Low Performance of BRAC's Health and Family Planning Facilitation Programme in Habiganj District and Hard to Reach Areas

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Abstract

Using data from qualitative interviews with clients (both females and males) and BRAC staff, this report examined the performance of BRAC's family planning programme in some low performing thanas and hard to reach areas in Habiganj. It was found that the poor performance of the family planning program in this particular area can be attributed to continual shortages of female and male staff, additional workload, and low morale, resulting in high drop out rates of staff members. Family planning is relegated to a secondary role because the service system provides little time or opportunities for staff to carry out effective mobilization. Moreover, geographical barriers, particularly in hard to reach areas (location, distance, lack of transport) make it difficult for female staff to access difficult areas. A number of depot holders expressed dissatisfaction with their voluntary work. There is a lack of adequate supply of contraceptives from the government in all of the thanas visited. Widespread religious ideologies against contraceptive use affect and influence the village communities. A considerable number of BRAC female staff have dilemmas with BRAC's mandatory policy of riding bicycles in the conservative areas, which affect the delivery of services. Performance of the programme can be improved by addressing the problems revealed in the study.

Introduction

The Health and Family Planning Facilitation Program

The Health and Family Planning Facilitation (H& FPFP) programme started in December 1994. It was set up to facilitate and implement the national family planning programme, providing management support and training to the national population programme. Since August 1997, the program supported by USAID has been further developed into the National Integrated Health and Population Programme (NIPHP). The focal point of the programme is to reduce fertility and improve family health. The program is a 7 - year programme, with a partnership between the Bangladesh government, non-governmental organisations (NGOs) and BRAC. This is basically an umbrella programme designed to contribute to the government Health and Population Sector Programme (HPSP). The NIPHP implements its programmes through the Rural Service Delivery Programme Partnership (RSDP) and the Urban Family Health Programme (UFHP), in conjunction with nine partners (1).

BRAC plays a dual role in NIPHP, firstly providing technical assistance to 19 NGOs of RSDP areas. Secondly it directly implements the Essential Service Package (ESP) through its H&FPFP in 33 thanas of 8 districts. Finally, it is involved in grant management for two NGOs, SHIMANTIK and SOUPPS in the Sylhet region, providing both technical and financial support to implement ESP in line with RSDP strategies. Presently, BRAC, along with Pathfinder International and Bangladesh Center for Communication Programmes (BCCP) has been implementing the ESP in 171 thanas (1).

BRAC's RSDP strategies are:

- To provide ESP directly through three service delivery points, i.e. BRAC Health Centers (BHC), *Shushasthya* at the thana level, Ante-natal Care Center (ANCC) at the union level and Depot Holder/ *Shasthya Shebikas* (SS) at the community level;
- To provide generalized services to ensure direct services in the allocated areas; and
- To facilitate government efforts in the selected thanas to maximize the ESP profit.

The project's agenda is to provide support to the government population program, by improving quality of care, implementing creative ways of social mobilization and communication, and supplementing areas where there are gaps in service delivery, and work towards increased male involvement in the program (1).

BRAC's FP-FP programme has a dual role in NIPHP. First, the plans are to implement the programmes in selected thanas of 4 districts (Nilphamari, Sherpur, Habiganj, Maulvibazar, and Shunamganj. Secondly, from August 1997 to July 2000, BRAC will implement the NIPHP in 29 thanas of the 5 districts. So far, BRAC has been covering a population of 5.3

million in 25 thanas in the 4 districts of Nilphamari, Sherpur, Habiganj, and Maulvibazar. (1). Twenty of the 29 selected thanas have been categorized as low performing (see table 1). However, in Nilphamari and Sherpur districts, the contraceptive prevalence rates increased by 18% (baseline August 1995) to 53% (June 1997); and in Habiganj and Maulvibazar the increase has been 13% from 15% (baseline May 1996) to 28 % (June 1997).

Although the programme has been successful in increasing contraceptive prevalence rates, some thanas in the districts of Sherpur, Habiganj, Maulvibazar, and Shunamganj have been plagued by low performance rates (BRAC Report, 1997). This was a qualitative study, exploring at a micro-level, the reasons for the low performance in some thanas in the Sylhet region. The paper focuses on Habiganj district to examine the possible reasons for its low performance, in the thanas of Bahubol, Baniachong, Ajmiriganj, Modhupur, Nabiganj and Lakhai, most of which are hard-to-reach and low performing areas. A majority of the villages located within this division are classified as hard-to-reach areas.

Table 1**. Thanas Allotted to BRAC (August 1997 - July 2002**)

District	Low Performing *Thana*	High Performing *Thana*	Municipality
Nilphamari		Dimla, Domar, Kishorgonj, Sayedpur, Joldhaka	Nilphamari Sadar
Sherpur	Nakla, Nalitabari, Jhenaigati, Shreebordi		Sherpur Sadar
Habiganj	Madhobpur, Lakhai, Baniachong, Nabiganj, Ajmiriganj, Bahubol, Chunarughat		Hobiganj Sadar
Maulvibazar	Sreemongal, Kulaura, Balarekha, Kamalgonj Rajnagar		Maulvibazar Sadar
Shunamganj	Chatak, Tahirpur, Dowarabazar, Dharmapasha		

Methodology

The study was conducted using research methodologies of direct observations, informal discussions and in-depth interviews. A total of 11 BRAC staff members, male program officers (P.O.s) and female paramedics were interviewed. In addition, 10 women clients, 6

males, 4 depot holders were also interviewed. Furthermore, informal discussions took place with staff and a number of clients in Habiganj Sadar and Maulvibazar Sadar.

The rural women and men in the villages were randomly selected. All the women and men were interviewed in the privacy of their own homes, so that they were able to speak freely about sensitive issues. A few informal discussions took place in the *baris* (households) with other family members of the clients as well.

The issues raised appear to be common operational constraints throughout the different thanas and districts.

Findings and Discussion

The service delivery approach: staff constraints

BRAC provides priority services in areas where government service delivery is inadequate or absent. The essential packages of services BRAC offers are static dinics termed as BRAC Health Centers (BHC), satellite clinics, providing ante-natal care (ANCC), and through community-based volunteers called depot holders (DH) or *shasthyo shebikas* (SS). ANCCs are held in areas not covered by the government satellite clinics and are integrated within the government's EPI[1] outreach services. The outreach sites provide family planning services such as providing pills, condoms, injectables, management of side effects, ante-natal and postnatal care, and referral services to BHCs (1).

Currently, the management structure proposes that for each *thana*, consisting of several unions, there should be a female paramedic assigned to every union. In addition, there should be two extra male programme organisers (P.O.) to assist in family planning mobilization, and help female paramedics access hard-to-reach areas. Each union on average has 20 villages, with a total average population of 20,000. There are on average 2,000+ eligible couples. The reality, however, is that in each of the *thanas* visited there appeared to be a shortage of staff.[2] It was clear from staff interviews in one of the *thanas*, where BRAC

[1] Expanded Programme on Immunisation.
[2] This scenario was also true for Habiganj and Maulvibazar Sadar.

was providing direct services to 125 villages, staff shortages made workload difficult to handle. Staff involvement appeared to primarily be with mandatory ante-natal care. There are 8 ANCCs per union, and one female paramedic is required for visiting 8 ANCC's in one month. Within these visits, female staff usually conduct discussions on family planning, and if time permits, carry out follow-up care of rural women. (See table 2 - to see workload of female staff).

Table 2. Female P.O.s monthly workload at a particular thana

Expected duties	**Current duties**
One union to oversee	Visiting at least 3 unions
8 ANCCs to look after	Organizing 12-14 ANCCs
Depot holder refresher once a month	Holding 2-3 depot holder refresher meetings
Depot holder follow-up/ PNC follow up	Depot holder follow-up/ PNC follow up
Female/male seminars; school meetings	Female/male seminars; school meetings
Newly wed couple mobilization meeting	Newly wed couple mobilization meeting
FWC mobilization/Union parishad meeting	FWC mobilization /Union parishad meeting
Family planning follow up/ mobilization	Family planning follow up/ mobilization
Illnesses/ contraceptive side effects- refer patients to BHC	Illnesses/ contraceptive side effects -refer patients to BHC

In the above table, instead of only being responsible for her particular union, this female staff was looking after more than 8 ANCCs, and responsible for organizing 3 refresher trainings[3] in 3 unions. She commented, *"our main work involves mobilizing for ANCC - where is the time to do anything else? I should be taking care of 7 ANC centers, but because there is fewer staff, I end up being responsible for 13 - sometimes 14 centers in a month. What happens is that sometimes we have to leave out one ANCC and visit it later!"* Skipping ANCCs result in negative consequences at the village level. Manager and staff agreed that mobilization was affected. *"Women wait and wait for the paramedics but what to do. They are unable to go. The rural women get upset waiting. Some also get angry with the staff. Then after some time they have to go and mobilize the women again."* One staff member commented, *"To mobilize means to give information. Where is the time to do anything else? One worker has to do someone else's work!"*

Staff shortages appeared to be caused by a number of factors, such as the large number of

[3] DH or SS are trained monthly on family planning mobilization and other health issues, and given their contraceptive supplies to sell in the village communities.

drop-out and resignations of staff, continuous internal training workshops,[4] absentee staff on sick or maternal leave, and the continual transfer of male POs to other BRAC programs, such as nutrition. Informal discussions revealed a similar trend of staff shortages in several *thanas*.[5] A family planning review meeting held at BRAC headquarters in June (1999) with field staff and senior management, revealed such concerns. A senior manager of Habiganj district mentioned severe staff shortage as one of the main barriers to improving their family planning performance (see Table 3 for outline of staff shortage).

Table 3 : Habiganj Staff Shortage

Staff	Number of Staff Required	Number of Staff Working
FWV	18	11 (less 7 staff)
P.O. A/C	4	4 (no staff shortage)
P.O. Mobilizer	23	19 (less 4 staff)
P.O. Paramedics	77	66 (less 10 staff)
Service Staff	9	9 (no staff shortage)

A senior manager from Shunamganj also blamed their low performance on staff constraints: *"Where there is meant to be 4 PO mobilizers there is not enough."* At Shunamganj thana, where 37 female paramedics were required, there were less. Interestingly, Nilphamari, previously considered a high performing area, was suffering from low performance as well. The senior *thana* manager in Shaheedpur, Nilphamari district, remarked on the problem of staff constraints as one of the main factors, besides other operational constraints, affecting their performance. He also mentioned continual staff training workshops[6] and inadequate government supply of contraceptives as contributing factors.

Numerous studies on family planning performance in Bangladesh reveal that the density of

[4] All female field staff are under going various training (rotationally) before they start working in the field - on ante-natal and post-natal care, family planning and health and so on.

[5] At the annual health programme's review meeting, most of the managers of the low performing areas mentioned staff shortages as one of the main problems.

[6] The question of too many staff involved in refreshers, ANC training and so on, highlights the issue of proper staff management at the field level. There does not appear to be a systematic process involved in sending staff to training workshops. Managers appear to send randomly nominated staff simultaneously for training, sometimes at the cost of a lack of any back up at the field level. However, whether this can be blamed solely on staff and managers at the field level is another subject altogether. To set up programs and meet program targets, managers need to have their staff trained as quickly as possible, and when there are staff shortages, it becomes doubly difficult for managers to ensure there is training as well as adequate service delivery at the field level.

field workers can positively or negatively influence contraceptive prevalence rates in any particular area (2-6). A recent study found that low performing areas such as Panchlaish, Teknaf, Zakiganj (Sylhet district), and Nabiganj (Habiganj district) had very low worker density, with less than 42% of the households not visited by government family welfare assistants FWAs (7).[7] As we have seen above, there are a number of repercussions to the problem of staff shortage, which directly affect the quality of BRAC services provided to rural women and their families.

In addition to staff shortages, given the existing fieldwork routine and low density of field staff, family planning work often competes with the performance of mandatory ante-natal care tasks. As such, the delivery of services and mobilization for family planning is relegated to a secondary role because the service system provides little opportunity or time for family planning workers to carry out effective interventions for improving family planning performance.

Hard-to-reach areas and long distances: is BRAC being inflexible?

One of BRAC's goals as part of the NIPHP is to extend MCH-FP (Maternal Child Health-Family Planning) services in areas with limitation, i.e.; hard to reach areas, units/unions without service providers by providing special means of delivery. BRAC staff, however have been unable to maintain service delivery in the hard-to-reach or *haor* areas (marshy land with rivers and canals) due to difficulties in accessing these areas. Neaz and Banu, suggest that in low performing areas, such as Sylhet, access and communication tend to be difficult, as only 24% of the land is easily accessible, with the rest being either marshy land or rivers and canals. These areas tend to remain under water for nearly 5-6 months, households tend to be scattered, and in most seasons only accessible by boat. Their study on family planning in low performing and high performing areas of Bangladesh, found that high performance areas were usually densely populated and easily accessible, with high family planning workers visitations (22%), compared to difficult areas, where there were low visitations (9.5%) by family planning workers (7).

[7] The study was conducted in 8 high performing and low performing *thanas* from identified districts. A list of 2000 HHs from a randomly selected area of each *thana*, and at systematic intervals, around 200 eligible couples from each thana were selected for interviews based on a structured questionnaire. In addition, focus group discussions were conducted to obtain qualitative information.

In most of the *thanas,* BRAC female staff are unable to regularly visit *haor* areas. First of all, in each *thana,* there are two male POs assigned to assist female paramedics access hard to reach areas. In reality, female paramedics cannot rely on male POs to assist them because of the shortage of male staff in the *thanas.* Thus, due to the low density of male workers, both POs and paramedics are already overworked with additional responsibilities, and female paramedics are unable to access hard-to-reach areas. A manager stated, *"If I had a male PO then I would have more of a systematic set up. One male PO has been on sick leave for two years, and the other has been transferred, which leaves me with only one male PO. He is busy with forum mobilizations, meetings, refreshers and training."*

There are further barriers that hinder female paramedics from providing regular family planning services in these areas. Difficulties in accessing marshy areas particularly during certain seasons was the primary problem for female paramedics. *"We cannot even walk there during those times of the year and even boats cannot go there as there is not enough water. Sometimes I have walked for miles and by the time I got there wading through the water I was so tired. I have to carry the bag,*[8] *which is so heavy. One female paramedic has injured her arm carrying the bag such long distances and is recovering from the pain."* A few female paramedics spoke of the various ordeals they faced having to walk such long distances in areas where no boats or rickshaws were operating. One of them commented, *" I have to go in a rickshaw and then by bus to Tegoria union. It is 17 km away. It takes me about 30 minutes. Then I walk for one and a half miles. During the rainy season, I take a boat (2 km) and then its takes me an half and hour to go to Sayedabadh (marshy area). Sometimes I go there and there are no boats running. The water is partially dry - so I walk halfway and then wade in the water. There is another village in Shekerpur and it takes me 45 minutes to come and go."*

Some unions such as Kalibanga have villages at a distance of even 10 to 12 km from each other. To go from Baniachang *thana* to Kalibanga (a hard-to-reach area) takes about 12 hours by foot, and about 4 hours by boat. Simmons et al (1990), examined the issue of service constraints in the family planning program in Bangladesh, and found that female paramedics rarely visited the field because of the lack of transportation. They further argued women experienced difficulties in moving around a large field area, especially when unaccompanied

and without transportation facilities (2). In our interviews, some of the paramedics also shared their fears of going alone to remote and hard to reach areas. A female paramedic narrated an incident of harassment, *"Once I was going in a boat to a haor (marshy) area and the boatman said to me, 'what will you do if I take you somewhere else now. What will you do then?' I was very scared and I tried not to show it, so I told him, 'be quiet and take me to the village. I am a BRAC staff.' He didn't say anything after that and took me to my place of work."*

Other issues mentioned were the loss of time and energy involved in walking such long distances, which made it strenuous for them to mobilize potential clients. Another concern mentioned, besides distance and the inaccessibility of *haor* areas, was the issue of BRAC's mandatory policy of riding bicycles. BRAC policy insists all field staff, male and female[9] ride bicycles in both urban and rural areas, where there are BRAC programmes. Some of the female paramedics[10] spoke of the harassment they were subjected to when riding bicycles in some of the villages.[11] Very few rode their bicycles; instead they opted to pay out of their own salary for bus and rickshaw fares to go to villages located great distances away. Unlike *haor* areas, where staff are allowed to charge for boat and other transport costs, areas that are not considered hard-to-reach are not covered by BRAC. In a conservative area like Sylhet, for some female staff, riding bicycles in some of the villages appears to be impossible to practice.[12] A female paramedic remarked, *"I spend almost taka 250 to 300 of my salary on transport costs as I am unable to bill BRAC for it. I cannot ride my bicycle although BRAC bosses expect me to do so. So I just pay for it. What to do? I need the job."* This appeared to be the pattern of behavior for a considerable number of female staff. If staff tend to pay for their own transport, it can be assumed that visitations may not be carried out regularly, as personal financial costs are

[8] The bag appeared to weigh at least 10 kgs. I had difficulty lifting the bag.
[9] Upto a certain level
[10] This issue came up in informal and formal discussions with staff.
[11] Sylhet is an extremely conservative area and all the local women wear mostly burkhas (long dress covering the person from head to toe), with an open umbrella covering themselves, both from the heat and for social reasons of *purdah*. It was not surprising to find that the female paramedics were hesitant to ride bicycles around Sylhet district. In fact, in some of the urban areas of Dhaka, similar concerns among the female staff (RDP), were also apparent. They admitted to lying and hiding their bicycles, and then they would go off to work. However, a 'culture of silence' forbids this information from going to senior management at BRAC headquarters. While this comes under the gender empowerment policy of BRAC it is questionable how effective this kind of "empowerment" has been as young girls are subjected to severe harassment in some areas. Despite the cultural variations within Bangladesh, and resulting exploitation of women, BRAC continues to enforce a uniform policy.
[12] One female staff was pushed off her bicycle while riding and sustained minor head injuries - she was

involved.

Staff suggested that BRAC should incorporate a more flexible policy in difficult areas. They argued that this would make work much easier for female staff who already face numerous constraints in this region. An example of an NGO (grant management provided by BRAC), SHIMANTIK working in Sylhet, was cited for its flexible policies. They argued that SHIMANTIK allowed for travel costs for their female paramedics. In their budget, they have a section for travel and associated expenses, particularly for villages located in remote areas and for *haor* areas as well. They also have two staff members conducting field visits together. SHIMANTIK has had a high staff retention rate. In their working areas, there has been an increase in contraceptive prevalence rates, because of their strong delivery and field mobilization. For BRAC female staff, riding bicycles, the distance of villages, fear of remote areas, and the inaccessibility of *haor* areas all have direct bearings on their morale and the quality of their fieldwork.

The problem of high drop out rates of BRAC staff in Sylhet

There appears to be a problem of very high drop out in BRAC programmes in the low performing areas of Sylhet region. Staff shortages, exhausting work schedules, long distances, the mandatory policy of riding bicycles (a concern for female staff), inflexible BRAC management policies, difficulties in accessing remote areas, the rigid religious cultural environment in the villages and so on, work to discourage staff from remaining in the programme. Moreover, the reasons for continual staff shortages can partially be attributed to the high number of resignations frequently occurring in the Sylhet Division (Table 4). Neaz and Banu found in their evaluation of the reasons for low performance of the government family planning programmes was that worker density appeared to be very low (1: 8000) and 33% of the FWA (family welfare assistant) positions in the government programme were vacant (7).

Table 4: **List of BRAC Staff who did not join, transferred, dropped out and resigned - July 1998 to May 1999**

Name of Thana	Name of Staff	Designation	Present Status	Total No of Staff in

later transferred to another district (As told to me by some female paramedics).

				Thana
Hobiganj Sadar	Md. Sikder	P.O.	Transferred	11
	Kaderia Akhter	FWV	**Resigned**	
	Ismath Ara	P.O.	**Resigned**	
	Santosh Kumar	P.O.	Transferred	
	Mofazzel Haque	Sr. AM	Transferred	
	Barendra Ghosh	TM	Transferred	
Bahubol	Anwara Khatun	FWV	**Resigned**	8
	Aleya Khatun	FWV	**Resigned**	
	Anjana Begum	P.O.	**Resigned**	
	Roksana Begum	P.O.	**Resigned**	
	Farida Yasmin	P.O.	Transferred	
	Dr. M Hossain	M.O.	Transferred	
Nabiganj	Indira D Nath	P.O.	**Resigned**	14
	Shamsun Nahar	P.O.	**Resigned**	
	Rina Rani Maz	P.O.	**Resigned**	
	Shapna Rani	FWV	Transferred	
	Md. Shahjahan	P.O.	Transferred	
Lakhai	K. Chakraborty	P.O.	**Resigned**	6
	Nishi Kanta Dey	P.O.	Transferred	
	Aklima Khatun	FWV	**Resigned**	
	Dr. Nasiruddin	M.O.	**Resigned**	
Baniachong	Anwara Akhter	P.O.	**Resigned**	

* Another 15 staff members resigned from Habiganj district (as of last week). This is the previous list, not including the 15 who recently resigned.

An extensive study on the reasons for low performance of family planning in some areas of Bangladesh suggested that in order to encourage staff to remain in their jobs in difficult areas, their qualifications should be relaxed and work areas made more flexible to accommodate constraints[13] (7). BRAC staff indicated that the programme needed to be more adaptable and yielding to staff members concerns in hard to reach areas to stop the flow of resignations. They felt to improve performance in the difficult areas it was crucial to retain staff.

Depot holders: key persons of BRAC's family planning programme

One of the core elements of BRAC Health programme are its depot holders or *shasthya*

[13] Referring to successful family planning and health programs, the authors (Klitsch and Walsh,1988) refer to a BRAC, OTEP pilot project, set up in a very conservative district in Bangladesh - BRAC relied on a groups of women living together, who moved from village to village to implement the project. However, the key to the success of the program was that it was kept simple and flexible; the key word being flexible.

shebikas (SS - community health volunteers). These are rural health volunteers who help deliver the different health services. The depot holder or SS's work is voluntary. They are given several training and refresher courses to build up their awareness on community health and family planning issues. Sylhet Division, where Habiganj district is located, is well known for being a religiously conservative area. Rural women tend to be secluded, and have limited access to formal and informal learning outside the home. It is in this context that household visits by depot holders or female field staff have special significance. Thus, the depot holder or SS acts as an intermediary, connecting women and men to new ideas, influences and to 'the legitimacy of alternatives' (3). While their role is important, interviews revealed their disinterest in working for the programme.[14]

In some areas, such as Bahubol, depot holders were previously working as LIPs (local initiative program with the government) and earning a fixed amount of tk. 50 distributing and disseminating family planning methods. Others earned tk. 150 monthly for mobilizing and distributing contraceptives to eligible couples as BRAC staff. However, currently there is a new policy that stipulates that a depot holder or an SS can earn an income by selling contraceptives and medicines. BRAC programme staff stated that depot holders can earn up to tk. 200 per month by selling contraceptives. This is a shift from BRAC's previous policy of giving them a fixed amount of money monthly, and has left most of the depot holders dissatisfied. They complained of the paltry amount of money earned while selling contraceptives, and the tk. 18 they receive when they go for their monthly refresher training. A common complaint to BRAC staff was, *"We work so hard and we only get 18 taka from you."* Another depot holder commented, *"What we get is not manageable. I am going to leave BRAC. What we used to get before was better."* [15]

Moreover, in a number of BRAC areas, government workers are working alongside BRAC staff, providing government contraceptives for free. This works negatively for BRAC depot holders and staff, as they are unable to sell their supplies as easily in their working areas. Moreover, when government workers are providing contraceptives for free, while BRAC staff are charging money for similar methods, this creates suspicion and distrust amongst the village poor. One depot holder commented, *"No one is buying BRAC medicines (contraceptives). The medicine remains and then I have to give it to the others for free. I don't bring or sell contraceptives from BRAC, as no one buys it. The government worker gives me medicines to distribute."*

It appears, however, that idiosyncratic characteristics of depot holders probably account for

[14] This sentiment may not apply to all depot holders (DH) or *shashtyo shebikas* (SS), but according to staff there was widespread dissatisfaction amongst the DH or SS with their work.
[15] There have been numerous internal studies at BRAC's RED regarding issues of financial remuneration of depot holders/ *shasthyo shebikas*, problems with low motivation, and the high turnover of depot holders, and its implications for BRAC's programmes at the field level (8, 9).

some of the family planning performance differences in local village communities. For instance, Gobindapur village was mentioned over and over again by field staff for its very active depot holder, fairly strong programme and decent performance levels, despite the overall religious cultural environment of the area. The depot holder in this village appeared to be very motivated, and had been serving in the community for a very long time. In addition, contact between the depot holder and female paramedic appeared to be strong, and there was an ANC centre, thus ante-natal check ups took place regularly as well. Whereas, in Shathparia, the depot holder appeared to be inactive, and had completely stopped working for BRAC. Moreover, there appears to have been virtually no contact between female paramedics and the depot holder, and the community has refused to allow an ANC centre to be opened due to religious objections by some members (both male and female) in the village. It can be safely assumed from the following two examples, that the fault partially lies with the role of inactive[16] depot holders and mobilisation by programme staff, if there are low contraceptive prevalence rates in a village. The differing attitudes of both depot holders and other significant contributing factors, 'illustrate the key role volunteer workers can play in directly affecting performance levels.

Inadequate government supply and other service delivery constraints

Inadequate or irregular supplies of contraceptives is a serious and persisting constraint of this program (6). Almost all of the low performing *thanas* including Habiganj district admitted having inadequate supplies of contraceptives from the government. A manager of one of the *thanas*, in Habiganj, stated that although he had asked the government office to supply 50 injectables, only 10 were delivered. In Ajmiriganj, the BRAC office had asked for 94 injectables, but only 50 were sent. The following month they asked for another 67 injectables, including follow-up doses for their clients, but once again only 25 were sent, with less than the required amount for follow up doses for their clients. In Lakhai *thana*, government supply continued to be very low, with no injectables available, as government storage had run out of stock, with only 25 injectables sent the previous month. Discussions revealed that complaints to Pathfinder and the government by BRAC managers, pleading with various local level government *thana* officers, had not eased the supply problem. An inadequate supply indicates a weak service delivery programme.

A few studies documenting the repercussions of inadequate supply, found family welfare visitors (FWV) who distributed contraceptives, sometimes attempted to cope with short supplies by distributing less than the required dosage to clients. This increases the risk of pregnancy for the woman, which in turn acts negatively on

[16] Inactive – meaning depot holders who are not working at all but are still considered a part of the

the adoption of contraceptive methods (6).

Technical competence of female workers was identified as a potential problem. A number of managers complained that the CMT[17] training given by the government was insufficient, as a considerable number of the workers were unable to insert IUDs and claimed a lack of knowledge in insertion techniques. Badly trained workers unable to insert IUDs despite demand, reveal the need to monitor the quality of training provided to family planning staff. Further, in some *thanas* there appeared to be a scarcity of workers[18] to insert IUDs to potential clients.

Another serious concern mentioned both by managers and field staff[19] was the duplicity of work occurring in allocated areas. When implementing the NIHPH programme, BRAC and the government agreed upon a strategy to divide the various districts and *thanas* into government and BRAC working areas. It was decided that in BRAC allocated areas, only BRAC staff would work, providing contraceptives at a minimum price for clients. The government FWA would perform a supervisory role in those areas. In several BRAC areas, however, government FWAs continue to work alongside BRAC staff, providing government contraceptives for free. This appears to be a gross violation of the agreement between BRAC and the government, and the duplication of services continues to take place in numerous *thanas.*

Religious and cultural constraints

There has been disagreement regarding the extent of religious opposition to family planning in Bangladesh. At its annual planning conference on population in 1987, the government declared that religious opposition was the single greatest obstacle to programme success. Evidence in support of this has been mixed, and national surveys have portrayed the opposition as significant, but not a major obstacle to the expanded acceptance of modern contraceptives (10).

Sylhet division is well known for the devoutness of its population, and its reported widespread religiously based opposition to family planning. With respect to fertility, a high value is placed on large families, especially sons, and the husband plays a dominant role in fertility decisions. However, interviews with rural women and men about contraceptive use revealed mixed concerns about family planning. Various reasons were given for not using methods such as, religious retribution, potential problems within the household, inadequate knowledge of and access to various methods, and health troubles related to side effects of contraceptive use. A majority of the women stated that they were uncomfortable using contraceptives because of the fear of angering God, scolding from family members - particularly from their husbands; and threats of divorce from their husbands. A few women were evasive, while others wanted more information regarding access to contraceptives. Husbands gave contradictory views on this subject; some suggesting that it was un-Islamic behaviour to use

programme.
[17] Contraceptive Management Training.
[18] Government trained field staff

contraceptives; and a few simultaneously stating that they would be willing to try methods, provided they were given the relevant information.

A common gap revealed in the interviews was the lack of adequate support and information from health workers (government and BRAC) about the methods. Men spoke of the need to have male workers to discuss family planning methods, as they were embarrassed to discuss the issue with female field workers. Women spoke of the necessity of having field workers convince their husbands of the importance of family planning, since most were scared to use contraceptives without their husband's permission.

Altogether responses were mixed, and it can be argued that the assumed strong religious opposition to family planning is exaggerated, and can be altered, if there are effective interventions and mobilization at the field level. In rural areas of Bangladesh, Bernhart and Mosle Uddin, found that the presence or absence of religious opposition appeared to be associated with programme effectiveness. They carried out a wide range of field worker activities and programme variables as predictors to determine a superior programme and worker performance. It was found that a strong programme, which in turn translates into higher performance levels, weakens overall religious opposition. On the other hand, in low performing areas with weak programmes, there was stronger religious opposition and lower contraceptive prevalence rates (10).

Conclusion

This report was a preliminary examination of the performance of BRAC's family planning programme in some low performing *thanas* and hard-to-reach areas in Habiganj. It was found that the poor performance of BRAC's family planning programme can be attributed to a number of operational factors, such as severe staff constraints, low morale, and high drop-out of staff members. Local staff suggested that in order to encourage BRAC recruits to remain in their jobs in difficult areas, such as Sylhet, their qualifications should be relaxed and work areas made more flexible to accommodate constraints. They felt to improve performance in the difficult areas it was crucial to retain staff.

Furthermore, shortage of staff, existing field work tasks, relegates the delivery of family planning to a lesser role because the service system provides little opportunities for staff to carry out effective mobilisation. Moreover, barriers such as distance and lack of transport to remote areas make it difficult for female staff to work. A number of depot holders and *shasthyo shebikas* expressed dissatisfaction with their voluntary work. This affects the quality of family planning services provided in the community and has significant repercussions on

[19] Staff and managers from a number of thanas brought up this issue at the Annual HPD Review Meeting.

the programme, as they are the key motivators and providers for the local community. Moreover, there appears to be a continual problem of inadequate supply of contraceptives from the government in most of the *thanas.* Technical competence of staff was also identified as a problem, which highlights the need to carefully monitor government training workshops. Further, the duplication of government and BRAC services continues to take place in numerous *thanas,* thus affecting BRAC's performance levels.

There are some socio-cultural barriers to the family planning programme. In Habiganj, there are some widespread religious ideologies against contraceptive use, which affect and influence rural women and men. However, the assumed strong religious opposition to family planning can be altered gradually, if there are effective interventions and mobilisation in villages. A considerable number of BRAC female staff have dilemmas with BRAC's mandatory policy of riding bicycles in conservative areas. For BRAC female staff, riding bicycles is a significant issue and has direct bearing on the quality of fieldwork and staff morale. In addition, since some female staff are paying for their own transport in some areas, and BRAC management refuses to acknowledge the issue, it can be assumed that visitations may not be carried out regularly, as personal financial costs are involved.

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