DEVELOPING APPROPRIATE STRATEGIES FOR PROMOTIONAL CAMPAIGN FOR FAMILY PLANNING IN BANGLADESH

Thesis submitted
in partial fulfillment of the Requirements for the Degree of
Doctor of Philosophy (Ph. D.) of the University of Dhaka

BY

Khalid Has an
Ph. D. Student
Regn. No. 42/98-99
Institute of Business Administration
University of Dhaka

Supervisor

Professor Dr. Hafiz G. A. Siddiqi
Pro-Vice Chancellor
North South University, Dhaka

400478

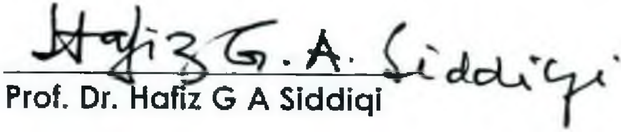
May 15, 2002

DECLARATION

I hereby declare that the material embodied in this thesis is original. It has neither been copied nor submitted earlier in part or full for any other diploma or degree of the University of Dhaka or any other Universities/Institutions.

Khalid Hasan

Countersigned by the Supervisor:



Prof. Dr. Hafiz G A Siddiqi

400478

Dhaka University Institutional Repository

ACKNOWLEDGEMENTS

I would like to express sincere appreciation to Prof. Dr. Hafiz G A Siddiqi, Pro-Vice Chancellor of North South University, Dhaka, Bangladesh for his guidance and encouragement throughout the research.

I am grateful to Prof. Dr. Anwar Hossain, Director Institute of Business Administration (IBA), University of Dhaka who always inspired me to complete the research in time. His suggestions helped me finalizing the research.

I am also thankful to IBA authority for providing me with all kinds of library facilities. I would also like to express my gratitude to Dr. M. Shamsul Huque, Dr. Rahim B. Talukdar and Dr. Abdur Rab, Professors of IBA who inspired me in different stages of the research.

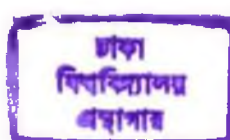
My loving appreciation goes to my wife, Witty for her emotional and physical support during my PhD studies. To my affectionate children Tasnia and Abid for their all time best wishes. I would also like to thank my parents for their blessings. I want to acknowledge my gratitude to my father in law who always inspired me and expressed his ardent desire to witness the award of Ph. D degree to me even fifteen days before his sudden death.

Mr. Abdul Karim, Section Officer, IBA also deserves thanks for inspiring me during the whole period, from M. Phil to Ph.D.

Finally, I would like to express my sincere gratitude to all the respondents who provided data and information in preparing the model.

Khalid Hasan

400478



Dhaka University Institutional Repository

Table of Contents

SUMMARY

CHAPTER 1
INTRODUCTION 1

1.1 Background 1
1.2 Research Objectives 4
1.3 Research Issues 5
1.4 Hypotheses 5
1.5 Research Indicators 6
1.6 Purposes of the Research 7
1.7 Rationale of the Research 7
1.8 Structure of the Thesis 8

CHAPTER 2
LITERATURE REVIEW 10

2.1 BCC – the Current Role of The Government 10
2.2 Health and Population Sector Program (HPSP) 11
2.3 Health and Population in the Light of Fifth Five-Year Plan 21
2.4 Success in a Challenging Environment: Fertility Decline in Bangladesh 24
2.5 Summary of Literature Review 45

CHAPTER 3
RESEARCH METHODOLOGY 51

3.1 Methodology 51
3.2 Literature Review Through Desk Research 51
3.3 Primary Survey 52
3.4 Data Collection Process for Developing The Strategy 56
3.5 Summary of sample distribution using different techniques 59

CHAPTER 4
QUALITATIVE FINDINGS AND ANALYSIS 61

4.1 Knowledge and Practice 61
4.2 Decision Making on Family Planning Aspects 70
4.3 Sources of Information 74

Dhaka University Institutional Repository

CHAPTER 5
FINDINGS ON SPECIAL INTERVENTION PROGRAMS 77

5.1 Purpose of Selecting Intervention Program 77
5.2 Findings of Intervention Areas 82
5.3 Brief Summation of Findings 92
5.4 Conclusion 94

CHAPTER 6
DISCUSSIONS ON FINDINGS & TEST OF HYPOTHESES 96

6.1 Qualitative Findings 96
6.2 Case Studies 105
6.3 Quantitative Analysis 116
6.4 Test of Hypotheses 120
6.5 Conclusion 127

CHAPTER 7
NEED FOR DEVELOPING BCC MODEL & REVIEW OF RELATED APPROACHES 129

7.1 Need for Developing BCC Model 129
7.2 Review of Related Approaches 131
7.6 Summary of Related Approaches 144

CHAPTER 8
THE THEORY OF BEHAVIOR CHANGE: PROPOSED MODEL 145

APPENDIX

Basis for evaluating promotional campaign
Literature Review & Situation Analysis
Bibliography
Abbreviations

Dhaka University Institutional Repository

SUMMARY

Although Bangladesh has achieved considerable success in its health and family planning program over the past years, in order to achieve national demographic goal of replacement level fertility by 2005, the program not only has to sustain the current users of contraceptives, but also quite importantly, need to bring within its fold the never users and dropouts.

The research was carried out to evaluate the effectiveness of various existing approaches of promotional campaign for family planning carried out by government and different organizations in Bangladesh and to improve the existing strategies for promotional campaign for family planning with special emphasis in rural Bangladesh. The findings suggest to develop a model for prediction of knowledge, attitude and practice (KAP) and finally the behavioral change (i.e. changing attitudes, intention and behavior of people; building effective community support for health seeking behavior, and changing attitudes, intention and behavior of service providers to provide client centered services) through promotional campaign which may be used by policy makers and researchers.

The study covered all over Bangladesh and was done within the six administrative divisions. The study was done with a view to examine the current family planning operations carried out by the government mechanism and under different community based intervention programs.

This is basically a qualitative study, with some quantitative probing. Respondents were both female and male. With a view to assess the behavioral issues related to the objective of the study, data were collected through using qualitative technique of FGD and in-depth interviews. With a view to test the hypotheses, a few essential indicators

Dhaka University Institutional Repository

were probed among the respondents during conducting in-depth interview. These responses were analyzed quantitatively.

It was found that there is still a huge potential for changing the level of practice or changing behavior in terms of family planning, healthcare and decision-making rights. Although the level of awareness has changed it is still not adequate since people are not practicing what they have learnt. There are significant gaps between the level of knowledge and practice (significant at 95% confidence level) in all the study-related indicators. Although people are aware to an extent, they are not changing practices according to that level of awareness. In essence, the real picture is very different from the expected picture. The gap is the most widened in areas such as family planning, condom use when having sex with sex workers, ANC, PNC, home deliveries, joint decision making rights etc. Apparently, past intervention and behavior change communication programs have not been very effective in changing the practices of people in such areas. In light of this, there is room for further intervention where more result-oriented campaigns should be enforced.

Based on the findings, a communication model is developed. The proposed model may be used to change different in-built beliefs as well as other inferential and intervening beliefs of a person with the aid of communication intervention. The model depicts the different stages through which various inter-linking and pertinent information are communicated and processed throughout the flow chart of the model.

It was found that the level of awareness and knowledge was evident among the target respondents along with belief and attitude among individuals. It was also found that due to certain circumstances and unanticipated situations, the positive intention to change behavior is effected. Such circumstances can be either unanticipated situations or deliberate acts, which prevent the individual from changing their behavior. This happens since despite having the awareness, knowledge and positive attitude, the individual sometimes ignores all this and does not permit the change in behavior to take place. Proper investigation

Dhaka University Institutional Repository

followed by corrective measures may lead toward reestablishment of positive intention and thereby changing behavior.

Knowledge is not every thing rather internalizing the whole message plays a vital role in changing the behavior. As stated earlier that the people have gathered knowledge on health and family planning issues, but there is still a gap in practicing the message. Therefore, unless the whole message is not internalized, change of behavior toward practicing family planning and health seeking issues remains a pipe dream. Once the cause(s) of effecting/influencing attitude is identified and proper actions are taken, positive attitude may be re-established and therefore, this may help developing positive intention. Proper counseling and advocacy may help toward creating a foundation for positive intention. Only then the process of behavior change may start functioning.

Dhaka University Institutional Repository

CHAPTER 1
INTRODUCTION

Dhaka University Institutional Repository

Chapter 1

INTRODUCTION

1.1 BACKGROUND

The majority of people in Bangladesh lives under the poverty line and has trouble making ends meet. Since they cannot eat healthily and do not have access to proper healthcare, the overall health, especially reproductive health of the people of this country is very poor. Furthermore, they are malnourished as young malnourished mothers produce even weaker and undernourished children. Moreover, young mothers frequently die and the rate of maternal mortality is very high as compared to other developing countries of the world.

To combat these problems people need to be given proper and effective knowledge on family planning, reproductive health and safe motherhood so that their behavior is changed. The Government of Bangladesh and Non-Government Organizations (NGOs) are working simultaneously to educate people by launching different interventions to spread awareness and change the behavior of the people. This has been done through communication programs that have resulted in some increase in awareness and contributed to a more use of health and family planning services in the country. The communication can occur both spontaneously, within and between social groups of a society, and deliberately, by means of planned intervention of governmental and non-governmental organizations and commercial enterprises. Communication can spread knowledge, values, and social norms[1].

Providing health care is the constitutional obligation of the government. The Constitution mandates that: "it shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural

[1] Piotrow, PT. Et al, Health Communication, Lessons from Family Planning and Reproductive Health, Johns Hopkins University USA 1997

Dhaka University Institutional Repository

standard of living of the people, with a view to securing to its citizen (a) the provision of the basic necessities of life, including food, clothing, shelter, education and medical care"[2]. The Government of Bangladesh, since independence, has been investing substantially in the institution building and strengthening of health population services in the country, giving special attention to the vast population that resides in the rural areas[3]. The Bangladesh health and family planning program has made remarkable progress over the last two decades. The fertility transition is already well underway in the country and the success of the immunization campaign is most impressive. The contraceptive prevalence rate has already reached about 54 percent. According to the recent BDHS[4], the fertility rate has declined from 6.3 in 1971-75 to 3.3 in 1999-00. The under-five mortality rate has declined from 133 for the period 1989-93 to 94 for the period 1999-00, and over the same period infant mortality has also declined from 87 to 66 per 1000 births. Despite these, however, Bangladesh still remains as one of the few countries in which life expectancy at birth is lower for females than males. About half of the population has access to basic health care, and 63 percent of pregnant women do not receive antenatal care or assistance from a trained attendant at the time of childbirth.

The population size and growth rate of the country has undergone significant changes over the past few decades. The population of the area, which now constitutes Bangladesh, was about 42 million in 1941[5]. Since then, Bangladesh have experienced relatively high rates of population growth. The total population grew from 76 million in 1974 to 129 million in 2001 census[6]. The inter-censal growth rate of population peaked in the mid-1970s at around 2.5 percent per annum, followed by a continuing decline to 2.2 percent in 1991[7]. At present the population is around 129 million and the growth rate is around 1.48 percent[8] per annum.

---

[2] Bangladesh Constitution, Government of the People's Republic of Bangladesh.
[3] The 5th Five Year Plan (1997-2002), Planning Commission, GoB, 1998
[4] Bangladesh Demographic & Health survey, 1999/00, NIPORT, Mitra & Associates & Macro International
[5] Bangladesh Bureau of Statistics, Population Report 1999
[6] Population Census 2002, Preliminary Report, Bangladesh Bureau of Statistics, Dhaka 2001
[7] Bangladesh Bureau of Statistics, Statistical Yearbook, Dhaka 1993
[8] "Report on Population Growth", MOHFW, GOB, 2001

Dhaka University Institutional Repository

BANGLADESH POPULATION CONTROL SCENARIO

Although Bangladesh has achieved considerable success in its health and family planning program over the past years, in order to achieve national demographic goal of replacement level fertility by 2005, the program not only has to sustain the current users of contraceptives, but also quite importantly, need to bring within its fold the never users and dropouts.

In terms of land area, Bangladesh occupy less than 1/3000th of the total land area of the world, with an area of 56,977 sq. miles (or 147,570 sq. km.)[9]. Except some island states, Bangladesh has the highest population density in the world, which it self, has increased by about four times during the last nine decades.

A review of the population situation[10] shows that the area now comprising Bangladesh had only 22.8 million populations in 1872 when first census took place. Since then, it took 80 years to double the population, and thereafter the growth started increasing due to high fertility and falling mortality giving rise to a serious population growth momentum with the result that since 1961 census, the population has become more than double in less than 30 years. The rapid population growth during the past three decades has resulted from high birth rate, accompanied by declining death rates.

The progress in the family planning program and the onset of fertility decline has not yet achieved its desired goals to achieving the demographic goal of NRR (Net Reproduction Rate) =1 by 2005. In fact, the slowing down in contraceptive prevalence since 1991 has become a matter of major programmatic concern. Hence, this concern needs to be addressed with utmost consideration, if the recent onset of fertility decline is to be continued. This is especially so in the context of low continuation and high dropout rates (in practicing family planning methods), especially among the very poor rural women, rural women who want another child, and urban women who get their supplies from pharmacies.

---

[9]Statistical Pocketbook Bangladesh 96, Bangladesh Bureau of Statistics, Dhaka 1997.

Dhaka University Institutional Repository

In Bangladesh, the family planning movement began in 1953, when a group of dedicated social workers realized that the development efforts of the country would be adversely affected as a result of an accelerated rate of population growth. This led to the establishment of the Family Planning Association. Since then, the family planning activities in the country have been carried out in five distinct phases[11]: (I) voluntary activities without Government support (1953-55); (ii) voluntary activities with some limited Government support (1955-60); (iii) the first national family planning program (1960-65); (iv) the Government-expanded family planning program (1965-70); and (v) a multi-sectoral and broad-based population control and family planning program soon after liberation with the launching of the First Five-Year Plan (1973-78). The Two-Year Plan (1978-80) aimed at raising the contraceptive prevalence rate (CPR) to 22 percent by 1980.[12] The Second Plan (1980-85) aimed at raising the CPR from 14 percent to 38 percent by 1985.[13] The Third Plan (1985-90) aimed at raising the CPR from 25 percent to 40 percent by the terminal year.[14] A comprehensive Health and Population Program was drawn up for the Fourth Plan (1990-95) with view to attain two broad goals: (I) Health for All by the year 2000 and (ii) an NRR of One by the year 2005[15]. Fertility in Bangladesh is declining, yet the growth rate of the population is still high and its consequences have adverse effects on various development efforts. One significant consequence of high fertility and the declining mortality trend is a built-in "population momentum," which will continue to generate population increases in future, even in the face of rapid fertility decline.

1.2 RESEARCH OBJECTIVES

This research was conducted with a view to achieve the three objectives –

- To evaluate the effectiveness of various existing approaches of promotional campaign for family planning carried out by government and different organizations in Bangladesh.

---

[10]Mabud, M A, Bangladesh's Demographic Scenario upto 2010 AD, Planning Commission, GOB, Dhaka 1990.
[11]Khuda; Barkat-e and Abul Barkat: The Key Bangladesh Family Planning Program, URC 1994
[12]The Two-Year Plan of Bangladesh 1978-80, Planning Commission, Dhaka 1978
[13]The Second Five-Year Plan of Bangladesh 1980-85, Planning Commission, Dhaka 1980
[14]The Third Five-Year Plan of Bangladesh 1985-90, Planning Commission, Dhaka 1985
[15]The Fourth Five-Year Plan of Bangladesh 1990-95, Planning Commission, Dhaka 1990

Dhaka University Institutional Repository

- To improve the existing strategies for promotional campaign for family planning with special emphasis in rural Bangladesh.

- To develop a model for prediction of knowledge, attitude and practice (KAP) and finally the behavioral change[16] (i.e. changing attitudes, intention and behavior of people; building effective community support for health seeking behavior, and changing attitudes, intention and behavior of service providers to provide client centered services) through promotional campaign which may be used by policy makers and researchers.

1.3 RESEARCH ISSUES

The following research issues were addressed:

- How effective is the existing promotional campaign launched by the government and some selected organizations?

- Is there any room for improvement of the present promotional campaign?

- Is it possible to develop a model for predicting the behavioral change, which may be caused by the campaign?

1.4 HYPOTHESES

There were two hypotheses, as follows:

H1: Change of behavior does not necessarily depend on change of awareness and knowledge;

H2: More the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.

[16]According to HPSP, "Behavior Change Communication" is one of the most important priority areas of Essential Service Package (ESP).

Dhaka University Institutional Repository

1.5 RESEARCH INDICATORS

Following indicators were investigated to evaluate the effectiveness of various existing approaches of promotional campaign for family planning carried out by government and different organizations in Bangladesh and thereby suggesting the need for any behavior change communication model.

Knowledge and Practice

- Knowledge and practice of family planning, especially oral contraception
- Delaying pregnancy
- Source of contraception
- ANC - knowledge and practice
- Traditional rules that pregnant women should adhere to
- Pregnancy related complications - knowledge and practice
- Place of delivery
- Reasons of home delivery
- Dangers during delivery
- Assistance during delivery
- Post delivery complication
- Prevention of post-delivery complications
- Right age for having first child: awareness and practice
- Age gap between two pregnancies

Decision Making on Family Planning Aspects

- Decision on using type of contraception
- Decision on number of children to have
- Role of senior family members

Dhaka University Institutional Repository

1.6 PURPOSES OF THE RESEARCH

The main objective of the study was to measure knowledge, attitude and practice of the target audience with regard to different programs. Measuring knowledge helps in identifying the gap between existing and correct conception regarding a particular topic or subject, ascertaining attitude helps to know the positive and negative perception, and understanding practice helps in identifying wrong and right practices amongst the target population. This information, in turn, helps developing appropriate communications strategy and prepare proper communication model.

1.7 RATIONALE OF THE RESEARCH

Policy planners in the family planning program in Bangladesh have been struggling against many odds to curb high growth rate population in the country for more than two decades. Achieving success in this sector is expected to lead to improve economic conditions in the country[17].

According to Kantner (Kantner 1992), despite the uncertainty that surrounds much demographic data in Bangladesh, it would not be accurate to conclude that the demographic levels and trends is a total jumble. Different organizations are promoting for their products in different ways though the ultimate goal of all is to control population growth. Simple illiterate rural people may be getting confused resulting to unfavorable impact on total family planning program.

Curtailing population growth rate is a major public health challenge today. High population growth rate is one of the most critical problems faced by Bangladesh. That is why the limited free land holding is gradually being taken over by the excessive population. Family planning (FP) is the only effective method for reducing population growth rate. It consists of adaptation of various methods for birth spacing. Thus, a gap between the births of two children will eventually reduce the growth rate.

---

[17] Andaleeb, SS, Explaining the Commitment of Field Workers in the Family Planning Program: Perspectives from Bangladesh; USA, 1995

Dhaka University Institutional Repository

In view of the above, various government agencies and NGOs are working since years for communicating the idea of family planning, using different tools besides distributing contraceptives. The government and NGOs use traditional and non-traditional media to educate the people about the various methods for controlling and spacing birth.

In Bangladesh, total dissemination of knowledge about family planning only through the print media is not possible because the vast majority of our population is either illiterate or does not possess the basic knowledge required for reading and writing. Similarly, as most of our population lies below the poverty level, excessive spending is not possible on their part for watching/possessing the various electronic media like radio, TV, etc.

It is evident from another report on National FP-MCH IEC Strategy[18] that coordination of activities of different related organizations was not satisfactory, possibly because of the fact that objectives, and measures to achieve the objectives, are probably not done to foster cooperation and coordination among the concerned sections. Moreover, people's participation in planning, implementation, monitoring and evaluation is not properly practiced, and with complete understanding of the issues. More importantly, there is a lack of confidence in the general population due to various reasons.

It is evident from reviewing the various literatures that different organizations are continuously working to combat population growth. This research will help to develop an appropriate strategy for promotional campaign for family planning especially for rural Bangladesh and thereby will help the program managers to cease further growth of population.

1.8 STRUCTURE OF THE THESIS

In Chapter 1, introduction about the research is stated. Various related literature is reviewed and explained in Chapter 2. In Chapter 3, the methodology is explained. Qualitative findings and analysis are given in

[18] "A Report on Institutional Analysis for the development of The National FP-MCH IEC Strategy", Johns Hopkins University, 1992

Dhaka University Institutional Repository

Chapter 4. Findings on Special Community-based Intervention Programs are explained in Chapters 5 and discussions on findings and test of hypotheses are narrated in Chapter 6. Need for developing Communication Model and Review of Related Approaches are shown Chapter 7. Finally, the Theory of Behavior Change i.e. the proposed model is explained in chapter 8. Bibliography and other information are given as an appendix.

Dhaka University Institutional Repository

CHAPTER 2
LITERATURE REVIEW

Dhaka University Institutional Repository

Chapter 2

LITERATURE REVIEW

2.1 BCC – THE CURRENT ROLE OF THE GOVERNMENT

Communication is the key process underlying changes in knowledge of the means of contraception, in attitudes toward fertility control and use of contraceptives, in norms regarding ideal family size, and in the openness of local cultures to new ideas and aspirations and the new health behavior (Piotrow 1997). Communication can help spreading knowledge, more specifically values and social norms therefore help changing behavior. Recently, government and other partners advocate that Behavior Change Communication (BCC) is one of the important factors with a view to change behavior of the target population toward achieving various health and population related goals.

The provision of information and education on selected health and family planning issues has been the important intervention of agencies in the health and population sector of Bangladesh for more than two decades. The Information, Education and Motivation (IEM) Unit of the Directorate of Family Planning and Health Education Bureau (HEB) of the Directorate of Health Services have played the major role in the IEC activities in the country. Besides, population cells of Bangladesh Betar and Bangladesh Television (BTV), different private organizations and NGOs such has BCCP, FPAB, PSTC, BRAC, CARE etc. also have produced IEC materials to support the activities of the health and population sector.

IEC Activities

IEC (Information, Education and Communication) activities have contributed to the increase in the utilization of services as well as development of favorable environment towards family planning, including a sustained strong political support and reduction of religious barriers. Today nearly all married women (over 98%) know about clinical and non-clinical methods. Due to

Dhaka University Institutional Repository

increased mass awareness and community participation in health activities, a great success has been assured in control of diarrheal diseases, achievement in TT immunization, promoting of safe drinking water and sanitation and other programs to control emerging and reemerging diseases in the country. But there has been little effective coordination mechanism developed between IEM Unit, BHE and other concerned agencies. As a result the health status of the poorer community remained far below the expectation, particularly in the urban areas.

2.2 HEALTH AND POPULATION SECTOR PROGRAM (HPSP) [19]

The Non-Government Organizations (NGO) and private agencies provide mainly by the Government and in a limited way health and family planning services in Bangladesh. In the Government sector the main responsibility for Health and Family Planning services falls to the Ministry of Health and Family Welfare (MOHFW). The Ministry of Health and Family Welfare is responsible for developing policy and programs for Health and Family Planning services and promotion of good health.

Health and Population programs in the past have made significant achievements, — especially in lowering fertility and improving child health status. The demographic transition is well underway as Bangladesh is the only country among the 20 least developed countries where sustained fertility reduction has taken place over the last 15 years. The Total Fertility Rate (TFR) has declined by more than half since the 1970s. Child immunization has increased from 10% to 70% and there have been substantial reductions in infant and child mortality. At the same time, major challenges remain; the main cause of death remains poverty- related infectious diseases, which are exacerbated by malnutrition. Gender differential in health persists. The Maternal Mortality Rate (4.2 per 1000 delivery) is one of the highest in the world. About 70% of mothers suffer from nutritional deficiency anemia and 75% of the pregnant women do not receive assistance from a trained attendant at the time of delivery. Over 90% of children have some degree of malnutrition. Other issues of concern are overall poor utilization of government services, as well as the cost-effectiveness, sustainability and quality of service.

[19] Paper prepared by Management Change Unit (MCU)

Dhaka University Institutional Repository

Recognizing these challenges and constraints, the Government, in consultation with development partners and stakeholders formulated the Health and Population Sector Strategy (HPSS) to reform the sector for providing a package of essential health and family planning services for the people of Bangladesh, specially the most vulnerable ones in the society e.g. women, children and the poor. The HPSS was approved by the Executive Committee of National Economic Council (ECNEC) in its meeting held on 19 August 1997.

Principles on which the vision of HPSS is based include the following:

- Client-centered services focusing on the needs of women and children

- At all level of services, increase:
  - Quality of Services;
  - Equity of access;
  - Efficiency of service.

- Focus on Essential Services Package with priorities in:
  - Interventions that have public-good character; and
  - Interventions related to maternal and child health.

In the light of the principles of HPSS the MOHFW prepared a five-year (1998-2003) sector-wide program - the Health and Population Sector Program (HPSP). The HPSP was approved by the ECNEC on 28th June 1998 and its implementation has been started from 1st July 1998.

The Health and Population Sector Program (HPSP) was prepared in the light of the experience gained during the implementation of the Fourth Population and Health Projects (FPHP). During FPHP implementation it was felt that the basic issues relating to health sector planning and implementation strategy and the health care delivery system need a thorough review to facilitate accelerated progress and optimum utilization of available resources. The weaknesses and deficiencies of the Sector were analyzed and the objectives and challenges were identified. Thus the purpose of HPSP is set to achieve

Dhaka University Institutional Repository

client centered provision and client utilization of an Essential Services Package (ESP), including other selected services. In the HPSP various reorganizations and reforms have been incorporated to achieve more cost-effective and effective delivery of the ESP, as well as to improve quality, ensure better utilization of scarce resources and to reduce duplication and waste. Besides under the HPSP, groundwork has been initiated for broader reforms in the sector, including greater involvement of NGOs and the private sector in the service delivery, restructuring and decentralization of management, cost sharing (with a safety net for the poor) and new approaches to financing. Because these efforts involve changes throughout the public health system the implementation of the HPSP has been planned under a result-oriented, sector-wide approach rather than the input-driven projected approach of past programs.

Objectives and Goal of HPSP

The goal of HPSP is to bring about an overall improvement of the health and family welfare status of the people particularly among the most vulnerable women, children and poor of Bangladesh. HPSP coupled with a number of programs in other key sectors implemented throughout Bangladesh will contribute to the achievement of these specific goals:

- Improvement of the health and family welfare status of the population particularly of the most vulnerable women, children and poor of Bangladesh.
- To reduce maternal mortality, infant mortality and morbidity and to slow population growth.

The Government of Bangladesh formulated HPSP because of the following reasons[20]:

- Efficiency, that will be ensured through avoiding duplications in the structure and program by restructuring and reforming the existing system
- Effectiveness, that will be ensured through extension of services and service structures, to be given by a cadre of skilled providers and by involving community in the organization

Dhaka University Institutional Repository

- Quality, to sustain the efforts (it has been envisioned that if improvements in effectiveness and quality could be ensured then this expectation will come true through sharing of the financial responsibility partly by the beneficiaries. Because the latter will be encouraged and interested to pay for services).

Purpose of HPSP Sector Program

The main purpose of HPSP is to achieve –

- Client-centered provision and client utilization of an Essential Services Package plus selected services.

Some of the key indicators to be used for monitoring of implementation activities of HPSP within the stipulated time frame will include reduction in:

- Maternal mortality;
- Infant mortality;
- Mortality of female and male children under 5 years;
- Communicable diseases and
- Unwanted fertility and total fertility rate (TFR);

And increase/ improvement in:

- Life expectancy at birth for females and males;
- Age of women at birth of first child;
- Nutritional status; and
- Healthy life style.

Components of the HPSP

The HPSP programs have the following four main components:

A. Essential Services Package;
B. Integrated Support services;
C. Hospital Level Services; and
D. Reforms to improve service delivery including program planning & implementation.

---

[20] Dr. A M Zakir Hussain, Challenges in Health Services Delivery in Bangladesh; Journal of Social Research, Vol 1, No 1, 2000

Dhaka University Institutional Repository

Details of the above four components are explained below:

A. Essential Services Package (ESP) has five major components:

- Reproductive Health Care (Safe Motherhood, Maternal Nutrition, Family Planning, Adolescent Care, Infertility, Neo-natal Care and Prevention and control of RTI/STD/AIDS);
- Child Health Care (Diarrhea diseases, Nutritional deficiency, Acute Respiratory Tract Infection and Vaccine preventable diseases);
- Communicable Disease Control (Malaria, Filaria, Kala-azar, TB, Leprosy, Intestinal Parasite and STD/HIV/AIDS);
- Limited Curative Care (First aid of accident, limited curative care of fever, pain, eye diseases, skin diseases including primary care of Vit-A deficiency, iodine deficiency, intestinal worms, ARI, simple injuries, snake bite, dog bite, drowning and poisoning); and
- Behavior Change Communication (BCC) which is of high priority for the ESP

B. Integrated Support Services:

Human Resources Development:

- Improved staffing condition;
- Improved basic education and in-service training; and
- Modern personnel administration/performance management.

Facilities:

- Establish and functionally improve the infrastructure and major equipment, with particular emphasis on mother, baby and the disabled friendly environment.

Procurement and Logistics:

- Emphasis on annual procurement plan;
- Logistics support for ESP; and
- Minimize system loss.

Quality Assistance:

- Develop norms and standards; and
- Address the QA in all service delivery points and institutions (public, NGO & private);

Behavior Change Communication (BCC):

- Institutionalize new approach to BCC;
- Reorientation of the system toward a client-centered approach;
- Improve provider relations;
- Ensure a BCC program that can effectively foster healthier behavioral patterns in the population; and
- Greater community involvement.

Research and Development:

- Focus on priority issue;
- Institutional strengthening; and
- Regular flow of information for decision making.

Management Information System:

- Personnel;
- Logistics;
- Financial;
- Services statistics; and
- Epidemiological surveillance.

C. Hospital Level Services: This component aims at bringing about qualitative and visible improvement in hospital level services by means of:

- Improving the performance through greater administrative and financial authority;
- Improvement of infrastructure & equipment;
- Women and baby friendly hospital;
- Local level accountability;
- Improving quality of services and QA;

Dhaka University Institutional Repository

- Cost-recovery keeping safety net for the poor;
- Self-sustaining autonomous blood-bank;
- Improving the existing waste management; and
- 70% beds to be earmarked for women and children in all new hospitals.

D. Reforms in HPSP

Reorganization of service delivery:

- This emphasizes an integrated, client-centered and decentralized delivery of an Essential Services Package (ESP) and a one-stop service delivery provision through Community Clinics for more or less 6000 people in the rural areas. This is a timely initiative and a new dimension in the health and family planning service delivery in this country.

Restructuring of the Management:

- Unified health and family planning structures which emphasizes the complete merger of health and family planning services at upazila level and below under a single management structure and restructuring of other levels of management during second phase;

Decentralization at lower levels; and

Sector Wide Management (SWM):

The major advantages for the GOB for adopting SWM are as follows:

- It will increase the efficiency and coverage of health services;
- Instead of trying to convince funding agencies to fund particular activities and accommodate their requirements, the GOB should be able to take leading role in defining the health strategies and plans and in identifying its requirements;
- Facilitates management of resources in a more comprehensive and integrated way with better accountability;
- Ensures better monitoring of overall sector goals and objectives;

Dhaka University Institutional Repository

- Saves overhead and recurrent expenditures on account of project staff/office;
- Saves time for planners and leaves more time for implementation and supervision; and
- Facilitates better coordination and supervision.

ESP and Expected Outputs from HPSP

Satisfactory provision of ESP services and their utilization by targeted clients will result in implementation of a wide range of activities over the five-year period of HPSP. These activities will produce the following eight component outputs:

- Essential Services Package defined, funded, promoted and implemented;
- Services delivery mechanism unified, restructured and decentralized;
- Integrated support systems strengthened;
- Hospital level services focused and improved;
- Sector-wide program management system established and operational;
- Policy & regulatory framework strengthened;
- Other services of public health importance strengthened; and
- Other health and nutrition services strengthened.

It is envisaged that the provision and utilization of ESP services will attain the HPSP sectoral objective of not only maintaining but further accelerating the momentum of efforts in Bangladesh to lower fertility and child mortality, reduction in maternal mortality and morbidity and reduction in the burden of communicable and other diseases.

Five major areas of an effective and client oriented Essential Services Package as focused in the HPSP are:

- Reproductive Health Care
- Child Health Care
- Communicable Disease Control
- Limited Curable Care
- Behavioral change communication (BCC)

- Saves overhead and recurrent expenditures on account of project staff/office;
- Saves time for planners and leaves more time for implementation and supervision; and
- Facilitates better coordination and supervision.

ESP and Expected Outputs from HPSP

Satisfactory provision of ESP services and their utilization by targeted clients will result in implementation of a wide range of activities over the five-year period of HPSP. These activities will produce the following eight component outputs:

- Essential Services Package defined, funded, promoted and implemented;
- Services delivery mechanism unified, restructured and decentralized;
- Integrated support systems strengthened;
- Hospital level services focused and improved;
- Sector-wide program management system established and operational;
- Policy & regulatory framework strengthened;
- Other services of public health importance strengthened; and
- Other health and nutrition services strengthened.

It is envisaged that the provision and utilization of ESP services will attain the HPSP sectoral objective of not only maintaining but further accelerating the momentum of efforts in Bangladesh to lower fertility and child mortality, reduction in maternal mortality and morbidity and reduction in the burden of communicable and other diseases.

Five major areas of an effective and client oriented Essential Services Package as focused in the HPSP are:

- Reproductive Health Care
- Child Health Care
- Communicable Disease Control
- Limited Curable Care
- Behavioral change communication (BCC)

Dhaka University Institutional Repository

Behavior Change Communication (BCC) as Outlined in the HPSP

Behavior Change Communication (BCC) is one of the important factors HPSP with a view to change behavior of the target population toward achieving various health and population related goals.

According to the Fifth 5-Year Plan (1997-2002) is to provide information, education and cross-communication services. It is central to improving the health of individuals and based on the notion that information provided on the causes of ill health and the services available and what individuals and communities can do to improve their health contribute to the improvement of health status.

The emerging of "new" or previously uncommon diseases in Bangladesh such as cardiovascular diseases, cancer, renal disorder, mental illness, HIV/AIDS etc. are closely associated with personal life style or behavior whose prevention requires a multi-dimensional intervention program. One of the most cost-effective means to promote and to protect health is to introduce IEC programs and activities.

BCC Component

The primary aim of the BCC component will be to shift health and family planning service provision from a sectoral and provider-based system to an inter-sectoral, client-oriented, demand-based system emphasizing community and women's empowerment; with a focus on social and gender issues, elderly and the poor. Target clients will understand their need for, and entitlement to, the Essential Service Package and demand them.

The components are-

- Changing attitudes and behavior of people to improve their health status
- Building effective community support for health seeking behavior
- Changing attitudes and behavior of service providers to provide client centered services

Dhaka University Institutional Repository

BCC will use six basic promotional strategies:

- Social change issue of familial support to women and children particularly to gain consensus and pro-active support from husbands and mother-in-law
- Social ownership (ownership of service delivery network by target audience)
- Provider relation (shift provider attitudes and practices towards a client-oriented)
- Advocacy (gain concurrence and support from community and media)
- Interventions promotions (social and gender issues)
- Social marketing (contraceptives, ORS, malaria Pills, impregnated mosquito nets etc.)

New Service Delivery Strategy

One of the aspects of HPSP is to develop and implement program in delivering Essential Service Package (ESP) in the rural and urban areas of Bangladesh under the new service delivery system. It has given impetus toward changing the behavior of the people. It is well known that in order to make a program successful, establishing positive behavior amongst the target audience is of utmost importance. In doing so, the role of new approach in reaching the target audience and providing health and family planning services with adequate QOC (quality of care) can hardly be over emphasized.

The service delivery strategy of Rural Service Delivery Partnership (RSDP) and Urban Family Health Partnership (UFHP) significantly changed from traditional home delivery to use of clinics. The RSDP strategy replaces fieldworkers with depot holders (who would not visit couples at their homes) and uses community mobilizers and additional paramedics/FWVs to help with static and satellite clinics and other field activities. The UFHP supported NGOs operate exclusively in the urban areas using Physicians, Paramedics and Service Promoters in a system of linked static and satellite clinics. Hence both RSDP and UFHP service delivery models utilize the clinics for service provision

with outreach extensions that include satellite clinics, while RSDP has another level of outreach extension of commodity supply depots in the community.

Community Clinic: Cafeteria Approach & One Stop Shopping

Government plans to provide all service to the target group's community clinics where all services can be availed. It will offer –

- Contraceptives
- Medical services
- Counseling
- Media and promotional services (each clinic will be decorated with TV)

2.3 HEALTH AND POPULATION IN THE LIGHT OF FIFTH FIVE-YEAR PLAN

The main objective of the Fifth Plan[21] is to create a greater degree public awareness of the population problem through a social movement and countrywide approach and there-by, to ensure people's participation fully in order to achieve the demographic goal of NRR – 1 by 2005. The Plan envisages to reduce the rapid growth of population through strong MCH-based family planning within the framework of reproductive health care and reorganized health and family planning service delivery system, provision of quality service, decentralized administration and inter-sectoral programs, cooperation of all public bodies and resource mobilization.

With a view to reach health facilities to the population the government has accepted the Primary Health Care approach as a strategy to achieve the goal of Health for All by 2000. PHC services will be provided through four tier systems – a) community level, b) ward level through satellite clinics, c) union level through HFWC and d) upazila level through UHC.

Main objective of the 5th Plan:

To ensure universal access for the people of Bangladesh to essential health care services of acceptable quality and to further reduce population growth to NRR – 1 by 2005.

---

[21] The Fifth Five Year Plan 1997-2002, Planning Commission, Government of Bangladesh

The plan emphasizes:

- To reduce infant mortality and morbidity
- To reduce maternal mortality and morbidity
- To improve nutrition status
- Reduction of fertility
- Ensure quality care.

Some of the major specific objectives related to health and population as shown in 5-FYP:

- Reform health and population sector to provide adequate basic and essential health and family planning services of the population
- Increase coverage of primary health care services for achieving 'Health for All' by the Year 2000;
- Develop behavioral change communication in order to provide information, education and communication (IEC) services
- Provide essential package of child health care, reproductive health, family planning, CDC, LCC services for the people at one-stop service points with acceptable quality and equity.
- Ensure regular monitoring, evaluation and research to determine the current status of the program including future need in a changed situation
- Quality of services
- Promote client oriented family planning and health care delivery system

The National Integrated Population and Health Program (NIPHP)

The National Integrated Population and Health Program (NIPHP), patronized by USAID, is designed to support the Essential Services Package (ESP) by providing people with much needed basic health services, that has been implemented by Urban Family Health Partnership (UFHP) and the Rural Service Delivery Partnership (RSDP). This program provides integrated health services throughout Bangladesh for primarily rural people at static sites in fixed clinic sites, satellite clinics and through RSDP depot holders. A large number of NGOs are contributing in providing health care services, especially family planning and reproductive health, to the beneficiaries. The contribution of these NGOs is enhancing toward achieving the overall mandate of HPSP.

Dhaka University Institutional Repository

The National Integrated Population and Health Program (NIPHP) is already under implementation in collaboration with the development partners, with a view to improving the quality of life of the people of Bangladesh, especially the poor and under privileged. One of the components of NIPHP is to develop and implement IEC related activities. It is well known that in order to make a program successful, establishing positive behavior amongst the target audience is of utmost importance. In doing so, the role of IEC can hardly be over emphasized.

The NIPHP is a partnership program on health and family planning services between USAID, its seven cooperating agencies (CAs), and government of Bangladesh (GOB). The components of the NIPHP are:

- Rural service delivery
- Urban service delivery
- Social marketing
- Quality improvement
- Urban immunization
- Operation research and
- Contraceptive logistics.

As mentioned above, NIPHP's mission is to enhance the quality of life of the poor and under-privileged members of society by helping to reduce fertility and improve family health. The NIPHP will focus on delivering and essential service package of high quality and high impact services and products, backed by effective and culturally appropriate communications, strong organizations and support services, a favorable GOB policy framework and close building sustainability throughout.

ESP of NIPHP

The components of the essential service package (ESP) of the NIPHP are:

- Family Planning
- Antenatal care
- Vitamin A

Dhaka University Institutional Repository

- Expanded Program on immunization
- Acute Respiratory Infection
- Control of Diarrheal Disease
- RTI/STD and HIV/AIDS.

2.4 SUCCESS IN A CHALLENGING ENVIRONMENT: FERTILITY DECLINE IN BANGLADESH[22]

Bangladesh is one of the poorest and most densely populated countries in the world, but it is committed to a policy of lowering the rate of population growth by means of family planning and related measures. Due to the War of Liberation, which was preceded by a countrywide civil disobedience movement, most of 1972, was spent on relief and rehabilitation work. The family planning program was subsequently transferred and renamed the Bangladesh Family Planning Executive Board. An integrated program was launched in January 1974 after almost a year's preparation. The new plan emphasizes population planning operating within a broader framework of economic and social development; and intensified educational and publicity campaign; a reduction of the growth rate by 0.2% (GOB 1994); prevention of births by emphasizing use of oral contraceptives, condoms, IUDs, and vasectomy; orientation courses and workshops; special attention given to the organized sector where family planning has a better chance of success; and the marketing of contraceptives through commercial channels.

The rate of total fertility in Bangladesh fell from 6.3[23] births per woman in 1975 to 3.3 births by 2000 (BDHS 1999-00[24]). Among the world's twenty most poor countries, only Bangladesh have experienced a significant, sustained fertility decline over the past two decades. Even so, however, its current population of about 129 million could double in 35 years. The leadership of the country has therefore given high priority to population control and family planning. Bangladesh's experience in addressing rapid population growth highlights the importance of sustained political commitment to an effective family planning program, adopted and pursued at the highest levels of government, and the

---

[22] This section is based on the abstracts noted from POPLINE, prepared by Johns Hopkins University 2000.
[23] 1975 Bangladesh Fertility Survey, Ministry of Health & Population Control, GOB, 1978.
[24] Bangladesh Demographic and Health Survey, 1999-2002, NIPORT, Mitra and Associates, Macro International Inc., USA, June 1997

Dhaka University Institutional Repository

need to adapt service delivery to cultural realities such as a patriarchal system with limited female mobility. (Carty, 1993)

The 1999-00 Bangladesh Demographic and Health Survey (BDHS 1999-00) was conducted among around 10,000 ever married women 10-49 years old and 3000 husbands of respondents. It is evident from this report; the contraceptive prevalence rate has increased seven folds since 1975 from around 8% to 54% of married women. In the three years since 1996-97 BDHS[25], CPR has increased by 10%; from 49% to 54% of currently married women. The method mix has also changed over time. Evidence suggests rapid and accelerating fertility decline to 3.3 births during 1999-00, a drop of 22% from 1989-91. Levels of fertility varied by region. Chittagong had a total fertility rate of 4.0 births per woman compared to Rajshahi and Khulna Divisions with 3.0 births. Fertility was about 30% higher in rural areas. Fertility was 4.12 for women with no formal education and 2.4 for women with at least some secondary education. Age at first birth averaged around 18 years during 1999-00 of women 15-19 years old were pregnant or have had their first birth. The percentage of women with two children who desired no more children increased from 39% in 1991 to 73% during 1993-94. More than the half of married women (54%) were current users of family planning; around 30% were modern method users. Pill use doubled within 4 years. Sylhet had low contraceptive use (34%) followed by Chittagong (44%). On the other hand high performance was observed in Khulna (69%), closely followed by Barisal (59%) and Rajshahi (59%). Knowledge about sources of supply was high throughout Bangladesh. Family planning messages were widespread throughout the media. Unmet need among currently married women declined from 28% in 1991 to 19% during 1993-94. 70% of total demand was being met. The pill was used correctly. About 49% of contraceptive users discontinued use within the first 12 months. Discontinuation rates were high for the condom (67%), withdrawal (51%), and injections (50%) compared to IUDs (34%) and the pill (47%). About 63% received no antenatal care during pregnancy and 92% of births were home deliveries, 22% were assisted by trained or skilled persons like doctors, nurse/midwife or trained TBAs. Majority (88%) are still dependent on untrained or relatives. (BDHS 1999-00)

---

[25] Bangladesh Demographic and Health Survey, 1996-1997, NIPORT, Mitra and Associates, Macro International Inc., USA, June 1997

Dhaka University Institutional Repository

Demographic Indicators and Household Amenities Affect Contraception?

Contraceptive prevalence differs in rural and urban areas of Bangladesh. Hoque (Hoque 1995) in a recent study examines the probability of using contraceptive methods by using logistic model. The findings demonstrate that socioeconomic development and women's status significantly impact on the use of contraceptive methods. Data are obtained from the 1983, 1989, and 1991 Bangladesh Contraceptive Prevalence Surveys among a nationally representative sample of currently married women, 15-49 years old. Contraceptive use patterns show a doubling during the study period in urban and rural areas. Modern method use prevalence increased from 21.5% in 1983 to 49.5% in 1991 (43.7% in rural and 53.8% in urban areas). Contraceptive use levels changed differently among subgroups (age, education, urbanization, child loss, and region). Only among highly educated women was change in contraceptive use minimal. The results of multivariate logistic analysis reveal that educated, employed women were more likely to use contraception than women who had little or no education were. Women with the highest levels of education were 3 times more likely to use modern methods than women who had no education in rural areas. In urban areas, highly educated women were 2 times more likely to use modern methods than women with no education were. Child mortality was not a significant predictor in either rural or urban areas. Desire for no more children was positively and significantly related to use, even with controls for other variables. Religion was a positive and significant determinant of contraceptive use in rural and urban areas. Women with modern conveniences such as flush toilets were more likely to use contraception regardless of place of residence. Women who visited a hospital or health center were 2 times more likely to use contraception. Efforts to increase accessibility of contraception by region may have been more efficient in some regions. Urban-rural differences in educational composition were found to play a significant role in contraceptive use differences. 12% of absolute differences in use are explained by educational differences; 15% is explained by toilet facilities and hospital visits, and 10% is explained by region of residence. (Hoque 1995). The similar trend was observed in 1999-00 BDHS.

Dhaka University Institutional Repository

Though family planning program has gained tremendous achievement, there has always been a gap between the desired fertility goal and actual fertility. Abedin (Abedin 1994) in his study describes methods for estimating the total fertility rate (TFR) given a known level of contraceptive prevalence (CPR). In identifying the gap a linear regression equation is used to general TFR from a known CPR based on biennial longitudinal data on TFR and CPR for 1979 to 1984 in Bangladesh.

In another study, Khan (Khan 1994) investigated the influencing factors on fertility. "Path analysis" was used to determine the influence of socioeconomic and demographic variables on fertility. Data was obtained from the 1989 Bangladesh Fertility Survey (BFS) on 11,905 ever-married women: 8466 rural women and 3439 urban women. The number of children ever born (CEB) was examined in terms of the influences of age, religion, childhood place of residence, and educational background. In the urban model women's age, education, and childhood background significantly influenced CEB. Religion indirectly influenced CEB through women's age at marriage and education. Women's age did not indirectly significantly influence CEB. In the rural model women education, marriage age, religion, and age directly and significantly influenced CEB. Education had a smaller influence in the rural setting and indirectly influenced marriage age but to a lesser extent than in an urban setting. In the rural setting women's age did have an indirect affect on fertility through educational status. Childhood background influenced the education of women in rural areas. He (Khan) further stated that in the rural setting age and religion had stronger impacts than in urban areas. In urban areas the indirect influence of age on women's education was stronger. The findings suggest that urbanization is an appropriate explanation for fertility decline in that it reduced fertility and increased educational levels. Between 1975 and 1989 religion had a diminished affect on urban fertility, and women's education and marriage age increased in their impact on fertility over time. In rural area religion's impact increased over the 14-year period, but women's education and marriage age decreased the impact of increased religious influence.

For most of the developing countries of the world fertility analysis presents special problems because of the inadequacy of the basic data. Prof. Kabir (Kabir 1977) estimated fertility levels in Bangladesh by applying a method known as the reverse survival method to census age distribution data. The analysis suggests that fertility level is high in Bangladesh, but how high it is a matter of conjecture. Despite serious limitations of the Bangladesh age data, the evidence points to a rather narrow range of variability in fertility trend. However, since rising age at marriage and family planning has as yet had little impact, the young age structure of the Bangladesh population also favors high fertility in the future. Evenfalls in fertility far faster than at present seem possible; but that would not alter this prospect because of the momentum from high fertility rates of the past.

Islam (Islam 1995) examined data from the 1989 Bangladesh Fertility Survey were used to investigate the contraceptive behavior of married adolescents (age range: 10-19 years) in comparison with that of married adults. Marriage occurs at an early age in Bangladesh and is almost universal. Thus, adolescent fertility contributes substantially to overall fertility. The 11,906 women interviewed included 1922 (16.1%) adolescents. Knowledge of family planning (FP) was almost universal between both groups, with specific knowledge about methods slightly lower among adolescents. Ever 26.3% of the adolescents and 48.4% of the adults reported ever-use of a method. The contraceptive prevalence rate was 15.3% among adolescents (10.7% modern and 4.6% traditional methods) and 34.4% for adults (10.5% female sterilization, 9.9% oral contraceptives, and 6.4% traditional methods). Little difference was found in the attitudes towards contraceptives of adults and adolescents. 83% of adolescents and 58% of adults indicated an intention to use a method in the future. When attitudes about family size were indecisive, contraceptive usage was very low. The analysis revealed that increased education is the most important factor having a positive effect on the contraceptive use rate for adolescents, followed by participating in family decision-making, frequency of visits by FP workers, region of residence, husband's occupation, and availability of electricity in the household. The policy implication of these findings is that as women's status improves with increased opportunities for education and employment, they will

Dhaka University Institutional Repository

find ways to meet their contraceptive needs. Also, program managers could exploit the popularity of traditional methods, since traditional methods can be effective if taught properly and used consistently. Adolescents need to become aware of the negative consequences of early marriage, early pregnancy, and large family size, they need information on the availability of FP methods and their use-effectiveness, they need improved reproductive health care services which are readily available, and they would benefit from programs designed to overcome the resistance of older family members and husbands to FP.

Community Participation

Bangladesh government and other agencies are giving impetus on community participation to curb population growth. The vast majority of Bangladeshi is poor and unable to provide for even the most basic of human needs. These landless and marginal farmers constitute 70% of the rural population, which in turn constitute about 90% of the country's population. Effective development of the country would mean the development of these people, past efforts of which had failed. One of the development goals of the Bangladeshi government is to improve the quality of life among the rural population through health and population control measures. Overpopulation, malnutrition, and diarrhea are the major impediments to socioeconomic development in Bangladesh. Haider (Haider 1989) in his study tried to identify whether there is effective opinion leadership among these people affecting decisions on acceptance or non-acceptance of family planning methods and oral rehydration therapy (ORT) in the selected rural areas of Bangladesh. The study was conducted in 8 randomly selected villages with funding by the Ministry of Health and Family Planning, Bangladesh. 125 opinion leaders were interviewed after being identified by 408 rural couples owning land less than 2 acres and wives' age below 50. The study was conducted in 2 phases; 1st came the couples' interviews, then those of the leaders. Findings revealed that opinion leaders influencing adoption of health and family planning among landless and marginal farmers belong to the same class. These individuals own much less land than the rich farmers and the formal leaders in the rural areas. The majority of these individuals are friends, neighbors, and relatives; others are businessmen

Dhaka University Institutional Repository

and professionals and some are field workers in health and family planning. Source of influence as a factor contributes most in differentiating use and nonuse of family planning and ORT among couples and leaders. The most frequent sources of influence according to both groups are the fieldworkers in health and family planning, followed by peer opinion leaders (friends, neighbors, and relatives), and spouse. The opinion leaders do not differ much from poor couples on land holding, a strong indicator of economic status; however they do differ considerably on social factors such as family planning practice, education, and exposure to mass media. The study suggests that future development efforts in Bangladesh must ensure community participation by the landless and marginal farmers and opinion leaders belonging to their class.

Community based distribution (CBD) approach plays a significant impact on change in behavior and practice of contraceptives toward planning family size in Bangladesh. Phillips (Phillips 1994) tried to analyze the latent demand and the fragile demand hypothesis of community-based distribution (CBD) and demand for services. The latent demand hypothesis tests whether outreach impact is greater at the beginning period of a project; there is an expected decline as the program becomes established. Longitudinal data were obtained from the Sample Registration System and 19% of households in 2 study districts of central and western Bangladesh. Controls were respondent's age, years of schooling, square feet of dwelling space, proportions desiring no more children, and Muslim religion. Several models were tested: the reproductive change model, which tested the relative significance of the latent and fragile demand notions in a time-period conditional (1982-84, 1986-88, and 1990-92) estimation of unknown parameters technique; and the ideational change model, which probes the impact of exposure to the program and changes in preferences in a cohort of women in 1982, 1985, and 1990. Sample size was 43,000. The results indicated that background characteristics are important in determining contraceptive use over time.

Philips further tried to explain that educational and demographic characteristics were weakly related to contraceptive prevalence. Outreach was found in

reduced form models to have incremental impact on program activity as a substitute for underlying demand. Female community workers were found to be more effective at encouraging continued contraceptive use than male workers, who provide supplies to already motivated women. Over time, the impact of outreach on contraception adoption increased, and the odds of discontinuation decreased, thus, outreach had a continuous impact on programs. In the service exposure model, outreach by government workers had significant effects. Contact had a significant impact on change in family size desired. Son preference declined by 26% in the more recent program period. Outreach contributed 13.2% in 1990 to the decline in the desire for another child. Workers contact encouraged ideational change.

In March 1995, the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) and the government of Japan sponsored a 2-week international workshop on Family Planning Programs of NGOs (non-governmental organizations) in the SAARC Region (South Asia). The purpose of the workshop was to share experiences with family planning and reproductive health of the Matlab Project and the MCH-FP (maternal and child health-family planning) Extension Projects in urban and rural areas with family planning program managers from NGOs and policy and operations researchers. It also intended to examine those family planning and reproductive health projects of the NGOs in Bangladesh that fostered significant improvement of the national family planning and MCH program in Bangladesh. Participants were presented with effective family planning and MCH program design and strategies to strengthen improved management. The workshop emphasized the emerging norms of quality of care in family planning and reproductive health. An NGO - Family Planning Association of Bangladesh initiated the concept of family planning in Bangladesh in 1953, so they are considered innovators. Accordingly, they are expected to develop designs and models for effective service delivery systems, training, management information system, IEC (information, education, and communication), community participation as well as to set social norms and values for small families. At the workshop, Bangladesh was offered as an example of how innovative NGO activities, sustained partnership between the NGOs and the government, and technical support

Dhaka University Institutional Repository

from ICDDR,B lead to progress in family planning and MCH programs, despite the great poverty and economic stagnation. Contraceptive prevalence has increased from around 7% to almost 45% between 1977 and 1994. (ICDDR,B 1995)

Although recent advances in family planning in Bangladesh might be said as 'somewhat trivial' when compared with major successes elsewhere, it was suggested that there could be few instances 'in a traditional society living on the margin of life' where so much progress towards a family norm had been achieved. If the population continues to grow at its present rate of 1.8% annually, it could double by around 2030. Efforts are now being made to increase current contraceptive prevalence (approximately) 40% to 60% by 2000; if replacement levels of fertility are to be achieved, the figure will have to be raised still further--to over 70%. While more than 80% of women of reproductive age now seem to be aware of at least 2 modern methods of contraception, it is recognized that there is an urgent need to expand uptake among newlyweds and young couples with few children. The latest 5-year plan aims to increase contraceptives choice, to improve program sustainability by exploring the possibilities of local manufacture and offsetting costs by charging for products, and to focus attention not only the Pill and condoms but also on longer-acting methods of birth control, such as sterilization, injectables, and IUDs. It also includes provision for monitoring stock flows in order to ensure uninterrupted supplies, raising the quality of care by delivering reliable services suited to the needs of clients, and strengthening ties with NGOs.

Religion and Contraception

Miah in another study (Miah 1992) conceptualizes the link between cultural and social structural factors (economic, familial, and political) and high fertility. These factors include the old agrarian social structure, that emphasized the large family and devalued formal education, and entrenched religious beliefs and practices that encourage women's fertility and retard women's control over their own reproductive processes. Both Hindu and Muslim women face tremendous pressures from family life, religious rituals and practices, politics, and the economy for high fertility. Population control will not be possible without

were due to user failure. The contraceptive failures resulting in births would constitute more than 20% of total births, if general fertility were 150 per 1000 women. Injectables and the IUD had the lowest failure rates, but the lowest use.

Ullah studied (Ullah 1994) the use pattern of traditional and modern methods of fertility control among currently married women of reproductive age utilizing the data extracted from the 1989 Bangladesh Fertility Survey (BFS) conducted during December 1988 to April 1989. This national two-stage probability sample survey selected 175 rural and 100 urban clusters. At the second stage, from 11,236 households (7984 rural and 3252 urban) a total of 11,906 ever-married women under 50 years old (8467 rural and 3439 urban) were successfully interviewed, constituting the reference population. Bivariate analysis studied the differentials in the use pattern by some selected demographic and socioeconomic characteristics. Also, multivariate logistic regression analysis was used to identify independent contributions of each selected covariate. There was universal knowledge about contraceptive methods. The contraceptive prevalence rate amounted to 31%; 23% were using modern methods and 8% relied on traditional methods. Logistic regression showed that visits of family planning workers had very strong positive influence on the current use of modern contraceptives as compared to traditional methods. Duration of marriage influenced modern method use negatively. Residents of Rajshahi division were significantly more likely (relative odds of 2.5) to use modern methods than residents of Chittagong division. Women having electricity in their household were almost 2 times more likely to be current users of modern contraceptives compared to women without electricity. Non-Muslim women were significantly less likely to use modern contraceptives (relative odds of 0.5) compared to Muslim women. Women whose husbands had secondary and higher levels of education were 1.5 times more likely to use modern methods than women whose husbands lacked education. However, wives of landowners were less likely (relative odds of 0.72) to use modern methods vs. traditional methods than wives of laborers or farmers. Women who discussed family planning with their husbands tended to use modern contraceptives more (relative odds of 1.5) than those who did not.

Dhaka University Institutional Repository

Operations Research

The Bangladesh family planning program has succeeded in increasing the contraceptive prevalence rate (CPR) from 7% in 1974 to 54% in 1999-00. The success can be partly attributed to the use of 'operations research' to test strategies and program elements. Matlab as a research station and Maternal-Child Health/Family Planning (MCH-FP) as an extension project of ICDDR,B have assisted in this process by developing innovative program ideas to provide quality of care in a research setting, and then testing the ideas in realistic field trials. A field-oriented international workshop on "Improving Family Planning Program Effectiveness and Quality of Care through Operations Research" was held in Bangladesh from December 5-14, 1993, jointly organized by the International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) and ICOMP with the aim of learning about both the actual interventions tested at the national level, and the process by which research findings were translated into policy and programmatic changes. 16 senior program managers from Bangladesh, China, Egypt, India, Indonesia, Pakistan, Sri Lanka, USA and Vietnam participated. The Matlab and MCH-FP Extension Project in Bangladesh as a partnership between program managers and researchers has resulted in the successful implementation of a family planning (FP) program under conditions of pervasive poverty and economic stagnation, which could provide an object lesson for other countries with similar conditions. In 1994, two 3-day field trips were organized to allow the participants a first hand look at the workings of the Matlab and MCH-FP Extension Project. (ICDDR,B 1994) The first field trip was to the original Matlab project site, and the second was to the extension projects in Abhoynagar in Jessore district. The key lesson from the 2 projects is that an increase in CPR and a reduction in fertility in a poor socioeconomic setting are possible through effective program management based on sound operations research findings.

Desire for Children/Son Preference

The desire for additional children plays an important role in planning family size. In 1994, Kabir (Kabir 1994) attempted to investigated the desire for additional children in Bangladesh with Bivariate and multivariate techniques in logistic

models, which include socioeconomic and demographic characteristics. The sample is nationally representative of ever-married women aged under 50 years. Data were obtained from the Contraceptive Prevalence Surveys for 1983, 1985, 1989, and 1991. Independent variables are educational attainment, current contraceptive use, engagement in an income generation activity, Muslim religion, land ownership, member of a social organization, and availability of electricity in the household. The desire for additional children was higher among younger cohorts (aged 15-19 and 20-24 years with increased desire in 1991 compared to 1983 and the age group 20-24 years with a decreased desire). 99% of women with no children in 1991 desired additional children compared to 97% in 1983. 10% of women with 5 or more children wanted additional children in 1983, whereas only 4% desired additional children in 1991. Those with no children or one child were among the largest percentage desiring an additional child. The general pattern is a decline in desire for children over time. More mothers with two sons and one daughter desired no more children compared to mothers with two daughters and one son in 1983 and each survey year. Many desired a balanced number of sons and daughters.

Pennsylvania University in 1993 developed a theoretical model, by a doctoral candidate, (Allen 1993) to analyze data on 12,986 married, non-pregnant women; 233 field workers; and 201 supervisors of a USAID-supported family planning program implemented by 3 non-government organizations. The model assumed no variation in supply of contraceptive methods. The proximate determinants included desire for no more children, attitude toward contraceptive methods, and proxies for unmeasured fecundity, sexual exposure, and motivation to space births. Client/program interactions, program and field worker characteristics, and socio-demographic characteristics of clients formed the basis for these proximate determinants. The student used a new methodological approach to test and control for endogeneity and correlated error structures. She evaluated the contribution of program and non-program factors to contraceptive supply, desire for no more children, attitude toward contraceptive use, and contraceptive use. The analysis indicated that differences in family planning program design, personnel, and service delivery

Dhaka University Institutional Repository

are not a significant demand side force. In fact, family planning program design, personnel, and service delivery had little effect on desire for more children. Instead, clients' socio-demographic characteristics, particularly family size and years married, accounted for most of the variation in desire for more children. Program factors did influence attitude toward methods, but attitude did not affect contraceptive use. Reliable home delivery of popular contraceptive methods (i.e., supply side effects) appeared to be the only program contribution to contraceptive use.

Coordinated Effort of Working Force Increases Contraception

It is found that through a study sponsored by FPAB/USAID and conducted by Mitra (Mitra 1992) that the coordinated efforts of different forces working in the field of health and family planning can help to combat population explosion. The Traditional Healers Project in Bangladesh was initiated in 1982 in 10 "upazilas" with 500 traditional healers, who by means of home visits motivated people with IEC materials and supplied contraceptives. In 1992 there was a shift to 30 upazilas, of which 20 were new, with 100 healers. Mitra conducted the survey in January and February 1989 to evaluate the performance of the healers. The FPAB healers were successful in increasing contraceptive prevalence, but were less effective in reaching much of the target population. 60.6% of ever married women were aware of the healers' services, and only 60.5% of those aware of healers had ever discussed family planning with a healer. The low coverage was attributed to the possibility that healers only helped those who sought their services; also, community performances and films about family planning were not well publicized. The survey of 267 influential persons and 243 family planning officials found that over 50% considered healers earnest in their efforts. (Mitra 1992)

Unmet Need

Although the Bangladesh family planning program has operated for more many years, contraceptive use is cannot reach to a sound platform. In a study conducted by Mitra and Pebley in 1982 (Mitra 1982) assessed the family planning needs in Bangladesh with a view to evaluate the unmet need for contraception in the developing countries as a part of World Fertility Surveys

Dhaka University Institutional Repository

(WFS). This paper explores family planning demand in Bangladesh to assess program goals and to determine the proportion of potential users. The WFS interviews of 6,513 ever-married women provide data. The Bangladesh data differ from other WFS data since interviewees were asked if they wanted another child soon rather than if they wanted any more children. The data, therefore, cannot be as readily compared with those of other countries, but they provide a complete estimate of unmet need of contraception. The authors (Mitra and Pebley) find that 1) the proportion of women who do not want more children soon rises with age and marriage duration, 2) women who have most recently had a child are most likely and women with the longest birth intervals are least likely to want another child soon, and 3) contraceptive use by women who want no more children soon in increases with age and parity, and to a lesser extent for marriage duration and interval length since the last child. Comparing responses to an ideal family size question, the authors find that 9.6% of currently married women at risk of pregnancy want no more children, 50% of women are not a pregnancy risk (largely because they are breast feeding), 6% use contraception, and the majority of the 44% of non-contracepting women want more children soon. The authors identify 9.6% and 14.9% of non-contracepting women as having unmet needs for birth termination and spacing, respectively. Given these results, more emphasis should be placed on providing contraception for spacing. In general, the women most likely to have unmet need for birth limiting are between ages 30 and 39, poorly educated, have several children, are working, and live in rural areas; an unmet needs for birth spacing varies but is more likely for women less than 40, who have a least 1 child, and live in rural areas. Meeting unmet need for women wanting no more children would result in a birth rate decline of only 7%. (Mitra 1982)

Information Education & Communication (IEC)

It is evident from a recent study conducted by Hasan (Hasan 1998)[26] that recently government and various partners (donor and NGOs) could create awareness among the target audience especially among the women. What is most heartening evidence from this study is the emergence of the "second

[26] Hasan K, National IEC Study, Bangladesh Center for Communication Programs/Johns Hopkins University 1998

generation FP method user". The females between 35-39 years of age are extremely aware of the benefits of the FP. Over the last 10 years, they have been a regular pill user and have derived the benefits by keeping her family small. Since the woman knows that it is her body and she should look after it, she is the one who cautions her daughter against having a big family. She advises her daughter to take oral pills (even giving it to her on her wedding night.). What she could not achieve due to various social prejudices, she gives it to her daughter. When her daughter becomes pregnant, she registers her with a local FP clinic for all ANC/PNC services.

This welcoming social change needs to be speedily transferred through IEC for the rural audience, where some decisions are taken together in health and FP matters because there is still a good percentage that still does not communicate with their husbands and wives. Addressing this change through a parallel situation following the same income level could be a good way. An *enter-educate* film in an ad format highlighting appropriate behavior of service providers (of all categories) in hospitals and clinics at upazila (administrative unit) level and below should be developed. Since the study endorsed that "no treatment for the *poor*" – a mid to long-term IEC policy regarding appropriate behavior of service providers mingled with *kindness* and *taking care* should be developed. (Hasan 1998)

Women's Involvement in Family Planning

According to Prof. Yunus (Yunus 1994), reaching the poor with any development program is a very difficult task. Reaching the poor women, in a country like Bangladesh is almost an impossible task. Improvements in the economic and social conditions of a poor households can be produced faster if the process of change is initiated through the woman of the household, rather than through the man. Various agencies, both NGOs and the government bodies are working to uplift the socio-economic status of women and thereby enhancing women empowerment.

Dhaka University Institutional Repository

Simmons (Simmons 1995) in her study among the women tried to investigate the involvement of women in changing their life pattern through practicing various measures of family population. The study was conducted in Matlab using qualitative techniques (focus group discussion). The conclusion from the analysis of focus group discussions among women in Matlab, Bangladesh, was that women were not only aware of widespread contraceptive use in their communities but were also aware of the timing of fertility decline. Women were aware of the broad changes, usually considered demand-side determinants of fertility decline: socioeconomic change and modernizing influences. Media exposure and the Matlab community-based family planning workers did have strong program impacts, both in the Matlab area and diffused throughout the countryside. Women were aware of changes in the "new culture of contraception," increased costs of living, rising educational desires, changes in women's position, and the increased influence of modernization. Major structural changes in social and economic life have not occurred, but evidence has indicated that land holdings have become increasingly fragmented and schooling has increased. The onset of fertility transition was considered to be influenced by small changes in economic and social life in the direction of modernization and supply-side measures. The subjective meaning of women's position has taken on much larger meaning than the objective measures of change in women's role. The subjective meaning plus strong family planning program influence may have contributed to new desires for smaller families. The evidence from Bangladesh has suggested simultaneous effects of both demand and supply. The strong supply-side program effect has acted to complement and heighten the awareness of demand-side effects, although small. Strong programs help people to understand the changes taking place. The Matlab family planning worker was a catalyst for diffusion of new ideas and information to young, unmarried women outside the reach of formal program strategies. Ideas were presented through agents of the family planning program, and "women's gossip" served to transmit notions about women having a say in their reproductive lives and about the appropriateness, in modern terms, of fertility regulation. The focus groups did not directly address diffusion of ideas about family size desires. Simmons further suggests that "Policy should continue to support female family planning outreach workers".

Dhaka University Institutional Repository

During a focus group study by Mita (Mita 1995), examining the relationship between women's status and family planning in Matlab, Bangladesh, researchers learned that a group facilitator had clearly remembered the arrival of the community family planning worker in her village 10 years earlier when she was not yet married and the effect her arrival had on the facilitator and her friends. Four more focus group sessions with 15 young, recently married women (mean age = 16.7 years) and questions about young women were added to the study and session guidelines. The study revealed that the media was an important influence. These focus group discussions indicated that the family planning worker contributed greatly to the diffusion of information and ideas in the late 1970s, when the Matlab family planning/maternal and child health project began, and during the 1980s. The media, the rise of a culture of contraception, and the influence of modernization facilitated the family planning worker's role. Her presence in the community and the information disseminated through the media stimulated conversations. The interaction of peers and family members processed new knowledge and ideas. The Matlab project through its community workers introduced the idea that women can control their reproductive lives and consciously determine their family size. These findings emphasize the significant role of the female outreach worker in rural Bangladesh. They suggest that employment of women as community family planning workers may have had benefits other than those expected. The findings show the need for family planning programs to address the contraceptive needs of young, married women.

In late 1992, in rural Bangladesh, 1305 married women were interviewed by Schuler (Schuler 1994) to determine whether financial credit affects contraceptive use and to examine its effects on women's level of empowerment. Some women were members of Grameen Bank or the Bangladesh Rural Advancement Committee (BRAC), both of which lend money to the landless rural poor, they attended regular meetings, which increased their mobility and access to information. Other women lived in villages where Grameen Bank operates but were not members. The last group were women living in villages not served by Grameen Bank (i.e., comparison villages), and who had limited public mobility. Grameen Bank members were more likely to

use contraceptives than those in comparison villages (59% vs. 43%; $p < .01$). Non-members in Grameen Bank Villages also used contraceptives more often than did women in comparison villages (48% vs. 43%; $p < .05$). Even though BRAC members used contraceptives slightly more than did women in comparison villages, the differences was not significant (47% vs. 43%). The Grameen Bank stressed credit more than did BRAC and required members to perform membership rituals, which likely accounted for the significantly higher contraceptive use among Grameen Bank members and those living in Grameen Bank villages. In fact, the regimentation and chanting reinforced the bank's 16 decisions, 1 of which was to have a small family. The empowerment score was a composite of the woman's economic security, mobility, ability to make small and larger purchases and major decisions, subjection to domination and violence, political/legal awareness, and participation in protests campaigns. Grameen Bank membership ($p < .01$), BRAC membership ($p < .01$), and being a non-member living in a Grameen Bank village ($p < .05$) all contributed to women's empowerment when contribution to family support was considered, suggesting that credit programs strengthen women's economic roles. These findings show that credit programs modeled on the Grameen Bank strengthen women's economic roles and promote women's empowerment, thereby accelerating a fertility transition. (Schuler 1994)

Schuler conducted another study in 1992 (Schuler 1992) in Bangladesh interviewed 1500 women (1300 married and under age 50 years). Women who participated in 1 of 2 non-governmental programs which provide small business loans for women (the Grameen Bank and the Bangladesh Rural Advancement Committee) were compared with women who were not members but lived in villages served by the programs and with women who were eligible but lived in villages where the loans were not available. It was found that Grameen Bank membership had a significant positive effect on the use of contraceptives and on the rate in which the level of contraceptive use increased. The greater economic independence enjoyed by the Grameen Bank members is a factor in the increased contraceptive usage as is the promotion by the Bank of a small family norm. Empowerment indicators for women in Bangladesh include mobility, economic security, the ability to make purchases, freedom from domination and violence within the family, political and legal awareness, and

Dhaka University Institutional Repository

participation in political activities. Women are able to achieve their fertility goals by participating in programs that decrease their social isolation and their economic dependence on men.

Husband-Wife Communication

Chowdhury (Chowdhury 1994) investigated the impact of husband-wife communication on female contraceptive continuation. In this study 120 non pregnant married women of reproductive age who were selected from three family planning clinics in the Dhaka city area, Bangladesh, were interviewed. 60 of these had been using some form of birth control for at least 6 months. The other 60 women had discontinued use in the last year. Face-to-face interviews during July-October 1991 provided the data. The average age of respondents was 27.7 years, with an average of 3.4 living children and 1.7 sons. 93.4% were Muslim, and the average duration of marriage was 10.6 years. 38.4% women desired more children and 36.0% had a sex preference for future pregnancies. 36.7% of continuers worked outside the home for pay as compared to 18.3% of discontinuers ($p < 0.05$). 96.7% of women among continuers and 88.3% among discontinuers said that their husbands supported their use of contraception. 93.3% of continuers and 98.3% of discontinuers reported that they talked to their husbands about contraception use; and 90.0% and 95.0%, respectively, felt comfortable talking to their husbands about contraception. On a 4-point scale regarding the husband's view on use of a method, however, the mean score for continuers was 1.9 vs. 3.0 for discontinuers ($p < 0.001$), indicating stronger disapproval for discontinuers. Continuers were significantly more likely to avoid getting pregnant in the next 6 months ($p < 0.05$); they considered it important not to get pregnant ($p < 0.001$) and to use contraception ($p < 0.001$), as compared to discontinuers. A significant correlation was found between the variables of contraceptive use and motivation to avoid pregnancy among women who perceived that their husbands were supportive ($p < 0.001$). A logistic regression was performed to determine if the husband's influence was a major predictor of contraceptive continuation. The measure of the husband's influence was highly significant in its relationship to discontinuation. These data suggest that the husband's influence on contraceptive use is of major significance in contraceptive continuation among urban Bangladeshi women. (Chowdhury 1994)

Dhaka University Institutional Repository

In 1993, Riley conducted a study (Riley 1993) among the rural women to examine the determinants of age at marriage in Bangladesh. Determinants considered important were age at menarche, nutritional status, and participation in the informal labor market, vital statistics, and socioeconomic factors. The average age at menarche in Bangladesh is 15.8 years due to poor nutritional status and health. The average age at marriage is young at 17.3 years. Background information is given on cultural and demographic marriage patterns. Data were obtained from the International Center for Diarrheal Disease Research in Matlab on 382 women in 1976 and 1989-90. Socioeconomic variables include religion, education, and household wealth (land, radios, wristwatches, traditional quilt, and kerosene lamp). The results confirm that both social and biological factors determine the timing of marriage in rural Bangladesh. Menarche is an important predictor and does not affect the waiting time to marriage, but does act as a step function. Household wealth was not important in determining marriage age. There is the suggestion that women's income generation may delay age at marriage. When menarche and nutritional status are added to the socioeconomic models, there is not a great reduction in the hazard. Even though increased nutritional status may increase fertility, policy should still promote health gains for females; physical development may be a more important factor in maternal and child outcomes than maternal age.

Decision Making Process

Piet-Pelon et al (Piet-Pelon 1999) in their recent study on men in Bangladesh, India and Pakistan viewed that power or husbands than by wives exercise control in family decision-making more often. While men are granted a traditional right to have the information and expertise as well as financial power to implement their decisions. Unfortunately, men are woefully ignorant on matters of reproductive health and usually do not have knowledge required to protect either themselves or their partners.

In another recent study, Hasan (Hasan 2002) expressed similar views. Females have very little decision making power in the family. They rarely decide on

Dhaka University Institutional Repository

where to go for treatment facilities, where to have the delivery or how many children to have for instance. The family-head i.e. either the husband or father-in-law of the pregnant woman usually makes all the crucial decisions. Even household decisions and decisions regarding children, women have very limited say whether it may be decisions related to their education, health or marriage. Furthermore, women do not have the right to make financial decisions either. It was found that three fourths of the fathers-in-law of the females are still making all the money-related decisions in the household.

2.5 SUMMARY OF LITERATURE REVIEW

The major findings were drawn based on the review of literature:

Educated Women

- Educated women were more likely to use contraception than women who had little or no education.
- Women with the highest levels of education were 3 times more likely to use contraceptives than women who had no education in rural areas.
- Highly educated women in urban areas were 2 times more likely to use modern methods than women with no education.
- Childhood background influenced the education of women in rural areas. It was found that in the rural setting, age and religion had stronger impacts than in urban areas.
- Women whose husbands had secondary and higher levels of education were 1.5 times more likely to use modern methods than women whose husbands lacked education.
- Birth control may be viewed by poor uneducated Muslims as implausible because of the will of God in determining life, death, sustenance, and wealth; only in the belief of "tagdir" or achievement through one's own efforts is contraceptive use accepted. Hindu beliefs are similar, but there is greater acceptance of contraceptives.

Desire for Children

- Desire for no more children was positively and significantly related to use contraceptives;
- More mothers with two sons and one daughter desired no more children compared to mothers with two daughters and one son;
- Those with no children or one child were among the largest percentage desiring an additional child.
- The emphasis on sons serves to reinforce lower economic value of women;
- The desire for additional children was higher among younger cohorts (aged 15-19 compared to 20-24 years)

Religion

- Religion was a positive and significant determinant of contraceptive use in rural and urban areas.
- The Laws of Manu for Hindu Bengali women stipulate that her father protects her in childhood, her husband in youth and adulthood, and her sons in old age.
- Both Hindu and Muslim women face tremendous pressures from family life, religious rituals and practices, politics, and the economy for high fertility.
- Lower failure rates for oral pills, IUDs, and injectables occurred among Hindus compared to Muslims.

FP Workers

- Women who visited a hospital or health center were 2 times more likely to use contraception.
- Significant determinants of failure were quality of worker, age, women's education, and religion.
- Visits of family planning workers had very strong positive influence on the current use of modern contraceptives as compared to traditional methods.

Dhaka University Institutional Repository

Opinion Leaders

- The most frequent sources of influence are the fieldworkers in health and family planning, followed by peer opinion leaders (friends, neighbors, and relatives), and spouse.
- Findings revealed that opinion leaders influencing adoption of health and family planning among landless and marginal farmers belong to the same class.

CBD

- Community based distribution (CBD) approach plays a significant impact on change in behavior and practice of contraceptives toward planning family size in Bangladesh.

Household Amenities

- Women with modern conveniences such as flush toilets were more likely to use contraception regardless of place of residence.
- Women having electricity in their household were almost 2 times more likely to be current users of modern contraceptives compared to women without electricity.
- Grameen Bank members were more likely to use contraceptives than those in comparison villages (59% vs. 43%; $p < .01$).

Husband-Wife Communication

- Women who discussed family planning with their husbands tended to use modern contraceptives more than those who did not.
- Significant correlation was found between the variables of contraceptive use and motivation to avoid pregnancy among women who perceived that their husbands were supportive.

Dhaka University Institutional Repository

Menarche

- Due to nutritional deficiency, majority of the female (80-90%) in Bangladesh had their menarche at the age 13-15. Marriage is settle not by age rather by menarche in rural Bangladesh.

Decision Making Process

- The family-head that is either the husband or father-in-law of the pregnant woman usually makes all the decisions regarding what treatment facilities to take and where to go for treatment during and after pregnancy.
- Even in decisions regarding children, women have very little part in decision making in terms of issues regarding the education and marriage of their children.
- Females don't have equal rights like their husbands to make household decisions or money decisions either. Moreover they do not get to choose the person who carries out the delivery nor the delivery place since mothers-in-law decide on these mostly. Only a few females could make decisions regarding the education of their children.
- They are a powerful force and should be empowered in every way possible so that they become accountable for their own health and welfare.
- Husbands and parents-in-laws should be motivated to give decision-making rights to females regarding their children and their education and marriage issues.

Inferences

According to Kantner (Kantner 1992), despite the inaccuracy that surrounds much demographic data in Bangladesh, it would be unrealistic to conclude that professional opinions concerning demographic levels and trends is a total failure.

It is observed through reviewing various literature that awareness of at least one modern method of family planning is universal. However, awareness of

Dhaka University Institutional Repository

traditional methods of family planning is low. Also there is `a scope for increasing knowledge and practices of several methods such as vasectomy, injectables, condoms and IUD. About one-half-half of eligible couples never practiced contraception, although there has been a steady increase over time. There is not only a wide gap between awareness and use of family planning methods, but also a gap between use (both ever and current) of any method (Khoda 1992).

Prof. Khoda (Khoda 1992) further emphasized that there is a need for more intensive IEC efforts among users of traditional methods.

It is also observed from the literature review that the gap between awareness, attitude and usage of contraceptives varies from area to area. The performance is the lowest in the Sylhet and Chittagong region compared to other regions.

It is evident from reviewing literature that desire for additional children is the most important reason for non-use of family planning. Desire for additional children as a reason for non-use of family planning is lower among couples living in the electrified households and/or localities having electricity than those living in non-electrified households and/or localities in urban and rural areas, declines with education.

In addition to desire for additional children, "son preference" is also very common in Bangladesh. As a result, population is fast growing among all the sociographic segments, covering both rural and urban Bangladesh.

It is evident from reviewing the various literature that though the government and different organizations are continuously working to combat population growth the program cannot reach its desired goal effectively. The review of literature on population control and family planning in the recent past suggest the following considerations regarding the nature of promotional campaign and activities on family planning programs and the requisites for their success:

Dhaka University Institutional Repository

- Thorough research to evaluate the existing promotional campaign;
- Explore the management and other essential issue(s) responsible for the overall lacking.

Therefore, a study is of utmost necessity to improve the existing communication campaign and help developing an appropriate strategy for promotional campaign of family planning for rural Bangladesh and thereby helping to cease further growth of population. Hence, this study would be able to identify the current shortcomings of various relevant programs and it will formulate an appropriate strategy for promotional campaign of family planning in Bangladesh.

Dhaka University Institutional Repository

CHAPTER 3
RESEARCH METHODOLOGY

Dhaka University Institutional Repository

Chapter 3

RESEARCH METHODOLOGY

3.1 METHODOLOGY

Population researchers have developed various methods to evaluate communication campaign and intervention programs. While designing the methodology for this research, those methods were critically studied (stated in the appendix). After reviewing those techniques, the researcher of this study designed the research methodology.

Following steps were followed in conducting this study.

- Literature review: Desk/library research through review of (a) present status of promotional campaign used by different agencies and (b) research findings, based on secondary sources of information.
- Primary Research

3.2 LITERATURE REVIEW THROUGH DESK RESEARCH

At this stage, available formal publications, such as research reports, program plan, media campaign etc. undertaken by various agencies in Bangladesh, were intensively reviewed.

It may be mentioned here that in preparing this proposal, a large number of reports and articles were reviewed. During and after conducting the survey, more number of relevant studies were consulted based on the direction and dimension of the findings as derived from the primary survey. Attempts were also made to search for studies outside Bangladesh through the services of Internet. This reduced costs, which was very essential given the cost limitations.

Findings on the basis of the literature review is highlighted in Chapter 2.

Dhaka University Institutional Repository

3.3 PRIMARY SURVEY

Research Design

The other part of the research methodology besides the literature review, was the primary research survey. This primary research survey comprised of exploring the reach of the following activities –

a) The current GOB family planning related program and
b) The community based intervention programs (i.e. Jiggasha and LIP).

GoB Program

The survey in the GOB program area covered all over Bangladesh and was done within the six administrative divisions (i.e. Dhaka, Chittagong, Sylhet, Rajshahi, Khulna and Barisal divisions). The rural areas of Bangladesh were randomly selected and the study was done with a view to examine the current family planning operations carried out by the government mechanism.

Community-based Intervention Programs

In addition to the survey on GoB program, the two special community based intervention programs, the Jiggasha and LIP programs were included in the primary research survey. These two Jiggasha and LIP programs were reviewed in some randomly selected areas.

This part of the research was carried on the basis of control and experimental design. As a result, Jiggasha was experimented in Bhaluka and controlled in Gaffargaon. Likewise, the LIP program was experimented in Debidar and controlled in Daudkhandi.

Intervention Program	Experimental Area	Control Area
Jiggasha of BCCP	Bhaluka	Gaffargaon
LIP	Debidar	Daudkandi

Dhaka University Institutional Repository

Control and Experimental Design

Key indicators of both the groups were evaluated through common parameters. The control area were one where no intervention by any NGOs or private organizations on health and family planning was occurred as such i.e. no specific program or model is intervened in the specific area. On the other hand, experimental areas receive the program intervention on health and family planning i.e. any or some kind of specific program or model is operated in that specific area; for e.g.: BCCP program area in Bhaluka, LIP- Local Initiative Program in Debidar. It may be mentioned that the Government program covers all the areas. Therefore, the government program is common to both the control and experimental areas.

Experimental Areas

The following two special intervention were considered as "experimental areas"-

- Jiggasha model area under BCCP/Johns Hopkins University, and
- Local Initiative Program (LIP) supported areas

Control Areas

The areas where no Jiggasha or LIP intervention was done were selected in order to make a comparison between the areas where these interventions had been done. Thus, two more areas were selected close to experimental areas and this part of data collection was considered as the "controlled areas".

Posttest-Only Control Group Design

The use of this type of experimentation is called as "Posttest-Only Control Group Design"[27]. This is a true experimental design and there is no baseline (pretest) measurement. Since cases were assigned randomly to the experimental and control group, these groups are assumed to be similar before the program intervention. This design allows measuring the effect of a program intervention on the experimental group by comparing that group with the controlled groups.

The control and experimental design were used to avail all possible answers to the research questions. The objective in selecting this study design is to eliminate "design" errors by maximizing the reliability and validity of the data.

Dhaka University Institutional Repository

Reliability refers to the consistency, stability or dependability of the data. Validity refers to data that are not only reliable but also true and accurate. This study design helped to obtain accurate and meaningful data.

Data Collection Techniques

- Focus Group Discussion
- In-depth interview
- Experts Opinion

With a view to assess the behavioral issues related to the objective of the study, data were collected through using qualitative technique of FGD and in-depth interviews.

Qualitative Analysis through Focus Group Discussion (FGDs)

To gain the insight into attitudes, beliefs, motives, and behaviors of the target population, when applied properly, qualitative techniques are used along with other techniques (in-depth interview, expert opinion etc.) in an interrelated, complementary manner. Qualitative approach provides depth of understanding about respondent responses.

Depth Interview and Quantitotive Probing

A total of 24 FGDs were conducted among males and females, covering all the six divisions. In addition to the FGDs, a sample of 400 samples[28] were drawn for in-depth interview with some quantitative probing.

[27]Fisher AAA et al; *Handbook for Family Planning Operations Research Design*, The Population Council USA 1991

[28] $$n = \frac{p(1-p) \times Z^2}{e^2} \times Deff$$

Where:
n= required sample size
p= estimated value of the parameter; Here the value of p is estimated based on current BDHS study; p=0.5
e=sampling error (degree of accuracy desired, 5%)
z= the standard normal deviate, usually set at 2.0 (1.96) which corresponds to the 95% confidence level
1-p is sometimes considered as q
Deff: Design Effect = 1
Therefore, the estimated sample size is around 400.

Dhaka University Institutional Repository

Test of Hypotheses

With a view to test the hypotheses, a few essential indicators were probed among the respondents during conducting in-depth interview. These responses were analyzed quantitatively. The quantitative approach provides a measurement of respondent responses. It helped to evaluate various emerging behavioral concepts relating to the objective and hypotheses of the study, using statistical tools (such as T-test for Regression Co-efficient).

Pre-final Stage

Based on the findings derived from the FGDs and in-depth interviews, a model was developed. With a view to examine the applicability and feasibility of this 'model', around **60** respondents and experts were interviewed in-depth.

Experts Opinion: Final Stage

As stated earlier, **10** experts were further interviewed in-depth. Their views and suggestions were incorporated in the model-developing and finalization process.

Respondents

The respondents were both males and females. Since family planning is a joint process between husbands and wives, essentially the respondents were married males and females. Discussion between spouses and the process of making decisions that affect the family are important issues in determining the extent of acceptance of use of family planning. According to BDHS[29], in 82% of the couples, both husband and wife approve family planning and had equal influence in the decision to use family planning.

[29] Bangladesh Demographic and Health Survey 1996/97, NIPORT, Mitra and Associates, Macro Int'l Inc.

Dhaka University Institutional Repository

Since family planning is a sensitive issue and husbands and wives (i.e. males and females) both take part in the process, they were considered as the target respondents. According to the 2001 census, there are no such variations in the male-female proportion. Therefore, the number of male and female samples was of equal size. Therefore, the respondents' selection criteria were as follows:

Females: Married women of reproductive age (MWRA): In this study, selected one married female between the ages of 15-49.

Males/Husbands: One married male (essentially husband) whose wife is between the ages of 15-49 was selected and interviewed from each household.

Considering the neutrality of data, no male and female were selected from one household. Only one eligible person was selected randomly and interviewed in each household.

Data Collection Tools

The in-depth questionnaires and FGD checklist for specific target groups were developed in consultation with the Supervisor. Before final printing, the questionnaire was pre-tested among the target respondents.

3.4 DATA COLLECTION PROCESS FOR DEVELOPING THE STRATEGY

A strategy was needed to help promote the campaign for health and family planning issues. In order to develop an appropriate strategy it was imperative that all the data be obtained effectively.

Thus, with a view to develop an appropriate strategy for promotional campaign for family planning, the following six steps or activities were carried out:

Step #	Basic Task	Details
Step # 1	General assessment covering all the six divisions	To assess the current scenario, survey areas were selected in such a way so that each area fell under each regional division within Bangladesh. Thus, in order to cover all parts of the administrative divisions, six areas from six administrative divisions (i.e. Dhaka, Chittagong, Sylhet, Rajshahi, Khulna and Barisal divisions) of rural Bangladesh were randomly chosen.
Step # 2	To conduct survey in the experimental and control areas	The next activity was to conduct a survey in the experimental and control areas. The people of experimental areas received the community-based intervention on health and family planning while in the controlled areas no special intervention had taken place. The survey was conducted in order to find the differences in responses of people in the experimental and control areas. The experimental areas were the two project areas (as stated earlier) and the control areas were matched to these experimental areas. It may be worth mentioning that while interviewing the respondents in-depth, some interesting cases were observed which seems to be very much related to my topics. These cases have given a new direction in developing the communication model. In addition to the FGDs, a sample of 400 samples were drawn for in-depth interview with some quantitative probing. The hypotheses were tested through the quantitative data.
Step # 3	Development of an outline of the proposed model	Based on the findings through steps 1 and 2 (as described above), an outline of a model was developed. The proposed model was needed so

Dhaka University Institutional Repository

	proposed model	as to facilitate certain guidelines by which strategies would be implemented. The promotional campaign for family planning in Bangladesh would revolve around this model. Thus, an outline of the model was developed for these appropriate strategies, which would promote the campaign for overall health and awareness on family planning for the people in Bangladesh, especially the rural population.
Step # 4	The model was pre-tested through qualitative research.	After the completion of a substantial model, the next activity comprised of testing it on target respondents. This testing gauged out the responses of the people and gave a picture of the possible impact that should be expected. This proposed outline of the model was tested through qualitative research using in-depth interviews among the target respondents.
Step # 5	Pre-final Stage	Based on the pre-test findings, the model was further developed. With a view to examine the applicability and feasibility of this 'model', 60 respondents (male and female) were interviewed in-depth.
Step # 6	Experts Opinion: Final Stage	Finalization of the model. The final activity was implemented with the completion of the proposed model. For fine-tuning of the model, about 10 experts on health and family planning issues were interviewed in-depth. Their views and suggestions were incorporated in the model-developing process for the promotional campaign needed for these health and family planning issues.

Therefore, a model for effective communication campaign is developed.

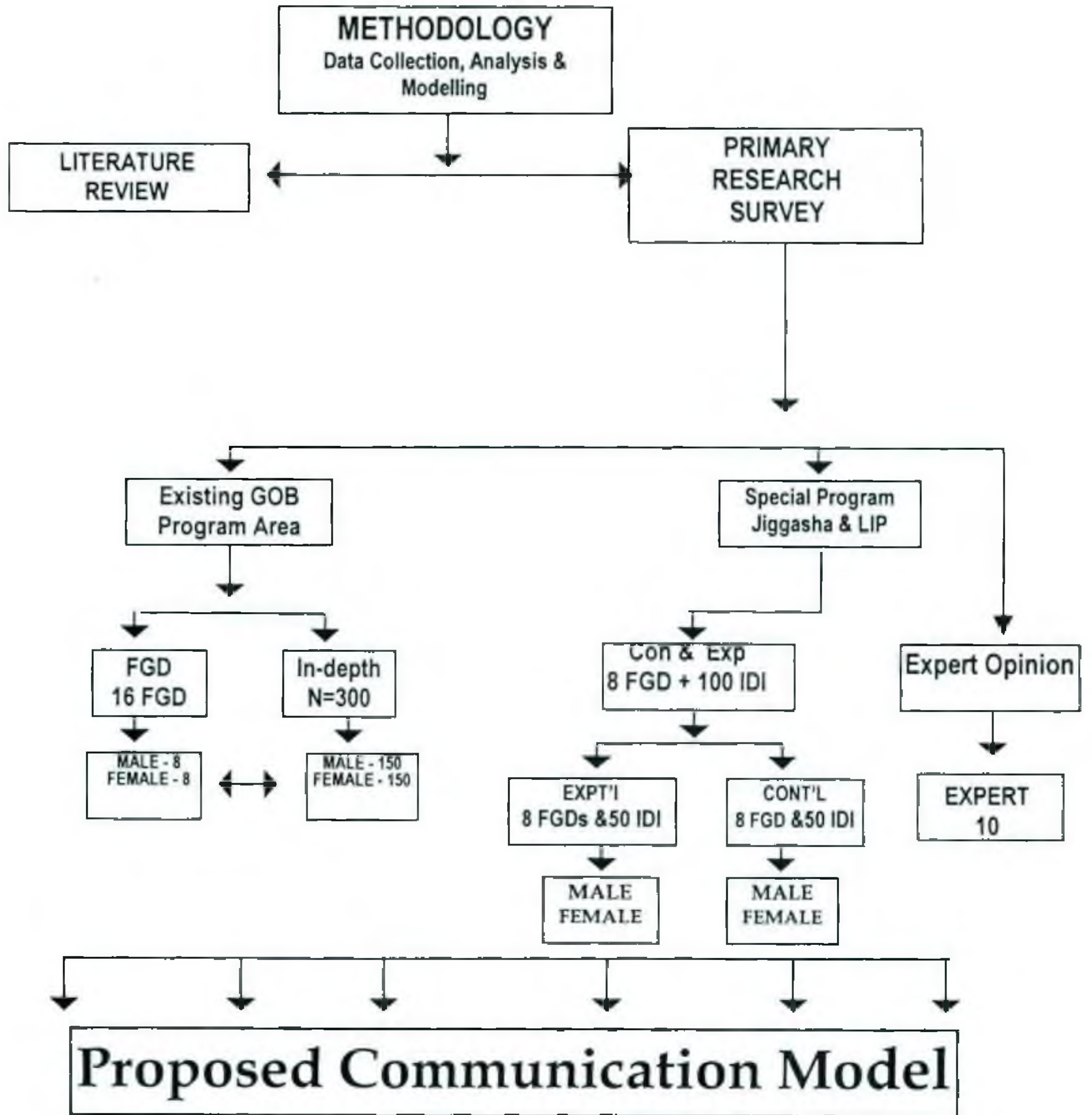
Dhaka University Institutional Repository

3.5 SUMMARY OF SAMPLE DISTRIBUTION USING DIFFERENT TECHNIQUES

Step #	Activities	Study Areas (# & type)	# of FGDs (Male)	# of FGDs (Female)	# of FGDs (Total)
Step # 1	FGDs for General Assessment	6 divisions	8	8	16
Step # 2	FGDs for Experimental (Intervention areas)	4 areas	2	2	4
	FGDs for Control (Non- Intervention Areas)	4 areas	2	2	4
	Sub-total FGD (Steps 1 & 2)	**14**	**12**	**12**	**24**
			# of In-depth (Male)	**# of In-depth (Female)**	**# of In-depth (Total)**
	In-depth Interviews	Control-Exp'tl areas	50	50	100
	In-depth Interviews	For general assessment	150	150	300
Step # 3	Model Development				
Step # 4	In-depth with target respondents	Pretesting of model	10	10	20
Step # 5	In-depth with target respondents (pre-final stage)	Validation of the proposed model	20	20	40
Step # 6	In-depth with the experts (Final output)		5	5	10
	Total In-depth		**235**	**235**	**470**
	Total FGD		**12**	**12**	**24**

(Note: In addition to FGDs and IDIs, there were six case studies.)

Dhaka University Institutional Repository



Note: After developing the model, it was pretested among 60 respondents, both male and female. Further it was discussed 10 experts.

Dhaka University Institutional Repository

CHAPTER 4
QUALITATIVE FINDINGS AND ANALYSIS

Dhaka University Institutional Repository

Chapter 4

QUALITATIVE FINDINGS & ANALYSIS

4.0 CURRENT PRACTICE IN BANGLADESH

This section of the study comprises of the current practice of the people of Bangladesh regarding three crucial issues relating to their family planning practice in general. The findings are based on qualitative research techniques, such as focus group discussions and in-depth interviews.

- Knowledge and practice
- Decision making
- Sources of information

4.1 KNOWLEDGE AND PRACTICE

Respondents were asked questions on family planning related knowledge and practices. The elaboration of the findings are given below:

Views on Population and Family Planning

The respondents were queried upon population and the relation it has with family planning. It was found that the majority of respondents realize the importance of keeping a family small. The females stated that the family members are happy and healthy if the family is kept small, while the males are more conscious about the economic reasons behind maintaining a small family. According to them, maintaining a large family with disproportionate income causes major problems. It is the reason why they live in poverty and have so many problems revolving around it.

Currently the population density is 834[30], people per square KM, which is the highest in the world. Due to over population, the serious effect is fallen on the per capita land availability. At present the per capita land availability is around 0.18 acre. It was found that most of the respondents are aware of the consequence of over population on the economy. Most of them are aware that Bangladesh is a densely populated country and one of the major

[30] Agricultural Statistics, Bangladesh Bureau of Statistics. 2001

Dhaka University Institutional Repository

problems created from over population is inheriting less property. They stated that the process of "land fragmentation" is increasing day by day. It was observed in almost all the groups, especially in the rural areas, that the per capita land availability is decreasing at a faster rate due to the massive growth in population.

Almost all couples want to keep their family small for their own welfare. All of them admitted that population is a very serious issue and results from having large and unplanned families. Most know and acknowledge that having more children creates insufficient basic needs for the children. Hence, all the respondents emphasized on the necessity of using various methods of family planning for population control. Similar views were found among respondents in more or less all other parts of the country.

- A rural female respondent mentions, *"more the number of family members, serious is the crisis. I have seen many families, how ruined due to only large family size. No matter whether rich or poor, if family size is quite large (say 7-12), it is just unmanageable."*

Knowledge and Practice of Contraception

The study revealed that respondents across the study regions are quite aware of family planning as a whole. All the respondents have heard about it and have some level of knowledge regarding aspects of family planning. Moreover, the majority of them practice methods of family planning throughout the country. Apparently, the pill was found to be the most prevalently practiced method among the study respondents.

Matter of Shyness!

Sakhina[1], 26, mother of two child, Mymensingh, stated, I prefer injection since it is safer than the pill. Most importantly, others will not understand why I am taking it. People will think that I am taking it for common disease like fever. You know taking contraception like pill, condom it considered as a matter of shy (i.e. "lajjar bepar"). If I take something for family planning purpose, I'll have to face lot of questions, starting from my mother-in-law to any one.

However another injection user, Shilpi, 24, viewed, No method is free from any side effects, but injection has comparatively less problem to me. And it is convenient, just taking once in three months'.

Dhaka University Institutional Repository

It was found that Shukhi[31] was the most commonly used brand of a type of pill, both in the rural and urban areas. It was unveiled also that the reason the majority of current users prefer use this particular brand is because of its low price and availability all over Bangladesh, especially in the rural areas. Among other brands, the respondents also use Nordette-28, Marvelon and Femicon.

Another method that was mentioned by a high number of the respondents was the 'injection'. This method was equally popular among the ELCOs in the rural and urban areas too. As a whole, it was found that those who were previously pill users have now switched over to injection. Still some of the respondents have complained about side affects of the injection. Only a few of other respondents in the groups felt that the injection was convenient for them.

Female sterilization is also done by a lot of the respondents. This method is the next most used method after the injections. Moreover, it was found that even in the rural areas, it was popular among the age group ranging between 35 to 45. Only a very few respondents in the rural areas mentioned about condoms.

Apparently, it was revealed that a lot of respondents have knowledge about various methods of contraception, but in reality about half of them are still not practicing properly. Among those who practices family planning, a portion have inadequate knowledge on proper use, especially oral pills.

Delaying Pregnancy

When the respondents were asked to mention ways by which pregnancy could be avoided, most of the respondents mentioned about using oral pills, injection, condoms etc. A few respondents also mentioned some traditional methods such as abstinence from sexual activities and withdrawal methods. One or two respondents in each groups stated that they maintain a "safe period" occasionally, that is, refrain from intercourse during certain times during the month and by this, they control childbirth.

[31] Mitra & Associates, NIPORT and Macro International found similar findings in 1999-2000 BDHS.

Dhaka University Institutional Repository

It was also found among a large number of respondents, especially in the rural areas, although they had knowledge on contraception but they do not use it regularly. Major reasons are lack of coordination and communication between the husbands and wives. As a result, wives could not take any proper steps. Sometimes, the husbands do not cooperate in taking decisions. Religious feelings among the Muslims also create barriers to a large extent.

- A female respondent mentioned, *"I do not use any method. I strictly follow natural method. I am a Muslim, I don't like to follow others path. I know what Islam says. way"*.

Source of Contraception

The study asked respondents from where they usually obtain their contraceptives. Most of the males stated that they purchased them from family planning health workers, clinics, maternity hospitals and pharmacies. These pharmacies are often known as a 'medical' pharmacy or dispensaries. The respondents also mentioned that at present, family planning health workers do not come and visit their homes regularly like before and therefore, they need to procure contraceptives from clinics, hospitals, and pharmacies themselves. In the rural areas, the family planning workers are the main source of providing family planning services, especially pills to the people. However, it was found that the respondents are purchasing contraceptives from the nearby local pharmacy. The buying frequency is increasing in pharmacies since family planning health workers do not visit them regularly.

Buying Condom – After the Dusk?

Kashem, 36, a garment supervisor, married and studied up to grade 12, stated, I use condom but I feel embarrassed always. Facing the problem for the last 16 years! I prefer to buy just after the dusk, less number of buyers are there. Before buying Panther, I see whether there is any customer. If none, I rush in the shop and buy a pack of Napa (analgesics), just to camouflage the whole purpose. And then I indicate the retailer to give me two or three packs. He understands and very silently gives me the pack of condoms, wrapped with paper.

Dhaka University Institutional Repository

Most of the rural females collect pills from upazilla health complexes and some times satellite clinics and also from the EPI health workers. According to them, previously health workers visited frequently and it was not at all a problem to receive pills even by staying at home. Now, they cannot get any at a low price and have to buy them from hospitals, or maternity clinics. It was also found in some of the cases, their husbands buy pill from the pharmacies, while they go for weekly "bazaar".

On the other hand, most of the males mentioned that they buy condoms from pharmacies at retail prices. However, it was rarely found that females buy any condoms. A segment of the females stated that they do not go to the hospital or clinic just for buying pills but instead they visit family planning clinics for taking contraceptive injections. Thus, it appears that some females are buying pills only when they go to hospital for taking injections.

- A female respondent stated, *"I have to maintain my body. I learned from "apa" (female field worker). My husband have very little knowledge and interest on using pill or any other contraceptive. Of course, other than condom (it directly effects him!) I can use any method."*

ANC - Knowledge and Practice

When respondents were asked to comment on ANC, it was apparent that the majority of them do not consider antenatal care as very important. Evidently, they are aware of ANC and recognize that women should take proper care of themselves throughout the pregnancy. They stated that ANC is more crucial for respondents who are weak and need to visit doctors and health clinics for regular check-ups.

Another group of respondents stated that they do not go for ANC due to religious bindings, as it is shameful to go to a male doctor. Previously, mothers or grand mothers did not have to go to health centers for treatment but had children naturally. This group of respondents still has reservations about visiting health centers and cannot break free of old customs and traditions.

Dhaka University Institutional Repository

However, in the urban areas, newly weds spontaneously said that they would go for antenatal care when they become pregnant. Those in the group who were already pregnant said that they had visited the local doctor and have been prescribed medicines.

It was found that the husbands do not take their wives for ANC either. This is mostly because they think that pregnancy is something very natural and nothing to worry about.

Traditional Rules that Pregnant Women Should Adhere To

> **Sabuj Chhata Clinic Visit – Why?**
>
> This is my third pregnancy, Lipi, 31, Khulna rural, said. Six month running. I know I should go to Sabuj Chhata clinic for regular check up, but my husband and mother-in-law are not convinced that I should go for regular check ups. They say that pregnancy is a normal phenomenon. If there are any complications, only then I should visit clinic.

It was found through in-depth interview that the pregnant, especially in rural areas, are still kept under the system of age-old myths and beliefs. When the respondents were asked to name some traditional rules that pregnant women are told to adhere to by elders, the majority of them stated that pregnant women should not go out of the house. Both the males and females mentioned this in unison. However, the females mentioned a few more rules that elders tell them to abide by. Some of them are given below:

- Pregnant should not go out of their houses during mid day or just before and after the sunset. According them, genie moves at that time!
- Pregnant women should not cut fish during a lunar eclipse, as that could be harmful for the unborn baby.
- Pregnant women should not visit doctors during delivery, as it is shameful, instead the delivery should be done at home.

Dhaka University Institutional Repository

Pregnancy related Complications - Knowledge and Practice

It was discovered that both males and females know a lot of the common complications. Most of them mentioned loss of appetite and body of pregnant women becomes weak. However, the females mentioned three or four more complications than the males such as oedema, blurred vision, hemorrhage, eclamptia etc.

Although they are aware of the pregnancy related complications, the practice is quite frustrating. There is still a gap exists between the knowledge and practices. Following sub-sections highlights some of their actions related to place of delivery, assistance during delivery etc.

Place of Delivery

It was found from the study that the majority of the respondents, especially females, mentioned that the safest place of having the delivery is at home. However, a lot of them preferred their husband's house the most. Some mentioned that it is best to bring doctors home at the time of delivery whichever house it was.

Although the respondents named upazila health complex, hospitals, maternity clinics or private doctors as good places for having complicated deliveries such as cesarean sections, most of them just stated that their mother's house was the only proper place to have the delivery.

...she is tied with superstition, age-old practice, myths and beliefs ..

Putul, 22, rural, studied upto grade 6 stated,

The mother-in-law is the person who makes the decisions regarding where to have the delivery. Most of the time we are not asked about this matter and elders decide on the place.

In my last case, the delivery was at my home and the elders, such as mother-in-law, my mother and my husband took the decision too. We know that there may be complication and there may be risk at home delivery, but again we have seen mothers die in the hospitals too. And lastly we depend on God.

You know during delivery, a mother is the weakest person in that family, both mentally and physically. She has to depend and rely on others. She could not judge right or wrong. Beside this, she is tied with superstition, age-old practice, myths and beliefs and many more."

Dhaka University Institutional Repository

It was also revealed in the group discussions that none of the respondents or their families had fixed the place of delivery beforehand. Apparently, they just wait until the delivery itself and assess the situation at that time. Thus, if they see that an emergency arises then only they decide to go to the health center for assistance otherwise they remain at home and have the delivery there.

Reasons of Home Delivery

When it was discovered in the study how the majority of respondents still prefer having home deliveries, extra queries were made to decipher why respondents still avoided going to health centers. The foremost reason was due to the bindings and barriers of religion. Moreover, the absence of lady doctors is another reason why patients were not keen to go there.

It was found in the FGDs that majority of the females still "feel" that their homes are quite safer than other service centers.

- *"My last baby was born in the house. My mother was with me. It was just OK!"* (Female respondent)

Another slum respondent said " *I and my husband do not want that some one (male doctor) will touch my body, especially the private part. I am comfortable with the 'dais' (i.e. TBA)*

However, another group of respondents stated that they cannot afford going to hospitals or doctors as they have limited financial means. These groups were ready and wanted to go to doctors but they do not have the money to go to health centers for treatment.

A slum dweller of Dhaka mentioned, " *Nobody takes risk if she or he has money. But what can we do, we have to have the delivery at home?"*

Dangers during Delivery

It was found that the majority of respondents mostly mentioned how excessive bleeding was the common complication at the time of delivery. However, some others mentioned some more complications like that of pregnant women becoming weak, position of the baby becoming wrong and prolonged labor pain before delivery. A few other respondents mentioned that the placenta coming out or a part of the baby coming out early was some more complications. Yet another group of respondents revealed how problems occur when at times part of the placenta remains in the uterus of the women even after the delivery.

Assistance during Delivery

It was found that most of the respondents had their previous delivery performed by untrained traditional birth attendants (dai). Only a very few of them stated that trained nurses had done their delivery. However, in all the cases, mother or mother in laws were present with the dais. Only one in a group actually had their delivery carried out by MBBS female doctors.

Nevertheless, it was found that instead, of doctors, the people who assist women during delivery are the family members such as mother, aunt, elder sister or mother in law or grandmother. A group of respondents, in both urban and rural areas, said that they bring TBAs to their homes at the time of delivery. It was found that the people perceive these TBAs as very skillful people who can deliver babies successfully at home. Others bring nurses, village doctors, mid wives health workers etc.

Post Delivery Complication

The most common type of complication mentioned by respondents after a woman has delivery is loss of too much blood. Some others stated that the mother becomes weak and her health deteriorates, as well after the energy and pain she has to endure during the pregnancy. Others stated that mothers are vulnerable to have bad health always and that children are also malnourished as the mother is weak and prone to diseases.

Dhaka University Institutional Repository

Prevention of Post-Delivery Complications

It was found from the study how the majority of respondents had similar responses regarding how to prevent complications of pregnancy and delivery. The overall comment from respondents revealed that pregnant women should eat lots of good food and take proper care if they are to prevent pregnancy complications.

When respondents were queried upon how to prevent complications after delivery, the majority of responses revolved around the fact that pregnant women should not be allowed to do too much work or lift heavy objects after the delivery. A few others stated that it was crucial for mothers to take the advice of doctors and try to build back their strength. Apparently, most of them realize how the mother is affected all her life if she does not look after herself after pregnancy.

Although a large number of the respondents have fairly good idea about how to prevent post delivery complication, majority of them still either ignore the whole situation or adopt age-old practices of going to "kabiraj" or "hakims".

"During my both the deliveries, I was never sent to a doctor (i.e. MBBS), rather my husband, insisted by my mother in law, brought the "imam" for some "Jhar-fuk". (Farida, 25, Fulpur)

4.2 DECISION MAKING ON FAMILY PLANNING ASPECTS

As a whole, it was revealed in the study that males still make most of the decisions regarding the number of children to have and the type of contraception to use. However, it was found that nowadays more and more couples are making decisions jointly on the number of children to have. Nevertheless, in terms of choosing the type of contraception, males remain pre-dominant in making a choice regarding the family planning method.

Dhaka University Institutional Repository

Women were found to be playing very little roles in taking decisions on the place of having the delivery. It was found that women themselves make decisions only about one in ten cases of the time. However, a few females (two in ten maximum) stated they could make decisions jointly with their husbands while half of them clearly stated that generally their husbands make the decision on day-to-day personal issues like family planning, contraception, delivery etc.

The aspects covered in this section are as follows:

- Type of contraception to use
- Number of children to have
- Females role
- Role of senior family members
- Right age for having first child
- Proper age range of pregnancies
- Age gap between two pregnancies

The findings revealed in the study regarding these are given briefly below.

Decision on Using Type of Contraception

It was apparent that the almost all the respondents have knowledge on family planning and different contraceptive methods. All of them were able to mention some modes of contraception however, after being shown some materials (e.g. pill, condom, injection etc.) their level of response increased even more. Among the females the most mentioned contraception was the pill followed by the injection, sterilization and the condom. A large number of them, however, mentioned about practicing the natural method.

When respondents were queried about the person who makes the decision on family planning methods or contraception, less than half of the females stated that husband and wife decide jointly. However, only a few males confessed during group discussion that they take the decisions and their wives carry them out.

Dhaka University Institutional Repository

It was found in different groups that the role of the females in changing in a positive way. Both husbands and other senior members agree that females have a great role in family planning activities. A large number of women, both in the rural and urban slum areas stated they are the "initiators" in the use of contraceptives. They are more aware and conscious about family planning aspects than the males, and therefore, most of the time they convince (or try to convince) their husbands.

- A female said, *"Initially my husband was not in favor of using any contraceptives. He thought that it has negative side effect. He even said that due to using contraceptive, one might loose his/her 'sexual power'. I could make him understand. I took the decision and my husband approved that. Actually it hardly bothers him. He just wants sex, if it is there he is happy!"*

Interestingly also found that they try to keep the "information" of contraceptive use secret to their mother-in-law or father-in-law. According to them, they (in-laws) may be a barrier or may create unnecessary "issue".

Another female stated *"we (husband and wife) took the decision. No one in my family knows about it. Not even to my mother in law. She may not like it, but I know she will create an "issue" and will make "noise".*

Decision on Number of Children to Have

Respondents were asked which family member makes the decision on the number of children to have. According to the females, it was found that about half of the times both husband and wife jointly decide. In few cases wife decides.
It was also found that in many cases mother in law tries to pressurize to take another issue, especially when there is a "demand" for a son.

Son Preference

" My, mother in law has made my life hell. Since I have two daughters, they just want a son. My husband has soft inclination toward this "demand". I don't want any more children. But I don't know how long I can stand against it.

It was also found that some still says,

"Other than Allah no one can take the decision". This group of respondents are apparently too religious since they think that they have no say in the number of children to have since it is willed and controlled by only Allah."

Dhaka University Institutional Repository

Role of Senior Family Members

Majority of the people of Bangladesh have always depended on their senior family members to make decisions and advise them on aspects, even in family rearing aspects. Therefore, the mother in laws of young females used to take advantage of this power. Previously, the mother in laws used to discourage their children from practicing family planning but today situation is gradually changing. A few of them started realizing the consequences of too many children.

Thus, the attitude and behavior of the senior members in the family like mother in laws, elder sister-in-laws '*bhavi*', grand mothers/fathers etc. is in the process of change. It was found that the role and importance of dominating mother in laws seems to have partly diminished over the decision on practicing family planning especially in the urban areas. Nevertheless, some women still feel pressurized to give birth to a baby and produce an heir of the family.

- A female mentioned in distress, '*My mother-in-law wants a grand child because I am the eldest daughter-in-law of the family.*

Right Age for Having First Child: Awareness and Practice

On the context of the proper age, a girl should be when she has the first child, the respondents were asked to comment on their views on this issue. Both females and males had similar views and stated that a girl should be no less than 20 when she has the first child. Others stated that 22 to 24 was the right age range to bear the first child.

The reasons behind these ages were several. Some of them stated that girls should complete their education first before marriage and children. Others stated that girls need time to grow up first while some stated that 20 years is appropriate, not before that.

The respondents were asked as a whole, what was the duration of years between which women could have children. Both females and males mentioned collectively that 20 to 40 were the appropriate age range.

Dhaka University Institutional Repository

However, among these the prime years would be when a woman is between 25 to 35 years. This was mentioned by most of the respondents.

Ironically the practice was quite reverse to their views and knowledge. Although majority of them stated the "ideal answer" but when asked what would happen if they have to take decision about their daughter or sisters. A large number of them stated that –

"It may be even earlier to our statement. The reason is, it is quite tough to get a good bridegroom. So if we get some one who is financially solvent we will compromise with the age. Moreover, the society is not safe, mastans (gang leader) are there, and it is increasing. Gang rape is increasing, so if I get some one suitable, I'll not wait".

All the males and females implied that a women would face health problems of different types if she became pregnant outside this age. Some of them mentioned that she might either die at delivery or face life long health problems. Apart from these problems, a few others stated that health of the babies deteriorate as mothers become weak and cannot look after their children properly either.

Age Gap between Two Pregnancies

The adults were also asked to state their views on the number of year's gap that should be kept between two births. They declared that five, was the appropriate gap that should be kept. The majority of respondents were in agreement regarding the number of year's gap that should be kept between two births. Others stated that 3 to 5 year spacing should be kept.

4.3 SOURCES OF INFORMATION

There is evidence of remarkable change in the scenario in relation to the awareness of family planning compared to the prevalent scenario over the last decade. The level of awareness has increased largely and almost all the people have heard about family planning at one time or another. Most respondents said that they have known about family planning from listening

Dhaka University Institutional Repository

to the radio, watching television and so many other sources. Among them some mentioned how they heard about it from family planning worker or health workers and doctors as well. Some of the literate respondents mentioned the magazine and newspaper as the sources of their knowledge and information gathering on family planning.

The comments of some respondents in relation to this are:

- *Nowadays everyone knows about family planning, even before marriage, as the radio and TV are always broadcasting it on the air in both mediums.*

It was found that the radio was the most common source of information in both urban and rural areas. Others stated that the neighbors, local pharmacy, doctors are also viewed as important sources of information about family planning and health issues.

Among the newly weds, both in the rural and urban areas, it was found that TV and radio were important sources of information for family planning. Neighbor, relatives and mother were the second important source of information. Although the female respondents had access to information in the rural areas, they did not listen to radio or watch TV a lot, like their male counterparts due to religious bias or excessive work in household. This was reflected in the rural group of 35-45. However, in the urban areas the female respondents of all groups said, TV was the most important source of information.

A female respondent stated, "*Sitting together we listen to radio and watch TV'. These days everybody is very conscious about family planning*".

It was found that the doctors and health workers are usually the major role players in terms of suggests couples to use different family planning methods.

When respondents were asked to comment on the sources of information that was available to them, large number of them mentioned television and radio. They stated that these two mediums were the two best and most common sources of information for people in rural and urban areas.

Dhaka University Institutional Repository

Moreover, they mentioned that TV was the main source for the urban respondents, while the radio was more common for respondents in rural areas.

The other modes of information mentioned by respondents was discussion sessions and inter personal communication among general people. Some of these respondents mentioned that discussion would be the best among the rural people as they would be able to understand better as well as be motivated more on a one on one basis.

Dhaka University Institutional Repository

CHAPTER 5
FINDINGS ON SPECIAL INTERVENTION PROGRAMS

Dhaka University Institutional Repository

Chapter 5

FINDINGS ON SPECIAL COMMUNITY BASED INTERVENTION PROGRAMS

5.0 BACKGROUND

The overall reproductive and general health of the people of Bangladesh is very poor. The majority of people live under the poverty line and those who cannot afford food, do not eat healthily and do not have access to proper health care. Consequently, they are malnourished and new mothers produce even weaker and undernourished children. Moreover, problems are being magnified due to insignificant knowledge on family planning and safe motherhood. In the event, young mothers frequently die and the rate of maternal mortality is very high as compared to other developing countries of the world.

To combat these problems and bridge the gap between people who are deprived of proper reproductive health, the Government of Bangladesh and different NGOs are working simultaneously to bring changes for the betterment of the people. Different community based interventions were thus launched to spread awareness and change the behavior of the people. Such two prominent community based interventions are the Local Initiative Program - LIP and Jiggasha approach. Jiggasha was developed by Bangladesh Center for Communication Programs/Johns Hopkins University (BCCP/JHU).

5.1 PURPOSE OF SELECTING INTERVENTION PROGRAM

These two community based intervention projects develop a package of practical and effective rural communication with a view to strengthen and extend the MOHFW's service delivery system at the Upazila level.

As already stated in Chapter 3 that the performance of these two projects would be considered as experimental which would be compared with non-project intervention performance i.e. control.

Dhaka University Institutional Repository

The objective was to find out the difference between the experiment and control part of both Jiggasha and LIP projects that were intervened in different places. Here, the similarities and differences in the two modes of awareness building were looked at and a comparison was drawn between the two. Below the break-up of the two experiment and control modules that had been intervened in some of the rural regions within Bangladesh.

The two different interventions of BCCP and LIP are looked at individually below:

BCCP[32] in Brief

The BCCP is a collaborative effort with the Johns Hopkins University, USA that was designed to develop, test, and adopt a variety of rural communication interventions.

BCCP was developed based on the following considerations:

- That there existed a gap between the almost universal awareness about family planning in Bangladesh and the existing CPR;
- That communication activities implemented during earlier plan periods, although they enhanced the knowledge level of the people, could not accelerate the CPR to a desired level

BCCP has the experience of developing, implementing and monitoring local level campaigns for Urban Family Health Partnership (UFHP), Rural Service Delivery Partnership (RSDP) of National Integrated Population and Health Program (NIPHP).

BCCP developed the Green Umbrella logo, was launched and promoted to symbolize the national integrated health and family planning services throughout the country. Today this logo is one of the most familiar in the country.

[32] BCCP Report

Dhaka University Institutional Repository

Recently, the NIPHP program has begun providing health services under a new symbol/ brand, known as the 'Smiling Sun'. In light of this, Bangladesh Center for Communication Programs (BCCP) has been assigned to develop and implement a campaign to familiarize and establish the brand so as to make the people aware of it. At present, the campaign has been implemented at three levels; national, community and local levels. The campaign program includes spreading messages through television drama, television spots, radio spots, posters, billboards and press ads in daily newspapers.

Activities/Programs Conducted

On September 23, 1990, JHU launched the Jiggasha communication program in Trishal and started its activities of IEC interventions.

Jiggasha

The Jiggasha approach enables field workers to reach up to a dozen people at a time in groups. In Bangla *Jiggasha* means, "to inquire."[33] Jiggasha is a social network approach to community mobilization and sustainability. The local volunteers supported this and GOB workers conducted the programs holding group meetings and discussions with people at different locations. This approach used existing communication networks in the community to help promote healthy reproductive and family planning practices among the people. This Jiggasha approach is intervened through the deployment of link persons who contact people who sit down with a group of people and spread the messages of the program. They in turn choose the second links that are usually the most informed member of the group. Thus, a snowball affect is achieved with one link reaching another to ensure that many people are reached one after another through the contact with different link persons.

It is an innovative approach, which uses a social network approach to community mobilization and sustainability applied to Family Planning and MCH programs. It has been working to reach the people of rural areas in the

[33] Piotrow, PT. Et al, Health Communication, Lessons from Family Planning and Reproductive Health, Johns Hopkins University USA 1997

Dhaka University Institutional Repository

knowledge of family planning and contraception and to spread the usage of these contraceptives among the people. The Bangladesh Family Planning programs' success in creating and meeting demands for contraceptive use under conditions of pervasive poverty and under development created new challenges. In Bangladesh the Jiggasha community meetings are reinforced by Enter-Educate audio-apes, portable flip charts, and regular national radio broadcasts. Everywhere, posters and client materials help providers to explain what family planning means and how to use specific methods.

Local Initiatives Program (LIP)[34]

The Local Initiatives Program (LIP) helps communities take charge of their own health and family planning programs by training family planning staff and local leaders at the village level to manage the program themselves. LIP activities play a key role in furthering the goal of the Government of Bangladesh in providing high quality, locally managed family planning services.

The Local Initiative Program (LIP) helps communities take charge of their own health and family planning programs by training family planning staff and local leaders at the village level to manage the programs themselves. LIP activities play a key role in furthering the goal of the Government of Bangladesh in providing high quality, locally managed family planning services.

The LIP evolved from an USAID-sponsored project in the early 1980's that sent family planning officers from the sub-district level on study tours to Indonesia to observe the exemplary, locally run family planning program there. Subsequently, an in-country Management Training Program (MTP), using successful Bangladesh programs as prototypes, replaced the Indonesian study tours.

[34] Local Level Initiatives Bangladesh brochure; MOHFW, A project of Management Science for Health (MSH)

Dhaka University Institutional Repository

This program was first begun in Indonesia in 1987 as observation study tours. In 1988, it added action-planning module to study tours for planning and implementing family planning activities. Management Training Program (MTP) was started in Bangladesh in 1990. In 1993, it replaces Indonesia study tours with Bangladesh Management training program (MTP). Successful LIP upazilas in Bangladesh become the new models for LIP participants. In July 1994, LIP was operating in 84 upazilas (sub-district), reaching an estimated 1.75 million eligible couples. By December 1996, LIP covered 107 upazilas, reaching an estimated 3.3 million eligible couples. Contraceptive use levels in LIP areas average 60 percent, compared to a national average of 38 percent modern methods.

The LIP has been successful in several important areas. It attracts high-level support from the Ministry of Health and Family Welfare and increases community participation in the family planning program. It improves collaboration between government administrators, family planning program staff, and locally elected leaders. It provides management training to help professional staff and local leaders define roles and responsibilities, develop work plans, use monitoring and supervisory tools, identify and solve problems, and use local resources, Finally, LIP increases the sense of community ownership and accountability for program performance by training the communities to manage program finances. The results are dramatic, showing an increase in contraceptive prevalence rates of 15 to 20 percentage points within six to nine months of initiating LIP activities. LIP provides continuous technical assistance to the upazila teams with the help of its 15 professional staff.

LIP is involved in some of these activities:

- Started action-planning module to study tours for planning and implementing family planning activities.
- Began management-training program for the upazila managers and stakeholders in Bangladesh.

Dhaka University Institutional Repository

- The successful LIP upazilas in Bangladesh become the new models for LIP participants.
- It attracts high-level support from the ministry of health and family welfare and increases community participation in the family planning program.
- It improves collaboration between government administrators and other key community personnel.
- It provides management training to help professionals identify and solve problems with local resources.

Aim of Jiggasha and LIP

The overall aim of LIP and Jiggasha is to support and strengthen the efforts of the Government of Bangladesh in providing high quality, sustainable family planning and maternal as well as child health services at local levels. The service delivery is based on local government officials, community leaders, service providers and other citizens who can participate and contribute in one way or another. In other words, the people at grass root levels are reached through these key participants of the different regional areas.

5.2 FINDINGS OF INTERVENTION AREAS

The study depicts the level of awareness of the people of targeted areas in terms of family planning, safe motherhood and how their attitudes on the issue relate to their life practices. In other words, the comparison study will show how the two programs have been able to impact the people. Therefore, it will bring forth the underlying changes in attitude and find out if the people have actually started to adapt to those changes after the interventions.

The two projects in question are, Jiggasha and LIP.

JIGGASHA:

- Experimental area: Bhaluka
- Control area: Gaffargaon

Dhaka University Institutional Repository

LIP:

- Experimental area: Debidar
- Control area: Daudkhandi.

Findings

The study revolved around the following criteria:

- Awareness and use of contraception
- Type of contraception used
- Who/what was responsible for spreading news on family planning
- Problems of using contraception
- Gap between two children
- Place of treatment during pregnancy-medical services
- Problems during delivery
- Satisfaction with the treatment
- Media preference
- Decision making
    - Decision making on contraceptive use
    - Who is called to help during delivery
    - Delivery place of previous child
    - The right age of taking first child

Elaboration of these are mentioned briefly below:

Till the present day different programs have been intervened to inform and educate people. Two such well-focused programs are Jiggasha and LIP. A study was conducted to find out the impact of these programs. The findings based on qualitative research conducted in those programs are presented below.

Awareness and Use of Contraception

All the respondents were asked on whether they knew about contraception and family planning. The majority of the respondents stated that they practice family planning and it was found from the study that almost all the

respondents mentioned that they used contraceptives, especially the female respondents. All of them are aware of the impact of using contraception to keep a family small even in controlled areas where there was no intervention.

A male respondent of Bhaluka (Jiggasha) stated, "*My wife takes the pill regularly but at first she was not used to it as she used to vomit before. There are some persons who trained by Jiggasha helps us a lot and tries to answer all the queries and solves the problems*".

Beauty[35], 23, a respondent of the same village, stated that "*now I know what to take (as contraceptive). If needed I'll motivate my husband too. Because, without contraception, my family will be ruined. There would be huge children, who will take care?*"

On the other hand, a female (age 27) respondent of Gaffargaon viewed that she doesn't take any measures; her husband doesn't like to use any method.

Type of Contraception Used

The majority of the female respondents of all the areas stated how they take pills to combat pregnancies. Along with this, the other types of contraceptives used most frequently by respondents are injection, ligation, Norplant, etc. However, it was found that some male respondents of Debidar (LIP experimental) seemed somewhat convinced that it is the women's problem and so it is her job to think about what to use.

It was obvious that most do not practice family planning themselves and do not even encourage their wives openly. According to them their wives could handle the problem so they do not worry about this matter much. Overall, the response of respondents was better in the experimental areas such as Bhaluka and Debidar than Gaffargaon and Daudkhandi.

- A male respondent stated, " *I do not use anything and my wife does what she needs to do, I do not ask her as she handles it all.*" Bhaluka (Jiggasha)
- Another male respondent stated, "*I do not use contraception myself, it is my personal business but my wife uses it instead.*" Daudkhandi (Control)

---

[35] Names used in this thesis are not real; the author gives all.

Dhaka University Institutional Repository

Who/What Was Responsible for Spreading Information on Family Planning

It was discovered in the FGDs how the respondents of both projects have had significant exposure to the messages of family planning. However, there is slightly better response rate in Bhaluka and Debidar observed than the areas where there was no intervention such as Gaffargaon and Daudkhandi. The LIP volunteers and Link person of Jiggasha act as a source of information and guide in solving various health and family planning issues. However, majority of respondents also have heard about the need and importance of family planning from the TV, radio and also from the female field worker who make visits to their homes. The females appreciated the efforts of the field workers the most, as they receive a lot of advice from them.

They were all familiar with the aspect of using family planning methods to keep from having too many children and they have access to all the mediums especially that of radio. Posters/leaflets/fliers were also mentioned a lot.

A female respondent stated, " *We were able to get information on family planning from the women who come to our homes from time to time and give advice. Moreover, we hear about it on the radio and TV as well. I know one apa (volunteer), who informs me about many health and family planning issues. Whenever I face any problem, I go to her.* " Debidar (LIP)

Similarly in Bhaluka, another female respondent stated, " *FWVs, FWPs, field workers, doctors etc. all notified us about the need for family planning.*" (Jiggasha)

A male respondent stated, " *I got to know all this from the local bazaar and school.*" Bhaluka (Jiggasha)

Problems of Using Contraception

Most respondents from the female category said that they had noticed some health problems after using contraceptives. Those who take pills mentioned side effects of these such as weakness and dizziness while those that have had an operation and used injections, complained about irregular and

Dhaka University Institutional Repository

decrease in the menstruation flow. A male respondent stated that he took his wife to the doctors whenever she faced problems with side effects of the pill.

A female respondent stated, " *I had taken the injection but I faced some problems so I have started the pill now. Female field worker ("apa") has suggested me to switch to injection.*" Bhaluka (Jiggasha)

On the other hand, a female respondent of Gafargaon stated, " *I experienced dizziness, weakness and at times gas forms inside as well.*" (Control). However, a male respondent of the same area stated, " *If our wives do face health problems from time to time, then we take them to the doctor.* "

Gap Between Two Children

The majority of respondents of both the groups stated that 2 to 3 years (maximum 5 years) should be kept between two children. They were all unanimously decided upon this and they were able to understand that frequent pregnancies are not good for the mother or the baby. One female mentioned how the mother will be able to raise the children more comfortably if the gap between children is at least 5 years.

A female respondent stated, " *The gap between two children needs to be 5 years as then this will bring relief for the mothers because they can raise children in a bit of comfort.*" Bhaluka (Jiggasha)

Quite similar to Bhaluka, a female respondent of Gafargaon stated, " *The gap between two children should be at least 2 to 3 years.*"

A male respondent stated, " *Women should take another child after at least 2 to 3 years gap*." Debidar (LIP)

Place of Treatment during Pregnancy-Medical Services

When the respondents were asked where they went for treatment, they mentioned the doctors and FWVs. The respondents in the experimental areas, both at Bhaluka and Debidar, mentioned about the "link person" and "volunteers".

Dhaka University Institutional Repository

The male respondents all stated that the women go to the local health centers and hospital from where they usually get treatment on delivery and pregnancy problems. It was found that the males and females had consistent statements in regard to this and they know where to go for complications and medicines.

A female respondent stated, " *I go to the FWC center for treatment and for anything else I need.*" Bhaluka (Jiggasha)

Another female stated, "*We can get medicines and regular check ups for pregnancy related issues in the hospital near us. Our LIP Apa (volunteer) always gives advice on check ups and other complications.*" Debidar (LIP)

A male respondent stated, " *The doctors in the health centers usually help us with any treatment.*" Bhaluka (Jiggasha)

A male respondent stated, " *The women can usually go to health centers and hospitals for treatment.*" Daudkandi

Problems during Delivery

From the comments of the majority of respondents of both the groups, it is obvious that they all recognize the many symptoms of delivery complications. The females mentioned all the different types of problems stating the major complications such as excessive bleeding, retained placenta, babies limb coming out awkwardly, eclamptia and also the possibility of the mother dying. The majority of males were also able to identify some of these major and most occurring problems.

A female respondent stated, "*There are many problems of delivery especially excessive bleeding, retained placenta, babies limb coming out awkwardly, eclamptia and the mother may even die.*" Bhaluka (Jiggasha)

A male respondent stated, "*Problem could be that the baby is not born on time and we might have to rush to the hospital in the end.*" Daudkhandi

Dhaka University Institutional Repository

A female respondent stated, " The mother and her baby may die if the limb of the baby comes out first." *Gafargaon*

A male respondent cited, " *Eclamptia and tetanus also might happen when the delivery is in progress. If we visit the health centers frequently, the chances of being any casualty is minimum*" Bhaluka (Jiggasha)

Satisfaction with the Treatment

The respondents in Debidar, it seems are satisfied with the treatment they get from the local upazila health complex hospital. It is obvious that the staff there is very helpful. The males as well as the females mentioned how they are satisfied since they have a good hospital to go to and they can get treatment there.

The majority of respondents are somewhat satisfied in other areas but want treatment facilities at home. They are reluctant to go to the hospital apparently. As a whole, both the males and females are more or less satisfied with the treatment they are getting at present.

A female respondent stated, "*The 'apa' i.e. sister of local hospital is very helpful and she gives us advice whenever we want it.*" Debidar (LIP)

A male respondent stated, " *We are of course satisfied with the treatment we get from the hospital.*" Daudkhandi

A female respondent stated, " *There should be more ways to follow family planning so that we can keep our family small.*" Bhaluka (Jiggasha))

A male respondent stated, "*We would have been satisfied if we could get treatment at home since it is not possible to go to the hospital all the time.*" *Gafargaon*

Dhaka University Institutional Repository

Decision Making Related Issues

Decision Making on Contraceptive Use

The majority of respondents stated that both husband and wife make decisions together after discussion. However, this response was not always evident since some of the males stated that the women should decide more thus indirectly implying the decision of contraceptive use as the sole problem of the women more than the men should.

However, two of the female respondents of Debidar have stated here, that the mother or women should be the one to make the decision on what method to use and decide to take a baby when she feels convenient to do so. It was found that the female respondents of Bhaluka (Jiggasha) were more confident in taking decision on using contraceptives, as compared to other areas. According to them, the link person of Jiggasha were very helpful in explaining the pros and cons of using contraceptives.

- *"Usually I and my husband take the decision on using the method of contraceptive. I know all about these from the "apa" and I am confident now. I also give advice to my neighbors." (Female of Bhaluka, Jiggasha)*

- Another female respondent stated, "*It is the decision of the women since it is her personal right to choose what contraceptive method she wants to take.*" Bhaluka (Jiggasha)

- A female respondent mentioned, "*The mother takes the decision on when to take children.*" Daudkandi

- A female respondent stated, "*If the husband does not take the decision then who will?*" Gafargaon

- Another female respondent stated, "*Sometimes the women takes the decision while at other times the husband may want to take it but it should be the choice of them both.*" Debidar (LIP)

Dhaka University Institutional Repository

The Right Age of Taking First Child

When the respondents were asked about the right age of having children, they had more or less the same responses. They all stated that the females should not be too young neither too old as that will have adverse affects and make the delivery very hazardous. The majority of them chose 20 to 25 as being the right age range.

According to the majority of them, the age to have the first-born is when the mother is from 20 to 25. The respondents stated how the mother and child would face problems all their lives if the mother is too young and above 35 when she has her baby. All of them understood that if the age is not right then the risks will be high at the time of delivery and the children will be malnourished.

Although majority of them preferred 20-25 as right age, but in reality all of them had there first age at below 20. A few had at age 15 even. According to them, the mothers had a little say in talking vital decision. Interestingly, a mother of Bhaluka stated that now she stands boldly for other females who are under pressure to take first child at below 18. She said –

- *"If one takes a baby before 20, then both the mother and child could die. There are many girls who are pressurized by their in-laws to take first child before 18, even at 15. I stand for those pity girls and try to convince both the in-laws and husbands. It works."* Bhaluka (Jiggasha)

- A male respondent stated, *"The right age of taking the first child should be between 20 to 30, if the women is less than 22 then the baby will be weak."* Debidar (LIP)

- Yet another female mentioned, *"The pregnancy becomes risky for both the mother and baby if the mother is more then 35."* Gaffargaon

- Another male respondent mentioned, *"The mother will suffer from anemia if she is too young to carry a child."* Bhaluka (Jiggasha)

Dhaka University Institutional Repository

Delivery Place of Previous Child

It is apparent that the majority of respondents have had their delivery at home and they only go to the hospital if they hove no other option at the time of an emergency. One female respondent stated that she was forced to go to the hospital for her delivery as she had a hard pregnancy and was facing health problems even before that.

- A female respondent stated, *"I had my delivery at home since the hospital is near we have access to doctors all the time."* Bhaluka (Jiggasha)
- Another female respondent mentioned, *"I was very sick so I had to go to the hospital for the delivery."* Daudkhandi
- Another female respondent mentioned, *"I was well and had a normal pregnancy so I knew I would not need to go to the hospital for the delivery."* Gaffargaon
- A female respondent stated, *"I had the delivery at home since I did not have any problems during the pregnancy itself."* Bhaluka (Jiggasha)

Who Is Called To Help during Delivery

In the case of who to call for helping at the time of delivery, the respondents mentioned that the local hospital doctors and also TBAs (traditional birth attendants) are called home to help at the time of delivery. It was evident that they have ample doctors and Dhatris at the hospital but as a whole, the respondents prefer to call neighbors and TBAs at the time of delivery. Most of the time they call midwives, take the assistance of the village women also, and do not call doctors from the hospital if they can get neighboring experienced midwives instead.

- A female respondent stated, *"The women usually decide to call a midwife but the in-laws make the ultimate decision and call the right person when the time arrives."* Bhaluka (Jiggasha)
- A male respondent mentioned, *"There are 'dai' midwives who help during pregnancies. They are not trained but can handle deliveries. If they can not do the delivery then they will tell us to go to the hospital instead."* Gaffargaon

Media Preference

Among the males and females of all the regions, it was apparent that the TV is the favorite as the majority of them mentioned it the most. It seems that they like watching films and can learn and understand from those better than the radio.

Those who responded stated how they could only hear from the radio and that was not enough for them to learn. Both the males and females like the dramas the most and they stated how they could understand the messages from them better. The radio was the second highest mentioned while posters and the respondents mentioned fliers.

One female respondent cited, "*When the messages are shown for us via dramas on the TV, then we can understand better as we can see and hear everything.*" Bhaluka (Jiggasha)

A male respondent stated, " *I like the TV since I can see everything and so I am able to understand properly what they want to say.*" Gaffargaon

A male respondent stated, "*We like the TV better than the radio as we can see and understand from the live face to face pictures. So that if we do not understand the words we can realize from the picture instead.*" Gaffargaon.

5.3 BRIEF SUMMATION OF FINDINGS

Although the respondents were found to be responsive in all sites, overall, the response was better in the experimented areas such as Bhaluka and Debidar than the controlled areas such as Gaffargaon and Daudkhandl. Likewise, in terms of Jiggasha and LIP, it was apparent that the areas where Jiggasha was intervened, the response was slightly better there than the LIP intervened areas.

Most male and female respondents could answer queries on aspects such as family planning and different contraception methods but the majority of males were not too aware of the complications of pregnancy and delivery.

All the male and female respondents in all the FGDs conducted were found to know about family planning and are aware of the implications of keeping a small family.

The response on awareness of family planning and contraceptive methods was found to be more in the areas where Jiggasha was intervened, that is, Bhaluka. The awareness is more in Bhaluka than in Gaffargaon where respondents are much more conscious about family planning and pregnancy related issues. This is expected since there was no Jiggasha intervention in Gaffargaon.

As a whole, the females are more involved with family planning and practiced contraception more vigilantly than the males. This was apparent in both the experimented and controlled areas.

The respondents get family planning information from TV, radio and field-working women who make visits to their homes.

It was found that most of the respondents understand that if the age of the mother is not right then the mother and child will face high risks at the time of delivery and the children may be malnourished in some cases too. Most of the respondents in the experimented areas such as Bhaluka and Debidar could respond like this. However, it may be mentioned that there was somewhat less response in the controlled areas such as Gaffargaon and Daudkhandi.

Overall the majority of respondents in all the areas both with and without intervention stated that the first child should be born when the mother is from 20 to 25 years old.

The majority of respondents of both Jiggasha and LIP intervened areas stated that 2 to 3 should be kept between two children so that the health of mother and children are sound.

400478

ঢাকা
বিশ্ববিদ্যালয়
গ্রন্থাগার

Dhaka University Institutional Repository

It was found that the males and females have similar responses concerning visiting health care centers and where to go for treatment during pregnancies and at the time of delivery so as to avoid complications. Likewise, in this aspect also, the response from respondents was better in the areas where Jiggasha and LIP interventions had taken place.

Most of the time the respondents call midwives when the time of delivery comes and prefer to have the delivery at home. However, they call doctors from the hospital and make trips there only at the time of emergencies. Otherwise, very few go to doctors in health centers or hospitals.

The majority of respondents were somewhat satisfied but want treatment facilities at home as most are reluctant to go to the hospitals. However, as a whole, both the males and females are more or less satisfied with the treatment they are getting at present.

It was found that the respondents like watching pictures and image on TV the most as compared to radio and other mediums. Nevertheless, they have access to the radio the most.

5.4 CONCLUSION

This study attempted at making a comparison between the two different types of programs, namely LIP and Jiggasha. The area where the Jiggasha program was intervened was rewarded with somewhat better response than the area where LIP was intervened. Furthermore, the people of the experimental areas (Bhaluka and Debidar) also responded more than the people of controlled areas such as Gaffargaon and Daudkhandi.

These interventions have been working to alleviate the shortcomings of Bangladesh in the context of family planning and reproductive health. As a whole, the study revealed how these two interventions were able to bring slight changes in knowledge but the level of practice among the people has not increased very much to that extent.

Dhaka University Institutional Repository

As a whole, the people of the areas where Jiggasha was intervened were somewhat more aware since their response was slightly higher and more informative. Apparently, lots of people were able to recognize the need for family planning and are aware of the consequences of having a large family where the children and mother are all malnourished. Moreover, the females of this area seemed to be more concerned in terms of family planning and contraceptive use than males who took a back seat. The females were more conversant of the health risks of pregnancy and delivery related aspects as well. However, the general practices regarding health care of the people were not found to be up to the mark as they were not proactive enough in terms of looking after their health as a whole.

It can be concluded from the study that these programs have been successful to a certain extent to spread knowledge and create awareness on these issues and identify the problems as well as causes of reproductive health and maternal mortality. Although people have been able to identify some of the common problems relating to health in general, they are not adequately prepared to eventually curb them. So future interventions should work at not only increasing knowledge on these aspects but also mobilizing people to change the present behavior and practices. However, between the two programs conducted so far, the Jiggasha program was apparently, slightly more effective than the LIP program. It was found that the link person under Jiggasha program more participatory in motivating the couples toward practicing family planning as compared to LIP intervention. It was observed that the close inter personal contact of the Jiggasha linked persons perhaps accelerated the program faster among the couples. The linked person could satisfy all the confusions and doubts instantly that helped them toward minimizing any gap between knowledge and practice, changing attitude toward positive intention and thereby changing behavior.

Dhaka University Institutional Repository

CHAPTER 6

DISCUSSIONS ON FINDINGS & TEST OF HYPOTHESES

Dhaka University Institutional Repository

Chapter 6

DISCUSSIONS ON FINDINGS & TEST OF HYPOTHESES

6.0 DISCUSSIONS ON FINDINGS

Following section discusses on findings, both qualitative and quantitative, and test of hypotheses. Qualitative discussion covers focus group discussions (FGDs), in-depth interviews and case studies. On the other hand quantitative analysis covers face-to-face interviews.

Cases: It may be worth mentioning that while I was interviewing the respondents in-depth, I got some interesting cases, which seems to me very much related to my topics. These cases have given me a new direction in developing the communication model.

6.1 QUALITATIVE FINDINGS

REVIEW OF CHAPTERS 4 AND 5

It is evident from the previous chapters (Chapters 4 and 5) that knowledge on health and family planning issues were there. The level of awareness on different indicators, such as family planning and contraceptive use, reproductive health, ANC, PNC, measures during delivery, birth attendant, decision making process etc. was quite high (especially in the experimental areas, due to continuous interception by the project people) but still could not make a significant break through. Still mother/father-in-laws and husbands take the major decisions. Women can't go outside their homes freely without the permission of their husbands. Continuous communication campaign could develop positive attitude, but still active intention is absent to a great extent!

Following findings, based on FGDs and in-depth interviews, will explain how there is still lacking of active intention toward behavior change -

Dhaka University Institutional Repository

Place of Treatment / Health Center Visitation

The majority of people do not go to government health centers or hospitals when they are sick or for getting pregnancy-related treatment. Instead most of them visit village doctors and private doctors (MBBS). The majority of them are not satisfied with the treatment available in health centers and are reluctant to go to the hospitals since it is not near their homes and expensive as well. However, a significant number of people mentioned that they do go to the local health centers since more facilities like better equipment, qualified doctors as well as medicines are available there.

Although a large number of the respondents were found aware of health facilities, but they do not go there. They are quite reluctant to go there. The husbands do not send their wives and children to the health facilities. They do not give due importance to it or they think "it is their fate". It was found that most of them, even those who stated visit health centers, do not go to these government centers for treatment in reality. The foremost reason is due to the bindings and barriers of religion. Moreover, the absence of lady doctors is another reason why female patients were not keen to go there when they become pregnant.

However, another group of people especially the elder citizens and parents-in-laws were not found to go to health centers for treatment at all, rather, they go to religious priests such as 'Fakirs and Pirs' from time to time. Occasionally, they perform religious acts such as chanting and giving patients holy water. So, instead of taking modern treatment and medicine they rely entirely on religious priests and bring 'moulvis' to their homes as well as.

<u>Family Planning and Use of Contraception</u>

As a whole, all of the respondents are aware of the impact of using contraception to keep a family small. The majority of the respondents stated that they practice family planning and a lot of them mentioned that they use contraceptives, especially the female respondents. Nevertheless, there are still a large number of respondents especially in the rural areas, who evidently did not practice any family planning method, although they had knowledge on it.

Dhaka University Institutional Repository

Some of the reasons for not using any family planning method as mentioned by some are:

- In most of the cases, husbands do not discuss family planning issues frankly with wives,
- Females are too shy to ask for advice to anyone
- Wives can not "trust" husbands at first as they have not adapted to one another yet

The contraceptives used most frequently by respondents are the pill followed by injection, ligation, Norplant, etc. In few cases males do not practice family planning themselves and do not even encourage their wives openly. In the rural areas, females mostly collect pills from clinics, maternity hospitals and from EPI health workers. These are mostly procured at either a lower price or free of cost. The least used method as mentioned by the respondents was the condom, which is used by a few of the men. According to these men, they use condoms to relieve their wives of the burden of using contraception. It may be noted that in reality the males are not willing to use condoms at all and do not want to be burdened with contraception.

As a whole, men are less interested to use contraception by themselves and they wish that females should practice it. Most of the time the females convince their husbands and urge them to use contraception. They are more aware, conscious and responsible about family planning aspects than the males.

The female category mentioned some health problems after using contraceptives. Those who take pills mentioned side effects of these such as weakness and dizziness while those that have had an operation and used injections, complained about irregular and decrease in the menstruation flow. It was discovered that the majority of respondents have heard about the need and importance of family planning from the TV, radio and also the female field workers who make visits to their homes.

Dhaka University Institutional Repository

Females have very little decision making power in the family. They rarely decide on where to go for treatment facilities, where to have the delivery or how many children to have for instance. The family-head i.e. either the husband or father-in-law of the pregnant woman usually makes all the crucial decisions. Even household decisions and decisions regarding children, women have very little say whether it may be decisions related to their education, health or marriage. Furthermore, women do not have the right to make financial decisions either. It was found that three fourths of the father-in-laws of the females are still making all the money related decisions in the household. Moreover, the majority of females are not allowed to go anywhere without taking permission from their husbands (in some cases from mother-in-laws).

When respondents were asked to mention the person in their family who prevents women from making decisions, it was found that according to the majority of females, it is their husband, followed by father-in-law and mother-in-law.

Early Marriages and Birth Spacing

The majority of people are aware of the consequences of early marriages and motherhood. As a whole, people understand that children will be malnourished and the mother and child would face problems all their lives if the mother is too young when she has her baby or if she has too many children.

Even so, decisions regarding young marriages and early motherhood are more or less similar to old those made in earlier times. This is evident since people have more than two children and young marriages and child bearing at an early age are rampant even today.

This is quite surprising because studies show that almost all people are aware that if the age is not right then the risks will be high at the time of delivery for the mother and unborn child. Ironically, the reality is just the reverse. Childhood marriage and pregnancy is still prevalent. A large number of the female respondents agreed that the teen-aged girls are compelled to marry aged men, sometimes quite aged.

Dhaka University Institutional Repository

Likewise, in terms of the appropriate gap to be kept between two children, the majority of males and females stated that no less than 3 to 5 years of gap should be kept between two children. However, in reality a gap of about two years or slightly higher is kept by most of the couples even today.

Pregnancy and Delivery Related

It was found that a lot of people do not visit health centers for treatment on a regular basis even when women are pregnant. Instead, they go to village doctors or religious priests for any health or pregnancy complications. Likewise, at the time of delivery they bring TBAs home for performing home deliveries.

Most of the people are still abiding by old habits and customs and are not conscious of the adverse effects of pregnancy complications as a whole. And most of those who are conscious are not breaking free and are too timid to have the delivery outside their homes. As a result, even today, most women abide by religious customs and traditions and continuously have their children delivered in their homes. Some of elders of the community still make women take traditional precautions when they become pregnant. One main precaution that they advise pregnant women to follow is not to venture out of the house when they are expecting.

Some other traditional precautions are mentioned below:

- Pregnant women should not cut fish during a lunar eclipse, as that could be harmful for the unborn baby.
- Pregnant women should not visit doctors during delivery, as it is shameful, instead the delivery should be done at home.
- Pregnant women should not wear red colored or bright clothes outside the house.
- Pregnant women should not go out of their houses during mid-day or just after the dusk. They may be attracted by the genie ("bhoot")

Dhaka University Institutional Repository

On the aspects of delivery, such as who to call for help and what are the complications involved, the people still abide by old customs as well. They call TBAs or 'traditional birth attendants' to help at the time of delivery. Some prefer to call neighbors and not call these TBAs even at the time of delivery. They feel it shameful and embarrassing for them. According to some that delivery at home is a matter of pride and heritage.

In terms of recognizing the many delivery complications, it was found that the females know more of them than the males as a whole. Most of them mentioned excessive bleeding, and eclamptia as some of the major and most occurring delivery related problems. It was also found that males do not give proper importance to the complication.

When respondents were queried upon how to prevent complications after delivery, the majority stated that pregnant women should not be allowed to do too much work or lift heavy objects after the delivery. Only a few others stated that it was crucial for mothers to take the advice of doctors and try to build back their strength if they are to prevent post delivery complications. Ironically the real situation is somewhat different. When asked to the female respondents who gave birth recently, they stated, that their family members, especially the in-laws, do not take special care to them. According to a respondent, her mother-in-law often says, *"I have given birth to eight children, nothing happened seriously. I did every thing for my family."*

Therefore, a gap between knowledge and practice exists?

It was found that majority of the respondents have fairly good knowledge about the issues related to health and family planning, but in reality, the behavior is quite different and in some cases, just opposite. Therefore, legitimate questions arise – what are the barriers to communication? How to develop a behavior change communication?

Dhaka University Institutional Repository

Barriers to Communication

In the use of the communication strategy for health and family planning, message is the key. Evaluators of communication materials offered by programs must continually ask the question: Is the audience getting the message? Is the audience interpreting the message correctly? The message must not only be meaningful and motivating, but it must also "overcome audience resistance to change". Before the message is designed, marketers have to conduct qualitative research to search out resistance points to the change advocated. This is based on the theory that no form of communication, whether interpersonal or mass media, can be effective without overcoming cultural, religious, and/or psychological barriers[36].

Analysis of the findings reveals similarities in the resistance points in the acceptance of new ideas and concepts on contraception and other health issues.

Probable factors responsible to create barrier to communication:

- Demographic factors
  - Widespread poverty and high infant mortality
  - Majority of population in rural areas with limited access to contraceptive services and information.
- Social factors
  - Low status of women
  - Patriarchal society; preference for sons; funeral rites of parents and other rituals may be conducted only by sons;
  - Existing values encourage high fertility
  - Lack of communication between spouses and decisions regarding family size made by the male, also by parents-in-law;
  - Birth control topic regarded as taboo
  - Religious conservatism (more in Islam); practice of family planning has connotations of interfering with god's will

[36] Manoff International, *Social Marketing: New Imperative for Public Health*, USA 1988-1989

Dhaka University Institutional Repository

- Early marriage: There is a feeling among the parents, if there is a good "offer" i.e. if the proposed son-in-law is a good one, usually father of the daughter dos not regret the offer. "Good" bridegroom means, he is financially sound.

  "I was not getting a good offer for a long time, when they requested me, I instantly accepted that. I know the bridegroom is quite aged (18 years gap), but he is rich!"

Even though people were aware of the benefits of family planning, they did not internalize them due to social and religious ideas. Low status of women and lack of communication made family size the decision of males; more children were equated with property in the community; and the number of children was considered to be pre-determined by God[37].

- Education factors
  - Lack of knowledge regarding temporary methods of contraception.
  - Fear of detrimental health effects of reversible methods of contraception and rumors regarding their effectiveness
  - Family planning generally associated with sterilization

All of these resistance points are present in Bangladesh. In Bangladesh, a predominantly Islamic country, it is reported the major resistance points as religious conservatism, where the practice of family planning had religious connotations of interfering with God's will.

Factors related to religion, morality, and social norms

There is a strong belief among the elderly males and religious groups the family planning and contraceptive may effect religious belief and social norms and values. Other opinions are -

---

[37] Evaluating the Effectiveness of a Family Planning IE & C Program in Bangladesh, "Manoff International, 1985. Courtesy: Population Service International

- The belief among religious groups that practice of family planning is anti-religious; means prevention of a birth and thus destruction of life
- Family planning will change the social norms and structure of the population
- Family planning will change the normal way of life accepted by the community
- Family planning can corrupt the morals of the young
- Family planning is promoted by the rich to prevent the poor from having children
- Family planning encourages sex among teenagers

Factors related to health information and education

- Rumors and misconceptions about side effects and harmful effects of pills and sterilization
- Beliefs that condoms and other methods are unnatural
- Fears that contraceptives can cause serious illnesses, cancer, and permanent sterility[38].

6.2 CASE STUDIES

In addition to FGDs and in-depth interviews, the researcher carried out case studies among six respondents. During the interview stages, the researcher came across to some interesting cases, which was considered as very much related to the topics. These cases have given a new direction in developing the communication model. Initially it was not designed to include any cases.

Using IEC materials or some other communication campaign cannot necessarily change behavior. It can change awareness, belief and attitude to an extent, but changing of positive intention toward changing the

---

[38] Dennis Hapugalle, "Planned Parenthood and Community-based distribution of contraceptives in Sri Lanka/" in Jacqueline S. Gardener et. al. ed. "*Village and Household Availability of Contraceptives: Africa/West Asia* (March, 19977), pp. 309-312.

Dhaka University Institutional Repository

behavior is not always possible. Different situational factors and underlying circumstances are responsible for preventing the change. These situations and circumstances come into play thus disrupting or making the objective of change to become blurred. As a whole, IEC or communication materials can spread awareness and knowledge among people but it cannot always change their attitude or behavior. The following cases would explain that behavior cannot always be changed by the use of IEC or communication materials.

Following six cases would explain that only IEC material or any communication campaign cannot necessarily change behavior. It can change awareness, belief and at best attitude, but changing of positive intention toward changing the behavior is not always possible. Different situational factors are responsible for restricting or influencing the change of behavior.

Case 1

A Mother of Five Children[39]:

This is a case of Salma[40], a resident of Fulpur, aged 27 years and who studied up to grade 5. This lady has had five children to date and she is aware of the need to take TT injections while pregnant. In the event she has taken these injections when she first became pregnant as well as at the time of the second pregnancy too. Both times she gave birth to a girl child. In the process of her third and forth pregnancies she began to wish for boys and when she kept on giving birth to girls she became very frustrated.

As a result, while she had taken TT injections during all her four pregnancies, when she became pregnant the fifth time she had willingly not taken any TT injections. Apparently, she thought she would get a girl yet again and so was determined to give birth to a stillborn girl. She consciously made this decision

[39] While conducting a case study on MNT, Khalid Hasan came to know about Salma from Dr. Monzur of UNICEF, Bangladesh

Dhaka University Institutional Repository

and did not bother to take any TT injections purposely expecting to deliver another girl. The thought of having another girl was making her lose control. However, when she had a son in the end, she was severely worried since she thought she had risked the life of her son since she had not taken any TT injections during that last pregnancy.

To prevent such conduct in the future among other females like Salma, less emphasis should be given on IEC materials and more attention on moral and resolve building instead. This should include working on the motivational part of their attitude and stimulating them by provoking their thoughts and beliefs about the specific issue. In this case, this can be done by giving them counseling and making them aware that girl and boy children are equally precious and that no one has the right to put the lives of children at a risk through any gender partiality.

> *I know that one should take TT injection during pregnancy since this is essential for the mother and her children. However, when I gave birth to only daughters my relatives, my neighbors and many others kept on irritating and pestering me saying that it was my fault. But how could it be my fault? Besides, I don't mind too much if I have only girls. It is our society, which expects us to have boy heirs and this creates a pressure on us since we are expected to produce an heir. That is why I became frustrated after my first couple of pregnancies when I was giving birth to girls every time. People intentionally disturb me and treat me badly like anything since I have no son.*
>
> *I feel so ashamed now that I took such a wrong decision, I should not have done this deed. I have now hampered the health of my son forever. But I earnestly believe that if others had told me or if I was counseled on the fact that there was no pressure on me for producing a son, this would not have happened. No one had given me any moral support, not even my own husband. That is why I took such a bad decision. Now I regret it completely.*

[40] With a view to maintain confidentiality, all the names used in this thesis are not real, this are given by the researcher himself.

Dhaka University Institutional Repository

It may be mentioned here the importance of counseling and how it would have impacted on the life of Salma and others like her who go through such dilemmas continuously. If everyone around her had given her proper counsel or moral support, then she would have not done this stupid act and stopped taking the TT injections.

Case 2

A Sex Worker's Tragedy[41]

Abeda, aged 24, is a street based sex worker, who came to Dhaka from rural Jamalpur. She had studied up to grade seven but had no option but to become a sex worker after coming to Dhaka. The harsh reality of the horrific lives that prostitutes lead was revealed with graphic clarity after she was interviewed. The extent of degradation and humiliation that she and others like her have to bear on a daily basis was revealed. According to her, men abuse them and discard them like filth and everyone in the society looks down upon them with disgust.

When Abeda, was asked if she used condoms while having sex with clients she responded negatively. However, she apparently knows what condoms are and how they protect one from catching deadly diseases. She also knows the harsh consequences of not using condoms. In fact, she realizes that she may get infected with deadly disease like AIDS and die even but she does not seem to care at all. On the contrary, this female was so ashamed of being a sex worker that she did not consider death as anything significant for someone like her.

In light of this, she does not tell her clients to use any condoms during sex. She could not care less if they used condoms or not. Furthermore, she stated that even if she did not die from any disease and survived somehow, she does not have any value or worth in the society and thus there was no need for her to be concerned about using condoms and being cautious about infectious diseases.

---

[41] Interviewed by the researcher. Abeda resides in an urban slum, Dhaka.

Dhaka University Institutional Repository

There is a thin line between the survival and death of a sex worker like Abeda. They do not want to live since they have nothing to live for. They can hardly differentiate between the meaning of survival and death since they are already somewhat dead inside. Abeda also mentioned that most of the time she does not care if she lives or dies since she is hated and stigmatized in the society anyway. Similar stories are common to many other "Abedas" throughout the country.

Sex workers should be given counseling and discussion sessions for boosting up their morale. Likewise, they should be given advice on taking care of themselves so that they are empowered to take decisions and thus increase and upgrade their self-esteem even if they are working in a "degrading" job.

Case 3

Mother in law – Power Play and Double Standards![42]

One mother-in-law, Kulsum Bibi, aged 52 coming from an urban middle-income background, was found to be fully aware of the need for proper pregnancy care for pregnant mothers. It was apparent in her interview that she knew about all the aspects of pregnancy and how it is a time when the expecting mother should take extra care. Likewise, on the aspect of making crucial decisions related to pregnancy she knew that pregnant mothers should be empowered to take control and make those decisions according to their own needs and suitability. However, it was found that she does not permit her daughter-in-law to take control and make pregnancy decisions. Instead, it was found that this mother-in-law is making all the pregnancy-related decisions throughout the pregnancy such as when and where to visit health clinics for ANC, choosing the birth attendant, where to have the delivery etc.

> *"I have no say in my family. My mother-in-law guards and rules over everything and she has all the decision making power. It's a joint family but I am totally isolated. No one is in favor of me, not even my husband. My mother-in-law is quite educated and is a social worker*

[42] Interviewed by the researcher. This is a case of urban area, Dhaka.

Dhaka University Institutional Repository

herself. However, she does not act like a social worker with me. She has a different attitude with everything, which is related to me. So I believe that, only having awareness is not enough since one must have the proper attitude as well. My mother-in-law thinks that if I am given something to do then I might take control and she will lose her power. She is very jealous of me but I do not understand why? How can her mind and negative attitude be changed?" (Roxana, age 23, grade 9, Jessore Sadar Upazila)

This decision-making power position should be changed. Mothers-in-law should not be given the sole power position in the family. Pregnant women should be empowered to understand their own health care needs and take hold of the reins and make their own pregnancy-related decisions. On the other hand, mothers-in-law should also be motivated and counseled that if she cooperates with her daughter-in-law, she (the mother-in-law) would be more honored and looked upon by others. Besides, she will have nothing to lose, rather by changing her behavior; she (the mother-in-law) will gain more respect and love from her daughter-in-law as well as everyone else around her.

Another incriminating attitude that mothers-in-law have is in the case of double standards. It has been observed that mothers-in-law display a different standard while dealing with the same issues for their daughter-in-law and their own daughters. They treat them both differently even though they may be in the same scenario. For instance they will assume that their daughters should have the right to make decisions in their respective in-laws house however, they will refrain from giving those same rights to their daughter-in-law in their own household. Such double standards are in built behavior patterns that are hard to overcome by mothers-in-law in the society even today.

Dhaka University Institutional Repository

Case 4

Marriage, Poverty and Female Trafficking[43]

The parents of the girls who they end up marrying are usually the poor and illiterate who have no option but to get their girls married off. They usually have enough trouble feeding their children as it is and getting one married relieves a lot of their burden. As it is the fathers of the girls are burdened with giving dowry anyway and between the dowry and their poverty they have no place to go. They are in such a situation where they have no option but to take the risk that if their daughter is ever divorced by her husband then she will not get a single penny from the marriage deal.

> *"We have 5 daughters and 3 sons; 2 children died just after their birth. My husband is a poor agriculture labor. I also work as a maidservant in the neighboring house. We have only homestead land, inherited from my father. We pass our days hand to mouth. There are many days we could not eat three times a day i.e. breakfast, lunch and dinner. I lost my eldest daughter. We arranged marriage with a person who was not known to us. He said that he works in the town in Bonga – the neighboring district in India. Some of our relatives were against this marriage, but we ignored. Due to our extreme poverty we could not think twice, knowing fully that there is a risk! It is more than two years, we don't her whereabouts. We want to see her, we pray to Allah every day, every moment."* (Shahida, 38, Benapole, Jessore)

Parents of these young girls turn a blind eye to this fact since this system of mostly unregistered marriages is possible in the society and they cannot do anything about it. It is found that most of them are aware of "unknown fate" of their daughters. Due to extreme poverty and sometimes illiteracy, trafficking and unregistered marriage cannot be stopped.

---

[43] While the researcher was discussing on family planning and decision making related issues, the respondent narrated this case and relates her role in decision-making process, especially on the fate of her daughter in the name of so called marriage.

Dhaka University Institutional Repository

Trafficking of females is on the rise in Bangladesh. Due to extreme poverty and destitution females are lured into the trap of looking for a better life. Different groups of illegal and organized human traffickers seek out destitute and poor families and lure them into the trap. The females go willing since these groups tell them about the prospects that are available outside their home village or town. Thus, for the hope of earning a better income these females put themselves in the hands of these groups.

In this process poor women are lured from all over the country and sent to a foreign country. Mostly they are sent to India, Pakistan and other neighboring countries[44]. These poor and destitute women are usually illiterate and do not know what is actually going on. In the name of giving them a better life, these females are being trafficked to a foreign country from where they cannot get out. As a result, these women end up in an even worse situation than before where they are stripped of their dignity and lose their freedom as well.

Parents are aware that they place their daughters in the wrong hands when getting them married without a registration but they have no option otherwise. They are forced to turn a blind eye to the whole issue since their hands are tied.

In order to change the attitude and practices of these people a lot of campaigning (supported by counseling, advocacy) will have to be done. The people must be made aware that they can change these attitudes and practices if they wish to do so. However, it is not enough just to increase the awareness of the people in terms of these activities but other factors responsible for the whole situation i.e. poverty and illiteracy has to be reduced if not eliminated totally. The entire dynamics of the situation will have to be changed and people must be made to believe that getting their females married and sending them away to earn a living outside the country is not the answer to eradicate their poverty.

---

[44] Similar findings were found in "Research on Women Trafficking", MRC-MODE, 2002

Dhaka University Institutional Repository

Case 5

Non-Smoking Behavior of a Smoker[45]

While discussing with a male respondent on decision-making process, Karim, 38, rural schoolteacher said,

> *"I know smoking is injurious to health, but I am smoking for the last 18 years; more than a pack every day (more than 10 sticks). I cannot give up smoking, tried twice but failed. I create defense mechanism that my father survived for about eighty years and he was a smoker. He did not died by Cancer. So nothing would happen, and this is how my decision making process on health seeking behavior is effected and guided."* (Mymensingh Sadar Upazila)

It is evident from the above case that, Karim is a literate person, teaches other, but he could not take proper decision on health seeking behavior, rather he creates "self defense mechanism" just to validate his failure. Is it just failure or negligence or lack of total commitment?

Case 6

Virility of a Husband!

While interviewing Khaleda on birth planning, she narrated how the whole process on family planning is guided by her husband. The problem here is not only the sexual factor between the couple but also the economic status.

Khaleda, a poverty stricken rural woman of Kurigram, age 31 and illiterate, whose husband is a migrated truck driver staying in the city. This husband is very sexually active and always needs a women partner for mitigating his sexual appetite and he does irrespective of the place he stays. Earlier he visited commercial sex workers in Daulatdia brothel. He is not even aware of the effects of AIDS. Khaleda came to know the 'virility' of her husband!

Presently the husband is living-in with another woman and sometimes - maybe once in six months - visits his village to meet Khaleda. The want of a son forced Khaleda to conceive and finally she gave birth to a son. Khaleda is already a mother of a daughter. So this is the situation as of today. Khaleda started working as a maidservant to rear her son single handedly. But still now deep down her heart she has a constant fear of losing her "husband" literally. Therefore, she unwillingly keeps her husband satisfied and try to win him over the 'other' woman.

She does not want to loose whatever small amount of money her husband gives.

> *"What can I do, I know I might become 'ill' (read sexually transmitted infection), I can approach women's group, but what should I do? My in laws will not like this at any circumstances. Where would I go if he deserts me?"*

Says Khaleda, with a very broken heart. Knowing fully well, Khaleda admits to the sexual demands of her husband and, she also knows that it is unwise to accept the "virility" of her husband. She looks tired of her life. And the story continues....

Summary of Case Studies

All the six cases clearly shows that it is not enough just to increase the awareness and knowledge of the people to change their behavior but other factors responsible for the whole situation should be addressed. In Case 1, initially the mother has positive intention toward taking TT and she had already taken TT. During her first or second delivery, son or girl preference was not a serious issue, but the close relatives and other member of the society turned the issue of "son preference" as an "only thing of life!" Similarly in Case 2, Abeda has lost all her desire to survive. The society has made her life

---

[45] Interviewed by the researcher. While discussing with a male respondent on decision making process, the researcher observed how knowledge and awareness can be "by passed" deliberately. This is a case of rural area, Comilla.

"stigmatized". On the other hand, Kulsum Bibi, in Case 3, plays a double standard. Knowing fully well, she advocates in favor of her daughter and plays against her daughter-in-law. In Case 4, Shahida due to extreme poverty she had to hand over her daughter to an "unknown so- called son-in-law". Similarly in case 5, Karim, a school teacher, knows that smoking is injurious to health but he could not implement this message to himself. And in the last case where the story of an unwilling woman is narrated. Here Khaleda is fully aware that what her husband is doing in the name of so called 'virility' cannot be at all accepted, but due to various socio-economic reasons, she has to accept the reality. Her long developed norms and values is ignored painfully.

It is evident in all the six cases that awareness and knowledge, believe and positive attitude were there, but due to some unanticipated situation or unavoidable factors, audience or respondents could not possess positive intention toward changing behavior.

Dhaka University Institutional Repository

6.3 QUANTITATIVE ANALYSIS

Following issues were based on the quantitative survey, conducted among 400 respondents, both males and females. The findings were used to either validate or nullify the hypotheses.

Family Planning

It was found in the quantitative survey that the level of awareness of respondents in the study areas in terms of family planning is around 99%. As a whole, the majority of respondents know the importance of planning a family and using contraceptives. However, further investigation has also revealed that respondents are not practicing family planning to the extent in which they are aware of it. It has been evident that only 58% of the respondents are actually using some sort of family planning methods in the study areas in reality.

Family Planning Awareness & Practice

Dhaka University Institutional Repository

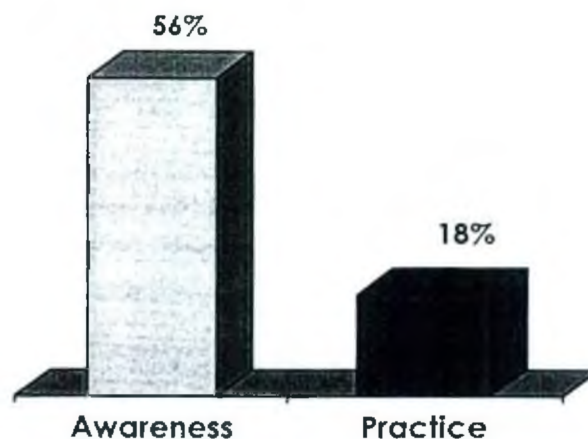
Proper Use of Oral Contraceptives

Respondents in Bangladesh are using oral contraceptives for quite some time now. However, it was found that a little over half of the respondents (55%) are actually aware of the proper use of the different contraception pills (i.e. timing, doses etc.). This discouraging figure throws light on the fact that although the respondents are aware of oral contraception, they still do not know how to use them properly. Recent studies have also shown that the practice level of oral contraception is even more dismal. Only 42% of them actually can properly use oral contraception.

Condom Use Eliminates the Risk of HIV/ AIDS

The study has also revealed that about half of the respondents (56%) know that condom use during sexual intercourse with commercial sex workers reduces the risk of HIV/ AIDS. To date, past interventions have not been able to convey to the respondents the risks of having unprotected sex, especially with sex workers. About half of them are still not aware of this dangerous fact. However, the level of condom use while engaging in sexual intercourse with commercial sex workers is even more depressing. Only 18% of the respondents who have sex with sex workers actually use condoms to protect themselves from HIV/ AIDS.

Condom Use Vis-à-Vis Risk of HIV/AIDS



Delivery At Home Is Risky

The level of awareness of respondents in terms of home deliveries being risky is almost complete with 99% of the respondents knowing this fact. But this awareness has not been helpful in changing the practices of people. The research has revealed that about 92% of the respondents are still having home deliveries. Apparently, although they are aware of the risks involved in home deliveries, they are still willing to follow the age-old tradition and continue to have home deliveries. They still can't break free of old practices and traditions.

Delivery Attendant Should Be Skilled

Around 43% of the respondents as a whole are aware that the delivery attendant should be either a skilled nurse, paramedic, health worker etc. But as discovered in this research, the level of practice according to this level of awareness is not satisfactory. In reality, only 18% of the respondents actually have their delivery carried out by a skilled attendant. Thus, unskilled attendants carry out 82% of the deliveries in Bangladesh today.

ANC

Pregnant mothers in Bangladesh are more or less aware that they must go for antenatal care (ANC) during pregnancy. As a whole, about 73% of the respondents are aware of this fact. But what are the practices in terms of ANC? Studies have revealed that less than half of the expecting mothers i.e. around 45% are going for ANC services even though about 73% of them are actually aware that ANC is needed for pregnant women. This is another area where there is a huge gap between the level of knowledge and practice.

PNC

Similar scenario is evident for postnatal care (PNC) related issues. Apparently, 83% of the respondents in the study areas are aware of the need for proper care of mothers after they have had the delivery. However, the number of new mothers that actually go to health centers for PNC is limited. The research has revealed that only a dismal 22% of the new mothers opt for care after they have had the delivery. Apparently, they do not see it very important to go for care after they have delivered their baby.

Dhaka University Institutional Repository

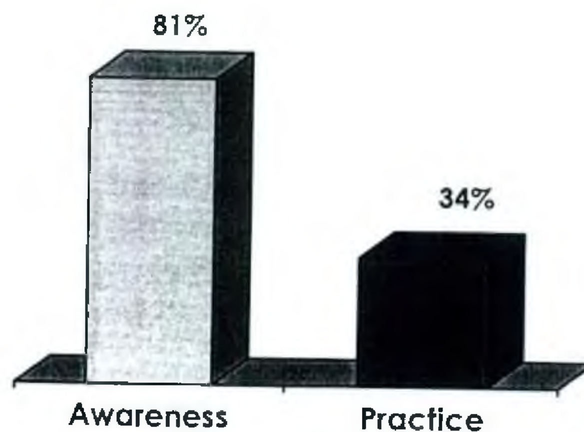
TT Vaccination

Today a lot of expecting women in Bangladesh, i.e., around 78%, are aware of the need for taking TT injections while pregnant. Likewise, in reality many women are in fact going for vaccination. However, this level is not proportional to the level of awareness since about 61% of the women are practicing taking TT, at least two doses.

Joint Decision-Maker on Contraceptive Use

Formerly men in Bangladesh used to make all the decisions related to choosing the contraception method. The wife was then expected to accept that decision. However, today around 81% of the respondents know that this decision should be jointly made between husband and wife. But even then the level of practice of respondents in making joint decisions is still very low. It was found in this research that even now only 34% of the respondents make contraception decisions jointly.

Decision by Husband & Wife



Summary of Quantitative Findings

It may be concluded that there is still a huge potential for changing the level of practice or changing behavior in terms of family planning, healthcare and decision-making rights. Although the level of awareness has changed it is still not adequate since people are not practicing what they have learnt. There are significant gaps between the level of knowledge and practice (significant

at 95% confidence level) in all these areas still today. Although people are aware to an extent, they are not changing practices according to that level of awareness. In essence, the real picture is very different from the expected picture. The gap is the most widened in areas such as family planning, condom use when having sex with sex workers, ANC, PNC home deliveries, joint decision making rights etc. Apparently, past intervention and behavior change communication programs have not been very effective in changing the practices of people in such areas. In light of this, there is room for further intervention where more result-oriented campaigns should be enforced.

6.4 TEST OF HYPOTHESES

There were two hypotheses, as follows:

H1: Change of behavior does not necessarily depend on change of awareness and knowledge;

H2: More the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.

The above two hypotheses are tested by using the following formula on T-statistic Regression Coefficient, as below:

Consider the simple regression model

$$Y_i = a + bx_i + e_i$$

Where,

$$\text{estimate of } b = \hat{b} = \frac{SP(XY)}{SS(X)} = \frac{\sum (x_i - \bar{x})\ (y_i - \bar{y})}{\sum (x_i - \bar{x})^2}$$

$$\text{estimate of } a = \hat{a} = \bar{y} - \hat{b}\bar{x}$$

Dhaka University Institutional Repository

at 95% confidence level) in all these areas still today. Although people are aware to an extent, they are not changing practices according to that level of awareness. In essence, the real picture is very different from the expected picture. The gap is the most widened in areas such as family planning, condom use when having sex with sex workers, ANC, PNC home deliveries, joint decision making rights etc. Apparently, past intervention and behavior change communication programs have not been very effective in changing the practices of people in such areas. In light of this, there is room for further intervention where more result-oriented campaigns should be enforced.

6.4 TEST OF HYPOTHESES

There were two hypotheses, as follows:

H1: Change of behavior does not necessarily depend on change of awareness and knowledge;

H2: More the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.

The above two hypotheses are tested by using the following formula on T-statistic Regression Coefficient, as below:

Consider the simple regression model

$$Y_i = a + bx_i + e_i$$

Where,

$$\text{estimate of } b = \hat{b} = \frac{SP(XY)}{SS(X)} = \frac{\sum (x_i - \overline{x})\ (y_i - \overline{y})}{\sum (x_i - \overline{x})^2}$$

$$\text{estimate of } a = \hat{a} = \overline{y} - \hat{b}\overline{x}$$

Table 1:

Awareness and practice of different family planning and health related indicators

Awareness and practice of different family planning and health related indicators

Indicator	x	y	xi-x̄	yi-ȳ	(xi-x̄)^2	(yi-ȳ)^2	(xi-x̄)(yi-ȳ)
Family planning	99.00	58.000	29.00	24.14	841.00	582.88	700.14
Proper use of oral contraceptive	55.00	42.000	(15.00)	8.14	225.00	66.31	(122.14)
Condom use eliminates risk of HIV/AIDS during sex with CSW	56.00	18.000	(14.00)	(15.86)	196.00	251.45	222.00
Delivery attendant should be skilled one (nurse, HA/FWA etc.)	43.00	18.000	(27.00)	(15.86)	729.00	251.45	428.14
ANC	73.00	45.000	3.00	11.14	9.00	124.16	33.43
PNC	83.00	22.000	13.00	(11.86)	169.00	140.59	(154.14)
TT Vaccination (2 doses or more)	81.00	34.000	11.00	0.14	121.00	0.02	1.57

N	8.000
X	70.000
Y	33.857
Sum(yi-ȳ)^2	1,416.857
Sum(xi-x̄)^2	2,290.000
Sum(xi-x̄)(yi-ȳ)	1,109.000
Estimate of b	0.484
Estimate of a	(0.042)
Estimate of Correlation Coefficient ®	0.616
Regression ss	537.066
Residual ss	879.791
Estimate of error Std.(Se)	12.109

Dhaka University Institutional Repository

Dhaka University Institutional Repository

T(b)cal	1.914
T(tab)	2.447
Accept the hypothesis?	**No**

Inference: We reject the Hypothesis 1 and conclude that X has no significant effect on Y i.e. *change of behavior (i.e. practice) does not necessarily depend on change of awareness and knowledge.*

Dhaka University Institutional Repository

Hypothesis 2

H2: *More the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.*

Lets test this hypothesis with the quantitative data (as shown in the Table 2).

We accept the hypothesis and conclude that x has significant effect on Y. (Details are explained below.)

Where

X = independent variable (i.e. exposure to IEC)

Y = dependent variable (i.e. change of behavior)

Dhaka University Institutional Repository

Table 2:

H2: More the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.

Indicator	x	y	$x_i-\bar{x}$	$y_i-\bar{y}$	$(x_i-\bar{x})^2$	$(y_i-\bar{y})^2$	$(x_i-\bar{x})(y_i-\bar{y})$
Reach of radio and family planning practice	42.00	27.000	(4.63)	0.38	21.39	0.14	(1.73)
Reach of TV and family planning practice	45.00	26.000	(1.63)	(0.63)	2.64	0.39	1.02
Reach of IPC and family planning practice	31.00	20.000	(15.63)	(6.63)	244.14	43.89	103.52
Reach of radio and visit to health centers	42.00	22.000	(4.63)	(4.63)	21.39	21.39	21.39
Reach of TV and ANC	45.00	25.000	(1.63)	(1.63)	2.64	2.64	2.64
Reach of radio and PNC	42.00	15.000	(4.63)	(11.63)	21.39	135.14	53.77
Reach of TV and TT Vaccination (2 doses or more)	45.00	32.000	(1.63)	5.38	2.64	28.89	(8.73)
Joint decision maker on contraceptive use	81.00	46.000	34.38	19.38	1,181.64	375.39	666.02

N	8.000
x	46.625
y	26.625
$Sum(y_i-\bar{y})^2$	607.875
$Sum(x_i-\bar{x})^2$	1,497.875
$Sum(x_i-\bar{x})(y_i-\bar{y})$	837.875
Estimated b	0.559

Dhaka University Institutional Repository

Estimated a	0.544
Regression ss	468.687
Residual ss	139.188
Estimate of error variance (Se)	4.816
T(cal)	4.495
T(tab)	2.447
Accept the hypothesis?	**Yes**

Inference: We accept the Hypothesis 2 and conclude that X has significant effect on Y i.e. more the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior.

Summary on Test of Hypotheses

It is evident from the analysis that the first hypothesis is rejected i.e. "change of behavior does not necessarily depend on change of awareness and knowledge" and the second hypothesis is accepted i.e. "more the exposure to IEC influenced with counseling and advocacy more the possibility of changed behavior". These indicate that change of behavior does not only depend on knowledge, belief and attitude. Before reaching to positive intention toward final act, other essential factors may influence in changing behavior.

Dhaka University Institutional Repository

6.5 CONCLUSION

The research has shown that the level of awareness of respondents has increased to an extent with the onset of various behavior change interventions and campaigns. People are no longer ignorant about issues such as the importance of taking TT injections, pregnancy complications, early marriages, family planning, ANC, PNC etc as they had previously been. Likewise, in terms of issues such as double standards of mothers-in-law in regard to their own daughters and their daughters-in-law things have not changed as such. However, there is ample evidence justifying the fact that although the knowledge has increased, the level of practice has not increased proportionately to that. Furthermore, there are significant gaps prevailing between the belief and attitude of people in all these issues as a whole.

Overall, the practices of people regarding family planning and health seeking behavior were found to have changed little in terms of the level of practice prevalent. A large number of the people are still not seeking health care from government health centers but preferring instead to go to quacks and untrained medical practitioners or traditional herbal healers. They may be aware of the "dangers" of going to such practitioners but don't have the positive intention to change their in-built behavior. There may be various reasons why even after being exposed to the information in past interventions people are still not changing their deep-rooted behavior and practice towards health care.

A sound and all encompassing BCC campaign will need to be intervened to induce change among the people who are not as yet changing their attitudes and intention towards getting better health care and practicing family planning. Apparently, past campaigns have not been very effective in changing the practices of people so a different approach is essential now. The communication model of this campaign should be one, which will be more focused, and result oriented and one that will be devoid of the flaws of

Dhaka University Institutional Repository

all other past intervention programs. This campaign should be able to sway all the last inhibitions and doubts of the people revolving around any imbued beliefs, values and attitudes which they may have preconceived notions about.

Therefore, there is a need to develop a forceful communication model, which will help changing the behavior.

Dhaka University Institutional Repository

CHAPTER 7
NEED FOR DEVELOPING BCC MODEL & REVIEW OF RELATED APPROACHES

Dhaka University Institutional Repository

Chapter 7

NEED FOR DEVELOPING BCC MODEL & REVIEW OF RELATED APPROACHES

7.1 NEED FOR DEVELOPING COMMUNICATION MODEL

Social changes can be brought about by means of changing attitude and behavior of individuals. If they are influenced in certain ways then their attitude can be changed. Attempts to bring about change in individuals involve exposure to new information about some object[46], event, issue or aspect. This exposure may lead to changes in beliefs, which will ultimately create a basis or foundation from where influence can be affected. It may be stated that a person's belief about an object focuses on the perceived relation between the object and its attitude. Moreover, the formation of one belief may lead to the development of other related beliefs. Usually an attitude of a person is determined by his/her salient beliefs about the attitude object. Moreover, beliefs about a given behavior determine a person's intention to perform the behavior and thus manifest that behavior as well.

The belief plays a guiding role in forming the overall conceptual framework. According to Fishbein[47], beliefs can be directly influenced by two ways: 1) A person can be placed in a situation where he can personally observe that an object has a given attitude, and secondly the person may be told by an outside source that the object has the attribute in question. These two alternative ways of directly influencing beliefs correspond to change 1) active participation and 2) persuasive communication. Active participation helps bringing about changes in different forms, such as contact and interaction with other people, choice between several alternatives, performance of some other behavior etc. on the other hand, individual may gain information by observing object, and event in a given situation etc.

[46] Object may be any physical object, a person, an institution, a behavior, a policy, an outcome etc. that may lead to form belief.
[47] Fishbein, M., and I. Ajzen, Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research, Reading, MA: Addison-Wesley 1975.

Dhaka University Institutional Repository

every day of one lives. People are exposed to persuasive communication, designed to influence their beliefs, attitude and behaviors. Individuals receive object through own sense organs may be termed as "informational items". Informational items based on own sense organs forms "proximal belief".

If the individual's belief directly corresponding to an informational item (e.g. a person, an institution, or media, or direct experience) is termed as proximal belief. For example, a receiver of an information item may be exposed to such a statement, as "Bangladesh government doesn't accept homosexual act." This information item links the object "Bangladesh government" to the attribute "doesn't accept homosexual act." The corresponding proximal belief is the receiver's initial (pre-exposure) subjective probability concerning this object-attribute link. In other words, by virtue of the information item, the receiver acquires new descriptive beliefs about the matter or the consequences of his own or others' behaviors, or about an environment.

The beliefs, which serve as the fundamental determinants of the dependent variable, are termed as primary beliefs. In behavioral science, if we need to make any attempt to influence on something or to change human behavior we identify a belief or a range of beliefs in order to influence the dependent variable. Let's take an example: An "institution" is an independent variable and "attitude" towards this institution is the dependent variable. A particular belief or a range of beliefs about this institution's characteristics is some of the primary beliefs at which the influence attempt can be directed.

Psychologists posit the view that changes in proximal beliefs may have impact effects on relevant external beliefs, thereby producing unexpected changes in primary beliefs and dependent variables. Primary beliefs, proximal beliefs and external beliefs are interrelated concepts, which leads to changes in certain human behavior. There are various inference processes - first changes in proximal belief then external belief then the primary beliefs. Once changes in primary beliefs occur behavior change is expected. However, it depends on various parameters.

For example, in order to change the attitude of people towards health-seeking behavior possible attitude must be effected towards Sabuj Chhata

clinic. This change in the individual's health seeking behavior will lead to positive change if properly communicated to the people.

However, beliefs that do not correspond to any informational items may also influence external beliefs termed as "impact effects". Like direct effects on proximal beliefs, these indirect impact effects will influence the dependent variable only if the external beliefs affected serve as primary beliefs or if they are related to the primary beliefs.

One of the fundamental problems is to identify any influential attempts that need to be changed in order to influence the dependent variables under investigation. Such belief serves as the basic developments of the dependent variables, called "primary beliefs". For example when the dependent variable is the attitude towards an institution, for instance, "Sabuj Chhata", the beliefs about the characteristics of Sabuj Chhata is a primary belief at which the influence attempts can be directed.

7.2 REVIEW OF RELATED APPROACHES

With a view to develop the proposed communication model, a few much discussed related approaches are reviewed, stated below.

Fishbein and Ajzen Approach

According to Fishbein and Ajzen (1975) Figure 1.1 illustrates some possible links between informational items and dependent variables. Informational items included in an influence attempt may produce changes in the receiver's proximal beliefs corresponding to the informational items. These proximal or external beliefs may themselves be primary beliefs (one-step chain), they may be directly related to the primary beliefs (two-step chain), or they may influence intervening external beliefs that are related to the primary beliefs (multiple-step chain). Some, all or none of the beliefs in fig. 1.1 may serve as target beliefs.

Dhaka University Institutional Repository

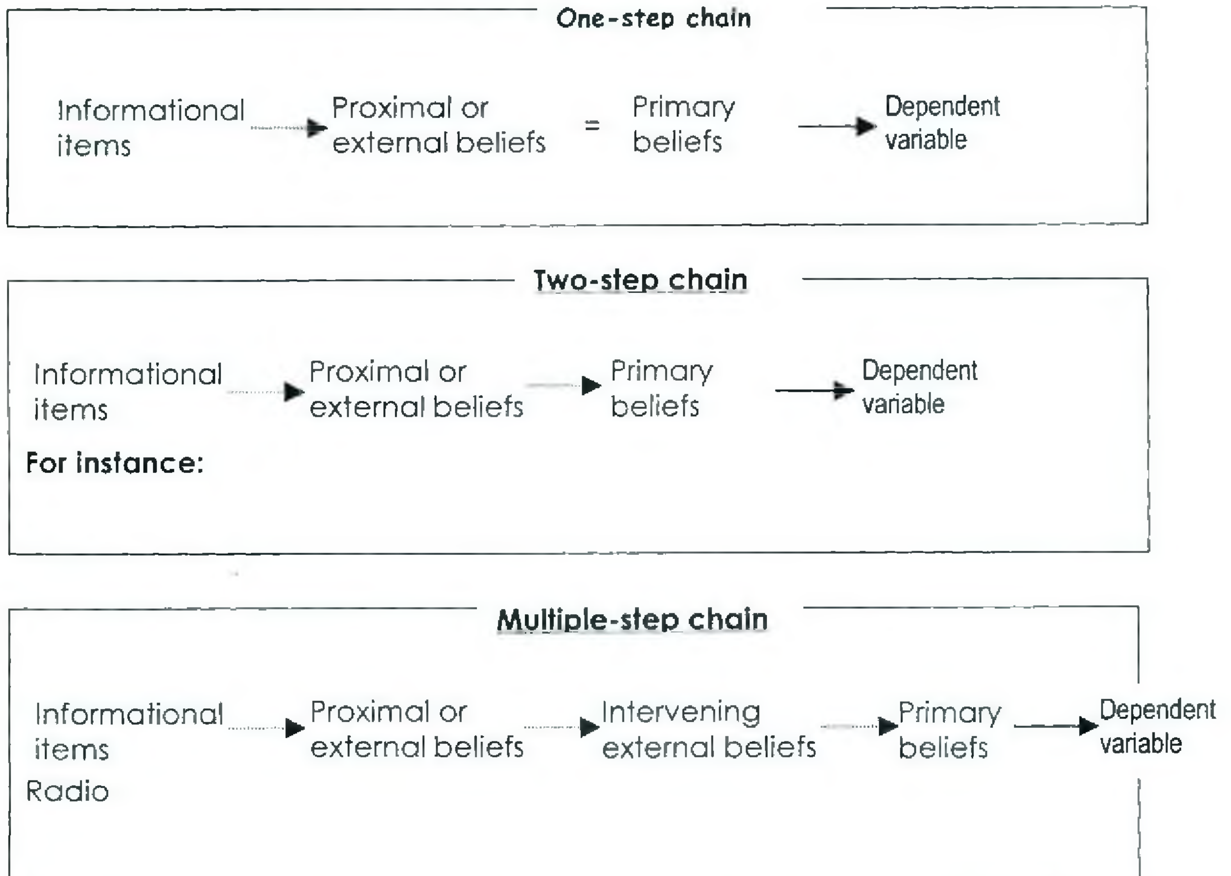


Fig 1.1. Chain of effects involved in an influence attempt

An influence attempt is designed to change a given dependent variable by providing informational items that correspond to and may affect certain proximal beliefs. The influence attempt will produce change in these proximal beliefs if the informational items are perceived and accepted. Even if not accepted, the informational items may produce changes in external beliefs. Changes in proximal and external beliefs are expected to influence certain primary beliefs, which constitute or are related to the immediate determinants of the dependent variable under consideration.

This principle emphasizes the need for careful selection of informational items and target beliefs. By selecting target beliefs that constitute primary beliefs or that are related to the primary beliefs, the likelihood that changes in target beliefs will have the desired effects on the immediate determinants of the dependent variable is increased.

Dhaka University Institutional Repository

A person may form a belief directly by observing an object-attribute relation or accepting information to the effect that the object has the attribute, or he may form a belief indirectly by means of some inference process. Inferential beliefs are formed on the basis of other beliefs that the individual holds. Changing some or all of the relevant (or primary) beliefs that provide the basis for the inference process can bring about change in an inferential belief.

An individual may arrive at a given belief in various ways. As an example, consider the belief "Rahim is honest." Since honesty cannot be directly observed, the only way a person can acquire this belief directly is by accepting information from some outside source indicating that Rahim is honest. In an attempt to find a casual explanation for Rahim's behavior, he may make the attribution that Rahim is honest. Alternatively, he may reach this inference on the basis of logical reasoning. If we assume that he held the prior belief that people who return lost objects are honest, he might reason as follows: Rahim returned a lost wallet; people who return lost wallets are honest; therefore Rahim is honest.

The ultimate purpose of an influence attempt, then, may be to change an inferential belief of some kind. To do so, one must induce changes in primary beliefs that are probabilistically related to and thus relevant for the inferential belief. In fact, the dependent inferential belief may be the end product of a chain of prior inferences also.

Guidelines for Changing Inferential Beliefs

Fishbein and Ajzen had drawn four basic guideline, which leads to change inferential beliefs. According to their model, a distinction between belief, attitude, intention, and behavior is essential for an analysis of the influence process. This distinction is necessary since different factors serve as the immediate determinants of these variables. Moreover, what serves as a determinant in one situation may represent the dependent variable in another, resulting in a chain of influence effects that ranges from beliefs to behavior? Thus, in order to change behavior, there should be the intention to perform that behavior. To change that intention, it will be necessary to focus on attitude toward the behavior or subjective norms. Influencing primary beliefs about the attitude object can change attitude toward the behavior.

Dhaka University Institutional Repository

These considerations lead to the formulation of first principle of change.

1. *The effects of an influence attempt on change in a dependent variable depend on its effects on the primary beliefs underlying that variable.*

This principle emphasizes the need for careful selection of informational items and target beliefs. By selecting target beliefs that constitute primary beliefs or that are related to the primary beliefs, the likelihood that changes in target beliefs will have the desired effects on the immediate determinants of the dependent variable is increased.

To produce the desired changes in primary beliefs, the influencing agent provides informational items, which may lead to changes in the receiver's corresponding proximal beliefs. Changes in these proximal beliefs are expected to influence certain target beliefs that are assumed to be directly or indirectly related to the dependent variable. The changes in proximal and external beliefs, therefore, are ultimately responsible for any changes in the dependent variable. The second principle of change is:

2. *The effects of an influence attempt on changes in a dependent variable are ultimately the result of changes in proximal beliefs.*

To change a person's intention to perform a given behavior, the attitude toward the object of the behavior of that person should be changed. Although a change in these proximal beliefs about the behavior may have no effect on attitude toward the object, it may influence attitude toward the behavior and may thus have the desired effect on intention. Thus, many different processes intervene between an influence attempt and change in some dependent variable. The number of links involved varies from one dependent variable to another. The third general principle of change deals with this chain of events.

3. *The effects of an influence attempt on change in beliefs, attitudes, intention, and behavior depends, in that order, on an increasing number of intervening processes.*

The smallest number of steps intervenes between an influence attempt and

Dhaka University Institutional Repository

change in proximal beliefs. The number of intervening steps increases when the dependent measure of change involves an inferential belief. The final principle of change is:

4. *An experiment manipulation can affect amount of change in a dependent variable only to the extent that it influences amount of change in proximal and external beliefs.*

Interpersonal Contact

Interpersonal contact between people tends to produce more favorable interpersonal relations and is expected to lead to a reduction in prejudice as a whole. Since subjects while interacting are exposed to different items of information, it is difficult, to identify the proximal beliefs that are influenced by the contact experience. It is not at all clear what new beliefs the subject may be expected to form or which of his existing beliefs are likely to change.

Interpersonal contact induces attitude change and improves relation because it provides individuals with an opportunity to get to know each other, to appreciate and perhaps to accept the other's point of view. Some contact situations favor the development of positive beliefs, and others lead of the formation of negative beliefs. When these beliefs are related to the dependent variables under investigation, favorable or unfavorable effects may be observed.

For instance if we consider the interaction between a pregnant women and a mother-in-law, when they are associated with one another, there will be an interchange of inferential beliefs and attitudes. As a result, this interaction will then lead the formation of positive and favorable attitudes towards one another. This will ultimately eliminate prejudices and change any preconceived views that one race had about another. Thus, interpersonal contact is likely to produce change in beliefs, attitude, intentions, and behaviors with respect to an ethnic, religious, or national group only when participants come in contact with individuals who are identified as members of that group.

Dhaka University Institutional Repository

Yale Approach to Communication and Persuasion

Hovland and his associates (Hovland 1959) have investigated factors influencing effective persuasive communication. They defined communication as "the process by which an individual (the communicator) transmits stimuli to modify the behavior of other individuals (to whom with what effect). According to these researchers, with a view to change attitude and thereby opinion, perception, affect and finally action, following model was developed. Three important factors i.e. source, message and audience play important role, which mediate attention, comprehension and acceptance. The Yale approach to communication and persuasion is stated below:

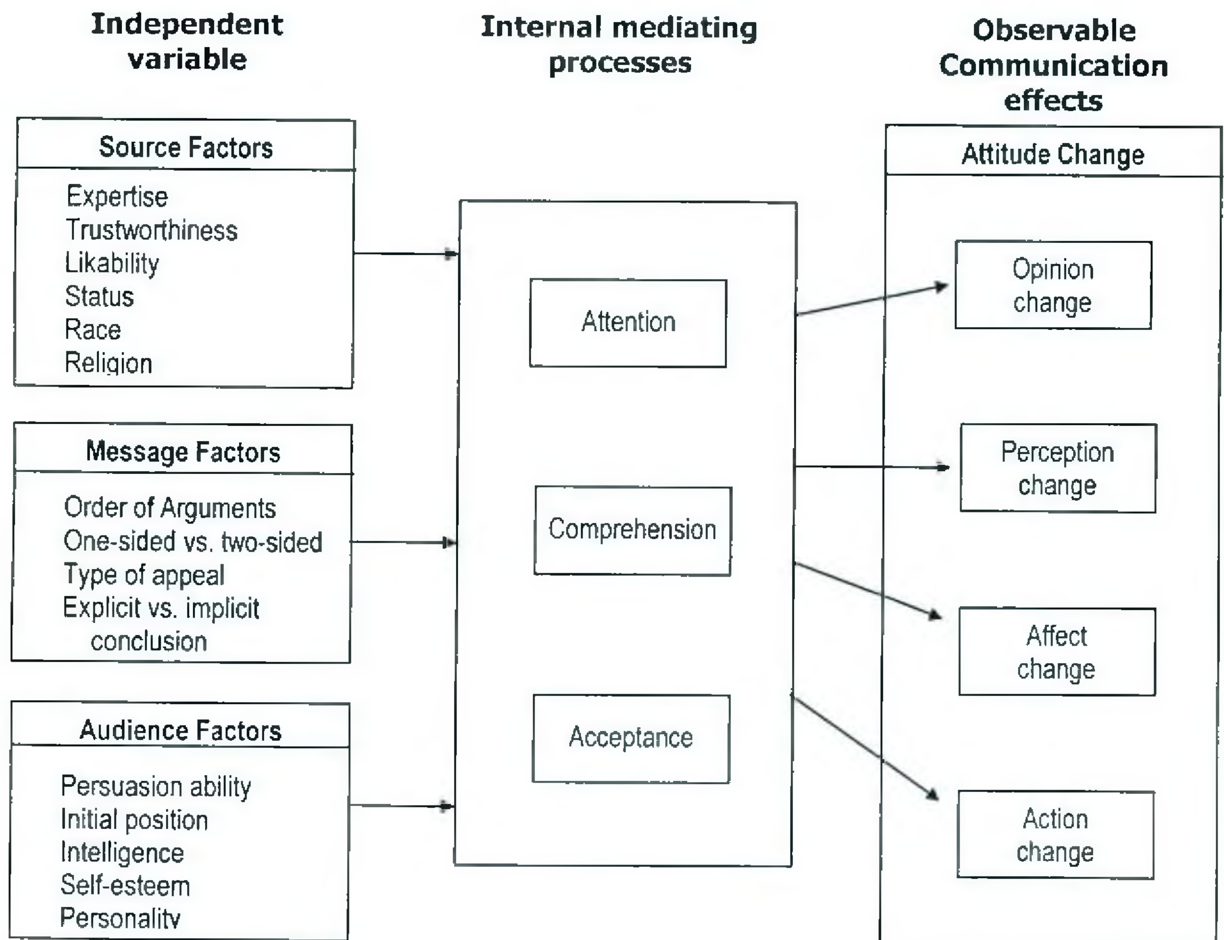


Fig. 1.2 Yale approach to communication and persuasion, (Based on Hovland and Janis, 1959)

Dhaka University Institutional Repository

The Theory of Reasoned Action

The theory of reasoned action[48] builds on research conducted by Fishbein and his associates. It represents a comprehensive integration of attitude components into a structure that is designed to lead to both better explanation and better predictions of behavior. This model incorporates a cognitive component, an affective component, and a conative component. [49] The cognitive component consists of a person's cognition's i.e. the knowledge and perceptions that are acquired by a combination of different experiences with the attitude object and related information from various sources. This knowledge and resulting perceptions commonly take the form of beliefs, that is, the consumer believes that the attitude object possesses various attributes and that specific behavior will lead to specific outcomes. A consumer's emotion or feelings about a particular product or brand constitute the affective component of an attitude (i.e. the extent to which the individual rates the attitude object as "favorable" or "unfavorable", "good" or "bad"). The conative component is concerned with the likelihood or tendency that an individual will undertake specific action or behave in a particular way with regard to the attitude object[50].

Figure 1.3 is a depiction of the theory of reasoned action. Working backward from behavior (e.g. the act of purchasing a particular service, product, or brand), the model suggests that the best predictor of behavior is the intention to act. Thus, if consumer researchers were solely interested in predicting behavior, they would directly measure intention (i.e., using an intention-to-act scale). However, if they were also interested in understanding the underlying factors that contribute to a consumer's intention to act in a particular situation,. they would look behind intention and consider the factors that led to intention, that is, the consumer's attitude toward behavior and the subjective norm.

---

[48] The theory of reasoned action was developed by Icek Ajzen and Martin Fishbein; Understanding Attitudes and Practicing Social Behavior, Prentice Hall 1980.

[49] This is taken from Consumer Behavior, written by Leon G Schiffman and Leslie Lazar Kanuk, Prentice Hall, 2000.

Dhaka University Institutional Repository

The consumer's attitude toward behavior can be directly measured as affect (i.e., a measure of overall favorability toward the purchase). Furthermore, as with intention, we can look behind the attitude to its underlying dimension.

In accordance with this expanded model, to understand intention we also need to measure the subjective norms that influence an individual's intention to act. A subjective norm can be measured directly by assessing a consumer's feeling as to what relevant others (family, friends, roommates, co-workers etc.) would think of the action being contemplated; that is, would they look favorably or unfavorably on the anticipated action? For example, if a college student were considering purchasing the Minolta camera and stopped to ask himself what his parents or girlfriend would think of such behavior (i.e., approve or disapprove), such a reflection would constitute his subjective norm.

As with attitude, consumer researchers can get behind the subjective norm to the underlying factors that are likely to product it. They accomplish this by assessing the normative beliefs that the individual attributes to relevant others, as well as the individual's motivation to comply with each of the relevant others. For instance, consider the student contemplating the purchase of a 100 CD Changer. To understand his subjective norm about the desired purchase, we would have to identify his relevant others (parents and girlfriend); his beliefs about how each would respond to his purchase of the Minolta camera (e.g., "Mom and Dad would consider the Minolta camera an unnecessary luxury, but my girlfriend would love it"); and finally, his motivation to comply with his parents and/or his girlfriend.

The above discussion and examples suggest that the theory of reasoned action is a series of interrelated attitude components (i.e., beliefs precede attitude and normative beliefs precede subjective norms; attitudes and subjective norms precede intention; and intention precedes actual behavior).

Consistent with the theory of reasoned action, an attitude is not linked to behavior as strongly or as directly as intention is linked to behavior.

---

[50] The word "object" include specific consumption or marketing related concepts, such as, product, product category, brand, services, possessions, causes or issues, people, ad, price, retailer etc.

Dhaka University Institutional Repository

Why study attitudes at all, if intention is ultimately a better predictor of behavior? The answer is simple: intention may be a better predictor, but it does not provide an adequate explanation of behavior. When marketers want to understand why consumers act as they do, they require something more than a basically mechanical measure of what consumers expect to do (e.g., their buying intentions).

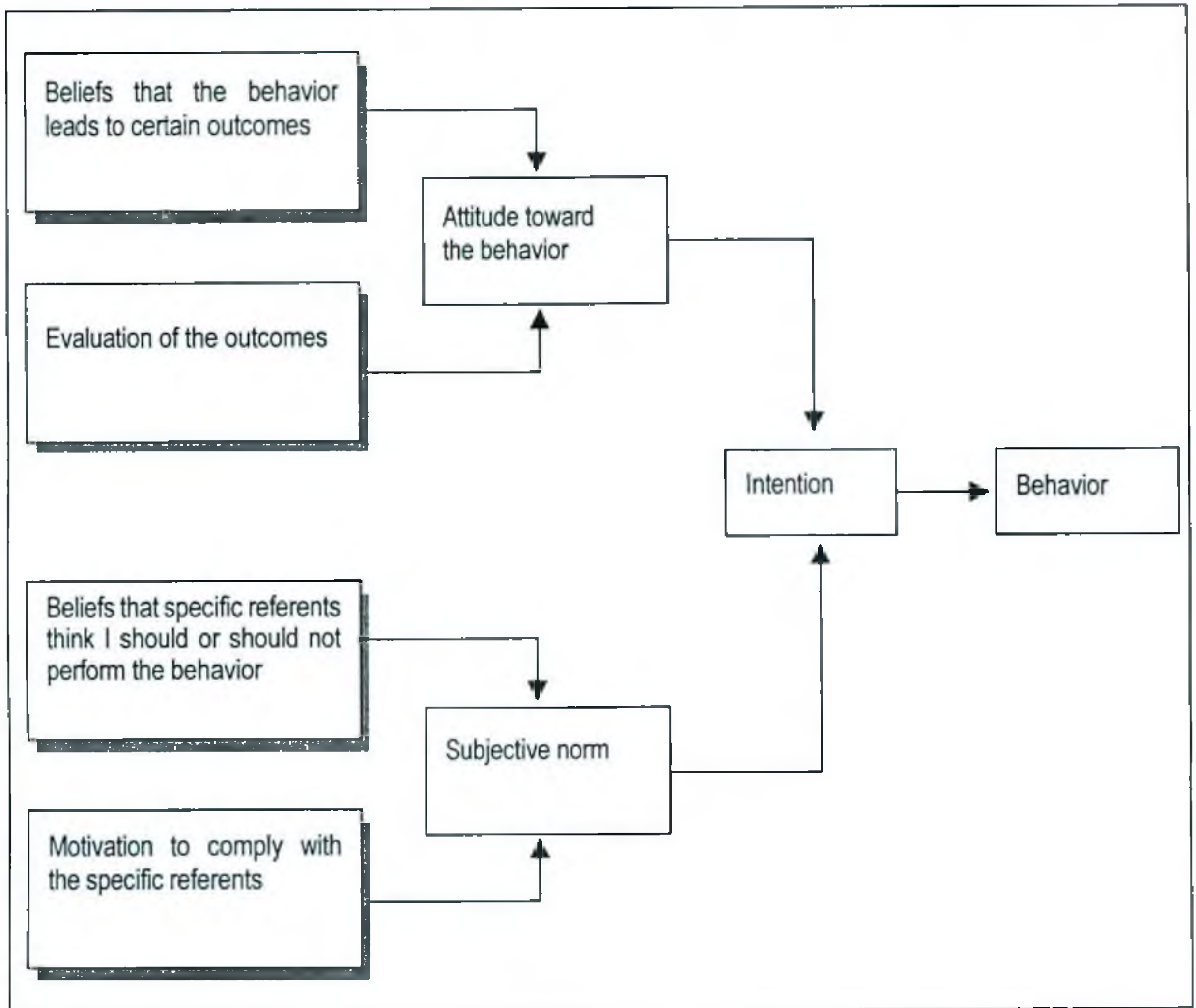


Fig. 1.3: A simplified version of the theory of reasoned action.

Dhaka University Institutional Repository

Fishbein and Ajzen in their Theory of Reasoned Action explained the relationship between intention and behavior, stated below:

- Intention – Behavior Relationship
- Determinants of Intention
- Determinants of Attitude and Subjective Norm

Elaboration of these are mentioned below:

Intention – Behavior Relationship

The Theory of Reasoned Action proposes that a person's decision to engage in a particular behavior is influenced by the extent to which the person intends to do so. Behavioral intentions reflect the extent to which the person is motivated to perform the behavior or, in other words, the person's willingness to perform it since motivation typically precedes determinant of behavior.

Fishbein and Ajzen (1975) described three factors that may weaken the intention–behavior relationship. First, the relationship between intentions and behavior is weakened if the measures of intention and actual behavior are not obtained at the same level of specificity. For example, a measure of the person's general intention to engage in HIV-preventive behavior is likely to have only a weak relationship with his or intention to use a condom with a regular partner.

A second factor that may weaken the intention – behavior link is the instability of a person's intentions. For instance, a person who intends to use a condom on every sexual encounter may start a relationship with someone who does not wish to use condoms. The person may, therefore, change his or her intentions, which means that the relationship between the earlier intention and subsequent behavior is weakened. The longer the lapse of time between a person's indication of his or her intention and the assessment of behavioral actions, the more likely it is that a person's intentions will change (Ajzen, 1988).

Dhaka University Institutional Repository

The third factor that they identified states that the strength of the intention may be influenced by behavioral links. A central assumption of the theory of reasoned action is that intention is an accurate predictor of behavior only when the person can perform the behavior at will or, in other words, is able to perform the behavior if he or she wishes to do so. According to Fishbein and Ajzen (1975), there should be a strong relationship between a person's intentions and his or her behavioral response.

Determinants of Intention

The second major prediction of the Theory of Reasoned Action is that a person's behavioral intentions are influenced by two conceptually distinguishable components, namely, attitude and subjective norm. This latter component refers to the extent of perceived social pressure to perform the behavior, whereas the attitudinal component of the model reflects how favorable or unfavorable a person feels towards performing the behavior. For some groups of people or some behaviors, attitude may be the primary determinant of intentions, whereas for other behaviors or other groups of people, intentions may be normatively controlled.

Determinants of Attitude and Subjective Norm

The Theory of Reasoned Action also identifies determinants of both attitudes and subjective norm. The person's attitude towards the behavior is proposed to be influenced by his or her beliefs about the consequences (i.e. costs or benefits) of performing a behavior. In representing the effects of these beliefs on a person's attitude, Fishbein and Ajzen (1975) adopt an expectancy-value model of attitude, which proposes that a person's attitude is influenced by his or her beliefs about the consequences of the behavior, weighted by the person's evaluation of these consequences. According to the expectancy-value formulation, a person will have a positive attitude towards performing the behavior if he or she believes that performing the behavior will lead to mostly positive outcomes; that is, positive outcomes are considered likely, while negative outcomes are considered unlikely.

Fishbein and Ajzen (1975) focus on a person's salient beliefs. For any one behavior, people typically have many beliefs (for instance, the average person is likely to be able to generate a large number of beliefs about safer sex). In the case of subjective norm, they also highlight the importance of considering the beliefs that are salient to a person.

Continuing Behavior Change

According to Kotler[51], getting individuals or groups to change their behavior permanently is harder than getting them to make one-slot action changes. People must unlearn old habits, learn new habits, and freeze the new pattern of behavior. In the area of birth control, for example, couples have to learn how to use new devices such as condoms and get into habit of using them regularly without anyone being around to help them or to reinforce the behavior. Change agents rely primarily on mass communication to influence permanent changes in low involvement behavior. In some case, mass communication can be counterproductive. For instance, in the late sixties, when many young people were experimenting with hard drugs, ad agencies, social agencies, and legislators felt that ad could be a powerful weapon for discouraging drug usage among non-users. Fear appeals were first tried, followed by more informational ad. Soon people began to voice doubts about the good that this was doing. The UN Secretary General , presenting a drug evaluation study to the UN in 1972, cautioned: "Special care must be exercised in this connection not to arouse undue curiosity and unwittingly encourage experimentation."[52] Anti drug messages, especially on TV, reach a lot of young persons who may never have thought about drugs. These young persons do not necessarily perceive the message negatively and might in fact develop a strong curiosity about the subject. Therefore, in changing continuing behavior, the researchers stressed the need to take enough measures so that insufficient knowledge of the audience or testing of the probable effects of their message upon the audience is not reflected as "experiment". In Bangladesh, the ad developers and communication persons have created various communication campaigns on some sensitive

---

[51] Kotler, Philip and Alen R. Andreasen; Strategic Marketing for Non Profit Organization, Prentice Hall, USA 1996

Dhaka University Institutional Repository

issues without proper research or investigation. As a resuit the end beneficiaries, i.e. the people became the "innocent victim" (for example, there was an ad on AIDS prevention, which was not pretested. Since there was a black cat in the ad, the audience perceived that cat is a source of HIV[53].)

Behavior Change Communication - BCC

In recent years, health and communication researchers have been concerned with investigating the factors and cause that influence peoples' willingness to engage in health care behavior (i.e. actions that promote well-being and help prevent disease). Research into the determinate of health care behavior is very important for both the individual and community as a whole. More recently, health and population researchers concentrate on behavior change communication (BCC) and how BCC can contribute and guide health-seeking behavior. With a view to having a planned and control life style, various BCC approaches are being developed.

Current BCC Approach in Bangladesh

Government of Bangladesh in collaboration with development partners (USAID, UNICEF, DFID etc.) and NGOs have taken various IEC activities/interventions, as follows[54]:

- Electronic mass media (TV, radio)
- Print media
- Visual materials (slides, cinema spots etc.)
- Clinic based counseling
- Field based campaign
- Flash cards, flip charts, booklets, short film etc.
- Folk songs, courtyard meting
- Enter-educate drama serials (Sabuj Chhaya, Eyi megh Eyi Roudra etc.)
- Nationwide training program on IEC

---

[52] Chicago Sun-Times, Wrong Publicity May Push Drug Use: UN Chief; May 8, 1972

[53] Hasan K, National IEC Study, Bangladesh Center for Communication Programs/Johns Hopkins University, 1998

[54] Integrated Behavior Change Communication Strategy for Health and Population Sectors; HPSP, MOHFW, GoB, 1999

Dhaka University Institutional Repository

7.3 SUMMARY OF RELATED APPROACHES

In summary, the Theory of Reasoned Action and further extension by different researchers, are based on the assumption that when making behavioral decisions, people consider the information available to them (the informational items as a whole), guided by the source of information and the message content. Specifically, it is also found that the immediate determinant of behavior is intention, which is expected to be influenced by the person's attitude towards performing the behavior and the extent of perceived normative pressure to do so. Personal beliefs about the behavior under consideration, as well as the person's beliefs about the expectations of others are, in turn, found to provide the informational bases of attitudes and subjective norms.

As discussed, Fishbein and Ajzen had drawn four basic guideline, which leads to change inferential beliefs. According to their model, a distinction between belief, attitude, intention, and behavior is essential for an analysis of the influence process. It is evident from the findings and case analysis that these four components do not always functions smoothly. On the contrary these theories and approaches, in real life situation there are some more factors which bars to create positive intention toward changing behavior.

The legitimate questions are –

Despite all the awareness and knowledge, beliefs and attitude toward change, people still do not change their behavior. Why people behave differently? What factor still exists which guides people in changing behavior? Following section explains how other factors guide in changing positive intention and thereby

Dhaka University Institutional Repository

CHAPTER 8

THE THEORY OF BEHAVIOR CHANGE: PROPOSED MODEL

Dhaka University Institutional Repository

because they themselves were treated badly by their mothers-in-law previously and now they are treating their own daughter-in-law the same way as a sort of revenge. Likewise, some double standards are prevalent where mothers-in-law cannot look upon their daughter-in-law as their daughter and thus have different attitude towards them.

Marriage, Poverty and Women Trafficking:

Parents are aware that they place their daughters in the wrong hands when getting them married without a registration but they have no option otherwise. They are forced to turn a blind eye to the whole issue since their hands are tied.

In order to change the attitude and practices of these people a lot of campaigning (supported by counseling, advocacy) will have to be done. The people must be made aware that they can change these attitudes and practices if they wish to do so. However, it is not enough just to increase the awareness of the people in terms of these activities but other factors responsible for the whole situation i.e. poverty and illiteracy has to be reduced if not eliminated totally.

Smoking Behavior:

Like schoolteacher Karim, there are many smokers who do not give up smoking despite knowing fully well that it is injurious to health. They "cannot" not take proper decision on health seeking behavior, rather they creates "self defense mechanism" just to validate their failure. Is it just failure or negligence or lack of total commitment?

Virility of a Husband:

Knowing fully well, Khaleda admits to the sexual demands of her husband and, she also knows that it is unwise to accept the "virility" of her husband. Khaleda could not take any action to change the behavior of her husband, rather she accepts his 'devil' deeds. She, due to socio-economic reasons, have to recognize her husbands desire, which she doesn't believe to act. The problem here is not only the sexual factor between the couple but also the economic status.

Dhaka University Institutional Repository

Positive Attitude Re-established & Change of Intention

Investigation, Counseling and Advocacy:

With a view to overcome unanticipated and deliberate act (as stated in the above cases), proper investigation (or research) followed by counseling and advocacy may lead toward positive intention. Following steps may be adopted:

- Investigate the situation and find out the real cause of unanticipated or deliberate act.
- Take corrective measures
- Behavior change communication for the object responsible for the situation
- Advocacy for the individual (i.e. target audience)
- Motivation and stimulus provided by peer groups and educators.
- Brainstorming and debates among peer groups, target audience and other related parties
- Spread messages by word of mouth or by gathering a group of people and then utilizing the snowballing effect.

Internalize the Whole Message:

Knowledge is not every thing rather internalizing the whole message plays a vital role in changing the behavior. As stated earlier that the people have gathered knowledge on health and family planning issues, but there is still a gap in practicing the message. Therefore, unless the whole message is not internalized, change of behavior toward practicing family planning and health seeking issues remains a pipe dream.

Once the cause(s) of effecting/influencing attitude is identified and proper actions are taken (as narrated above), positive attitude may be re-established and therefore, this may help developing positive intention, which further may lead toward behavior change.

Dhaka University Institutional Repository

Final Action: Behavior Change

At this stage of research, it is expected that the audience may change their behavior or the process of changing behavior may be initiated. After investigating the cause of creating negative intention and taking corrective action may induce some effect on the audiences' attitude and intention. Proper counseling and advocacy (on the basis of investigation) may help toward creating a foundation for positive intention. Only then the process of behavior change may start functioning.

CONCLUSION

The proposed model may be used to change different in-built beliefs as well as other inferential and intervening beliefs of a person with the aid of communication intervention. The model depicts the different stages through which various inter-linking and pertinent information are communicated and processed throughout the flow chart of the model.

This flow chart may be implemented with the exposure of people to various information items such as communication materials that may depict various aids and illustrated messages. These items are treated and filtered through the first phase of the model according to three distinct nodes namely source, message and audience. This filter mechanism will ensure that the information gathered by the target audience is from the proper source and presented through proper reasoning and argument. It will also account for the intelligence and personality of the audience. In the event, all information will be screened and filtered ensuring that the information gathered is both credible and trustworthy as a whole. But if due to some reason the information is not adequately credible, then these will be filtered again to ensure that the source, message and audience have been accounted for.

The next step of the flow chart shows how the credible information items are then imposed on the different beliefs of the people. An individual may arrive at a given belief in various ways. For instance, if someone, then based on this belief, holds the belief that people who visit health centers are health conscious, it can be assumed that these health conscious people will not get

Dhaka University Institutional Repository

deadly diseases. This conclusive attitude is assumed and reached by that person on the inference based on syllogistic or logical reasoning. Thus, that person may assume that those who visit health centers will not get deadly or serious diseases as they are health conscious. Since health consciousness cannot be directly observed, the only way a person can acquire this belief directly is by accepting information from some external source indicating that visiting health centers ensures the prevention of deadly diseases.

The external source is thus, in the form of communication materials such as posters, banners, leaflets etc that may be used to make people aware of the importance of changing the attitude towards visiting health centers to prevent the occurrence of deadly diseases. But for the external source to affect the beliefs positively there must be a degree of acceptance by the person. A new belief cannot be formed without this acceptance. However, if the person either consciously or unconsciously rejects acceptance, then the credible information will have to impose on the proximal, inferential and intervening beliefs once again.

On the other hand if the external source is able to impact the proximal, inferential and intervening beliefs of that person and bring forth some form of acceptance, then change in attitude, intention and behavior will be forthcoming. The external source or materials may also be used in the form of a catalyst and act as intervening beliefs, which cause an impact on dependant variables or basic beliefs of that the person holds. So it can be assumed and expected that a new belief will be formed at this stage of the process with the acceptance of the person. Since if the belief is not accepted then the credibility of the information items will not be ensured.

Moreover, if a person does not have the positive intention to change, then that change cannot be brought on. Supposing that person may have the positive attitude that is conducive to positive intention, even then, situational factors such as unanticipated and deliberated situational factors will come into play and prevent the positive intention from taking place altogether. In this case, there will be no intention of the person to change his or her attitude.

Dhaka University Institutional Repository

In the event of this happening, the flow chart shows how the situational factors will have to be investigated in order to find what had caused the intention of the person not to change. Once the cause is identified and isolated then corrective measures may be taken to rectify the hindrance. If and when this hindrance and obstruction is isolated only then can it be possible to focus the campaigns towards thot incriminating aspect. As a direct result of this, counseling and advocacy can then be accurately directed to the specific problem and thus rectified.

As the flow chart implies, after all the information items are properly processed through this model, only then can the positive changes in intention and attitude be achieved. The final action or behavior change of an individual can thus be brought on with the accurate execution of stages depicted in this model.

Dhaka University Institutional Repository

APPENDIX

Dhaka University Institutional Repository

APPENDIX

BASIS FOR EVALUATING PROMOTIONAL CAMPAIGN

Some International Methods for Evaluating Promotional Campaign

Monitoring and evaluation are tools that help measuring how successful the campaign is. Too often, monitoring and evaluation are seen as one activity. Also, many people assume they are carried out at the end of a campaign to make a critical judgment about it (in other words, to determine whether the campaign "succeeded" or "failed"). In fact, monitoring takes place during every step of the campaign and evaluation comes at the end of the campaign and tries to assess what the results were.

What to Monitor

Monitoring overall process in terms of:

- Timeliness -
- Cost - activities costing as per budget?
- Cooperation and Collaboration
- Personnel - are staff carrying out their assigned duties

Monitoring outcomes in terms of:

- Research
- Messages
- Pre-testing
- Information Channels

Evaluation Techniques As Suggested By Different Authors

There are several approaches to assessing the quality and impact of communication campaign. Now some of the well-accepted approaches are stated below:

Dhaka University Institutional Repository

"Getting the Message Out: Designing an Information Campaign"

By Ann M. Starrs & Rahna R. Rizzuto, NY, USA 1995

Evaluation process:

- Review of project documents: Records of the monitoring activities during information campaign be a valuable resource for the evaluation.

- Interviews with staff and those responsible for managing and conducting the campaign: These interviews give an insider's view of what happened during the campaign.

- Review of records

- Individual interviews with representatives of the target groups: In the communities where the information campaign was conducted, representatives of the target group(s) can be chosen at random and interviewed in the following ways:
    - In-depth interviews
    - Quantitative surveys

- Focus Group Discussions: FGDs with the members of the target groups who had access to the messages. The same types of questions that were asked in an in-depth h interview can be used to guide the group discussions. Only one has to make sure the participants are not the same people who were interviewed during any other stages of the campaign.

- Observation of the target groups to study people's reactions to the messages.

- KAP Survey: These surveys provide a statistical measure of whether people's attitudes and behavior have changed. For e.g. Aware of the danger signs of pregnancy? Going for antenatal care? Using STD services? Have more positive attitudes toward the use of condoms? This

Dhaka University Institutional Repository

kind of information is very valuable for demonstrating whether a communication campaign has had impact. Steps to do a KAP include:

- Decide on sampling frame
- Draft, pretest and finalize the questionnaire
- Train interviewers
- Conduct the survey
- Clean, input, and tabulate the data
- Interpret the data and the findings

What to Evaluate:

➢ The overall process and structure:

- Were all the activities carried out according to the original work plan or timeline?
- Did expenses fall within the original budget?
- Did staff carry out their duties and responsibilities?
- What lessons were learned during this project?

➢ The outcome of each stage of the campaign:

- What new information did the research uncover?
- How these information be shifted?
- How did the goals, objectives, and activities change during the campaign as a result of new information and activities?
- Was the communication messages accepted, understood, and liked by the community?
- Are the communication messages and materials being used in the target communities?
- How effectively did the chosen information channels convey the messages or materials?
- Who is being reached by the communication campaign (according to target characteristics such as gender, age, and educational background)?

Dhaka University Institutional Repository

- The results of the campaign:
  - Did the objective of the campaign materialize? Why not?
  - Have target groups, both health care providers and clients, changed their attitude or beliefs as a result of the communication campaign?
  - Have target groups changed their behavior as a result of the communication campaign?

"Strategies for Family Planning Promotion"

World Bank Technical Paper # 223, World Bank, USA 1994

IEC programs, no matter how carefully designed, rarely proceed exactly according to plan. An effective monitoring and evaluation systems help to make the campaign successful. The overall impact of the campaign is evaluated and future activities are planned accordingly. According to this World Bank paper, *evaluation should be an integral component of IEC programs built in from the beginning.*

Some of the effective evaluation techniques used to measure changes in knowledge, attitude and behavior are:

- Baseline and Follow-up sample surveys
- Time series analysis of data/records before, during and after the campaign/intervention;
- "Mystery clients" interview

Hierarchy Of Communication Effects Evaluation:

- Knowledge Stage:
  Recall (spontaneous and aided) of messages
  Comprehension of messages
  Knowledge and skills for effective practice (of methods, for e.g. FP, ORS etc.)

Dhaka University Institutional Repository

- Persuasion Stage:

  Liking, positive emotional response, and approval

  Discussion of sensitive issues with spouse, friends etc. as promoted through the campaign

  Acceptance/agreement of messages

  Positive image of service providers

- Decision Stage:

  Intention to take additional information and advice

  Intention to practice the information

- Implementation Stage:

  Acquisition of additional information, advice

  Acquisition and use of appropriate method as stated in the campaign

  Continued use of method

- Confirmation Stage:

  Recognition of the benefits as promoted through the campaign

  Integration of practice (e.g. FP, STD/AIDS prevention etc.) into one's life

  Promotion of practice among others

"Model Protocol for Tracking Promotional Campaign"
by SOMARC, USA

Methods followed to evaluate promotional Campaign:

- Tracking Survey (Pre-launch and Post launch campaign); it is basically a quantitative survey among the target audience with a view to track knowledge, attitude and practice (KAP) of concept and product related to the campaign.

Dhaka University Institutional Repository

Chapter 8

THE THEORY OF BEHAVIOR CHANGE: PROPOSED MODEL

Social changes can be brought about by means of changing attitude, intention and behavior of individuals. If they are influenced in certain ways then their attitude, followed by intention can be changed. Individuals need to be exposed to new information about some object, event, issue or aspect if this is to lead to changes in beliefs without which there is no scope or foundation from which influence attempts can be made.

Usually an attitude of a person is determined by his/her salient beliefs about the attitude object. Moreover, beliefs about a given behavior determine a person's intention to perform the behavior and thus manifest that behavior as well. It may be stated that a person's belief about an object is based on the perceived relation between the object and its attitude.

Behavior change is found to be the most difficult part of every effort. It is obvious that people take a long period to change their behavior, and it is not expected them to change over night. A person cannot adopt a new behavior just by hearing it once or just seeing an IEC material or just exposing to a BCC campaign. In general there are five characteristics steps associated with the process of individual behavior change:

- Awareness and knowledge
- Approval through belief
- Formation of positive attitude
- Positive intention
- Counseling and Advocacy
- Practice and change of behavior

Dhaka University Institutional Repository

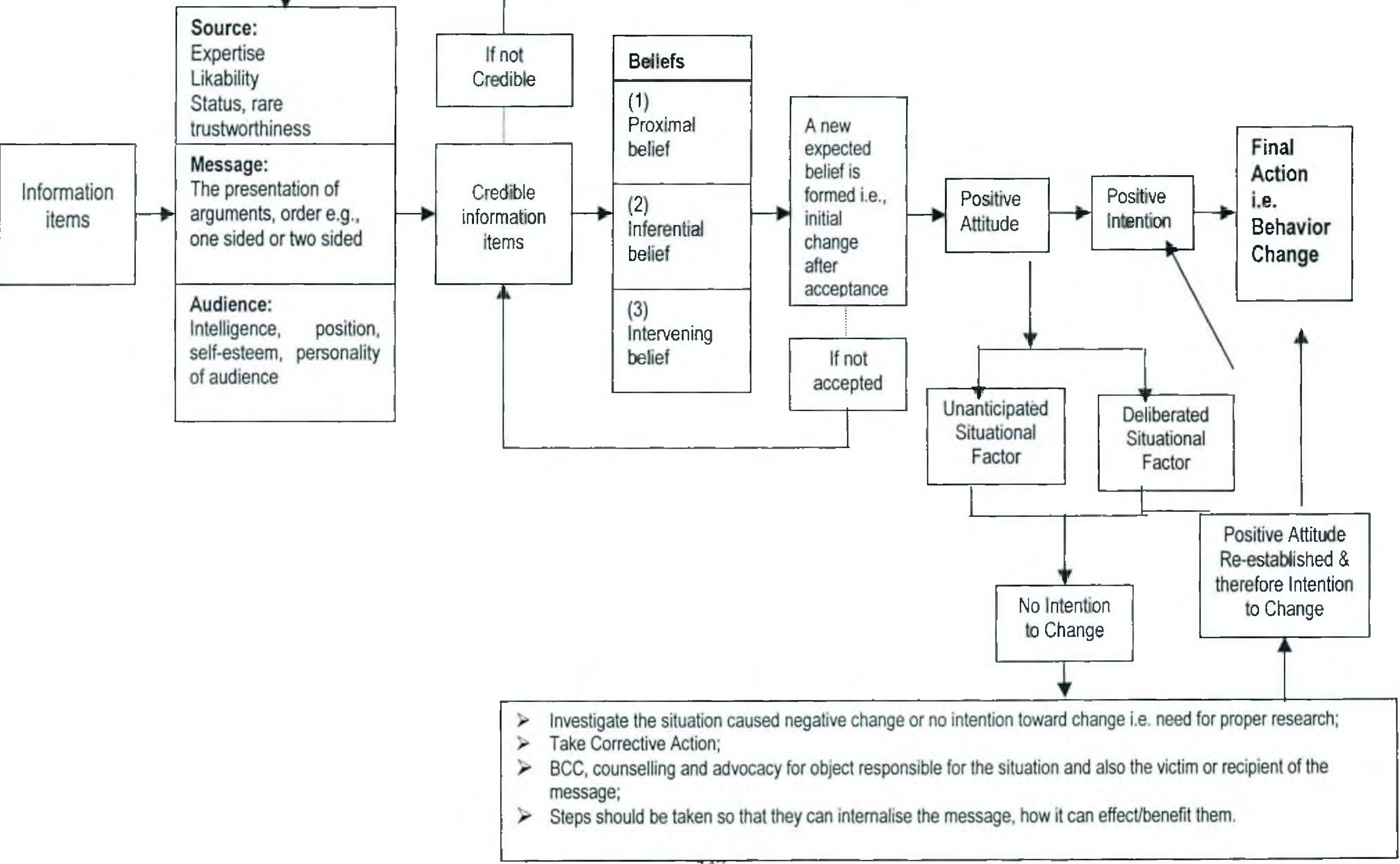
It is not necessary for an individual to go through all five steps, but sometimes it occurs that way. If we look on those steps, step one and two are the easiest one and being achieved in most of our areas in our life cycle. The variation of behavior change process starts during formation of positive attitude toward the desired object. For instance, people have knowledge on how HIV/AIDS is transmitted and how can an individual avoid it; people agree and approve the preventive methods, but in reality, as observed in many cases, people (clients of sex workers or some times the sex worker her self) do not comply with their knowledge, behave differently.

The big problem, which contributes towards not changing behavior, is "intention" - that is where we need to look upon. We need to make our efforts and our campaigns concentrate on how we can increase the intention process and not the knowledge. Many times we have been looking on the knowledge and awareness creation, something that we no longer need. The intention will lead to the practices, hence changing behavior. It is imperative to find out why people behave differently knowing fully the curse of not having positive intention. Do they not "internalize" the message? The following "model" will show the process of changed behavior under the caption - Theory[55] of Changed Behavior.

[55] Theory is a set of interrelated principles and definitions that serves conceptually to organize selected aspects of the empirical world in a systematic way. A theory includes a basic set of assumptions and axioms as the foundation and the body of the theory is composed of logically interrelated, empirically verifiable propositions. A theory thus is the scholar's construction of what an experience is like, based on systematic observation. Theory in the strict sense means a set of propositions comprising a system, from which justifiable conclusion can be drawn from a confrontation with observed data. (Source: Wolfgang J. Koschnick, Dictionary of Social and Market Research New York 1996)

Dhaka University Institutional Repository

The Theory of Behavior Change: Proposed



Dhaka University Institutional Repository

The above proposed model has been designed to show the various stages by which the behavior of people can be influenced through a versatile approach that enhances ways to effectively impact individuals. This model is based on a progressive flow chart that depicts all the steps in the stages leading up to the behavior change. A brief elaboration of the model is mentioned below.

Information Items

Information items such as communication materials or campaigns play a huge role in impacting people to a great extent. Thus, prime information items could be in the form of communication materials such as posters, leaflets, flyers, banners or/and video films etc. that are strategically positioned to communicate targeted audience.

Other information items could be key personnel who can impact the attitude of others through interaction or by giving advice and counseling. Inter personal informal communication may also play a positive role toward creating a basis for informational items.

Filter Mechanism

A filter mechanism is used to sieve through the different information items that people may be exposed to. The flow chart depicted in the proposed BCC model highlights the different ways by which information is filtered in order to ensure that people are exposed to information that is from the proper source and presented through experts or credible source that have proper know-how. This filter mechanism is enforced by ensuring three things, that is, the information gathered must be from the proper source, have the accurate and effective message and be targeted to the proper audience.

Credible Information Items

The flow chart depicts how information is presented as credible only after it passes through the filter mechanism. People will be exposed to information items so as to influence their respective primary, inferential and intervening beliefs. However, there is no point imposing a target group of people with

Dhaka University Institutional Repository

information items that hold no credibility in terms of the source or message it contains. Needless to explain that if the information is not credible then there will be no influence ultimately. Therefore, on the basis of experience, understanding and skills, the audience would verify the credibility of the information items. If it were found credible, the information would create a basis for belief – proximal, inferential and intervening belief.

Beliefs and Values

As a whole, information items that revolve around other pertinent beliefs can directly influence the beliefs of people. Thus, in a broad sense, beliefs are broken down into three distinct types of beliefs as mentioned below:

- Proximal or external beliefs
- Inferential beliefs
- Intervening beliefs

Brief descriptions of these are mentioned below.

Proximal or external beliefs:

One of the fundamental problems is to identify any influential attempts that need to be changed in order to influence the dependent variables under investigation. Such belief serves as the basic developments of the dependent variables, called "primary beliefs".

Case 1:

For example when the dependent variable is the attitude towards an institution, for instance, "Sabuj Chhata Clinic", the beliefs about the characteristics of Sabuj Chhata Clinic is a primary belief at which the influence attempts can be directed. It is deep-rooted belief that one gets cured if he/she visits a clinic. There is a correlation between "clinic" and "cure".

Ruki, 22, a newly wed, has similar feelings. Since Sabuj Chhata is a clinic, there is a possibility of every "good cure". She holds a primary belief that Sabuj Chhaya provides good services, especially on EOC.

Dhaka University Institutional Repository

Inferential beliefs:

An inferential belief is primarily a belief, which is not induced directly but is instead induced indirectly where individuals decide themselves and come to their own conclusion about holding a belief about an aspect. Inferential beliefs are formed on the basis of other beliefs that the individual holds. Changing some or all of the relevant (or primary) beliefs that provide the basis for the inference process can bring about change in an inferential belief. An inferential belief of some kind can be changed by an influence attempt. To do so, one must induce changes in primary beliefs that are probabilistically related to and thus relevant for the inferential belief. In fact, the dependent inferential belief may be the end product of a chain of prior inferences also.

Case 2:

After a while, Ruki has experienced that her friend went to a Sabuj Chhata Clinic. And after some days they happily (i.e. friend) returned to their normal life. She made an inference that Sabuj Chhata Clinic provided a treatment and it seems that is satisfactory.

Intervening beliefs:

Intervening beliefs are in fact a part of primary beliefs. While primary beliefs are already developed in a person and are not subject to change most of the time, intervening beliefs are those that can act as a catalyst to make room for change in the primary beliefs. Thus, in a broad sense, intervening beliefs are additional beliefs that become associated with the inherent primary beliefs of a person.

Moreover, a person may form a belief directly by observing an object-attribute relation or accepting information to the effect that the object has the attribute, or he may form a belief indirectly by means of some inference process. Inferential beliefs are formed on the basis of other beliefs that the individual holds.

Case 3:

By now Ruki has formed an additional belief that Sabuj Chhata Clinic is a good clinic. He has seen IEC materials on the Sabuj Chhata Clinic, which had already created a base. Primary belief supported by inferential belief and further propounded by intervening beliefs has helped to form a new belief.

Formation of New Belief

The next step in the flow chart of the "model" depicts how the formation of a new belief is enforced after the different types of beliefs have been targeted and changed. But it may be mentioned that an individual does not form new beliefs until and unless these are consciously or sub-consciously accepted by that individual.

Case 4:

Ruki is now pregnant, advanced stage. She has seen that her friend who is satisfied with the service of the clinic. As a result a new feelings start working within her mind. And has formed a new "expected belief" that if she goes to Sabuj Chhata clinic she will get "good" treatment and care. She and her husband decided to go to the Sabuj Chhata clinic for delivery. This is the formation of positive attitude toward Sabuj Chhata clinic.

Positive Attitude

The next stage of action depicted in the proposed model comprises of the formation of positive attitude of an individual in terms of a certain behavior or attribute. This change in behavior can be enforced if changes had been brought on with the change in existing belief of that individual. Thus, the action is in fact the sequence of events that have led to the positive change and thus making that individual want to change that existing attitude for another attitude or behavior. But in order for the change in belief to actually occur, there must be a stimulating factor that will provoke the existing belief or attitude that is already in-built within that person. This stimulating factor will have to be very significant and change defining aspect otherwise a built in attitude or belief can never be changed.

Dhaka University Institutional Repository

No Impact on Awareness and Attitude turned Negative

Impact is hard to enforce if values and beliefs are deep-rooted within a person. If a certain awareness is deep rooted, there can be limited impact upon it. Likewise, if an existing attitude is already imbued within an individual, there is the chance that the attitude will become negative when change needs to be brought on.

On the other hand, if the information items are against the existing belief and could not contribute toward desired changes and moreover the information is against the values (which is deep-rooted), the individual will stick to her/his old practice and behavior. It may be worth mentioning that if the information items stretch the individual's values, negative attitude may or will form toward the desired behavioral changes.

Case 5

Amina had gone to Sabuj Chhata clinic once for treatment. She had not anticipated finding a male doctor as she was hoping to discuss her problems with a female doctor instead. She is conservative and she doesn't want to discuss her private health problems with a male doctor. Her cultural and religious values go against the aspect of confiding in a male doctor. The society and Islam as a whole, do not permit females to associate with any type of males except one's own family members. After her arrival at the clinic she saw a male doctor (which was not known to her earlier) and she was faced with an initial shock. The male doctor wanted to listen to her and requested her to come to his room and explain her problems. The whole approach of the doctor and the thought of talking about her pregnancy problems with him were not favorable circumstances to Amina and she left the clinic.

Positive Intention

Positive intentions are usually formed from positive attitude. So it is expected that if a person has a positive outlook or attitude, he or she will also have positive intentions as well that stems from that positive attitude. However, this

Dhaka University Institutional Repository

simple scenario may not have a smooth outcome always. In reality, many incriminating circumstances occur which act as hindrances and cause some "unanticipated" situations to appear. Such unanticipated situations lead the individual back to their original behavior. Despite having the awareness, knowledge and positive attitude, the individual sometimes ignores her/his knowledge and attitude deliberately. In the process, the change in behavior does not take place.

Unanticipated Situation

Due to unanticipated situational factors, one may not intent toward fulfilling his/her desire toward inducing actions i.e. change of behavior. For instance, if a woman wishes to go to the health center for pregnancy care, she may suddenly change her mind after she reaches the hospital and sees the dead body of another mother who had come for treatment at that same health center for the similar issue i.e. pregnancy and delivery. She will automatically feel that she may end up dead also and thus she will turn back and decide to take more traditional or herbal treatment instead. This unanticipated occurrence will prevent her from taking treatment from that health center and she may never return there either.

Case 6

The circumstances of another case revolve around a similar scenario. Rahima was mentally prepared to have her child delivered in the Sabuj Chhata clinic. Just before taking admission she came to know that two newly born children died due to lack of proper and quality of care. She instinctively changed her mind about having the delivery in that health center after overhearing people talking about the death of the babies occurring due to the poor performance of the doctor and nurse. As a direct result of this, Rahima changed her mind about having her delivery there and went back to her old preference i.e., to deliver at home as she had done with her first baby. This unanticipated news prevented her from having the delivery in the health center and she got a bad vibe about the health center and thus opted for a home delivery instead.

Dhaka University Institutional Repository

Thus, unanticipated factors and occurrences may hinder the resolve of people at the time of decision-making. Likewise, certain impeding situations and circumstances may suddenly get in the way and prevent that extra push which is needed to direct someone towards that change. In other words, the instincts and vibes that a person has about a situation gets in the way and even if he or she wants to, their gut feeling does not permit them to move towards that change in the end.

Deliberate Act

Despite of knowledge and awareness, the audience may act deliberately against his/her acquired knowledge and some times her believe. The following cases (which are already explained in Section 6.2) are the examples of such deliberate acts.

TT Case:

It has been observed in many cases how the mothers of only girl children are frustrated with the pressures of producing a son heir. Thus they do not want to give birth to another girl child and in the event, they deliberately do not taken TT injections so that unborn child may die. Everyone in the society so much harasses them that they would rather deliberately kill the unborn baby instead of giving birth to another girl.

Sex worker:

The sex workers are looked upon with disgust and hatred and as a result the sex workers themselves consider themselves to be worthless human beings. Due to this stigmatization they would rather die than live in a hated society. Thus, some of them deliberately do not take precautions (by using condoms) with clients even though they know that they may get infected with deadly disease like AIDS.

Mothers-in-law:

As a whole, mothers-in-law are weary of their daughters-in-law. They do not treat them properly and are not given any decision making power. This is

"Communicating Population and Family Planning Information"
by OPTIONS for Population Policy, The Futures Group, USA 1994

There are several approaches to assessing the quality and impact of communication campaign. These approaches fall into three categories:

- Performance evaluation
- Outcome
- Impact

Research methodologies to collect information and thereby evaluating the campaign:

- National surveys
- Small sample survey
- Focus Groups and in-depth interviews
- Panel study
- Experts contacts
- Media review
- Administrative and political data

"Quality of Care in Family Planning"
by Family Health International, USA 1993

Assessment tools and methods to evaluate any communication campaign:

- Client Satisfaction Studies
- Consumer intercept studies
- Demographic and health survey
- Focus Group Discussion
- Observation
- Operations Research
- Panel Studies
- Simulated/Mystery Client Studies
- Situation Analysis

Dhaka University Institutional Repository

BIBLIOGRAPHY

1. Abedin S; Islam MN, "Implications Of Contraceptive Practice On Future Fertility Trends In Bangladesh" *Journal Of Family Welfare*. 1994

2. AED; *Handbook for Excellence in Focus Group Research*, Academy for Educational Development Healthcom, USA, 1991

3. Andaleeb, SS, "Explaining the Commitment of Field Workers in the Family Planning Program: Perspectives from Bangladesh"; USA, 1995

4. Allen KB, "Desire, attitude and supply: why contraceptive use is so high in three Bangladesh family planning programs". Doctoral dissertation, University of Pennsylvania, 1993.

5. Amin R, "Evaluation in Bangladesh family planning program". Proceedings of the Seminar on Family Planning, November 21-25, 1972. Dacca,

6. *"Bangladesh Population Report"*, Ministry of Health and Family Planning, 1973.

7. *Bangladesh Constitution*, Government of the People's Republic of Bangladesh.

8. Bangladesh, South Asia Region. International Planned Parenthood Federation [IPPF]. Public Affairs Department IPPF *Country Profiles*. 1994 Jan;:1-6.

9. Bangladesh Bureau of Statistics, *Statistical Yearbook*, Dhaka 1993

10. Bangladesh Bureau of Statistics, *Agricultural Statistics*,. 2001

Dhaka University Institutional Repository

11. Bairagi R; Becker S; Kantner A; Allen KB; Datta A; Purvis K, "Evaluation of the Bangladesh 1993-94 Demographic and Health Survey within the Matlab Demographic Surveillance System": initial findings.[Unpublished] 1995. Presented at the Annual Meeting of the Population Association of America, San Francisco, California, April 6-8, 1995.

12. Bairagi R; Rahman M, "Levels, patterns, and determinants of contraceptive failure in rural Bangladesh", [Unpublished] 1994. Presented at the Annual Meeting of the Population Association of America, Miami, Florida, May 5-7, 1994.

13. Carty WP; Yinger NV; Rosov A "Success in a challenging environment: fertility decline in Bangladesh". Washington, D.C., Population Reference Bureau, 1993 Sep.

14. *Chicago Sun-Times*, Wrong Publicity May Push Drug Use: UN Chief; May 8, 1972

15. Chowdhury D; Harvey SM, "The male role in contraceptive continuation among urban women of Bangladesh". [Unpublished] 1994. Presented at the 122nd Annual Meeting of the American Public Health Association [APHA], Washington, D.C., October 30 - November 3, 1994.

16. Dennis Hapugalle, "Planned Parenthood and Community-based distribution of contraceptives in Sri Lanka/" in Jacqueline S. Gardener et. al. ed. *"Village and Household Availability of Contraceptives: Africa/West Asia,* March, 1977.

17. Donnay F; Jourdain A, Controlling fertility. *Children In The Tropics*. 1991

18. EWC; "Population Dynamics in Bangladesh", East-West Center, USA, 1992

Dhaka University Institutional Repository

19. Fishbein, M., and I. Ajzen, Belief, *Attitude, Intention and Behavior: An Introduction to Theory and Research*, Reading, MA: Addison-Wesley 1975

20. Fisher AAA et al; *Handbook for Family Planning Operations Research Design*, The Population Council USA 1991

21. Folmar S; Alam SM; Sharif AH, "Condom use in Bangladesh". [Unpublished] 1993. Presented at the Annual Meeting of the Population Association of America, Cincinnati, Ohio, April 1-3, 1993.

22. GOB, "Integrated Behavior Change Communication Strategy for Health and Population Sectors"; HPSP, MOHFW, 1999

23. GOB, "Bangladesh family planning programme 1986" Bangladesh. Directorate of Family Planning. Information Education and Motivation Unit 1989.

24. GOB, "*Report on Family Planning in Bangladesh*". Directorate of Family Planning. Dhaka 1995.

25. GOB; *The Two-Year Plan of Bangladesh 1978-80*, Planning Commission, Dhaka 1978

26. GOB; *The Second Five-Year Plan of Bangladesh 1980-85*, Planning Commission, Dhaka 1980

27. GOB; *The Third Five-Year Plan of Bangladesh 1985-90*, Planning Commission, Dhaka 1985

28. GOB; *The Fourth Five-Year Plan of Bangladesh 1990-95*, Planning Commission, Dhaka 1990

29. GOB; "*Report On Population Growth*", MOHFW, GOB, 1996

30. GOB; *Statistical Pocketbook Bangladesh 96*, Bangladesh Bureau of Statistics, Dhaka 1997.

31. GOB; *Bangladesh Family Planning Program: Achievements and Challenges*, 1993

32. GOB; *1975 Bangladesh Fertility Survey*, Ministry of Health & Population Control, 1978.

33. Haider SJ, "Study of rural leadership and implications for community participation and development in the health and family planning programs in Bangladesh". Doctoral dissertation, University of Texas, 1989.

34. Hasan K, "Population Growth and Development in Bangladesh", *Business Executive*, Dhaka University, 1992

35. Hasan K, "National IEC Study", Bangladesh Center for Communication Programs/Johns Hopkins University 1998

36. Hasan K, "Baseline Survey on Nirahpad Ma Project, CARE Bangladesh" Dhaka 2002

37. Hoque MN; Murdock SH, "Trends and differentials in contraceptive use in rural and urban Bangladesh, 1983-1991". [Unpublished] 1995. Presented at the Annual Meeting of the Population Association of America, San Francisco, California, April 6-8, 1995.

38. Hovland, C. I., and I. L. Janis. *Personality and Persuasibility*. New Haven, CT: Yale University Press, 1959

39. Hussain A, "Communication and motivation in the Family Planning Programme in Bangladesh".; Report of the seminar on Regional

Dhaka University Institutional Repository

Consultation on Updating the Motivation Strategy, 1st to 4th October 1979. Colombo, International Planned Parenthood Federation, 1979.

40. Hussain A M Zakir, Challenges in Health Services Delivery in Bangladesh; *Journal of Social Research*, Vol 1, No 1, 2000

41. ICDDR,B: "Report on Two Field trips & Comparative Analysis", MCH-FP Division, Dhaka 1994

42. ICCDR,B: "Center shares its success in family planning work with the NGOs in the SAARC region". *GLIMPSE*. ICDDRB, Dhaka 1995 Mar-Apr;

43. IPPF, "Bangladesh: strengthening of the IEC component of the Family Planning Programme at the union level. Report of the seminar on Regional Consultation on Updating the Motivation Strategy", International Planned Parenthood Federation, Indian Ocean Regional Office, 1979

44. Islam MA, "National family planning programme of Bangladesh-past, present and future". Dacca, January 1975.

45. Islam MM; Mahmud M, "Contraception among adolescents in Bangladesh". *Asia-Pacific Population Journal*. 1995 March

46. Johns Hopkins University, A Report on Institutional Analysis for the development of The National FP-MCH IEC Strategy", 1992

47. JSI; *Projection of Contraceptives Commodity Needs 1995-2005*, JSI, 1994, Dhaka

48. Government of Bangladesh; "Draft PIP of HAPP 5", 1997

49. Government of Bangladesh, The Fifth Five Year Plan 1997-2002, Planning Commission

Dhaka University Institutional Repository

50. Kabir M, "Fertility trends in Bangladesh since 1951". Genus 1977.

51. Kabir M; Amin R; Ahmed AU; Chowdhury J, "Factors affecting desired family size in Bangladesh". *Journal of Bio social Science*. 1994 Jul;

52. Khan HT; Raeside R, "Urban and rural fertility in Bangladesh: a causal approach". *Social Biology*. 1994 Fall-Winter

53. Khuda; Barkat-e and Abul Barkat: "The Key Challenges to Bangladesh Family Planning Program", URC 1994

54. Khuda, Barkat-e and Abul Barkat, 'The Bangladesh Family Planning Program: Key Programmatic Challenges and Priority Action Areas", Dhaka 1994

55. Khoda, B et al; *Literature Review for the Development of the National FP-MCH IEC Strategy*, Johns Hopkins University, Dhaka 1992

56. Khuda, B et al; "Agriculture Development in Bangladesh: A Macro Study on Sustainability Considerations", University Research Corporations, Dhaka 1991

57. Koschnick, Wolfgang J., Dictionary of Social and Market Research New York 1996

58. Kotler, Philip and Alen R. Andreasen; *Strategic Marketing for Non Profit Organization*, Prentice Hall, USA 1996

59. Kuhn RS; Menken JA, "Fertility seasonality: toward the next generation of modeling and analysis". [Unpublished] 1995. Presented at the Annual Meeting of the Population Association of America, San Francisco, California, April 4-6, 1995.

60. Local Level Initiatives Bangladesh brochure; MOHFW, A project of Management Science for Health (MSH)

61. Mabud, M A, *Bangladesh's Demographic Scenario upto 2010 AD*, Planning Commission, GOB, Dhaka 1990.

62. Manoff, *Social Marketing: New Imperative for Public Health, 1988-1989*

63. Miah MM, "The cultural-structural contexts of high fertility in Bangladesh: a sociological analysis". *International Review Of Modern Sociology*, 1992

64. Mita R; Simmons R, "Diffusion of the culture of contraception: program effects on young women in rural Bangladesh". *Studies In Family Planning*. USA, 1995 Jan-Feb

65. Mitra SN; Ali MN; Islam S; Cross AR; Saha T, "*Bangladesh Demographic and Health Survey*", Mitra & Associates, NIPORT and Macro International USA 1993-1994. Dhaka,

66. Mitra & Associates; *Bangladesh Demographic and Health Survey 1996-97*, NIPORT, Mitra & Associates and Macro International Inc. USA 1997

67. Mitra & Associates; *Bangladesh Demographic and Health Survey 1999-00*, NIPORT, Mitra & Associates and Macro International Inc. USA 1999-2000

68. Mitra SN; Pebley AR, "Assessment of family planning needs in Bangladesh. Unmet need for contraception in World Fertility Surveys of developing countries". Honolulu, Hawaii, East-West Population Institute, 1982.

69. Mitra SN; Naser A, "Utilisation of traditional healers in Bangladesh family planning programmes. Population transition in South Asia", edited by Ashish Bose and M.K. Premi. New Delhi, India, 1992.

Dhaka University Institutional Repository

70. Piotrow, PT. Et al, *Health Communication, Lessons from Family Planning and Reproductive Health*, Johns Hopkins University USA 1997

71. Phillips JF; Hossain MB, "The long-term demographic role of community-based family planning in rural Bangladesh". Presented at the Annual Meeting of the Population Association of America, Miami, Florida, May 5-7, 1994.

72. Piet-Pelon, Nancy J, Rob U and Khan ME, *Men in Bangladesh, India and Pakistan, Reproductive Health Issues*, Dhaka 1999

73. Planning Commission, GoB, *The 5th Five Year Plan (1997-2002)*, 1998

74. Planning Commission, *The Two-Year Plan of Bangladesh 1978-80*, Dhaka 1978

75. Planning Commission, *The Third Five-Year Plan of Bangladesh 1985-90*, Dhaka 1985

76. Planning Commission, *The Fourth Five-Year Plan of Bangladesh 1990-95*, Planning Commission, Dhaka 1990

77. PSI: Population Services International Report, Washington, USA 1996

78. Rahman SM; Bari A; Gofran A, "Family planning service dispensation: procurement, storage, distribution and supplies". Proceedings of the Seminar on Family Planning, November 21-25, 1972. Dacca, Bangladesh, Ministry of Health and Family Planning, 1973.

79. Rahman MM; Haaga JG; Maru RM; Hossain MB, "Access of rural women to family planning service: a study in Bangladesh". [Unpublished] 1993. Presented at the Annual Meeting of the Population Association of America, Cincinnati, Ohio, April 1-3, 1993.

80. Riley AP; Khan NU, "Age at first marriage for women in Matlab, Bangladesh: the role of biological and social determinants".[Unpublished] 1993. Presented at the Annual Meeting of the Population Association of America, Cincinnati, Ohio, April 1-3, 1993.

81. Schiffman, Leon G and Leslie Lazar Kanuk. *Consumer Behavior*, Prentice Hall, 2000.

82. Schuler SR; Hashemi SM, "Credit programs, women's empowerment, and contraceptive use in rural Bangladesh". *Studies In Family Planning*. USA, Mar-Apr; 1994

83. Schuler SR, "Empowerment and family planning in Bangladesh". *NETWORK*. USA Aug; 1994.

84. Simmons R; Mita R, "Women's status and family planning in Bangladesh: an analysis of focus group data". Population Council, 1995 Feb.

85. Ullah MS; Chakraborty N, "The use of modern and traditional methods of fertility control in Bangladesh: a multivariate analysis". *CONTRACEPTION*. 1994 Oct

86. United Nations Development Program; *Human Development Report*, Oxford University Press 1991

87. UNFPA; *Contraceptive Requirements and Logistics Management Needs in Bangladesh*, Number 23 USA

88. UNICEF 1997: *Progotir Pothey*, Dhaka July 1997

89. USAID; "Population Dynamics in Bangladesh", USAID, Dhaka 1992

90. "Voluntarism in the Bangladesh family planning program". Bangladesh. Ministry of Health and Family Planning. Family Planning Wing 1986

Dhaka University Institutional Repository

91. Waliullah S and Nessa S, "Family planning communication reach study". Dacca, Bangladesh, Directorate of Population Control and Family Planning Research, Evaluation, Statistics and Planning Wing, April 1977.

92. *World Bank Report*, Oxford University Press New York 1993

93. Yunus M; Grameen Bank *As I see it*. Dhaka 1994

Dhaka University Institutional Repository

ABBREVIATIONS

AIDS	ACQUIRED IMMUNO DEFICIENCY SYNDROMES
ANC	ANTENATAL CARE
ARI	ACUTE RESPIRATORY INFECTION
BCC	BEHAVIOR CHANGE COMMUNICATION
BCCP	BANGLADESH CENTER FOR COMMUNICATION PROGRAMS
BDHS	BANGLADESH DEMOGRAPHIC AND HEALTH SURVEY
BFS	BANGLADESH FERTILITY SURVEY
BHE	BUREAU OF HEALTH EDUCATION
BRAC	BANGLADESH RURAL ADVANCEMENT COMMITTEE
BTV	BANGLADESH TELEVISION
CA	COOPERATING AGENCIES
CARE	COOPERATIVE AMERICAN RELIEF EVERYWHERE
CBD	COMMUNITY BASED DISTRIBUTION
CPR	CONTRACEPTIVE PREVALENCE RATE
DCD	COMMUNICABLE DISEASE CONTROL
CEB	CHILD EVER BORN
CSW	COMMERCIAL SEX WORKERS
EC	EXECUTIVE COMMITTEE
ECNEC	EXECUTIVE COMMITTEE FOR NATIONAL ECONOMIC COUNCIL
ELCO	ELIGIBLE COUPLE
EPI	EXPANDED PROGRAM ON IMMUNIZATION
ESP	ESSENTIAL SERVICE PACKAGE
FC	FIELD CONTROLLER
FGD	FOCUS GROUP DISCUSSION
FI	FIELD INVESTIGATOR
FP	FAMILY PLANNING
FPAB	FAMILY PLANNING ASSOCIATION OF BANGLADESH
FPI	FAMILY PLANNING INSPECTOR
FS	FIELD SUPERVISOR
FWA	FAMILY WELFARE ASSISTANT
FWC	FAMILY WELFARE CENTER
FWV	FAMILY WELFARE VOLUNTEER
GD	GROUP DISCUSSION
GOB	GOVERNMENT OF BANGLADESH
HA	HEALTH ASSISTANT
HFWC	HEALTH AND FAMILY WELFARE CENTER

Dhaka University Institutional Repository

HIV	HUMAN IMMUNODEFICIENCY VIRUS
HPSP	HEALTH AND POPULATION SECTOR PROGRAM
HPSS	HEALTH AND POPULATION SECTOR STRATEGY
HW	HEALTH WORKER
IEC	INFORMATION EDUCATION & COMMUNICATION
IEM	INFORMATION EDUCATION & MOTIVATION
IDI	IN-DEPTH INTERVIEW
IUD	INTRA UTERINE DEVICE
JHU	JOHNS HOPKINS UNIVERSITY
KAP	KNOWLEDGE ATTITUDE PRACTICE
LCC	LIMITED CURABLE CARE
LIP	LOCAL INITIATIVE PROGRAM
MCH	MATERNAL AND CHILD HEALTH
MOHFW	MINISTRY OF HEALTH AND FAMILY WELFARE
MTP	MANAGEMENT TRAINING PROGRAM
NIPHP	NATIONAL INTEGRATED POPULATION AND HEALTH PROGRAM
NIPORT	NATIONAL INSTITUTE FOR POPULATION RESEARCH & TRAINING
NGO	NON GOVERNMENT ORGANIZATION
NRR	NET REPRODUCTION RATE
ORT	ORAL REHYDRATION THERAPY
PNC	POSTNATAL CARE
PSTC	POPULATION SERVICES AND TRAINING CENTER
QA	QUALITY ASSURANCE
QOC	QUALITY OF CARE
RSDP	RURAL SERVICE DELIVERY PARTNERSHIP
RTI	REPRODUCTIVE TRACT INFECTION
STD	SEXUALLY TRANSMITTED DISEASES
SWM	SECTOR-WIDE MANAGEMENT
TBA	TRADITIONAL BIRTH ATTENDANT
TFR	TOTAL FERTILITY RATE
THC	THANA HEALTH COMPLEX
TT	TETANUS TOXOID
UFHP	URBAN PRIMARY HEALTH PARTNERSHIP
UHC	UPAZILA HEALTH COMPLEX
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT