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A Tale of Two Wings
Health and Family Planning Programmes in an Upazila in Northern Bangladesh

Research and Evaluation Division, BRAC

rural study series

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Upazila in Northern Bangladesh

Bangladesh Rural Advancement Committee

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F O R E W O R D

This report is the outcome of an intensive study conducted in an upazila in northern Bangladesh. The study looked at the existing domiciliary health and family planning services in the rural areas and attempted to identify the areas where BRAC could facilitate for their improvement. The core respondents were domiciliary health and family planning workers, appointed by the government, working under the Upazila Health Complex (UHC).

We hope the findings of this study will stimulate new discussions about programme performance and ultimately be useful in improving the health and family planning services at the periphery.

The study was carried out by a five member research team of BRAC who received good cooperation from the respondents. We owe a lot to them. We are also grateful to the Health and Family Planning Divisions of the government for allowing us to do this study.

F. H. Abed
Executive Director
May, 1990 Bangladesh Rural Advancement Committee

ACKNOWLEDGMENT

Ever since the first draft of this study report was circulated, we have been receiving tremendous amount of comments/reactions from different sections of the people connected with the development world including the government bureaucracy, programme implementers, researchers, academics and journalists. Such responses included criticisms, appreciations and suggestions. We have not made much changes in the text, except for a few typos, in this edition. However, it is with great pleasure that we acknowledge these comments/reactions. We look forward to incorporating them in our future work. Excerpts from some of these communications are given at the back cover.

We are also grateful to different national dailies for giving excellent coverage to the study findings. In this connection the 'Sangbad' should be particularly mentioned which published the major findings in seven installments.

A.M.R. Chowdhury
Study Coordinator

February, 1991

CONTENTS

GLOSSARY

AHI	—	Assistant Health Inspector
B/D	—	Birth/Death
BIDS	—	Bangladesh Institute of Development Studies
BRAC	—	Bangladesh Rural Advancement Committee
CS	—	Civil Surgeon
DDS	—	Drug and Dietary Supplement
DHS	—	District Health Superintendent
DPHE	—	Department of Public Health Engineering
EPI	—	Expanded Programme on Immunization
FP	—	Family Planning
FPA	—	Family Planning Assistant
FPO	—	Family Planning Officer (Upazila)
FWA	—	Family Welfare Assistant
FWV	—	Family Welfare Visitor
GR	—	Geographical Reconciliation
HA	—	Health Assistant
HFA	—	Health For All
HH	—	Household
HI	—	Health Inspector
IV	—	Intravenous
LDC	—	Lower Division Clerk
MA	—	Medical Assistant
MBBS	—	Bachelor of Medicine Bachelor of Surgery
MLSS	—	Member of Lower Subordinate Staff
MO	—	Medical Officer

NGO — Non-government Organisation
ORS — Oral Rehydration Salt
PCD — Passive Case Detection
PHC — Primary Health Care
RMO — Resident Medical Officer
RED — Research and Evaluation Division (BRAC)
SI — Sanitary Inspector
TBA — Traditional Birth Attendant
TEMO — Transport & Equipments Maintenance Organisation
UHC — Upazila Health Complex
UHFPO — Upazila Health and Family Planning Officer
UHFWC — Upazila Health and Family Welfare Centre
UP — Upazila Parishad
UZ — Upazila (Sbu-district)
UNICEF — United Nations Children's Emergency Fund
VAC — Vitamin A Capsule
WHO — World Health Organization

EXECUTIVE SUMMARY

Bangladesh is committed to attaining Health for All by the year 2000. The Upazila Health Complex, supported by union level sub-centres and domiciliary health and family planning activities, are the major vehicles through which the government wants to achieve this goal. Several non-governmental organisations, including BRAC, have come forward to help achieve the goal. In order to identify possible areas of intervention, BRAC carried out an intensive study of the government health and family planning activities of an upazila in northern Bangladesh, emphasising particularly at the domiciliary levels. The study team collected a large volume of quantitative and qualitative information about how the different systems operate in that upazila. The data were collected through observation, interviewing, discussion and reviewing of records over a period of three months in mid-1988.

A dismal picture emerged from this study about the state of the health and family planning services in the upazila, particularly at the domiciliary level. Although there are a large number of field staff in health and family planning in each union (about 15 for a population of 20,000), they were found to be spending less than half of their scheduled working time on the job. According to our observation, the actual number of hours spent by different type of workers on their job in a week were as follows:

Health Assistant	–	18
Health Inspector	–	15
Sanitary Inspector	–	15
Medical Assistant	–	15
Family Welfare Assistant	–	9.5
Family Planning Assistant	–	2
Family Welfare Visitor	–	15

Many of the assigned duties are not done, or done only partially. The main task of the domiciliary workers is to do home visits, but this is their least popular activity. Work which is more closely supervised (such as emergencies like floods) and which involves greater commitment of the higher authority (such as immunisation) or for which adequate supplies (such as ORS) are made available tended to be done more seriously.

This indicates a tremendous wastage of resources. If these existing resources are optimally used, the goal of achieving 'Health for all by 2000' may not remain only a policy.

A sense of mutual suspicion and mistrust seemed to exist between the workers of the Health and the Family Planning Wings which tended to affect their performance. Attempt to integrate their activities may not be successful unless the suspicion and mistrust are overcome.

Some specific findings

1. Home visits least done.
2. The FPA is least active amongst all the domiciliary staff.
3. Supervision at all levels is virtually absent.
4. There is a shortage of supplies of medicines and contraceptives. The shortage of contraceptives affects the performance of FWAs.
5. Very little working relationship exists between the staff of domiciliary and UHC/UHFWC levels.
6. The relationship between health and family planning workers is not friendly and is not mutually cooperative.
7. No satellite clinic is in operation.
8. A good amount of time is spent by HAs in blood sample collection for malaria control, which may not be justified. On the other hand, activities to tackle other important health problems (such as tuberculosis) are non-existent.
9. There are some “ghost” patients who fetch medicine from UHC/UHFWC.
10. The reliability of reports/records (such as GR) is questionable.

It is assumed that many of the findings of this study will be useful to the government in assessing and improving its health and family planning services at the periphery. A major review of the health and family planning services in rural areas is warranted.

1. INTRODUCTION

Since independence, Bangladesh has been pursuing a policy of providing health care to all, particularly to the rural population who are often unsaved or underserved. National commitment to making essential health care accessible to every individual and family in the community by 2000 AD has been amply reflected in its Second and Third Five Year Plans wherein primary health care has unequivocally been accepted as the key approach to attain the objective.

As the main instrument for delivering primary health care, the upazila health complex (UHC) in each upazila (UZ) has been envisaged as the 'nucleus'. The UHCs are to offer comprehensive health services and, at the same time, serve as referral centres to better equipped district hospitals. Health services at the UHC level include both in- and out-patient facilities, including family planning services, pathology and x-ray facilities. Besides, UHC offers domiciliary services through its multi-purpose field workers. These services include home visits by health and family planning workers for counselling on preventive and primitive health aspects and family planning, collection of blood slides for malaria, immunisation, distribution of vitamin-A capsules and deworming tablets, and basic treatment of simple and common illnesses.

With an average population of 200,000 in an upazila, it is considered too large for an UHC to provide proper health services. To make health services more widely accessible to the rural people, the government has started establishing a health and family welfare centre (UHFWC) in each union, the smallest and most peripheral unit of health care system covering an average population of 20,000. These centres are to provide curative services as well as basic primary health care, family planning and maternal and child health (MCH) care. Each UHFWC has an annual budget of Tk. 30,000 - 40,000 plus three to four DDS kits from UNICEF. With no surgical services or beds, these centres refer the more seriously ill patients to UHC.

For providing health related domiciliary services, there are 3 Health Assistants (HA) for each union, 1 Assistant Health Inspector (AHI) for every two unions and 2 Health Inspectors (HI) for each upazila. On the other hand, family planning domiciliary services are provided by 3 Family Welfare Assistants (FWA), and 1 Family Planning

Assistant (FPA) in each union. Domiciliary health and family planning workers are expected to offer their services by visiting each home in their stipulated area. Some of them have union level supervisors, while others are supervised from upazila level.

A study conducted (1988) by Bangladesh Institute of Development Studies (BIDS) to evaluate PHC and family planning (FP) facilities and their limitations, specially in rural areas of Bangladesh, found low contact with the household as major problem constraining the effectiveness of domiciliary services. The study reveals that a very small proportion of households (26.35%) was contacted by domiciliary workers during a three-month period. Like domiciliary services, the picture of outreach-based services, is equally disappointing. With inadequate supplies, limited equipment and little or no supervision, these centres are probably accomplishing little more than relieving some pain. But, if PHC is to be made successful, these peripheral centres and domiciliary service delivery should improve the conditions of health of the surrounding communities, not just relieving pain or providing what people want. The community must be involved in the management and shaping of their own health.

The Bangladesh Rural Advancement Committee (BRAC) is a Bangladeshi non-government organisation (NGO), and health has been one of the important facets of its programmes. Over the past few years, BRAC has been helping the government in its expanded programme on immunisation (EPI)*. In order to identify other areas where BRAC could facilitate the improvement of existing health services, particularly Upazila Health Complex (UHC)-based curative and domiciliary services, an intensive research study was undertaken in an Upazila in Northern Bangladesh. The present report portrays a picture of the prevailing health services, especially domiciliary health and FP services, as observed through the study. The identification possible areas where BRAC can provide facilitation assistance and the

* In a recent study it has been shown that the proportion of children fully immunised was much higher in BRAC assisted areas in comparison to government areas in which no such assistance was provided (41% vs. 15%).

facilitation strategies to be adopted have been presented elsewhere (BRAC, 1989). Some findings which are not strictly relevant to the purpose of the study are also presented here since these are considered interesting and important for dissemination.

2. METHODS AND MATERIALS

Stages of the Study:

The study was carried out between July and September 1988. A 5-member research team, drawn from BRAC's field programme and the Research and Evaluation Division was responsible for this study (see Appendix-1 for their background). The whole study was done in five major stages:

The First Stage

In this stage, the team recorded what each type of health and family planning worker actually does. For this purpose each type of worker was closely observed for at least a week. During observations, the team members did their utmost to remain neutral and passive observers. The staff were followed throughout their working hours and all their activities recorded. The study team observed not only what the health staff did or did not do, but also noted their knowledge on different subjects, methods of communication, attitudes towards rural people, and, above all, how much time they spend on each activity. On the basis of a week's activities, the time (hours) they spent in each activity for that week was calculated.

The Second Stage

The second stage consisted of identifying the type of work they were supposed to do (e.g., their duties). This was based upon the following sources:

a) Their own version of their job (what they think they are supposed to do).

b) Manuals or any other official instructions (what the government expects them to do).

While collecting their versions of their jobs, the team wanted to know whether s/he had any official job description. Most of them stated that they had no official job description; even the Medical Officers (M.O) did not have any. They, however, did not feel the necessity to have any job description because they thought they were well aware of what they were supposed to do. Some MOs suggested that their job descriptions might be available with the Deputy Director's (DD) office at the divisional level.

When asked to describe their jobs most of the field workers mentioned one or two tasks. At this stage, they had to be prompted. The team had previously developed a fair idea of the duties and responsibilities of each type of worker from their respective official job descriptions/manuals collected from Dhaka. After being prompted, some staff members instantaneously started describing their jobs in greater detail, while others flatly denied such responsibilities, saying either they had not heard about them before or that they were not theirs. The staff was asked to estimate the number of hours they are supposed to spend on each activity per week.

The Third Stage

In the third stage, the study team tried to identify the tasks that are officially assigned to each type of worker but were not being performed. In doing so, the previous two stages were compared. Both the type of work as well as the number of hours worked per week for each type of worker were used.

The Fourth Stage

With results available about their work from stage 3, the study team approached each worker observed previously to ascertain what had prevented them from doing their assigned jobs. The question WHY was never explicitly asked. Rather, while keeping question in the back of their minds, the team tried to elicit responses through friendly and informal discussions. This was possible because of the relationship already developed with them. Most of them were not shy in narrating their problems. Some even went so far as to complain about their immediate and higher-level supervisors. They resented that no one cared about their problems (in performing their duties) much less did

anything to solve them, however, were reluctant to talk about their problems. Their aversion seemed to have developed from their previous experience that disclosing problems was of no use, it changed nothing.

The Fifth Stage

In the fifth and last stage, the data collected in the previous stage were analysed to identify the areas where BRAC might be able to assist. As mentioned before, this is dealt with in a separate report (BRAC, 1989).

Other Activities

Rapport Building:

Before observing each worker, the study team spent several days with him or her and developed a friendly relationship. The observers not only met them in the field or at their health centres, but also met informally/socially with them in market places, restaurants, clubs, discussing subjects ranging from politics to personal matters, from floods to the Olympic Games. This helped develop a relationship devoid of formality and suspicion. It may be mentioned that one of the team members had spent nearly a year in this upazila working on EPI before this research was undertaken, and this played an important role in building rapport with the health and family planning staff.

Sample Area Selection:

The upazila understudy was selected for a number of reasons. BRAC had a presence in this upazila through EPI. A BRAC staff member who had worked in the immunisation programme here was included in the research team. Because of this, he had a fair knowledge of health and family planning service conditions in this upazila. Besides, the Upazila Health Complex (UHC) is conveniently located, just 30 km from the divisional town where BRAC has its local office which provided logistical support for the research team.

The study upazila has six unions. In order to observe the outreach and domiciliary services, the study team studied two unions selected on the basis of their distance from the UHC. The management of the outreach centres was not identical*, and this was also taken into consideration when selecting the outreach centre. The team observed on UHFWC run by the Health wing (close to UHC) and one FWC run by the FP wing (not close to UHC). In each of these unions, one HA, one FWA, one AHI and one FPA were observed. In observing the work of Family Welfare Assistants (FWA), the responsiveness of the local people towards family planning was considered. While one FWA functioned in an area which was said to have better acceptance, the other FWA worked in an area known for low acceptance. Acceptance turned out to be higher in the ward closer to UHC and lower in the remote ward.

The research team stayed in the Health Complex, and the UHC officials were mostly cordial and cooperative.

Problems Encountered:

The study in the upazila went smoothly except for a few small problems. The Family Planning Officer (FPO) was at first not very cooperative because he thought that NGOs received exclusive privileges from the government through clandestine means. This was thought to make high officials at the ministry level subservient to NGOs, thereby giving NGOs the chance to influence policies which, according to him, often goes contrary to the interest of the people for which it is meant.

Having no official letter from the ministry instructing the FPO to participate, the team was in somewhat of an awkward position.

However, after interacting with him and procuring a letter from the ministry, he cooperated. A few more days were lost because of an unfortunate incident which ensued between medical officers at UHC and local youths, including even physical assault. The only problem

* Some were controlled by the family planning wing while others by the health wing of the Ministry.

which could not be solved was the collection of data on disease patterns for a year at the UHC and UHFWC. Doctor's writings were illegible and even some medical assistants would not take the responsibility for the huge volume of work involved.

Limitations:

The study suffers from several limitations. Each type of workers was observed for only a short period making it possible only to generalise about a worker's work for the whole year. However, the member of the research team who had previously worked in the upazila for a period of 12 months in 1986-1987, knew the individual attitude, sense of responsibility and quality of work of each member of the staff. Even intimate details of some workers were known to him. This background knowledge proved advantageous. Taking this into consideration, it can be said that the actual observation period extend far beyond the time the study team spent in the upazila collecting data.

It is possible that the health and family planning staff might have an inkling of our purpose, and because of this, they might have worked harder during the Team's presence than what they do usually. Thus what is reported might be positively biased. In a normal situation, they probably work less than what was found in this study.

The purpose of the present study is to describe the UHC-based health and family planning service delivery system with special emphasis on the domiciliary side. It is not intended to focus on particular individual's performance. Therefore, pseudonyms have been used where necessary in this report to avoid implicating any individual worker.

Is the upazila typical of Bangladesh? It is difficult to say. It appears that socio-economically or culturally this is a typical upazila. However, it is probably a “better upazila” with respect to the health and family planning facilities. The Health Complex was built several years ago, and all the unions have some fixed centres. Except for the post of two Assistant Health Inspectors, all other posts are filled. Because of its

location, the UHC is a favourite place for visitors*. Due to these reasons, the health and family planning activities are likely to be more effectively carried out here than in many other upazilas.

3. THE UPAZILA PROFILE

The upazila (UZ) studied is typical of most other UZs of the country. It is located about 30 km from the divisional town linked by a good road. With an area of 75 sq miles, the UZ has six unions and 183 villages. According to 1981 census, the population of the UZ is over 1,25,000 of which about 51% are male 49% female.

The most important health care facility is the Upazila Health Complex (UHC), which was set up in 1983 with World Bank assistance. Besides the UHC, there are six outreach centres delivering health and family planning services.

Except for the post of Assistant Health Inspector (AHI), as mentioned previously, all other posts at the fixed centres and field are fully manned. Out of three sanctioned posts for AHI, only one was filled. Details regarding staff position are given in Appendix 2.

4. THE HEALTH ASSISTANT

In the delivery of domiciliary health services, the Health Assistant (HA) has an important role. He is to build a bridge between the people and the local government institutional facilities. At the same time, he has to ensure active community participation for control and surveillance of communicable diseases, sanitation, nutrition, personal hygiene, etc.

For each ward (the lowest administrative tier with a population of about 7000), there is one HA. He is a regular employee of the

* During the three-month stay, many high level officials stopped by the UHC. They included the Minister of Health and Family Planning, Directors General of both Health and Family Planning and Director (PHC).

government and recruited locally. He is required to make a fixed number of house visits per day to provide domiciliary services. The total number of HAs in the study upazila is 18.

Most of the HAs of this upazila were recruited during the Malaria Eradication Programme as Malaria Supervisor (MS). Their average service length is 16 years. All but two of them have either SSC or HSC degrees. Most of them have come from economically better off families with an average land holding of 3.6 acres. Much of their time is spent on farming activities, though none will admit to this.

To get an accurate and first hand idea of how HAs perform their duties, the study team observed two of them very closely for a period of two weeks. They came from two different unions. The following table presents what the two HAs were observed doing as against what they thought they should be doing.

Table 1: Time actually spent and required to be spent by the HAs in different activities as per their own version.

	Average Hours Per Week	
Activity	Expected as per own version	As observed
EPI registration	5.0	0.0
EPI session	8.0	5.5
EPI follow-up	1.0	0.0
PCD collection at UHFWC	5.5	3.0
Health education (hygiene, sanitation, family planning)	8.0	0.5
Diarrhoeal disease control	8.5	0.5
Malaria (PCD slide collection)	4.0	2.5
Emergency (flood, epidemic)	0.0	3.0
Reporting at UHC	2.0	2.5
Vit-A capsule distribution	6.0	0.5
Total hours spent per week	44.0	18.0

The HAs spent only 18 hours in a week doing their work as against 44 hours which they are required to devote according to their own account. Out of this, 5.5 hours were spent in EPI sessions. Activities which require home visits such as EPI registration or follow-up, health education, etc. were done least.

In terms of detailed findings from study observations, let us first present data regarding those assigned activities which the HAs do not do and the reasons given. This is followed by a presentation of those activities which they partially do and their reasons for not performing them fully. Then the activities which they do more or less properly are described and the reasons why provided.

A. Tasks not done:

i) EPI registration and updating. This important function should be done by the HAs a day prior to vaccination. But at present, this task is hardly done, resulting in low coverage and high drop out rates. On the day before vaccination, they sometime visit a few houses around the vaccination centre and ask the mothers of those houses to inform their neighbours about it. The lack of registration and updating became more evident when mothers coming for vaccination at the EPI centre at UHC were interviewed. Most of them said that they did not know when and where vaccinations are given in their villages. However, there were other reasons for their turning up at UHC fixed centre which we shall discuss later (see Chapter 12).

Why didn't the HAs do this job? They offered the following reasons:

a) Vast area with too many households,

b) Requires too much time,

c) Non-availability of an action plan,

d) Confusion arising from the complexity in doing this task,

e) Lack of supervision from above.

Some of the above are probably not real reasons. If they were doing their home visits regularly, they could have easily identified and

registered the newborn babies and the left out women. Consequently, on the day before vaccination they would have needed to visit only those houses which had clients. As it is, they need to visit each and every household.

With regard to the non-availability of an action plan, the MO (EPI) informed us that all HAs are provided with copies of an action plan from his office. The HA's stated confusion about registration work is also not a valid reason. However, periodic refresher training for the HAs might prove useful in skills development and in overall immunisation performance.

Lack of supervision by higher authorities is really a problem and is responsible for these and other shortcomings. The HAs confessed that lack of supervision from above often makes them less attentive.

Same applies to EPI follow-up. After each vaccination, the respective HA is to visit the area to find out if there is any complication. But there is little or no follow-up. Moreover, if a HA happens to find any case of abscess or other complication developed after vaccinating, he will not refer it to the UHFWC or UHC, even if the complication turns out to be serious. He does not want it to be known, partly because of his fear of reprimand and partly because it will discredit him in the eyes of other HAs.

ii) Family Planning motivation: Each HA is expected to provide motivation for family planning, particularly to the males, during their routine home visits. They have to achieve monthly targets of contraceptive practice. But this was not found to be the case. Regarding their nominal involvement in family planning activities, Has had an unequivocal reply: it is not their responsibility; it lies with the family planning wing. One of the HAs said that although family planning was not their responsibility he worked on it. However, he was not observed doing anything for family planning. This spirit of “departmentalism” was found to be pervasive from top to bottom among the upazila health and family planning personnel (see also Chapter 19).

iii) Health education: One of the most vital components of PHC and one that occupies an important place in domiciliary service delivery is health education. It plays a critical role in preventive health care,

generating appropriate attitudes towards better health among the people. The person who is the most peripheral arm of the present health service structure to perform this vital task is the Health Assistant. But observations revealed that the HAs, who are often described as the key to the success of PHC, were almost non-functional so far as health education is concerned. HAs did not even devote one hour a week for this purpose.

What is more frustrating is the way they deliver health education. What that HAs delivered was very superficial and too often given in a very haphazard way. They never tried to make mothers participate, it was one-way communication. HAs did not seem to care whether mothers learned. In turn, the mothers were not interested in what the HAs were saying.

A few examples of health education as given by HAs will help one understand the present status of this crucially important factor in the domiciliary service delivery system.

In one case, a man was taking his bath on a tube-well platform. The HA happened by an started giving him lesson on health education. The man hardly listened to the HA, but this did not concern the HA. Thus, bathing and health education were going on simultaneously, neither disturbing the other. In another house, a woman was cooking in her kitchen. The HA started giving health education at the top of his voice from the verandah. Here too, health education and cooking went on simultaneously, and the HA cared little if the mother had learned anything or had any questions. It was observed that HAs never say hello or good-bye to the mothers. The HAs only have to see an adult in a house, never knowing whether the person a member of the house or a guest, they would start saying, “keep your house neat and clean, it is very important”; “wash your hands with ash after defaecating”; “include enough vegetables in your diet”; “why not cultivate vegetables, you have enough land laying vacant”; “use latrines, they are easy to build”; and so on. This health education (?) is given as if they are reciting from a verse. They were not observed using flip charts or any other communication materials, nor giving health education in a group.

The purpose of ensuring active community surveillance of communicable diseases, sanitation, personal hygiene, nutrition, material and child health, etc. through a domiciliary health service delivery system is not met at all. Most of the rural people are still not aware of the government health services, particularly the domiciliary service delivery system. Therefore, people's participation in their own health management is still a remote possibility. Health education and motivation, the vehicles for bringing people's participation in health management, is simply rhetoric of the government's health policy; no trace of it was found in the field.

B. Tasks partially done:

i) Domiciliary visits: Domiciliary visits by HAs is the main means of reaching people with PHC services which is conceived as the central focus of the government's health service delivery system. But the actual picture of domiciliary visits, particularly by HAs, is painfully gloomy.

During the observation period, the field locations where the HAs were supposed to be working were checked for a number of consecutive days*. But none of them showed up on those days. Even when appointments to meet them in the field were made, the HAs sometimes did not show up. Once when a study team member was visiting a village with a HA, a mother, who happened to be a distant relative of the HA, expressed her astonishment that he was doing this work. The said HA had been serving in this area since 1986. Many more such examples could be cited to substantiate the deplorable plight of domiciliary visits.

It was observed that HAs are most irregular in making domiciliary visits. The study team could not find them in the field even when appointments were arranged. When asked about their 'irregular' performance, they said they felt demoralized. The reasons given were: absence of supervision, dishonesty on the part supervisors, non-availability of medicines, and lack of responsiveness from people. These factors often make them feel disinterested which, they confessed, eventually lead them to disregard their responsibilities.

* Their monthly work schedules were collected from them

ii) Malaria slide collection: Under the present system, each HA is supposed to collect slides equivalent to 1% of the total population he covers each month for control and surveillance of malaria, there is a lot of developmental pressure to achieve this monthly target, failure to do so may result in an official reprimand and, in some cases, holding up of salary. Slide collection is done in two days, one from field visits, the other from the health facilities, the UHFWC or FWC.

Because of the pressure from above, HAs were found to be chasing people for blood collection. It is collected from anyone having a low fever or running nose; people were never asked about malarial symptoms. People from whom blood is taken are not informed about why the blood was being taken. We talked to some of these persons. The bulk of them expressed their ignorance while some said that this might be required for treatment, i.e., after giving blood, they become eligible to receive medicine.

To reach the slide target HAs often resort to many unfair tactics. One HA confessed that sometime HAs prepare a number of slides from the blood collected from a single person. He said that he did not feel any guilt for adopting such unethical practices since these slides are never examined.

A number of HAs interviewed expressed great dissatisfaction with this responsibility. All of the HAs were skeptical as to whether any lab test of the slides was ever done. To date none of them had ever heard of any "positive" result from the blood-assay although from November 1987 to October 1988, a total of 5,843 slides were collected and sent for testing in this upazila. Besides, for a single lab- technician, it is a heavy load to test all these slides as he is always busy with other types of lab tests.

At present, the 1% target set by the government is not being fulfilled. According to 1988 GR, the total population of the upazila is 1,43,116 and 1% of it stands at 1,431. Therefore, the total number of slides for a one year period should be 17,172. But the figure for ten months (November 1987 to August 1988) was only 5,843, which is 41% of the stipulated target.

C. Tasks done more or less regularly:

The task which is attended to more or less regularly by the HAs is the emergency service delivery (i.e., during a flood or an epidemic outbreak). There are three reasons for this. First, there is a stringent supervision from high levels and strict action is taken against negligence. Second, logistics and supplies (e.g., ORS, medicine) are better. Last but not least, it (emergency service) is not a year round phenomenon.

5. THE HEALTH INSPECTOR

For supervising the domiciliary health servicse delivery in an upazila, there are two posts of Health Inspector. Both of them report to the UHFPO. In the study upazila, the work of one HI was intensely observed.

Although supervision of health assistants at the field level is the single most important function of an HI, he was never observed going to the field. The health assistants in the study revealed that he sometimes visited outreach immunisation centres, but hardly ever turned up in the field to observe health education, GR and other activities. Neither HA interviewed could recall when he last visited them in the field.

During the entire study period, the HI was either in his office, writing reports, or in a nearby restaurant gossiping with acquaintances. He has to prepare five types of reports which require considerable time. It was observed that HAs submit their reports to the HI in a very haphazard way. As a result, the HI has to devote extra time to clean them up for his report. He said that several times he advised the HAs to submit their reports in proper form, but he complained that the HAs did not listen to him.

It had been reported that the HI often resorted to embezzlement of medicines. He makes the HAs put their signature on blank receipt forms for medicine. And because of their clandestine dealing of medicine with HI, they do not mind in doing so. One HA even openly

said that he and another HA sell the medicines which they procure from the HI in black market. They have to give him a certain "percentage". It was observed that the HI does not give the HAs even half of the medicines which he enters in his record register. It is an open secret, but since the HAs are associated with him in this deal, they keep silence.

His control over the HAs was minimal. He was unable to discipline them because his own misdeeds (e.g., misappropriation of medicines, reluctance to go to the field) are known to the HAs.

Table 2: Time spent by HI in different work.

Activity	Hours per week	
	Expected as per own version	As observed
1. Report writing and compiling	16.00	15.00
2. Supervision on:		
Health Assistants		
Malarial control		
Epidemic control		
3. Follow up of information sent by HAs	24.00	0
4. Ensuring field level training of HAs		
5. Ensuring health education and motivational work		
6. Others		
	40.00	15.00

The HI regularly went to the local bazar at 11'0 clock. There he spent more than an hour in a tea stall. On only one day during the observation period did he stay in office from the beginning to the end of the office hour (at 2 p.m.). The local area commander of Bangladesh Army was scheduled to visit the UHC on that day.

Based on observation during the study, Table 2 shows how much time he spent in different activities. It is evident that the HI works only 40% of the time and on only one particular kind of activity, viz, report writing and compilation. All other work remains undone.

When the situation was reviewed with the HI, he never admitted any negligence on his part. He said that he could not visit the field because he was preoccupied with report writing and compilation. He said that he badly needs an office assistant to help him. It should be mentioned that he keeps one Health Assistant in his office to help him compile the reports. Only on the day of vaccination in his area does this HA go to the outreach centre. When this was mentioned, the HI first denied that he kept a HA in his office. However, he admitted that occasionally the said HA helps him when it becomes almost impossible for him to prepare the reports on time. Moreover, he attributed his infrequent field visits to the dearth of supervisory staff in the upazila. It may be recalled here that there is only one Assistant Health Inspector (AHI) in this upazila instead of three. He said that two HIs and one AHI are not enough to do the supervisory work. He claimed that although he did not visit the field last week he normally visits it at least 15 days a month.

It became quite evident that the relationship between the domiciliary staff and medical personnel, particularly the MOs, was neither cordial nor friendly. Bitterness surfaced over even the most trifling matters. The HI said that the bitterness arose out of the Medical Officers' "superiority complex". "They do not believe that we are important in the health management of the community. They do not know or believe in the preventive health care system". The HI added that domiciliary service delivery in the upazila should be entrusted to a separate group headed by a non-medical person.

When asked when he was last visited by his supervisor, he could not remember whether the UHFPO ever visited him in the field. However, the District Health Superintendent (DHS) had made a visit about a month ago.

6. THE SANITARY INSPECTOR

For each upazila there is one Sanitary Inspector (SI), having the responsibility for the improvement of sanitary conditions in the upazila. He is supposed to work in close collaboration with the domiciliary staff and relevant departments. The study did not find any functional involvement of the SI in the improvement of sanitary or hygienic conditions in the upazila.

During the observation period, the SI performed no "inspection". He only did office work for two hours or less a day. One day during the observation period, he went to a local market for inspection. Sitting in a sweetmeat shop, he gossiped and ate two plates of sweetmeats. He neither paid for the food himself nor allowed any one else to pay saying, "If I need to pay the price, what the hell have I been doing as Sanitary Inspector for so many years?" He did not visit any other restaurant/shop nor he did observe the sanitation or hygiene aspect of the shop where he ate the sweetmeats. It is worth mentioning that the total number of licensed restaurant/sweetmeat shops in the market was 12 and the total number of the same in the upazila was 95.

An appointment had to be arranged with the SI to see the kind of inspection he does. Despite the appointment, the SI never showed up at the stipulated market. It was latter learned that on that day, the SI had gone to the district town and spent the whole day there.

Once he left his office telling the peon that he was going to an EPI vaccination centre in a certain village. In fact, he was found chatting with people at a nearby tea stall.

Table 3: Time spent by SI in different work.

Activity	Hours per week	
	Expected as per own version	As observed
Field level activity	24	3
UHC duties	18	12
UHFWC duties	--	0
Total	42	15

Table 3 shows how much time he spent at various activities during the observation period. He worked for 15 hours during this period or 38.4% of the total working hours and that was all paper work. He never did any work on sanitation development in the area during this time.

Among the urgent problems of sanitation in rural areas, inadequate excreta disposal and water supply top the list. Less than 2 per cent of the households in the rural area use sanitary latrines. The health hazards associated with inadequate excreta disposal are immense. Another hazard is the inadequacy of safe water, although recent studies indicate that more individuals and families are now using safe water supplied from tube-wells. Any effort to improve rural sanitation should begin with these grave issues.

To enable the rural people to maintain a minimum standard of health, the government has chalked out a comprehensive programme. Under the Department of Public Health Engineering (DPHE), tubewells and low-cost slab latrines are being made available at the upazila level. But this effort does not seem to have made any progress. In the study upazila, the SI was not playing any role in this regard. He merely blamed the DPHE for not supplying the tubewells and slab latrines. He complained that DPHE personnel were involved in malpractice in the supply of tubewells and slab latrines. DPHE, on the other hand, gave a different report - that they had plenty of slab latrines, but there was no demand. The Health Assistants maintained that the demand was there, but, because of the cumbersome procedures involved in the release of tubewells and slab latrines from DPHE, people were not interested. They also held the SI responsible for not taking any initiative to improve the sanitary condition of the upazila. Thus, the SI, HAs, DPHE personnel all blamed someone else. No one was making any effort to integrate or collaborate with the other.

7. THE MEDICAL ASSISTANT

The number of Medical Assistants (MA) in an UZ corresponds to the number of outreach centres. If the outreach centre is an UHFWC, an

MA will be deployed from the health wing; in the case of FWC, he will be from family planning wing. In the former case, he will be reportable to the UHFPO, but in the latter, he will report to the FPO.

In the study upazila there are five MAs out of which two were observed. The findings from the observation of two MAs are almost identical so they are presented together.

Both the MAs observed were not investigating the cases in details. They hardly talked with the patients, they only asked their names and the villages they hailed from. They did not give any advice regarding the doses of medicines/drugs to be taken at different times. In the case of antibiotics, the full course was never given. In the UHFWC, the Medical Officer (MO) had been absent for the last year. (He was said to be doing a post graduate course in Dhaka). Consequently, all the patients were being cared by the MA alone.

The MA often arrived late at the centre. On one of the days of observation, he turned up at the centre after noon. In his absence, the pharmacist was prescribing medicines while the MLSS was dispensing them.

None of the MAs were found writing any details about the disease in the prescribed column of the registration book. They just wrote cough, fever, etc. They attended huge number of patients in an hour or two. On 20th September 1988, the MA at the UHFWC examined 145 patients in two and a half hours. That is, he spent approximately one minute per patient. This aged MA often got angry with patients on trifling matters.

Local anesthesia was often not available in the outreach centres, and antibiotics were always in short supply. MAs were found to keep some anesthesia (spray) and antibiotic in reserve, claiming to have purchased them privately. In case of minor operations, they use their personally managed(!) anesthesia and antibiotics and charged the patient.

The MO of the FWC had no residential quarter at the centre. He (a bachelor) stayed in the UHC dormitory 5 km away. He was often late in arriving. During six days of observation, the MO was absent without leave for two days. The MA was found taking advantage of the MO's

irregular hours. One day he left the centre for the local bazar despite a heavy rush of patients. He told the MO that he would return soon. The MO had no choice but to allow him to go since he himself was often absent. Not only the MO and the MA, but the pharmacist and the MLSS were also found to be absent because they knew that neither the MO nor the MA could reprimand them. They were all guilty of the same offense. The pharmacist of this centre was absent without having any official leave from 15 to 25 September. As far as the observation team could learn, no action was taken either by the MO or the MA.

One MA was found treating private patients during office hours. Both the MAs were found writing prescriptions for a number of patients who did not come to the centres, but sent someone else with a letter or a verbal request. It was observed that they did not prescribe for all absentee patients but only for those who were somehow or other influential. However, some interesting exceptions were noted. Once a poor woman came, not for herself but for her grandmother. She was not influential, but she was good looking and the MA did not deny her medicines.

It was found that there was always a crowd in the MA's chamber. Mothers fought for their chance. The MLSS occasionally attempted to form a queue but with little or no success.

The MAs worked only 15 hours of their time, and all of that only in patient care. There was no field activity.

Table 4: Time spent by MA in different work

Activity	Hours per week	
	Expected as per own version	As observed
UHFWC	27.00	15.00
Field	--	0
EPI	--	0
UHC	--	0
Total	27.00	15.00

When asked about their work and why a full course of antibiotics was not being given, they identified two reasons: extreme shortage of medicines and people's ignorance (they stop taking medicine after partial recovery). Regarding the way they examined patients, both of them admitted that they could not examine each and every patient properly because of the excessive number. For the same reason, they could not advise each patient about how to take the medicine correctly.

When asked why they prescribed medicines to absentee patients, one of the MAs said that he had given medicines to those absentee patients who were suffering from diarrhoea. The other MA stated that he gave medicines to those absentee patients who were personally known to him.

Why did they just write 'cough', 'fever', etc. in the diagnosis column without proper investigation? Both of them gave the identical reply: the first time they gave anti-fever/cough tablets for three days; if the patient was not cured and returned, they did a proper investigation and if necessary, referred the patient to the UHC for tests.

Replying to another question they said that they did not get involved directly in vaccination (EPI) but had it done by HAs. Because of the great number of patients at these centres, they only had time to see patients and could not afford any time for vaccinations or any other type of work.

They used the same excuse of 'patient rush' to explain their non-involvement in periodic health education, sanitation and ensuring community participation in control and surveillance of communicable diseases.

They said they had no working relation with the domiciliary staff because they were always very busy with patient care and it was absurd to expect them to work with the domiciliary staff.

8. THE MEDICAL OFFICER

With its commitment to provide better health services to all, the government places high priority to rural health and family planning

activities and consequently plans to post medical graduates (MBBS) to rural outreach centres. Though all the outreach centres do not yet have an MBBS doctor, the upazila under study has MBBS doctors in all five of its outreach centres. One of the outreach centre doctors was absent for the last year as he was reportedly doing post-graduate study in Dhaka.

No MO was observed as other members of the staff were. However, during the observation of other staff, frequent visits to outreach centres were made and had the opportunity to observe the MO's work in his chamber for several hours. What follows is a collection of the findings based on these segmented observations of MOs in various UHFWCs.

Most of the MOs interviewed were found to be suffering from culture shock. The expectation that they will be assigned to central areas (at UHC, District Hospital) after they reached a certain level of seniority was their only consolation. Because of the minimum facilities an little scope for private practice, these doctors were always depressed and were either waiting or lobbying for posting to a more central area.

Regarding patient care and behaviour, they were in no way different from the MAs. It was observed that MAs hardly ever referred patients to the MOs. Almost all the MAs were found to be somewhat hostile toward their respective MOs. It arises out of professional conflicts. Both regarded each other as rivals in their private practices. Despite their hostility, they maintained at least reasonably cordial relations for mutual benefit. They often enjoyed ‘french leave’ (i.e. absence without permission), and protected each other.

During the three-month observation, no MO from the outreach centres had any working relationship with the domiciliary staff of their respective union.

While all the MAs resided at their respective outreach centres, only one MO out of the five used the UHFWC residential quarters that were available. MAs were found to be more available at their centres than MOs.

9. THE FAMILY WELFARE ASSISTANT

The most peripheral worker for delivering family planning domiciliary services is the Family Welfare Assistant (FWA). She is entrusted with the responsibility of mobilising people for family planning and increasing the rate of contraceptive usage among eligible couples. The total number of FWAs in an union is three - one in each ward. In the study upazila with six unions, there were 18 FWAs and two were observed in the study.

First, the FWA's monthly action plan were collected and their specified field sites visited. None of them showed up in the field for three out of six days observed. Upon visiting their homes, the study team found them there or at relatives.

Even when the FWAs visit the field, they do not cover all the stipulated households. At best they go to half of the households and return home before mid-day. They were observed visiting 10 to 12 households.

Information, education and motivation (IEM) plays an important role in raising the number of acceptors of family planning. However, none of the FWAs was found providing IEM. All they did was to distribute a limited number of contraceptives. Occasionally they held discussions on complications arising out of contraceptive use.

The FWAs did not use the flip chart or any other communication materials. They were always late in arriving at field. They typically went to the field around 10 a.m. and came back, as mentioned earlier, before mid-day. These two hours included the travel time, thus the time actually spent on performing their duties was even less.

FWAs have no working relations with the domiciliary staff of the health wing. They do not have any contact with the Family Welfare Visitor (FWV) from whom they are supposed to seek technical guidance.

At the time of the study there was severe dearth of contraceptive supply. Since the demand surpassed the supply; all family planning personnel from the FPO to FWA were found complacent, feeling that

their respective areas did not need any further motivation. In reality, however, there remains many more eligible couples who are not practicing any method. Many such couples were identified during the study. Many mothers complained about complications after adopting different temporary or permanent methods. Their number is quite large. These mothers did not visit the hospital to consult with doctors about their complications. They agonize at home by themselves and ultimately become disgusted with family planning. The FWA is supposed to refer these cases to the hospitals, but nothing is being done in this regard. A number of mothers spoke of physical problems like anaemia, insomnia, etc., which are probably not related to contraceptive use. Proper family planning motivation which favourably influences habits, attitudes and knowledge can dispel such misgivings. But this was not being done by the FWAs. The prevailing family planning activity in the study upazila was contraceptive distribution. But simply making contraceptives available is not sufficient. To bring all eligible couples under family planning and to dispel existing misgivings, education is the most vital factor. It must include both motivational support and information about methods.

Under the present set up, an FWA has an important role to play in EPI. In the study, they did little in this regard. Many outreach vaccination centres were visited FWAs were found not adhering to any timetable. They arrive at the centre around 11 O'clock and leave by 1 O'clock. They mostly do the registration. The rest of the work (sterilization, vaccination, tally sheet maintenance, etc.) is done by the HA. FWAs felt that this job was the responsibility of the health wing.

The Table 5 shows the amount of time the FWAs spent and on what work during the observation period.

Table 5: Time spent by FWAs in different works

Activity	Hours per week	
	Expected as per own version	As observed
1. FP information, education and motivation	12.00	3.5
2. Couple registration	--	0
3. Immunisation	6.00	0
4. Birth death information collection	42	15
5. Acceptor follow up	--	0
6. Referral & follow up	--	0
7. Contact with FWV for technical guidance	--	0
8. Saline preparation & ORS distribution	--	0
9. Contact with union parishad	--	0
10. FP card distribution & Updating	--	0
11. Contraceptive distribution	6.00	2.0
12. Health education, personal hygiene etc.	9.00	--
Total	41.00	9.5

The table shows that FWAs spend less than 25% of their time in the work. It was observed that both of them often did not visit all the households as per schedule. When asked, they gave the identical reply: owing to the shortage of contraceptives, they did not go to the households. They said that people got angry and rebuked them if they fail to provide contraceptives. The point to be noted here is that both of them had limited the purpose of home visits to contraceptive distribution.

One FWA was found distributing family planning cards in a number of houses for the first time. The reason given was that cards were distributed a few years back, but mothers had lost them. Because

of a shortage, she could not distribute them earlier. Both the FWAs interviewed expressed their dissatisfaction about irregular logistic support.

It was found that FWAs were always in a hurry in the field, never making any effort to discuss family planning motivation with mothers.

We asked why they just discussed the side effects of contraceptives and did not motivate those not contracepting, one FWA attributed it to the conservative nature of her working area. She said that she did not dare offend people by talking too much about on family planning. "After all I live in this village*. How could I dare risk offending the villagers?" She said that her problem was communicated to the higher authority (FPA, FPO). The other FWA replied just the opposite, that people of her area were quite enlightened and they needed contraceptives not motivation.

We did not find them playing any role in sanitation or personal hygiene. Both said that it was of no use advising people on personal hygiene when they were so poor. "People have no interest in these matters, what matters to them is food. We cannot keep on repeating something which the people are not interested in". One, however, added that she would start advising people on personal hygiene since supervisors have started to check on them in the field. "None came to supervise our work before (you)".

As mentioned, neither FWA went to field for three days out of the six days' they were observed. One FWA explained that as per her schedule, those days were meant for birth/death information collection. She said that she gets birth/death information even if she does not visit the field. If there were any death it is known in neighbouring villages. However, news of births does not spread so rapidly. She said that she got birth information from her routine home visits. Besides, her husband, a small trader in the local market, helped her collect birth/death information.

* This is the sole village of the ward.

During the study several mothers were found who had been ligated 7-8 months ago and complaining about complications. The FWAs were asked why they had not talked to them earlier. Both of them said that they had not visited their field frequently due to the lack of contraceptives. As a result, they had not met these mothers. They, however, said that mothers often do not heed their advice to consult doctors at hospital because they have an aversion to visiting UHC/outreach centres.

10. THE FAMILY PLANNING ASSISTANT

Of all the staff observed in this study perhaps no one was as frustrating as the FPA who was found to be working only 5% of his scheduled time.

The number of FPA in an upazila corresponds to the number of unions. Therefore, in the study upazila with six unions the total number of FPAs was, six. The first FPA chosen for observation never went to the field. A second one was selected. This time it was decided to collect his monthly tour schedule from the upazila Family Planning Officer. According to the schedule, his programme for the week was as follows:

Date	Programme
24th September	Birth Death (B/D) Registration rechecking
25th ”	EPI Session visiting
26th ”	B/D Registration rechecking
27th ”	”
28th ”	”
29th ”	Monthly meeting

The emphasis given to birth/death registration and its rechecking was noted. On the first day, the FPA was found gossiping in the local Union Parishad office. The Chairman of that Parishad was his friend. The FPA spent most of his time there. He talked a lot about his influence in that area. It should be mentioned that most of the FPAs come from the rural elite. They are young and often have their own motorbike.

On the following day, he was again found in the Parishad office. He could not talk because he was going to a nearby village with the Chairman to arbitrate a dispute. The FPA boasted that the Chairman depended a great deal on him, particularly in matters relating to litigation. Before leaving, he said that he had called a meeting of local elites for the following day at Parishad office to discuss family planning in the locality. According to the action plan, the day was meant to be for B/D registration follow-up.

The following day he was found gossiping with some people at the Parishad office, but there was no trace of a meeting. The FPA apologised that despite all his efforts the meeting could not be held.

"How could I arrange a meeting? I do not have any funds. I must send the Chawkidar to invite the elites, but how will I remunerate him? After all he is a poor man. I just cannot force him to work. It is not my ethic". The FPA then bought tea for all and started gossiping once again about his power and influence.

On the fourth day, he was found loitering at the UHC. The FPO had called him to discuss an FWA whose salary had been held up. However, the said FWA was not from his union. The FPA had been called because he was "influential". The FPO did not dare to make an independent decision on such a serious matter. According to his tour schedule, on that day he should have been at ward I, rechecking B/D registration.

The FPA was not at the Parishad office on the fifth day. The possibility of his being at field was ruled out both by the pharmacist and FWV of that centre.

It was on the sixth and the last day of the observation that the FPA did what he was supposed to do according to the action plan. This day was meant for the monthly staff (FWA) meeting. He first collected advanced action plan of three FWAs and then delivered a lecture on family planning and staff sincerity. The meeting ended around 11 O'clock. He immediately rushed to meet one of his friends and the FWAs left.

Based on the observation, Table 6 was prepared detailing what time the FPA spent in which activities.

Table 6: Time spent by FPAs in different works.

Activity	Hours per week	
	Expected as per own version	As observed
1. Staff supervision	18.00	0
2. Report collection and compilation (once in a month)	5.00	2.00
3. Supply assurance (once in a month)	1.00	0
4. Liaison with UP, Volunteer organization, NGOs and elites for promotion of FP activities	12.00	0
5. Other (monthly meeting in UHC etc.)	2.00 (Once in a month)	0
Total	38.00	2.00

It is evident from the table that the said FPA worked for only two hours which is equivalent to 5% of the total working hours for a week, and that was spent in a staff meeting. Otherwise, his working time would have been zero.

When asked why he was not available in the field as per his action plan he said that most of the days mentioned were meant for B/D registration rechecking. He said that for rechecking B/D registration he did not need to visit the field so many days. He maintained that the present system of monthly birth/death registration could be changed to a quarterly or half yearly one. Regarding his non-appearance at the EPI session (on the 2nd day of the observation), he said that EPI was the responsibility of the health wing. He, however, promptly added that he would have gone there had the EPI action plan been provided to him. He complained that the MO (EPI) or EPI technician never gave him the EPI schedule.

As mentioned earlier, the FPA denied that the bulk of the job responsibilities were his. It became evident that he was very much influenced by the present tussle between the health and family planning wings. He said that many of the tasks, which he denied as being his responsibility, were very important. But he does not get himself involved in these works because he never finds any health worker doing any of his work (family planning). Thus he did not feel any obligation or motivation to do their work. It is pertinent to note here that this feeling of "departmentalism" was very much present among the staff at all levels which sometime leads them to become hostile to each other.

Finally, he was asked when he was last visited by his supervisor in the field. "Never" was his reply.

11. THE FAMILY WELFARE VISITOR

In the study upazila the total number of FWVs was six. It was planned to observe two FWVs, but it was not possible because of the non-cooperation from the FPO. Later the FPO received departmental instruction to cooperate with the BRAC team. But this did little good as he did not allow observation in any of the outreach centres selected. Instead, he allowed the team to work only in the UHFWC which was adjacent to the main road. This permission was given after he had a meeting with his staff about BRACs possible intervention. Later he allowed work in another outreach centre. However, because of this delay, valuable time was lost and only one FWV could be observed.

The FWV observed was found to be attending her office regularly. She was very punctual, never coming late or leaving early. This outreach centre is adjacent to the main road and was frequented by high officials. During observation, she had scheduled field visit on two days, according to the action plan she provided. But on both the days she was found in the office.

The way she treated the patients was less than perfect. She did not examine patients. Nor did she talk with them beyond asking them their names and addresses. She did not listen to the mothers' complaints. She

started prescribing medicines as soon as a mother mentioned the first word of her problem.

A number of mothers came with their sick babies. The FWV just gave them a prescription never advising the mothers on nutrition or such things as immunisation. Though a scale was available, not a single baby was ever weighed during the observation period. She referred to the MO/MA the cases which she could not treat by herself. By 11 o'clock there was hardly any patient left at the MCH counter. At this time the FWV was found either doing embroidery or taking a nap by laying on a bench.

On EPI vaccination day (once in a week), no clinical service was provided by the FWV. On that day she maintained records for the vaccines. The HA of the ward where the UHFWC is situated did the vaccination. The MA of that centre was not involved in EPI. The MA is supposed to do the vaccination, but in this case he had the HA do it. The same practice was found in other outreach centres.

The FWV never checked the fever of any of the patients. When asked, she replied that she had no thermometer. She had a stethoscope but did not use it, it stayed in the almirah.

The average number of patients per day who turned up during the observation period was 24. The figure would be reduced to 14 if the number of patients referred to the MO/MA were omitted.

After a weeklong close observation, a table showing the time she spent in various activities was prepared (Table 7).

Table 7: Time spent by FWV in different works

Activity	Hours per week	
	Expected as per own version	As observed
- Neat and cleanliness of the centre and sterilization of equipments/apparatus.	1.00	0
- Weekly chart preparation for clinical day, satellite clinic, home visiting etc.	1.00 (once per month)	0
- Record keeping and report writing	3.00	0
- Staff meeting with FPA, FWA.	4.00 (once per month)	0
- Attending at the meeting called by M.A	No such meeting is held in UHFWC	0
- Care of pregnant mother, postnatal care, child care (growth monitoring, EPI, nutrition education etc.)	27.50	15.00
- Injection & follow-up.	-	0
- Help to MO in ligation and follow-up.	-	0
- Home visiting	6.00	0
- TBA liaison and upgrading	-	0
- Meeting with mothers to teach them health education (at clinic)	-	0
Total	42.50	15.00

The table shows that in a week the FWV worked only 15 hours, or 35.3% of the prescribed time, all of which was spent on patient care. She did not spend any time in the field.

When asked about her role in sterilising the equipment/apparatus, she said that there was nothing to do since no ligations/vasectomies were done in that centre. Therefore, sterilisation of equipments was not necessary.

When asked why she did not maintain weekly chart on clinical day, attend satellite clinic, do home visits, etc., she said that she did not know what "clinical day" actually meant for. Therefore, maintaining of weekly chart on clinical day did not arise. She said that owing to a dearth of medicines, satellite clinics were not regular in her area, and so she did not maintain any weekly chart on the same. She, however, provided with us a copy of her home visiting schedule.

An FWV should keep a monthly performance record. The FWV could not produce any. The old one hung on the wall was from 1986. She said that she did not get any hard paper from the FP office to write monthly performance records on. "Our officer (FPO) orders us to keep it updated, but does not supply hard paper even after repeated requests".

According to the manual, the FWV is to attend the meetings called by the MA. No such meetings were ever held in this union. The FWV said that since the MA is from health department, she need not attend any meetings called by him.

An FWV has many technical duties, including the care of pregnant mothers and post-natal care. During the observation period, no such mother came to the clinic. Thus, there is no way to know if she performs these duties, and, if so, how.

It was observed that the FWV did not play a significant role in either growth monitoring or nutrition and health education. Her activities were limited to curative service delivery. The FWV said she had a tremendous work load and could not afford the time to talk with mothers. When reminded of the small number of patients she had cared during the observation period, she said that mothers had no interest in education, they only wanted medicines. In addition, the FWV said that it was not possible to advise each and every mother who came to the UHFWC, nor was there any system of giving them health education in group sessions.

The use of child growth chart is very important and can help mothers detect hidden malnutrition and alert them to their babies' need for supplementary diet. But the FWV did not weigh the babies though a 'Salter scale' was available. She said that she did not have any growth charts. She blamed the ministry for not providing logistic support.

The FWV's treatment of patients was lacking. Being a family planning worker, the FWV is expected to advise eligible mothers to adopt family planning practices. But the said nothing in this regard. The reason given, once again, was the excessive pressure of patients and that she does this during her home visit.

According to her action plan, the FWV was supposed to visit the field for two days during the observation period. Instead, she attended the clinic. When asked why, she said that she could not move outside the clinic because of excessive rush of patients. When reminded about the small number of patients, she kept silent. Regarding satellite clinics, she revealed that no such clinics were ever held in the union or in the whole upazila for that matter. She identified a number of reasons for that. First, the shortage of medicine. No extra drugs were supplied for satellite clinics. It any amount is reserved for satellite clinics, the UHFWC would have to close. Besides, she said that FPA and MA were not cooperative - "No one shows interest; what can I do all alone".

A FWV is supposed to keep contact with the dais (TBAs) of her union. At present, the government plans to upgrade 15 dais from each union to ensure safe deliveries. Discussions revealed that the FWV had no contact with any dai in her union. She said that dais were previously given a remuneration of Tk.50 per month. But this had been discontinued. "With no remuneration why would these poor women work with me?"

12.THE EXPANDED PROGRAMME ON IMMUNISATION (EPI)

The EPI had been underway in the study upazila since February 1987. Here BRAC assisted the programme on social mobilisation for

the first year. A study of the immunisation programme during the observation period revealed the current position.

Supply Position: The vaccine supply position was quite satisfactory. However, there was dearth of shot cards for the children. At that time, female cards (for TT) were being used. Sometimes mothers were being given records of doses on a piece of scrap paper which are often lost or becomes so wrinkled that they become worn out and illegible.

There was also a shortage of needles. During the observation period in the EPI outreach centres many of the needles were not pointed. These blunt needles caused extra pain and, sometimes, bleeding. The HAs complained that in spite of their repeated requests, they were not supplied with needles and cards. The EPI technician at the UHC said that they did not receive a regular supply of needles from the district level. He, however, complained that the HAs did not have proper records regarding needles used. Under the prevailing system, they were supposed to return used needles before replacement. Typically this was not done. The EPI technician expressed his apprehension that the HAs might be misappropriating some of the needles and using the rest repeatedly resulting in bluntness.

The technician also mentioned several other reasons for blunt needles. He said that the HAs were not careful in putting the needles in the steriliser. The HAs, however, said that the needles were blunt because of over-use. Neither the HAs, the EPI technician nor even the MO (EPI) could say for certain how many times a needle should be used. Different papers and manuals available with EPI technician were consulted but did not give any instruction regarding this.

Problems observed: There were many problems in the EPI, the most serious of them being the lack of proper supervision. There was virtually no record of those children who were left out or dropped out. With no supervision, the euphoria which was created during the early stage of the immunisation programme through BRACs involvement and the official's motivation disappeared. Workers were found demoralised. They remembered the initial period of EPI when all the officials were active. Now nobody showed any interest. They regretted BRACs withdrawal from EPI in the upazila. During the observation

period, sterilisation of the immunisation kits was being done at home by the HAs. They often complained that they did not get reimbursed for the kerosene they used. There was reason to wonder whether sterilisation was being done properly or at all. In a related story, one FWV told how a mother came to the outreach centre with her baby for vaccination when they HA was packing up the steriliser. He had no sterilised needles so he lit the torch light and placed the needle near the bulb. After a while the needle supposedly became “hot”. Using that sterilised(!) needle, he vaccinated the last client of the day.

Pre-contact and follow-up: As mentioned previously (section 4), these two very important tasks are not done which ultimately leads to low coverage.

Mothers had no confidence in HAs, most of whom were in their fifties, with weak vision and shaking hands. They tried easily and often got angry over small matters.

The MO (EPI) rarely visited outreach centres. In the past he used the excuse of not having any transportation. Recently this changed when he got a motor-cycle from his department; however, he still hasn't made any field visit. He said he felt in secured visiting outreach centres because of the recent incident at the UHC which led to scuffling between doctors and outsiders with injuries on both sides.

It has been mentioned earlier that no pre-contact was ever made by the HAs. With no EPI registration, updating, follow-up or supervision, the immunisation programme in the outreach centres was fast becoming inactive.

13. VITAMIN A CAPSULE DISTRIBUTION PROGRAMME

While malnutrition is an overwhelming and crucial health problem in Bangladesh, vitamin A deficiency is extremely serious due to its effect on child blindness. More than 30 thousand children under 6 years of age become blind each year due to vitamin A deficiency. Three out of every 100 children in this age group suffer from various degrees of

night blindness in the rural areas. Realising the magnitude of the problem, the government of Bangladesh started a programme in 1973 to distribute vitamin A capsules. Under this programme, vitamin A capsules (VAC) are distributed twice a year to all children between the age of six months to six years.

Supply Position: In the study upazila, VAC distribution was first started in 1975. No irregularity in VAC supply from the district have been reported by concerned officials.

Coverage Survey: A survey was conducted in a village where 43 households having children eligible to receive vitamin A capsules were contacted. Only 34.8% reported having received a VAC during the previous six months.

Problems: Since the study period did not coincide with a VAC distribution period, it was not possible to identify the problems relating to the actual operation of the VAC programme. However, from the experience of one of the team members who had previously worked in this upazila on EPI for 12 months and from interviews with mothers, there were widespread complaints against the HAs for not visiting the households to distribute VAC. Instead, the HAs gave a fistful of capsules to a small boy or a mother with the advice to distribute these among young children. The Health Inspector and the UHFPO admitted this malpractice. Recently, the salary of one HA was held up for such behaviour.

The HAs said that they were always busy with their routine work. Imposing extra responsibilities like VAC distribution makes their work difficult. None of them, however, admitted to any malpractice. Even the HA whose salary had recently been held up denied any fault; rather, he complained that the villagers misinformed the higher officials, out of a personal grudge.

Mothers did not know why vitamin A capsules were necessary, nor did they know the dose or how many times a year it should be taken. Their indifference and ignorance permitted the Health Assistant to be more negligent in VAC distribution.

14. DIARRHOEA CONTROL PROGRAMME

For diarrhoeal control there is a comprehensive preventive and curative programme. The HAs are to collect diarrhoeal information from their routine home visits and supply ORS to their patients. In addition, they are supposed to advise people on safe drinking water, sanitation, cleanliness as preventive measures against diarrhoea and similar diseases.

Diarrhoeal control activity becomes more visible during flood period. In their daily flood reports, the HAs are supposed to furnish the total number of diarrhoeal patients in their respective areas and give details on curative measures taken including ORS distribution, and, in acute cases, referral to the UHC. Besides, a large number of diarrhoeal patients are given in- and out-patient care at the UHC.

It is reported by concerned officials that the supply of ORS, particularly during the flood period, is always satisfactory. Two unions of the study upazila were affected by flood during the observation period and ORS was distributed by the HAs.

During interviews with mothers, they were well acquainted about home-made solutions and its preparation. At the same time, they expressed trust in ORS packets.

15. MALARIA CONTROL PROGRAMME

The government has a comprehensive programme on malaria control - both preventive and curative. Though no trace of preventive activity could be found at the field level, activity on the curative side was evident. Each HA has to collect “slides” equivalent to 1% of the population of his ward. They send them to the UHC for laboratory testing. If any malarial parasite is identified, the respective HA is supposed to contact the patient and initiate treatment. Moreover, to date, no incidence of malaria has been reported.

Malaria control consists only of blood collection. Nothing is done with it. The HAs doubt whether the slides are tested at all. From November 1987 to October 1988, a total of 5,843 slides were collected

and sent for testing with no positive result being reported (see also section 4).

The shortage of laboratory technicians is a great problem. For a single laboratory technician to assay such a huge number of slides in addition to doing other routine tests (blood, urine and stool) is unrealistic. The HAs believed that the authorities give too much attention to blood slide collection; they think that emphasis should be shifted to more acute problems.

16. OUTDOOR ACTIVITIES

A. UHC.

The total number of out-patients who turned up at the UHC from January 1988 to October 1988 was 50,888. The number of patients affected with specific diseases was, however, not separately available. However, the numbers for the UHC and UHFWCs together, were available. Diarrhoea tops the list of diseases (21.47%) followed by respiratory tract infection (RTI) (12.35%), skin disease (12.09%) and worm infestation (10.89%).

Problems: The medical officers and other staff of the UHC identified several problems pertaining to out-patient services. A shortage of medicines was identified by all as the single most serious problem. Doctors said that they often could not prescribe full doses of medicines. This, particularly in case of antibiotics, can result in increased resistance to the particular antibiotic. They further complained that they often could not prescribe the particular medicine required. Drugs shortages at government hospitals result in patients never being cured and losing faith in the health systems. Other problems with outdoor services include the non-availability of doctors during office hours. As a result, patients had to wait for a long time in a corridor with no sitting arrangements. In addition, there is no queue system resulting in mothers fighting to get their chance.

B. UHFWC

The total number of patients who turned up in the five outreach centres during the period between January-October 1988 was 1,16,977.

The following table shows the distribution of the patients according to different age cohorts.

Table 8: Number of patients in outreach centres by broad age groups

Age group (years)	No. of patients	Percentage
0-1	10,167	8.7
1-5	16,390	14.1
5-15	35,528	30.3
15-above	54,892	46.9
Total	1,16,977	100.0

Only one outreach centre could provide a disease profile for the period. Acute RTI patients were most common with 22.6% of total patients. The major diseases recorded were anaemia (9.4%), skin disease (7.7%), peptic ulcer (7.4%) and worm infestation (7.0%).

Problems: The problems at outreach centres are almost identical to those at the UHCs. However, one additional problem was identified. Local youths, particularly those in schools and colleges, were found to be using force to extract medicines from these centres. The study identified cases where adolescents who were not sick would come to the out-patient clinics at the UHC for the primary purpose of getting free medicines. Many young boys of school/college age often went to the UHFWC in a group with no ailment at all or a minor running nose or headache. They did not wait outside for their turn. Rather they entered the chamber of MO/MA demanding medicines. In one UHFWC a boy requested a phial for worm. The MA instantly prescribed the same. Later he told the observer that the boy was actually not a patient. The MA, however, would not dare challenge him for fear of being insulted.

It was widely complained by MAs that many mothers come to outreach centres as patient companions. Once at the UHFWC, these mothers also become patients and take free medicine. This problem makes the drug shortage worse and increases the lack of confidence the people have in the government health services.

17. INDOOR ACTIVITIES

No. of Beds:

In the UHC being studies there were 31 beds for in-patient services. The breakdown of these beds are:

Male	:	10 beds
Female	:	15 beds
MCH	:	6 beds

Table-9 shows bed occupancy by age and sex for a period of one year. Males outnumbered females in young and older ages. However, females have a consistently higher admission rate during reproductive ages (15-39).

Table 9: Bed occupancy in UHC by age and sex

Age	Male	Female
00-04	72	43
05-09	43	27
10-14	60	37
15-19	47	61
20-24	83	118
25-29	86	83
30-34	76	101
35-39	34	48
40-44	39	36
45-49	28	22
50-54	39	41
55-60	22	17
60>	75	48
Total	704	682

Fifty seven patients marked as “children” in sex column could not be classified by gender.

Problems: To know the problems in in-patient service delivery, the Resident Medical Officer (RMO) was interviewed. As usual, the shortage of drugs and poor logistic support were identified as major problems. The following were the most serious shortages:

- essential drugs/antibiotic
- I.V. fluid*
- gauze, bandage, cotton
- life-saving drugs, and
- non availability of oxygen.

Laboratory Services:

Though the number of laboratory technician is two, only one had been performing all the tests for months. Because he was always over burdened with a huge number of tests and report writing it is assumed the quality of his work was not good. Just the malarial slides sent by HAs alone numbered nearly six thousand last year. Besides, there were other types of routine tests which had to be done.

X-ray services:

The total number of x-rays done from September 1987 to August 1988 stood at 492. Of these, 477 were done free of charge. The x-ray machine is often out of order. And once it becomes non-serviceable, no matter how small the faults, it usually took months to fix it. It required many formalities - note writing, reminding, Upazila Parishad meeting, again reminding, tender, retender, etc.

The shortage of a radiologist is another serious problem. Only one MO has the requisite qualification, but he is posted at the UHFWC and not at UHC. However, he resides in UHC dormitory since there was no residential accommodation for him in his UHFWC. This MO sometimes examines x-ray photos and prepares reports. In his absence, this job is performed by senior MOs. Since they do not possess any requisite training, they do not write the reports. Instead, they communicate their findings verbally.

It should be noted that in-patient and referral patients are not charged any fees. However, private patients must pay. Half of the payment goes to government fund and the rest is divided between the doctor who prepares the

* Because of the shortage of IV fluids, patients are supplied with half the requisite amount and asked to purchase the rest from outside.

report (30%) and the x-ray technician (20%). Since only one doctor had the relevant degree and he was posted outside the UHC, many x-rays are not done. Previously there was a shortage of film.

The condition of the x-ray room is not hygienic. This room is on ground floor, under the toilet on the first floor. There are some cracks on the ceiling which allows filthy water leak into the x-ray room. As a result, the wall and floor are always damp and obnoxious odours fill the room.

This matter was discussed with the UHFPO and RMO. The problem was administrative procrastination and procedural complexity. Both of them said that the matter would be raised again in the next Upazila Parishad meeting, but they expressed their fear that little would come of it.

Financing of Health Services:

UHC: The UHFPO was asked about the annual budget for drugs in the UHC. While reluctant to reveal the amount spent and under what head he provided some information. For the year 1987-88, a total amount of Tk.3,00,000 was received. Apart from this, UNICEF donated 13 DDS kits.

The total amount of drugs, purchased and donated was insufficient according to the UHFPO. With the ever-increasing number of patients, particularly in the outdoor department, they found it difficult to cope. The shortage of drugs could be decreased if the drugs were supplied on the basis of disease patterns. Under the existing system, they get 31 kinds of drugs on a quota basis. They receive many drugs for which demand is very low, while some essential drugs are always in short supply.

The UHFPO said that the drugs in UNICEF-supplied DDS kits were appropriate for the disease pattern that existed. However, only 13 DDS kits was totally insufficient.

The annual budget of Tk.3,00,000 includes the cost of gauze, bandages, cotton, etc. The UHFPO felt that a separate allocation should be made for these.

The Upazila Parishad allocated 7% of its development budget for 'health and social welfare'. According to UHFPO, the quota of health budget at the Parishad is very small, and that too much of it used only for emergency health services. During the last flood (1987), an amount of Tk. 1,000 was sanctioned for emergency health services. The Upazila Nirbahi Officer (UNO) was interviewed who said that the health department never asked for this money. As a result, the whole amount (7%) is spent for what is called social welfare (i.e. clubs, sports, etc.) activities.

The UHFPO thought that 10% of the Upazila Parishad budget should be earmarked for meeting emergency needs. He supported his view by adding that there was an extreme shortage of gauze, cotton,. bandages, etc. If a certain amount were put at their disposal (UHFPO and Civil Surgeon (CS)), they could purchase the supplies required to meet the emergency.

UHFWC: The drug budget for the UHFWC varies from time to time. Generally the annual budget provision is thirty to forty thousand taka and four to eight DDS kits per year. Table 10 presents the annual drug budget for an UHFWC.

Table 10: Drug budget of an UHFWC in 1987-88

Financial year	Total Budget	Date of receiving	Amount received
1987-88	Tk. 40,000	15-09-87	Tk. 12,687.00
		02-11-87	Tk. 15,183.00
		20-06-88	Tk. 11,342.00
			Total Tk. 39,212.00
	8 DDS kits	07-08-87	2
		02-11-87	2
		16-02-88	2
		18-04-88	2
1988-89	Tk. 30,000	17-08-88	Tk. 10,173.00
		17-10-88	Tk. 12,307.00
			Total Tk. 32,480.00
	1 DDS kit	05-09-88	1

Alternative Way of Financing?

Considering the severe budget constraints the UHFPO and other health officials were asked about alternative sources of financing health care activities. The UHFPO suggested that the present allocation from the upazila should be regularised. He, however, ruled out the feasibility of a ticket system. He thought that such measure would cause more problems than it would solve. When asked to be explicit, he said that local political leaders would exploit the situation. The MOs agree. The MAs were, however, much more optimistic; they were less concerned about the local politicians. They only had to be convinced. They thought that a ticket system would have two benefits. On the one hand, it would be source of income and, on the other, non-patients would ultimately disappear, which would reduce the pressure on the already limited drug supply as well as on their time.

Deaths at the UHC

Statistics at the UHC indicate that only a few people are brought to hospital, even when they are close to death. Only twelve deaths occurred in UHC over a 12-month period. Death certificates which are supposed to be issued, generally are not, except in the cases of some abnormal circumstances (e.g., accident assault, suicide). There was also a tendency to shift the responsibility. Seriously ill patients are often diverted to the district hospital even when they could be treated at UHC.

18. SATELLITE CLINIC

No satellite clinics were being held at the observed upazila. The most important reason for this is the lack of initiative on the part of the FPO, FPAs and FWVs. Only the senior FWV, who had recently been transferred to the upazila, was found to be active. But her effort, by itself, was not enough. The said that the FPO was actually not as interested as much as he seemed when one talks with him about this matter. She complained that the FPO had no control over FPAs. She lost her enthusiasm for satellite clinics which she had previously.

Why were the FPO, FPAs and others reluctant to start satellite clinics? As far as could be determined, it was the shortage of drugs.

19. SOME OTHER ASPECTS

Question of Supervision:

Supervision and periodic monitoring of programme activities are essential to ensure that health and family planning services are being carried out as planned and that the results are satisfactory. But during the observation period, it was found that supervision was almost absent at all stages, particularly in domiciliary and at the UHFWC.

The Field-level workers interviewed said that they had not seen their supervisors in the field since they had been in government service. Thus, it was not a question of the "last visit", rather it was a question of "had they ever been supervised" and the answer was an emphatic "No".

One FWA mistook the observation team as high-level supervisors though informed otherwise. She said that she did not have any experience of being supervised. "Now that supervision has started, we must become serious in our work" she said.

One FWA complained that at the initial stage of EPI, "bosses" used to go the field. But now they are not seen in the field. Even the BRAC personnel are not available*. Because of the lack of support, the FWAs said they no longer got pleasure from their work (EPI) like they did in the initial stage of EPI.

The FPAs could not recall the FPO visiting them in the field. The HAs said they sometime got their bosses (HI & AHI) in the field but they did not supervise their works, they just gave "a few rounds". The visits were rare and did nothing to raise the field staffs motivation or improve the quality of their service.

* BRAC withdraw from this upazila a year earlier.

Besides, action is rarely taken in case of any negligence of duty detected. Once the UHFPO went to an UHFWC for supervision. The MO of that centre was in "french leave". The UHFPO went round the compound all alone. Coming back to the MOs chamber, he asked the medical assistant to bring tea. When the medical assistant produced the visitor book, the UHFPO did not sign it, saying that since the medical officer was not available, he would come back another day.

The supervisors such as HIs, MOs, UHFPOs, FPOs, etc. were interviewed to know the problem of supervision. There was no unequivocal answer. The MO-EPI mentioned about the non-availability of motor cycle. However, he was not found supervising even the fixed EPI centre located at UHC. The Sanitary Inspector said that if he did supervision seriously he would find faults with the field staff and would have to take action against them. This would hamper his own security. "After all I am an outsider here. I reside here with my family. How could I dare to take action against these people who are local?" Besides, the Health Assistants were reportable to Health Inspector (HI) and as a result, he had no administrative authority. In fact, supervisors at all level have an aversion to supervise their staff at field levels. Some feel insecured to take any action which ultimately keeps them away from supervision of their staff. Others complained against irregular reimbursement of conveyance bills. Some supervisors, however, flatly resorted to falsehood saying that they were regular in doing supervision.

A proper supervision may also bring problems for the supervisor himself. The research team was told of a Civil Surgeon (CS) who was said to be very active and honest. He took about administrative actions against two UHFPOs for negligence of duty by suspending them. Since these UHFPOs were well connected, they got their suspensions withdrawn, and the poor CS was transferred to head a newly created district hospital, a less attractive position. In this new situation he was still keeping himself honest in dealing with new construction work for the hospital. When he awarded the work order to the lowest bidder, and not to a particular contractor belonging to a particular political group, he had to embrace another transfer. This time he was also warned to cooperate with local "people".

In another case, an UHFPO stopped the salary of two HAs. But these HAs influenced the local upazila Chairman who got the suspensions overruled by CS.

Reporting System:

Reporting system works from bottom to upward direction. It was observed that there was pressure at all levels for sending reports but none seemed to bother about the authenticity of the report sent.

Reliability of Records:

At the last leg of the study, the team tried to know how reliable were the records kept by the officials of both the health and family planning departments. Gross anomalies and a disappointing picture came up.

i) Geographical Reconciliation (GR)

To know the reliability of GR, 60 households of a village which had 106 households were surveyed. Out of these 31 households (HH) had no HH number. Some inmates said that the HA did not come in recent months* for numbering, while others said that they could not recall whether any such numbering was ever done on their houses. Some also said that the number was there, but it had disappeared when the old doors were replaced.

To verify the reliability of government GR, the report for 1988 was collected. First the HA who did GR in that village was contacted. Knowing that a survey had been done, he confessed that his report would not coincide with the survey – "I did the GR survey of 1988 not very carefully. But I shall be sincere next time when I do it". He could neither provide the Gr report nor the consolidated one but referred it to upazila health and family planning office. There the Health Inspector was contacted. He tried to avoid it in many pretext. The consolidated figure that he gave was not serving the purpose and the UHFPO was approached who instructed the HI. But all the efforts went in vain as no HH wise GR list was available with anybody. As a result, the government GR record could not examined.

* GR is done once in each year, normally in January.

ii) Couple registration:

In the above survey with 60 households, a total of 58 couples were found, as shown in Table 11.

Table 11: Couple registration reliability

Total household surveyed	No. of couple in surveyed HHS		No. of couples with no trace	No. of couples newly married
	Couple register record	Actual		
60	48	58	2	2

In the couple registration book, however, the figure was found to be 48, which will come down to 46 if we exclude the two couples - no trace of whom could be found through our survey. In the surveyed area the actual number of couples was 58, but in the government record it was 46. However, two newly married couples (i.e. marriage was held after Oct'87 registration) were also found. This brings down the difference to (58-48) 10.

iii) Acceptors of family planning methods:

The survey on the above households found that the number of acceptors of different methods as reported by FPO was almost authentic.

Table 12: Acceptors in surveyed area

Total	Ligation		Vasectomy		Copper T		Pill	
House-holds surveyed	Couple regt. record	Actual	Couple regt. record	Actual	Couple regt. record	Actual	Couple regt. record	Actual
60	12	14	1	1	1	0	17	18

Among the users of pill, five women were found to be purchasing it from the market. The rest depended on government supply.

Health and Family Planning Tussle:

There is an undercurrent of hostility between health and family planning wing which surfaces on triffling matters. The following are a few examples indicating the nature of the tussle between health and family planning which had been observed by the research team at different times of the study.

- After one week of arrival at the study upazila the research team convened a meeting at the office of UHFPO where all the MOs and FPO were invited. Though promised, the FPO did not turn up in the meeting.

- The senior FWV had been working in the UHC for the last four months but the UHFPO did not know her nor did she know him. The research team introduced them to each other.

- All the FWVs of outreach centres said that they were reportable to FPO. But according to the official manual they are reportable to MO of the respective centre via MA.

- No FPA ever goes to EPI session. When contacted they said that they did not get any action plan. Besides, they are not called in the planning meeting by the health staff. Whereas, the health people say, family planning personnel do not work with them.

- FPA and HA are both domiciliary staff. FPAs are comparatively young and more educated than HA. They always undermine HAs, because of their being less educated. On the other hand, HAs with longer period in service belittle FPA as fledglings.

- FPAs, FPO and even DD-FP complained that the health department had misused huge quantity of contraceptives. It may be mentioned here that during the integrated programme (H&FP) of 1981-83, the health staff were also involved in contraceptive distribution. But they, it is alleged by family planning personnel, could not give proper accounts.

- No domiciliary staff of the health department had any functional relationship with that of the family planning.

- One MA complained "when an FWV does not attend her duties regularly, I complain to UHFPO who informs the civil surgeon. The FPO does not bother about this and the FWV continues to receive her salary regularly". Because of the lack of coordination, there is not much scope to enforce work ethics.

- The FPO suspects an anti-family planning attitude amongst all health officials even those at the top. The short supply of contraceptive was related to the fact that the head of TEMO* in Dhaka was a doctor and that he "deliberately created this problem to sabotage the family planning programme".

- The enmity and ill feeling is so pervasive that the FPO demanded that his office be moved from the Health Complex. "Overpopulation is a socioeconomic problem, not a disease. Either you take us to the Upazila Parishad Office or erect a wall here separating us from the Health Wing", commented the FPO.

In short, workers and officials of one wing nurture malice for their counterpart in the other wing which becomes evident as soon as one raises the topic. Now we discuss how this tussle affects their work.

EPI: It has been observed that involvement of the family planning personnel in EPI is almost absent. Because of their non-cooperation the EPI suffers a lot. According to EPI policy, an FWA should visit that part of her working area where vaccination (at outreach centre) would be given on the following day. The FWA should prepare her monthly action plan accordingly so that she could visit the area before the vaccination day. But this was not happening.

As a result the task of FWA on that day (information and motivation) remains unaccomplished. FPAs were not found directing their workers (FWA) to prepare their monthly action plan accordingly. FPAs themselves do not visit any vaccination centre.

* Central warehouse.

Their version is that 'health' does not provide them advance action plan on EPI 'so why should we feel the urge?'. On the other hand, 'health' complaints that FPAs are not at all interested in EPI. Neither FPO nor UHFPO takes initiative to resolve this stalemate condition. Sense of departmentalism keeps them apart from taking joint action.

Besides, the FPAs complained that they do not get TA/DA for this purpose. They believed that huge fund had been allotted for TA/DA but health officials (UHFPO, MO-EPI) were devouring all those money depriving them.

The FPO also held similar opinion - that huge some of money of EPI was being embezzled by health officials. He agreed that whatever involvement the 'family planning wing' had in EPI was just for courtesy sake. Citing an instance of non-cooperation from 'health' he said that once he had requested them to help him doing couple registration in two wards where FWAs were temporarily absent, but none came up to help him. "Now if this be their attitude how could we work together?" said the FPO.

Sterilization: The FPO complained that the clients for sterilisation were ill treated at UHC. They are kept waiting for hours together. Besides, he complained, operation was not done carefully. If "health' were cooperative, said the FPO, the number of sterilisation cases could have been raised.

MO - EPI, on the other hand, complained that the family planning workers (FWA, FWV, FPA etc.) did not work. But he could not take any administrative action against them. He also complained against the non-cooperation of FPO. He informed that even after repeated request he could not take the FPO to outreach centres.

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Appendix - 1

The Research Team

1. Mr. Munir Ahmed, Health Economist
2. Dr. Monoronjan Sarkar, Physician
3. Mr. Joglul Islam, Health Programme Manager
4. Mr. Shahnoor Mahmud, Health Programme Organiser
5. Dr. AMR Chowdhury, Demographer (Study Coordinator)

Appendix - 2

Upazila Health and Family Planning Staffing

4.1. Staff position, Health (UHC)

(i) Medical officers: All the nine medical officers are posted here.

Sl.	Designation	Sanctioned	Posted
1.	UHFPO	1	1
2.	RMO (Resident Medical Officer)	1	1
3.	MO – Medicine	1	1
4.	MO – EPI	1	1
5.	MO – Gynaecology	1	1
6.	MO – Surgical	1	1
7.	MO – Dental	1	1
8.	MO – MCH	1	1
9.	MO – General	1	1

(ii) Administrative/Service Staff (UHC)

Sl.	Post/staff	Sanctioned	Posted
1.	Head Assistant cum Accountant	1	1
2.	Statistician	1	1
3.	LDC cum typist	1	1
4.	Office Assistant	1	1
5.	Store Keeper	1	1
6.	Cashier	1	1
7.	MLSS	1	1

(iii) Clinical Service Staff (UHC)

Sl.	Post/staff	Sanctioned	Posted
1.	Senior staff Nurse	5	5
2.	M. A	2	2
3.	Pharmacist	2	2
4.	Laboratory Technician	2	2
5.	X – ray	1	1
6.	Junior Mechanic	1	1
7.	Word Boy	3	3
8.	Aya	2	2
9.	Peon	-	-
10.	Driver	1	1
11.	Cook	1	1
12.	Mosalchi	1	1
13.	Sweeper	5	4

(iv) Domiciliary Health Service staff:

Sl.	Post/staff	Sanctioned	Posted
1.	Sanitary Inspector (SI)	1	1
2.	Health Inspector (HI)	2	2
3.	Assistant Health Inspector (AHI)	3	1
4.	Health Assistant (HA)	18	18
5.	EPI technician	1	1
6.	MLSS	1	1

(v) Health Service staff, outreach centres:

Sl.	Post/staff	Sanctioned	Posted
1.	MO	5	5
2.	M A	5	5
3.	Pharmacist	5	5
4.	MLSS	5	5

(vi) Staff position, Family Planning (UHC)

Sl.	Post/staff	Sanctioned	Posted
1.	Family Planning Officer (FPO)	1	1
2.	Senior FWV	1	1
3.	Family Planning Assistant (FPA)	3	3*
4.	Family Welfare Visitors (FWV)	2	1
5.	Peon	2	2

(vii) FP staff, outreach centres:

Sl.	Post/staff	Sanctioned	Posted
1.	MA	-	-
2.	FWV	5	5
3.	Pharmacist	-	-

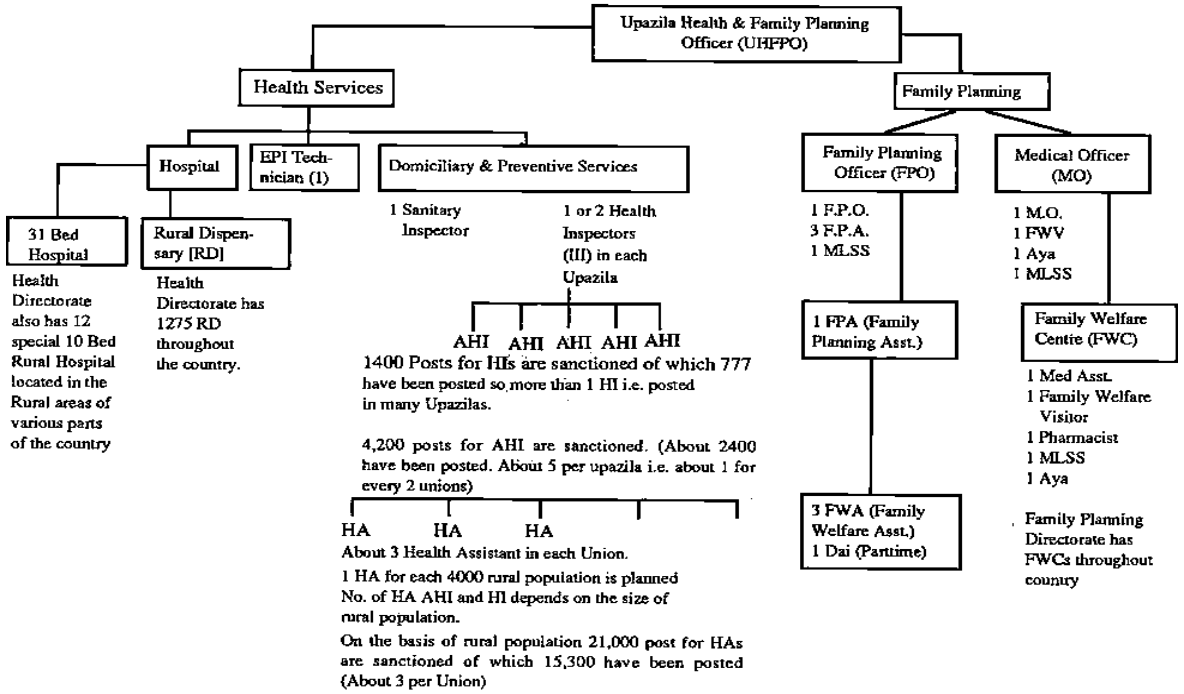
(viii) Domiciliary FP service staff:

1.	Family Welfare Assistant (FWA)	18	18
2.	Family Planning Assistant (FPA)	6	6

* One each in store, cash & clerical side.

Appendix-3

Organizational Structure of the Ministry of Health and Family Welfare at the Upazila Level



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   An Analysis of Resource Flows

A Tale of Two Wings

This study looks at how the government health system, incorporating the health and family planning wings, functions in an upazila in northern Bangladesh. By staying in one upazila for more than three months and working closely with different levels of health and family planning officials, the study team gained many insights into the dynamics of different programme components, some of which are startling. The study portrays a dismal picture of the situation at the periphery. The field staff of the two wings spend less than half of their time in official work. They tend to be more attentive to work which is more closely supervised, to programmes which involve greater national commitment (such as immunisation), to emergencies (such as floods), and to efforts where the relevant supplies (e.g., ORS) are more available. It is assumed that many of the findings will be useful to the government in assessing and improving its health and family planning services at the periphery. Based on this study a major review of the health and family planning services in rural areas is warranted.

About This Study

"The [amount of] work actually done by the field workers of the Health and Family Planning sector is not altogether unknown to us. Information documented through this study are close to those found by some of our own assessments. The analysis provided in this study on the amount of time spent in a week by the field workers on their assigned duties has given us a new perspective of looking at the problem. What has been documented through this study is a harsh reality" (from Bangla text).

M. Asahabur Rahman
Sr. Assistant Secretary
Ministry of Health and Family Welfare, Dhaka

"I would like to congratulate you and your research team for undertaking field study on the operational aspects of health care delivery, an innovative approach for Bangladesh. The study brought to focus once more the major problems impeding health care delivery in Bangladesh".

R.S. Giri
Acting WHO Representative, Dhaka

"We found that the findings of the case study would be useful particularly to our Action Research Programme Division while planning its projects not only in Bangladesh but in our other member countries".

ATM Shamsul Haque
Director
Centre on Integrated Rural Development for Asia and the Pacific (CIRDAP), Dhaka

(continued overleaf)

"It has been a revelation worthy of emulation, and has demonstrated the value of combining both quantitative and qualitative methodologies".

James L. Ross
Program Officer
The Ford Foundation, Dhaka

"I was fascinated with its content and the thoroughness of the investigation".

Abbas Bhuiya
Associate Scientist
International Centre for Diarrhoeal
Disease Research, Bangladesh (ICDDR,B), Dhaka

"It makes interesting reading, though it is somewhat depressing to read of such complacency within the health services. Are you planning to investigate another area or an NGO for comparative purposes? If so, it would be interesting to see the difference in service provision".

Fiona Duby
Project Coordinator
Overseas Development Administration, Dhaka

"The lack of supervision, the lack of commitment on higher levels and more specific the lack of proper supply/logistics described in the report as key issues is also our findings".

Finn Schleimann
Adviser
Primary Health Care Preparatory Unit, DANIDA, Dhaka

"Unlike most research it has the human touch. It can be read by both technical and general background people, very easily. I hope the Government of Bangladesh takes this study in good grace and spirit and uses it as a basis to improve health and family planning services to the people".

Sandra M. Kabir
Executive Director
Bangladesh Women's Health Coalition, Dhaka

"Through this [study] the actual situation prevailing in the health sector of the country has been clearly presented" (from Bangla text).

Letter to the editor, The Daily 'Sangbad'.