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MCH AND FAMILY PLANNING - USER PERSPECTIVES AND SERVICE
CONSTRAINTS

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INTRODUCTION

The debate over the integration of maternal and child health with family planning has lost much of its intensity over the past fifteen years. Consensus has been reached in many nations and international organizations that family planning services are an essential public sector activity and that these services must be tied to other areas of health and development. The idea of integration has broad ideological and political appeal, symbolizing for many the positive values associated with desired outcomes of programmatic action: health and welfare for all. Nonetheless, the practical and operational issues of how services are to be effectively delivered in rural areas of the Third World remain often unresolved. Especially lacking is an understanding of the pervasive constraints in the implementation of integrated service packages through large-scale national programs.

Arguments in support of integrated services are often conducted in terms of what is desirable, rather than what service modalities are feasible within ministry-of-health bureaucracies. Moreover, it is seldom appreciated that operational constraints affect the delivery of maternal and child health and family planning services in very much the same way. The administrative and operational barriers that prevent delivery of quality care in family planning often stand in the way of effective delivery of MCH services as well.

Closer attention to the realities of program implementation in resource-poor bureaucracies is required in order to establish what combination of services might most effectively be offered, and how existing constraints to integrated service delivery could be overcome. This paper provides such background through a micro-analysis of interactions between female fieldworkers and women in rural Bangladesh, and a discussion of the broader organizational constraints which hamper service delivery. Focus will be on the female fieldworker in the government health and family planning program

since in this setting she constitutes the key link to rural women.

We argue that the fieldworker, herself a rural woman, is faced with considerable demand for both MCH and reproductive health care services, but that operational constraints prevent her from realizing her potential in both of these areas. Qualitative data show that, in the eyes of rural women, contraceptive use and health care are intricately intertwined, and that this often confronts the worker with a range of questions which she cannot competently address. Given current fieldwork routines, MCH functions at times compete with the performance of family planning tasks, but in large measure, the delivery of MCH services is relegated to a secondary role because the service system provides little opportunity or encouragement for effective intervention.

BACKGROUND AND METHODOLOGY

The female worker (Family Welfare Assistant, FWA), of the government health and family planning program functions under the control of the family planning wing of the Ministry. Currently she covers an average population of 7500. Her job description includes duties in both family planning and MCH. In the area of family planning, she is responsible for information, education and motivation, distribution of contraceptives and referral for clinical methods. In the area of MCH she is required to provide pre- and post natal advice, distribute oral rehydration packages (ORS) and refer for tetanus and DPT immunization.

The female worker is supervised by staff connected with the rural health center at the subdistrict level, which provides both preventive and clinical services under the care of several physicians for an average population of 200,000. The rural health center acts as administrative headquarter for family planning and preventive health measures undertaken by the government.

Technical support to the female outreach worker is the responsibility of a female paramedic who works at a rural subcenter covering a population of approximately 20,000. The main focus of this paper is on fieldworkers' interaction with rural women, because only they have some contact with the large majority of rural households at regular intervals. The rural health clinic and its subcentres see only a small proportion of the population.

The data presented here were collected in connection with the MCH-FP Extension Project of the International Centre for Diarrhoeal Disease Research, Bangladesh (1). The Project works in collaboration with government officials in two subdistricts of rural Bangladesh to achieve improvements in the management and quality of health and family planning service delivery and to test promising service innovations. Research on program operations and service impacts makes it possible to assess program functioning prior to, during, and after interventions.

Part of this paper uses qualitative data based on observations of the exchanges between female workers and rural women during the workers' regular household visits. A total of 65 encounters between 22 workers and rural women of reproductive age were observed. Some, but not all of these workers, had received special training from the Extension Project (2). The paper is based on a content analysis of translated conversations and fieldnotes (3). We quote extensively from conversations to provide a contextual understanding of the worker's initiatives and the perspectives of rural women. Each case presented is drawn from observations of a different worker.

Data on worker-client interactions are supplemented with observations about the nature of program operations at the level of the field, union and rural health complex. These observations are based on findings from operations research studies conducted by the project, and on the experience

project staff have acquired in the course of their close association with the government service program.

FAMILY PLANNING AND HEALTH - PERSPECTIVES OF RURAL WOMEN

Family planning in Bangladesh, while more acceptable now than in the past, still raises a multitude of concerns in the minds of rural women. Foremost among these are anxieties about the health consequences of contraceptive use. Arguments over the need for services in MCH, as opposed to family planning, at times imply that the latter are separate and distinct from health issues. Field observation, however, reveals that there is hardly a moment in the daily work routine of the female worker when she is not confronted with issues about women's health while dealing with family planning services.

From the perspective of rural women, family planning is a major health issue. For many users or potential users, the perceived health costs are considerable; in fact most rural women perceive the health risks of contraceptive use to be far more extensive than those medically indicated. In their view, there is no distinction between the actual side-effects of, or complications from, contraceptive use, and general health problems. Most health complaints which occur subsequent to adoption of contraceptive methods are attributed to family planning.

The field worker encounters a population of women with extensive health care needs, most of which go unattended due to the scarcity of available and accessible medical and health facilities. Women turn to the worker in the hope that she will provide solutions to their multiple health concerns, but she is ill-equipped to address these effectively and recognizes that service capacities at the level of the subcentre and the rural hospital are also limited.

We present two examples from the data to show that clients often link major suffering to the use of contraception, and request support and assistance from the worker.

case 1 :Fear of the IUD

The worker is leaving the house of a woman who has just consented to adopt the IUD. The client follows her out of the house with two other women of the family, and asks:

Woman: Are you sure that the Copper T will not do any harm to me?

Worker: No, no, you will be alright.

(One of the other women comes close to the worker and asks:)

2nd woman: Will she have any problem with that?

3rd woman: I am not sure what she might have if she takes that thing.

No matter what reassurance the worker provides, anxiety about "that thing" lingers on, not only in the mind of the new acceptor, but among other women in the family. Evidence that one might in fact "ruin one's life" by using contraception, appears readily at hand:

case 2 Fear of the pill

Woman: We heard that if the pill is suitable for someone, then it is alright. But if not, she will be ruined.

Worker: Who told you that?

Woman: One of the neighboring women is suffering for a long time because of the pill.

Worker: Go and ask clearly, she must have some other disease.

In all likelihood the worker is correct that the woman is suffering from a disease unrelated to the use of the pill, but in the minds of the women she visits, the thought that pill use leads to extensive suffering is both plausible and frightening. Later examples will provide additional evidence on this point.

The worker attempts to address women's fears with reassurance and with the argument that not all subsequent illness is associated with contraceptive use. This same approach is repeated in the following case, which begins to show the limits to the worker's ability to provide relief. To obtain vitamins, she must refer women to the hospital, which is usually miles away from their residence. Supplies for general distribution in the field are usually not provided.

Case 3: Reassurance and Referral

The worker is in a household where she talks to several women of reproductive age. One of the women, an IUD user, complains to the worker:

IUD Client I feel weak and get headaches often; sometimes also white discharge, which is a nuisance.

(The worker checks her eyes:)

Worker: These symptoms are very common for the first few months.

IUD Client: It is not new, about four to five months. I never had this problem last time (with her first IUD).

Worker: It has only been two months, not four or five. You will be alright.

IUD Client: I had no problem initially and I was healthy like she. But now I feel so weak that it is difficult to do all the household work.

Worker: Don't you feel that you are doing more hard work now than before? Otherwise what is the problem? Truly speaking, you do not have enough blood. (i.e. she is anemic)

(checks her eyes)

IUD Client: My husband was asking me to tell you about this - what medicines should I take to get well?

Worker: Get some vitamin tablets from the hospital.

IUD Client: You get some for us.

Worker: I will try. But the officials usually do not want to give medicines to us without the patient. The other day I saw one worker who came to the rural health clinic and asked for some medicine

for the tubectomy client after taking the stitches out. But she did not get any. If things are like this, how can we work? And if we cannot give some medicine to the patients, how can we get more clients?

While the worker is capable of identifying a most basic medical need - iron for anemia - she must rely on hospital referral, not because of her lacking competence, but because there is currently no provision for field distribution of iron tablets or any other medical supplies in the government program.

Not only does the worker lack medical supplies needed for basic treatment, she also lacks technical training and the orientation to deal with more complex issues. For example, a standard response, when faced with complaints in the first few months after IUD insertion, is to encourage patience, and reassure the woman that her health will improve in the near future. The worker does not pursue contraceptive follow-up with systematic questions about the woman's menstrual cycle, but discards complaints about white discharge without further exploration to assess whether referral to the subcentre or rural hospital is indicated. Screening for risk factors has not been part of her training and is not encouraged through the supervisory process. The female worker's inability to address technical issues is also reflected in the next case of a vaginal infection subsequent to a tubectomy.

case 4 : Tubectomy Follow-Up

Worker: How are you ?

Woman: Just pulling on.

Worker: You have any problems, difficulty?

Woman: Yes, I have some difficulty.

Worker: What are these?

Woman: I can't say these in front of everyone.

(she takes the worker aside)

Ever since I have had my operation done, I have been feeling a sense of itching in my vagina. I have never experienced this before. I have had three children, one boy and two girls, but I have not had this kind of difficulty.

Worker: (turning to the observer)

What do you think this is, what should she do?

(turning finally to the woman:)

Why don't you go to the hospital?

Woman: I have been there. They do not give the right medicine.

Worker: Come on a day when I am there, come on Wednesday. I will see that they pay some attention to you.

The worker knows nothing about gynecological infection, which is not covered in her training. Not knowing how to deal with the situation, the worker first turns to the observer (who had been instructed not to participate in service delivery), and then suggests referral to the rural health centre, only to learn that the woman had already been there but had not received satisfactory treatment. Promising to intervene on the client's behalf if she made another attempt, the worker reveals that effective service delivery at the rural health centre cannot be taken for granted. Or, as is illustrated in the following case, where the worker visits a woman who had a tubectomy three years previously, referral to either the local subcentre or the health centre produces a request to accompany the client.

case 5

Worker: Tell me what is the problem?

Woman: For the last few months I feel like something is poking in my abdomen.

Worker: Do you feel that always?

Woman: No, not all the time but some time. And then I also had head spinning. I cannot look upward. I feel like lying in bed - not doing any household work.

Worker: I think you should first go to our visitor apa (female paramedic) at the clinic and take what medicine she gives you. If that does

not work, then go to our new hospital at N.H.

Woman: I will not be able to go. You should take me there. I don't know people there and I have never gone on my own.

In a society which values female seclusion, it is unusual for a woman to leave the vicinity of her household. When she must do so, however, social norms prohibit unaccompanied travel. Because she is known and trusted, the worker can serve as a link to the unfamiliar and distant service system. She generally accompanies acceptors of clinical methods to the subcentre or rural health complex. For other cases, she sometimes makes arrangements to accompany women when she has to go to the health complex for meetings or other administrative matters. Given her current work load of quarterly visits to a population of 1,250 women, she cannot respond regularly to such requests for accompaniment.

Family planning and women's reproductive and general health care are empirically a single dimension. Rural women associate a range of medical complaints with contraceptive use, whether or not they actually constitute side-effects and complications. These complaints do not fall under the rubric of what is conventionally thought of as maternal health, namely the health care needs arising from pregnancy. From the perspective of rural women reproductive health concerns are of great consequence. Contraceptive users expect help from the female worker, but the best she can do is to provide reassurance and referral to the rural health centre. Most of the issues raised are currently beyond the worker's competence, and as we shall show later on, service capabilities at the rural health complex and the subcentre to address these needs are also limited.

MATERNAL AND CHILD HEALTH: A SECONDARY CONCERN OF THE FAMILY
PLANNING WORKER

Concerns about women's reproductive and general health discussed in the previous section are only one set of issues which the worker cannot adequately address. There is both need and demand for her to provide care to children and pregnant women, that is to cover the areas that are conventionally defined as maternal-and-child health functions. The cases presented in the following section indicate that her assistance in these areas is as limited as her ability to respond to women's reproductive health concerns.

There are several examples in the observations where MCH issues were neglected even though urgent attention was needed, especially in cases of severe diarrhoeal disease or acute respiratory problems in children. Even though MCH is formally part of the worker's job description, she did not make any effort to provide assistance. She seemed to perceive these functions as entirely outside of her realm of work, showing no more concern than for the education of the woman's children, or the husking of paddy in the courtyard.

Competition with the family planning task is at least a partial explanation for the neglect of MCH duties. This is suggested in the following case where a young mother is concerned about the health of her small child, but the female worker has great difficulty shifting attention from family planning to the child's problems.

Case 6:

The worker is in a household which she has obviously not visited for quite a while. While she is busy asking women about their children and recording the names in her record book, a young woman, whose little boy is crying in her lap, tries to catch the attention of the worker. Finally she says, almost shouting:

Young mother: Listen to me... Do you know that this little boy has loose stool? What can be done about this?

The worker does not answer, but continues to write down names in her record book. She then turns to the daughter-in-law, asking whether she has had a period since her baby was born? The conversation among the worker and the women continues to be focused on family planning concerns, until finally the young mother once again proclaims:

Young mother: Listen, my son has loose motions.

Again the worker continues to talk to another woman about family planning. The young mother repeats her question again; at this point the worker responds:

Worker: Who has diarrhoea? What does the stool look like?

But she immediately gets distracted by questions from another young woman, who asks the worker whether she has given her husband a supply of pills recently. The conversation continues with this woman until the young mother mentions her son again, and the worker asks:

Worker: How many times did he pass stool today?

Mother: Two to three times. Give some medicine.

Worker: How is the stool?

Mother: Whatever he is eating, he can't digest the food. Indigestion is the problem.

Worker: You have to see a doctor.

Mother: We saw so many doctors.

Worker: Which doctor have you seen for him?

Mother: X doctor in Y

Worker: Did he see the baby?

Mother: No, his father brought some medicine.

Worker: Go and see the doctor with the baby.

Once the worker focuses on the child's problem, referral to the doctor is her only recourse, demonstrating her limits in addressing MCH tasks. But one should not conclude that the shift from family planning to MCH is always a difficult one. In the following example the worker moves smoothly from family planning to maternal and child health, showing the natural affinity between these fields.

Case 7:

The family planning worker reaches the house of a young woman who had four children in rapid succession, but in each case the child died soon after birth. The worker tells the woman that it would not be good for her health to become pregnant again soon, and insists that she will not leave the house unless the woman accepts a method of family planning. The woman gestures towards her mother-in-law to indicate that the decision lies with her. The worker and mother-in-law then discuss various methods, settling on injectables, but when the worker asks about the date of her last period, she discovers, to her dismay, that the young woman is probably pregnant again.

Worker: I know that you want a baby, but so soon? You really got pregnant just after the delivery - right?

Woman: How do I know?

(The mother-in-law makes a sound indicating she just realized her daughter-in-law is pregnant.)

Worker: Do you feel pregnant now?

Woman: Can anybody say that unless the baby moves?

Worker: All pregnant women can say that. Anyway, if you are pregnant, then I have nothing to say. But if not, then inform me through someone on the fifth day after you get your period. I will come and take you to the clinic for injection.

After a moment she adds:

And if you don't get your period, then you are sure that you are pregnant. You should eat lots of vegetables, if possible one half boiled egg daily, and drink lots of water.

Sister-in-law: Yes, you need good food.

Worker: The baby gets food from the mother, so you need to eat double the amount you usually eat. The baby takes blood from the mother. That is why pregnant women become anaemic. For that at least once a day cook a Khichuri (rice and pulse) with rice, some red lentil and all other vegetables - cook it and eat it. Don't give it to anybody else in the house -- this is only for you.

Both the young woman and the worker laugh together.

Worker: Some people take vitamin pills but food is better than pills, good for blood. Actually, I did not think that she is again pregnant so quickly.

Sister-in-law: Which vegetables have most vitamins?

Worker: All vegetables, but Kochu Shak (spinach) is best.

Mother-in-law: I did not know that she was pregnant.

Worker: And this time you should not stay at home. You must go to the clinic every month and check every month - what is the condition of the baby, ok? You should get a card from there and get the necessary medicine. When it will be five months, get a TT injection from the clinic, and then at seven months, the second dose of TT.

(The worker continues to advise the young woman, and leaves the house saying she will be back again soon.)

In this particular case the worker treated the pregnancy as well as she could have been expected to, providing nutritional advice and insisting upon regular clinic visits for monthly check-ups and later on for tetanus immunization. It cannot be assumed, however, that all pregnant women receive even this level of advice. Moreover, almost anyone could have identified this case as a high risk pregnancy, and the worker certainly treated it as such. Whether she has the competence to diagnose less obvious cases is doubtful.

Other instances of MCH care noted during observations are advice on deworming, scabies, and immunization. Perhaps the most standard MCH measure taken is to suggest to mothers that they take their children to the rural hospital for immunization. As we saw above, this suggestion almost inevitably leads to the request to be accompanied. On the whole, though, these

observations revealed that MCH is a secondary concern, and that the worker's ability to provide assistance is severely constrained.

CONSTRAINTS ON THE FIELDWORKER'S DELIVERY OF MCH AND
FAMILY PLANNING SERVICES

The female worker is an important link between the health and family planning program and rural women. This linkage function is especially important in light of cultural constraints that often prevent women from seeking care at subcenters or at the rural hospital. Use of contraception raises frequent questions about women's health, and the need for MCH services is extensive. However as we saw above, while there is an important role for the female worker, her contribution in both of these areas has been limited. When MCH appears at times secondary, this does not result from any intrinsic disinterest in this line of work but is produced by a set of operational constraints which in large measure affect the worker's performance in both MCH and family planning. Key dimensions of these constraints on effective performance are outlined below.

Density and Work Motivation: Female workers always tend to be in a hurry. They have to cover a large work area, and are unwilling to spend long hours in the field. They are not particularly interested in MCH because it adds to an already heavy burden of work. Unfavorable worker-to-population ratios and low overall work effort are key factors explaining these tendencies.

The current female worker-to-population density does not favor close relationships with rural women. The female worker covers an average population of 7,500, and requires approximately three months to complete one round of household visits to an average of 1,250 eligible women. This assumes the worker visits about twenty households a day, six days a week, with some allowance made for meeting days. Such a schedule implies that she has five

minutes available for each household visit (Koblinsky et al., 1987). If the twenty households were located near the worker's residence, her task would be relatively manageable. But since a worker is responsible for several villages, she must frequently walk for more than an hour before reaching some of the households in her area.

Moreover, workers do not spend as much time in the field as is expected. In the government bureaucracy generally, but even more so in field positions, where presence on the job is less easily monitored, actual working hours often amount to no more than half, possibly less, of the expected number (Simmons, et al., 1984). This is also borne out by longitudinal survey findings which show worker-client contacts at levels considerably below mandated patterns (Clark et al., 1986).

In one of the areas studied, almost one third of the women had not been contacted by a female fieldworker in a two year period. And among those who had been contacted a considerable number reported that the worker had neither talked to them nor distributed contraceptives in the course of their visit. These are instances where the worker's sole interest is to sign the household visitation card kept in the client's house, to convey to her supervisor the impression of regular visits.

Low worker-to-population ratios combined with low work effort detracts from MCH, just as it affects the quality of care in family planning. While MCH tasks may add to the credibility of the worker, they also add to the amount of time she must spend in a household. And, as we saw in the case studies, an MCH emphasis inevitably produces requests to accompany women to the rural subcentre or hospital. The worker generally takes IUD acceptors to the subcentre, and tubectomy clients to the rural health centre. The small referral fee she receives for such clients is in part intended to compensate

for the extra effort involved. She sometimes has to spend the night at the health centre to attend to her client. Given such demands, the size of her work area and transportation difficulties, and the fact that referral fees do not exist for MCH care, she does not respond to many MCH requests.

Worker's Technical Competence and MCH Supplies: Most female workers have acquired considerable skill in educating women about contraception and persuading them of the importance of limited childbearing and spacing (Simmons, et al., 1988). They also have some general knowledge about the type of advice to give for pregnancy and for the care of small children. Nonetheless, the worker's technical competence to provide quality care in both MCH and family planning is limited. She cannot screen family planning acceptors for contraindications and is capable of identifying only the most obvious high risk pregnancies. She often lacks the detailed knowledge necessary to provide useful advice to mothers, for example, nutritional advice on the type and amount of food to be given at the time of weaning. Such advice could make a significant contribution to child development.

An additional factor which militates against the effective delivery of integrated services is the worker's inability to provide preventive or curative medicines. She carries only contraceptives, and no medical/MCH supplies of any kind. MCH supplies currently approved for field distribution in the government program are Vitamin A for the prevention of nightblindness, and oral rehydration salts (ORS) for the treatment of diarrhoea. Vitamin A capsules are distributed twice a year by male health workers, who work under the administrative control of the health wing of the ministry, and are expected to cover the same rural households as the female worker. ORS, on the other hand, is supposed to be available for distribution by both male and female workers. However in practice, only male workers tend to receive such

supplies. As ORS distribution occurs through the health wing of the ministry and pervasive service rivalries between health and family planning hamper coordination, field level supply of ORS to female workers usually does not occur.

No medical supplies are provided to the female worker to support her MCH and family planning functions in the field. Because she has no medical supplies, minor childhood diseases, such as scabies, worms, eye infections, and for adult women's minor health complaints go untreated or depend on an uncertain system of referral to the nearest subcentre.

Supervision: Supervision of the female worker is one of the weakest links in the government health and family planning program. Only a small portion of the supervisors' time is directed at organizing work aimed at increasing the fieldworker's productivity and achievement. The remainder is spent on routine paper work, report writing, other administrative tasks, or on unrelated personal business. Exceptional supervisors, who show dedication and creativity in guiding and supporting the fieldstaff, tend to be no more appreciated by higher authorities than mediocre ones and their supervisory tasks are hampered by the absence of a client-oriented record keeping system.

The immediate supervisor of the female worker is the male family planning assistant (FPA), who in turn is under the administrative control of the family planning officer (FPO) at the rural health complex. Both levels of supervisors belong to a cadre of workers originally recruited and trained at a time when family planning was a vertical program in which MCH was not included. When supervisors visit the female worker in the field, or review her performance at subcentre or health complex meetings, the focus is on family planning not MCH.

Moreover, supervisory emphasis is placed on quantitative performance

rather than on the quality of care. For several years the government has been providing small referral fees to workers for the recruitment of IUD and sterilization acceptors. These fees, as well as targets for the recruitment of contraceptive acceptors, have provided clear indications of what are to be considered core tasks, and that the quantitative dimension of performance is more important than the quality of care. Given this context greater emphasis on MCH is only appropriate when accompanied by a shift towards greater supervisory emphasis on quality of care in both health and family planning.

While quantitative performance indicators for family planning have been well established, MCH work targets have not been well-defined, and even if they were, no easy mechanism for their measurement is available. It is quite clear that program planners have not considered these issues. MCH was added to the job description of family planning personnel and to some extent integrated into the training curriculum, but the implications of this addition for the work routines of the female worker and her field supervisors have not received systematic attention.

Least well understood is the technical dimension of supervision, which in theory is exercised by the female paramedic (Family Welfare Visitor, FWV) at the union level centre and by the medical officer for MCH and family planning at the rural health complex of the subdistrict. The paramedic has completed 18 months training in MCH and family planning, which qualifies her to perform gynecological examinations, IUD insertions, menstrual regulation, maternity care and deliveries, as well as treatment of common childhood diseases and the provision of basic adult primary care. But the link between the female paramedic and the field has not been operationalized.

Satellite clinics are supposed to be held twice a week, but this pattern of village-based service delivery remains largely unimplemented. Similarly, home visits for pre- and postnatal care, and for sterilization and and IUD

follow-up, as well as for general support to field workers are mandated, but not practiced. The female paramedic rarely visits the field, because she lacks transportation and the necessary supervisory encouragement to emphasize the field component of her work. As a woman, she continues to experience difficulty in moving around in a large field area, especially when unaccompanied and without transportation facilities. Since the paramedic's field responsibilities are in practice not monitored by officials from the health complex, she restricts her work to services at the union family welfare center, thereby depriving the female worker of technical guidance in both family planning and MCH (Koblinsky, et al., 1984).

Availability and quality of care at subcentre: Referral and advice are, as we showed above, the two MCH functions a female worker can perform in the village. Referral means sending a woman and her child to the union-level subcentre, where a male and female paramedic provide curative and preventive services, or to the rural health complex, where a number of physicians and a female paramedic provide services under the administrative control of a medical administrator. From the perspective of rural women, the female paramedic is the most relevant health care provider. As a woman it is culturally acceptable for her to address reproductive and MCH care issues and to conduct physical examinations. Male physicians can provide care in emergencies, but for routine family planning procedures and maternity care, only female providers are perceived as appropriate (Peters, 1987).

Utilization of services at subcentre facilities is generally low. Moreover, in study areas, the patient load consisted predominantly of adult females and males seen for curative care of illness, rather than for MCH and family planning (Baqee and Koblinsky, 1986). Since the female fieldworker does not emphasize MCH, referrals to the subcentre are minimal. But low

rates of utilization are also a function of the nature and quality of care. As a recent observer put it, "the services given are so poor and sparse, that most people do not turn up for them" (Peters, 1987).

MCH and family planning care at the subcentre and health complex are often substandard, both in terms of their interpersonal as well as their technical dimension. Interpersonal relationships are critical in influencing the degree to which health care messages are accepted, and technical components of care are successful (Donabedian, 1980). These are especially important in a setting where women approach the health center and its provider with reluctance and trepidation. Observation of the interactions between female paramedics and rural women revealed a lack of sympathy and respect for the patient; weak listening skills, and inadequate concern for the patient's need for privacy. Long waiting times added to the discomfort involved in making the trip to the centre (Nessa and Hurrell, 1985)

From a technical perspective services are also often inadequate. Low standards of hygiene and asepsis, improper storage of equipment and medicines, incomplete screening of both MCH and family planning patients, and complete absence of attention to post-natal care are typical characteristics of service delivery (Nessa and Hurrell, 1985). The female paramedic is generally capable of providing only partial diagnosis and partial treatment, or has insufficient medical supplies to address patient needs.

Limits to the availability and quality of care at the subcentre and rural health complex make referral an empty gesture. These limitations, not just the cultural difficulties women experience in leaving their home, account for low levels of utilization. Limits implied in referral as well as the structural overload of the worker's job routines and the absence of support, guidance and supplies explain her disinclination to engage more

fully with the multiple reproductive and MCH needs she encounters in the field.

CONCLUSION

It has been argued that the focus on population objectives in Bangladesh has diminished available health services, because institutional processes and inputs have been concentrated on the former, therefore reducing attention to the latter (Feldman, 1987). In this paper we have taken a different approach and argued - implicitly - that the zero-sum-game assumption of the population versus health perspective is unproductive. It obscures the basic commonality between family planning and other dimensions of promotive and preventive primary health care. The commonalities we have emphasized pertain not only to affinities in the services per se - especially from the user's point of view- but to the operational constraints which characterize the delivery of both health and family planning.

The problem is not so much that institutional processes have been diverted to one dimension of primary health care but that the ministry-of-health bureaucracy is inadequately geared towards the delivery of acceptable standards and appropriate scopes of care, be they in health or family planning. The critical constraint lies in the government's limited capacity to organize user oriented preventive and promotive health services of any sort. As a consequence not just health but family planning services have suffered.

A link has been created in the form of the female outreach worker who connects rural women to a service delivery system, giving them access to family planning and some dimensions of MCH. As we saw in the case studies, this link is both real and weak. The worker provides contraceptive services and education and she also renders some advice to pregnant mothers or refers

sick children to the subcentre or rural hospital. The frequency of contact between worker and client leaves much room for improvement, her skills and professional competence are inadequate for the tasks at hand, and in order to be more effective in both MCH and family planning, she must be given at least the most minimal medical and preventive supplies such as oral rehydration packages, ointment for scabies etc.

In this paper we have focused on the interactions between female fieldworkers and her clients, because it is at this level of service delivery that most rural women encounter the government health and family planning program. We have furthermore shown that existing weaknesses in the field are mirrored at other levels of care, i.e. at the rural subcentre or rural health complex. The overall quality and availability of services remains severely inadequate be it in the area of medical backup for contraceptive complications or other dimensions of reproductive health or care for pregnant mothers or children.

We have indicated a number of specific operational barriers that stand in the way of better services, pointing to worker densities, motivation of staff, supervision, recordkeeping etc. Each of these barriers - and many others could have been cited - constitutes an important obstacle by itself. But what is perhaps more important is that each is symptomatic of a general institutional weakness in the ministry-of-health bureaucracy to organize itself for the delivery of user-oriented health and family planning services while maintaining adequate and appropriate standards of care.

This institutional weakness is reflected in the fact that although the objective of integrated MCH and family planning services has been reiterated numerous times at highest levels of policy making, the practical and operational dimensions of integrated service delivery are not systematically addressed. Many of the operational problems identified here are well known at

the highest levels of policy making, where their systemic nature and their close linkage to bureaucratic politics is appreciated.

The reason for the continued existence of the weaknesses we described here, then is neither misplaced emphasis on one component of primary health care, nor inadequate information at highest levels of decision making. A major reason is the fact that the systemic nature of the problems defies, by definition, ready-made, simple solutions. While it is eminently useful to address any of the specific operational barriers to service delivery identified, (and in fact the Extension Project, which has provided the framework within which the present study was conducted, has demonstrated that progress can be made by working on specific improvements), we wish to emphasize here that it is only when some of the underlying systems dynamics are restructured, that major change will result.

Notes

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2. For a description of the Extension Project see Phillips et al., 1984, Simmons et al., 1984 and Simmons et al., 1987.
3. For a more detailed discussion of this methodology see Simmons et al., 1988.

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