AN APOLOGY

Please note that Bangladesh is misspelled on the cover page of this working paper. We apologize for this unfortunate mistake.

Urban Health Extension Project

Urban FP/MCH Working Paper No. 9

Issues for Family Planning in Urban Slums of Dhaka, Bangladesh: Opinions and Perceptions of Field-Level Workers

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Foreword

I am pleased to release these reports on urban health and family planning issues which are based on the activities of the Urban Health Extension Project (UHEP). UHEP is a follow-on activity of the former Urban Volunteer Program, a pilot project funded by the United States Agency for International Development (USAID).

The poor health status and the health needs of the urban poor continues to be an important emerging public health issue in the Developing World. Bangladesh is no exception. Despite the constraints of poverty and illiteracy, there are proven strategies to provide basic health and family planning services to the urban poor. In Dhaka alone, aside from the Government health care facilities, there are numerous NGOs and private sector providers giving needed services to the urban population. The Centre's own Urban Health Extension Project continues to focus on the urban poor, especially the slum populations, in providing basic family planning and health services through outreach activities (viz. health education, ORS distribution and referral services to service points).

However, enormous challenges remain in providing an optimum level of services to the urban poor. The UHEP, with the support of the USAID, will focus on health and family planning services delivery strategies in reaching the needed services to the urban poor. We certainly look forward to learning more about the health and family planning needs of the urban poor, testing sustainable strategies and applying these proven strategies in collaboration with other partners in government, NGOs and the private sector.

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Introduction

Family planning has been identified as an area of top priority by both the Government of Bangladesh and donor agencies. Despite the remarkable success of the family planning program in Bangladesh over the past 10 years or so, many issues remained unresolved, and it is readily apparent that the urban areas have been neglected, both in terms of research and government service provision. In response to this, a continuing focus of the activity of the Urban Health Extension Project (UHEP) over the coming years will be research into family planning and contraceptive use dynamics among the urban slum population of Dhaka.

UHEP, previously the Urban Volunteer Program, has been working in the slums of Dhaka since early 1980s. The project currently maintains a demographic and health surveillance system, and supervises the work of 383 volunteers -- slum mothers who are involved in health and family planning education -- and basic service provision to their local communities. The project has a number of different kinds of field-level workers, who have close contact with the slum communities, including interviewers, field research officers, trainers, and community health coordinators. Since its inception, the project has aimed to assess the impact of volunteers on the health status of their communities, as well as address a number of other public health issues facing the urban slums. Until recently, family planning was a relatively small component of the volunteers' work and the broader research agenda. Project staff, including volunteers, have received basic training in the area of family planning and are expected to make referrals for family planning services. Family

planning has a high profile within the slums of Dhaka with many non-government organizations providing services, and it is necessarily an issue that project staff deal with regularly in their field work. Since mid-1992 the project has been collecting information on contraceptive use patterns as a regular part of its Urban Surveillance System (USS), with a view to understanding more about the contraceptive and reproductive behaviour in the slums of Dhaka.

A workshop was held in November 1992 to discuss family planning in the urban slums of Dhaka. This workshop was designed to draw on the experiences of the field-level workers in the area of family planning to identify important program and research issues that need to be addressed. The underlying assumption was that the field-level workers, by virtue of their close contact with the people, have important knowledge and insights regarding the communities the project seeks to serve. The workshop was intended to increase dialogue between staff and, thus, access this body of information. In particular, the workshop aimed to explore the uniqueness of the urban slum setting, since the vast majority of existing recommendations for family planning activities in Bangladesh result from the rural experience.

This paper documents the results of the workshop and is intended to stimulate discussion within and outside the project. The report first presents the views and ideas of the participants, as they were expressed in

the workshop.[1] Some of the comments made are in agreement with the earlier studies, others represent new information, or contradict previous findings.

The following section discusses the workshop findings, their limitations, and the usefulness of this kind of data. This is intended to put the workshop results into the context of ongoing program and research activity in Bangladesh, and to highlight areas that deserve future attention.

Organization of Workshop

Following an introduction, a group discussion took place on current issues in family planning in the urban slums of Dhaka. This was intended to familiarize the participants with the topics of interest and to encourage every one to contribute to the discussion.

The participants then split up into three small groups to focus on three topics that had been previously identified by the facilitators. Group discussions were led by the facilitators following a prepared semi-structured guideline. The topics covered:

[1] Facilitators were instructed to play as small a part as possible in the discussions so that the results reflect the ideas and opinions of the field-level workers. As far as possible the participants' comments have been recorded as they were made during the workshop, though translation from Bengali into English necessarily involves some interpretation on the part of the facilitators.

(1) Barriers to adoption of contraception among never-users.

(2) Barriers to effective family planning among adopters of contraception.

(3) Problems and issues in family planning service provision.

The results of the small-group work were then presented to the whole group in a plenary session for feedback and discussion.

Results

The results are presented here for each group in turn. Comments that were made by the participants during the plenary session have also been incorporated where appropriate.

Group 1: Barriers to Adoption of Contraception Among Never-users

(1) Concept of Family Planning

The group work was started with a discussion about the concept of family planning. The participants gave their own definition of family planning and then discussed slum women's understanding of the term. Little variation was found among the participants' responses:

> *'After marriage, both the partners will decide how many children they will have in the future'*
>
> *'Decision is taken by the couple depending on the economic status'*
>
> *'Gaps in between two children and in between marriage and first child'*

The participants were asked about what they understood to be the difference between contraception and family planning. Some of the responses were:

'Family planning is total'

'Contraception is the exact way or method which would be adopted'

'To achieve the plan is contraception'

The participants felt that the views of women living in the slums were somewhat different. On the whole, they felt that the slum women had a narrower definition of family planning:

'Adopting contraception after they have more than two children'

'Brother sister all living together'

'Stopping of more children'

'Taking the pill'

(2) Never-users of Contraceptives

The second part of the discussion focussed on women who have never used any type of contraceptives. We were interested to know from the participants whether never-users could be identified by certain characteristics. The participants felt that never-users were:

'newly married couples'

'conservative religious people (mainly Mullah)'

'women suffering from repeated abortion'

'women of higher socioeconomic status having 2 or 3 children'

'women who have several daughters but no son'

(3) Barriers to Adoption of Contraceptives among Never-users:

The main part of the group discussion focussed on barriers to adoption of contraception among never-users. The following important areas were identified.

Barriers related to men:

The participants felt that husbands and other men sometimes represent a barrier to contraceptive use.

> *'In our society, especially in the slums, decision-making power lies with the husband. Husbands are not well-motivated to use contraceptives themselves or to allow their partners to use. They always say that they are the ones who will earn money to run the family and so their wives should not worry about the number of children'*

> *'Some women believe that after marriage a child will give them social security'*

> *'A husband may divorce or marry again if a woman has no children'*

Some participants also talked about the demand for children. They felt that among the slum population children are considered as property and that they will be a source of income and will support the parents during their old age. The prevailing high infant mortality rate was also identified by some members of the group as a barrier to contraceptive adoption.

Objection by other family members:

It was also noted that sometimes family members other than the husband object to adoption of contraception, especially those who have control over the family, such as the mother-in-law or elder sister-in-law.

Lack of proper knowledge about family planning:

Most of the women living in the slums have received no education and the participants identified insufficient knowledge about family planning and contraceptives as a barrier to the adoption of contraception. Fear of side-effects was also felt to be a factor that prevents contraceptive use.

> *'Some women believe that they may suffer from amenorrhoea or become infertile if they use contraceptives'*

The participants stated that family planning workers working in the field do not give sufficient advice about family planning, and that sometimes, the women are not confident enough to take the contraceptives from the family planning workers.

> *'In some cases, women are interested to use contraceptives, but find it difficult to decide which method to use'*

Some participants had noticed that warnings given in the contraceptive booklets are sometimes misinterpreted, for example the warning against pill use by a hypertensive patient, and that these misconceptions discourage use.

Religious objection:

Religious objections were mentioned as barriers to adoption among some people.

> *'Some people believe that adopting contraception is a sin'*
>
> *'People say that children are the gift of God'*
>
> *'Some people believe that other surviving children may die if they use contraceptives'*

The participants felt that these kinds of beliefs are mostly found among Muslims.

Lack of effective plan and policy in family planning:

Another important theme that was discussed by the group was the lack of attention given to men in the family planning program activities.

'Although eligible couples are the target group for adoption of contraception, most of the available methods are for women'

'Plans and policies are directed towards women'

It was pointed out that since family planning workers are female they have difficulty in motivating men.

Supply problem:

The participants talked about supply factors that affect adoption. They mentioned that there were some areas where there was no family planning worker. It was felt that in this situation, some women who are interested to adopt contraceptives are not able to do so due to the non-availability of the methods at the household level.

Others:

Several other factors were mentioned as influencing adoption of contraception. Some participants said that discussion about family planning methods is not considered to be good in the slum. This means that some women who feel the need for contraception remain unsure about the type of method suitable for them, because they feel uncomfortable discussing this with their neighbours or relatives. The participants felt that a lack of privacy to talk pri-

vately with family planning workers is also a barrier to the adoption of contraception.

(4) Ways of Overcoming Barriers:

The group next explored possible ways of overcoming the barriers identified above. The following steps were suggested by the participants:

- **Emphasizing the role of males in adopting contraceptives. In addition to female workers, male workers should be used to motivate men who are the key people in family decisions.**

- **Increasing general awareness that family planning is the responsibility of both the male and female partner.**

- **Ensuring proper counselling about family planning along with supply.**

- **Motivating elderly family members about family planning.**

- **Motivating religious leaders.**

- **Improving the quality of family planning worker and their services.**

It was suggested that a variety of people should be involved in these activities, including:

- **Family planning workers**
- **Local leaders**
- **Religious leaders**
- **Teachers**
- **Volunteers (good quality)**
- **Mass media**

Group 2: Barriers to Effective Family Planning Among Contraception Adopters

(1) Concept of Family Planning

In Group 2, work was initiated by a discussion on the concept of family planning. It was interesting to find a variety of definitions being offered, with some people thinking of family planning as a much broader concept than others. The participants gave the following as definitions or elements of family planning:

'Limiting the number of children according to the income'

'Improving and keeping the mother's health good'

'Thinking about the future of the whole family'

'An organised family where the number of children is limited within the means of earning through methods to keep the family small'

'Both husband and wife deciding the number and timing of children'

'Birth spacing between two children'

'Keeping the family small'

'Stopping having children by using methods -- both husband and wife'

'Having children in an organised way'

'Balancing the economic status of the family by keeping a small family in a nice way'

'Birth control, by keeping the family small through methods for both husband and wife'

'Thinking beforehand'

(2) Users of Contraception

The second stage of the group work involved a discussion about the users of contraception. We were interested to hear the participants' ideas about what kind of people adopt contraception and their reasons for doing so. The discussion produced the following ideas and opinions.

Age and life-stage: The participants identified women in the middle of the reproductive years as the most common users of contraception.

'Women using contraception are generally between 20 and 35 years old'

'Younger women, in their teens, do not use contraception'

'Few women use contraception when first married, or when they do not have any children'

'Older women often think that they can no longer produce children and so do not use contraception'

It was also pointed out, however, that some young, newly married couples do use contraception, particularly when the wife wants to work outside the home in a garment factory. Those women who stay at home after marriage were believed to want to have a child soon after marriage. Some participants reported cases where the newly married woman wanted to use contraception but her husband would not allow it.

It was felt that women generally start to use once they have three or four children. It was also pointed out that women who are aged over 35 years and have a large number of children usually opt for sterilization. The participants stated that in some cases women believe that if they use contraception before having a child they will lose their ability to procreate.

Religion: The participants felt that Hindu women use contraception more than Muslims and that this is in part because Muslims are more likely to believe that there are religious barriers in using contraceptives.

'In the same area you can find large numbers of Hindus using contraception side-by-side with Muslims who do not'

In some Hindu areas, a very high prevalence of sterilization was noted.

Education: The participants noted that mothers who have attended school are more likely to use contraception.

Male users: The group was questioned about the use of contraception by the males. It was felt that men who use contraceptives are usually doing so because their wife has first tried to use a method but has faced problems.

> *'The wife is the first one to try, and only if she fails does the husband adopt a male method'*

It was mentioned by some participants that working women may have more dominance in the family and that, in these cases, the husband may be more willing to use a method. In this situation, it was felt that the avoidance of pregnancy is more important, since the wife is also a wage earner.

> *'In some cases, where the woman is working outside, the husband is more willing to use contraceptives'*

On the whole, however, the participants noted that condom use is very rare, and that very few young men use them.

'Most condom users are over 40 years of age'

'In a few cases, newly married couples are using condoms, but this tends to be where the man has some education'

It was interesting, however, to hear participants note that husbands usually go to the pharmacy to get contraceptive supplies, indicating their involvement in family planning.

Reasons for use: The participants were asked about what they felt were the reasons that people living in the slums adopt contraception.

Most participants felt that use for limiting births was more common than for spacing between two births.

'People use contraception when they already have 7 or 8 children and do not want any more'

'Few users are spacing their births'

'Spacing is mainly found among the younger generation'

The participants felt that the people living in the slums do not see contraception as something you do to preserve health, rather they

see numerous health hazards associated with the adoption of contraception. In general, it was felt that this group of people does not recognize the risk of childbirth and regards modern contraception as more dangerous.

> *'Many believe that good food is needed if a woman uses contraception to build her up and protect her from side-effects'*

(3) Barriers to Effective Family Planning among Contraception Adopters

Having discussed the characteristics of the people who adopt contraception and the reasons for the adoption of contraception, the conversation turned to the reasons why many people who adopt contraception still do not manage to effectively plan their families. Numerous barriers and problems were identified.

Incorrect use: Incorrect use of contraceptives can lead to accidental pregnancy or discontinuation. The participants pointed out that incorrect use may result for a number of reasons.

In the case of pills many participants felt that women either forget to take it regularly or they lack correct knowledge about how to use the method.

'Some women only take a pill when their husband is staying with them'

It was noted that this type of incorrect use may result from inaccurate knowledge, or dependence on the husband for supply of the method.

It was mentioned that in some cases incorrect use results from not getting supplies from workers on time.

'In some cases women borrow one or two pills from their neighbours until they obtain new supplies'

'Women may not be able to take their injections on time'

The participants felt that incorrect use of condom is common. It was pointed out that field workers teach women how to use condoms, but that men have to learn from their friends. Male family planning workers are not available to teach men the correct use of condoms.

Some participants mentioned the fact that a large number of women use periodic abstinence, but that many do not use it correctly. It was suggested that women tend to learn about this method from older relatives and that the information they receive often seems to

be inaccurate. Some felt that Hindu women know how to use this method better than Muslims.

Herbal or other traditional methods of contraception were also mentioned as being in common use. These may not effectively prevent pregnancy.

The participants mentioned several common misconceptions that may lead to incorrect or discontinued use.

> *'People think that when they have been using the pill or the injectable for a length of time that they have built up protection against pregnancy and do not need to continue with contraception anymore'*

> *'Many people say that good food, particularly eggs and milk, are needed if a women takes the pill or injection'*

> *'Some people think that they need to take extra vitamins, or bottled tonics if they are to take modern contraception'*

It was also mentioned that indecision and uncertainty about which method is suitable may lead to inconsistent use and unwanted pregnancy.

Supply factors: The participants came up with many supply factors they felt affected use patterns.

They noted that areas that are well-served by family planning workers and places where family planning workers live have higher use rates. Their presence and the ready availability of services mean that more women use contraceptives. In other areas, it was noted that supplies are not received regularly by clients, and that time and financial costs may lead people to discontinue use. The distance to services may act as a barrier and it was noted that, in some cases, women are not aware of places that provide services.

It was felt that payment for services may affect use. In some cases, participants had found that if the health worker asks for money for contraceptives, people prefer to get their supplies from the pharmacy. It was mentioned that people do not trust the workers and think that they are taking the money themselves. This has been noticed where supplies were initially free and later a fee was introduced.

> *'Many people stopped using the methods, others decided to get their supplies from the pharmacy'*

Some participants felt that the attitudes of health workers are sometimes off-putting and may lead people to stop use.

Side-effects: Side-effects were identified as an important reason why women stop using contraception. Menstrual disturbances and fear of abnormal bleeding were reported to be a common complaints.

> *'When women have amenorrhoea they fear that blood is building up inside them and they often also experience waist and stomach pain'*

An interesting finding was that some women use pills continuously, without the seven-day break, to produce amenorrhoea. This may be done during Ramazan when women want to be able to fast for the whole month. One participant suggested that in this case amenorrhoea is not feared, because it is under the woman's own control, whereas amenorrhoea induced by injectable contraceptives is frightening, since this is outside the control of the woman.

Vomiting, dizziness, and headache were also mentioned as common problems with some methods.

> *'Women complain of weakness and want to take vitamins'*

The participants felt that both men and their wives fear vasectomy and that it is often thought that vasectomy makes the man weak. A few participants said that they felt Norplant has fewer side-effects.

It was pointed out that when side-effects are experienced people generally do not do anything.

> *'When women face problems, family planning field workers have nothing to offer them'*

> *'People do not have the money to seek treatment and contraceptive suppliers do not provide follow-up care'*

It was also stressed that, since alternative methods are not available to people who face problems, discontinuation often results rather than switching to another method.

The participants also pointed out that husbands may particularly object to the use of contraceptives when they experience side-effects that affect the woman's work and the couple's sex life. Abnormal and excessive bleeding can disturb sexual relations between husband and wife. It was noted that, in many cases, husbands are unwilling to pay for the treatment of side-effects, and this may lead a woman to stop use of contraceptives.

Influence of others: An interesting discussion that emerged from the group was that contraceptive use is found to cluster. The participants felt that, in certain areas, people behave in similar ways. It was noted that influential people, such as landlords and

their wives, can have an effect on the contraceptive behaviour in the area.

> *'If the landlady uses contraception she may encourage all women living in her area to do so. On the other hand, she may discourage workers from visiting the houses and put pressure on people not to use contraception if she herself disapproves'*

It was felt that influential family members, particularly older men and women, may also exert pressure on a woman to stop using contraception. Husbands were also mentioned as having an important influence. They often act as a barrier to use, and may encourage a woman to stop use especially when she starts to face problems.

> *'Some men object to contraceptive use, because they think it allows women to commit adultery'*

It was, however, mentioned that, in some cases, women are using contraception without the knowledge of their husbands.

No risk of pregnancy: It was felt that, in some cases, women may stop using contraception, because they perceive no risk of pregnancy. It was mentioned that some women think they are infertile once they reach 35 years and above, and that other women

stop use of contraceptives, because they feel that their older husbands have become infertile.

It was also pointed out that women perceive no risk of pregnancy during the postpartum period and may conceive again before they have time to obtain supplies. Some participants were aware of long-term users of contraceptives who believe that they are permanently infertile and thus stop use of contraceptives.

(4) Priority Areas

The group work was brought to a close by asking participants to decide which areas they felt were priorities for future research. The following were identified.

- **Side-effects: what kinds of side-effects cause people to stop using contraception and why?**
- **Supply: field-worker supervision, clinic-level services.**
- **Communication networks: what influences people's attitudes and behaviours? Where do people get information from?**
- **Men: men as family planning workers and family planning clients.**

Group 3: Family Planning Services

(1) Concept of Family Planning Services

The group discussion began by exploring what the participants understood by "family planning services." Among all the participants of this group, the concept of family planning services was much broader than just the provision of contraceptive methods.

The participants felt that family planning services should include the provision of information about the different methods available, how to use the methods, and their use-related pros and cons.

> *'Education on family planning and contraception methods'*

The participants mentioned the provision of consultation and motivation to use family planning as elements of family planning services.

> *'Motivation to plan family size before it becomes a problem'*

Making contraceptive methods available and accessible, including referral to other providers when the desired method is not avail-

able, and follow-up services were also felt to be important components of family planning services.

Next, the participants discussed the slum residents' understanding of family planning services, including what is expected by the slum dwellers when they seek family planning services.

The participants thought that most slum residents equate family planning services with the provision of contraceptive supplies. They also, however, expect consultation and treatment when they experience use-related side-effects.

(2) **Family Planning Services: Availability and Accessibility**

The discussion then turned to the current availability and accessibility of family planning services in the slums of Dhaka.

Service providers: The participants noted that family planning services for the slum residents are mainly available through field workers and clinics, with most of the field workers working for NGOs and more limited government services.

Types of service provided: The participants stated that most field workers provide supply of oral pills, and some education on how to use the method. It was also noted that the field workers provide motivation to use family planning, but on a limited scale. The methods mentioned as being available through most clinics were

oral pills, injectable, IUD, condom. A limited number of the service points that have sterilization services available. It was noted that some treatment of side-effects is also available in these clinics.

In general, the participants felt that education on family planning is marginal.

Knowledge of service providers: The group thought that certain women were more likely to have knowledge of service providers. These were identified as:

- those who have some interaction with communities outside their slum of residence (e.g. domestic workers)
- women of high parity who are likely to be potential users
- those who have some association with health institutions
- current of contraceptive users.

Supply of methods: The participants felt that women obtain pills and condoms mainly from field workers. However, it was noted that if they are charged a price for the supplies, many women opt for other sources of supply, or discontinue use. The relatively economically "better-offs" and the self-motivated users were thought to use pharmacies for their supplies. Family planning clinics were thought to be most commonly used for supplies of clinical methods.

It was noted that women themselves obtain methods from the field workers and clinics, but that husbands often get the methods from pharmacies, provided they have no objection to contraception.

Consultation and education on family planning: The group identified the following sources of information:

- UHEP volunteers, where available
- Clinics
- Neighbours (a very important source)
- Field workers
- Source from which supplies are obtained.

Motivation to use contraceptives was thought to come from neighbours, relatives, UHEP volunteers, field workers, mass media, and *"self realization through suffering."*

The target population: The participants felt that both users and non-users are approached by field workers when the field workers' program requires them to achieve a desired number of users or new acceptors. However, it was felt that continued motivation or family planning education is lacking, particularly for non-users.

It was noted that hardly any organization targets men in the provision of family planning services. Some kind of services targeting men were thought to exist in the Bangladesh Association for

Voluntary Sterilization and the ICDDR,B's Community Health Program.

(3) Family Planning Services: The Unmet Need

Service need and availability--the gaps: The group was asked to identify areas where they thought the needs of the slum residents were not adequately addressed by the service providers.

A lack of proper initial counselling about methods was mentioned. It was felt that information on method-effectiveness, and possible problems related to use is rarely provided. The participants felt that most slum residents are unaware of these issues, because the service providers do not spend enough time on these topics.

A shortage of alternative brands, or methods for switching to in the face of problems, was another factor felt to be of importance.

> *'Women are only offered a very limited choice'*
>
> *'Many complaints arise, because users find the brand of pills provided unsuitable'*
>
> *'When the preferred method is not available, it often results in non-use, rather than consideration of alternative methods'*

It was noted that organizations try to promote the methods that they supply and that proper counselling is often lacking about other methods that the organization does not provide.

Side-effects were stressed as an important cause of discontinued use. The group noted that side-effects are often not treated in time, or are ignored by the service providers.

> *'News of side-effects spreads fast among the slum dwellers creating fear of use among other users and also among potential users'*

Some members of the group noted that, even among those who do not want any more children, sterilization is considered as a drastic step. There is a general fear about its consequences because of its irreversibility, and also a concern about the effects of the operation on health.

The group was asked to discuss how use of methods, like the injectable and IUD, can be promoted among the slum residents. It was felt that service providers should spend more time in explaining the benefits of the methods and should make the users aware of the potential side-effects. Members of the group thought that service providers need to be more aware of the concerns women have regarding these methods and should incorporate proper counselling and education as a necessary and important component of their services.

Unmet service needs of current users: The participants discussed certain needs, specific to current users, that were felt to be relatively ignored or inadequately addressed by service providers at present.

The group noted a lack of counselling on switching to methods that the service providers do not themselves provide. It was felt that there is an emphasis on promoting the few methods that they supply, rather than addressing the needs of their clients. The participants noted that most switching actually occurs under the influence of neighbours' recommendations rather than in consultation with field workers.

It was felt that family planning workers emphasize acceptance and/or continuation but not effective continuation. Since the field workers provide limited education on methods to acceptors, questions that arise regarding the use of the method in between the scheduled visits of the outreach workers are not addressed. The group members felt that this leads to ineffective use or discontinuation.

The group noted that field workers sometimes do not adhere to their scheduled visits, which leads to discontinuation among those who rely on field workers for their supply of contraceptives.

Another area highlighted by the participants was the inadequate response to use-related problems. Field workers do not always

address the issue, and in cases where the organization cannot provide proper treatment of a problem, adequate referral is not provided to the clients.

Unmet service needs of non-users: The participants also discussed certain issues that need to be addressed to reduce the risk of unwanted pregnancies among non-users.

It was felt that certain groups of women are not served by the current family planning programs.

> *'Newlyweds are not targeted for family planning motivation'*

It was noted that the contraceptive needs of women experiencing postpartum amenorrhoea are not addressed by the service providers. Some participants noted that women who seek counselling from family planning workers during the postpartum period are mostly advised to accept a method after the return of the menses. In addition to this group of women, it was felt that family planning workers assume infertility of some women and thus do not provide services.

It was also pointed out that there is a lack of preparatory counselling for those who intend to use contraceptives in the future.

(4) Improving Service Provision

Since the topic was very broad, the discussion on this issue was structured through some open-ended questions initiated by the facilitator on certain areas of primary interest.

The role of field workers : how can their services be more effective?

The group made the following suggestions:

- Improve training of field workers. It was felt that the field workers are not sufficiently trained to effectively meet the different needs of the population.

- To ensure high quality care, there should be greater supervision of field workers.

- Field workers should focus education on effective use of the methods and possible side-effects.

- Follow-up visits to ensure appropriate side-effect management and solutions to other use-related problems should be emphasized.

- Field workers should be able to provide a larger choice of brands of the methods that they are offering.

Referral to appropriate service providers according to the need of the clients should be an important component of the service.

Training of field workers in some other basic health issues pertinent to the slum population might aid in building rapport with the slum population.

Are field workers essential for the provision of family planning services in Dhaka urban slums?

All the members of the group felt that field workers play an important role in disseminating information about family planning, and that their presence has a motivational effect on people.

However, some participants had reservations regarding their role as method distributors. They thought that door-to-door delivery of methods is not an essential part of their service. They felt that the role of field workers could be more effective in the long run if it was limited to motivation, education and referral. It was suggested that once slum residents are motivated and have knowledge of supply sources, they will seek supplies outside their homes. The Expanded Program of Immunization (EPI) was cited as an example of slum dwellers moving outside their homes for a service. If mothers can bring their children to EPI centres for immunization, it was argued, they should also be able to seek family planning services outside their slum of residence. It was also felt that door-to-door delivery of contraceptive methods creates dependency on

field workers, and if the field workers fail to keep up their scheduled visits most clients are not aware of other sources of supply, or simply do not seek alternative sources. It was felt that contraceptive method distribution through paid field workers is not a sustainable program in the long run.

Other members of the group had the opinion that family planning service provision for the slum residents would be more effective, if it were offered through different levels of workers. For example, volunteers could primarily be used for motivation, dissemination of information, and referral purposes, and field workers could be mainly used for education, consultation, and supply of methods.

Slum dwellers as volunteers : can this mode of service-delivery be effective?

The participants felt that volunteers did and could play an important role in motivation and family planning education. It was emphasized that volunteers are considered as an 'insider' in the slum community, that they are more aware of the local problems, and that service-seekers may feel more comfortable sharing their problems and worries with someone they know. It was also noted that volunteers are more accessible and more readily available to the slum population.

The group felt that this mode of service-delivery may have a greater impact, if the volunteers could provide effective referrals to their

clients. It was also suggested that they could be used as depot-holders of non-clinical contraceptives, which would ensure easy access to supply.

Is social marketing of contraceptives a viable option for providing family planning services to the slums?

The participants felt that most slum residents who want to use contraception would be willing to pay for family planning services, provided that some quality of care is ensured. However, they felt that the cost of these services may need to be subsidized according to the economic conditions of the clients.

How can male involvement in family planning be improved?

Group members made the following suggestions:
- Have male field workers to target men;
- Use mass media to increase male involvement;
- Use local male leaders as motivators;
- Use Associations and *Samity* to motivate and educate their members.

The group suggested that some integration of other basic health services with family planning could help in the success of the family planning programs. What could these services be?

The suggestions made were:

- Services that target the health problems of women;
- Services that effectively respond to contraceptive use-related side-effects;
- Health services to deal with minor but common health problems of children.

Discussion

It should be remembered that the information presented here represents the opinions and perceptions of field-level staff working for the Urban Health Extension Project as they were expressed in a project workshop. These are not findings from a rigorous scientific study of the determinants of contraceptive use patterns in the urban slums of Dhaka. It is also important to note that, largely because of time constraints, the workshop had a pre-determined format and aimed to elicit certain types of information. This means that important information is lacking, such as the workers' own attitudes to family planning and its relative importance in their work. Nevertheless, the information is extremely interesting, and is an important reminder of the wealth of knowledge held by field staff that is so often overlooked by researchers and program managers alike.

Although, many of the opinions voiced by the field-level workers were in line with findings from the previous surveys and studies, some of the information was contradictory to other sources of information. This may reflect a divergence between the ideas held by the field workers and the current reality. This in itself is of interest, since perceptions and beliefs held by field workers, whether from service or research organizations, undoubtedly influence the way they work. Knowing more about the ideas and attitudes of field-level staff will be important in any attempts to understand the operations of an organization at the field level. In other cases, it seems likely that the ideas expressed by the participants reveal important gaps in our knowledge of family planning in the slums of

Dhaka. The workshop, thus, managed to highlight a number of areas which remain open to debate and further investigation.

The dominance of the oral pill both among users and in the minds of non-users was noted. It was pointed out that, for many slum dwellers, family planning is synonymous with the oral pill, and in particular "Maya bori", the first pill to be introduced by the Social Marketing Company back in 1976. A UHEP baseline report shows that 91% of the women spontaneously mentioned the oral pill when asked about the methods of contraception that they knew. The figures for the injectable and IUD were 54% and 48% respectively (Figure 1). In 1990, over half of current users were using the oral pills (Jamil K, et al., 1993, and Figure 2). Clearly, the oral pill is a suitable method for only a fraction of potential users, and many of the women who adopt this method face side-effects. Although there are evidences that the injectable is becoming more widely known and that many women express interests to use in using this method, it is clear that more needs to be done to provide information about, and access to other forms of contraception to couples living in the slums of Dhaka.

The lack of male involvement in family planning was emphasized by all groups in the workshop. In Bangladesh, almost all family planning program activity and research has been focussed on women. The participants in the workshop pointed out that men often present a barrier to contraceptive adoption, and that without male field workers it is not possible to educate and motivate men. Aside from clinics for vasectomy, no family planning services are being directed towards men in Dhaka by

either government or NGOs. This is an area that deserves immediate attention.

A lack of adequate knowledge was identified as a continuing barrier to the adoption and successful use of contraception. Despite the fact that levels of awareness of family planning methods now appear to be high, it is apparent that there are major gaps in the understanding of method use, side-effects and their management, contraindications and so on. Misconceptions and fears remain common, and evidence suggests that field workers often provide incomplete or inaccurate information to clients. Larson and Mitra (1991) have documented some of these misunderstandings in their study of pill use. The workshop produced many examples of common misunderstandings and gaps in knowledge among the slum residents. It was emphasized that field workers need better training, so that they can provide accurate and detailed information, and address the concerns of their clients.

The importance of side-effects as a barrier to adoption and to effective continued use of contraception was noted. Side-effects have been found to have an important influence on contraceptive use in many settings. It was noted here that the field workers generally provide neither good advice nor treatment to women facing side-effects. It was also noted that many women do not receive proper education meaning that they are unaware of potential side-effects before they adopt a method. Recent work has suggested that prior knowledge of possible side-effects may greatly reduce discontinuation rates among rural Bangladeshi women using the injectable (Stewart MK, et al., 1991). The finding noted in the work-

shop that some women intentionally induce amenorrhoea by continuous pill use suggests that in some cases it may not be the type of side-effect itself that leads to discontinuation, but rather a fear of the unanticipated and unknown. If women were better informed and felt more in control of their bodies, they might continue to use methods despite experiencing side-effects.

The workshop included the discussion of many elements of what is commonly referred to as "**quality of care**" (Bruce J, 1990). The picture painted of the family planning services being provided to slum residents is not unlike descriptions of the rural, government setting (Simmons R, et al., 1984). The participants felt that a very narrow range of services are being provided and that those services, in many respects, fail to meet the needs of individual couples residing in these areas. The services being provided in the slums largely come from NGOs, and it is perhaps surprising that they are perceived as being so inadequate. NGOs should be more flexible than government and thus more able to improve their services. The participants of the workshop produced some important recommendations for this.

The above discussion suggests that in many respects the issues for family planning in the urban slums reflect national patterns and trends. However, the workshop also provided a good deal of new information, some of which highlights the fact that the urban slum setting has specific characteristics that need to be taken into consideration in both program planning and research.

The participants noted the important influence of people other than the woman herself in decisions regarding fertility and contraceptive use. In particular, it was pointed out that in the slum setting certain non-kin individuals may have tremendous influence over the behaviour of those around them. In some areas, wives of landlords may prevent or encourage women to use contraceptives. In other areas, religious leaders may be dominant. It may be that in the slum setting kin become less important as sources of information and guidance, and that other individuals take on this role. Programs and research that focus only on "**eligible women**" ignore important determinants of reproductive behaviour. The importance of understanding **networks of influence and communication** was stressed.

Whether **door-to-door delivery of contraceptives** is necessary in the urban slums was a subject of some debate during the workshop. Some field experience suggests that field workers are very important. For example, the observation that areas served by workers have higher levels of use and that irregular visitation by workers leads some women to discontinue use since they are unable to get supplies. However, some participants felt that residents of slum areas would travel outside their homes for supplies and that workers should instead be responsible for education, motivation and follow-up services. Clearly, if people could be served effectively through clinics, worker visits could be cut down and it would be far cheaper. It might also have the effect of improving services, since clients would play a more active role in getting their supplies and might come to demand more from providers. In the UHEP baseline survey, around half of pill and condom users cited sources other than field

workers, suggesting that large numbers of users will move outside their homes for supplies (Jamil K, et al., 1993, and Figure 3). Recent work by UHEP, however, suggests that door-to-door workers do have an impact on contraceptive use levels. It also appears that clinics providing injectable contraceptives may alter the method mix in favour of injectables, without increasing overall contraceptive prevalence (Jamil and Salway, 1993). The appropriate constellation of services in the urban setting is likely to differ from the rural, where field workers are currently an integral part of the government's program. This is an area that needs more investigation.

The topic of **cost recovery** was also raised during the workshop. Aside from the important issue of whether very poor people should be expected to pay for health and family planning services, there are many unanswered questions regarding the viability of different cost-recovery schemes. The participants generally felt that couples living in the slums would be prepared to pay for services, but only if this ensured high quality care. It was also pointed out that if services are at first offered free it is difficult later to get people to pay for them. Studies that address this issue with particular reference to poor slum residents are needed.

Another important issue raised during the workshop was the **provision of multiple methods** and multiple brands of the same method, such as oral pills. The participants felt that more varied methods would be beneficial, since women would be able to choose one that suits them best, and switch between methods when facing problems. However, experience with the government program in rural areas has shown that this may lead to complex logistical problems (Rahman F, et al., 1992a). The

suggestion that field workers should be better able to refer women to places offering other methods may be a viable option. This is another issue that needs to be addressed with reference to the urban slum setting where, as mentioned above, effective patterns of service-delivery are likely to differ from the rural context.

Although the division into "**demand-side**" and "**supply-side**" factors is to some extent artificial, it can be a useful way of thinking about the determinants of contraceptive use. During the workshop a number of comments were made that raised the issue of the role of demand-side factors. The participants mentioned that women would not adopt contraception until they have a son, that many women see children as a source of security, and that children are regarded as property with the potential of earning money in the future. Despite these comments, the workshop was dominated by supply-side factors. Quality of service provision, avoidance and treatment of side-effects, education and motivation by field workers, and the like were important topics of discussion. This reflects the trend in recent years towards family planning research focussed on service and supply factors. Researchers and program managers have spent many hours talking about quality of care and how to improve services to meet existing demand. Though these are no doubt important considerations, research into the demand-side has perhaps been neglected.

Contraceptive use has risen and fertility has fallen over recent years in Bangladesh. However, whether we can expect these trends to continue in a setting where neither the extreme poverty of the majority of the

population, nor the economic and social dependency of women on men is lessening is open to question. The average number of births per woman may have fallen from six to around four, but will it fall much further? Recent work by Rahman M, et al. (1992b) suggests that gender preferences may represent a significant barrier to further fertility reduction in this country. As Caldwell and Caldwell (1992) point out, Bangladesh is the only country among the world's 19 poorest where the fertility transition has begun. Understanding why this is so, and what prospects there are for further decline, without input into spheres other than family planning services, deserves greater attention.

The rapidly increasing number of urban poor in Bangladesh and the accompanying societal changes demand that this group be given special consideration by both researchers and program managers. Lessons learned in the rural setting cannot blindly be applied in the urban context. Information on the patterns of livelihood and the structure of social networks among the urban poor is still remarkably limited. In addition to operational research aimed at improving modes of family planning service-delivery, our understanding of the social, economic and cultural context of the urban slums must greatly be increased, if we are to effectively serve the needs of the people in the urban slums.

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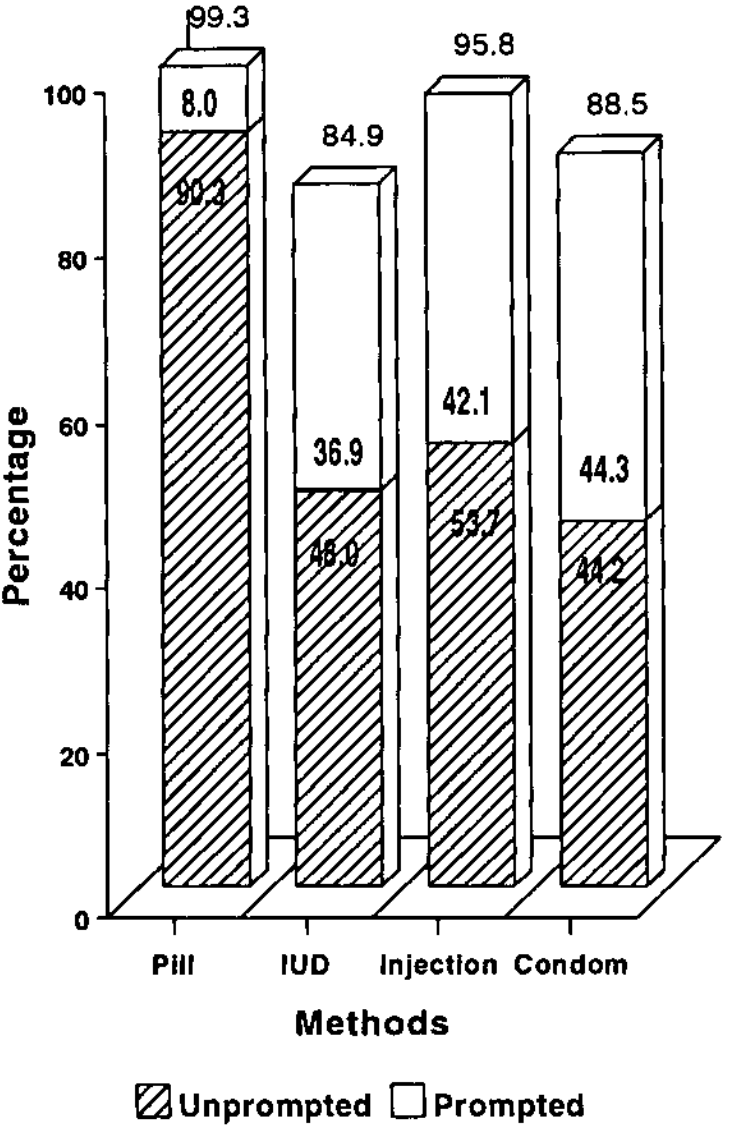

Fig. 1. Awareness of contraceptive methods among every married women under age 50: Dhaka Urban Slums, 1990

Source: Jamil K, et al., 1993

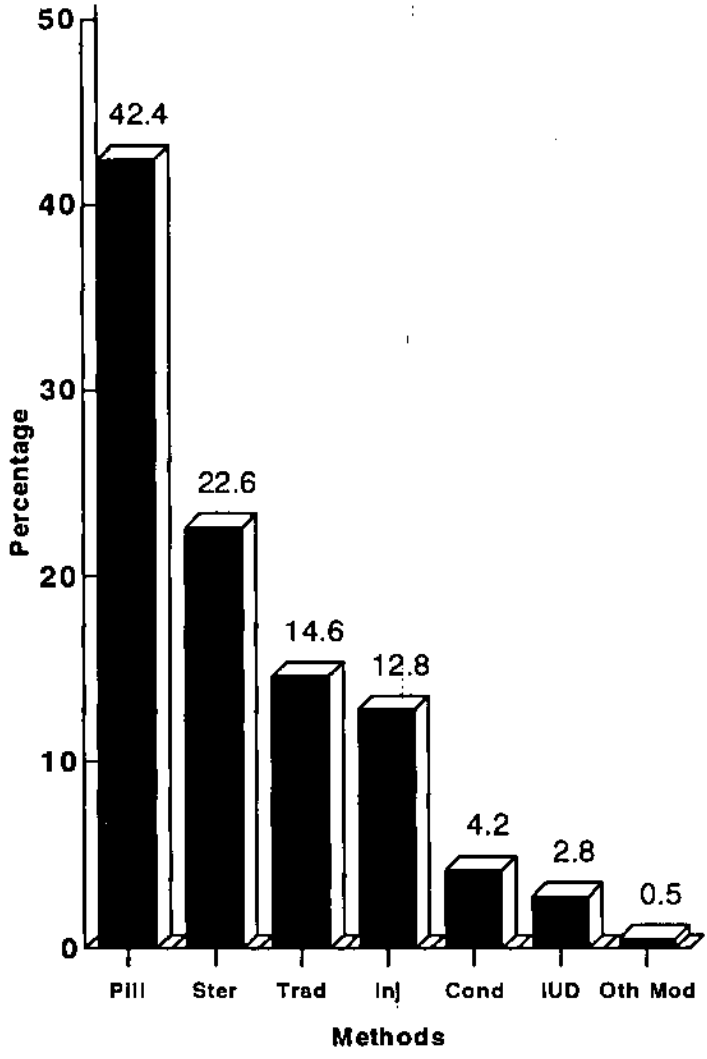

Fig. 2. Contraceptive method mix among currently married women under age 50: Dhaka Urban Slums, 1990

Source: Jamil K, et al., 1993

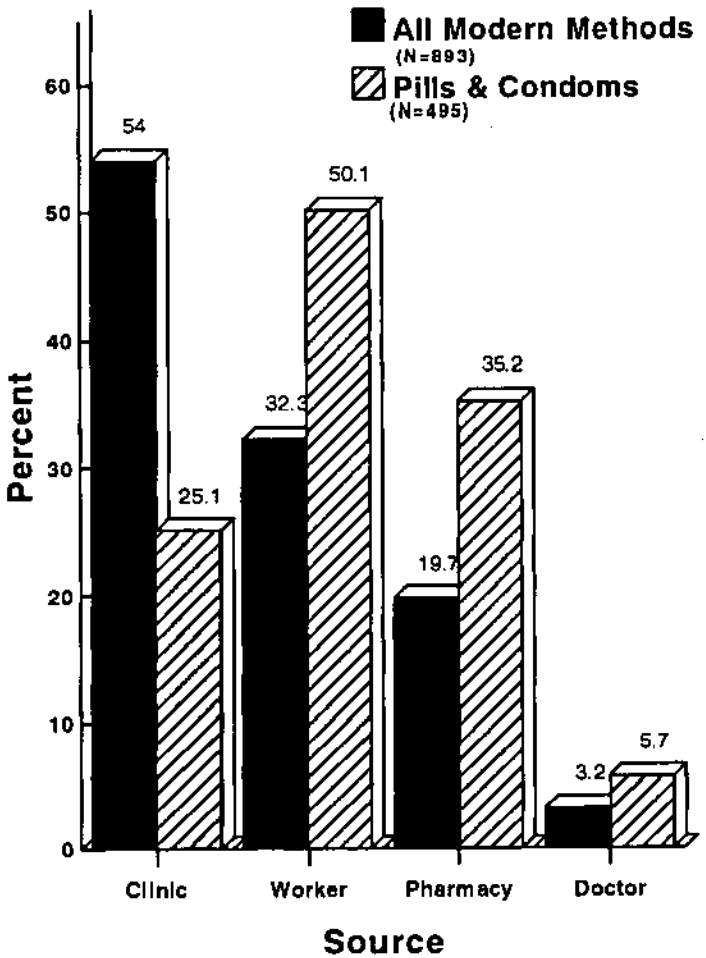

Fig. 3. Supply source of modern contraceptive methods among current users under age 50: Dhaka Urban Slums, 1990

Source: Jamil K, et al., 1993