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Strengthening Government Health and Family Planning Programs: Findings from an Action Research Project in Rural Bangladesh

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An ongoing study at the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is based on the premise that public sector health and family planning programs can be improved through an assessment of the dysfunctional aspects of their operations, the development of problem-solving capabilities, and the transfer of strategies successfully tested in a small-scale pilot project. This paper reports findings from a field trial implemented in a subunit of the project area at an early stage of the project. Operational barriers to public sector program implementation are discussed with regard to the quantity of work, the quality of work, supplies and facilities, integration of health and family planning, and leadership, supervision, and decision making. Initial results of the ICDDR,B intervention on these managerial processes are also indicated.

What can be done to improve the performance of public sector health and family planning programs in Third World countries remains a continuing puzzle. Better management or better implementation has become a frequently emphasized theme in the literature and in policy discussions. Focus on organizational determinants of performance constitutes progress in a policy debate that has ignored these issues in the past. However, there are still no clear answers to the question of how such improvements in program management and implementation are to be accomplished.

An ongoing study at the International Centre for Diarrhoeal Disease Research in Bangladesh (ICDDR,B) has adopted an organization development approach to this issue.¹ The study is based on the premise that public sector programs can be improved but that they need help in assessing the dysfunctional aspects of their operations and in developing new approaches for dealing with organizational problems and resource constraints. Such assistance in planning and guiding organizational diag-

nosis and renewal is provided by the ICDDR,B team, which brings to this endeavor the experience and expertise of managing a successful maternal and child health-family planning (MCH-FP) pilot project. This collaboration with the national MCH and family planning program is occurring in two thanas,² with the intention of testing the capacity of the government health services system to absorb the managerial and service delivery strategies that have been successful in a small-scale pilot project.

This paper reports findings from a field trial implemented in a subunit of one of the thanas at an early stage of the project. Designed to test the interventions to be undertaken in the project area as a whole, this field trial produced insights into the functioning of the public sector health and family planning program in this area and clarified the constraints and possibilities inherent in the ICDDR,B collaboration with thana-level officials and staff. Results from this field trial are supplemented with findings from a survey of rural women in the experimental area about the extent and nature of their contacts with government health and family planning staff. Findings reported here relate to managerial aspects, not outcome measures in terms of contraceptive acceptance or MCH indicators. The underlying hypothesis is, however, that improved program implementation will have an impact on outcomes.

Background and Framework

Since 1963 the ICDDR,B has been engaged in field-based research in Matlab Thana, in Comilla District. Although the main emphasis of the Centre is on diarrheal research,

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it has for the past eight years also been engaged in the testing of delivery strategies for health and family planning programs. These activities organized in Matlab have demonstrated significant accomplishments: a rise in contraceptive prevalence from 10 to 40 percent and a decline in mortality.³ This success has been attributed to the ICDDR,B's ability to "train, field, supervise and support a comprehensive contraceptive service program."⁴

This achievement in Matlab contrasts with the performance of the national family planning program, which has achieved much lower prevalence rates⁵ despite two decades of official commitment to increasing family planning practice through the provision of village-based services. Originally organized under a National Family Planning Council and Provincial Family Planning Board, the program has since 1975 been located in the Population Control and Family Planning Division of the Ministry of Health and Population Control (MOHPC). A second division of this ministry, the Health Division, is responsible for all other preventive and curative activities of the government. Each division has its own budget, field staff, supervisory personnel, and high level officials.

The family planning field staff consists of three female family welfare assistants and one male family planning assistant per union. They are supervised by a nonmedical official at the thana health complex. Paramedical family planning and MCH services at the union level are provided by a female family welfare visitor stationed at a family welfare center. Her supervisor is the physician at the thana health complex who has been designated as the medical officer for MCH and family planning. The line of authority continues through the subdivisional family planning officer and the deputy director for family planning at the district level, to the director of implementation in the Population Control and Family Planning Division at the national level.

The field staff of the Health Division consists exclusively of male workers—government health assistants and family welfare workers—of which there are approximately eight per union. They are responsible for communicable disease control programs, sanitation, and hygiene. They function under the control of a health inspector and the thana health administrator, the senior medical officer of the thana health complex. Lines of authority extend from these thana administrators at the thana level through the civil surgeon at the district level to the director of implementation of the Health Division at the national level.

Health and family planning field staff have a history of working independently of each other in their respective field areas. A 1982 government order, however, mandated an integrated work pattern for field workers and their immediate supervisors.⁶ This required the establishment of work teams consisting of one female family planning worker and either one or two male health workers. The extensive network of field workers and supervisors has been relatively ineffective in delivering health and family planning services.⁷

The MCH-FP Extension Project of the ICDDR,B focuses on the question of whether close collaboration with the government program in two thanas can lead to improvements in program functioning and effectiveness. The project uses the techniques of organization development from the field of social psychology and organization behavior. Organization development has been defined as "a long-range effort to improve an organization's problem-solving and renewal processes . . . with assistance of a change agent, or catalyst, and the use of the theory and technology of applied behavioral science."⁸ Typically, it involves the following steps: (1) awareness of the need for change and request for outside assistance on the part of key organization representatives; (2) organization diagnosis—the systematic and ongoing process of data collection on all aspects of organization functioning; (3) intervention design, implementation, and assessment of impact as well as ongoing process maintenance. The MCH-FP Extension Project contains all three of these components:

- 1 The project came into being at the request of senior officials in the Population Section of the Planning Commission who were conscious of shortfalls in program implementation and performance and interested in distributing special resources to thanas other than Matlab. The ICDDR,B project was to be institutionalized through joint implementation committees at the national, thana, and union levels. At the time of the implementation of the field trial discussed here, such project implementation committees had been established in two thanas and the national-level coordination committee was being constituted.
- 2 Assessment of program functioning undertaken by the MCH-FP Extension Project is based on formal surveys of program staff, officials, and clients; informal interviews of program staff and officials; and participant observation of program activities, including the medical services provided at family welfare centers. The project has established a rigorous data collection system designed to monitor demographic trends and changes in client attitudes toward program activities. These data will be used for systematic feedback to program officials at all levels.
- 3 The intervention strategy involves the transfer of both MCH and family planning service components and organizational elements from the Matlab experiment. Matlab demonstrated the effectiveness of combining contraceptive services, oral rehydration, and tetanus immunization—three relatively inexpensive and technically feasible services. It is expected that these services can be effectively implemented within the government program through the intervention of the ICDDR,B.

The service delivery strategy used in Matlab shares several characteristics with formal policies of the government health and family planning program: (1) an extension approach designed to provide village-based ed-

education and services; (2) utilization of multipurpose workers; (3) establishment of union-level family welfare centers for the delivery of basic health, MCH, and family planning services, with provision for referral of complicated cases. In contrast to the government program, however, the Matlab service strategy is implemented through a small, autonomous, decentralized, and vigorous field organization that controls considerable physical and financial resources as well as a technically competent and motivated staff.

In the extension project, senior staff and a small team of paramedical and field staff from the ICDDR,B are working on a continuing basis with government program officials and staff in the intervention thanas in an effort to overcome currently existing implementation bottlenecks. The ICDDR,B team (1) offers assistance with the mobilization of local resources and resources officially available through formal program channels; (2) provides formal training for field and paramedical staff; (3) demonstrates the effectiveness of sustained extension work and provides on-the-job training through its counterpart field workers; (4) provides general managerial assistance in the organization of regular meetings and in strengthening middle management's field orientation; (5) facilitates highest level problem solving through the national coordinating committee of the project.

Methods and Procedures

After the ICDDR,B had initiated baseline demographic work in project thanas and conducted several months of project implementation committee meetings with government staff, the importance of implementing a field trial of the intervention strategy prior to the completion of data collection became apparent. It was essential to try out the operational details of the intervention, especially the joint working patterns of ICDDR,B and government staff. Moreover, the careful phasing of research and intervention that was preferred from a scientific point of view was not practical in the context of an ongoing program with pressures to show results and to demonstrate the benefits of intervention.

As a consequence, the original project design was adjusted to allow for an early field trial of the intervention approach in one union outside of the formal experimental area. Establishing this demonstration site led to field observation, joint diagnosis, problem solving, and action that informed the more general intervention strategy of the extension project and intensified collaboration between the ICDDR,B teams and their government colleagues. Initially, the field trial had two components: (1) establishment of a family welfare center with local resources; and (2) support to field activities provided by four ICDDR,B field workers from the Matlab project assigned to government health and family planning field staff of two wards in the demonstration union. The notion here was that the government field staff would acquire more effective work styles from their association

with Matlab counterpart support staff.

Findings are based on (1) interviews with five government health and family planning workers in the two wards in which the field trial was conducted and with the program officials at the thana health complex; (2) interviews with the four ICDDR,B counterpart support field staff posted to the field trial wards, where they worked side-by-side with the government staff; (3) observation of and participation in project implementation committee and subcommittee meetings, jointly organized by key thana health complex and senior ICDDR,B project staff over a period of seven months; (4) regular observation of joint ICDDR,B-government field-worker teams during the two months of the field trials; (5) examination of minutes of project implementation committee meetings, and project staff field notes; (6) a survey of 2,396 women in the experimental area of the thana where the field trial was implemented.

Results

Much has been learned during the first few months of collaboration between thana-level health and family planning staff and the ICDDR,B team, and in the process of instituting this field trial. We report key findings about the functioning of the government health and family planning program, about operational barriers that prevent implementation, and about the impact of the ICDDR,B's presence on the functioning of the program in the thana. Five critical organizational variables are discussed: (1) the quantity of field work; (2) the quality of the field work; (3) supplies and facilities; (4) integration of health and family planning; (5) leadership, supervision, and decision making. We also analyze how the intervention of the ICDDR,B has begun to address these problems. These variables have been selected because they were identified as key barriers to program implementation and had also been found to be of critical importance in previous research.⁹ The present analysis constitutes a review of certain aspects of the organizational functioning of the government health and family planning program in study areas; a more complete analysis must await the full implementation of the research and intervention strategy of the MCH-FP Extension Project.

Quantity of Work

Previous research and evaluation reports have concluded that the limited quantity of work performed by health and family planning outreach staff can be a major program weakness.¹⁰ Although field workers are hired, trained, given a job description, and posted, this does not assure that they will actually work the expected number of hours contacting rural families in their assigned areas. This problem has been recognized in the literature and is acknowledged in frank exchanges with program officials, but there is little information on its dimensions. To obtain more precise information is difficult because

direct questions about the number of work hours produce inflated results. Even field observations, unless conducted over long periods of time, are likely to lead to short-term increases in the number of hours worked. Evidence from this field trial therefore falls short of measuring the quantity of work precisely, but it nevertheless approximates the range of what constitutes the average work pattern of health and family planning field staff in a union.

Official government hours for work in the field are from 9 A.M. to 4 P.M. ICDDR,B counterpart staff reported that government workers on the team appeared at 9:30 at the earliest and, more frequently, closer to 10:30 and began to leave around 2:00. On several occasions, individual workers left even earlier. Unless observed by outside visitors, they were inclined to rush quickly from one house to the next to complete their assigned daily quota of 40 houses within the shortest time possible. They complained to their ICDDR,B counterpart team members, and more subtly during in-depth interviews, about having to work harder and longer hours as a result of the project. In their view, they deserve more pay because of the additional burden that has been placed on them. They also admitted frankly during informal conversations with ICDDR,B field staff that they work less when on their own. As one health worker put it: "Previously, we used to come to the field when we wished and go away when we liked. And there was no problem." According to some of the thana-level officials, this means no more than three work hours on a day when a worker actually comes to the field. It was also acknowledged that there are days when workers do not visit their areas at all. This would imply that government field-workers in this area devote no more than 10-15 hours per week to their assigned responsibilities.

Data from a survey conducted in the experimental area of a representative sample of 2,396 women provide further evidence on the extent of work performed by MOHPC workers. A large majority of respondents indicated that they had been visited by a health and a family planning worker; however, only 59 percent had been visited by a health worker and only 42 percent by a family planning worker during the last three months (see Table 1, rows 1 and 2)¹¹ despite government orders stipulating that each household be visited every other month by both types of workers. Table 1 data suggest, moreover, that visits are often perfunctory at best. Fewer than half of the women visited reported having a conversation with the worker during the last visit (see Table 1, row 3).

These findings nevertheless demonstrate that, although workers do not contact rural families as often as prescribed, the government health and family planning program has a presence in the rural areas. This is important because it has at times been argued that the field staff does not visit the villages at all. However, research from programs in India and from other parts of Bangladesh suggests that the frequency of contacts between the rural population and government staff in some areas is lower than findings from this area indicate.¹² The slightly higher percentage of reported contacts of rural women with health workers than with family planning workers in Table 1 may arise from the considerably longer tenure with the MOHPC among health workers relative to the family planning field staff, and their greater geographic density. Thus, although the total percentage of reported contacts is lower for the family planning field staff, it represents a greater work effort for the average worker than among health staff.

The quantity of work performed by the government health and family planning workers increased consid-

Table 1 Percentage of village women reporting contacts with health and family planning workers

Nature of contacts	With health workers (male)	With family planning workers (female)
Respondents:		
1 Ever visited	87.8	82.3
2 Visited during past three months	58.6	42.3
3 Ever visited reporting conversation during last visit	46.1	48.4
4 With conversation during last visit reporting topic was related to health (when talking with health worker) or family planning (when talking with family planning worker)	90.8	68.0
5 With conversation during last visit reporting topic was related to both health and family planning	9.4	0.2
6 Knowing worker's residence	8.0	35.3
7 Knowing worker's residence reporting they would go there if necessary	49.7	53.7
8 With health or family planning conversation during last visit reporting they learned something during last visit	15.6	42.3
9 With health or family planning conversation during last visit reporting they received something that helped their family	74.6	12.1

* Total number of respondents—2,396.

erably with the posting of ICDDR,B field staff in the demonstration union. Control systems are essential for effective management, and the presence of this counterpart staff helped introduce an effective, previously non-existent control system. ICDDR,B field staff were perceived by junior government staff as informants who would provide reliable information on the work hours of the government field staff to senior project members and thana and district officials. Although they had no official role in the program, the ICDDR,B counterparts exerted considerable influence. For example, one ICDDR,B counterpart to the government family welfare visitor remarked perceptively: "In the back of their minds, the government staff know that you [senior project staff] can always go to the deputy director." The thana medical officer for MCH and family planning in turn observed: "Your people are everywhere. Now we have to work." Thus, although they did not exert formal control, ICDDR,B change agents derived a measure of informal authority from their special relationship with senior officials. This, in turn, energized a work system that previously functioned at a low level.

Posting ICDDR,B staff in the thana was a necessary but not a sufficient condition for the introduction of a functioning control system. Support from thana and district officials was also an essential ingredient. Higher level officials gave explicit instructions to workers to cooperate with the extension project and told them that, in the absence of such cooperation, officials would not hesitate to impose sanctions in the form of salary reductions. To maintain this system and establish positive reinforcements for performance has been a major concern as the project progresses from a field trial to full implementation of the experimental design.

While higher level officials support the project and insist that the field staff increase their work effort, they also communicated several problems that they believe will critically hamper work. Salaries for fieldwork are so low that it is impossible to support a family on this income. Therefore, workers are dependent for their livelihood on such other sources of income as small businesses, agriculture, or even the practice of medicine. Male workers live as much as ten miles from their work area, so that coming to the field involves expenditure of considerable energy, money for cycle repair, and time. Out of appreciation of these fundamental constraints, thana officials were sympathetic to the plight of workers and felt there should be a limit to how hard staff should be pushed to work. The extent to which low salaries account for poor performance of the field staff will be further investigated in the course of the project.

Quality of Fieldwork

The mandated tasks of the government field staff during household visits include (1) recording basic demographic, health, and family planning information; (2) checking for the presence of diarrhea, malaria, and other communicable diseases; (3) providing education in the

area of family planning, sanitation, hygiene, nutrition, and oral rehydration; (4) recruiting family planning acceptors; (5) distributing contraceptives and vitamin A capsules; and (6) referring tubectomy and IUD as well as serious medical cases to the family welfare center or the thana health complex.

The field observation of MOHPC staff in the demonstration area was instructive because it provided direct insights into the quality of services that are provided if an inactive service system is put to work. In the course of their observation, a consensus evolved among ICDDR,B observers and thana-level officials that the quality of work performed by the field staff in the demonstration area is poor and that technical training is needed to make workers more effective. For example, male workers, according to their own comments to counterpart field staff, put on "a real show" for visitors who had come to observe them. They lectured villagers with much pathos about an assorted set of topics. Some points made were appropriate; others were quite unsuited for the setting. One health worker informed an astonished villager that he ought to remove his pumpkin and bean plants in front of his house because they were a source of mosquitos; on another occasion, an impoverished villager was told to install a latrine that would cost more than a month's income.

Exchanges with villagers assumed the character of a lecture comprising unconnected themes presented rapidly and mechanically. Villagers were often asked to avail themselves of services and resources that did not exist, or as illustrated by the following exchange, they were given inappropriate advice.

Worker: "How much land do you have?"

Villager: "Two bigha."¹³

Worker: "Can you get enough rice to feed your family from this land?"

Villager: "No."

Worker: "Well then, why aren't you practicing family planning?"

Villager: "But I am."

Team members did not interact much with each other during their joint visit to a household and sequentially confronted family members with unrelated topics. There was much emphasis on data collection but little awareness of how data might be used to support future service contacts. The routinized and impersonal style of interaction conveyed the impression that the field staff cared little about their work or their clientele.

Villagers' responses to these visits were mixed. Some were impressed with the attention they received—in one instance commenting that this was evidence of a new and more effective government in Bangladesh; others were visibly amused. Everyone observed in this case study gladly accepted the distribution of vitamin A capsules to their small children. Some people willingly agreed that hygiene, proper sanitation, and immunization are important, but there was little indication that what they had heard would affect their behavior in any way. In several instances, villagers reacted angrily with com-

ments that showed their impatience with the worker's instructions in light of the villagers' inability to respond. One woman, for example, said, "Why don't you build latrines and tubewells for us. We will gladly use them."

Among the workers observed, male workers, even when they were clearly trying to do their best, performed poorly in comparison to female government workers. Female family welfare assistants were relatively personable, direct, and empathetic during exchanges with women about the health of their children and family planning. But even among female field workers, substantial improvements are needed. Although one of the two family welfare assistants successfully recruited several family planning acceptors since project activities in the demonstration union began, the female ICDDR,B counterpart worker was a primary influence in this success. The welfare assistant, although reserved and quiet, was cooperative and obviously pleased to be working with such a skillful counterpart worker. The second female government worker was more outspoken and active but not subtle enough in her approach and failed to make women feel at ease.

The family welfare visitor, a paramedic with 18 months of training in MCH, midwifery, and family planning, was the most impressive government worker in the demonstration area. She typically spent three days a week seeing patients at the family welfare center at the union level and two days visiting pregnant women and lactating mothers in the field. Both the Matlab physician who observed her work and the ICDDR,B counterpart paramedic who worked with her agreed that she is competent and effective. To the extent that problems exist with the quality of her work, this is, as will be discussed below, a function of the serious shortage of medicines.

It is plausible to argue that the ICDDR,B female field workers act as role models for the government family welfare assistants, who will gradually learn to imitate their approach to village women. In the case of the female paramedic, consultations with ICDDR,B male and female physicians are likely to have an impact on both her work motivation and competence. However, it is questionable whether the presence of ICDDR,B counterpart staff will lead to improvements in the quality of work of the male staff. The Matlab experiment, as other special projects, relies primarily on female workers to conduct outreach work. The government program, by contrast, has a large cadre of male workers, who are expected to perform both health and family planning duties. ICDDR,B male counterpart staff have experience with data collection and supervisory tasks rather than with educational and motivational work. As a consequence, they have acted more as observers and resource persons than as major participants in the educational tasks. In this role, they are by definition unlikely to have a major impact on the quality of work of the male government staff.

The survey of rural women in the experimental area provides additional information on the quality of work. Several findings support the notion that male and female workers differ in their relationships with clients. Ac-

ording to the reports of the respondents, 32 percent of the most recent conversations with the female workers and almost 9 percent of the most recent conversations with the male workers related neither to health nor to family planning matters (see Table 1, row 4). Although this finding lends itself to several interpretations, it might be argued that this is evidence of a more subtle approach among the female workers whose emphasis on rapport and trust goes beyond a narrow focus on health and family planning. Village women are more familiar with the place of residence of the female than the male workers (see Table 1, row 6). This difference may be due to the fact that female workers live in their assigned work area, whereas male workers are often posted outside of the ward of their residence. Nevertheless, the percentage of respondents who knew the worker's residence and expressed a willingness to visit the worker's home if necessary was only slightly higher for female than for male workers (see Table 1, row 7). A higher percentage of women reported that they learned something from female than from male workers during the last visit, but almost 75 percent of the respondents who had a conversation with male health workers during the last visit reported they received some help on that occasion (Table 1, rows 8 and 9). Most of the women who reported receiving help from male health workers were referring to the distribution of vitamin A capsules. This distribution occurs twice a year and happened to coincide with the survey that collected Table 1 data.

Physical Resources and Supplies

Lack of physical facilities and inadequate supplies of medicine are well known constraints on family planning and health programs in Bangladesh. In the project thana discussed here, thana health complex buildings are newly built, but only one of the eight required family welfare center buildings is currently under construction; none of the remaining seven unions has a government-constructed building, and most of these unions have no functioning family welfare center. The field trial union thus did not have a building for a family welfare center at the beginning of the extension project. Therefore, the question of what to do in a situation where no center exists posed itself from the very beginning.

To solve this problem, the project implementation committee approached local community leaders for an appropriate building. When initial plans to use a government seed store were not supported by the agricultural office, the union chairman, a local political leader, managed to make available and renovate a small, two-room structure. Since it is the purpose of the extension project to demonstrate what can be accomplished within the constraints of existing program structures and local resources, this contribution of a building, no matter how small and primitive, is a crucial indication that community resources can indeed be mobilized. Spare pieces of furniture were collected by the thana health admin-

istrator, since the allotted money for the welfare center furniture can only be spent once the government facility has been constructed.

The thana health complex has no discretionary funds from which minimal supplies or furniture can be bought, nor are funds available for operational costs of the family welfare center from which paper or cleaning materials can be purchased. This shortage of the most basic supplies and facilities constitutes a critical barrier to implementation. In the case of the family welfare center in the demonstration union, it was possible to obtain the necessary furniture and other supplies from existing stocks of the thana health complex. However, the thana health complex does not have enough furniture for the seven remaining centers and rules prohibit district officials from assigning furniture and equipment to facilities not explicitly constructed by the MOHPC for use as family welfare centers. These problems persist despite the fact that functioning centers are crucial to the MOHPC strategy of delivering health and family planning care. Since donated buildings are often available, the demonstration union's experience indicates a need for an interim strategy for implementing family welfare services in unions not yet equipped with a constructed facility.

The project implementation committee has not yet found ways of overcoming the shortage of medical supplies—a serious and persisting problem at thana, union, and field levels. Each field team carries vitamin A capsules, a few oral rehydration packages, and contraceptive supplies. Basic medicines are available at the family welfare center, but supplies are always short and certain essential items, such as iron tablets, are out of supply. Copper Ts have been scarce, and several motivated patients have had to return home without one. The family welfare visitor attempts to cope with these shortages by distributing less than the required dosage of medicines to patients. Since there is no budget for paper, she wraps medicines in used paper and uses minuscule amounts of cotton in applying medicines, hoping that her supply will last a little longer. ICDDR,B counterpart workers and visiting observers have no answer to the question of how these minimal supplies could possibly meet the demand for medicines.

Physicians at the thana health complex face similar shortages. These shortages are likely to become accentuated as field teams in the demonstration area begin to make more rigorous efforts to refer villagers to the thana health complex for immunization, medical relief, and sterilizations.

Integration of Health and Family Planning

In January 1980 the government announced the merger of health and family planning delivery systems at the thana and union levels for both outreach and static services. This integration scheme was intended to:

- 1 Provide an integrated package of health and family planning services to the client population.
- 2 Improve coordination and supervision between

health and family planning personnel and establish a unified command at the thana level.

- 3 Provide advancement prospects for field staff and field supervisors.
- 4 Avoid duplication of physical facilities.
- 5 Involve medical doctors at the thana level more directly in family planning.
- 6 Reduce the work area of the field staff.¹⁴

Prior to the initiation of the field trial in fall 1982, no action had been taken in the thana to implement this integration scheme. Thana-level officers continued to be known by the familiar designation of thana health administrator instead of thana health and family planning administrator; thana family planning officer rather than thana health and family planning officer; family planning assistant instead of health and family planning assistant; and so on. Although formal designations are not crucial for actual program functioning, they do reflect the underlying reality in this thana that family planning and health had been linked in neither a structural nor a functional sense. Field workers continued to work in either health or family planning in their previously assigned work areas and to identify with either the Health Division or the Population Control and Family Planning Division of the ministry. The thana health administrator reported to the district civil surgeon in the Health Division. The thana family planning officer, in turn, related to the family planning field staff and received his instructions from the deputy director for family planning of the Population Control and Family Planning Division.

The observation that integration of activities had not occurred is borne out by findings from the client survey. According to the women interviewed, the large majority of health workers discussed health topics during their last conversation with them, whereas a majority of family planning workers discussed family planning (see Table 1, row 4). Fewer than 1 percent of the respondents reported that workers discussed both topics (see Table 1, row 5).

With the decision to run a field trial, the project implementation committee decided to implement the government's integration order for the field staff in the demonstration area. Male health workers (government health assistants and family welfare workers) and a female family planning worker (family welfare assistant) were asked to work as a team to be assisted by ICDDR,B counterpart staff. The male family planning worker (family planning assistant) was placed in a supervisory position.

Although workers seemed comfortable working in a team, and indicated this explicitly in their interviews, it is worthwhile to reflect what kind of integration occurred. Working as a team does not necessarily imply that each worker automatically addresses both health and family planning questions with villagers or that they agree on a coordinated approach to their work. Health workers continued to emphasize health issues, whereas family planning workers emphasized MCH and family planning.

Moreover, even though workers were comfortable with the team pattern of work, health workers voiced a major concern: they resented the fact that the male family planning worker had been placed in a supervisory position. This complaint is significant, because it demonstrates that, as long as the two separate divisions continue to exist within the MOHPC, each side will fear that any changes that are instituted will create opportunities for advancement or for the control of resources for members of the other division.

Similar dynamics could be observed at the thana level. Under the compensation scheme for sterilizations, considerable financial advantages accrue to the physician at the thana level who is on deputation to the family planning department. This physician performs sterilizations and receives 22 taka (approximately US \$0.98 in 1984) for each operation. In the study thana, where approximately 15 sterilizations¹⁵ are performed per day, this amounts to a considerable sum of money and is likely to evoke the jealousy of doctors in the health division who are not allowed to perform sterilizations. Many of the small controversies that arose in the monthly project implementation committee meetings between thana and ICDDR,B staff were exercises in careful guarding of territory. For example, the suggestion that several of the remaining family welfare centers could be opened if the family welfare visitors were stationed in government dispensaries provoked heated discussion. Because government dispensaries are under the control of the Health Division, the medical officer for MCH and family planning feared that his authority might be reduced. What are perceived as conflicting and ambiguous government orders exacerbate existing rivalries. District-level officials are often helpless in clarifying government orders and refuse to approach officials at the national level; bureaucratic norms and procedures make it difficult for thana officials to approach the national headquarters directly.

Leadership, Supervision, and Decision Making

Patterns of leadership, supervision, and decision making in public health and family planning programs in South Asia tend to emphasize adherence to bureaucratic procedure, narrowly defined reporting systems, and mechanical inspection. Guidance, support, and problem-solving capabilities are generally absent.¹⁶ The study thana is no exception in this regard.

Several middle- and senior-level thana officials are formally responsible for providing leadership and supervision to health and family planning field staff. However, contacts between thana officials and field staff focus on routine personnel and reporting purposes and not on problem-solving activities aimed at improving delivery of services to the rural population. Thana-level officers are not in close contact with village-based activities. The medical officers for MCH and family planning, the thana family planning officer, and the health inspector are supposed to spend a large proportion of their time supervising field workers in the village. According to their own

admission, our observations, and reports of the field staff, actual field visits are infrequent.¹⁷ The senior thana physician responsible for all supervisory, administrative, and curative matters has even less contact with and close understanding of field activities. He comes to this position without any background in field-oriented programs.

The geographic area to be covered by thana-level officers is sizable, and difficulties with transportation are mentioned as a major reason for the lack of contact. Motorcycles have been provided by the Population Control and Family Planning Division, but they are either in a state of disrepair or not used because of shortages of fuel. The use of motorcycles and fuel for personal purposes is also an important problem, as is the increased burden of administrative work at the thana. Moreover, responsiveness to client needs as well as supportive problem-solving supervision are not the usual pattern in the bureaucratic culture of public sector programs in Bangladesh. In a hierarchy-conscious organization where junior officials and subordinates are not expected to speak freely in the presence of their seniors, a basic ingredient for problem-solving exchanges is missing.

Given the national emphasis on population control and family planning, supervisors exert pressure on workers to recruit family planning acceptors. The threat of sanction for noncompliance may be abused for personal advantage. There are reports that field staff have had to "buy off" an official who threatened to exercise sanctions because of inadequate performance. Control over scarce medical and contraceptive supplies can also be exercised for personal advantage rather than for improved service delivery.

A major objective in the intervention strategy of the MCH-FP Extension Project has been to develop thana-level organizational capabilities to provide vigorous support and encouragement to field programs. Given the conditions described above, such interventions require careful and sustained nurturing. The project scored some successes in this regard prior to and during the activities in the demonstration union that are worth recording.

The design of the extension project envisaged regular meetings for thana-level and project staff, but initial resistance was encountered when project staff attempted to schedule such meetings. Providing tea and lunch is what made meetings possible. "If you don't serve lunch," said the thana health administrator, "I don't think anyone will come." During the first meetings of the project implementation committee, thana officials adopted a largely passive stance. They listened patiently to explanations of project objectives, research, and intervention components, and answered with polite speeches assuring everyone of their fullest cooperation: "Whatever you want to do, we will support you." A second phase continued to be characterized by formal speeches interspersed with a few lively exchanges. When project staff attempted to communicate the notion of a collaborative project, thana officials asked: "If this is our project, then what are you doing here? Will you provide vehicles? Jobs?"

The breakthrough in project implementation com-

mittee meetings occurred when the committee began to address the question of what to do in the absence of a government-constructed family welfare center in the demonstration area. The initial response was: "We cannot do anything about the welfare center. We have to wait until the government constructs a building." One of the experienced organizers of the Matlab program took the committee on a round of visits to community leaders. His speeches set in motion the process that led to the opening of the community-donated family welfare center. Since that time, the medical officer for MCH and family planning describes the welfare center projects as "his" scheme and has taken independent initiatives to assure its functioning. This incident demonstrates the principle that good management means mobilizing resources within existing constraints and that some resources can be mobilized even under the conditions of extreme poverty that characterize rural Bangladesh.

A later exchange over the money required to renovate the community-donated building further clarified this principle. Thana officials approached ICDDR,B project staff for the required 500 taka (approximately US\$19 in 1984) but were told that solving problems in this manner would defeat the purpose of showing what can be accomplished with local resources. These conversations helped to clarify the purpose of the project and to demonstrate to thana officials their own power and competence to solve problems.

From this point on, thana officials became active participants in committee meetings, which have been lively, unpredictable, and oriented toward problem solving. Senior ICDDR,B project staff keep in close touch with the field, inform thana officials of their observations, and raise questions that need to be addressed. The medical officer for MCH and family planning has begun to visit the field teams in the demonstration area of his own accord and to bring his own perspective to meetings.

Conclusion

Analysis of these initial results demonstrates that problems of organization and management are indeed a pervasive characteristic of program implementation in this part of rural Bangladesh. Problems are systematically interrelated and deserve careful attention. Findings presented here vindicate the views of those who for the past several years have argued that managerial problems are serious and must be addressed.

To many observers of health and family planning programs in Bangladesh, and elsewhere, the large gap between program design and implementation is a familiar reality. Many of the operational details of this implementation gap are also well known to policymakers and program leaders at the highest level. However, these issues are often treated as "family secrets" rather than as legitimate organizational problems deserving systematic documentation, analysis, and policy intervention. Implicit in this hesitation to place organizational barriers

on the policy agenda is the notion that these problems are unmanageable. The extension project is based on the assumption that careful diagnosis of organizational functioning will make it possible to identify areas where management interventions are appropriate and where national-level policy change can facilitate implementation at all levels.

The experience of collaborating with thana-level staff in the organization of a field trial demonstrates that management improvements are indeed possible. Thana officials have begun to work together in addressing field problems, and field workers have, at least for the moment, increased their efforts. Extensive field-based training with close supervision by an ICDDR,B counterpart and thana staff is currently under way. This continuing collaboration between ICDDR,B and government staff will provide insights about both the possibilities and the constraints of improving the management of program implementation through organization development.

For the ICDDR,B project team, this field trial was an important and necessary learning experience in the complex process of implementing an intervention strategy in a public sector program. It has facilitated the development of working relationships between public sector officials and the ICDDR,B team, and demonstrated the need for adjustments in operational details that may turn out to be crucial in shaping the project's ultimate outcome. The field trial has facilitated the type of learning process that some observers of the development field argue should be incorporated into program implementation everywhere.¹⁸

Notes

- 1 For detailed discussion of the project design, see Phillips et al., 1984. For other relevant publications on the Matlab MCH-FP Project, see Rahman et al., 1980; Bhatia et al., 1980; Phillips et al., 1982; and Stinson et al., 1982.
- 2 The thana is an administrative subunit of Bangladesh comprising a health complex and a police station serving a population of approximately 200,000. The 437 thanas of Bangladesh are grouped into 20 districts. A thana is divided into 8-15 unions, each with a population of approximately 20,000-25,000. Unions are further subdivided into three wards. In 1983 thanas were renamed upazillas, or subdistricts.
- 3 Chen et al., 1983.
- 4 Phillips et al., 1982.
- 5 The most recent available national estimate of prevalence is 18 percent, of which 6 percent is traditional contraception. (See *Bangladesh Contraceptive Prevalence Survey—1981*, unpublished.)
- 6 In September 1982, the MOHPC decreed a crash plan in which all field workers were to participate in a one week training course covering 27 health topics given by senior thana program staff. After completion of the course, work teams comprising family welfare assistants and family welfare workers were to be fielded. The field observations for the present analysis took place in the crash plan implementation period. One year later, in September 1983, this team concept was reviewed by the MOHPC and a new order

was promulgated instructing field staff to work separately but under a unified thana administration. This new scheme, termed "functional integration," has been equivalent to a return to the system of work antedating the crash plan. The 1983 order that promulgated functional integration: also changed designations from thana to upazilla, or subdistrict. The reversal of the 1982 integration order is widely viewed as a vindication of noncompliance with the 1982 order and lends support to a pervasive view that orders need not be implemented, particularly if the order entails major changes in the pattern of work.

- 7 Pillsbury et al., 1981.
- 8 French and Bell, 1982, p. 14.
- 9 Misra et al., 1982.
- 10 Misra et al., 1982; Pillsbury et al., 1981; Minkler et al., 1983.
- 11 The results of the cross-sectional survey reported in Table 1 may have been biased by the fact that vitamin A capsule distribution, which occurs biannually, preceded the survey and may have spuriously increased the health worker contact rate relative to rates for family planning workers. Moreover, it must be noted that villagers may have had difficulty remembering the exact time of visit by a government worker or the content of the conversation that occurred.
The significance of the percentages reported here lies, therefore, not so much in the specific numbers as in their general range and in the fact that they confirm results from field observations and interviews with government workers and ICDDR,B field staff posted to the demonstration area. Percentages are consistent with subsequently collected panel data.
- 12 A study conducted in Chittagong District found that 43 percent of respondents were visited by a family welfare assistant at least once (see Quddus, 1979). Misra et al. (1982) found that only 12.9 percent of husbands and 7.6 percent of wives had ever been visited by a family planning worker.
- 13 A bigha is one-third of an acre.
- 14 As quoted in Minkler et al., 1983, p. 23.
- 15 Government regulations have subsequently allowed these thana health complex physicians to perform the operation: who have received training.
- 16 Misra et al., 1982; Pillsbury et al., 1981; Minkler et al., 1983; Hussain, 1983; and Ahmed and Muhuri, 1982.
- 17 Hussain, 1983, p. 12-14.
- 18 See Rondinelli, 1983; Johnston and Clark, 1982; Korten, 1980.

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