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# Family-planning Services in a Low-performing Rural Area of Bangladesh: Insights from Field Observations

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## ABSTRACT

This paper mainly reports the results of an observational study carried out during 1994-1995 in five rural unions of Bangladesh to identify the barriers to adoption of family-planning methods. At the time of the survey, one-fifth of 1,889 mothers with a living child, aged less than five years, were practising modern family-planning methods. Of the methods used, oral pill was the most common (50%), followed by injectables (20%), female sterilization (13%), IUD (11%), and condom (4%). Various factors that were responsible for the low performance of the family-planning programme included: inadequacy of motivational work by the field workers, poor counselling on the management of contraceptive-related side-effects, inadequate response to the needs of clients, irregular field visits, and poor supervision and monitoring. The efficiency of the programme needs to be improved to meet the demand for family-planning methods in Chakaria, Bangladesh.

***Key words***: Family planning; Family-planning programmes; Contraceptive usage; Contraceptive methods; Bangladesh

## INTRODUCTION

Bangladesh is often cited as one of the most successful examples in popularizing its family-planning programme (1). The contraceptive prevalence rate (CPR) of 45% among the eligible couples in 1993-1994 is considered a commendable success despite the existing poor level of socioeconomic development in the country (2). The family-planning programme has been equipped with 35,000 service outlets, most of which are organized at the district level and below. The activities are most intense at the union level, with 3,000 Family Welfare Centres (FWCs), 1,275 rural dispensaries, and 23 Mother and Child Welfare Centres (MCWCs). At the village level, basic maternal and child health and family-planning (MCH-FP) services are provided, free of charge, by the staff of FWCs at the satellite clinics at the rate of 30,000 clinic-days per month. Besides, 23,500 Family Welfare Assistants (FWAs) provide additional free doorstep services (3). The methods of contraception include pill, IUD, condom, and sterilization. Although injectables are available to women on a limited scale for a decade, their use has soared since 1990 (2). IUDs are inserted at the FWCs and satellite clinics, and sterilizations are performed at the Upazila Health Complexes (UHCs).

Despite such an intense programmatic input, the level of success in terms of contraceptive-use rate has not been uniform across the various administrative units. In the recent past, the Chittagong division, one of the six administrative divisions, has been consistently identified as the lowest-performing area with a CPR nearly half the national average (2,4). The low contraceptive prevalence has largely been attributed to the religious conservativeness of population, restricted mobility of women, and insufficient contacts by field workers with clients (2,5). Chittagong is 264 km away from the capital

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city, with less intense development and research activities. As a result, the family-planning situation in the area is inadequately understood.

This paper mainly reports the findings of an observational study conducted during 1994-1995 in Chakaria, a remote rural upazila (subdistrict) situated in the southeast of Chittagong division. The investigation sought an explanation for the low acceptance of family-planning methods in the area by investigating various programmatic issues, which would be of potential importance for the present-day programme.

## MATERIALS AND METHODS

### Study area

Data for this study were obtained from five study unions of the Chakaria Community Health Project (CCHP) of ICDDR,B: Centre for Health and Population Research. Since 1994, the CCHP has been engaged in a community development-oriented programme for improving the health of the local people. The programme inputs include health education to avoid diarrhoeal diseases, promote hygiene, raise awareness about safe water and sanitation, promote immunization, and provide information about the existing government health services in the area. Details of the project strategies and interim outcomes were reported elsewhere (6).

Chakaria, located in the southeast coast of the Bay of Bengal, is an upazila under Cox's Bazar district with 400,000 population. The highway from Chittagong to Cox's Bazar passes through Chakaria. Its east side is hilly, while the west side is low toward the Bay of Bengal. Like other parts of Bangladesh, the major means of livelihood in the study area is agriculture. Nearly 40% of the household heads are engaged in agricultural activities as day-labourers, 25% in farming for themselves, 20% in small trades, 10% in low-paid jobs, and 5% in self-employment (7).

The study area is also backward in terms of modern education. Nearly half of the males and two-thirds of the females, aged over six years, have never been to school. Only 7% of the males and 2% of the females have more than 10 years of schooling. Ninety-one percent of the population are Muslims, and the remaining ones are Hindus and Buddhists. It is one of the most conservative areas in terms of religious bindings and disregard to modern ideas. Movement of women is very restricted, and purdah (veil) is strictly observed. It was in this area that the nationwide anti-NGO (non-government organization) campaign started in 1994. More details about the study area can be found elsewhere (7).

### Family-planning activities

The government records show that there were 14,860 eligible couples in 1994 in the five study unions. There is one government FWC each in two of the five unions. In the other three unions, the government workers provide MCH-FP services from the leased clinics. The extension services in all the unions are provided through the monthly satellite clinics at the community level. Twenty-eight workers manage the government family-planning service-delivery system in the five unions. All the unions, except one which has only four workers, have six workers each. The union-level government service team comprises one male Supervisor, one female Family Welfare Visitor (FWV), and at least two female Family Welfare Assistants (FWAs). The staffing pattern was at par with the one expected under the then government system.

The primary responsibility of motivation and distribution of non-clinical methods at the doorstep of clients lies with the FWAs. The FWVs, on the other hand, are responsible primarily for the clinical and non-clinical methods at the static facilities and satellite clinics. The primary task of the male supervisor is the overall supervision at the union level. The government services include home-delivery of pills, injectables, and condoms and IUD insertions at the FWCs, leased, and satellite clinics. Sterilization services to males and females were provided at the UHC. In addition to the government programme, the NGOs, which had an additional 13 field workers involved in service-delivery, had also some provision of family-planning service. The major difference between the FWCs and the leased clinics is in terms of physical facilities and working days. The FWCs have attached staff accommodations, whereas there is no accommodation for the staff of the leased clinics. The services were available in all working days at the FWCs and only twice a week at the leased clinics.

### Respondents and methods of data collection

Data for this study were collected from various sources of the five study unions, using interviews and observational techniques following the semi-structured guidelines. The major sources of data were family-planning workers and clients and observations of family-planning services at the government satellite clinics. Mothers of children, aged less than five years, were interviewed to collect information on contraceptive use and reason(s) for non-use, using a pre-tested

questionnaire in Bangla (their native language). This was done as part of the baseline survey, covering 12% of the randomly-selected households (7).

The CCHP staff collected information from the government family-planning workers, clients, and service facilities, including satellite clinics, through continuous informal interactions and observations for nearly 18 months in three of the five unions (lowest administrative unit with 10,000-15,000 population living in 15-20 villages). Informal interviews of the service providers were conducted, and the activities at the government facilities were observed by three male and three female community organizers, two male researchers, and one male and one female community health educators who, as part of their job, had day-to-day interactions with the village women and MCH-FP programme personnel. In total, 48 satellite clinic sessions, conducted by the government service providers, were observed.

The CCHP staff made informal interactions and observations by attending the satellite clinics of the government and the meetings of women organized by the CCHP to communicate health messages. The informal observations focused on interactions of the family-planning workers and the clients in terms of motivational activities, services offered, information shared, responses to complaints made by family-planning method users about side-effects, and regularity in holding the satellite clinics. Besides, informal discussions were held between the project staff and the service providers in the villages whenever they met. All the above observations were recorded in field notes maintained by the project staff. At the female group level, while discussing health, the issues of family planning were raised either by the women or by the project staff. The project staff recorded the feedbacks received from the women in their field diary.

The study was also aided by personal communication between the project staff and the village women, when the former visited the women at their households to discuss health problems and possible preventive measures. The observations were subsequently recorded in the form of notes.

## RESULTS

### Family-planning practice

Of the 2,161 women interviewed, 218 were pregnant at the time of interview, 38 were widowed, 13 had their husbands away, and three had missing information, leaving 1,889 for analysis. Three hundred ninety-eight persons (21.07% of the total 1,889 eligible respondents) were practising family-planning methods at the time of interview. These included seven users of traditional methods, such as safe period and withdrawal. Oral pill was most commonly used (50%), followed by injectables (20%), female sterilization (13%), IUD (11%), and condom (4%). There was only one case of male sterilization.

### Reasons for non-use of family-planning methods

The respondents cited a variety of reasons for not using family-planning methods. More than one-third (34.4%) of the non-users reported that they were not practising any family-planning methods, because they wanted children. Non-approval of the use of family-planning methods by religion was cited to be the second important reason (17.7%). Fourteen percent stated that they did not use any method, because their living children were too young; 12% mentioned side-effects; 6% did not consider it necessary to limit their family size, and a same proportion did not have the approval of their husbands; and less than 2% mentioned lack of visits by the family-planning workers or unfamiliarity with them.

### Government programme personnel and their perspectives

Most government programme personnel were from the locality, and most of them were quite senior in terms of both age and experience. The mean age and the length of work experience were 36 and 15 years respectively.

The government programme personnel maintained a list of the eligible couples of the area and of family-planning methods distributed to or accepted by them. Based on their records, they calculated the contraceptive acceptance rate (CAR) used for monitoring the performance of the programme. In the study unions, the CAR varied from 30% to 50% around the time of survey, whereas in 1996, it ranged from 50% to 70%. Most programme personnel were satisfied with the level of CAR.

With regard to the question on barriers to improving CAR further, the programme personnel mentioned various factors. The most important factors were: illiteracy, non-conformity of family-planning methods with religion among the Muslims, side-effects of contraceptives, lack of motivation, demand for a large family size, son preference, an irregular supply of family-planning methods, lack of supervision from the senior staff, and non-cooperation of the social and religious leaders. Besides, the programme personnel also put blame on each other for the lack of dedication. Misunderstanding between the health and family-planning workers was also mentioned as a hindrance.

When asked about their opinion on strategies to improve the situation, the programme personnel suggested various measures. Of these, steps to motivate the couples and social and religious leaders, swift management of side-effects, training of the field staff to provide curative services to mothers and children, strict supervision of the field staff, incentives to users, improved coordination between the FWAs and the static facilities and their staff, and dedication of the programme staff were stressed. In some instances, the supervisory staff complained about their helplessness in taking any actions against the local field workers. They reported that, despite their knowledge about serious negligence of duties on the part of some field workers, no administrative actions could be initiated against them, because they hailed from very powerful local families.

**Insights from field observations**

The inhabitants of the area are unwilling to accept modern ideas, and the religious orthodoxy dominates the traditional leadership. NGOs are viewed as the agents of the Christian world to convert the people into Christianity and are compared with the East India Company which came to this part of the world during the pre-British period. These views were reinforced during the study period in the Friday prayer in almost every mosque in the area. Thus, it was no surprise to hear a group of village leaders proudly reporting that they had pushed away the Grameen Bank workers from their village and warned them not to visit the village ever again. "Anybody enrolling in the Grameen Bank activities will be ousted from the society," the village leaders warned. (Grameen Bank is a special-purpose Bangladeshi bank which forms groups with women from very poor households and provides collateral-free credits.)

In some villages, the house owners banned the insertion of IUDs at the satellite clinics. A senior family-planning worker reported that it was difficult to get individuals from the locality to work for the family-planning programme. The programme was, however, lucky to have some people to join it and take salary for this, let alone working for the programme. The CCHP staff observed that, despite the religious conservativeness in the study area, there existed an unmet demand for contraceptives, especially among the women. Whenever the CCHP staff visited the women's group to provide health education, almost everyday some women inquired about family-planning methods from them. It was observed that the women wanted to use family-planning methods even without the knowledge of their husbands and in-laws, especially the males and mothers-in-law.

In relation to the intensity of the service that was being provided by the family-planning workers, it was almost always observed that they hardly made any efforts to motivate an individual to adopt family planning. Some field workers made house-to-house visits, but they paid inadequate attention to the clients and their needs. The complaints raised by the users of family-planning methods about side-effects were not appropriately handled. When a client requested a switchover from injectables to pills, the field worker screamed at the client and said, "You cannot even handle this, how can you have pills? I will not give you any other thing, you have to stick either to this or forget getting anything from me."

Lack of effective supervision was a contributory factor in the poor performance of the programme. Periodic absence of the family-planning staff from the workplace was common. In one instance, the work of a field worker has been performed regularly by her young daughter, and in another instance by a traditional birth attendant in exchange for a nominal fee. In some cases, the family-planning workers had even been residing in towns far away from the workplace, and it was an open secret. Strict personnel management could not be practised by the authority, because most workers came from the influential local families. During the study period, a supervisor was even physically assaulted for suggesting punitive measures against a local field worker.

The satellite clinics, to be held once a month in eight places in a union, did not take place regularly. Of the 48 scheduled sessions observed in the study unions, only 27 were held, with some irregularities in session timing. In 13 of the remaining 21 sessions, neither the clients nor the service providers attended. In eight sessions, only one party came, i.e. either the clients or the service providers. In places where the clinics were held, the village women sometimes were not well-informed of the date and time of the clinics.

It was observed that the family-planning workers promoted injectables more than any other methods. Some users appeared with complaints of side-effects after using injectables, but the worker present paid no attention to these complaints. The women who came for treatment of their illnesses at the satellite clinics were quite often ignored, especially if they were non-users of family-planning methods or were from the poor households.

## DISCUSSION

This study analyzed the situation of a family-planning programme in a low-performing rural area of Bangladesh and the observations made by the independent workers of the CCHP who participated in the programme as health

promoters without any vested interest in it. The exercise involved 18 months of close interactions with the villagers and the government programme personnel to identify the factors responsible for the low contraceptive prevalence. Hence, this qualitative study was unique in bringing out the programmatic issues that can rarely be identified and understood through any quantitative surveys. However, the study was based on one area only implying that one should be cautious to generalize the findings for other low-performing rural areas of Bangladesh.

It is true that the unions studied were difficult to access because of their location and the traditional attitude of the local people. The area being situated with the coast of the Bay of Bengal on one side and the hilly areas on the other side has made it extremely difficult for movement within the area. Moreover, during the monsoon, the study area experiences heavy rainfall, and the plain part normally remains submerged for a couple of months. Therefore, the use of contraceptives among the respondents could be much less during the rainy season than what was found during the present survey carried out during the dry season.

The area has been highly vulnerable to cyclones and tidal bores which have caused loss to human lives, shelters, and other property in the past. It is quite natural that, under these circumstances, the people consider themselves to be totally dependent on the mercy of nature. The natural calamities are viewed as punitive measures taken by God against the community for their deviation from the moral code of conduct. The moral codes are dominated mostly by the orthodox view of the dominant religion in the area. Involvement of women in work outside home, interference with childbirth, NGO activities involving women, and institutionalized interest on loans have been viewed as deviations from behaviour acceptable by God. "If you try to avert births, God will be displeased and will take away many more" is a common utterance by the elderly people of the villages. The family-planning programme has also been considered to be responsible for promoting pre-marital and extra-marital sexual relations in the society. Thus, the social environment has been quite difficult for the family-planning adopters, and the odds against which the family-planning workers have been working are well-understandable. Accepting the job of a family-planning worker has itself been a challenging task for the local individuals, let alone working actively. Thus, it was strategically important to recruit field workers from the influential families of the locality.

Under the above circumstances, one can argue that the family-planning use-rate of 20% among the mothers of children aged less than five years has been quite a success. Now, the question is whether one should be happy with this level of programme performance or should try hard to improve the situation. If so, how can this be done?

If one carefully examines the reasons for the non-use of family-planning methods as mentioned by the respondents, it can be seen that most barriers could be removed through motivation in favour of birth spacing and improved service-delivery. Given the quality of the programme efforts revealed from the field observations, the low contraceptive prevalence in the area is no surprise. A similar situation was also prevalent in other parts of the country in the past, when the programme was weaker than now (1).

Monitoring and supportive supervision of the programme staff can play an important role in enhancing the performance of the programme (8). It should be emphasized that the engagement of local personnel in the programme has both positive and negative sides. Unless they are managed well, they can be counter-productive as has been happening in some cases in Chakaria. Another issue to notice in this context was that, despite poor service and irregular visits by the family-planning workers, surprisingly, the respondents did not mention this as a reason for not adopting family-planning methods. In fact, two factors were in operation: the respondents did not know what to expect from the workers and also that the workers came from local influential families, and the respondents did not like to say anything which may sound like a complaint against them. To improve the situation, the programme managers should look into the matter and find ways to tackle this. One of the ways can be to make the community members aware of the responsibility of the programme personnel and to involve them in finding an appropriate solution and to monitor the progress due to the corrective measures.

Also important in this context are the limitations of CAR as a monitoring tool. While discussing the programme performance with the field workers, they always tended to refer to the high CAR or distribution of contraceptive supplies, without concern for whether these supplies were actually used. It seems that the issue of the gap between CAR and CPR or the wastage of contraceptives did not concern the workers much. The programme managers should explain the limitations of CAR in monitoring the performance of the programme and calculating the need for contraceptive supply to the

field staff. Due emphasis on alternative indicators of the programme outcome, including aspects of quality of service, should also be incorporated.

The inefficiency of the MCH-FP programme at the field level was also documented earlier for other parts of rural Bangladesh (9). Nevertheless, the results of the analysis of correlates of using family-planning methods in other studies showed that reasonable progress has been made in some segments of the population (10). This implies that the social, cultural and religious barriers are not as strong as one would think for some individuals. In fact, it has been seen in Matlab, a rural area in Bangladesh that, with a quality service-delivery system, the illiterates and women from the economically-disadvantaged families are as likely as literate and economically better-off couples to use family-planning methods (11). The religious and other barriers mentioned by the family-planning workers also existed elsewhere in this country in the past but have been substantially relaxed in recent times.

The society in Bangladesh has been passing through a change, and Chakaria is no exception to this. Several NGOs have been working with the female groups in the area despite the prevalent negative attitude toward them. This can be an inspiration for the family-planning workers to be enthusiastic and work more effectively. Although some segments of the population have reservations against family planning, the demand for contraceptives among women has risen in the study area. Now, with appropriate corrective measures, the government family-planning programme should be able to contribute enormously to help the couples meet their reproductive goals in a short period of time.

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