

The Delivery of Maternal and Child Health and Family Planning Services Through Cluster Visitation

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Background

For over a decade, the delivery of selected maternal and child health and family planning (MCH-FP) services to the homes of rural mothers by 23,500 Family Welfare Assistants (FWAs) and about 10,000 NGO field workers has been an important element of the Bangladesh MCH-FP programme. The Bangladesh Demographic and Health Surveys (BDHS 1996-1997) reported a national contraceptive prevalence rate (CPR) of 49 per cent [1]. This is largely due to the efforts of these field workers achievement (Phillips *et al.*, 1996) [2]. It is projected that by 2004, an additional 9,000 FWAs and 2,000 Family Planning Inspectors (FPIs) will be needed to meet the demand of the 31 million married women of reproductive age (MWRA) under the current programme structure (Janowitz, *et al.*, 1996)[3].

Holtman *et al.*, (1996) estimated that in meeting acceptable CPR projection, the programme will need an additional amount of \$42 million in 2001-2002 [4]. Sixty-three per cent of the funding for the Bangladesh family planning programme are contributed by donors. The costs of doorstep delivery will increase substantially if the current service-delivery model is maintained over the next 10 years (Rahman *et al.*, 1996a, 1996b; Janowitz *et al.*, 1996a, 1996b). Thus, concern has been expressed as to the cost-effectiveness of such a labour-intensive and "spoon-fed" approach to FP service delivery. Moreover, debate is going on as to whether the current service-delivery strategy will be able to meet the new requirements.

It is reported in the BDHS that 62 per cent of the eligible women in rural areas had not been visited by an FWA during the previous six months. In some areas, FWA posts are still vacant; and in others, households are hard to reach due to geographical barriers, like waterbodies, terrain, etc. It is widely believed that, in these areas, household visitation rarely occurs. An additional Family Welfare Visitor (FWV) at each union would allow for more Satellite Clinics, and thus, greater coverage from the fixed sites. This approach is being tested in selected areas of the country.

Two unions each from the high-performing and low-performing areas were selected. The Management Information System (MIS) data of the DFP from July 1994 was used for selecting Mohakhal and Paira unions, each with CARs over 60 per cent (from Abhoynagar subdistrict of Jessore district; a high-performing area) and Ichakhali and Karerhat unions with CARs of less than 60 per cent (from Mirsarai subdistrict of Chittagong district; a low-performing area) to field-test this new mode of service delivery. Both the unions have hard-to-reach areas, such as charland² and irregular terrain. This arrangement provided an opportunity to test whether coverage and performance could be increased and sustained in the high- and low-performing areas.

Objectives and Methodology

The main objective of the evaluation was to examine whether shifting from doorstep to fixed-site service delivery in the intervention unions has resulted in any decline in the overall CPR. The specific aims were to assess:

- a. differentials in the CS use among various socioeconomic groups
- b. awareness among the MWRA about the CS and knowledge of services offered there
- c. changes in source of contraceptive supplies
- d. changes in the CPR.

Prior to implementation, the intervention strategy was subject to final modification and approval by the Directorate of Family Planning (DFP). Some of the planned activities were finally eliminated. The evaluation

²Area which has, over time, changed from unusable flood plain to habitable land through continuous siltation.

objectives had to be modified, so that they could include only the activities that were actually carried out. Outcome indicators included changes in awareness and knowledge of the CS; attendance at the CS; difference between CAR reported by the FWA, and CPR reported in the survey; source of contraceptive supply; method-mix; and CPR. The indicators have been compared between the intervention and the non-intervention unions wherever possible.

For the purpose of the evaluation, various data sources were used, such as

- service statistics reported by the FWAs
- unscheduled observations at the CSs conducted by the members of the project staff
- cross-sectional post-intervention survey of 2,304 MWRA from all four intervention unions, carried out from December 1996 to January 1997
- longitudinal data from the Projects surveillance systems, known as Sample Registration System (SRS), were used. Of the 2,304 MWRA in the survey, longitudinal data about contact with an FWA and contraceptive use were available, since November 1984, for 480 women at Paira union; and since August 1995 for 605 women at Durgapur union. These women were selected through systematic random sampling (Mozumder *et al.*, 1990)[5]. After the intervention was introduced in these two unions, visits to the CS, the types of services obtained at the CSs, and the reasons for not visiting the CS were monitored on a bi-monthly basis through SRS.

All units with FWAs in the selected unions were used for this intervention. For simplicity of operation and effective measurement of the impact of the intervention, the vacant units were excluded. However, the Karerhat union had to be excluded in July 1995 as its geographical inaccessibility made the holding of CSs infeasible. It was subsequently replaced by Durgapur union.

Two of the intervention unions -- Mohakal and Durgapur -- are located on a major highway. There are eight unions in Abhoynagar and 16 unions in Mirsarai. Mohakal is in the industrial belt. Paira union in Abhoynagar, although somewhat remote, has access to an extensive irrigation network and is near the main road between Jessore and Khulna. Because of access to the irrigation network, the farmers in Paira can grow more than two crops, and, thus, have a socioeconomic advantage. The project has been testing various interventions at Paira union of Abhoynagar since the mid-1980s, and is one of the country's high-performing areas. Except for Durgapur, all four unions have Hindu populations larger than the nation's average (ranging from 25 to 35%). At Paira union, the Health and Family Welfare Centre (H&FWC) is the only available government health facility, and the Thana Health Complex (THC) is six km away. The Ichakhali union is also rather remote. Unlike Paira, however, a large portion of it is *charland*, and remains inaccessible much of the year. At Ichakhali, the H&FWC is the nearest government health facility, and the THC is more than 10 km away from the union.

The following working definition was used for the cluster visitation approach: **the delivery of MCH-FP services by an FWA from a pre-determined household to a defined group of current and potential contraceptive users in the same vicinity.**

Prior to the onset of the intervention, a series of activities were undertaken. These included mapping the proposed unions; determining the criteria for the selection of CSs; identifying potential CS sites; briefing the concerned officials/personnel/community leaders about the cluster visitation approach; preparing guidelines for the FWAs about serving in the CSs, preparing guidelines regarding the role of FPIs in IEC activities, as well as record-keeping and reporting.

The map contained the following information for each of the selected unions: (a) current residence of FWAs and FPIs; (b) existing boundary of FWA unit; (c) location of H&FWC/SC sites/EPI spots; (d) location of combined Satellite Clinic + EPI sites; (e) location of union parishad office; (f) geographical barriers (canals/swamps/hills); and (g) important landmarks (schools/mosques/madrassas/temples). The map was then used for

establishing the CSs. Over 800 *baris*³ per union were identified as the potential CS site. The number of CSs was established, based on the number of FWAs available in the union. The following criteria were used for selecting the CSs: (a) easy accessibility from other households; (b) positive social standing in the neighbourhood; (c) moderate-to-large size (5-10 *baris*); (d) availability of space to serve 20-50 eligible women; and (e) having a highly-motivated user of any family planning method preferred.

The number of CSs and MWRA per CS varied due to the clustering of MWRA, as well as geographical and other barriers. Since Satellite Clinic and EPI spots are already known to most beneficiaries, the remaining CSs were selected in consultation with FPIs and FWAs. The FWA Register data and all other available relevant information were used extensively for preparing a list of all CSs. A cluster-wise couple-listing format (Appendix 1) was used for recording the locations of all CSs. Then, a physical verification of the list was done by the subdistrict officials to validate the selection made by the field workers and their supervisors.

After finalizing the CS, a field guide was provided to the FWAs and FPIs. The guidelines included the following: (a) principles to be followed while selecting a CS; (b) physical verification process; (c) cluster visitation cycle; (d) preparation of advance tour programme; (e) messages to be communicated to eligible women; (f) issue of women coming and those not coming to the CS; (g) the number of cycles or units of contraceptives to be distributed in the CS; and (h) record-keeping of absentees and users from other sources, clinical method users, births and deaths, and reporting of worker performance. The field guide is available in a separate volume.

A briefing for the divisional, district and subdistrict officials about the intervention was conducted by the intervention lead person. The briefing session included orientation about the concept of cluster visitation, implementation strategy, role of concerned officials and field personnel, as well as the type of technical assistance provided by the MCH-FP Extension Project (Rural) for this intervention.

³ Cluster of 4-5 households.

A one-day workshop for the FWAs, FPIs, FWVs and MAs was organized at the subdistrict level to: (a) discuss the implementation strategy of this new approach; (b) re-distribute the MWRA among the FWAs (entering the names of MWRA in the FWA Register, if necessary); (c) prepare the list of CSs following the guidelines; and (d) designate each cluster for an average of 25 MWRA. The district and thana officials played an important role in briefing the concerned field personnel of the selected unions.

Initially, all FWAs of the selected unions were retrained to provide MCH-FP services to an average of 25 MWRA from each of the CSs on a bi-monthly basis. The total number of the CSs per union ranged from 80 to 220, and the average MWRA load per cluster ranged from 20 to 26. The availability of a large number of CS in a union provided more options for the MWRA to avail of the MCH-FP services on their own. Prior to the new work routine, the FWAs used their usual bi-monthly household visitation rounds to inform all MWRA about their new work routine and mode of service delivery. The FWAs had to adjust to the visitation cycle of each CS when preparing their advance tour programme. The Satellite Clinic timing of the DFP was followed, so that the FWAs would be able to offer the required services at the CS.

According to the design of the intervention, the FWAs were first required to make home visits to inform the MWRA about the CS sessions for the resupply of contraceptives and other services. Therefore, the FWAs were the primary source of information about services available in the CS for the MWRA. The FWAs were required to visit the areas around the CSs for an hour every day to: a) encourage the current users to visit the CSs, b) visit the newly wed women, c) motivate MWRA to visit the next CS, d) update the FWA Register for the women using contraceptives from other sources, and e) to record any births and deaths. Then the FWA would come back to the scheduled CS to serve the women for two hours on the same day.

After serving at the scheduled CS, she would visit the women who had not come to the CS. During this visit, she was allowed to distribute contraceptives. The FPIs were motivated to support each FWA for at least three days a month to check the FWA Register and to assist the FWAs in identifying those women who had not attended the CS. This strategy was

continued until December 1995. Since the FWAs had to visit the women who had not come to the CS, the FWAs considered this an additional responsibility.

The bi-monthly round was changed to a monthly round by the DFP in March 1996. Therefore, the CSs already established were needed to be readjusted. With the introduction of a monthly round, the load of MWRA per cluster had to be changed from 25 to 50, and the number of CSs ranged from 64 to 112 per union. Other than the combined spots, the FWAs are the main provider of pills, condoms and injectables on a monthly basis. Each FWA had an average of 16 CSs, with 43 MWRA per CS. The FWAs provided counselling on family planning, contraceptive methods, child immunization, antenatal and postnatal care and supplied pills, condoms, and injectables. With the introduction of the monthly round in March 1996, the FWAs were required to update the FWA Register, while visiting each home to invite the women to come for services at the CS. The invitation is still continuing, and the FWAs also considered this an additional responsibility. If a client requested a method, such as IUD or sterilization, the FWA was required to accompany the client to the H&FWC or the THC after completion of the activities at the CS. The intervention made use of the national programme's record-keeping and reporting system; no changes or adjustments were required.

The Karerhat union was replaced in July 1995, because some of the sanctioned FWA positions were unfilled and geographical inaccessibility posed a series of obstacles, such as high-travel cost for the field workers, supervisors and managers, distance from main highway, etc. But an even more serious problem came from the workers themselves. The field workers, supervisors and their managers were all somewhat suspicious about the objectives and possible implications of the intervention. The field workers believed that the success of this intervention would result in the retrenchment of many FWAs and the ability of the government to provide services with reduced number of FWAs. This has hindered the intervention's implementation. The supervisors were concerned that they would also lose certain authority. Moreover, the FWA practice of delivering the services at each household may have resulted (at least among some FWAs) in selective

doorstep distribution. It took two months to complete a routine update of MWRA in the FWA Register. One FWA was transferred to another union. The political unrest during 1995 and early 1996, and natural calamities, such as cyclones, floods, and water-logging in some parts of the FWAs' units at Abhoynagar, all caused disruption in the intervention.

Findings

Both education and land ownership have been used as important socioeconomic indicators in sociodemographic studies of Bangladesh. Data on selected socioeconomic and demographic characteristics of MWRA and their spouses in the four intervention unions have been collected to examine differential patterns in the use of the CS among the various groups.

The literacy level, landholding status and spouse's occupation in all the intervention unions have been shown in Table 1. Education, above the primary level, ranged from 16 to 25 per cent in all unions with Durgapur having the highest proportion. The proportion of women with no schooling was nine percentage points higher at Ichakhali than it was at the other three unions. This pattern was also found among their husbands. Forty-seven per cent of the households in Durgapur had more than three acres of land. In Ichakhali, this figure was 38 per cent. The percentage of landlessness was lower in these unions than that in Paira and Mohakal.

Although household work is the most common occupation among rural women, between four and 13 per cent of the women have income-earning work. The main occupations of their spouses, however, are farming, small business, service and day labour. The proportion of farmers is much higher in Paira than that in the other three unions, while the proportion of service-holders is much higher in Ichakhali than that in the other three unions.

Table 1: Per cent distribution of socioeconomic characteristics of MWRA's and their spouses in the four intervention unions: 1997

Variables	Per cent distribution			
	Mohakal (n = 699)	Paira (n = 480)	Durgapur (n = 605)	Ichakahli (n = 520)
Education (in years)				
None	49	49	49	58
1-5	32	33	27	26
6 +	19	19	25	16
Landholding (in decimals)				
Landless	56	72	45	45
100-299	10	8	8	17
300 +	34	20	47	38
Spouses occupation				
Day labour	16	18	7	6
Farmer	44	58	36	43
Business	5	4	13	5
Small business	17	9	5	8
Service	10	5	10	31
Others/unemployed	8	6	29	7

Source: December 1996-January 1997 Survey.

Selected demographic characteristics, such as age, parity and contraceptive use, have been shown in Table 2. The majority of the women were aged between 20 and 39 years. Compared to the two unions of Abhoynagar subdistrict, the percentage of women with a parity of three or more was much higher in the two unions of Mirsarai. The CPR ranged from 33 per cent at Ichakhali to 60 per cent at Paira union.

Table 2: Per cent distribution of sociodemographic characteristics of MWRA in the four intervention unions: 1997

Variables	Per cent distribution			
	Mohakal (n = 699)	Paira (n = 480)	Durgapur (n = 605)	Ichakhali (n = 520)
Age (in years)				
< 20	13	10	7	7
20-29	41	39	40	36
30-39	30	31	36	32
40 +	16	20	17	25
Parity				
0	10	11	10	7
1	21	22	18	14
2	27	31	21	16
3 +	42	36	51	63
Currently using contraception				
Yes	54	60	45	33
No	46	40	55	67

The CPR in the Mirsarai intervention union before the intervention in late 1994 was 29 per cent, whereas by February 1997, the end of the intervention, the CPR had reached 40 per cent.

Awareness of CS has become universal for all the intervention unions, except at Ichakhali where it was 50 per cent. It should be noted that this union is far from Mirsarai THC and, for much of the rainy season, is inaccessible. Not surprisingly, the FWAs often remained under-supervised which could result in irregular field visits.

Ever-visit to the CS has increased more than doubled at Abhoynagar (from 20% to 61%) and two-fold (from 19% to 36%) at Mirsarai (Figure 1).

Education and landholding were the two indicators used for analyzing the relationship between socioeconomic characteristics and visitation. MWRA with little or no education made more visits to the CS (Table 3). This was found to be statistically significant at Abhoynagar.

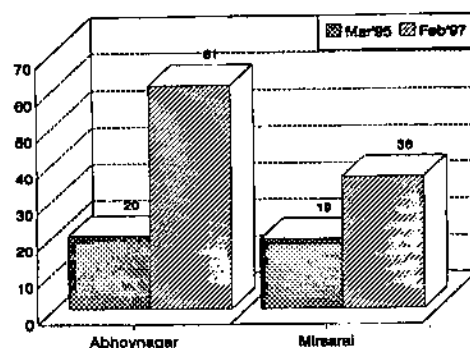


Fig.1. Ever-visit to cluster spots in the intervention areas

Table 3: Ever Visit of MWRA to CS according to Education

Education (in year)	Abhoynagar		Mirsarai	
	% Ever-visited	Number	% Ever-visited	Number
None	50.0	573	26.0	596
1-5	53.0	381	33.0	300
6 +	32.0	225	27.0	229
Total:	47.2	1179	19.4	1125
Statistics	$\chi^2 = 27.7$; p value = 0.0000		$\chi^2 = 5.0$; p value = 0.0830	

Source: — SRS and survey 1986

Similarly, those with little or no landholdings were more likely to have visited the CS at both areas. However, the relationship was significant in Abhoynagar.

Table 4: Ever-visit of MWRA to CS according to landholding

Landholding (in acre)	Abhoynagar		Mirsarai	
	% Ever-visited	Number	% Ever -visited	Number
Landless	42.0	566	32.0	648
100 - 299	48.0	385	25.0	271
300 +	34.0	228	28.0	206
Total:	47.2	1179	19.4	1125
Statistics	$\chi^2 = 7.8$; $p \text{ value} = 0.0203$		$\chi^2 = 4.5$; $p\text{-value} = 0.1076$	

Ever-visit to the CS was also examined by age group (Table 5). Visitation was quite low among the women aged less than 20 years particularly in Mirsarai and largely concentrated among the prime age (20-39 years) group. This was statistically significant in both areas. This also reflects the low use of contraception by the newly married women. A major concern is how to attract young women.

Table 5: Ever-visit of MWRA to CS according to age-group

Age group	Abhoynagar		Mirsarai	
	% Ever-visited	Number	% Ever-visited	Number
< 20	38.0	141	5.0	82
20-29	53.0	474	31.0	425
30-39	54.0	356	36.0	385
40 +	34.0	208	15.0	233
Total:	47.2	1179	19.4	1125
Statistics	$X^2 = 31.0$; $p\text{-value} = 0.0000$		$X^2 = 56.2$; $p\text{ value} = 0.0000$	

The increase in awareness of the CS during the two-years intervention period was promising. Visits to the CS have been monitored longitudinally for 480 MWRA of Paira and 605 MWRA in Durgapur on a twice-monthly cycle since the beginning of the intervention. During each visit, the project interviewers asked whether the MWRA had visited the CS in last two months and what type of services she received. This visit

figure went from 16 to 31 per cent during the study period. Until February 1997, the visit figure was around 19 per cent for two unions (Fig. 2).

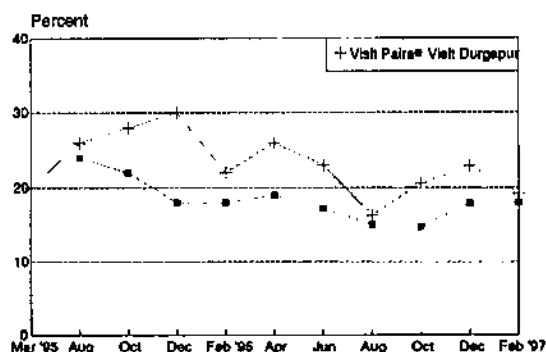


Fig. 2. Visit to CS in 1995-1997

Source: SRS

At Abhoynagar, the average attendance per CS session rose from 11 to 16 clients per session. This was higher among the users. At Mirsarai it was from eight to nine (Table 6). The attendance increased most impressively at the combined spots, where the attendance increased from 12 to 20 at Abhoynagar, and more than doubled in Mirsarai from 9 to 23. This demonstrates the potential for including additional services at the CS.

Table 6: Observed average attendance at CS and combined spots in Abhoynagar and Mirsarai: 1995 and 1997.

	Abhoynagar		Mirsarai	
	1995	1997	1995	1997
ONLY CS				
Sessions Observed	84	83	74	107
User	9	14	5	7
Non-user	2	2	3	2
All attendees	11	16	8	9
COMBINED SPOT				
Sessions Observed	12	23	15	57
User	6	16	6	11
Non-user	4	4	3	3
Attendees	12	20	9	23

Source: Observation at spots

The CPR is used as a primary indicator for the Bangladesh Family Planning Programme's success. Most increase in Bangladesh CPR has been due to the increased number of pill and injectable users. To measure the intervention's impact on performance, a comparison between CAR and CPR, method-specific CPR and source of contraceptives have been used.

CAR data for all the intervention unions during door-step delivery and after discontinuation of door-step delivery have been compared with the CPR generated through the SRS. The comparison between CAR and CPR shows that the gap between MIS and SRS has declined over time in Mirsarai indicating an improvement in data quality in the intervention area (Fig. 3).

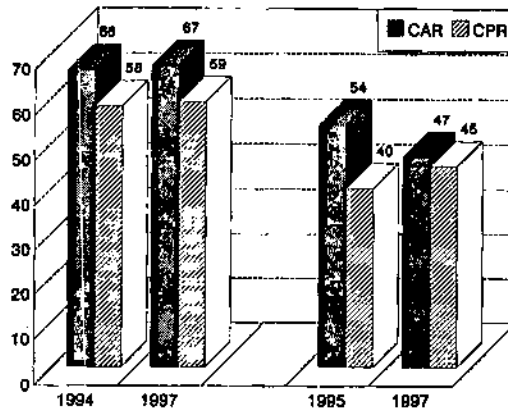


Fig. 3. Difference between CAR and CPR in the intervention areas: 1994-1997

The method-specific CPR is available from the Project's SRS for both areas. There has been no negative impact on overall performance (Fig. 3).. The CPR continued to increase both in the intervention and comparison areas.

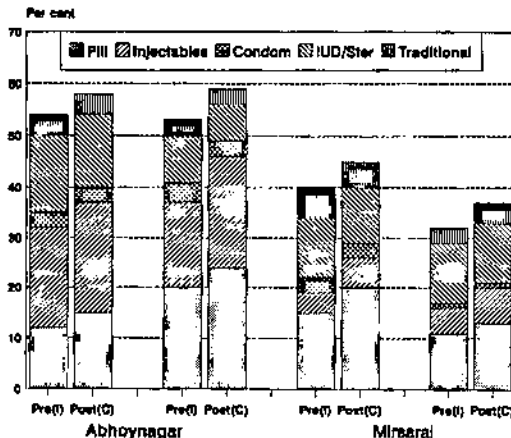


Fig. 4. Method-specific CPR in the intervention and comparison areas

Despite the movement away from doorstep delivery, the CPR has not declined in the intervention areas. Growth in the popularity of pill and injectable use is quite visible in the low-performing area. The use of injectables, however, is low at Mirsarai (Fig. 4).

This could be due to the fact that the DFP has not authorized the FWAs to administer the first dose. However, at Abhoynagar, the FWAs were authorized to

administer all doses in 1987, but this authorization was withdrawn in mid-

1995. The Project trained the FWAs to administer injections, and they were offering all doses of injectable at Abhoynagar until the withdrawal of authorization. The Project also trained the FWAs of Mirsarai on injectables and followed national policy guidelines.

The impact of door-step discontinuation on a source of contraceptives has also been examined. The relative share of CS as a source of contraceptive supplies has increased in both areas, while the proportion of contraceptives received at home has declined (Fig. 5).

As mentioned earlier, the FWAs are responsible for routinely informing the MWRA about the CS as a source of contraceptive services and supplies. She will also play a large role in delivering condoms, pills and injectables at the CSs, where she will also be able to encourage MWRA to accept and continue the use of these methods. Then, when she is not engaged in the

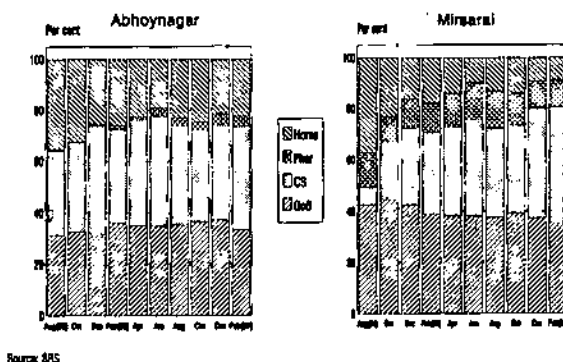


Fig. 5: Sources of modern contraceptives in the intervention areas

CS responsibilities, the FWA will be required to make targeted home visits with non-users, pregnant and post-partum women. Therefore, the FWA's role in the programme is likely to remain prominent.

Discussion, Conclusions and Policy Implications

This discussion highlights a number of important issues for policy-makers to consider. This intervention has demonstrated that women will come forward to collect their contraceptive supplies from the fixed sites. However, this does not mean that the FWA's role has become less important.

This intervention has demonstrated that the FWAs can provide services on a monthly, instead of a bi-monthly basis through the cluster approach. Supervision of the FWAs by the FPIs has become easier. The cluster visitation as an approach to shift away from door-step is promising in terms of relative share of supplies and CPR. In the longer term, the cluster approach will serve as a transition from doorstep to the fixed sites; in the shorter term, an opportunity to provide additional services included in the ESP. One important effect of the intervention is that the FWAs now have some free time to visit special target groups, such as non-users, low-parity couples and newly weds. Special IEC is needed, however, to attract more women. The project is currently designing a new IEC strategy, and will target these women in the next phase. House-to-house recording of FWA register and monthly reporting requirements need review.

The intervention provided a series of lessons for redesigning the Bangladesh Family Planning Programme. Providing services at the CSs should be viewed as an approach to introduce a gradual shift away from doorstep service delivery and toward greater use of the fixed-site services. Also, the FPI can play a more active role in IEC, which will eventually lead to increased male involvement and community participation in the MCH-FP programme. Once the system of providing services at the CSs is established, it will be possible for the FWAs to receive additional training and to provide a wider variety of services to a larger number of women. A separate service-delivery strategy and management and supervision system may be needed for the inaccessible areas.

This new service -delivery strategy could potentially deliver the additional services included in the ESP and will thus, attract more women, thereby increasing the use of health services and female mobility as well.

As the programme concentrates more on the fixed-site services in the future, the role of FWAs will clearly need to be redefined.

The intervention has been underway for two years. The Project is currently modifying the intervention design. Once all modifications have been finalized, the intervention will be tested further.

Several NGOs have already replicated the cluster approach intervention. The National Integrated Population and Health Programme (NIPHP), funded by the United States Agency for International Development (USAID) also supports the gradual phasing out of doorstep delivery. Thus, it is hoped that this alternative mode of service delivery will be able to deliver the Health and Population Sector Strategy (HPSS)'s "one-stop-shop" approach at the national level.

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