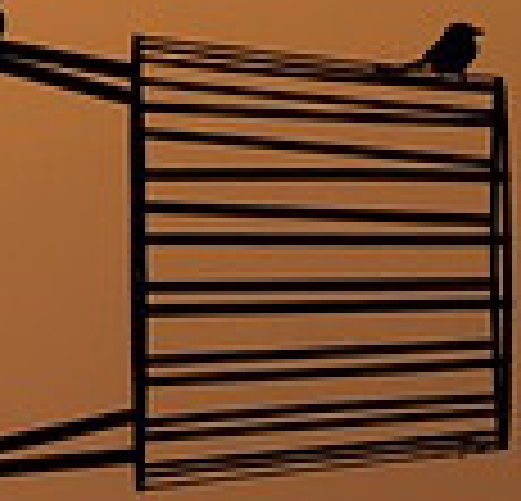
LSE-UC Berkeley Bangladesh Summit

February 2019

Negotiating Uncertainty: Health, Politics, and Environment in Bangladesh



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Working Paper 2: Negotiating Uncertainty: Health, Politics, and Environment in Bangladesh

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Contents

Executive Summary

Bangladesh offers an interesting context for health research, across the disciplines of epidemiology and anthropology. It is clear that government, civil society, and NGOs will continue to play an important role in public health in Bangladesh.

The country has a track record of successfully delivering public health interventions at scale, which indicates potential for future progress on efforts to reduce child malnutrition, a problem which persists in the region in spite of increasing life expectancy. Recent epidemiology research suggests that our current strategies for preventing child malnutrition may be too narrow, and effective intervention strategies require broader thinking.

Anthropological work in Dhaka slums also supports a more expansive view of health; the biomedical model of health can serve to privilege certain types of data and evidence over others. In the slums of Dhaka, one result is that public health fails to identify and address the conditions reported by women living with the chronic stresses of poverty.

Finally, we must consider the political nature of a health-based framing. The legal recognition of hijra in Bangladesh has been hailed as a progressive achievement, yet the formal definition of third gender by the physical body can lead to the medicalization of hijra and new issues such as government-sanctioned gender testing.

Panellists

- Sabina Rashid, Dean & Professor, BRAC University School of Public Health
- Jade Benjamin-Chung, Epidemiologist, UC Berkeley School of Public Health
- Adnan Hossain, Researcher in Social and Cultural Anthropology, Vrije Universiteit Amsterdam

Moderator:

- Lawrence Cohen, Professor of Anthropology and of South and Southeast Asian Studies, UC Berkeley

Is it life trauma, chronic life disorder? Everyday existence in Dhaka slums

L-R: Adnan Hossain, Jade Benjamin-Chung, Sabina Rashid (via Skype) and Lawrence Cohen (Moderator),

The prevailing biomedical model of health focuses on a conventional notion of body and disease-based illness, with the self and being forced into these boxes. However, to make public health whole, it is important to transcend this framework. Sabina Rashid draws from extensive medical anthropology fieldwork in slums of Dhaka to identify ways in which our current model of public health fails to describe and address the conditions of the women living under the chronic stresses of poverty.

The first specific case described was that of a 23-year old woman who was divorced. In order to obtain a divorce, she had recorded audio on her phone of her abusive husband; no one believed her without it.

When she told her story, she had initially been unwilling to share that she was divorced, and she felt she had been abandoned by her local community. She believed her problems were due to excessive tensions, from both her abusive marriage and the death of her father. A mathar doctor prescribed marriage as the cure for her.

A second case described was that of a 40-year old widow who felt her life was full of constant anxieties and tensions, with no networks or support. They could describe their condition as depression, tension, durbalata, or chinta roga, but there is not one formal public health term that sufficiently describes their condition of stress as a daily reality of existence.

In conclusion, while public health examines disease, we must better examine the limitations of public health itself in order to fully address the ways in which negative health manifests in these communities.

Strategies to reduce child malnutrition in Bangladesh

Bangladesh presents as a public health paradox, in that the country's life expectancy is steadily increasing, yet there remains a high prevalence of child and maternal malnutrition. Around 40% of children under 5 remain chronically malnourished. In recent years there has been a call within the public health and development communities to reduce child stunting (low height for age) in South Asia, the region poses unique risk factors that potentially motivate unique solutions.

Traditional risk factors for child malnutrition are poor maternal diet, infection, and poor child feeding practices from birth to 2 years of age.

However, interventions to address these risk factors only reduce stunting at age 2 by about one-third. Thus, there is an unanswered question about how to further reduce child stunting. Because evidence suggests that when children are raised in optimal environments, they all have similar growth potential, a new hypothesis emerged that environmental contamination could be a risk factor.

Specifically, when children grow up in highly fecally contaminated environments, they can develop gut dysfunction that prevents nutrient absorption. Thus, improving water and sanitation was hypothesized to have an impact on stunting.

To test this hypothesis, researchers designed and implemented the WASH Benefits trial in Bangladesh with the question: Can water, sanitation, hygiene, and nutrition interventions, individually and/or in combination, improve child growth outcomes at 2 years of age?

Unfortunately, the results were disappointing, with only small reductions in stunting observed. There are numerous lessons and implications for the public health community as further work is undertaken to address stunting. One is that the interventions simply were not radical enough to reduce fecal contamination to the extent needed to impact child growth; this is supported by the observation that the sanitation intervention had a minimal effect on microbiological indicators of fecal contamination in the environment.

It was not a community-wide intervention, rather it focused on clusters of households with pregnant women, and perhaps that scale would be required for impact. A second implication is that perhaps broader interventions to improve women's health before pregnancy may be needed.

For example, perhaps child malnutrition prevention efforts need to expand in scope to including interventions that increase women's decision-making power, their agency and social status, and their education. These could include interventions such as microfinance and cash transfer programs, which may not be typically considered for this objective.

In conclusion, while there remains no easy answer to the issue of child and maternal stunting in Bangladesh, there is a lot of potential for future progress on this issue. The country has world class research institutions and NGOs, a culture that values scientific evidence, a unique history of successfully delivering public health interventions at scale, and a history of putting women at the center of development.

Legal recognition of third gender, hijra, and sexual rights in Bangladesh

There exists a cultural paradox in Bangladesh around the discourse and legal recognition of the hijra and a third gender. While this has been hailed as a progressive political and legal achievement, this has resulted in a new discourse of the hijra as disabled. Adnan Hossain argues that this legal recognition works to categorize and fix the definition of hijra in a way that excludes those who identify as such, yet are outside the strict legal category.

The dominant representations of hijra are as a third gender or sex, as neither men nor women. They are linked to emasculation and hold a ritual power to be able to bless and curse.

The hijra conceptualization is of hijra as an occupation. There is a desire for masculine men, and both those with and without a penis are included as hijra. However, society's mainstream conceptualization is of hijra as asexual, using the term as a pejorative for masculine deficiency, and equating emasculation with fakery.

Furthermore, this recognition serves to shift the conversation on male sexual health in Bangladesh from health to rights.

There is a misleading conception of the emancipatory potential of multiple genders, couched in an idea of acceptance. It hides the social and political power relations that resulted in a need for the recognition of a third gender, and it does not redress the marginalization of this group.

This can be read as a recognition of gender failure, in that hijra failed to be sufficiently one or the other gender.

This discourse can result in a conceptualization of a third gender into a form of disability, with the potential for medicalization through gender testing, which has been conducted by the government.

Institutional bodies have been complicit in this discourse in their attempts to gain credibility as rights protectors, when in fact they are trafficking in the marginalization of the hijra.

Furthermore, legal recognition formally defined only by the physical body generates a hierarchy within the hijra community, which instead recognizes different bodies within the group.

Discussion

On allocation of limited public health dollars

While it is true that public health is biased toward prevention over treatment, stunting is so indicative of other negative health consequences over life that it makes a lot of sense to spend resources on stunting prevention. Vaccines, the most cost-effective public health intervention, is a great example of allocation of limited sources in a smart way toward prevention.

On the need for an expanded discourse and how we frame issues

In the current discourse, hijra are viewed as victim. There is also a new development where people claim the identity of hijra without the occupation that is conceptualized as central to hijra, and there has emerged a false binary between those affiliated and unaffiliated with the NGOs working in this space.

Additionally, the penis-centric view of sexuality can explain the discourse of problem and disease in response to “gay” versus provocative for “lesbian”. It is also important to consider the extent to which framing an issue around health can serve to depoliticize certain groups.

Within the public health discourse, there is a need to look critically at how the field privileges certain types of data over others, which determines what is considered health. For those in extreme poverty, for example, a definition of health is expansive. The terms “gastric” and “tension” can mean many different things linked to health, and all parts of life and body can be interconnected. What counts as evidence and valid data, what is considered measurable, is a limitation in public health. A focus on epidemiology and biostatistics contributes to a loss of the human dimension of public health.

A lack of effect on child health from improved access to water, sanitation, and hygiene means that

these interventions perhaps cannot be framed as a magic bullet for health, but they are still human rights and should be invested in as such. The health framing can allow examination of difficult topics. For example, framing domestic violence as a public health topic allowed researchers to investigate it within the WASH Benefits study.

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