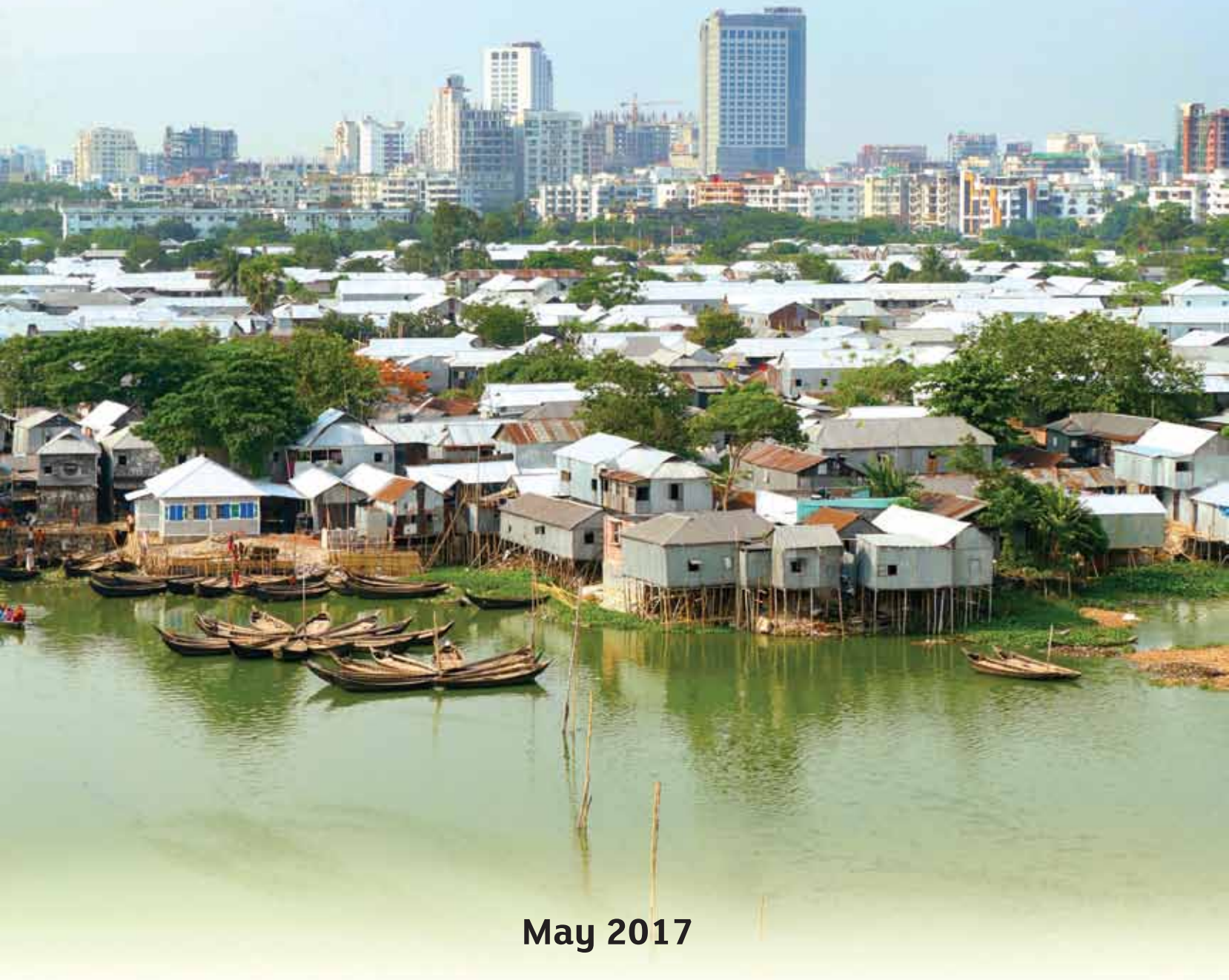


QUALITATIVE STUDY EXAMINING MIGRATION, MATERNAL HEALTH CARE, AND FAMILY PLANNING PRACTICES AMONG SLUM DWELLERS LIVING IN DHAKA AND CHITTAGONG



May 2017



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DHAKA AND CHITTAGONG**

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May 2017



icddr,b Special Publication No. 151
May 2017

ISBN 978-984-551-369-2

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Cover Photo Courtesy: Eminence

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Suggested Citation: R. Gazi, Q. Nahar, S.B. Shelly, P.K. Streatfield, L. Blum. 2017.
*Qualitative Study Examining Migration, Maternal Health Care, and Family Planning
Practices Among Slum Dwellers Living in Dhaka and Chittagong.* icddr,b.

Printing:

Dynamic Printers, Dhaka, Tel: 00-02-7192623

ACKNOWLEDGEMENT

The study team would like to thank all the individuals and organizations that have assisted and supported completion of this study entitled “Qualitative Study Examining Migration, Maternal Health Care, and Family Planning Practices among Slum Dwellers Living in Dhaka and Chittagong”.

This qualitative research study was an extension of the Bangladesh Urban Health Survey 2013 (BUHS). Financial assistance for the main survey was provided by the USAID and DfID, and was carried out by National Institute of Population Research and Training (NIPORT), with technical assistance from icddr,b and MEASURE Evaluation. The qualitative study was entirely conducted by the team of icddr,b with assistance and guidance from the main survey team. The funding assistance for the qualitative study was received from DfID. icddr,b acknowledges with gratitude the continuous support of USAID and DfID towards such research efforts.

The researchers are grateful to the main survey’s data collection teams of the Associates for Community and Population Research (ACPR) and Mitra & Associates for assisting the team in finding informants before collecting data. In addition, the team would like to thank all the study participants who took the time to respond to the survey questions and provide vital information.

The researchers acknowledge the support of the Ministry of Health and Family Welfare (MoHFW), Government of the Peoples’ Republic of Bangladesh for its constant support to carry out the study. icddr,b also acknowledges Global Affairs Canada (GAC), Swedish International Development Cooperation Agency (SIDA), and the Department for International Development (UK Aid) for providing unrestricted/core support to the centre.

Special thanks to Dr. Kanta Jamil, Senior Monitoring, Evaluation and Research Advisor, Office of Population, Health, Nutrition and Education, USAID, Bangladesh for her guidance and support through all steps of the study implementation and report generation.

The study team acknowledges Shusmita Khan, Research Associate, MEASURE Evaluation, Carolina Population Centre, University of North Carolina at Chapel Hill, USA for her valuable review comments and Sifat Shahana Yusuf, Research Investigator, icddr,b for editing the report.

Contents

EXECUTIVE SUMMARY	1
INTRODUCTION	5
OBJECTIVES	7
<i>General Objective</i>	7
<i>Specific Objectives</i>	7
RESEARCH METHODS	8
Key Informant Interviews (KIIs)	8
In-Depth Interviews (IDIs)	8
Sampling Strategy	10
Study Site	11
Data Collection Process	11
Data Analysis	11
Ethical Assurance for Protection of Human Rights	11
RESULTS	12
Key Informants	12
In-depth interviews	12
DHAKA MIGRATION	13
Background of respondents	13
Figure 1. Migration from place of origin to Dhaka City	15
Reasons for migration	16
Additional reasons for migration	18
Accompanying Family Members	18
Decision Making for Migration	19
Selection of Urban Sites to Migrate	20
Experiences in the Urban Slum	20
Challenges after Migration	21
Visiting the Village and Family Obligations	23
Health Care	24
Recommendations for Improvements in the Slum Setting	24
Future Plans	26

MATERNAL HEALTH	27
Background Information	27
Migration History	27
Health Care Options	27
Maternal Health Care Options	28
Antenatal Care.....	29
Childbirth.....	33
Recommendations Regarding Delivery	39
Spousal Involvement	39
Delivery Comparisons	40
Postnatal Care	41
C-SECTION DELIVERIES.....	42
Background Information	42
Health Care Options	42
Maternal Health Options.....	42
Antenatal Care.....	42
Childbirth.....	45
Decision Making Related to C-section Delivery.....	47
Cost of C-section Delivery.....	48
Postnatal Care	49
Perceptions of C-section Deliveries.....	49
Perceptions of the Care during C-section Delivery.....	50
Maternal Health Care Challenges for New Migrants.....	50
FAMILY PLANNING OF COUPLES WHO DO NOT DESIRE MORE CHILDREN : FEMALE RESPONDENTS	51
Background Information	51
Number of Children, Decision making for having no more Children, Current Contraceptive Method Use.....	51
Obtaining Contraceptive Methods.....	51
Contact with Field Workers.....	51
Previous Use of Contraceptive Methods.....	52
Knowledge and Perceptions of Long Acting or Permanent Methods (LAPM)	52
Husbands' Involvement in Family Planning.....	54
Suggestions regarding Improvements of Family Planning Services	55

MALE RESPONDENTS	56
Background Information	56
Number of Children and Current use of Contraceptive Methods.....	56
Source of Knowledge about Methods.....	56
Contact with community health workers	56
Knowledge and Perceptions of LAPM.....	57
Husbands' Involvement in Family Planning.....	57
Suggestions Regarding Improvements of Family Planning Services	58
CHITTAGONG: MIGRATION	59
Background of Respondents.....	59
Figure 2. Migration from place of origin to Chittagong City.....	61
Reasons for Migration	62
Additional Reasons for Migration.....	65
Accompanying Family Members	65
Decision Making for Migration	65
Selection of Urban Sites	66
Experiences in the Urban Slum	66
Post Migration Challenges.....	66
Visiting the Village and Family Obligations	69
Health Care	69
Recommendations for Improvements in the Slum Setting.....	71
Perceptions of the Decision to Migrate	72
Future Plans	73
MATERNAL HEALTH	75
Background Information	75
Migration History	75
Health Care Options	75
Maternal Health Options.....	75
Antenatal Care.....	76
Childbirth.....	80
Recommendations for Improvement.....	82
Delivery Comparisons	83
Postnatal Care	84

C-SECTION DELIVERIES	85
Background Information	85
Health Care Options	85
Maternal Health Options	85
Antenatal Care	85
Childbirth	87
Decision Making related to C-section Delivery	89
Cost of C-section Delivery	89
Postnatal Care	90
Involvement of TBAs	90
Perceptions of C-section Deliveries	90
Maternal Health Care Challenges	91
FAMILY PLANNING OF COUPLES WHO DO NOT DESIRE MORE CHILDREN: FEMALE RESPONDENTS	92
Background Information	92
Number of Children, Decision Making not to have More Children, and Current Method Use	92
Source of Knowledge of Contraceptive Methods	92
Availability of Methods in the Area	93
Previous use of Contraceptive Methods	93
Knowledge and Perceptions of Long Acting or Permanent Methods (LAPM)	94
Husbands' Involvement in Family Planning	95
Suggestions regarding Improvements of Family Planning Services	95
MALE RESPONDENTS	96
Background Information	96
Number of Children, Decision Making not to have More Children, and Current Method Use	96
Contact with Health Workers	96
Source of Knowledge of Contraceptive Methods	96
Knowledge and Perceptions of LAPM	97
Husbands' Involvement in Family Planning	98
Suggestions regarding Improvements of Family Planning Services	98
SUMMARY OF FINDINGS COMPARING FINDINGS FROM DHAKA AND CHITTAGONG SITES	100
REFERENCES	109

List of Acronyms

ADB	Asian Development Bank
ANC	Antenatal care
BDHS	Bangladesh Demographic Health Survey
BMMS	Bangladesh Maternal Mortality and Health Care Survey
BUHS	Bangladesh Urban Health Survey
C-Section	Caesarean Section
DMCH	Dhaka Medical College Hospital
EmOC	Emergency obstetric care
ERC	Ethics Review Committee
IDI	In-depth interviews
KII	Key-informant interviews
LAPM	Long acting permanent methods
MBBS	Bachelor's in Medicine, Bachelor's of Surgery
NGO	Non-government organization
PNC	Postnatal care
RRC	Research Review Committee
TBA s	Traditional Birth Attendant
TT	Tetanus toxide vaccine
UPHCSDP	Urban Primary Health Care Service Delivery Project (Phase 2)

EXECUTIVE SUMMARY

Introduction

The population of Bangladesh continues to rise rapidly, with roughly two-thirds of the population growth taking place in urban areas. Climate change appears to be increasing the natural disasters that have historically plagued Bangladesh, causing permanent alterations in the rural landscape and forcing people to alter their source of livelihood and to move away from rural communities. Migration plays a major role in urban growth, resulting in an increase in informal, poor settlements. Little is known about the implications of migration of rural inhabitants to urban centres in response to natural disasters like flooding, river erosion, and cyclones or the mechanisms these vulnerable populations use to survive.

In Bangladesh, a large proportion of births are still taking place with unskilled attendants in household settings, and this is particularly true of women from lower socioeconomic status. The 2006 Bangladesh Urban Health Survey (BUHS 2006) identified inequities in utilization of maternal care when comparing slum and non-slum populations, and overall there appears to be poor utilization of maternal services in slum settings. Information about the decision-making process and the choice of facilities in the urban slum settings, or how the urban poor cope with the costs related to C-section deliveries, is limited. In addition, use of contraception continues to be higher in urban compared to rural areas, with pill being the most commonly used method. It is important to understand reasons for non-use of long-acting methods in urban settings, particularly when couples do not desire to have additional children.

Objectives

The 2013 Bangladesh Urban Health Survey (BUHS 2013) collected information on health issues facing vulnerable urban populations. This qualitative investigation focused on three specific thematic areas that required more in-depth exploration, including migration history, maternal health and selected family planning issues, and was designed to complement the survey results. One primary objective of this qualitative study was to examine rural to urban migration strategies and the coping mechanisms people employ to survive in crowded slum settings. The study also aimed to shed light on strategies used by slum residents related to maternal and reproductive health, including decision making and care-seeking for maternity care and knowledge and perceptions of long acting and permanent family planning methods.

Research Methods

Qualitative research was carried out in urban city corporation areas of Dhaka and Chittagong between September 2013 and May 2014, with five slum communities selected in each city. The study involved a mix of qualitative methods including key informant and in-depth interviews. Purposive sampling was used to identify study respondents from the quantitative umbrella survey based on selection criteria per each study theme (urban migration, maternal health, and family planning). In each site, key informant interviews (KIIs) (took place with experts in the different thematic areas including health care providers offering services to the urban poor, slum owners, community leaders, and employers of slum residents. A total of 17 KIIs were conducted. In-depth interviews (IDIs) were carried out in each site with males who had migrated within the past three years (10), women who had given birth in the past year (10) and women who had experienced C-section (5), and couples who did not want additional children and were not using long-acting or permanent contraceptive methods (5).

Collected in Bangla, the interviews were transcribed and translated into English by data collectors and coded. Content analysis was used to identify trends of key concepts in and across individual codes. Data, methodological, and environmental triangulation was employed to ensure that the findings were validated across different data collection methods (KII and IDI) and across and between respondents representing the different sub-themes.

Results

Migration

Environmental events reported to have occurred in the villages of origin included flooding, cyclones, river erosion, rising sea water and siltation, precipitating a loss of land and family assets, reducing crop production or fishing yields, and impacting on livelihoods. While these factors pushed the male migrants into poverty, ecological influences were rarely mentioned as explanations for migration, with respondents generally indicating that they chose to migrate due to lack of employment and financial deprivation. Most respondents had incurred debt, which in some cases was sizeable and came from a variety of lenders. Urban areas offered job opportunities for themselves and female family members, resulting in cash income to repay loans.

Respondents typically migrated to urban locations where they had relatives or friends who could assist them to find a room and job. Living conditions were described as extremely challenging, particularly in Chittagong where slums appear to be less organized and frequently lack basic facilities such as a regular supply of gas, electricity and water. Respondents lived in small, overcrowded living quarters where they shared a toilet, bathing facility, and gas stoves for cooking with as many as 90 families. Respondents from both sites mentioned that the dirty, unsanitary environments were difficult to tolerate. Particularly at the outset, respondents reported difficulties finding suitable work or performing well in their jobs, with most having no or limited schooling and no former job experience other than farming or fishing. The physical strain and long hours required to maintain jobs was described as exhausting, causing respondents to search continually for less strenuous, but better paying work. At the same time, there was much pressure to maintain a regular wage to cover both daily expenses and to repay loans. Despite the challenges, many respondents indicated that since moving to the urban area, their financial state was improving. Families with multiple earning members appeared to be able to improve their financial situations more rapidly. After repaying their loans and saving some money, most respondents intended to return to the village.

Maternal Health

Almost all respondents in Dhaka and Chittagong received ante-natal care (ANC) during their most recent pregnancy, with the majority receiving the four recommended visits. However, a considerable number of women also indicated that they had not received any ANC during the pregnancies, prior to the last/most recent one. The majority of respondents in both sites were identified as pregnant by BRAC workers during home visits and cited BRAC as their primary ANC provider, with most receiving home ANC on a monthly or more frequent basis. Other respondents received ANC from formal maternity facilities or satellite clinics. Home ANC with BRAC included a limited number of services, while ANC consultations in formal clinic settings were far more comprehensive. Despite this, women appreciated BRAC ANC services due to the convenience of home visits, the fact that maternal services were nearby and available 24-hours a day, and because services were essentially free of charge. While the vast majority of respondents received ANC, knowledge of the number of recommended visits, timing and purpose of ANC was poor.

All but one respondent had made birth plans, with most women in Dhaka planning to give birth at home with a traditional birth attendant (TBA) commonly known as *dai*. In Chittagong most women receiving BRAC ANC planned to deliver in the BRAC birthing hut, while the others decided to deliver at home. Reasons for deciding to give birth at home included that *dais* were experienced and skilled, the woman had a strong bond with the *dai*, the *dai* lived nearby, the woman believed she was in good health and would not experience complications, and women had negative perceptions of clinic deliveries. Plans to deliver with BRAC workers were guided by the fact that the birthing hut was nearby, the woman had received a BRAC card, the woman had established a relationship with the health providers during ANC, delivery services were free, and the woman would be referred to an EOC if needed. Notably, in all but one case mothers-in-law were absent from decision making.

In Dhaka, six women delivered at home with a *dai*, three delivered in a BRAC birthing hut, and one woman delivered in a maternity clinic, while in Chittagong five women gave birth in the BRAC birthing hut, four delivered at home, and a final woman was referred by BRAC workers to an emergency facility. Women generally appreciated assistance provided by *dais* at home and deliveries were uneventful; several *dai*'s contacted a local shopkeeper to administer medicine to speed up delivery. In the birthing hut women also delivered with a *dai* and births occurred normally, and women were generally satisfied with the services. Virtually all women followed their birthing plan, in part because most occurred without complications and few people were involved in decision making at the time of delivery. Labour occurring in the middle of the night presented an obstacle to leaving the household for delivery care, even in cases where the delivery centre was in proximity to the woman's home. Costs for a home and BRAC delivery were comparable and involved small gifts of appreciation for the services *dais* provided.

Husbands who were more engaged in the pregnancy and knowledgeable about ANC and delivery services appeared to play a positive role in encouraging their wives to deliver outside of home. Several women, particularly in Chittagong, highlighted the potential danger of delivering at home with a *dai* and the rising social acceptability of facility deliveries. Some women mentioned that facility deliveries offer privacy, which is difficult to achieve in the slum setting. Even women choosing to deliver at home with a *dai* appreciated the fact that a wide range of emergency facilities are available in urban areas if obstetric complications occur.

While BRAC workers had regular contact during the pregnancy of most respondents, services provided did not appear to fulfil requirements for a complete ANC visit. Interestingly, most women receiving ANC from BRAC workers in Dhaka still preferred to deliver with a *dai* at home. From a biomedical, economic and cultural standpoint BRAC delivery services appear to be very similar to those offered at home with TBAs. However, BRAC workers serve as an important link to formal maternity health services when a complication arises.

Family Planning

At the time of the interviews, all female respondents were using contraceptive methods with most using the pill, which was frequently obtained at local pharmacies. Dhaka female respondents, who seemed to have more exposure to health workers offering information on contraceptives, appeared to be more knowledgeable about long acting or permanent methods (LAPM) than Chittagong female respondents. All respondents were familiar with injectables, which were frequently associated with negative side effects such as heavy bleeding, missed periods, body pain and excessive weight gain. In regard to other long acting methods, much of the information respondents shared appeared to be anecdotal. Most female

respondents were aware of implants; some were opposed to the method because insertion involves cutting the flesh and is believed to cause ongoing pain, is believed to cause excessive weight gain, and because it entails inserting a material object, potentially opposes Islamic tenets proclaiming that all material items be removed from the body after death. A few respondents in each sample mentioned Copper-T as a long acting method. Respondents mentioned that the metal insert (Copper T) can move up the woman's body to the stomach, and if this happens an operation is required or the woman can die. Respondents further mentioned that the procedure of inserting a Copper-T is shameful because the private parts of the woman are exposed to the health provider, and that once inserted inside the body, Copper-T can also oppose religious principles.

All respondents were aware of permanent methods for both men and women and were more knowledgeable about vasectomies, which many stated had been promoted in the past in exchange for a small sum of money and a *Lungi* or *Sharee*. The study uncovered multiple misconceptions regarding how the procedures are carried out and the various adverse health effects believed to occur post operation. Side effects mentioned included infections and loss of sexual prowess, as well as weakness and chronic stomach pain which may result in decreased ability to carry out arduous activities or to work. Some respondents mentioned that the permanence discourages them from accepting the method, indicating that later in life they may opt to have additional children. Male respondents mentioned that the methods their wives were currently using suited them well and there was no need to consider alternative long term or permanent methods.

The respondents appeared to have limited contact with trained health workers on family planning methods. Those community and facility based health workers offering family planning services primarily provided information on and offered short term methods. Pharmacies, which are where the respondents obtained methods, can only provide pills and condoms. If use of long-acting methods is going to increase, the data suggest a need to inform slum dwellers better about long acting and permanent methods in an effort to address and dispel some of the misconceptions and fears identified. The results also highlight the need to educate religious leaders about long term methods.

Ethics

The study was approved by the icddr,b Research Review Committee (RRC) and Ethical Review Committee (ERC). Written informed consent was obtained from all respondents prior to data collection. All critical ethical aspects related to the right of the respondent and confidentiality of the data collected were maintained.

INTRODUCTION

The population of Bangladesh increased by approximately 21 million over a 10 year period from 129 million in 2001 to close to 150 million in 2011, with roughly two-thirds of the population growth occurring in urban areas (from 29 million in 2001 to 42 million in 2011). The urban population of Bangladesh is expected to increase by another 13 million by 2021 as per UN estimates (World Population Prospects 2011). Migration plays a major role in urban growth, resulting in an increase in informal settlements, poverty, and crime and violence (UN-HABITAT 2009). Other manifestations of rapid urban growth include overcrowding, underemployment, and lack of clean water and sanitation, leading to health problems and social and economic vulnerability.

Previous studies on urban migration in Bangladesh mostly examined general causes and consequences of migration (Afsar, 1995; Hossain, 2001) and remittance issues (Sabur, 2008). Study findings showed that gender, age, education, occupation, and land ownership were significantly associated with decision making related to migration, the choice of urban destinations and type of employment sought (Chant, 1992, Hossain, 2001). For example, due to poor employment opportunities for women living in rural areas, women were more likely than males to migrate to urban areas to seek employment in garment industries or as housemaids (*pull factors*) in order to support their families. Another study done in the urban slums of Dhaka reported that higher income probability, positive information on city life, easy access to informal employment, and the fact that they would be joining relatives acted as pull factors for people to migrate to urban areas (Ullah 2004). A more recent study carried out by Farhana and colleagues (2012) identified unemployment, poverty, and political, ethnic and religious conflict as factors that *push* people to migrate from rural to urban areas.

The climate changes that are presently occurring appear to be increasing the frequency and intensity of natural disasters that have historically plagued Bangladesh. There appears to be an increase in warming and climate variability, leading to a rise in sea levels and inhabitable coastal areas (IOM report, undated). Environmental changes are causing permanent alterations in the rural landscape and major shifts in employment options and competition over scarce natural resources, forcing people to alter their source of livelihood and to move away from rural communities. Seasonal unemployment during lean periods of agriculture production has also been reported to trigger migration from northern rural districts to urban cities (Ahamad et al 2011). Gray and Mueller showed that flooding affects mobility moderately for women and the poor, while crop failure has strong effects on mobility of larger groups of people from the affected areas (Gray and Mueller, 2011). Another assessment done by Walsham on environment, climate change, and migration in Bangladesh highlighted that migration is a multi-causal phenomenon; even in cases where the environment is the predominant driver of migration, it is usually compounded by social, economic, political and other factors. Overall, studies are few and little is known about the implications of migration in response to natural disasters like flooding, river erosion, and cyclones or to seasonal droughts. Decision making around migration has been reported to depend on available resources, social networks and perceived options in regard to places to move and job availability (IOM Report).

The urban poor, particularly new migrants, are typically dependent on low wage jobs often involving temporary or seasonal work. As a result, cash flows may be intermittent and may not be sufficient to cover such living essentials as housing and fuel, costs that migrants may not have had to pay in the rural setting. Food consumption is reported to be an area where the urban poor cut costs and save money, leading them to buy foods on a daily basis and compromising both the quality and quantity of intake (IPHN and ICDDR,B). A study in a low income urban settlement in Dhaka reported that 23.6% of households fall below the recommended level of calorie consumption (IFPRI 2007). Water and sanitation is also reported to

present a problem for the urban poor living in densely populated settlements in South Asia. For example, inadequate sanitation compels slum residents to use hanging latrines in open spaces, creating risks related to disease transmission (Ahmed 2005, Buttenheim 2008). Particularly for migrants coming from rural areas, changes in water and sanitation create new challenges and alter health care needs.

In Bangladesh, the majority of births are still taking place with unskilled attendants in household settings, and this is particularly true of women from lower socioeconomic status (BMMS 2010). The 2006 Bangladesh Urban Health Survey (BUHS) carried out in Bangladesh identified inequities in utilization of maternal care when comparing slum and non-slum populations, and overall there appears to be poor utilization of maternal services in the slum setting. A study conducted in slum areas of Dhaka found that 18 to 21% women did not receive any antenatal care (ANC) and that 47 to 59% of deliveries in slum areas of Dhaka were assisted by unskilled birth attendants (Gazi et al, 2009). While the 2010 BMMS data shows major changes in treatment seeking for women with obstetric complications, with facility deliveries rising from 16% to 29% and C-section rates rising from 2.7% in 2001 to 12.2%, little is known about the decision making process and the choice of facilities in the urban slum settings, or how the urban poor cope with the costs related to C-section deliveries.

Use of contraception continues to be higher in urban (64%) than in rural areas (60%), (BDHS 2011), with the pill the most commonly used method. Little is known about contraceptive use patterns among slum dwellers, particularly those who have recently migrated to urban slums from rural areas. It is also important to understand reasons for non-use of long-acting methods, particularly when couples do not desire to have additional children.

Migration from rural areas plays a major role in urban growth in Bangladesh. Most migrants have few resources and limited earning capabilities when they arrive in cities where they are faced with inadequate infrastructure and public services, and a slow-growing and limited labour market, leading to an increased trend in urban poverty and growing intra-city inequality in relation to health outcomes. The 2013 BUHS collected information regarding the pressing health issues facing vulnerable urban populations. This qualitative investigation focused on three specific thematic areas that required more in-depth exploration, including migration history, maternal health and selected family planning issues, and was designed to complement the survey results. A primary objective of this study was to examine rural to urban migration strategies and the coping mechanisms people employ to survive in crowded slum settings. The study also aimed to shed light on strategies related to maternal and reproductive health, including care seeking and

OBJECTIVES

General Objective

The overall objective is to generate information on three thematic areas (internal migration, maternal health, and family planning practices) of urban poor populations that complements information collected through the Bangladesh Urban Health Survey 2013. Specific objectives related to the three themes include:

Specific Objectives

Urban migration due to environmental reasons

- To explore the migration history, including push and pull factors, decision making, and the urban area selected for settlement;
- To describe employment in the new urban area, including challenges and coping strategies in relation to obtaining paid and sustainable employment;
- To describe social or other bonds between the village of origin and the destination area; and
- To understand sources of information related to health care, changes in health care needs and patterns of care-seeking.

Maternal care

- To describe decision making related to where to go for maternal health services,
- To understand causes of low attendance of ANC;
- To describe obstetric care experiences and associated costs; and
- To examine decision making for caesarean delivery, descriptions of caesarean deliveries, and coping mechanisms to manage costs for caesarean deliveries.

Family planning issues

- To understand knowledge of long acting permanent methods (LAPM) for family planning; and
- To describe reasons for not using long acting permanent methods (LAPM) by couples who are living together and do not want more children.

RESEARCH METHODS

Qualitative research involving key informants and in-depth interviews was carried out in urban city corporation areas of Dhaka and Chittagong between September 2013 and May 2014, with five slum communities selected in each city. The study focused on three thematic areas including rural to urban migration, maternal health, and family planning. Study respondents were identified from the quantitative umbrella survey and sampling was based on selection criteria according to each study theme. Slum communities were identified according to the number of eligible respondents that met the selection criteria for the different sub-themes.

Key Informant Interviews (KIIs)

Key informant interviews were carried out with experts in the different thematic areas including health care providers offering services to the urban poor, slum owners and community leaders, and employers of slum residents. The purpose of these interviews was to understand patterns of livelihood of people who had migrated to urban areas in terms of social and financial capital, coping mechanisms used to meet basic needs in slum settings, health care options and challenges in relation to obtaining professional health care, and care-seeking behaviour for maternal health care and family planning. During the KIIs information collected through the in-depth interviews that were carried out with sub-samples of slum residents (see below) was shared and verified. The KIIs also attempted to identify additional areas of research that needed to be further explored. Key informant interviews were open-ended in nature. When required and possible, respondents were interviewed on more than one occasion.

In-Depth Interviews (IDIs)

Respondents for each of the qualitative research themes were recruited for in-depth interviewing. Respondents were selected from lists of respondents participating in the quantitative survey, which commenced prior to the in-depth research. The sampling criteria for each study sub-theme were given to the survey data collection agency which provided a list of eligible respondents. The qualitative team grouped the lists of eligible respondents according to their living areas.

Initial interviews were carried out with eligible recent male migrants. In instances where the study team was unable to locate the respondent, the researchers attempted to find the next person on the list. After completion of each migration interview, we assessed whether the respondent selected or his spouse met the sampling criteria for the other sub-themes (maternal health and family planning). For instance, if a recently migrated male respondent had a wife living with him in the urban slum who had delivered within the past year she was requested to participate in the maternal health component. Or, if the couple did not desire additional children and were living together but not practicing long acting permanent method (LAMP), the wife was asked to partake in the family planning component.

While we developed tentative sample sizes for each sub-component, the final number of respondents included was modified according to when data saturation was reached. A description of each of the study sub-components is presented below along with a breakdown of the number of each qualitative interview conducted.

Table 1. Research methods and number of interviews

Method	Study theme	Respondent criteria	Study areas in Dhaka	Study areas in Chittagong	Total number of respondents
Key informant interviews	Migration, maternal health care, and family planning	Informal and formal community leaders, slum owners, employers of slum residents health care providers	8	9	17
In-depth interviews	Migration	Males who migrated within the last 3 years due to environmental reasons	10	10	20
In-depth interviews	Maternal health	Woman who delivered in the past year irrespective of migration status. Samples included at least one first time mother.	10	10	20
In-depth interviews	C-section deliveries	Women who had had a C-section within the last year	5	5	10
In-depth interviews	Family planning	Married couples living together who did not desire to have additional children and do not use LAMP	5 couples		10 couples

Sampling Strategy

Migration

Purposive sampling was used to identify males who had migrated from rural areas to one of five urban slum areas in the last three years due to environmental reasons. The survey firm provided detailed information on the location of each potential respondent. The qualitative team started by attempting to visit the first respondent on the list. If an eligible respondent was unavailable after three visits, we approached the next respondent on the list. When respondents had a history of multiple migrations, we considered the last time the person had moved to the city.

The aim of these interviews was to examine the migration history of each respondent including push and pull factors, decision making that guided migration, and reasons for selecting the urban area for settlement. Other issues explored included social ties between the home of origin and the urban settlement setting, employment options, and coping mechanisms used to adjust to the challenges faced in a densely populated urban environment. Obligations and remittance to family members in the village setting were also explored, as were changes in health care options, health care practices and patterns of care-seeking. At the outset, a target was set to interview 10 male migrants in each study site.

Maternal health

Interviews were carried out with women who had delivered within the past year. Purposive sampling was used to include both first time and multi-parous women. We also attempted to include both young and older mothers in the sample. Initially, it was planned that 10 interviews would be conducted in each field site. At the outset of data collection, we used social mapping methods in each of the five neighbourhoods to identify local maternal health facilities known to respondents. Topics explored during IDIs included ANC attendance during pregnancy, birth planning prior to delivery, decision making regarding selection of birth attendant and place of delivery, the delivery experience, costs incurred, how payment was made for delivery care, and how the delivery costs impacted on the family economy.

As part of the investigation examining maternal health care, we also aimed to interview women who had experienced C-section deliveries within the past year, with the aim to interview five women in each research site. The purpose of these case studies was to understand the type of complication the woman experienced that triggered care seeking to an emergency obstetric care (EmOC) facility, decision making including who was involved and what guided health seeking to professional care, care-seeking behaviours and processes, including referrals, and the economical and socio-cultural impact of the procedure on the family.

Family planning

We aimed to interview five female respondents and their husbands in each site, with respondents purposively selected from the main survey sample. Selection criteria included that the women were 35 years of age or less and the couples lived together, did not desire more children, were not using any long term or permanent contraceptive methods, and lived in one of the five neighbourhoods identified in Dhaka and Chittagong by the qualitative research team. Each partner was interviewed separately to examine their reproductive history, history of contraceptive use, knowledge and perceptions of long acting permanent methods, and reasons for not using long term or permanent methods.

Study Site

The five neighbourhoods where the study was carried out in Dhaka included Lalbagh, Khilgaon, Sobujbagh, Pollobi, and Mohakhali. Neighbourhoods in Chittagong included Double Mooring, Pahartoli, Bondor, EPZ, and Bakulia.

Data Collection Process

Data collection was carried out by three research officers and three senior research officers with extensive experience in qualitative research. Prior to the onset of the study, a three-day training was held to introduce the protocol, review critical aspects of qualitative data collection techniques, and introduce the data collection tools. Sessions were also devoted to research ethics and taking informed consent. After the training, the research instruments were translated into Bangla. Subsequently, the tools were pre-tested in slum communities and modified according to the pre-test results.

All efforts were made to conduct the interviews in private settings. Interviews were carried out in Bangla and audio recorded. Each IDI took between 1 to 1 ½ hours. Shortly after completion, interviews were transcribed and translated into English by the data collector who conducted the interview.

Data Analysis

Transcripts generated through the interviews were reviewed by the principal investigator and medical anthropologist who served as a consultant on the study on an ongoing basis as the data was being collected. Detailed feedback was given to the data collectors who were often required to collect additional information in person or by phone with respondents. Based on these ongoing reviews, modifications were made on the study instruments as needed.

Once the qualitative data collection was completed, training on coding and analysis led by the medical anthropologist took place. During the training, a coding system was developed, capturing the main research themes and concepts at the outset of the study and generated through the data. Interviews were coded on ATLAS.ti, a text-organizing software. Content analysis was used to identify key concepts in and across individual codes. Data, methodological, and environmental triangulation was employed to ensure that the findings were validated across different data collection methods (KII and IDI) and between respondents representing the different sub-themes. Efforts were made to identify direct quotations and case studies that illuminated key data findings.

Ethical Assurance for Protection of Human Rights

Before field implementation, the study was approved by the icddr,b Research Review Committee (RRC) and Ethical Review Committee (ERC). Written informed consent was obtained from all respondents prior to data collection. During the consent process, informants were informed about the use of the audio recorder and how and why it was being used. All critical ethical aspects related to the right of the respondent and confidentiality of the data collected were maintained.

RESULTS

Key Informants

Eight interviews were conducted in Dhaka as follows: health care providers (5), school teacher (1), rickshaw garage owner (1), and slum owner (1). In Chittagong nine interviews were conducted with health care providers (3), community leaders (3), school teacher (1), rickshaw garage owner (1), and a slum manager (1). Only five key informants were interviewed on more than one occasion.

In-depth interviews

Migration

In total, ten interviews were conducted with males who had migrated within the past three years in each of the field sites. While in Dhaka the lists of eligible respondents generated by the survey was used to identify respondents, in Chittagong the lists identified only four respondents who had migrated due to environmental reasons to the study neighbourhoods in the last three years. Therefore, in Chittagong snowball sampling was used to identify additional respondents. Attempts were made to include respondents who had migrated from different regions of the country.

Maternal health

Over 250 women in Dhaka and 120 women in Chittagong met the initial study criteria related to delivering in the past year and residing in a city corporation area. Subsequently, eligible respondents in the five study neighbourhoods according to parity and age were purposively selected. Ten women were interviewed in each site. In addition, five C-section respondents were interviewed; respondents were the first five women on the list provided by the survey firm who had delivered by C-section within the past year in any of the five neighbourhoods in the two study sites.

Family planning

Five couples were targeted and interviewing took place covering both husbands and wives, in each site for the family planning component.

DHAKA MIGRATION

Background of respondents

The age of the migrant respondents ranged from 19 to 58 years, and the mean age was 39.8 years. Respondents had been living in Dhaka for one to three years, and the average time since migration was close to two years. Six out of 10 respondents lived in nuclear households, and the rest lived in extended families; the mean number of family members was 4.7 and all but one respondent was married. Six out of 10 respondents had no education. For those who had attended school, the mean years of schooling was four years. Occupations at the time of the interview were as follows: day labourer (3), rickshaw puller (2), garbage collector (2) garment factory worker (1), small businessman (1), and daily worker in a paint shop (1). Monthly income of respondents ranged from 7,000 to 20,000 taka and the mean income was 11,150 taka (Table 2).

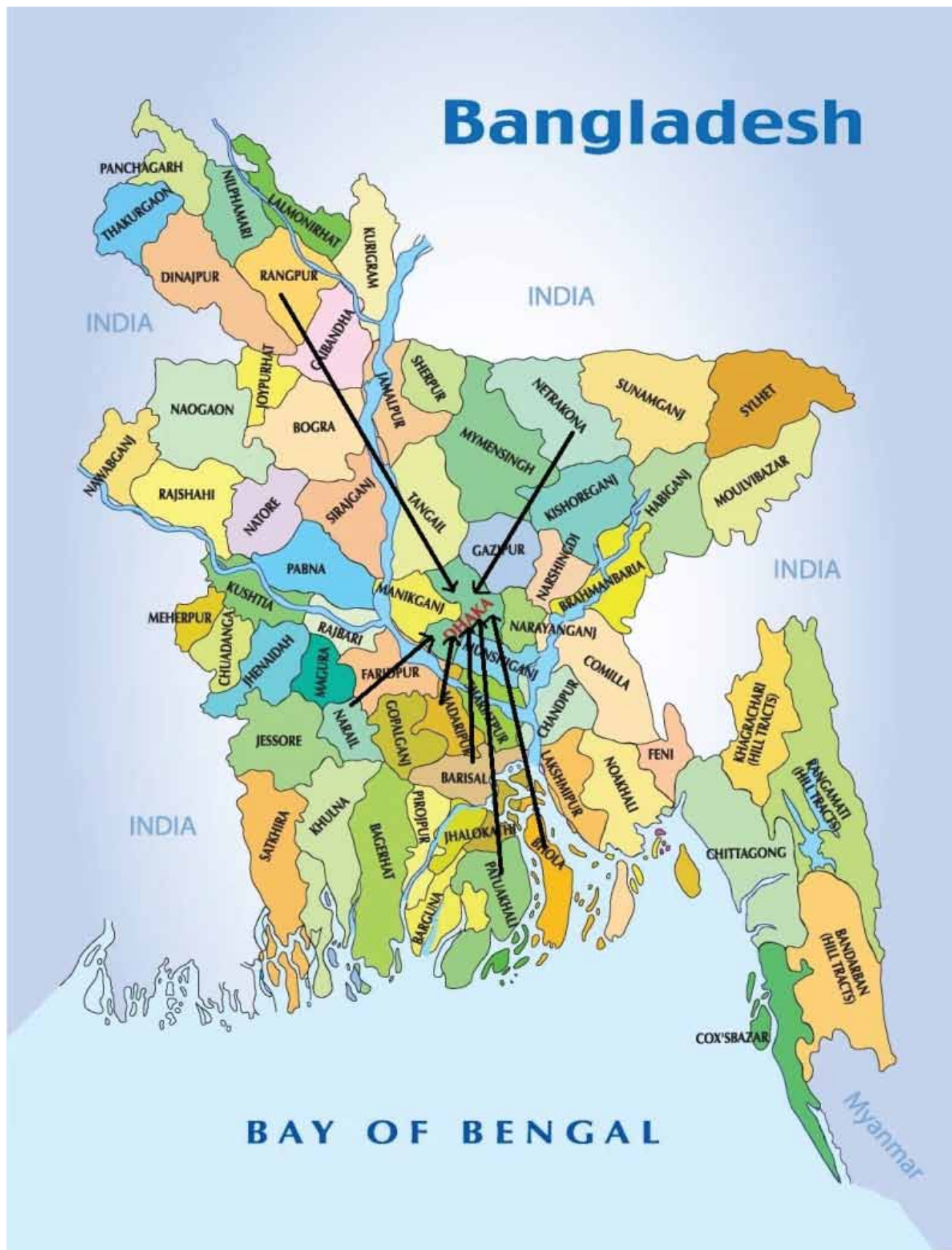
All married respondents were staying with their wives at the time of the study. Seven out of nine wives had no education. Of the two who had formal schooling, one had completed grade three and the other had finished grade eight. Four of nine of the wives were involved in garment work, and another woman worked as a housemaid; the other four were housewives. Those women who worked in garment factories earned 4,000 to 6,000 taka per month. In one instance, both the respondent's daughter and his wife worked in a garment factory, contributing 8,000 taka to the family income per month.

Respondents were originally from the following districts: Bhola (3), Norail (2), Barisal (1), Netrokona (1), Potuakhali (1), Madaripur (1) and Rangpur (1) (see Figure 1). It should be noted that Bhola, Barishal, Potuakhali are areas known for flooding and river erosion.

Table 2. Background information of migration respondents in Dhaka

Variables	Number	Range
Age of respondents	39.80 (mean)	19 to 58
Education <ul style="list-style-type: none"> - No education - Years of schooling for those with education 	6 4 (mean)	2-10
Occupation		
Day labourer (e.g. construction worker)	3	
Garment factory worker	1	
Small business	1	
Waste management	2	
Worker in a paint shop	1	
Rickshaw puller	2	
Number of living children	2.60 (mean)	0 to 5
Type of family <ul style="list-style-type: none"> - Extended - Nuclear 	4 6	
Years of Marriage	16.20 (mean)	1 to 38
Age of spouse	32.30 (mean)	17-51
Education of spouses <ul style="list-style-type: none"> - No education - Years of schooling for those with education 	8 5.5 (mean)	3-8
Occupation of spouse <ul style="list-style-type: none"> - Housewife - Garment worker - Housemaid 	4 4 1	
Religion <ul style="list-style-type: none"> - Muslim 	10	
Years in Dhaka	1.90 (mean)	1-3
Number of family members	4.70 (mean)	2-6
Monthly income	11,150 taka (mean)	7000-20,000 taka

Figure 1. Migration from place of origin to Dhaka City



Reasons for migration

(a) Environmental

Respondents reported several environmental factors as being directly or indirectly associated with the loss of cultivable land and hence their livelihoods, which forced them to migrate. These factors included flooding, cyclone (Aila), river erosion, the rise of sea water, and siltation. One respondent who moved with his family from Bhola to Dhaka said,

In our village, the villagers suffer a lot from flooding each year. This year most of the village was flooded by river water. People in our village suffered during the flooding season. Flooding impedes daily life and transport because the roads are covered with water. We had a very small area of cultivable land and the lands were swamped by the river. Only the land where our house was located remained. After this, I worked as a day labourer. Later our house went under water and we had no place to live in the village.

One respondent living in the Pallabi slum described the problem of siltation in his village, stating,

It seems to me that this problem started about twenty years ago. When the sand comes from the mountain, then the whole Haor (back swamp) area gets infiltrated with sand. Thus, crop production decreases and is in short supply. If there is not enough production of crops how can people survive?

Another respondent from Barisal who described environment changes affecting fishermen said,

The river changed its previous flow, the bank of the river broke, which created a huge char (island) in the river.

According to this respondent, these environmental changes prevented fishermen in the area from pursuing their profession.

In general, environmental changes and natural disasters impacted on livelihoods, forcing our respondents to borrow money from one or multiple sources. Subsequently, they could not repay the debt, ultimately deciding to migrate to Dhaka where they assumed there were opportunities for fast cash.

(b) Joblessness

Respondents described joblessness as an important reason for migration from rural to urban areas, with all respondents mentioning that they migrated because of their inability to work regularly and cover family expenses. When describing the challenges faced in the village, one respondent from Barisal living in the Dhanmondi slum said,

People of our home area are financially poor due to river erosion. We always face scarcity of work, we cannot manage to buy enough food regularly. So, we are forced to come to Dhaka city.

Another respondent in the Pallabi slum of Mirpur who migrated from Netrokona indicated that a vicious cycle of joblessness and poverty compelled him to move to Dhaka. He said,

I could not cope with the sufferings of my family. If I got one day's work, then for the next four days I had no work. I failed to manage family living costs. I could not cope up with the situation. That is why I came here to Dhaka.

The following case studies describe how joblessness in rural villages influenced migration to urban areas.

Case study: One

A middle-aged man who moved from Bhola to the Mohammadpur slum originally worked both as a farmer and a fisherman in his home village. He first lost all of his agricultural land due to river erosion. He also faced losses in his fishing business in part due to the government prohibition of fishing in the river during the rainy season; per the respondent, big fish were becoming scarce, and fishermen only caught small fish which were inadequate, both in terms of selling value and also food for family consumption. In addition, the government outlawed the use of nylon nets, damaging or burning the nets when fishermen were caught using them. This man was apprehended for using nylon nets two times, causing him financial loss. When sharing his situation in the village, he said,

I used to cultivate land in the village. The river erosion damaged everything. Over time there was no land left to cultivate crops. There was no way to fish in the river because government people came and stopped fishing in the river. What could I do given the situation, would I stay put so that we die in the village?

While he tried working as a day labourer, the man was unable to cover his family expenditures through the small sums of money earned. He and his wife finally decided to move to Dhaka. His brother-in-law, who resided in Dhaka, also suggested that they migrate to the city to get employment. At the time of the interview, this respondent was working in waste management and earning 6,000 taka per month; his daughter also earned 4,000 taka per month as a garment worker, resulting in a total monthly family income of 10,000 taka.

Case study: Two

Another middle aged man moved to the Lalbagh slum from Bhola with his family. He was a boatman and also rented the cultivable land he owned. When a dam broke, causing river erosion, he lost his farming land. Subsequently, he was robbed three times where fishing nets and other possessions were taken from the boat; one time he was beaten badly, and his leg was broken. He also faced big losses in other businesses he pursued, including the selling of dried fish, vegetables and rice, which caused him to accumulate a huge debt (up to 5.5 Lac) owed to local money lenders. A relative who resided in Dhaka recommended that he migrate to the city. During the study he worked as a day labourer in construction, earning 14,000 taka per month.

Case study: Three

A respondent from Netrokona, who lived on the river Kongso, indicated that in his village they experienced flooding every year. He mentioned that there was no safety dam near Netrokona, and therefore uncontrolled flooding occurred during the rainy season. He also explained that water coming from the mountains carried a lot of sand, which infiltrated the agricultural land so that crop production was damaged and reduced. This man was a farmer, but because he did not own agricultural land, worked on other people's land. Over time, he was no longer able to find work farming. While he tried to work as a day labourer in the village, he was unable to obtain enough work to support family expenses, eventually being forced to migrate to Dhaka. At the time of the study, he worked in Dhaka as a daily labourer (loading and unloading sand) and earned 300 to 500 taka per day.

(c) Loans

Out of 10 respondents, eight had accumulated loans in their villages, with the largest loan reported to be 5.5 lac taka, which was procured from an *Arottdar* (money lender or someone local who gives loans with interest). This respondent was required to pay 6,000 taka to each 100,000 taka per month. Another respondent borrowed more than 2 lac taka from a local money lender in the village. Other respondents had loans ranging from 3,000 to 1.5 lac taka, receiving loans from individuals, local creditors or money lenders (Mohajan), cooperative groups (Shomity) and microcredit institutions, namely BRAC and the Association for Social Advancement (ASA). The respondents indicated that they had to pay monthly instalments, which they were unable to meet in the village setting. They needed more cash to make the payments and therefore moving to Dhaka was the only solution. One respondent said,

I used to farm (in the village). I faced losses during the last three years doing agricultural work. I took loans from the Shomity to meet the increasing price of agricultural materials like fertilizer and pesticide which are essential to cultivate crops. Moreover, the amount of the loans was increasing day by day. That is why I moved to Dhaka.

Additional reasons for migration

While facing economic crises, several respondents were convinced by relatives and friends living in Dhaka that there were better prospects of earning money in the city. One respondent residing in Mohammadpur stated,

Some relatives of my father-in-law who lived in Dhaka told me to come to Dhaka with my family to work as there was no work in the village. They said, come here (to Dhaka) and do work with us, we will look after you.

Several respondents believed that they would not be able to survive if they stayed in the village, and they had the belief that if they moved to the city, they would be able to earn more money, repay their loans, and maintain ongoing family costs. Some families were able to generate money from multiple salaries. One respondent residing in Hazaribug said,

The decision was based on the fact that there was no alternative way. There was no work for me in the village. So, why would I stay in the village? I was willing to do any type of work to survive. If we four people (his wife and brothers) all earned money in Dhaka, the income of two people could be used to pay for meals, the income of the other two people could be saved.

In this case, the respondent and his two brothers worked in waste management/garbage disposal (*Moila tana*), together earning 20,000 taka per month.

Accompanying Family Members

Most respondents moved to Dhaka with their wives and children, with a few first moving alone, and once they were settled, later bringing their family members. In one case, the wife and children moved first, and the male respondent joined them two months later. One respondent moved with his wife, leaving his children in the village with their grandparents. The only unmarried respondent moved with his brother.

Decision Making for Migration

The decision to migrate was generally made in conjunction with other family members, with most mentioning their wives, children, and parents. They may also have discussed the possibility of migration with extended family members and friends. As indicated, in several instances relatives and friends who had already moved inspired the respondent to migrate to the city. However, in some cases, family members initially opposed the decision. One respondent shared his experience related to decision making regarding migration, stating,

As I had never been to Dhaka, she (his wife) was opposing the idea. I was not familiar with the roads in the town. She was afraid of the environment in Dhaka so she was not agreeing with my decision. Then I said, you know that I have never stayed anywhere without you and it is not possible for me to stay without you. You know that without my family my mind will be unstable, so please let me go and please come with me to Dhaka. My wife said, "I have tried so hard and faced so much suffering to build this house, now how can I go to the city and leave this house?" I said that, if we want to survive and to lead good lives, then we must go to the city. Finally, I managed to get her to agree.

Another respondent indicated that his father opposed the decision to migrate. He said,

I had never been to Dhaka, I wasn't familiar with Dhaka city. I didn't know the roads of Dhaka. Dhaka is considered a very crowded and risky place. My father didn't want me to go to Dhaka city. He said, "You never know when you might be run over by a car; someone might beat you anytime or in anyplace. So rather than going there, you should stay here and do your work as a day labourer."

In other instances, family members and neighbours in the village encouraged the respondent to migrate in search of better prospects. One respondent who had lost much of his cultivable land due to river erosion and was jobless in the village, stated,

Nobody opposed. They blessed us. They told us to move, they said it would be better to go to the city to find a job.

Another respondent, whose wife was motivated by the belief that multiple job possibilities existed in Dhaka, said,

She (his wife) was interested. She said, "As there is no hope of doing work in the village, let's go to the city. I will work, you will do work. We will work together for the survival of our family."

Another respondent mentioned that before migrating, his daughter assured him that she would also assist the family by getting a job in the city.

Several respondents indicated that it didn't require much time or preparation to move, with most having few possessions and desperate to improve their lives. The essential requirement was that they had a connection with somebody already living in the city.

Selection of Urban Sites to Migrate

Respondents migrated to areas where relatives or people from their village lived, first communicating with them over the phone before moving. Once they arrived in the city, they obtained assistance from these individuals who helped them find a job and a place to live. For instance, one respondent who migrated from Narail, Narakuti Thana to Mirpur contacted his brother who had already migrated. Our respondent stated,

I talked with my brother while I was in my village; I asked my brother if I moved to the area where he was living, whether it would be suitable for me. He said, "Come here, I will manage a job for your wife and daughter. If I can manage jobs for them and if you work, hopefully you be able to live without problems."

After he migrated, other people from his village who lived in Dhaka also helped this respondent during his initial months in the city. For instance, his landlord, who was also from the same area, was willing to accept late rent payments, and a local shopkeeper, also from the same village, allowed him to postpone payment for goods he obtained.

Another respondent who migrated from Bhola chose to move to a slum where his uncle-in-law lived for 15 years. He said,

At first I came to Dhaka alone. I came here and stayed with my uncle-in-law in this area. I worked with my uncle for one month, and then I found a home for my family and brought my family to Dhaka.

He later explained the reason for not bringing his family with him initially, stating,

I didn't know the area, so I came alone so that I could learn the main roads and other key locations. If you want to migrate to an urban area, you must find a job first. Moreover, it is not possible to have two families in a single house. So, I came alone. We have five family members, my uncle's family has four members, and how could nine people all stay in a single house?

After a month, his uncle helped him locate a house to rent so that he could bring his family to the city.

Experiences in the Urban Slum

Data collectors visited various slum settings in Dhaka city in order to interview respondents. The smallest slum was located in Mirpur where one of the respondents resided in a tin-shed building consisting of seven rooms with one bathroom (used for bathing and washing clothes), two toilets and three gas stoves, all to be shared by residents. On the other hand, the largest slum that was found during the data collection included 100 households; where, every 12 families had to share two toilets and one bathroom. Regarding rent, the most expensive was 4,500 taka for one tin-shed room measuring 7 x 10 ft. The rent included access to a common toilet, bathroom and cooking stoves, which were to be shared among nine families. The least expensive rent was 1,300 taka for a room in Pallabi, with a tin-shed measured 6 x 8 ft room with walls made of bamboo. In this location, 24 families shared two bathrooms, two toilets and eight gas stoves. Although water, gas and electricity were available in the slums, respondents reported irregular supply of utilities as a common problem.

Respondents also shared that living expenses were much high in the city compared to the village setting. Eight out of 10 respondents, earned enough money to maintain their monthly family expenses and to pay off debt. However, two respondents indicated that their earnings were insufficient to cover ongoing living costs. One respondent residing in Dhanmondi said,

In the village expenses are low, and the living environment is good and peaceful. While in Dhaka the income is high, expenditures are also high. The living environment in Dhaka is also very difficult. I spent my income on the house rent and family needs. I can't meet the expenses with my earnings.

Challenges after Migration

Most respondents indicated that when they came to Dhaka, they faced multiple problems related to their living conditions, household environment, financial situation, employment and social life. A more detailed description of the various challenges can be found below.

a) Living conditions

All respondents stated that they had to share toilets, bathrooms and cooking facilities with many other families. Some indicated that they felt embarrassed to have to stand in long queues to avail these basic amenities. One respondent said,

Surviving in the city is much harder. Here we suffer a lot. When we were in the village, we could keep poultry, children used to move around freely, but here in the city we have no space. We must stay in the room.....we don't go to the roads because many vehicles are always moving in the roads.

Another respondent shared his initial struggles in the city, stating,

When we first came to Dhaka there was no electricity, no fan, and no bed in the room. Those are some of the problems we faced. Later we bought got things by doing hard work.

When describing the irregularity of the water supply, one respondent said,

The house owner doesn't give continuous supply of water. He only supplies water three times a day. So, we need to fill up the jug, jar and drum when the water is available.....But in the village, there are ponds, tube-wells and the river. We could always get water. We also used to bathe in the village river. There is no river in Dhaka.

One respondent from Mirpur said,

After moving to Dhaka, I could not eat properly. ... I would think about the bad smell and dirty environment around the place, and I could not take meals.

Often, such challenges forced the respondents to switch residences, with only three respondents never having moved since arriving in Dhaka and one respondent having moved 10-12 times in the past three years. Common reasons for switching homes included insufficient space to accommodate their family, overcrowding, limited supply of resources (such as water, cooking stoves, and clean toilets), and long distances to job locations. . The most frequently cited reasons for moving were related to overcrowding in the immediate living area and limited toilets and cooking facilities. When explaining the reason for changing households, one respondent from the Hazaribagh slum whose family shared two toilets with 26 families, said,

Problems were related to sharing the kitchen, bathroom, and space for washing utensils. I came here to live in a quiet environment. There were problems with the toilet. There were too many households in one slum.

Another respondent who lived in the Lalbagh slum area said,

There were lots of people living in that place. For that reason, problems occurred. We could not cook properly. The bathrooms and the toilets were always occupied.

One respondent in the Dhanmondi slum claimed that inadequate water supply at their initial residence forced them to move to another area. He said,

I moved due to the scarcity of the water supply. I worked all day in a dusty environment, so I needed to take a bath after coming from work. But the place, where I used to reside, often there was no water. So, I changed my house. Here there is a tube-well, and we have no problem with the water supply.

One respondent in the Mohammadpur slum indicated that he felt insecure in the initial home he rented because the house owner was a drug addict. He said,

I left the house because the house owner has questionable character, he was addicted, he used to come home late night and talk nonsense. I think a house owner should be mild-mannered. I wanted a safe environment and that is why I left that house.

b) Financial/Job related

As indicated, most respondents were involved with agricultural work or fishing before migration. Because they lack other skills and were often inadequately trained, they frequently faced difficulties finding work or performing adequately in their new job in the city. In this regard, one respondent said,

When I migrated to Dhaka with my entire family, I faced many problems. I couldn't manage the house rent, I couldn't manage to find work daily, and I couldn't manage money for daily household needs.

After migration, common occupations included rickshaw or van puller, garment worker, garbage collector, construction worker, painter, and small trade (fruit, vegetable, cigarette, cloth). Pulling a rickshaw or van was the most common work, with four of ten respondents working as rickshaw pullers at least once since migrating. One respondent explained why he choose rickshaw pulling, by stating,

I don't know how to read or write, I am not literate, for that reason I have no other way to earn money, that's why I decided to pull a rickshaw.

However, work as rickshaw puller posed certain challenges, with another respondent saying,

We didn't know about the roads in the area, so I kept the boundary for rickshaw pulling to a limited, small area. I only pulled the rickshaw around Kallyanpur to Mirpur, I never went outside of this boundary.

Monthly incomes of the male respondents ranged from 7,000 to 20,000 taka, while family incomes ranged from 8,000 to 30,000 taka. At the time of the interviews, most respondents received minimal daily wages, with rickshaw pullers earning 200 to 400 taka, garbage collectors earning 200 taka, and construction workers and fruit sellers earning 300 to 500. Often the respondents had to give a share of the earnings to a middleman or broker who had helped them to find a job. .

The respondents often switched jobs, mostly to avoid strenuous activities or for better wages. Nine out of the ten respondents had been involved in more than one job, with one respondent having engaged in five different jobs since migrating, which included working as a painter, mason's assistant, selling cloth scraps, rickshaw puller, and van puller for a mobile food (*kabab*) shop. As per the respondents, pulling rickshaw or van, construction work, loading and unloading materials, and welding were described as some of the most strenuous jobs.

Respondents frequently reported working long hours, 7 days a week, with no weekends. Since all of the respondents depend on daily wages, they were continuously concerned about the continuity of their work and how they would survive if they did not earn a regular income. A respondent who described the situation as "*Kosto*" (suffering/painful) said,

"I had to work hard, I had to go to work every day or we would not survive."

Another respondent mentioned that, while it was difficult to work daily, otherwise he and his family could not eat. One respondent explained that his job required that he work daily, saying,

If I miss work for one day, I will be held responsible. The job I do is garbage collecting. No one wants to keep dirty things in the house, they want to put it outside the home as soon as possible. If I miss one day of work, the garbage will be there until the following day up to noon. The house owners will scold me. I must work daily, and if I feel sick for one day, I need to find a replacement.

Several indicated that they also worried that they could not save enough money to repay the debts in the village.

c) Social

A few respondents experienced challenges related to childcare, particularly in cases where both the husband and wife were working and thus forced to leave their small children at home unsupervised by an adult. One respondent mentioned that his 10-year-old daughter took care of her 5-year-old brother, causing the father grave concerns. Another respondent who was forced to leave his children alone during the day explained that he was afraid that his children might wander near the busy roads or get kidnapped. The couple who left their children in the village were also anxious about their children's welfare, but because both he and his wife were working, they felt that they could not bring their children to Dhaka because it would be too expensive to pay for childcare. In respect to overall security, another respondent residing in Mohammadpur stated that there were many drug addicts in his living area, raising fears about safety for himself and his family.

Respondents were initially unaware about health facilities, the road systems and transportation available in the locality where they resided. One respondent who lived in Mohammadpur stated,

When I first came to Dhaka I didn't know anybody, I didn't even know the roads. I couldn't travel from place to place as I didn't know the area well. I had a low income and couldn't afford even essentials. I avoided highways as we were afraid of busy roads.

Visiting the Village and Family Obligations

Most respondents visited their villages once a year, mentioning that they could not make frequent visits because travelling was costly. They reported sending money to their parents in the village, but not routinely, with respondents mentioning sums ranging from 200 to 4000 taka per month. Several respondents stated that their brothers and sisters took care of their parents in the village and that they were not obligated to send money on a regular basis. The exception was the respondent whose children were residing in the village with their grandparents. In this case, the respondent sends monthly 1000 taka for his children.

Health Care

Even though respondents reported that there were many health facilities in the urban area, most preferred to go to a pharmacy for minimal health problems like fever, cough, and diarrhea or even for more serious problems such as jaundice. Reasons for choosing pharmacy to seek care includes, close proximity to their homes, presence of a MBBS doctor, familiarity with the pharmacist, and availability of good treatment at a low cost. Other health care options included Dhaka Medical College Hospital, Bangabandhu Medical College Hospital, and NGO clinics like BRAC and Smiling Sun. Some of the respondents also knew of individual doctors working in private facilities near their homes. In addition, two respondents mentioned availing care from homeopathic provider, while one respondent sought treatment from a traditional healer for jaundice. A few respondents mentioned that they or their family members have received health care from a provider in the garment factory where they worked.

Respondents were poorly informed about the range of health care facilities and available services in their closes proximity. Majority received information about health facilities primarily from their neighbours, relatives and friends. Few male respondents mentioned that health workers conduct visits to their homes; however, they themselves had no direct contact with the health workers, who apparently only met with their wives.

Some respondents stated that they and their family members have experienced different types of health problems since they arrived in the city. For example, one respondent reported that he had to take his child to a hospital three times for diarrhoea and that his wife frequently suffered from diarrhoea and headache. Another respondent reported that his daughter suffered from typhoid twice since they migrated to the city, and the wife of another respondent had problems with her gallbladder. These conditions forced them to visit other, more sophisticated facilities. Several respondents who had visited government or private health facilities in the city were dissatisfied with the behaviour of the service providers. Many of them perceived the notion that, they were not treated well because they are poor. One respondent shared his experience visiting a tertiary hospital, stating,

Once my wife had a problem with her throat, we went to (name of a hospital.) The doctor did not treat me well because I was wearing a lungi (local dress for males). People who wore a shirt and pants got respect and proper treatment.

Respondents often expressed the need for more qualified health providers and health services at low cost in their living area. One respondent from the Hazaribug slum area stated,

There is a dispensary in this area but no MBBS (graduate) doctor. We have to go to Dhaka Medical College for better treatment.

A few respondents mentioned that they know the health care providers in the village better and thus feel more comfortable consulting with them as and when required.

Recommendations for Improvements in the Slum Setting

Suggestions about ways to improve living conditions in the slum areas included better job opportunities, government assistance in the form of money or land, and qualified health providers and health facilities in their locality. One respondent said,

I am a poor man. What I need is a job, a VGF (vulnerable group feeding) card, or the government should donate land to poor people. I have no other desires except for these.

Other suggestions included regular and uninterrupted electricity and gas supply, and improved drainage systems. One respondent said,

Poor people suffer from having no gas supply. They are forced to cook with firewood. We have to pay 1800 taka for room rent and spend 600 taka for firewood. Another problem is health care and the unavailability of trained doctors.

Another comment was,

I first recommend a government hospital, then suggest establishing an industry, construction of roads and a good (clean) environment. I would also recommend building a drainage system and providing loans for poor people.

One respondent maintained that in the village, residents shared a social bond and worked together to achieve collective goals, but in the Dhaka slum, residents lack social networks and therefore fail to communicate and work together to identify and fulfil common social aspirations. He said

In the village, we sit, talk and spend time together and identify our communal needs. But here we cannot do this. Here all the people do the same thing; after waking up in the morning, all the people go to work, come back in the evening and go to work the next day. No one has a relationship (communicates) with others.

Effect of Migration Decision on General Livelihood

Eight of ten respondents believed that their financial situation was getting better since moving to Dhaka. In several cases, an added benefit was that female family members, including children, were involved in income generating activities. One respondent said,

My wife has a job, and my daily income is 300 taka, so we can manage our regular meals, pay debts and send money to our children, who live in the village.

Earning enough money to repay debts was critical, and this was achieved by most respondents. One respondent explained,

I will be free from loans very soon. Allah will make me free from my debts within a short time. I will die without having any debts owed to other people. This satisfies me the most.

Another respondent shared gratification for being able to save money, stating,

We - husband and wife – earn approximately 20,000 taka per month. We spend 10,000 taka and the rest is saved.

Two respondents in particular reported that their overall financial status remained the same or was only improving slowly after migration. One said,

I have no improvement in my financial condition (after migration). I am doing the same as I was in the village. There is little change; however, in the village I had to take loans from village people or sometimes I had to sell household property, but in Dhaka this is not happening. Here my income and expenses are equal.

However, he thought that the decision to move was good, adding,

I think the decision (migration) was right for me. Comparing the two situations, I am much better now than in the village. If I hadn't come to Dhaka, we would have suffered a lot in the village. In the

village, it would have been very hard for me to get a job and earn money. Now after migrating to Dhaka, I am working and earning and at least we are surviving here.

In general, respondents valued the fact that they had provisions for regular cash earnings, confirming that the decision to migrate was appropriate.

Future Plans

Some respondents had short term targets to improve their lifestyles. For instance, one respondent who was a rickshaw puller wanted to get a license so that he could work as a driver of a private car, another wanted to move to Savar (a peri urban area) which he felt, resembled to a village, and a third respondent sought to move to Chittagong, where he thought he could make a better living.

In regard to long term goals, eight of 10 respondents wished to go back to their villages after repaying their debts. Some also indicated that their goal was to earn additional money, which will allow them to start a business or purchase a house or land when they return to the village. One respondent from Hazaribagh said,

I do not think I will live in Dhaka forever. I have a plan in my mind that if I can complete the full repayment of debts, then I will go back to the village.

Another respondent stated,

I want to repay my debts and I also want to save some money so that after going back to my village, I can start a business with my sons.

One respondent maintained,

I have a plan. After repaying the loans, I want to buy land for a homestead in my village. I am interested to buy land if Allah allows me to do that.

Half of the respondents (five out of 10) mentioned that with their earnings in the city, they would save money for the marriage of their daughters, and that only after this was accomplished, would they think about going back to their villages.. One respondent said,

Whether I live in Dhaka for five or 10 years, afterwards I will go back to the village, I will arrange the marriage of my daughters and I will start a business.

There was even one respondent, whose daughter was only three years, who talked about arranging for her marriage prior to moving back to the village. Among respondents, the expected time to stay in Dhaka before returning to the village ranged from one to 10 years.

Two respondents wanted to settle in Dhaka, stating that they had greater opportunities to earn money. One respondent from Hazaribug said,

There is no benefit to go back to the village, what will I get in the village? What will I eat over there? I should not think about going back. My parents still live in the village, I need to send money to them on a regular basis, otherwise they can't survive. If I can't earn money, all of us, including my parents, will suffer.

Another respondent from Mohammadpur stated,

I have no land in the village. The people who have homestead land can think of returning to the village, but I have none.

MATERNAL HEALTH

Background Information

The average age of the respondents was 24 years, with an age range of 19-29 years. Three women had no formal schooling; those who had attended school received on average five years of schooling. The women were married on an average of nine years, and all but one woman reported to be a housewife. Husbands were on average 31 years of age. Only one husband had not received any formal schooling; the average years of schooling for the other husbands was six years. The most commonly reported occupation for husbands was rickshaw puller (3), followed by small business (2), day labourer (2), driver (1), painter (1), and other (1). The reported average monthly income was 10,750 taka.

All but one family was nuclear, and the average number of people living in each household was four. All respondents were Muslim.

Migration History

Respondents came from a range of districts including Bhola (2), Faridpur (1), Bikrampur (1) Netrokona (1), Manikgong (1), Gaibandha (1), Noshindhi (1) and two women were born and raised in Dhaka. The average time respondents had spent in Dhaka was 12 years with a range of 2-26 years. Only three respondents were asked why they moved from the village to Dhaka, with two indicating that they came in search of work and the other woman having come to Dhaka when her marriage was arranged. Four women had lived in one location in Dhaka and the other six had moved at least once.

Health Care Options

Open ended questions about health care elicited diverse responses reflecting the wide variation of formal and informal health care services offered in Dhaka. Health providers commonly mentioned as available for general health problems included clinics or health facilities such as Urban Primary Health Care Service Delivery Project clinics, Manowara clinic, Marie Stopes, or Shurjer Hashi, clinic. Hospitals including Dhaka Medical, Sohrawardi, Mirpur, or Dhaka Shishu were reported for more serious conditions. Local pharmacies where trained doctors may also provide services and private doctor's chambers were also reported as other choices.. Depending on the perceived cause of the problem, respondents also mentioned visiting a range of traditional and religious healers.

Respondents indicated that new migrants initially face major challenges obtaining health care. One respondent explained,

Those who are newcomers face problems. They do not know the roads and places where they can get services or which facility is good. Hence they don't go anywhere.

Some explained that the in urban areas the health system is not uniform or well-planned, making it confusing and difficult to know where to get care. Another respondent said,

The people who are newly settled in urban areas do not know their neighbours. Also, they do not know the area. They do not know about health facilities or doctors. They do not know where to go for good health care. As they are uninformed, in the beginning they do not seek treatment.

Another challenge is the cost, which is comparatively higher in urban areas than in the village. In addition, in urban areas, migrants are trying to reinstate themselves and make a livelihood. As such, during the initial period, new migrants may postpone health care-seeking or need to borrow money to obtain care.

Respondents reported that generally new migrants first endeavour to obtain information on health care options from neighbours who are long term residents and can offer advice based on their personal experiences. In addition, care-seeking behaviours also greatly depend on the economic circumstances of the new migrants. In some cases, long term residents may even accompany newly arrived migrants to the health centre or pharmacy to show them the location and make an initial introduction to health workers.

Maternal Health Care Options

In the study areas, the most frequently mentioned maternal health service centre was BRAC. Respondents indicated that BRAC offers free home based ANC services and delivery in a nearby birthing hut. BRAC also refers to nearby hospitals in case of complication. The second most commonly mentioned facility was the Urban Primary Health Care Centres (these are ADB funded urban clinic facility that runs under the local government division), which provides clinic based ANC as well as delivery services. Other centres mentioned by the respondents, that provides ANC, are World Vision, Monowara hospital, and Smiling Sun clinics. In addition, the Azimpur Maternity Hospital which offers both ANC and delivery services was also mentioned. Some also indicated that private doctors provide ANC, but it's usually expensive and unaffordable to people living in the slums. Several respondents mentioned that satellite clinics in the area also offer vaccinations for pregnant women.

Some respondents indicated that the first place where new female residents go for help regarding a health issue is often a local pharmacy which sells medicines and offers a pregnancy test. However, they emphasized that it is difficult for newly arrived women to obtain information on maternal care. As one respondent (explained,

They face troubles. We guide newcomers where they should go. They do not know where the delivery centre is. We take them to the delivery centre or give them the address. We advise where to go for delivery. A few days back one woman came to me to learn where my delivery took place. I told her BRAC centre. She requested that I bring her there. I introduced her to the Madam in BRAC centre and they issued a card for her.

When talking about maternal health, this respondent said,

Newcomers do not know where they should go to deliver their baby. They stay at home. Thus, sometimes women die during delivery.

Another woman said,

It is normal that newcomers face problems seeking care from facilities. They usually take neighbours with them who are older and know the local area. Many newcomers do not have money and they are unable to seek care in time. Many can't avail C-section when they need it due to lack of money. They have a normal delivery (instead of C-section) and sometimes women die.

One respondent recounted a situation when a new family moved to her area and she assisted a female member of that for antenatal care. She recounted taking the woman to a clinic for delivery, but because the woman did not have an ultrasound as recommended by the health personnel, the clinic staff refused to provide care. She said,

The doctor prescribed an ultrasound. It is recommended that three ultrasounds are needed. It costs 350 taka each time. Maybe this money is nothing to you, but for us 350 taka is a big amount. The patient couldn't do the ultra-sonogram, but that doesn't mean you don't accept the patient (for delivery). They didn't take the patient; I took the patient in a rickshaw in that condition (labour) when anything can happen. You know about labour pain, the mother was screaming. Three of us brought the mother home; we shouted at the clinic staffs for their misbehaviour.

When asked about primary sources of information regarding maternity care, the most common response was health workers from different NGOs or maternity clinics including BRAC, Smiling Sun and Urban Primary Health Care Service Delivery Project centre going door-to-door identifying pregnant women and offering or promoting services, as well as information provided by neighbours. Some said that women share information about maternal health and family planning when gossiping in the courtyard.

Antenatal Care

Knowledge of ANC

Nine of 10 respondents who had at least one ANC visit were asked about the recommended number of ANC visits. Five of them stated that they did not know how many ANC visits women are supposed to have. One respondent said,

I don't know how many times are required. I see women go for check-ups but how many times they go I don't know. I went for check-up only once. The second time I never went. Maybe they told me, but I cannot remember.

Two respondents believed that ANC should be done on a monthly basis, and two other respondents mentioned that three or four ANC visits are appropriate. Only one respondent indicated when ANC visits should start, which according to her was at six months of pregnancy. The other women did not know when the first ANC visit should take place.

Regarding the purpose of ANC, one woman who had not attended ANC and another woman who only had one visit were unable to describe the aim of ANC. Answers from other respondents were vague, with most women indicating that the purpose is to assess the position or health of the baby and the health of the mother, with some mentioning that the woman's blood pressure and weight should be checked. Ultra-sonogram, which was frequently mentioned as part of ANC and believed to be done to assess the position of the baby, appears to be highly valued, which respondents maintained is validated by the fact that women are willing to pay a lot of money for the procedure.

Previous ANC

Eight women who had delivered previously, were asked whether they had attended ANC during previous pregnancies. Interestingly, four women had never attended ANC, stating that they were not informed about the purpose, nobody had encouraged them to attend or they were healthy and did not think it necessary. This woman said,

I didn't go. I have three children and never had a check-up. By the mercy of God, I delivered the children safely with no complications. I delivered my three children at home. I didn't face any problem during pregnancy. The baby was all right inside (the womb).

ANC during the Recent Delivery

Nine out of 10 women received ANC during the most recent pregnancy. Six respondents received ANC from BRAC health workers, two went for ANC in Azimpur Maternity, one went to the Urban Primary Health Care Service Delivery Project clinic, and one received care from a Smiling Sun clinic. The woman who went to Azimpur Maternity for ANC was also visited by BRAC workers at home, who she claimed forced her to enrol/register in their program. Women generally received an ANC consultation once a month, with most starting in the second trimester of pregnancy. Three women did not meet the recommended four visits during pregnancy. A description of the services given by the different providers is as follows:

BRAC

Pregnant women were typically identified during a home visit. During the initial interaction, information was collected from the woman related to how many months she was pregnant, whether she had previously received TT vaccine, and whether she had any health problems. Before issuing a card, BRAC workers also described their services, indicating that they would visit the woman regularly up to the time of delivery. Respondents indicated that two to three days later, one or two BRAC workers came to their home to provide ANC. The woman who claimed to have been forced to enrol described the initial interaction as follows:

“They forced me to have ANC here in my house. But I made up my mind that I will not go there because I already had a card from [Azimpur] Maternity. What would I do with two cards? Yet they gave me a card and told me to visit their centre. Then I said okay, if you don’t have any problem that I have another card, then give it to me.”

BRAC workers continued to come to her home on a monthly basis to do check-ups.

In regard to the six women who received ANC primarily from BRAC, three women were visited once a month, two women were visited every 15 days and one woman only had three home visits. Respondents consistently mentioned that the blood pressure was measured, they were asked whether they had any problems or felt pain, and the position or movement of the baby was checked. Other services mentioned by some but not all women included that the workers recommended that they take iron, calcium or vitamin tablets and that the woman have an ultrasound. We were told that ultrasound is offered free of charge in a health facility on Green Road. Three women actually went for ultrasound; however, the purpose of ultrasound and location of the facility was not always clear to the respondent. One woman said,

They gave me a slip and asked me to go to a clinic which is situated just beside the urban clinic. I never went. They advised me to go there for a check-up. As I was quite fit I didn’t go there. I didn’t know the exact name of the clinic.

Another woman who was advised to go for a second ultrasound stated,

I didn’t do it because I didn’t feel any problem; I was in sound health. I thought I didn’t need an ultra-sonogram. My two babies were born safely at home, I thought this one would also be born safely, I wouldn’t have to go anywhere.

Other services BRAC provided, as mentioned by one respondent included taking the pulse, weighing the woman, providing counselling on food intake and workload, advising the woman to deliver in the birthing hut, and recommending family planning methods postpartum. One woman mentioned that the BRAC workers did not always do a check-up, but sometimes simply asked if the woman had any problems. Another respondent indicated that the health workers appeared to be primarily focused on completing the paper work related to the visit rather than carrying out a consultation. Only two women mentioned being advised to go to the birthing hut before delivery, in one instance to obtain the card and in the second instance because the woman had a pain in her abdomen. Respondents underscored the convenience of home visits, which also served to reach women who would not normally have ANC. One woman (R8) stated,

In the beginning, I didn't understand that I was pregnant. When I realized, it I thought I am healthy and have no problem and for that reason did not go anywhere. BRAC workers came to my home and did my check-up. I depend on Allah and for that reason I didn't go anywhere.

Urban Primary Health Care Service Delivery Project (UPHCSDP) Centre

Only one woman obtained services from UPHC. In her third trimester of pregnancy, this woman said she was unable to eat and move properly. The BRAC *dai* examined her and indicated that her baby was in a reverse position and recommended she go to UPHCSDP centre for an ultrasound. She went to the clinic in her seventh month of pregnancy, doing so primarily in order to have the ultrasound. In the clinic she received a full check-up, which entailed being weighed, having her blood pressure measured, taking blood tests, receiving medicines and counselling on food intake and proper rest. She had the ultrasound, which cost 600 taka; the total cost of the visit was 1000 taka, which discouraged her from returning.

Smiling Sun

The only woman who got care from Smiling Sun had an ANC consultation at six months of pregnancy. She indicated that health staff first came to her home as part of a program designed to identify pregnant women, and at that time they recommended that she attend their satellite clinic where ANC sessions were held in the community three times a week. The check-up involved a fee of 40 taka and entailed the following: examining the woman's abdomen, measuring her blood pressure; weighing her, asking about the movement of the baby, asking whether the woman had any health problems, and administering a TT vaccine.

Azimpur Maternity Hospital

Two women went to formal maternity centres where more sophisticated services and trained personnel were available. The woman who went to Maternity started going for ANC at six months and had three visits all free of charge. The second woman who received care at Azimpur started ANC when she was five months pregnant and had four ANC visits. Services appeared to be far more comprehensive and entailed: measuring blood pressure, checking the pulse; weighing the woman, measuring the woman's abdomen, testing the blood and urine, providing counselling on heavy work and eating nutritious foods, and having ultrasound. Women also said that they received feedback regarding their health and the baby's condition.

World Vision Clinic and Marie Stopes

Both clinics were mentioned as offering TT vaccine for pregnant women. Two women receiving ANC from BRAC went to these facilities for vaccinations.

Decision making process for availing ANC services

Of the six women asked about decision making, four mentioned their husbands were involved in various stages of decision making, either by letting the wife to get ANC or get an ultrasound or suggesting a facility. However, in some cases the husbands also refused to give permission for the woman to leave the household for any check-up. Nevertheless, in two cases, the women disregarded their husband's advice to attend ANC or get ultrasound, either because they felt it was not needed or it was expensive. Parents and in-laws were notably absent from decision making.

The analysis suggests that health workers carrying out household visits to identify pregnant women were persuasive in convincing women to receive home visits. The decision to accept home ANC was also guided by convenience. In this case, the convenience included fact women not needing to travel out of the neighbourhood, (which in some cases would require spousal permission), a perceived need for ANC, and the low service cost. Women were able to decide on their own to accept ANC consultations at home.

Barriers related to obtaining ANC in a clinic were associated with the travel, the need to get permission from their husbands, the perceived need for more specialized care and the cost. One woman whose child was in a breech position said,

The health care providers came to my home and asked me to go for check-up, saying, "Go there and have check-up. You are sick.But I didn't go there as it requires money. For a health card, you need 40/50 taka. If they prescribe medicine it also requires money. I did not have money at that time. I was weak and could not take much food during the first trimester but did not have other complications. That's why I didn't go there.

One respondent mentioned that it was difficult to find somebody to accompany her to Azimpur Maternity clinic to avail ANC, and she therefore sometimes missed visits. Two mothers said that, because they did not feel any problems and were in good health, they decided there was no need to leave the house to go for a consultation in a clinic or to have an ultrasound, which in both cases had been recommended because the baby was believed to have breeched.

The one woman who did not have any ANC appeared to make the decision on her own, stating that she had no problems during the pregnancy and did not feel there was a need to attend ANC. This woman also indicated that did not know where to go for ANC.

Perceptions regarding ANC

Of the nine women asked about their perceptions about ANC, eight indicated that ANC is important. Aspects of ANC which were valued included the woman's opportunity to better understand her physical condition as well as the health and position of the baby. Several respondents suggested that when problems are identified, they can be remedied, with some suggesting that ANC served as a sort of solution for having a good pregnancy and ensuring an uncomplicated, safe delivery. One respondent said,

I came to know whether the baby is well inside the womb. I could stay free of worry. Check-up is essential for the better health of mother as well as the foetus in the womb.

Another respondent stated,

Regular check-up keeps the mother and baby well. When I went, the doctor said I and my baby are well, my pressure and weight are all ok. If a pregnant woman has any problem it is identified during check-up, treatment can cure the problem. The mother learns about her health condition and the condition of the baby.

The one woman who did not have a positive perception of ANC claimed that she had not faced any complications during her two previous pregnancies and had delivered normally at home, and after attending one ANC visit she felt that ANC is too expensive and not needed. She said,

For doing check-up, blood test, vitamin tablets and other medicines they take 1000 taka. Is it possible for poor people like us to manage such an amount again and again? Due to my husband's (low) income I didn't go. If I spend 1000 taka I might face hardship maintaining my other family costs. So, although my husband told me to have a check-up to know the condition of the baby, I didn't go (again).

Of the four women asked whether they were satisfied with the ANC they had received, three responded positively, with the two women receiving services from BRAC highlighting the good behaviour of the health workers. The woman who attended Azimpur Maternity for ANC stated that the services were of high quality, comprehensive, the staff was trained and polite, and the facility was close to her home. One woman who was not satisfied with service has taken service from Smiling Sun clinic and stated that, there was no privacy during the consultation, the health workers failed to use medical instruments, and they did not offer advice on important issues like dietary requirements during pregnancy. She was also dissatisfied because she had been obliged to see several different members of the health staff and had to pay 40 taka for services. When explaining why she did not return for additional consultations after her first visit, she said,

What type of check-up is this? I myself understand the movement of my baby. For that reason, I didn't go for additional check-ups. For check-up they took 40-taka from me. I came home and said to my husband, "They only checked my stomach with their hands, we can do this on our own." Hearing this my husband said, "You do not need to go there, is this called a check-up for which they charged 40 taka? What would they understand by checking your stomach with their hands?" I said "I will never go again."

Only one woman was formally asked how to increase ANC. She suggested that health workers carrying out home visits should make women more aware of the importance of check-ups with trained providers and inform the pregnant women about essential components of ANC like TT vaccination.

Childbirth

Birth History

Of the 10 women in the sample, eight were multipara; two had undergone three deliveries, and the rest had given birth twice. All but one of these former deliveries had taken place at home with a *dai*. The remaining one woman had delivered with her mother, who she claimed was a BRAC field worker. Of these eight multiparous women, four went back to their home village to deliver the first child, one stayed back in the village after the delivery and the other three delivered in Dhaka.

Birth Planning

All but one of the 10 respondents appeared to have made a formal birth plan prior to delivery, with six women planning on delivering with a dai at home. In two cases, the woman and her husband appeared to be the ones primarily involved in the planning, while on several instances the woman's family members are also involved, and one the seemed to make the decision on her own. Mothers-in-law were never mentioned as contributing to decision making.

Four women who received home ANC from BRAC planned to deliver at home; while two women indicated that if they experience complications, they would go to the BRAC centre. The other two women stated that they would not consider delivering anywhere but at home. This woman (R8) said,

Nobody in our family ever delivered in a hospital. Village people are not willing to go to a hospital. I was determined to deliver my child at home. If Allah saved me after home delivery I will be alive and if Allah takes me away, then I will die. Why should I be afraid, today or tomorrow, one day I must die. My husband said my child will deliver at home.

These women planned on delivering with a dai who was a neighbour and described as experienced and skilled. The same woman (R8) stated,

From the time, I came to this area I got to know her. I know many women who have delivered with her. Women do not have any problems. I first saw her when she visited another house. I went to her and told her my physical condition. She told me to call her any time. Whenever I phone her, she comes to me. From my seventh month of pregnancy she always keeps contact with me.

Later she said,

There are reasons for home delivery. If women go to a doctor and have any problems the doctor says to do Caesarean. Such delivery needs minimum 10,000 taka. We are poor, we live hand to mouth, how will we manage the money? We poor people think if Allah wants and has mercy, delivery will happen at home. If Allah takes away (if we die) there is nothing to do. My husband said to me, "You do not need to go anywhere. People say many things. They say to go to BRAC. Who knows what will happen. No need to go anywhere. Delivery will happen at home. Both of our wish was that delivery should happen at home.

Two of these women had already successfully delivered with a dai in the area, and based on these experiences, they felt confident that she was skilled. This woman said (R5),

I delivered my three babies with assistance from the same dai. I knew she was very skilled. That is why I delivered my other two children with her assistance.

Her plan was also guided by negative perceptions of clinic deliveries. She said,

I myself decided. I didn't want to go to UPHC for delivery. There the new-borns die. They take out the child by cutting (kaita). They do C-section when it is not needed. I am scared going to any clinic. C-section requires lots of money, minimum 20-30 thousand taka.

Two women who received ANC from BRAC planned on delivering in the BRAC birthing hut. In one instance, both the husband and wife appreciated the quality of service BRAC provided and noted that many women in their area were delivering with BRAC, signalling that it was socially acceptable. In addition, the husband attended health sessions at the BRAC birthing hut, which solidified his relationship with the health workers and trust in their services. The woman's mother, who lived in the village, also encouraged her to deliver with BRAC. An advantage the woman cited was that, if needed, she could obtain a referral slip for 1500 taka to go to an emergency obstetric care (EmOC) facility. The second husband and wife felt that the slum setting was not appropriate for delivery. This respondent said,

A slum house is not safe for delivery. Lots of people live here together. The environment is not pleasant. Therefore, I thought BRAC "hospital" is the best place for delivery.

Both women indicated that BRAC staff also encouraged them to deliver in the birthing hut; the fact that they had a card and had received ongoing ANC visits solidified their plan.

A first-time expectant mother attended Azimpur for ANC, decided with her husband and mother that it would be best to return to the village where her grandmother was an experienced birth attendant and where there were female family members who could care for her post-delivery. Another woman attended Maternity clinic for ANC was persuaded by her husband that the services were of high quality, and she should deliver there. When asked about transport, she said that rickshaws were always available. Another woman who went to UPHCP clinic for ANC plans to give birth in the village where she delivered her first child. The woman who attended Smiling Sun ANC and was dissatisfied with their services, never discussed a delivery plan with her family and was not empowered to make any decision regarding delivery. Both her parents and husband does not want her to have a facility delivery – mentioning facility deliveries are unaffordable. This women's husband opposed to have a baby shortly after marriage and had even urged her to abort the baby.

It is important to note that, among the three women who were recent migrants, two planned on returning to the village for the delivery. The third woman, who was 19, was the woman who did not have a plan.

Delivery

Of the 10 women, six delivered in a home setting with a TBA (in one case the woman's grandmother), three delivered with BRAC workers in a birthing hut, and one woman delivered in the Azimpur Maternity. Regarding home deliveries with TBAs, four births took place in Dhaka with a dai living in their immediate environment, and one woman delivered with her grandmother in the village. TBAs were described as experienced, skilled, and well known to the woman, with some TBAs having assisted with previous births. In one case, the woman had a particularly close bond with the TBA, referring to her as "grandmother"; this woman insisted that delivering with a close "relative" in the household was the priority. The one woman who had not made a birth plan delivered with her mother who had limited experience assisting births. The woman said,

My husband, mother, father, nobody decided to take me to the hospital. They said, "Now it is night (1 am), where can we go, let's see what happens at home." Then Almighty Allah ordered and my baby was delivered at home.

The respondent said,

My grandmother delivers babies in the village. My mother learned from her. My mother phoned her and asked how she will assist. My grandmother described each step clearly. Then the delivery was assisted by my mother.

Care given by TBAs typically involved massaging the woman's abdomen with oil to alleviate pain, with some also mentioning massaging the hands and feet. Some said that the dai inserted their bare hand or fingers to assess the position of the baby. Birthing materials included blades, needles, thread, cloth and a plastic sheet, which was placed on the ground for delivery. In three instances, the TBA felt the pain was not increasing quickly enough and called a local pharmacist to administer "saline" to speed up contractions; no other medications appeared to be given during labour. *Dais* typically instructed the women when to push, and the dais were responsible for cutting the umbilical cord after delivery. All of the deliveries appeared to occur without complications. Some women mentioned that the *dai* helped clean the mother and dispose of the afterbirth. Dais most frequently assisted the delivery on their own or with one other woman, sometimes the woman's mother. Women generally appreciated the *dai's* behaviour, with two women mentioning that the *dai* cared for them like their own mothers, giving them comfort and courage during delivery.

In one case, the BRAC health worker who had provided ANC during pregnancy came to the woman's home when she was in labour; she was concerned and encouraged her to go to the BRAC centre. When the woman arrived at the centre, the BRAC health workers found that her blood pressure was dangerously high. The woman, whose parents were adamant about a home delivery, was determined to give birth in her home. She said,

A BRAC worker lives beside my house. At 1 pm she came to my house. Observing me she said, "You are not looking well." Hearing that I was in pain she took me to the BRAC delivery centre. They found my blood pressure was very high. She gave me lemon water to drink and told me to lie down saying that within some hours my delivery would happen. I said to my husband, "My father, mother, everybody said not to do my delivery here, now what do you say". My husband said, "No need to stay here, let us go home." I told them a lie and returned home.

She delivered in her home with a dai the same day after receiving saline.

In regard to the BRAC deliveries, two women had planned in advance on delivering in the birthing huts. In both cases, the husbands made a call to the BRAC health personnel to indicate when the woman went into labour. In one instance, the BRAC staff encouraged the woman to come to the birthing hut immediately, and in the second case, the BRAC dai went to the woman's home, checked her, and advised her to go to the BRAC centre. These women lived in walking distance or a short rickshaw ride from the BRAC birthing hut. Both were in labour for several hours, during which they were given drinks and food, told to walk, and massaged with oil. No medications were given, and both deliveries were assisted by the dai and occurred normally. The BRAC staff cut the umbilical cord and wrapped the baby, and the women were able to return home shortly after delivery. Regarding the third woman who delivered in the BRAC centre, because the woman went into labour in the middle of the night, a local dai had already been called to the household to assist the delivery. She (R1) said,

I didn't go there (the BRAC hut) then because where would we go at late night 2 am.

However, at 5:30 am the woman's sisters-in-law came to the household and forced her to go to the BRAC centre. The woman said,

At that time my sisters-in-law came and they became annoyed. All babies of my sisters-in-law were born in the BRAC centre. That's why they also took me to the delivery centre. They thought that if the delivery happens at home everyone will try to peep in (uki dibe) to see what is going on.

Also, an ultrasound during the pregnancy had shown that the baby had breached, and the woman's sisters-in-law were concerned that there was danger in delivering at home. The woman had a normal delivery shortly after arriving in the birthing hut.

Two of the women who delivered at the BRAC centre expressed satisfaction with the services offered, saying that the staff were compassionate and kind and provided all the facilities needed for delivery. One woman stated,

They behaved well with me. They gave me lot of advice. I had a normal delivery as I followed their instructions. I love their conduct as they are gentle. I am happy. They have taken care of me and my child. They served me well.

While the third woman appreciated the behaviour of the health workers, she wasn't completely satisfied, indicating that she had expected to receive money, nutritious foods (e.g. sui, rice, vegetables, sugar), or cloths, all items which she reported are provided by BRAC in village settings.

After she went into labour, the woman who delivered in the Azimpur Maternity took a relatively long rickshaw ride to the facility. She was delivered by a doctor, who gave her an injection to induce the labour pain; three *Ayas* (health workers) also assisted. Family members were not allowed in the delivery room. The delivery took place about an hour after she arrived in the hospital. This woman was satisfied with her experience, indicating that both the behaviour of the health workers and facilities were good, highlighting that electricity was available and the beds clean.

Decision Making related to Delivery

Much of decision making during the delivery process appeared to mirror the birth plan prior to delivery, which had been established in all by the household. This was possible because all respondents did not have any complications. In addition, there were more than one person involved in the delivery process, making it perhaps easier to carry out the original plan.

In the households of the two women who had planned on delivering in the BRAC birthing hut, both husbands called the BRAC birthing hut field worker when their wives were into labour. In both cases, the BRAC workers (one first went to the woman's home) told them to come to the birthing hut immediately. The birthing hut was nearby and transportation was easy.

In the case of the woman who had planned with her husband to delivery in the Azimpur Maternity, the husband called a female relative (*fufu sashuri/aunt-in-law*) when the wife went into labour. When the relative arrived, the pregnant woman indicated that she was reluctant to go because of her concern that it was false labour, and she would be mocked if she returned still pregnant to her household. However, the relative took charge, preparing the woman's belongings and insisting that they leave as soon as possible.

For women who planned on having home deliveries with dais, for three cases, the births happened as planned. When the pregnant women notified their husbands that they were in labour, a dai living nearby was contacted. Respondents emphasized their strong desire to deliver with somebody well known and in their own homes, with some indicating that in the birthing hut the birth attendant may be unfamiliar. One woman said,

At home the delivery seems to happen normally. It is good to have it at home as close relatives are there during delivery. Other advantages are available at home, water or food or anything else needed. And if we go to the clinic we must carry all these things.

This woman mentioned that women who do not have relatives to assist them or have complications should go to the birthing centre. Another woman who chose to deliver with the same dai who had assisted her previous births indicated that her decisions were guided by concerns about C-section and the associated costs. In the third case, because there was nobody to care for the woman in Dhaka, the woman and her husband travelled to their village where she delivered with her grandmother, who she described as an expert birth attendant. Her mother was also by her side.

However, some of the planned home delivery did not go as anticipated. In one case, while the husband and wife planned on travelling to the home village where she had delivered her first child, they prolonged their departure so that the husband could earn additional money. Then it was too late and the woman went into labour. To tackle the birth, the land-lady contacted a neighbour who was a dai to assist the delivery. In another instance, the woman contacted a dai living nearby who assisted with the delivery of newly migrated women, indicating that they could not go to the birthing hut where the delivery was planned because the labour happened in the middle of the night. The woman's sisters-in-law were contacted and they "forced" her to go to the birthing hut out of concern that the ultrasound had shown that the baby was breech, and the birth might be complicated. In the third case, the BRAC worker, who was a neighbour, happened to come to the woman's home when she was in labour. The respondent claimed that she was then forced to go to the BRAC delivery centre by the BRAC worker. However, the woman, who was determined to deliver at home, lied to the health workers at the BRAC centre so that she could return home. Once home, a local dai was identified to assist the delivery. The woman's mother was concerned about her daughter's condition and insisted that the dai call a shopkeeper for assistance. A local pharmacist arrived with saline, and the TBA delivered the baby normally. Pressure from both the woman's parents and her husband, who were all opposed to a non-home delivery, guided the decision making. The woman said,

My husband said to me, "You do not need to go anywhere. People say many things. They say to go to BRAC. Who knows what will happen. No need to go anywhere. Delivery will happen at home." Both of us wished that delivery happened at home.

One woman, who did have any delivery plans, indicated that she did not know any dais in her area. The baby was unplanned, and even at the time of labour, the husband was reluctant to help her in any way. This woman had no decision making power and was completely dependent on her husband and parents. When describing the decision making she said,

We had no plan and nobody would take me to the hospital. My husband didn't want to take me to hospital; my parents also did not want that. My mother tried to assist and my baby was delivered at home. My husband did not have any money.

She later said,

I saw many women go to the hospital and have a Caesarean delivery. For that reason, when my pain started I didn't inform anybody. My husband and my parents both have a shortage of money. Nobody had taka with them. None of them had the ability to take me to hospital. My parents tried to have me deliver at home. Then Almighty Allah ordered and my baby delivered at home.

As no formal plan was established and a *dai* was not contacted, the woman's mother, who lived nearby and had assisted some deliveries previously, was contacted when the woman was in labour. Her mother called the woman's grandmother, an established village *dai*, prior to assisting the delivery, to get guidance.

Delivery Costs

Costs for the deliveries carried out in the BRAC birthing hut were minimal, ranging from 20 to 1000 taka. They involved the purchase of a sari for the dai or refreshments or sweets for the dai or other people living near the home of the family. In regard to home deliveries, in five cases the cost ranged from 150 to 4000 taka. Once again expenses entailed gifts such as a sari, oil, soap or money (500-600 taka) for the dai, sweets distributed to family members and neighbours in celebration of the delivery, materials such as mustard oil and soap needed during the delivery, and medication such as saline or pain relief post-delivery. One family spent 12,000 taka, giving more substantial gifts to the dai and a neighbouring woman who assisted the birth and spending a large sum of money on the baptism. Finally, the woman who delivered in the Azimpur Maternity spent approximately 1000 taka, including a 60 taka admission fee, 200 taka for a dai working in the hospital, and 500-600 taka for medicine and materials such as saline and gloves used by the health provider.

Recommendations Regarding Delivery

When asked about the ways to improve delivery services, one woman recommended increasing BRAC birthing huts, indicating that if a complication arises, delivery is safer there than it would be at home. She also suggested improving BRAC services by investing in more beds and toilets to accommodate patients and the provision of medicines inside the centre. Another woman recommended increasing efforts to encourage women to deliver in facilities where they have full-fledged delivery services. This can be ensured by community outreach with health workers from various maternity centres with frequent home visits to establish good relations with women, other community members and to provide integrated information on childbirth and the delivery services.

Spousal Involvement

There was a continuum of roles which spouses played, with some being very supportive while others showed little interest or even kept their wives from getting care. In general, the women who attended regular ANC and opted for delivery care outside the household appeared to have husbands who were more engaged, valued ANC and trained delivery care, and were concerned that their wives receive quality care during pregnancy and delivery. For instance, one of these husbands decided that his wife would attend ANC and deliver in Azimpur Maternity, stating that he did not have confidence in the services offered by BRAC. These husbands accompanied their wives to the ANC facility, and in one instance, the husband even attended BRAC sessions for husbands. However, there were also cases where one husband who opposed to the pregnancy, refused to assist his wife in any way and did not give credence to any problems, concerns or desires the woman had during pregnancy and delivery. When talking about her husband one respondent reported,

My husband didn't want me to have the child. Suddenly I became pregnant; he didn't take care of me or take me anywhere for treatment. I conceived just after marriage, he didn't want the baby so early. On my delivery day, I was at my home. My husband didn't want me to go anywhere. In the beginning of my pregnancy, my husband wanted to abort the baby but I didn't agree with him. For that reason, I didn't go anywhere.

Even when the woman was experiencing severe contractions, this husband refused to respond to a request the woman made for holy water, stating that he was tired and actively discouraged his wife from delivering in a facility.

As indicated, most husbands were involved in decision making regarding the place of delivery. Other roles at the outset and during labour included calling the family members or female neighbours dai or BRAC personnel; accompanying the women to the facility; obtaining foods to give the woman to eat; seeking a local shopkeeper to administer saline and obtaining medicines. During post-delivery situations, such husbands were involved in obtaining necessary medicines and vitamins and paying for the expenses incurred in the delivery care and take active part in any celebrations to welcome the new-born. During the delivery, husbands were generally in an adjacent room available to respond to requests as and when required.

Delivery Comparisons

Several respondents were asked to compare their past delivery experiences with the most recent birth. Several women highlighted the comforts of delivering at home with a well-known dai and being close to relatives, stating that the preference is to deliver at home. One respondent highlighted the advantage of home delivery in the village, stating that labour and delivery can be kept private, whereas in the urban slum everybody knows what is happening, which is embarrassing to the woman.

Two women who delivered in the BRAC birthing hut felt that, while the BRAC workers used traditional birthing practices and were extremely caring, childbirth with the BRAC attendants was slower. One of these women who had previously delivered with BRAC in the village indicated that in the village, gifts and money are being offered by BRAC, whereas nothing was offered in the slum, making delivering with BRAC in the village more beneficial.

Several respondents highlighted advantages of being in an urban centre with access to emergency care if needed. This woman said,

In the urban centre there are more facilities. In case of emergency we can go to Dhaka Medical or any other clinic. All facilities are very near. That's why everyone wants to live in Dhaka. You can rush with patients to any clinic in case of emergency. In the village, you have to go a long way to get a vehicle and also the facilities are far. People have to spend too much money for all these issues (transport).

Another respondent said,

In the urban centre every facility is near. It doesn't take time to call a rickshaw. In the case of the village you must go a long way to get a rickshaw. Also, medical facilities are very far. It takes time to go there. The mother can die or complications can arise due to the delay. Hence urban is better.

Even those who had planned a home delivery mentioned that, in case of any dire complication, the dai would recommend that the family take the woman to a more qualified provider, indicating that the BRAC birthing hut or other facilities are always available.

When asked specifically about facility care, a few respondents stated that facility care is particularly beneficial for women who do not have a female relative or other family members available at home to care for her post-delivery. Another advantage to facility delivery was that the woman gets to give birth out of the crowded urban living conditions, allowing for more privacy and less hassle. Women generally indicated that the birthing services available, even BRAC, are superior and safer. The main disadvantage mentioned is the cost in one maternity facility, where even in the case of a normal delivery, the cost was astonishingly high in case of emergency care.

Postnatal Care

Of the four respondents who were asked about postnatal care, two delivered in the BRAC birthing hut, one delivered at home with a dai, and the final woman delivered in her village home with her grandmother. Both the women who delivered in the BRAC birthing hut claimed to have jaundice, and one stated that baby too had jaundice after delivery. One sought treatment with a traditional healer (kobiraj) and a pharmacist who supplied modern medicine, and the second woman, focusing on baby's jaundice, first got advice from the BRAC staff, who told her to place the baby in the sunshine for seven days. This mother also purchased blessed green coconut water for herself, as well as medicine from a pharmacist, which she and the baby ingested. These women also stated that they received vitamin A capsule after birth, as well as a white pill. However, both were disappointed that no painkillers were provided by the BRAC dai after delivery. In the case of the woman who delivered at home in the slum, the neighbours advised that she be given a pain killer and vitamins after the delivery, which the husband purchased in a local pharmacy. The last woman in discussion stated that she did not have any specific needs regarding postnatal care. None of these women had formal postnatal care.

Two women who had received ANC from BRAC were asked why they did not attend PNC. Both indicated that BRAC workers did not recommend a check-up postpartum, with one indicating that women do not comprehend why it is necessary to see medical personnel after delivery.

C-SECTION DELIVERIES

Background Information

The average age of respondents was 28 years (23-32 years) and their median years of schooling was five years. Three of the five women were housewives, and the other two were working as housemaids. One woman gave birth for the first time, two women delivered their second birth, and two women delivered for the fourth time. All five respondents were Muslim. Their husbands' average age was 34 years, and they attended school for a mean of four years. The husbands' occupations included shop owner (2), rickshaw puller (1), auto rickshaw driver (1), and private car driver (1), and their average monthly income was 10,700 taka. The median number of family members was five.

Respondents had been living in Dhaka for an average of 16 years (range of 2-32 years). Two women had lived in Dhaka their entire lives, and the rest had migrated from rural areas, typically after they got married. Respondents were originally from Shariatpur, Bhola, Comilla, Sherpur and Bogura Districts.

Health Care Options

According to respondents, the most common health care options were pharmacies. Respondents reported going to government or private hospitals only when treatment from the pharmacies did not provide remedy. Respondents stated that local pharmacies are preferable because of its close proximity, free consultation, and the friendly providers. Other health care facilities mentioned included Urban Primary Health Care Centre and Mohammadpur Fertility and Training Centre, where respondents go for both general health problems and family planning services. Smiling Sun and Dhaka Shishu hospital for child immunization and general child care was also mentioned.

Maternal Health Options

When asked where they go for maternal care, respondents mentioned a range of facilities including BRAC delivery centre, private hospitals or clinics, Dhaka Medical College Hospital, Sohrawardi Medical College Hospital, and Mohammadpur Fertility and Training Centre. They also mentioned name of some diagnostic centres, pharmacies and private doctors' offices. Mohammadpur Fertility and Training Centre was described as one of the most popular government health facilities where ANC care and C-sections are provided to card holders with free of cost. Medical college hospitals were also reported to be popular because of the low costs. One woman said she preferred private hospitals due to the experienced staff and specialized doctors and the fact that the facilities are well equipped.

Antenatal Care

Knowledge of ANC

When asked about the appropriate number of ANC visits during pregnancy, two women suggested monthly visits, with one emphasizing in particular the importance of ANC during the seventh month of pregnancy when she stated the baby's growth and position and the mother's health can be appropriately assessed. The other three women had varying responses: one stated that a woman should have three ANC visits during months 5, 7 and 8; a second woman recommended two visits, both involving ultrasound and carried out during months 6 and 9 of pregnancy; and the third woman suggested that the number of visits is variable, stating ,

It varies from woman to woman. Some women need to go to an ANC check-up every month; some need to go at 10/15 day intervals. During the last trimester, a pregnant woman should have more than one visit in a month.

All women believed that it is important to attend ANC so that a woman can understand both her physical condition and the baby's position. Unfortunately, respondents were not asked when pregnant women should start ANC visits.

Previous ANC

Three of the four women who had previously been pregnant had not sought antenatal care during their prior pregnancies, stating that they did not understand the importance of ANC or were not informed about where services are available or could not attend due to financial constraints. The last woman in discussion was a primiparas mother.

ANC during the Recent Delivery

Three of the five women made their own decisions about where to obtain ANC. In the two remaining cases, the husband and mother-in-law played critical roles regarding where to seek ANC. On average, women started ANC visits during their fourth month of pregnancy, with all but one woman seeking antenatal care from more than one health facility. They sought ANC from BRAC delivery centre (3), Mohammadpur Fertility and Training Centre (3), Ma and Shishu clinic (1), Islamia Hospital (1), Dhaka Medical College Hospital (1) and a doctor's private practice (1). Because BRAC provides limited services, women receiving care from BRAC providers went to other facilities for diagnostic testing and formal consultations.

Three of the five women started ANC during their fifth month of pregnancy and had received some ANC from Mohammadpur Fertility and Training Centre. Reported services in this facility included measuring blood pressure, taking the woman's weight, measuring the woman's abdomen, conducting blood and urine tests, and administering an ultrasound, with all three women having had three ultrasounds during pregnancy. However, each woman's ANC experience was quite different. One woman was advised by the health care providers at Mohammadpur Fertility and Training Centre to take medication for high blood pressure during her last trimester. The day before her expected delivery date, the woman went for a check-up and was admitted to the facility due to high blood pressure and oedema, which she was told were precursors to convulsions. This woman had 10 ANC visits during the pregnancy.

A second woman had received home check-ups by BRAC health care providers; she had also attended two meetings at the BRAC delivery centre during months six and eight of pregnancy. During the eighth month of pregnancy this woman thought her water was breaking and was advised by a neighbour to go to the Mohammadpur Fertility and Training Centre where an ultrasound was done showing that the baby was in a reverse position; the health providers suggested that a C-section might be needed. Subsequently, she received a second opinion from a doctor in a private practice who recommended a second ultrasound, which confirmed that the baby was in a reverse position. Shortly thereafter, she experienced abdominal pain and returned to Mohammadpur Fertility and Training Centre; while they believed, she was in labour, she had not reached her due date, and the facility incubator was not working. She was referred to Dhaka Medical College Hospital (DMCH) for a C-section; however, after doing a third ultrasound, the doctor at DMCH advised her to go home and return several days later so that the baby could gain more weight. Overall, this woman had three ANC visits (one at Mohammadpur Fertility and Training Centre, one with a doctor working in a private practice, and one at Dhaka Medical College hospital), all during the last

trimester; she also received regular home visits from BRAC workers and had two ANC visits at the BRAC delivery centre.

The third woman received a card which allowed her to obtain ANC from the Mohammadpur Fertility and Training Centre, where she had apparently been receiving birth control. This respondent paid five taka for the card and five taka for each ANC visit. Although her blood and urine were tested, she had ultrasound at a different centre due to the long waiting time at the Mohammadpur Fertility and Training Centre. This woman had also received an enrolment card from the BRAC health care providers, who visited her home for ANC check-ups. In addition, she attended three ANC consultations with an MBBS doctor who was the brother of her husband's employer. The MBBS doctor advised her to have ultrasounds as well as blood tests at medical facilities, and he reviewed the diagnostic reports for free. During the eighth month of pregnancy, this woman experienced vomiting and dizziness; she then went to Mohammadpur Fertility and Training centre where she was told that her condition was not serious, and she could return home. Her husband subsequently took her to Sohrawardi hospital, where doctors told her she was suffering from gastric problems. She was also taken to the private doctor whom she had been consulting during pregnancy; he indicated that she did not have any major health problems.

A fourth woman visited two facilities for ANC, including a private hospital and BRAC. However, at BRAC she only had her blood pressure and weight measured. She started ANC visits during her fourth month of pregnancy and had six visits overall.

The fifth woman was the first-time mother; this woman received a card from the Ma and Shishu clinic during her third month of pregnancy and subsequently received ANC monthly, attending five consultations overall. She reported that visits entailed measuring her weight and blood pressure, checking her abdomen, and receiving a prescription for iron tablets which she had to purchase.

According to the findings the most common antenatal services received were:

- blood pressure measured (5)
- weight taken (5)
- ultrasound (4)
- baby's position assessed and abdomen measured (5)
- blood tested (3)
- urine tested (2)

Check-ups from BRAC were limited and involved measuring the blood pressure, weighing the woman, examining the abdomen to understand the position of the baby and providing counselling related to appropriate food intake, taking proper rest, and avoiding heavy household work. However, women considered home ANC preferable because it is free of cost, does not require transportation and is carried out in the privacy of their homes, where they could talk openly with the health care providers. All women had at least one ultrasound during the pregnancy (in one case the woman had ultrasound during labour, but did not have ultrasound during routine ANC). Respondents reported that ultrasound is needed to confirm the pregnancy, to learn about the child's sex, and to assess the position of the foetus.

When asked who accompanied them during ANC visits outside the home, two women reported being accompanied by their husbands, with one occasionally going for ANC alone. In one of these cases, the husband, who was a rickshaw puller, was very supportive of his wife, accompanying her for ANC visits to a variety of facilities for different complications she experienced, stating that consultations were for both the mother's and the child's well-being. The other women reported being accompanied by their mother-in-law, sister or neighbour. Women reported to learn about antenatal care facilities from neighbours and facility-based health care providers.

In regard to cost for ANC, ultrasound ranged from 200 -400 taka and blood and urine tests were 400-420 taka. Transport did not cost more than 150 taka for each formal visit.

Childbirth

Birth History

Two women had previously delivered at home, with one giving birth to three children in the village with assistance from elderly female family members, and another delivering at home in Dhaka with assistance from a dai. Of the rest, one had undergone a C-section delivery in a facility, another had experienced three normal deliveries in Dhaka, two of which were at home and the third in a BRAC delivery centre, and the final woman was a primiparas mother.

Birth Planning

In all five cases, birth plans appeared to be made prior to delivery. Four women had planned to deliver in a facility, either because they had previously delivered in the facility, an ultrasound report indicated a potential complication (the foetus was big or in a reverse position), or there was no one to assist the delivery at home. In two of these cases, the decision regarding the place of birth was made by the husband and wife together. Two other women first held discussions with their husbands, but apparently made the final decision on their own. The final woman had planned to deliver at home with a dai, with the decision made by her family members.

Of the four women who planned for a facility delivery, two intended to deliver at Mohammadpur Fertility and Training Centre. While one of these women had initially planned to deliver at the BRAC delivery centre, she later learned that BRAC would refer her to Mohammadpur Fertility and Training Centre if complications occurred and considered it better to go there directly, saying,

In case of any complication, if BRAC sends me to the family planning (centre) then it is better to get a card from there and do my delivery at the family planning (centre).

This woman had previously had three normal deliveries and expected this last birth to be the same. However, when the ultrasound showed that the child was overweight, she decided not to take a risk and to have a Caesarean delivery. The second woman herself decided to give birth in the facility because there would be nobody to assist her at home. Although her mother asked her to give birth in the village where she had had her previous three deliveries, she was adamant about her decision and was supported in that by her husband. A third woman had previously had a C-section delivery and decided to deliver in a private hospital, where she believed services were of high quality. Her husband saved the money needed, knowing she would have a C-section delivery. While a fourth woman had planned to deliver at the BRAC birthing hut, during ANC the ultrasound showed the foetus in a reverse position, and BRAC referred her to a higher-level facility for additional ANC care. In the case of the final respondent, who was a primiparas mother, her

in-laws decided she would deliver at home and therefore contacted a dai early in the pregnancy. This woman did not have an ultrasound during antenatal check-ups and therefore did not know that the baby was in a reverse position.

Except for the one woman who had had a C-section previously, no other family had saved money for delivery costs prior to the birth. Three women had received a card from Mohammadpur Fertility and Training Centre where C-section costs were covered, and another woman expected a referral slip from BRAC if needed, which would reduce C-section costs at the referral facility. The final respondent's family did not have any savings and had decided the baby would be delivered at home.

Only one woman had contacted a blood donor in the event she might need blood as her blood group was rare (A negative).

Reason for C-section Deliveries

The major reasons for C-section deliveries were that the child was in a reverse position (2), the child was bigger in size than normal (1), the woman had delivered by C-section previously (1), and the woman experienced high blood pressure and convulsions during labour (1). In four cases complications were identified during antenatal check-ups, and these respondents were informed by formal health care providers before delivery that they would require a C-section.

Onset of labour /C-section Deliveries

Two women went to Mohammadpur and Fertility Centre around their expected date of delivery. Both were advised to be admitted immediately but were reluctant because one did not want to have a C-section and the second had no one to look after her children at home. In one case, an ultrasound showed that she should have the C-section immediately, and after first going back home, she returned to the facility where the C-section took place. The second woman returned home, where she performed all household chores. However, the night after her return, she experienced convulsions; because it was night time, her husband could not transport her to a facility. Early the next morning, she went to Mohammadpur Fertility and was subsequently referred to Medical College Hospital.

Another woman first called a dai who was close to the family. The dai was unable to deliver the baby and informed the family that the foetus was defecating inside the womb. The husband called the BRAC delivery centre where the woman had been issued a card and was told to take the woman to a private clinic where C-section costs were unaffordable for the family. The dai then advised them to go to Dhaka Medical College Hospital where a C-section was performed.

The woman who had undergone a C-section delivery previously had been advised by a doctor to have a C-section at the time of her expected delivery date. Even though she did not experience labour pain, she went to a private hospital at her expected delivery date and was given a C-section.

The final woman, who did not have ultrasound prior to the onset of labour, first experienced light labour pain and subsequently reported that her water was breaking. A dai was called, but because there was little change in the labour, the dai suggested administering saline. The husband summoned a medicine shopkeeper who administered an injection, but the woman's condition remained unchanged. The family was advised by the shopkeeper to take her to a hospital. She was transported to Ma O Shishu clinic where she had received a card during pregnancy. From there she was referred to Sohrawardi Medical College Hospital, where she was told to have an ultrasound at a local diagnostic centre. The ultrasound report

showed that the child was in a reverse position and that both lives were at risk. She had a C-section at Medical College Hospital; two bags of blood, which the family had to purchase outside the hospital, were administered.

Three of the five women were told that they needed blood after the C-section, but only one could manage to obtain the blood. One woman failed to get blood even though before the delivery she had contacted a potential blood donor. The third woman was instructed by a physician to have a blood transfusion but was unable to do so due to financial constraints.

Two of the five cases first called a TBA at the onset of labour; one TBA was working in the BRAC delivery centre, and the second had no formal training. In both instances, the TBAs felt that the complications the women were experiencing were potentially life threatening for the woman and suggested transporting her to a facility. The TBAs accompanied the women and their families to the facilities; this was appreciated by the families who were unfamiliar with the facility settings and had no other relatives in the city to advise them. One of these women (R3), who had visited a dai throughout her pregnancy, expressed her satisfaction as follows,

The dai can tell about any complication when they do check-ups. For example, my dai was able to inform us about my complication during the delivery. If needed, you can then move to the facility. Those who do not have any complications can have a safe delivery at home with their assistance.

Later the same woman added,

My dai was illiterate, but regarding my complication she said the same thing as the MBBS doctor. My point is the dai is a doctor without a degree and she (the MBBS) is a doctor with a degree. I am tension free with her (the dai). She lives close to my house and she comes whenever we call her. She is very popular in the community. She is very skilled. During delivery if the legs or hands of the baby come first, she is able to handle the situation, but she is totally illiterate. She has proven her skill many times.

Only two of the women delivered in the location where they had originally planned to give birth. Of the remaining three, one woman had planned for a home delivery with a dai but was transported to a facility because the labour was prolonged. A second woman planned to deliver at the BRAC delivery centre but when labour pain started, she was advised to go to a clinic because the child was in a reverse position. The final woman had planned to deliver at Mohammadpur Fertility and Training Centre, but she was referred to a medical college hospital because she had convulsions. Women did not mention having problems reaching the facilities.

Decision Making Related to C-section Delivery

As indicated, two of the five women decided to deliver at Mohammadpur Fertility and Training Centre. Both went to the facility around their expected date of delivery. One woman had no labour pain, but a physician recommended that she undergo a C-section delivery. Initially, she and her mother felt that because the ultrasound indicated that the baby was in a good position, and the woman had already had three normal deliveries, the C-section was not required. Although her husband and in-laws agreed that the C-section was not needed, she was finally convinced by health workers to have the C-section to avoid losing the baby.

The second woman who went to Mohammadpur Fertility and Training Centre was advised by physicians to get admitted due to their concern that she might experience convulsions. The woman refused, stating that there was no one at home to care for her child. She returned home and experienced convulsions two nights later. After having consultations, she was taken to Mohammadpur Fertility and Training Centre and from there she was referred to Dhaka Medical College Hospital.

One respondent's baby was shown on an ultrasound to be in a reverse position; however, the husband learned that surgical intervention was unavailable at the BRAC delivery centre where they had planned she would deliver. When this woman went into labour, the husband, along with a local dai, sought advice from the BRAC delivery centre about the appropriate facility for the woman to deliver. The health care provider advised them to go to a clinic where C-section costs were unaffordable for the family. The husband said,

I was informed about that clinic earlier because other women who had also been issued a card from BRAC delivery centre were referred there when they had delivery pain. They had a C-section there. It was a not big deal for them because they had money. But I do not have money like them. I pleaded with the providers (BRAC workers) a lot saying, Apa, please give me a slip (referral slip to go to a government hospital). But they didn't respond to my request.

Finally, the husband and dai decided to take the woman to Dhaka Medical College hospital where service costs were lower.

The only primiparas mother initially planned to deliver at home with the assistance of a dai, but the labour was prolonged. While in labour, she was at her in-laws' home, and her husband and mother-in-law were present. However, when the woman's sister arrived, the sister insisted that they go to a facility, saying,

I will not let her deliver at home any more. I will take her to the hospital.

The woman's husband and in-laws took her to Ma and Shishu clinic and from there she was referred to Medical College Hospital.

The final woman had previously had a C-section, which is why the doctor advised her to have a C-section again. Even though she did not experience labour pain, she went to a private hospital at the time of her expected delivery date.

Overall, the reasons for selecting a given facility were that they were referred from another facility where they had attended ANC (2), the private hospital was perceived to offer quality care (1), the facility offered C-section at low cost (1), or the facility offered surgical intervention (1).

Cost of C-section Delivery

Of the five cases, two women spent 30 to 40 thousand taka. One family was able to pay the amount without difficulty. In the second case, the family had some savings, and the rest of the money was borrowed without interest. At the time of the interview, the respondent did not know whether the loan had been paid. In a third case, the cost was 20,000 taka. After the C-section, the woman developed an infection around the sutures. In addition, the baby was born with jaundice and required extra care, with the mother and child staying in the hospital an additional 15 days. The woman's husband was an auto rickshaw puller and barely able to eke out enough money to cover daily household expenses. He contacted his father-in-law who lived outside of Dhaka. While the father-in-law was also poor, he mortgaged his land for the needed cash. Another relative also borrowed money from her employer to assist with the payment.

The final two families had to pay 5-7 thousand taka for the care associated with delivery, with many of the costs related to the purchase of food and for transport. In one of these instances, the woman was treated at the Mohammadpur Fertility and Training Centre, and the family did not need to pay for the C-section or to purchase medicines. The second case delivered at DMCH; this family was only required to purchase medicines in pharmacies located outside the hospital. In both of these cases, the women did not have additional complications, and their hospital stay was relatively short. In one instance, the family had

sufficient savings to cover costs, and the second family had to borrow money. In this second case, the husband was extremely frustrated with the health care providers in the hospital who he claimed only provide care when money is given.

Overall, the C-section costs were much higher in the private hospital where one respondent delivered. While the other two cases who paid higher amounts sought care in government facilities, the women had long stays in the hospital due to complications, thus incurring high fees.

Postnatal Care

General problems reported by the women post-delivery included weakness and pain in the stomach (around the stitched area) and shoulder. Three of the five women received some sort of postnatal care, with two seeking care in a formal health facility (one due to pain and the second experienced high blood pressure). The third woman sought care from a medicine shopkeeper for pain and weakness postpartum and also because her stitched area got infected, or so she claimed. The remaining two women did not experience any complications post-delivery and did not have any postnatal care.

Perceptions of C-section Deliveries

Respondents commonly indicated that they were no longer able to perform household chores as they had before having the caesarean delivery. One woman said,

Yes, it's good to do Caesar[ian] as you don't feel labour pain. But after the Caesar[ian] it's difficult to work. If you are only with your immediate family members, then it is quite difficult to take care of yourself.

Another woman said,

I became disabled, isn't it? I am like a disabled person as I had a surgical intervention. Whenever I do heavy chores I feel pressure in the stitched area. If I had had a normal delivery at home I would never have faced all these complications.

This woman also complained about the lack of privacy that occurs with a C-section, saying,

At home, no one can learn about the delivery. Does anyone want to show her private parts to others? In the hospital, many people learn about it (the delivery).

Other negative perceptions regarding C-section delivery included the fact that postpartum, the woman can experience spinal and abdominal pain and have problems moving about and that the cost is exorbitant for low income families. However, one woman had a more positive opinion regarding C-section, stating,

If a pregnant woman doesn't have any complications, then it is better to have a normal delivery. C-section is not harmful; if somebody needs a C-section then she must have it.

Perceptions of the Care during C-section Delivery

Most women were satisfied with the care received from the facility during the C-section delivery. One woman who delivered in a private hospital said,

In the hospital, the doctors, nurse, and attendants, everybody was well behaved with other patients and with me. The quality of services was also very good. From time to time they come and check

the blood pressure and the heartbeat of the baby inside the womb. They are soft and polite with the patients. Food and medicine is given regularly and they check whether the mothers are taking it or not. They helped me move around because I was a Caesarean patient. Even they help a mother breastfeed her child if she finds it is not easy as a Caesarean patient.

Later, when describing the health care provider's behaviour, she said,

Everybody at the hospital behaved well with me. When we entered the hospital they first requested the patient to have a seat, and then asked about any problems which they noted down in a card. They listened to me with patience. They made things clear to me. They never became angry, always they talked politely. They gave me food in a timely fashion and took proper care of me. They did tests when needed. I received quality treatment from there, which I expected. The hospital environment was very neat and clean. The cost was lower than any other hospital.

However, one woman was dissatisfied with both the health providers in the facility where the woman initially planned to deliver and the facility where she had been referred. This woman initially planned to deliver at a BRAC birthing hut where she had been issued a card during pregnancy. When complications occurred, she and her family requested a referral slip to a government facility, which was not granted by the BRAC delivery centre. The woman was eventually taken by her family to a government medical college hospital; the husband claimed that the quality of care was poor and that he had to pay for all, even negligible, services. He (R3) said,

The behaviour of the ayahs was very bad. They always demanded money before doing anything. They were brutal...forcing us to give them the money they demanded. They acted like they had given me their own money and were demanding their money back.

When respondents were asked for suggestions regarding ways to improve maternal health care, they consistently requested that a specialized maternal care facility be available in proximity to their homes so that they would not need to travel far to seek care. One woman suggested that facilities offer transport so that during emergencies women can seek care rapidly. This woman explained that male family members are frequently away from the household working and therefore are not available to accompany the woman to the facility when needed, which she indicated is why many deliveries occur at home. Women also suggested raising community awareness about maternal health facilities and the services available. Several also recommended that facility-based providers be more cordial and caring towards patients. Another recommendation was that doctors specializing in maternal and child health be permanently available in the facilities.

Maternal Health Care Challenges for New Migrants

When asked about challenges for new migrants, respondents indicated that facilities and their services are not known, with most newcomers in urban areas learning about health facilities from their neighbours. One woman described the situation as follows,

Most of the urban migrants are illiterate. Their living area is unknown to them. They do not know the health facilities available in the area. When they need care, they cannot seek treatment immediately. Many pregnant women do not seek care as they don't know where they can have treatment free of charge.

This respondent recommended setting up monitoring systems to help the health care providers track new migrants. She also advised that health workers carry out frequent door-to-door visits to inform poor and illiterate migrants about the availability of health services within communities.

FAMILY PLANNING OF COUPLES WHO DO NOT DESIRE MORE CHILDREN : FEMALE RESPONDENTS

Background Information

The age of the female respondents ranged from 24 to 34 years, with the mean age 28.6. Two respondents had no education, for other educational attainment ranged from five to eight years, with the mean six years of schooling. Four of five were housewives and one respondent worked as a housemaid. All five respondents lived in nuclear families and the duration of marriage ranged from 11 to 21 years (mean 15.6 years). Duration of time in Dhaka was on average 15 years.

Number of Children, Decision making for having no more Children, Current Contraceptive Method Use

Three families had one son and anywhere from one to three daughters. One respondent had five daughters and the sixth child was a son. The remaining family had one son who stayed with his grandparents in the village; the mother indicated that they kept their son in the village because both she and her husband were working and it was difficult to find childcare in the city. This respondent said,

If I take more (children) I cannot rear them properly, it will require more money..... we do not have excess money, and we are not able to raise any more children (because both the husband and wife were working).

Three out of five respondents made the decision jointly with their husbands not to have any more children. Two respondents mentioned that they initially made the decision and their husbands later approved it. At the time of the interview, all of the respondents were using temporary methods, with four women using the pill and one husband using condoms

Obtaining Contraceptive Methods

All respondents in Dhaka obtained contraceptive methods from local pharmacies; one respondent brought pills herself while in the other cases the women's' husbands purchased the methods. Femicon was the most common brand of oral pill that respondents used. One respondent stated that she had previously received pills from a Marie Stopes health worker who made household visits, but door-to-door visits were curtailed and therefore the couple was required to purchase the pill from a local pharmacy.

In regard to the couple that used condoms, the female respondent said that her husband purchases condoms from the pharmacy and also occasionally collected them from a local clinic (NGO) at a cheaper rate. She added that only women generally visit the clinic and therefore her husband feels reluctant to go there, which is why he prefers to obtain condoms in a pharmacy. She indicated that she never obtains the condoms. She also mentioned that when her husband forgets to buy condoms, they avoid having sexual intercourse.

Contact with Field Workers

All respondents knew about health workers who made door-to-door visits promoting contraceptive methods, with three out of five respondents having received a household visit from health workers. They reported that the health workers were from BRAC, Marie Stopes and 'Urban' (Urban Primary Health Care Program) and that during the visits they typically distributed contraceptive methods for free. One respondent, who was working outside the home, mentioned that the way household visits are carried out does not suit all women's needs, saying,

They (health workers) come in the morning, I go out for work in the morning and return in the afternoon. There are many women like me who leave for work in the morning and return in the afternoon. If family planning workers come in the evening they can also talk with us and we can get methods from them free of cost. Then I would not need to buy tablets each month for 35 taka.

Previous Use of Contraceptive Methods

Generally, respondents indicated that they did not use any contraceptive methods until after having their first baby. One respondent mentioned that if women use contraception at a young age and before having their first child it may cause harm and burn the *nari* (uterus). In her case, a doctor had advised the woman not to use any contraceptive methods other than condoms until she and her husband had a child. She followed this advice, believing that it would allow her uterus to be 'safe' and there would be no negative impact on her fertility. This woman also reported that one of her neighbours became infertile using contraceptive methods before having a child.

Another respondent stated that she started using contraceptive methods after having two children, using the rhythm method up to that time. To prevent getting pregnant, she indicated that she and her husband would refrain from sexual intercourse for 10 days after menstruation. This respondent claimed that during a home delivery the *dai* had told her that, as she had three knots in her umbilical cord, she would have three children. Therefore, after the birth of her second child she started using contraceptive methods to prevent further pregnancy. At first she received injections that she obtained from Marie Stopes, receiving injections at three month intervals over a nine month period. However, she experienced heavy bleeding and therefore switched to the pill. The pill caused her headaches, vomiting, and dizziness, and due to these side effects, her husband started using condoms.

A third respondent explained that she had previously stayed in the village and her husband lived in Dhaka, only making occasional visits to the village. As they were not always together, she only took pills when her husband visited her, taking pills for two to three days during her husband's visits to the village and subsequently stopping after his departure. Her husband, who would bring the pills with him during his visits, advised her when to take the pill. For about two years she continued using the pill this way and never got pregnant. After moving to Dhaka she started using the pill on a regular basis.

Another respondent explained that after the birth of her first child she started taking the pill. At first, she used the 'Minicon' pill, but she experienced irregular menstruation and excessive bleeding during menstruation. Then she started taking injections, but that also caused irregular menstruation and excessive bleeding during menstruation. She subsequently stopped taking injections and started taking the 'Femicon' pills, which caused her no problems and which she continued to use for seven years.

The uterus respondent had always used the pill (Femicon) and was happy with this method and said that she would use it as long as she can.

Knowledge and Perceptions of Long Acting or Permanent Methods (LAPM)

Injectables

All respondents were familiar with injectable methods and knew the dose and where they can be obtained. Two respondents had previously used injectables, but later switched to the pill. One of these women explained that she used injectables for three months, but experienced extreme blood loss and therefore stopped using it. The same respondent also stated that injections cause obesity. The second respondent

stated that in her village most women used to take injections or oral pills, which influenced her decision to try injectables. According to her, women of her native village are very religious and these methods better suit their religious beliefs.

Implants

The respondents generally knew about implants which are known as *khathi vora* (capsule insertion). One respondent, who was better informed, maintained that implants provide protection from pregnancy for three to five years and are inserted in the arm. This woman stated that she would not talk to women who had implants in their arms, indicating that, due to religious beliefs, she opposed these women's choice of contraceptive methods. She added that, according to Islam, if a woman dies with a capsule inserted in her arms she will never go to heaven.

Copper-T

No information was collected on the Copper T because respondents were not familiar with the method. It should be mentioned that two respondents mentioned that Copper-T, as well as injections, implants and condoms, are available in Marie Stopes clinics.

Ligation and Vasectomy

When asked about permanent methods, one respondent explained that the woman's uterus is removed and that the nerves in the man's penis are cut. Another respondent, who claimed to learn about permanent methods for both males and females, which she referred to as "operation," from health care providers, described the procedures as follows:

They (the health provider) tell us that they cut the male nerves; in the case of females they do an operation on the uterus. I don't know more about what they do with the uterus; by doing this no one will be able to give birth.

Overall, we discovered many misconceptions about how the procedures are done.

In general, respondents did not opt for permanent methods for three main reasons: 1) they believed the methods would cause physical problems; 2) permanent methods were opposed by Islam and 3) the permanence of the method and inability to change the decision. Physical problems experienced post-surgery mentioned by our respondents included weakness, weight loss, and the inability to walk. According to one respondent, only when the couple becomes older and have already had three children and are sure they don't want any more children should they consider permanent methods. Another respondent stated,

If someone wants to take a child then she can stop taking the pill and she will get pregnant again. But once the operation takes place then even God is unable to make somebody pregnant. For this reason I absolutely don't want to do the operation.

Apparently, a health worker had discussed ligation with her husband, who was opposed. The woman stated,

She (the health provider) offered a 'saree' and 2000 taka. She discussed with my husband. He was scared. He couldn't accept the idea, believing that it may be harmful and lead to serious physical consequences. According to him, this method would make a woman bed ridden. We could not take such a risk. No one would be available to look after us.

This respondent asserted that health care providers previously offered 2000 taka and a lungi as motivation to encourage males and especially targeted rickshaw pullers to accept the operation. She said that going through the operation is a great offense per *tablig* and *jamat* (religious groups), adding that as there are many other types of family planning methods available, people should use those instead. She shared her views about the operation as follows,

It is not good. It's a sin in present life and also for akhirat (akhirat is an Islamic term referring to the afterlife). It's an offense. When you go to tablig and jamat (religious groups who discuss and share principles related to Islam) meetings, you will hear about this, you will be forgiven for all faults except for the sin of doing an operation (ligation and vasectomy). Those women (who go through the operation) will never be forgiven.

She also stressed that while going through the operation the doctor will see the woman's private parts, which is both shameful and signifies a loss of respect (*izzot er byapar*) for the woman. This woman was also critical of the incentives used to influence men and women to accept permanent methods, highlighting the fact that people who are ignorant about the methods may have regrets later. She shared the case of a male drug addict, who she claimed did not understand the outcome of the procedure, who was motivated by health care providers to have a vasectomy for 2000 taka. Later the man got married and five to six years after the marriage his wife learned that her husband had undergone the operation. The man regretted having a vasectomy, indicating that he did not understand the outcome and only agreed to do it for money.

Another respondent explained that using a permanent method would destroy both her life on earth and life after death, also explaining that the *moulana* and *hujur* (religious leaders) claimed that those who take permanent methods will not have their *janajar namaj* (final pray and rituals after death) recited. She even maintained that cows that eat grass growing over the grave of somebody who had accepted permanent methods would not qualify for *qurbani* (sacrifice to god). She said that, according to the hadith (saying of the prophet), undergoing a permanent method is prohibited and anyone who accepts a permanent method will not go to heaven. According to her, a woman who does not want to have additional children should take contraceptive methods, but not permanent ones. She said,

If we trust God, if God helps us, then we do not need to take such a decision (accepting permanent methods). My point is that I will never take the decision to do the operation if I am alive. If I do that then my present life, and life after death, both will be destroyed. For poor people like us, it is hard to go to heaven. Moreover, if we do that (operation) then we will be blamed. Then we will lose the possibility of going to heaven. During the operation, the uterus is removed, but taking the pill there is no risk like that. If someone wants to take a child, then she can stop taking the pill and can get pregnant again. But once the operation takes place then even God is unable to make somebody pregnant. I believe in these (religious prohibitions) and I absolutely will not go through the operation.

Husbands' Involvement in Family Planning

According to respondents, women were more knowledgeable about contraceptive methods than men, and one respondent stipulated that educated men are more knowledgeable than uneducated men in regard to contraceptive methods. Overall, our respondents believed that it was primarily the responsibility of women

to use contraceptive methods. However, according to one respondent, when a woman cannot use methods due to physical reasons, the male partner should take the method. This woman stated,

Women who cannot take the pill because of side effects, or are unable to take an injection, in that case the male should take the responsibility. Males can use condoms or do the operation, it depends on the situation.

While women were perceived to be the appropriate partner to use the methods, the male partners in our sample were generally the ones in charge of obtaining the methods.

Our respondents maintained that their male partners are not interested in using methods. For instance, one respondent mentioned that her husband was opposed to using the condom, citing the fact that it could burst or leak and was therefore risky because she might get pregnant at any time. Another respondent indicated that in her living area there are a total of 13 families. With the exception of her husband, the other men refused to use condom, with all other women living in her immediate area taking the pill, which she learned while gossiping with other women.

When asked how male participation in family planning can increase, several women mentioned that men don't have time to attend meetings organized by NGOs, explaining that particularly men employed as day labourers have difficulties leaving their work to participate in meetings, which would deprive them of earning money. According to most respondents, the best approach is for women to become more knowledgeable about family planning methods; then they will be able to inform their husbands. In general, respondents indicated that men learn about methods from their wives and other males, but not from health providers.

Suggestions regarding Improvements of Family Planning Services

When asked how to improve family planning services in their local area, many respondents recommended that government providers and other health facilities with family planning services should be more readily available. Several respondents suggested having male providers available to provide services to males. They also indicated that facilities should provide contraceptive methods free of cost, emphasizing that methods are not affordable to many people. While most respondents mentioned that health care workers no longer make or have decreased the rate of door-to-door visits, they emphasized that the population would greatly benefit if health workers visited households to share information and materials regarding contraceptive methods. It was also recommended that those men who are knowledgeable about family planning issues should be encouraged to share information with other men who are less aware, and that women, who were considered more knowledgeable about family planning methods, should also continue sharing information with their husbands and motivate them to take methods. When respondents were asked how family planning information can be shared with women who are not at home in the day time, it was suggested that health care workers make household visits on weekends.

MALE RESPONDENTS: Background Information

The age of male respondents ranged from 28 to 41 years, with the mean age 35.8. Two respondents had no formal education. Educational attainment of male respondents who had attended school ranged from two to eight years, with the mean seven years. Three out of five respondents were involved in small business, one worked as a mason, and one respondent worked in a leather processing factory. The mean income of male respondents was 16,800 taka.

Number of Children and Current use of Contraceptive Methods

As indicated, four respondents had at least one son and one daughter, and the final couple had a son. Four out of five male respondents reported that their wives were using oral pills at the time of the interview; the final respondent used condoms for birth control. Two respondents indicated that their wives had previously used injections or implants, but switched to the oral pill because the methods did not suit them.

Source of Knowledge about Methods

Respondents learned about contraceptive methods from different sources. For instance, one respondent reported that he learned about the pill when visiting a community clinic located in his village. He also learned about other family planning methods such as ‘injectables’ and ‘operation’ from neighbours in the village who had used these methods, indicating that when people in the village face complications using methods other people learn about the problems. This respondent maintained that people in urban slums learn about family planning methods from one another, such as when women gather in groups and gossip they may share information about family planning methods. Two other respondents mentioned that they or their wives mostly learn about contraceptive methods from neighbours or friends. Although mentioned less frequently, respondents also appear to get information directly or indirectly from health providers. For instance, one respondent explained that his wife learned about methods from health workers during satellite clinics or household visits, and that he relied on his wife’s knowledge regarding methods. Another respondent reported learning about permanent methods for males from a NGO health worker who offered 2000 taka and a *lungi* (a traditional skirt like menswear) to men who accepted to have a vasectomy. One respondent additionally reported the private hospital and pharmacies as sources of information relating to contraceptive methods. Two out of five respondents also mentioned learning about contraceptives methods through the TV and posters.

One respondent stated that there are fewer short term methods for men, claiming that most men only knew about condoms as a birth control method for men. According to this respondent, men are not aware about the different types of family planning methods.

Contact with community health workers

Only one of the five respondents had ever talked to a NGO health worker who visited households in their neighbourhood. Three respondents knew that female health workers visit women in the locality and talk about issues related to pregnancy, child health and family planning methods, stating that the health workers encourage women to use the pill and injections. One respondent reported that a few days before the interview a health worker had visited his house and advised his wife to take injections for birth control. He forbade his wife from taking the injection, suggesting that it could cause physical problems; however, he was unable to specify the types of problems that could occur. Another respondent mentioned that health workers from Marie Stopes clinic used to provide condoms and pills during household visits, but they had discontinued these visits. The final respondent, who had been living in Dhaka for three years, said that he was not aware of any health workers visiting his home.

Knowledge and Perceptions of LAPM

As indicated, all couples were using short term methods and were unwilling to switch to any long term or permanent methods, with male respondents citing several reasons including the following: the methods they currently used suited them well; they believed there were many side effects associated with the long-term methods; they wanted to keep open the option of having additional children in the future; and there were religious barriers associated with using longer term methods.

Three out of five respondents stated that permanent methods can have adverse consequences on health. One respondent reported that the husband of his cousin who had had a vasectomy was unable to do heavy work after the operation, including pulling a van or rickshaw, which had been his previous occupation. In another case, his wife had wanted to undergo an 'operation' (ligation), but the respondent did not agree due to the belief that, after having the operation, his wife would no longer be able to carry out heavy work. In another instance, a health provider from Marie Stopes clinic had tried to persuade a respondent to undergo a vasectomy for which he was promised two to three thousand taka along with a *lungi*. But he refused, claiming that his pharmacist had told him that he would lose his sexual power. The respondent said,

He (the pharmacist) discouraged me to go through the operation. He told me that if you have the operation you will lose your sexual power, you will be a man with a male body but will have nothing (no sexual prowess).

Two respondents stated that permanent methods are forbidden in Islam. One said,

In our religion doing 'operation' is forbidden. I will not do the operation. How can I give up my fertility power! I feel guilty when I think about the permanent method (referring to the fact that it is perceived as a religious sin). I will never do the operation.

Another respondent stated that if he would lose his sexual desire as a result of undergoing an operation he would never feel proud as a man. Due to this, he would never accept going through a vasectomy.

Husbands' Involvement in Family Planning

Four out of five respondents thought that women should be primarily responsible for family planning and contraception, maintaining that females are more knowledgeable than males about issues related to reproductive health and that women stay at home and can therefore more readily consult with health workers. When asked about their involvement in family planning, a frequent comment was that health workers do not talk to males. Respondents also commonly mentioned that males were always busy with their work and therefore unable to meet with and talk to health workers about family planning issues. Only one respondent thought that males should also be using contraceptive methods, particularly if the partner has adverse health reactions when using methods.

Two out of five respondents reported obtaining contraceptive methods (both pills and condoms were mentioned) from pharmacies. One respondent said that he purchased three packets of pills at a time, and after finishing two packets and when there were 10 tablets left, his wife would remind him to purchase more pills. He indicated that, as he was familiar with the medicine seller, he did not feel embarrassed buying the pills. In the other cases, it was mentioned that their wives purchase pills from a pharmacy, which contradicts information collected from their spouses.

Suggestions Regarding Improvements of Family Planning Services

When asked about what can be done to improve the use of contraceptive methods and enhance family planning, respondents suggested that there is a need for more health facilities in their living area that provide family planning services for both males and females. One respondent said,

The government and NGOs should take initiative to establish family planning centres in each area and provide more services to the people. People should also be informed about family planning centres. Poor people can't travel far (to get services). In every centre there should be enough health workers. People should be ensured that all the required services expected by clients are available at the centres.

It was also recommended that health centres provide methods at low cost or free of charge to poor people, which will better allow them to use methods according to their needs. One respondent suggested that government facilities should be more engaged in providing information related to family planning. Another respondent pointed out that in government facilities, corruption in the distribution of methods is common, which he stated should be controlled.

Most respondents recommended that family planning workers visit households on a regular basis. One respondent stressed the importance of greater awareness raising, claiming that only if residents are better informed will there be improvement in the use of family planning methods. He asserted that health workers need to spend more time in communities in order to motivate people to go to health centres to receive family planning methods. This same respondent also indicated that information spreads quickly in slum settings, claiming that if one person is informed about family planning, that person will typically share the information with ten other people. It was also suggested that more male health workers be available to talk to men.

One respondent recommended that workers like those working in garment factories get a day off during the week to obtain health care including family planning services. This same respondent also recommended that health workers provide health services to the garment workers during their lunch time or visit garment workers during holidays.

Two out of five respondents mentioned that family planning related information should be broadcast through the mass media such as the TV and radio. One respondent suggested that people are often embarrassed to purchase family planning methods, and that if advertisements are widely shown on the TV or in public places such as on billboards and posters, people might overcome any embarrassment to obtain methods.

CHITTAGONG: MIGRATION

Background of Respondents

The average age of respondents was 36.2 years, with the mean number of years having lived in Chittagong 1.1 years (Table 3). All respondents were married and lived in a nuclear family; the mean number of family members was four. Five of 10 respondents had no formal education, and those respondents who had attended school had on average 1.8 years of schooling. When living in the village, the primary livelihood of three respondents was agriculture, and four were fishermen. Two respondents were day labourers (digging soil for construction) and the final respondent was a rickshaw puller. At the time of the interview, their employment was as follows: rickshaw puller (5), construction worker (1), street vendor (1) auto rickshaw driver (1), cart puller (1), and mason (1). The monthly income of respondents ranged from 6,000 to 15,000 taka with the mean income 9,900 taka.

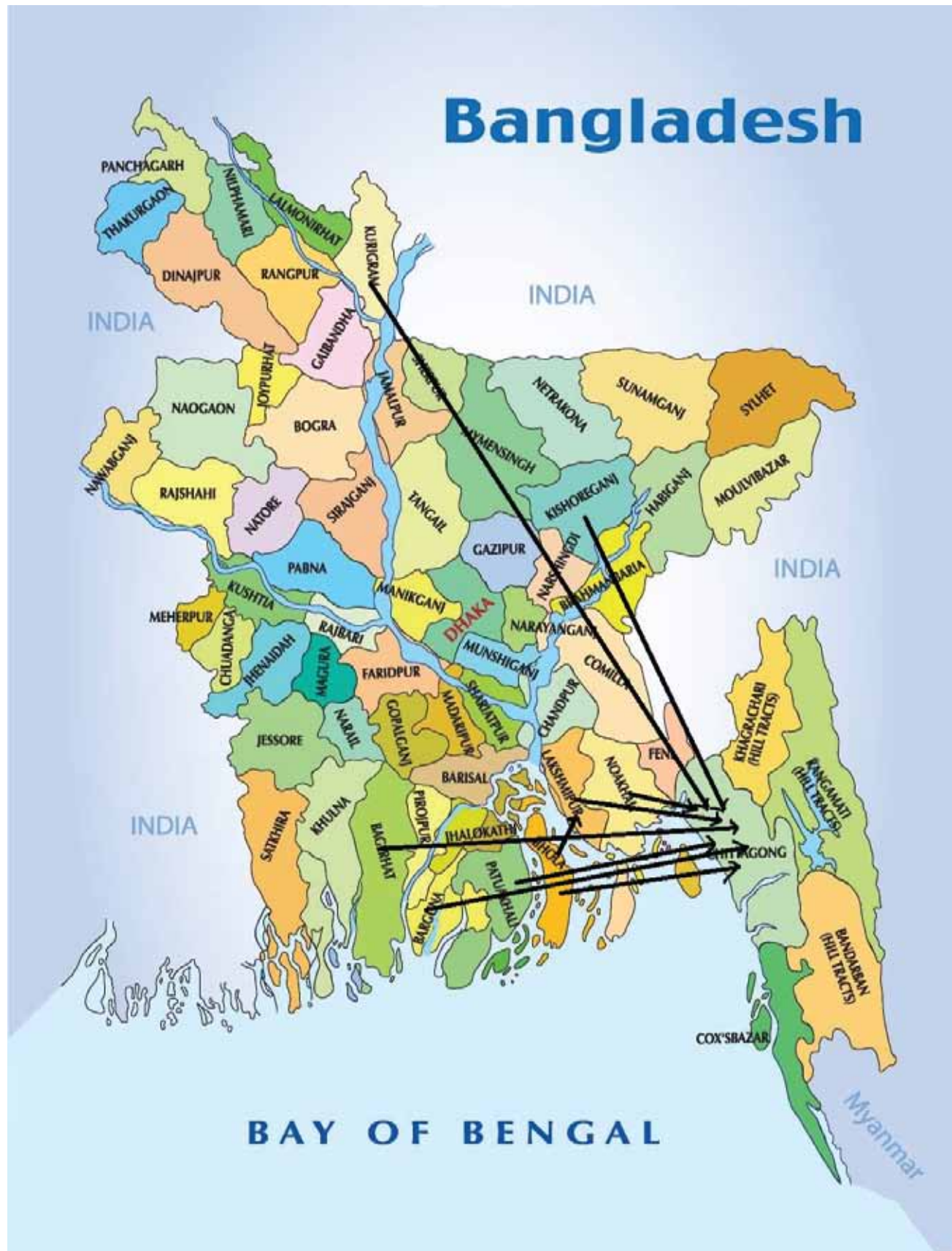
All respondents were living with their spouses at the time of the study. Four of the respondents' wives had no education; of the six who had attended school, the mean educational attainment was 3.2 years. Four of 10 of the respondents' wives worked as garment workers, and the rest were housewives. One respondent had two daughters working in the garment industry, with one daughter earning 3,000 and the second earning 5,000 taka per month. Another respondent's daughter was earning 5,000 taka per month.

Respondents living in Chittagong migrated from Bhola (3), Kishorgonj (2), Bagherhut (2), Noakhali (1) and Borguna (1) (Figure 2). One respondent stated that he had first moved from Bhola to Lakshmipur and later migrated to Chittagong. In general, respondents were from known cyclone and flood prone areas like Bhola, Potuakhali, Barishal and Bagherhut.

Table 3. Background information of migration respondents in Chittagong

Variables	Chittagong	Range
Age of respondent	36.20 (mean)	32-45
Educational status No education Respondent having formal education	5 1.8 (mean)	1-4
Occupation at the time of interview Day labour(Road construction)	1	
Small business(Street vendor of fruits)	1	
Rickshaw puller	5	
Driver(auto rickshaw)	1	
Cart puller	1	
Mason	1	
Number of living children	3.20 (mean)	2-5
Type of family Extended Nuclear	10	
Years of Marriage	14.20 (mean)	7-19
Age of spouse	28.20 (mean)	22-33
Education of spouse	2 (mean)	0-8
Occupation of spouse House wife Garment worker	6 4	
Religion Muslim	10	
Duration of stay in Chittagong(years)	1.1 0 (mean)	1-3
Number of family members	4 (mean)	1-7
Income(monthly)	9,900 taka (mean)	6000-15000

Figure 2. Migration from place of origin to Chittagong City



Reasons for Migration

a) Environmental

Primary environmental reasons linked to migration included: flooding (1), river erosion (5), cyclones (3), and sea water infiltrating their agricultural fields (1), with some respondents affected by multiple disasters. A common pattern found in seven out of ten cases was that respondents had lost their land, homestead, crops, and animals due to environmental causes, in the process losing all of their assets as well. Subsequently, respondents had to take loans but were unable to maintain loan payments and daily living costs. All respondents eventually decided to move to the city due to poverty. One respondent affected by the cyclone *Sidr* explained,

Before Sidr my economic condition wasn't so bad. If I worked one day, I could rest for the next five days relying on one day's income. After Sidr I fell into trouble because my house and property were damaged I had some goats, but two goats died. My house was destroyed. My father's house was also destroyed. The night when our house was damaged we took shelter in my uncle's house because it was safer. We passed that night anxiously. In the morning when I inspected our land it was very difficult to identify the house. Everything was damaged by the storm.

Another respondent who was affected by two big cyclones (*Sidr* and *Aila*) said,

Sidr came at midnight and at that time my family members were staying in the house. It had one room, six or seven trees fell on that room and it was covered, but the pillar of the room was strong and the room did not collapse. We, around 13 people, climbed on to the roof. My father measured the water level with a piece of bamboo; it was 8 to 10 feet....we were not able to leave the roof because trees had fallen on the house and water was flowing into our home.

This same respondent also described how his fishing business was affected by cyclone *Aila*, which occurred nine months later. He said,

The water that came with Aila was salty. As a result, the entire cultivation was spoiled. The land lost its fertility. Shrimp left their enclosures. All of our fish escaped from the pond.

Another respondent mentioned that in his area, people affected by river erosion and displaced to other places were referred to as *Ola* (destitute). He shared his experience with river erosion in his village as follows,

When my house went under water, our paddy field was not too far from the river. While at night there was still some land between the field and the river, in the morning I saw the distance between the river and paddy field getting closer and assumed that after a day the entire paddy field would go under water. At that time the paddy needed more time to be fully mature.... I didn't want to cut the immature paddies. The paddy was growing very well. I thought that around 30 to 40 mon (1 mon= 37.324 kg) would grow which would be enough food to supply my family for a year. But within four days the whole paddy field was under water.

b) Joblessness

While environmental factors pushed these families into joblessness and poverty, ecological causes were rarely mentioned as explanations for migration. Rather, respondents generally indicated that they migrated to Chittagong due to joblessness, loss of assets, and poverty, describing an inability to maintain basic family needs due to financial deprivation in the village setting. For example, one respondent had a tractor which he rented to other farmers and this was his primary source of income. After a big storm occurred, local people lost their crops, did not have work and could no longer pay rent for the tractor. The respondent suffered a big financial loss, forcing him to take loans and sell the tractor. He described his situation as follows,

The people who used my tractor to prepare their land refused to pay the fee for renting the tractor. They argued that the flooded water damaged their land and therefore it was not possible to pay me the money they owed. They said that in the subsequent season they would cultivate the land again. If the crops grew well, I would be paid. The farmers faced financial losses, so they could not pay the dues they owed me.

Another respondent whose village experienced river erosion described joblessness in the village.

The erosion of the river Meghna was so rapid. I lost my house and cultivated land. I had cultivated land that was destroyed by the river.....as a result, I became jobless. You know, after the land was flooded by the river, the land had disappeared forever and there was nothing else. When I became poor how could I survive there? Where could I build a house? There was also no work.

c) Loans

Nine out of 10 respondents acquired loans ranging anywhere from 1,500 to 2 lac taka. Loans were obtained from different sources, including institutions like BRAC, ASA, HEED, Uddipon, Grameen Bank, as well as from individuals such as relatives, local money lenders, and neighbours. Some respondents procured loans from multiple sources, with one loan taken to repay another. As the situation worsened, they searched for ways to pay the loans and decided to migrate to the city. One respondent, a fruit seller in Chittagong, described why his financial situation in the village forced him to obtain loans, saying,

In the village, I could not provide support for my family. There was not much work. Even when you don't have any work you still must eat because your stomach will not listen to the fact that you are jobless. I had to buy basic foods like rice and lentils for the children. When I had no work, I got loans (20,000 taka). I paid 15,000 taka by selling my house and the remaining 5,000 taka I paid after migrating to the city.

Another respondent who lost his house, fishing nets and cattle during the cyclone *Sidr* explained the reasons he was forced to take loans when living in the village. He said,

In total, I lost 1 to 1.5 lac during the disaster (Sidr). My nets, cattle, and house, everything was gone. That's why I migrated to Chittagong. My daughter had taken the JSC examination but we didn't wait to receive the results. We could not continue living in the village. I was in debt.... how many days could I stop them (the creditors)? That is why we migrated here.

This respondent took out loans from Grameen Bank, ASA, and BRAC. At the time of the interview, he was repaying the money through instalments. Another respondent described how sea water damaged his crops and impacted his economic situation, forcing him to take out loans. He said,

The first time water affected the newly cultivated paddy. The paddies were under water (sea water). When heavy rains occurred again water flooded my paddies a second time. Again, just when the paddy grain was starting to grow, the water damaged the crops.... These were the major losses in my life. These losses made me vulnerable economically. As a result, I fell into debt, having to borrow 70,000 to 80,000 taka

One respondent explained how he was repaying loans amounting to 15,000 taka through instalments. He said,

I have taken loans from the Uddipon and ASA. I paid these loans through my wife's salary I had a good relationship with the NGO manager and I migrated to Chittagong without paying the loans. After migrating to Chittagong, I sent instalments (through email banking called Bkash). The manager was a good man and he talked with me over the phone and agreed that I send the money gradually. I paid the instalments monthly instead of weekly. By this way, I paid back all the loans.

Another respondent described how desperate the situation was. He said,

There was no way to survive in the village, I was in extreme debt and people were asking me to repay their money. In this situation, I took the decision (to migrate) because I thought that it would be very difficult to stay there (in the village). Then I came to the city.

The following case studies provide more in-depth descriptions of the reasons respondents migrated to Chittagong.

Case Study One

A man 35 years of age migrated to Chittagong a year prior to the study. When he was in his native village of Bhola he was engaged in agricultural work. However, his farming land was flooded and, as a result, all his crops were destroyed. Because he had borrowed money (8,000 taka) from local money lenders to invest in farming inputs, he fell into debt after the flood. As a result, he had to sell his house to repay the loans. Subsequently, he decided to pursue a fishing business in Bhola. In the rainy season he continued his business, but when the rainy season was over, he did not have sufficient work and migrated to Lakhkipur with another fisherman. There he borrowed 80,000 taka from another source, and he bought a boat for fishing. When he started to re-establish his financial situation, his boat was captured by thieves who also demanded 30,000 taka. He subsequently migrated to Feni where he was employed to operate a machine to thresh paddy. He was able to save some money which he used to purchase a piece of land in Lakhkipur. However, during the rainy season the land went under water due to river erosion. He leased another piece of land to cultivate, but again lost this land due to river erosion. Finally, he decided to migrate to Chittagong where, at the time of the interview, he drove an auto rickshaw earning 9,000 taka per month. His wife worked in the garment factories where she earned 4,000 taka per month.

Case Study: Two

Another respondent from the southern part of Bangladesh was a van puller in his village; his daily salary, along with income collected through various assets, allowed him to support his family costs. After his village was struck by a powerful cyclone (Sidr), he lost his home, his cattle and the little property that he owned. His father's house was also destroyed, and he and his family had to take shelter in his uncle's house. This respondent had an estimated loss of 50,000 to 60,000 taka due to the cyclone Sidr. After the cyclone, his income decreased, and he was no longer able to cover his family costs. He sold his van and took out loans of around 20,000 taka from Asha and Uddipon (NGOs) but continued to struggle economically. He communicated with his brother who had migrated to Chittagong, and then moved there with his wife and a child. In Chittagong, he worked as a rickshaw puller and earned around 300 taka per day. His wife got work in a garment factory, and her income was 5,000 taka per month.

Additional Reasons for Migration

Respondents believed the city would provide opportunities to earn more money, repay their loans, and maintain family costs. One respondent described Chittagong as a holy place and a symbol of hope, saying,

From early childhood, I heard that people can earn money in Chittagong and that it is the place of 12 saints (Aulia). In the 12 saints land, people can become someone (meaning as a holy place people can become successful).

Many respondents had learned from their relatives and friends who had already migrated to the city that there were job opportunities, and it was possible to improve their economic situation in the city. Fewer respondents also mentioned that female family members would also be able to work and earn wages in the city. One respondent said,

I used to fish when I was in the village. I could not maintain my family with my earnings. Then some people advised me to go Chittagong for work. They also told me that in Chittagong it was possible for my daughters to earn and by this way (multiple wages) we could lead a better life there.

Accompanying Family Members

In a few instances, the male household head first sent either his wife or daughters to Chittagong so that they could start earning money prior to his joining them in the city. In most cases, the entire nuclear family moved to the city at the same time, or the husband moved first and was later joined by his wife and children. One respondent and his wife left their children, who were care for by their grandparents in the village.

Decision Making for Migration

The decision to migrate was taken jointly by members of the nuclear family and was also frequently discussed with friends, relatives, and extended family members. Issues that contributed to the decision making process included the fact that different types of jobs were available, there were job prospects for female members, loans could be paid off, and they could avoid the creditors who hounded them in the village. While respondents were uncertain about the type of work they would do, they knew what jobs their relatives, friends and acquaintances, who had already migrated, were engaged in work after having moved to the city.

Selection of Urban Sites

Selection of the initial location chosen by the migrating people and the first household where they resided in Chittagong was influenced by social connections with family members, friends and acquaintances who had already migrated to the city. It came out from the study that, people choose to migrate to areas where they have relatives or which are inhabited by people from the same village. These contacts can assist migrants to cope with their new and unfamiliar living environment by housing them temporarily or helping them find work and a place to live. They also typically provide the new migrants with important information related to house rents and wages. In our sample, five out of ten respondents mentioned that they initially stayed in the homes of relatives before moving to a rented house.

Experiences in the Urban Slum

In Chittagong, slums are commonly referred to as ‘colony’, which are often inhabited by people from the same district. At the time of the study, most respondents lived in a single room with rent ranging from 1,200 to 3,000 taka. Housing conditions varied according to the price. In general, respondents paying cheaper rents lived in rooms made of raw materials, with the less expensive rooms having bamboo walls and mud floors. The least expensive home rented by one of our respondents had a tin roof with bamboo walls, measured about 7 x 9 ft., did not provide gas for cooking, and had water available only two times during the day. On the higher end, the walls were made of tin, and while small, rooms had a veranda; there were also cooking stoves shared by multiple families. Irrespective of the type and size of the room, almost all respondents shared the bathing room and toilet with multiple families; for instance, in a large slum two toilets were shared by 90 families.

Post Migration Challenges

Respondents reported that as new migrants, they faced multiple challenges related to their living conditions and financial and social situations.

a) Living Conditions

Respondents made comparisons between their new residences and the village setting, mentioning that in the village their homes were relatively big, and they lived in open spaces, but in the city they were confined to one room and resided in congested and overcrowded quarters where their children were unable to move around freely. They also highlighted the difficulties they faced sharing toilets, bathrooms and cooking facilities with many other families, maintaining that they had to stand in queues to use these facilities, which was inconvenient and caused them embarrassment. Two respondents mentioned that their immediate surroundings were often swamped with stagnant water, particularly during the rainy season. During times of water inundation, it was difficult to move from one place to another and often impossible to visit the market. One respondent said,

It was so difficult to live here; we used to keep the children on the bed while we went out to collect drinking water and food from the market. Because the stove was under water it was not possible to cook in the house. During these times it was not possible to go out for work.

Irregular water supply and poor water quality was also a big concern for many of the respondents. Respondents from Pahartoli and the EPZ and Port areas, which included five out of ten of our study sample, reported an irregular water supply, forcing them to use pond water for cooking, washing, and bathing. One respondent said,

There is a small *puskuni* (ditch/closed water body) beside the road, and we take baths and wash utensils and cooking materials with this water. I can't take my meal when I think about the dirty water, I feel bad to use this water but we have no choice. ... We collect drinking water from a pond in the *Mazar* area and use fitkiri (alum/a purifier) for drinking.

Another respondent said,

Here there is no water supply. We drink water from a pond. For cooking we purchase a water drum which costs 400/500 taka monthly. For 12 households, there are two different toilets (one for males and one for females) which remain very dirty.

The third respondent stated,

We have no problems with drinking water, but we have problems getting washing and cooking water. We have to collect cooking water from other people's ponds, but sometimes the pond owners don't allow us to take the water and force us to pour the water from the pitcher back into the pond.

Water for bathing was also frequently mentioned as a problem. One respondent indicated,

In the village, we used to bathe in the river, but here we have to take a bath in the ponds which are full of rubbish. The water is very dirty. When we came here (to the city) we developed rashes which caused itching all over our bodies due to this.

Three of ten respondents mentioned that they had no gas supply in their house and had to use mud ovens and wood for cooking. Of the others who shared gas stoves with multiple families, several reported the gas supply was often inadequate, sometimes not permitting them to cook.

b) Financial/Job Related

Most respondents indicated that finding a job was initially difficult. Although some respondents were assisted by their social contacts who already lived in the city, often engaging in the same job as their family members or friends, or were helped by their landlord to find a job, others faced challenges finding suitable work. As indicated, before migration most were farmers or fishermen. After migration, they got involved in various types of work completely unrelated to their former work experiences, including pulling a rickshaw or van, repairing roads or doing construction work, working as a security guard, and selling goods (e.g. fruits, vegetables, cigarettes, clothes). Initially, they often lacked appropriate skills and faced multiple challenges as they became accustomed to the job. As a result, respondents frequently switched from one job to another, with each of the respondents attempting at least two different jobs and one respondent changing jobs four times. Reasons for switching jobs included that they did not have the appropriate skills, could not endure the physical demands of the work, or found that the wage was too low to cover ongoing living costs. One respondent shared his experience stating,

Initially, I was involved with road construction work but switched to rickshaw pulling because in road work I had to dig soil and experienced pain in my body. I told my wife that I could no longer tolerate the work involved in constructing roads and wanted to drive a rickshaw. My wife told me that I might have an accident because I did not know how to pull a rickshaw. Then I asked my cousin and he also advised me against pulling a rickshaw. I felt that I did not need any training and went to a garage and rented a rickshaw anyway.

While a common occupation was pulling a rickshaw or van, many respondents indicated that the work was very strenuous and the hours were long, with respondents often having to work the entire day and into the evening seven days a week, earning on average 120 to 250 taka per day. At the outset, rickshaw pullers indicated that they did not know how to handle the rickshaw properly, did not know the distances to places or the appropriate fares, and could not identify roads and the destinations of clients. One respondent stated that he was slapped twice by passengers for poor control of his rickshaw. The dialect used in Chittagong also posed a problem in communicating with the rickshaw owners or passengers. One respondent shared the difficulties he experienced,

I was completely new here, I did not know the place and language. The first eight or ten days the problems I faced were very difficult. They (passengers) asked me to go places but I did not understand.

Another rickshaw puller stated,

After coming here I only worked in areas near my neighbourhood and after some days the place gradually became known to me. I located a new place one day and another day located another one. When I didn't know the fare I would ask another rickshaw driver.....the driver would tell me the right fare and I demanded that fare accordingly. I never demanded excessive money from passengers. If you demand too much money the local people may get angry and beat you.

Respondents who pulled battery driven rickshaws had higher earnings, ranging from 500 to 600 taka per day. However, they had to spend money (80 taka) to charge the battery of the rickshaw; rent for the rickshaw was also higher, averaging 300 taka daily.

Almost all respondents reported earning a daily wage and working over nine hours seven days a week. While respondents indicated that it was difficult to work daily, they explained that otherwise they could not meet family expenses. Overall, rickshaw pulling, construction work, loading and unloading of material, digging soil and welding were described as particularly strenuous. One respondent said,

I have only one problem here (in the city) and that is I feel pain in my legs after pulling a cart and usually I need to take medicines daily.

In addition to problems related to the physical strain and relying on a daily wage, respondents expressed concerns about the continuity of the work or the fact that, if they got sick, they would lose wages and not be able to earn money to provide for the family needs. Some worried that they could not save enough money to repay loans in the villages. Unexpected problems also occurred. For instance, after spending one year in Chittagong, one respondent took out a loan amounting to 10,000 taka to start a small business selling fruit. When strikes occurred, he was unable to sell his produce which subsequently spoiled, causing him a substantial loss of money.

c) Social

As newcomers, our respondents stated that they had limited contact with city residents other than the people with whom they had prior relations. They were also uninformed about health facilities, roads and transportation systems. One respondent expressed worry about his children who were left in the village, stating,

I always feel tension, I live here but my children live in the village and it causes tension. If I spend time unemployed, my family will suffer there (in the village).

Respondents frequently switched their residences, with the most common reason for moving related to problems with the physical environment, such as overcrowding or insufficient toilets and cooking facilities. Another common reason was to be closer to the work place, particularly as it affected employment for female family members. For instance, two respondents mentioned that they moved to the EPZ or Port areas so that they could find work for their wives or daughters in the garment factories. Seeking lower room rents was another reason for changing residences.

Visiting the Village and Family Obligations

Respondents only visited their extended family members once or twice a year but communicated by cell phone with family members regularly. Two respondents mentioned that they limited visits because of the transport costs involved. In several cases brothers or sisters looked after their parents in the villages, and most respondents felt they had no obligation to send money to family members in the village. A few respondents did report sending money to their parents, but only periodically.

Health Care

Respondents perceived health care costs in the city to be high compared to the village. One respondent said,

I think in the city people have a lot of money to get health service. The cost of treatment is so high in the city. If you want to consult with a good or qualified doctor, you need to spend at least 400 to 500 taka.

The second respondent said,

Here the price of medicine is so high. Medicine costing two taka sells for five taka. You have to buy medicine according to the price they ask. As not everybody can read, we are often fooled (into paying extra money).

Another respondent also explained that people are cheated when availing health care. He said,

People cheat the patient; there are many dalal (brokers) who influence patients to go to low quality providers. The broker will suggest a doctor (with whom the broker is linked), but we don't know about doctors and the treatment they give. The people who are educated may understand. On the other hand, people who are not educated like me will not know which doctor is good and which is bad. We are easily fooled and can fall into a trap.

Some respondents also mentioned that they felt more comfortable visiting the health workers in the village because the providers were known and respondents were familiar with the health facilities. One respondent said,

The health service in the village was very good because my house was there (close by) and most of the providers were familiar with me. On the other hand, in Chittagong the people in health care are not familiar.

At the same time, respondents occasionally mentioned that an advantage in the urban area is that there are many health facilities, which is not the case in villages. However, they indicated that they lacked information on the specifics of the facilities and services offered. One respondent stated,

I don't know about it (health facilities) because I am a newcomer in this area. The people who are living here for many years know about health care services.

Only two of ten respondents mentioned that female health workers visited their homes; however, they explained that these workers only provide maternal health care to women and never share information with males. One respondent said,

They (health workers) come from the BRAC and they provide pusti (nutritional supplements) and iron tablets to the pregnant women. They also provide check-up services to the pregnant women.

Due to the costs, respondents generally preferred pharmacies for health care, indicating that they weren't required to pay a consultation fee but simply purchased the medicines prescribed. A respondent said,

I get treatment from a roadside pharmacy. In the hospital if you consult a doctor it will require money. That is why I go to the pharmacy.

Respondents mentioned consulting providers in pharmacies for common conditions like diarrhoea, cough, fever, and body ache. Only rarely was the provider in the pharmacy a qualified practitioner "MBBS doctor," and in these cases, consultation fees had to be paid. In addition to the lower costs, other reasons for preferring pharmacies included that they were located near the home, the provider was always available, they liked the behaviour of the provider, there were no other health care options nearby, the quality of treatment was perceived to be good, and the cost involved was related simply to the medicine purchased, whereas the health facilities charged for costly lab tests. Several respondents were unable to describe health services in the city other than those offered in pharmacies. One respondent, who valued obtaining treatment from qualified providers, was an exception. He stated,

Actually I don't take treatment from ordinary doctors (medicine sellers). I will tell them one problem but they may understand another, they may give me the wrong medication. The sickness can be aggravated by taking the wrong medication. On the other hand, if I spend 30 or 100 taka I will get proper treatment in a health care centre (formal health care facility like NGO clinic or hospital). They will check my pressure and will give me proper medication.

Those who knew about health care facilities typically had received information from neighbours, friends and relatives, and they or their family member visited the facility only for a special health problem. Two out of ten respondents knew about NGO clinics, namely Smiling Sun and BRAC, where their wives went for maternal health care. Four out of ten respondents knew about private practitioners and private clinics like Momota and Chander Alo, with two obtaining care at Chander Alo, and two respondents mentioned clinics run by the Chittagong City Corporation called "Nagar Sayastho Kendro". One respondent mentioned receiving care for severe diarrhoea at the Chittagong Medical College Hospital, and one respondent went to the eye hospital for eye problems. Interestingly, government facilities were generally not preferred as a health care option. One respondent said,

Government health facilities are not 'government' (meaning free of cost). The government supplies medicine to the facility but the hospital people don't give it to the public. If you go there, the hospital people give a medicine and ask for 10 taka; they also give a list of medicines to buy from

the pharmacy. In the government hospital, you have to wait in a line; if you go there in the morning you will return home at midday. If I have to buy medicine from outside the hospital, it does not make sense to go to the government hospital. They take bribes. Only people familiar with the staff get medicine for free.

Recommendations for Improvements in the Slum Setting

Respondents made various suggestions aimed to improve their living conditions. These included a cleaner physical environment, ongoing access to gas for cooking and electricity, better water supply, improved sanitation, and better transport systems. One respondent said,

We want a good water supply, drainage systems and solutions for the gas problem in this area. We need a government hospital in this area to get better treatment for poor people.

Another respondent responded,

I pay 1,200 taka house rent in a month. There is no gas in the house. We use fire wood for cooking. We need a gas connection in the house. But if I demand the gas connection, the house owner will say, who are you? If the owner gives the gas connection he will raise the house rent. He may charge 2,000 taka per month.

One respondent who expressed the need for a cleaner physical environment, said,

At first they (the government) need to improve the living environment of this area. The toilets are unhygienic, full of germs and spread a bad smell. We can't eat properly due to the bad smell.

Another respondent stated,

If the roads are good, the gas facility and the drainage systems are improved, that would be good for the people of this colony. The waste water is stagnant outside of the colony. It emits a poisonous smell. If the drainage system is developed, the waste water will flow and the smell will be gone.

Several respondents expressed a need for low cost health care facilities. One comment was,

We have no health facility for poor people. Imagine when a child falls sick, it will require at least five to ten thousand taka for treatment in a hospital. If we had a health facility for poor people, we could go there for health problems.

Another similar comment was,

If a government hospital is established that would be good for the poor people. They could get treatment and medicine free of cost. Poor people have to buy medicine from the outside (pharmacies). Suppose the price of a medicine is 150 or 100 taka, and our daily earning is 150 to 200 taka. We have to buy other goods for the family. How it is possible to manage?

Another respondent suggested that more job opportunities should be created so that poor populations can have greater job security and improve their financial situation.

Perceptions of the Decision to Migrate

Most respondents acknowledged that after migration their economic situation was better, maintaining that in the city they were earning money to meet their daily needs and could eat regularly. Although they reported that the living environment in the village was more peaceful and comfortable and that they missed their relatives and friends, they did not regret the decision to move, mainly because they had work, earned an income and were hopeful that their economic condition could improve in the near future. One respondent said,

Now our condition is getting better. There were no jobs in the village, we had no land, all our land was ruined by the river. In the city, I can drive a rickshaw or van and survive. In the village, we had huge loans, so I sold the house.

Another respondent described the changes from village to city life as follows,

We did not usually eat two times a day in the village. Here we can eat at least twice a day. Here my children can wear cloths, can eat regularly. They do not confront the sufferings which we used to face in the village. Here we are passing our days in one kind of peace. If we had stayed in the village, we could have fallen into huge debt.

There were several examples of how earning regularly and having access to cash was valued by respondents. One respondent stated,

I earn cash here, meaning 200 to 500 taka daily. This amount is always available in my pocket. If I want, I can spend it anytime; that was not possible in the village. I worked as a day labourer in the village, but the employer would not pay me regularly, he would ask me to come for payment the next day. He didn't understand that I had no food in my house.

Two respondents mentioned that female family members were also generating wages in the city, which they viewed as an added opportunity to improve the family economic situation.

Earning enough money to repay outstanding loans was generally a very important target for our respondents. Most of the respondents (eight out of ten) who had loans in the village were paying instalments to creditors and institutions through e-banking (Bkash). One respondent said,

I think I have taken the right decision (by moving to city); we have a goal to pay off all our loans before going back to the village again.

However, two respondents stated that their economic situation had not improved much, and they could not save enough money to repay their loans. In addition, four respondents mentioned that paying for education of their children was financially difficult for them, with some more willing to invest in the education of their sons. One respondent stated,

My son (ten years of age) is studying but my daughter (14 years) is not. I am not able to continue to pay for my daughter's studies because of economic problems.

Another respondent also indicated that he is unable to send his daughter to school due to financial problems, saying,

She was in class four. Now I can't get her into a school.....extra money is needed to admit her into school but I don't have the ability to pay. Moreover, she needs the school dress and many other things (to continue studying).

One respondent mentioned that his two children were studying in a 'madrassa' (Arabic school) because it was less expensive compared to formal schooling. Another respondent did not send his daughter to school because he needed her to generate an income. He indicated,

My daughter (15 years old) is now working as a garment worker. Because I am experiencing a financial crisis, I could not enrol her in studies. She works far from here in a garment factory at Barisalla Bazar.

Only one respondent appeared regretful about moving, stating,

I did not know that I would experience such a difficult life here. If I compare the conditions of urban to village life, then it would not be possible to continue to stay here.

Future Plans

The majority of respondents desired to go back to the village after fulfilling their goals in the city, which most commonly related to repaying loans they had accumulated. Therefore, they were trying hard to earn enough money to meet their ongoing costs and to send regular instalments to repay loans. One respondent explained, "If I can earn enough to set aside big savings and pay off all the loans, I will move to the village again, because most of our relatives are living in the village." Often respondents considered the city as costly and a foreign place and therefore did not want to stay permanently. Another respondent said,

This is not my birthplace, so I do not want to live here permanently. It is a kind of foreign place for me. I have my own district. I will go back to my district. Suppose I have a huge problem here, then who will take care of me, here I have no relatives. If I lived in my village, relatives would help me to solve my problems. For example, if I need 5,000 taka for an emergency, then I can borrow it from my relatives in the village, but I can't manage to get it here in Chittagong.

One respondent also highlighted the high cost of living in the city as a reason to return to the village, he stated,

I want to go back in the village. It is not possible to live in the city. Day by day the house owner raises house rent. Now, how can I meet my household expenses? How can I pay the house rent? After the end of the month I have to pay 3,000 taka (for house rent). It is not possible to pay this money by doing this job.

Several respondents were also determined to save enough money to re-establish their former lives in the village, expressing the desire to buy a house, land for cultivation, animals, or materials such as a boat and fishing nets to continue their former professions in the village. Overall, living in the village appeared to present a more dignified existence. One migrant said,

When I can go back in the village depends on how much money I earn. I have to earn enough money to build a house in the village. Then I will think about going back.

Another respondent explained,

When my son is grown enough then we will do fishing together. If I buy a boat for 15,000 taka with a motor for a total of 20,000 taka and a net for 5,000 taka, then we will catch fish and earn 500-700 taka (daily). These are the hopes I have.

Another comment was,

Now I am living in a rented house as a tenant. If I can make some capital, I will go to the village. I have no land now, but if I make some capital I will buy one gonda of land for my family members. Is it possible to advance by living in a rented house? So, if I have some money, I will buy land (in the village); it may be a small piece of land, but it will be my own land.

Another respondent who wanted to re-establish agriculture work in the village, said,

Now they (his children) are little. When they grow up, then I can go back to the village. You know, in our village the paddy cultivation is good this year. I think day by day the paddy production will be better. If the production improves in the village, it will not be necessary to stay here. I will start paddy cultivation by working leased land in the village.

A few respondents mentioned that they were saving money for the marriage of their daughters. Others were also focused on investing in their son's future, believing they may be in a better position to help the family. One respondent said,

Every man has a plan for their children, I also have a plan. If my son can study and get a good position that would be good. ... We are surviving doing other people's work as day labourers. I will try for my son to get a good position and not be like his father doing day labour. On the other hand, if my daughter passes S.S.C, then it will be good for her; then I can arrange her marriage with a good man.

One respondent wished to send his children abroad for higher education so that they could later assist him financially. He said,

If Allah helps me, when my children are grown up, I want them to be educated. After that, if I send them outside (abroad) and I can buy some land, that would be good. If when the children are grown up, they do good work it will be possible to improve our financial situation.

In addition to long term goals, respondents also had short term targets to be fulfilled while living in the city. For instance, one respondent who worked as a day labourer wanted to save money to start a small business selling *Lungis*. He stated,

I want to establish a lungi business because doing business I will do less hard (physical work) work. If I do the lungi business, my legs can take rest. If I am successful in the lungi business, I will not need to carry heavy bricks on my head.

MATERNAL HEALTH

Background Information

The average age of respondents was 24 years (range 19-30 years). Four of the 10 respondents had not received any formal education; the others had attended on average six years of schooling. Respondents had been married on average six years. All but one woman were housewives, and the final woman worked in a garment factory. Husbands were on average 28 years of age. Four husbands had no formal education, and the other six attended school for an average of seven years. Occupations of the husbands were as follows: small business (4), rickshaw puller (2), shoemaker (1), driver (2), and day labourer (1). The average reported monthly income was 12,900 taka.

Seven families were nuclear and the other three were extended; the average household size included close to five people. Seven families were Muslim and three were Hindu.

Migration History

Two respondents were born and raised in Chittagong with one woman living in the same neighbourhood all her life. The other women had been in Chittagong for an average of 12 years, with several moving to the city at a young age. Home districts of respondents included Noakhali (3), Chittagong (2), Chandpur (1), Comilla (1), Feni (1), Bhola (1) and Sitakundo (1). While not all respondents were asked why they had migrated, several moved to Chittagong to join their husbands in marriage; one went to Chittagong at a young age to study. Living arrangements appeared to be relatively stable, with the majority living in the same location from the time they got married.

Health Care Options

Open-ended questions about health care options elicited a range of responses, which reflected the variability of services offered in the city corporation areas of Chittagong. Commonly mentioned sources of health care included BRAC; different clinics or health facilities (e.g. Mehman, Momota, Smiling Sun, Urban Primary Health Care Centre, Mustofa Hakim Health centre); hospitals such as Childrens, Chauck Bazar, Soudarn, and Chittagong Medical college which were generally far away and accessed for more serious conditions; local pharmacies where residents obtain medications; private doctor's offices; and satellite clinics where vaccinations are given. More traditional healers such as homeopathic healers, *huzurs*, *molli* (offering abortion), and *kobiraj* were mentioned by at least one respondent as sources of health care.

Maternal Health Options

When asked about maternal health care options, all respondents mentioned BRAC which appeared to be available in every neighbourhood where we carried out the study. Some women mentioned that BRAC is popular due to the fact that ANC services are provided at their homes, maternal services are available 24-hours a day, services are free of charge and no other formal deliveries services are offered in the immediate living area. This respondent said,

BRAC offers delivery free of cost and provides door-to-door service. People who are poor go to BRAC. Moreover, in this area there is no other facility that provides delivery service. There is a satellite clinic run by Smiling Sun, but delivery services are only available in their clinic which is far from here. That is one of the reasons poor people go there (to BRAC) whether they provide good or bad service.

Respondents mentioned that services offered by BRAC include ANC not only at home but in the birthing centre as well, a full pregnancy check-up given at seven months in a maternal health facility, delivery care, and PNC. While BRAC does not provide vaccination services, they refer women to the nearest satellite clinic where vaccinations are available. Some explained that BRAC workers visit all women in their area to gather lists of women of reproductive age, identify pregnant women, and do ANC check-ups.

Other maternal health care options mentioned by at least one respondent included Smiling Sun, Mustofa Hakin, Urban Primary Health Care Centre, Mehman clinic, and Momota clinic, which all offer ANC and delivery services. Smiling Sun, UPHCC, Mehman and Momota provide ANC in both their permanent and satellite clinics. ANC consultations offered by these latter facilities appear to be comprehensive, although some respondents emphasized that they do not offer ANC at home. It was also mentioned that women go to hospitals such as Chittagong Medical Hospital, Chauck Bazaar and Shishu Hospital for treatment related to maternal health.

Antenatal Care

Knowledge of ANC

Only one of 10 respondents knew that at least four ANC consultations should be carried out during pregnancy. The same woman indicated that ANC should start the first trimester of pregnancy. Of the other nine respondents, three stated that ANC should be done on a monthly basis. One respondent indicated that BRAC workers told her to go for three “formal” visits in a health centre, in addition to having home visits. Several respondents receiving BRAC services distinguished between clinic and home visits, with home visits perceived to be less formal and effective. The other respondents said that they did not know how many ANC visits were recommended despite the fact that several were attending consultations.

Questions regarding the components of ANC were not asked systematically. Respondents who were asked frequently mentioned that the mother’s and baby’s health and the position of the baby is checked. Two respondents emphasized the importance of ANC, particularly when the pregnant woman does not feel well or is experiencing a physical problem, with these respondents confident that the health workers can address any health problems. For example, if the child is in a breech position, it was believed that the health workers can change the position of the baby.

Several respondents mentioned that they learned about ANC from neighbours. When asked where women who had only recently arrived receive information about ANC, this respondent said,

They learn from us. We talk during our cooking time. When we have free time in the afternoon we gossip. If anyone wants to learn anything then we share the information. When I first came here I didn't know the address of the health centre where I can get medicine. I came to know by listening to people living nearby.

Other mentioned sources of information included health workers during household visits or satellite clinics, landlords, mothers-in-law and a cartoon (Mina and Raju) shown on television.

Previous ANC

Five respondents who had been pregnant previously were asked about ANC during other pregnancies, during which three women did not have any ANC consultations. One woman indicated that she lived far from a facility, and another woman said that her mother-in-law refused to have her visit a facility with the respondent stating,

They visited and told me about facility delivery but my mother-in-law said, “No, I will send her to the village. There is no need to do any treatment here.” I didn’t understand anything at that time, neither did my husband. We followed the advice of my mother-in-law. She said it’s not needed to do ANC here because she will send me to the village for delivery.

This woman’s first pregnancy resulted in a stillbirth, and she decided to attend ANC for subsequent pregnancies. The third woman did not elaborate on why she did not attend ANC. The two women who had ANC went to health clinics (Momota and UPHCC) for full check-ups three or four times. At the time, home ANC services were not offered.

ANC during the Recent Delivery

All respondents had ANC consultations during the most recent pregnancy, with all but one having the four recommended visits. Five of the 10 women, including three who chose to go to maternal health clinics, started ANC during the first trimester of pregnancy; the others started ANC in the second trimester. Several women had at least one visit per month from the first trimester onwards.

Of the 10 respondents, nine received some ANC from BRAC, with seven indicating that BRAC was their primary ANC provider. Of the seven women, five were regularly receiving ANC in their home and the other two were going to a BRAC centre. The services which the five mentioned receiving at home included being asked by the health worker whether the woman had any health problems, questions about the movement of the baby, checking the position of the baby, checking the blood pressure, advice about eating nutritious and sufficient foods and about resting, being provided with calcium and iron, and the recommendation to get tetanus vaccine at a nearby satellite clinic. In the BRAC centre, women appeared to have a more thorough exam, which was reported to include vaccinations, weighing the woman, urine tests and measuring the uterus. While women were referred for ultrasound in the eighth or ninth month of pregnancy, only one woman mentioned receiving ultrasound. Although ANC was generally free, a 20 taka fee was charged for vaccinations in the satellite clinics, and women were required to pay approximately 1000 taka for ultrasound.

Two of the other women received check-ups in formal health clinics (Mustofa Hakim and Mehman), and the final woman received ANC in a Smiling Sun satellite clinic. These consultations appeared to be more comprehensive; in addition to assessing the position of the baby, measuring the blood pressure, offering dietary advice, and providing calcium and iron, services included weighing the woman, offering vaccinations, doing blood and urine tests, receiving medication based on test results, and having an ultrasound (mentioned by two women). In regard to costs, the woman who attended Mehman clinic paid 125 taka initially to get a card, 100 taka for each ANC visit, and 310 for each of the two ultrasounds she had. She also had to pay for blood and urine tests. Smiling Sun charged 50 taka per ANC visit. The final woman who went to Mustofa Hakim did not mention the cost.

Interestingly, the women receiving ANC at Mehman clinic and Smiling Sun were both visited by BRAC workers when they were five months pregnant and already enrolled in other ANC programs. Despite this, the BRAC workers insisted they enrol in the BRAC program. One respondent (R3) explained,

A health worker from BRAC came to my house and asked whether she could talk to me. I said yes. Then she asked whether she could do a check-up? What could I say? She came to my house; how could I stop her? I said ok. Then she did a check-up but she gave me the wrong information. My baby was born on March 1st but she informed me that my delivery would happen on January 8th. My mother-in-law was worried to hear this.

This woman maintained that BRAC workers continued to visit her two times a month and encouraged her to deliver in their centre, stressing that their services were free.

Decision Making related to ANC

Only five of 10 women were asked how decisions were made with regard to attending ANC. Generally, the data suggest that women themselves were the primary decisions makers, deciding where to attend ANC, when to consult a health worker if they had a health concern, and what additional services (e.g. ultrasound) were essential. Women who used BRAC services were influenced by the convenience of home visits, the fact they could call a health worker to their homes at any time, and the free cost. One respondent (R1) explained,

BRAC health workers come to the house for ANC check-up. I do not need to go anywhere for check-up. I am poor, I cannot afford facility delivery care. BRAC does delivery free of cost. For that reason, I decided to deliver at the BRAC centre.

Later she said,

Most of the women go to the BRAC delivery centre. We are poor, BRAC does not take taka from us. BRAC Health workers always come to our house. They do check-up of pregnant women at home. They tell pregnant women to go to the BRAC centre for their delivery.

Clearly, BRAC workers going door-to-door were also instrumental in influencing women to use their services. Husbands also endorsed BRAC services. One woman (R7) said,

I told my husband that the BRAC health worker came to the house and did a check-up and that if I go to their centre during delivery there is no cost. Hearing this he said, "Where money is less and service is good you should go there. Talk to them and do what they say."

Other people influencing the decision to attend ANC included neighbours and landlords; in one case, the woman needed permission from her mother-in-law to attend ANC. It is important to note that one woman who attended ANC in a clinic was persuaded by the high quality of services.

Perceptions of ANC

Most respondents indicated that ANC is beneficial, with several specifying that it allows women to stay healthy. Aspects cited as particularly useful included learning about the woman's physical condition, understanding the position and movement of the baby, receiving vitamins and medicines, and identifying and finding solutions to health problems. This woman said,

ANC visits were very useful. Here there is nobody (no relatives). I benefited by getting service free of cost. This was a great support. During check-ups they identified the position of the baby and my physical condition. During delivery, many women have problems. Sometimes the baby's hand or leg comes out first. This is very dangerous for the mother. Check-ups identify the position of the baby. If the mother takes medicine (vitamins, calcium, iron) regularly, she stays healthy.

Another woman said,

During pregnancy, the mother cannot understand the condition of the baby. During check-ups the baby's position and the mother's physical condition are identified. They check the blood pressure which is very important. Health workers checked my eyes and told me I have anaemia. They advised me to eat more food. If a check-up is not done mothers do not know this information.

This woman explained,

During pregnancy, antenatal check-up is necessary. They assess the position, movement, condition and weight of the baby. Blood pressure check-up is also important. For this kind of information women should complete all antenatal check-ups.

While one respondent was ambivalent and refused to venture outside her household for ANC, she still received the recommended number of visits through BRAC household consultations.

Women indicated that most women in their neighbourhood attend ANC consultations, attributing the convenience of home visits and free services offered by BRAC and satellite clinics to the increase of ANC among poor populations. This woman said,

Women go to the BRAC delivery centre in this area. Also, every week women come and sit in a house (satellite clinic). They give vaccines to women and children. Women also go there (to the satellite clinics). BRAC centre is open 24-hours a day. Health workers come to our house twice in a week. Almost every pregnant woman in this area receives antenatal care. They do not take any fee from pregnant women. During pregnancy, we want the mother and child to stay healthy. For that reason, we have check-ups.

Some specified that wealthier women go to formal health facilities, but that the free, door-to-door services offered by BRAC is more aligned with the needs of poor populations.

Suggestions to Increase ANC

Respondents indicated that due to the door-to-door services offered through BRAC, most women now have ANC check-ups. They suggested that the more women are aware about the importance of ANC and the more extensive provision of free services in clinic settings to poor populations, will motivate women to attend ANC even outside the household. One woman said,

We are poor, we do not go for ANC, but rich people go. Poor people think if they go for check-up at a clinic they will need money. Women should know the importance of antenatal care. Those who do not know should be motivated. Poor people like me should be informed about health facilities like BRAC delivery centre where no money is needed.

Respondents recommended that an increase in contact with health workers will improve understandings of the purpose, motivate women and increase ANC attendance. They also suggested targeting sectors of the population who have limited access to services, such as women working outside the household, indicating that health workers adjust home visits to accommodate the schedules of working women. One woman recommended that husbands and mothers-in-law opposed to ANC be targeted so that they understand what ANC entails.

Childbirth

Birth History

Three women of the ten women delivered for the first time, six had delivered once previously, and the last respondent had had two previous births. Five of the seven women had previously delivered in the slum setting at home with a dai, with one resulting in a stillbirth; one woman had delivered in the village with a dai. The final woman had previously delivered in Mehman clinic. This woman indicated that the cost in the clinic even for a normal delivery was high, influencing her decision to go to BRAC for her subsequent birth.

Birth Planning

All 10 respondents appeared to make plans prior to the most recent delivery. In five instances the husband and wife planned together, in three households the woman predominantly planned on her own, in one instance the mother-in-law took charge, and in the final household the mother of the pregnant woman guided decisions about the place of delivery. In this case, the woman was pregnant for the first time, and her mother decided that her daughter would deliver at the BRAC centre. One woman even defied her mother-in-law, who wanted her to have a home delivery. Whenever the husband and wife decided together, the plan was to deliver in the BRAC birthing hut. In several instances, women indicated that if they had not delivered at the BRAC centre, they would have planned to deliver at home with a dai. Overall, respondents made plans regarding where and with whom they would deliver but did not discuss issues related to transport and costs. Women who delivered with BRAC did not need to think about transport due to proximity to the centre.

In one case, the husband had assumed that the birth would take place in Mehman Hospital where their elder child had been born. However, during labour the woman revealed her plan to deliver in the BRAC birthing hut. She said,

At 3 am my husband came for sahri (food served at midnight) and I told him I didn't feel well. He said let's go to Mehman Hospital. I said no need to waste money. My elder son was born at Mehman. At that time we had to pay 5000-6000 taka. He was born normally (vaginally) and yet some medicine was needed. I said let's go to BRAC. Then my husband said, "Ok, let's go to BRAC. If normal delivery does not happen then we will go to Mehman because we have the card of Mehman." Then we went to BRAC. They saw me and said the baby would be born, by 10 am.

In the instance where decision making was driven by the mother-in-law, this mother-in-law decided that the same dai who had successfully assisted the first birth would deliver the second baby; the dai lived in proximity to their home and was described as highly skilled. The mother-in-law had kept ongoing contact with the dai, who visited the woman on two occasions during the pregnancy.

Delivery

Of the 10 mother-respondents, five delivered in a BRAC birthing hut, three women delivered at home with a dai, one woman delivered at home on her own, and the final woman delivered in the Chawkbazar Medical Hospital. Women who delivered in the BRAC centre indicated that they spent a minimal amount of time in the birthing hut before delivery and that the birth was assisted by a dai; in one instance, a health worker also assisted. We were told that the BRAC dai checked the position of the baby with her fingers and conducted an examination of the woman's abdomen, and that generally she carried out practices similar

to those followed by dais in the home setting (e.g. massaging the woman with oil, talking to the woman, etc.). In four cases, the woman was given a pill which we were told was to strengthen contractions and speed up delivery. All deliveries were performed without complications. Women were washed by the dai post-delivery and the baby was wiped with a cloth. All the women were allowed to return home several hours' post-partum, which was highly appreciated. BRAC dais were described as polite, caring, and attentive to the woman's immediate needs and emotions.

The three women who called a dai to their home described the dai as highly experienced and living in proximity to the household. In one instance, the woman had already delivered with the same dai, and in another case, the dai had assisted in the birth of the woman herself as well as that of her siblings and knew the woman's mother well. Dais followed traditional practices such as checking the position of the baby with their hands and massaging the woman with oil. In one instance, the father of the pregnant woman believed the labour was prolonged and called a midwife living nearby who provided medication to speed up contractions. In a second case, the dai summoned a pharmacist to administer saline to increase the labour; this dai was reported to check the position of the baby repeatedly with her un-gloved hands. In these instances, dais was assisted by older family female members. Another woman who delivered at home had planned on delivering in the BRAC birthing hut; however, labour occurred in the middle of the night, and the delivery happened suddenly. She delivered in the presence of her mother-in-law, who cut the umbilical cord. Two hours after the birth, the BRAC worker came to the house to check the baby's health and weight.

The final woman who had planned on delivering in the birthing hut was told by BRAC workers during labour that the baby was in reverse position, and an episiotomy was required. BRAC personnel in the birthing hut referred her to an EOC hospital where she was in labour for over 12 hours; she received saline to increase contractions and had an episiotomy. This woman described the behaviour of hospital workers as bad and stated that delivery attendants should treat family members with respect.

All but two women delivered in the planned delivery location. Both women had planned on delivering with BRAC, with one going into labour in the middle of the night and unable to travel to the BRAC centre, and the second requiring emergency care.

Decision Making for Delivery

Reasons for deciding to deliver in the BRAC birthing hut included that services were free, the BRAC workers had provided home ANC regularly and given the woman a BRAC card, the hut was nearby, and the BRAC workers encouraged them to deliver in the BRAC centre. Other reasons mentioned less often were that larger facilities are extremely expensive even for normal deliveries, health workers often conduct "side cut" (episiotomy), and the staff allow women to have little control in the hospital setting. Other explanations were that the family had no money, the woman was unaware of other delivery facilities in the area, BRAC takes good care of women, or the woman had developed a close bond with the BRAC worker, motivating them to deliver in the birthing hut. This woman said,

We have no money. How could we manage money to go to a specialized hospital? BRAC delivery centre does not take any money for delivery. For that reason, I went there.

Later she explained,

A BRAC health worker told me, "If you deliver with a TBA you may have problems. You may have fever, your baby may be in a bad position, what will you do at that moment? It is not good to deliver with a dai at home. The health centre is nearby and costs are less. Delivery in the health centre is good."

In one case, due to the insistence of her mother-in-law, the woman had delivered her first child at home with a dai. The child subsequently died, and as a result, the woman was unwilling to have her mother-in-law involved. Another woman was also encouraged by her mother-in-law to deliver with a dai, but this woman refused.

In regard to delivering at home with a dai, two women had special relationships with the dai, with one woman having already delivered with the same dai; in the second case the dai had delivered both the woman and her siblings. While this woman had received ANC from Smiling Sun, their delivery services were far away, and she felt it was risky to travel by rickshaw during labour. These women indicated that dais live in proximity to their homes, are always available, and are experienced and skilled, with one dai said to have received “formal training.” In addition, the dais had visited and examined the women during pregnancy, confirming that the baby’s position was good, and the woman would be able to give birth at home without complications. One woman was convinced she could deliver safely with a dai because ANC suggested there were no problems, and the baby was in a good position for delivery. Another woman said that the tendency to carry out C-sections deterred her from going to a health facility. She said,

TBAs are always available. The dai who delivered my child also delivered me. I always think that if I go to the doctor the doctor will do Cesar. This was the reason I didn’t go to a hospital. The dai who delivered my child, if she was unable to deliver the baby, she would tell us to go to the hospital. I had no problems or complications (during pregnancy). The dai said that she would be able to do my delivery at home.

While the BRAC birthing hut was close to her home, this woman did not have confidence in BRAC services. A third woman stated that normal deliveries should take place at home and that women do not want to deliver in a facility. This woman was also guided by the fact that her family was small, and therefore it was not necessary to leave the household in search of privacy during the delivery. The woman who had planned on delivering in the BRAC birthing hut but experienced strong contractions in the middle of the night was concerned that she would deliver on the way to the BRAC centre, and/or be exposed to “bad air,” and therefore remained at home. She delivered spontaneously before they were able to call a dai for assistance.

The final woman was referred by the BRAC dai to an EmOC hospital because the baby was breech and the woman had a history of a stillbirth.

Costs

Costs incurred at the BRAC birthing centre were minimal, with three women giving the dai a gift involving 200 to 600 taka in appreciation for their services. Another woman, who too had been assisted by a second BRAC health worker, also provided a sari for the worker. The other two women did not incur any costs. In regard to home deliveries, dais were given a small gift involving soap, oil, clothes, a sari or a small sum of money, such as 200 taka, and in two instances, dais were also invited to the family home for a meal. The woman who delivered on her own did not incur any costs. The woman who delivered in the hospital paid 5500 taka for the delivery, room, transport cost, food, and medicines. Her husband was able to pay the entire sum directly.

Recommendations for Improvement

Only two women were asked about how to improve local maternal health services. One woman recommended the provision of more maternal health facilities, indicating that many live in a remote area where roads are poor, health facilities are limited and distances to delivery care are far. She said,

Apa of Smiling Sun advised me to go to their main clinic for delivery. But it is risky to go there during delivery because it is too far. That is why many women go to BRAC.

The second respondent indicated that women and their family members, mentioning husbands and mothers-in-law, need to be better informed about the risks of home deliveries with TBAs. She suggested that greater knowledge about the danger of home delivery will increase utilization of formal delivery services.

Spousal Involvement

As indicated, in five instances the husband was to some extent involved in selecting the place of delivery, with each of these men endorsing delivery in the BRAC birthing hut. Husbands were particularly keen on the fact that the birthing hut was nearby and free of cost. This woman said,

I talked with my husband. He knew that BRAC health workers had come to the house, that they gave me a card, and that every week they come and do a check-up. He said, "BRAC centre takes no money, you go there."

Another woman said,

I told my husband, "The health worker from BRAC delivery centre came, she gave me a book and did my check-up. She advised me to do my delivery at their centre. They do not take any delivery fee." He said, "Ok you can go there. The centre is nearby, we will have no problem to go there."

In two instances, when their wives were in labour, their husbands accompanied them to the health facility, and one husband summoned a shopkeeper to the home to administer saline to increase the contractions. Husbands were responsible for payments associated with the birth.

Delivery Comparisons

When asked why fewer women living in poor urban areas are delivering at home, five of nine respondents explained that it is better to deliver in a facility, with three women stating that there are no or few dai's in their area. One of these women had previously delivered with a dai, but since the time of her last birth the dai had died. Three women attributed the reduction in home deliveries to the advent of BRAC services. They explained that it is less risky to deliver in the BRAC facility, the centres are close to their homes, service are free or not costly, and in their neighbourhood it has become socially less acceptable to deliver at home with a dai. This respondent highlighted multiple advantages to the care provided by BRAC.

I have no money, I am poor. I went to BRAC delivery centre. There I got proper care, they did my delivery carefully. I didn't pay any taka. There I saw one woman experience prolonged labour. They referred her to Chittagong Medical Hospital. There the woman had a Caesarean delivery. If BRAC workers are unable to deliver the baby, they refer the mother to another hospital. They do not charge any taka.

Another respondent who delivered in the BRAC birthing hut underscored the changes that are occurring in the urban slums, and the perceived danger of delivering with a dai. She said,

Now there are hospitals and clinics. But in previous times dai used to deliver the baby at home. These dai's, learn how to deliver a baby from their mother and aunt. If the mother has complications dais cannot do anything, they are helpless even if the mother needs to be taken to a hospital for delivery.

Even the four women who preferred home delivery stated that many women in their area are now delivering in facilities. However, when asked to compare facility delivery in urban versus rural settings, they indicated that distance, poor roads and high transport costs still make it difficult to reach health facilities in rural areas.

When asked why some women still deliver at home with a dai, respondents explained that home delivery requires less money, women are scared to go to the hospital due to the perceived high costs, women do not want to leave their homes, women are unwilling to travel long distances or do not have time to reach the facility, transport fare can be costly, and there are no BRAC facilities in the area. Two women who preferred home delivery indicated that only if a complication arises is it necessary to go to a facility. One respondent who lived in an isolated area said,

Most people want home delivery. If they face any problem, then they go to a facility. Apa of Smiling Sun advised going to their main clinic, but it is risky to go there during delivery because it is far away. That is why many women go to BRAC. Apa, this is a very poor area. Most people prefer home delivery due to lack of money.

Another woman explained that only if many people live in the household, does the woman need to go to a facility where she can have more privacy during delivery.

Postnatal Care

Of the nine women asked about postnatal care, eight had received a home visit two to four days after the birth, with four respondents receiving a postnatal visit from BRAC workers and one woman visited by Smiling Sun staff. The other women did not indicate the affiliation of the health workers. Household postnatal visits involved a physical exam of the woman (in some cases the blood pressure was taken), the women were questioned about their health and the health of the child, and the baby was weighed. In fewer cases there was counselling on what to eat, how to wash the vaginal area, intake of iron and calcium, breastfeeding, and vaccinations for the baby. Three women also received advice on family planning, with one given a supply of the pill. The one woman who did not receive a home postnatal visit mentioned that she took her child to a clinic for vaccinations. She stated,

I didn't go for postnatal care and didn't see anyone who provided this service. We went there for child vaccine. I didn't see anyone for a check-up. If I had seen women having a check-up, then surely, I would also do it.

Interestingly, when asked about postnatal care, several women mentioned that they and their baby were in good health and therefore did not need to seek care after the birth. One woman said,

After delivery, why should I again go for a check-up? I didn't know that a check-up is needed. If I knew that before, then I would have gone for a check-up.

At least one woman recommended that health workers inform women better about the importance of PNC.

C-SECTION DELIVERIES

Background Information

Respondents were on average 26 years (ranging 19-30 years). Their median years of schooling was six years. All respondents were housewives. Three respondents were Muslim and two were Hindu. Their husbands' average age was 32 years, and the median years of schooling of the husbands was seven. The occupations of the husbands included worker in laundry shop (1), shop owner selling mobile phone cards (1), car business (1), garment worker (1) and small business. The reported monthly median income was 13,800 taka. Three respondents were living in nuclear families and the other two lived in extended families; households had on average six family members.

Respondents had been living in Chittagong for an average of nine years. Four respondents were from different Thanas in the Chittagong District and one respondent was from Cox's Bazaar District.

Health Care Options

When asked about health care facilities that are widely used, respondents first mentioned pharmacies and the Momota clinic, which is popular for its low cost maternal, reproductive health and primary health care services. Other facilities mentioned less frequently included the Medical College Hospital, Smiling Sun (respondents often mentioned this as the place to obtain vaccinations), and private medical offices. Respondents indicated that treatment for children is often sought at Chittagong Ma o Shishu Hospital (a semi-charitable hospital). A few women reported seeking care with traditional healers for conditions related to bad spirits.

Maternal Health Options

According to respondents, the most popular facility for maternal care is Momota clinic, which is known for high quality ANC and delivery services, diagnostic tests and low costs. Apparently, women in need of special care are sometimes advised by BRAC health workers to go to Momota clinic. Respondents also reported seeking maternal care in pharmacies, private medical offices, and BRAC delivery centre (known as Munshi Para clinic). Less frequently mentioned maternal health facilities included Smiling Sun, Urban Primary Health Care Centre (also known as Abdul Hakim Hospital) and some private clinics and hospitals including Chawuk Bazar Medical, Niramoy clinic, and Taisef Hospital.

Antenatal Care

Knowledge of ANC

When asked how many ANC visits are recommended during pregnancy, three of the five women indicated that they didn't know. One woman said,

If a woman (pregnant woman) feels bad, then she should contact a doctor. The number of times to visit the doctor depends on the woman's condition (during pregnancy).

The other two women suggested that women should have five to six antenatal visits, with one of these women suggesting that visits should start at five months of pregnancy and continue on a monthly basis.

All respondents stated that antenatal care is important, indicating that check-ups allow health providers to identify any physical problems the woman might have and to assess the baby's movement, position and general condition. They also noted that it is important to do tests on the woman's blood and urine to identify any diseases she might have. One woman said,

During pregnancy visiting the doctor is good. If women have any problem, it is identified during the check-up and the doctor can provide treatment. During pregnancy, sometimes the baby is in an abnormal position in the mothers' womb. If you have this type of problem how can a woman learn about it if she doesn't have any check-ups? During antenatal check-up mothers get to know about complications and can get advice from doctors regarding what to do."

Another woman explained,

By doing tests during pregnancy you can learn whether you have any physical problems or not. During ANC visits you can also learn what is good and what is bad for your baby.

Previous ANC

Two women had experienced one ANC visit in a health facility during their previous pregnancies. One woman went to a Smiling Sun clinic, and the second went to a doctor's private office. Of the other three women, one woman stated that she did not have any ANC visits due to financial constraints, another woman was pregnant for the first time, and no information was collected from the final woman.

ANC during the Recent Delivery

Three of the five women had previously had a C-section and therefore assumed that the second delivery would also be by C-section. These women were variously advised, the first by health care providers working in the BRAC delivery centre, the second by a land lady and the third by one of the respondent's sisters to seek ANC care from Momota clinic where C-section costs are low. These women believed that they would deliver in the same location where they had received antenatal care. In regard to the other two women, who had received ANC from a doctor working in a private office, the decision regarding where to get antenatal care was made by their husbands. In one instance, the woman explained that the doctor's office was close to her home and that, if her husband were unavailable, her sister-in-law could accompany her to ANC visits. Interestingly, one woman was visited by a BRAC health care provider when she was four months pregnant; however, her mother-in-law forbade the BRAC worker to visit again because the pregnant woman was already seeing a doctor for ANC consultations.

All respondents had an ANC consultation at least one time in a health facility, including either Shavron hospital, a doctor's private office, Niramoy clinic, Momota clinic, Mostofa Hakim maternity and Medicure. On average, women started ANC visits at four months of pregnancy, with three women starting ANC during their first trimester. These women had at least four ANC consultations in formal facilities; all the women mentioned that their weight was taken and blood pressure measured, with two women indicating that they were given iron and calcium tablets and had blood and urine tests. All three of these women also had an ultrasound, with one having four ultrasounds, one having three ultrasounds and the final woman having one ultrasound. The other two women started ANC visits during the fifth month of pregnancy. The first of these women was advised by a BRAC worker during home visits to go to the BRAC delivery centre for ANC. Because she had already had a C-section, when she went to the BRAC centre, the health care provider advised her to go to Momota clinic for ANC where she could have an ultrasound and blood tests. The second woman started ANC visits both at the BRAC delivery centre and Smiling Sun. She reported that the health care providers checked her abdomen to know the position of the baby, measured the blood pressure, and advised her to drink more water and to take iron and calcium tablets. However, because she had previously had a C-section delivery, her landlord advised her to go to Momota clinic for ANC because the BRAC delivery centre and Smiling Sun did not offer C-sections. Due to financial constraints, this woman was unable to continue to go to Momota clinic for more than one ANC consultation.

In addition to the care obtained from formal facilities, three of the five women had at least one home visit carried out by health care providers from BRAC. Of these three women, two had multiple home ANC visits. The mother-in-law of the third woman forbade BRAC workers to return to their home because the woman was already receiving antenatal care from a doctor working from a private office. During home visits, the health care providers from BRAC delivery centre measured the blood pressure, examined the women's abdomen to understand the position of the baby, and provided counselling related to food intake, taking proper rest, and avoiding heavy household chores. It was reported that home ANC visits were preferable because they were free of cost, did not require transport and the women could talk more freely in the privacy of their homes with the health care providers.

Overall, the most common antenatal services received were:

- blood pressure was measured (5)
- woman was weighed (5)
- ultrasound was done (5)
- abdomen measured, position of baby assessed (5)
- women were prescribed iron and calcium tablets (3)
- blood and urine was tested (2)

In regard to the cost, two spent 100 and 300 taka per visit for the doctor's fee; one of these women spent 1000 taka for blood and urine tests. A third woman reported spending 600 taka for ultrasound and 200-250 taka per visit for transport in a CNG (motorized rickshaw). No other information regarding ANC cost was available.

Childbirth

Birth History

For four of five of the women, this was their second birth; the final woman was delivering for the first time.

Birth Planning

Respondents were not systemically asked about birth planning. Although three of the five women had previously had a C-section and knew they would need a C-section delivery, no special preparations were made for the birth. No information regarding birth planning was available for the other two women.

Reason for C-section Deliveries

The major reasons for having a C-section were:

- Woman had previously had a C-section delivery (3)
- Foetus was in a reverse position (1)
- Foetus was assessed to be bigger in size than normal (1)

Complications were identified during ANCs.

Onset of labour /C-section deliveries

All three women who had previously had a C-section, first went to Momota clinic for delivery, but only two eventually gave birth in the clinic. The first woman did not experience labour pain but went to Momota clinic on her expected delivery date and had a C-section. The second woman experienced labour pain in the morning when nobody was home. A neighbour, who realized that the woman was in labour, called a trained TBA. While the woman had previously had a C-section, due to financial constraints she wanted to deliver at home. The TBA refused to assist the birth, advising the woman that a home delivery was potentially dangerous for the mother and baby and that she should go to a facility. At midday this woman was taken by the neighbour and the TBA to Momota clinic. However, health providers in the clinic at first refused to do a C-section because the woman had not received certain of the tests recommended during ANC. While the woman's husband reached the clinic, he did not have enough money to pay for the tests and had to leave the hospital to borrow money. After the tests were done, this woman waited another two hours while other C-section patients were being delivered before she herself received a C-section.

The third woman, who had undergone a previous C-section delivery, had labour pain around her due date. There was no one at home, so she called her sister who took her to the Momota clinic. While the health care providers indicated that a C-section was needed, they were unable to perform the procedure because anaesthesia was only available after 5 pm. The woman's condition was critical, and her family members pleaded with the health providers to do the C-section immediately; they refused, recommending she go to another facility. The family took her to a private clinic, and she had a C-section there.

In regard to the other two women, one had an ultrasound during her last trimester which showed that the child was overweight. Based on advice received from the doctor where she received ANC, her husband took her to a private hospital, and a C-section took place the next morning. The final woman also visited a doctor working in a private for ANC. She was advised to have an ultrasound during the last trimester, and this showed that the child was not in the right position; however, the woman and her family members believed that the baby would change its position before the delivery. Because she did not have labour pain, the woman waited 16 days after her expected delivery date. Finally, the doctor advised the family that she be admitted to a private hospital. Once admitted, the woman had another ultrasound. She stated,

Everyone waited for a normal delivery. Sixteen days' past after the due date but nothing happened. Then I went to the hospital to do an ultra-sonogram. (Seeing the ultrasound report) the doctor asked, why are you waiting? Sixteen days have passed. Everyone thought that they will admit me when my labour pain starts. After hearing the doctor my family members decided to take me for admission to the facility the next day. But the doctor didn't agree. She said that I had to be admitted immediately, that it was an emergency. I was admitted that night. They administered saline the whole night and the next day also. The doctor (providing ANC) visited two times. She saw that the baby had not come in the right position up till that point. Then she announced that a normal delivery could not take place. The doctor asked my family members whether they wanted to do a Cesar or not? Then my mother-in-law said, we want to wait until the night, and then we will decide whether to go for Cesar. Then the doctor said that we can wait but that they (the medical staff) will not take the blame, stating that if anything wrong happens to the baby or mother, it is the family's decision. Then my family members gave consent for a C-section delivery."

Decision Making related to C-section Delivery

Of the three women who had experienced a previous C-section delivery, two women learned from the health care providers working in the Momota clinic during ANC visits that they would once again need a C-section delivery. In both cases, their husbands were concerned about the cost. One husband said,

We have no money, how you will go there. However, if the doctor advises you for Cesar, we have to do that. You need to go there and get admitted.

The third woman also said that her husband was concerned about the cost of facility care and therefore called a dai when labour pain started, believing that his wife would have a normal delivery. However, after checking the woman, the trained dai refused to assist the delivery and took the woman to Momota clinic. Because the clinic could not provide anaesthesia, family members took her to another private clinic where the C-section took place.

Of the other two women, one learned she needed a C-section based on an ultra-sonogram report. One day before her estimated delivery date, she experienced bleeding, and her husband took her to a private hospital. Because it was determined there that the baby was bigger than normal, the doctor recommended a C-section. The husband, who was concerned about the cost, requested that the doctor attempt a normal delivery, but because the woman's condition was considered life threatening, physicians insisted that a C-section was needed. Even at the time of the interview, the respondent maintained that she had an unnecessary C-section, stating,

I didn't feel that I was a serious patient. Even up to the last trimester I felt like I would have a normal delivery but the Doctor Apa said I needed C-section delivery.

The final woman had an ultrasound during the last trimester of the pregnancy, and the report showed the baby was in a reverse position. The doctor advised her to get admitted to the hospital one day before her expected due date and that she might still have a normal delivery. However, the woman waited and did not experience any labour pain up to 16 days after her due date. Finally, she was taken to a private hospital. While family members wanted to wait to see whether she could have a normal delivery, the doctor told them they would be taking a big risk and the health staff would not take the blame if she experienced complications. Then the woman's husband and other family members decided she would have a C-section.

Cost of C-section Delivery

Four women spent between 19000 to 28000 taka which included costs for the C-section, medicine, the hospital bed, food and transport. Three of these families had to borrow money to pay for the delivery; in the final case, the husband had some savings and the remaining costs were managed by people in his office. When asked whether they have repaid the loan, one respondent said that her husband was working hard to repay the loan, one woman said that her husband and brother had paid a large portion of the loan, and another woman said her husband already repaid all the money he borrowed.

In the remaining case, the family was initially requested to pay 9,500 taka, but due to the family's poor financial situation, the fee was subsequently reduced by 4,000 taka. Even with the reduction, the amount was beyond the ability of the husband to pay in full; as a result, the woman had to stay in the clinic for additional days as the husband collected the amount of money needed. The owner of the garment factory where the husband worked ended up helping him financially, and the woman was finally discharged from the hospital. Due to lack of money, the family was unable to purchase medicines which the doctors had prescribed.

Postnatal Care

Four women received postnatal care from health care providers, with three women obtaining care in health facilities, including Shishu Hospital, Holy Metropolitan clinic and Lion Private Hospital; the final woman received home visits from BRAC health providers. Of the three who sought postnatal care in facilities, two went to the facility primarily to get care for the area that was stitched after surgery. The first respondent went to Sishu Hospital to have her stitches removed 10 days after the delivery. She was prescribed medicine for three months but she claimed that she was not told why she needed to take the medication. Her baby, who had jaundice, received light therapy and was also given a vaccination and weighed. The second woman visited the facility to have the sutured area cleaned and dressed at 6, 15 and 30 days after her delivery. The respondent also brought her baby, who we were told was checked (weighed and had the eyes checked) by a health worker. The third woman reported losing feeling in her hands and legs and becoming semi-conscious five days after having the C-section; she was diagnosed with severe anaemia. She was admitted to a hospital six days after the C-section where she stayed for three days.

BRAC health care providers visited the fourth woman, checking her and her baby seven days after the delivery. Although she claimed to be very weak after the delivery, due to financial reasons she was unable to go for postnatal care in a facility.

Involvement of TBAs

Only one family called a TBA after the onset of labour to assist the delivery; this was even though the woman had previously had a C-section. Due to concerns regarding the costs associated with a C-section delivery, the family hoped the woman would have a normal delivery. As indicated, the dai refused to assist the delivery and accompanied the woman to Momota clinic.

In general, respondents indicated that they have faith in the skill of both trained and untrained TBAs. We were told that TBAs are respected due to their experience and reputation, and respondents also appreciated the way they communicate and behave with community members. Women stated that they prefer to deliver with TBAs because the delivery can take place at home and is low in cost. Respondents acknowledged that TBAs are unable to assist complicated deliveries, for instance, when the woman has high blood pressure, and that in these instances the TBA must refer patients to maternal health care facilities. One woman said,

Many aged women in the area work as TBAs. Local people know them very well and call them when needed. Women learn about dais from other women. In addition, TBAs learn about pregnant women from other women. The advantage of delivering with a TBA is that the pregnant woman can stay at home and it is low in cost compared to a facility delivery.

Perceptions of C-section Deliveries

Overall, two women said they were satisfied with the services they received during the C-section delivery. However, postpartum four of the five women experienced problems, claiming that they were less able to move about and indicating that they could not do heavy work after the C-section delivery. One woman said that her abdomen felt heavier and it was difficult to do household chores, forcing her to employ a housemaid. She said,

Up to now I can't do any work which requires sitting a long time. My belly is getting bigger and creating a problem. I had to get a housemaid to wash cloths which is difficult work. Yes, it's good to do Cesar. You don't feel pain. But after the Cesar it's tough to do work. If you are alone in the family (living in a nuclear family) then it's quite tough to take care of your family.

This same woman said those who undergo a C-section delivery cannot have many children. She said,

It is very painful for the initial 24 hours after C-section delivery. Fever and other health problems arise. You can't move for two days. I don't like Caesarean delivery. It may create more problems. Moreover, you can't take more than two children by Cesar (due to physical problems). Hence my advice is not to do Cesar.

These women also complained that C-section delivery is costly.

The remaining woman explained that, although she appreciated the fact that she did not have to endure labour pain, generally people dislike C-section because it involves cutting the abdomen and can lead to problems postpartum.

Maternal Health Care Challenges

Women indicated that the main challenges for new migrants is that they are not well informed about where to obtain maternal health care and are nervous and embarrassed to seek care. Specifically, it was stated that newcomers are not familiar with their surroundings, do not know the location of the facilities, do not know what services are available in which facilities, are not informed about the cost of services, and that women feel shame about the possibility of receiving treatment from male doctors. We were told that new migrants generally first seek advice from their neighbours regarding where to get maternal care. One woman said,

Newcomers do not know the area. They ask their neighbours for information. For health care they go to pharmacies. Sometimes pharmacy people tell them to go to Munshipara Board (BRAC) clinic, Munshipara delivery centre. Women from Munshipara delivery centre visit people house to house. When they meet new women, particularly pregnant women, they inform them about their centre and advise them to go to there.

One woman discussed the barriers faced by women who each day work outside of the household, which is especially true of garment workers. She said that garment workers are unable to seek care from maternal health care facilities because it requires that they take time off from their work, and they thus lose their daily wage.

When asked how maternal health services can be improved, women recommended that facilities be available in proximity to their living areas. In general, distance to the facilities was perceived to be a barrier which prevents women in labour from accessing facilities. One respondent said,

If in our area there should be an arrangement to take the pregnant mother to hospitals during an emergency. When facilities are far away, it is tough to call a vehicle during an emergency and then take the mother there. If the facility is nearby, then another female can take the pregnant mother quickly. Otherwise, we have to wait for a male member to take us to the facility. My husband's working place is very near, that is why he was able to come whenever I called him, but the husbands of those women who work in the garments cannot come quickly as my husband could. For this reason many deliveries happen at home.

FAMILY PLANNING OF COUPLES WHO DO NOT DESIRE MORE CHILDREN: FEMALE RESPONDENTS

Background Information

The age of the female respondents in Chittagong ranged from 25 to 35 years, with the mean 30.4 years of age. One female respondent had no schooling. Educational background of respondents who had formal schooling ranged from two to eight years, with the mean four years of schooling. All five respondents were housewives. Four respondents lived in nuclear families and the final respondent lived in an extended family. The mean number of family members was four. Duration of stay in Chittagong city for the female respondents ranged from 4 to 26 years with a mean of 14.2.

Number of Children, Decision Making not to have More Children, and Current Method Use

Of the five respondents, two families had one son and one daughter, one family had one son and two daughters, another family had two sons, and the final family had only one son. All respondents mentioned that they had no desire for any more children, with four out of five respondents making the decision jointly with their husbands. One respondent mentioned that she made her own decision not to have additional children when she got pregnant for the third time. Her husband only approved curtailing childbearing when she gave birth to a baby boy. The respondent said,

It is important to have a son to continue the family dynasty. Only a male member can bury the dead body of parents, not a female.

None of the respondents were using any long acting or permanent methods. Out of five respondents, four were using oral pills. One respondent mentioned that she took medicine from a traditional healer to prevent pregnancy.

Source of Knowledge of Contraceptive Methods

Four out of five respondents knew about a variety of family planning methods, including the pill, condoms, rhythm method, injections, *Mayadi* implant or Norplant (respondents mentioned that a capsule is inserted in the arm), Copper T and permanent methods for both men and women (operation). Respondents had received information about contraceptive methods from multiple sources including family members, neighbours, NGO health care providers (Momota, Urban Development Corporation, Marie Stopes clinic, Smiling Sun clinic), and written materials such as posters during visits to the health clinic or books. One respondent said that she gets information on different family planning methods while gossiping with other women. Field workers were generally not mentioned as a common source of information as most respondents did not have regular contact with community health workers. One respondent reported that she heard that health care workers make visits in her neighbourhood, but that she herself had never received a home visit. The same respondent said that she shared problems she had after using injections with one of her neighbours, who advised her to switch to oral pills due to the side effects associated with injections.

One respondent did mention that she has monthly contact with health workers who make door-to-door visits in her living area. This respondent also indicated that it is possible to obtain family planning methods from the community health workers working for “Board” (City Corporation), stating that “Board” issues a card for 50 taka, which allows cardholders to avail themselves of family planning methods free of cost.

Availability of Methods in the Area

All respondents knew that oral pills and condoms were available in local pharmacies. Three of five respondents knew that injections, Copper T, implants or *Mayadi* were available in NGO clinics, namely Smiling Sun and Momota, with one respondent also mentioning that Smiling Sun organizes a satellite clinic near to her home. The other two respondents did not know where Copper T and *Mayadi* could be obtained.

Previous use of Contraceptive Methods

All respondents had previously used pills or injections over a period anywhere from five to eight years, often switching between different types of pills and injectables. Only one respondent mentioned that her husband had used condoms many years earlier and for three months after she gave birth. Typically, respondents made decisions on their own or got advice from a non-technical person like a neighbour or medicine seller regarding which method to take and when to switch methods. The following case studies give examples of the respondents' family planning histories.

Case Study: One

One respondent reported that 40 days after giving birth to her first child she started taking the oral pill (Femicon) based on advice from one of her neighbours. However, she experienced frequent bleeding over short intervals, causing alarm. She went to an NGO clinic (Momota) and was advised to follow the rhythm method. She followed the rhythm method for two and half months and then decided on her own to use the pill again because she found the rhythm method inconvenient. She continued taking the pill for three years, and thought the pill suited her well. After three years, a medicine seller in her neighbourhood told her that she should not take the pill for such a prolonged period. She was also considering having another child and therefore stopped taking the pill and got pregnant. After the birth of her second child, she started injections, believing that injections would not interfere with her breastmilk production, while the pill is known to decrease breastmilk. However, during this period her menstruation stopped and she gained an excessive amount of weight. After receiving an injection two times within a six month period, she stopped taking injections and didn't use any contraceptives for the next four months, subsequently becoming pregnant again. She went to a pharmacy and purchased a pill to induce an abortion, but the medication did not have any effect. She then went to the Marie Stopes clinic where an ultrasound confirmed that she was pregnant with twins; she decided to have an abortion. She was subsequently advised by clinic health care providers to take *Shukhi bori* (name of a pill), but once again decided on her own to take Femicon, which is the pill she had used earlier in her life.

Case Study: Two

Another respondent reported that after her first delivery her husband used condoms for three months. Later on, she started using the pill, indicating that she was ashamed to purchase condoms from the health workers carrying out household visits because children in her neighbourhood were often present. She stopped using the pill to get pregnant, and after her second child was born, again started using the pill, but often forgot to take it. She decided to go to the Urban Development Centre and take injections. She took two injections over a six month period, but experienced a heavy flow of bleeding during menstruation and therefore decided to discontinue the injections. She subsequently got pregnant with her third child. One month after her third child was born she again started taking the pill and continued using the pill for another three years. At the time of the interview, she had used the pill for eight years, even though people told her that her *nari* (uterus) would get burned by using the pill over such a long time period.

Knowledge and Perceptions of Long Acting or Permanent Methods (LAPM)

In general, most of the respondents were reluctant to use any long acting or permanent methods due to perceived harmful effects. When asked about the source of information regarding these methods, most once again indicated that they learned about long-term methods from relatives, neighbours and friends, with none mentioning health providers. We uncovered multiple examples of the perceived negative consequences of long-term methods. For instance, one respondent who knew that the Copper T could give protection over several years did not want to use it because she believed that the Copper T might move inside her body up to her stomach, get damaged and cause her to die. Another respondent had heard that a woman in her village had had the Copper -T inserted, but it moved into her stomach and, as a result, she had to be admitted to a hospital. The process of inserting Copper-T was described as 'shameful' by one respondent because the private parts of a woman are exposed to the health provider; for this reason, she would not consider using the method. One respondent expressed fear about the procedure used to insert implants (referred to as capsules), indicating that it involved cutting flesh. She was also concerned that the implant might cause ongoing pain at the location of the insertion. Another respondent indicated that a neighbour's daughter used Norplant and afterwards became very fat. One respondent who was diabetic had learned from a doctor in the Chittagong Medical College Hospital that Norplant was not appropriate for women with her condition.

All respondents knew that there were operations used as permanent methods of contraception for both males and females. We uncovered multiple misconceptions about both ligation and vasectomies. For instance, three out of five respondents thought that the 'nerve of the penis' needed to be cut as part of the operation for males, resulting in reduced sexual desire and loss of strength. One respondent said,

As females have many methods to use, why is it needed to make husbands weak by having an operation. When it (the nerves of the penis) are cut then the man will be weak for sure. He will lose his sexual desire.

In regard to ligation, two respondents believed that an operation was performed on the uterus or that the entire uterus would be removed, with one respondent indicating that she learned this from her ninth grade text book. Fear of infection following operative procedures carried out for ligation and vasectomy was also common among respondents. One respondent reported that one of her sisters-in-law had had the operation (ligation) and subsequently was unable to do household work properly due to stomach pain.

Many religious beliefs that opposed the use of long-term methods was also uncovered. For instance, any method that required operative procedures including Copper-T and implants were perceived as sinful. One respondent reported that she would continue to take the pill until her death, stating that other methods opposed her religious beliefs. When talking about Copper T she said,

After death, how can you take this out? There is no way to take this out. Except for your husband, no one will know that you put in the method. Females don't inform other members of her family about this. But it is necessary to take this out after death. Otherwise it is an akul (opposed in the Muslim religion).

This woman was referring to the religious tenet that opposes being buried with a foreign object on or inside the body.

Another respondent said,

One of my aunts used Copper T. After her death, her husband did not inform others about it due to shame. When people learned about it (the respondent knew that Copper T had been inserted and informed others) everyone was shocked. The lady who bathed the dead woman said to the respondent 'you saved me from a big sin by informing me she has Copper-T inserted.' Eventually, the Copper T was removed from the body.

One respondent thought that using a permanent method and thus preventing conception was a serious religious offence and a sin. She said, "Allah gives us children and we destroy it." Another respondent claimed that if a woman has the operation, when she dies even her husband is not allowed to look at or touch her dead body. When describing ligation, another respondent said,

The uterus, which is created by Allah, is cut by operation. Removing it is an offence and may lead to negative effects on the woman's husband and children.

This woman also considered ligation to be a religious offence; she believed that having a ligation might lead to detrimental consequences on the woman's husband and children, even leading to their death.

Husbands' Involvement in Family Planning

Generally, our female-respondents indicated that they take on the responsibility of obtaining and using contraceptive methods, reporting that their husbands usually do not want to use methods. We uncovered the belief that, as men are the earning members of the family, they should not be pressured to use contraceptive methods. Several respondents expressed concern that the strength of men may decrease if they use methods, thus affecting their ability to work. Therefore, women must take charge of family planning, which many maintained is a women's issue. In a few rare instances respondents reported having requested husbands to use contraceptives, but the husbands didn't agree because the only viable option was condoms, which they stated men do not like to use. One respondent who regularly brought oral pills from a nearby pharmacy stated,

Females have to be responsible for family planning, males can't do it. They are the earners. They come back to the home with their earnings and need to sleep. It's not necessary for them to be concerned about it.

In this case, her husband had never asked whether she had taken or had adequate supply of pills. It is important to note that our respondents generally recommended that their husbands be made more aware of family planning issues, but they highlighted the challenges in reaching out to men, who remain outside the household working during the day.

Suggestions regarding Improvements of Family Planning Services

The respondents suggested a number of ways to improve use of contraceptive methods by both females and males. A common recommendation was to raise awareness of males about issues related to family planning, which our female respondents maintained, would better motivate them to use the methods. One respondent recommended that men could be informed about family planning through SMS.

The respondents also highlighted the need for more clinics or government hospitals in their immediate area offering family planning services at low costs. They also recommended regular door-to-door visits by the health workers providing information and supplying contraceptive methods. One respondent stated that many women in their area work in garment factories and are therefore at home only on Fridays. If health workers could visit door-to-door and arrange weekly community meetings on Friday, the garment workers could also benefit. The same respondent also suggested that posters on family planning issues be hung in the neighbourhood, giving exposure to both men and women. According to her, illiterate people could learn from their friends who know how to read and the information would subsequently spread in communities. One respondent added that community members are uninformed about contraceptive methods like Copper-T and implants, and as a result, they are often frightened about using these methods. If health workers provided more information about Copper T and implants, their concerns could be addressed and perhaps they would become more motivated to use these methods.

MALE RESPONDENTS

Background Information

The age of the male respondents in Chittagong range 30 to 45 years, with the average age 38.6 years. One male respondent had no schooling. Educational background of respondents who had formal schooling ranged from grade five to eleven years, with a mean of eight years. Two out of five respondents sold bus tickets, one was working in small business, one worked as a day labourer, and the final respondent was an auto rickshaw driver. The mean income of male respondents was 17,400 taka.

Number of Children, Decision Making not to have More Children, and Current Method Use

As indicated, three out of five respondents had at least one son and one daughter and all respondents had at least one son. All respondents stated that they did not want to continue having more children, citing economic constraints as the main reason.

All five male respondents in Chittagong reported that their spouses were currently using oral pills. Only one respondent said that his wife had previously used a different method, using injections for a short period, before switching back to the pill. A common perception was that their spouses were well adjusted to the pill and therefore did not consider using any other method. One respondent stated,

By using pills women do not face any problems. Nowadays there are different methods...women insert a needle in the hand (implant) or get injections, but women face many problems using these methods. Women get pain in their hands, legs and waist. The pill is better than any other method. The pill doesn't create any problems in the body.

Four out of five respondents indicated that it was their wives who were primarily in charge of obtaining pills from the pharmacy. Respondents explained that their wives typically decided on their own to take the pill and subsequently sought their husband's approval. However, one respondent indicated that after consulting with a pharmacist, the respondent and his wife jointly made the decision to use pills, and that they both purchased the pill according to who was available to do so. When he went to the pharmacy to purchase pills, he would show an empty packet to the pharmacist and get a replacement. This respondent also mentioned that his wife was getting fat when taking the pill, so he purchased and used condoms for a period of time after each month that she took the pill, often continuing this process of switching methods.

Contact with Health Workers

Four out of five respondents mentioned that they knew that health workers from NGOs (Smiling Sun was mentioned) made door-to-door visits in their area, with one mentioning that both male and female health workers make household visits. However, it was indicated that the health workers place more emphasis on maternal and child health and provide little information on family planning issues. One respondent stated that, as the health worker visits were irregular, people in the area had to go to Smiling Sun Clinics, which was located far away, to seek health care or advice.

Source of Knowledge of Contraceptive Methods

The respondents learned about contraceptive methods from different sources, particularly neighbours, friends or relatives. For instance, one respondent stated that his wife learned about the oral pill from her sister-in-law and he in turn was informed about the pill from his wife. Two out of five respondents suggested that people in the area also learned about family planning and contraceptive methods from

health personnel working for NGOs such as BRAC, Smiling Sun, and the NGO run immunization centre. Two respondents also mentioned that females in the area have opportunities to learn about contraceptive methods from gynaecologists working in health clinics. One respondent reported that he personally learned about contraceptives from health workers who made door-to-door visits in his village. However, he had never seen any community health workers in the area where they lived in Chittagong. One respondent mentioned that banners and other forms of written material are an important source of information.

When asked about the availability of contraceptive methods, all mentioned they can be obtained in pharmacies located either in their neighbourhood or in the market.

Knowledge and Perceptions of LAPM

In general, respondents did not have a clear idea about long-term or permanent methods. Moreover, we identified many misconceptions and perceived religious barriers related to the use of long-term and permanent methods. For instance, one respondent mentioned that he was not aware of the name of the permanent method for men, stating that in his village people called the permanent method '*khasi kora*', which refers to the process of removing the genital organs of male animals to increase muscular growth. He also indicated that a person who uses this method cannot be buried after death; because it would be taboo to even touch the dead body or put soil on the grave. In addition, a person who has gone through the operation is not allowed to touch a dead body or put soil on a grave. He further stated that he had heard that using this method might prevent life after death.

Another respondent reported that it is prohibited in Islam to stop conception or to "spoil" a baby by going through the operation, which he described as a sin similar to an abortion. He said,

We are Muslim. Allah has sent us on the earth by means of conception. If we spoil our conception, Allah will not be pleased. For this reason, my parents were forbidden to spoil conception.

Respondents also expressed fear of experiencing side effects associated with using long term methods, but were often unable to specify what the side effects might be. For instance, one respondent said,

We are not unaware. I know only a little bit about family planning. Taking long-term methods may cause various problems in the body. I know that by taking more permanent methods people get different diseases. Still now my wife is okay taking the pill. Only if she feels uncomfortable to take the pill will she use another method or seek advice from a family planning centre.

The same respondent mentioned that he knew a woman who had gone through the operation; he reported that after the operation, her menstruation permanently stopped, and her blood pressure increased. At the age of 40 or 45, she died. This respondent indicated that he had heard about permanent methods for males but was not knowledgeable about what they entailed. This respondent had not considered taking any long term methods, stating that he did not have a clear concept about the procedures and how they worked.

Another respondent who was a day labourer mentioned that he could not afford to miss work, indicating that he would have to rest for three to four days subsequent to undergoing an operation, and it would be difficult for him to maintain his family needs during that period. A third respondent said he heard there are many harmful side effects associated with female methods other than the pill, mentioning that the menstruation might stop, the woman could develop high blood pressure, or the method might not be appropriate for the woman's body. This respondent stated that the majority of males would not consider

using contraceptive methods because they believe that family planning is only for women, maintaining that males do not know much about methods and there are few methods suitable for men. Another respondent indicated that he was not willing to spend money to purchase other methods and that the pill suited both the respondent and his wife. While the final respondent mentioned that it would be better if they could use a birth control method other than the pill, he did not know which method would be appropriate for him. He further added that he was afraid of taking medication or family planning methods from a government hospital, as he had heard that many people die after ingesting medicine from government facilities.

Only one respondent appeared to know about implants, mentioning that there was a method which requires that women insert “sticks” in their hands. However he was unaware of the duration of protection when using the method. He said that he does not know much about family planning, as he never discussed the topic with anybody. Another respondent was aware about injections as a method for females, but he did not know about any methods for males other than condoms. When asked why he and his wife were not using long-term or permanent methods, he replied that his wife had never experienced any health problems using the pill and they did not need to explore other methods. He also stated that, if they had an unintended pregnancy, they would treat it as a gift from Allah.

Husbands’ Involvement in Family Planning

While respondents agreed that females are much more knowledgeable compared to men regarding family planning issues, the general consensus was that both males and females should be informed about family planning issues. When asked about the reasons that women are better informed, male respondents explained that women gossip with each other about these issues and that men work during the day and have little time to think about it. The general recommendation was that females take responsibility for using family planning methods, with the male respondents indicating that they are busy with their work and do not have time to deal with family planning. However, one respondent suggested that men should take greater responsibility for family planning, explaining that women are less able to learn, and that if men got more involved, it would improve the overall use of family planning methods. He further stated that the reason men are not much involved in family planning is because there is limited advertising that reaches men, and health workers do not talk to men about family planning. As a result, males do not use methods.

One respondent stated that less educated males have limited awareness of family planning issues compared to educated males, while another respondent thought that in recent years people generally have become more aware about the importance of family planning, which he maintained is confirmed by the fact that families are much smaller than they were in the past.

Suggestions regarding Improvements of Family Planning Services

All respondents thought that more community outreach was required to make people aware and encourage them to use family planning methods. One respondent indicated that in the past health workers visited households door-to-door and held meetings with groups of women in village settings to explain the benefits of family planning methods and places where methods are available, but in the urban slums these interactions do not exist. The majority of respondents said that health workers should carry out household visits. One respondent said,

Family planning services should be given door-to-door because often people do not go to the facility due to shyness.

He suggested that mass media, particularly television, has a potential role in informing people about family planning.

A few respondents indicated that it would be more effective to develop programs specifically for males and to inform men better about contraceptive methods, rather than focusing solely on educating women; they indicated that informed men would share the information with other males and gradually the information would be disseminated. One respondent thought that health centres need to offer more consultations and increase the information available to men about contraceptives, also stating that men need to visit health centres to become better informed. It was suggested that health workers motivate males to use different types of family planning methods, indicating that men would benefit if they learned about the advantages and disadvantages of each method. One respondent added that an integral component of motivating families to use methods is to promote the economic advantages of a smaller family. Another male respondent suggested that, once men are informed, they could subsequently educate their wives, claiming that females are dependent on men and can better absorb information that comes from their husbands. Another respondent recommended approach was that health workers identify people who are less aware or uneducated and have little financial means, providing them with family planning services.

While respondents generally thought that that NGO workers are more active compared to government workers, and that NGO clinics would be a better option for obtaining family planning services, they emphasized that more NGO clinics need to be made available. One respondent said,

There is no clinic in the area; a clinic should be established, it should be a NGO clinic rather than a government one. They (government facilities) demand money.

Generally, respondents expected to receive methods free of cost, stating that in the past people got methods for free during home visits. They underscored that free or low cost services are particularly important for poor populations. Another respondent suggested that information related to family planning be given at work places like garment factories, stating that it would be much more efficient to target large audiences than to try to reach individuals through one-on-one consultations.

Summary of findings comparing findings from Dhaka and Chittagong sites

Introduction

The qualitative nature of this study allowed us to examine in depth key issues related to male migration, maternal health, and family planning among couples who do not desire to have additional children. While the study themes were very diverse, the common thread was that respondents in each sub-sample resided in poverty stricken, crowded urban settings where families barely eke out a living and have limited access to high quality health care. Despite the squalid conditions, slum settings allowed residents to earn cash incomes and were generally seen as a better option to rural village life. The comparisons between Dhaka and Chittagong consistently highlighted commonalities in the challenges and coping strategies slum dwellers use to survive, as well as similarities in perceptions of and care-seeking related to maternal health and family planning services in these settings. The study also offered a glimpse of the severe hardships slum dwellers confront daily and the fortitude of residents. Key findings from this report are presented below.

Migration

Socioeconomic information on the study respondents from Dhaka and Chittagong were remarkably similar, with about half of the respondents in both locations ever having attended school; those who had gone to school received minimal education. While the mean age of respondents was similar, the age range of male migrants from Dhaka was far greater. Respondents worked as day labourers, with the majority in each site doing construction or pulling rickshaws and earning approximately 10,000 taka per month. All married respondents lived with their wives. Five spouses in Dhaka and four in Chittagong worked outside of the household, with the majority working in garment factories. In one or two cases in each sample, families had one or two daughters working in the garment factories. These additional wages served to bolster the family income. It is important to note that several respondents in the Chittagong sample came from districts closer to Dhaka, apparently choosing to bypass Dhaka city to move to Chittagong.

Environmental events reported to have occurred in the home villages of male migrants included flooding, cyclones, river erosion, rising sea water and siltation, precipitating a loss of land and family assets, reducing crop production or fishing yields, and impacting on livelihoods. In some instances, families were affected multiple times by environmental disasters. While these factors pushed the male migrants into joblessness and poverty, ecological influences were rarely mentioned as explanations for migration, with respondents generally indicating that they chose to migrate due to lack of employment and financial deprivation and in search of a cash income. The majority had incurred debt, which in some cases was sizeable and came from a variety of lenders; after having borrowed money, our respondents were unable to maintain family expenditures and to repay loans through the meagre earnings they earned in the village setting, forcing them into a steep spiral of poverty. The urban centres offered job opportunities for themselves and female family members and cash income to repay loans and the associated interest and provided a means to distance themselves from money lenders.

Respondents typically migrated to urban locations where they had relations or friends who could assist them to find a room and job and get adjusted to the urban environment. Living conditions were described as extremely challenging, particularly in Chittagong where slums appear to be less organized and frequently lack basic facilities. Respondents lived in small, overcrowded living quarters where they shared a toilet, bathing facility, and gas stoves for cooking with as many as 90 families. Some respondents did not have access to gas or the gas supply was frequently inadequate, and electricity and water were also reported to be irregular, particularly in Chittagong where some respondents were forced to use pond water

for cooking, washing and bathing. In one slum in Chittagong, the living environment was often swamped with stagnant water, sometimes preventing residents from leaving their homes even for work. Respondents from both sites mentioned that noxious and ubiquitous odours and the dirty, unsanitary environments were difficult to tolerate. These challenges, along with changes in jobs and the pursuit of lower room rents, precipitated frequent moves from one slum to another.

Particularly at the outset, respondents reported difficulties finding suitable work or performing well in their jobs, with most having no or limited schooling and no former job experience other than farming or fishing. The strain and long hours required to maintain jobs was described as physically exhausting, causing respondents to search continually for less strenuous, higher paying work. At the same time, there was much pressure to maintain a regular wage to cover both daily expenses and to repay loans. Other challenges reported by respondents living in Dhaka related to childcare for families with two working parents and general lack of familiarity with the road systems, transport and health care, as well as fear of the bustling and dangerous city environment. Respondents from both sites visited the village setting infrequently and were not obligated to send remittances to family members.

While respondents from both sites underscored the fact that there was a wide range of health facilities in the urban centres, in both samples pharmacies were reported to be the preferred health care option due to the convenience, lower fees (no consultation or lab fees), the fact that pharmacy workers were familiar, and treatment was perceived to be adequate. In Chittagong, several respondents mentioned that pharmacies were the only option in their respective residential areas. Respondents were generally poorly informed about the facilities and the health services offered in their living areas. In both sites they expressed a need for more quality health care providers in their neighbourhoods. The study results highlight the need to inform slum residents better about professional health care services, particularly for low income populations. Other recommendations solicited from respondents to improve living conditions included the need to provide electricity and gas and potable water on a regular basis, as well as a cleaner physical environment.

The majority of respondents indicated that since moving to the urban centre, their financial situation was improving, with most highlighting the fact that they were earning enough money to meet daily needs and to send monthly instalments to pay off loans. Families with multiple earning members appeared to be able to improve their financial situations more rapidly. Several Chittagong respondents indicated that educating their children was financially difficult, with some reducing costs by curtailing the education of female children or having their female children work in the garments. After repaying their loans and saving some money, most respondents intended to return to the village, which was described as tranquil and “home,” where they aimed to buy a house and land and re-establish their former lives, with some hoping to embark on a small business.

Maternal Health

Information on the social and economic background of respondents showed similarities in regard to age, education, the fact that respondents were predominantly housewives, family size, and duration of years in the city. In each sample two women were originally from the urban slums, while other respondents migrated from rural areas to the urban centres. While the occupations of their husbands was similar, in Chittagong monthly salaries appeared to be slightly higher.

The maternal health care service most commonly mentioned was BRAC, which appeared to be available in most of the sites in Dhaka and all of the neighbourhoods sampled in Chittagong. Respondents indicated that BRAC offers home ANC and delivery care in a nearby birthing hut. In addition, respondents reported a range of government, NGO, and private clinics giving antenatal care, with some offering ANC in satellite stations and clinic settings, as well as maternity facilities and hospitals providing treatment for maternal health problems and delivery care. With regard to information on maternity care, the most common source appeared to be health workers representing NGOs (e.g. BRAC, Urban Health Care Centre, Smiling Sun) or maternity clinics going door-to-door to identify pregnant women and offering or promoting services, as well as neighbours and friends.

Nine of 10 respondents in Dhaka and all respondents in Chittagong received ANC care during the most recent pregnancy, with only three women in Dhaka and one woman in Chittagong not meeting the four recommended visits during pregnancy. Interestingly, the majority of women who were asked about ANC visits during prior pregnancies indicated that they had not previously received any prenatal care. Majority of respondents in both sites (six in Dhaka, seven in Chittagong) had been identified as pregnant by BRAC workers during home visits and cited BRAC as their primary ANC provider, with most of these women receiving home ANC on a monthly or even more frequent basis. Other respondents received ANC from formal maternity facilities or satellite clinics. Home ANC with BRAC included a limited number of services and did not appear to fulfil requirements for a complete ANC visit. In comparison, ANC visits in formal clinic settings involved physical examinations of the woman, as well as lab tests, treatment when needed, counselling and ultrasound, and were overall far more comprehensive. It is important to note that BRAC workers were at times reported to be aggressive in enrolling women, forcing women who were already receiving ANC elsewhere to accept their services. Despite this, overall women appreciated BRAC services; advantages to obtaining care with BRAC included the convenience of home ANC, the fact that maternal services are nearby and available 24-hours a day, services are essentially free of charge, and BRAC refers to higher facilities in case of complications. The decision to accept home ANC was predominantly made by the pregnant woman herself. The fact that the woman did not need to travel outside her immediate area, which entails additional costs and in some cases spousal permission, along with perceptions related to the high expense of facility-based delivery care, also influenced decision making. Several women in the Chittagong sample also reported the limited availability of other maternal services close to their living areas, making BRAC the only option. In one instance, BRAC offered educational sessions to husbands, which appeared to inform the spouse about prenatal care and convince him of the importance of delivering outside the home. Regular contact with BRAC workers and the described warm and compassionate behaviour of workers appeared to solidify relations and perceptions of their services.

Despite the fact that the vast majority of respondents received ANC, knowledge of the number of recommended visits and the timing of ANC was poor. Respondents were also not well informed about the purpose of ANC, frequently expressing a false sense of confidence that receiving ANC served as a panacea to ensure that the woman stayed healthy during pregnancy and had an uncomplicated delivery. Given that BRAC was the primary provider, these data, along with information indicating that ANC services provided by BRAC was not complete, raises questions about the quality of BRAC ANC. It is also important to note that several women who had attended one or two consultations in health clinics believed that the positive report they received during the ANC visit confirmed that they were in good health and did not need to attend additional clinic consultations. These women did not meet the recommended four ANC visits.

The vast majority of multipara women in both samples had formerly delivered at home with dais. Regarding the pregnancy under investigation during this study, all but one respondent had made birth plans; most of the women in Dhaka planned to give birth at home with a dai. In contrast, in Chittagong most women receiving BRAC ANC planned to deliver in the birthing hut, while the other respondents decided to deliver at home. Reasons for deciding to give birth at home included that dais were experienced and skilled, the woman had a strong bond with or had already delivered with the dai, the dai lived nearby, the woman believed she was in good health and would not experience complications, with some mentioning this was confirmed during ANC, there was a preference to deliver in the familiar home environment near family members, and women had negative perceptions of clinic deliveries, particularly related to the high cost and tendency to perform invasive procedures. Reasons for delivering in the BRAC birthing hut included that it was nearby, couples appreciated the quality of services, they had received a BRAC card, the woman had established a relationship with the health providers during ANC, the staff encouraged them to deliver in the birthing hut, BRAC delivery services were free, the birthing hut offered more privacy and a better delivery environment, it was socially acceptable to deliver with BRAC, and the woman would be referred to an EmOC if needed. Notably, in all but one case mothers-in-law were absent from the decision making process.

In Dhaka, six women delivered at home with a dai, three delivered in a BRAC birthing hut, and one woman delivered in a maternity clinic. Delivery patterns in Chittagong was somewhat different, with five women giving birth in the birthing hut, four delivering at home (three with dais and one on her own), and a final woman having been referred by BRAC workers to an emergency facility. Dais carrying out home deliveries used traditional practices; several also contacted a local shopkeeper to administer medicine to speed up contractions and delivery. Women generally appreciated the behaviour of the dais and home deliveries were uneventful. Women who delivered in the birthing hut also delivered with a dai; practices used were described as traditional and births occurred normally, and women were generally satisfied with the services and praised the dais for their kind behaviour. As indicated, one woman in Chittagong whose baby was breech was referred from the birthing hut to a higher level facility. Virtually all women followed their birthing plan, in part because most occurred without complications and also due to the fact that few people were involved in decision making at the time of delivery. Labour occurring in the middle of the night presented an obstacle to leaving the household for delivery care, even in cases where the delivery centre was in proximity to the woman's home. Costs for a home delivery and BRAC delivery were comparable and generally involved small gifts of appreciation for the services dais provided.

Husbands who were more engaged in the pregnancy and knowledgeable about ANC and delivery services appeared to play a positive role in encouraging their wives to deliver outside of the household. Interestingly, women, particularly those in Chittagong, had more positive perceptions of facility deliveries, highlighting the potential danger of delivering with a dai and the rising social acceptability of facility deliveries, and attributing a general reduction in home deliveries to the advent of BRAC services. Some women mentioned that facility deliveries offer privacy, which is difficult to achieve in the slum setting, and are also advantageous for women who do not have a female member at home to provide care for the woman and family members post-delivery. Even women choosing to deliver at home with a dai appreciated the fact that a wide range of emergency facilities are available in urban centres if obstetric complications occur.

While BRAC health workers had regular contact with most of respondents in our study, many of whom would probably not have left their homes for ANC, the services provided did not appear to meet ANC criteria. Interestingly, the majority of women receiving BRAC ANC in Dhaka still preferred to deliver with a dai at home. From a biomedical, economic and cultural standpoint BRAC delivery services appear to be very similar to delivery attendance at home with TBAs; particularly the cultural similarities make BRAC delivery services attractive to families, which was especially true in Chittagong. BRAC does serve as an important link to formal maternity health services when a complication arises. While only one woman in our study sample was referred, the referral system seemed to function smoothly.

C-Section Delivery

Demographic and educational background of the respondents was similar. While two women in the Dhaka sample worked as housemaids, the women in the Chittagong sample were all housewives. Women in the Dhaka sample had been living in the urban centres for an average of 16 years, compared to nine years in the Chittagong sample. Husbands in the Chittagong sample appeared to be better educated and had slightly higher monthly salaries.

There was one primiparous woman in each sample, and the majority of other women in both samples had previously delivered one time. One woman in the Dhaka sample and two women in the Chittagong sample had attended ANC during their previous pregnancies, with the women in the Chittagong sample mentioning that they had only attended ANC one time. Three of the five women in the Chittagong sample had previously had a C-section delivery, while one woman in Dhaka had already experienced a C-section delivery.

During the most recent pregnancy, three women in the Dhaka sample received regular home visits from BRAC and all had at least one consultation in a formal facility. While all of the Dhaka respondents had had more than four ANC consultations, several lacked continuity in the care, receiving ANC from a mix of formal facilities, MBBS doctors offering private services and BRAC. All of the women in the Chittagong sample had at least one ANC consultation in a formal health facility, with three women receiving the minimum four ANC visits in formal facilities or private doctors' offices. The other two women, both of whom had previously had a C-section, started with BRAC services but were recommended either by BRAC staff or an acquaintance to get more complete ANC in a health centre. The three women who had previously had C-section were all recommended to go to Momota clinic for ANC care where C-section costs were reported to be low. Three of five women in the Chittagong sample received at least one home ANC visit from BRAC health workers. Once again, BRAC ANC in both sites appeared to be limited and did not constitute a comprehensive visit. Despite this, women receiving BRAC ANC appreciated the convenience and free cost. At least two women in each site reported having blood and urine tests, and all women received ultrasound. It appears that the results of the ultrasound, which often identified a potential complication, were not always adequately conveyed to the woman or her family members. Women in both samples were unaware of the recommended number of ANC visits. All respondents in both sites valued ANC, stating that it allows the health workers to assess the woman's health and the movement, position and general condition of the baby.

Three of the five women in the Dhaka sample had planned on having a facility delivery and another expected to deliver in the birthing hut. In one instance the woman had previously had a C-section delivery in a facility, in two instances an ultrasound showed a potential complication (baby was big or in reverse position) and in another case the woman reported that there was nobody available to assist the delivery at

home. Two of these women expected that they would have a C-section delivery. Three of these women had a card from a large maternity centre which they understood covered C-section costs, and the fourth woman, who knew the child was in a reverse position, had a card from BRAC and was referred to a higher level facility for ANC care. The final woman was primiparous; this family did not have savings for a facility delivery and the in-laws decided that the baby would be born at home. Birth plans for the Chittagong sample were not adequately collected. However, the three women who had previously had a C-section delivery expected that they would once again require a C-section.

The birth plans of the Dhaka women did not necessarily go as planned, with two women altering their plans at the time of delivery out of concern about facility based and C-section deliveries. Two women, one of whom had previously had a C-section delivery, went to a private facility at the time of their expected due date and had a C-section. While one woman had not expected to have a C-section, an ultrasound showed that a C-section was needed immediately, and she and her family accepted to undergo the procedure. Another woman who had planned on a facility delivery went to the health centre on her expected delivery date; when she was told that a C-section was required she was reluctant to go through the procedure. She returned home, only to experience convulsions the same evening; she returned to the facility, and because her condition involved convulsions, was transferred to a medical college where the C-section was performed. A fourth woman's family first called a dai to assist the delivery, but because the dai said the baby was defecating inside the womb, the family was advised that the woman be taken to the BRAC birthing hut where the woman had a card and had planned to deliver. However, the respondent claimed that the BRAC workers would not give her a referral slip to a higher level facility. The dai subsequently referred the family to Dhaka Medical College Hospital where the C-section was performed. The final woman, who had planned on a home delivery, had prolonged labour and was advised by the dai and a shopkeeper who administered saline to go to the clinic where she had received a card during ANC for delivery. Her baby was determined to be in a reverse position and she was subsequently transferred to Dhaka Medical College Hospital for a C-section. Interestingly, the two dais called to assist deliveries both felt that the complications the women were experiencing were potentially life-threatening and recommended the women be taken to a health centre, with both accompanying the woman and family members to the facility. In all cases, the fact that women had ANC cards reduced barriers to careseeking; three women were transferred to higher level facilities and all referrals appeared to function well.

In regard to the three women in Chittagong who had previously had a C-section, two women went to the clinic on their expected delivery dates for the C-section, but one was referred to another facility because anaesthesia was not available. The third woman did not want to have the C-section due to the perceived costs; when the family called a dai to assist the delivery, the dai refused and insisted she go to the facility. The dai accompanied the woman to the health centre where she had received ANC. The other two women had ultrasounds around their delivery due dates showing that the baby was either too big or in a reverse position. While one woman was immediately admitted to a private hospital where she had a C-section, the second woman believed the baby's position would change and therefore prolonged going to a maternity facility to deliver. Sixteen days after her due date she was taken to a facility and an emergency C-section was performed. Careseeking for delivery was guided by the fact that the woman had previously had a C-section, concerns about complications and the perceived need that a C-section would be required, and the fact that the woman had received a card during ANC and was eligible to receive assistance from the health centre. Only one woman attempted to deliver at home with a dai, and in this case the dai refused to assist due to concerns that the woman had a history of C-section and required professional care.

Three women in Dhaka and four women in Chittagong had to pay sizeable costs for the C-section delivery, with most having to take loans with interest. Costs were particularly high, reaching as much as 40,000 taka, in private facilities. While the other women in both samples went to facilities offering reduced costs for poor populations, in two cases families still struggled to gather the necessary money for payment and were forced to borrow money.

Perceptions of the C-section deliveries were generally negative and related to the fact that women were unable to do heavy work and move about normally postpartum. Another common complaint related to the exorbitant costs. Interestingly, only one of ten women mentioned that C-section delivery is essential for women experiencing complications. In both sites, respondents recommended that specialized delivery care be made available in their immediate neighbourhoods so that during an emergency, women can seek rapid care. Dhaka respondents recommended raising community awareness about maternal health facilities and the services offered.

Only two women in Dhaka and three women in Chittagong received postnatal care in health facilities. Another woman in Chittagong received postnatal care from BRAC health workers. The other women did not seek postnatal care either because they were concerned about the expense or did not experience any problems and did not think it necessary.

We identified several cases where even if the woman had previously had a history of C-section or was informed prior to delivery that a complication was detected and a C-section would likely be needed, the family still tried to avoid or delay a facility-based delivery. In most cases, the fact that the woman had attended ANC and was linked to health providers facilitated their access to EOC care; interestingly, in a few cases dais also helped to ensure that the women accessed emergency care. The findings illuminate the need to understand why some families disregard medical advice regarding the need to obtain professional maternity care and how better to convey the potential danger of delivering in a non EOC facility when a complication is detected. Despite that fact that most women had received a card for reduced maternity care, the data suggest that the costs incurred were extremely high and beyond the means of poor families, causing many to go into debt.

Family Planning

The demographic and socioeconomic background of female and male respondents in the two samples was similar, with women on average approximately 30 years of age, having limited schooling, and being primarily housewives. The average age of husbands was in the mid- to late 30s, and their educational backgrounds, work and income was similar. Dhaka couples had on average three children, while Chittagong respondents had on average two children; all couples had at least one son. All couples indicated having no desire to have more children, with most having made the decision jointly.

Sources of information about contraceptives were somewhat different, with Dhaka female respondents more often mentioning obtaining information from pharmacists and field health workers carrying out door-to-door visits, while Chittagong female respondents generally indicated that their primary source of information was family members and neighbours, followed by local pharmacists and clinic based NGO health care providers. Female respondents from Chittagong did not appear to be visited at home by community health workers offering information on family planning. Men had limited contact with formal health workers regarding family planning, with most suggesting that they learn about contraceptives through neighbours, friends or family members, particularly their wives, and some admitting that they were generally uninformed. Women were commonly described as more knowledgeable and primarily

responsible for taking methods, with some female Chittagong respondents indicating that using contraceptive methods can decrease the strength and income earning ability of their husbands. Some noted that women stay at home, making them more readily available to consult with health workers who rarely interact with males. Furthermore, contraceptive options for men were perceived as limited, with condoms not well liked.

At the time of the interviews, all respondents were using temporary contraceptive methods with most women using the pill, which was frequently obtained at local pharmacies. Most of the female respondents in Dhaka had primarily used the pill throughout their reproductive health history, while Chittagong respondents had alternated between the pill and injectables. Although women were generally responsible for taking methods, in Dhaka husbands were in charge of getting the methods, while in Chittagong women obtained contraceptives.

Dhaka female respondents, who seemed to have more exposure to health workers offering information on contraceptives, appeared to be more knowledgeable about long acting or permanent methods than Chittagong female respondents. All respondents were familiar with injectables, which all Chittagong respondents and some Dhaka respondents had used. Respondents generally had negative views of injectables, which were frequently associated with such negative side effects as heavy bleeding, missed periods, body pain and excessive weight gain. In regard to other long acting methods, much of the information respondents shared appeared to be primarily anecdotal and based on interactions with neighbours or friends. Most female respondents were aware of implants; the data revealed that some women were opposed to implants due to the fact that insertion involves cutting the flesh and is believed to cause ongoing pain at the location of insertion, is also believed to cause excessive weight gain, and because it involves inserting a material object, potentially opposes Islamic tenets proclaiming that all material items be removed from the body after death. A few respondents in each sample mentioned Copper T as a long acting method, with more specific information on Copper T shared by Chittagong respondents. These respondents mentioned that the metal insert can move up the woman's body to the stomach, and if this happens an operation is required or the woman can die, mentioning as well that inserting Copper-T is shameful because the private parts of the woman are exposed to the health provider, and that because it is inserted inside the body, Copper-T can also oppose religious principles.

All respondents were knowledgeable of permanent methods for men and women, particularly vasectomies, which many stated had been promoted in the past in exchange for a small sum of money and a lungi, with some suggesting that the incentives offered were insignificant compared to the life changing effects. Once again, information collected on permanent methods was generally based on anecdotes and uniformly negative. We uncovered multiple misconceptions regarding how the procedures are carried out (e.g. the nerve of the penis is cut or the uterus removed) and the multiple adverse health effects believed to occur post operation, which entailed in the short term infections associated with the surgery and over the long term loss of sexual prowess, as well as weakness and chronic stomach pain causing a decreased ability to carry out arduous activities or to work. Male respondents in Chittagong also mentioned that permanent methods can lead to disease. The fact that a woman's menstruation cycle would permanently stop was perceived to be another serious and negative side effect. In addition to physical consequences, male and female respondents consistently cited religious prohibitions which oppose long acting and permanent methods, with many indicating that preventing conception over a long period is sinful, and that changing the human physiology through an operation to stop conception permanently is a serious religious offence forbidden in Islam that may have detrimental consequences on those who accept the procedure and their family members. Some respondents mentioned that religious groups and their leaders are highly opposed to permanent methods, calling this the ultimate, unforgiveable sin, which prohibits Muslims from receiving

religious burial rituals considered a necessary passage to heaven and life after death. Some respondents also mentioned that the permanence discourages them from accepting the method, indicating that later in life they may opt to have additional children. Males in particular mentioned that the methods their wives were currently using suited them well and there was no need to consider more long term or permanent methods.

Recommendations included increasing formal health facilities offering family planning services in their immediate residential areas, increasing or re-establishing community outreach including household visits to provide both information and contraceptives, adjusting the timing of household visits to accommodate women who work outside the household, offering services in garment factories and other places of work, having more male health workers to provide services to men, better informing and motivating men to use methods through targeted educational campaigns, making methods free or at low cost, and raising general awareness through mass media and one-on-one consultations.

The slum dwellers in our samples appeared to have limited contact with trained health workers on family planning methods. Moreover, those community and facility based health workers offering family planning services seem primarily to be providing information on and offering short term methods, including the pill and injectables. Pharmacies, which are where slum dwellers in our samples obtained methods, can only provide pills and condoms. If use of long-acting methods is going to increase, our data suggest a strong need to inform slum dwellers better about long acting and permanent methods in an effort to address and dispel some of the misconceptions and fears about long term methods. The results also highlight the need to inform and educate community leaders, particularly religious leaders, about long term methods.

REFERENCES

- Afsar R (1995). Causes, consequences and challenges of rural urban migration in Bangladesh, Doctoral Dissertation, University of Adelaide, Australia.
- Ahamad, Mazbahul Golam, et al. (2011). Seasonal Unemployment and Voluntary Out-Migration from Northern Bangladesh. *Modern Economy* 2.
- Ahmed, Sadiq, Junaid Ahmad, and Adeeb Mahmud (2007). *Making Dhaka Livable*. University Press Limited.
- Bartram, Jamie, et al. (2005). Focusing on improved water and sanitation for health. *The Lancet* 365.9461: 810-812.
- Biplob P, Chandra DS, Sarker RC (2011). Assessment of water supply and sanitation facilities for Korail slum in Dhaka City. *International Journal of civil & Environmental Engineering IJCEE-IJENS* 11(5);115-27.
- Buttenheim, Alison M. (2008). The sanitation environment in urban slums: implications for child health. *Population and environment* 30.1-2: 26-47.
- Chant S (1992) *Gender and Migration in Developing countries*. London: Belhaven press.
- Chowdhury Mahbub Elahi, et al. (2009). Causes of maternal mortality decline in Matlab, Bangladesh. *Journal of health, population, and nutrition* 27.2: 108.
- Ellis F and Harris N (2004). *New Thinking about Urban and Rural Development*" (Keynote paper for DFID Sustainable Development Retreat, University of Surrey, Guildford.
- Farhana et al (2012). Factors of migration in urban Bangladesh: An empirical study of poor migrants in Rajshahi city. *Bangladesh e-Journal of sociology* 9.1: 105-115.
- Gazi et al (2009). Base line and endline survey on demand based reproductive health commodity project. ICDDR,B, NIPORT, and UNFPA.
- Gray CL, and Mueller V (2011). Natural disasters and population mobility in Bangladesh. www.pns.org/cgi/doi/10.1073/pns.1115944109.
- Habitat, U. N. (2009). *Planning sustainable cities: Global Report on Human Settlements*. 2009. Earthscan, London
- Health. *Population and environment* 30.1-2 (2008): 26-47.
- Health and Science Bulletin* (2012) Vol 10 n1
- Hossain MZ (2001). Rural-urban migration in Bangladesh: A micro-level study. Paper presented in a poster session on Internal migration at Brazil IUSSP Conference during August 20-24, 2001.
- Hossain, Shahadat (2008). Rapid urban growth and poverty in Dhaka city. *Bangladesh e-journal of sociology* 5.1: 1-24.
- Hussain, Akhtar, et al (1999). Determinants of mortality among children in the urban slums of Dhaka city, Bangladesh. *Tropical Medicine & International Health* 4.11: 758-764
- IFPRI (2007). *Study of household food security in urban slum areas of Bangladesh, 2006. Final Report for World Food programme-Bangladesh*. International Food Policy Research Institute. Washington. D.C, USA.
- IPHN and ICDDR, B (2008). Food price hike in Bangladesh: A rapid assessment of coping strategies and nutrition status of women and children in selected areas. Institute of Public Health Nutrition and ICDDR, B. Dhaka. Bangladesh.

Jamil, Kanta, et al (1999). The immunization programme in Bangladesh: impressive gains in coverage, but gaps remain. *Health Policy and Planning* 14.1: 49-58.

Jamil, Sofiah. (2013). connecting the DOTS: The urban informal sector and climate vulnerabilities in Southern Asia megacities, Centre for Non-Traditional Security (NTS) Studies for NTS-Asia.

Kamal, SM Mostafa (2009). Factors affecting utilization of skilled maternity care services among married adolescents in Bangladesh. *Asian Population Studies*, 5.2: 153-170.

Khan R, Blum L, Sultana M et al (2012). An examination of women experiencing obstetric complications requiring emergency care: perceptions and sociocultural consequences of caesarean section in Bangladesh. *J Health Popul Nutr*, 30(2):159-171.

National Institute of Population Research and Training (NIPORT), MEASURE Evaluation and icddr,b (2012) *Bangladesh Maternal Mortality Care Survey* 2010. Dhaka, Bangladesh: NIPORT, MEASURE Evaluation, and icddr,b

National Institute of Population Research and Training (NIPORT), Mitra and associates, and Macro International (2009). Bangladesh demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training , Mitra and Associates, and Macro International.

National Institute of Population Research and Training (NIPORT), MEASURE Evaluation and International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR, B), and associates for community and Population Research (ACPR) (2008). 2006 Bangladesh Urban Health Survey. Dhaka, Bangladesh and Chapel Hill, NC, USA: NIPORT, MEASURE Evaluation, ICDDR, B and ACPR.

Pervin J, Moran A, Rahman M et al (2012). Association of antenatal care with facility delivery and perinatal survival- a population based study in Bangladesh. *BMC Pregnancy and Childbirth*, 12:111.

Sabur MA and Mahmkud H (2008). Political impacts of remittance: A micro-level study of migrant's remittances in a village in Bangladesh. *Asian Social Science*, 4(12):128-134.

Sachs, Jeffrey D. (2012). From millennium development goals to sustainable development goals. *The Lancet*, 379.9832: 2206-2211.

Sarker BK, Higgins J, Mridha MK et al (2012). Caesarean delivery in urban slums of Dhaka city: indications and consequences. Manoshi Working Paper no 18. Brac and icddr,b.

Ullah, AKM Ahsan (2004). Bright City Lights and Slums of Dhaka city: Determinants of rural-urban migration in Bangladesh. *Migration Letters* 1.1: 26-41.

United Nations (2012). Department of Economic and Social Affairs. Population Division. World urbanization prospects: the 2011 revision. UN.

Water Aid (2008) Turning slums around: The case for water and sanitation. Discussion Paper by Uwejamomere T. Urban Water Supply and Sanitation Services, WaterAid.

Walsham M (undated). Assessing the Evidence: Environment, climate change and migration in Bangladesh. IOM Report.

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