

Special Publication

An Assessment of Health and Family Planning Needs in Rural Chittagong

Volume 1

**Mizanur Rahman
Barkat-e-Khuda
Mian Bazle Hossain**



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Foreword

The MCH-FP Extension Project (Rural) is a collaborative effort of the Ministry of Health and Family Welfare and ICDDR,B. Its overall purpose is to improve the effectiveness and efficiency of the national health and family planning programme through operations research (OR), dissemination, and technical assistance. An important area of OR of the Project relates to improvements in the management capability of the national health and family planning programmes.

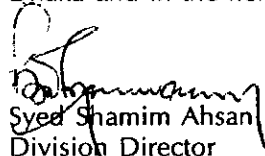
I am pleased to see that the Project has made significant progress in the area of improvement of management capability through its "district approach" (DA) intervention in rural *thanas* of Chittagong district. It has developed an assessment procedure to be used by the local level health and family planning programme managers. The managers are now able to identify strengths and weaknesses of their programmes, and develop strategies for programme improvement.

The present special publication is an outcome of the DA activities in Anowara, Boalkhali, Lohagara, Sitakunda, and Rangunia *thanas* of Chittagong district. As mentioned in the report, it was completed in several methodological steps with effective collaboration between the district and the *thana* managers of the Directorates of Health and Family Planning and ICDDR,B colleagues. The final step was a workshop, conducted on January 20-21, 1996, participated by health and MCH-FP managers of the above *thanas*, Chittagong district, Chittagong division, and some national directors of both Directorates. Mr. Khairuzzaman Chowdhury, Director General, Family Planning chaired the concluding session of the workshop.

It is identified that improved client-worker contact and better management of the fixed-site service centres can increase use of health and family planning services without any additional monetary, personnel, logistic, and other resources. I strongly believe that the activities identified in the report will be implemented, in a phased-in manner. The Project will continue to provide its technical assistance in achieving the goals.

Many more challenges remain in the national health and family planning programmes in the areas of improvement of management capability, quality of care of services, and developing sustainable strategies. The MCH-FP Extension Project (Rural) is already working on some of these issues, and will continue to do so in the future. Additionally, the Project will continue to provide technical assistance to the national programme to address its various new and emerging problems.

I thank all those who have been involved in the DA activities including the workshop participants for their hard work and valuable inputs in identifying the interventions that help improve the programmes in the above *thanas*. My special thanks are due to our colleagues from the Directorates of Health and Family Planning, both at Dhaka and in the field, for their continued collaboration with us.



Syed Shamim Ahsan
Division Director

Health and Population Extension Division

Preface

The performance of the health and maternal and child health and family planning (MCH-FP) programme in Chittagong division is low compared to that of other divisions, although Chittagong division is economically better off. The Ministry of Health and Family Welfare (MOHFW) faces the challenge of improving Chittagong division's programme.

The MCH-FP Extension Project (Rural), a collaborative effort between the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) and the MOHFW, has been conducting operations research (OR) to find affordable and efficient ways of improving health and MCH-FP activities. The "District Approach (DA)" is one of the Project's interventions, which attempts to help capacity building of programme managers at various levels.

The programme managers of five rural *thanas* (Anowara, Boalkhali, Lohagara, Rangunia, and Sitakunda) of Chittagong District undertook an assessment of the programme needs in their *thanas* with technical assistance from the DA team of the MCH-FP Extension Project (Rural). A needs assessment report of each *thana* was prepared by the DA team, after careful review of findings by the respective *thana* managers.

The data from the needs assessment studies were further analyzed by the DA team to identify potential factors associated with programme improvement. The findings were presented at a DA dissemination workshop by the district health and MCH-FP managers, and were reviewed by the concerned managers of five *thanas* and some national level directors of the Directorates of Health and Family Planning. The managers developed a plan of action, delineated responsibilities among themselves, and made an implementation schedule. These were presented at the concluding session, which was chaired by the Director General, Directorate of Family Planning.

We strongly believe that the DA intervention of the MCH-FP Extension Project (Rural) has made a remarkable achievement in the capacity building of programme managers to assess their programme strengths and weaknesses and to identify actions for programme improvement. It has been a rewarding experience working together with the colleagues of the Directorates of Health and Family Planning to identify needs and plan actions. We are confident that the actions that have been planned will be implemented and the programmes will enhance use of services.

We congratulate Dr. Barkat-e-Khuda, Project Director, MCH-FP Extension Project (Rural) for his able leadership of the Project. We also appreciate the hard work of the DA team and other colleagues of the MCH-FP Extension Project (Rural), which, together with our colleagues, made the need assessment work and workshop a success.



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The authors would like to express their thanks to Mr. Khairuzzaman Chowdhury, Director General, Directorate of Family Planning, who kindly participated in the Workshop to chair the concluding session. Thanks are also due to Dr. Jahir Uddin Ahmed, Director (MCH), Directorate of Family Planning and Dr. ASM Humayun Faruque, Deputy Director, Directorate of Health Services, who served as discussants at the Workshop.

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Kumar Goshwami, Assistant Director (Clinical Contraception), and Dr. Mamunur Rahman, Medical Officer (Clinical Contraception) of Chittagong District. The *Thana* Health and Family Planning Officers, *Thana* Family Planning Officers, Medical Officers (MCH), Assistant Family Planning Officers and Senior Family Welfare Visitors of Anowara, Boalkhali, Lohagora, Mirsarai, Rangunia, and Sitakunda *Thanas* participated in the design and conduction of the needs assessment studies and in the review of findings and preparation of a plan of action for programme improvement.

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Acronyms and Abbreviations

AD (CC)	Assistant Director (Clinical Contraception)
AD (Coord)	Assistant Director (Coordination)
AHI	Assistant Health Inspector
ATFPO	Assistant <i>Thana</i> Family Planning Officer
BDHS	Bangladesh Demographic and Health Survey
CC	Clinical Contraception
CAR	Contraceptive Acceptance Rate
CPR	Contraceptive Prevalence Rate
CS	Civil Surgeon
DA	District Approach
DCS	Deputy Civil Surgeon
DD (CDS)	Deputy Director (Communicable Disease Services)
DD (FP)	Deputy Director (Family Planning)
DG (FP)	Director General (Family Planning)
DG (Health)	Director General (Health Services)
EPI	Expanded Programme on Immunization
FP	Family Planning
FPI	Family Planning Inspector
FRM	Field Research Manager
FRO	Field Research Officer
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant
H&FWC	Health and Family Welfare Centre
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IEC	Information, Education and Communication
IUD	Intra-uterine Device
MA	Medical Assistant
MCH	Maternal and Child Health
MCH-FP	Maternal and Child Health and Family Planning
MIS	Management Information System
MO	Medical Officer

MO (CC)	Medical Officer (Clinical Contraception)
MO (FW)	Medical Officer (Family Welfare)
MO (MCH)	Medical Officer (Maternal and Child Health)
MOHFW	Ministry of Health and Family Welfare
MWRA	Married Women of Reproductive Age
NGO	Non-Government Organization
N.M. Consultant	National Medical Consultant
N.N. Consultant	National Nursing Consultant
OPH	Office of Population and Health
OR	Operations Research
REM	Research, Evaluation, and Monitoring
SC	Satellite Clinic
SFRA	Senior Field Research Assistant
SFRO	Senior Field Research Officer
Sr. FWV	Senior Family Welfare Visitor
SOR	Senior Operations Researcher
SRS	Sample Registration System
TA	Technical Assistance
TFPO	<i>Thana</i> Family Planning Officer
THC	<i>Thana</i> Health Complex
THFPO	<i>Thana</i> Health and Family Planning Officer
TT	Tetanus Toxoid
UCN	Unmet Contraceptive Need
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

1. Introduction

The MCH-FP Extension Project (Rural) is a collaborative effort of the Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh and the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). The Project: (i) conducts operations research (OR) on programme management, quality of care, and sustainability of the national health and maternal and child health and family planning (MCH-FP) programmes, (ii) disseminates OR findings, and (iii) provides technical assistance (TA) for programme improvement. As part of the Project's ongoing OR activities, "district approach" (DA) intervention has been implemented in 13 rural *thanas* of Chittagong district, one of whose objectives is to enhance the capacity of district- and *thana*-level health and MCH-FP managers in assessment and planning of the programme.

The overall objectives of the present study are to (i) assess management factors of the programme that influence the accessibility to, and the use of, health and MCH-FP services in five rural *thanas* of Chittagong district, and (ii) assist the local-level programme managers in developing an action plan for programme improvement.

The specific objectives are to: (i) estimate the level of use of contraception and immunization, desired fertility, and demand for contraception; (ii) determine the extent of client-worker contact, and its association with the use of services; (iii) estimate the level of use of Satellite Clinics (SC), Expanded Programme on Immunization (EPI) spots, Health and Family Welfare Centres (H&FWC), and *Thana* Health Complex (THC); and (iv) develop an action plan for programme improvement that will lead to the better use of services.

2. Methods and Materials

The study was conducted in five of the 13 rural *thanas* of Chittagong district, namely Anowara, Boalkhali, Lohagora, Rangunia, and Sitakunda, which serve as the laboratory *thanas* of the DA intervention of the Project. The completion of the present study involved several stages: (i) development of a rapid procedure to assess the accessibility to, and the use of, health and MCH-FP services; (ii) review of the procedures by the *thana* managers;

(iii) collection, processing, and analysis of data; (iv) review of the findings by the *thana* managers of individual *thanas*; (v) a comparative analysis of data of five *thanas*; and (vi) a review of the findings of the comparative analysis at a workshop aimed at developing an action plan for programme improvement.

The assessment procedure involved the collection of information from the married women of reproductive age (MWRA) and from the fixed-site service facilities, like SC, EPI session, H&FWC, and THC. Using a cluster sampling procedure, at least 600 MWRA were interviewed from 20 clusters, each from a randomly selected village representing each union of a *thana*. The procedure (survey methodology and data collection instruments) was critically reviewed by the district, *thana* health and MCH-FP managers in several "need assessment workshops." The DA team of the Project provided TA in the areas of collection, processing, and analysis of data: Four female Senior Field Research Assistants (SFRA) interviewed the sample MWRA, using a one-and-a-half page structured questionnaire, under the supervision of a Field Research Officer (FRO). Data collection from MWRA in one *thana* was completed in 5-6 working days. Three other FROs collected relevant information from SCs, EPI sessions, H&FWCs, and THC in each *thana*. Data were collected from the five *thanas* during July-December 1995. The collected data were then entered in the computers of the Project's District Office in Chittagong. Analysis of data was done in Dhaka. Findings of the "need assessment survey", based on bivariate analysis, were reviewed by the *thana* health and MCH-FP managers at a meeting held in each *thana*.

A comparative analysis of data of the five *thanas* was undertaken to identify a common set of programme factors that influence programme performance, which can be improved through management intervention. The comparative analysis was restricted to information obtained from MWRA. The findings of the comparative analysis were presented by the district managers at a DA workshop held on 20-21 January, 1996 in Chittagong. The health and MCH-FP managers of the five *thanas*, Chittagong district and Chittagong division and those of the Directorates of Health and Family Planning, including the Director General, Family Planning, participated in the workshop. The designated discussants and the participants reviewed the findings extensively. The participants were, then, divided into two groups, and developed an action plan after identifying and prioritizing activities that will lead to: (i) improved client-worker contacts; and (ii) an increased use of health and MCH-FP services from the fixed-site service centres.

3. Findings

3.1. Health and family planning situation

The client environment is favourable to better use of the health and MCH-FP services in the five *thanas*. Around half of MWRA reported that they did not want any more children. Over three-quarters of contraceptive non-users wanted to use contraception in future. The literacy rates in these *thanas* are high, and representative of the district. This is favourable to the higher use of health and MCH-FP services. Low use of SC or H&FWC is related to the clients' limited awareness of the services available there, but not due to their unwillingness to use them because of family objection or religious conservatism. There was a high prevalence of reported contraceptive side-effects, which might have led to high discontinuation of methods, resulting in a low-contraceptive prevalence.

The contraceptive prevalence rate (CPR) ranged between 35 and 47 per cent in the five *thanas*. The low CPR may be associated with poor worker-client contact, irregular holding of SC, and poor use of the health and MCH-FP services available at SC and H&FWC.

3.2. Performance of health and family planning workers

Less than 40 per cent of MWRA reported that they were contacted at their homes by FWAs or NGO field workers in last two months. About one-quarter of MWRA reported that they were not contacted, or that they could not remember when they were last contacted by FWAs or NGO field workers. The results show that CPR substantially increases with frequent contact of FWAs or NGO workers with MWRA. A simple simulation exercise shows that a regular bimonthly client-worker contact could raise CPR to 50 per cent from its current level of 39 per cent. Strengthening of the field activities can indeed increase the client-worker contact, leading to an enhanced CPR.

There was a high vacancy of both FWAs and HAs in the five *thanas*. The FWA vacant areas were covered by the NGO field workers, but there were no substitutes for HAs. Contact between the clients and HAs was also quite weak: about 35 per cent of MWRA had been contacted at their homes by HAs in last two months, and 23 per cent of MWRA were either not contacted or could not remember when they were last contacted by HAs. The poor client-HA contact was probably due to the high HA vacancy. However, efforts are underway to recruit HAs in the vacant areas in the study *thanas*. The performance of EPI was quite good. Seventy to ninety per cent

of MWRA reported that they attended the EPI spots or have received the TT shots. This indicates that MWRA would go outside their homes for the health and MCH-FP services, if such services are appropriately offered.

3.3. Use of fixed-site health and MCH-FP services facilities

The attendance of women at SC was quite low: 4-17 per cent of MWRA had ever attended a SC for health and MCH-FP information, counselling, or services. Of the SC visitors, half sought for curative services for themselves or for their children, and the rest sought for the MCH-FP services. Provision of a need-based and well-designed curative service-delivery system can popularize SC, leading to its higher use, which has a positive impact on reproductive and child health.

The most important reason for not attending a SC was the MWRA's limited awareness of the SC services or its location. Family objection to going outside the home to attend a SC was cited as a reason only by a small proportion of the respondents. Regular holding of SCs, dissemination of information about SCs by FWAs, HAs, and NGO workers, and regular contact of these field workers with clients will enhance use of the SC services, leading to a rise in contraceptive use, and antenatal, and postnatal care.

The attendance of MWRA at H&FWC varied substantially; between 30 to 50 per cent of MWRA reported that they had been to a H&FWC for the curative and/or MCH-FP services. Similarly, 40-50 per cent of MWRA reported that they had been to a THC for health services. FWAs, HAs, and NGO workers, through regular contact with their clients and FWVs at SC, can advise MWRA to attend H&FWC and THC for the health and/or MCH-FP services. This will lead to the higher use of H&FWCs and THCs.

4. Conclusions, Recommendations, and a Plan of Action

The findings of the study show that the use of health and MCH-FP services can be enhanced further by strengthening the field activities, which do not require any additional resources in the areas of recruitment, training, or supplies. Therefore, the participants recommended to: (i) improve the client-worker contact and (ii) improve the management of fixed-site service centres.

An improved client-worker contact at the clients' homes or SCs or H&FWCs would, in the one hand, increase contraceptive use and attendance at the fixed-site service centres, whereas on the other hand, the enhanced activities and supervision of fixed-site service centres would enhance the use of their services.

The *thana* health and MCH-FP programme managers, under the leadership of the district managers, identified the following actions to implement the two recommendations: (i) Strengthen supervision of FWAs and NGO field workers by FPI/AHI/NGO supervisors; (ii) ensure residency of HAs in work units; (iii) strengthen supervision of FPI/AHI/NGO supervisors by the *thana* managers; (iv) introduce a performance review mechanism; (v) rationalize the job descriptions of the field workers; (vi) combine eight SCs and EPI spots to provide health and MCH-FP services and strengthen the supervision of SCs; (vii) introduce 16 SCs in each union where there are two FWVs; (viii) improve the information, education, and communication (IEC) activities on the services available at fixed-site service centres; and (ix) organize the THC activities to increase the coverage of the MCH-FP services.

The workshop participants identified certain responsibilities for the managers working at different levels of the programme for these tasks. A time frame for the completion of various activities was also finalized. The MCH-FP Extension Project (Rural) will provide the necessary TA at various stages of implementation of the plan of action.

It is expected that implementation of the proposed activities will lead to a significant increase in the use of contraceptives and MCH services in these five *thanas*. These activities, if found successful, will be recommended for replication in the low performing areas of the country.

INTRODUCTION

The MCH-FP Extension Project (Rural) is a collaborative effort of the Ministry of Health and Family Welfare (MOHFW) and the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), with financial assistance from the United States Agency for International Development (USAID) and support from The Population Council. Its overall objective is to improve the effectiveness and efficiency of the national family planning (FP) and maternal and child health (MCH) programme through operations research (OR), dissemination, and technical assistance (TA). OR is carried out in three government field sites, Abhoynagar *thana* in Jessore district, Mirsarai *thana* in Chittagong district, and in a limited way in Sirajgonj Sadar *thana* in Sirajgonj district. In addition, 13 rural *thanas* of Chittagong district serve as the non-intensive laboratory areas. The Project focusses primarily on the following three major areas in the field of MCH-FP: (i) an improvement of the management capability of the national MCH-FP programme, (ii) an improvement of the quality of MCH-FP services, and (iii) promoting the sustainability of the national FP and MCH programme. As part of its OR activities in the current phase, the Project has been field-testing several interventions at Abhoynagar and Mirsarai *thanas* since the end of 1994, as well as some ongoing interventions initiated prior to 1994. The Project has also been monitoring the sustainability of its selected interventions after one of its old field sites, Sirajgonj, was phased-out.

The successful interventions, currently being field-tested at Mirsarai and Abhoynagar *thanas*, will be scaled-up in a phased-in manner in the 13 rural *thanas* of Chittagong district under the Project's "district approach (DA)" intervention. The concerned health and family planning managers of the 13 rural *thanas* are being sensitized, motivated, and updated on the various Project activities being undertaken at Mirsarai and Abhoynagar *thanas* through workshops, meetings, training, needs assessment, and other related activities. Capacity of the concerned *thana* managers is being developed for initiating activities that will enhance the accessibility to and coverage of the MCH-FP services in their *thanas*.

Chittagong district was selected for the DA intervention because of its overall low-contraceptive prevalence in Chittagong division¹. For the Bangladesh family planning programme to achieve its objective of replacement fertility, it will be necessary to raise CPR to over 70 per cent. This will particularly be a challenging goal in Chittagong where CPR was less than 30 per cent during 1993-1994. It is, therefore, necessary to make increased efforts to improve programme performance in Chittagong division.

1.1. Health and Family Planning Situation in Chittagong Division

Chittagong division, including the current Sylhet division, is characterized by the lowest contraceptive prevalence in the country as well as by other health and FP service indicators in Bangladesh. In 1993-1994, CPR was 29 per cent in Chittagong division, while it ranged between 44 and 55 per cent in other divisions (Table 1.1). Regarding desire for no additional children, Chittagong division remains behind other divisions, with 53 per cent of the married women of reproductive age (MWRA) not wanting to have any additional children compared to 56-60 per cent in other divisions (Table 1.1). In contrast, the unmet contraceptive need (UCN), i.e. couples not using contraception and not wanting any additional children, is much higher in Chittagong division than that in other divisions (33 versus 19-23%, Table 1.1).

Socioeconomic conditions are comparatively better off in Chittagong division than those in other divisions. For example, both the male and female literacy rates as well as the mean number of articles owned by households (a proxy for family income) are higher in Chittagong. However, the women's participation in income-earning and NGO activities (which is generally common among the poor women) are lower in Chittagong division compared to those in other divisions (Table 1.1).

Low-health and FP performance in Chittagong division is due, among other reasons, to the relatively high demand for children (low proportion of eligible couples desiring no additional children). The high demand for children and the low use of contraception are generally determined by a complex interplay of a number of cultural, social, economic, and programmatic factors. In the case of Chittagong division, some demand- and supply-side factors can be identified. For example, people in this division are

¹ The data refer to the then greater Chittagong division (Chittagong and Sylhet divisions); any reference in this section to Chittagong division would, henceforth, refer to both Chittagong and Sylhet divisions.

Table 1.1. Programmatic, socio-demographic, and fertility-related variables by division of Bangladesh: currently married women of reproductive age

Variable	Division					
	Year	Chittagong	Dhaka	Khulna	Rajshahi	Total
Contraceptive prevalence rate (CPR)	1983	12	17	21	22	17
	1993-94	29	44	53	46	46
% want no more children	1983	56	63	65	67	63
	1993-94	53	56	60	60	57
% unmet contraceptive need	1983	41	41	43	40	41
	1993-94	33	23	20	19	24
% FP worker's visit in last six months	1983	24	31	29	37	30
	1993-94	34	41	52	48	43
% women know about at least 7 methods	1983	18	22	28	24	23
	1991	56	69	78	66	66
Average maternal age	1983	28	27	28	27	28
	1991	29	28	28	28	28
Average number of living children	1983	3.1	3.0	3.2	2.9	3.1
	1991	3.0	2.9	2.9	2.7	2.9
Maternal education (%)						
Primary	1983	24	20	30	21	23
	1991	28	25	33	23	27
Above primary	1983	5	6	8	5	6
	1991	14	12	11	7	11
Husband's education (%)						
Primary	1983	19	16	21	19	19
	1991	31	27	28	23	27
Above primary	1983	22	20	26	24	23
	1991	23	20	24	21	21
% Muslim	1983	87	96	87	83	88
	1991	87	92	83	88	88

Contd...

Table 1.1. (Contd).

Variable	Division					
	Year	Chittagong	Dhaka	Khulna	Rajshahi	Total
Mean of articles owned by household	1991	2.5	2.1	2.1	2.1	2.2
% women's work	1991	19	27	24	40	28
% women's membership in NGO	1991	2.7	6.5	2.7	7.1	5

Source: Mitra et al., 1985, 1993, 1994 (1-3).

generally considered to be more conservative; there is greater degree of out-migration of adult males in Chittagong division; and the FP programme has grown at a slower pace than in other divisions, probably because of the low demand for contraceptive services in Chittagong during the 1970s-1980s. Barkat et al. documented a number of factors that are likely to be associated with low performance of MCH-FP programme in Chittagong division (4).

There is an evidence that the health and family planning programmes are relatively weak in Chittagong division. For example, there was less frequent home visitation by the field workers in Chittagong division (34%) than that in other divisions (41-52%) (Table 1.1). The needs assessment study conducted by the ICDDR,B MCH-FP Extension Project (Rural) in 1994 at Mirsarai *thana*, the Project's experimental *thana* in Chittagong, indicates such weaknesses of the programme as vacant Family Welfare Assistant (FWA) positions, irregular and infrequent contact of FWAs with clients at homes, weak supervision of field activities, poor knowledge and skills of FWAs and the paramedics and their supervisors, lack of regularity of work in fixed-site service facilities (5). These weaknesses of the programme probably resulted in the low use of services in these areas. An improvement in programme management is quite likely to enhance the accessibility to services thereby increasing the use of services.

However, an irregular contact of the workers with clients at their homes in Chittagong division might have been due to the fact that there are more geographically less accessible areas in this division than in others, which may hamper the regular FWA visitation and that of their supervisors. This may particularly be a problem during the monsoon. There may be some geographically less-accessible areas in Barisal division, although CPR is high

there. It has also been observed that, in some places of Chittagong division, the educated women are not willing to work as the family planning workers.

It can be assumed that an improved programme management may increase the demand for, and use of, services. An improved programme management includes the recruitment of FWAs, an enhancement of knowledge and skills of service providers, ensuring a regular client-worker contact, ensuring monitoring and supervision of work, an improvement in the accessibility to and quality of services in the fixed sites, and an improvement in local-level planning.

1.2. Objectives

The overall objectives of this study are: (i) to identify programme management factors that influence accessibility to, and use of, health and MCH-FP services in five rural *thanas* of Chittagong district, and (b) to assist the local-level managers in developing a plan of action for programme improvement.

The specific objectives for this study are to:

- i) estimate the level of desired fertility, demand for contraceptive use, actual use of contraception, including contraceptive method-mix, and acceptance of immunization;
- ii) determine the regularity of field work of FWAs and Health Assistants (HA), and the influence of client-worker contact on the use of health and MCH-FP services;
- iii) estimate the level of use of the health and MCH-FP services available at the fixed-site service centres like Satellite Clinics (SC), EPI spots, Health and Family Welfare Centres (H&FWC), and *Thana* Health Complex (THC); and
- iv) develop a plan of action for the five *thanas* to improve programme management that will lead to the higher accessibility to, and use of, health and MCH-FP services.

1.3. Current MIS and the Proposed Assessment Procedure

A well-developed and efficient health and MCH-FP programme should have a built-in, routine, or periodic assessment mechanism, which allows for the design of programme improvement strategies. The Directorate of Family Planning, for example, has its Management Information System (MIS), which

produces a monthly contraceptive acceptance rate (CAR) of MWRA and other MCH-FP service statistics according to union, *thana*, district, and division. The programme managers can review the progress of their activities, using the monthly CAR and other service statistics. Such statistics, however, have a limited use due to four main reasons. First, since the service statistics are produced by the providers and these are used for assessing the workers/supervisors' performance, such statistics are, therefore, likely to suffer from an upward bias. For example, the national CPR during 1993-1994 was 45 per cent (3) compared to a CAR of about 60 per cent for the similar period (6). Second, the MIS service statistics do not cover any information on key programme inputs that directly affect the use of services. For example, FWAs are supposed to contact every MWRA once every two months to provide information, counselling, and supplies of MCH-FP services. No service statistics show the extent to which the client-worker contacts are made in the field. Third, the MIS information is not collected from clients, who can report their use of services from FWAs, NGO workers, SCs, H&FWCs, and THCs. Finally, there is no information on the clients' demand for services, and such information is necessary for proper design of service-delivery strategies.

A conceptual framework is presented in Figure 1.1, showing that the use of services is determined by the client's demand for services, and which is influenced by their characteristics. This can be stimulated by programme efforts, which are, in turn, determined by programme management and efficiency. Moreover, the client's demand and the use of services as well as the programme efforts are influenced by opportunities and constraints prevailing in the community but exogenous to the programme. A carefully designed programme, in contrast, can influence community constraints, leading to the higher use of services.

The conceptual framework shows that the use of services is influenced by a complex interplay of the individual demand for services, which is influenced by the client characteristics, programme efforts and management capabilities, and community characteristics. An effective improvement of the programme can be achieved through an understanding of these issues in a more holistic way. The programme managers need some sensitive and objective indicators of accessibility to, and use of, services that are based on the information collected from the clients. MIS provides only service statistics that are based on the providers' reports. These do not reflect the

clients' actual use and demand for services. In this study, we use a procedure that allows, based on the clients' information, an assessment of the health and MCH-FP programme activities at the *thana* level or below.

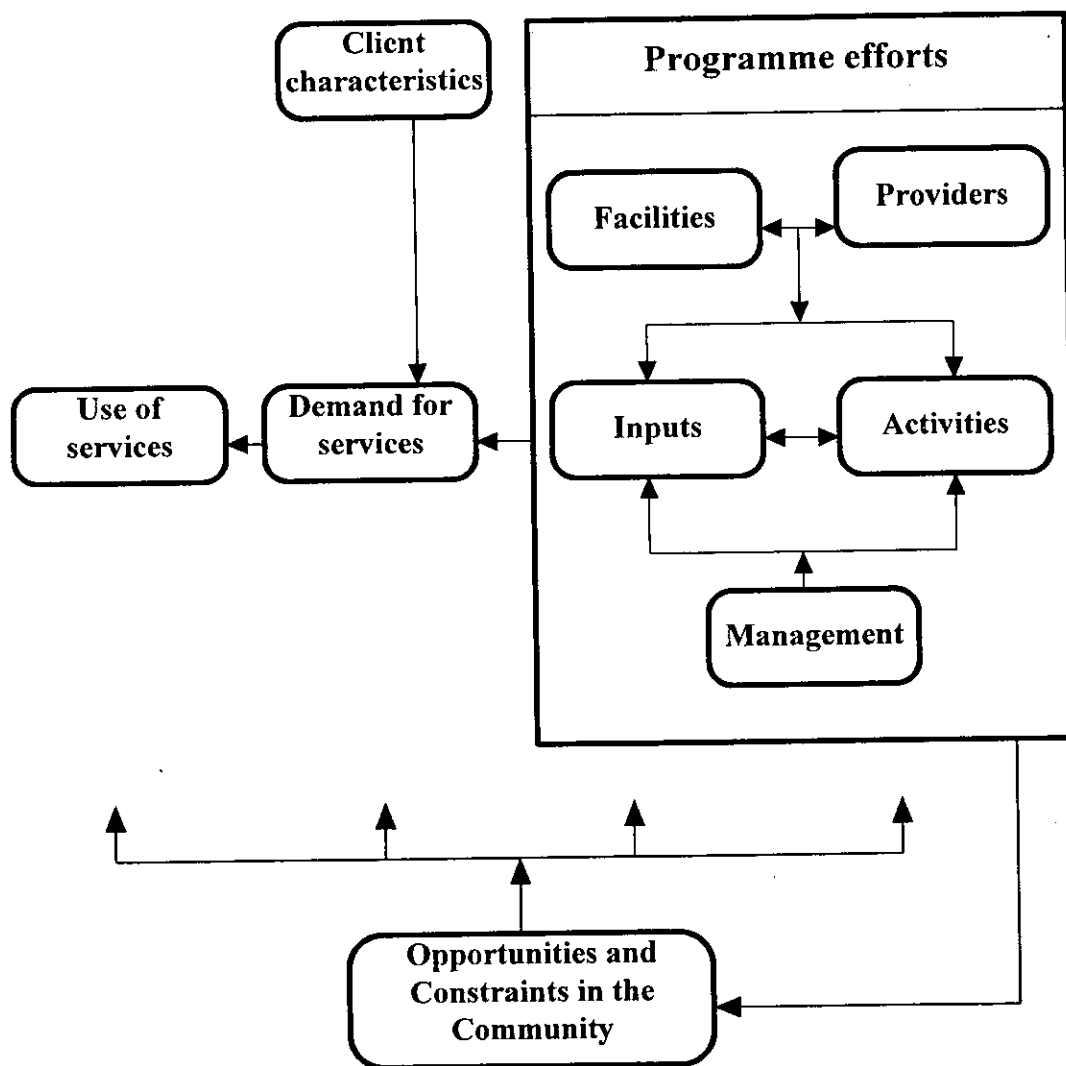


Fig. 1.1. Factors that may influence demand for, and use of, health and family planning services

METHODS AND MATERIALS

The study was conducted in five of the 13 rural *thanas* of Chittagong district, namely Anowara, Boalkhali, Lohagora, Rangunia, and Sitakunda, which serve as the non-intensive laboratory *thanas* of the DA intervention of the Project. The needs assessment activities of the programme are being undertaken in the remaining seven *thanas*, which are expected to be completed in July 1996².

The completion of the present study involved several stages: (i) development of study design, including data collection instruments; (ii) review and finalization of the design and data collection instruments by the *thana* managers in "needs assessment" workshops; (iii) collection, processing, and analysis of data; (iv) review of the findings by the managers of individual *thanas*; (v) a comparative analysis of data of five *thanas*; and (vi) presentation of findings, based on the comparative analysis, at a workshop in Chittagong aimed at developing an action plan for programme improvement in the five *thanas*.

2.1. Study Design

A rapid procedure to assess the accessibility to, and use of, health and MCH-FP services was developed by the members of the DA intervention team (6). A number of sensitive and objective indicators of accessibility to, demand for, and use of, services were identified for the collection of information from the clients, i.e. MWRA, using a one-and-a-half-page structured questionnaire. The rapid assessment procedure also includes information on facilities, like SC, EPI session, H&FWC, and THC. Two-to-three-page simple checklists were developed to collect relevant information on various aspects of management and quality of care related to these facilities.

The following methodology was adopted to collect information from the clients. A cluster-sampling procedure was used for collecting information from MWRA to minimize time, personnel, and management resources. A sample of 600 MWRA per *thana* was found to be appropriate in terms of statistical and operational procedures (7). At least 30 MWRA from each of 20 clusters were interviewed. Twenty clusters were selected from 20 villages, covering all unions in a *thana*. For each union, the village was randomly selected.

² Satkania *thana*, one of these 13 *thanas*, serves as a comparison area of Mirsarai *thana*, and is covered by the Project's Sample Registration System (SRS). Therefore, needs assessment study will not be undertaken in Satkania *thana*.

The index household in the selected village was also selected randomly. Interviews of the neighbouring permanent resident MWRA, following the one(s) in the index household, continued until interviews of 30 such MWRA were completed. The direction in which the interviewer should move to complete the interview was decided in advance, and the same direction was followed for all clusters in a *thana*.

The names of the sample villages in which MWRA would be interviewed were given to the interviewers or their supervisors in the morning of the day of data collection, so that neither the service providers nor the interviewers know in advance from where the data would be collected. FWAs, NGO field workers, or their supervisors did not accompany the interviewers at the time of interviewing MWRA. Table 2.1 shows the number of MWRA interviewed during the surveys.

The following methodology was adopted to collect information from the facilities. At least one Satellite Clinic (SC) and one EPI session per union, each Health and Family Welfare Centre (H&FWC) in a *thana* and the *Thana* Health Complex (THC) were observed to collect information, using the structured checklists. The information recollected were based on one day of observation and included some selected service statistics of these facilities.

2.2. Review of the Study Design

Workshops with district and *thana* health and MCH-FP managers were conducted to: (i) review the needs and utility of periodic programme assessments in a *thana*; (ii) review and finalize the proposed data collection procedure and instruments; (iii) prepare schedule of field work; and (iv) identify the technical assistance needed for the collection, processing, and analysis of data. The methodology of data collection and the data collection instruments were critically reviewed by the participants of workshops, namely district and *thana* health and MCH-FP managers, and were finalized after appropriate modifications proposed at the workshops.

2.3. Collection, Processing, and Analysis of Data

Information from MWRA was collected by four female Senior Field Research Assistants (SFRA), under the supervision of a Field Research Officer (FRO). A SFRA completed interviews of at least 30 MWRA in a cluster. Data collection from MWRA in 20 clusters in 20 different villages of one *thana* was completed in 5-6 working days. Table 2.1 shows the number of MWRA interviewed in each *thana*.

Three other FROs collected information, using the relevant checklists, from SCs (at least one SC per union), EPI sessions (at least one session per union), FWCs (every union), and THC. They spent the whole day (working period) in each of these facilities. Table 2.1 shows the number of facilities surveyed. The data collection was done during July-December 1995. The entire field activities were supervised by a SFRO.

Table 2.1. Needs assessment samples by *thana*

Respondent/facility	Thana					Total
	Anowara	Lohagora	Rangunia	Sitakunda	Boalkhali	
Clients						
Married women of reproductive age	637	642	658	646	646	3,229
Service centres						
EPI spots	7	7	9	28	10	61
Satellite Clinic	9	6	9	20	10	54
Health and Family Welfare Centre	9	9	9	9	9	54
Thana Health Complex	1	1	1	1	1	5

Each data collection form was edited in the field office. Those forms which had errors in any items were returned to the field for verification and necessary corrections. The edited forms were then sent to the Project District Office in Chittagong, where data were entered into the computer by the Project data entry person. Preliminary computer editing and cleaning of data were done in Chittagong.

An analysis of data was done in Dhaka, following the final editing and cleaning. Findings, based on simple bivariate analysis, were displayed in graphical forms for the *thana* health and MCH-FP managers.

2.4. Review of Findings at the *Thana*

Relevant findings of each *thana* were reviewed separately at a meeting of the concerned *thana* health and MCH-FP managers and the members of the Project scientific staff. The results were interpreted at the review meeting in respect of strengths and weaknesses as well as the threats and opportunities of the programme activities, resulting in the identification of activities that could lead to programme improvement in the respective *thanas*.

The entire process of collecting, processing, and analysis of data, reviewing the findings with the managers, and the preparation of the report was completed in about one-and-a-half months for each *thana*.

2.5. Comparative Analysis of Data of Five *Thanas*

A comparative analysis of data of five *thanas* obtained from MWRA through the cluster surveys was undertaken to identify a common set of factors that influenced the programme performance, and which can be improved through management intervention. The analysis includes the areas of demand for children, contraceptive use and immunization, and use of services offered at the fixed service sites.

2.6. The Workshop

The findings of the comparative analysis were presented at a district approach workshop held on 20-21 January 1996 in Chittagong. Appendix A gives the workshop agenda. The concerned health and MCH-FP managers of the five *thanas*, Chittagong district and Chittagong division, and those of the Directorates of Health and Family Planning, including the Director General, Family Planning participated in the workshop. Appendix B shows a list of participants.

The key findings on the accessibility to and use of health and MCH-FP services, based on the comparative analysis, were presented at the workshop by the concerned district health and MCH-FP managers. This was followed by a thorough discussion of the findings by the designated discussants and the general participants. Following the major presentations and discussions, the participants were divided into two groups for more detailed discussion of the findings and to be able to identify and prioritize activities that will lead to: (i) improved client-worker contacts; and (ii) an increased use of health and MCH-FP services from the fixed-site service centres. After group discussions, the groups made recommendations and identified specific activities aiming at bringing about improvements in health and MCH-FP programmes in the five *thanas*³.

³ The Deputy Director, Family Planning, Chittagong district, led one group and identified specific actions necessary to improve the client-worker contact. The Deputy Civil Surgeon, Chittagong district, led the other group and identified specific actions necessary to increase the use of the fixed-site service centres. Each group listed all possible steps and actions required to bring about the improved client-worker contact and increased use of the service centres. These implementation strategies, time frame, and agencies/persons responsible for each sub-activities were identified.

FINDINGS

3.1. Health and Family Planning Situation

Health and family planning situation in a community is usually associated with its socioeconomic conditions, of which literacy being an important indicator. The use of health and family planning services is usually higher among the literate than the less-literate persons. Figure 3.1 shows the literacy rates (percentage of persons seven years and above who reported that they can read and write in Bangla) of the five study *thanas*, Chittagong district, and the country as a whole. The literacy rate in Chittagong district is substantially higher than the national rate, both for males and females. The average literacy rate of the study *thanas* is slightly lower than the district average, but considerably higher than that of the national average.

The high literacy rate in Chittagong district, in general, and in the study *thanas*, in particular, can be seen as an opportunity which can be exploited to improve the use of the health and MCH-FP services, if such services are delivered in an appropriate way.

The desired family size can indirectly measure the demand for contraceptive use.

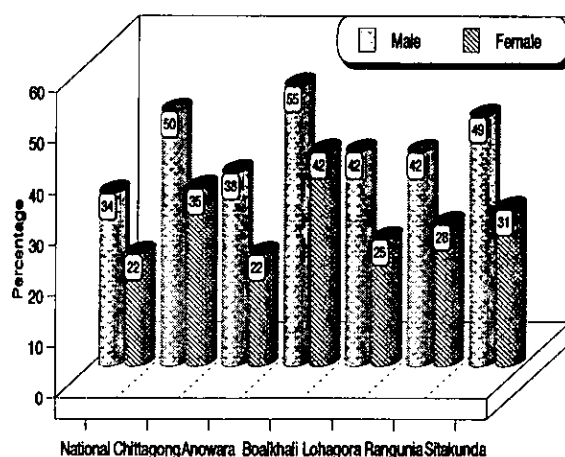


Fig.3.1. Literacy rate (aged 7 years +) by sex and area, 1991 census

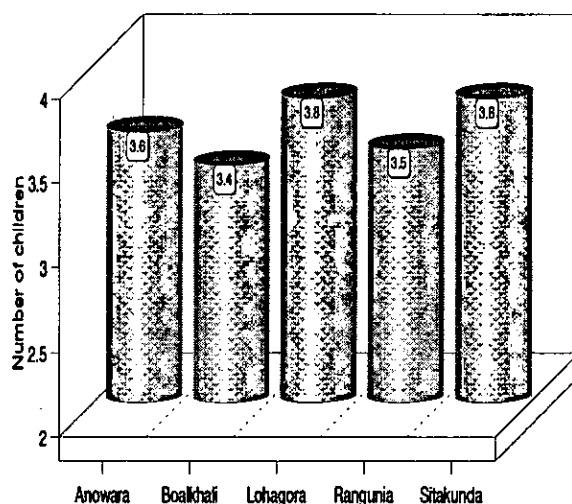


Fig.3.2. Mean desired family size by thana

Figure 3.2 shows the mean desired family size, which varies from 3.4 to 3.8 in the study *thanas*. These means are not comparable to the means of *ideal* family size, because the *desired* family size was calculated by adding the desired number of additional children to the number of currently living children. The desired family size in the study *thanas* is relatively high. Given the large desired family, 47-56 per cent of MWRA in the study *thanas* did not want to have any more children (Fig. 3.3) meaning that these MWRA have achieved their fertility goals. The proportion not wanting any more children is positively related with parity. About half of those with 2-3 children do not want any more children compared to over 80 per cent for those with 4 or more children. There is a high demand for contraceptive use; Figure 3.4 shows that 72-85 per cent of MWRA, who were not using any contraceptives at the time of survey, intend to use contraception in future. The health and MCH-FP programmes should take the advantage of this favourable situation.

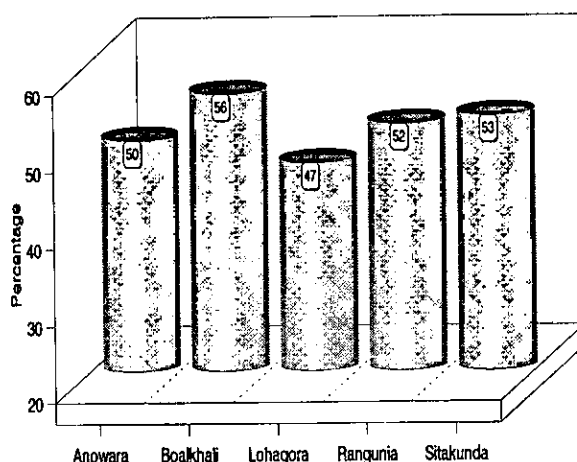


Fig. 3.3. Percent of MWRA who do not want any more children by *thana*

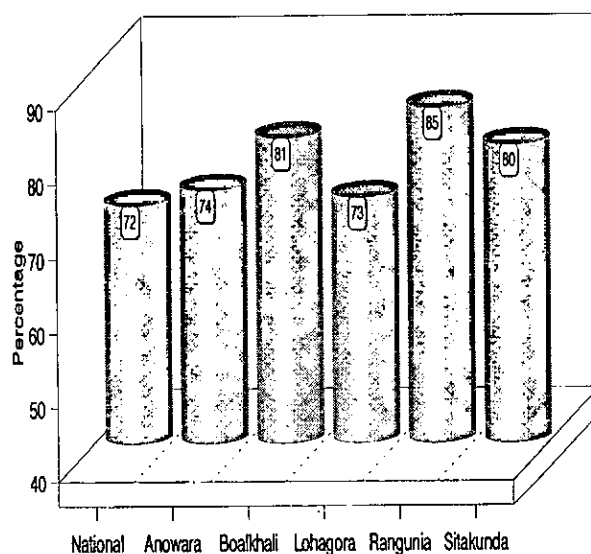


Fig.3.4. Percent of non-users who intend to use contraceptives in future by area

Figure 3.5 and 3.6 show CPR by area and by method respectively. CPR and the method-specific CPR at the national level and in Chittagong district during 1993-1994 are also compared with the figures of the five study *thanas*. The average CPR of 39 in the five *thanas* during 1995 is lower than

the national CPR of 43 during 1993-1994, but 10 percentage points higher than that of Chittagong division. The higher CPR in the study *thanas* indicate that either the contraceptive use has increased over the last one and a half to two years or that the very low CPR in Chittagong division is due to the much lower level of CPR in *thanas* of other districts, like Cox's Bazar district or Sylhet division.

CPR in Boalkhali and Sitakunda (47 and 40%) is higher than that in Anowara, Lohagora, and Rangunia (33, 35, and 36%) respectively. Higher CPR in the first two *thanas* than in the other *thanas* is probably explained by the socioeconomic and programmatic differences. The former *thanas* have higher urban influences, higher literacy, higher demand for contraception, and strong programme management than the latter *thanas*. It is encouraging that programme improvement can increase contraceptive use in those *thanas* where management is currently weak, but could be improved in future.

Figure 3.6 shows that the contraceptive method-mix was similar in the study *thanas*. It is also comparable to the national as well as the divisional method-mix. Pills are the dominant method, followed by tubectomy and traditional methods. Injectables and IUDs are also common.

Sources of contraceptives are shown in Fig. 3.7. The use of the private sector as a source of contraceptives is higher in the study *thanas* than that in the

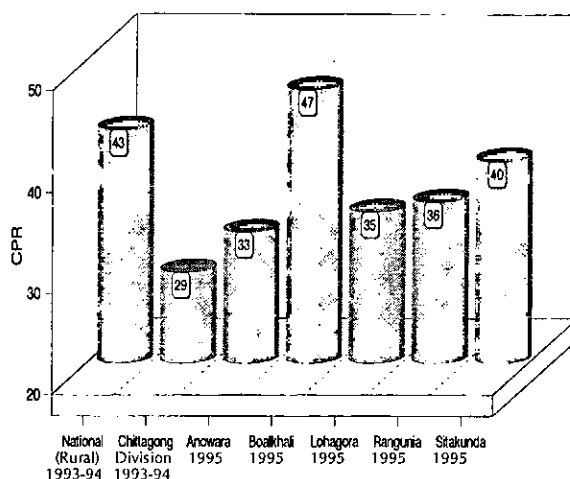


Fig.3.5. Contraceptive prevalence rate (CPR) by area

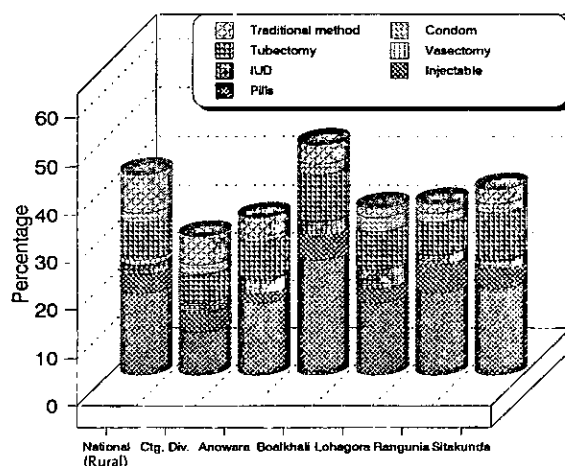


Fig.3.6. Method-specific CPR by area

country as a whole. Pharmacies, shops, and private medical sources account for 22 per cent of contraceptive sources compared to 17 per cent in the

Study *thanas*

Bangladesh

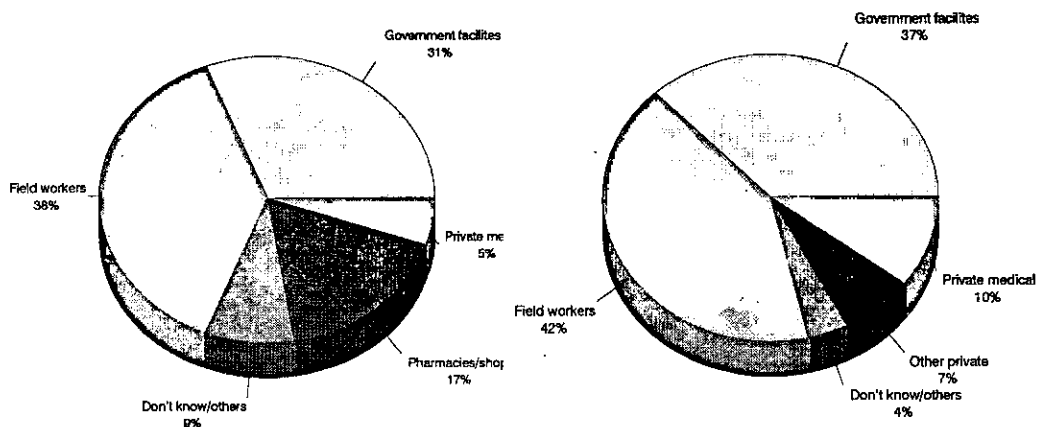


Fig. 3.7. Source of modern contraceptive methods in five *thanas* and Bangladesh

country as a whole. The 1993-1994 Bangladesh Demographic and Health Survey also found that the share of the private sector is higher in Chittagong division than that in other divisions (3), indicating the relatively greater importance of the private sector in Chittagong division. Figure 3.8 shows that the distribution of contraceptive sources is similar in the study *thanas*.

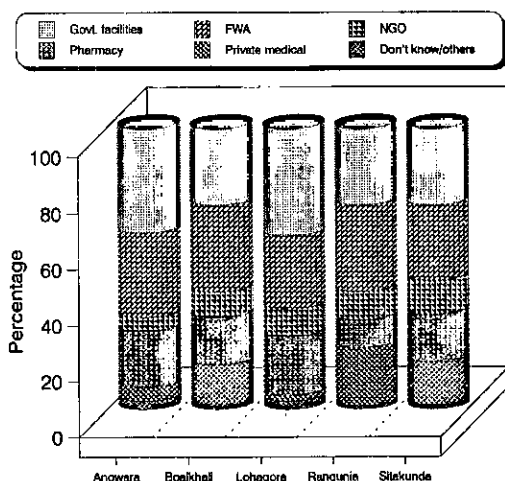


Fig.3.8 Sources of modern contraceptive by *thanas*

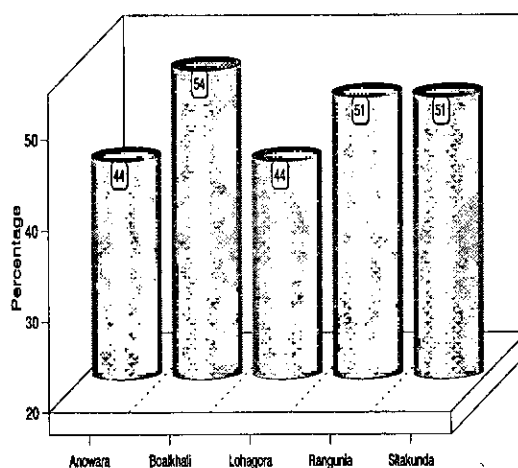


Fig. 3.9. Reported side-effects from FP method use by *thana*

experiencing side-effects when using the current method. However, a large proportion of reported side-effects may be perceived side-effects. Further detailed and in-depth studies on method-specific side-effects should be undertaken, since side-effects are important reasons for the discontinuation of clinical temporary methods of contraception. About half of the users in Bangladesh discontinue contraceptive use within 12 months, and one-fifth of them do so because of side-effects (3). Over 40 per cent of the pill users, over 60 per cent of IUD users, and about 60 per cent of the injectable users reported that they discontinued their method because of side-effects (3).

3.2. Performance of Health and MCH-FP Workers

3.2.1. Performance of Family Welfare Assistants

FWAs are the grassroots-level female family planning workers, who provide information, counselling and supply of MCH-FP services at the homes of the clients. These services are provided by a FWA during her bi-monthly household visits to around 700-800 MWRA and their children. On an average, 5-6 FWAs are supervised by a male Family Planning Inspector (FPI).

A sizeable proportion of FWA positions are vacant in the study *thanas* (Fig. 3.10). However, there are a number of local-level NGOs operating in the vacant FWA areas, using either the full-time or part-time female workers. NGOs receive supplies from the government *thana* MCH-FP managers. The Deputy Director of Family Planning (DD-FP) coordinates the MCH-FP activities of NGOs.

Each sample MWRA was asked if a MCH-FP field worker (an FWA or an NGO worker in areas where an FWA position is vacant) had contacted her to provide information and counselling on MCH-FP or to provide contraceptive supplies and MCH services. If the response was affirmative, the

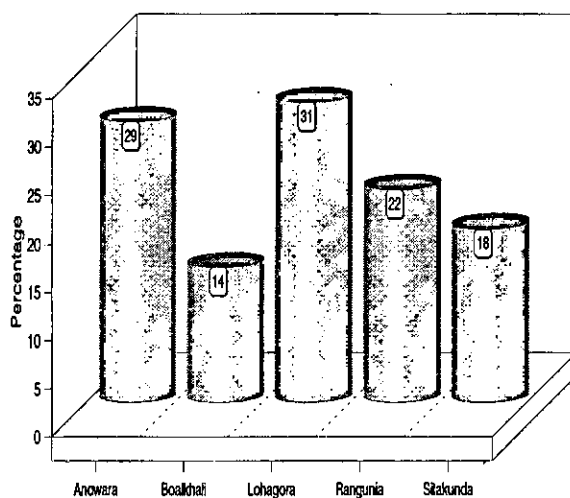


Fig.3.10. Percent of vacant FWA positions by *thana*

respondent was asked how many months ago was the last visit made by the worker. To assist the respondent in recognizing the MCH-FP field worker, the name and some other identification(s) of the worker were specified when the worker-related questions were asked. This helped avoid any confusion in identifying the field workers of various agencies working in a village.

Figure 3.11 shows the distribution of MWRA, according to the worker's last contact at home. The women who said that no worker contacted them were classified as "cannot remember when the last contact was made." Such a classification was made to take care of possible recall bias among the respondents about worker's contact. A woman might have forgotten, if she was contacted by a worker a long time ago. In such a case, the answer might have been in the negative. Less than 40 per cent of MWRA stated that they were contacted by workers at their homes in the last two months. About one-quarter reported that they were not contacted, or they could not remember when a worker last contacted them at their homes. This indicates considerable room for improvement in MWRA-worker contact.

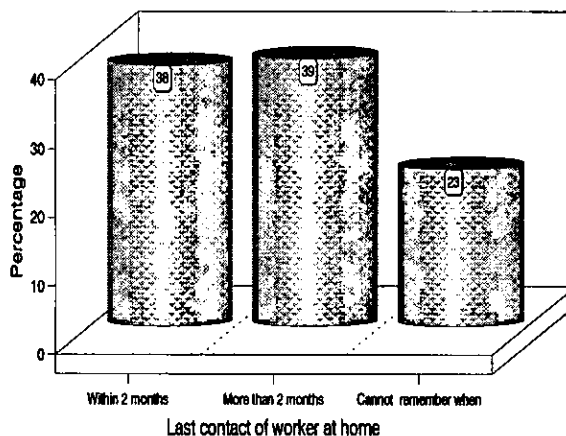


Fig.3.11. Percent of MWRA by worker's last contact in four thanas

It appears from the data that 23 per cent of MWRA did not have any access to information, counselling, or services provided by the MCH-FP field workers through their home contacts. This proportion is high indeed. There are several probable explanations for this high proportion, and part of it might have resulted from the strict definition of contact. A woman had to be personally approached by FWA or NGO worker providing information, counselling, or services to consider that she was contacted.

There are sociodemographic factors associated with the frequency of MCH-FP field worker's contact at homes (4,8-9). Married women aged less than 20 years, women without living children, and the newly weds are less likely to be contacted than others by the field workers. Data from the present study also show that the MCH-FP field worker's contact with the above categories of women was quite low. Our observations also suggest that

a significant proportion of MWRA receive supplies from their husbands who buy or obtain the required MCH-FP supplies and services either from Chittagong City or from the health and FP service units of the mills and factories where they work.

There may be some disadvantaged groups or communities of MWRA, like relatively poorer or uneducated MWRA, who are less likely to be covered by the workers. There may also be some localities which are less easily accessible by the workers. Poor contact of the workers with MWRA in such groups or localities might have pushed the overall client-worker contact to a low level.

Of the MWRA who were contacted by the FWAs, 27 and 45 per cent reported that they received contraceptive supplies and advice respectively (Fig. 3.12). About 11 and seven per cent reported that they received advice on maternal health and antenatal care (ANC) respectively.

There was a strong positive association between the frequency of worker's contact with MWRA and contraceptive use in the five study *thanas* (Fig. 3.13). Half of MWRA who stated that they were contacted by the field

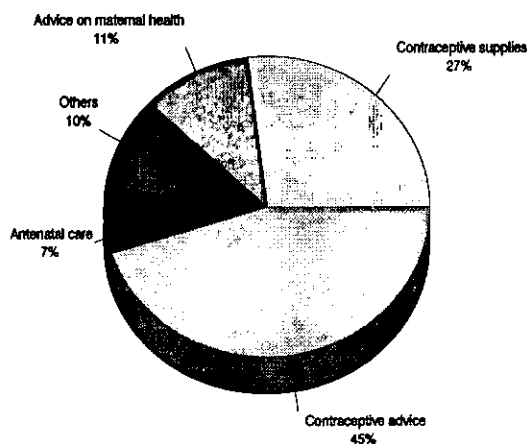


Fig.3.12. Types of services received from FWAs in five *thanas*

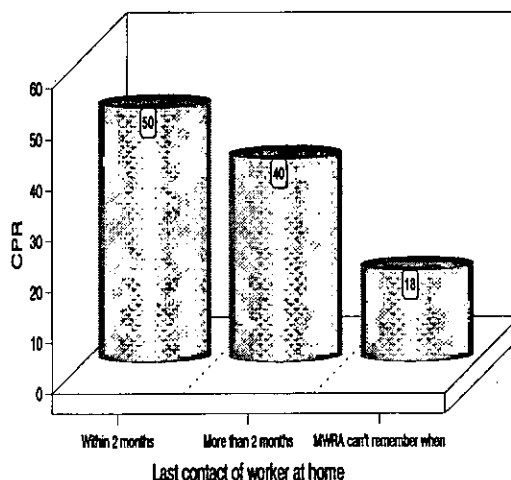


Fig.3.13. Contraceptive prevalence rate by worker's home contact

workers in last two months were using a contraceptive method at the time of the survey. Four of the 10 MWRA who stated that they were contacted by the field workers more than two months ago were using a contraceptive method. In contrast, only 18 per cent of MWRA who could not remember when they

were contacted by the field workers were using a contraceptive method. However, the strong positive association between the worker's contact and the contraceptive use suffers from a bias associated with the problem of reverse causality. The probability of workers' contacts at the homes of the contraceptive users is likely to be higher, because the workers would have contacted the users in the recent past to replenish the contraceptive supplies. In contrast, the frequency of contacts to the non-users would be low, since the workers did not have to contact them to supply methods.

Frequent worker's contact at MWRA's homes has a positive influence on the use of MCH-FP services at the fixed-site service centres. Rahman and Hasan (9) showed that the use of services at SCs or H&FWCs was higher among MWRA who were frequently contacted by FWAs than those who were less frequently contacted. Data from the present study and previous research of the MCH-FP Extension Project (Rural) indicate that an increase in the worker-client contact can increase the contraceptive use as well as use of the fixed-site service centres (10).

An over-simplified simulation of CPR on the basis of the observed association between the worker's contact with MWRA and the contraceptive use shows that CPR in the five study *thanas* could be raised to 50 per cent, if the worker contacts all MWRA once every two months (Fig. 3.14). The observed average CPR in the five *thanas* was 39 per cent. Despite the limitation of this simulation due to its bias mentioned above, it is encouraging for the programme managers to note that improvement in the field activities through regular contacts of the workers with their clients can increase CPR by over 25 per cent. No additional resources, such as refresher training of workers, enhanced IEC activities, improved contraceptive method-mix, and improved quality of services would be necessary for such an increase in CPR.

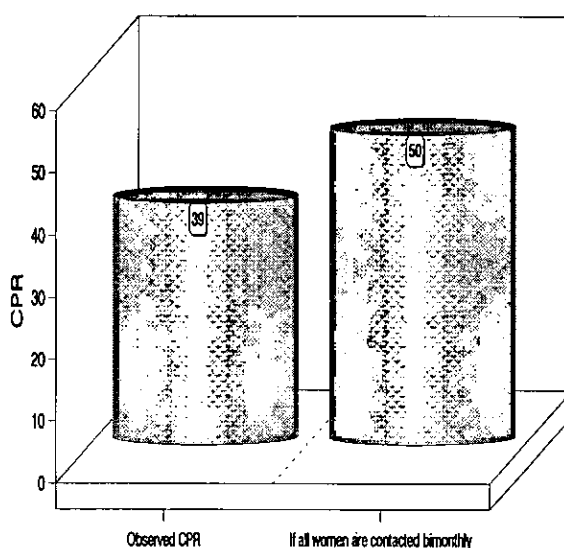


Fig.3.14. Contraceptive prevalence rate observed vs. projected for the five *thanas*

3.2.2. Performance of Health Assistants

A substantial proportion of the Health Assistant (HA) positions also remained vacant in the five *thanas*, ranging from 13 per cent in Boalkhali to 51 in Sitakunda (Fig. 3.15). The Civil Surgeon of Chittagong district has already undertaken necessary measures to recruit HAs in the vacant positions. Frequency of contact by HAs⁴ at MWRA's home in last two months in the five *thanas*, ranged from less than 25 per cent in Lohagora to 60 per cent in Anowara (Fig. 3.16). On an average, 23 per cent of the sample MWRA could not recall when they were last contacted by HAs. A large part of the inadequate HA coverage has probably resulted from the high HA vacancy rate.

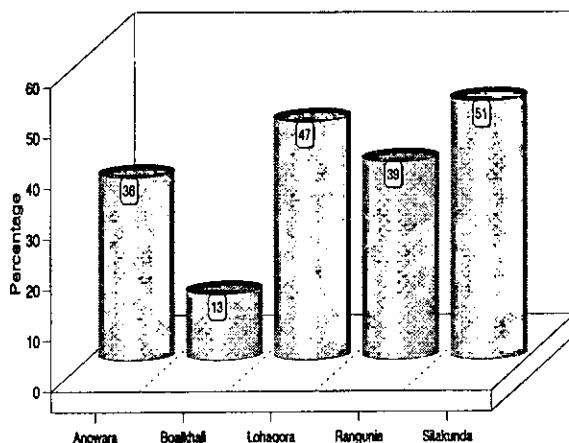


Fig.3.15. Percent of vacant Health Assistant (HA) positions by *thana*

It was also found that 23 per cent of MWRA in the five study *thanas* reported that either they were not visited by HAs or the respondents could not remember when HA last contacted them at their homes. This suggests that there might be a common group of clientele population who are less likely to be contacted by both the MCH-FP and health field workers. Our analysis also suggests that the majority of MWRA who were not contacted by FWAs were also not contacted by HAs.

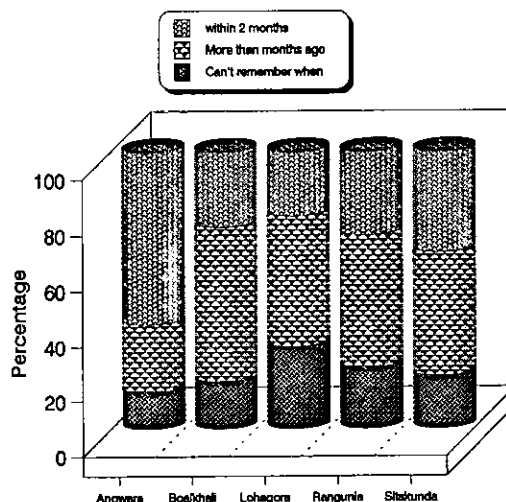


Fig.3.16. Percent of MWRA by HA's last home contact by *thanas*

⁴ A HA is supposed to contact at least one member of each household once in a month to provide health education and limited health care services on several specific diseases.

HAs organize 24 EPI sessions per union per month, covering, on an average, 6,000 MWRA and their children aged less than five years. Each session is served by an HA and an FWA who give vaccinations to MWRA and children aged less than under five years. Each MWRA was asked if she had ever been to an EPI spot. About three-quarters of MWRA reported that they had been to an EPI spot (Fig. 3.17), and this is quite a positive finding in the context of rural Chittagong district, where it is widely believed that women are reluctantly allowed to go outside the home to avail themselves of health and family planning or other services. The finding is reassuring, and indicates that the appropriately designed fixed site service centres can be effective in delivering the health and MCH-FP services in rural areas of Chittagong.

An acceptance of TT shots by MWRA was also remarkably high, as shown in Fig. 3.18. The TT shots are given at the EPI spots by HAs, and the high rate of acceptance of the TT shots corresponds with the high attendance by MWRA at the EPI spots.

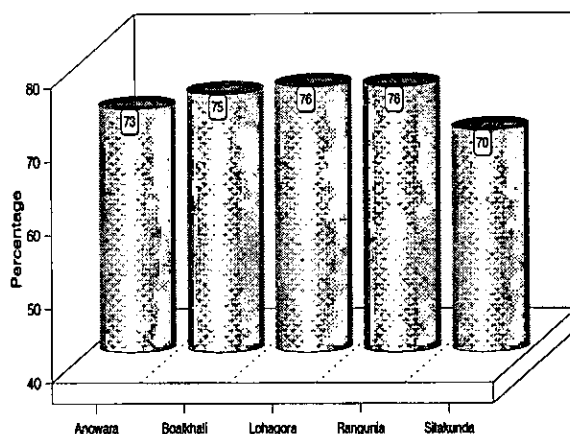


Fig. 3.17. Percent of MWRA who ever attended an EPI spot by thana

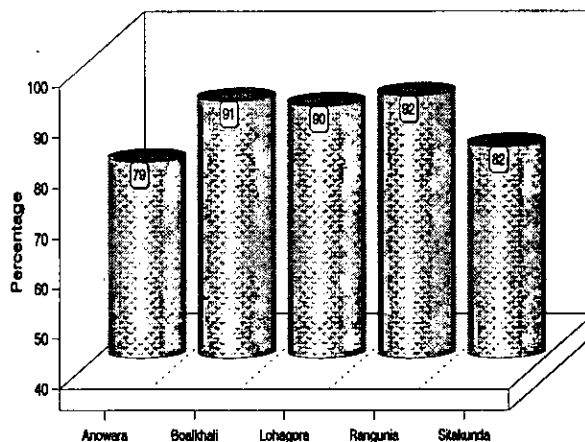


Fig. 3.18. Percent of MWRA who received TT by thana

3.3. Use of Fixed-site Health and MCH-FP Service Facilities

3.3.1. Use of Satellite Clinics

A female paramedic, known as Family Welfare Visitor (FWV), runs SCs every month in eight fixed places spread over a union covering approximately 6,000

MWRA and their children aged less than five years of age (11). She provides MCH-FP services, including injectables, contraceptives, IUDs, and management of contraceptive side-effects. The FWA of the SC catchment area remains present at SC to assist FWV. During her bimonthly home visitation, FWA informs MWRA about the day, time, and place of SC. Moreover, in the morning of the SC day, FWA also visits the surrounding houses of MWRA to invite them to come to SC.

Each sample woman was asked if she had visited a SC for any MCH-FP services or information. If the answer was affirmative, she was asked what type of services she received. For the convenience of recognizing SC or distinguishing it from the EPI spot, the respondent was told about the household where SC is held in

the area and was also told that a female paramedic or FWV provides MCH-FP services from SC. Figure 3.19 shows that the MWRA's attendance at SC was quite low, ranging from 4 per cent in Lohagora to 17 per cent at Boalkhali. Among the SC visitors, about half received the curative services, equally for themselves and for their children (Fig. 3.20). This indicates that there is a demand for the curative services from the MCH-FP service centres, like the SC.

According to the 1993-1994 Bangladesh Demographic and Health Survey (BDHS), 26 per cent of MWRA reported that they had visited a SC at some time (3). In Chittagong division 24 per cent of MWRA reported that they have ever visited a SC.

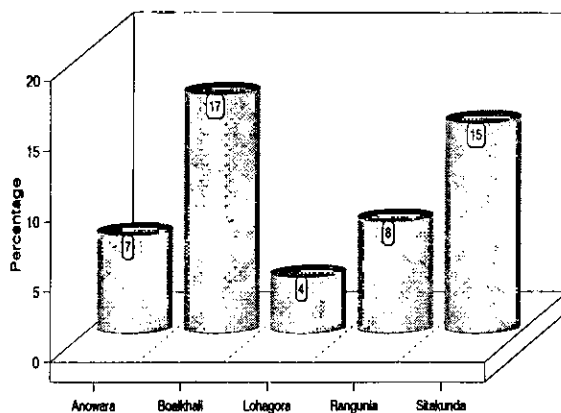


Fig. 3.19. Percent of MWRA who have ever visited a Satellite Clinic (SC) by thana

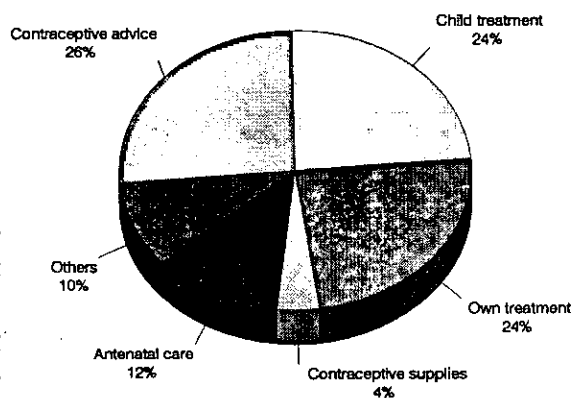


Fig. 3.20. Types of services received from SCs by thana

The large difference of the reported use of SC between the respondents of BDHS and our surveys is probably explained by the respondents' misclassification between SC and EPI sessions. In our survey, interviewers specifically mentioned about FWV who runs a SC, types of services offered at SC, and also the households where SCs are held. In our surveys, it is very unlikely that the respondents were confused to distinguish a SC from an EPI session. About 86 per cent of the BDHS respondents said that they received immunization from SC. The respondents of our surveys reported that each of about one-quarter received contraceptive advice, own treatment, and child treatment. About 12 per cent reported that they received antenatal care, 4 per cent reported that they received contraceptive supplies, and 10 per cent reported that they received other services (Fig. 3.20). The reported service-profile in BDHS reflects that the respondents probably were referring to the EPI sessions. In contrast, the service-profile given in Fig. 3.20 is consistent with the services offered at SC.

Each sample MWRA who said that she did not visit the SC was asked about the reasons(s) for her not visiting the SC. Over four-fifths of MWRA mentioned that they were not aware of a SC. They either did not know where it was held or what services were available at SC (Fig. 3.21). However, the proportion of MWRA who mentioned family objection to visiting SC was small, indicating the potential of greater use of SC provided adequate information is available with the clientele population.

The findings suggest that SCs are not held regularly or FWAs do not inform MWRA about the day, time, and place of SCs. Dissemination of information about SCs and holding of SCs are highly interrelated. If SCs are held regularly, FWAs would inform MWRA to attend. Regular holding of SCs and routine

dissemination of information about SC and their services will increase the use of SCs, resulting in an increased contraceptive, particularly the use of

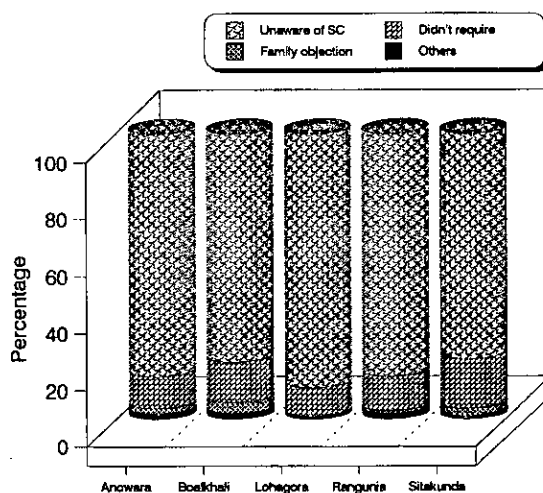


Fig.3.21. Reasons for not visiting SCs by thana

clinical contraceptives, management of contraceptive side-effects, as well as MCH services.

There was a positive association between the contraceptive use and the attendance at SC (Fig. 3.22). However, the association was not strong probably because of the low proportion of MWRA who ever attended SCs. Caution should be exercised in concluding that an increase in attendance at a SC will lead to an increase in contraceptive use, as the above findings are affected by reverse-causality in the sense that contraceptive use may lead to a need to seek services from FWVs for the management of contraceptive side-effects. Rather, it can be argued that MCH services of FWVs are required for the proper management of side-effects, provision of injectable services, and antenatal and postnatal care.

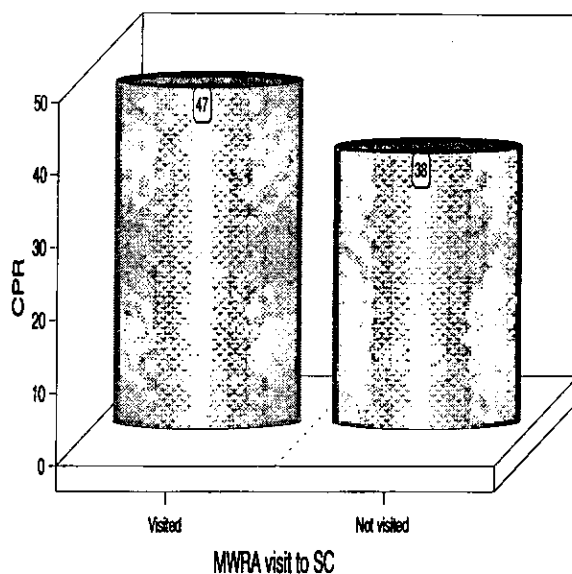


Fig. 3.22. Contraceptive prevalence rate by MWRA's visit to SC

3.3.2. Use of Health and Family Welfare Centres

Each union with an average population of 25,000, including about 6,000 MWRA and their children, has a H&FWC. Health and MCH-FP services are provided by an FWV and a male paramedic, known as Medical Assistant (MA). Each respondent was asked if she had ever visited a H&FWC for any health or family planning services or information. The location and types of services at a H&FWC were described when asking questions to ensure that the respondent properly understood the question.

Over 30 to 50 per cent of MWRA reported that they had visited a H&FWC for information, counselling, or services (Fig. 3.23). This proportion is much higher than attendance at SCs; however, there is room for improvement. The health and MCH-FP field workers, like HAs, FWAs, and NGO workers can inform villagers about the services available at a H&FWC. The field workers can also refer villagers to H&FWCs for various health care

and MCH-FP services. Improved field activities will increase the use of H&FWC.

Figure 3.24 shows that slightly less than half of the H&FWC visitors received curative services, suggesting that MWRA regard H&FWC as a health

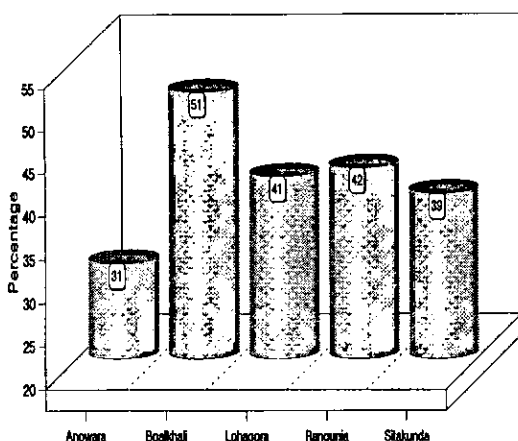


Fig. 3.23. Percent of MWRA who ever visited a H&FWC by thana

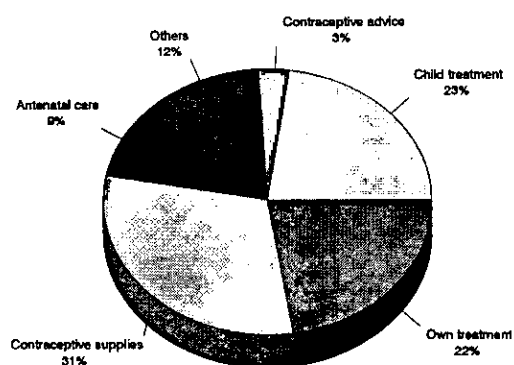


Fig. 3.24. Types of services received from H&FWC

centre where they can obtain general health-care services. More than one-third of the H&FWC visitors received family planning supplies and advice. One in 10 visitors received antenatal services in H&FWC.

A majority (50 to 55%) of the MWRA who reported that they did not visit a H&FWC mentioned that they did not require any services from there (Fig. 3.25). A small proportion of the non-visitors mentioned that they were not aware of services available at H&FWC or its location. Only 10 to 20 per cent of MWRA mentioned that they did not visit a H&FWC due to family objection. "Poor quality of services" at H&FWC was also mentioned as a reason for not

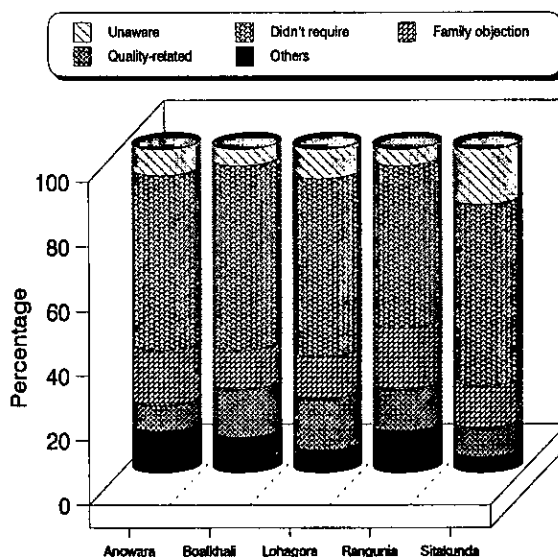


Fig. 3.25. Reasons for not visiting H&FWCs by thana

visiting: 8-15 per cent of MWRA mentioned that they did not visit a H&FWC because the quality of services was not satisfactory. The health, MCH-FP, and NGO field workers can educate and motivate MWRA about the availability of services at H&FWCs, thereby increasing the demand for use of services available at a H&FWC.

Contraceptive use was higher (52%) among MWRA who visited a H&FWC than those who did not (29%, Fig. 3.26). This strong association between the contraceptive use and the attendance of MWRA at a H&FWC probably indicates either or all of the following: First, attendance at H&FWC influences MWRA to adopt a contraceptive method. Second, the likelihood of visitation at H&FWC is higher among the contraceptive users than the non-users, because the former are likely to be innovators who also have a greater tendency to avail themselves of the services offered at H&FWC than others. Third, the contraceptive users are required to visit H&FWC either to obtain the methods or to obtain services related to contraceptive side-effects.

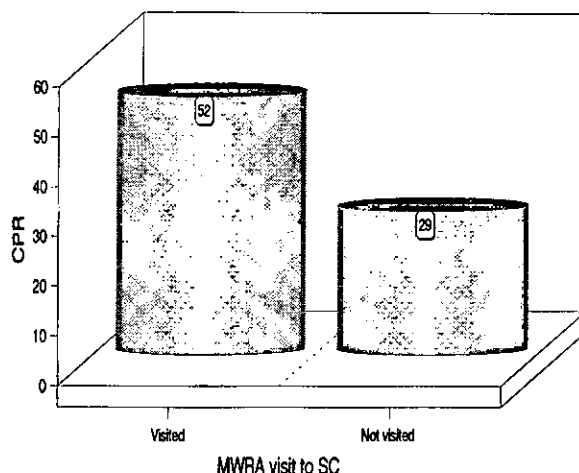


Fig. 3.26. Contraceptive prevalence rate by MWRA's visit to H&FWC

3.3.3. Use of *Thana* Health Centre

Over 40 per cent of MWRA reported having attended THC (Fig. 3.27). Figure 3.28 shows that THC plays a limited role in delivering the contraceptive services. Figure 3.29 shows that about half did not visit a THC, since they did not require services offered from that facility. One-quarter mentioned that they

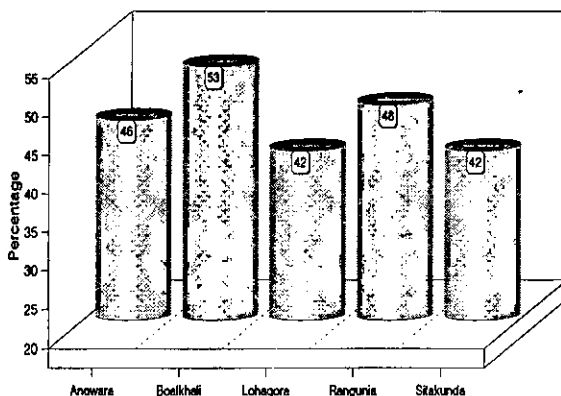


Fig. 3.27. Percent of MWRA who ever visited THC by thana

did not go to THC for services, because they thought that services offered there are of poor quality. However, family objection is not an important reason for not visiting a THC.

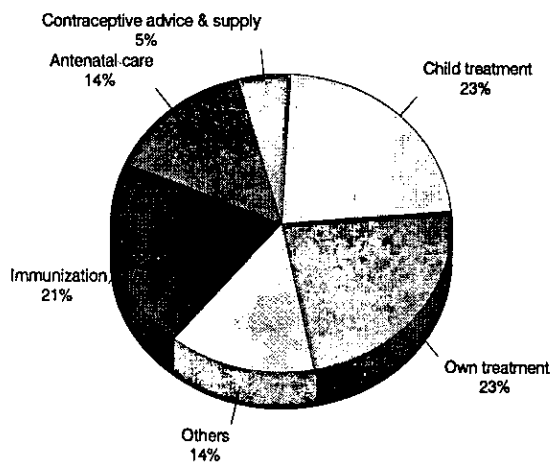


Fig. 3.28. Types of services received from THC

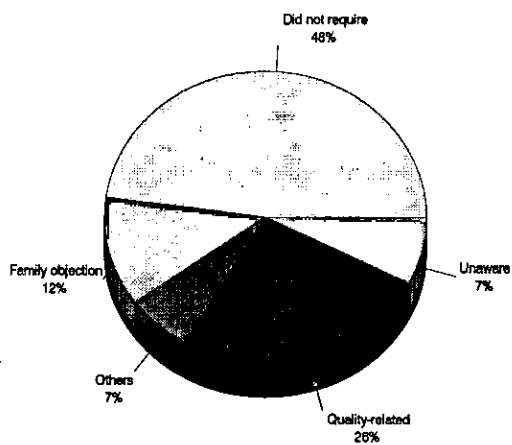


Fig. 3.29. Reasons for not visiting THC

CONCLUSIONS, RECOMMENDATIONS, AND PLAN OF ACTION

4.1. Conclusions

The findings of the needs assessment surveys conducted during July-December 1995 in five rural *thanas* (Anowara, Boalkhali, Lohagora, Rangunia, and Sitakunda) of Chittagong district show that the contraceptive use, and the use of SCs, H&FWCs, and THCs are relatively low. Contacts between clients and the health and MCH-FP field workers were poor indeed. However, there are also encouraging signs that the use of health and MCH-FP services can be improved, if the programme can be strengthened. The EPI performance was good and, thus, acceptance of immunization was quite high.

The relatively high-literacy rates in the five *thanas*, and which is representative of the district, are favourable to higher use of the health and MCH-FP services. Over half of MWRA reported that they did not want any additional children. Over three-quarters of the non-users of family planning intend to contracept in future. The low use of SCs and H&FWCs is related to the clients' limited awareness of the services available there, but not because of their unwillingness to use such services due to family objection or religious conservatism.

CPR varied between low (35%) and moderate (47%) in the five *thanas*. The low CPR seems to be associated with poor client-worker contact, irregular holding of SC, and poor use of the health and MCH-FP services available at SC and H&FWC. There was a high prevalence of reported contraceptive side-effects, resulting in high discontinuation of methods, and thus, low-contraceptive prevalence.

Less than 40 per cent of MWRA reported that they were contacted at their homes by FWAs or NGO field workers in last two months. About one-quarter of MWRA reported that they were not contacted, or that they could not remember when they were last contacted by FWAs or NGO field workers. Data show that CPR substantially increases with frequent contact of FWAs or NGO workers. A simulation exercise shows that a regular bimonthly client-worker contact could raise CPR to 50 per cent from its current level of 39 per cent. Strengthening of the field activities can increase client-worker contacts, leading to a rise in CPR. There was a high vacancy of both FWAs and HAs

in the five study *thanas*. The FWA vacant areas are covered by the NGO field workers, but there were no substitutes for the HA vacant areas. Contact between HAs and clients was also low: about 35 per cent of MWRA had been contacted at their homes by HAs in last two months, and 23 per cent of MWRA either had not been contacted or they could not remember when they had been contacted. The poor client-HA contact was largely due to the high HA vacancy. However, efforts are underway to recruit HAs in the vacant areas of the study *thanas*. Performance of EPI was quite good: 70-90 per cent of MWRA reported that they had attended the EPI spots or that they had received the TT shots, indicating that women would go outside their homes for the health and MCH-FP services, if such services were appropriately offered.

Attendance by MWRA at SCs was quite low: only 4-17 per cent of MWRA had ever attended a SC for health and MCH-FP information, counselling, or services. Among the SC visitors, half sought curative services for themselves or for their children, and the rest sought MCH-FP services. Provision of a need-based and well-designed curative service-delivery system can popularize SC and lead to its higher use, and thus, have a positive influence on reproductive and child health.

The most important reason for not attending a SC was the MWRA's unawareness of SC services or its location. Family objection against going outside the home to attend a SC was cited as a reason only by a small proportion of the respondents. Regular holding of SCs, dissemination of information about SCs by FWAs, HAs, and NGO workers, and regular contact of these field workers with clients will enhance the use of SCs, leading to a rise in the contraceptive use, as well as antenatal and postnatal care.

Attendance of MWRA at H&FWCs varied between 30 and 50 per cent. Similarly, 40-50 per cent of MWRA reported that they had been to THCs for health services. FWAs, HAs, and NGO workers, through regular contacts with clients, and FWVs at SC, can provide advice to MWRA to attend H&FWCs and THCs for the health and MCH-FP services, leading to higher use of H&FWCs and THCs.

4.2. Recommendations and Plan of Action

The findings suggest that further improvement in the use of health and MCH-FP services can be brought about by strengthening the field activities which would not require any additional recruitment, training, and supplies. After

thorough review of the findings presented at the workshop, the participants made two major recommendations:

- i) Improvement in client-worker contact; and
- ii) Increased use of fixed site service centres.

An improved client-worker contact, be it at the clients' homes, SCs, or H&FWCs, would increase contraceptive use and attendance at the fixed-site service centres.

The activities that were recommended for the improvement of client-worker contact are:

- i) Strengthening the supervision of the FWAs and NGO field workers by the FPI/AHI/NGO supervisors;
- ii) Ensuring the residency of HAs in work units or future recruitment of HAs should be from the work units;
- iii) Strengthening the supervision of the FPI/AHI/NGO supervisors by *thana* managers;
- iv) Introducing a performance review mechanism; and
- v) Rationalizing the job descriptions of the field workers.

The activities that were recommended for the increased use of the fixed-site service centres are:

- i) Combining eight SCs and EPI spots to provide health and MCH-FP services and strengthening the supervision of SCs;
- ii) Introducing 16 SCs in one union where there are two FWVs;
- iii) Improving the IEC activities on the services available at the fixed-site service centres;
- iv) Improving referral of clients having contraceptive side-effects; and
- v) Providing refresher training to paramedics.

A plan of action for the implementation of the above activities is described in Table 4.1 through Table 4.9.

Group 1: *Improve Client-Worker Contact*

Table 4.1. Proposed activities to strengthen supervision

Proposed activities	Officers responsible
Introduce FPI diary and AHI checklist	THFPO/TFPO
• FPI diary already exists • Develop AHI checklist • Print diaries and checklists	ICDDR,B colleagues -do-
Train FPIs and AHIs on the use of diaries and checklists	CS/DD-FP/THFPO/TFPO
• Prepare training module • Impart training to FPIs/AHIs	ICDDR,B Colleagues -do-

Table 4.2. Proposed activities to ensure residency of HAs in work units

Proposed activities	Officers responsible
CS issues a circular to THFPOs asking them to instruct HAs to reside in their respective work units or future recruitment of HAs should be from the work units	CS/THFPO

Table 4.3. Proposed activities to strengthen supervision of FPIs/AHIs by thana managers

Proposed activities	Officers responsible
Introduce supervision checklist for thana managers	
• Develop checklist • Hold orientation workshop for thana managers • Implement use of checklist	ICDDR,B colleagues CS/DD/THFPO/TFPO/MO-MCH THFPO/TFPO/MO-MCH

Table 4.4. Proposed activities on performance review

Proposed activities	Officers responsible
Union-level H&FWC meetings be attended by thana managers	
• Prepare a schedule of thana managers	THFPO/TFPO/MO-MCH
• Hold orientation workshop for thana managers	CS/DD/THFPO/TFPO/MO-MCH/ICDDR,B colleagues
• Implement performance review at H&FWCs	THFPO/TFPO/MO-MCH
Mid-level supervisory meetings at the thana on the first working day of the second week of every month	
• Prepare a yearly schedule	THFPO/TFPO/MO-MCH
• Arrange a place of meeting	THFPO/TFPO/MO-MCH
• Hold orientation workshop for thana managers	CS/DD/THFPO/TFPO/MO-MCH/ICDDR,B colleagues
• Implement performance review at the thana	THFPO/TFPO/MO-MCH

Table 4.5. Proposed activities to rationalize job descriptions of field workers

Proposed activities	Officers responsible
• Revise job descriptions of FWA/HA	THFPO/TFPO/CS/DD/ ICDDR,B colleagues
• Hold workshop to finalize job descriptions	CS/DD/ICDDR,B colleagues
• Get approval of the Directorates	CS/DD/ICDDR,B colleagues
• Implement modified job descriptions	THFPO/TFPO/MO-MCH

Group 2: *Improve Management of Service Centres*

Table 4.6. Proposed activities to increase the number of clients at the satellite clinics

Proposed activities	Officers responsible
• THFPO, TFPO, and MO-MCH instruct paramedics and workers to hold joint sessions of SC and EPI	THFPO/TFPO/MO-MCH
• Assist thana managers to ensure that combined SC and EPI sessions are in place	ICDDR,B colleagues
• Prepare a checklist for monitoring the combined activities	ICDDR,B colleagues
• Provide TA to monitor progress of eight combined SCs with EPI	ICDDR,B colleagues

Table 4.7. Proposed activities to increase 16 satellite clinics in one union where two FWVs are available

Proposed activities	Officers responsible
• Identify a union where there are two FWVs and select one for the intervention	DD-FP/ICDDR,B colleagues
• Allocate monetary resources for transport allowance and Aya's salary	ICDDR,B colleagues
• Prepare schedules of SCs so that these can be held jointly with EPI spots	TFPO/MO-MCH/THFPO
• Allocate required supplies for the SCs	TFPO/MO-MCH/DD-FP
• Implement holding of 16 SCs	MO-MCH/TFPO/THFPO
• Provide TA to monitor the progress of 16 SCs	ICDDR,B colleagues

Table 4.8. Proposed activities to improve IEC and to increase use of SC, H&FWC, and THC

Proposed activities	Officers responsible
• Arrange health education at the H&FWC by MA and FWV	TFPO/MO-MCH
• Ensure that FWAs, FPIs, HAs, and AHIs provide information about the services available at fixed sites	THFPO/TFPO/ MO-MCH
• Ensure that FWAs, FPIs, HAs and AHIs refer clients to paramedics at SC, or H&FWC, or THC	TFPO/MO-MCH/THFPO
• Post bill-board in front of the H&FWC	TFPO/MO-MCH

Table 4.9. Proposed activities to improve supervision and technical skills of paramedics

Proposed activities	Officers responsible
• Ensure that the senior FWV makes regular field visits to SCs and H&FWCs	MO-MCH
• Ensure that the MO-MCH supervises the activities of SCs and H&FWCs	MO-MCH/DD-FP
• Ensure that MO-MCH provides counselling and services to referred clients with contraceptive side-effects	MO-MCH/DD-FP
• Provide refresher training to paramedics	TFPO/MO-MCH/DD-FP

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**Agenda of the Fifth District Approach Dissemination Workshop
January 20-21, 1996**

Session I: Introduction to the Workshop

Chairman: Professor Barkat-e-Khuda, Project Director, MCH-FP Extension Project (Rural)

Topic	Presenter
Objectives of the workshop	Mr. Kabir Uddin Ahmed, DD (FP), Chittagong District Dr. Mizanur Rahman, ICDDR,B, Dhaka
Methodology of the needs assessment	Dr. Mamunur Rahman, MO (CC), Chittagong District Mr. Mian Bazle Hossain, ICDDR,B, Dhaka
Opening remarks	Dr. Jahir Uddin Ahmed, Director CC and MCH, Dhaka Mr. Absar Ali Mollah, Director (FP), Chittagong Division Dr. Osman Gani Chowdhury, Director (H), Chittagong Division
Chairman's remarks	Professor Barkat-e-Khuda

Session II: Field Work and Related Issues

Chairman: Mr. Absar Ali Mollah, Director (FP), Chittagong Division
Co-chairman: Dr. Jahir Uddin Ahmed, Director, CC and MCH, Dhaka

Topic	Presenter
Health and FP situation	Mr. Kabir Uddin Ahmed, DD (FP), Chittagong District Dr. Mizanur Rahman, ICDDR,B, Dhaka
FWAs' work and related issues	Dr. Monoj K. Ghoshwami, AD (CC), Chittagong District Mr. Mian Bazle Hossain, ICDDR,B, Dhaka
HAs' work and related issues	Dr. Mazharul Islam, DCS, Chittagong Mr. Mafizur Rahman, ICDDR,B, Dhaka
Open discussion	Participants
Chairman's remarks	Mr. Absar Ali Mollah, Director (FP), Chittagong Division

Session III: Use of Fixed-site Service Centres

Chairman: Dr. Osman Gani Chowdhury, Director (Health), Chittagong Division
Co-chairman: Dr. S.M. Humayun Faruque, DD (CDS), Dhaka

Topic	Presenter
Satellite Clinic (SC) and Health and Family Welfare Centre (H&FWC)	Dr. Mamunur Rahman, MO (CC), Chittagong District Mr. Yousuf Hasan, ICDDR,B
Expanded Programme on Immunization (EPI) and Thana Health Complex (THC)	Dr. Mazharul Islam, CS, Chittagong District Mr. Mafizur Rahman, ICDDR,B, Dhaka
Open discussion	Participants
Chairman's remarks	Dr. Osman Gani Chowdhury, Director (H), Chittagong Division

Session IV: Review of Findings

Topic	Presenter
Group I: Improve Client-Worker Contact	
Group Leader	Mr. Kabir Uddin Ahmed, DD (FP), Chittagong District
Facilitators	Mr. Mafizur Rahman, ICDDR,B, Dhaka Mr. Abdul Wazed, ICDDR,B, Chittagong Dr. Mizanur Rahman, ICDDR,B, Dhaka
Group B: Improve Management of Fixed-site Services Centres	
Group Leader	Dr. Mazharul Islam, DCS, Chittagong
Facilitators	Mr. Yousuf Hasan, ICDDR,B, Dhaka Dr. Dipak Mitra, ICDDR,B, Mirsarai Dr. Shameem Ahmed, ICDDR,B, Dhaka

Day 2: January 21, 1996

Session V: Review of Findings

Chairman: Mr. Khairuzzaman Chowdhury, Director General (FP)

Topic	Presenter
Group reports	Mr. Kabir Uddin Ahmed, DD (FP), Chittagong District
	Dr. Mazharul Islam, DCS, Chittagong District
Open discussion	Participants
Remarks	Mr. S. Ali Noor, REM (OPH), USAID
	Mr. Absar Ali Mollah, Director (FP), Chittagong Division
	Dr. Osman Gani Chowdhury, Director (Health), Chittagong Division
	Professor Barkat-e-Khuda, Director, MCH-FP Extension Project (Rural)
Chairman's remarks	Mr. Khairuzzaman Chowdhury

**List of Participants at the Fifth District Approach Workshop
January 20-21, 1996**

Sl. No.	Name of the participant	Designation	Place of posting
1.	Mr. Khairuzzaman Chowdhury	DG (FP)	Dhaka
2.	Dr. Osman Gani Chowdhury	Director (Health)	Chittagong
3.	Mr. M. Absar Ali Mollah	Director (FP)	Chittagong
4.	Dr. Jahir Uddin Ahmed	Director (MCH)	Dhaka
5.	Dr. ASM Humayun Faruque	DD (CDS)	Dhaka
6.	Mr. Kabir Uddin Ahmed	DD (FP)	Chittagong
7.	Dr. Mazharul Islam	DCS	Chittagong
8.	Dr. Monoj Kumar Goswami	AD (CC)	Chittagong
9.	Dr. Mamunur Rahman	MO (CC)	Chittagong
10.	Mr. Lutfar Rahman	AD (Coord)	Chittagong
11.	Dr. Kazi Shafiqul Alam	THFPO	Boalkhali
12.	Mr. A. Azad Siddiqui	TFPO	Boalkhali
13.	Dr. Sambhu Kumar Mallick	MO (MCH-FP)	Boalkhali
14.	Mr. Saif Uddin Ahmed	ATFPO	Boalkhali
15.	Ms. Bani Das Gupta	Sr. FWV	Boalkhali
16.	Dr. Md. Feroz Khan	THFPO (in-charge)	Anowara
17.	Mr. M.M. Ershad	TFPO	Anowara
18.	Dr. Morshedul Karim Chowdhury	MO (MCH-FP)	Anowara
19.	Mr. Dilip Kanti Moharer	ATFPO	Anowara
20.	Ms. Arati Das	Sr. FWV	Anowara
21.	Dr. Md. Shah Nawaz	THFPO	Sitakunda
22.	Mr. Ajoy Ratan Barua	TFPO	Sitakunda
23.	Dr. ASM Abdul Momen	MO (MCH-FP)	Sitakunda

Sl. No.	Name of the participant	Designation	Place of posting
24.	Mr. Md. Fazlur Raheem	ATFPO	Sitakunda
25.	Ms. Joynab Akhtar Alam	Sr. FWV	Sitakunda
26.	Dr. Nirmal Kanti Barua	THFPO (in-charge)	Rangunia
27.	Mr. Md. Alauddin Al Azad	TFPO	Rangunia
28.	Dr. Md. Yunus Haroon Chowdhury	MO (MCH)	Rangunia
29.	Dr. S.M. Ibrahim	THFPO	Lohagora
30.	Mr. Samiran Chakma	TFPO	Lohagora
31.	Mr. Ahmed Kabir	ATFPO	Lohagora
32.	Ms. Chhaya Biswas	Sr. FWV	Lohagora
33.	Mr. S.M. Khairul Amin	TFPO	Mirsarai
34.	Dr. Md. Nurul Islam	MO	Mirsarai
35.	Mr. Syedul Hoque	ATFPO	Mirsarai
36.	Ms. Bul Bul-e-Ferdous	Sr. FWV	Mirsarai
37.	Ms. Selina Begum	Sr. FWV	Double Mouring
38.	Sk. Ali Noor	Chief REM, OPH	USAID, Dhaka
39.	Dr. Capt. (Rtd.) Mahboob	N. M. Consultant	FPSTC,
40.	Ms. Sabita Mondol	N. N. Consultant	FPSTC,
41.	Prof. Barkat-e-Khuda	Project Director	ICDDR,B
42.	Dr. Shameem Ahmed	Health Scientist	ICDDR,B
43.	Dr. Mizanur Rahman	Demographer/Scientist	ICDDR,B
44.	Mr. Yousuf Hasan	SOR	ICDDR,B
45.	Mr. Mafizur Rahman	SOR	ICDDR,B
46.	Mr. Mian Bazle Hossain	SRS Manager	ICDDR,B
47.	Mr. Abdul Wazed	FRM	ICDDR,B
48.	Dr. Dipak Mitra	MO	ICDDR,B
49.	Mr. Ahsan Kabir	SFRO	ICDDR,B
50.	Mr. Syed Shahidul Hoque	FRO	ICDDR,B