Summary

Bangladesh, with an estimated population of 150 million and a corresponding population density of more than 920 people per sq km, is regarded as one of the most densely populated countries in the world (National Institute of Population Research and Training, 2007). Development policies in Bangladesh recognized the pressing need to reduce the population growth rate in order to ease the mounting pressure on the country’s finite resources. This sense of urgency was amply expressed in the First Five Year Plan statement that “No civilised measure would be too drastic to keep the population of Bangladesh on the smaller side of 15 crores for the sheer ecological viability of the nation” (Government of Bangladesh, 1973).

Realizing the urgency of the need to contain the rapid population growth, the Government of Bangladesh introduced domiciliary services in 1976 as an innovative approach to provide maternal and child health and family planning services. Family Welfare Assistants were recruited for delivering the domiciliary services nationwide. One Family Welfare Assistant was to serve 500 to 600 eligible couples. All Family Welfare Assistants were women and local residents.

By introducing domiciliary services, the Government wanted to generate demand for family planning through counselling, cater to the people’s need for contraception, ensure easy access to services, and bring about changes in reproductive-health behaviour among
Summary (continued)

target groups. Poor infrastructure, the conservative attitude of people towards contraception, a high fertility rate but a low demand for contraceptives, a low literacy rate, the poor economic conditions of the people, and gender inequality were all the background reasons for starting this innovative approach.

With the introduction of the domiciliary service-delivery model, the Family Planning Programme of Bangladesh achieved remarkable results, with a rise in the contraceptive prevalence rate from 7.7 per cent in 1975 to 56 per cent in 2007. The population growth rate came down substantially, the level of knowledge of contraception increased to 100 per cent and maternal mortality was considerably reduced.

Doorstep service delivery provides benefits extending beyond those arising from the receipt of family planning services. Considering their socio-economic situation, hiring young women as providers of family planning services was a milestone in the history of women’s empowerment in Bangladesh. In time, Family Welfare Assistants became role models for the other women in the community. This service-delivery system for rural women was introduced in an effort to ensure universal coverage of services upon acknowledging the restricted mobility of village women. With the introduction of this service-delivery strategy, the overall demographic scenario of Bangladesh changed within two decades.

In 1998, the Government introduced a static, centre-based, service-delivery system to replace domiciliary services and Family Welfare Assistants were asked to provide services from fixed sites. As a result, the use of maternal and child health and family planning services decreased and the total fertility rate remained stagnant for a decade (1993-2004). Recognizing this adverse effect, the Government repositioned the domiciliary service-delivery system and the total fertility rate started to decline again.

This service-delivery system is replicable and can be a good option to provide specific priority services in areas with low resource settings, low education levels and poor accessibility to service facilities. Considering the results achieved, this system of service delivery is also cost effective.

Information on the Author

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INTRODUCTION AND BACKGROUND

Bangladesh is located in the northeastern part of South Asia and covers an area of 147,570 sq km. The country has a population of about 150 million. With a corresponding population density of 920 persons per sq km, it is the most densely populated country in the world, excluding city states such as Singapore. For the last four decades, the Government has been actively trying to reduce the population growth by adopting various measures.

Family planning was introduced in Bangladesh (erstwhile East Pakistan) in the early 1950s through the voluntary efforts of social and medical workers. During the 1960s, the Government took over the programme, and, after independence, family planning received unanimous, high-level political support. All subsequent Governments that have come into power have identified population control as the priority for Government action.

In the period 1971-1975, women in Bangladesh were having an average of 6.3 children, the contraceptive prevalence rate was 7.7 per cent and the population growth rate was almost 3 per cent. The high total fertility rate with a corresponding low contraceptive prevalence rate was about to cause a population boom; this in turn also adversely affected maternal mortality, child mortality and the nutrition status. During this period, there were very limited services for the people in regards to contraception and reproductive health. Only clinic-based family planning activities were available, which was highly insufficient. Domiciliary services were introduced to generate demand for family planning, to cater to the pressing need for contraception, to ensure easy access to services, and to bring about changes in reproductive health behaviour among the target groups. Poor infrastructure, the conservative attitude of people about contraception, a low literacy rate, the poor economic conditions of the people, low demand for contraceptives and gender inequality were the main reasons for starting this innovative approach.

Fully aware of the importance of family planning services, the Government developed a population policy in 1976, declaring population control as the number one issue, and introduced a broad-based, multisectoral family planning programme. Recognizing the urgency of the need to contain the rapid population growth, it introduced domiciliary services in the same year as an innovative approach to provide maternal and child health and family planning services. Family Welfare Assistants were recruited to deliver the domiciliary services. Over the years, 23,500 Family Welfare Assistants were recruited.

Family Welfare Assistants play a very important role: they are the first contact person for maternal and child health and family planning services in the community. They complement the facility-based services provided by skilled human resources through their outreach services.
and they link their services with the static service for referral of clients as and when required. In addition, they conduct advocacy programmes and are part of a network comprising local government representatives, local elites, non-governmental organizations (NGOs) and other government agencies. This network creates broader social support for the Family Planning Programme.

**Description of the Practice**

The Family Welfare Assistants are female grass-roots-level fieldworkers of the Directorate General of Family Planning. Their immediate supervisors are the Family Planning Inspectors. Initially, one Family Welfare Assistant was recruited for one ward of the Union parishad. In 1990, each ward was divided into two or more units and one Family Welfare Assistant was given the responsibility of one unit comprising 500 to 600 eligible couples. Nowadays, the number of eligible couples has increased to 900 to 1,200 couples per unit. Family Welfare Assistants are locally appointed and operate from their own houses.

It is important to mention that women's mobility, that is, women's ability to leave their homes and to visit health facilities, was restricted in the 1970s. Doorstep family planning services for rural women were introduced in an effort to ensure universal coverage of services upon considering the restricted mobility of village women (Rob, Talukder and Ghaful, 2006). Moreover, because Bangladesh is a moderately conservative Muslim country where women feel more comfortable receiving family planning services from women service providers, the Government adopted the policy of employing only women to work as Family Welfare Assistants.

The Family Welfare Assistants providing door-to-door services to village women are paid by the Government exchequer (financial department). Their salaries are included in the revenue budget. Initially, they were recruited under the development budget but were absorbed into the regular payroll once the importance of their services was realized.

**Features of the Domiciliary Approach**

The domiciliary approach has the following characteristics:

- **Confidentiality.** Bangladesh is a country where contraception issues need to be dealt with confidentially. Women in particular do not like to talk with others about the need for and use of contraceptives. For this reason, confidentiality is a top-priority issue in delivery of family

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1A parishad is the lowest local-government administrative unit, comprising around 30,000 to 35,000 people. One Union parishad was then divided into three wards. Later it was divided into nine wards.
planning services;

- **generation of demand.** Given that the total fertility rate was high at the time when domiciliary services were introduced and the contraceptive prevalence rate was very low (7.7 per cent), creating demand for contraceptives was another major function of domiciliary services;

- **interpersonal communication.** A country such as Bangladesh with poor economic conditions, a low literacy rate, a high level of gender disparity and low accessibility to the information network requires interpersonal communication for the discussion of family planning. The development of good interpersonal relationships with the clients is the key strategy for domiciliary services. It is also essential for disseminating information, providing counselling and increasing the demand for family planning services;

- **upholding the cultural and social values.** In the rural areas, social taboos and reservations about women's mobility, family planning and reproductive health issues were prevalent. To address this issue, the Family Planning Programme has been designed in such a way that it will not create any conflict with the existing social norms and values of the country;

- **special care for the marginalized people.** A high level of poverty exists in Bangladesh, with almost half of the people living below the poverty line. Poverty is a barrier that hinders the access to services. The domiciliary service-delivery system has broken this barrier as it has been specially designed to reach the poor and the marginalized people;

- **female-focused service.** Both the health and the economic status of women are low in Bangladesh. One of the primary focuses of domiciliary services has been to improve women's reproductive health status through contraception and counselling;

- **informed choice.** One of the basic features of this service-delivery model is to disseminate information regarding different contraceptive methods to help the clients to choose the option best suited for her, taking into account the age of the woman, the number of children that she has and her reproductive health condition; and

- **client screening.** Since all contraceptive methods are not suitable for all clients, screening is needed to identify the most appropriate contraceptive method for an individual client. The primary screening for contraception is done by Family Welfare Assistants.
Recurring and Training of Family Welfare Assistants

Recruitment

The Family Welfare Assistants had to meet the following requirements:

- **be female.** The primary objective of domiciliary service delivery is to reach the poor, vulnerable women of rural Bangladesh, where gender inequality exists at all levels. Women are the target beneficiaries, and to reach them, women service providers have been assigned to provide domiciliary services;

- **reside in the same locality.** Maternal and child health and family planning service providers were recruited from the same locality (unit). Being part of and responsible to the community ensures Family Welfare Assistant accessibility to the households as well as the trust of the people;

- **at a minimum, be a high school graduate.** Women with the minimum of a high school certificate were recruited for this special type of service; and

- **cover a specified number of eligible couples.** Initially, each Family Welfare Assistant had to provide services to 500 to 600 couples in her working area.

Training

Two months of basic training were provided to the newly appointed Family Welfare Assistants. The training covered family planning, maternal health, child health, primary health care, limited curative care, nutrition, gender issues, sexually transmitted diseases and communication skills (especially one-to-one and one-to-many). New topics such as reproductive health and HIV/AIDS were added at a later stage to the foundation training.

Maternal mortality in particular is a sensitive indicator of inequity. It reflects the status of women and their access to health-care services that respond to their needs. High maternal mortality in Bangladesh is due to the alarmingly low use of professional maternity care. The percentage of deliveries attended by medically trained persons is very low (18 per cent). For this reason, the Government has undertaken an initiative to provide midwifery training to the Family Welfare Assistants so that they can give assistance at home births. Some of the Family Welfare Assistants received six-month, competency-based, skilled-birth-attendant training. Family Welfare Assistants trained in midwifery are now conducting safe deliveries at home, on average performing three deliveries per month. They also provide antenatal care and postnatal care services and are trained in administering misoprostol and oxytocin.
OBJECTIVES OF THE DOMICILIARY SERVICES

The main objectives of the domiciliary services are to:

- provide reproductive health and family planning services as per clients’ needs;
- increase the number of contraceptive acceptors;
- reduce the total fertility rate;
- increase the demand for long-acting and permanent methods of contraception;
- improve women’s health status;
- ensure safe motherhood;
- improve the nutritional status of the community; and
- improve children’s health status.

JOB RESPONSIBILITIES OF FAMILY WELFARE ASSISTANTS

A clearly defined job description was initially formulated for the Family Welfare Assistants: they were to provide family planning services at the household level, the main aim being the regulation of population growth. Later on, some adjustments were made to the original job description to widen the scope of family planning services.

The Family Welfare Assistant is the principal fieldworker of the Maternal and Child Health and Family Planning Programme. During home visits, Family Welfare Assistants regularly collect information on eligible couples, acceptors of contraceptive methods, pregnant women, and birth and death statistics. They also provide services to young children, assist in child vaccination and provide adolescent health-care services. They register all these data in the Family Welfare Assistant register. For each month, the Family Welfare Assistants make a work plan, which must be approved by the immediate supervisor, namely, the Family Planning Inspector. After approval, Family Welfare Assistants, through door-to-door visits, distribute temporary methods of contraception and give advice on safe motherhood, nutrition and other related topics. At the end of the month, they submit a performance report to their
supervisors. The responsibilities of the Family Welfare Assistants are described below.

**Planning and Organizing**

In the Maternal and Child Health and Family Planning Programme, Family Welfare Assistants must participate in the target-setting process and prepare a work plan for achieving the set target. They attend monthly and fortnightly meetings, organize satellite clinics, refer clients and assist Family Welfare Visitors in providing services to the pregnant mothers.

**Responsibilities Regarding Service Delivery**

**Family Planning**

Through information, education and motivation activities, Family Welfare Assistants create demand among eligible clients for accepting contraception. They do this through home visitations. Family Welfare Assistants play a vital role in many aspects of reproductive health such as the screening of new acceptors, the distribution of oral pills and condoms to the clients, and the referral of clients for sterilization, intrauterine devices (IUDs), Norplants, injections and menstrual regulation. They also follow up with clients and provide injectables from the second dose. To provide need-based services, Family Welfare Assistants design their work plan according to client segmentation.

**Satellite Clinics**

Another important task of Family Welfare Assistants is to help in selecting sites for satellite clinics. It is important to mention here that satellite clinics are located in the outreach area within the working unit of the Family Welfare Assistant, at a considerable distance from the static service centres (Union Health and Family Welfare Centre). Satellite clinics are usually set up in suitable houses in the community. A Family Welfare Visitor from the nearby static service centre goes to a satellite clinic to provide services such as family planning, antenatal care, postnatal care and immunization. Family Welfare Assistants inform the communities about the locations, dates and times of the satellite clinics. They motivate the mothers to attend health sessions, tell the Family Welfare Visitor to visit complicated cases at home, and provide health education at satellite clinics.

**Pregnancy and Childbirth**

Pregnancy and childbirth constitute another important area where Family Welfare Assistants play an active role. Family Welfare Assistants maintain a current list of pregnant mothers in the area and submit an updated list to the Family Welfare Visitor each month. They give mothers and family members basic information on safe delivery, exclusive breast feeding, safe water and sanitation, nutrition and immunization. They also identify high-risk pregnancies and refer them to satellite clinics or the health and family welfare centres at the union level. In addition, they refer complicated cases to the Medical Officer (Maternal and Child Health and Family Planning) at the Upazila Health Complex and normal pregnancies to Family Welfare Visitors,
community-based skilled birth attendants and trained traditional birth attendants for safe delivery. Family Welfare Assistants also provide postnatal care to the mother and to the newborn. Community-based skilled birth attendants (midwifery-trained Family Welfare Assistants) perform deliveries and provide postnatal care and essential newborn care.

**Immunization**

Family Welfare Assistants participate actively in the national immunization programme. They educate mothers and women of childbearing age about the importance of immunization for themselves and for their children, inform the community about the time and place of the sessions of the expanded programme of immunization, immunize the children in the outreach centres of the expanded programme of immunization, and follow up on and motivate the drop-outs to achieve full immunization. Each Family Welfare Assistant prepares a list of the children living in her working area.

**Nutrition**

Family Welfare Assistants also put a great deal of effort into improving the nutritional status of malnourished women and children. They provide information and education on health and convey nutrition messages to mothers by using flash cards or through practical demonstrations. They distribute vitamin A capsules to children 12 to 59 months old twice a year and to post-partum mothers within 42 days of delivery. They also provide counselling on the early initiation (within one hour of birth) of breastfeeding and exclusive breastfeeding for six months.

**Monitoring and Supervision**

To ensure effective service delivery, a systematic, goal-oriented monitoring and supervision mechanism is ensured from the national to the grass-roots level. At

**Figure 2** | A Family Welfare Assistant gives advice on the use of contraceptives.

**Figure 3** | A Family Welfare Assistant and a Family Planning Inspector attending a courtyard meeting.
the bottom level, Family Welfare Assistants provide performance reports to their supervisors, which are then compiled by the supervisor and sent to the next-higher authority. Finally, the reports are analysed at the Directorate level and feedback is given to the lower level. To ensure smooth operational activities, the Directorate General of Family Planning has an administrative setup from the national to the ward level. Various categories of technical and non-technical personnel with a standardized skill mix work in the service centres as well as in the administrative offices. The Director General along with the directors supervises and monitors the activities.

IMPLEMENTATION

OVERVIEW

After adopting the domiciliary service policy, the Government started to recruit and train Family Welfare Assistants nationwide. A Family Welfare Assistant register was developed to record family planning and demographic events of every household. This is a comprehensive register in which all demographic information on eligible couples and their children is recorded.

The couple register is updated once a year. After completion of the registration, Family Welfare Assistants prepare their “advance tour programme”. Once their advance tour programme is approved by their immediate supervisor (the Family Planning Inspector), they start visiting the households. To cover all the couples within a two-month round, they visit 15 to 20 couples each day. Family Welfare Assistants always carry temporary methods of contraception (oral pill and condom) for distribution among eligible couples along with the register and flip charts. Besides home visits, they also organize courtyard meetings with the clients, non-users, adolescents and pregnant women where they discuss issues such as contraception, safe motherhood and immunization and motivate the clients to receive the related services.

PARTNERSHIPS

The programme is being implemented by the Government and the NGOs.

Government Initiatives

The public sector provides contraceptives to half of all the users, particularly in the rural areas. Government fieldworkers are the most important source of contraceptives for the rural population, supplying one in five users (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, 2009). Government supplies contraceptives through multiple channels. One fifth of the total contraceptive supply is distributed through doorstep services. The remaining 30 per cent is distributed in hospitals (3.8 per cent), Upazila Health Complexes (9.1 per cent), Mother and Child Welfare Centres (2.2 per cent), Health and Family Welfare Centres (9.1 per cent), satellite clinics (5.2 per cent) and community clinics (0.2 per cent). It is important to note that the urban population
does not fall under the direct purview of the Government Family Planning Programme. In urban areas, family planning services are provided by fixed service centres, mostly by NGOs with the local government authority coordinating the programme.

**Non-governmental Initiatives**

NGOs also provide reproductive health and family planning services along with the Government programme. There are 160 NGOs currently working in Bangladesh that provide maternal and child health and family planning services, primarily in disadvantaged urban areas and in selected rural areas. NGO clinics provide a full range of family planning services along with maternal and reproductive health services and a functional referral system. In general, an NGO network has three levels of service delivery: a comprehensive reproductive health-care centre, a static clinic and a satellite clinic. The most important facility in the NGO health network is the comprehensive reproductive health-care centre, which serves as a referral centre for the static and satellite clinics. With the support of the referral centre, family planning, pregnancy care and immunization have been brought to the community through satellite clinics. Doorstep services are also in place to publicize available services as well as to provide necessary information (Talukder, Rob and Rahman, 2009).

NGOs provide services to 5.2 per cent of all the contraceptive users in Bangladesh (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Some of the NGOs provide services through a depot-holder approach. The depot holders are women from the community who keep a stock of commodities (contraceptive pills, condoms, oral rehydration saline, etc.) at home to distribute to women and children in time of need. They also promote good health practices and refer clients to nearby clinics. NGO fieldworkers coordinate their activities with Family Welfare Assistants.

**Social Marketing Programme**

The Social Marketing Programme was started in 1974 through an agreement between Population Services International and the Population Control Department of Bangladesh. The country has an active contraceptive Social Marketing Programme that distributes pills, condoms, injectables and oral rehydration solution through a network of retail outlets (pharmacies, small shops). Forty-five per cent of pill acceptors use social marketing brands compared with 52 per cent who use the Government-supplied brand, “Shukhi”. The Social Marketing Company sells a wide variety of pills with a nominal margin while the Government distributes only a single brand free of charge. Condom brands sold by the Social Marketing Company have a high market share: almost three in five condom users buy Social Marketing Company brands. This marketing system supplements the Family Welfare Assistant network.
**Challenges**

A few challenges remain that must be addressed appropriately to achieve maximum results, including the following:

- **timely recruitment and training.** The recruitment procedure in the Government sector is sometimes time-consuming in Bangladesh. In the near future, the country will have to face the challenge of mobilizing new human resources since a large number of government fieldworkers in the family planning sector will be retiring soon (Rob and Talukder, 2008). There is apprehension that a shortage of well-trained, skilled and competent service providers and fieldworkers at the local level will slow down the performance of the Family Planning Programme across the country (ibid.);

- **reducing the unmet need for contraception.** Overall, 17 per cent of the currently married women in Bangladesh have an unmet need for family planning services. Unmet needs increased from 11 per cent in 2004 to 17 per cent in 2007. The apparent increase in unmet needs reflects problems in the supply of family planning services and/or an increase in the demand for family planning (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Reducing the unmet need for contraception requires the particular attention of the fieldworker. To respond to these unmet needs, Family Welfare Assistants must update their registers to identify the clients who are not using any contraceptives and they need to ensure an uninterrupted supply of contraceptives; and

- **an uninterrupted supply of contraceptives.** Family Welfare Assistants distribute short-acting contraceptives (pills, condoms and injectables) to the clients. However, when they do not have enough supplies, they hesitate to perform their regular home visits. This has resulted in a reduction in the frequency of visits.

In addition, the following challenges should be considered:

- Initially, each Family Welfare Assistant was in charge of 500 to 600 couples. She could easily make her round and was able to visit each and every couple within the two-month schedule. Nowadays, however, the number of couples to visit has almost doubled for each Family Welfare Assistant. Consequently, it is difficult for them to ensure home visits to all the couples in due time. Moreover, the overall workload of the Family Welfare Assistants has increased significantly;

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2 Fecund women who are currently married and who say either that they do not want any more children or that they want to wait two or more years before having another child but are not using any contraception are considered to have an unmet need for family planning.
• Another important issue is the absence of scope for carrier development. After a certain period (15-20 years) of working in the same position, Family Welfare Assistants become reluctant to do their job. Their work is demanding and tiring. House-to-house visits are made on foot. Commitment gradually declines and this is reflected in the reduced number of visits by Family Welfare Assistants and in the services offered by them.

**Results and Achievements**

**Direct Impact**

From 1976 to 1997, the Government of Bangladesh recruited and trained married women to provide family planning counselling and services to couples in rural households. At the peak of the programme, a total of 23,500 Family Welfare Assistants worked throughout the country. By the early 1990s, doorstep service delivery had helped to increase family planning awareness as well as the rate of method uptake and continuity of method use among rural couples (Koenig, Hossain and Whittaker, 1989).

Home visitation by Family Welfare Assistants affected women’s fertility behaviour since it increased their awareness of family planning and maternal and child health services. The more visits the women received from Family Welfare Assistants, the more likely they were to experience an increase in status (Phillips and Hossain, 2003). However, the gender benefits came from the programme’s impact on fertility regulation rather than directly from the social interaction occurring during home visits. Family Welfare Assistants indirectly enhanced the status of women by fostering reproductive health autonomy. Nevertheless, domiciliary service delivery had a direct influence on the following areas:

• **Reducing social barriers.** Reproductive health and family planning services had been suffering from a social taboo in Bangladesh, where people hesitated to talk about the issues. By providing domiciliary services, an existing social barrier was broken. Women in particular were encouraged to receive family planning and maternal and child health services, which made them socially empowered. The Government accepted the help of local elites and opinion leaders from different levels to motivate women to work in the family planning sector;

• **Increasing the contraceptive prevalence rate.** Domiciliary services had a strong influence on increasing the use of contraceptives. Various studies reported that the use of contraception was greatly influenced by the field-workers’ visits. For example, studies showed that clients who had more than one contact with a worker were more knowledgeable and used family planning methods more often (Huq and Al-Sabir, 1992). The same study indicated
that clients who had not received information on family planning from fieldworkers preferred having male children and large families. Moreover, it was found that the frequency of home visits also reduced religious contentions regarding family planning. The domiciliary services enabled the system to achieve the objectives of the programme successfully and effectively. Evidence suggests that the introduction of domiciliary services into the Family Planning Programme sharply increased its performance. The contraceptive prevalence rate increased from 7.5 per cent in 1975 to 56 per cent in 2007. The Bangladesh Family Planning Programme earned a worldwide reputation and much of the credit should go to the pro-poor service-delivery system in rural areas (Rob, Talukder and Ghafur, 2006);

• reducing the total fertility rate. With the increase in the contraceptive prevalence rate, the total fertility rate came down substantially, from 6.3 births per woman in 1975 to 2.7 in 2007 (see graph). Findings suggest that contraception is the most important proximate determinant, contributing to more than 50 per cent of the total fertility reduction (Islam, Chakraborty and Rob, 2004);

• reducing the maternal mortality ratio. Family planning is the pillar of safe motherhood. The Family Planning Programme adopted the maternal and child health-based approach in 1976, and since then, maternal and child health-based family planning has been the key feature of the Family Planning Programme (Mabud and Akhter, 2000). Maternal and child health-based family planning services

Trends in the total fertility rate (TFR) and the contraceptive prevalence rate (CPR), 1975-2007.
were extended to the community level and large numbers of female fieldworkers (Family Welfare Assistants) were deployed to provide maternal and child health and family planning services at the doorstep level. Domiciliary services have encouraged pregnant women to visit the static centres for antenatal check-ups. As a result, the rate of antenatal visits has increased over the years, reaching 52 per cent in 2007. The increase in the contraceptive prevalence rate, number of antenatal check-ups, safe deliveries and postnatal check-ups has contributed to the recent decline in the maternal mortality rate; 

- **increasing the knowledge of contraception.** It has been observed that counselling and advisory services by the Family Welfare Assistants helped to increase couples’ knowledge of contraception. Awareness of contraceptive methods is now high; roughly nine out of ten women know what pills, condoms, injectables and female sterilization are (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). Findings from a study suggest that this knowledge was acquired primarily from family planning fieldworkers (39 per cent) but also from the mass media (26 per cent) and from neighbours (23 per cent) (Huq and Al-Sabir, 1992); and

- **reducing dropout rates.** Retaining users of temporary methods is another important aspect of the family planning service. Domiciliary services have proved to be an effective approach in this context. Routine visits by the field-workers help clients to obtain contraceptive methods and resupplies in due time, especially in remote areas where there is no alternative source of contraceptives. Moreover, in case of problems linked to the use of contraceptives, timely and effective help can be provided to the clients.

**Indirect Impact**

A qualitative study concluded that doorstep delivery of services enhanced women’s status (Simmons et al., 1988). For example, Family Welfare Assistants themselves benefited directly from receiving cash wages and indirectly from gaining mobility, prestige and authority from their work. In turn, the large-scale deployment of female family planning workers changed people’s perceptions of women’s roles: every hamlet in Bangladesh had a Family Welfare Assistant acting as a household visitor, adviser and confidante, clearly showing that women were employable, mobile, socially gregarious and autonomous, without depending on male partners or the extended family. Young female clients were particularly influenced by interactions with Family Welfare Assistants. The programme was thus characterized as having a “beyond-supply” social effect. In
addition, by helping clients to achieve control over their fertility and therefore their lives (Huq and Murdock, 1997), doorstep delivery produced benefits extending beyond those arising only from the receipt of family planning services. The work of the Family Welfare Assistants initiated a wider social impact: it has impacted women’s empowerment and gender equity and has brought about greater social change.

**Assessment and Evaluation**

The Bangladesh Family Planning Programme is a success story and a model programme for many countries. Its success is due to a large extent to the deployment of a large contingent of government and NGO fieldworkers who made door-to-door visits to promote family planning and who distributed contraceptives. These visits along with mass media campaigns resulted in a remarkable increase in the contraceptive prevalence rate within a very short time span. Studies have shown that frequent home visits to all eligible couples, irrespective of their current status, are associated with higher family planning performance (Phillips et al., 1989).

A study has shown that the success of the Family Planning Programme is due to the contributions made by Programme interventions over the last two decades and more particularly in the mid-1970s, when the first Five Year Plan of the Government of Bangladesh on health and family planning was launched (Ali et al., 1994).

The development of interpersonal contacts through home visits has proved to be undoubtedly effective. The key players in this process of building interpersonal contacts were the large number of full-time female fieldworkers recruited and deployed within the locality of their permanent residence.

Almost 83 per cent of rural eligible couples using family planning methods received contraceptives from Family Welfare Assistants. A continuous supply of contraceptives prevents unwanted pregnancies and ensures safe motherhood. By improving the health status of the mother, child mortality and morbidity have been reduced to a large extent.

The source of contraceptives is an important issue of the Family Planning Programme, which has a direct linkage with the domiciliary services. In Bangladesh, both the public and private sectors are important sources of modern contraceptive methods (50 per cent and 44 per cent, respectively) (National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International Inc., 2009). The table shows that with the introduction of domiciliary services, the total fertility rate declined dramatically from 6.3 births per woman in 1975 to 4.3 in 1991. After that date, the rate remained stagnant for more than a decade (1993-2004). This was the time when domiciliary services were withdrawn. When the domiciliary service
system was reintroduced in 2003, however, the total fertility rate started to decline again, as evidenced in 2004.

Contraceptive discontinuation, another source of concern for the Family Planning Programme, has a negative correlation with domiciliary visits: the decreasing number of home visitations caused the dropout rate to increase (see table). However, in reading the table, a question arises: why, despite the decrease in home visits over the years, is the contraceptive prevalence rate increasing and the corresponding total fertility rate decreasing? As explained earlier, Family Welfare Assistants not only provide family planning services but they also strive to generate demand for family planning services from the health facilities among the people. This is why, although the number of domiciliary visits gradually declined from 1989 to 2007, the impact of demand generation in the early years facilitated the increase in the contraceptive prevalence rate and fostered the corresponding decrease in the total fertility rate in the following years.

The political standpoint on how to deliver family planning services in the communities is changing over time and new approaches are being examined. Domiciliary services, although very...
effective and needed at a time when communication networks and media coverage were not good, may be replaced by other types of services.

In the absence of domiciliary services, people can receive contraceptives from other sources such as pharmacies, shops and fixed service-delivery points. The problem is that in most cases, the husbands are the ones buying the contraceptives for their wives; thus women no longer have access to key aspects of maternal and child health and family planning services: contraceptive counselling and follow-up services.

During the implementation of the first sector-wide programme (the Health and Population Sector Programme 1998-2003), domiciliary services were withdrawn, and for that reason, the percentage of home visitations dropped to the minimum (see table). It was reported that rural people wanted to receive family planning services through home visitations. The Government started to provide domiciliary services again with the second sector-wide programme (the Health, Nutrition and Population Sector Programme 2003-2011).

**Lessons Learned**

• The introduction of domiciliary services was a milestone for maternal and child health and family planning services in Bangladesh, which contributed to the success of reproductive and family planning services.

• Women are especially efficient in providing family planning and reproductive health services at the doorstep.

• Domiciliary services contribute to the improvement of women’s status and their empowerment at the grass-roots level.

• Initially, the domestic financial involvement was high but international agencies such as the United Nations Population Fund, the Canadian International Development Agency, the Norwegian Agency for Development Cooperation, the Overseas Development Administration (now DFID) (United Kingdom) and the Swedish International Development Cooperation Agency came forward and offered financial assistance. The initial financial burden was thus reduced.

• No major change has taken place in the domiciliary delivery pattern until now except for some changes in the job description of the Family Welfare Assistant, which now includes more areas of service delivery. The increasing literacy rate, women’s empowerment, the existing micro credit system, a different lifestyle and the development of mass media have brought about significant changes in the way of life. However, there is still a strong demand for more trained and capable Family Welfare Assistants to respond to the needs of a growing population, especially of the huge number of newly-wed couples.
• The reproductive behaviours of the people changed over the years thanks to the motivation and counselling activities of Family Welfare Assistants.

• Couples trust Family Welfare Assistants. Not only do they trust them with regard to family planning and reproductive and child health issues but also with respect to other family-related matters such as children’s education and the receipt of micro credit from NGOs.

It is therefore possible to say that domiciliary service delivery is suitable for replication in similar settings in other countries.

**Potential for Replication Elsewhere**

Domiciliary services have been established and recognized as an effective service-delivery model, especially for rural communities. This model is suitable mostly in low socio-economic settings where the demand for priority services has not yet been created. During the last three decades, this service-delivery pattern has changed the overall demographic profile of Bangladesh.

Domiciliary services are suitable in the following situations:

• Domiciliary services can be a good option for providing specific priority services in settings with low economic resources, a poor level of education and low accessibility to service facilities.

• In situations where particular services are needed urgently, domiciliary services can be introduced to achieve immediate results.

• This service-delivery model is also suitable when the geographic locations are dispersed over a large area and are hard to reach.

• In case of natural disasters, when all communication channels collapse, doorstep service delivery is a window through which primary health care, reproductive health, family planning and other emergency services can be provided.

This service-delivery pattern is not needed in areas where economic development has taken place and demand for maternal and child health and family planning services has already been created. This kind of service delivery can also be conducted on a voluntary basis, keeping a close watch on the achievements because professionalism is a must for achieving any desired goal.

**Overview of the Evolution of Domiciliary Services**

Domiciliary services have gone through various stages, as has the Bangladesh Family Planning Programme. The Government policy guidelines contributed a great deal to these changes. Initially, when domiciliary services were introduced, the primary goals were
twofold: generation of demand through counselling and distribution of contraceptives. With the introduction of domiciliary services into the Family Planning Programme, Bangladesh achieved immediate results: an increase in the contraceptive prevalence rate from 7.7 per cent in 1975 to 18.6 per cent in 1980 and a decrease in the corresponding population growth rate from 3.0 to 2.32 per cent. Currently, the contraceptive prevalence rate is 56 per cent and the growth rate is 1.39 per cent. In time, new activities (e.g., safe motherhood, immunization, adolescent health and early childhood development) were introduced into the national Family Planning Programme and Family Welfare Assistants are now providing all these services through the domiciliary model.

The following is a chronology of the significant events in the evolution of the domiciliary services:

- 1976: full time fieldworkers providing domiciliary services were deployed;
- 1980: registers of Family Welfare Assistants were introduced at the unit level to record family planning and demographic events of households. In the same year, special training institutes

Experiences of a Family Welfare Assistant

Ms. Alim a Begum became a Family Welfare Assistant in 1980 at the age of 28. Her working area was 1/ka unit of the Toakul union of the Gowainghat Upazila in Sylhet District, which is the remotest part of Bangladesh and one of the lowest-performing areas in the context of reproductive health and family planning activities. During the 1980s, poor infrastructure, coupled with religious barriers, made the family planning activities difficult to conduct.

When Ms. Begum started her journey as a Family Welfare Assistant, local people initially did not welcome her as a service provider. On the contrary, they pressured members of her family to make her resign from her job. Putting those adversities aside, Ms. Begum continued her work. When she joined the domiciliary services, the population of her working area totalled 3,445, among whom were 685 eligible couples. Out of the total number of eligible couples, only 15 were using family planning methods. Ms. Begum used to leave home in the morning and walk far to reach the clients’ houses. In the beginning, people did not listen to her advice but she did not give up and continued with her mission: she incited people to use contraceptive methods and to keep the size of their family small.

After six years of relentless effort and hard work, she was able to increase the number of contraceptive acceptors to 101 out of 715 eligible couples. All the people in her working area used to call her by her nick name, “Maya apa”. Maya was the brand name of the oral contraceptive pill supplied by the Family Planning Department. After serving 30 years with the Government, she retired in 2010. At the time of her retirement, she left 1,054 eligible couples in her unit; 631 of them were contraceptive users with a corresponding contraceptive acceptance rate of 59.43 per cent.
(the National Institute of Population Research and Training and the Regional Training Centre) were established;

- 1990: a broad-based, multisectoral approach was initiated to mobilize the community and engage civil society;
- 1998: domiciliary services were withdrawn;
- 2003: domiciliary services were reintroduced.

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