



**ESRC Research Group on  
Wellbeing in Developing Countries**

**WeD Working Paper 15**

**The Cultural Construction of Wellbeing:  
Seeking Healing in Bangladesh**

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## **WeD - Wellbeing in Developing Countries**

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WeD is a multidisciplinary research group funded by the ESRC, dedicated to the study of poverty, inequality and the quality of life in poor countries. The research group is based at the University of Bath and draws on the knowledge and expertise from three different departments (Economics and International Development, Social and Policy Sciences and Psychology) as well as an extensive network of overseas contacts and specific partnerships with institutes in Bangladesh, Ethiopia, Peru and Thailand. The purpose of the research programme is to develop conceptual and methodological tools for investigating and understanding the social and cultural construction of well-being in specific countries.

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## SUMMARY

The aim of this paper is to explore the 'cultural construction of wellbeing', and question the dominant ways that culture has figured in discussion of wellbeing and development. The approach to culture is informed by perspectives from social anthropology, particularly as these relate to three main wellbeing themes: values, goals and ideals; welfare and standards of living; subjective perceptions and experience. Where much discussion of wellbeing has been normative and generalised, the analysis here is grounded in a practical situation: an extremely poor family in rural Bangladesh, faced with multiple challenges to health and well-being, and the diverse ways they sought medical care across the public and private sectors. These show the falsity of any notion of a hermetically sealed, uncontested 'traditional culture', and the inadequacy of any simple mapping of culture onto social group or nation-state. In place of the dominant understandings of culture as a 'lens', the paper suggests that the cultural construction of wellbeing should be considered a form of work. This restores the subject to the subjective, and shows people as agents of culture, constructing wellbeing in at once material and symbolic ways. The cultural construction of wellbeing thus appears as a contested *process*, and an always unstable and composite *outcome*, constituted through the work of human subjects operating at the interstices of social structure, institutional culture and political economy.

**KEYWORDS:** Culture, Wellbeing, Development, Health, Bangladesh

### RELATED READING:

Appadurai, A. (2002), 'The capacity to aspire: culture and the terms of recognition', Paper for World Bank Conference on Culture and Public Action.

Das, V. (2000), 'The Act of Witnessing: Violence, poisonous knowledge and subjectivity', in Das, V., Kleinman, A., Ramphela, M. and Reynolds, P. *Violence and Subjectivity* Berkeley/Oxford: University of California Press, pp. 205-241.

Sahlins, M. (1976), *Culture and Practical Reason*, Chicago/London: University of Chicago Press.

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## INTRODUCTION

*A dark night. As I approach the house I hear the old woman's piteous, unearthly cries ring out across the pathways. They explain what is wrong. Her arm, broken after a fall, is bound in a bamboo bracket wound round with a piece of cloth. Set by a local healer several weeks ago, the pain is still so bad that her daughter unwrapped the binding to find the bones still moving inside. She is not walking either. Her body, a bag of bones, has to be lifted everywhere by her daughter - to eat, to sleep, to defecate. She spends the days sitting under the eaves outside her hut, holding her arm in her good hand, weeping.*

*Her daughter, As ha, says that she is not well herself. Extremely thin, her eyes are deep set in hollows ground by poverty. For months now, she says, she has been suffering pains in her belly. It gets worse when she walks or does heavy work, but what option has she? The old man her father is nearly blind and badly lame himself. A doctor in a private clinic on the outskirts of town diagnosed appendicitis and prescribed strong drugs for it. They cost a lot but she took them as he said. The pains go on and she's afraid there's something really serious wrong. He said to return but it is too far away: with her mother so unwell she cannot leave the village.*

'The ultimate aim of development is the universal physical, mental and social well-being of every human being.'

(Pérez de Cuéllar 1996:16)

The promotion of 'wellbeing' as the ultimate goal of social, health and development policy is now well established amongst academics and policy-makers alike (Sen 1999; Nussbaum 2002; McGillivray 2006; Gough and McGregor 2006). It promises a rounded, positive, and human-centred approach in place of narrowly economic conceptions of poverty, or restrictively medical understandings of health. While notoriously difficult to pin down (Gasper 2005, Sointu 2005) the notion of wellbeing directs attention beyond external measures of welfare to people's own perceptions and experience of life. At a simple level, this can be seen in terms of a contrast between the familiar 'objective' indicators of income, nutrition, life

expectancy etc with the 'subjective' dimension of how individuals feel about their health or economic status. But understandings of 'the good life', as well as the capacity to achieve it, clearly differ from person to person and from place to place. Between individual and statistic lie culture and society, shaping both access to resources and the meanings these bear.

The relevance of culture is increasingly recognised in writings on both wellbeing and development. Perhaps the most prestigious international measure of wellbeing, the World Health Organisation's Quality of Life Profile (WHOQOL), involves extensive cross-national testing to assure its applicability within differing cultural contexts. The issue of cultural difference also appears within work on subjective well-being within psychology and in the practice of psychotherapy (see e.g. Chirkov et al. 2003; Krause 1998). The Wellbeing in Developing Countries research group (WeD) at the University of Bath, UK, has at its core a commitment to studying 'the social and cultural construction of wellbeing.'<sup>1</sup> Amongst theorists of international development, culture constituted a significant subject of study during the 1960s modernisation debates, but then fell into a long decline. More recently, however, it has been experiencing a revival. 1988-1997 saw the United Nations World Decade for Cultural Development, culminating in the report of the World Commission on Culture and Development (Pérez de Cuéllar 1995). Interest within the World Bank in the significance of culture was rekindled under the presidency of James Wolfensohn, and finds recent expression in the prestigious collection *Culture and Public Action*, edited by two of the Bank's economists (Rao and Walton 2004).

The aim of this paper is to investigate further the significance of culture in the construction of wellbeing. Where much discussion of wellbeing has been normative and generalised, I ground my analysis in the practical situation presented above: an extremely poor family in rural Bangladesh, faced with multiple challenges to health and well-being. They are people I know well, since Asha acted as research assistant during my PhD fieldwork in the mid 1980s, assisting in interviews and helping to interpret the information people gave me (see White 1992). The passage introducing this

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<sup>1</sup> The WeD research group, of which I am a member, is funded by the Economic and Social Research Council, UK, 2002-2007. An interdisciplinary study with country teams in Peru, Ethiopia, Thailand and Bangladesh, this involves a major programme of comparative empirical research. My thanks for much helpful advice and discussion over the argument in this paper go to colleagues within the WeD group, and to Wendy Coxshall, also at the University of Bath. For further details see [www.welldev.org.uk](http://www.welldev.org.uk).

paper describes how I found them when in 1994 I made a short visit back to the village. The paper is structured around the various moves to secure healing which they made over the days that followed, drawn from my field notes at the time. The household comprises Asha, a Muslim woman in her mid thirties, and her elderly parents. Asha was married and divorced as a child and has remained single since then. The family are landless, surviving on a mix of sharecropping and marginal activities pursued by Asha, including helping in other households, bits of petty trading, and tending animals.

This paper asks what is shown of the 'cultural construction of wellbeing' in the options Asha and her family pursued in seeking medical care. It draws on perspectives from social anthropology to explore this, and aims thereby to question the dominant ways that culture has, and has not, been understood in the discourse on wellbeing and development more broadly. Before proceeding it is worth setting out briefly some dimensions of 'wellbeing' that the paper will aim to explore. As many commentators have noted, the term is used in so many different ways that trying to fix its meaning precisely is an impossible task. 'Wellbeing' is like a broad and welcoming delta, where the flow of many rivers merge and intermingle as they run into the sea.<sup>2</sup> Included amongst these are discourses on human need and human development (e.g. Doyal and Gough 1991; Sen 1999, Nussbaum 2000; Alkire 2002; Gasper 2004); on life satisfaction and quality of life (Calman 1984; WHOQOL 1995; Ruta *et al.* 1994; Cummins 1996; Camfield and Skevington 2003); on the economics of happiness (e.g. Easterlin ed. 2002) and on the psychology of subjective wellbeing (e.g. Ryan and Deci 2001). Amongst the many streams and tributaries, three broad currents are of significance to this paper. First, there is the question of values and ideals, how people understand wellbeing, what 'the good life' is or what it means to 'live a good life.' Almost all commentators recognise that the answers to these questions differ by context, and for many this would be the main focus for a question about 'the cultural construction of wellbeing.' Second, there is an abiding association of wellbeing with welfare, standards of living, or what Gasper (2005) calls 'well-having'. In most of this literature this is defined in narrowly material terms and seen as outside the scope of culture. This paper takes a different approach, and asks how culture is implicated in the construction of this family's wellbeing, in terms of their original situation described above, the options they pursued to address it, and the health outcomes they were able to achieve. What is

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<sup>2</sup> In navigating my way through this I draw on the analysis of Des Gasper (2004; 2005) and of the WeD group at the University of Bath.

at issue here, therefore, is not simply the health or wellbeing *status* of the family, but also the social, economic, political and cultural *processes* which bring this about (see McGregor and Kebede 2002). Third, there is a clear concern with the subjective and experiential, the goals people identify and how they feel about their lives. Again, there is a tendency in the wellbeing literature for the social and cultural dimensions of this to slide, as the focus settles on individuals as the locus of goals, perceptions and traits. In this paper 'the cultural construction of wellbeing' is sought in going beyond the subjective into subjectivity, where the person is realised not simply through one-off thoughts or feelings, but through the 'work' of making meaning out of their lives.

## **RELATING CULTURE TO DEVELOPMENT AND WELLBEING**

This is not the place for an in-depth review of the relations between culture and development, since several good analyses already exist (e.g. Cooper and Packard 1997; Schech and Haggis 2000; Rao and Walton 2004). However, in order to situate the argument in this paper, it is necessary to review briefly how culture has been treated in the literature discussing development and wellbeing. As noted by numerous authors, the dominant way in which culture has been conceived in relation to international development is as obstacle. In modernisation theories, tradition was opposed to modernity, and culture used as a mark of the otherness of peoples still prevented by primordial bonds from joining the rational pursuit of progress. Since colonial times, however, the relationship has also been seen in reverse, with development as the threat and 'indigenous cultures' endangered, needing protection if they are to retain their local values and integrity. More recently these oppositional understandings of the relations between culture and development have been re-cast. Rather than inhibiting progress, culture is now celebrated as a resource for development. Religious institutions such as churches, mosques and temples, which were formerly seen as diverting investment into 'unproductive' activities are now welcomed as potential partners in development. Understanding (other) people's culture is seen as critical to enhancing development effectiveness (Rao and Walton, 2004). While this rehabilitation of culture is in some ways welcome, it should not simply be taken at face value. On the one hand it reflects the more general tendency within globalisation to re-inscribe the value of the 'local'. On the other hand one may read against the grain of development discourse, to see in this new celebration of culture the shadow of a perceived threat which needs to be neutralised. Articulated by Samuel Huntington (1993) as a 'clash of civilizations'; embodied on the streets in the

anti-globalization protests and the destruction of the twin towers; culture has become a major site of struggle for those who wish to preserve or challenge the hegemony of the present international order.

Writings on wellbeing and development use the notion of culture in a number of different ways. For some, culture is twinned with 'the arts', leisure, and/or religion, to define a particular area of human action and public policy. Conventionally a matter for personal or national investment, this has long been an area of concern for UNESCO, and its place has been consolidated within international policy through the recent World Bank interest in supporting 'cultural heritage' (Serageldin and Martin-Brown 1999).

The predominant use of 'culture' in this literature, however, is more general. Talk is of 'other cultures' or 'a people's culture'. 'Cross-cultural' is often used interchangeably with 'cross-national.' 'Culture' thus appears as a shorthand for group identity, often co-terminous with a nation-state, or (increasingly) language-based or ethnic groups within it. This is the classic way in which the utility of culture to development has been, and indeed still is in some circles, assessed.<sup>3</sup> The World Commission on Environment and Development, however, suggests the rather different possibility that culture may encompass development, rather than vice versa:

'Culture.... however important it may be as an instrument of development (or an obstacle to development), cannot ultimately be reduced to a subsidiary position as a mere promoter of (or impediment to) economic growth. Culture's role is not exhausted as a servant of ends – though in a narrower sense of the concept this is one of its roles – but is *the social basis of the ends themselves*. Development and the economy are part of a people's culture.'

(Pérez de Cuéllar, 1996:15, emphasis added)

Another strong trend in the wellbeing and development literature is to identify culture cognitively, that is with ideas, beliefs, and values. This is a step forward from a simple opposition of (individual actors'?) subjective perceptions versus (outsiders'?) objective measures, since it recognises that perceptions do not belong simply to isolated individuals, but are conditioned by societal norms and expectations. Nonetheless, to use Marxist terminology, this still situates 'culture' at the level of superstructure,

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<sup>3</sup> See for example Sen's (2004) discussion of Huntington's (2000) spurious attribution to culture of the difference in Ghana and South Korea's economic fortunes since the 1960s.



rather than seeing it as structuring society in a more fundamental way. A good example of this approach is given by Vijayendra Rao and Michael Walton, in their introduction to the World Bank sponsored *Culture and Public Action* (2004: 9):

‘A culturally informed perspective is thus not so much a prescription as it is a lens – a way of seeing. It sees individuals as driven by a culturally influenced set of motives, incentives, beliefs, and identities that interact with economic incentives to affect outcomes..... We believe that incorporating this lens into more conventional economic ways of understanding will, in many situations, lead to more effective policy.’

This approach has much to recommend it over the simplistic notion that beliefs and values are somehow fixed or given for a nation or social group as a whole. Instead, culture is viewed more flexibly, as giving people ways of seeing the world. However, the movement is not perhaps as great as it might at first appear. Seeing culture as a ‘lens’ does not undermine the ‘analytic primacy of the rational, value maximizing individual’ (Good, 1994: 39, after Sahlins, 1976) which is so foundational to Western economic thought. Individuals and the economic incentives to which they respond remain, it seems, outside culture, and even motives, beliefs and identities are only ‘influenced’ by it. Similarly, the confidence that such a lens may be ‘incorporated’ within existing approaches suggests that there is no need for a fundamental shift in the existing institutions of international development. This rationale for taking account of culture is in fact highly reminiscent of arguments for increasing people’s participation in development projects: the more people are involved themselves, the more effective projects are likely to be. As many critics have pointed out, instituting participation in public projects does not necessarily signal any real shift in power relations. It may simply neutralise and de-politicise a potential threat (Selznick 1949; White 1996; Cooke and Kothari 2001). If a ‘cultural lens’ is to be used to enhance policy effectiveness, this leaves open the bigger question: who owns the policy?

## **ANTHROPOLOGICAL PERSPECTIVES ON CULTURE AND WELLBEING**

Since debates about culture constitute the staple diet of social anthropology, it would be foolhardy of me to try and summarise these here. Instead, therefore, I take as general starting point Arjun Appadurai’s (2004:61)

helpful summary of current points of consensus on culture in anthropology. These are as follows. First, relationality, that cultural meaning lies in the relationship between different elements rather than inhering intrinsically within a particular item considered in isolation. Second, dissensus, that culture is non-unitary, subject to considerable internal negotiation and dispute. Third, leakiness, that the boundaries of culture are highly porous, such that flows, borrowing and interaction across borders are the norm, not the exception.

In his discussion of 'the capacity to aspire', Appadurai goes on to develop an approach that bears directly on debates about wellbeing, particularly with regard to the links between personal goals and cultural values. Aspirations, he claims,

'form parts of wider ethical and metaphysical ideas which derive from larger cultural norms.'

(Appadurai 2004:67-8)

He identifies three levels which nest people's aspirations in culture. The first, most immediate level, consists of a 'visible inventory of wants.' These contain the specific wants and choices for this piece of land or that marriage partner which people consciously identify and may seek to pursue. It is this level that commonly appears – though usually in a rather more generalised way - when people are asked to itemise their goals or desires by development agents or scholars of wellbeing. At the next level are the 'intermediate norms' which may not be expressed, but nevertheless structure the particular wants through local ideas about marriage, family, work, virtue, health and so on. These in turn relate to 'higher order normative contexts' which comprise a larger 'map' of ideas and beliefs concerning such matters as life and death, the value of material goods versus social relationships, this world and other worlds, peace and conflict. 'Culture' is not then something separable from the everyday, but structures material and relational desires through a cascade of associations that makes them meaningful and designates some as pressing.

The relationship between culture and materiality in human welfare is discussed at length by Marshall Sahlins in his *Culture and Practical Reason* (1976). For Sahlins, the making of meaning is the key distinguishing characteristic of humankind (*ibid*:102). It is not that materiality does not matter, he argues, but that rather than social and cultural life being shaped by 'nature' and economy, it is the other way around:

“No society can live on miracles... None can fail to provide for the biological continuity of the population in determining it culturally....Yet men do not merely “survive”. They survive in a definite way.’

(*Ibid*: 168)

That ‘definite way’, the aspiration, as Appadurai might put it, not just for shelter but a particular kind of house, not just for calories but a particular kind of food, is given by culture. The material and cultural are not separable, such that one can separate ‘objective reality’ from ‘cultural values’, but fundamentally intertwined:

‘It is not that the material forces and constraints are left out of account, or that they have no real effects on the cultural order. It is that the nature of the effects cannot be read from the nature of the forces, for the material effects depend on their cultural encompassment. The very form of social existence of material force is determined by its integration in the cultural system.’

(Sahlins 1976:205-6)

As an example, he offers the fact that in the United States dogs are considered inedible, but cattle ‘food’ (*ibid*: 169). The fondness for beef in the North American diet has major material outcomes, in terms of prices of meat, land use, agricultural subsidies, health issues and so on, with knock on effects which ricochet around the world. But the basis of the choice of cattle over dog meat, the root cause of all these many effects, is neither ‘nature’ nor ‘utility’, but culture.

In seeking to explore the cultural construction of subjective experience, I draw on the work of Veena Das, and particularly her paper ‘The act of witnessing: violence, poisonous knowledge, and subjectivity’ (2000). In this paper, Das describes how a Punjabi woman, whom she also calls Asha, responds to the disasters that the Partition of India and Pakistan wrought in her family life. As an urban, elite woman her outer circumstances were very different from those of the Asha I have described here, but in her early widowhood (at age 20) she came to occupy a position of cultural ambivalence and vulnerability which is not unlike that of her Bangladeshi namesake.

In the wellbeing literature, the point of reference for 'the subjective' is its opposition to 'the objective.' At its most extreme, culture may be completely excluded from this, as with the 'global happiness' questions which are now quite common in economic household surveys: 'Taking all things together, how would you say things are these days?' (Andrews and Withey 1976). Answers describing the self as 'very happy,' 'fairly happy,' or 'not too happy' appear as a number on a Likert scale which may be subjected to exactly the same computations as any other piece of quantitative data.<sup>4</sup> While following a similar methodology for measurement, the WHOQOL Group (1995) put forward a more culturally cognizant view in their definition of quality of life:

'An individual's perception of their position in life, in the context of the culture and values in which they live, and in relation to their goals, expectations, standards and concerns.'

The imagery here is reminiscent of Rao and Walton's cultural 'lens'. There is a similar stress on seeing (perceiving), a notion of culture as filter or horizon, and a commitment to the individual as the source of perceptions, with his or her own personal set of goals and priorities. Such approaches clearly reflect the disciplinary background from which they derive (economics and psychology) and are oriented towards the production of quantitative measures of wellbeing. The danger, however, is that the stress on perceptions, and on numerical answers, can divorce the subjective from the subject. Despite the stress on individuals, the individual person in practice gets lost, as the numerical answers given to particular questions become the data, which can then be cross-tabulated with answers to other questions, or with the same questions answered by other respondents. 'Culture' may then be invoked, if at all, to explain certain clusterings of response, evident in one social group and not in another. The methodology requires that the relationship should be between culture and abstracted perceptions, rather than the person whose perceptions they are.

For Veena Das, by contrast, what is important is not primarily perception, but the practical *work* that is done in constructing subjectivity out of a context of violence and subjugation, 'not through an ascent into transcendence but through a descent into the everyday' (2000:208). In place of seeing culture in

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<sup>4</sup> This question has been used by Global Barometer surveys in Europe, 'New Europe', Africa, and Latin America and numerous economic surveys, & national general household surveys. Other similar questions ask about life satisfaction, and may require a five point answer. My thanks to Laura Camfield (WeD) for this information.

the morally neutral way of the wellbeing literature, Das faces directly the fact that the overall cultural terms, or resources, which defined Asha's identity were patriarchal forms, and that even in pursuing the relationships that were important to her (with her dead husband's sister and her son) she adopted a patriarchal idiom in speaking of these. However, Das (*ibid.*: 210) claims:

'cultural representations do not become completely mapped upon the self.....Thus individual lives are defined by context, but are also generative of new contexts.'

She stresses therefore Asha's active constitution of her subjectivity, forged through her careful repair work over many years of damaged relations with her first husband's family, guided by her love for key individuals and 'the temporal depth in which she saw her relationships' (*ibid.*: 217). The meaning of this was given by culture, since she saw in her first marriage the connections that she would carry into eternity. But the settled cultural world to which these meanings belonged was smashed by the disaster of Partition and the fracturing of relations that followed. Critically, therefore, this cultural meaning and these relations were also re-claimed by her, and re-inhabited, as a long act of witnessing to the hurt she had suffered through them. The 'cultural construction of wellbeing' that emerges here is not sweet and easy but hard and painful, not an inflexion of goals, but a lived experience achieved through a lifetime's struggle.

Having set down some markers in the intellectual debates concerning culture and wellbeing, it is time to pick up again the story with which this paper began. The following three sections thus return to Bangladesh, and present Asha and her family's encounters with different kinds of medical specialists over the days that followed.

## **SEEKING HEALING (i) THE KOBIRAJ<sup>5</sup>**

*A neighbour knocks and enters: bad news. The new healer they are seeking was not at home, he's making a call in a village way out west. They confer - what to do? It's dark and the neighbour wants to go home, isn't ready to make another journey now. Asha's mother wails. She's frightened, desperate. He relents. If they'll cover the costs*

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<sup>5</sup> A *kobiraj* is a traditional healer. Many have specialisms, such as bone-setting or mental health problems. Approaches vary, but they often use plant-based medicines of their own concoction, and tend, as here, to have a supernatural aspect to the treatment they offer.

*he'll make the trip. But he's tired, is getting old himself. There's no way but foot to travel, he won't return before morning.*

*As I check on them the next morning, the neighbour brings word: the healer has agreed to come. They all breathe out - relief. The earlier healer is bad-mouthed now, this one's good name talked up. He knows all about herbs and plant medicines. He's a special healer for broken bones. Other neighbours arrive to confer - yes, in this case and that his medicine proved successful.*

*Much later the healer arrives. He's a small man, unshaven. His bright glinting eyes take in the scene: the poverty of the house, the skin-bone people, the anomaly of my presence, a foreign woman. The first move, to state his price. Anxious looks confer, and yes, it is agreed.*

*He begins with talk. Much talk. It feels like a sales pitch, reminding me of the patter of travelling salesmen who board buses or occupy street corners to peddle miracle cures. But Asha and her family want to believe. Want desperately that he be the one, the miracle worker. They look at him with eyes full of trust, of hope. Hang around him, waiting to do as he asks.*

*He requests a stick, and draws with it on the mud floor. He explains that the lines represent the old woman's leg, and as he strikes the different parts of it, the pain is to be drawn away. He chants something no-one can understand, flicks a forked branch over her head and around. As he directs, the daughter tosses money into the small pile of holy things he blesses. One hundred taka, two hundred, three, four.... the fee he'd asked for, two months' rice for them.*

*He touches the leg now, and talks to Asha's mother. Gently he pulls her up, supporting her. They all catch their breath, and, yes! she's walking. For the first time since she had her fall. Crying still, in short sharp gasps, but walking. A flickering hope flames up in Asha's eyes.*

*Now the arm. Asha passes him the paste she's ground on his instructions, from the roots he'd brought. With more chants and swaying movements he applies it to the arm. The potion is so powerful, he claims, that within a moment she'll be healed. To prove it he demands she stand and swing her arm. Up and down and round again. The old woman's cries are searing, but the onlookers encourage her. It seems that I am the only one who is horrified by what she sees.*

*The session completed, the healer makes as if to go. The fee must now be paid. The family is taken aback - but that money they had already given? That was just for the purposes of the ritual, he says. Single taka notes would have done as well. Their mistake. He couldn't keep that money himself, as it had been used in the healing. He would have to give it away, the fee was quite separate.*

*Alarm and confusion shows on their faces, he should have made it clear! But they don't want to cross him, are afraid that the cure will be revoked. They fight back their regret and ask me - could I pay the fee? Meanwhile they offer him some lunch. But he refuses - he has other people to see. Only when they make it clear that their one chicken will be killed in his honour, does he finally agree to stay.*

*After he leaves the doubts re-surface, the recriminations begin. He took twice the fee he asked! And who knows if the arm will set this time. Doubt and hope and anger battle together in people's faces. Don't give doubt voice! The chance of healing will be affected! But unease and misgivings hover like a dark bird.*

Episodes such as this offer the classic ingredients for discussion of 'local' medical culture: a textbook case of cultural display, rich with esoteric knowledge and exotic ritual. Even viewed like this, however, the 'text' shows itself to need de-coding. It is not a simple case of classical practice within either Muslim or Hindu healing traditions. Instead, as commonly in Bangladesh (see e.g. Blanchet 1984, Kotalova 1992, Islam 1985), it is a clear case of Appadurai's 'leaky' boundaries: a composite of Hindu, Muslim and folk Bengali elements, tossed together with a considerable degree of

showmanship. Such crossing of social and cultural differences seems a common pattern all over the world, as if health problems offer a place where culture becomes unusually porous. Kakar (1982) thus talks of the 'brotherhood of sickness' which transcends religious and ethnic (and presumably gender!) barriers. This is only one side of the picture, however. If health problems may at times dissolve social difference, they can also deeply underscore this, as poverty of environments expose disadvantaged people to excess health risks, and ethnicity, gender and class structure access to quality care (e.g. Scheper-Hughes 1992; Farmer 1997).

Perhaps the most striking aspect of this episode is its character as a social event. From the early debates of which healer to approach, through the therapy episode itself and into discussion of it afterwards, all of the action took place in 'public'. The physical location was the veranda and courtyard of the family's somewhat tumbledown two-roomed mud house. This is the place where much of the household work gets done, where women gather to chat in the afternoons and men in the evenings, a mid-way private territory with public access. While wealthy families have high walls and doors to regulate entry, the poverty of Asha's family means that access is much more open: they do not have the social status to exclude, nor does their makeshift mud wall offer a physical barrier. The group involved also reflects this. It was a motley collection of friends and neighbours, waxing and waning in size with the action itself. Like the family involved, it was more female than male, more Muslim than Hindu, more poor than wealthy. At times it contained their only kin in the village - Asha's brother and his family, living separately next door - at other times they were absent.

This pattern of a reference group being constituted around the pursuit of therapy is widespread, in both the West and South (Sharma, 1992). In the West, however, considerable effort goes into marking a distinctive, confidential space for the actual practice of therapy - the use of curtains around a hospital bed, the psychoanalyst's couch, or the closely bounded counselling hour (Bondi and Fewell, 2003). In this case, by contrast, as often in informal contexts in the south, the therapy itself took place in public. It felt in fact like a highly theatrical performance, a show to convince the audience of the actor's esoteric power. As commonly whatever the context, the healer required not just the compliance of the patient, but also the support of her family in administering the remedy. But the audience was also drawn into the act. Their hope, their faith, their excitement and will to see wonders were solicited by the healer. The group's sharp intake of breath as the old lady swung her arm around signalled their taut



engagement. Far from an unwanted intrusion onto the real action, in a quite tangible sense, 'the public' made the event what it was. This echoes Jonathan Spencer's (1997) discussion of the importance of public performance in the rather different context of enchantment in rural Sri Lanka. Unlike the practice of psychotherapy in the West, where success seems to lie in achieving a new narrative for the self, it was critical to the authenticity of this story of possession and cure that it be told in public and ratified collectively. Only then, Spencer argues, could the episode be a therapeutic success, which enabled the woman concerned significantly to expand her social room for manoeuvre.

The other side of this public ratification, of course, is that the healer's performance is also subject to collective appraisal. For a short while the healer might succeed in enrolling people in his script, but quite quickly the tension loosens, they stand back, they begin to assess. Again, this is not done privately, but is a collective process, achieved in public through conversation. At any point, the appraisal is provisional, a temporary negotiated outcome which is open to subsequent revision. This appraisal is done both with and against 'culture'. On the one hand there is simple scepticism, doubts of the efficacy of such a display. On the other hand, however, room for debate is also available *within* culture. This particular performance is thus vulnerable to assessment not only in relation to other healers they have seen, but also to the mythic figures of gifted healer and charlatan, both of which are commonplace in Bengali popular culture. Where does this *kobiraj* fit? While this process is clearly discursive, both in terms of discussion amongst people and comparison with the subject positions offered in popular discourse, it is important not to over-intellectualise it. As Kakar (1982) states in his study of faith healing in India, belief is critical, but appraisal takes place far beyond the verbal or cognitive level. Not only is there the involuntary response to another person's charisma, but also hope and doubt may both be experienced in the body, and neither is entirely within one's conscious control. As Obeyesekere (1990:288) says, there is a 'will to believe.' The appraisal is not therefore a free, open, intellectual exercise, but carries heavy emotional weighting, at least for the core participants. As Budd and Sharma (1994:8) point out, emotions have tended to be neglected in studies of healing, but are in fact of critical importance.

## SEEKING HEALING (ii) THE PUBLIC HOSPITAL AND PRIVATE ULTRASOUND

*Some days later Asha decides to go to the hospital to seek help for her own problems. One of the doctors there is daughter-in-law to a family in the village, she'll see her. The town is a morning's journey away, four miles trudge to the bus stop, and then two to three hours bumping along pitted roads, stopping every few minutes to pick up more passengers. The hospital is crowded, confusing, a place of passage more like a railway station than a place of healing. It's dirty and has a stale air: no wonder the villagers joke that you're more likely to catch something here than get well.*

*The daughter-in-law is in family planning, but she writes a note for Asha to see the doctor who deals with stomach problems. Having me, a foreigner, alongside helps a lot in getting her seen. Even so, Asha is ill at ease, does not tell the doctor all her symptoms, and he dismisses her peremptorily. He can feel nothing wrong. Appendicitis is unlikely. She should have blood and urine tests at a private clinic. Ultrasound if she can afford it.*

*Private clinics and small dispensaries clutter the roads all around the hospital. We make for the one he mentioned. Asha registers for the tests and asks about ultrasound. They can do it, but not until this evening. It will cost another four hundred taka. The test results will not be ready before morning. It means staying a night in town. Anxiety again. Where will we stay? And we hadn't said we'd stay the night away, her parents will worry. There's no phone in the village, no way to send word. But there's really no choice, no point in returning now. Luckily I have friends in town with whom we can stay. We make our way there.*

*The ultrasound shows nothing. Nor do the other tests. The daughter-in-law/doctor advises that Asha should return another time, bringing the test results for the hospital doctor to see. But by the time she receives them*

*it is too late, surgery hours are over. Anyway it seems just hit and miss, with guesswork playing as much a part as expertise. Empty handed but with little option we return to the village.*

The contrast between this episode and the previous one could hardly be more striking. To a Western eye we seem to have leapt over four or five hundred years of history. Scene changes do not come any more rapid. Exit the mud house and enter the concrete institution. Exit the magical branches, enter the hi-tech. Exit the lungis<sup>6</sup> enter the white coats. And it is not just the props that are different, but the characters too. Gone is the public, the collective. Gone too is the performance, the drama, the affect. What we have instead approaches the caricature of biomedicine: 'the leg in bed nine'. There is no attempt to engage with the person who is suffering, and little sign even of any real interest in diagnosing what is wrong.

This second episode points up the importance of political economy to understanding the cultural construction of options and the outcomes they achieve. As Budd and Sharma (1994) note, relationships outside the consulting room are critical to understanding what takes place within it. Before pursuing this it is perhaps important to note that this episode was no more or less steeped in 'culture' than the previous one. On stepping into the hospital entrance hall and the reception area of the private clinic, we entered new worlds governed by their own particular norms, values, identities and forms of behaviour. These institutional cultures were expressed in the personal interaction, such as it was, between doctor, technician and patient. But the cultures themselves are forged in relation to the wider political economy in which the hospital and clinic are set. Morale in public hospitals in Bangladesh is not high. Although services are nominally free in fact almost everything has to be paid for. Doctors make their money in private clinics and put their energies into that work. This is so strongly the case that when I first presented this paper the (Bangladeshi) audience immediately suggested that the doctor we saw probably had personal links with the clinic to which he referred us. The (diverse) private sector in medical provision is thus constructed quite directly in relation to its public counterpart, and vice versa.

The choices that people make in seeking health care are similarly forged through this context of political economy. This can be clearly seen in the

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<sup>6</sup> The cloth worn around their lower body by men in informal settings in Bangladesh.

decision to seek a *kobiraj* to set Asha's mother's arm. In theory, primary health care is available at the sub-district level, just four miles down the road from the village. An imposing gateway declares that such a clinic with twelve beds for in-patients does indeed exist. However, the personal and professional interests of doctors lie in an urban appointment, where there are more facilities and chances of preferment as well as better schools and services for their families. As a result, few doctors are ever available at sub-district level. The work of those that remain is hampered by very limited provision of drugs and equipment. If the sub-district health centre had been the local resource it was intended to be, it is likely that Asha's mother would have gone there for treatment in the first place. Alternatively, if corruption had not continually undermined the proper construction of a metalled road, there would have been more frequent buses and better communications with the town, so going to the district hospital would have been much less of an issue.<sup>7</sup> As it was, she was afraid both of making the journey into town and that when she reached the hospital they would want to break the arm again. By comparison, the *kobiraji* option was both more accessible and less frightening.

### SEEKING HEALING (iii): HOMEOPATHY

*One of the men in the neighbouring village is a homeopathic doctor. His main job is college lecturer, but after hours he sits in a small shack near the market place, making diagnoses and prescribing remedies. Asha is sceptical - he'll just say it's gas in the belly, it'll be more money paid out for no benefit. But she can't make another trip to the hospital, it's too far and her parents can't spare her. So one afternoon we set off for the homeopath - it wouldn't cost much, and had to be worth a try. We move aside the curtain hanging across the doorway, and enter the small dark room. The little group of men chatting with the doctor stand up and go out. He greets us warmly, recognises Asha, asks after her family, her health. For the first time someone allows her space to describe what the problem is. A general picture of chronic ill health comes out. Weariness, unexplained pains, irregular menstruation. A body weakened by too much worry,*

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<sup>7</sup> After many years of failed attempts and false promises from politicians, the road was finally completed in the following year, and communications with the town and to other areas have been tremendously improved since then.

*heavy daily labour, poor and scanty diet. But being able to talk cheers her a little. For a modest fee he gives her pills and we come away with somewhat lighter hearts. And rather to Asha's surprise, she says the pain does ease over the weeks that follow.*

Again, the contrast between this episode and the previous ones is striking. The setting is minimalist: a small wooden hut with a simple desk and chairs, no paraphernalia except for a set of phials containing the different remedies. As before, Asha's social and economic disadvantage is a significant factor in the interaction. As she described to the doctor her physical condition, the implication of poverty and inequality in poor health was set out tangibly before us. But whereas in the other cases her social marginality was used against her, to extort money or deny her proper care, here it was grounds for gentleness, for compassion.

The critical factor in the healing power in this episode seemed to be the recognition that the doctor gave to Asha, his simple treatment of her as a person, due respect in her own right. This re-confirms the widespread finding that the quality of the therapeutic relationship is a primary factor in whether healing takes place. As the doctor evoked his knowledge of Asha over several years, her family background and some parts of her personal history, he set their present interaction in the context of a broader social relationship. This contrasts strongly with all the other episodes, in which the underlying idiom was a market transaction. This was most baldly so at the private clinic, where a standard fee was charged for a particular treatment, and it was simply a matter of whether or not Asha could pay.<sup>8</sup> At the other extreme was the *kobiraj*, where the market aspect was most treacherous. First, as Sharma (1992) states, there is an ambivalence around payment in the case of spiritual healing, since the healing is seen to be given by God and the healer merely the medium of the gift. In this case, however, the healer had no hesitation whatsoever in stating his fee up-front, and for such a poor family the sum he demanded was a great deal of money.<sup>9</sup> This was compounded by the misunderstanding - if that is what it was - about the money used as part of the ritual. This was troubling not only because it doubled the price, but also because it cast questions on his character, in a context where good character is thought to be a critical factor in healing

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<sup>8</sup> This 'simplicity' may be somewhat misleading, of course. Such clinics are a resource for the rich, not the poor. It is unlikely if I had not been present whether Asha would have ever gone to such a clinic, let alone pay the fee that they demanded.

<sup>9</sup> I cannot know for sure if he asked more because of my presence, but this is quite likely.

(Kakar 1982). On the other hand, through inviting the healer to stay and eat with them, the family was able to rescue this exchange from being a crudely economic transaction. The healer became the guest, and the client the generous host.

The importance of personal relationship is a cultural dynamic which is evident in all these episodes. This confirms the findings of other studies that notions of belonging and relatedness are central to constructions of person and wellbeing in Bangladesh (see e.g. Kotalova 1993; Devine 1999; White 2002). In seeking the *kobiraj* Asha's family had to rely on the goodness of a neighbour to track him down. In going to the hospital Asha tried to transform an impersonal context into a personal one, through her approach to the daughter-in-law from the village. Appadurai (2004:69) describes the capacity to aspire as a 'navigational capacity', with the double aspect of enabling people to stretch their imagination and to link their particular wants to broader norms and narratives. In a more tangible way, 'navigational capacity' in being able to choose and achieve desired outcomes in Bangladesh depends critically on the ability to mobilise a relationship with an empowered other. In these episodes I provided some of this for Asha, bolstering her confidence to enter the public hospital, helping to ensure that she was seen, rather than just left to wait all day, and possibly – though this is more uncertain – helping her to be taken seriously by the homeopathic doctor. But my usefulness was very limited. What I critically lacked was any insider knowledge of the different medical options and institutions, how to negotiate access or navigate my way through the many gatekeepers. Such practical knowledge of 'how to go on', is a vital part of what people seek in drawing on relationships in times of trouble in Bangladesh.<sup>10</sup> Accompanying Asha and her family through these days, from the choice of healer or doctor, to tracking him down, to receiving treatment, it all seemed to me a tremendously hit and miss affair, in which chronic lack of information and the associated absence of control, fear, uncertainty and vulnerability were the most powerful characteristics. In part this is due to material poverty, which, inflected by gender, significantly limits opportunities to gain knowledge of options (Appadurai 2004:68). But perhaps more vitally, it also reflects the fact that they are 'poor in people' (White 1992) and thus lacked connections with people who would know how to go about it. Asha's pulling power as a client is very limited. With no assets, low social status, no significant social relationships, female labour of minimal market value and no able-bodied male labour in the household, she

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<sup>10</sup> My thanks go to Joe Devine for this insight. The argument here clearly has affinities with Bourdieu's (1977) analysis of social practice.

has little to offer in return for any favour. Her treatment in the hospital expressed this most starkly. Even with me present, she was treated not as a person, but as representing a social category of minimal value, a piece of social flotsam - poor, rural, unmarried, female.

## **THE CULTURAL CONSTRUCTION OF WELLBEING**

The juxtaposition of these three episodes within the experience of a single family over the course of just a few days points up the unevenness of 'modernisation', the falsity of any notion of a hermetically sealed, uncontested 'traditional culture', and the inadequacy of any simple mapping of culture onto social group or nation-state. On the contrary, the local medical culture appears bewilderingly diverse, with each of the options both generating and subject to agency, resulting in an overall picture which is plural, contested, and open to constant (re)-negotiation.

Faced with such complexity, the metaphor of culture as a lens becomes considerably more problematic. Is there a single lens which comprehends all of these options? Or does the family switch lenses as they move between practices rooted in totally different cosmologies, technologies and institutions, seeking whatever will meet their immediate need? The relationship between different systems of healing and the sense people make of these as they move between them, has been a major subject of debate within the anthropology of health and illness (e.g. Feierman and Janzen, eds. 1992; Johnson and Sargent, eds. 1991; Nichter and Lock, eds. 2002). This reflects a broader tendency to focus on issues of cognition and belief (Good 1994). Murray Last (1992) however, questions the terms of this debate, arguing that it may exaggerate the knowledge and the will to know of both the healers and those seeking healing. Rather than being fully cognizant of the whole 'system' of healing in which they engage, it may be that in each context people know just enough to be able to get by - and are not particularly interested in knowing more. While people may face many problems in accessing appropriate health care, the intellectual coherence of the mix of options available to them is rarely among these. Rather, in negotiating 'alternative systems' of medicine, Murray Last (1992:403) says: 'people in practice do not so much "switch codes" as simply switch off.'

An alternative perspective on this issue is suggested by Marcia Inhorn (2003) in her study of elite Egyptian couples suffering infertility. She stresses how important religion was to all her respondents, and how significant Islamic teaching and observance was in defining which options

could be pursued and which doctors could be trusted.<sup>11</sup> In her earlier research amongst the poor, people saw infertility as ‘testing’ from God and drew on theodicies which sustained them through suffering (*ibid*:101). In this later study, elite couples seeking IVF treatment also saw children as God’s gift and their fate as ultimately in God’s hands, but saw the doctors (and their extremely high-tech medicine) as the means of God’s will (*ibid*:103). ‘Science’ and ‘religion’ both informed their goals and aspirations, but in ways that, for both doctors and patients involved, seemed complementary, rather than in conflict.

During the episodes described here, neither Asha nor her parents referred explicitly to any ‘higher order’ or even ‘intermediate norms’, aside from some fairly formulaic comments by her father, concerning their being in the hands of Allah. That they were not spoken does not, of course, mean that such concepts are absent, but that they may be part of the ‘tacit understandings’ (Giddens 1977: 169) which constitute the ‘common-sense’ that shapes people’s life-worlds. Conversations with Asha and her family at other times suggest that the quasi-magical world invoked by the *kobiraj* had the greatest resonance with their general worldview. Like other rural Bengalis, they share their time and space with various forms of spirits, ghosts, and sorcery which appear disproportionately in relation to ill health and ill fortune (see e.g. Blanchet 1984 and Callan 2003). As Obeyesekere (1990:66) suggests, like other religious convictions, such awareness coexists easily with an everyday engagement in the mundane world of want and scarcity:

‘Though the external world is culturally defined, it is naïve to assume that all its segments or domains are of the same qualitative order, or that individuals orient to the different domains in identical fashion.’

Nancy Scheper-Hughes (1992) suggests another possible aspect of this silence. She states that poorer people typically express distress somatically, while middle class people are more likely to do so psychologically. Whether this holds as a general rule or not, for someone like Asha, on the moral as well as material margins of her society, physical malady constitutes a rare sanctioned form in which personal need and vulnerability can be expressed. This is not to suggest that her pains were

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<sup>11</sup> For example, all agreed that IVF was only religiously approved (*halla*) if all elements came from the husband and wife, thus precluding any egg or sperm donation (Inhorn 2003:105). The personal faith of Muslim doctors was also seen to be important as a safeguard against immoral practices, for Coptic as well as Muslim patients (*ibid*:118-9).



unreal or psychosomatic, but simply that they offered one of the very few means available to her to seek the attention and care that she (also) needed. As if in confirmation of this, since that time she has established a strong relationship with another *kobiraj*, whom she visits on a regular basis. He lives at a considerable distance from her village. To go there and back takes the whole day, and involves travel by bus, truck, and bicycle van. In rural Bangladesh, where it is not socially sanctioned for women to travel alone, this is a considerable moral as well as financial undertaking. From observation of one of these visits, and the way she talks about this *kobiraj* in general, it seems clear to me that, as with the homeopathic doctor described above, part of what she receives from him is the value and recognition he gives to her as a person, and this may be as important a part of the healing as the pills he prescribes.

Rather than seeking to explore culture through the metaphor of lens it may be more useful to consider it as a form of work. This would clearly resonate with the approach to subjectivity taken by Veena Das. For society more broadly, the idea of 'the work of culture' is proposed by Gayanath Obeyesekere (1985; 1990). For Obeyesekere, writing at the boundary between psychoanalysis and anthropology, the 'work of culture' is the process whereby the deep and often darkly painful sides of human existence rooted in the unconscious are transformed symbolically into publicly shared meanings and imagery. In the context of this paper, to consider the cultural construction of wellbeing as a form of work has three main implications. First, it sees people as agents of culture, who both use the resources culture gives them and reproduce or transform these through their actions. Second, it recognises that the work of constructing wellbeing is at once material and symbolic. As Asha persists in seeking healing, she is simultaneously pursuing her needs *and* contesting the terms of local culture, which say her needs are unimportant. Third, the agency expressed and forms of wellbeing constructed are not free-floating, but shaped by the specific institutional context in which each encounter takes place. The cultural construction of wellbeing can thus be seen to be affected as much by institutional setting as by national or religious context. This is in line with the suggestion by Jonathan Spencer (1997) that part of the apparent contradiction between anthropological accounts of the person as robust individuals or transient nodes in relationship may be solved by paying closer attention to the different contexts - legal, therapeutic, or educational - in which stories of the person are told.

Like other kinds of work, the work of constructing wellbeing is clearly conditioned by broader social and cultural structures of class and patriarchy. Asha and her family's position of extreme social disadvantage sets the terms of engagement for all of the encounters, which are forged through the violence of two crude questions: 'what can they afford?' and 'what are they worth?' These reflect not only their material poverty, but also their 'extremely weak resources where the terms of recognition are concerned' (Appadurai 1994:66). Power relations were most equal in the *kobiraji* case. He was, like Asha and her family, illiterate, a poor man from a village much like their own. This, I suspect, explains the effort that he put into his performance. He needed the patter, and perhaps some of the magic, to buttress his power over them. With the public hospital, private clinic and the homeopathic doctor, by contrast, superiority by class, education, and institutional location assured unassailable dominance. In one case this was abused, in the other it was used to empower.

When social structure is put together with the political economy of medical provision, it provides a powerful explanatory tool. Where the cultural picture is so complex, it may be tempting to jettison the notion entirely and to settle on explanations in terms of political economy and social structure: a policy regime combining with marginality and poverty, inflected by gender, disability and age. But if explanations in terms of 'culture' make no sense in the absence of an awareness of social structure and political economy, nor can these be understood in abstraction from culture. While class, gender, disability and age may be common axes of differential advantage, they do not always and everywhere mean the same. This links back to Sahlins' statement noted above, that people do not only survive, but do so 'in a particular way.' But it also goes beyond this, because the making of social difference is not simply coloured by culture, but at its heart. The current enthusiasm to celebrate culture in development circles notwithstanding, the creation of differing value, the affirmation of some and the debasement of others, is absolutely central to the work of culture. As Sahlins (1976:102) puts it:

'the creation of meaning is the distinguishing and constituting quality of men – the "human essence" of an older discourse – such that by processes of differential valuation and signification, relations among men, as well as between themselves and nature, are organized.'

The character of the threats to Asha and her family's wellbeing, the ways they seek to address them and the dynamics within therapeutic relationships cannot be understood except through the cultural meanings which they express. The cultural construction of wellbeing thus appears as a contested *process*, and an always unstable and composite *outcome*, constituted through the work of human subjects operating at the interstices of social structure, institutional culture and political economy.

Inga-Britt Krause (1998:2) describes how when beginning psychotherapy with clients from a different cultural background, there is a common experience of paradox. At first there is an easy personal connection, but then there comes a gulf of unknowing. It is perhaps this sense of unknowing that scholars of wellbeing and development need to rediscover. Rather than thinking of the culture of others as a lens, it may be useful to become more aware of how 'our' higher order and intermediate norms, positions within social structure and political economy, institutional cultures and disciplinary or professional techniques act as lenses, conditioning vision and pre-shaping understanding of other lives. Veena Das (2000:224) suggests something of what this might mean as she states:

'the moral stakes for Asha can only be understood if we can enter a lifeworld in which she felt that her eternity was in jeopardy.'

The key word here is *enter*, suggesting an imaginative and intuitive leap, a joining in, which disrupts settled assumptions about dispassionate observers objectively assessing the values, achievements, and subjective perceptions of others.

The plasticity and negotiable character of cultural constructions of wellbeing was ironically re-stated when I made another visit back to the village in 2003. Asha and I went to visit the *kobiraj* mentioned above for her continuing health problems. In the course of the journey Asha got talking to a man who asked her the usual questions about her family circumstances. On hearing that she had neither husband nor children his reaction was simple: she might as well die! What good was she? What did she have to live for? After a swift double-take to make sure the man had said what he did, Asha raised a wry eyebrow, threw back her head and laughed.

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