

MALE MIGRANTS' RETURN, WOMEN'S FERTILITY AND HIV STATUS IN BANGLADESH

Patricia Lyons Johnson

ABSTRACT

This paper deals with the potentially deleterious effects of the return of male migrants on both the fertility and health of their wives who, because of cultural constraints, are unprepared to protect themselves against unwanted pregnancy and/or sexually transmitted diseases, such as HIV/AIDS. I explore the relationship between male migration, commercialized sex and HIV infection and argue for the use of condoms as both contraceptives and prophylactics. Immediate intervention to promote condom use may mean prevention of an AIDS epidemic that would take the lives of millions of Bangladeshis.

Introduction

Bangladesh has been notable for the amounts of development funding donated to the country in an attempt to alleviate the overwhelming poverty and correlated misery that have characterized the nation since its inception in 1971. Most observers would agree that particular initiatives, such as fertility reduction through family planning and mortality reduction through better delivery of health care, particularly to women and children, have been highly successful. There is, however, less consensus about the success of development programs designed to reform the Bangladeshi economy (Shand and Alauddin 1997, p.3). Although unemployment rates have improved since 1990 (Bangladesh Bureau of Statistics 1999, p. 148) large numbers of the labor force have sought better opportunities through both rural to urban internal migration and international migration (Chaudhury 1978; Hossain and Roopnarine 1992; Mahbub 1985-86; Matin 1986; Osmani 1986). Much of this migration involves males whose wives remain at home. This paper deals with the potentially deleterious effects of these migrants' return on both the fertility and health of these wives who, because of cultural constraints, are unprepared to protect themselves against the possibilities of unwanted pregnancy and/or sexually transmitted diseases. I argue that both Bangladesh's peripheral position in a global economy and women's peripheral position within Bangladeshi society contribute to this problem.

The Scope of Bangladeshi Migration

Migration is not a new phenomenon in Bangladesh. During the 19th century, while still part of India, East Bengal sent migrants to the

west, particularly to the United Kingdom, and almost exclusively from the Sylhet area. In the 1970s patterns of migration changed radically as Great Britain implemented stricter immigration legislation while, at the same time, the oil-rich countries of the Middle East experienced a need for cheap and primarily low-skilled labor (Osmani 1986, p. 24-26). Although Mahmood (1995, p. 700) notes the presence of Bangladeshi migrants in "...South Korea, Japan, Taiwan, Hong Kong, Thailand, Malaysia, Singapore, Brunei...the U.K., Germany, Sweden, Italy...and in the U.S. and Canada," labor migration has, since 1971, remained focused on the Middle East. This migration has been characterized by short-term contracts of one or two years, with a much smaller number of three or four year contracts. These prosperous destination countries are interested in Bangladeshi migrants not as future citizens, but as temporary workers in low paying jobs that require little in the way of already formally acquired skills. While it is extremely difficult to determine the current numbers of international migrants, the official number of Bangladeshis employed abroad in 1994 was a bit over 186,000; in 1998 it was almost 268,000, an increase over 4 years of about 44% (Bangladesh Bureau of Statistics 1999, p. 179). These are official figures, which "significantly understate total labour outflows" (Athukorala and Wickramasekara 1996, p. 555), and they do not include students, migrants who are not employed and migrants who are illegally resident in foreign countries. Between 1980-90, almost 297,000 Bangladeshis were recorded as entering the Gulf States as migrants; by the early 1990s, the figure had risen to almost 508,000 (Massey et al. 1998, p.139). Accurately assessing the number of Bangladeshi international migrants is extremely

difficult, but it is even more problematic to determine the number of people who have migrated internally, since people move freely about the country. However, its magnitude may be gauged by the effect on urban populations of rural-urban migration, the most important type of internal migration. In 1990 the population of Dhaka, the capital and a primary target area for rural migrants, was 6.2 million; the projected population by 2015 is 19.5 million. (Consultative Group on International Agricultural Research 2000). While part of this increase will be due to the fertility of current residents, the "most important contributor to increased urban population has been rural-urban migration" (Mahmood 1995, p.710).

It is equally difficult to assess return flows of migrants, an important aspect of this paper, since records on returns are not kept either for internal or international migration. In some sense, it may not be reasonable to discuss return flows for internal migrants since in many cases, migrants return quite regularly as visitors to their home areas although they continue to live and work elsewhere. With respect to international migrants, the brevity of labor contracts suggests a considerable return flow and Osmani (1986, p. 34) has calculated, for a three-year period, return flows ranging between 43 and 69 percent. I can provide some information from my own experience in Matlab, a rural area, where I conducted fieldwork for a year in 1998. Although my work had no direct connection with migration, one criterion for inclusion in my sample was that husband and wife be cohabiting. In the three largest villages of the six from which the research sample was to be drawn, there were 1751 married women who met the other criteria for inclusion. However, 38% of these women had non-resident husbands who had migrated, either internally or internationally to pursue labor opportunities. Once the sample was selected from those women who met all the criteria, including a resident husband, the situation became more complicated, but also more informative. Over the course of the project, a sizeable number of women who had not been included in the sample subsequently asked to be included because their husbands had since returned. Conversely, many women who had been included in the sample had to be replaced because, between the drawing of the sample and the actual interview, their husbands had left. The point to be made here is how widespread migration has become and, even more

importantly, how fluid the status of "migrant" can be. And it is precisely this fluidity, this high unpredictability of male migrants' returning that bears particularly on the questions of interest, the fertility and health consequences for their wives when these men return.

Functional Marital Status and Fertility

Bangladesh has experienced remarkable change in fertility over the past 25 years. In 1975 the country's total fertility rate (TFR) was 6.3 (Mitra et al. 1995, p.27). That meant that the average woman could expect to produce 6.3 children if she survived to age 50, and current age-specific fertility rates continued. By 1994 TFR had declined to 3.4 (ibid.) and the international database of the U.S. Census bureau estimates the 2000 TFR as 2.9 (U.S Census Bureau 2000). This marked and rapid decline has been attributed to the success of family planning programs and to the consequent increasing use of modern contraceptives. This is usually expressed in terms of increasing contraceptive prevalence rates (CPR). Those rates are calculated by dividing the number of women using contraception by the number of eligible women, and the number of eligible women is defined as the number of women exposed to the risk of conception because they are in marital unions. If 600 women are using contraception in a population of 1000 eligible women, we talk about a 60% CPR. Limiting "women at risk for conception" to married women often inspires skepticism. We know that women can be "at risk" and not married. But in Bangladesh, and probably in many Muslim countries, that is probably a more realistic definition than in many other parts of the world, largely because of the effects of *purdah*, the seclusion of females that begins as they approach puberty. I focus on the concept of CPR because it is useful in trying to understand the ambiguity inherent in being the non-migrant wife of a migrant husband.

Most wives in Bangladesh are both officially and functionally married; their official status is "married woman" and they fulfill the functions, sexual and otherwise, of married women and are appropriately included in the number of women at risk for conception. Unmarried women, similarly, are officially and functionally unmarried; their official status is unmarried and they perform the functions of unmarried women, which means, among other things, that they are not sexually active and consequently not at risk

for conception. In both these cases, official and functional statuses coincide.

The position of wives of migrants, however, is more complicated. Women whose husbands are absent are, in one sense, like unmarried women and should not be included in the number of women at risk, because, like unmarried women, they are *culturally* not at risk for conception since they cannot properly engage in sexual intercourse because their husbands are not present. But the wives of migrants are also different from unmarried women. In general in Bangladesh, entering into or exiting from marriage, through divorce or widowhood, is relatively dramatic, and the probability of multiple marital transitions within short periods of time is small. For example, a woman might experience a sudden move from marriage to widowhood or divorce, but it is unlikely that over a short period of time she will experience multiple such changes in her status. Unmarried women are also unlikely to move suddenly from the unmarried to the married state and become wives, since marriage usually requires considerable negotiation and preparation. But the wives of migrants occupy a position in which their official status and their functional status are not necessarily consistent at any one time. They are officially married, but functionally unmarried, in that, since they are not cohabiting, they are not at risk for conception. But what is probably more important is that, if their husbands have migrated over such short distances within Bangladesh that they can visit, these women may change their functional married state every week, moving from "unmarried" to "married" each weekend. In the case of long distance migration within Bangladesh or international migration, their functionally unmarried state is likely to be more long term, but their change back to a functionally married state may be equally unpredictable, in that a husband may return without forewarning. Either of these scenarios presents particular problems for these women in terms of family planning.

Using contraceptives implies the likelihood of sexual intercourse, since otherwise, there is no need to contracept. The most popular reversible contraceptives in Bangladesh are pills and injectibles and both require advance planning if they are to be used effectively. This means that women who want to be protected against the risk of conception when their husbands return need to

use these contraceptives during a period when their husbands are away, that is, when they do not have a resident legitimate sexual partner. The cultural assessment of women who use contraceptives when they have no resident legitimate sexual partner is highly negative, since this behavior can be interpreted as suggesting that they have or want to have illegitimate sexual partners. Not surprisingly, this does not encourage women to use contraceptives while their husbands are away, even if they want to limit family size. The result is that women whose husbands return from migration and who wish to avoid pregnancy are unlikely to be protected against the risk of conception at the time of the husband's return. What is needed in these cases is a contraceptive that can be used expediently and without prior preparation.

Migration and Sexually Transmitted Diseases

A further consideration for these women and their families is becoming painfully clear as we learn more about the relationship between migration and sexually transmitted diseases. Recent research has brought to light a great deal of information about this relationship and the news is not good. "As people migrate, the rules of sexual behavior change, opening new avenues for sexual encounter, but also exposing the person to enhanced risk of HIV and STDs" (Herdt 1997, p.3). While any STD can have devastating effects, HIV/AIDS¹ presents an especially serious prognosis and the almost certain mortality connected to this disease in impoverished nations makes efforts at prevention urgent. Numerous studies have connected transmission of the human immunodeficiency virus to commercial sex (Caldwell et al. 1997; Singhanetra-Renard 1997; Crael 1997), a common behavior throughout the world for migrant men who are unaccompanied by their wives. It seems to me to be a special problem, however, in countries like Bangladesh and the Muslim countries of the Middle East, where families seclude their female members and virtually the only available extramarital heterosexual partners are sex workers. Data on commercial sex in Bangladesh are scanty, but a study done in a brothel in Tangail, about 60 miles north of Dhaka, provides some worrying figures. "Sex workers entertain an average of three clients per day. While 90 percent are aware of diseases like syphilis and gonorrhea, only 3 percent reported using condoms. Sixty percent reported having had an STD (20 percent have an

active STD)" (AIDSfocus Newsletter 1997, p.1). In Bangladesh's major port, Chittagong, a study "...found that nearly 42,000 men access sex workers every week...with each sex worker averaging between nine and 15 partners per week. ...Chittagong sex workers rarely request condom use since condoms are known locally as useful only for family planning purposes" (MAP 1999, p.14). This same report (op cit, p.16) goes on to say

In the Asia/Pacific region, sex workers are particularly vulnerable to HIV...and represent the most significant core group for transmission to the rest of the population through their clients. The critical factors influencing the rate of spread from sex workers include the number of clients per day and the proportion of men in a society who regularly visit sex workers. In nations with high levels of both of these factors and where sex is not protected by condoms, HIV epidemics spread very rapidly.

Clearly, when sex workers engage in unprotected intercourse with multiple partners, the probability of contracting an STD increases both for them and for men who resort to commercial sex.

With respect to the relationships among migration, commercial sex, and HIV/AIDS, Caldwell et al. (1997, p.51-52) note about the African situation:

AIDS probably has a closer relationship to migration than any other infectious disease...for migration is a primary cause of behaviour which facilitates the transmission from one person to another. Migrant men are more likely to seek new sexual partners and more likely to find them in commercial sex than when at home ...commercial sex is more dangerous because the women involved in it usually have a large number of partners and because some of these partners live particularly high-risk lives.

Given what we know about the relationship

between migration and HIV/AIDS, we should perhaps be thinking about what the return of male migrants may mean for their wives not only in terms of fertility, but also in terms of their health and, perhaps, their very lives and the lives of their children. For these women contraceptives may be able to serve as both protection against unwanted pregnancy and protection against sexually transmitted diseases. The ideal contraceptive method, then, for women whose husbands return from migration would be one that addresses both the problem of advance preparation already mentioned, and that also inhibits transmission of such diseases. As with any contraceptive, it would also be desirable that health side effects of its use be minimal or non-existent. Low cost would also be an advantage. There is an obvious contraceptive method that fulfills all these requirements: condoms. They can be used expediently, they are low cost, their side effects are minimal, and they inhibit the communication of sexually transmitted diseases. In the words of a UNAIDS report (ibid, p. 59-60) "All the scientific evidence points in the same direction: correct and consistent use of condoms of good quality vastly reduces the likelihood of HIV transmission." The high rates of Bangladeshi male migration would suggest, then, that, in areas characterized by such migration, development monies would be well used in programs that emphasize, promote, and encourage the use of condoms.

It seems relevant at this point to discuss what is known about the prevalence of HIV/AIDS in Bangladesh and in the Middle Eastern countries to which so many migrants travel. Within Bangladesh, data are again few and pertain to small samples. Officially, Bangladesh is listed as a country with low HIV prevalence and with projections over the next 3-5 years of a slow increase in prevalence. It is worth noting, however, that West Bengal, the contiguous Indian state and one with which there is considerable border crossing, has an adult HIV prevalence among high risk populations of over 5% (MAP 1999, Annex 1, p. 13). Moreover, projections for India's future are dire: "with a population approaching one billion...3 million to 5 million of its people are infected, and the number of new infections will double every 14 months" (Satcher 1999, p.1479). Figures from the World Health Organization on North Africa and the Middle East are similarly low, with an adult prevalence rate in 1999 of .12%² (World Health Organization 2000)). In both Bangladesh and the countries to which men predominantly

migrate, it appears, on the basis of limited sampling, that there is not yet an HIV/AIDS epidemic. That means that in Bangladesh aggressive action taken at this point may well be able to avert the effects of the predicted Asian pandemic. Indeed, a recent World Bank news release (No. 99/2268/SAS) speaks of Bangladesh's "unique opportunity...to act early and decisively."⁵

Approaches to Promoting Condom Use

A useful paradigm for the development of condom promotion policy is what has been termed "harm reduction," an approach that has been used in a number of countries, including Holland, the United Kingdom, Australia, Canada and the United States (Erickson et al. 1997; Marlatt 1998; Inciardi and Harrison 2000) to reduce high-risk behaviors. Although the primary focus of harm reduction strategies has been addiction, it can also provide a model for dealing with other high risk behaviors (cf. Shell-Duncan-Schell 2001), including high risk sexual behaviors. An important assumption of harm reduction programs is that although the elimination of high risk behavior is an ideal, the reality is that most individuals will not practice abstinence. Consequently, harm reduction attempts to minimize the deleterious effects of ongoing high risk behavior through education and the provision of safer alternatives. It is important to note that, contrary to some criticisms, harm reduction policies are not opposed to abstinence, nor do they advocate high risk behavior. Their efficacy comes from the recognition that even if humans strive toward perfection they are fallible, and from their attempts to ameliorate the outcomes of such fallibility for both those engaging in high risk behavior and the other people upon whom those behaviors have an effect. In the case of intravenous drug use, an early arena for such programs, the provision of safer alternatives has included strategies such as medicalization of addictive drugs, substitution of less harmful substances (such as methadone), and needle exchanges.

The appropriateness of a harm reduction approach in Bangladesh at this crucial time is perhaps best summed up by Marlatt (1998, p. ix)

[H]arm reduction is much more than a humane approach to those at highest risk and already suffering the consequences of their

behaviors, it can apply to the whole population, stretching along a continuum of risk from high to low. **The broadest way that harm reduction can be conceptualized is in relation to prevention in populations who are not yet afflicted by the problem in question** (my emphasis). A great number of individuals in a society fall into those low- and moderate-risk groups, making the potential benefit of harm reduction large.

Marlatt's category "populations who are not yet afflicted" would seem to currently fit most of Bangladesh and the potential for keeping those populations protected through harm reduction procedures is great. But the country is at a critical point that requires that such policies be formulated and implemented soon if they are to be effective in averting the potential cataclysm that ignoring HIV/AIDS may produce.

We know that there are effective measures to limit the transmission of HIV/AIDS and that successful programs stress the importance of prevention, focusing on education and behavioral change. With respect to education, research concerning knowledge of HIV/AIDS in Bangladesh provides some depressing data. Only 19% of ever-married women and 33% of currently married men have ever heard of AIDS, and that knowledge is greatly skewed toward the educated and the urban in a country where most people have low levels of education and are rural. Of those few who have heard of AIDS, 41% of the women and 27% of the men believe there is no way to avoid HIV infection, and of those who believe there is a way to avoid the disease, 69% of women and 51% of men have no idea of how that might be done (Mitra et al. 1997, p.181). In another survey of girls and boys aged 15 to 19, approximately 95% of the girls and just under 90% of the boys did not know how to protect themselves against HIV (UNAIDS 2000, p.43). These studies suggest that HIV/AIDS education within Bangladesh will require a major commitment and will have to start early in life. While it may be discomfoting to some to consider the discussion of sexuality as part of the educational system, it is possible to conduct such programs without offending sensibilities since they can be designed around informing students of the possible fatal

outcomes of unprotected sexual intercourse and can offer abstinence as a possible strategy. Once educational systems impart basic information about HIV/AIDS, those who choose not to pursue abstinence can obtain further information from more general programs designed to meet the needs of all individuals. The harm reduction paradigm has shown that such programs work best as local level programs, conducted by local people, often those who have themselves been members of high risk groups. Returning migrants would seem to be an ideal group for recruitment of such educators; they have gone through the migration experience themselves and are able to speak with authority to future migrants. Such migrant educators would themselves need education designed to deal with the etiology, prevention and treatment of HIV/AIDS before they could, in turn, act as resources for local people. The costs of training such peer educators to work locally with people who know and trust them would be considerably less than initiating a top-down program to address the problem, and miniscule when compared to the financial and social costs incurred by increases in HIV/AIDS. Migrant men can provide information for local males, whether they intend to migrate or not, but they will probably not be able to discuss the subject with women. It is crucial that both males and females have access to information that can save their lives and the lives of their children. In terms of reaching women, Bangladesh has a great advantage in that the government has already established a system of female family health workers whose principal responsibilities involve family planning information and who focus on women; these workers are a natural local level source of information about HIV/AIDS for those women. At the same time, a more general public information program needs to be mounted, using the same kinds of media coverage utilized in family planning campaigns. Radio would be of particular importance in reaching a large illiterate population.

Beyond education, the means to engage in safe sex need to be available, since presumably some percentage of the population will continue to engage in potentially high risk sexual practices. Information about AIDS transmission without the ability to prevent that transmission will not deter the spread of the disease. Since condoms have been proven as effective prophylaxis, they would seem to be an obvious choice for those

who will not or cannot choose abstinence as a strategy⁴. There has been no dearth of condoms in Bangladesh and social marketing has made them an affordable means of contraception for many. For those for whom the minimal costs are still too high, further subsidies could be provided. Again the costs of these subsidies are inconsequential when compared to the costs of epidemic AIDS. More importantly, the double protection provided by condoms has not been emphasized in campaigns designed to foster their use, which have focused on their contraceptive properties. Responsibility for family planning has largely been delegated to women and men have been minimally involved, with the result that female contraceptives have been emphasized. It is understandable that family planning has focused on women, who have a greater interest in controlling fertility because the physical costs of pregnancy fall disproportionately on them. But it is possible to make men active participants in promoting condom use, both for family planning and prophylactic purposes. During my own research on family planning men continually told me that they appreciated being included and consulted, since they felt that family planning had become exclusively a female domain. Because men do not bear the greatest physical burden of pregnancy does not mean that they are oblivious to or uncaring about the welfare of their wives. Programs that emphasize the double protection provided by condoms need to include men and to appeal to their desire to protect their loved ones, both wives and children.

While high rates of marital condom use (at least 20%) have been reported for some countries (Knodel and Pramualratana 1996, p. 101), there are also reports that suggest problems in promoting such use (ibid). The experience of Thailand is instructive since that country has been recognized as vigorously addressing its AIDS epidemic. According to Knodel and Pramualratana (1996) Thai men are willing to use condoms in commercial sex encounters because they recognize the dangers of contracting HIV/AIDS. In marital sexual relations, however, men are reluctant to use condoms because they are felt to decrease men's pleasure and to create questions as to spousal fidelity. While men are willing to forego some pleasure in nonmarital sex for the sake of safety, only 2% of marital contraception involves condom use. Condoms are seen as an effective prophylactic, but not as a desirable or

particularly effective contraceptive, the opposite of the Bangladeshi perception. It is important to remember that Bangladeshis are not Thais and that different initial environments, different approaches to the problem and different views of sexuality may well create different outcomes. In Thailand, for example, "both commercial sex patronage and noncommercial sexual contacts are common for married...men" (Knodel 1996, p.97). This is not the norm for Bangladesh and the men most at risk for such behaviors are migrants when they are apart from their wives. What might prove to be the best harm reduction strategy for such men and their wives is one that emphasizes the use of condoms upon return for a period during which wives could arrange to avail themselves of other means of contraception and men could undergo voluntary testing for STDs of all types. Testing cannot, of course, stand alone and needs to be accompanied by adequate counseling for those found to be HIV positive. That counseling would presumably include discussions of safe marital sex. Such a strategy would meet the needs of harm reduction for both partners. Suggesting voluntary testing and counseling in Bangladesh may seem unrealistic, given the costs of such programs, but AIDS is a development issue as well as a public health issue and development funds would be well used to support such programs. "Redirecting to AIDS existing project resources already programmed for social funds, education and health projects, infrastructure and rural development is fully justified, as the AIDS epidemic ...undermin[es] the very goals of these other investments" (UNAIDS 2000, p. 114).

Personal Agency and Condom Use

There are two major potential objections to any policy measures that encourage condom use as an effective measure for the double protection of non-migrant wives. The first is a practical objection based on the assumption that men will not use condoms. Indeed, based on past usage, this is not an irrational argument. Condom use has increased in Bangladesh, but condoms have never constituted a large percentage of total contraceptive methods, rising from 0.7% in 1975 to 3.9% in 1996-97 (Mitra et al. 1997: 50).³ This argument is clearly based on the assumption that because Bangladeshi men have not used condoms, they will not use condoms. Perhaps the best counter to that argument is the history of family planning in Bangladesh. When family planning programs began in the early 1950s in

what was then East Pakistan, no one could have predicted their eventual success. It was assumed that, for a number of reasons, people would not use contraceptives to limit family size. Among those reasons were high infant and childhood mortality; a cultural preference for large families and especially for sons; the economic dependence of the elderly, especially women, on their children and, again, especially on sons; and the labor value of children. Nonetheless, as Figure 1 shows, these programs enjoyed enormous success and a reasonable question concerns what created that success.

Some important supply side factors helped. In the early 1970s the newly independent government of Bangladesh widened contraceptive options while simultaneously providing greater access through what has since been termed "doorstep delivery," in which contraceptives were delivered to women by health or family planning workers. But there have been important changes on the demand side as well. Infant and childhood mortality have declined dramatically (Figure 2). In 1979-83 there were 117 infant deaths per 1,000 live births. By 1989-93, that number had dropped to 87 (Mitra et al. 1995, p.14) and in 1998 to 72.8 (Development Data Group 2001). A similar decline has taken place in under-five mortality (Figure 3), from 180 deaths per 1,000 live births in 1979-83 (Mitra et al. 1995, p.14) to 96 in 1998 (Development Data Group 2001). What that means, of course, is that people can expect that a greater percentage of their offspring will survive; they no longer have to produce "excess" children in the expectation that some will be lost. The decline in mortality is, of course, welcome, but there are other factors contributing to lower fertility that are not such boons to Bangladesh.

Between 1960 and 1985, landlessness increased dramatically, from a total of 1.5 to 7.75 million landless households, and the percentage of families considered functionally landless, i.e., with 0.5 acres or less, grew from 35 in 1960 to 50 in 1978 (Hossain 1987, p.25). In 1998, 56% of all land holdings qualified as functionally landless (Bangladesh Bureau of Statistics 1999, p.196). Increasing landlessness has resulted from a combination of population growth with partible inheritance, land loss through natural disaster, and land transfers that have sharply distinguished the landless poor from what have been termed "middle peasants" and large landholders (Hossain 1987, p.24) or what White

(1992) has referred to as the distinction between *chotolok* (little people) and *borolok* (big people). The relative returns of agriculture and dealing in land, e.g., letting land to sharecroppers or tenants, make the latter a more profitable use of land. Because large landholders therefore opt to specialize in land dealing, even they do not provide agricultural opportunities for the landless poor. Consequently, the increase in landlessness has not been offset by increases in reliable agricultural employment, and landless farmers are forced into service or artisanal employment. At the same time, the decline in income for rural farming creates limited markets for such goods and services, and people thus employed are seriously underemployed (Hossain 1987, p. 22:24). Landless households cannot benefit from the labor of children on family farms, and the saturation of the agricultural labor market and the underemployment of non-agricultural workers in rural areas suggest that adults, not children, will benefit from the few employment opportunities available.

With respect to children's value as old-age support, telling evidence comes from Duza and Nag's research in Matlab. The authors discuss parents' views on "the notion that male children provide a form of old-age security" as elicited in focus group sessions (Duza and Nag 1993, p. 73). Pointing to increasing scarcity of resources, including land, they summarize three reasons why parents now see sons as a less reliable source of support. While one reason has to do with perceived changes in marital relations such that sons are influenced more by wives than by parents, the other two refer directly to conditions of economic deterioration in which adult children are seen as incapable of supporting themselves because of scarcity of land or employment, and therefore incapable of supporting parents, either because of their limited income or their need to migrate for employment.

There are two points to be made here: conditions change, and people have agency, so that when conditions change, they are capable of adapting to new situations with new behavior. This has certainly been the case with respect to willingness to use certain contraceptive technologies. As people become more aware of the dangers of STDs, particularly of the potentially fatal danger of HIV and AIDS, practice can change as well. But motive, that demand element, will only follow education, and

even the best motives will not be sufficient to effect the necessary change if programs do not emphasize the supply element and advocate the use of condoms.

Structural Reform and Condom Use

The second objection is somewhat more complex and argues that advocacy of condom promotion ignores the underlying issues. Let me now address this objection which is sometimes referred to as a "band aid" argument, that is, as objecting to the use of temporary and expedient solutions instead of the radical solutions to underlying structural problems. There are two important and encompassing problems that need to be addressed: Bangladesh's peripheralization in a global economy, and women's peripheralization in Bangladeshi society. I want to be clear here that I am using "peripheral" not as a synonym for unimportant, but rather in the sense associated with underdevelopment theorists, as simultaneously necessary for the continued operation of a system, and without power within the system. Bangladesh has been peripheralized for a long time and with devastating effects. When the country was still East Bengal, the British consciously demolished the prosperous native textile industry in order to eliminate competition with British textiles and to provide a market for them. In destroying an industrial base, the policy also effected the relocation of urban textile workers and their greater direct reliance on an agricultural base, increasing the demands on rural resources. At the same time, British fiscal policy revised an existing prebendary system in ways that made it insensitive to fluctuations in production and increased the economic and political powers of the zamindars (tax collectors-landlords) in ways that still redound in village level patron-client relationships. East Bengal's agricultural production was also manipulated to meet British needs. When the Crimean war closed the Russian hemp trade to Britain, colonial policy encouraged production of jute and it became East Bengal's primary export. This cash crop became so important that land was removed from rice cultivation to meet the demand. But jute processing took place far from the local source. Factories were located in West Bengal as part of an overall process that assigned West Bengal, and especially Calcutta, to the position of internal core to East Bengal's internal periphery, a process that was to have further repercussions after Indian partition left Muslim East Bengal

seriously lacking in industrial facilities and knowledge (Baxter 1997). After partition assigned East and West Bengal to Pakistan and India, respectively, factories for jute processing were established in East Pakistan, but the capital for those factories came from West Pakistan, the richer, more politically powerful, and more technologically skilled province. Management also came from West Pakistan and there was, consequently, little advancement or training in management for East Pakistanis. Moreover, Muslim Bihari refugees from northern India, Urdu speakers and consequently favored by West Pakistan, were employed for skilled labor, further constraining opportunities for Bengalis in what was now their own country.

It is important to remember that Bangladesh is one of the most densely populated countries in the world with a population of over 131 million in approximately 133,000 square kilometers, an area roughly the size of the state of Minnesota, slightly larger than Greece and somewhat smaller than Nepal. Almost 64% of the labor force is in the agricultural sector. This distribution of the labor force is analogous to locating 30% of the U.S. population in Minnesota and expecting them to make a living as farmers. Industrialization has increased in Bangladesh, but is still a minor element in terms of the number of people it employs. Independence has not changed Bangladesh's peripheral position in a global economy. What has changed is that, now, instead of exporting agricultural raw goods, Bangladesh is exporting people, a migrant labor force, and so long as that labor force cannot be fully and gainfully employed at home migration will continue and probably increase. Given the chance, people leave and will continue to do so.

Just as Bangladesh and other developing countries are crucial to developed countries' prosperity, so are women in Bangladesh crucial to the continuation of patriarchy and the associated privilege of being male.

Hierarchy is a crucial concept in social relations in Bangladeshi society. An individual's access to power and material resources is largely determined by three attributes: class, age, and gender. Although there is room for individual variation, generally, rich supercedes poor, age supercedes youth, and male supercedes female. Kinship is based on patrilineal principles and postmarital residence is virilocal, with the result

that wives produce members for but are not themselves members of the localized patrilineal group into which they marry. Male children are preferred over female and one of a woman's most important roles within the family is producing sons. The birth of sons, indeed, improves a woman's position within the kin group and sons provide her one of the few avenues through which she may be able to pursue her own interests. Sons are valued as perpetuators of the lineage, as repositories of social prestige, as financial and political supports for their parents. Sons are especially important for women, since, in consolidating their position within the family, they provide their mothers some security against divorce. Sons are also expected to provide support for their mothers in the event of divorce or widowhood, the devastating effects of which arise from the institution that most seriously affects women's lives, their seclusion under the rules of purdah.

Purdah ("veil" or "curtain") enjoins the seclusion of women and the prohibition of their interaction with unrelated males. Girls begin to be subject to rules of seclusion shortly before puberty. Although the degree to which women can be secluded varies, particularly by the wealth of a family, the ideal is for women to be confined to the *bari* (a homestead that encompasses a number of patrilineally related households) or to interconnecting homesteads, if they are joined by paths that enable women to travel without being seen by men. The degree to which a family is able to maintain its women in seclusion is an indicator of its respectability; a woman's chastity is directly associated with her family's honor. Seclusion seriously curtails women's access to local knowledge, to formal education, and to economic opportunities beyond the household level. Purdah creates and reinforces women's dependence on men, especially their economic dependence. Indeed, the ideal of men's and women's roles within the family reflects this dependence: men are responsible for supporting their families and can expect to receive in return deference and obedience from their wives. The division of the world into male public space and female private space, and the division of behavior into male initiative and female passivity both affect women's autonomy in ways that may influence women's sexuality. Women's economic dependence, a result of purdah, denies them power over most of Bangladeshi life, but perhaps most poignantly, denies them power over their own bodies. It is difficult, if not

impossible, under this system for women to define the conditions of sexual intercourse, to insist, for example, on the use of condoms.

Obviously, these internal and international inequities have to be addressed if Bangladesh's future is going to be better than its present. And obviously development funds can be used to address these problems, but the solutions that would create equity for Bangladesh in a world economy and for women in Bangladeshi society have not yet appeared. While I alluded earlier to the importance of agency, it is important to note that that agency was able to operate to change fertility patterns in Bangladesh only after the institutional commitment was made by the government and international funders to provide alternatives from which people could choose, a regime of natural fertility or reproductive control. Changing Bangladesh's position in the world economy and women's position within Bangladeshi society are not matters of individual choice and will not be effectively addressed until there is the possibility that individual choices can be effective as part of larger movements. In the interim, my response to the "band aid" argument is perhaps best framed as an analogy. If you see people bleeding to death because they have been victims of a traffic accident, you do not ignore them while you focus on better traffic safety legislation. The developed nations have a responsibility to recognize the importance of advocating and supporting reform on the policy level that will work to overcome the current conditions that drive Bangladeshi men to choose to leave and that require Bangladeshi women to relinquish control over the conditions of their own sexuality. But we cannot abdicate the equally important responsibility to work for expedient, intermediate measures until such reforms are enacted. Something has to be done in the meantime for the people whose lives are in danger and I would argue that advocating as simple a change as condom use, in this case, is not a band aid but rather a tourniquet that may in fact save the lives of many men, women and children while they wait for the better day.

Conclusion

I have outlined in this paper the potential problems for the wives of returning migrants in terms of protection against both unwanted pregnancy and sexually transmitted diseases, particularly, HIV/AIDS. Male migration has been and continues to be an important

demographic phenomenon in Bangladesh. When migrants are away from home without their spouses, the potential for commercial sexual encounters is high and these encounters are usually what can be termed high risk, because of the likelihood of unprotected sex and multiple partners, some of whom may engage in further high risk behaviors. When men return to their wives, these women are unlikely to be using effective contraception and are not protected against sexually transmitted diseases. I argue that programs designed to increase the use of condoms could deal with both these problems in a simple and cost-effective manner. I fully acknowledge that higher level, long-term reforms are crucial in changing two major structural problems, Bangladesh's peripheral position in a global economy and women's peripheral position within Bangladesh society. I strongly advocate, however, more immediate measures designed to protect the Bangladeshi population from a potentially devastating epidemic and I urge that these measures begin as quickly as possible to take advantage of the country's current low rates of infection. Bangladesh has an invaluable opportunity at a unique moment and pursuing that opportunity may enable the country to save literally millions of Bangladeshi lives.

Endnotes

¹ To describe HIV/AIDS as a sexually transmitted disease is, of course, to isolate and focus on one of several modes of transmission. However, preliminary data from Bangladesh indicate that heterosexual transmission is, at this point, the most common mode of infection in that country and, consequently, I will focus on that mode throughout this paper. Any suggestions about policy can be extrapolated to other high risk groups, such as men who have sex with men and intravenous drug users.

² The World Health Organization groups North Africa and the Middle East in the reporting of these statistics and it is not possible to separate the two regions. Some Bangladeshis do migrate to North Africa, particularly to Libya, but that migration is quite minor when compared to the Middle East. For this grouped region, the main modes of transmission are intravenous drug use and heterosexual intercourse; it is not possible to determine from WHO data which mode is more important in each area.

³ The government of Bangladesh, despite scarce resources, took a major step with the testing of high-risk groups begun in 1998.

⁴ In the latter category I would include sex workers who have no other means of earning a living.

References

AIDSfocus Newsletter (1997), *CARE-Bangladesh: The Peers*. Electronic document. <http://www.care.org/publications/aidsfocus/nov97/focus1.html/>

Athukorala, Prema-Chandra and Piyasiri Wickramasekara (1996), "Internal Labour Migration Statistics in Asia: An Appraisal," *International Migration XXXIV-4*: 539-565,

Bangladesh Bureau of Statistics (1999), *Statistical Pocketbook of Bangladesh 1998*, Dhaka: Bangladesh Bureau of Statistics.

Baxter, Craig (1997), *Bangladesh. From a Nation to a State*. Boulder: Westview Press.

Caldwell, John C., John K. Anarfi, and Pat Caldwell (1997), "Mobility, Migration, Sex, STDs, and AIDS: An Essay on Sub-Saharan Africa with Other Parallels," in *Sexual Cultures and Migration in the Era of Aids. Anthropological and Demographic Perspectives*, Gilbert Herdt, ed. Oxford University Press, New York.

Carael, Michel (1997), "Urban-Rural Differentials in HIV/STDs and Sexual Behavior," in *Sexual Cultures and Migration in the Era of Aids. Anthropological and Demographic Perspectives*. Gilbert Herdt, ed. Oxford University Press, New York.

Chaudhury, Rafiqul Huda (1978), "Determinants and Consequences of Rural out-Migration: Evidence from Some Villages in Bangladesh," in Vol. 2, IUSSP, *Economic and Demographic Change: Issues for the 1980's, Proceedings of the Conference, Helsinki 1978*. Pp. 213-228. IUSSP, Liege, Belgium.

Consultative Group on International Agricultural Research (2000), *Asia Goes Urban*. Electronic document. <http://www.cgiar/IRRI/Hunger/Urban.htm>

⁵ Interestingly, husbands report a higher rate of use, 5.7%, than do their wives, 3.9%. The discrepancy may reflect "contraceptive use with non-marital partners, which is presumably higher among men than women" (Mitra et al. 1997, p.56).

Development Data Group (2001), World Development Indicators. Electronic document. http://devdata.worldbank.org/epidemic_update/

Erickson, Patricia G., Diane M. Riley, Yuet W. Cheung and Patrick A. O'Hare (1997), eds. *Harm Reduction: A New direction for Drug Policies and Programs*. University of Toronto Press, Toronto.

Herdt, Gilbert (1997), "Sexual Cultures and Population Movement: Implications for AIDS/STDs," in *Sexual Cultures and Migration in the Era of Aids. Anthropological and Demographic Perspectives*. Gilbert Herdt, ed. Oxford University Press, New York.

Hossain, Mosharaff (1987), *The Assault That Failed: A Profile of Absolute Poverty in Six Villages of Bangladesh*. U.N. Research Institute for Social Development: Geneva.

Hossain, Ziarat and Jaipaul L. Roopnarine (1992), "On the Fringes: Urban Living among Squatters of Sarajganjtown in Bangladesh," *Urban Anthropology* 21(1): 45-65.

Inciardi, James A. and Lana D. Harrison, eds. (2000), *Harm Reduction: National and International Perspectives*. Sage Publications, Inc., Thousand Oaks, California

Knodel, John and Anthony Pramualratana (1996), "Prospects for Increased Condom Use Within Marriage in Thailand," *International Family Planning Perspectives* 22(3): 97-102.

Mahbub, A.Q.M. (1985-86), "Mobility Patterns of Working People from Rural Areas in Bangladesh," *Oriental Geographer* 29-30:73-91.

Mahmood, Raisul Awal. 1995. "Emigration Dynamics in Bangladesh," *International Migration* 33(3-4): 699-728.

Marlatt, G. Alan, ed. (1998), *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors*. The Guilford Press, New York.

Massey, Douglas S., Joaquín Arango, Graeme Hugo, Ali Kouaouci, Adela Pellegrino and J. Edward Taylor (1998), *Worlds in Motion. Understanding International Migration at the End of the Millennium*. Oxford University Press, New York.

Matin, Khan A. (1986), "Residence Background and Fertility Change in Chittagong, Bangladesh," *Genus* 42 (1-2): 141-151.

Mitra, S.N., A.A. Sabir, A.R. Cross, and K. Jamil (1995), *Bangladesh Demographic and Health Survey, 1993-94*, NIPORT, Dhaka, Bangladesh and Calverton, Maryland.

Mitra, S.N., A.A. Sabir, A.R. Cross, and K. Jamil (1997), *Bangladesh Demographic and Health Survey, 1996-97*, NIPORT, Dhaka, Bangladesh and Calverton, Maryland.

Monitoring the Aids Pandemic (MAP) Network (1999), *The Status and Trends of the HIV/AIDS/STD Epidemics in Asia and the Pacific*, Electronic document. Family Health International: <http://www.fhi.org>

Osmani, S.R. (1986), "Bangladesh," in *Migration of Asian Workers to the Arab World*. Godfrey Gunatilleke, ed. The United Nations University, Tokyo.

Satcher, David (1999), "The Global HIV/AIDS Epidemic," *Journal of the American Medical Association* 281:1479.

Shand, Ric and Mohammad Alauddin (1997), *Economic profiles in South Asia: Bangladesh*. Australia South Asia Research Centre, Research School of Pacific and Asian Studies, Australian National University, Canberra.

Shell-Duncan, Bettina (2001), "The Medicalization of Female "Circumcision": Harm Reduction or Promotion of a Dangerous Practice?," *Social Science & Medicine* 52 (7): 1013-1028.

Singhanetra-Renard, Anchalee (1997), "Population Movement and the Aids Epidemic in Thailand," in *Sexual Cultures and Migration in the Era of Aids. Anthropological and Demographic Perspectives*. Gilbert Herdt, ed. Oxford University Press, New York.

UNAIDS (2000), *Report on the Global HIV/AIDS Epidemic, June 2000*. UNAIDS, Geneva..

U.S. Census Bureau International Data Base (2001). Electronic document. <http://www.census.gov/ipc/www/idbsum.html>

White, Sarah C. (1992), *Arguing With the Crocodile. Gender and Class in Bangladesh*, University Press, Dhaka.

World Health Organization (2000), *Report on Global Surveillance of Epidemic-prone Infectious Diseases*, Electronic document. <http://www.who.int>

Patricia Lyons Johnson
Associate Professor
Anthropology and Women's Studies
Pennsylvania State University
University Park PA 16802
Plj2@psu.edu