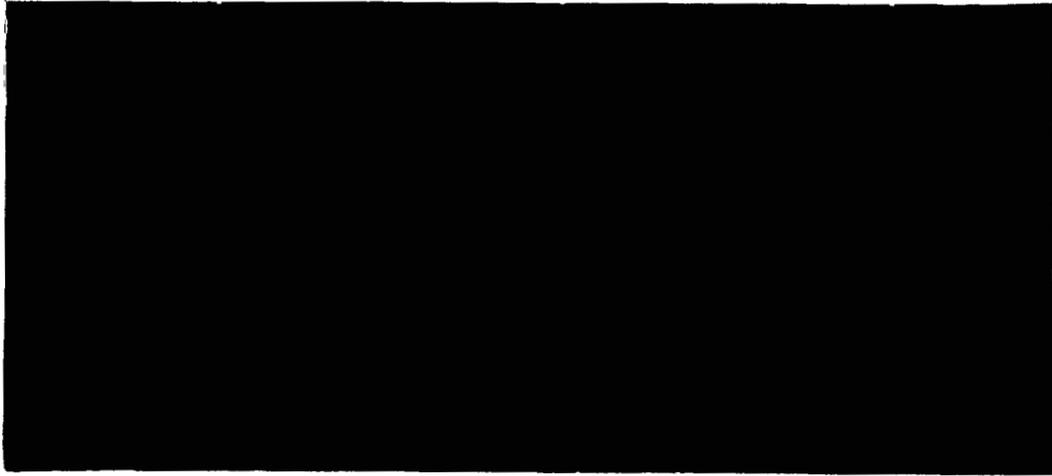


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**REORIENTING COMMUNITY-BASED FAMILY
PLANNING SERVICES IN BANGLADESH:
PROBLEMS AND PROSPECTS**

Sidney Schuler, Amy Cullum and Sharif Shamshir

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JSI Research and Training Institute,
1616 N. Fort Myer Drive, Arlington, Virginia 22209

Development Research Centre,
74 Tej Kunipara, Tejgaon, Dhaka, Bangladesh 1215

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ABSTRACT

Door to door family planning services by women to women have been the central strategy in the highly successful national family planning program of Bangladesh. There is a growing consensus within the Bangladesh government and the donor community, however, that domiciliary services are no longer necessary and are not cost effective. This paper examines some of the perceptions, strategies, and patterns of interaction that have developed in relation to the domiciliary system of family planning service delivery. It presents data from a six year, six village ethnographic study of changing reproductive and gender norms, drawing in particular on a recent intensive assessment to document community perceptions of, and interactions with, health and family planning services. It highlights problems that need attention as the role of community-based family planning workers is modified and clinics and satellite clinics become the focal point for reproductive health services. It also identifies aspects of the current system that might be built upon in devising transition strategies.

The national family planning program of Bangladesh is thought to be a driving force in the rapid fertility transition that is now underway. The central strategy of the program has been provision of domiciliary services to women by community-based women family planning workers. Family planning is poorly integrated with health services, despite shared facilities and overlapping mandates. Attempts at functional integration have failed for the most part because of a bureaucratic bifurcation at the central level. In the near future it is likely that the Bangladesh family planning program will change and move away from domiciliary family planning services as a result of two policy trends. One is the Programme of Action promulgated at the 1994 United Nations International Conference on Population and Development in Cairo, that calls for family planning services to be offered within a broader framework supporting women's social and economic advancement, reproductive rights and health. The Bangladesh Government and the family planning program's principal international donors have endorsed the Cairo agenda. How this agenda will be implemented is still rather unclear, but initiatives to expand education for girls, and to make a broader range of reproductive health services available are already underway. The latter will almost certainly require a greater emphasis on clinics. The second major policy trend addresses the financial and institutional sustainability of health and family planning services. Despite a decreasing fertility rate, the reproductive age group, and the population as a whole, is still growing rapidly as a result of population momentum. There is a growing consensus within the Bangladesh government and the donor community that domiciliary family planning is an insufficient service delivery mode for the future, not least because of the cost of the huge workforce required.

Recent papers based on longitudinal research of the International Centre for Diarrheal Disease Research (ICDDR,B) and the Population Council argue that cutting down on home visits by family planning workers would likely result in higher discontinuation of family planning method use (Hossain and Phillips, 1996), lower contraceptive prevalence rates (Phillips et al., 1996), and diminished quality of care (Hossain, Barkat-e-Khuda and Phillips,

1995). Reducing home visits, it is feared, might even undermine demand for contraception (Phillips et al., 1996). The paper by Phillips et al. (p. 214), concludes, "the present analysis demonstrates that household services are needed, not only to introduce family planning, but also to sustain contraceptive practice over time." Hossain et al. (p. 13) warn that "any new strategy that diminishes the intensity of domiciliary outreach risks diminishing support that individual women view as being crucial to the quality of services." Hossain and Phillips (p. 104) close with an even more dire warning:

If household contact is reduced by changing the program to a more passive service approach, this finding suggests that the positive role of outreach would be lost; discontinuation rates would increase....Results suggest that household outreach substitutes for client motivation, providing an incentive for practicing contraception that would not otherwise arise. As time progresses, the effect of outreach in sustaining use gains in importance....In the absence of active household outreach, many women will stop using contraceptives, not because they plan to do so, but because they depend upon the program for outreach support.....Policy deliberations on the merits of scaling back household service delivery in the interest of fostering sustainability of the program may undermine the sustainability of contraceptive practice instead.

The analyses presented in these papers are based on data from 1987 to 1989 (Hossain et al., 1995), 1984 to 1992 (Hossain and Phillips, 1996), and 1982 to 1992 (Phillips et al., 1996). The papers' conclusions assume that the relationships between home visits and contraceptive use that existed during these earlier periods still exist today and are expected to continue in the future. With contraceptive use having more than doubled between 1982 and the present (Mitra et al., 1994), however, and in light of the radical and rapid changes that have taken place in norms related to childbearing and contraceptive use (Simmons, 1996; Mita and Simmons, 1995; Schuler et al., 1995, 1996), this is not necessarily the case.

Furthermore, the analyses by ICDDR,B and the Population Council implicitly compare the effects of home visits with no visits, or fewer visits, in a situation where many women

have no contact with the family planning program other than through home visits. Thus Hossain and colleagues find, not surprisingly, that women who are visited more frequently by outreach workers are more satisfied with the outreach services and perceive them to be of higher quality than those visited less frequently. The study was not designed in such a way that women could say they might have preferred more extensive services.¹ Even assuming that the family planning workers have strong skills and good attitudes, which may not always be the case, the brevity of home visits raises a question about the quality of services that family planning workers provide (Koenig et al., 1995; Koblinsky et al., 1989).² Only a fourth of the women visited by an FWA in the study by Koenig et al. indicated that they would welcome another visit (p. 18). Despite the limitations of the domiciliary services, Hossain and colleagues use the results of their analysis to suggest that real innovations are not needed, and might even undermine contraceptive prevalence rates. The possibility that better support might be provided to women who use contraceptives by concentrating on clinics is not considered.

We have argued (Schuler et al., 1995, 1996) that a shift away from family planning services in the home could be beneficial not only from the perspective of sustainability, but because this would open the way to offer a broader range and higher quality of reproductive health services, in a manner that is more empowering for the women who use them. The fact that women are increasingly coming out of their homes for employment and to participate in microcredit and other programs weakens the rationale for bringing family planning services to the door. In light of the positive changes documented in the lives of women who discover new opportunities and roles in the public sphere (Hashemi et al., 1996; Simmons et al., 1992), it would not be surprising if rural women also responded positively to a new set of family planning program norms which require them to become more active in getting contraceptive methods and services (through clinics, satellite clinics and supply depots), particularly if this gives them better access to other resources that they value, such as health services. But bringing the pill to the doorstep is an accepted norm in rural Bangladesh, and many women depend on this service. If home visits are simply discontinued, new norms will gradually evolve as women and couples find alternative sources of contraceptive methods. Without some

sort of intervention, however, the transition period could be difficult for many, and unsafe abortions and unwanted births could increase considerably.

This paper presents data from a six year, six village ethnographic study of changing reproductive and gender norms. It draws in particular on an intensive assessment to elicit community perceptions of, and interactions with, health and family planning services, conducted between August, 1996 and January, 1997. Assuming that change is on its way, we consider what can be learned from both the positive and the negative aspects of the present system. Although we are mainly concerned here with women's use of and experiences with family planning services, the scope of the field study was broadly and somewhat loosely defined. Notwithstanding the bureaucratic divisions between public sector health and family planning services in Bangladesh, family planning is best seen as part of health care. Furthermore, in a traditional, patriarchal society such as this one, women's health seeking behavior cannot be well understood except in relation to men's perceptions of women's health care needs, men's views of health services in general and family planning services in particular, and men's decisions about their own and their families' health care.

The initial sections of the paper describe our research methods and data, the family planning service delivery system in rural areas, and the study sites. In the sections that follow we examine some of the norms, perceptions, strategies and patterns of interaction that have developed in relation to the present system of family planning service delivery. We highlight problems that need attention as the role of community-based family planning workers is modified and clinics and satellite clinics become the focal point for reproductive health services. We also identify aspects of the current system that may facilitate a transition from services in the home to services in clinics, and might be built upon in formulating transition strategies. This paper focuses on community-based services and decisions about use of various health and family planning services. A companion paper describes the experiences of women who use clinics for reproductive health services.³

DATA AND METHODS

Our ethnographic research is based in six villages, located in Magura, Faridpur and Rangpur Districts. Here we include four types of data:⁴

(1) Descriptive statistics based on a 1994 survey of all currently married women under age 50,

(2) Observations and unstructured interviews by male-female pairs of researchers who lived in each village for two years (1991 and 1992) and have been visiting since that time,

(3) A set of semi-structured in-depth interviews with 104 married women of reproductive age and 92 men from 120 randomly selected poor households about reproductive decision-making and use of family planning methods and services, conducted by the resident researchers in 1992-93, and

(4) Findings from an assessment of health and family planning services from the client perspective conducted in each village from August through November of 1996 by seven of the field researchers and the authors. The latter had five components:

- (a) An inventory of providers of health and family planning services accessible to each village (those located in or near the village, and those which were farther away but were used by residents of the village).
- (b) Clinic observations. A pair of researchers (a man and a woman) spent a full day at the Family Welfare Center (FWC), the government clinic offering family planning services at the lowest administrative level (union), nearest each village.
- (c) Interviews with family planning staff of the clinics. In government clinics these were the Family Welfare Visitor (FWV), and in NGO clinics the equivalent of the FWV.
- (d) Community perceptions of health and family planning services, and patterns of use. A set of interviews was done in each village to elicit perceptions of the services offered at various nearby facilities and by private practitioners, traditional and modern, and to explore how decisions were made about utilizing these services. An interview guide was provided, in the form of a list of general questions about available services and utilization decisions, and attitudes as to

whether it was appropriate for women to visit health and family planning facilities, accompanied or unaccompanied. The field researchers decided how these questions could be pursued.

- (e) Interviews with 34 women who had recently gone to a clinic or satellite clinic for family planning services. In each of the six villages family planning workers and key informants were interviewed to identify women who had visited such clinics within the previous three months. The women were interviewed by female members of the research group regarding the circumstances of the visit, their experiences and assessment of the services rendered, and whether they were criticized by their families or others in the village for going there (for breaking purdah or for other reasons).
- (f) Semi-structured, in-depth interviews with a subsample of women and men from the 120 focus households mentioned above (3). The interview guide was adapted for each respondent in order to update the earlier information about family planning decision-making, fertility, contraceptive use and contact with family planning services. Additional questions were added to probe for health problems, including symptoms of reproductive tract infections (RTIs), and to elicit details regarding contact with family planning workers, clinics, satellite clinics and other sources of health and family planning services.

BACKGROUND

Family Planning Services in Rural Bangladesh

The Bangladesh government employs some 24,000 Family Welfare Assistants (FWAs), and 6000-8000 similar workers are employed by NGOs, who visit married women of reproductive age in their homes to promote family planning and supply pills and condoms. Each FWA is expected to serve about 750 women. Their official job description includes a range of responsibilities related to maternal and child health, but they tend to concentrate their efforts on family planning (Simmons et al., 1990; Koenig et al., 1995). The FWAs are employed by the family planning wing of the Ministry of Health and Family Welfare. Community outreach

activities to promote infant and child health are conducted by separate, mostly male staff under the health wing of the ministry, occasionally with assistance from the FWAs.

The lowest level government clinic in rural Bangladesh is the Family Welfare Center (FWC), which serves an average population of about 24,000, the average population of a union.⁵ The FWC is staffed by a female paramedic called a Family Welfare Visitor (FWV), who provides family planning and maternal and child health (MCH) services, and a male paramedic with the title of Medical Assistant, who provides basic health services. Eight times a month the FWVs are supposed to conduct outreach services through "satellite clinics" at various sites in the union. The primary emphasis in satellite clinics is on making injectable contraceptives and IUDs available to women who may not be willing or able to go to fixed clinics farther from home.⁶ The domiciliary workers assist in organizing the satellite clinics in their assigned areas. They refer, and sometimes accompany, women who wish to use clinical methods or menstrual regulation (MR)⁷ to the FWC or a satellite clinic. For sterilization women are referred to *Thana* (subdistrict) clinics or District-level government hospitals. In areas that the government has allocated to NGOs, the NGO family planning workers refer clients to an NGO clinic if such a clinic exists and, where it does not, to the FWC or a higher-level government facility.

The FWAs have played various important roles in the evolution of Bangladesh's highly successful family planning program. They have functioned as agents of social change, spreading and legitimating the idea of family planning (Simmons, R. et al., 1988; Simmons et al., 1992; Mitra and Simmons, 1995; Schuler et al., 1996). They have been active in expanding access to female sterilization, motivating women to adopt sterilization, accompanying them to clinics, caring for their children, bringing food, medicines and other supplies that are often unavailable in the clinics where sterilizations are performed and, in some cases, even staying overnight with them. During the period of 1985-93, as domiciliary services expanded, sterilizations declined (Mitra et al., 1994, pp. 45-46).⁸ Now the oral pill is by far the most commonly used method, with about half of all couples who use modern contraceptive methods relying on it (Mitra et al., 1994, p. 46-47), and the work of the FWAs is primarily directed toward recruiting new oral contraceptive users and delivering supplies of oral pills to

continuing users. The FWA is currently the most frequent source of supply for family planning methods and serves more family planning clients than all types of clinics combined; seventy percent of women using pills rely on FWAs or their NGO counterparts for supplies of pills (Mitra et al., 1994, p. 60).

A large number of FWAs working in the government program were hired between 1976 and 1980, and the program underwent another major expansion from 1985 to 1990 (Larson and Mitra, 1992). Many of the FWAs have been working in the same communities for 10 years or more; one recent study in 2 districts found an average length of service of 13 years (BRAC, 1996). Therefore, depending on their ages, clients of an FWA may have had a dozen, or dozens, of contacts with her. Surveys show that desired family size has dropped to about 2.5 and knowledge of modern contraceptive methods is virtually universal (Mitra et al., 1994, p. 40-41). The survey findings along with findings from qualitative research (above citations), suggest that the community-based workers have indeed succeeded in popularizing the family planning message.⁹ As a result, their roles are now comparatively limited.

The Study Villages

Our ethnographic research was based in six villages, three in the northern part of the country, in Rangpur District and three in the central-west, in Magura and Faridpur Districts. The first three villages, in the district of Rangpur, are more economically depressed, and somewhat more conservative in terms of women's roles than the three communities in Magura and Faridpur. The public sector health and family planning services to which people have access are much the same across the six villages, however distances to fixed facilities vary. The nearest clinic (in most cases an FWC) is closer for households in the Magura-Faridpur group of villages, compared with the Rangpur group. Villages 4, 5 and 6 are between one half and 1.6 miles from an FWC, whereas villages 1, 2 and 3 are 2.5 to 3.9 miles from an FWC or a comparable NGO clinic. (About half of all respondents in the 1993-4 DHS lived within a mile of an FWC.) Women in villages 4, 5 and 6 are much more likely to visit a fixed clinic, hospital or private doctor's office for health or family planning services than those in villages 1, 2 and 3. The proportions who had done so within the year prior to the survey in early 1994

ranged from 5% to 20% in villages 1, 2 and 3, compared with 31% to 46% in villages 4, 5 and 6. Although there was generally greater use of all levels of health facilities in villages 4, 5 and 6 compared with 1, 2 and 3, the contrast was particularly great with regard to use of FWCs, probably in part because of the relative distances involved. Village 5 also had a high percentage of women who used health facilities at the district level (Table 1).

Comparing their impressions from the in-depth interviews done in 1992-93 with those done in late 1996, the field researchers observed that women were more open and articulate about family planning, side effects and sources of services, and more active in seeking out family planning and health services, both within the village and from clinics. The researchers also saw more evidence of mutual support among women who used contraceptives, some of whom had once been reticent to talk with neighbors about family planning or had tried to keep their contraceptive use a secret. In the 1996 interviews there were many examples of women sharing information and advising one another, sharing pill supplies, sending the family planning worker to homes of women who were interested in starting a method, providing moral support, and accompanying other women to clinics.

Levels of contraceptive use in the six villages ranged from 28% to 66% in 1993. Despite this variation among villages, comparison with data from the 1993-94 DHS suggests that in the aggregate the six villages are not atypical for rural Bangladesh in contraceptive use levels or method mix (Table 2). The contraceptive prevalence rate (CPR) was above the national average at the time in three of the villages (1, 5 and 6), below average in two (2 and 4) and about average in one (village 3). The high levels of contraceptive use in villages 5 and 6 (Magura District) reflect and slightly exceed the relatively high CPR in Khulna Division (55%). In all but one village (village 4, where female sterilization is most common) the pill is by far the most frequently used contraceptive method. Use of traditional methods, particularly withdrawal, may be under-reported in our survey.

All six villages are served by government FWAs or NGO family planning workers, but the quality and intensity of their services varies. In three cases the family planning workers reside in the villages where they work, and in three cases they live outside the village and visit periodically. Those who come from outside deliver oral contraceptives to clients' homes, and

in some cases use volunteers to help distribute them. In the villages with resident family planning workers women often go to the workers' homes to collect their supplies of contraceptive pills. Male Health Assistants live in two villages, male supervisors (Family Planning Inspectors) reside in two, and a nurse lives in one village. In one village there are five family planning volunteers trained by the government's Local Initiatives Program; three of them assist the FWA in disseminating information and supplying pills in the village, and two are assigned to another village. Another village has a now semi-active volunteer trained under another government program, *Jigasha*. A female health worker (*shastho shebika*) trained by the NGO BRAC provides information in another community, and sells basic drugs and oral contraceptives.

In addition, a variety of private medical practitioners, both traditional and modern, provide health care in or near each of the six villages. Traditional birth attendants (TBAs) trained through government programs practice in five of the villages and untrained TBAs practice in all six. In or near all of the villages there are pharmacists and homeopathic and allopathic "village doctors" with some medical or pharmaceutical training, but no formal medical degrees, as well as traditional healers, in most cases known as *kobiraj* (Table 3).

KNOWLEDGE, PERCEPTIONS AND DECISION-MAKING

Even though the dominant service delivery mode is household-based, some rural women rely on clinics for family planning and other reproductive health services. Understanding who now uses clinics, for what purposes clinics are used, and what information and perceptions decisions regarding clinic use are based on may help in developing strategies for a transition from domiciliary family planning services toward a broader package of reproductive health services provided primarily through clinics and satellite clinics.

Knowledge and Perceptions of Services

The ability to make optimal use of whatever health services exist requires a certain basic knowledge of these services, which many rural people in Bangladesh lack. Residents of the six villages were generally uninformed regarding the structure through which modern health and

family planning services are provided, the technical training and titles of service providers, and the range of services which might be expected from various facilities. The villagers were quite unaware even about the system of community-based services. For example, many respondents guessed incorrectly when we asked whether the local family planning worker was employed by the government or an NGO. In one village people speculated that the NGO family planning worker must be a government employee because she had been working in the village for a long time. A man in another village said the NGO worker was probably employed by the government because she received a regular salary. The family planning workers who live in the research villages are usually referred to as “mother of [one of her children]” or “wife of [her husband]” and addressed with kinship terms such as *apa* (sister) or *bhabi* or *boudi* (brother’s wife). Those who come from outside the village are usually addressed as *apa* and described as “the pill-giving sisters.” Virtually everyone above the level of the FWA, and in some cases even the male village health worker, is described as *daktar*, although distinctions are sometimes made between “big” and “little” doctors. Some people (mainly wealthier men) also distinguish and seek out doctors with MBBS degrees and doctors who hold professorships in the medical college. The female paramedics (FWVs) are also referred to as *apa*, or *daktar apa*.

Most of the women interviewed who had recently visited a clinic for reproductive health services could not name the clinic and, in some cases, could not say whether it was run by the government or an NGO. Most of them knew only the name of the place where the facility was located. When there was more than one facility at a particular location, the researchers had to probe for details to ascertain which one the woman had visited. Within the health and family planning facilities the women knew only the titles of the lowest ranking staff (guard and female attendant). The residents of village 5, where clinic use is higher, were somewhat better informed about health services and used a wider variety of health and family planning service providers.

When criticizing health services, people did not distinguish between the inherent limitations of a facility or provider and malfunctioning. The most common complaint against health facilities, and the Family Welfare Center in particular, was that the staff withheld

medicines, or gave out the same medicines for every ailment. Whereas there very likely were shortages of medicine, and although drugs may or may not always have been dispensed appropriately, the fact that FWCs are supposed to be stocked with a comparatively limited range of drugs was not taken into account. Rather, the situation was viewed with suspicion. Clients who had to wait, sometimes for hours, for a female paramedic to arrive at the FWC did not seem to be aware that the FWC was supposed to open and begin providing services at a certain hour. They were generally annoyed at having to wait, but nevertheless seemed to see this as normal. Those who avoided going to an FWC never mentioned that these clinics were staffed only by paramedics, that they were equipped to provide only a limited range of diagnostic tests and treatments (although they did know that complicated problems were best treated in hospitals), nor that the female paramedic was unavailable on days when satellite clinics were scheduled in her union (and it was clear that they did not know which days these were). They said only that the FWC often wasn't open (or the *daktar* wasn't present) when they went there, that they had to wait a long time, and that all too often they went away without medicine. They often summarized the perceived deficiencies of the FWC or other health facility by saying "they just don't care about poor people."

In the two villages where NGOs provided family planning services there was a small charge for pills and for injectables which, except for the first dose, were sometimes brought to the client's home. Many women wondered why they had to pay, and some seemed to suspect that something was amiss. Still, almost everyone we interviewed was willing to pay to receive contraceptives at home, because this was more convenient and cheaper than a trip to the clinic. In clinics, as at home, women often seemed unable to distinguish official charges from informal requests for gratuities or bribes. This was particularly evident among women who visited clinics for menstrual regulation (MR).

The interviews convey an aura of illegitimacy and ambiguity surrounding MR, perhaps reflecting a moral ambivalence in the society at large. The procedure is supposed to be provided at no charge in FWCs and other government facilities, yet it seems that MR clients are nearly always charged. Ten of the 31 women interviewed who had recently visited clinics for family planning and other reproductive health services had gone to seek MR. Of the 46

women who were interviewed in depth about reproductive decision-making, contraceptive use and contact with family planning services, six mentioned that they had been to clinics to seek MR within the three years since they were previously interviewed in depth. Ten of the 16 women told the interviewer that they were required to pay, in most cases between 100 and 300 *taka* (\$2.50-\$7.50). (One of them said they did not have to pay, one had gone to the facility after being refused services at the FWC because she could not pay 300 *taka*, one did not say whether she had to pay, and the other two were asked only for “tea money,” about ten *taka* apiece.) Many of the women tried to negotiate the price down, and four failed and went home. One of them later got the money from her husband, one was planning to go to a traditional abortionist, and three had unwanted children. None of the women seemed surprised at being charged for this service.¹⁰

Health Care Decision-Making

Despite limited knowledge, health care decision-making in the six villages is a relatively complex process of assessing probable costs and benefits, based on whatever information is available, correct or otherwise. The strategies that affect the use of various services appear to be much the same from village to village, even though there are different configurations of health service providers in and near each village, and variations in cost and quality. The factors mentioned in the general interviews regarding which providers were consulted for various purposes included the cost of services, medicines and transportation, distance (usually in the context of cost), predictability (whether one could be reasonably certain that a clinic would be open, staff would be present and medicines would be available), availability of particular specialized services, technical quality, quality of interpersonal relations, whether an individual has a personal connection with the provider and, in a few cases, whether a doctor is female.

Some independent providers, clinics and hospitals are perceived as specializing in certain types of services or capable of providing more technically advanced care for serious problems. Although the Family Welfare Centers offer some general health services, these lowest level clinics are seen mainly as a source of family planning for women, and to some extent maternal and child health services. It is rarely a first option for general health care. In

one village a particular local doctor is known as being good at treating children's illnesses. The district hospitals and medical colleges are known to have highly trained doctors and specialists capable of treating serious and intractable health problems. The interpersonal dimension in health care was often mentioned, particularly in the case of private doctors, both qualified physicians and "village doctors" who had some medical training but lacked formal accreditation. Perhaps not surprisingly, the most popular local doctors tended to be those who show compassion for the sick, provide treatment without charge to those in need or accept whatever payment is offered, are kind in their dealings with patients, and do not overtly discriminate against the poor. Technical quality was also mentioned frequently in the interviews. The respondents did not seem particularly aware of, or worried about, their lack of ability to judge technical competence and thought they knew where the best services were available. The principle source of uncertainty typically was how much time and money should be expended for a particular problem. Those who can afford it prefer private doctors with MBBS degrees, or visit the private practices of public sector doctors.

In all villages respondents said that only the wealthy could get good health care. This is partly but not only a straight-forward matter of high prices that only some can afford. More generally, it reflects a configuration of social relations in which deference is paid to the powerful and influential. Although wealthier patients obviously are more able to pay, doctors sometimes treat them for free, either because there is a personal connection (sometimes kinship-based), or because the physician in turn may eventually need assistance. At times of economic stress the poor often seek loans or other assistance from the better off, for which they typically must reciprocate through informal unpaid labor and other forms of patronage. The same pattern can often be seen in seeking health care. Faced with a health crisis, a poor person will often appeal to someone more powerful not only to pay for medical treatment, but to identify a capable doctor and to use his connections to arrange for treatment.

Poor families will often ignore a health problem that is not perceived as life threatening until it begins to cause a significant disruption in their lives. In many cases treatment is first sought from less expensive traditional practitioners or village doctors, some of whom charge only for medicine, not for examination. Those who feel they have other options, men in

particular, avoid the FWC, which is usually the clinic nearest their home. This is in part because the FWC is seen as a place for women and infants, and for family planning, which is viewed as women's responsibility and, secondly, because of the low quality of services provided by the FWC. Hence, rather than go to the FWC, men in particular often skip a level and go directly to subdistrict or district hospitals. They tend to describe the *thana* and higher level hospitals as their last, best hope, knowing that qualified staff will be there and that they will receive some care at little or no cost, even though they may not have enough money to fill the prescriptions they are given. People generally are willing to pay for services when they have the cash, feel the situation is serious enough to warrant the expenditure, and believe they will get good quality service. Yet even in our small sample there were situations in which people simply did not have the money to pay for services they badly needed. The poorest would often travel long distances and wait for hours in the hope of getting free medicine, knowing from experience that they might fail and come home empty handed.

The Role of Intermediary

Even though basic health services are financed with public funds, there is a general perception that the poor do not have full access to them. People typically feel that they need an intermediary to get proper treatment in a clinic or hospital. Village elites sometimes serve as intermediaries for their employees, neighbors and poorer relatives, but to be an intermediary one does not necessarily have to be wealthy and powerful. A distant kinship tie with someone working in the clinic is often seen as adequate. FWAs, their supervisors (the Family Planning Inspectors), even family planning volunteers and women who frequently visit a clinic and therefore know the staff, often play the role of intermediary for women in the study villages seeking family planning or MR services from clinics. Of the 31 recent clients of family planning clinics that we interviewed, 17 went with intermediaries (Table 4). Among those who did not rely on an intermediary, many had initially visited a clinic with an intermediary, and later began going alone or with a companion who was not necessarily more familiar with the clinic than they were. A few became intermediaries themselves. Reliance on intermediaries in

seeking services from clinics appears to be least common in village 5, where women are less socially restricted and their use of clinics is highest.

The concept of the intermediary is, from one perspective, rooted in the traditional system of social relations based on power and patronage. It also has a precedent in the family planning program: for some years, almost all sterilization and IUD clients were brought to clinics by referral agents, who could be family planning workers or members of the public, and both the client and the person who accompanied him or her received a compensation payment.¹¹ While the compensation payments were criticized by many, and became politically controversial, many poor rural women might otherwise have been unable to bear the costs of the trip for herself and a companion (who often had to stay overnight and sometimes care for the woman's children), and for medicine. It is still common for FWAs to personally accompany women seeking services in FWCs and other clinics, although they are no longer paid to do so on a per capita basis. The following is an example of how clinic intermediaries are perceived.

Salima (pseudonym), from village 6, had thought she never needed to use contraception because she always had had difficulty conceiving. Her youngest child was nine years old. Then she stopped having her periods and began to experience symptoms of pregnancy. She sought advice from the FWA, who told her to go to the clinic for a checkup, and accompanied her there in a bicycle rickshaw. They arrived at the clinic and sat on a bench with three other patients for about half an hour, waiting for the FWV to arrive. Salima explained, "As soon as the *apa* [FWV] arrived, [the FWA] took me inside to see her. She made arrangements to treat me immediately...She [the FWV] behaved quite pleasantly with me...I think it was because [the FWA] was with me that I received attention so soon. There was no fan where we had been sitting earlier. It was quite uncomfortable because of the heat."

Probably because of the program's emphasis on family planning, we did not see the FWAs or family planning volunteers acting as intermediaries to help women get other types of reproductive health care or general health services, and several women who wanted their IUDs removed had difficulty getting an FWA or a family planning volunteer to escort them to the clinic. The family planning program at the lowest level focuses on increasing contraceptive use

and, so, its employees are most willing to act as intermediaries for women seeking contraceptive methods from clinics. FWAs do also assist women in getting MR services, probably because they are specifically encouraged to do so by their superiors (who, it appears, unofficially collect fees for this service).

Failure to Acknowledge Women's Reproductive Health Needs

Apart from the need for contraception, women's need for reproductive health care is often overlooked by the women, their families and the health care system. Of the 17 women in the in-depth sample who gave birth during the three years prior to the interview, only five were attended by a trained midwife/TBA or a doctor.¹² The others were attended by untrained TBAs or relatives, and one woman delivered alone. Two of the women experienced serious complications during their pregnancies. The first failed to progress and was given an injection by a village doctor, and later gave birth to a stillborn child. The second had severe edema and was transported by ambulance to the district hospital, where she was delivered by Caesarian section. Of the 20 women who gave birth or were pregnant at the time of the interview, six had received no antenatal services from a trained provider; of the 14 who obtained any antenatal care (in most cases from clinics), 12 received tetanus toxoid injections, and two were given only vitamins or iron tablets. Only one woman said that she had received postnatal care, and this was only because she and her newborn both became extremely ill, with high fevers. They were checked into a maternity clinic at the district level; after they waited a day and a half to see a doctor, the woman's husband removed them from the hospital and took them to a private clinic.

More than two thirds (32/46) of the women interviewed in depth in 1996 said that in the past three years they had experienced at least one reproductive health problem. Nearly two thirds (30/46) reported symptoms associated with reproductive tract infections (RTIs), such as heavy white discharge, genital boils, itching, or unusual bleeding.¹³ Other symptoms experienced included dysuria, dislocated IUDs, infertility, extreme side effects,¹⁴ and complications during pregnancy (the two cases mentioned above). Eleven of the men interviewed in depth had wives who reported reproductive health problems (in all cases RTI

symptoms); eight of the eleven stated that their wives had no such problems. Our impression is that some of these men did not know about their wives problems and others did not care.

Among the 32 women who experienced symptoms that might have warranted a visit to a clinic, three quarters (24) did not seek medical care. Thirteen of the 19 women who gave reasons for not seeking treatment for their problems cited either economic constraints or husband's resistance as the reason they did not seek treatment. Four did not consider their conditions serious enough to justify visiting a clinic. An additional three women said that they were too embarrassed to seek treatment. Among those women citing economic constraints, most also mentioned that they were embarrassed about the problem that they were facing, and this very likely magnified their perceptions of the economic constraints, or of spousal disapproval, that kept them from seeking care. Although the women often cited a specific reason when asked directly, in most cases there seemed to be a complex of factors discouraging the women from seeking care for reproductive health problems, including low self esteem and low status within the family. For example, after describing various occasions on which her husband had bought medicine for himself and their son, one woman explained why she did not seek treatment for symptoms of a urinary tract infection by saying,

I don't need any medicine. There isn't any money — how will he [my husband] get medicine [for me]? Women don't need medicine. When you have no money, you don't need medicine.

Four women had quit using contraception because of side effects that were bothersome but probably not serious, without having first sought advice or assistance from a clinic. There is an obvious need to increase awareness both among providers and in rural communities regarding when women need treatment for reproductive health problems, and when they need preventive care.

Decision-Making Regarding Family Planning Services

Compared with health services, there seems to be a much narrower range of factors influencing use of various sources for family planning services. Most women simply follow the norms that have been established by the family planning program. Although theoretically the program offers a “cafeteria” of contraceptive methods, most women first adopt the oral pill because this is the method offered by the family planning worker who comes to the door. Use of male methods remains low, at least in part because the dominant mode of family planning service delivery is by women to women.¹⁵ If the family planning worker recommends switching to another method in case of problems or side effects, she will most likely also specify a source from which to obtain it and may accompany the client to the supply point: typically an FWA will bring women to the nearest FWC or a satellite clinic, and an NGO worker will bring women to an NGO clinic if she is affiliated with one.

We found little evidence that fear of social stigma was impeding women’s use of family planning services offered in clinics. The one exception was in village 2, where women seemed worried that if they went to a clinic they would be suspected of having gone there for abortions. The level of contraceptive use in village 2 is quite low and, although we did not attempt to measure this, anecdotal evidence suggests that women in this village frequently resort to abortion; thus, it may be that women use clinics as often for pregnancy termination as for family planning. In all of the other villages, and to some extent even in village 2, social barriers to women’s use of clinics appear to be breaking down, just as stigma against contraceptive use did. Although the *pardah* system still exists, going to a clinic is now widely seen as a legitimate reason for a woman to be seen in public. Only one of the 31 recent clinic clients said that she was criticized for going to the clinic (most were asked directly), and none of the 25 women interviewed in depth about reproductive decision-making and contraceptive use, who had visited clinics in the past three years for purposes related to reproductive health, said that they were criticized for visiting the clinic (this group was not asked directly). The one woman who was criticized was chided by her mother-in-law for going to the clinic without having first finished the housework, not for going to the clinic per se. Two women (both from village 6) said that if they had not been accompanied by their husbands they might have faced

criticism. Four women met with social disapproval for having abortions, but not because these took place in a clinic.

Fear of side effects from the methods offered in clinics, and lack of conviction that one would benefit from visiting an FWC or other clinic for family planning seemed to be more important barriers to clinic use than social stigma. Not surprisingly too, women were generally unwilling to travel somewhere for services they could get in the village, just as they usually would not pay for contraceptives that they could just as easily get for free, unless they became convinced that the free version of a contraceptive method was inferior and causing health problems.

Seeking Assistance for Contraceptive Side Effects

Contraceptive side effects are an ongoing problem for women using contraceptives in all of the villages. Most (33/40) of the women interviewed in depth who had used a contraceptive method at any time during the three years prior to the interview reported persistent health problems which they associated with their contraceptive use.¹⁶ Among the most commonly cited problems were nausea and dizziness (symptoms experienced mostly by pill users), and irregular menstruation (reported most often by injection users). IUD users most often complained of vaginal discharge and itching. Of the women who experienced what they considered to be side effects, about a third (10/33) volunteered that these side effects were significantly disruptive to their lives, interfering with their ability to do household work and, they believed, endangering their overall health.

The majority (29/33) of the women who reported side effects sought help with these problems, in most cases from a village-based family planning worker or volunteer (20/33), and sometimes from a paramedic in an FWC or an NGO clinic (11/33). When FWAs were consulted about side effects they either encouraged the women to continue use, saying that the side effects were temporary, or suggested an alternate method. They rarely recommended seeking advice from providers with more technical training. In village 1 the family planning worker seemed reluctant to recommend methods obtainable only from a clinic, and concentrated on the two methods for women that she herself supplied, recommending

injectable contraception for women having problems with the pill, and vice versa. In three cases her focus on promoting pills and injectables led to a back-and-forth switching between these two methods in women who had experienced side effects with both. Six of the 33 women who experienced side effects during the three years prior to the interview stopped using contraception because of these problems. Four had consulted a family planning worker for help but failed to resolve the problems, one consulted a local family planning volunteer, and one did not consult anyone. Five had unwanted children as a result of discontinuing use.

These findings suggest that women do often seek advice from village family planning workers for health problems they perceive as contraceptive side effects, but that the ability of these workers to provide assistance is limited. The limitations of the family planning workers in helping women to negotiate or overcome contraceptive side effects are in part a reflection of the state of the art. Every contraceptive method has its disadvantages; either it produces side effects or it has some other characteristic that many will find undesirable. Thus, family planning often entails resigning oneself to accept the lesser of various (usually mild) evils. The FWAs' lack of training and limited mandate to provide health care, however, is also an issue in the rural Bangladesh setting, where many women have little or no contact with trained modern health care providers other than the FWAs, and where various health problems may be mistaken for side effects, or may exacerbate contraceptive side effects or make women more vulnerable to them.

Seeing FWAs as their primary family planning providers also limits women's perceived alternatives. Method choice is limited in a practical sense because the FWAs promote, provide and support mainly the use of oral contraceptives. The FWA may give advice, or take or refer women with side effects to clinics, but when the problems are not immediately resolved the women often give up using contraception, or continue in a state of anxiety and uncertainty about whether they are bringing serious harm upon themselves. Their attitude is that the FWA has not been able to solve the problem, even by taking them to the clinic. They feel that they have exhausted their options, and do not consider returning to the clinic to request further assistance, or going to a different clinic.

The Domiciliary Norm and Variations

The idea that family planning workers are supposed to bring pills to the doorstep has become ingrained. Both the FWAs and the communities in which they work see home visiting as their “duty.” Through the home visits she is supposed to “motivate” couples who do not yet use contraception, and she is supposed to supply pills. Now that the FWAs have become accepted and valued in performing these roles, it is not unusual for others in the village to help them by bringing new clients, or directing them to the homes of women who may want to initiate contraceptive use, or whom others feel ought to do so. This tends to be seen by the FWA and by the intermediary both as helping the FWA and as helping the woman who may want family planning services. Although most people now want to limit their family size, and see high fertility as a route to impoverishment and other problems, family planning services are still perceived to some extent as something the government promotes for its own purposes. And even though in the typical visit no services are provided other than dropping off three cycles of pills, visiting homes is seen as more than simply a way to ensure that women have continuing access to supplies of contraceptive pills. It is what FWAs are supposed to do. In two of the villages people criticized FWAs, or their NGO counterparts (to the researchers), for failing to visit every home. In another, the FWA told the researchers that some of her clients in a neighboring village felt sorry for her because she had to trudge through the mud to bring them pills, and offered to come to her home and pick them up. She told them that bringing pills to their homes was her duty, and so she would continue to do it, rain or shine.

Notwithstanding the well-established domiciliary family planning norm, intelligent family planning workers can modify the system of supplying oral contraceptives door-to-door without creating significant inconvenience to their clients. In village 6, for example, most women go to the house of the FWA to pick up their pills at least as often as she visits them. If she happens to be away from home their clients borrow from neighbors, as she has instructed them to do. Although the FWA in village 3 makes routine home visits in the neighboring village, which is part of her assigned area, within her own village most of her clients come to her home to collect pills. She married into a relatively conservative and prestigious family and so is under pressure to limit her visibility within her own village. She is well-liked among her

clients, however, and makes them feel that she is personally concerned about their welfare. When she took her daughter to Dhaka for medical treatment she left pills for her clients with her son's wife. None of the women that we interviewed in these two villages saw pill supply as a problem, since they always knew where to get them.

The FWA assigned to village 5 lives in another village, and when she visits she does not personally visit all women who use pills. Instead, she goes to a house or a central location in each of several *para(s)* (sections) of the village, where women seek her out to obtain their supplies of pills. When she misses clients she sometimes gives their supplies to a neighbor. In other cases, the women who miss her have to buy the pills from a pharmacy, or send their husbands or children to buy them. We found only one woman who was significantly inconvenienced by this arrangement. Her husband wanted another child and therefore disapproved of her use of contraceptives and would not give her the money to buy pills. The FWA rarely visited her neighborhood because many of the women there had been sterilized. The somewhat less restrictive norms governing women's behavior in village 5, compared with the other villages, may partially explain the apparent ease with which the women have adjusted to a pill supply system that requires that they take greater initiative. Also, the FWA who served the village from 1989 to 1991 lived just outside the village and was very well-liked and described by her supervisor as being "very good at motivation." She most likely visited individuals in their homes and made the job of her successor easier by educating women about family planning and kindling demand for contraception.

When the FWA assigned to village 4 visits, she goes to individual *bari(s)* rather than to each home (the *bari* is a much smaller residential cluster than a *para*, usually consisting of a small group of houses inhabited by close relatives). The researchers observed that she was not particularly well-liked or skilled in her work. Rather than attempting to have individual discussions with her clients, she would typically stand on a porch, tell the women who assembled that they had too many children and ought to use contraceptives, and hand out supplies of oral pills. The FWA assigned to village 2 visits individual homes, and the information from our 1994 survey shows that her coverage is quite high. Prior to that,

however, she had to come from a much more distant location, and the researchers saw that she spent little time in the village, and looked tired and stressed.

For some years village 1 was in an administrative area that had not been clearly demarcated as an NGO area, and contraceptives were available both from a government FWA and from a family planning worker from a nearby NGO, both of whom resided and still reside in the village. Women tended to prefer to get their pills free from the FWA, but some found it convenient to buy them from the NGO family planning worker, particularly when the FWA was working in the other village to which she was assigned. Now that the government has formally demarcated the area and assigned village 1 to the NGO, women, at least in principle, no longer have the option of receiving free pills from the FWA, although they have been told that they can get free pills from the FWC. Certainly women would prefer not to pay, but among the women that we interviewed only one was unwilling to pay the NGO family planning worker. Many of them knew the two workers only by name and did not realize that one worked for the government and the other for an NGO. Nor did they realize that the FWA had been officially reassigned to work elsewhere. They only knew that they rarely saw her. Even in the village with the lowest level of contraceptive use (village 2), where one might expect to find weaker demand for family planning, women were paying for oral pills because they had no convenient source for free pills.

These findings suggest that from the perspective of most rural women who use oral contraceptives, a convenient and reliable supply system is not necessarily one which delivers pills free to their doors. There are important differences between a system that breaks down when a family planning worker fails to bring the pills, and a system that takes into account the fact that she will not always bring the pill to every home, in which clients are informed about alternative sources of supply, such as depot holders, pharmacies or even neighbors. In terms of where women get the pills there may be little difference, but the difference in client satisfaction may be great. Clients are passive and unempowered in the broken-down domiciliary version. Seven women among the 104 interviewed in depth in 1992-93 had discontinued contraceptive use because of supply problems, whereas there were no such cases

among the subgroup of 46 interviewed in late 1996, suggesting that, in the study areas at least, women's dependence on home delivery of pills is decreasing.

CONCLUSIONS

In policy discussions the government of Bangladesh and international donors have embraced the idea of moving toward a more integrated and comprehensive model for providing health and family planning services. This will probably entail an administrative reorganization, a redefinition of the roles of community-based workers, a stronger focus on clinic-based services, and alternatives to home delivery of contraceptive methods. Small-scale testing of alternatives has already begun (ICDDR,B, 1996). Our community-based study documented many of the perceptions, norms and patterns of interaction that have formed around the existing system of family planning and health services in rural Bangladesh. It examined some of the problems that need to be addressed to make health and family planning services more responsive to the needs of rural people. It also identified features of the current system that may facilitate change, some of which might become the basis for targeted interventions to ease the transition away from domiciliary services.

Our findings suggest that a gradual shift away from home delivery of family planning methods and information would not have the dire consequences that some researchers have predicted, at least not if family planning clients are presented with reasonable alternatives. The variations that we documented among the six villages in systems of pill supply illustrate that while home delivery of contraceptives is a well-established norm, many of the FWAs are more resourceful and their clients more adaptable than is sometimes assumed. A system of pill supply can be convenient and reliable for village women without requiring the FWA to personally deliver pills to every door on a regular schedule, and it is likely that many FWAs, like those in several of the research villages, have realized this. Spontaneously occurring variations in the domiciliary system can serve as models for more cost-effective mechanisms for resupplying pills to women who use them. The relatively high contraceptive use and minimal evidence of hardship on the part of pill users in the study villages where such variations in the outreach system had emerged is consistent with the preliminary findings of

field tests being conducted by the ICDDR,B Extension Project, in which FWAs visit one household in a cluster rather than going to every home. There was no decline in contraceptive use in the ICDDR,B field sites between January, 1995, when the intervention began, and August, 1996 (ICDDR,B October, 1996). Our findings suggest, however, that there is a widespread perception that an FWA is not doing her job properly unless she visits every home. As the role of the FWAs changes it will be important to inform the communities in which they work about their new roles, to enable them to form a new identity. Failure to do so could cause considerable confusion and might result in demoralization among the family planning workers.

There was little evidence that social stigma was inhibiting women's use of clinics for family planning and other reproductive health services. Women who did not go to clinics avoided them for a variety of reasons: they or their families doubted that the clinics had much to offer them; they were afraid to use contraceptive methods that the clinics offered (particularly the IUD); they relied on the FWA and she did not suggest going to a clinic; they had had a bad experience at a clinic; or they and their families did not consider their reproductive health problems and needs to be important enough to warrant the time and possible expense. Only in a few cases did families prevent the women in our study from going to clinics for fear that others would criticize them for breaking *purdah*. Nevertheless, there will very likely be a continued need for home visits to make contact with women who face relatively greater barriers in accessing services from clinics and satellite clinics, such as young, newly married women, and women in regions of the country where gender norms are particularly restrictive.

A sizeable minority of participants in the study mentioned cost as a barrier in obtaining health services. Health crises are typically accompanied by economic crises for families whose livelihood is derived from daily wages. Strategies for introducing or increasing user fees in public and NGO health facilities in rural Bangladesh should take into account the fact that there are times when the very poor are unable to pay for services. A shift towards clinic-based services, however, will improve program sustainability by reducing recurrent costs, particularly for salaries, as the number of FWAs is gradually cut back through attrition. This

may in turn lessen the mounting pressure to increase charges to clients for both health and family planning services.

The study findings suggest that rural people, and women in particular, often have limited knowledge regarding how modern health and family planning services are organized, the qualifications of service providers, and the range of services that might be expected from various facilities. In criticizing health services they received, people sometimes seemed unable to distinguish system malfunctions and provider misbehavior from inherent limitations of the provider or the system. They were often unaware of the scheduled hours of operation of the clinics, and in some cases women waited for hours for an FWC to open. Although these long waits annoyed the clients, they considered them normal. Nor did they know that the paramedic was supposed to conduct satellite clinics in other places on certain days, and therefore would not be available in the FWC. A recent study by ICDDR,B found an FWV present on only slightly more than half of the 82 days that 13 FWCs were visited (Khanam et al., 1996, p. 8). As the FWVs' absences were for a variety of official and unofficial reasons, knowing the FWV's official schedule would not guarantee that a trip to the FWC would not be in vain, but it might help to reduce the appearance of capriciousness in service availability. In our study villages, women in particular seemed unable to distinguish official charges from informal requests for gratuities or bribes. This was most apparent among those who visited clinics for menstrual regulation (MR). MR procedures are supposed to be performed free of charge in the government facilities that offer it, yet it appears that women are nearly always charged. Those that we interviewed did not seem particularly surprised at being asked to pay.

A new approach to providing information and education is needed so that rural people come to know their rights, know what to expect, and can make informed decisions in utilizing health services. As private sector options for health care and family planning services expand, and as NGO and public sector clinics increasingly charge for services, such education will become more and more crucial so that the scant financial resources of poor families are not wasted on inappropriate health treatments. Rural people better informed about public sector health and family planning services would also be in a better position to demand that the services become more accountable to their clients.

The common notion that an intermediary is needed to obtain services at health and family planning facilities could be built upon in redefining the roles of the FWAs. For example, it might be possible to expand the role of the FWA as intermediary to bring groups of women for a wider range of services and, more generally, to help establish a greater sense of connection between the clinic staff and the communities they are meant to serve. The greater frequency with which women in village 5 use clinics, and the fact that they are less reliant on intermediaries in getting services from clinics, suggests that the need for FWAs or others to act as intermediaries would gradually lessen.

Although decisions about use of health care services typically take into account a wide range of factors, in choosing contraceptive methods and sources of methods and services there is a tendency to follow the norms set by the family planning program. While this may not be an ideal situation, it does imply that rural women might respond positively to a new set of program norms, provided these are clearly articulated and seen as beneficial by the women. In an earlier paper we suggest that in rural Bangladesh women were ready to accept the idea of family planning even though it was not their own idea but, rather, the government's, because controlling the number and spacing of their children was congruent with their own felt needs and experience (Schuler et al., 1996). Our research on changing gender relations documents how women's lives often change in positive ways when they enter into the public sphere for paid employment or join credit programs (Hashemi et al., 1996). This is in spite of the fact that seclusion of women is still an ideal norm in much of rural society, and to some extent also a status symbol. Women who develop even a minimal level of sophistication in speaking with outsiders and interacting with institutions are proud of these skills and often achieve a new kind of recognition in their communities. Other women ask them for assistance in finding employment and in seeking benefits from various social service and development programs. Domiciliary family planning workers have gained status in their communities and found fulfillment in their initially nontraditional work (Simmons et al., 1992). Similarly, our data suggest that family planning volunteers, and even informal intermediaries who take women to clinics, find both personal and social benefits in the increased mobility and social contacts, and in establishing a relationship with an institution (the family planning program and/or clinic). In

light of the positive changes documented in the lives of rural women who discover new opportunities and roles in the public sphere, it is quite probable that they will also respond positively to a new set of family planning program norms which require them to become more active in getting contraceptive methods and services, particularly if this gives them better access to other resources that they value, such as health services.

1. Indeed, even if it had been, it would be difficult to get women to compare something they knew with something they had no experience of.
2. In a survey of nearly 8000 women, 44% of those ever visited by an FWA reported that the worker spent less than five minutes with them during the most recent visit, and only 19% reported a visit of 10 minutes or longer (Koenig et al., 1995.) In the Ministry of Planning study the average time spent with a client was only four minutes (p. 35).
3. Sidney Ruth Schuler, Amy Cullum, and Zakir Hossain. 1997. "Family Planning Clinics Through Women's Eyes and Voices: a Case Study from Rural Bangladesh." JSI Working Paper No. 12.
4. For more information see Schuler et al., 1995 and 1997.
5. Bangladesh is divided into 64 districts, 486 *thanas* and 4405 unions; the union is the lowest level administrative unit for most purposes, and in most unions there is an FWC.
6. In 1993-94 satellite clinics were the most recent source of supply for only 2% of contraceptive users (Mitra et al., 1994, p. 60).
7. Menstrual regulation is the term commonly used to describe legal early abortion procedures that are performed in government clinics and also provided by a few NGOs (Dixon-Mueller et al., 1989).
8. Results of a recent study suggest that the decline is due to a variety of factors, including decreased availability of sterilization services, preference for other methods which are more easily available than they were in the past, withdrawal of the referral fee that used to be paid to family planning workers and others who accompanied sterilization clients to clinics, and the reduced amount of compensation that is paid to sterilization clients to offset travel and other costs (Miah et al., 1995).

9. A recent analysis of longitudinal data from two sites in rural Bangladesh found evidence that home visits by family planning workers had a significant effect on demand for contraception during the period of 1985-1990, as reflected in women's stated desired family size, but the effect was extremely small (Phillips et al., 1996). In contrast to the effects on desired family size, the analysis shows a substantial, continuing effect of family planning worker visits on current contraceptive use. Thus, it is apparent that women are heavily dependent on the domiciliary family planning system, but it appears that the main function of this system is now one of supplying oral contraceptives.

10. The NGO clinics in our study areas did not offer MR, most likely because they are supported in part by foreign aid with strings attached.

11. The Bangladesh Government still provides a small compensation payment to sterilization and IUD clients to offset the client's transportation and other expenses.

12. One of the women did not say who attended the birth.

13. It should be noted that the rate of over two thirds is based on a small, nonrandom sample. When we included the same questions on symptoms of reproductive tract infection (RTI) in a late-1996 structured survey of all married women of reproductive age in village 2, the rate of reported RTI symptoms in the three years preceding the survey was 25%. In this case there may have been under-reporting because the respondents were not acquainted with the interviewers.

14. As discussed below, 83% of the women who used contraceptives during the three years prior to the interview (33/40) experienced health problems that they felt were caused by their contraceptive use. The majority of the symptoms reported were common and bothersome but probably not associated with serious health problems, but three sounded potentially serious: one woman experienced severe abdominal pain after a sterilization procedure, an IUD user had a malodorous discharge, and in one case a woman's IUD could not be located in her uterus. Only a third (11/33) of women who experienced what they thought were side effects sought treatment from clinics.

15. In our small sample we found several cases in which men or their wives said that they had tried condoms but they were unreliable, and broke. Among men who do use condoms a substantial proportion obtain them from FWAs (Mitra et al., 1994, p. 60), who in most cases are probably too shy (and constrained by cultural standards of propriety) to explain how to put them on correctly. A male respondent asked one of the male researchers to explain how the condoms were used. With a note of surprise in his voice he remarked that no one had ever explained this to him before, or he would have been using condoms.

16. The 1993-1994 DHS reports that approximately 32% of current users of non-permanent modern methods experienced health problems with their family planning method. In our survey of all married women under 50 in the six study villages we found that 34% of women

who had used a nonpermanent method of contraception in the year preceding the census experienced health problems with that method. The apparently higher incidence of problems in this qualitative study is probably explained by the longer reference period (three years) as well as the more in-depth manner of questioning and the greater rapport between the interviewers and the respondents.

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Table 1: Facilities used by clinic visitors in the six study villages:

Village	Rangpur			Faridpur/Magura		
	1	2	3	4	5	6
Distance to nearest clinic	2.9 mi. (FWC)	3.9 mi. (THC)	2.7 mi. (FWC)	0.5 mi. (FWC)	1.6 mi. (FWC)	1.0 mi. (FWC)
% women ever visited a clinic	59	56	48	92	89	87
% women visited clinic in year preceding survey	20	14	5	46	44	31
Percentage of clinic visitors in the last year who visited:						
FWC	0	4	0	55	34	77
NGO clinic in union	13	15	0	0	0	0
THC	37	70	0	24	9	5
NGO thana-level clinic	9	15	0	12	1	0
Gvt. district hospital	48	0	80	6	59	9
NGO district hospital	4	4	0	6	2	5
Other*	0	0	20	1	9	9

*includes visits to satellite clinics, private practices of qualified doctors, and to the home of a trained health assistant

Table 2: Contraceptive use by village

Rangpur

Faridpur/Magura

Village	1	2	3	4	5	6	Six village total	1993-1994 DHS
N	116	187	109	171	185	70	838	
% nonusers	40	72	60	68	42	34	55	55
% using:								
pill	22	12	18	8	31	33	19	17
condom	2	3	3	4	3	6	3	3
injection	7	2	5	1	4	4	3	5
IUD	8	5	2	2	3	1	4	2
female sterilization	16	4	7	11	15	19	11	8
male sterilization	4	1	2	1	4	0	2	1
safe period	1	2	1	4	0	3	2	5
withdrawal	0	0	1	1	0	0	0	3
other traditional	1	1	0	1	0	0	1	1
Norplant	0	0	2	0	0	0	0	n/a
CPR	60	28	40	32	58	66	45	45

Table 3: Sources of health and family planning services in the six study villages

Village 1	Village 2	Village 3	Village 4	Village 5	Village 6
<p>Live in/near village: 1 FWA and 1 NGO FPW 2FPIs 1 unlicensed modern doctor 1 licensed doctor* 1 traditional doctor</p> <p>Visit village: HA 2 trained TBAs</p> <p>Used by villagers: 1 Gvt. FWC 1 NGO clinic 1 Gvt THC 1 Medical college hospital 1 Maternal and Child Welfare Center 1 licensed doctor 5 unlicensed modern doctors 15 pharmacists/ drug sellers</p>	<p>Live in/near village: 1 FWV** 1 Jiggasha family planning volunteer 1 depot holder 1 trained TBA 3 traditional doctors</p> <p>Visit village: 1 NGO FPW 1 FWV 1 female health worker</p> <p>Used by villagers: 1 Gvt. FWA (in next village) 1 Gvt. FWC 1 NGO clinic 2 Gvt THC 2 Medical college hospitals 1 Maternal and Child Welfare Center 1 licensed doctor 9 unlicensed modern doctors 3 traditional doctors 2 pharmacists/ drug sellers</p>	<p>Live in/near village: 1 FWA 1 BRAC healthworker 3 unlicensed modern doctors 1 trained TBA 2 traditional doctors</p> <p>Visit village: 1 FWV</p> <p>Used by villagers: 1Gvt. FWC 1 Gvt THC 1 Medical college hospital 1 Maternal and Child Welfare Center 1 licensed doctor 4 unlicensed modern doctors 1 traditional doctors 3 pharmacists/ drug sellers</p>	<p>Live in/near village: 1 FWA 5 Local Initiatives Program workers 1 unlicensed modern doctor 1 licensed doctor*</p> <p>Visit village: 1 FWV 1 HA 1 trained TBA (from THC)</p> <p>Used by villagers: 1 Gvt. FWC 1 Gvt THC 2 District gvt. hospitals 3 licensed doctors 6 unlicensed modern doctors 9 pharmacists/ drug sellers</p>	<p>Live in/near village: 1 FPI/supervisor 1 HA 6 traditional doctors</p> <p>Visit village: 1 FWA 1 FWV 1 HA 1 female health worker</p> <p>Used by villagers: 1 Gvt. FWC 1Gvt THC 1 District gvt. hospital 1 Maternal and Child Welfare Center 9 licensed doctors 1 unlicensed modern doctors 7 pharmacists/ drug sellers</p>	<p>Live in/near village: 1 FWA 1 licensed nurse</p> <p>Visit village: 1 FWV 3 HAs 1 trained TBA 5 licensed doctors</p> <p>Used by villagers: 1 Gvt. FWC 1 female health worker 5 licensed doctors 8 pharmacists/ drug sellers</p>

* lives elsewhere, but treats villagers for free when visiting

**Works at an FWC not used by villagers, but provides MR to villagers in Rangpur at her home