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# **Methodological Challenges on Community Safe Motherhood: A Case Study on Community Level Health Monitoring and Advocacy Programme Bangladesh**

M. Rezaul ISLAM<sup>1</sup>, Abu Bakar SITI HAJAR <sup>2</sup>

## **Abstract**

This paper discusses the methodological challenges on education for safe motherhood in Bangladesh with two interventions such as health monitoring and advocacy. This is a case study. Dhaka Ahsania Mission (a non-governmental organization (NGO) implemented these interventions at Hatibhanga Union (the lowest administrative unit) of Dewanganj Upazila in Jamalpur District in Bangladesh. Data were collected through a number of qualitative data collection methods on how local level monitoring and advocacy can ensure safe motherhood. The paper illustrated a number of methodological challenges that we faced during the data collection period. These challenges are analysed here into two main headings; commune level challenges and procedural level challenges. The objective of this paper is to demonstrate how these challenges limit the utilization of qualitative research tools and techniques on this particular case study. The research paper argues that the challenges were much more influential in terms of its contextual conditions rather than the original limitations of qualitative research.

*Keywords:* qualitative research; methodological challenges; community safe motherhood; health monitoring and advocacy; NGO: Bangladesh.

## **Introduction**

Community level monitoring and advocacy are two common and important interventions for safe motherhood. These interventions are frequently used for parental health education by both the governmental and non-governmental orga-

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nizations (GOs and NGOs) in Bangladesh. These interventions are important due to the fact that family risk factors such as low level of education, having multiple maternal responsibilities, difficulty in the learning of basic care routines, an ambivalent perception of pregnancy and drug abuse cause detriment to motherhood (Molina et al. 2011:39). Community level monitoring and advocacy ensure clients' participation and accountability to the accomplishment of the programme. This paper discusses the methodological challenges faced by volunteers from the Dhaka Ahsania Mission (a non-governmental organization) in delivering safe motherhood education to at-risk mothers in Hatibhanga Union (the lowest administrative unit) of Dewanganj Upazila in Jamalpur District of Bangladesh. Data were collected through a number of qualitative data collection methods. The paper illustrated a number of methodological challenges that we faced during the data collection period. These challenges are analysed here into two main headings; commune level challenges and procedural level challenges. Qualitative research has a number of limitations to visualize the social condition. The objective of this paper is to demonstrate how these challenges limit the utilization of qualitative research tools and techniques on this particular case study. The research paper argues that these challenges were much more influential in terms of its contextual conditions rather than the original limitations of qualitative research.

### ***Bangladesh: Country context and safe motherhood status***

The total population of Bangladesh is 152,111 thousands (Bangladesh Census Report, 2011). Bangladesh is a country with the highest population-density, with 1,031 living per square kilometre. Around 70% of the total population live in rural areas. The current national population growth rate is 1.35% as per provisional estimate of the 2011 census; the rural to urban migration rate is 21.9%; the male-female ratio is 100.3:100. The average household-size is 4.68. The 15-49 years age-group constitutes the largest segment (53%) of the population, followed by 33.3% in  $\leq 14$  years old age-group. The age-groups of 50-59 years and 60+ years comprise 7.2% and 6.8% of people respectively. Adult (5+ years) literacy rate is 58.4% (as of 2009). The life expectancy is 67.2 years (66.1 years for males and 68.7 years for females).

Its population places a tremendous economic, social and environmental strain on the country's resources. Due to widespread poverty, children (40%) and mothers (30%) suffer from moderate to severe malnutrition. Malnutrition is also a main contributor to the death of nearly a quarter of children under five. Bangladesh is also at high risk to the spread of HIV/AIDS, despite its low prevalence among the general population, due to a concentrated epidemic among injecting drug users. Bangladesh is considered as one of the 22 high burden countries for Tuberculosis (TB) and currently has the sixth highest frequency in the world. The Constitution of the People's Republic of Bangladesh is committed to provide

basic health and medical requirements to all people in the society. The Constitution ensures that “health is the basic right of every citizen of the Republic,” as health is fundamental to human development. Since independence (1971), the government has been pursuing a policy of health development that ensures provision of basic services to the entire population, particularly to the population in rural areas. The successive health plans of the country emphasize the Primary Health Care (PHC) as the key approach for improving health status of the people. The past plans in the health sector had endeavoured to provide essential healthcare to the general masses. To attain this goal, many development programmes have been undertaken in the health sector during the past years.

In Bangladesh, it is estimated that more than 85% of deliveries are conducted at home, and are attended by relatives, or neighbours that are not medically trained for delivery. Every year 12,000 Bangladeshi women die due to pregnancy or pregnancy-related causes (Bixby Centre, 2012). However, in recent time, there are some significant progresses in public health issue in Bangladesh. The great achievement has been made in maternal mortality by reducing it from 12 to 5 during the last one decade. IMR is 53 (2002) and MMR is 320. Maternal mortality has declined during the period of 1992-2002. Issues relating to safe motherhood are not well responded due to lack of governance, capacity and quality of services by GO and NGO. Ineffective policy implementation; especially in service provision and institutional management has become a challenge to deliver quality health services, particularly mother and child health care. The overall government policy on health and health care is reflected in the National Health Policy (NHP), which was first drafted in the year 2000. This policy included a wide range of services where there were 15 goals and objectives, 10 policy principles and 32 strategies. Regarding safe motherhood, the policy undertook programmes for reducing the rates of child and maternal mortality within the next 5 years, and reduced these rates to acceptable levels; and adopted satisfactory measures for ensuring improved maternal and child health at the union level and install facilities for safe and clean child delivery in each village.

Proper care during pregnancy and childbirth are important to the health of the mother and her baby. Antenatal care from a medically trained provider is important to monitor the status of a pregnancy and to identify the complications associated with pregnancy. To be most effective, there should be regular antenatal care throughout the pregnancy period. It is found that 68% of women with a birth received antenatal care at least once from any provider. Most (55%) women received care from a medically trained provider such as a doctor, nurse, midwife, family welfare visitor (FWV), community skilled birth attendant (CSBA), medical assistant (MA), or sub-assistant community medical officer (SACMO). Comparable data from the Bangladesh Demographic and Health Survey (BDHS) (2004 and 2007) shows that while antenatal care from any provider has increased by 17 percent over the past few years (from 58 percent in 2004 to 68 percent in 2011),

antenatal care from a medically trained provider during the same period has increased by seven percent only (from 51 to 55 percent, respectively). Inequity in use of maternal health services is a concern in Bangladesh and programmes are targeted to reduce the gap. In 2007, women in the highest wealth quintile were 2.6 times more likely to receive antenatal care from a trained provider; compared to those in the lowest wealth quintile. In 2011, this gap has not narrowed (rather widened slightly). Between 2007 and 2011, antenatal care from a trained provider to women without any education, in the lowest wealth quintile has declined.

It is found that 29 percent of births in Bangladesh are delivered at a health facility, 12 percent in a public facility, 15 percent in a private facility, and two percent in an NGO facility. The likelihood of delivering in a health facility is considerably lower for women 35 years or older compared to those who are younger. Facility delivery decreases sharply as birth order increases. On the other hand, the number of women's antenatal care visits, education level and wealth status have a positive relationship with their likelihood of delivering in a health facility. For example, only 11 percent of women with no education deliver in a health facility, the corresponding proportion for women with completed secondary education is 67 percent. Thirty-two percent of births in Bangladesh are attended by medically trained personnel, such as qualified doctor, nurse, midwife, family welfare visitor (FWV), or community skilled birth attendant (CSBA). Additionally, trained traditional birth attendants assist in 11 percent of deliveries. However, more than half of births in Bangladesh are assisted by *dais* or untrained traditional birth attendants (53 percent), and four percent of deliveries are assisted by relatives or friends. Medically assisted deliveries are much more common among young mothers and first order births.

### **The Study Location and the Focus of the Findings**

The study was conducted at Hatibhanga Union (the lowest administrative unit) of Dewanganj Upazila in Jamalpur District in Bangladesh. Dewanganj town is located at 25.1417°N 89.7833°E degree. Dewanganj town is now a municipality with an area of 4.54 sq km. It has 9 wards and 43 *mahallas*. It has 38023 units of household. As of 1991 Bangladesh Census, total population of Dewanganj was 34997; male 49.83%, female 50.17%, literacy rate 20.8% (male 27.25% and female 14.4%). The Upazila has one Upazila Health Complex, eight family planning centres, and two satellite clinics. Jamalpur, a district located in the north-western part of Bangladesh, is one of the worst survivors of riverbank erosion and floods. It is located in the lap of two mighty rivers- the Jamuna and the Brahmaputra. Everyday a number of localities, houses, infrastructures, and crop lands are swallowed by the rivers through riverbank erosion. This area also faces severe floods almost every year. These natural phenomena result in increased

landlessness, pauperization, unemployment, food insecurity and forced migration. Dewanganj and Islampur are the most vulnerable Upazilas within Jamalpur district to riverbank erosion and floods (Rahman, 2010).

Dhaka Ahsania Mission (DAM) implemented the Project Safe Motherhood through community level monitoring and advocacy with technical support from International Centre for Diarrheal Disease and Research, Bangladesh (ICDDR,B), funded by Rangpur Dinajpur Rural Service (RDRS). The major objectives of the project were: i) to ensure well functioning of Union Parishad Health Standing Committee (UPHSC) for enhancing safe motherhood; ii) to improve performance of public providers for safe motherhood at union level; iii) to sensitize private providers to enhancing safe motherhood; iv) to strengthen the capacity of community-based organisations (CBOs) to empower women for enhanced safe motherhood; and v) to take initiatives in such a way that the Ministry of Health and Family Planning (at union, upazila, district and national levels) take steps to improve health services provision for safe motherhood. The project stakeholders are the organizations (CBOs), groups and people that the project intends to work with *directly*. The stakeholders of this project are situated at *different levels*:

- At Union level: (1) UP health standing committees; (2) Public providers of safe motherhood facilities; (3) Private providers of safe motherhood interventions (including private for profit, informal providers, services provided by other NGOs); (4) Community Based Organizations (CBOs).
- At higher levels: (1) Upazila health authorities; (2) District health authorities; (3) Ministry of Health and Family Planning at national level; (4) NGOs working in health sector.

The ultimate beneficiaries of the project are the mothers and children from vulnerable and marginalized rural communities. The project worked with all stakeholders mentioned above to improve their responsiveness to the rights and needs of these women with respect to safe motherhood. The public providers in each union sensitized in workshops on the monitoring tools and the project interventions, and the project staff supported UPHCs to motivate providers to provide monthly monitoring data. There are few formal private providers (NGO and/of for profit) in the Unions, but there is a large number of informal providers, e.g. traditional birth attendants. Project staff organized workshops for all private providers to encourage them to follow the government rules and regulations, and refer women adequately. CBOs and/or civil society platforms in the respective unions were trained and facilitated to provide safe motherhood messages, to mobilize the communities, and to strengthen demand for safe motherhood services. The project staff encouraged becoming advocates for better service delivery by public and private providers. The regular monitoring and subsequent meetings on the problems and potential solutions helped to increase local problem solving capacity, which in turn had improved the quality of service delivery for safe motherhood. The UPSC reported on problems in their regular meetings with

the Upazila health and family planning officers (monthly). Project staff supported the CBOs/civil society platforms to organize half-yearly meetings at Upazila level to present their findings and recommendations in a public meeting to the health authorities, UP chairman and the communities. The project also used other opportunities to feed recommendations in relevant policy making processes, e.g. through participation in consultation meetings on the national budget. Frequent 'face-to-face' or 'one-to-one' meetings among agencies and stakeholders involved in the project also helped to solve local problems. The project also coordinated with other NGOs advocating for safe motherhood at different levels where possible, e.g. in development committee meetings at Upazila level. Through these interventions, the project did not only help improve Union level service provision for safe motherhood, but also motivated other UPSCs, Upazila and NGOs to replicate the project in other areas.

### **Research Methods**

The study used qualitative approach. The objective of the study was to evaluate the performance of the project for the last one year, from July 2011 to June 2012. The study finding was prepared mostly on the basis of data collected, prepared and reported by the field staff members of the project. Some data were collected through in-depth interview, focus group discussion (FGD), key informant interview (KII), and observation methods. Data were also collected through reviewing documentations such as project concept papers, monthly reports and monitoring results in order to understand the ways of introducing and implementing the Safe Motherhood project, and to assess the impact of the project activities. All of the project staff members including Unit Manger of DAM in Dewanganj, Jamalpur were interviewed to know the progress of the project. The study also attempts to know the problems, limitations, threats and challenges in policy, field operations and management. Unstructured interview schedule was used as guideline for interviewing, which included the key questions:

- What is the appropriateness of the project at the policy level?
- What are the roles and responsibilities of different stakeholders involved in the project?
- What major activities were carried out over the project period and what strategies are they using?
- Whether the Program has increased service utilization as expected, and if yes, what measures DAM had adopted to meet increased demand for services?
- What are the mechanisms of DAM used to closely monitor/follow-up the implementation of different activities of the project?
- What indicators are used to monitor project activities?

- What are the problems at management and project operation levels?
- What are the cultural, political, and social threats of the project?; and,
- What are the major barriers in implementing the project and how can the obstacles be reduced?

Two FGD sessions were arranged. One FGD was arranged with representatives of Union Parishad Health Standing Committee (UPHSC) and another with Community Based Organizations (CBOs). Separate guideline was prepared for both FGDs. Each session took one and a half hour time. One FGD was held with the representatives of UPHSC. All of the members of UPHSC (total 11, male 07 and female 04) were participated in the FGD session. This FGD mainly focused on the following areas (1) have an action plan in place, (2) properly use the monitoring tools, (3) translate community needs into proposals for local health authority/providers and advocacy for changes, (4) receives expressions of satisfaction by communities on how problems are addressed, (5) shares monitoring results with Union Parishad, (6) organize regular meetings (according to schedule) to discuss monitoring results with local community; with at least 70% participation of members, (7) provide feedback to the communities after meetings, (8) opinions about the women empowerment for safe motherhood? (9) major limitations, challenges and threats within this project at community? (10) specific recommendations for success of this project. The members of CBOs were participated (participants) from all nine CBOs from Hatibhanga Union where the project is being operated. The FGD with CBOs included the following areas: (1) knowledge about health monitoring and advocacy on safe motherhood project, (2) involvement in this project, (3) activities and outcome of motivational activity in the communities to seek adequate health services, (4) activate UPHSC, (5) refer increase number of mothers to the facility or skilled birth attendant, (6) cover number of mothers with safe motherhood messages, (7) advocate for quality health service, (8) inform community on what services are available, (9) evaluate the strengthening capacity of CBOs to empower women for enhanced safe motherhood, (10) sustainability of the initiatives (11) major limitations, challenges and threats within this project at community, and (12) specific recommendations for success of this project. A few community people (members) were also interviewed to assess their knowledge and attitude towards safe motherhoods.

The thematic approach was used to analyze data in which it was possible to incorporate all sorts of qualitative data. It is said that qualitative approaches are incredibly diverse, complex and nuanced (Holloway & Todres, 2003), and thematic analysis should be seen as a foundational method for qualitative analysis. One of the benefits of thematic analysis is its flexibility.



## Major Methodological Challenges

While applying qualitative approach in the particular union, we found a number of factors challenges and inhibited the application of this approach. We would divide these challenges into two broad categories namely- commune level challenges and procedural level challenges (). The commune level challenges were very much associated with the existing conditions of the community. It includes low socio-economical conditions, cultural barriers, lack of research knowledge, and non-cooperation from the funding as well as operating organization. On the other hand, the procedural level challenges are those challenges, which are considered as the limitations of qualitative research approach in data collection process. These include reliability and validity of research findings, complexity and diversification of human behaviour, research ethics, unavailability and inaccessibility of data, and power-relation. Each challenge is inter-related and inter-influenced, which later contributes to its complexity. This paper analyses these challenges with examples of the particular case study-

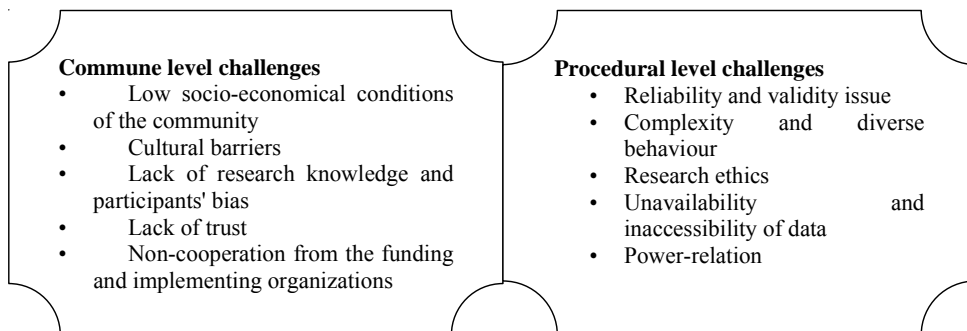


Figure – 1: Commune and procedural level challenges

### Commune level challenges

#### Low socio-economical conditions of the community

We conducted our research on a very remote community, where the peoples' socio-economic conditions in terms of their financial as well as social conditions are very poor. Most of them were hand to mouth. Their education, social mobility, social awareness, community level participation in development activities, and health awareness were found to be very low. Due to these disadvantaged socio-economic conditions, the expectations gap between the respondents and researchers were extremely big. It took a longer period to arrange FGD with the mother groups. One mother expressed her opinion: "We are poor people, we are illiterate, and so our opinions are valueless". Some mothers questioned us what

kind of financial help (such as loans) we were offering them. This kind of challenge was frequent throughout the study. We found that many of the mothers left the FGD session rapidly when they knew that we were not offering any kind of financial assistance to them. We observed that the local mothers were not only facing 'poverty related with finance' rather they were suffering from 'knowledge poverty'. The staff members of DAM stated that they could not take many initiatives due to local peoples' lack of awareness, conservative attitude, and social ignorance. Many mothers in this study were rigid and afraid to share their information regarding safe motherhood issue, as they thought they might get into trouble if they did so.

### ***Cultural barrier***

Cultural barrier is now a very considerable challenge in qualitative research to 'collect' valuable 'data' from the community (Sands et al. 2007). Difficulties in gaining access can arise when gatekeepers or participants deny access or erect physical or social barriers (Shah, 2004). Even if physical access is granted, participants may be reluctant to allow social access because of the interviewee's assumptions about the researcher based on his/her gender, age, status, and personal characteristics (Shah, 2004). Similarly, interviewers may be insecure, uncomfortable or afraid to interview across class, sex, race, or ethnic lines (Rubin and Rubin, 1995; Shah, 2004). Interviewers with *insider* status in a particular culture are thought to have advantages over those with *outsider* status in surmounting cultural barriers. Insiders can more easily gain access to participants and are better equipped to create an environment in which people feel comfortable and are willing to talk freely (Shah, 2004). But in indigenous cultures may regard outsider researchers as 'social intruders', who are 'uninvited' and 'unwelcome' (Shah, 2004: 565). On the other hand, outsiders are able to achieve acceptance as persons who can be taught (Rubin and Rubin, 1995). This issue became so much problematic when we introduce ourselves as University Professors to the community mothers. A number of the mothers called me *Professor Shaheb* (Mr./Mrs. Professor) and they were very scared to speak frankly in front of us and mentioned - "*It is very difficult to speak in front of Professors who are the most intellectual persons in the country. You know all, why you are asking us about the matter. We made a lot of mistakes in our life and this is why you are here, you please pardon us.*"

It was seen that due to the cultural barrier, many aspects in safe motherhood issue could not be possible to bring into light. As a matter of fact, we could not find real picture in some issues such as mothers' capacity building in term of the health care of the mothers during pregnancy period. In some cases, we could not locate how many mothers were missed to see doctors for health check up due to the lack of peers with them as they feel shame to see doctor in this regard.

However, the invisibility and darkness went throughout the data collection process.

### ***Lack of research knowledge and participants' bias***

Lack of research knowledge among stakeholders gives a 'worrying notion' to the researchers. It is particularly more important to conduct such kind of qualitative research where more social impact is related and where there is no immediate benefit under this circumstance. Though it is a big shortfall of the NGOs activity in Bangladesh that the investment of finance is less on the social activity where NGOs' financial gain is less (Islam & Morgan, 2012). Some are related with their privacy and confidentially. In addition, the participants' (beneficiary groups) lack of research knowledge is another challenge to get reliable information. The following figure (*Figure-2*) illustrates a number of steps that should be followed in order to achieve the project goal. It is a long term and complex process where such kind of goal can be achieved through active participation of mothers. These are subject to varying degrees of social, cultural, religious, moral and legal norms and constraints. A key challenge for such kind of research was to generate unbiased and precise measures of individual behaviour of the mothers. Participation bias describes error arising from systematic differences in the characteristics (for example, sexual behaviour) of those who agree to participate in a study compared with those who do not. For instance, 'How the mothers are following what they learnt about the sexual behavior with their husband during pregnancy period from the staff members of DAM. We found a high degree of mothers' bias in this regard either for their shame or ignorance of such kind of information to the researcher. We tried to follow all sorts of alertness to minimize measurement error which may be introduced by participation bias, recall and comprehension problems, and respondents' willingness to report sensitive and sometimes socially censured attitudes or behaviours, but we would agree that we failed to do so. It was found that sometimes this type of participation bias in which respondents refused to answer a particular question(s).

### ***Lack of trust***

'Trust' becomes an important element in qualitative research. It helps to build up rapport between researchers and participants in order to avail reliable and valid data. In a social context, trust has several connotations (McKnight & Chervany, 1996). Trust typically refers to a situation characterised- one party (trustor) is willing to rely on the actions of another party (trustee); the situation is directed to the future. In addition, the *trustor* abandons control over the actions performed by the *trustee*. As a consequence, the trustor is uncertain about the outcome of the other's actions; he can only develop and evaluate expectations. The uncertainty involves the risk of failure or harm to the trustor if the trustee will not behave as

desired. This kind of tyranny was more common for this piece of research where the participants' overall trust on the NGOs in Bangladesh is very low (Islam & Morgan, 2012; Islam, 2012) as the mothers thought that we were conducting such kind of research as a representative of DAM. It is also true in the NGO sector in Bangladesh that the trust between service providers (NGOs) and service receivers (beneficiaries) depend on give and take policy (Islam, 2009). We found some negligible and frustrated attitude from the parents about the positive impacts of the NGOs' intervention for safe motherhood as this kind of programme will not give them any kind of financial gain in the future. On the other hand, because of the nature of data, they thought, many aspects were challenging about the failure of their performances and the matter of confidentiality and anonymity. As a result, the understanding and explanation of the benefits of the research for the mothers did not function as safeguard to us.

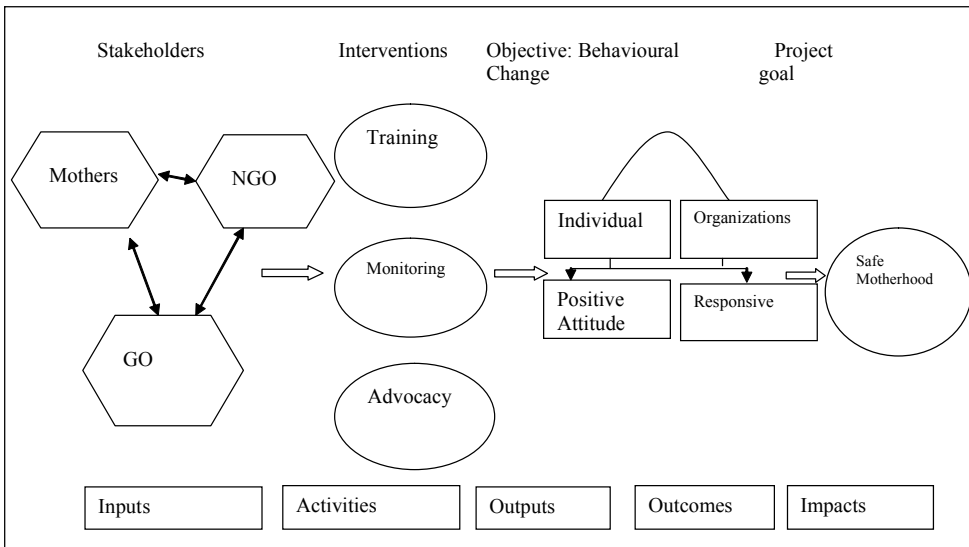


Figure 2: Steps to achieve safe motherhood

### ***Non-cooperation from the funding as well as implementing organizations***

There is a growing debate about the conflict of interest between the researchers and the funding as well as implementing organizations. It is a very common picture in NGOs' activities that they always hide the failure scenario and bring only their success story into light. The gap between the expectations of researchers and NGOs was elevated to such complexity that we could not overcome this challenge. The experience was similar to what Islam & Banda (2011) faced when they did their PhD works. They mentioned: *I could not see policy documents for four months during my fieldwork; I could not even view the whole documents at my house. I was told that they were very secret and only for office usage, or were 'not*

*permitted to take out'. After much correspondence, they agreed to allow me to photocopy some documents after five months of my fieldwork. Many of the field staff members, especially in Practical Action Bangladesh (PAB), were not cooperative in arranging the FGD sessions to share their experience about blacksmithing. They changed my FGD and in-depth case study schedules several times to say that their staff members were absent from the office. During FGD sessions, some of the main staff members were absent, and they were not happy to discuss with me in those sessions. I found some of them were less focused through their reluctance, and in some cases continued their work duties, which made matters very difficult (Islam & Banda, 2011).*

We found that this research was conducted with the demand of the donor rather than DAM's own interest. However, DAM's demand was to have positive report, which would provide good impacts for their interventions. As a result, it was a big challenge for us to produce impartial and authentic evaluation on the project interventions. We found a number of calls where they requested to produce 'a good report'. 'Good report' means writing the report positively. It means to provide a report, which will tell a successful story of the NGO's activity on different indicators of safe motherhood.

### ***Procedural Level Challenges***

#### ***Reliability and validity of research findings***

There is a growing debate about the reliability and validity issue in qualitative research. The notion of validity in qualitative research has been "championed, translated, exiled, redeemed, and surpassed" (Emden & Sandelowski, 1998:207). Many authors have a very restricted attempt to say that the findings of qualitative research are neither reliable nor valid. The other group of authors argued that qualitative approach provides very in-depth knowledge, which unruffled with the real understanding between human behaviour and their interacting factors (Healy & Perry, 2000) as it unfolds many hiding human behaviour, which is impossible neither by quantitative nor any other option. 'Reliability' referred to the stability of findings, whereas 'validity' represented the truthfulness of findings (Altheide & Johnson, 1994). However, the real meaning of validity in qualitative research is obscure and different opinions in the literatures make the concept very complex. Numerous terms have been suggested as those working within the interpretive perspective have struggled to articulate validity criteria in qualitative research. Truth-value, credibility (Lincoln & Guba, 1985), trustworthiness (Eisner, 1991), authenticity (Guba & Lincoln, 1989), and goodness (Emden & Sandelowski, 1998; Marshall, 1990) have all been proposed as more suitable criteria to judge the quality of qualitative research. Yet, none have been overwhelmingly supported (Whittemere et al. 2001). Kahn (1993) discussed the implications of idiosyncratic terminology associated with validity in qualitative research and emphasized that

language should not obscure understanding. Within this compass, this piece of research made a number of connotations, which were difficult to fill the gaps of qualitative research. As researchers, we found that there are five wheels where we need to satisfy them (Figure-3). These are researchers ourselves, direct beneficiaries (mothers), different actors (GO-NGO), implementing organization (DAM), and funding organization (RDRS). Everyone has their own freedom to see the facts and findings of the research. However, it was very difficult to satisfy all of them as the reliability and validity rigor of the research. One opponent came from the implementing organization is to produce positive report. On the other hand, the mothers appealed to add some recommendations within the report so that they get some income generation activities from DAM, which is a common expectation of the beneficiaries from the NGOs (Islam et al. 2005). The qualitative research cannot prove the performance level of the mothers and other actors accurately on how the safe motherhood was encountered and what were the gaps between the impact of monitoring and advocacy. In this circumstance, the researchers' position was so vulnerable that it was extremely hard-hitting to maintain the validity and reliability to all groups.



Figure 3: Five wheels expectation of the Researcher

### **Complexity and diversification of human behaviour**

Qualitative research comes in a variety of forms. We produce ‘qualitative data’ in the course of our attempts to understand a range of different events, processes, behaviours or people, and such data are inherently diverse, non-standardized, heterogeneous and difficult to classify. This is not to suggest, though, that such

data are peculiar (Turner, 1994). It is seen that the language barriers and use of language is another difficult to comprehend the correct meaning of what the respondents really want to express. As well as the knowledge that we acquire through formal learning, we also acquire 'tacit knowledge' that is harder to describe or explain (Moriarty, 2011). There is some variation to use the word within the Bengali word between Dhaka and Jamalpur Districts. However, we could not understand some words what the mothers used locally. Within the diverse spectrum of human behaviours of the mothers and other actors for safe motherhood programme was so diverse that the measurable performances were not possible to encounter accurately. It was not only the problem rather we found different opinions from the mothers from different events (i.e. in-depth interviewing and FGD session) on the same enquiry but from the same mother. This complexity and diversification of human behaviour made us so dissonant that we could not clear many performances of the mothers for safe motherhood issue.

### ***Unavailability and inaccessibility of data***

The challenge was hoisted because of the unavailability and inaccessible of data in some areas. It is a common matter in Bangladesh that in many cases the NGOs do not show the official documents and information due to their unfolding evidence whether this can be public (Islam & Morgan, 2012). Some data were too invisible that the local level office staff could not documented those properly. According to the project objectives, all of the records, related to achieve the goal and objectives, should have been ready, but many records were not found properly and adequately, and in some cases, it was inaccessible. For instance, the functioning Union Parishad Health Standing Committee (UPHSC) for enhancing safe motherhood, according to the project guideline, the UPHSC was responsible for enhancing safe motherhood in the community. In this occasion, the UPHS's progress indicators were measured by the indicators such as- to have an action plan in place, properly use the monitoring tools, translate community needs into proposals for local health authority/ providers and advocacy for changes, receives expressions of satisfaction by communities on how problems were addressed, and shared monitoring results with UP. Another example was regarding to improve performance of public providers for safe motherhood at Union level. Here, the performance of the public health providers were measured through disclose of their plan and budget to the public, deliver health care as per plan and budget, maintain the standard protocol (government rules and regulations); have a positive attitude towards patients, look for/ advocate for solutions in case of (budget, human resources, medicines, equipment and cleanliness) constraints; referring mothers timely & properly to adequate facility levels; provide more counselling to patients; use the existing management Information System (MIS) functionally; and meet regularly with UPHSC. It was found that we could not get data from

both interventions accordingly; whether those were incomplete or in some cases it was very difficult to verify the measures with the performance indicators.

### ***Research Ethics***

Research ethics become a very important issue in qualitative research. Now a day, it is an obvious condition that the researcher has to collect the ethical approval from the recognized ethical body to conduct such kind of research. Ethics can be defined as ‘set of moral principles and rules of conduct’: ethics in research, as one author has put it, relates to ‘the application of a system of moral principles to prevent harming or wronging other, to promote the good, to be respectful, and to be fair’ (Seiber, 1993:4). Ethical issues associated with undertaking qualitative research also feature prominently in the paper by Elmir et al (2011), which examines the researcher’s experience of interviewing women on potentially sensitive topics. It is mentioned here that there is no ethical body in Bangladesh, but we followed the four principles of ethical issue provided by Beauchamp & Childress (1983): (1) Autonomy: respect the rights of the individual; (2) Beneficence – doing good; (3) Non-maleficence: not doing harm; (4) Justice – particularly equity.

Matthews and Grant (2004) suggested that concerns about ethical issues could be considered using the four principles of respect for autonomy, beneficence, non-maleficence and justice and a scope of application approach. This framework provides no way of determining which, if any, of these principles should take priority, but it does at least provide a common moral language. Miles & Huberman (1994) elaborately explained and discussed the ethical guidelines for qualitative research which we tried to follow as well. They identify the worthiness of the project (i.e., is my contemplated study worth doing?); competence boundaries; informed consent; benefits, costs and reciprocity; harm and risk; honesty and trust; privacy, confidentiality and anonymity; interventions and advocacy; research integrity and quality; ownership of data and conclusions; use and misuse of results; and conflicts, dilemmas and trade-offs. Consider carefully the context in which we worked with, the aim of research and how sensitive the topic was. It is particularly important for such kind of research where we asked the mothers about their practices related to secure safe motherhood that make them uncomfortable/fearful of consequences. It is important that asking a person to talk about experiences that were frightening, humiliating and painful can cause or increase anxiety. It might not only create distress during an interview, but might also emerge after. However, we importantly considered the care how while asking a question, and where we choose to ask questions. In many cases, the gender issue in terms of their anonymity, privacy and confidentiality were questionable. However, influenced by western ethical guidelines, we faced big dilemma in applying those in this local context (Islam & Banda, 2011).



### ***Power-relation***

Power relation is considered as multiple ethical dilemmas and serious methodological challenges in qualitative research (Karnieli-Miller et al. 2009). Though, it is claimed that most researchers have organizational and institutional power (Henry, 2003). The researcher felt powerless while trying to recruit participants and was constantly anxious about losing their interest during the study and during the validation phase of the study. Tang (2002) also supported this notion that the assumed dominant position of the researcher can be questioned. Grenz (2005) proposes that power is fluid and is not possessed by anybody, neither the researcher nor the researched, and hence it is not possible to conceptualize power in these terms. This movement of power between the researcher and the researched and suggests that this movement is shaped by the different positions that researcher and researched take within the research encounter which subsequently shapes the data and outcomes of the study. Das (2010) argued this researcher's positionality: The feelings of power and powerlessness were often located within the positionality of the researcher as we introduced ourselves as University Professors. This kind of 'positionality' was indicative of the particular social, structural and organizational positions that we ourselves occupied that defined the identity, power structures and social fields which mediated my interactions with the mothers. In addition, qualitative inquiry draws on a critical view of hierarchical relations of power between us and participants: "In traditional research, the roles of researcher and subject are mutually exclusive: the researcher alone contributes the thinking that goes into the project, and the subjects contribute the action or contents to be studied" (Reason, 1994: 42). Here, the division of roles between researcher and participant is dichotomous, unequivocal, constant, uniform, and predetermined. This division follows from the positivistic world view that sees the researcher as a neutral observer who objectively examines various human phenomena (Reason, 1994). Drawing predominantly on constructivist and critical paradigms of understanding, qualitative research fosters a rebalancing of power in the researcher-participant relationship and encourages a focus on marginalized understandings and experiences (O'Connor & O'Neill, 2004). Now a day, the Anti-oppressive Practice (AOP) and Anti-Discriminatory Perspectives (ADP) are largely prominent in such kind of research context (Das, 2010). As a result, our exercise of research practice and data collection procedures went through balancing such kind of power relations. We found that commanding 'high voices' (in some cases) were visualized by mothers as much 'control' and low voices show our 'vulnerability' which underweighted our sincerity and seriousness to the research.

## Conclusions

A qualitative inquiry is the process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. This paper presented the main challenges in parental health education under a particular project, which aimed to secure safe motherhood through two interventions such as community level monitoring and community level advocacy. This research was multi-method in focus, involving an interpretive, naturalistic approach to its subject matter. We studied mothers and other actors' (GO-NGO) performance level in their natural settings, attempting to make sense of or interpret different interacting phenomena in terms of their own meanings. We used a variety of empirical materials case study, personal experience, introspective, life story interview, observational, interactional, and visual texts-that described routine and problematic moments and meaning of safe motherhood issue. This case study provides a number of commune level challenges and procedural level challenges in a particular remote community in Bangladesh. The paper argues that the community level challenges may not be applicable to other communities where the socio-economical, cultural, political and geographical location is different. It was found that the procedural level challenges that we analysed here seemed much harder with inclusion of the commune level challenges.

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