

# Demographic Transition in Bangladesh: What Happened in the Twentieth Century and What Will Happen Next?

*Policy makers need to pay attention to  
effecting a change in the current desired family  
size and the practice of son preference*

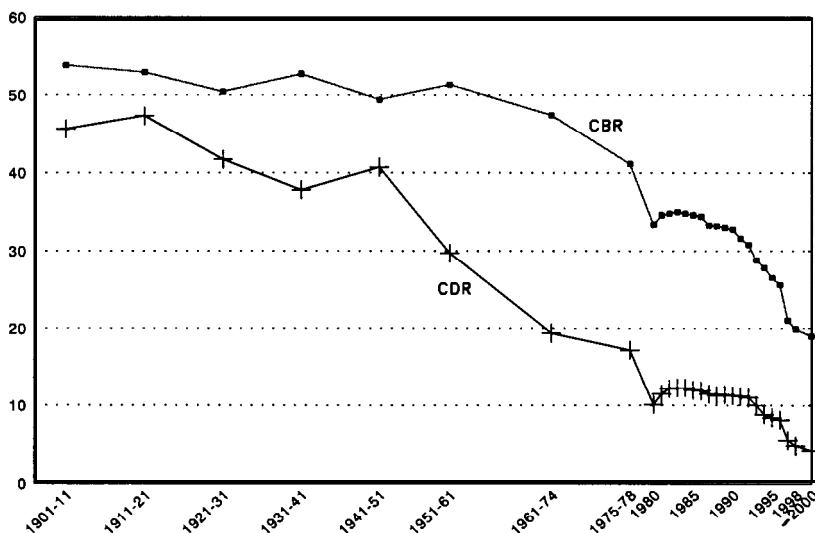
**Radheshyam Bairagi and Ashish Kumar Datta\***

At the beginning of the twentieth century, the total population of Bangladesh was less than 30 million. The annual growth rate of the population was less than 1 per cent until 1951, when the population reached about 44 million (Bangladesh Bureau of Statistics, 1998). From the early

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\* Radheshyam Bairagi, Senior Scientist, and Ashish Kumar Datta, Research Officer, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B): Centre for Health and Population Research, GPO Box 128, Dhaka 1000, Bangladesh. Fax: 880-2-8826050; E-mail: [bairagi@icddr.org](mailto:bairagi@icddr.org)

**Figure 1. Crude birth rate (CBR) and crude death rate (CDR) in Bangladesh, 1901-2000**



*Source:* Bangladesh Bureau of Statistics.

1950s, mortality started to decline while fertility remained high until the 1970s. Owing to the changes in fertility and mortality rates, from the 1950s the population started to grow at an unprecedented rate, reaching an all-time high (about 2.5 per cent per year) in the 1960s and 1970s. The growth rate then started to decline in the 1980s and is currently about 1.5 per cent per year (figure 1). At the close of the twentieth century, the population of Bangladesh stood at about 130 million.

The main force behind the decline in the population growth rate of Bangladesh in the 1980s and 1990s was a remarkable decrease in fertility during that period. In the early 1970s, the total fertility rate (TFR) was about 7 children per woman, and an estimated 3.4 children per woman in the first Demographic and Health Survey (DHS) in 1993-1994. TFR was so surprisingly low in the first DHS that many people questioned the quality of the DHS fertility data. However, Bairagi and others (1997) validated the DHS total

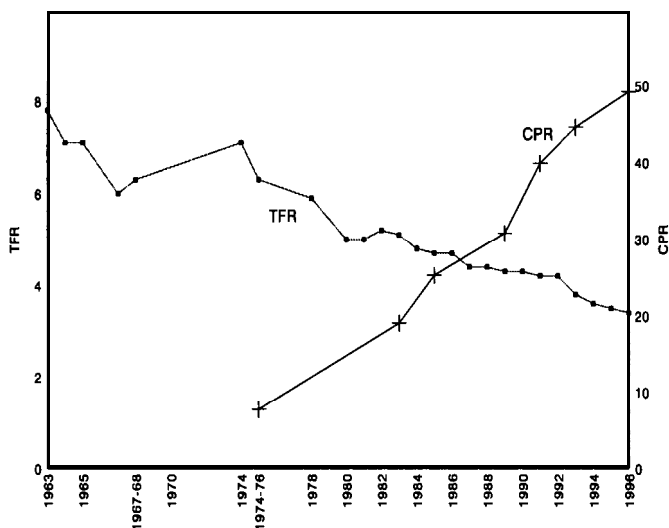
fertility rate from the Matlab demographic surveillance system (DSS). TFR remained almost unchanged at 3.3 children per woman in the next two DHSs conducted in 1996-1997 and 1999-2000 (Mitra and others, 1997; Demographic and Health Survey, 2000). That unexpected halt in TFR naturally raises questions about the factors of fertility dynamics and the future prospect of fertility decline in Bangladesh and has created concern among planners and policy makers. The stabilization of fertility, despite an increase in contraceptive use, was extensively discussed during a seminar organized by the United Nations Population Fund (UNFPA), held at Dhaka on 17 May 2001. Subsequently, a committee was established at the national level to find the reasons for, and a solution to, this problem.

In 1978, the Government of Bangladesh declared population pressure as the leading problem of the country. Since then, the Government as well as non-governmental, private and international organizations have undertaken several programmes to solve the population problem. Some successes in different areas have been achieved. For example, female field workers, known as Family Welfare Assistants (FWAs), have established a well-designed network for providing door-to-door family planning services. As a result, a substantial increase in contraceptive use and a remarkable decline in fertility have been achieved in the past two decades (figure 2). The Bangladesh family planning programme is therefore now considered to be a model for less developed countries. However, despite these achievements, the present TFR is far above the replacement level and the population problem remains the leading problem in the country.

Many experts hold the strong view that the family planning programme played a major role in the rapid decline of fertility in the less developed countries, including Bangladesh, in the 1980s and 1990s. According to Lapham and Mauldin (1984), family planning programmes contributed to the change in fertility while, according to Robey, Rutstein and Morris (1993), family planning has had the most direct influence on fertility. Cleland and others (1994) concluded that the Bangladesh family planning programme was the main factor responsible for fertility decline in the country. They also noted that “if policies are implemented with sustained resolve, fertility decline is possible, even in the absence of rapid economic development and social change”.

However, many other experts do not agree that a family planning programme can have a major effect on fertility. They consider that the major change in fertility has been brought about not by birth control methods but by other changes in the desire to have children. In their view, an improvement in birth control methods is mainly an induced response to other decreases in the desire for children rather than an important cause of the decreased demand

**Figure 2. Contraceptive prevalence rate (CPR) and total fertility rate (TFR) in Bangladesh, 1963-1996**



Source: Bangladesh Bureau of Statistics, *Statistical Pocket Book*, 1983-1996

(Becker, 1991). Caldwell and others (1999) expressed doubt that only the Bangladesh family planning programme could bring TFR down from the mid-1970s' level of more than 6 children per woman to nearly 3, without a change in society.

Pritchett (1994) argued that to reduce fertility in a population, desired fertility (which depends on development, culture and so forth) was important. He noted that a family planning programme and even contraceptive use itself had a very minor role to play in decreasing fertility in a population. Citing examples of different countries, he demonstrated that, in keeping the desired family size constant, contraceptives had no major role to play in bringing fertility down. The most notable example, he said, was in 1977 "when Haiti's desired fertility was 4.3, while the modern contraceptive prevalence rate (CPR) was only 4.7 per cent; whereas Zimbabwe's desired fertility was 4.3 (in 1989), the modern contraceptive prevalence rate was 36.2 per cent . . . fertility in Haiti was actually only 0.4 births higher than Zimbabwe's fertility (5.6 versus 5.2),

despite the large difference in modern contraceptive use". His argument is also supported by the recent relationship between TFR and CPR in Bangladesh, where CPR was 44.6 per cent in 1993/1994, 49.2 per cent in 1996/1997 and 53.8 per cent in 1999/2000. TFR in those three periods was 3.4, 3.3, and 3.3 respectively. It means that, although there has been an increase in CPR of about 9 percentage points since 1993/1994, there has been virtually no decrease in TFR during the same period.

However, none of these empirical examples provides any convincing justification or argument for clarifying why fertility remains the same in different populations with very different levels of contraceptive use but with the same level of desired family size. Where will the effect of contraceptive use, which is a proximate determinant of fertility, be felt? How is it possible? There is no information available in the literature on any investigation into the role of other proximate determinants of fertility that might have (a) compensated for the effects of contraceptive use on fertility and (b) led to the TFRs of the two populations, which differ significantly in contraceptive use, being very similar. In examining this issue, the results of the study carried out at Matlab in Bangladesh are instructive.

### **Data and methods**

The ICDDR,B: Centre for Health and Population Research maintains a DSS in Matlab, a typical rural area of Bangladesh, with an economy dominated by subsistence farming and fishing. Since 1966, under DSS, Community Health Workers (CHWs) have been collecting data on deaths, marriages (since 1974), and migrations, births and other pregnancy outcomes, including abortions (since 1978). DSS covers a population of about 200,000. CHWs collect the data through home visits at two-week (monthly since 1997) intervals. Their work is supervised and checked at different levels. Thus, a well-defined system of management and supervision for producing quality data exists in Matlab.

The ICDDR,B started a maternal and child health-family planning (MCH-FP) project in October 1977 in half of the DSS area, known as the MCH-FP area, to test the hypothesis that demographic change can be induced through an intensive MCH-FP project without any intervention in the socio-economic status of a poor society. The other half of the area, known as the comparison area, remained under the usual government programme. An ideal design for studying the impact of an MCH-FP programme would be to find a control area in which no family planning and health services are offered. Such areas are not available in Matlab or any other part of rural Bangladesh, because basic MCH-FP services are provided in all areas by the Government's rural healthcare system. However, the Matlab research design enables a comparison

of the effects of services at different levels of intensity, including the density of workers, supervision and coverage.

There is one CHW for about every 2,500 persons in the MCH-FP area, whereas there is one worker for about every 6,000 persons in the comparison area. Injectable contraceptives are delivered to the doorstep in the MCH-FP area, whereas in the comparison area users of injectable contraceptives are required to visit a Family Welfare Centre. Regular supplies of different types of contraceptives are ensured in the MCH-FP area, but that cannot be done in the comparison area. The MCH-FP project has a record-keeping system for routinely recording and monitoring maternal, child health and family planning services, but the comparison area has no such system. In addition, the management of contraceptive-related side-effects is much better and supervision is much stronger in the MCH-FP area. As a result, CPR between the two areas became very different within a year of launching the MCH-FP project. In 1996, CPR was about 20 percentage points higher in the MCH-FP area than in the comparison area (48 versus 68 per cent) (Razzaque and others, 1998).

Before the implementation of the MCH-FP project in 1977, both areas were demographically and socio-economically the same (LeGrand and Phillips, 1996; Razzaque and others, 1998). After the implementation of the MCH-FP programme, the decline in both fertility and mortality was much faster in the MCH-FP area than in the comparison area. TFR remained one child less, while the under-5 mortality rate was lower by about 20 per cent in the MCH-FP area for the most part during the past 20 years.

Abortion is a sensitive issue in Bangladesh and many women who have had an abortion do not disclose this fact to others, particularly to outsiders. This makes it extremely difficult to get a clear picture of abortion from survey data in this country. The situation is quite different in the Matlab DSS area, where the CHWs have been visiting each household regularly for the past 30 years to collect vital data. If the pregnancy of a woman is observed or reported during the routine visit of a CHW to either area, it is recorded. A CHW and her supervisor jointly complete a pre-designed pregnancy outcome form. They know the correct definition of each of the possible outcomes of a pregnancy, including spontaneous and induced abortions.

A CHW is considered a member of the family in her area. Yet, some induced abortions are reported as spontaneous abortions in the DSS (Bhuiya, Aziz, and Chowdhury, 1999), and the number of abortions in each area is underestimated (Johnston, 1999). This misclassification and underestimation is thought to be consistent over time and between areas, because the same procedures have been followed. Thus, the trend of abortion over time and a

**Table 1. Desired family size in Matlab by area and time**

Year	MCH-FP area	Comparison area
1975	4.2	4.3
1984	3.4	3.5
1999	2.5	2.6

comparison of abortions between areas are not expected to be affected by misclassification or underreporting. In this study, an abortion means an induced abortion, including menstrual regulation (MR). The MCH-FP project discontinued giving MR services from 1984. If a woman in the MCH-FP area needs MR, she is advised to go to a government Family Welfare Centre (FWC). Both the MCH-FP and comparison areas have FWCs.

In addition to longitudinal DSS and record-keeping system data, this study used the data from three socio-economic surveys conducted in 1974, 1982 and 1996, and three knowledge, attitude and practice (KAP) surveys conducted in 1975, 1984 and 1999 in the DSS area.

## Results

Data on the desired family size for both the areas in Matlab were available for three time points from three KAP sample surveys conducted in 1975, 1984 and 1999. It was shown elsewhere that subsequent fertility depended significantly on the desire for children (Razzaque, 1999). The results concerning the desired/ideal family size are shown in [table 1](#). The desired family size in both areas has been decreasing, but the difference between the two areas has been negligible at any given time. It means that the Matlab MCH-FP project has not been able to bring about any change in the desired family size in the area. It supports the view of Freedman (1997) that a family planning programme, as such, does not usually have any effect on fertility preferences.

Since the 1970s, there have been many changes in the lifestyle of the people of Bangladesh, as well as in the agricultural system and cultivation procedures (Caldwell and others, 1999). Socio-economic surveys were conducted in the Matlab DSS area in 1975, 1982 and 1996 (Razzaque and others, 1998). The use of some durable goods, which were common in each of the surveys, is shown in [table 2](#). It is evident from the table that the standard of living, measured by the possession of durable goods in both the areas, has improved substantially over the years. There has also been a remarkable

**Table 2. Percentage of households possessing selected consumer durable goods in Matlab by area and time**

Possession	1974		1982		1996	
	MCH-FP	Comparison	MCH-FP	Comparison	MCH-FP	Comparison
Blanket	36.7	31.0	43.6	35.1	63.3	56.6
Lantern	59.2	56.0	70.8	68.4	86.7	89.3
Watch	13.0	11.7	14.7	15.4	55.5	51.5
Radio	11.6	10.7	16.8	16.2	45.8	40.1

improvement in women's education in the area (table 3). About 75 per cent of women reported having had no schooling in 1974. That figure declined to about 70 per cent in 1982 and about 45 per cent in 1996. Only about 5 per cent of women had schooling higher than primary level in 1974, but that figure increased to more than 7 per cent in 1982 and 25 per cent in 1996.

Surveys on the desire for more children among all married women of reproductive age in the MCH-FP area (about 15,000) have been conducted since 1990 at intervals of 18 months. An analysis of those data (results not shown) found that, controlling for demographic variables such as age, parity and sex composition of children, socio-economic status, such as education and empowerment of women, had a negative effect on the desire for more children. In the national data, both the desire for more children and ideal family size were found to be associated negatively with the education of women (Mitra and others, 1997).

The results presented in tables 1, 2 and 3, as well as those of other studies, suggest that an improvement in socio-economic status, particularly women's education, or in lifestyle helps, to some extent, to reduce the desired family size in the area. A part of the decline may also be the result of information, education and communication (IEC) services provided by the Government to bring down fertility preference (Freedman, 1997).

Figures 3a and 3b show CPR, abortions per 100 live births, desired family size (interpolated for 1979 and 1997), and TFR in the Matlab MCH-FP area and the comparison area from 1978 to 1998. A big change in contraceptive use and fertility rate took place in the MCH-FP area immediately after the implementation of the MCH-FP services. At the beginning of the project, CPR was 10 per cent, but it rose to 25 per cent within one year, and finally to 69 per cent in 1998. The increase has continued, although growth has recently slowed to 1 per cent annually.



**Table 3. Distribution of females (aged 14-49) by years of schooling according to area and year**

Years of schooling	(Percentage)					
	1974		1982		1996	
	MCH-FP (N=15,657)	Comparison (N=16,265)	MCH-FP (N=22,463)	Comparison (N=21,916)	MCH-FP (N=27,272)	Comparison (N=24,872)
No education = 0	74	71	67	71	44	45
Primary = 1-5	20	18	24	22	28	30
Secondary = 6-10	5	4	8	6	24	22
SSC <sup>a</sup> + = 10+	1	1	1	1	4	3
Total	100	100	100	100	100	100

<sup>a</sup> Secondary School Certificate.

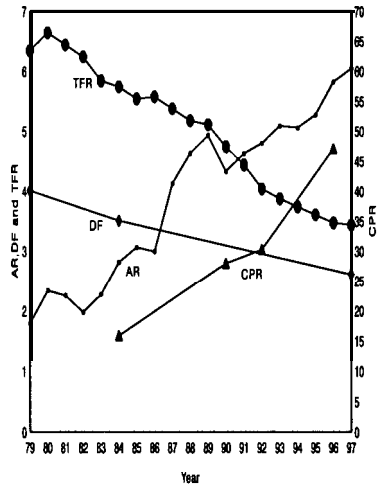
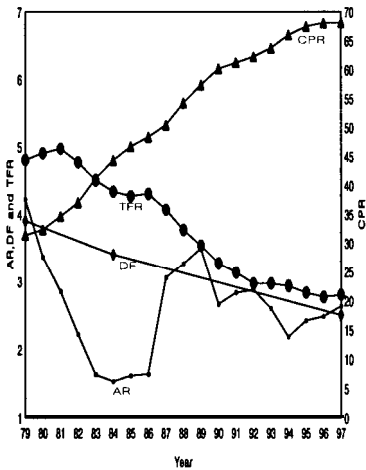
It was possible to calculate CPR for the MCH-FP area for each month using the record-keeping system (RKS) data. But for the comparison area, data were only available from four sample surveys carried out in 1984, 1991, 1994 and 1996. In the comparison area, CPR also increased to about 47 per cent in 1996, which was 20 percentage points lower than that in the MCH-FP area.

The effect of the increased CPR on fertility in the MCH-FP area was enormous. Before the implementation of the MCH-FP project, fertility in both areas was almost the same (figure 1 in LeGrand and Phillips, 1996). However, TFR declined by more than 1 child per woman in the MCH-FP area within the first two years of the project. This decline in TFR continued in the MCH-FP area until 1991, when it was about 3 per woman. Since then, up until 1998, TFR in the MCH-FP area remained more or less stable, although CPR increased by about 8 percentage points during that period. The 8 percentage point increase should have brought down TFR by about 0.5 children<sup>1</sup> per woman, but the effect of the increased CPR is still not visible.

In the comparison area in 1991, CPR was about 26 per cent and the TFR was 4.3 children per woman. CPR and TFR were 48 per cent (projected) and 3.5 children respectively in 1998. The increase in CPR and the decrease in TFR in the comparison area appear to be consistent. But virtually no effect from the increased CPR on TFR was seen in the MCH-FP area during that period. The question, therefore, remains: how was it possible? The effect of contraceptive use must have been compensated for by one or more of the other direct determinants of fertility, the important ones of which are: abortion, post-partum infecundability and age at marriage (or the proportion of women of reproductive age in sexual union) (Bongaarts, 1978). Marriage has been almost universal in Matlab and age at marriage has been increasing, although it is comparable between the areas at any given time. Post-partum amenorrhoea is

**Figure 3a. Contraceptive prevalence rate (CPR), abortion ratio (AR) per 100 live births, desired fertility (DF) and total fertility rate (TFR) in MCH-FP area, 1978-1998**

**Figure 3b. Contraceptive prevalence rate (CPR), abortion ratio (AR) per 100 live births, desired fertility (DF) and total fertility rate (TFR) in comparison area, 1978-1998**



not expected to be very different between MCH-FP and the comparison areas because the duration and patterns of breastfeeding are not likely to differ much between the areas. Moreover, the effects of post-partum amenorrhoea alone could not keep TFR stable in the MCH-FP area throughout the period 1991-1998.

Figure 3a shows that the abortion ratio was very high in the MCH-FP area immediately after the launching of the MCH-FP project in 1977, due mainly to the MR facility of the project. The MR facility was withdrawn from the project in 1984, and the status of abortion facilities including MR have remained the same in the two areas since then. The abortion ratio increased slightly in the 1980s, perhaps as a result of a growing need to control family size in the country (Cleland and others, 1994; Bongaarts and Westoff, 2000), and then started to decline again. On the other hand, the abortion ratio increased linearly in the comparison area throughout the project period. Except for the first few years of the MCH-FP project, the ratio was always much higher in the comparison area. It is evident from figures 3a and 3b that the MCH-FP project was not only successful in bringing fertility down, but it was also successful in reducing abortions in the area.

These figures also indicate that (a) the women in both areas were using contraceptives as well as abortion as means of controlling fertility, and (b) the effect of increased contraceptive use on fertility was counterbalanced by a decreased abortion ratio in the MCH-FP area, particularly in recent years.

Fertility in both areas was converging to the same level. The difference in TFR in the two areas was more than 1 child in 1990. However, it declined to 0.5 in 1997, although there was a vast difference between the areas in terms of both CPR and abortion ratio. This raises the question of why fertility was converging to the same level in the two areas. Did “desired fertility”, considered by Pritchett (1994) to be the major important factor for determining fertility, have anything to do with it? Figures 3a and 3b show fertility in the two areas converging towards the desired family size, which is currently about 2.5 children in both areas. TFR has remained stable, at 3, since 1991, and is only 0.5 children higher than the desired family size in the MCH-FP area. On the other hand, fertility continues to decline in the comparison area, and the couples there have been using both contraceptives and abortion to keep family size at the desired level.

## Discussion and conclusions

It appears from this study that fertility in Matlab has converged to the desired rate. The Matlab couples used different proximate determinants of fertility, including contraception and abortion, in the converging process. The study neither supports the hypothesis that an MCH-FP project alone can bring fertility down to any particular level, nor the view that the Government of Bangladesh will be able to bring population growth down by 25 per cent by increasing only CPR from its present 51 per cent to 71 per cent, as was previously thought (POPLINE, 2000). If that goal can be achieved, why did fertility not decline after 1991 in the Matlab MCH-FP area for the ensuing seven years, when CPR increased by 8 percentage points? This study suggests that the level of development, which includes socio-economic status, education, modernization and so forth, determines the desired level of fertility, and that an MCH-FP project helps to bring about a desired level of fertility more rapidly.

Although currently desired fertility in Matlab is about 2.5 children per woman, the expected desired fertility is unlikely to be less than 3, owing to the practice of sex preference for children in the region, even under a perfect fertility control situation. Matlab is a son-preferring area (Bairagi, 2001), where the desired number of sons was recently found to be 35 per cent higher than the desired number of daughters. Sheps (1963) demonstrated that expected fertility would be higher than desired fertility in the presence of sex preference for

children. For example, if desired fertility is 2, the expected fertility with an intention to have one son and one daughter is 3 while with the intention to have 2 sons is 3.88, and so on. Thus, it may be perceived that fertility in the Matlab MCH-FP area has already declined to the current desired level. A further decline may require a decrease in desired fertility or gender preference, or both. This study also suggests that without effecting any change in these phenomena, further emphasis on the family planning programme may increase CPR. However, its impact on fertility is likely to be counterbalanced by a decline in the impact of any other direct determinants of fertility, such as abortion and the inefficient use of contraceptives (failure). Contraceptive failure in the Matlab MCH-FP area is already very high, but it has been showing a declining trend (Bairagi and others, 2000).

As previously mentioned, DHS data show that the recent impact on fertility of the Bangladesh national MCH-FP programme is negligible. Although CPR increased by about 9 percentage points from 1993/1994 to 1999/2000, there was virtually no decrease in TFR during that period. The effect of the increased CPR was counterbalanced mostly by the decreased abortion ratio in the Matlab MCH-FP. It is important to examine the factors responsible for nullifying the effect of the increased use of each type of contraception, including modern methods, on TFR at the national level.

Abortion data at the national level are not reliable. However, from the Matlab results we can assume that a decline in the abortion ratio or rate might be partly responsible for the stable situation of TFR in spite of the 9 percentage point increase in CPR during the six or seven years after 1993/1994. It is important to note that the impact of the MCH-FP project in reducing the number of abortions in the Matlab area was remarkable. The abortion ratio was less than 50 per cent (the abortion rate will be lower than this because of lower fertility in the MCH-FP area). Nor can an increase in contraceptive failure in the country during the period under review be ruled out.

Based on the results of this study, we can conclude that a change in the desired family size and gender preference, together with family planning and reproductive health services, is apparently essential to bringing about a further decline in fertility or to completing the demographic transition in Bangladesh. However, the mechanism of achieving a lower fertility preference (a lower ideal family size) needs to be explored.

A change in socio-economic status, particularly in women's education, is likely to bring about a change in the desired family size. IEC services may indeed play a major role in both motivating people to have a small family and ending son preference (Freedman, 1997). Policy makers need to pay attention

to bringing about a change in the current desired family size and the practice of son preference, both among males and females, in addition to placing emphasis on the importance of family planning to bring down TFR further in Bangladesh. It should be noted that any decision by a woman in Bangladesh regarding fertility will be heavily influenced by her husband.

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### Endnote

1 According to Bongaarts and Poter (1983),  $TFR = 7.3 - 0.063 \times CPR$  (where TFR is the total fertility rate and CPR is the contraceptive prevalence rate. If CPR is 60 per cent, for example,  $TFR = 7.3 - 0.063 \times 60 = 3.52$ . With an increase of 8 percentage points,  $TFR = 7.3 - 0.063 \times 68 = 3.02$ . The difference is  $3.52 - 3.02 = 0.50$  child.

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# Effects of the Productive Role of Bangladeshi Women on their Reproductive Decisions

*The participation of women from traditional communities in microcredit-based productive activities significantly modifies their perceptions of reproductive decisions*

**By Abdullahel Hadi\***

The role of reproductive health care in reducing maternal mortality and morbidity has been widely reported; in most developing countries, however, women still have little control over their sexuality and reproductive decisions (Cook and Fathalla, 1996; Hadi, 1999). This adverse situation has direct impacts on fertility, maternal morbidity, the transmission of sexually

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\* Senior Research Sociologist, Research and Evaluation Division, Bangladesh Rural Advancement Committee, 75 Mohakhali, Dhaka, Bangladesh. Fax: (880-2) 882-3542, E-mail: [shirsha@bangla.net](mailto:shirsha@bangla.net)

transmitted diseases and neonatal mortality (Heise, Moore and Toubia, 1995; Sadik, 1998; Berer, 2000). Although feminists have long been struggling to improve conditions for women, reproductive rights issues have only recently been getting recognition in demographic discourse. The long-term effects of violations of reproductive rights are not yet adequately understood, although it has been reported that abused women might have developed multiple medical complications such as chronic pelvic pain and somaticized symptoms. Although sex is a natural part of life, the ability of women to determine when they should copulate has a strong positive association with the prevention of unwanted pregnancy (Cook and Fathalla, 1996).

The International Conference on Population and Development (ICPD), held in Cairo in 1994, endorsed a new agenda for population programmes at the global level, focusing on reproductive health, human rights and women's empowerment, among others. The right to decide freely and responsibly the number, spacing and timing of children was recognized in the ICPD Programme of Action (United Nations, 1994). Thus, the rights of bodily integrity, sexual health and freedom from sexual coercion were formally recognized as core principles for the first time in history (Correa, 1997; Petchesky, 2000). Gender equity in sexual relations, mutual respect and consent for sexual behaviour were also recognized and endorsed (Correa, 1997).

Although ICPD and other such forums have condemned sexual rights violations and coerced intercourse, the concept of the reproductive rights of women has hardly been recognized by most health care providers in Bangladesh. While Bangladeshi society accepts the notion that sexual activity is natural and an indication of the intimate relationship between spouses, forced sex within marriage has not only been tolerated (Heise, Moore and Toubia, 1995), but the socio-cultural context has shaped and supported such sexual coercion (Hadi, 2000). Women are taught to be obedient when their husbands ask for sex. On the other hand, husbands are socialized to exercise their right to dominate their spouses, including in making demands for sex. In the cultural context, even if the wife is unwilling to participate, sexual relations can be demanded. No major religious code of ethics recognizes as rape sex coerced by one's spouse. The existing legal or criminal justice system reflects the dominance of males in sexual matters, a situation that perpetuates sexual victimization.

The ICPD Programme of Action clearly states: "Improving the status of women also enhances their decision-making capacity . . . especially in the area



of sexuality and reproduction” (United Nations, 1994). The reproductive health agenda of the ICPD Programme of Action is based essentially on the human rights approach; as a result, the success of the Programme will depend largely on establishing conditions which will enable women to make choices concerning their sexuality and reproduction (Salm, 2000).

As mentioned above, women’s position in reproductive decision-making has remained very poor in most developing countries (Cook and Fathalla, 1996; Hadi, 1999). Recent studies have shown that the participation of women in economic activities and their ability to contribute financially to the family can significantly increase their role in the household decision-making process (Petchesky, 2000; Hadi, Nath and Chowdhury, 2001). A clearer understanding of the links between women’s position in the household and the change in their perceptions of sexuality and reproduction hold significant implications for policy purposes (Mahmud and Johnstone, 1994).

### **Microcredit-based employment and reproductive choice**

Considerable resources have already been spent on promoting reproductive health services in Bangladesh. A combination of various promotional approaches, such as via the mass media, via health campaigns, and via routine counselling at health facilities, have been attempted by the Government and other agencies. The assumption has been that the provision of varied and comprehensive information through multiple sources would help create positive behavioural changes in health and health care. Unfortunately, many of the promotional approaches were not appropriately designed for reaching the poor in remote areas of the country. However, microcredit-based development programmes,<sup>1</sup> introduced primarily by non-governmental organizations (NGOs), were regarded as successful because of their emphasis on planned intervention at the grassroots level (Uphoff, 1993; Bangladesh Rural Advancement Committee, 1999).

NGOs in Bangladesh have introduced not only collateral-free credit for poor women, but a package of support services such as group formation, skills training, adult literacy, basic health services and legal awareness. Many NGOs, although not directly providing reproductive health services, have been promoting the messages that women should have control over their own bodies as well as the right to decide when they should have children and how many. The awareness of women’s rights has been an important goal to be achieved by microcredit-based development organizations in Bangladesh.

When a woman gets credit and invests her money in a successful enterprise, she needs to attend weekly meetings and participate in skills training sessions. As an active participant of the programme, she has culturally legitimate reasons to go outside her home as well as opportunities to interact with others. Her access to credit without any collateral raises her position within the family. After becoming involved in income-generating activities, she finds herself as a productive and income-earning member of the family, with increasing self-reliance and confidence. Her relationship with her husband is modified as a result of her financial contribution to her household (Hashemi, Schuler and Riley, 1996; Husain, 1998; and Hadi, Nath and Chowdhury, 2001).

It is not known, however, whether the involvement of women in NGO-led development programmes has also improved their level of awareness of their reproductive and decision-making rights. This study assesses the contribution of women's participation in productive activities in terms of modifying their perceptions of reproductive decisions in the traditional communities of Bangladesh. Three domains of reproductive decisions (that is, copulation, childbearing and contraception) are considered in this study.

## **Data and methods**

The study was carried out in the villages of two districts in the northern and central regions of Bangladesh where the Bangladesh Rural Advancement Committee (BRAC) has both microcredit and family planning facilitation programmes.<sup>2</sup> Data were collected by a team of female investigators who had professional training and experience in both qualitative and the survey research techniques. A structured questionnaire was used to collect detailed information about respondents' socio-demographic characteristics and their involvement in credit operations. Information about issues related to reproductive decision-making was captured by in-depth interviews.

All married women less than 50 years old were considered for inclusion in the sampling. A systematic random sampling technique was followed to select a sample from the Couple Registers.<sup>3</sup> In total, 1,145 women were selected<sup>4</sup> from 30 villages in both regions. The data were collected in August 1997.

The study focused on the change of perceptions regarding the reproductive decisions<sup>5</sup> among poor women as a result of their participation in productive activities. Only poor women were eligible<sup>6</sup> to participate in the

NGO-led, income-generating activities. Microcredit organizations generally target adult women of poor households who own a very small amount of cultivable land for involvement in their productive activities. In identifying the poor in the rural areas, BRAC generally considers marginal landowners who survive by selling their manual labour. In this study, the households that owned less than 50 decimals<sup>7</sup> of land and survived on selling manual labour were considered poor households. Although eligible, not all women of poor households participated in NGO-led, credit-based productive activities. The women covered by the study were thus categorized into three groups: (a) the poor who were productively self-employed, (b) those who were poor and not employed and (c) women who were not eligible to participate in the programme. The perceptions of the (productive) participants were compared to those of non-participants (domestic only) in order to assess the change.

The present study focused on three issues concerning perceived reproductive decisions, that is, the timing of copulation, timing of childbearing and the right to use contraception. In measuring the perception regarding the timing of copulation, each woman was asked whether her husband alone should decide or whether a woman should have the right to refuse her spouse when asked for sexual intercourse. Only a negligible proportion believed that a woman should have the right to refuse her spouse, while the majority felt that copulation should be decided on jointly by both spouses. Thus, a joint decision compared to the decision taken by the husband alone was considered an improvement. Similarly, a joint decision regarding the timing of childbearing was considered better compared to a decision made by the husband alone. Finally, the perception regarding a decision on contraception was illustrated by asking whether a woman should have the right to use contraception even when her spouse disapproves it.

The net contribution of women's involvement in productive activities on these three reproductive decision issues was assessed by logistic regression. Other variables in the analytical framework, such as age and education of women, their exposure to the mass media, land ownership<sup>7</sup> of the family and religious beliefs, were assumed to have modified the effects of the productive role of women on their reproductive perceptions. The cross-sectional data used in this study might have generated biased estimates because women who are relatively innovative might be more likely than others to join in credit-based productive activities (Pitt and others, 1999). In the absence of longitudinal data, the influence of endogeneity or selection bias was adjusted by employing multivariate analyses (Aldrich and Nelson, 1994).

**Table 1. Profile of sample women by their participation in productive activities**

Study variable	Women's role			All women
	Domestic only	Productive	Not eligible <sup>c</sup>	
Percentage <30 years	63.0	51.7	53.5	56.8
Mean age (years)	28.0 (7.3)	29.7 (6.8)	29.7 (7.2)	29.0 (7.2)
Percentage literate	20.2	24.7	41.8	27.3
Mean schooling (years)	1.08 (2.56)	1.24 (2.58)	2.56 (3.57)	1.52 (2.93)
Percentage exposed to media	21.3	17.3	28.8	21.9
Percentage landless <sup>a</sup>	75.1	49.6	<sup>b</sup>	47.0
Mean land owned (acres) <sup>a</sup>	0.07 (0.13)	0.57 (1.25)	2.39 (2.32)	0.80 (1.68)
Percentage Muslim <sup>a</sup>	92.9	90.3	92.0	91.8
N	465	381	299	1,145

*Note:* Productive women are defined as productively self-employed women who also perform domestic duties.

Standard deviations are shown within parentheses.

<sup>a</sup> Estimated as household level variable.

<sup>b</sup> No case is found.

<sup>c</sup> The proportion of women productively employed is insignificant in this category.

## Findings

### Profile of women

Although nearly 74 per cent of the women were eligible to participate, only 33 per cent (381 out of 1,145) actually participated in the credit-based, income-generating programme. The others were involved in domestic activities only. The differentials in socio-demographic characteristics by programme participation were very wide (table 1). Most of the study women were young (56.8 per cent were aged under 30 years) with a mean age of 29 years. The women who participated in productive activities were generally older than the non-participants, as reflected by the differences in mean age and proportion in the age groups (at  $p < 0.01$ ). Only 27.3 per cent of the women were literate, with a mean of 1.52 years of schooling. Both the literacy and the mean years of schooling were higher among the productive women than among the housewives (domestic).

After joining the credit-based, income-generating programme, the women were expected to participate in basic literacy and skills training programmes in order to become eligible to receive credit. This requirement might have raised ( $p<0.05$ ) the literacy level among the participants. On the other hand, it is also quite possible that relatively more literate women joined the microcredit programme as they were more aware of the benefits of the programme than were the illiterates. Exposure to the mass media in rural settings in Bangladesh was found to be very poor, as only 21.9 per cent of the women in the sample had access to electronic media. When a comparison was made between domestic and productive women among the poor, no significant difference in media exposure was found.

Landlessness was much higher among the non-participants (domestic only) than participants (productive). The difference in land ownership between the two groups of poor women supports the assumption that for the poorest women the credit-based, income-generating programmes remain out of reach. Nearly 92 per cent of the sample women were Muslims. The difference in religious beliefs between the two groups was minor. Women who were generally better in all socio-economic indicators were not eligible to participate in income-generating programmes. But the differences between the domestic and productive groups of eligible women were also significant, indicating the existence of some bias in the selection of participants in microcredit programmes.

### **Correlates of reproductive decisions**

Overall, most women felt that the timing of sexual intercourse (67.5 per cent) and childbearing (78.3 per cent) should be decided jointly by both spouses (table 2). However, only 21.8 per cent of the women felt that they should have the right to use contraception without the approval of their spouse. The perceptions regarding reproductive decision issues were significantly different among women by their educational level and media exposure but not by age, land ownership and religion. For example, the variation in the reproductive perceptions among women had no significant relationship to their age. Ownership of land showed a positive association with the right to use contraception but had no association with the perception of other reproductive issues. There was no significant difference in the perceptions of reproductive issues in terms of religious belief.

Education appeared to play a significantly ( $p<0.01$ ) positive role in raising women's perceptions regarding copulation, childbearing and the right to

**Table 2. Women's perceived reproductive decisions  
by socio-demographic characteristics**

Socio-demographic factors	Reproductive decision		
	Timing of copulation	Timing of childbearing	Right to use contraception
<b>All</b>	<b>67.5</b>	<b>18.3</b>	<b>21.8</b>
<b>Age (years)</b>			
<25	69.5	77.2	19.9
25-34	66.5	80.5	21.5
35≥	67.4	75.3	24.4
<i>P-value</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>
<b>Land ownership</b>			
Landless	67.8	80.7	18.0
<2 acres	66.1	76.0	24.0
2≥ acres	70.6	76.5	28.8
<i>P-value</i>	<i>ns</i>	<i>ns</i>	<0.01
<b>Religion</b>			
Muslim	67.7	78.6	22.2
Non-Muslim	64.9	74.5	18.1
<i>P-value</i>	<i>ns</i>	<i>ns</i>	<i>ns</i>
<b>Education (years)</b>			
No school	63.5	74.9	19.7
1-5	76.7	83.9	23.3
6≥	80.8	92.5	34.2
<i>P-value</i>	<0.01	<0.01	<0.01
<b>Media exposure</b>			
Poor	65.1	75.4	19.0
Good	76.1	88.4	31.9
<i>P-value</i>	<0.01	<0.01	<0.01

*ns* = Not significant.

use contraception. The gap in perceptions in terms of educational level (in bivariate relationships) supported the assumption that socialization and the learning process in school had important implications in modifying reproductive perceptions. Exposure to the mass media also played a significant role in changing perceptions of reproductive issues.

### **Productive role and reproductive decisions**

Women's involvement in credit-based, income-generating programmes showed a significant association with their perceived reproductive

**Table 3. Women's perceived reproductive decisions by their participation in credit-based productive activities**

Women's role	Reproductive decision		
	Timing of copulation	Timing of childbearing	Right to use contraception
Domestic only	63.4	74.0	17.2
Productive (<3 years)	70.4	81.6	25.5
Productive (3≥ years)	72.4	85.9	23.8
Not eligible	68.9	77.9	25.4
<i>P-value</i>	<0.10	<0.01	<0.05

decisions (table 3). Programme participation appeared to have a positive influence on joint decision-making with regard to copulation and childbearing issues. Similarly, the perception that women should have the right to use contraception was significantly higher ( $p < 0.05$ ) among the productive than domestic-only women. The influence appeared to be more pronounced when the duration of the productive role increased to five years or more.

The multivariate analysis (table 4) also showed similar findings when women's individual and family characteristics were controlled. The odds ratios demonstrate that the longer a woman is involved in productive activities, the greater the likelihood that her perceptions about reproductive issues will change. The data suggest that media exposure and years of schooling also explain a large part of the perceived reproductive decisions. It is not known, however, how the participation in the productive activities relates to the modification of perceptions regarding reproductive decisions. Involvement in a credit programme helps women to gain public exposure as they attend weekly meetings with credit officials and fellow group members. Attending such meetings might broaden their exposure regarding their role in the reproductive decision-making process.

How does participation in credit-based, income-generation programmes relate to the modification of women's perceptions about reproductive issues? One explanation suggests that by providing opportunities to earn and financially contribute to the family, such programmes might reduced gender inequality within the household. A woman's control over resource flow and ability to contribute financially to their family may strengthen her bargaining

**Table 4. Odds ratios for the perceptions of women regarding their reproductive decisions**

Explanatory variable	Reproductive decision		
	Timing of copulation	Timing of childbearing	Right to use contraception
<b>Women's role</b>			
Domestic only	1.00	1.00	1.00
Productive (<3 years)	1.31	1.64 <sup>b</sup>	1.58 <sup>b</sup>
Productive (3≥ years)	1.61 <sup>b</sup>	2.52 <sup>c</sup>	1.57 <sup>b</sup>
Not eligible	1.11	1.37	1.33
<b>Socio-economic</b>			
Years of education	1.13 <sup>c</sup>	1.17 <sup>c</sup>	1.06 <sup>b</sup>
Media exposure (rc = poor)	1.37 <sup>a</sup>	2.06 <sup>c</sup>	1.73 <sup>c</sup>
Age of women	1.01	0.99	1.01
Land ownership	1.00	0.99 <sup>b</sup>	1.00
Religion (rc = Muslim)	0.91	0.84	0.79

<sup>a</sup> = p<0.10;

<sup>b</sup> = p<0.05;

<sup>c</sup> = p<0.01.

position with her husband when negotiating a new role. The success of self-employed women in gaining more autonomy should also be viewed from the structural context. Given the cultural context, the expected role of the husband as the provider creates a dilemma when the wife is employed in economic activities and is able to contribute financially to the household. Through the process, a woman's decision-making capacity increases because she performs both domestic and productive roles if the husband does not play any additional role except in undertaking culturally assigned productive activities (Hadi and others, 2001). One study illustrated how the newly empowered credit programme participants reacted. For example, one participant said: "I now feel the difference. My husband cannot take control over my body". During one in-depth interview for the current study, one woman commented: "My husband used to threaten me and remind me that he had the right to enjoy me whenever he desired". The cultural sphere of rural women has been changing as economic life has become more complex and a large number of poor women have become engaged in productive activities outside the home (Cleland and Phillips, 1993). The microcredit programme has



widened the opportunity for poor women to reduce the unequal relationship and redefine their relationship with their spouse.

## **Discussion**

Overall, the perceptions regarding reproductive issues, as discussed in this study, indicate that Bangladeshi women have begun to move forward in achieving the goals set in global conferences held during the 1990s. Social, economic and cultural factors have played important roles in changing their perceptions, although the mechanisms through which such factors operate are not clearly known. Among these changes, the improvement of education among women has broadened their ability to understand the options available to them, and enabled them to re-think traditional cultural values and modify their individual attitudes (Cook and Fathalla, 1996; Hobcraft, 1993). Exposing women to new knowledge has also influenced their reproductive decisions to reduce desired family size (Le Vine and others, 1994).

Although the social and cultural contexts largely determine women's accessibility to participate in the labour force outside the home, microcredit-based income-generating programmes have created an opportunity for many poor women to be employed productively in Bangladesh. As found in other studies, women's involvement in economically productive activities has reduced their dependency on their husband (Husain, 1998; Schuler and Hashemi, 1994). It has also modified the traditional gender relations within the household, created opportunities for women to exercise some degree of autonomy and enhanced their participation in decision-making, including the limiting or spacing of births (Mahmud and Johnstone, 1994; Hadi, Nath and Chowdhury, 2001). Income and control over family resources have created self-respect and the perception of self-worth, with a subsequent enhancement of a sense of identity. The programme participants have been able to bring home resources in the form of credit or income that have helped diffuse poverty-related stress in their families (Schuler, Hashemi and Badal, 1998). The present study shows that women's involvement in productive activities has the potential to reduce the gender gap and significantly modify their views regarding sexuality and the sexual relationship with their spouse. The notion that the wife has the right to refuse to take part in sexual activity is still unacceptable to most women in Bangladesh. The feminists and reproductive health policy makers should take note of this finding when considering the position of women. The perceptions of women regarding reproductive decisions should not be expected to change dramatically in Bangladesh in the near future.

While providing access to credit and opportunities to earn an income can play an important role in empowering rural women, a sustained programme effort that focuses on women's rights should be incorporated within various development interventions in the communities. Men also should be educated, sensitized and encouraged to participate in community-based reproductive health programmes. Activists should not only be developing strategies for achieving reproductive rights in practice (Berer, 2000) but should also encourage health professionals and feminist organizations to join hands with the Government in implementing the policies of the reproductive rights of women in Bangladesh. As the gaps between commitment and reality have remained unchanged, it is important for women to become united to enable them to face the challenges that are inherent in establishing the reproductive rights of women (Pitanguy, 1999).

The present study demonstrates that changing the perceptions of reproductive issues is possible and it argues that the productive role of women can create the context for them to think, make their own choices and participate equally in the reproductive decision-making process with their spouses. The study concludes that the economic and cultural aspects of participation in productive activities have the potential to modify the perceptions of reproductive decisions by poor women in Bangladesh.

### **Endnotes**

1. The microcredit programmes are designed primarily for poor rural women. The programmes include a package of support services such as group formation, skill training and basic literacy for the participating women. The successful implementation of the programme provides poor women with an opportunity to earn and contribute financially to their family.
2. As part of its efforts in assisting the Government, the Bangladesh Rural Advancement Committee (BRAC) began its Family Planning Facilitation Programme in December 1994 in those districts where contraceptive prevalence was very low. BRAC was given the responsibility of providing reproductive health and family planning services because of its success in microcredit-based development interventions for women in Bangladesh.
3. The family planning services were provided by the community health volunteers, where each volunteer was assigned to provide services to about 100-120 eligible couples in her catchment area. The volunteers maintained "Couple Registers" where all relevant events (e.g. pregnancy, childbirth and contraceptive use, along with basic demographic information) were documented. The Couple Registers, updated every month by the volunteers, were used as the sampling universe to select samples for this study.
4. The investigators were sensitized about potential problems in collecting information. Confidentiality of information was strictly observed. All sampled women were approached,

although their participation was voluntary. The participants were never pressed to provide information. Maintaining privacy during discussions with women was difficult in some cases and such occurrences led to incomplete interviews. In such cases, the women were replaced by new samples selected at random.

5. Although the concept of reproductive decisions generally implies the capacity to make autonomous decisions (Correa, 1997), the reproductive decisions in this study apply more to balancing power relations between the spouses in reproductive decision-making.

6. Not all women are eligible to participate in credit-based, income-generating activities. A woman is eligible if her family owns less than 100 50 decimals of cultivable land and if any adult member of that family sells manual labour for at least 100 days per year.

7. The amount of cultivable land owned by a family is considered an important economic indicator because agriculture is the main economic activity in rural Bangladesh. The amount of land is converted to decimals, with 100 decimals being equivalent to an acre (1 hectare = 2.47 acres).

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# The Oral Contraceptive Pill in Viet Nam: Situation, Client Perspectives and Possibilities for Promotion

*While radio and television are very effective channels for disseminating information, IEC (information, education and communication) work has not been closely integrated with the distribution of oral contraceptives*

**By Nguyen Minh Thang and Vu Thu Huong\***

Viet Nam has one of the highest rates of abortion in the world, according to the 1997 Demographic and Health Survey. Even though official statistics and survey fieldwork are likely to have underreported the number of abortions, the rate is still high at 340 per 1,000 pregnancies (Henshaw and Morrow, 1990;

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\* Nguyen Minh Thang, Carolina Population Center, University of North Carolina at Chapel Hill, North Carolina, Vu Thu Huong, Population Research Consultants, Hanoi, Viet Nam, and School of Social Work, University of Washington, Seattle, Washington, United States of America.

NCPFP, 2000a). This can be partly attributed to unmet need for contraceptives among married women and also to the fact that unmarried women do not have access to free modern contraceptives (Nguyen Minh Thang and others, 1999). To deal with this situation, the Vietnamese Government's family planning programme is expanding the contraceptive mix so that temporary methods such as condoms and oral contraceptive pills are being given more emphasis, especially the pills, as they are so effective in preventing pregnancy (NCPFP, 2000b; Harlap, Kost and Forrest, 1991).

However, according to recent surveys, the IUD (intrauterine device) is still the dominant method of contraception, used by 68 per cent of married women (NCPFP, 2001a). Although 90 per cent of the currently married women surveyed said they were familiar with oral pills, only 4 per cent were currently using them. Young unmarried women still do not have access to free oral pills, which are targeted at and distributed to married women through Population and Ministry of Health networks. A number of studies on contraceptive use in Viet Nam have been conducted; however, there are few studies on oral contraceptive use. Thus, the promotion of the pill among married and unmarried women needs to be examined. User knowledge and perspectives, the quality of provider services and counselling, the management of side-effects, and the distribution mechanism of oral pills were suggested as factors that influence the effectiveness of efforts to promote them (Population and Family Health Project, 2000).

This article is aimed at providing in-depth analysis to determine factors that promote the use of oral contraceptives in Viet Nam. It is hoped that this research will be useful in helping to plan, manage and implement projects that promote the use of oral contraceptives in a country where contraceptive use plays an important role in the Government's effort to lower fertility rapidly (Asian Meta Center, forthcoming).

### **Literature review**

When promoting a contraceptive method, it is critical to define the target group. In Viet Nam, a very small number of sexually active adolescents and unmarried women use a contraceptive to avoid an unwanted pregnancy (Gammeltoft, Tine and Nguyen Minh Thang, 1999). This is probably a result of both the focus of the national family planning programme and cultural factors.

A study of the opinions of population policy makers and programme managers revealed a significant conservative bloc, which questioned whether the reproductive health programme should be expanded to unmarried

women, especially adolescents (Nguyen Minh Thang and Vu Thu Huong, 1998). A family planning programme that focuses on married women will not create an environment that encourages many unmarried youth to use contraceptives during sexual intercourse (Belanger and Khuat Thu Hong, 1997).

Currently, Vietnamese society does not provide a favourable environment for unmarried women to buy and use either condoms or contraceptive pills. Studies have shown that the great majority of sexually active young women do not use any contraceptive methods, even though many of them understand the risks of unwanted pregnancy (Gammeltoft, Tine and Nguyen Minh Thang, 1999). Young women were interested in learning more about oral contraceptives, including not only how to use them but what their immediate and long-term side-effects were. Most of the women were very concerned about the impact of oral contraceptives on their health and future reproductive capacity (POPCON, 2000), but they were also uncomfortable buying condoms, which to them suggested a casual and unusual approach to sexual relations. This attitude may explain why there is such a high rate of reliance on traditional contraceptive methods, which are less effective in preventing unwanted pregnancies. How to meet the great need for contraceptives among young people is therefore a question that should be examined. This study suggests that the national family planning programme could achieve better reproductive health outcomes by providing more information and services to adolescents and unmarried women.

The experience of family planning programmes worldwide indicates that the use of modern contraceptives is significantly influenced by the quality of care women receive. The information and counselling choices given to users are an essential part of an effective campaign to promote contraceptive use (Bruce, 1989). A family planning worker's ability to provide both counselling services on contraceptives that are available at clinics and help to users in choosing an appropriate contraceptive method could improve both the number of users and the quality of care. In Viet Nam, one estimate indicated that 99 per cent of ever-married women reported that they knew of at least one contraceptive method, with oral contraceptives ranking fifth after IUDs, condoms, and female and male sterilization (Nguyen Minh Thang, Nguyen Thanh Nga and Nguyen Van Phai, 2000). However, there is some question about whether there was a gap in the women's understanding about each method, that is, many women had heard of the various contraceptive methods but did not know much about each method, for example, how it works and how to use it (Nguyen Minh Thang and others, 1998).

Aside from the competence of service providers, the attitude of family planning providers can also be a factor affecting the choice of oral pills as a contraceptive method. Surveys show that, in Viet Nam, the proportion of IUD users has decreased, but the IUD is still the dominant method of contraception among all users (NCPFP, 2001b). This is probably because family planning in Viet Nam has relied heavily on IUDs, because it is believed that the IUD is more convenient for both users and providers, and is safer for users when there is no follow-up. Thus, a service provider's knowledge, viewpoint and attitudes could have an impact on the effectiveness of the promotion of contraceptives, including oral pills.

Although being provided enough information to make an informed choice about contraceptive methods is an important factor, the quality and availability of services is also important. A number of indicators, for example, the degree of unmet need, can be examined to address the quality of service and its influence on service utilization. The 1997 VN/DHS showed that 56 per cent of women were using a modern contraceptive method (NCPFP, 1999). This level increased by 12 per cent during the four years following implementation of the "Population and Family Planning Strategy to the Year 2000". However, an in-depth analysis of the 1997 Viet Nam DHS also showed that the total unmet need for family planning in Viet Nam was 27.1 per cent (including traditional methods). The unmet need occurred mainly among women aged between 20 and 24 years. At least 12.5 per cent of married women with an unmet need said that they intended to use oral contraceptives (NCPFP, 2000a). Family planning efforts, technical capacity and the efficiency of services, therefore, could all be factors in preventing potential users from practising contraception in general and using oral pills in particular. The quality of health-care facilities at the local level should also be examined.

Research related to the utilization of the health-care network in Viet Nam has shown that there has been a general deterioration in the quality of commune health centres over time. The lack of access to facilities and medications increased from 1993 to 1998 (Indu and others, 2001). The question is whether reproductive health services meet the needs for convenience, safety and diversity. Does the social marketing of contraceptives, including oral contraceptives, still meet with numerous difficulties? What is the role of private service providers in terms of promoting contraceptive use?

The distance between the target population's residence and the nearest contraceptive provider is another possible impediment to improving access to contraceptives. The 1997 Viet Nam DHS showed that, although most users have to travel from 6 to 15 km to obtain a clinical method of contraception,



about half of the women could get oral contraceptives without travelling more than a kilometre. Access to pills therefore may be a positive factor in pill promotion. Thus, the availability of pills and the distribution mechanism should both be examined, as the contraceptive distribution mechanism at the grassroots level will favour the promotion of the pill for contraceptive purposes. However, the existing overlap in functions and duties among the health and population networks may make it difficult for users to access the service.

## **Data**

Both quantitative and qualitative methods were used in this research. A representative sample survey was conducted in seven provinces of Viet Nam from March to April 2000. In each province, a district was selected which had a rate of contraceptive use approximately equal to the provincial average rate, including the rate of oral contraceptive use. In each district, two communes were selected and 50 households in each commune were surveyed. Every woman in the selected households (whether married or unmarried) aged from 15 to 49 was interviewed. The total sample size was 702 women, with 47.2 per cent aged between 25 and 35 years, 36.9 per cent aged between 36 and 49 years, and 15.9 per cent aged between 15 and 24 years; just over 10 per cent were unmarried. Most of the women (96.4 per cent) surveyed belonged to the Kinh ethnic majority. The majority of the women interviewed (55.4 per cent) had a lower secondary education, 15.7 per cent had only a primary education. The majority (81.9 per cent) were farmers, 6.6 per cent were involved in business, 8.2 per cent comprised government employees and 3.3 per cent were students.

Group discussions and personal interviews were held in one commune of every selected province. The discussions were organized as follows: married women aged between 20 and 25 years, unmarried women aged between 18 and 25 years, and health workers and collaborators in the population and family planning programme. A total of 21 group discussions involving 126 people were held. A total of 40 personal interviews were conducted with leaders of the Mother and Child Health Protection and Family Planning Centres, the staff of the Women's Union, the Youth Union and private doctors.

## **Findings**

What do users know about oral contraceptive pills? As previously mentioned, the study found that a large number of women had heard about oral contraceptives, including knowing various brand names and where to obtain

**Table 1. Percentage of women who know about oral contraceptive, including where to get them and how to use them, by specific characteristics**

	Know about method		Know where to obtain and how to use method				N
	Prompted response	N	Know a source	Know to take the pill very day	Know how to take the pill when forgotten for one day	Know how to take the pill when forgotten for two days	
<b>Age group (years)</b>							
15-24	94.6	112	86.6	64.2	31.2	30.2	106
25-35	93.7	331	91.2	84.2	42.6	41.5	310
36-49	92.3	259	86.1	79.1	36.0	31.3	239
<b>Marital status</b>							
Unmarried	88.9	72	75.0	42.4	17.2	12.5	64
Married	93.8	630	90.2	85.0	40.8	38.6	591
<b>Education level</b>							
Grade 1-5	84.6	110	77.3	80.6	29.1	25.8	93
Grade 6-9	94.8	387	91.0	78.5	37.3	33.5	367
Grade 10 and above	95.1	202	90.6	79.2	44.8	44.3	192
<b>Planning for children</b>							
Want no more	94.7	475	91.0	81.1	39.6	37.8	450
Want another	89.4	151	86.8	88.1	42.3	40.0	135
Do not plan	92.1	76	77.6	48.5	22.9	14.3	70
<b>Region</b>							
North	99.0	300	97.3	80.8	48.2	42.1	297
Central	89.1	201	86.1	77.7	27.9	21.8	179
South	89.1	201	78.1	77.7	32.4	39.1	179
<b>Regarding televised advertisement for oral contraceptive</b>							
Ever seen	96.6	524	93.7	87.3	43.1	42.5	506
Never seen	84.3	178	74.2	58.2	22.9	13.5	150
<b>Total</b>	<b>93.3</b>	<b>702</b>	<b>88.6</b>	<b>79.1</b>	<b>38.4</b>	<b>35.7</b>	<b>655</b>

them. However, the number was considerably lower among women with only a primary education, women not living with their husband or those having no sex partner, women who had no intention of having more children, and women in the southern provinces. Although more young women aged between 15 and 24 knew about oral contraceptives than other age groups, they did not know where to get them. Those who had never heard or seen advertisements about oral contraceptives knew less about this method than those who had access to communications and advertisements (table 1). Quantitative analysis confirmed that, even though many people know about oral contraceptives, there is still a big gap in their understanding about them. The study also showed that 79.1 per cent of the women knew that the pill must be taken every day. This means that almost 20 per cent who knew or had heard about oral contraceptives did not know that they must be taken every day. The study also showed a relatively small percentage of women knew how to use oral contraceptives correctly: only 38.4 and 35.7 per cent of the women knew what to do if the pills were not taken for one or two days, respectively. More women aged between 25 and 35 knew that the pill must be taken daily and what to do if they forget to take the pills for 1-2 days, compared with the age groups 15-24 and 36-49 years.

Educational level has a certain influence on how much a woman knows about using the pills. The findings show that the more highly educated women are, the more they understand about how to use oral contraceptives correctly. The percentage of those who knew how to deal with missing a pill for a day or two also increased with an increase in their educational level.

There was little difference in knowing how to use oral contraceptives between women who did not want to have more children and those who did want more. However, women who did not plan to have children at all were much less knowledgeable (48.5 per cent) on how to use oral contraceptives than either those who planned to have more children or those who did not (88.1 and 81.1 per cent respectively). The same trends hold for knowing how to deal with the problem of forgetting to take pills for one or two days. This suggests that advocacy for oral contraception has not reached young and recently married couples, and that northern women are much better informed than their counterparts in the central and southern parts of the country.

Who are oral contraceptive users, why do people use or not use oral contraceptives, and how do they react to any side-effects? The rate of women using oral contraceptives in this study is rather high when compared with the country as a whole: 21 per cent of the respondents reported "ever use" of pills and 14 per cent that they were current users.

Use among women aged between 25 and 35 was about double that of women in the age groups 15-24 and 36-49 years. Only a very small proportion (1.4 per cent of unmarried women were ever users of oral contraceptives and none of them were current users. The low rate of oral contraceptive use among young and unmarried women is clearly a result of the limited efforts of the national family planning programme.

While neither the family planning programme nor society is supportive of premarital sexual activity, it is relatively common nowadays for many young people to have sex before marriage. Also, many of those who have premarital sex become pregnant, as they do not use any contraceptive method. A large number of interviewees said that they did not use a contraceptive method because such methods were not compatible with love. The findings clearly reflect that information is not being aimed at adolescents and unmarried women, where temporary contraceptive methods should be promoted in order to protect them from an unplanned pregnancy that would then likely end in abortion.

Table 2 shows that women with primary or upper-secondary education account for a relatively high percentage, 28.2 and 24.3 per cent respectively, of those women who have ever used oral contraceptives. It is interesting to note that women with more education know more about oral contraceptives but use them less than those with less education. However, the trend in pill use is more stable for more highly educated women. This might suggest that the women with less education were more influenced by a family planning campaign that focused on encouraging oral contraceptive use without providing adequate information. Oral contraceptive use among the group of women who did not want more children or the group who wanted to have more children is similar. Those who had no plans to have children (mainly unmarried and recently married women) had a very low rate of oral contraceptive use. Although knowledge about oral contraceptives is much higher for northern women than for southern women, the rate of use is much lower. Even though pill use in the northern and southern parts of the country is quite high, the dropout rate is also very high, especially in northern provinces. The study also showed that the rates of ever and current use are higher among those who had access to information about the pill and who had been exposed to advertisements for oral contraceptives than those who had not. The analysis showed an inverse ratio between knowing about and using oral contraceptives, which might be caused by the provision of inadequate information and counselling about oral contraception, leading women to misunderstand the facts about this method.

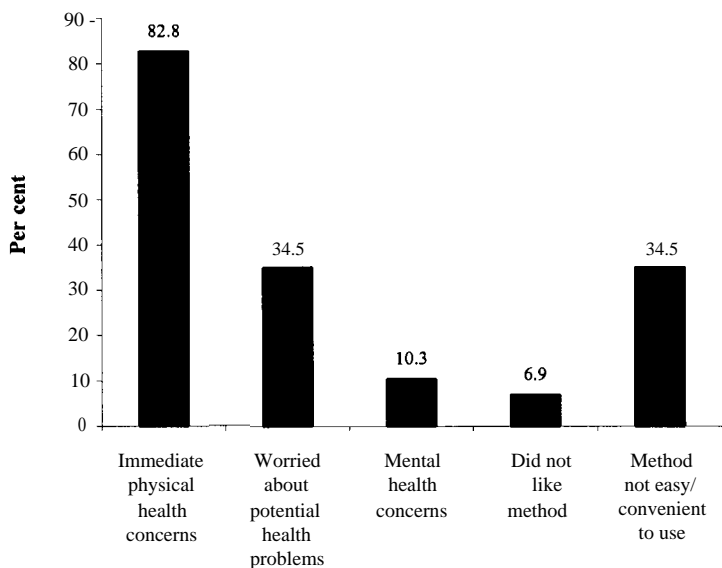
**Table 2. The use of oral contraceptives, classified by specific characteristics**

Characteristics	Ever used (percentage)	Currently using (percentage)	Dropout (percentage)	Comparative dropout <sup>a</sup> (percentage)	N
<b>Age group (years)</b>					
15-24	15.2	8.9	6.3	41.4	112
25-35	27.5	19.9	7.6	27.6	331
36-49	14.3	8.9	5.4	37.8	259
<b>Marital status</b>					
Unmarried	1.4	0.0	1.4	100.0	72
Married	22.9	15.7	7.2	31.4	630
<b>Education level</b>					
Grade 1-5	28.2	18.2	10.0	35.5	110
Grade 6-9	16.8	10.6	6.2	36.9	387
Grade 10 and above	24.3	18.8	5.5	22.6	202
<b>Planning for children</b>					
Want no more	22.3	15.0	7.33	2.7	475
Want another	21.2	14.6	6.6	31.1	151
Do not plan	9.2	7.9	1.3	14.1	76
<b>Region</b>					
North	22.0	13.0	9.0	40.9	300
Central	12.4	10.0	2.4	19.4	201
South	26.9	19.9	7.0	26.0	201
<b>Regarding televised advertisement for oral contraceptive</b>					
Ever seen	22.9	15.7	7.2	31.4	524
Never seen	14.0	9.7	4.3	30.7	178
<b>Total</b>	<b>20.7</b>	<b>14.2</b>	<b>6.5</b>	<b>31.4</b>	<b>702</b>

<sup>a</sup> Comparative dropout = dropout/ever use; this indicator provides a measure that can be compared with different groups, whether the value of ever use is low or high.

The study also showed that women who had ever used oral contraceptives reported that they trusted them; however, a number of these women shifted to other methods because of side-effects. In general, the quality of pills has won the hearts of users. An added advantage of oral contraceptives is that this method is promoted by Viet Nam's population programme. However, attention must be paid to side-effects to prevent a loss of popularity. If guarantees can be given and the use of this method regularly encouraged by functional agencies (the health and population servicing sectors), then users will possibly trust in its quality, with the rate of use likely increasing.

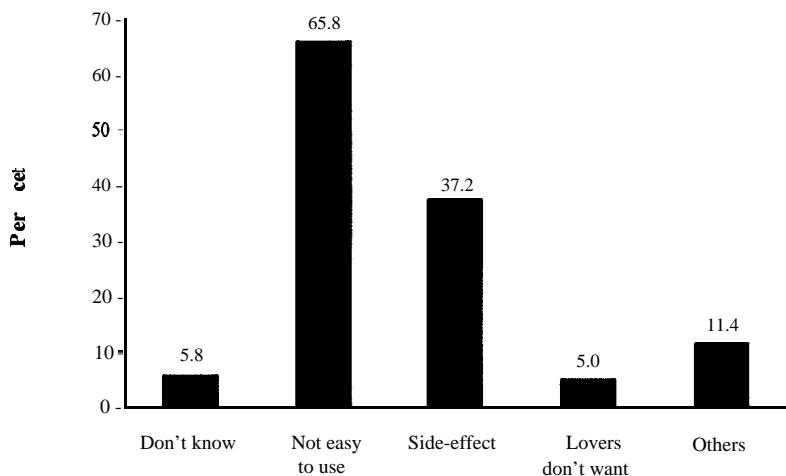
**Figure 1. Reasons for dropping out, by women who have ever used oral contraceptives**



The study showed a strong relationship between use and respondents' concerns related to the disadvantages of oral contraceptives: vaginal bleeding, headache, nausea and depression. These side-effects occur at different levels, depending on the adaptability of each individual. Some women have mild symptoms, which quickly disappear, but others have more troublesome and prolonged symptoms. Knowing how to solve these problems or how to develop positive attitudes regarding the possible side-effects will have a direct impact on increasing or decreasing use.

Women who had used modern contraceptive methods but never used oral contraceptives shed more light on the reasons why some women do not use the method: 65.8 per cent did not use oral pills because they felt the method is inconvenient (figure 1), and 37.3 per cent worried about possible side-effects (figure 2). Among the women who had never used any modern contraceptive methods, the major reason for not using oral contraceptives was that they did not know about this method (98.6 per cent).

**Figure 2. Reasons why users of other modern contraceptives do not use oral contraceptives**



Research findings on the knowledge about and practice of oral contraception were strongly supported by clients' perspectives related to further information, education and communication (IEC) efforts. More than 75 per cent of the women surveyed wanted to know more about oral contraception. Women who had ever used oral contraceptives needed even more information than those who had never used them (83.3 vs. 72.2 per cent). This comparison indicates that an increase in pill use is not related to an increase in knowledge about the method among users; it shows that there is a very high unmet need for information on oral pills among non-users.

Evidence from the study supports the hypothesis that contraceptive use in Viet Nam is dependent mainly on the quality of care rather than the cost of contraceptives. Women reported that they were willing to pay for the pills.

What can providers do to promote oral contraceptives? The current family planning service system includes provincial, district and commune health centres, pharmacies and population collaborators. In general, the staff of these facilities have acquired different qualifications, knowledge, servicing attitudes and professional skills as they were trained and retrained at different levels. On the other hand, many of them received no basic training to meet professional criteria, which prevents them from meeting clients' needs for information and counselling on oral contraception. However, health workers

and population collaborators are normally well informed about oral contraception. By contrast, service providers from NGOs or private pharmacies have little knowledge of the method. In our survey, they often did not even know the name of the pills that they distributed to users. Further, it is common to meet pharmacy owners, population collaborators and the staff of mass organizations who do not understand the usage and possible side-effects of oral contraceptives. Different levels of understanding lead to the provision of inconsistent information, counselling and answers to questions relating to the effects of oral contraceptives, thus puzzling and worrying clients.

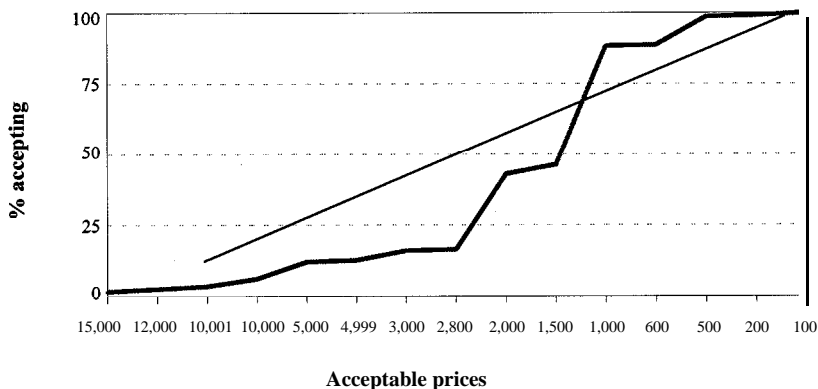
In reality, most service providers do not provide counselling for their clients. The reasons may include the following: lack of training, lack of incentives for trained health workers either to distribute the pills free of charge or to provide counselling to their clients. In addition, because pharmacy owners do not have many clients who use oral contraceptives, they do not have much incentive to pay attention to techniques for counselling them.

Service providers should provide counselling for their clients who experience problems in using oral contraceptives. Of the 43 women who had ever used oral contraceptives, 86.2 per cent said that they had asked their service providers for help. However, the women received different solutions: 88 per cent received assistance in choosing another contraceptive method, 48 per cent were asked about their health at that moment and in the past, and 28 per cent were helped to overcome their worries about using oral contraceptives. However, 8 per cent of service providers did nothing to help their clients even when the clients met with them in person. This is an indication of the service providers' weakness in counselling women about this method.

What is the impact of distribution factors on the promotion of oral contraceptives? The service capacity of providers plays an important role in promoting oral contraceptive use. However, whether the current providers of this method can meet their clients' needs or not depends very much on how the distribution is managed. In rural areas of Viet Nam, each commune's Population and Family Planning Committee compiles a list of women registered to use oral contraceptives and sends it to the district/provincial committees for the allocation of pills. In urban areas, women who want to use oral contraceptives must register their names at the commune health centre; then they must visit the centre or the population collaborators to receive the pills. The number of users is supposed to be monitored closely by the commune health centre. However, the fact is that most population collaborators at the local level cannot fulfil their task because they run short of time, or lack knowledge and encouragement. Thus, although the procedures for the management and distribution of oral contraceptives are clearly documented, in reality, they are not carried out well.



**Figure 3. Percentage of women accepting oral contraceptives at different prices**



At the grassroots level, oral contraceptives are distributed to married women only. Therefore, unmarried women have no access to service providers and cannot receive pills free of charge, no matter how great their need may be. Societal disapproval of premarital sex is a factor preventing adolescents and young adults from having access to oral contraceptives.

Price is an important component of marketing strategies; it plays a decisive role in market competition. Viet Nam's family planning programme currently advocates providing free oral contraceptives, including the German-made "Ideal" brand, which, although it is not for sale, can be found in the market for 1,000-2,000 Vietnamese Dong (US\$1 = about D 15,000). Other types of oral contraceptives are sold at different prices: D 2,000 for a package of "New Choice" and nearly D 40,000 for a package of "Marvelon". The diversity and complexity of the distribution system influences both the attitude and the practice of using pills. People do not want to pay high prices for oral contraceptives, but they still think that an oral contraceptive that is sold at a low price is of poor quality. The study showed that only a quarter of users said that they would be able to buy the pills if they are priced at D 2,500 or higher. The number rises to about half when the price of the pills is D 2,000 or lower. It is worth noting that, if the Government were to reduce the price of oral contraceptives to D 1,000, the number of users who could afford to buy pills would double. (The straight line in figure 3 illustrates this point; the figure might be useful in promoting oral contraceptives when comprehensively examining the pricing system).

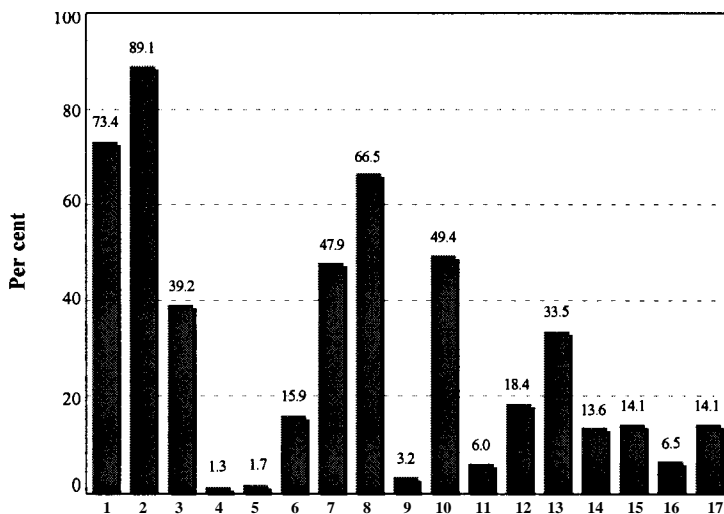
Experience shows that whenever a medicinal drug or drug-related product is mentioned, people tend to think that the national health service is the provider. When discussing contraceptive methods, they often refer to the population and family planning committees. However, many married women wish that the population and health sectors would provide contraceptive services because they are the most suitable providers of oral contraceptives: 74.4 per cent wished to receive oral pills from population collaborators, 63.8 per cent wanted to receive them from health workers, and 12.5 per cent would like to get them from pharmacies.

Campaigning is an important and effective tool in the marketing process. As discussed previously, although there are a large number of people who are aware of oral pills as a contraceptive method, they have little in-depth knowledge of the method. A lack of accurate and complete information is a potential impediment to public acceptance of oral contraceptives, particularly when they are commercialized. For example, an important attribute of both the “Ideal” and “New Choice” oral contraceptive brands is that they can be used as an emergency contraceptive. Qualitative research shows that most of the target group of women did not know about the emergency use of oral contraceptives. In fact, even some service providers did not know about this use. Such knowledge could be important to potential users, particularly unmarried ones. In general, one of the basic campaign activities in this regard is to provide comprehensive information about oral contraceptives.

There is much room for improvement in the promotion of oral pills as a means of contraception. The question is how to create a promotional campaign with suitable content and form, which not only meets the needs of the people, but also conforms to cultural traditions and the sensitive nature of this product.

In this regard, wide use has been made of the mass media as well as face-to-face communication. Advertisements had reached 85.3 per cent of the interviewees. [Figure 4](#) shows clearly how they receive information, whether from mass media or from face-to-face communication. In general, most of the respondents obtained information on contraceptive methods from the mass media, including television (89.1 per cent), radio (73.4 per cent), books and newspapers (39.2 per cent) and leaflets (33.5 per cent). The rest obtained information through face-to-face communication, namely, from population collaborators (66.5 per cent), the Women’s Union (49.4 per cent) and health workers (47.9 per cent). Other communication channels are insignificant ([figure 4](#)). Most of the women interviewed said that they would like to get information on oral contraception through television and radio spots. They also wanted to get more information through population collaborators and health-care workers.

**Figure 4. Percentage of women who had seen or heard an advertisement about oral contraceptive methods, by particular communication channels**



- |                            |                                  |
|----------------------------|----------------------------------|
| 1. Radio                   | 2. Television                    |
| 3. Books/newspapers        | 4. Parents                       |
| 5. School                  | 6. Friends/relatives             |
| 7. Health workers          | 8. Family planning collaborators |
| 9. Pharmacists             | 10. Women's Union                |
| 11. Youth Union            | 12. Print advertisements         |
| 13. Leaflets               | 14. Billboards                   |
| 15. Wall paintings         | 16. Banners                      |
| 17. Traditional folk media |                                  |

Studies show that 86 per cent of previous users and 95.9 per cent of current users of oral contraceptives discussed with their husbands/sex partners whether or not they should use oral contraceptives, which means that husbands have a significant impact on the decision to use the pill. Thus, information and promotion should also be directed at men.

In a market economy, packaging is also an important factor in attracting clients. The manufacturer or responsible agency normally provides users with necessary information by printing it on the product's packaging. For example, in Viet Nam's population programme, because it is not intended for sale on the

market, the Ideal brand cannot be promoted for commercial purposes, so packaging is intended for providing information only. However, this does not mean that users do not pay attention to its packaging, colours and decoration. Experience shows that people, particularly farmers, have difficulty in remembering a foreign name. However, they often remember the logo on the product's packaging. In general, the Ideal brand's packaging captures the attention of clients.

## Conclusions

Most users of oral contraceptives in Viet Nam are married women. Single women are still not considered a viable target of family planning services, as premarital sex is not socially acceptable, and the use of oral contraceptives among unmarried persons is correspondingly low. Although clients' general knowledge about this method is very good, an in-depth understanding of oral contraception is still lacking. In general, clients - including women who have ever used or have never used oral contraceptives - do not receive adequate information on the method, such as its positive and negative effects, use instructions and the address of distribution outlets. Many women, especially rural women, consider oral contraceptives to be inconvenient and easily forgotten. Many do not know or have forgotten that using oral contraceptives in a high dosage can serve as an emergency contraceptive. The main difficulty in using the method is the inconvenience of having to remember to take a pill every day at the same time. Also, some women are also afraid that they will experience side-effects. Most young women and adolescents do not dare to ask for oral contraceptives from population collaborators and are embarrassed to buy oral pills in their local pharmacies. Meanwhile, the national family planning programme has not encouraged schools to provide young girls and adolescents with adequate information on how to use the method or its potential side-effects.

Nonetheless, while IEC work has increased knowledge of as well as the use of this method, many gaps remain with regard to the dissemination of information and counselling. IEC work has not fully met the needs of clients, especially adolescents and young adults, for information on oral contraception. The current IEC work on oral contraception is still performed mainly within the framework of the national population programme and the Population and Family Health Project. Such information is provided through leaflets, brochures, or television advertising spots, but Viet Nam still does not have much in the way of broad campaigns specifically designed for promoting oral contraception. Those that do exist, are targeted at specific localities or groups

with programme priority. While radio and television are very effective channels for disseminating information in the form of advertisements promoting contraceptive use and the acceptance of this method, IEC work has not been closely integrated with the distribution of oral contraceptives.

Family planning providers have played an important role in improving clients' knowledge and changing behaviour. Nevertheless, their own knowledge and counselling skills are still far from adequate. In Viet Nam, providers of oral contraceptives include pharmacies, health stations and population collaborators at the communal level. Their contributions towards improving clients' knowledge and increasing the number of users of oral contraceptives is significant. However, they have been trained only to use checklists as a mean of providing more complete information about oral contraceptives; hence, their knowledge and counselling skills remain inadequate in terms of meeting the needs of clients. Most of them appear unconfident or confused while providing information. Further, most population collaborators still do not know that this method can also be used for emergency contraception. Although there has been more active participation on the part of women, younger people in communes and at school have not yet been included as target audiences in the dissemination of information on oral contraceptives and on how to obtain supplies.

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