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Local Hierarchies and Distributor (Non) Compliance: A Case Study of Community-Based Distribution in Rural North India

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Local Hierarchies and Distributor (Non) Compliance: A Case Study of Community-Based Distribution in Rural North India

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Community-based distribution of family planning services is particularly appropriate for South Asia, which has hard-to-reach rural populations. In Uttar Pradesh (UP), India, local status hierarchies of gender, caste, and generation shape the nature of relationships that community-based distributors (CBDs) create with their clients. In this case study of an "ideal" distributor, we uncover the conflicting expectations that many CBDs experience: to comply with project objectives without violating local social norms that limit interactions across status boundaries. Our CBD responded to these dual pressures with varying strategies, often perpetuating social distance and restricting information and services for men, adolescents, and other marginalized populations.

There is a continuing need for family planning and reproductive health services across many diverse and traditionally underserved communities

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worldwide, including men, youth, the poor, and rural populations. The community-based distributor (CBD) model, in which local residents are trained to deliver basic information and services through intensive individual- and community-level interactions, could be particularly well suited to reach these groups. Despite living in the same communities, however, CBDs often hold different status positions—with respect to gender or class, for example—than their clients. These status hierarchies within the local community can limit the interactions between CBDs and traditionally underserved client groups. In this article, we present a case study of one CBD working in a rural North Indian village, where the most important status hierarchies are constructed around gender, caste, and generation. The norms of behavior that accompany these hierarchies constrained the CBD's dealings with many clients, which ultimately impeded the comprehensive delivery of information and services within this case study community.

The CBD model has been a steady feature of rural health service delivery for over a half-century. Well-known examples include the barefoot doctor movement, which successfully brought primary health care to large populations in rural China as early as the 1960s (Rosenthal & Greiner, 1982; Shi, 1993; Zhang & Unschuld, 2008), as well as female family planning workers who have provided contraceptive information and services to women in Bangladesh "at their doorstep" since the late 1970s (Mita & Simmons, 1995;Simmons, Baqee, Koenig, & Phillips, 1988). The CBD model rests on the theory that the delivery of health services by trained, nonmedical personnel situated within the community decreases the *spatial distance* that precludes the accessibility of these same services from formal medical facilities (Arends-Kuenning, 2001; Phillips, Hossain, Simmons, & Koenig, 1993; Prata, Vahidnia, Potts, & Dries-Daffner, 2005). Use of CBDs is also believed to decrease the *social distance* that hinders interactions between providers and clients in clinic-based settings (Rosenthal & Greiner, 1982; Simmons & Elias, 1994; Simmons, Koblinsky, & Phillips, 1986). Because family planning distributors—usually women—hail from the communities that they serve, CBDs and clients are imagined as peers, and this social proximity enables the diffusion of new ideas and methods, such as fertility limitation and acceptance of modern contraceptives (Koenig, Hossain, & Whittaker, 1997; Phillips et al., 1993).

The CBD model of the 1960s and 1970s experienced renewed appeal after the 1994 International Conference on Population and Development (ICPD) held in Cairo. The ICPD Program of Action replaced the former use of top-down population control measures (such as contraceptive targets) with a bottom-up, holistic approach to family planning and reproductive health. The new approach emphasized gender equity and reproductive health and rights, including an expansion of information and services to men and adolescents (Luke & Watkins, 2002; McIntosh & Finkle, 1995). Far from obsolete, the CBD model is particularly suited to the Cairo agenda. Ideally, distributors

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can reach out on an intensely personal level to a variety of clients in the community, and they are situated to become agents of change who promote the empowerment of women and marginalized groups.

The CBD model of service delivery assumes that "community" is a geographically defined space, such as a village or neighborhood, in which CBDs are assigned to carry out their work. This view implies a homogeneity of norms, values, and status among community members that places CBDs and their clients on equal footing in their everyday interactions (Cornish & Ghosh, 2007). Indeed, this view is supported by numerous quantitative studies, which find that CBD performance is consistent enough across various demographic characteristics—such as age, gender, and marital status—to conclude that willingness to perform and proper training are the most important determinants of distributor behavior rather than specific traits that correspond to particular target populations (Bertrand, Mcbride, Mangani, Baughman, & Kinuani, 1993; Bertrand, Pineda, Santiso, & Hearn, 1980; Kipp & Flaherty, 2003).

"Community" also can be defined in relational terms, however, thereby distinguishing social groupings according to shared histories, identities, and interests (Cornish & Ghosh, 2007). Contrary to a purely spatial classification, this view recognizes the potential diversity of the local social environment and the hierarchies of power and status—such as gender, race, and class—in which individuals and subgroups are embedded. In the case of the CBD model, we believe that these hierarchies and their accompanying norms of behavior shape the nature and extent of relationships that distributors create with their clients. They also give rise to conflicting expectations for CBDs in the field. On the one hand, CBDs are trained and expected to engage with a variety of community members in their professional roles as distributors. On the other hand, distributors' interactions with clients are dependent on their relational status positions, which may constrain them from fully complying with the dictates of the project. These dual pressures of compliance can have important implications for distributor performance and overall program success.

Much of the literature that evaluates CBD projects identifies programmatic obstacles to implementation, including knowledge and training of CBDs and financial costs (Chege, Sanogo, & Askew, 2000; Janowitz, Chege, Thompson, Rutenberg, & Homan, 2000; Phillips, Greene, & Jackson, 1999; Prata et al., 2005; Rosenthal & Greiner, 1982; Zhang & Unschuld, 2008). With respect to CBD–client interactions, previous studies tend to highlight the positive benefits of this contact for female clients and others wary of contraception and fertility limitation, such as husbands, neighbors, and unmarried women (Mita & Simmons, 1995;Simmons et al., 1988); there is scant research that describes the tensions that arise between CBDs and their clients. Further, few studies examine the ways in which distributors—however eager and well-trained—are compelled to negotiate local hierarchies in their

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everyday duties and balance their positions as both professionals and community members (for an exception, see Kaler & Watkins, 2001).

Community-based distribution of family planning and reproductive health services is particularly relevant to South Asia, where large, hard-to-reach populations and low contraceptive usage present challenges to national family planning agendas (Bloom, Tsui, Plotkin, & Bassett, 2000; Singh, Bloom, & Tsui, 1998). The social context also poses obstacles to CBDs' efforts to engage with local clients. In settings such as North India, daily life and social interactions are highly stratified along multiple dimensions, particularly hierarchies of gender, caste, and generation. We worked with a rural community-based reproductive health project in the state of Uttar Pradesh (UP), India, and conducted a case study of an "ideal" distributor. We followed her daily interactions with a variety of clients and examined her strategies to comply with program directives while struggling to conform to the social realities on the ground. Her responses to these dual pressures ultimately affected her performance. Indeed, her efforts often perpetuated social—and in some cases spatial—distance and resulted in restricting information and accessibility for men, adolescents, and lower-caste populations.

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SETTING, DATA, AND METHODS

The Social Context of Rural Uttar Pradesh

Within India, the northern state of UP has the largest population and some of the lowest health and development indicators. In 2005, the total fertility rate was 3.8, the second highest of all Indian states, and the rural contraceptive prevalence rate (CPR) was 39.7%, with a heavy reliance on female sterilization and extremely low rates of male sterilization. It is estimated that 21% of currently married women in the state have unmet need for family planning. Furthermore, quality of care is poor; among female contraceptive users, less than one-quarter are comprehensively informed about side effects and method choice (International Institute for Population Science [IIPS] & Macro International, 2007).

This high fertility profile has been attributed to a social context that is characterized by "deeply ingrained patriarchal values that check social development" (Guilmoto & Rajan, 2001, p. 728). Women are subject to the norms of *purdah*, a cultural institution that strictly regulates interactions between men and women, especially married women, to protect the honor of the family (Dyson & Moore, 1983; White, 1977). Women generally are discouraged from being in the presence of and associating with unrelated males, and thus women's dress, mobility, and day-to-day actions within and outside of the home are considerably restricted. The practice of *purdah* and generally low levels of autonomy for women in North India have been

linked to low levels of female education, employment, and utilization of contraception and maternal health care (Bloom et al., 2000; Dharmalingam & Morgan, 1996). In the patriarchal organization of social life, men are the major decisionmakers in household matters, and their authority extends to issues related to health care for their wives and children (Das Gupta, 1995). Men's lack of knowledge about reproductive health in UP, particularly in rural areas of the state, calls into question their ability to make informed and careful decisions regarding reproductive health for themselves and their families (Bloom et al., 2000; Singh et al., 1998).

Women's position is further stratified according to generation and life stage. Childbearing, especially of sons, is a source of legitimacy and authority for women in the household and community, and women ascend the status hierarchy as they become mothers-in-law and then grandmothers (Bloom et al., 2000; Das Gupta, 1995). Accompanying these generational differences, parents rarely discuss sexual and reproductive health and other sensitive issues with their children, as there are strict taboos governing certain types of intergenerational interaction (Aggarwal, Sharma, & Chhabra, 2000; Garg, Sharma, & Sahay, 2001).

Caste is another element of stratification that organizes daily life for men and women in the community. Historically, the Hindu caste hierarchy was divided into groupings by occupation, with the lowest castes (*dalit* or "untouchable" groups) relegated to menial and ritually polluting tasks. Religious rules and norms prohibited close contact between castes, and thus lower castes were assigned separate hamlets, often on the outskirts of the village, in which to live and work (Milner, 1994). Although the caste system has been officially abolished in India, social and economic inequalities along caste lines persist today because of accumulated disadvantages as well as continued discrimination (Betancourt & Gleason, 2000; Mohindra, Haddad, & Narayana, 2006). Disparities between castes are reflected in health indicators. The lowest, most marginalized caste groups often have higher fertility rates and lower use of contraception, higher child mortality, poorer perceptions of health among women, and higher rates of domestic violence (Deshpande, 2002; IIPS & Macro International, 2007; Luke & Munshi, 2011; Mohindra et al., 2006; Subramanian et al., 2006). The enduring inequalities in health and development by gender, caste, and generation make UP an appropriate candidate for Cairo-influenced programs that seek to expand clientele and empower women and other marginalized populations.

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The CBD Project and Research Methods

The data for this study were collected from November 2004 to April 2005, during which time the first author conducted an independent research project under the auspices of an NGO in a rural district of UP. The NGO conducted projects in several areas of the state; among them was a community-based

distribution family planning and reproductive health project that was operating throughout an entire rural district. The CBD project was carried out from November 2002 to November 2004, and its major goal was to increase the CPR 10 percentage points within the rural district where it was operating. When the project ended, the NGO director reported that CPR in the district had risen exactly 10 percentage points, thereby successfully reaching its target quantitative outcome.[1]

The first author held numerous discussions with NGO program staff, including the NGO director and the CBD project manager, over the 6-month period. During many of these discussions, the NGO director articulated a second, less defined objective for the CBD project, which was to bring the community to "a position to create a demand for family planning services." The NGO director repeatedly stressed that the CBD project was guided by the Cairo Plan of Action and was a holistic reproductive health program that promoted reproductive rights and empowerment for women in addition to traditional family planning parameters.

The CBD project organization was based on local residential patterns. Following the historical model of caste segregation, villages in rural North India typically are divided into several caste-based hamlets. The project recruited 111 CBDs, each of whom was in charge of motivating and educating clients and distributing contraceptives in up to five hamlets, including the one in which she lived; most CBDs, as a result, worked with clients from various castes. For every seven CBDs there was one supervisor; all except one were male. The daily operations of the project relied on the CBDs, who were expected to work 4 to 5 hours a day. Their work entailed going house-to-house talking to community members about reproductive health, providing contraceptives—mostly oral pills, but some condoms—and referring clients to local health clinics for relevant services, such as sterilization and IUD insertion. All CBDs were female.

In order to get the best picture of how the CBD project played out in the community, the NGO director suggested that the first author shadow one of the CBDs and observe the way she performed her duties. He proposed a particular distributor, Manju (a pseudonym), as an example of an effective and model CBD. The CBD project manager explained that he selected distributors based on their position in the community, emphasizing that the women had to be well respected in order to carry out their jobs effectively. Manju was "ideal" in this respect: she was an upper-caste, literate woman in her early forties who was well known in her village. She had three sons well spaced apart and subsequently had been sterilized, making her a comfortable model of a family planning user. Because she previously had worked in a community-based child health and nutrition project, community members presumably saw her as a reliable source of health information, and villagers often asked Manju a great variety of medical questions, ranging in topic from stomach pains to tuberculosis. Based on the formal literacy requirement of

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the project and the informal "respectability" requirement of the project manager, most other CBDs were also upper-caste women well known in their communities. All were trained at the beginning of the 2-year project and underwent additional training throughout the course of the project through workshops and meetings.

The CBD project was drawing to a close as the first author began to visit Manju in the field. Although the distributors were no longer receiving their 600 *rupee* stipend per month,[2] Manju said she continued to make her rounds, encouraging women to persist in their use of family planning and to improve their health. Observations of and interviews with Manju and her clients occurred over an 8-week period in the field (November 2004 to January 2005), spent accompanying Manju on visits to her designated hamlets, including discussions with a variety of clients, and having informal discussions with her and her family members. Although Manju's official role as a CBD was ending, field visits nevertheless provided the opportunity to see the ways in which a dedicated and experienced distributor continued her work. Because Manju had been a CBD for approximately 2 years, one can assume that her relationships with clients from various caste hamlets were relatively representative of a well established pattern of interaction. Indeed, observation of these relationships shed a great deal of light on how Manju's interactions varied across status hierarchies and how these differences shaped the nature and impact of the counseling she offered.

The majority of the informal, unstructured interviews and discussions that took place with Manju, her clients, and her family occurred in small groups. All of these interactions were conducted in Hindi by the first author, and most were tape recorded and transcribed with the assistance of a Hindi–English translator. Daily observations in the village as well as discussions with NGO and CBD program staff were recorded in field notes. Transcripts and field notes were hand coded by the first author with respect to status hierarchies and other emerging themes, including management of program directives and strategies of compliance. The authors reviewed key themes and preliminary analyses and agreed on final interpretations. Key findings summarized by gender, caste, and generation are presented below, illustrated with quotations.

The first author's positionality vis-à-vis Manju is of particular significance considering the context and the data produced. As a young, White, female foreigner, the first author represented an outside observer to whom beliefs and behaviors needed to be explained and justified. Manju readily assumed the role of cultural interpreter, and the first author benefited from intense instruction on the realities of everyday rural village life from the CBD's perspective. The fact that the NGO director had referred the first author to work with Manju likely caused Manju to view her as a watch-dog figure. The most probable effect of this circumstance is that Manju strove to present herself as particularly compliant. It is precisely this effort, however, which

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allowed the first author to view Manju as an actor caught between the expectations of her job and her life in the rural community. Overall, we believe these "observer effects" diminished over the 8-week period in the field, as the first author witnessed remarkable variation in Manju's interactions with clients and seemingly candid opinions about the project and her role in it.

Ethical clearance to conduct this research was obtained from the Research Protections Office at Brown University. All interviews and small group discussions were conducted with the informed verbal consent of the participants after the objectives of the study had been discussed with them.

RESULTS

Gender and Maintaining Status Through *Purdah*

In rural UP, *purdah* is the primary lens through which status differences and social distance between men and women are maintained. As an upper-caste married woman, Manju had to comply with the norms of *purdah* in her daily life. The potential for unacceptable interaction between a woman like Manju and a man other than her husband severely limited the kinds of interactions that Manju was able to have outside of the home, especially when she worked.

There were numerous project elements that Manju chose not participate in as a woman. For example, Manju explained that she and her fellow female distributors declined to educate men about condoms, "Because this is our village, and as you know, the *purdah* system is prevalent here." She readily admitted that she would not directly speak to men even if explicitly instructed by the project, because it was against the dictates of the local norms of behavior. Another example illustrating the effect of *purdah* on Manju's work concerned the use of information, education, and communication (IEC) activities—such as role plays and puppet shows—to promote family planning to groups of people assembled in the village. Project officials often emphasized that distributors utilized IEC activities to spread basic messages about sexual health and family planning and to promote male involvement in these matters. When asked whether she had ever participated in IEC activities in public forums, Manju explained:

> There was one such [strategy], but we never used it. It was part of the scheme but we didn't do it, because out here we feel shy about doing such things.

When Manju explained that she and other female CBDs felt shy about performing sensitive themes in front of men, the source of her shyness was socially prescribed. As a compliant community member, she was expected

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to maintain social distance between men and women; therefore, she made an active decision to reject the program directive and its demands for interaction. This decision allowed her to maintain gendered distance and protect her status as a woman.

At other times, however, Manju claimed to be compliant with project expectations of male–female interaction and even was eager to share her success in targeting men. For example, the project promoted no-scalpel vasectomy (NSV), a form of male sterilization that is considered safer and less painful than female sterilization, the most common method of contraception in rural UP (IIPS & Macro International, 2007). Manju articulated enthusiastic support for efforts to encourage NSV and simultaneously draw men into the process of family planning decisionmaking and usage. She was also eager to report that, although cases were still few, the project was having some success in increasing the practice of NSV in the community:

> Just recently I got one of them [a male client] sterilized in that manner. Whatever progress has been made in the matter of family planning or sterilization has taken place in the time since we were working here.

In this conversation, Manju stated that *she* had motivated a male client. In a later conversation, however, she contradicted this claim by stating, "We [female distributors] cannot talk to [men] directly about this [NSV]." She went on to explain that male supervisors from the project were primarily responsible for the motivation of male clients, and that her supervisor had successfully recruited this client for NSV from one of the hamlets under her jurisdiction.

The inconsistency of Manju's responses reveals a sense of conflict that she endured in her professional position. Manju was able to make the first claim about her participation in successful NSV efforts because she had adopted a flexible view of the meaning of compliance and her role within the project. Because there were legitimate reasons that barred her from directly participating in NSV promotion, she did not feel that her refusal to act reflected noncompliance. Instead she claimed that as an individual CBD within the larger project she could defer her responsibilities to male members of the project—the supervisors and project manager—thereby ensuring success without compromising her social status. While she may not have convinced this particular client to undergo NSV, she claimed success in the collective effort and let it reflect on her own performance.

In numerous discussions, the CBD project manager made it clear that he was aware that female CBDs could not speak to men directly about family planning in a public or private setting. For that reason, he occasionally made himself and other male staff members available in the field as points of contact for men who wanted to learn about condoms, pills, or NSV. With 111 female CBDs and a handful of male supervisory staff for an entire district,

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however, it is doubtful that the male target population was benefiting from sufficient interaction with health workers or exposure to reproductive health ideas and services. Moreover, opportunities to engage men in intergender dialogue and transform the strict norms of *purdah* were not encouraged in the field.

Caste and Minimizing Interactions

The village in which Manju worked was, like many villages in the region, divided into half-a-dozen hamlets based on caste. Under the CBD project, Manju was expected to reach all sectors of the population equally in order to improve overall acceptance of reproductive health concepts and services. Manju was careful to point out that she visited each hamlet regularly, and she indicated no preferential treatment of any subgroup. She also mentioned, however, taboos regarding caste interaction and the fact that "upper-caste women will not be allowed to go into the houses of low-caste people." This admission reveals her practical awareness of the conflict between her CBD duties and local norms of spatial and social segregation by caste.

While Manju visited each caste hamlet under the observation of the first author, the quality and extent of her interactions correlated with the client's caste. In upper-caste hamlets, Manju approached the homes of her clients, often accepted a seat on one of the *charpoy* (woven cots) in front of their houses, and expressed familiarity with them through gestures and physical cues. The upper- and middle-caste women were comfortable talking with and being in the presence of Manju. In the *harijan* (untouchable, lower-caste) hamlet, however, Manju stayed at the perimeter of the cluster of houses and remained standing while she spoke with her clients; the tone of voice that she used was harsher and more instructional than the conversational tone that she used with upper-caste clients. The lower-caste women were almost apprehensive when she appeared, suggesting that they were unaccustomed to such visits and had not developed a rapport with the CBD.

From observations of Manju's visits with both upper- and lower-castes, it was evident that the diminished frequency and quality of interactions with lower-caste women had resulted in a corresponding lack of information sharing. In the following examples, several lower-caste clients were asked about their knowledge of contraception:

Researcher: How did you know about condoms?
Manju: [addressing client] Tell her that you learned about it from me. I was the one who told you, right?
Client: About the pill?
Manju: Yes. Tell her that sister [referring to herself] told you about this.
Client: *Bahen-ji*[3] told me about this.
Manju: They have learned about these things only through me. Earlier they knew nothing.

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Researcher: Did you take pills before sterilization, or not?
Manju: They knew nothing about them before meeting with me.
Client: Back then I didn't know about it.
Researcher: You didn't know anything?
Client: No.

In another visit, a young, lower-caste woman soon to be married was asked what she knew about sexual health and family planning. Manju interjected in this conversation as well, in fact not allowing the respondent to speak at all:

Researcher: Do you know about family planning?
Manju: No, she doesn't know. . .
Researcher: About preventing childbirth?
Manju: No. She knows nothing.
Researcher: [To Manju] Do you talk to her [the client] about these things?
Manju: The women here will not be able to talk about these things. I won't be able to talk to these people because they are so shy that even when they get married they won't be able to talk about these things.
Researcher: [To client] Don't you have any interest in family planning?
Manju: They don't have any idea what this means. They are not educated at all.

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In most of the researcher's observations and interviews, Manju strove to demonstrate compliance with CBD responsibilities and success in her efforts. In the conversations with lower-caste women, she managed this by invoking her power as an upper-caste woman to control her clients' speech and meanings. She continually interjected to speak for her lower-caste clients or dictated responses to them. Manju claimed success for the scant knowledge that these women did possess and justified her inability to further educate them by transferring agency from herself to them. She maintained that lower-caste women simply were not interested in family planning or were too ignorant to understand, and therefore she could not engage with them further.

Manju did not neglect to speak with lower-caste women, but it is quite apparent that her decisions to limit her interactions left them with less than comprehensive sexual and reproductive health knowledge after 2 years of the CBD project. Although the intention of the CBD model is to minimize social distance between providers and clients and promote a supportive environment for discussion of sensitive topics, in this context caste hierarchies were reenforced by Manju's actions, and the goals of equal access and informed choice were not fully realized.

Information and Services for Youth

Generational hierarchies are a third important measure of status and determinant of interpersonal relationships in rural UP. At Manju's stage of life, she

enjoyed a high degree of status within the family and community as a married woman with sons. Attendant with Manju's position were a set of norms regarding how she could interact with girls and women of lower generational status; specifically, it was considered taboo for parents like Manju to talk to their children about sexuality. When asked why sisters-in-law were allowed to talk to adolescents about sex but mothers were not, Manju answered, "mothers consider themselves to be an elder of the family and they feel embarrassed talking about these things." Manju extended this belief to her personal and professional life. Although she was trained to engage with adolescents, Manju limited her interactions and educational efforts with younger clients.

Manju's nieces, who lived in the same joint family and fell within the program's target group of adolescent girls, clearly did not benefit from their aunt's position as a CBD, as is seen in the following exchange:

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> *Researcher*: What do you know about sex, contraceptives, and family planning?
> *Adolescents*: We know nothing....
> *Manju*: They know everything, but they can't bring themselves to speak out.

In this example, as in the examples with lower-caste women, Manju tries to justify her nieces' apparent lack of information by faulting their own shyness. Subsequent private interviews, however, revealed that these adolescents actually had very limited knowledge about sexual health or reproduction; in fact, they desired to receive it. In a similar example, when explaining why she had few interactions with lower-caste adolescent girls, Manju remarked:

> Since these girls are not married yet, they don't feel the need to think about these things. If they needed the information, they would come to me.

In both examples, Manju manages to maintain her status by limiting her interactions with adolescents, and she justifies her clients' lack of knowledge in ways that continue to portray her as a compliant and willing CBD.

It is important to note that Manju's reluctance to discuss sensitive issues with adolescents was not due to negative personal attitudes toward the dissemination of reproductive and sexual health information to this population. In a conversation about adolescent knowledge of sex and reproduction, Manju commented positively on the fact that girls were being exposed to more details and spaces for dialogue about such topics. Because of the sensitivity of discussing such subjects between people of different generations and life stages, however, Manju advocated for impersonal sources

of information—such as books or the radio—or informal peer networks as appropriate avenues of sexual education for young people.

From Manju, these ideas represented not only a suggestion of more locally acceptable means of communicating sexual information to younger generations, but they also represented an admission that she was unable to comply with programmatic expectations because of social norms that dictated otherwise. Caught in these conflicting demands for compliance, Manju prioritized maintenance of her status position as an older woman and preserved the social distance between herself and younger clients. This decision continued to isolate this underserved population from important reproductive health information and services.

DISCUSSION

While community-based reproductive health projects continue to be designed and implemented across the globe, there are few in-depth studies of CBDs operating in the context of their daily work with observations of their personal relationships with clients. In contrast to quantitative findings on distributor performance, our qualitative case study reveals a more nuanced picture of the meaning of program success and the ways in which CBD behaviors impact the outcomes of the project.

We argue that social context and structure play an important role in the performance of distributors in community-based reproductive health projects and that distributors often disregard project directives in order to comply with local norms of behavior. In rural UP, traditional status hierarchies based on gender, caste, and generation govern whom CBDs can interact with as clients and to what degree. By shadowing an experienced CBD in her daily work in the village, we can better understand how she balanced the often conflicting positions of professional CBD and local community member. Although our CBD developed positive and supportive relationships with many clients, her status as an upper-caste, married woman severely limited her interactions with men, lower-caste women, and adolescents in both public and private settings. As a result, the array of information and services received by these traditionally underserved groups was restricted as well.

Our case study illustrates the conflicting expectations that CBDs experience: to comply with project objectives without violating local spatial and social boundaries. We observed the responses of our CBD to these dual pressures, which ranged from outright resistance to project directives to curbing interactions with specific populations in order to achieve a minimal form of compliance. She justified these actions in multiple ways. She reasoned that the project was a collective effort by all staff, and therefore her limitations could be addressed by someone who occupied a different status position and was not subject to the same social restrictions. To account for the apparent

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lack of reproductive and sexual health knowledge on the part of many of her clients, the CBD shifted responsibility for inaction from herself to her clients, claiming that they were disinterested or "too shy" to speak up in front of a foreign researcher. We believe these actions and explanations were not motivated by laziness, indifference, or a lack of training. On the contrary, our CBD was comprehensively trained and strove to fulfill her professional responsibilities to the best of her abilities given her position in the hierarchies of gender, caste, and generation. Indeed, pride in her successes and continued commitment to the project suggest that the ultimate intention of her noncompliance was compliance.

Although the project was able to claim success by increasing the CPR in the district by 10 percentage points over its 2-year course, this statistic offers little indication of how the delivery of information and services varied across subgroups. Based on the observed rapport between the upper-caste CBD and her higher-caste counterparts and their generally greater knowledge of reproductive health, we surmise that upper-caste women's usage was likely the main driver behind this increase in CPR. Unfortunately, we are unable to discern if success within this subgroup stemmed from the diffusion of new ideas about fertility limitation or merely increased access to contraceptives.

This study also calls into question the assumption that CBDs can foster broader social change—such as Cairo-inspired goals of reproductive rights and empowerment—simply because of their community-based nature. In the case of our "ideal" CBD, we find that she was not a model of change: she persistently maneuvered within the dominant hierarchies and did not challenge them in order to carry out the program. Instead, the CBD engaged a "safer," more traditional approach to family planning, one that delivered conventional information and services. Indeed, her actions worked to perpetuate unequal access by reinforcing distance and difference across gender, caste, and generation. Furthermore, her efforts did not appear to create communitywide demand for family planning as originally conceived by the NGO director.

Our case study focuses on the interactions of an "ideal" community-based distributor in a reproductive health and family planning project in rural North India in order to gain an in-depth understanding of the complex processes surrounding status hierarchies in a specific situational context (Yin, 1994). An analysis of the shortcomings of an exemplary distributor also allows us to imagine the ways that even less "compliant" distributors perform their jobs and affect program outcomes. This case study can be used as a valid starting point for further exploration of the limitations of the CBD model and the conflicts that distributors face as both agents of social change and community members embedded in local structures.

Our findings offer important clues about the ways in which distributors carry out reproductive health and family planning programs on the ground,

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and with this insight we can begin to ask what would make the CBD model more effective in terms of reproductive health and rights in social contexts like rural UP. We offer several suggestions. First, we find that CBD characteristics, such as age, caste, and gender, really do matter, and they matter particularly in relation to the specific types of clients the CBDs are meant to serve. If we embrace a *relational* definition of community instead of a mere spatial one, then CBDs could be matched by appropriate status grouping within the communities in which they live and work. In this way, CBDs would be better positioned to reach the entire community and perhaps tap into existing social networks among subgroups to promote ideational and behavioral change (Kincaid, 2000). These strategies should be evaluated so as not to reproduce differences in access and social distance across subgroups, however.

Second, CBD programs could embrace a qualitative approach to design and evaluation to enhance understanding of social features of reproductive health programming. Just like Cairo advocates going beyond measuring success solely with targets and aggregate rates of fertility and contraceptive use, researchers and program managers should also focus on the complexities of local interactions and the relationship between social context and project outcomes through qualitative research.

Third, we should heed the suggestions offered by our CBD. Her recommendations included distributing information on sensitive sexual and reproductive health issues through impersonal methods, such as radio or print media. Indeed, these sources may be very successful (even if only as points of entry) in traditional and highly stratified settings such as North India, where interpersonal interactions are so rigidly governed. Our CBD also relied on the collective efforts of staff members to ensure project success. When projects employ diverse strategies—beyond reliance on literate (upper class) women as peer educators—they may more effectively breach both spatial and social distance and reach whole communities with appropriate reproductive and sexual health information and services.

Finally, our findings are particularly significant in the context of the recently expanded Accredited Social Health Activist (ASHA) program employed nationally by the Government of India. Community-based ASHA workers are young women, ideally married and literate, and are selected by community groups, local government bodies, and local elites. Designed to be a link between the community and the health sector, their areas of responsibility range from sanitation to nutrition to contraception information and services (Ministry of Health and Family Welfare, n.d.). Many of the paradigms uncovered in this study are applicable to the community-based ASHA program as well. Program design, implementation, and evaluation could be scrutinized with an eye toward status hierarchies and the social relationships among ASHAs and their clients in communities across India.

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NOTES

1. The first author was unable to verify the accuracy of this measure from NGO documents or other sources.

2. Forty-five Indian *rupees* were equivalent to U.S. $1 at the time of the study. Manju's monthly stipend did not equate a full-time salary.

3. "*Bahen-ji*" is a respectful term used by women of lower status (by age, caste, or wealth) to address women of higher status.

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