Study of Depot-holders in Rural Service Delivery Partnership: Implications for Selective Visitation

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Executive Summary

Introduction: The Health and Population Sector Strategy (HPSS), adopted by the Government of Bangladesh, aims to address service-delivery needs through reform, restructuring, and reorganization of the health systems in providing an Essential Services Package (ESP). The package is designed to address the health needs of families in a comprehensive manner, meet the required standards of quality and to be available at one single service-delivery site in the community. The purpose is to ensure reduction of production costs and optimal use of resources. In the context of the National Integrated Population and Health Programmes (NIPHP), service-delivery is provided mainly through non-government organizations (NGOs) patented through the Rural Service Delivery Partnership (RSDP) and Urban Family Health Partnership (UFHP).

The NIPHP presents a programme setting that emphasizes on NGOs for providing an essential package of child survival and reproductive health services through static clinics and paid auxiliary and voluntary workers in poor and underserved communities. The previous system of providing limited family planning and maternal and child health services door-to-door was changed to one that emphasizes on the delivery of services from static and satellite clinics in the community. In the present non-government organization (NGO) service system under the NIPHP, the service-delivery occurs in the upazila comprising a fixed clinic, a number of satellite clinics, and limited service provision at the community level by Depot-holders (DHs), who are volunteer workers. The DHs are paid a commission through the sale of commodities, ensuring the supply of pills, condoms, and oral rehydration salt packets. They are also expected to be involved in various health-promotion activities, and, thus, can further promote and ensure the effective use of services and facilities among the catchment population, especially women and children. However, further expansion of their responsibilities requires operations research to understand how this can be done effectively.

Objective: The present study was designed to collect information on the current workload of DHs, the community's perceptions and expectations of DHs' activities, and finally to generate information to finalize selective visitation strategy by the DHs.

Methodology: The study was conducted in 5 selected areas of 5 Technical Assistance units of the RSDP during May-July 1999. The study adapted a rapid appraisal technique that included free listing, ranking, social mapping, and daily time-use assessments. Data were collected through 40 in-depth interviews with the DHs and 10 group discussions with women (5 with users of contraceptive methods and 5 with non-users). Information was also collected through 3 group discussions with the Community Mobilizers (CMs) informal discussions with health workers (3 with Family Welfare Assistants and 3 with Family Welfare Visitors), and observations of 3 satellite clinics.

Findings: The majority of users reported that the DHs and satellite clinics met most of their family-planning needs. Women who belonged to the non-user group could not always specifically identify the local DHs, but were aware, to a large extent, what services the DHs provide. Many non-users mentioned about the DHs as the source of family-planning methods and that they learnt about the DHs' activities from their friend-users and relatives. Almost all the participants preferred the DHs as the source of family-planning supplies because of their easy accessibility and credit options. Some users preferred to collect methods from Family Welfare Assistant (FWAs)/Family Welfare Visitors (FWVs), because they could get them free of charge. Although most users reported that they collected family-planning methods from the Satellite Clinics or from the homes of DHs, they suggested that, for some, home distribution was helpful, especially for women who reside in a distance place or had problems getting out of their homes, such as newly-married and wives of religious persons. Both users and non-users reported that it would be helpful if they could obtain common drugs from the DHs for simple health problems.

The participants of the group discussions could identify the DHs as suppliers of family-planning methods. However, the user group of women ranked Static Clinics or Satellite Clinics higher as sources of healthcare than non-user women. This means that the user groups of women were much more familiar with those sources than non-users.

The non-user women were asked the reasons for refraining from using family-planning methods. They commonly cited the following reasons: they were practising safe period contraception, believed that they were not fertile, fear of side-effects, lack of knowledge about suitable methods for them, etc. However, most non-users could be potential clients for the DHs.

There was a wide variation in numbers of catchment households by the DHs ranging from less than 100 to 500 households. The working areas of the DHs were usually not clearly defined. In one area, there was a duplication of Satellite Clinics by local NGO and the government workers. Most DHs interviewed expressed concern over loosing "customers" to the government health workers or workers of other NGOs, because these other sources distribute various methods either free of charge or at a lower price. On an average, they visited clients' houses for 3 days a week to motivate them to come to the Satellite Clinics for antenatal care, child immunization, injectable methods of family-planning, and other general health services. Most DHs and community mobilizers (CMs) admitted that the DHs distributed family-planning methods to selected clients' homes. The problems the DHs commonly faced were record-keeping and updating information. In some areas, the CMs modified the format. There were different record-keeping systems in different areas. The incentive system was different in BRAC and non-BRAC areas. The DHs were found to be participating actively when they were observed at Satellite Clinics.

Almost all DHs expressed their need for more money for the services they were providing. They desired for permanency of their jobs. Most DHs expressed their need to undergo more training, so that they can handle simple health problems of clients, such as common cold, headache, fever and so on. They also showed interest to keep and prescribe common drugs, such as 'Paracetamol', to the local people. The DHs also often mentioned their desire for articles, such as bags and umbrellas, from the NGO office.

According to the respondents, the factor that motivated them most to carry out their work as DHs was that it brought them recognition, respect and appreciation from the people they serve. It helped them acquire a heightened social status and importance that they previously did not enjoy.

Recommendations: Selective visitation by the DHs to selected clients might require:

- Clear demarcation of the working areas
- An effective, convenient, and uniform record-keeping system
- A simple workplan for targeting selected clients (non-user of family-planning methods, newlyweds, pregnant women, and children aged less than one year)
- More training for DHs for distributing additional commodities.

The Context

The Government of Bangladesh adopted the Health and Population Sector Strategy (HPSS) in 1998. The HPSS aims to address the service-delivery needs through reforms, restructuring, and reorganization of the various health sub-systems of the Government through which a package of essential health services (ESP) is provided. The package is designed to address the health needs of families in a comprehensive manner, aiming at (a) meeting the required standards of quality, (b) to be available at one single service-delivery site, (c) ensuring reduced production costs, and (d) optimal use of resources. The primary purpose of the ESP is to enhance the quality of life of the poor and under-privileged segments of society by helping them reduce fertility and by providing improved family health. The HPSS is the governing principle in planning for the National Integrated Population and Health Programme[1] (NIPHP), a bilateral programme between the USAID and the Ministry of Health and Family Welfare, Government of Bangladesh. The main vision of the NIPHP is to improve the quality of life in Bangladesh by directly supporting the national programme in a sector-wide approach toward providing essential health services. In this context, service delivery is provided mainly through non-government organizations (NGOs) patented through both Rural Service Delivery Partnership (RSDP) and Urban Family Health Partnership (UFHP).

The NIPHP presents a programme setting that emphasizes provision of essential package of child survival and reproductive health services through non-government organizations (NGOs) and also provision of paid auxiliary and voluntary workers in poor and under-served communities. The previous system of providing limited door to door family-planning and maternal and child health services was changed to one that emphasizes the delivery of a wider range of services from static and satellite clinics. Under the Rural Service Delivery Partnership (RSDP), the service-delivery, in a thana, comprises a fixed clinic, a number of satellite clinics, and provision of limited services at the community level by depot-holders (DHs). Fig. 1 shows the RSDP service delivery design (1). However, it is critically important that a mechanism exists to enable non-users, particularly those with unmet needs, to gain access to services and commodities of the various ESP components. A recent study reported that change in the service-delivery system, i.e. from doorstep delivery of supplies and commodities by field workers to one that emphasizes clinics, has created a situation where the sources of supplies for the majority of current pill and condom users have shifted to pharmacies and small shops (2). In the current RSDP model, there is no

[1] The National Integrated Population and Health Program (NIPHP) is USAID's Bangladesh Population and Health Project for the period of 1997-2004. It is an initiative of 9 partners including USAID, the Government of Bangladesh (particularly Ministry of Health and Family Welfare), Pathfinder International for rural service delivery, John Snow Inc. for urban service delivery, Immunization and Other Child Health Program (IOCH) for urban immunisation and child survival, Family Planning Logistic Management (FPLM) for logistic management, ICDDR, B for operations research, Social Marketing Company (SMC) for social marketing of contraceptives and health commodities, and Access to Voluntary and Safe Contraception (AVSC) for quality assurance.

established follow-up mechanism for certain clients, such as antenatal care, dropouts among family-planning users, and immunization of children aged less than 5 years, etc. There is also no specific strategy to reach the under-served groups, such as newly wed, men and adolescents.

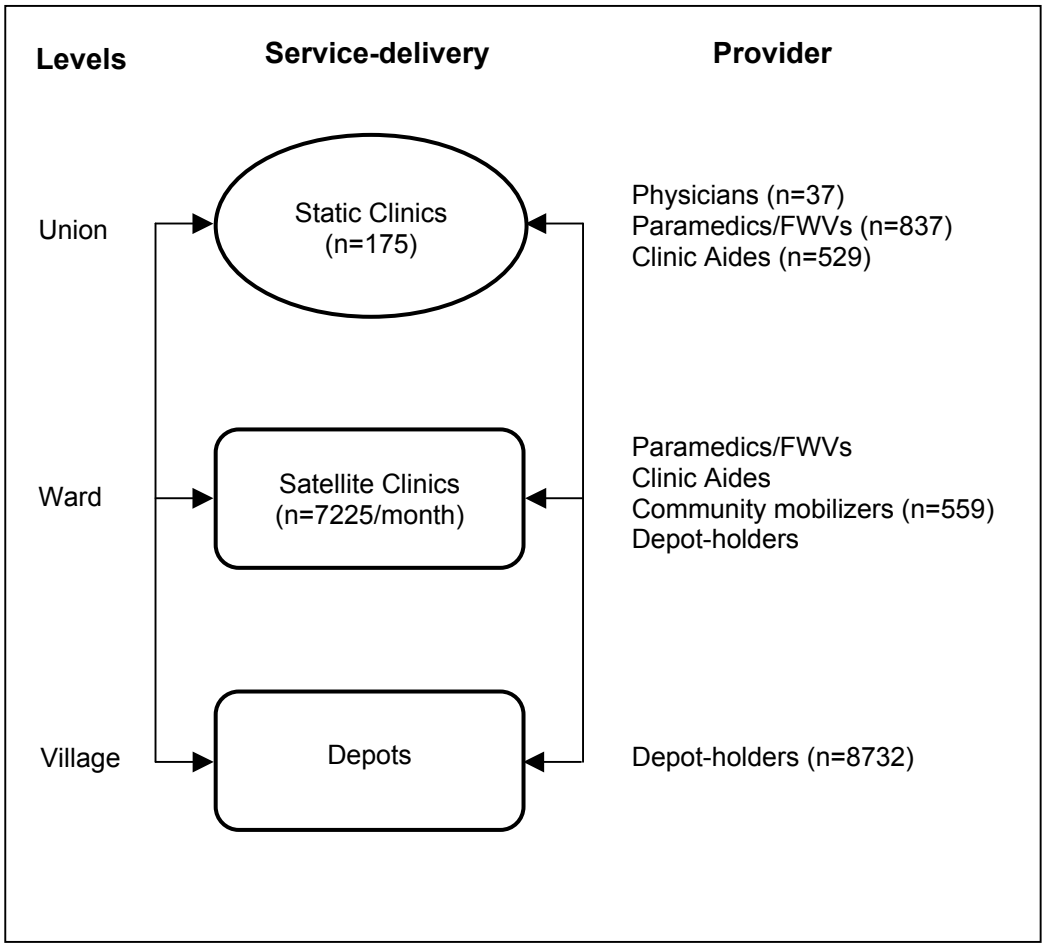

Fig. 1. RSDP service delivery structure

***Source**: RSDP semi-annual report, October 1999 to March 2000* (1).

RSDP Static Clinics

One hundred seventy-five RSDP Static Clinics have been functioning. Each clinic has a physician, paramedics and FWV, and clinic aides. Static Clinics offer services that are not possible to provide at Satellite Clinic setting, such as intrauterine device (IUD) services, oral rehydration therapy (ORT), and special care by physicians. Static Clinic also serves as an upazila office and storage place for logistics.

RSDP Satellite Clinics

To ensure the availability and accessibility of ESP at the community level, over 7,000 Satellite Clinics are held in RSDP upazilas each month. In rural villages, Satellite Clinics are run by the paramedics, supported by clinic aides, DHs, and community mobilizers. The community mobilizers are responsible for alarting the community of the monthly Satellite Clinic and promoting the need for health services in general. These clinics are in close proximity to women's home, creating easy access to needed information and services. Satellite Clinics offer most of the same services as Static Clinics.

Nearly 9,000 DHs work at the village level. They are volunteers receive a fixed monthly honorarium plus a commission by selling commodities, ensuring the supply of pills, condoms, and oral rehydration salt (ORS) packets in the community. Appendix 1 includes key activities of the DHs. They are paid an honorarium of Taka 250 as remuneration for their various tasks in the ESP service-delivery. At each thana, there are 2-3 community mobilizers who are responsible for promoting services and services centres in the catchment area, organizing satellite clinics, and supervising and providing logistics to DHs. Appendix 2 includes Terms of Reference for community mobilizers.

RSDP Depot-holders

The DHs are expected to be involved in various health-promotion activities, and can, thus, further promote and ensure the effective use of services and facilities among the catchment population, especially by women and children. However, further expansion of current responsibilities of the DHs who function as service promoters would require operations research to understand how this can be done effectively. Again, the programme recognizes specific needs of selected group of clients, such as non-users of family-planning methods, newly weds, infants aged less than five, etc. Thus, the present study was designed to collect information on the current functioning of DHs, assess the perceptions and expectations of the community about the activities of the DHs, and finally to generate information to finalize plan for visiting selected group of clients.

Objectives

General Objective

The general purpose of the study was to develop a selective visitation strategy for the depot-holders that would effectively expand their current responsibilities as service promoters.

Specific Objectives

This study was designed to:

- obtain information on community awareness, perceptions, and expectations concerning DHs
- present information on the current functioning and workload of DHs
- assess DHs' record-keeping system and possible needs for its improvement
- obtain information on needs, expectations, and motivation of DHs.

The Setting

The study was conducted in 5 selected areas of 5 Technical Assistance (TA) units of RSDP. The selected areas were: Alphadanga of Faridpur, Kalihati of Tangail, Chagalnaiya of Feni, Sreemongal of Hobiganj, and Rajarhat of Kurigram Table 1 shows name of the NGOs which have been working in the study areas.

Table 1. Name of NGOs working in the selected study areas of RSDP

Area/upazila	Non-government organizations
Alphadanga	BAMANEH
Chagalnaiya	Swanirvor Bangladesh
Kalihati	Swanirvor Bangladesh
Rajarhat	Debi Chowdhurani Poribar Unnoon Kendra (DCPUK)
Sreemongal	BRAC

Methods of Data Collection

The study adapted a rapid appraisal technique that included free listing, ranking, social mapping, and daily time-use methodologies. Table 2 shows the sources of data. In-depth interviews with DHs were conducted using a flexible guideline. A detailed diary of a full-working day of each DH was made. The DHs drew maps showing their working areas, which included the location of the clients. They were also observed at their work

at Satellite Clinics. Data were collected through group discussions among women who were residing in the catchment areas of DHs (both with users and non-users of contraceptive methods). In each group, 6-8 women participated in the discussion. During group discussion, the participants were asked to list sources of family-planing commodities and healthcare according to their preference. Information was also collected through group discussions with community mobilizers, and informal discussions with government health workers (FWAs and FWVs).

Table 2. Source of information

In-depth interview with DHs	Forty in-depth interviews (8 in each of 5 areas)
Group discussion with users of FP methods	Five group discussions (one in each of 5 areas)
Group discussion with non-users	Five group discussions (one in each of 5 areas)
Group discussion with CMs	Three group discussions (one in each of 3 areas, which was included in second phase)
Informal discussion with FWAs/ FWVs	Six (3 with FWAs and 3 with FWVs)
Satellite clinic observation	Three (one in each of three areas which was included in second phase)

Data collection was completed in 2 phases. In the first phase, data were collected from Tangail and Faridpur during the second half of May 1999. In this phase, 16 DHs were interviewed (8 from each area). In each area, 2 group discussions were completed (one with users and another with non-users).

Preliminary analysis of data from the first phase revealed that an assessment of current role, responsibilities, and performance of DHs would require exploring the views of CMs and government health workers in the respective DH's area. It was also determined that activities of DHs at the satellite clinics would also be observed to assess their involvement in satellite clinics. Thus, the second phase of data collection included some new components, such as group discussion with CMs, in-depth interviews with the government health workers, and observations at the satellite clinics. Information was collected from Sreemongal, Chagalnaiya, and Rajarhat for the second phase during July 1999. In the second phase, 3 group discussions were conducted with CMs (one from each area), 6 informal discussions were undertaken with the government health workers (3 with FWAs and 3 with FWVs), and 3 satellite clinics were observed.

Findings

Profile of Depot-holders

Sociodemographic background

Table 3 shows the socio demographic background of DHs. Most DHs were in the age group of 26-35 years. The majority of them had 5-9 years (grades) of schooling. Most of them (60%) had 2-3 children. More than half of the families owned cultivable land property. The main occupation of the family heads was small business. All were married except one.

Table 3. Sociodemographic background of depot-holders

Sociodemographic factors	No. of respondents (n=40)	Percentage
Age (in years)		
<20	1	3
20-25	10	25
26-30	11	27
31-35	12	30
35+	6	15
Education		
<Class 5	5	12
Class 5-9	29	73
SSC passed	6	15
Marital status		
Married	37	93
Unmarried	1	2
Widowed	2	5
Number of children		
No child	5	12
One	2	5
Two	9	23
Three	15	38
Four or more	9	22
Ownership of cultivable land		
Yes	25	63
No	15	37
Occupation of husband/family head		
Daily labour	4	10
Agriculture	4	10
Small business	19	48
Service-holder	9	23
Disabled	1	2
Unemployed	3	7

Experience and involvement of depot-holders in other activities

Table 4 shows the DHs working experience, the number of catchment households, and involvement in the other activities. Most of them were working as DHs for more than one year. There was wide variation in catchment households of DHs, which ranged from 100 to 500. However, on an average most DHs covered 100-200 households. All DHs received training from the RSDP. Although about half of them had no previous experience as a depot-holder in family-planning programme, the others had worked as FWAs, government DHs, NGO workers, or NGO volunteers. Some DHs (37%) were involved in other group activities and credit programmes of other organizations.

Table 4. Depot-holders experience and involvement

Variables	No. of respondents (N=40)	Percentage
Current working experience as DH		
One year	30	75
Two years	8	20
Three years	2	5
Coverage of households		
<100	5	12
100-200	29	73
201-500	6	15
Previous working experience		
FWA, now retired	3	7
Government DH	2	5
NGO worker	7	18
NGO volunteer	5	12
No work experience	23	58
Involvement with other group activities (such as credit groups)		
Yes	15	37
No	25	63

Views of Depot-holders about their Clients

Most DHs interviewed indicated that the majority of their customers were oral pill users. They also stated that people consulted them for various health matters, such as headache, diarrhoea, gastric problems, etc. Since the DHs were not qualified to prescribe drugs, they claimed that they referred the patients to the Satellite Clinics or Static Clinics. People also come to buy ORS packets, pills, and condoms. They

reported that mothers having 2-3 children were their most common customers. Often women sent their children to collect pills from the DHs. Since there were restrictions on mobility of newly-wed women and wives of religious persons, those women could not collect contraceptive methods from the DHs. In such instances, the DHs distributed family-planning methods to the clients' home. Some DHs reported that male customers also came to buy condoms from them. However, in Chagalnaiya and Sreemongal, customers for condoms were very rare. Of the 8 depot-holders interviewed in Sreemongal, only one said that she sold condoms. The DHs believed that people bought condoms from the pharmacies because they thought that those were 'fresh' (good quality), and they preferred a particular different brand (e.g. Panther) that DHs could not provide. They also believed that males might not feel comfortable to collect condoms from them (DHs) as they were females.

Most DHs stated that when any regular user stopped coming to her for supplies, the DHs investigated to find out the reason behind the drop-out. The DHs claimed that they could recall, without any written document, those who were using which method and the due time for getting the next supply. According to most DHs, the usual reasons of drop-outs were pregnancy, clients trying to have babies willingly, buying the method from the open market, getting it free from the FWAs, and switching from one method to other methods e.g. from oral pill to Copper-T or IUD, etc.

The DHs also identified some categories of women who would not come to them, such as women who have already undergone tubal ligation, women who are sterile, women who's husbands live away from the village, and women who are menopausal.

Many DHs interviewed said that they tried to convince the non-users to adopt any method, and in some cases they succeeded. According to one respondent, the older people and religious-minded persons were most difficult to be convinced. They reported that, inspite of misgivings of some people, such as *maulana*, they tried to convince people in the community to make use of various contraceptive methods available to them. However, some of them said they gave up trying to motivate such people because they would never come to them or it was impossible to motivate them.

Box 1. DHs identified clients and reasons for not coming to them

DHs identified and categorized non-customers according to the reasons for which women refrain from coming to them (DHs), such as:

- Resorting to natural, herbal, or 'azal' (withdrawal) methods
- Buying methods from the open market or obtaining methods free from a government-worker
- Suffering from side-effects
- Newly-wed women
- Wives of *maulanas* (religious persons)
- Women from well-off families
- Women residing at a remote place
- Want to switch to a different method, such as from pills to IUD, injectable etc.

Reported Activities of Depot-holders

Table 5 shows the reported activities of DHs with average time spent on each activity. The DHs listed a number of activities that they performed to accomplish their work. Of the reported activities, some are grouped as regular activities, some as periodic, and others may be categorized as occasional activities. Most DHs expressed that they were not over burdened with their current responsibilities. The daily time-use pattern reported by DHs have been attached in Appendix 3, 4 and 5, as for examples.

Regular activities

The main activity of the DHs was to distribute contraceptives and ORS packets to the clients at their own home. As a part of other regular activities, they needed to visit clients' houses for motivation, counselling, and follow-up of drop-outs of family-planning users, informing people about SCs, retrieving money which was due from selling methods on credits, etc. Most DHs admitted that they sometimes had to distribute methods to clients' homes, because the clients had some restrictions on coming out of their houses, e.g. newly-wed women and wives of religious persons. On an average, most DHs spent 2-3 hours visiting clients in a day 3 days a week. Some DHs had to visit clients' houses in far away areas. Some DHs visited clients' houses crossing rivers.

Although most DHs mentioned that record-keeping was a regular activity, it seemed that most of them had difficulty completing tally sheets and updating information. In most places, the tally sheets were not updated. In some areas, the CMs modified the format of the tally sheet according to the convenience of DHs. Often the DHs needed active help from the CMs, the husbands of DHs, or from other family members to complete the sheets.

Periodic activities

The DHs needed to visit the local NGO office once a month to report on method sales during the same visit to the NGO offices when they collected the contraceptive methods and ORS packets for the next month. The DHs also spent one day a month organizing SCs. Some DHs also extended their services to assist pregnant women to solve pregnancy-related problems and making sure that they receive the necessary vaccinations on time. They escorted pregnant women to the SCs. In some places, the DHs also assisted the newlyweds and helped the CMs organize discussion sessions for the newly-weds to make them aware of the importance of family-planning.

Occasional activities

The DHs reported that they occasionally needed to accompany clients with complications of contraceptive methods to the SCs.

Table 5. Reported current activities of DHs with average time spent

Activities	Time spent
Regular activities	
Distribution of commodities	Daily
Household visits for (2-3 hours a day): - Counselling - Motivation - Method distribution - Follow-up of drop-outs - Retrieve money - Inform people about SCs	2-4 days a week
Record-keeping	Not fixed
Periodic activities	
Help the CMs organize the SCs (whole day)	Once a month
Meeting at NGO office (whole day)	Once a month
Newly-wed orientation (in some places)	Not fixed
Occasional activities	
Refer and accompany clients with complications to SCs	2-3 cases in a month

Observed Activities of Depot-holders at Satellite Clinics

Three SCs were observed. The clinics started functioning at 10 a.m. and was closed between 2 and 2:30 p.m. The DHs were present in each clinic and actively participated in clinic management. Besides the DHs, a paramedic, a Clinic Aide, and a Community Mobilizer were present in each clinic. The DHs brought the clients from their homes, organized the place for clinic set-up (seating arrangements), maintained the serials of the clients, provided counselling to the clients, and helped the paramedic. In one village

(Kala Adharmanik), 2 SCs were held at the same time within a very short distance, with the local NGO conducting one SC and the other one was conducted by government health workers.

The clients attending the SCs reported that the DHs informed them about the date of the clinic one-day before the SC session, and they knew them very well. The clients could mention what services were provided from the SCs. However, 2 patients with possible Acute Respiratory Infection (ARI) did not receive any treatment, because they did not have money. In one SC, patients were found to be waiting for one hour before the clinic started. Most clients came to receive injections for family-planning or for general treatment.

Needs and Expectations of Depot-holders

Most DH respondents expressed their need for more money for providing services. The DHs reported that they have been receiving too little payment by any standard. Some were prepared to take on more workload if they were given more money for their work. However, a few, who were basically in extreme need financially, were willing to work more even without any extra incentives.

Most DH respondents looked forward to more permanency of their jobs, and were also hopeful that someday their experience as a DH would enable them to find a better job. They expected that if they worked with sincerity and hardship, their work would not go unnoticed by the authorities, and in due time they might be rewarded.

On many occasions, the DHs stated that they wished the authorities to provide signboards, and utility articles, such as bags and umbrellas, for their work as DHs. They also felt that these items can give them some sort of identity as being associated with an organization in a symbolic way.

Most DHs interviewed expressed their desire to undergo more training for being able to handle simple health cases, such as common cold, headache, fever, and so on. They also desired to keep and prescribe common drugs, such as ‘paracetamol’, for people in their area. Two DHs in Tangail were already selling paracetamol syrup in their localities. Some were interested in receiving training on pregnancy care, child health, and nutrition. Some were confident enough that, if they were provided the required training, they could push injections too well. Some of them asked for a transportation allowance for bringing patients to clinics and hospitals from their villages, because on some occasions they had to spend their own money to do so.

Concerns of Depot-holders

Most DHs interviewed expressed concern over loosing customers to the government health workers or workers of other NGOs as these other providers distribute various methods free of charge or at a lower price. The common expression was,

“Why would people buy the method if they can get it free?”

The DHs said that the working areas were not clearly demarcated, so there was some professional rivalry in most places. According to one DH, the government health workers often questioned the validity and employment status of the DHs. The same respondent also expressed concern that the health workers gave money to the women and motivated them to go to the government clinic to undergo ligation. Such

incentives cannot be obtained from the DHs. Some believed that withdrawal of the 'door-to-door' service was leading to a decrease in method sales. One DH said,

> "Many women may have problems at home, and they may not be able to come to me in person, if I don't visit them myself, then what will they do?"

However, a different view was expressed by some others, for examples

> "Now a days people are very alert, we do not need to distribute methods at their (clients) home, but they will find us and collect methods from us, because it is their need, we have informed them that our office has instructed us not to provide methods at your (clients) home."

A few DHs informed that they had to sell the methods to men and women on credit, as many customers did not have cash with them all the time. To retrieve that money later, the DHs had to go to the customer's homes.

The DHs reported that although it was not common, occasional commodity stock-outs, resulted in losing some customers.

In one case, a DH accused a CM of cheating her regarding splitting the cash from sold 'methods'. She was unaware of the standard practice of sharing the total profit with the local NGO. The DHs of Chagalnaiya mentioned that they previously used to get 500-700 Taka while they worked as a '*Secchasheb'* (volunteer), but presently their decreased income has made them frustrated. In Sreemongal, some DHs informed that some DHs had resigned because of low payment.

Social and Familial Support to Depot-holders

In most cases, the DHs informed the interviewer that they had received active support from the local chairmen, '*matbors*' (social leader), Union Parishad members, school teachers, '*imams*' (religious leaders), and youths in carrying out their work as DHs. They realized the necessity of maintaining liaisons with all key people in their area.

There were not many social barriers to their work as DHs, but in some cases they faced misgivings of their husbands or family members for spending so much time and energy without adequate pay. The major reason behind this was the extremely low remuneration the DHs received for their services.

According to a husband of one respondent (DH),

> "One can't even buy a decent saree with the amount of money they (NGO office) pay, why are you working? In some cases, the husbands asked for money from their DH wives."

Some admitted that their foremost priority was in keeping a sound and happy relationship with their husband, and only then they could carry out their duties as a DH.

Some reported incidents of hostility with local religious leaders. They commented,

> "Those who undergo ligation will not be allowed the sanctity of the grave."

Motivations for Depot-holders

Most respondents believed that the factor that motivated them most to carry out their work as a DH was that it brought them recognition, respect, and appreciation of the people. It helped them acquire a heightened social status and importance that they previously did not enjoy.

One respondent said,

> "I realize that Tk. 200 which we get is small. I am doing the job because I like it. Do I have options to undertake any other job or work? I am doing this because I can help people, which is actually a service to the society. If I go to people we become familiar with each other. One advantage of my work is that people currently know me. My prestige has enhanced. I will continue my work as long as the office keeps me. Through service to people one may even get closer to God."

Another comment was,

> "Whatever we get is good. We expect that salary might be increased in future. We work with the hope for the future."

The DHs believed that their role as DHs enabled them to develop social awareness among the people of their area. They feel that it is a great learning experience for them. It enabled them to come in contact with many people. Through their work they also learnt about family planning, health, and hygiene. Some even felt encouraged from the 'religious' point of view as they considered that they were serving God by serving their fellow human beings. Their work gave them the pleasure of being acknowledged as a valued member of the society. Because of their benefactor role in society, the important people of the village, such as '*matbors*', chairmen, and others, also recognized the DHs. One interviewee said,

> "Today I am better known in my area than my husband."

In some places, the local people often addressed the DH as the 'doctor'. This increased their self-esteem. One DH expressed,

> "When I enter a household, the men and women welcome me by greeting me as the 'doctor', which alone is a great satisfaction for me."

Another matter that worked in favour of continuing of their job was that the local people often considered them employed individuals, which invoked respect. Being respected as a contributing and proactive member of the society, the DHs would like to

continue their work as long as they are required. Some (not all) even would do some extra work without any increased remuneration. Most DHs said that they would like to keep on working as long as they are in good health or their husbands would not move away. However, some expected that with the improvement of the economy of the country, their status and payment would improve. If not, some would reconsider their decision to continue working as a DH. One comment was,

> "I would look forward for one more year, but if there is no increase of remuneration, I would think to give up working as a Depot-holder."

Remuneration for Depot-holders

The incentive system of BRAC was different from of other NGOs of the RSDP. BRAC does not provide any honorarium to the DHs, but DHs of the RSDP get a honorarium of Tk. 200 per month. The DHs of the BRAC areas get a allowance of Tk. 60 for attending monthly meetings, whereas the DHs in other areas get Tk. 50 for attending monthly meetings. The DHs in the non-BRAC areas receive one fourth to one half of the profits from selling family-planning methods and ORS. In the BRAC areas, in addition to a share of full profits from selling family planning methods and ORS, the DHs receive other incentives as follows: for pregnant mothers they get Tk. 3, for clients who needs iinjectables they receive Tk. 2, for ARI patients Tk. 5, and for Copper-T clients Tk. 5. Again, the BRAC members receive lower service charges. However, the average monthly income of BRAC DHs is Tk. 120 (maximum), whereas, in other NGO areas the DHs, on an average, get Tk. 300. In one area, 2 DHs admitted that they also get supplies of family planning methods from the FWAs, sold those methods, and shared the profits with the FWAs.

Community Perceptions

Perception of women about availability of family-planning services

Table 6 shows that the majority of users of family-planning methods reported that they received family-planning services either from the DHs or from the SCs. Although the women in the non-user group could not always specifically identify the local DH by name, they were aware of some activities of the DHs in the locality. Some non-users could identify the DHs as the source of family-planning methods, and they have learnt about the DHs from their user friends and relatives. The non-users mentioned the SC as another source of family-planning, although they did not use the particular term, SC. They referred to the SC as a place (house of someone) in the locality where some health providers used to come to provide services.

Table 6. Women's perceptions on sources of family-planning services

Areas	User group	Non-user group (sources for other family members or neighbours)
Alphadanga	SC DH UHC	SC DH
Chagalnaiya	No reference of DH	No reference of DH
Rajarhat	DH SC	SC DH
Sreemangal	DH SC	DH SC
Kalihati	DH UHC	DH Static Clinic Pharmacy

Box 2. Reasons for preferring depot-holders

The user participants preferred the DHs as the source of family-planning supplies because of their:

- Easy accessibility
- Credit options
- Provision of advice
- Locally known
- Friendly behaviour
- Caring attitude

The user women preferred the DHs as the source of family-planning supplies. On the other hand, the women mentioned that the market stores are too far to go for family-planning supplies. The SCs and static clinics were also favoured for their credit facility. Some participants preferred other sources of family-planning methods, such as pharmacies or their local market, because they used some brands that were not available from the DHs or at the SCs. In Chagolnaiya, the user women preferred to collect methods from the FWA/FWVs, because they were familiar with them for a long time, had intimate relationships, and could get methods free of charge. Some believed that the methods would be fresher and more effective if they were bought from a pharmacy or market. In some cases, the users would go to the UHC for family-planning services, mostly for IUDs, CT, and other clinical methods, which they could get free of charge.

Awareness of rural women on sources of healthcare in their locality

Table 7 shows that, in general, the DHs were perceived as family-planning providers. However, the women user group put higher ranking to the SCs as sources of healthcare than the non-user group of women. The participants preferred or selected the healthcare sources on the basis of nature and severity of a particular health problem. Most participants stated that they would go to the '*kabiraj*' for specific problems, such as sprains, eye infection, fracture, evil, etc. They would go to homeopathic doctors for private diseases, such as white discharge. If the disease was perceived severe, they would go to the pharmacy or to private chamber, since they believed that a qualified doctor and good quality medicine were available. Sometimes they reported visiting the UHC to collect prescriptions. Some others did not prefer the UHC because it was situated at a distance, medicine was not available, or it was overcrowded with patients. They often perceived that the behaviour of providers at the UHC was not good.

Table 7. Ranking of sources of healthcare by the rural women

Area	Heath care sources ranked by preferences by users of FP	Heath care sources ranked by preferences by non-users of FP
Alphadanga	Satellite Clinic (SC) Static Clinic UHC	Village doctors UHC Static Clinic
Kalihati	UHC Pharmacy Homeopathy	NGO UHC Pharmacy *Kabiraj*
Sreemongal	Private chamber SC UHC	Static clinic UHC Private chamber *Kabiraj* Homeopathy
Chagalnaiya	FWV Private chamber	Pharmacy UHC
Rajarhat	NGO SC Private chamber UHC District hospital	SC UHC

Box 3. Reasons for preferring Static Clinics

Women who preferred the static clinics cited some reasons why they would select those sites, such as:

- It was nearly always open
- Easy to get services
- Not rushed
- Could observe video films in some places
- Could get services on a credit system

Perceptions on Depot-holders Work

Attitudes of users

In most places, the user women could tell name the DHs unprompted, except in Chagalnaiya. Most of them could list a number of activities of DHs in their locality. As their place of contact with the DHs, they mentioned the SC, National Immunization Day (NID) sessions, DH's home, and clients' own home. Although most users stated that they collected family-planning methods either from the SCs or from the home of the DH, they suggested that home distribution be used for women who reside in a distance place. Many reported that some women had difficulties in getting out of the homes, and that they should get the methods at home.

It was said,

> "Sometimes it becomes difficult for women to collect the contraceptive methods, because they reside at a distant place or her family does not allow her to go outside, in those cases the depot-holders should provide methods at clients' home."

Box 4. Expected services from depot-holders

Women expected additional services/commodities from the DHs such as

- Medicine for common health problems
- More care for side-effects of family-planning methods
- Some home visits for special group of women, such as newly-weds, wives of religious persons, and women who reside at a distant place

In general, the users strongly suggested that additional commodities be available from the DHs. They suggested that the DHs could treat common diseases.

It was commonly said,

> "They (DHs) should sell medicines for other problems, such as cough, fever, gastric problems, etc., then we do not need to go to other places to buy these medicines."

The user women generally wanted extra care for side-effects of family-planning methods.

One user commented,

> "I had to spend a lot of money for treatment of complications (CT user), they (DH) did not take care."

Another comment was,

> "They (DHs) should accompany us visiting hospitals when we need to go there for complications."

The user group generally expressed that they respected the DHs, and acknowledged that the DHs were working very hard. One comment was,

> "She is like our friend." "They are working very hard, all for our benefit."

The user women stated that the DHs never faced any problem in delivering services in their area. Some users knew that the DHs received Tk. 200 per month for her work which they considered very low for the services the DHs provide. They also had the idea that '*boro apara*' (CMs) supervised the DHs. In some instances, the community mobilizer was be better known than the DHs as they worked for a longer period in the locality or had better contacts with the community.

Attitudes of non-users

Most non-users had a vague idea about the activities of the DHs. Most of them never met a DH. It was said that if the DHs were given proper training they could perhaps establish a proper liaison in the case of any medical emergency and work as their escort. Some non-users were more concerned about the general health services, and said that it would be helpful if they can obtain common drugs from the DHs for simple health problems, so they would not have to travel far to the UHC. Although they were not familiar with the term 'Satellite Clinic' they knew about the location and its function. A few of them acknowledged that the DH encouraged them to visit such a health facility, when the SC was arranged for their village.

The non-user women were asked about the reasons for their refraining from using family-planning methods. They commonly cited the reasons, such as they were practising safe period contraception practices, believed that they were not fertile, fear of side-effects, etc. It seems that most non-users could be potential users of contraceptive methods if they were approached or targeted in a planned way.

Box 5. Reasons for refraining from using family-planning methods by non-users

- Lack of knowledge about a suitable method for them
- They were practising safe period contraception practices
- Believed that they were not fertile
- Fear of side-effects
- Lack of knowledge about a suitable method for them
- Lactational amenorrhoea (however, the mothers were not exclusively breast-feeding)

Discussions with the non-users women yielded fairly positive attitudes toward the DHs. Non-user women from Rajarhat and Kurigram, said that the women who worked as the DHs in their area had a very pleasant personality. In general, the non-users also considered the presence of the DH as helpful and positive for the community.

Table 8. Perceptions of family-planning user and non-user groups of women on current functioning of DHs

Issues discussed about depot-holders	User group	Non-user group
Familiarity with the DHs	Familiar (except in Chagalnaiya)	Rarely could tell names of the DHs
Activities of DHs	Could list a number of activities	Some of her activities
Place of contact	SC, NID, DH's home, clients' home	Rarely met a DH
Quality of services in general	Satisfactory	Unclear
Behaviour, attitude, and commitment of DHs to work	"She is like our friend. They are working very hard, all for our benefit"	Unclear
Importance of supervision of DHs	The majority of women have the idea that the community mobilizer (*boro apara*) is supposed to supervise the activities of DHs. In some instances, the community mobilizer was better known than DHs	Not stated

Views of FWAs

The FWAs admitted that people insisted them to obtain family-planning methods, because they could provide these methods free of charge. One FWA said,

> "Since the depot-holders do not provide the methods at home and people have to buy these methods, they come to us, especially the poor people come to us."

As there was an official order not to provide methods to clients of the DHs, they did not give methods. One DH said that she informed people,

> "In the future, the GoB will be charging for these methods too."

The FWAs were aware that the DHs are not authorized to distribute family-planning methods to the doorstep of clients. However, the FWAs thought that there were some home distribution of family-planning methods by the DHs. One comment was,

> "The DHs have to go to the client's house for several reasons, such as informing them about satellite clinics, counselling pregnant mothers, and so on, they (DHs) sell the methods during these visits."

It was also commonly believed that the wealthy families would not come to the DHs' home, rather they would call the DHs to come to their (clients) home to provide methods.

However, all the FWAs believed that the performance of the DHs was good. It was thought that since the DHs were from the community, it was much easier for them to perform well. The DHs and the FWAs often met each other at the SCs. One FWA, from Rajarhat, Kurigram, said,

> "Most DHs in this area were our DHs (GoB), so we had a very good relationship for a long time. They (DHs) shared their problems with us, and we refer clients to them for obtaining methods."

The FWAs stated that the training for DHs was not sufficient and that they should get additional training. It was also stated that if the DHs could sell medicines for general illnesses, it would be financially beneficial for them: therefore, the DHs should get training on the treatment of general illnesses. One FWA commented,

> "We would be enough to supervise the DHs if needed".

One FWA, from Pattricul, Sreemongal, said,

> "I work in mutual understanding with the DHs. We know who should get methods free of charge (poor people) so we do not have any problem with the DHs."

The FWAs reported that there was a common perception among the general people that the medicines were of low quality.

> "The quality of medicines is not good when you get them free of charge."

Therefore, some people were interested in buying the methods from the DHs rather than trying to get them free of charge from the FWAs. One FWA, who worked in Doshghoria, Chagolnaiya, lived in the town area and used to meet the DHs at the SCs only. She said,

> "In my working area, I provide the methods free of charge. I do not know whether people also buy methods from depot-holders or not."

Views of FWVs

The FWVs were aware of the activities of DHs but did not always know them personally, and therefore, they could not make any comment on their (DHs) performance. However, in general, they believed that the DHs of the local NGO were sincere. The DHs often helped GoB staff on National Immunization Day (NID), vitamin A capsule distribution, and on EPI outreach centres. The FWVs reported that as the local NGOs did not arrange EPI sessions, the DHs referred clients to GoB staff for immunization. For other health problems the DHs referred clients to NGO clinics. It was commonly said,

> "They work (DHs of local NGOs) only in the areas, which we (GoB) allowed them to work."

An FWV of Suvapur Union of Chagalnaiya reported that in Champoknagar village both local NGO (Swanirvar Bangladesh) and GoB were operating CSs. She said,

> "In our clinic we provide free services, so people prefer to come to our clinic."

She gave an example of the DHs of Champaknagar village whose daughter used to take free medicine from her (FWV). The FWV said,

> "I have told her that she should take services from her mother (DH), it is apparent that she came to take service here because these are free."

She further indicated,

> "Sometimes we charge one Taka for condoms but all other services are free in our clinic."

Views of community mobilizers

Most Community Mobilizers who participated in the group discussions were involved with a local NGO for 2-3 years. Most of them passed HSC. Of them, 3 were male, and 6 were female. On an average, one Community Mobilizer supervised 10-15 DHs. They used to meet DHs 3-5 times a month.

Most CMs claimed that they visited the whole area before selecting the DHs to determine how many DHs would be required for each area. They emphasized on the criteria based on which they selected the DHs. In Rajarhat, Kurigram, the CMs could recall some selection criteria for DHs, such as DHs should have working experience as '*secchashebi'* (volunteers), should have a minimum of having Class Five passed, be a mother of at least 2 children, have familiarity with the local people, should be an active person, and have easy transportation access to her house. The CMs introduced the DHs with the community during the household survey and also through SCs and other meetings. The CMs reported that the number of DHs working in each union was not equal, and that possibly the local NGO office determined the number of DHs according to size of union population. The CMs commonly mentioned that demarcation of the catchment area was a problem when a particular village was very large. The CMs from Chagalnaiya mentioned,

> "The government has allocated the most inaccessible and problematic (low performing) unions for NGOs to work, so it is often difficult to find the required number of qualified DHs in a particular area."

They also added,

> "The working areas for local NGOs are not clearly demarcated, and FWAs might distribute free methods."

Most CMs reported that the DHs worked with the FWAs with mutual understanding in most places. But it was perceived by some CMs that there might be competition between DHs and other NGO workers to get the clients for injections if the incentive systems for the 2 adjacent NGOs were different.

Most CMs believed that, on some occasions, the DHs might have distributed methods at clients' home if they are called on and if the clients were their relatives. It was believed that they (DHs) might also distribute methods to newly-wed women and wives of religious persons who could not leave their homes to collect methods.

The CMs related that the DHs knew about natural events (birth, deaths, marriage, and pregnancy) through their regular activities since they (DHs) used to visit almost all households for different purposes, such as contacting pregnant mothers to come for anenatal care (ANC), counselling newly-wed women for contraception, motivation for child immunization, etc. However, they (DHs) rarely kept written information. Usually, they verbally reported information to the CMs who updated the information in their official record book. In one place, the DHs maintained personal notebooks in which they wrote about new events, such as marriage, pregnancy, birth, etc. They then reported this information to the CMs who updated their records.

The CMs reported that some DHs found it very difficult to fill out the tally sheet. The DHs often needed help from the CMs to fill out the tally sheet. The CMs suggested that it would be much easier if a record-keeping system in the form of a couple registration book is introduced instead of the tally sheet. The CMs thought that there were some problems in the tally sheets, such as little space in a single column, too many items to be filled in, etc. They further thought that the columns for "side-effects" and "referral" were not useful, because the DHs did not deal with those issues. One CM commented,

> "Some of them (DHs) have lack of interest in filling out the sheet because they are not getting much by doing all their work as a DH, some of them are not interested to continue the work without increasing the incentives."

The CMs believed that the number of clients at the particular SCs was dependent on the familiarity of DHs with the community, quality of services provided at the clinics, and contacts by the CMs with the community. They believed that the DHs were hard working people, and are committed to their work, but that they were not performing their tasks in a systematic way. One CM said,

> "Presently the DHs are not working in such a way that they can target the non-user women. If we want them to do that they need to go more frequently to the house of clients (non-users) and they will demand more incentives."

It was commonly reported that the DHs needed more training. The CMs suggested that if the DHs are trained on general illness and its treatment, they (DHs) could manage such types of patients. The CMs also thought that the DHs should get training on pregnancy care, safe delivery, child health and nutrition. However, the CMs believed that whatever training the DHs would need, active supervision from the CMs is required.

Discussions

The present study found that the DHs and the satellite clinics met most family-planning needs of the user women in the study areas, which is encouraging from a programmatic point of view. However, women who belonged to the non-user group were also aware, to some extent, of the type of services provided by the DHs which they had learnt mostly from their user friends and relatives. Thus, the users acted as mediators of information in this regard. The findings of the study also showed that the user group of women ranked Static Clinics or Satellite Clinics as sources of healthcare higher than the non-user women. This indicates that the user group of women was much more familiar with those sources than the non-users. Again, considering the commonly cited reasons for refraining from contraceptive use by the non-users, it was revealed that most reasons

were related to lack of effective information, which means the DHs have not been sufficiently targeting the non-users. Thus, many non-users might be potential clients for the DHs if they (non-users) would have been better targeted. In such a strategy, a guideline should be developed that would indicate the length of time spent with non-users, process of contacts, and at what point the DHs would decide to 'give up' the contacts.

The DHs were not perceived as healthcare providers among the participants of the group discussions, but they were identified as suppliers of family-planning methods. This finding is not surprising, because DHs have, at present, limited involvement in health related activities.

Almost all the participants preferred the DH as the source of family-planning supplies because of their easy accessibility since they belonged to the community. However, some DHs had to work in far-away and more remote areas. The study reported a wide variation in the number of DHs catchment households ranging from less than 100 to 500 households. As a result, workloads of DHs might also be different for each DH. Again, in most places, the working area of DHs was not clearly defined, and, thus, most DHs interviewed expressed concern over losing their 'customers.' The study also found that some user women preferred to obtain their family-planning methods from the FWA/FWVs, because they could get the methods free of charge. This finding is also not unexpected, since there are overlaps and duplications of activities by local NGOs and the government workers. For an effective service-delivery system, the programme needs to address the issues relating to demarcation of the working areas clearly and minimizing the variations in the number of the catchment households for the DHs.

The study also found that most users reported to obtain family-planning methods either from the SCs or from the homes of DHs. However, the users, non-users, CMs, and DHs suggested for doorstep distribution of family-planning methods for those women who reside at a distant place or have problems getting out of their homes (e.g. newly-married and wives of religious persons). In fact, most DHs admitted that they had to provide family-planning methods to such selected clients at the clients' homes. Therefore, there should be a provision for some home distribution of family-planning methods by the DHs for selected clients or potential clients only. The users commonly expressed that they needed some additional commodities and extra care for side-effects from the DHs and also expected that the DHs would accompany them to referral points, such as H&FWC or UHC.

The DHs commonly faced problems in record-keeping and updating client information. In some areas, the Community Mobilizers modified the format for the convenience of the DHs, and different record-keeping systems were used in different areas. In most places, the tally sheets were not updated. The DHs and CMs identified some specific problems with the format of the tally sheet. Therefore, the programme might require a unified and more effective record-keeping system for the DHs to monitor the programme performance.

The incentive system was different in BRAC and non-BRAC areas. Therefore, a kind of professional rivalry existed between DHs in BRAC and non-BRAC areas. In some places, condom sales were very low. The most commonly-identified reasons for this were 'Males do not feel free to collect methods from a female (DH)' or they preferred other brands that the DHs could not provide. In this context, the CMs suggested recruiting more male CMs in those places, so that they can motivate the males.

Most DHs expressed their need to undergo more training so that they can manage simple cases, such as common cold, headache, fever, and so on. They also wanted to be able to keep and prescribe common drugs, such as 'paracetamol.' The users, non-users, and CMs also expressed that it would be helpful for people if the DHs could provide drugs for simple health problems. Although most DHs expressed the need for more money for the services they were providing, the factor that motivated them most to carry out their work as DH, was that it brought them recognition, respect, and appreciation from the general public. It helped them to acquire a heightened social status and importance that they previously did not enjoy. Furthermore, if the DHs are commissioned to sell drugs for common illnesses, they can further increase their income. The present study observed that most DHs were willing to continue to work as DHs as long as it is required. Few of them were interested to do more work without any increase in incentives. The programmes could provide some utility articles that may increase their motivation.

The selective visitation by the DHs to selected clients might require clearer demarcation of the working areas, effective record-keeping, and a workplan for targeting selected clients.

Recommendations

Based on the finding of the study, the following recommendations are put forward:

- The working areas of DHs should be clearly demarcated.
- Variations in the number of catchment households should be minimized to avoid duplications in SCs by NGOs and the government, and standardize the workload.
- An effective and convenient record-keeping system must be developed for DHs which would be unified for all areas, and that would allow targeting the selected clients.
- DHs need a workplan to target the non-users of family-planning methods and other selected clients.
- DHs need more training, so that they can provide additional commodities.
- DHs might be commissioned to sell drugs for common illnesses and, thus, increase their income, but would require additional training about these health problem.
- Provision of signboards and utility articles for the DHs may increase their motivation for continuing the services.

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Appendix 1

Key activities of Depot-holders (3).

- Provide ESP information
- Promote one-stop shopping
- Provide non-clinical contraceptives
- Visit pregnant women
- Promote breast-feeding and complementary food
- Distribute iodized salt and vitamin A
- Promote awareness of HIV/AIDS, immunization, nutrition, family planning
- Work as referral agent
- Maintain family register.

Appendix 2

Main responsibilities of Community Mobilizers (3)

- Coordinate, organize, and supervise satellite clinics and mobilize the community before each clinic session
- Assist the FWV and Upazilla level Manager in maintaining and preparing reports, conduct health education, and register clients
- Contact, replenish supplies, supervise, and assist depot-holders in maintaining the client register
- Inform clients of their critical follow-up dates through depot-holders
- Collect baseline demographic and service data
- Conduct IEC campaigns to promote the use of Essential Health Services, and ensure social support in the community for satellite and static clinics
- Organize orientation and group meetings for special groups, such as newly-weds, adolescents, and males.

Appendix 3

A day in the life of a Depot-holder

Depot-holder: Meherunnesa
Education: Class 8 (passed)
Occupation of husband: Farming
Number of children: 3
Working as a DH: 1 year
Formal training: Received training from RSDP

Time schedule	Activity
5:00 am approx. (Fazr prayer time)	Waking up, Washing up *(Oju*), and, Saying Fazr prayer
6:00-10:00 am approx.	Cleaning, preparing breakfast, serving and having breakfast, and preparing lunch
10:00 am-12:30 noon approx.	Going to the site and performing the duties of DH (Going to people's home, talking to them about health-care and contraception, informing people about SC and also about the necessity of antenatal care, postnatal care, immunization, etc.)
12:30-1:30 pm approx. (Zohor prayer time)	Coming home, taking a shower, and saying the Zohr prayer
1:30-4:30 pm approx.	Rest for a while, doing house chores, having lunch (distribution of methods*)
4:30-5:30 pm approx. (Asr prayer time)	Saying Asor prayer and cooking dinner (visit neighbours*)
5:45-7:30 pm approx. (Magrib prayer time)	Saying Magrib prayer, helping her children with their studies and serving evening meal to her children
7:45-9:30 pm approx. (Esha prayer time)	Saying Esha prayer, serving dinner to her family, having dinner herself (record-keeping*)
10:00 pm approx.	Going to bed

* These are the common time slots for DHs for performing their official duties.

Appendix 4

Case study 1

Name of depot-holder: Momina
Age: 35 years
Marital status: Married
Education: Class VIII (passed)
Village and union: Kamrthi
Thana: Kalihathi
Distirct: Tangail

Momina has been working as a Depot-holder (DH) for one year. She went to the local school and studied up to class eight. Her husband is a veterinarian. They have 3 daughters and one son. The oldest daughter is married and lives with her husband. The younger daughters will appear for SSC examination. Her son is a student of Class VIII. She lives in her own house and also have a small cultivable land.

She was trained as a DH last year. She said that, during the training period, she received Tk 1,500. Her typical day starts with the morning prayer. After her prayer she starts her household chores. She cleans her house, sweeps the floor, makes bed, and feeds the family. After the children are gone to school and the husband to work, she goes to her working areas. She stays there till one in the afternoon. Her usual hour as a DH is from 10 in the morning till 4 in the afternoon. She makes her own schedule according to her own convenience. If she is too busy with her household work, she will not go to the field on that particular day.

Her regular activity as a DH is to distribute pills and condoms, motivate newly-married couples, newly-delivered mothers, and non-users of contraceptive methods. Accordingly, she gives her clients information about contraceptives, immunization, pregnancy care, satellite clinics, and also about services that can be availed from her. At the satellite clinics, she assists the FWV, collects money from her clients, brings clients to the satellite clinics, and helps in record-keeping.

Record-keeping is a regular activity for Momina as a DH. She maintains a register for herself and another one for her supervisor. Every night she sits with her own register to record all of her sales. Some times people come to her home to buy pills, condoms or ORS when she is in the field. In such a situation, her daughter gives them whatever the clients need. At the end of the day, she records her sale. She has a client profile. So, she knows who are her users and when to replenish her commodities. She is never out of stock. At the end of the month before the meeting, she compiles this information and puts it in the official register for the Community Mobilizer. She does not find difficulties in the present record-keeping system.

Occasionally, she has to make home visits, refer clients to the *Swanirvor Office* (NGO), and accompany patient to the Upazilla Health Complex. There are users who have constraints to go outside home, such as newly-wed women, wives of religious people, etc. So, she has to make some home delivery for these types of clients.

She works as a DH from 10 in the morning till 4 in the afternoon. Most of her time is spent on motivation. She thinks that the best time for motivation is after lunch when people rest and has leisure time to talk. Her most preferred activity as a DH is the discussion with the mother in the community.

She plans her own work schedule according to her convenience. She divided her work area in small parts and decides in which area she will work. Sometimes it is difficult to cover the entire area in one day. So, she does it in two days. She suggested that a map of the community would have been very useful in keeping track of her activities and clients. At a glance at the map she could get the status of her catchment area and clients. From the map she could tell which are the houses she needs to visit. She would know who are the users and non-users. It would have saved her time.

As a DH she receives a honorarium of Tk. 200. Every month when she goes to the monthly meeting and for transportation she gets Tk. 50 every month. She also earns half of the profits from selling condom, pills, and ORS. The rest she gives to the *Swanirvar Office*.

CM is her supervisor. The CM supervises her activities while she is on work and also at home. There is no fixed day for the CM's to visit DH. CM also checks the client profile on the day the FWV comes and on the meeting day.

She enjoys her work as a DH. She said that by her work she could meet many people and serve the community. She feels that she is helping the government, the community, and the family. She is becoming their friend. On the other hand, she is also getting respect, appreciation, and recognition from the local people. Before she was a DH, she did not even go out of her house. As a DH she gets to meet many influential people from the community, such as Village *Matabbar* and Imam (religious leaders), who help in carrying out her duty.

She feels that she needs more training on antenatal care. She informed that people often want medicines for general illness. Her income would have increased if she could include those in her service.

She expressed that she would continue giving this service as long as she can, and she is also prepared to take more workload. But in the future when her daughters are married she has to take care of her household and might decide to discontinue.

Appendix 5

Case study 2

Name of depot-holder: Nazma
Age: 20 years
Education: Class-VIII (passed)
Marital Status: Unmarried
Village: Barankhola
Union: Borach
Thana: Alfadanga
District: Faridpur

Nazma lost her father when she was only one-year old. She has 2 sisters and 2 brothers. She is the youngest in her family. All her siblings are married and live together in the same house with their children.

She has been working as a DH since last six months. She received her training at the Phelia BAMANEH Family Health Centre. She was trained on different contraceptive methods and distribution and promotion of oral rehydration salt (ORS).

Her typical day starts early in the morning. She spends her morning hours doing household work. After finishing her household work she starts her day as a DH. Her every day responsibility as a DH includes: visit to the community with the Community Mobilizer for motivation, inform the community about the day and the time of satellite clinic, assist the CM at the satellite clinic, and distribute pills and condoms. All the DHs meet twice a month to discuss about the client status, sale, and problems, and to replenish the supplies.

She has 139 eligible couples in 500 households in her area. Most of her clients are pill users, and have several children. The condom users are the ones whose husbands stay at the work place, away from home. The majority of the population in her area is Hindu, and has fixed regular income.

The non-users are either newly-married or suffer too much from the side-effects. She believed that it is the low literacy rate for which it is difficult to motivate the couples to become users in her area. She encourages the pregnant mothers to go to the clinics for antenatal care. During the interview, she also mentioned that her clients often want medication for common illness, such as worm, cold headache, and others. But she can not provide them the services.

She visits the entire village twice a month, and sometimes she also pays home-visits to distribute pills, condoms, and ORS packets. Although most distribution is done from her home. Though the CM maintains record-keeping, she feels that it is very easy and she will be able to do it. She sells oral pills (Femicom), at a cost of Tk. 5. Whatever amount she sells she gets a quarter of the profit.

She enjoys her work as a DH, and would like to continue till she is married or gets a better opportunity. The DH position has given her respectable status in the society. She feels that she is making some contribution to the society. Everybody in her village knows her as a DH, which has increased her self-esteem. She said that

whenever some government officials or visitors come to see the programme the CM calls her for introduction.

She is not facing any problem being an unmarried woman performing her duty as a DH, rather she feels that she could take more responsibilities. She said that most married women, who have been working as DHs, have commitment to the families, and are not able to give enough time as a DH. She mentioned that there will be no inconvenience for her if the workload is increased. She is hoping that this work will lead her to better opportunities in future.