice at the time. . It also introduced a system of cost recovery through health insurance with special provisions for the poor[4]. GK has been running their community based health programme in villages in Savar and 16 other other upazilas in 15 districts through community paramedics.[5]

The GK has the reputation of taking a very radical approach to health care provision, one that locates the problems of poor health care within the larger structures of power in the country. As one consequence of this it sets out to challenge social stereotypes that restrict women's movement and work outside the home. Unlike the other organisations that implicitly favour recruiting married women, GK recruits unmarried women, providing dormitory living arrangements for men and women on campus, and forbids the wearing of burkha by women at work. It insists on health workers wearing an identifiable uniform which enhances a professional image and requires health workers to ride bicycles. Unlike other organisations it has an active policy of transferring women to other locations. The required educational qualification is SSC with a science background. Unmarried girls from any place in Bangladesh can apply and they cannot get married for the first three years of employment. At the end of three years of training as paramedic, GK HWs get permission to marry and live outside if they wish.

GK HWs get the most comprehensive and structured training for six years to become qualified paramedics. They get academic training in the first three months and class and practical training in the field for the next three months. After that, they gain experience in the field for one and half years, and a one year internship in any location in Bangladesh. Then they work as staff in GK hospital in different wards (pathology, labour ward, male and female ward) for last three years. After training they may stay with GK as staff or get employed elsewhere. This is easy for them since trained paramedics are in high demand. Thus, of the four organisations, only GK health workers have definite chances of promotion and upward mobility, either within the organisation or outside.

4 Premiums are charged on a sliding scale in order to provide a degree of cross subsidy across classes.

5 GK started the Bangladesh Field Hospital during the 1971 liberation war. After the war it began its experimental village based health programme in Savar Upazila. Since then it has expanded to 592 villages in 15 districts, and claims to be the largest health care provider outside of the government programme (R H Chaudhury and Z Chowdhury 2007, pp 8-9).

To sum up, there are clear differences in the organizational culture and practices of the four programmes. HWs in the government and ICDDR,B programmes were the early innovators and ground breakers, helping to legitimise community health work as an option for women, creating an environment in which such work could be taken up by many more women without this being seen as a challenge to social norms by the family and the community. GK began on a far smaller scale but from the outset it used community work by women as a means of challenging various aspects of patriarchal structure (women's seclusion and purdah norms, women's home maker roles, sex segregation at work and living arrangements). The BRAC programme came somewhat later and built upon the social acceptability of the earlier programmes. Unlike the other programmes it opted to employ poorer and less educated women, giving them the training to carry out the work assigned to them, and at the same time also seeking to challenge purdah norms but less confrontationally than GK.

4. Methods and Respondent Profile

The objective of this paper is to evaluate the transformative potential of work as community health workers and to determine the extent to which this form of work has created new opportunities and aspirations among women in contemporary Bangladesh. The main research questions were: 1) have women's paid work as community HWs created pathways of empowerment within the context of the family, the community and the workplace? What are these pathways? 2) How have women HWs negotiated these pathways to bring about positive change in their own lives and to challenge or transform social/family norms that are unfavorable to women? 3) Are there differences in the pathways and in the empowering changes experienced by women HWs related to the organizational approach?

We selected four programmes that are generally seen as the pioneers in this field of employing women community health workers. These were the government family planning programme, the ICDDR,B health and family programmes, the BRAC health programme and the Gonoshasthya Kendra (GK). The primary respondents were women health workers in three rural locations who get regular salaries: BRAC in Jamalpur in the north; GK in Savar near Dhaka; ICDDR,B in Matlab in central Bangladesh; and government health workers in all three locations. We identified Shashtho Karmi (SK) from BRAC, Community Health Research Workers (CHRWs) from ICDDR,B, Health Assistant or Family Welfare Assistant from the government health service and Paramedics from GK.

In order to triangulate, the data and the research was carried out with a sample of four types of respondents using three different data collection tools. The types of respondents were: Women health workers; Health worker's household male member, usually husband; Supervisors or Higher management within the organization at local level; and Community people (male and female local residents from poor households and well off households).Main data collection tools were: in-depth interviews (II) with health workers, key informant interviews (KII) with male family members and higher management, and focus group discussions (FGD) with community people.The research instruments were piloted in Gazipur District. After piloting it was finalised through several day long discussions. Annex Table 2 provides information on respondents and tools.

In each area we conducted 15 interviews: 10 with health workers from one of the NGO programmes and 5 with government health workers. To select health workers from each area we collected a list of eligible health workers from each organization at the local office. From this list, we randomly selected 10 workers from each of the three non government organizations, 5 who had been employed for more than 5 years (old) and 5 who were employed less than 5 years (new). In each location we selected 5 workers from the government, giving us 15 health workers in each area. After selecting we contacted them to get their consent and to ensure it was possible for them to participate in this research. When someone was unable to take part we replaced them using the same process.

In addition, we carried out interviews with two sets of people as key informants: 43 male members (mainly husbands) of health workers' households and supervisors of health workers. To select male household member of health workers we prioritized the husbands. In case of absence we selected another male like father-in-law or brother-in-law or own father or brother. In case of higher management, we selected the person who was more knowledgeable on the health worker's responsibility and local service system. For Government we selected the *thana* Health and Family Planning Officer and for NGO we selected Program Manager or Director of the health programme.

To select community people as respondents for the FGDs we requested health workers to provide us a list of participants according to our criteria, and selected from that list. The different categories of FGD respondents are described in Annex Table 3.

The FGDs were conducted to get the community views on health workers' professional activities and their standing in the community. In depth interviews were structured around marriage and childbearing, the decision to take up the work, the impact of work on the workers themselves, family and community, and strategies used by health workers to negotiate family and community restrictions on their mobility and use of purdah. KIIs were structured around the impact of health workers' employment and incomes on the family, their position in the wider community, and the role of the organization in the health workers' work experience.

Data Analysis and Study Limitations

Data analysis was consisted in four steps – a) preliminary analysis according to rural location, organization and thematic area with research assistants; b) thematic categorisation of interviews according to checklist and report outline; c) data compilation by category to obtain quantitative proportion and systematic qualitative description d) compilation of observation and main data through category, sorting out cases and selecting appropriate quotations.

The following limitations were noted:

- The interviews took a long time (around 2 hours). Sometimes respondent felt bored and disagreed to give more time. Especially health workers of GK were unable to allow more time due to their work pressure as well as work time.

- Some male household members did not allow time willingly when we first approached them. Few husbands sat beside their wife during the interview session.

- When the respondent for male household member was father or brother, it was not easy to get information on the health workers relationships with her husband or in laws, or to get the husband's perspectives.

- The study was conducted during the rainy season, which was a big problem for FGD as well as gathering people. This was especially a problem in Matlab, which is a low lying area.

- In doing FGD, respondents sometimes raised irrelevant issues, which posed a challenge.

- Government officials were less cooperative than NGO supervisors and health programme managers.

- People have a common misconception that BRAC had very bad practices on micro credit. Sometimes respondents felt discomfort and were not welcoming as we were from BRAC.

- In GK, we had to spend many hours to adjust with the management for getting support on sampling, communicating with them and researcher's accommodation.

Profile of Community Health Workers

All 45 HWs had joined between 1973 and 2007, and it was the first job for most of them. Their ages ranged from 20 years to over 50 years. BRAC HWs were relatively younger while the majority of ICDDR,B and government HWs were over 40 years old. The median education level was SSC (attained by 24 HWs). The education level of HWs reflected the changing requirements of the four programmes and the increased availability of women with higher levels of education over time[6]. However, BRAC employed poorer and less educated women: all the HWs were only secondary school graduates. The majority of the HWs were currently married; only a few GK workers in our sample were unmarried and only one HW from BRAC was separated. About half of the HWs lived in nuclear families with the rest living in various kinds of joint/extended families. More than half of the HWs were the main income earners in their households, because husbands were either unemployed or retired or the woman was widowed or separated. This was more likely in the case of ICDDR,B and government HWs compared to GK and BRAC HWs because of the level of their salaries[7]. A third of the HWs' husbands lived away for various reasons (husband's business or job in another place, international migration, separation or second marriage)(See Annex Tables 4-9).

The majority of the HWs said the decision to take the job was a joint decision with her family members, indicating that she enjoyed the support of her family. However, there were a number of variations to this pattern. Younger women (aged 20-29) were more likely to report having made the decision themselves. BRAC HWs were relatively more likely than the others to say that the decision to join was their own, especially if the husband was unemployed, which probably reflects their greater poverty compared to HWs from the other organizations. In a few cases women had gone against the wishes of their husband and family to take the job but later tried to persuade their families, although in some cases this was after episodes of violence. For instance, a GK HW who faced the prospect of a forced marriage told us that she stole money to run away from

6 Earlier both government and ICDDR,B programmes employed women who had less than 10 years of formal schooling, but gradually the number of those who are higher secondary graduates and even with a college degree has gone up.

7 Partly also because they are older and more likely to have retired husbands.

home and join GK. On the other hand, there were also cases of men actively helping their wives find jobs. Their motivations appeared to revolve around considerations of prestige, honour and future security. It is not a surprise that this was more likely in the case of better paid jobs of government and ICDDR,B, but does indicate a trend towards increased family acceptance of women's outside paid work.

5. Personal Lives: Independence, Confidence and Aspirations

Generally speaking, earning an income and contributing to the family economy was a positive experience for all HWs, regardless of the amount of their salaries. In this section we look at changes HWs experienced in their personal lives as related to their jobs as HWs in terms of independence, self esteem and a sense of control over their lives expressed in their aspirations regarding the future.

Economic Independence

HWs' income and the fact that they contributed to the household economy gave them some degree of economic independence, even though most of their earnings went towards meeting household expenditure, children's education and marriage. Contributing to the family income raised their value in the family and thereby constituted an important pathway of empowerment. All the HWs contributed to the family income, but more importantly almost 60 percent (26 out of 45) retained control of their salaries and decided themselves how to spend it. HWs' ability to retain their salaries was similar across organizations[8].

All of them had saving in banks or with NGOs. These savings were very important in women's lives, because it mitigated economic vulnerability in case of sudden illness and unemployment and served as insurance for old age when they may not have family members to depend upon. In addition, savings were seen as important to establish one's children in life, build a house, purchase land and furniture, and even to go on hajj (pilgrimage). HWs used different types of savings tools, such as DPS in bank,saving with their own office, or with NGOs. An older health worker from ICDDRB said, "We are in a vulnerable stage. We are old people. If I lose my job, I will not even be worth two paisas. Now neighbours always come to me; I don't even have time to clean my house floor. After retirement from my job, not even a mosquito will come to me. At the last stage of my life these savings will be my only means."

HWs sense of economic independence is also derived from the fact that they contributed to the family economy by taking loans for purchasing assets or land, for investing in husband's farm or business, sending son/brother abroad and for children's marriage[9]. In fact, ICDDR,B , BRAC and government HWs had the opportunity to take loans from their organisations, which was an added benefit of their employment. All the government HWs, except one, had taken loans. For ICDDRB, all HWs except one had taken a loan to purchase land. In most cases the decision on loan use was jointly with their husbands, particularly among the ICDDR,B HWs, and only 9 HWs took decisions independently[10].

8 6 BRAC HWs, 7 Government HWs, 6 GK HWs and 7 ICDDRB HWs

9 BRAC (6), GK (1), ICDDRB (9) and government HWs (14)

10 BRAC (2), ICDDRB (5), Government (2)].

More importantly, however, the majority of HWs across organizations felt they had control over their salaries and could decide themselves how to spend it. Again, the break with long habits was not always easy, and we found that six HWs from three organisations (with the exception of ICDDR,B) handed over their entire salaries to other family members for spending. Thus, a mixed picture of continuity and change was seen with respect to women's control over their earnings.

Self esteem and Confidence

A general finding was that the HWs felt that their self-confidence and self-esteem had gone up as a result of their employment and the kind of work they were doing. One GK HW explained that the reason for her increased self-esteem was that she was financially solvent, and she did not need anyone's help. This confidence in one's ability to provide for one's needs even extended to the future, as one BRAC HW said: "I have the confidence that even if I leave this job I will be able to earn my living". One GK HW said: "Even if I do not have a job I can set up a pharmacy and get by", while another felt: "I have the courage that I can provide for myself".

Another general feeling was that the work has taught them various life-skills. One BRAC HW felt that they could now deal with adverse situations: "Now we can mix with all sorts of people and adjust to all kinds of situations: *pakka* house and mud house – both give me the same respect". Another BRAC HW said: "Even if I leave this job I will be able to earn my living". One government HW felt that earlier she could not talk to her supervisors (the Sirs) but now she can. The ICDDR,B HWs mentioned that they can now even deal with foreigners who visit Matlab. Another government HW mentioned that she was able to break out of a situation of violence by her in-laws and husband because of her job. She felt that after getting the job her husband took care of her ("gives her rice") and beats her less often[11].

The feeling of self confidence was most visible for GK HWs, who felt that rules and procedures in GK were so stringent and the work responsibilities so demanding that this prepared them for working anywhere and under any conditions. One GK HW saw being financially solvent and not needing to always rely on others as the reason behind her increased self-esteem. The sense of self-reliance that they had developed through earning their own living had strengthened their confidence in dealing with adversity. The GK HWs felt that they could work anywhere under any conditions. A GK HW said: "Even if I do not have a job I can set up a pharmacy and get by", while another commented: "I have the courage that I can provide for myself".

Male family members reinforced the accounts given by women with regard to their greater self-confidence and practical skills. The husband of a government HW in Savar explained: "Women who do jobs become practical. As they earn money, they understand how to spend properly. Those who are housewives have unrealistic expectations, they don't understand the limits of their situation. But the working women are quite different". Another husband of a government HW in Savar said: "As part of her job, she is mixing with all sections of the community. If she did not do this job, she would not know how to conduct herself with all kinds of people. She wouldn't be able to know what's going on in the society. Now she knows what's happening around her, she understands which is good or bad. (…) she has earned a status of her own from this job".

[11] She herself raised the issue of domestic violence on her own and did not want the research team to interview her husband. She was very nervous about their approaching him and the interview took place not in her home but in someone else's house.

Husbands by and large (30) believe that HWs gained self esteem and self confidence through their professional work. The husband of a government HW in Savar (SGH3) explained how knowledge and ability to make decisions had increased because HWs have to interact with various people and officials, go to different hospitals, union parishad, police station, court, or even go to Dhaka or other district for training. Sometimes higher official and foreigners come to visit their field area. His wife talks with them.

Control over Life and Aspirations

Women's own earnings and new skills had expanded their horizons and given them some sense of control over their lives. This was reflected in HWs aspirations for the future, both for their children and for themselves. Educating children to higher levels than what they themselves had achieved to have a better life was a common aspiration. Some even said they had no thoughts about their own future but only had aspirations for their children. One BRAC HW said that she "will even sell her blood" to educate her children as far as they can study so that their life is better. HWs with ICDDR,B and government had higher aspirations than the others, and wished to educate their children to be doctors, engineers, finish MBAs, or go to cadet schools and send them abroad (e.g. Italy).

Another common aspiration was to build and improve their homes. Some wanted to buy land, build a house, be independent and live there after retirement. Those who had relatively higher salaries wanted to have a house and live in Dhaka. Aspirations of securing their future by investing in a home of their own was particularly critical for women because they usually did not own land and property in their own names and had depend upon sons in their old age.

However, a few had aspirations beyond their children and their own future, in terms of a desire for a profession/career around health services. One BRAC HW spoke of wanting to establish a clinic or pharmacy in the area for the community. One ICDDR,B HW wanted to use her experience and be attached to clinics or set up pharmacies. Another GK HW was planning to set up a pharmacy on her husband's land and live with her in-laws. A government HW said she already had a pharmacy (for her husband), but she wanted to set up one more for herself. GK HWs particularly had professional ambitions. Two GK HWs were hoping to move to better jobs: one of them would like to work for BIRDEM hospital and another would like to work in a garments factory as aide nurse which paid more.

6. Family Relations: Valuing Contribution, Division of Labour and Gender Roles in the Family

Valuing HWs Work and Contribution

Across the organizations all male family members except two[12] and other family members acknowledge that HWs contribute significantly to the family income, and hence support them in their work. Nearly all the HWs felt that their families valued them and supported their work. Husbands were generally appreciative of their wives' financial contributions to the household economy, whatever the amount of women's earnings. The contribution of HWs is recognized as

[12] One husband (SGKH5) believes the income of his wife increases her own income and ability to spend as she wishes, he is not dependent upon her income. The father (SGKH10) thinks increased social status and people's respect is a greater asset than her daughter's income support.

important and valued by their husbands whatever the amount of their earnings. The husband of a BRAC HW made the following case: “It’s good even if she is only earning 1200 per month because if she couldn’t do that we would still have had to spend that amount. So this amount, though small, is contributing to total family expenditure”. Husbands were also pleased when HWs meet their own personal expenditures from their salaries. This was an important reason for husbands’ support, because although he may feel he is mainly responsible for providing for his family, if his wife earns he does not have to think about his wife’s expenses. The husband of a government HW said: "Prices are very high. It is not possible to run a family with one income. (Because she is working) I don't have to spend money for my wife." The ability of women HWs to get loans for investment for husband's farm or business was especially appreciated[13]. The husband of a ICDDR,B HW said: “My wife is working from 1991 till now. Over these years our financial condition has improved. We could spend money on our two children. When our elder son failed in the exams, my wife took a loan from her office and arranged everything to send him to Malaysia”.

More than two-thirds of male family members (18/43) of HWs acknowledge that HWs are making significant financial contributions to their children’s education, sending them abroad, or paying for their marriages. The brother-in-law of a ICDDR,B HW said: “As an employee of a cloth shop my brother’s salary was too small. So the daily family expenses, all education expenses of children and even his three children’s marriages were possible on my sister-in-law’s income”.

The husband of one ICDDRB HW said: “My wife’s job is a financial support. I think money is the main weapon in the society. Well-being comes through money. Where there is money there is no problem. So my wife’s job is a great advantage”. Another husband of a BRAC health worker said: “Nowadays cost of essentials is too much, nothing can be done by one person. She is earning as half part of this family. It’s a great thing that she is contributing to family well-being”.

The fact that family members can rely upon the HWs’ medical and health related knowledge is another common reason for supporting their work. Family members usually do not have to pay doctors’ fees for treatment of minor illnesses and primary care. In fact in some cases (ICDDR,B) receiving free treatment for family members was also a possibility. The husband of a ICDDR,B HW (MIH3) was very happy that his wife worked at ICDDRB because he said: “We all get free treatment, office gives us transport facility, especially to go to Dhaka we can have speed boat. Office gives us all accommodation facility as well”.

The reliance of family members upon the earnings of HWs and recognition of their contribution to the family had the potential for creating space to renegotiate their roles and responsibilities. Sharing of household work and child care was one potential area for renegotiation within the family. Another area for renegotiation was women’s homemaker role. Prevailing social norms appeared to be a major challenge in this process of negotiation, so that although the idea of husbands sharing household work was becoming socially more acceptable, it was yet to happen in reality. Similarly, on balance the roles of HWs as wives and mothers continued to be seen as more important than their income earning roles.

[13] ICDDR,B , BRAC and government HWs have the opportunity to take loans from their organisations, which is an added benefit of their employment.

Division of Labour in the Family

Overall, a little less than half (20/45) of the HWs claimed that their husbands shared the household work, while a similar proportion said household work was shared by other female household members. Husbands sharing the work was relatively more common among the older HWs, but female household members sharing the work was equally common among younger and older HWs. In 11 cases other family members,such as mother, mother-in-law, father or sister helped out. In joint or extended households, the husband's participation in domestic work was less common than in nuclear families. This was also true for HWs who could afford to hire domestic help to do the housework or look after children.

Husbands, however, appeared more willing to help with child care (bathing, feeding, homework), which was socially more acceptable, than housework. Husbands were more likely than wives to report sharing household work in the case of BRAC HWs, while the opposite was seen in the case of government HWs. This could be an organisational effect: the husbands of BRAC HWs may have felt it 'politically correct' to say that they helped their wives since BRAC raises awareness about gender equality; on the other hand, government HWs had more educated husbands who may have felt that it was socially not acceptable for men like them to help their wives. The husband of a government HW in Matlab, who did not help with housework, justified his position by saying: "Though it's natural for everyone to help one another, sometimes it becomes difficult to do because of the environment. If I try to help my wife other people will say that I am not manly". The fact that HWs with young children living in nuclear families had to bring in relatives to help with child care indicated that husbands' were also not very willing to share child care roles. The husband of one ICDDR,B HW commented: " We don't face much trouble because my in-laws are always helping us. Besides, we always keep domestic help".

At the community level poorer people had relatively more positive opinions regarding sharing household work by husband and wife when the wife was working outside the home. Relatively poorer men in Savar said: "If both husband and wife are working outside then both need to share the household work. There is no alternative to this." Others felt that sharing by husbands depended on the "understanding" between the couple. However the general feeling among better off women and men was that the responsibility of household work fell upon the women: "The women have to manage both the outside and inside work. They may need to keep domestic help for the household work, those who cannot afford this have more work to do. They have to do the household work at night and outside work during the day".

Gender roles

There was also pressure on HWs to fulfill their roles and responsibilities as wives and mothers. In fact many husbands (18) complained that HWs could not give enough time to the children because they were overburdened with their job duties. The husbands of BRAC HWs (6/10) were more likely to express such complaints compared to other husbands, possibly because husbands (8/10) felt the HWs got paid too little given their work responsibility[14]. The husband of a government HW in Savar said: "After coming back from office we both feel tired. Neither of us can allow enough time for the children. If she didn't do this job at least she would have time for our children". This double burden and expectation to fulfil the role of homemaker was a source of dissatisfaction for HWs. A common worry was that they were unable to give enough time to the family and the children. But at the

[14] BRvAC Shasthya Kormis were paid Tk. 1200 per month, which is lower than the salaries of other HWs.

same time, they complained of the burden of finishing household tasks before leaving for work and after returning home. One exhausted government HW complained of the double burden: "When we are out of the house others help us out but when we come home we have to do everything – no rest."

On the whole, change in family relationships was interpreted in terms of greater or lesser peace in the family. One view among the community people was that there was less peace and contentment because HWs were working outside and could give less time to the family and to the husband, or supervise the household help. FGD participants also articulated the feeling that HWs were becoming more assertive and displaying greater agency. In Jamalpur a participant of the poorer male group said: "women who are working are stronger (their 'gear', like in a car, has increased). They do not listen to their husbands". However, the consensus was that if wives working outside could bring economic solvency the families should overlook their assertive behaviour, for the sake of the children and the household. The more common belief was that family relations would improve and there would be greater peace when women could contribute to economic solvency of the family.

7. Acquiring a Professional Identity and Serving the Community

Change was also evident in the wider community, where women HWs were able to negotiate social norms and traditions and establish themselves as valuable community members in their own right. In the earlier study Simmons et al. (1994) examined whether community health workers had influenced their position in the community in terms of "prestige", which was the respect accorded by the community because she adhered to the standards of honour and morality; "professional status", which is the trust and confidence they enjoyed in the community because of their technical expertise in health and family planning; and "social influence" which was their ability to influence others in areas beyond health and family planning (Simmons et al., 1994: 325).

Besides these three dimensions of community standing this paper examined two other dimensions of HWs status in the community: the sense of satisfaction derived from providing an essential service to the community and helping poor people and women and serving as role models for young girls and women in their community.

Professional Status/Identity

Women HWs from all four organizations felt that they were accorded a professional status by the community because of their skills and professional expertise. A BRAC HW said: "Wherever I go, they say the doctor is here. I give people advice. They follow my advice". The same was true for HWs from ICDDR,B: "People in the community feel that I am very close to them. They show me hospitality. Everyone calls me a doctor". For a HW from GK her dream of being a doctor was partly fulfilled by being a paramedic. In recognition of their work HWs are called "shastyaapas" (health sisters) or "daktarapa" (doctor sisters).

The professional status of GK health workers was perceived as the highest in terms of skills and responsibilities, and this was recognized both externally and internally. GK provided relatively more opportunities for professional development, something which has expanded HWs' choices and horizons, as qualified paramedics were in high demand and could readily find jobs outside GK at higher salaries. GK deliberately encouraged and enabled nurses and paramedics to take on tasks that were traditionally performed by doctors, such as sterilizations and caesarean operations.

The health workers believed that they had been able to convince women of importance of getting antenatal care and to challenge erroneous beliefs regarding care of pregnant women. One HW in Jamalpur commented: “Before pregnant women did not understand (what they needed to do). Now if you explain to them they understand. Nowadays as soon as they are pregnant they come for a check-up. Before they did not want antenatal care. Now everyone is conscious, the in-laws are also more conscious”. Most of the health workers believed they have also been successful in motivation for family planning. Now couples came to health workers first when a pregnant woman is near delivery time, and went to hospitals with the references of HWs. The HWs claimed that their work had contributed to declines in the birth rate, maternal mortality rate and child mortality rate. All HWs felt that they were given greater social status than before in recognition of the work they perform in serving poor women and children, who are the most neglected in society. This work carries a special value in the community compared to other types of income earning work that women do.

HWs husbands also recognized their wives’ professional status. The husband of a government HW in Matlab commented: “Previously, if health workers offered women birth control pills they usually refused. They had no knowledge of family planning. Due to the hard work of HWs many women are now using ‘methods’”. Most husbands felt that their own status and prestige had increased because of their wives’ professional work and contribution to the family. The husband of a government HW in Matlab said: “I have been introduced to various people whom I didn’t know earlier through my wife’s job. These people always respect me”.

The community views on the HWs were positive on the whole. People knew about them and their work, and there has been a positive change in the attitude towards HWs. According to FGD participants, “Older generations believed in traditional medicine, and did not like doctors and hospitals. More mothers used to die. Now when the HWs see any complications they take them to the upazila health complex. …Before people would not let the HWs into their houses. People now are more aware, more civilized, better educated, more modern”. Health workers’ access to hospitals and their ability for referral was also valued. Some could also call in ambulances (GK) and speed boats (ICDDR,B) to take patients to hospitals when needed. A father of a ICDDR,B HW commented on his daughter’s status in the community as follows: “She is serving the community hundred percent, all are getting my daughter’s services. All the time people are coming to my house for treatment or medicine. Community people now and then come to our house, seek their apa, just to get suggestions or advice for any kind of treatment”. To some extent the social status of HWs varied according to organization. Government and ICDDR,B HWs had relatively greater social status because of higher salary, job security, higher pay and benefits than BRAC HWs, who had somewhat lower pay and were treated more like volunteers instead of full professionals.

The Upazila Health and Family Planning Officer in Savar mentioned that from a situation of outright hostility in the early 1960s HWs were now welcomed everywhere and their employment had gained social acceptability, even status. His opinion was that government HWs were the ground breakers in this transformation, absorbing all the initial hostility and creating an enabling environment and social acceptability for other women to enter this field. This was also true for ICDDR,B, which has been working in Matlab since the early 1960s and as mentioned earlier, earned a very good reputation and become integrated with village peoples’ lives in the Matlab area, where many families had members employed in ICDDR,B.

Social Influence/Informal Leadership

HWs have gained a kind of social leader role in the community. This was revealed by the fact that they were asked for advice on family problems, children's education, daughter's marriage, family disputes, husbands not looking after the family, writing job applications, raising money for dowry and savings in NGOs. Not only had they made a difference with health related advice, but were also found to assist with finding jobs and employment, help arrange marriages and even negotiate for reducing dowry. Some had mediated in conjugal quarrels and prevented divorce. A Government HW mentioned the case of a man who used to beat his wife because she only had daughters. The HW was able to counsel the couple and explained to the man that the wife was not responsible for having only daughters, and thus establish peace in the family.

A potential area for community engagement by the HWs was in conflict resolution and involvement in local government activities. Some health workers from ICDDR,B had participated in carrying out *shalish* to resolve a case of wife beating, although this was discouraged by their organisation. Some government HWs were members of local committees such as school committees, village police committees and the Union Parishad standing committee on health. Their presence and participation was valued by the Union Parishad Chairman and other members.

Job satisfaction and at Serving as Role Models

Serving the community and poor women was a source of satisfaction and gave HWs a sense of fulfilment and purpose beyond their roles as mothers and wives. They felt they were making an important contribution to their community as individuals by saving lives of mothers and infants. A BRAC HW expressed her satisfaction as follows: "What I like best is serving others. After a child is born the mother will let me hold the child before she gives it to the father…I am satisfied with my work because my work gives me peace. I am able to help people, serve people. People listen to my ideas and advice. They do what I tell them to do." The satisfaction of service is also cited as one of the most important reasons for joining and choosing this line of employment, as important as the need to earn money. This way of portraying what they did invested their decision to work with an altruistic motivation, a sense of community service rather than a self-interested one of earning an income.

A new dimension of the community role of the HWs was that they set examples for change. Many of them thought that their activities had indirect effects, like changing people's ideas about women's status. For example, they mentioned that earlier people would be unhappy if a girl child was born first, now they felt that it did not matter as much. One third of the health workers mentioned they had been able to influence sharing of household work among couples, and some husbands and mother-in-laws had started to help their wives or daughter-in-laws with household work.

HWs also served as role models for younger women in the community and strongly demonstrated the value of women's paid work and girls' education to the community at large. The majority of ICDDR,B HWs thought that now parents were inspired to educate their daughters because they saw women being employed as community health workers. One HW said: "When I go from house to house in the field, many fathers tell their daughters 'look your older sister has studied and now has a job. If you study too then you too can have a job.' Many people are encouraged like this". Another government HW in Matlab said "Nowadays people educate their daughters more.

This is bringing social change. People are not differentiating between sons and daughters. People say that daughters are best". Most of the health workers of GK believe that GK had opened the path of women's employment in their area (Savar).The case of one government HW in Matlab illustrated how education helped her get employment, and thereby gain her in-laws support when her husband married a second time. This demonstrated that women's education could be a very important fallback for women and a source of status and power.

Shifting Perceptions around Purdah and Women in Public

As pointed out by Ruth Simmons "Employment as a field worker in the Matlab project required a set of behaviour entirely inconsistent with (…) concepts of modesty and female seclusion" (Simmons et al, 1994: 326). Have community health workers been able to challenge purdah norms that seclude women and restrict their mobility? Have purdah norms weakened as a consequence of the work of community HWs? We found that purdah, as implied by women's visibility in the public domain, had weakened, but purdah as implied by veiling or covering the body by wearing a *burkha*, may have increased.

An ICDDR,B HW said: "After I got married I could not go anywhere. After I got the job I can now go anywhere". A government HW in Matlab mentioned that for the first two years her brother or father went to the field with her, but now she goes on her own. Another government HW in Savar was married into a poor but conservative family where the tradition was that women would not go out unaccompanied. Hence, her husband hired a domestic worker (ayah) to accompany her on her work, making break with tradition more acceptable. GK HWs also have stories of harassment in the community when they were seen moving around with unrelated men, and senior officials had to intervene to explain their work. Since then the idea of men and women working together has become more acceptable in the Savar area, as indicated by the fact that HWs feel more comfortable about travelling alone.

To some extent wearing of *burkha* contributed to the social acceptability of women's presence in the public domain. The practice of wearing the *burkha* has persisted among women HWs, unless explicitly challenged by the organisational practice such as those of GK and BRAC. HWs felt that the *burkha* legitimized their visibility in public places and increased social acceptance of the fact that they have to work outside the home with unrelated men. They felt that the *burkha* made life easier for them (walking about, riding buses etc without having to worry about clothes not being in place) and safeguarded their honour.

While working outside in the home and therefore being visible in the public domain was necessary, wearing a *burkha* was optional to some extent but strongly influenced by the organisational requirements. The government and ICDDR,B programmes did not encourage women to challenge the practice of veiling as much as GK or BRAC did. Most of the ICDDR,B and government HWs wore *burkhas* or covered their heads with their saris (in the case of Hindu HWs). These programmes consciously emphasized that the women were respectable and respectful of community values to minimise the hostility to their mobility. By contrast, deliberately seeking to break cultural norms, GK did not allow *burkhas*, long dresses or *ghomta* (head covering with veil or sari). BRAC HWs had to wear an "apron", a short white coat over their clothes, which is mandatory and imposed on the ground that they will be recognized by all as BRAC HWs. GK HWs have adapted and justify this by saying that "*purdah* is a question of attitude/mind

("moner baipar")[15]. The community accepted that GK HWs did not wear *burkhas* or cover their heads, and that BRAC HWs wore the aprons.

GK also encouraged women HWs to travel for work. Most of the GK HWs interviewed had worked and lived in various parts of the country. Three had gone aboard for training to India and Indonesia, and felt confident enough to work and live anywhere they were posted. The condition that GK trainee paramedics had to live on campus also increased acceptability of women living away from home.

The community generally supported working women wearing the *burkha* and women's mobility was not an issue, especially if women wore the *burkha*. The *burkha* was seen by better off people as a means of maintaining *purdah* while allowing women to be mobile and work outside the home. Community discussions stated that "in earlier generations women would go out at night so that no one would see them. Now more women go out during the day, even to markets. … Now when you go to the market you bump into women. Now half of the customers are women. Because of *burkhas* women's mobility has increased because people can't see who they are. Before, if you bumped into a woman she would protest. Now they don't. You don't know who they are".

8. Negotiations around Work and *Purdah*

The above findings suggest that despite personal empowerment, family acceptance and support, and greater prestige in the community, on a deeper levelthe women had to negotiate the conditions under which they could work outside the home.

While HWs were more successful in renegotiating family restrictions to taking up a public form of work, they were less successful in negotiating restrictions on mobility in the public sphere and particularly on the practice of veiling (wearing *burkha*). With respect to the former, HWs usually did not need permission when going out but had to inform their husbands or mothers-in-law as a social practice. One ICDDR,B HW said: "Obviously I have to tell (my husband) where I am going. I have to provide some information. Because Bangladesh is a male dominated society…. There is no problem if I don't tell him, but I still have to tell him. Then he won't worry". On the other hand, some did require permission from senior family members. One BRAC HW said: "I have to take my mother-in-law's and husband's permission to go anywhere. If it is work related they do not object. But if I visit relatives I need permission. They don't let me visit my parents. I have to hide my going". Sometimes, the barrier to mobility outside the home came from women themselves, who initially felt uncomfortable going out by themselves but were able to overcome this inhibition over time. One government HW in Savar recalled how earlier she never went out alone but now she does as she is more confident.

With respect to wearing the *burkha*, there were two types of responses. Some HWs voluntarily adopted the *burkha* to gain both respectability and the ability to move freely outside. The husband of a BRAC HW said: "She (my wife) wears *burkha* according to her own decision. In the beginning she didn't wear it. Now she is growing older. Basically, from my family there is

[15] The justification of mobility with veiling or *burkhas* or "decent" clothing and behaviour by emphasizing inner *purdah or "purdah* of the mind" that was also noted by others (Simmons et al 1994, Kabeer 2000andHuq S. 2010,) is also prevalent among the women HWs, their families and the communities.

no objection. I think wearing burkha is to some extent a problem, especially in summer, as it is really uncomfortable". The second type of HWs were those whose family members stipulated the wearing of *burkha*. Nearly half of the husbands wanted their wives to wear the *burkha* because they felt it increased social status, brought religious rewards and was a means of ensuring physical security. The husband of a BRAC HW said: "My wife wears *burkha* under an apron (white coat) according to my instructions. I believe that from an Islamic point of view we should do this as Muslims". The husband of a ICDDR,B HW commented: "If a woman doesn't wear *burkha* the villagers will criticize her. Actually a *burkha* helps a woman to do her job, because people say this woman is very good, no one has ever seen her without *burkha* so the woman has a sense of modesty".

However, the strict practice could be renegotiated invoking office rules. The husband of one BRAC HW said: "I told my wife to wear *burkha* but she replied that wearing apron over sari or *shalwar-kamiz* is the office rule". A few husbands actually supported HWs to challenge social norms. One BRAC HW related how her husband supported her to deal with the challenge of travelling outside the home on her own: "My husband knew that the job entails travelling/going around. So he took me around on his cycle to make me familiar with various places". In another case a BRAC HW related how her husband encouraged her to ride the bicycle despite strong family opposition. Only one BRAC HW had actually been able to overcome personal and family barriers to ride one because of her husband's encouragement, but she compensated by wearing a *burkha*.

Thus, with respect to mobility and wearing the *burkha* four types of practice by HWs were observed: women who had very restricted mobility and needed permission to go out for purposes other than work (some had to see their families in secret); women who opted to wear the *burkha* when going out; women who had supportive husbands (taking them around on the bike); and women who invoked office rules to challenge the practice of wearing the *burkha*.

Interestingly almost half of the male family members spoke rather liberally about *purdah*, emphasizing purdah as the state of mind and being modest in clothes rather than the covering of the body[16]. In two cases husbands strongly opposed the practice of wearing *burkha*. One husband of a government HW in Matlab said: "If I myself am good, I don't have to maintain purdah. I think we don't need any kind of *purdah or burkha*. Being good is a best way of purdah. So no one needs to wear *burkha* to do purdah".HWs themselves justified their visibility in the public sphere by referring to the "*purdah* of the mind" which they state that they follow[17]. Similar views were expressed by early garment factory workers, some of whom saw purdah as an individual responsibility and that 'every woman carried her purdah with her by her modest deportment, lowered eyes and covered head' (Kabeer 2000, pp 91).

However, it is difficult to disentangle from our interviews the extent to which HWs' ability to challenge the practice of wearing the burkha was related to organisational practice. On the one hand their mobility in the public sphere had increased when this was in relation to work. On the other hand, HWs had generally not been able to dispense with wearing the burkha even when there was organisational and family support to challenge such social norms (as in GK and BRAC). For example, four BRAC HWs do not wear burkha when working, but have to when they go out for other purposes.

[16] Except two husbands, however, all of them also accepted it if their wives wished to wear burkha.
[17] Also see Samia Huq 2010.

9. Conclusion

The experiences of paid work in women's lives is very important in determining the extent to which women are able to negotiate patriarchal structures of kinship and family that rule their everyday lives. Health workers' experiences with paid work outside the home revealed a mixed picture of changing norms in some areas, but continuity and compromise in others. While the job of a health worker was itself an extension of women's traditional care roles, this job has been able to negotiate norms to make women's breadwinner roles and mobility in the public sphere more socially acceptable. In this process of change and continuity, women's trade-offs have been more difficult within the sphere of family and their individual lives, and relatively easier in the sphere of community life.

Positive change was readily discernible in women's position in the community, and breaking with the norm of seclusion was made easier by wearing the *burkha*. In addition, jobs as health workers made women full and important members of the community. Their professional status was recognized and their contribution to the community in terms of reducing infant and maternal mortality and improving health in general was a common perception. Their social influence and leadership on matters outside health and family planning was apparent. They served as role models, encouraged families to invest in daughters' education and enabled other girls and women to consider paid work as an acceptable option.

In their personal and family lives women HWs had greater freedom of mobility, some degree of economic independence and had gained important life skills. But there was little change in the pattern of family decision making and not much change with respect to sharing of household work. In other words, when there was a gain for the family (women's income contribution to the household) breaking the norm was acceptable, but when there was an apparent 'cost' (sharing of household work) the norm was justified. Thus, families accepted women working outside the home and acknowledged their economic contribution as essential, but maintaining 'peace' in the family was still seen as the woman's responsibility.

Finally, on both fronts organisational support can play an important role in creating the environment for women to challenge family and social norms, in the first case by legitimising women's visibility in the public domain by providing gainful and fulfilling employment and in the latter by establishing workplace practices that support women to challenge prevailing gender norms. In a recent review of the relationship between paid work and women's empowerment Kabeer (2008) notes "Context is critical to research on the relationship between women's paid work and empowerment because context helps to shape both the availability as well as the acceptability of different kinds of work for women." In particular the organisational context, by determining the conditions of women's paid work, might also bear significantly upon how women bargain with the community structures of patriarchy.

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Annex Tables

Table1: Salary and benefits provided to HWs by organization

	Name of programme			
	Government	ICDDR,B	Gonoshashthya Kendra	BRAC
Salary per month(taka)	8,000-9,000	10,000-21,000	1,500 plus food and living allowance	1,200
Duration training	1.5 months	1 month	6 years	1 month
Benefits				
pension/PF	Yes	Yes		
paid leave	Yes	Yes	yes, including paternity leave	
child allowance		Yes		
medical allowance	Yes	Yes		
loan fund	Yes			

Table 2: Methods and respondents

Method	Jamalpur			Matlab			Savar			Total
	BRAC		GOVT	ICDDR,B		GOVT	GK		GOVT	
	Old	New	5	Old	New	5	Old	New	5	45
II	5	5		5	5		5	5		
II(male family member)	5	5	5	5	5	5	5	5	5	45
KII	1		1	1		1	1		1	6
FGD	2		2	2		2	2		2	12
Community Profile	1			1			1			3

Table 3: Types of respondents for FGD

Poor household		**Well off household**	
Male	Female	Male	Female
Farmer	Housewife	Village doctor	Employee of Insurance company
Tailor	Domestic servant	Pharmacy shopkeeper	Teacher
Small shopkeeper	Unmarried unemployed person	Teacher	Nurse
Wage labour	Small entrepreneur – mat maker, Katha stitch, poultry,	Local rich businessman	Employee of private company
Local sales man		Imam	NGO activist
Rickshaw puller		Doctor (MBBS)	UP member
Small businessman		Local Journalist	Nursery businesswoman
Cobbler			Tailor
Unemployed person			Trained Birth attendant
			Cosmetic shopkeeper
			Mobile phone shopkeeper
			Housewife

Table 4. Health Workers by age group and organization

Age	BRAC	ICDDRB	GK	GOVT	Total
20- 29	6	1	5	0	12
30-39	3	2	2	6	13
40 +	1	7 (4 are 50+)	3 (2 are 50+)	9 (1 is 50+)	20 (7 are50+)
Total	10	10	10	15	45

Table 5: Educational level of Health Workers

Educational Qualification	BRAC	ICDDRB	GK	GOVT.	Total
Non Matric	0	4	0	1	5
SSC	10	2	6	6	24
HSC	0	1	4	3	8
Degree pass	0	3	0	5	8
Total	10	10	10	15	45

Table 6: Marital status of Health Worker

Marital Status	BRAC	ICDDRB	GK	GOVT.	Total
Married	9	9	7	15	40
Unmarried	0	0	3	0	3
Widow	0	1	0	0	1
Separated	1	0	0	0	1
Divorced	0	0	0	0	0
Total	10	10	10	15	45

Table 7: Family Composition

Family Type	BRAC	ICDDRB	GK	GOVT.	Total
Nuclear / Single	5	6	6	12	29
Joint (Own House)	0	1	0	3	4
Joint (In-laws House)	2	1	1	0	4
Joint (Father's House)	3	2	1	0	6
Total	10	10	8(2 live in GK Dormitory)	15	43

Table 8: Length of Service of Health Workers

	BRAC	ICDDRB	GK	GOVT.	Total
0-5	10*		5**		15
6-15		3		2	5
16- 25		2	3	11	16
25+		5	2	2	9
Total	10	10	10	15	45

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