Social, Economic and Cultural Factors that Influences FP Acceptance in Low Performance Areas

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Foreword

The National Institute of Population Research and Training (NIPORT) under the Health Population and Nutrition Sector Development Program (HPNSDP) of the Ministry of Health and Family Welfare (MOHFW) has been assigned to conduct the study entitled "Social, Economic and Cultural Factors that Influences Family Planning Acceptance in Low Performance Areas". Human Development Research Centre (HDRC) carried out the study with an aim to address the causes of low family planning use in specific areas of Bangladesh.

The study identified that desire for more children, lower women's empowerment status, and lower age at marriage or in other words adolescent marriage in girls are the prime cause behind low Contraceptive Prevalence Rate (CPR). The age when women themselves are informed of the ways and benefits of family planning from fieldworkers, relatives and friends or any other means, they usually use it if available nearby. This important information is highly in favor of the mandate of the government that, 'Girls should not be married before the age of 19 years'.

I believe that the study findings will help in formulating policies to undertake BCC and other measures to inform people about the benefits of small family size, delay age at marriage among the girls through changing the current social norm and practice among the illiterate and poor families in rural areas.

I am grateful to the researchers of HDRC, who have so generously helped to bring out this research report within the stipulated time.

I express my gratitude to the professionals of NIPORT for their sincerest efforts in publishing this report.

(Shetina Afroza, PhD)

Acknowledgements

Population program has been duly inducted in Bangladesh in seventies, got accelerated momentum in the eighties and nineties. The Contraceptive Prevalence Rate (CPR) has although increased, but it varies from division to division. Rajshahi is the highest performing division followed by Khulna, Barisal and Dhaka, and Chittagong and Sylhet divisions are substantially lagging behind. CPR also varies from district to district within the divisions.

The low performing areas (divisions) historically remained almost unchanged, although in absolute terms some progress has been achieved overtime. In this backdrop, Human Development Research Centre (HDRC) has been offered to undertake the study entitled 'Social, economic and cultural factors that influences family planning acceptance in low performance areas' by National Institute of Population Research and Training (NIPORT).The study is of national importance in identifying the factors causing low performance and in suggesting ways and means for increasing contraceptive prevalence in low performing areas.

In terms of complexity, volume, extent of issues covered and very short time span, this study has been a challenging and not-easy-to accomplish endeavour. It is an outcome of team effort of the Consultants of Human Development Research Centre (HDRC) and relevant officials of NIPORT. We would like to express our sense of deep gratitude to Shelina Afroza, PhD, Director General, NIPORT, Mr. Md. Zakir Hossain, Director General (In-charge), NIPORT, and their team for entrusting us to conduct this nationally important study, as well as for their sincere cooperation extended throughout the study.

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We are grateful to all the Family Welfare Assistants who shared their thoughts and opinions pertaining to the existing service and management of facilities, and its' improvement. Our special thanks go to all respondents/participantswho participated in household survey and focused in-depth discussions.

We are indeed grateful to the technical and support staff of HDRC, and all the field staffs worked in data collection process for this study.

All our efforts with this study would really be fruitful on the day when family planning will be well practiced and Bangladesh will achieve the replacement level fertility.

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&
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Abbreviations

BDHS	Bangladesh Demographic and Health Survey
BFS	Bangladesh Fertility Survey
BMMS	Bangladesh Maternal Health Services & Mortality Survey
CPR	Contraceptive Prevalence Rate
DCI	Data Collection Instrument
FGD	Focus Group Discussion
FP	Family Planning
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
HA	Health Assistant
HDRC	Human Development Research Centre
HH	Household
IUD	Intrauterine Device
KII	Key Informant Interview
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MWRA	Married Women of Reproductive Age
NGO	Non-Government Organization
NIPORT	National Institute of Population Research and Training
PNC	Post-Natal Care
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
WHO	World Health Organization

CONTENTS

Sl. No.	Title	Page #

List of Figures

Sl. No.	Title	Page #

List of Tables

ANNEXURE:

Executive Summary

Background: Bangladesh was considered a milestone in success of Family Planning (FP) sector during 1980s and 1990s; currently it is losing momentum and dynamism. CPR in 2011 is 61 while the same was 40 in 1991, and 54 in 1999-2000. By all accounts, Bangladesh has to go a long way before reaching the national goal of NRR (net reproduction rate) = 1 or TFR = 2.2, and contraceptive prevalence rate (CPR) of 70-75. Notably, Rangpur, Rajshahi and Khulna are the highest performing Divisions (CPR ranging between 68 and 69), while Chittagong and Sylhet Divisions are substantially lagging behind (CPR 51 and 45 respectively). In this backdrop, National Institute of Population Research and Training (NIPORT) has undertaken an initiative to explore social, economic and cultural aspects that are influencing prevalence of FP method use in low performing areas.

Objectives: The general objective is to find out social, economic and cultural factors that influence FP acceptance in low performance-areas in Bangladesh. The specific objectives are (a) to investigate the characteristics that are influencing low performance, (b) to find-out the determinants of low performance, and (c) to determine what need to be done to increase acceptance of FP in low performing areas.

Methodology: Both quantitative and qualitative methods have been used for collecting data/information. A survey of total 976 couples with 530 couples in two lowest performance districts (Habigonj and Brahmanbaria), 192 couples in one of the highest performance district (Thakurgaon) and 254 couples in selected slums of Dhaka and Chittagong cities was conducted. In-depth interviews with married women of reproductive age, Focus group discussions with Family Welfare Assistants, and Key informant interviews with Upazila Family Planning Officers were also conducted.

Major Findings of the Study

Socio-economic and background characteristics

Average household size in low performing, high performing areas and in slum is 4.4, 4.0 and 4.3respectively. Two-third of the respondents in low and high performance areas, and urban slums fall within the age bracket of 20-34 years. About 31% respondents in both low and high performance areas and 55% in urban slums are illiterate. A higher proportion of husbands across study areas are literate. Only 9% of respondents in low performing areas have secondary and 17% completed primary education. In high performance areas 18% respondents have secondary and 10% completed primary education. In urban slums 2% and 17% have secondary and completed primary education respectively. Almost all respondents under this study irrespective of low (97.4%) and high (95.3%) performance areas, and 74% in slum areas are housewives. Regardless of low and high performance areas and urban slums, reported variety of durable assets own by the respondents is almost similar. However, household wealth index is low across the study areas.

Knowledge on family planning and sources of information

Over 99% respondents across the study areas are aware of family planning. Regarding specific contraceptive methods, pills, condoms and injectables are known to most of the respondents (over 90% each) in low and high performance areas as well as in urban slums. Knowledge about permanent and longer acting methods is low compared to temporary methods and it substantially

varies in low and high performing areas as well as in slums. The prime source of information in low performance areas is relatives/friends (73.3%), followed by private hospital/clinic (35.4%), television (25.2%), government/district hospital (24.2%), UHC (18.2%) and FWC (11.2%). On the other hand, main source of information in high performance areas is private hospital/clinic (88.0%) followed by UHC (60.9%), relatives/ friends (45.8%), FWC (31.8%) and television (14.6%).

Fertility history of the respondents

The mean and median age at first marriage of the respondents in low performance areas is 16.8 and 17.0 years, in high performance areas 15.8 years and 16.0 years, and in urban slums 15.9 years and 16.0 years respectively. Other proximate determinants of fertility – mean age at first pregnancy and the mean age at birth of first child in low performance areas are 17.8 years and 18.1 years respectively, while in both high performance areas and urban slums these are 16.8 years and 17.3 years respectively. Average number of pregnancy in low, high performance areas and urban slums respectively are 3, 2.6 and 2.3. Out of the pregnancies,average live birth is 2.6, still birth 0.12, miscarriages 0.15 and abortion 0.03in low performance areas. The corresponding figures in high performance areas are 2.2, 0.05, 0.07, and 0.06 respectively. In urban slums, live births 2.3, still birth 0.09, miscarriages 0.15 and abortion 0.14.

Attitude and perception about the acceptance of family planning

About 97.2% respondents in low performance areas, 100% in high performing areas and 98.4% in urban slums are in favour of acceptance of FP. This reveals their positive attitude. The positive factors that determined their positive attitude are mainly-'want no more children', 'prefer spacing between pregnancies', 'no desire for children' and 'to take care of other children'. Turning to the other side of the picture, negative factors that influenced (rather controlled) their behavior (in practical life) are mainly- 'want more children', 'husband's opposition', 'do not like FP', 'religious misconception/superstition', also 'want a son', 'want a daughter', and so on. There is apparent contradiction between attitude (positive) and behavior (negative).

Current family planning practice

CPR in low performing areas constitute 43.6% (rural Habigonj 42.7% and rural Brahmanbaria 44.4%; while, CPR in high performing area is 75.2% (rural Thakurgaon). About 35% of the respondents in low performance areas, 68.2% in high performance areas and 43.7% in urban slums are practicing modern contraception methods. Among the contraceptive users, pill is the predominant method in all the areas with 71% in low performance areas, 54% in high performance areas, and 45% in urban slums. The next popular contraceptive is injectables, being used by 16% in low performance areas, 27% in high performance areas, and 41% in urban slums. The uses of other contraceptives are not remarkable.

The most pronounced reasons for practicing family planning by the respondents in low and high performance areas and urban slums are 'have no desire for children at present' followed by 'want to have a space between the births' and 'keep the family small and happy'.

Previous practice of family planning

A 73% of contraceptive users in low and 79% in high performance areas discontinued use of family planning at one point of time mainly due to desire of more children, followed by 26% and 33% respectively due to health problem in low and high performance areas. Substantial parts (61%) have started to use contraceptive between ages 21 years and 30 years. Average duration of

contraceptive use in low and high performance areas and in urban slums are 6.3, 7.5, and 7 years respectively with an average interval of discontinuation of 18.9, 15.6 and 17.2 months in order. Just before discontinuation, pills were the most popular contraceptive followed by injectables and condoms in all the sample areas.

Sources and availability of contraceptive methods

The major sources of contraceptives in low and high performance areas follow a similar pattern. The sources in low and high performance areas are government health facilities (53% and 41%) followed by pharmacies (34% and 41%), and FWAs (29% and 19%). About 22% of the respondents in high performance areas get contraceptives from NGO clinic/workers. In urban slums, the most popular source of contraceptives is pharmacy (53%), followed by NGO clinics/workers (45%) and to some extent from government health facilities (16%) near to the slums. Except few, most of the contraceptive users across the sample areas know that required contraceptives are available in their areas at all the time.

Quality of family planning services

For family planning services, 45% respondents in low performance areas visit FWC compared to 74% in high performance areas. In low performance areas, reasons for relative lack of interest to visit service delivery points are misbehavior of service providers, bad communication and religious fanaticism. Often they are not receiving proper care from the service providers. In low performing areas the time to reach the FWC is less than 30 minutes for 45% respondents and 30-59 minutes for 35%. In contrast, for high performing areas 56% respondents require less than 30 minutes and 35% require 30-59 minutes to reach FWC. In urban slum, 75% require less than 30 minutes to reach NGO clinic, and 62% respondents in low and 81% in high performance areas have been visited by the FWA in last one month prior to survey. In urban slums, 58% households of the respondents were visited by NGO worker. According to service providers, contraceptives are always available in low and high performance areas as well as in urban slums.

Intention of family planning use in future

A 79% of the non-user respondents in low, 97% in high performance areas and 80% in urban slum intend to use family planning in future. Those who do not intend to use FP in future, the reasons for lack of interest in low performance areas are child preference (29%); health concern (28%), opposition from husband (15%) and religious sanction (13%), while in high performance areas child preference and preference for son are the sole primary reasons. In urban slums, main reasons for lack of interest are health concern (22%) and disliking to existing methods of contraception (12%).

Desire for birth intervals

Two-thirds of the respondents in low and high performance areas as well as in urban slums want an interval between the births. Expected average duration of birth intervals in low and high performance areas are 4.4 years and 4.5 years respectively, and 4.2 years in urban slums.

Household decision maker for acceptance of family planning

Regardless of low and high performance areas and in urban slums, decision of childbearing and family planning use are customarily made jointly with their husbands accounting 82%, 90% and 76% respectively. On the other, 12% respondents in low, 7% in high performance areas and 18% in urban slums take such decision in their own. For the rest husband is the sole decision maker.

Thus, proportion of respondents involved in contraceptive use decision making is higher than the proportion saying that the husbands are the sole decision maker.

Determinants of family planning acceptance in low performance area

Hypothesis testing reveals that use of contraceptives in low performing areas and slum does not differ significantly; and the use of modern contraceptive methods in high performing areas differ significantly as compared to low performing areas.

Odds ratio (OR) estimates depict that the higher is the education level of the women the higher is the chance of usage of modern FP methods (OR for women with SSC is 1.31 and OR with HSC is 2.20); the higher is the age of first marriage the more it is likely to use FP modern method (if the age at first marriage is 20 and above the OR is 1.48). Similar is case for those whose husband "does not object to FP method use" (OR 1.44) and those who perceive that there is "no religious prohibition on use of FP" (OR 1.25).

The results of a Logistic model reveal that there are eight demographic and socio-cultural factors which influence the usage of FP modern method of a couple. These include female education, number of living children, husband's supportive attitude towards FP, religiosity, frontline workers visitation, etc.

Recommendations on Means to Improve the Acceptance of Family Planning

In order to improve acceptance of family planning in low performance areas the programme implementing authority may consider the following recommendations deriving from the above findings:

1. People should be informed that FP methods are not harmful to females;
2. Launch effective behavioural change communication (BCC) campaign with greater focus on low-performing areas (including urban slums);
3. Establish a chain of quality FP services and follow-up care to counter fears of side-effects and misconceptions;
4. Create a social movement to stop marriage of girls below the age of 19 years;
5. Increase number of service-providers (FWAs, FWVs) and other field-level staff;
6. FWC/CC should be set up nearby/common place;
7. Ensure uninterrupted availability of FP methods near the community/family;
8. Involve local government institutions and NGOs;
9. Enhance rates of compensation package to the acceptors of FP terminal methods;
10. Undertake special programmes to increase rate of secondery education among girls;
11. Hold a workshop with all concerned stakeholders to develop an implementable Action-Plan to meet the study objectives.