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**Health Care Services Utilization  
and Behavioral Pattern in  
Save the Children/US Catchment Areas**

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**FINAL**

**HEALTH CARE SERVICES UTILIZATION AND  
BEHAVIORAL PATTERN IN SAVE THE  
CHILDREN (USA) CATCHMENT AREAS**

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**Submitted to:  
Save The Children (USA)**

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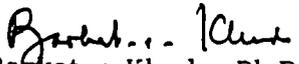
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# Preface

Save The Children (USA) has been operating in four thanas of Bangladesh, covering about 12,000 households in 10 unions. The program emphasizes on women's empowerment to be achieved through programmatic interventions in such areas as health, education, family planning, and income - generating activities. The health component of the program is aimed at achieving sustained improvements in infant, child, and maternal morbidity and mortality through promotion of health protective behaviors. Accordingly, a study was undertaken to assess utilization of primary health care services and behavioral pattern, identify factors responsible for utilization of various types of services and behavioral pattern, and assess sustainability related to health behavior among the clientele population.

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## LIST OF ABBREVIATIONS

AKAP	:	Awareness, Knowledge, Attitude, Practice
ARI	:	Acute Respiratory Infections
BFO	:	Bangladesh Field Office
CPR	:	Contraceptive Prevalence Rate
EPI	:	Extended Program on Immunization
FP	:	Family Planning
FWC	:	Family Welfare Center
FY	:	Financial Year
GHC	:	Government Health Centers
GOB	:	Government of Bangladesh
GOVT.	:	Government
GR	:	Government Responsibility
GW	:	Government Health Worker
MCH	:	Maternal and Child Health
MWRA	:	Married Women of Reproductive Age
NC	:	NGO Clinic
NGO	:	Non-government Organization
NHC	:	NGO Health Centers
NR	:	NGO Responsibility
NW	:	NGO Health Worker
OR	:	Own/Family Responsibility
ORT	:	Oral Rehydration Therapy
PHC	:	Primary Health Care
PMIS	:	Project Management Information System
RD	:	Rural Dispensary
RP	:	Registered Physician
SC	:	Save the Children (USA)
SCL	:	Satellite Clinic
SH	:	Spiritual Healer
SWOT	:	Strengths, Opportunities, Weakness, and Threats
THC	:	Thana Health Complex
TOWS	:	Threats, Opportunities, Weakness, and Strengths
URC(B)	:	University Research Corporation (Bangladesh)
VD	:	Village Doctor
WSG	:	Women's Savings Group

# EXECUTIVE SUMMARY

## 1. BACKGROUND

Save the Children (USA) has been operating in four thanas of Bangladesh, namely, Nasirnagar, Rangunia, Ghior and Mirzapur, covering about 12,000 households in 10 unions. The entire program of Save the Children (SC) is focused on women's empowerment, to be achieved through program interventions in such areas as health, education, family planning and income generation activities. The health program is aimed at achieving sustained improvement in infant, child, and maternal morbidity and mortality through promotion of health protective behaviors. The health care program of SC seeks to change behaviors and attitudes at the family level that would enable families learn behaviors that are within their control. In the cases of behaviors that would necessitate support services from other health providers such as government and NGOs, the SC would facilitate linkages with the local providers to ensure availability of services. Thus, sustainability related to health behavior is expected to be achieved. This study has addressed the issue of sustainability related to health behavior (i.e., behavioral sustainability) among the MWRAs and their family members in the SC catchment areas.

## 2. OBJECTIVES

The major objectives of the study were to:

- (a) examine the utilization of primary health care services, and behavioral pattern in respect of EPI, MCH, and family planning;
- (b) identify the factors responsible for the various types of services utilization pattern and behavioral pattern, with specific focus on EPI, MCH and family planning, and
- (c) assess, with special emphasis on the NGO health care approaches, the implications of services utilization and behavioral patterns on the sustainability related to health behavior among the clientele population.

## 3. METHODOLOGY

### 3.1 Sampling Plan

The study was carried out in four selected SC catchment areas (Nasirnagar, Rangunia, Ghior, and Mirzapur). The sampling frame for the study was the Project Management Information System (PMIS) of SC. According to SC PMIS, there are 11,825 MWRAs in the four study areas. By using appropriate sampling technique, the total sample size was estimated to be 384.

Based on the information available from the SC PMIS, a list of households in each area was prepared; and samples were drawn, using simple random sampling technique. The respondents were married women of reproductive age (MWRA) from each sample household.

## 3.2 Data Collection

Data were collected, using appropriate checklists and questionnaires, which were developed and finalized in consultation with SC. Checklists were used to obtain data about health centers, availability of health workers (both government and NGO), and availability of health services on MCH and FP. The questionnaires were used to collect data on demographic and socioeconomic characteristics of MWRAs, their awareness of and knowledge about health care facilities, behavioral pattern, utilization of health care facilities, perceived impact of health care facilities, and sustainability-related issues.

## 4. FINDINGS AND CONCLUSIONS

### 4.1 Characteristics of the Population

The mean age of the MWRAs is 29.3, ranging from about 29 years to about 32 years 28.5 and 31.5 across the four selected areas. The mean number of children ever born is 4.0, while that of living children is 3.2. Over one-third have dead children upto 2, and 13.5 percent of the MWRAs have wasted upto two pregnancies. On average, one child is either dead, or wasted during pregnancy.

Illiteracy among the MWRAs is widespread. About three-quarters have no schooling, although their husbands are relatively more educated. Over three-quarters, and about one-sixth of the MWRAs are Muslims and Hindus respectively, and Budhists are found only in Rangunia. Over three-fifths do not have any outside employment, and of those who have outside employment, a large majority are involved with poultry farming, followed by vegetable gardening. Their husbands are mostly farmers, service-holders, petty businessmen or agricultural wage labor. Among the sample MWRAs, 54 percent are WSG members and 46 percent are non-members.

### 4.2 Awareness and Knowledge

The level of awareness is quite high among the MWRAs related to (a) the need for health care facilities such as physicians and medicines, to meet the health problems of their own as well as their family members; and (b) the need for such health services as immunization both of mothers and children, accessibility to safe drinking water, oral saline to prevent rehydration, and check-up for pregnant mothers. However, the level of awareness related to accessibility to sanitary latrines and vitamin-A capsules, is quite low.

The knowledge among the MWRAs is almost universal in respect of primary health care components such as immunization both of mothers and children, and family planning. Also, the level of knowledge is quite high about (a) the check-up for pregnant mothers, and vitamin-A capsule; and (b) sources of health care facilities and services. The NGO clinics and the NGO workers are the major sources of both preventive and curative health services, while NGO clinics and Thana Health Complex are considered to be two important sources of competent medicare services. Government health facilities, in general, are less known. The village doctors dominate, next to NGOs, in providing curative services. The spiritual healers are not a well-known source of health care services.

The findings imply that the clientele population in the SC catchment areas have high awareness of and knowledge about the health facilities and services, thereby suggesting a high potential for sustainability of health-related behavior. However, lack of adequate knowledge about the government health centers needs be given careful consideration, if continued behavioral sustainability is to ensure.

### 4.3 Behavioral Pattern

In case of health-related problems of any family member, the MWRAs discuss mostly with neighbors, NGO workers, and village doctors. They attach equal preference to NGO clinics and village doctors for treatment of diseases of mothers, children, and other family members. The most widely approached sources for preventive health service, as well as for treatment of diseases at preliminary stages, are the NGO clinics and the NGO workers, followed by village doctors. However, although government health centers are given least importance for treatment, a significant proportion of MWRAs go to Thana Health Complex at critical stages of diseases.

That the MWRAs are dependent on NGO clinics for appropriate treatment of diseases is evident. Government health centers and other private providers are avoided primarily because of inadequate availability of medicine as well as non-availability of medicine free of cost, long distance from home, and inconvenience of transport. There is, thus, a need to provide health facilities at easily accessible locations either free or at affordable cost in adequate quantity, if health behavior is to be sustainable.

That the MWRAs and their family members have become quite conscious about the utility of preventive health measures, is evident from the behavioral pattern reflected in their adoption of such measures to minimize health problems. Four-fifths of mothers and children have been immunized either at own initiatives or at the initiatives of service providers. Over two-thirds of the MWRAs undertake regular check-up during pregnancy, have accessibility to safe drinking water, and use oral saline and vitamin-A capsule when needed, while less than half of them have accessibility to sanitary latrines.

Quite a high level of consciousness among the clientele population about the preventive health care services, reflected in the pattern of adoption of such services, is an indication of potential for sustainability related to health behavior. However, efforts need to be directed toward enhancing the level of consciousness about the utility of using sanitary latrines.

#### **4.4 Health Services Utilization Pattern**

The health services utilization pattern, as determined by (a) the quantum of health services received from the health workers, (b) satisfaction with such services, (c) proportion of health expenditures to other household expenditures, and (d) distance between homes and health centers, is quite interesting. The MWRAs mostly receive from NGOs such services as child delivery, check-up of pregnant mothers, deworming, treatment of diarrhoea, immunization, and family planning. The government health centers mainly provide such services as counselling on family planning, delivery of family planning methods, and immunization. However, the level of satisfaction with the health services received from the NGOs is quite high. The reverse is true in case of government health providers, suggesting that NGO health providers have been relatively more successful in providing satisfactory health services. There is, thus, a need to improve the quality of health services provided by the government health centers, if the potential for achieving sustainability related to health behavior among the clientele population is to increase. Since a dissatisfied user is likely to become a non-user, the issue of less satisfaction with the government health services needs to be given due consideration.

The MWRAs and their family members spend nine percent of their annual household expenditures for health care services, indicating that the clientele population has the ability to pay for at least a part of their health needs. It is found that the MWRAs and their families in Nasirnagar attach less priority to health care in terms of health-related expenditures, compared to other areas. Furthermore, utilization of health services is adversely affected in all the areas, except Rangunia, due to long distances between the government health centers and homes, suggesting that the clientele population may not be able, when NGO assistance would be withdrawn, to avail of health services from the government centers, if such services are not made available at easily accessible locations.

#### **4.5 Perceived Impact of Health Care Facilities**

Majority of the clientele population, except in Nasirnagar, have the willingness to avail of health services from the health centers/clinics, in case government or NGO workers do not approach to provide them with such services. This indicates that sustainability related to health behavior has not been fully achieved in Nasirnagar unlike in other areas. Furthermore, the perceived ability to pay for most health services appears to be poor in Nasirnagar, compared to other areas.

According to the MWRAs, NGO clinics are the most credible service institutions, followed by Thana Health Complex. Other government health centers such as Family Welfare Center and Government Rural Dispensary appear to have much less credibility in terms of satisfactory treatment, regular availability of health personnel in need, pleasant behavior etc., thereby indicating that the NGO clinics enjoy better credibility than most government health centers.

Thus, it appears that behavioral sustainability among the MWRAs is not achievable in, particularly Nasirnagar, because of the low level of willingness as well as poor ability to avail of health services at own cost. Lack of adequate credibility of the government health centers is likely to further delay the achievement of

sustainability. There is, thus, a need to undertake (a) motivational campaign to raise the level of willingness to spontaneously avail of health services, (b) income generation program to increase the economic ability of the clientele population to enable them to pay for health expenditures, and (c) appropriate measures to improve the credibility of the Government health centers.

#### **4.6 Sustainability Related to Health Behavior**

An analysis of the findings about awareness and knowledge of health care facilities and services, behavioral and health services utilization patterns, and perceived impact of health care facilities, presented in a SWOT model, indicates that there is a certain degree of sustainability related to health behavior among the clientele population in the SC catchment areas, except in Nasirnagar and Rangunia.

It would be desirable that the SC continues its operation in Nasirnagar. The 'threat' elements, combined with low priority attached to health care as well as unwillingness to avail of health services, and high dependence on NGO clinics, suggest that it would take some more time to attain sustainability related to health behavior. It may be noted that, given the existing unfavorable socioeconomic conditions, compared to other areas, the MWRAs in Nasirnagar are quite likely to attach low priority to health care over other household necessities. Also, since they are geographically disadvantaged, it is not unusual that they would have low willingness to avail of health services at own initiatives from the government health centers located far away from their homes.

The health behavior among the MWRAs in Ghior, Mirzapur and Rangunia, as evident from SWOT analysis, is relatively sustainable, although some difficulties may be encountered with the lower socioeconomic groups in Rangunia. However, to ensure continuation of sustainability, a number of measures need to be undertaken, so that the 'threats' could be transformed into 'opportunities'.

In view of inadequate knowledge among the clientele population about the government health services and facilities, resulting in low utilization of, as well as low priority to, such services/facilities, there is a need to increase their knowledge through effective dissemination of health-related information regarding services available at the government health centers. Furthermore, in order to counteract low credibility of government health centers, there is a need to increase the efficiency of, as well as enhance the quality of service provided by, the health personnel of such centers.

Because of high dependence on the village doctors for treatment, there is a need to train them up in preventive health care as well as in the basic curative health services, so that they can deliver quality services at the village level. Such a measure is likely to contribute toward attaining sustainability, among the clientele population, related to health behavior. Also, attaining and/or continuing behavioral sustainability would necessitate providing health services at easily accessible locations either free or at affordable cost.

## **5. RECOMMENDATIONS**

### **5.1. Strengthening Government Health Centers**

The evidence indicates that the MWRAs and their family members have inadequate knowledge of the government health services and facilities, resulting in low utilization of, as well as low priority to, such services/facilities. There is, thus, a need to increase the knowledge among the MWRAs and their family members about the services available at the government health centers such as THC, FWC, and RD. This would require strengthening of the government health centers in the SC catchment areas through wider dissemination of information regarding health-related services available at the government health centers. Such information dissemination could be done by both the government workers and the local NGO workers. This would further be facilitated, if the NGOs work in collaboration with the government health program.

Furthermore, the government health centers enjoy less credibility than the NGO health clinics in terms of the clients' level of satisfaction with treatment, availability of adequate quantities of medicines, behavior of personnel, regular availability of service, and availability of service providers. Thus, there is a need to undertake appropriate measures to close the credibility gap. Suggested measures include motivational efforts among the Government service providers to increase their efficiency in terms of providing quality service as well as improving their personal behavior with the clientele population, and establishing accountability on the part of the service personnel.

### **5.2. Developing Quality of the Village Doctors**

In all the project areas, village doctors are considered to be the second most important source of medicare services, thereby indicating high dependence on such doctors, particularly for curative services. It would, therefore, be appropriate to provide the village doctors with appropriate training in preventive health care as well as in the basic curative health services. The local NGOs, including the SC, may undertake the responsibility of providing medical training to the village doctors. Such training would enable the village doctors to improve the quality of their services, thereby contributing to the process of behavioral sustainability among the clientele population.

### **5.3. Providing Health Services at Accessible Locations**

Location of the government health centers at a long distance from homes, and inconvenience of transport were reportedly the two important reasons for not availing of health services from such centers. This is indicative of the fact that if NGO services are withdrawn from the project areas, the clientele population would be adversely affected. There is, thus, a need to make health facilities available at easily accessible locations at the village level. Toward this end, the Government has introduced the concept of satellite clinics to be held close to the homes of the villagers so that they can avail of selected MCH-FP services. Also, health services should be provided free or at affordable cost in adequate quantity, if health behavior among the clientele population is to be sustained.

#### **5.4. Raising Awareness among the Clientele Population**

Most MWRAs in the SC catchment areas are not aware of the facilities for laboratory tests such as urine, stool, blood tests, etc., and health counselling. Also, the level of awareness about such health services as sanitary latrines, and vitamin-A capsules, is low. There is, thus, a need for more intensified information, education, and communication (IEC) efforts to raise the level of awareness about laboratory tests, health counselling, sanitary latrines, and vitamin A, etc.

#### **5.5. Special Focus on Nasirnagar**

Behavioral sustainability related to such services as check-up of pregnant mothers, treatment of ARI, and family planning has not been quite achieved in Nasirnagar. Thus, the clientele population of Nasirnagar should be made special target group insofar motivational efforts related to health-program inputs are concerned. Also, it would be difficult to achieve behavioral sustainability in Nasirnagar, in view of the low perceived ability to pay for health services. Thus, there is need to intensify income-generation activities among the clientele population, so as to help improve their economic condition.

## **1. BACKGROUND**

### **1.1 Save the Children: A Brief Description of the Program**

Save the Children (SC), USA, has been working in Bangladesh as a non-governmental organization (NGO), with major focus on health, education, family planning, and income generating activities for the rural poor, particularly the disadvantaged women. It offers a highly integrated program with multidimensional developmental activities and multiple effects aimed at "achieving long-term, sustainable community development" (BFO Program Description, SC (USA), p.1). Its program package includes child survival, credit and income generation, community and home infrastructure, agriculture, education and human resource, pisciculture, women's savings groups, maternal and child health, sponsorship, family planning, water and sanitation, and resource conservation.

Save The Children operates in four thanas of Bangladesh, namely, Nasirnagar, Rangunia, Ghior, and Mirzapur, covering about 12,000 households in 10 unions (re: SC PMIS data). In these areas, the SC workers help identify community needs, and devise and implement strategies to address them. Village volunteers promote EPI, ORT, infant feeding practices, detection and treatment of neonatal infection, family planning, maternal care and vitamin-A distribution. Their promotion activities are carried out at the family level.

It may be noted that, among the four SC catchment areas, Nasirnagar is relatively in a disadvantaged position in terms of socio-economic and cultural conditions as well as geographical locations. It is a 'haor' area, situated approximately 135 km. north-east of Dhaka. It is the poorest, has the least developed infrastructural as well as service facilities, remains inundated for 4-6 months of the year, and has only one harvesting season (Save The Children (USA), 1993, pp.6-7). Most of the people are illiterate, especially women; majority of the women do not have any formal employment; over one fifth of the MWRAs are landless; half of them are 'poor' in terms of ownership of family assets, and overall family health status is low (Khuda et al., 1990a, pp.13-31).

The health program of SC is aimed at achieving sustained improvement in infant, child, and maternal mortality, as well as infant, child, and maternal morbidity through promotion of health protective behaviors. Child survival and maternal health interventions are targeted for under-5 children and 15-45 years old women in the SC catchment areas. An estimated 18,065 under-5 children and 30,249 women of 15-45 years old are targeted (Save The Children, 1993, pp.7-8). By the end of Financial Year (FY) 1994, SC expects to cover a total estimated population of 140,042 or 25,462 households.

In 1982, savings groups were introduced in 13 villages of Nasirnagar, Mirzapur and Ghior, and in 4 villages of Rangunia in 1986. Such group formation began on an experimental basis in 5 villages (old experimental villages) of Nasirnagar, and was subsequently expanded to 3 adjacent villages. The SC program in 'old experimental villages' is generally run by a team of a male and a female community worker, recruited from within the village by the village development committees with financial assistance from SC. The team covers approximately 225 families, irrespective of the women's membership status in the groups, and meets with eligible couples on a regular basis, providing services in the areas of health, nutrition, and family planning (Khuda et al., 1990a, p.5).

The entire program of the SC is focused on women's empowerment. The women's program started in 1975, with family planning services as its component, and subsequently, it was integrated with MCH, education, income generation, credit, agriculture, and pisciculture.

In the process of achieving women's empowerment, the SC uses Women's Savings Group (WSG), which is the main forum for targeting mutually-reinforcing sectoral interventions in health, economic development, and education. The WSGs provide institutional support to members to improve their social and economic conditions. The WSG members provide some services such as health promotion free of cost, while other services such as poultry vaccination are provided for a fee. These women members eventually become technical resource for the community.

All women, living in the SC catchment areas, benefit from MCH activities, nutrition counseling, and pre-and ante-natal care. Over the years, the small savings groups have evolved from simple "savings" groups to dynamic forums to improve the women's economic and social horizons, and enabled them to gain greater control over their lives and those of their children (Khuda et al., 1990b, p.5). Studies of the BFO's experience has shown that participation in WSG is associated with lower rates of mortality among girl children, higher CPR, and greater participation in family decision-making.

Utilizing their own savings and matching funds and grants from SC, members of the savings groups undertake such income-generating projects as rice processing, handicrafts, and poultry-raising. A part of the income earned from these projects directly benefits their families by supplementing the household income, and the balance is reinvested in additional income-generating activities (Khuda et al., 1990b, p.5). Studies indicate that WSG members have benefitted in terms of getting loans from SC loan fund, borrowing from group savings, and accumulation of savings which they can use for investment purpose (Khuda et al., 1990a, p.7).

SC has developed a computerized Project Management Information System (PMIS). Individual records, on each person in the catchment areas, are entered onto the PMIS through a family registration system. The residents are categorized by socioeconomic groups: A/B (better-off households) and C/D (poorest households). The PMIS data show that approximately 70 percent of households are in the C/D groups, who are targeted for interventions through WSGs (Save The Children (USA), 1992, p.5).

A study in Nasirnagar SC catchment area shows that both the members and non-members of savings groups have equal access to FP motivation and services offered by SC; the only difference is their participation or non-participation in the savings groups. The hypothesis is that the savings groups, combined with FP motivation and services, stimulate greater adoption of FP through encouraging women who would not otherwise accept FP to do so. That is, the savings groups stimulate demand among women who might not be likely to be FP acceptors because of male dominance, religiosity, strong son preference, etc., the degree of which is reduced as a result of women's involvement and participation in savings group activities (Khuda et al., 1990b, p.6).

As is known from the official records, the SC has undertaken a five-year strategic plan to enhance its ability to empower poor women and their families through WSGs (Save The Children (USA), 1992, p.5). The plan priorities include strengthening and institutionalization of the BFO training capacity, and expansion of linkage with other NGOs and government agencies. The SC plans to confine its

activities at the village level by deploying a cadre of para- professionals and WSG members, while the government program operates at the union level, thereby linking the government services effectively with SC activities with the ultimate objective of sustaining such a link.

By 1994, SC is planning to phase out its program to the WSGs and to other NGOs operating in Ghior and Mirzapur thanas, which are relatively well-served by other NGOs and are also more accessible to services provided by the government sector.

To achieve sustainability in its programs, the SC has begun implementation of a sustainability strategy. The objective is to develop institutional and financial sustainability of the WSGs within a five-year time-frame (Save The Children (USA), 1993, pp. 5-6). The SC would phase out at the completion of its program. By the time it phases out, there will be a cadre of trained village-level volunteers who would work as community resources, and the WSGs who would have acquired the skills and abilities, as well as have the services required to operate independently. Also, the SC seeks to change the attitudes and behaviors at the family level, which would enable families acquire new behaviors that are within their control. In respect of behavior that would necessitate support services as well as materials from other providers such as the Government and the NGOs, the SC would facilitate linkages with the local providers to ensure availability of services. Thus, behavioral sustainability, i.e., continued practice of individual behaviors after SC involvement is phased out, is expected to be achieved.

## **1.2 Objectives of the Study**

The overall objective of the study, per the TOR, related to identification of the determinants of utilization/non-utilization of primary health care services. The ultimate objective was to assess the implications of such services insofar as sustainability of the NGOs health care program related to health behavior among the clientele population, in four SC catchment areas, namely, Nasirnagar, Rangunia, Ghior, and Mirzapur, is concerned.

The specific objectives of the study were to:

- (a) examine the utilization of primary health care services, and behavioral pattern in respect of EPI, MCH, and family planning;
- (b) identify the factors responsible for the various types of services utilization pattern and behavioral , with special focus on EPI, MCH and family planning; and
- (c) assess, with special emphasis on the NGO health care approaches, the implications of services utilization and behavioral patterns on the sustainability related to health behavior among the target population.

## 1.3 Methodology

### 1.3.1 Identification of Variables

The variables, sub-variables, and their indicators which have been identified, are presented in Table 1.1.

TABLE 1.1: LIST OF VARIABLES IDENTIFIED

Variables/Sub-Variables	Indicators
1. Population Characteristics:	
1.1. Demographic Characteristics	1.1.1. Age of MWRAs 1.1.2. Living children, dead children, and pregnancy wasted
1.2. Socioeconomic Characteristics	1.2.1. Education (both of MWRAs and their husbands) 1.2.2. Religion 1.2.3. Occupation (both of MWRAs and their husbands) 1.2.4. WSG membership status
2. Awareness of and knowledge about Health Care Facilities	2.1. Awareness of health care facilities 2.2. Knowledge about primary health care 2.3. Knowledge about the availability of health care facilities and services 2.4. Knowledge about the availability of most competent medicare services
3. Behavioral Pattern	3.1. Discussion about health-related problems 3.2. Pattern of approach in case of health problems 3.3. Preventive measures adopted to minimize health problems
4. Utilization of Health Care Facilities	4.1. Assistance provided by health workers 4.2. Satisfaction with the health services received 4.3. Health related expenditures 4.4. Distance between health centers and home

Variables/Sub-Variables	Indicators
5. Perceived Impact of Health Care Facilities	5.1. Extent of willingness to spontaneously avail of health facilities 5.2. Ability to avail of health services at own cost 5.3. Perceived credibility of service institutions 5.4. Perceptions about the improvement of health situation 5.5. Perceived responsibility for health care
6. Sustainability of Health-related Behavior	6.1. Perceived health problems if NGOs are withdrawn 6.2. Availability of health facilities/services vis-a-vis utilization and behavioral patterns

### 1.3.2 Sampling Plan

The PMIS data on the number of MWRAs by four SC areas comprise the sampling frame for the study. According to the SC PMIS, there are 11,825 MWRAs in the 4 project areas. By using the sampling technique, proposed by Fisher for a population of more than 10,000, the estimated sample size for this study was estimated to be 384 (Fisher, A.A et al., 1991). The samples have been distributed among the four SC project areas, using the standard statistical technique of probability proportionate to size (Table 1.2).

TABLE 1.2: POPULATION AND SAMPLE SIZE IN THE FOUR SC CATCHMENT AREAS

SC Catchment Areas	POPULATION (MWRAs)		Sample
	Number	Proportion	
1. Nasirnagar	7,151	60.47	232
2. Rangunia	1,678	14.20	55
3. Ghior	1,859	15.72	60
4. Mirzapur	1,137	9.61	37
<b>TOTAL</b>	<b>11,825</b>	<b>100.0</b>	<b>384</b>

Based on the information available from the SC PMIS, a list of households in each area was prepared; and the required number of samples was drawn, using simple random technique. The respondents were married women of reproductive age (MWRAs) from each sample household. However, due to genuine non-responses, substitute samples were drawn in Ghior and Nasirnagar (three in Ghior and four in Nasirnagar).

### **1.3.3 Data Collection Instruments**

Data were collected, using appropriate checklists and questionnaires, which were developed and finalized in consultation with the SC. Checklists were used to obtain data about health centers at the thana, union, and village levels, availability of health workers (both government and NGO), and availability of services. The questionnaire was used to collect data on demographic and socioeconomic characteristics of the MWRAs, their awareness and knowledge of health care facilities, behavioral pattern, utilization of health care facilities, perceived impact of health care facilities, and sustainability-related issues (Annex-A).

### **1.3.4 Recruitment and Training of Field Staff**

Appropriately qualified and experienced field staff were recruited for the study. Preference was given to existing field staff of URC(B) as well as those with previous work experiences at URC(B).

The field staff were trained by the Research Associate. Training comprised classroom lectures on the objectives of the study, as well as the data collection instruments, role plays, etc.

### **1.3.5 Supervision and Quality Control**

A sound supervision and quality control system was set up to monitor the quality of data collection.

The Field Supervisors were assigned the responsibility to assist the Interviewers, and ensure that the latter work in strict compliance with their job requirements. Besides the Interviewers and the Field Supervisors, there were two Quality Control Officers who randomly visited the field during the time of data collection and kept constant contact between field and Dhaka Office.

### **1.3.6 Time Frame**

Data were collected between 30 June 1993 and 12 July 1993. Filled-in questionnaires were checked, edited, and data were entered onto the computer between July 13 and 28, 1993.

## **2. CHARACTERISTICS OF THE STUDY POPULATION**

### **2.1. Demographic Characteristics**

The demographic variables covered in this study are age of the respondents (MWRAs), number of living children, number of dead children, and pregnancy wasted.

#### **2.1.1. Age**

The mean age of the MWRAs was 29.3, ranging from about 29 years to about 32 years (Table 2.1). Half of the MWRAs were under 30 years of age, indicating potential for future births unless adequate efforts are made to promote contraception.

#### **2.1.2. Living Children, Dead Children, and Pregnancy Wasted**

Number of children ever born as well as number of pregnancies wasted affect the health status of married women and their living children. The mean number of children ever born was 4.0, ranging between 3 and 4 (Table 2.2). The mean number of living children was 3.2, equally for sons and daughters. Over two-fifths of the MWRAs reported of child deaths, with over one-third reporting upto two dead children. Pregnancy wasted was not uncommon; 13.5 percent of the MWRAs had upto two pregnancies wasted (mean number 0.2). The data show that, on average, one child was either dead, or wasted during pregnancy, suggesting that there may be desire for more children among the MWRAs to compensate for the dead children as well as pregnancies wasted.

## **2.2. Socio-economic Characteristics**

The socio-economic variables covered include education of the MWRAs and their husbands, religion, outside employment, occupation of husbands, and WSG membership status.

### **2.2.1. Education**

Illiteracy was widespread among the MWRAs, with 70 percent of the MWRAs with no schooling (Table 2.3). The mean number of years of schooling was 1.6 and 3.0 for the MWRAs and their husbands respectively. Their husbands were relatively more educated. Illiteracy among the MWRAs and their husbands were more pronounced in Nasirnagar than in the other areas. Among the educated, a low proportion had schooling beyond the fifth grade, especially among the MWRAs.

TABLE 2.1: PERCENTAGE DISTRIBUTION OF THE SAMPLE MWRAs BY AGE IN SC CATCHMENT AREAS

Age	SC Areas				
	Ghior	Mirzapur	Nasirnagar	Rangunia	Total
<20	8.3	5.4	7.3	-	6.3
20-29	36.7	51.4	46.1	38.2	44.0
30-39	40.0	21.6	36.3	45.4	36.7
40-49	15.0	21.6	10.3	16.4	13.0
N	60	37	232	55	384
Mean Age	30.4	29.3	28.5	31.5	29.3

TABLE 2.2: PERCENTAGE DISTRIBUTION OF MWRAs BY NUMBER OF LIVING CHILDREN, DEAD CHILDREN, AND PREGNANCY WASTED

Status of	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Living Children:					
Upto 2	53.3	56.8	39.2	32.7	42.2
3-4	35.0	27.0	31.9	30.9	31.8
5 +	11.7	16.2	28.9	36.4	26.0
Mean number	2.6	2.6	3.4	3.7	3.2
Living Boys:					
None	25.0	24.3	14.2	18.2	17.4
1	40.0	40.6	38.8	23.6	37.0
2+	35.0	35.1	47.0	58.2	45.6
Mean number	1.2	1.2	1.8	1.8	1.6
Living Girls:					
None	25.0	29.7	22.4	18.2	22.8
1	43.3	29.7	29.4	30.9	31.8
2+	31.7	40.6	48.2	50.9	45.4
Mean number	1.3	1.3	1.7	1.9	1.6
Dead Children:					
None	65.0	67.6	52.2	69.1	58.1
1	15.0	18.9	24.6	18.2	21.6
2+	20.0	13.5	23.2	12.8	20.4
Mean number	0.7	0.5	0.9	0.7	0.8
Preg. Wasted*					
None	83.4	78.4	87.5	90.9	86.5
1	13.3	16.2	10.3	3.6	10.4
2	3.3	5.4	2.2	5.5	3.1
Mean number	0.2	0.3	0.1	0.1	0.2

\* Exclusive of dead children.

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TABLE 2.3 PERCENTAGE DISTRIBUTION OF MWRAs BY THEIR EDUCATION IN SC CATCHMENT AREAS

Education	SC Areas								Total	
	Ghior		Mirzapur		Nasirnagar		Rangunia			
	Own	Husband	Own	Husband	Own	Husband	Own	Husband	Own	Husband
No Schooling	61.7	30.0	54.1	40.5	80.2	72.4	47.3	23.6	70.1	55.7
Grades: 1-2	1.7	1.7	2.7	-	4.3	4.3	16.4	14.5	5.5	4.9
3-5	16.7	16.7	18.9	13.5	9.5	8.6	10.9	20.0	11.7	12.0
6+	20.0	51.7	24.3	45.9	6.0	14.7	25.4	41.8	12.7	27.3
Mean # of years of schooling	2.5	3.7	2.8	3.2	1.0	1.5	2.9	3.4	1.6	3.0
N	60	60	37	37	232	232	55	55	384	384

## 2.2.2. Religion

Four-fifths of the MWRAs were Muslims. While all the sample MWRAs in Mirzapur were Muslims, one-third in Ghior were Hindus. One-quarter of the sample MWRAs in Rangunia were Buddhists (Table 2.4).

TABLE 2.4: PERCENTAGE DISTRIBUTION OF MWRAs BY THEIR RELIGION

Religion	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Islam	66.7	100.0	84.5	63.6	80.2
Hinduism	33.3	-	15.5	10.9	16.1
Buddhism	-	-	-	25.5	3.6
N	60	37	232	55	384

### 2.2.3. Occupation of MWRAs and Their Husbands

Over three-fifths of the MWRAs did not have any outside employment (Table 2.5). Outside employment was more prevalent in Nasirnagar, with about half of the sample women being involved in outside employment than in the other SC areas (Table 2.5). It is interesting to note that the higher prevalence of outside employment among women in Nasirnagar may be associated with the higher illiteracy among those women (compare Tables 2.3 and 2.5).

Among those with outside employment, four-fifths were involved with poultry farming, about one-third with vegetable gardening, and the rest with livestock, domestic service, and earth digging (Table 2.6). None was employed in earth digging in Ghior and Mirzapur, and none in domestic service in Mirzapur.

The husbands of the MWRAs were mostly farmers, service holders, petty businessmen, and agricultural wage laborers (Table 2.7). While three-fifths of the husbands of the respondents in Nasirnagar were involved in the agriculture sector, the proportion was considerably lower in the other three Project areas. In contrast, services sector was considerably more important in Mirzapur and Rangunia.

### 2.2.4. Membership Status

Among the sample MWRAs, 54 percent were WSG members and 46 percent were non-members (Table 2.8). However, the proportion of non-members was higher in Mirzapur and Rangunia compared to the other two areas.

TABLE 2.5: PERCENTAGE DISTRIBUTION OF MWRAs BY INVOLVEMENT WITH INCOME GENERATING ACTIVITIES

Outside Employment Status	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Yes	26.7	24.3	46.4	27.3	38.5
No	73.3	75.7	53.4	72.7	61.5
Total	100.0	100.0	100.0	100.0	100.
N	60	37	232	55	384

TABLE 2.6: PERCENTAGE DISTRIBUTION OF MWRAs BY CATEGORIES OF INCOME GENERATING ACTIVITIES  
(Multiple Responses)

Income generating activities	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Poultry farming	68.8	62.5	84.3	75.0	80.4
Vegetable gardening	18.8	37.5	38.0	6.3	32.4
Earth digging	-	-	4.6	6.3	4.1
Domestic service	12.5	-	4.6	18.8	6.8
Live-stock	12.5	37.5	4.6	25.0	9.5
N	16	9	108	15	148

TABLE 2.7: PERCENTAGE DISTRIBUTION OF MWRAs BY PRIMARY OCCUPATION OF THEIR HUSBANDS

Primary occupation of husbands	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Farming	18.3	16.2	40.1	1.8	28.9
Agr. Wage Labor	1.7	-	20.7	16.4	15.1
Non-Agr. Labor	10.0	2.7	11.6	18.2	11.5
Petty business	23.3	8.1	15.1	16.4	15.9
Trading	11.7	10.8	1.3	7.3	4.7
Service	18.3	51.4	6.9	30.9	16.4
Fishing	10.0	-	0.9	1.8	2.3
Others	6.7	10.8	3.4	7.2	5.2
N	60	37	232	55	384

TABLE 2.8: PERCENTAGE DISTRIBUTION OF MWRA<sub>s</sub> BY THEIR MEMBERSHIP STATUS WITH THE SAVE'S WOMEN SAVINGS GROUPS (WSG)

Member- ship Status	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
WSG Member	60.0	45.9	54.7	49.1	53.9
WSG Non- Member	40.0	54.1	45.3	50.9	46.1
N	60	37	232	55	384

### **3. AWARENESS AND KNOWLEDGE OF HEALTH CARE FACILITIES AND SERVICES**

Awareness facilitates increase of knowledge, and knowledge favorably changes attitudes, leading to practice. Sustainability of NGO programs -- health-related or others -- is linked to the awareness-knowledge-attitude-practice (AKAP) continuum. The more the AKAP gap can be reduced, the more sustainable the Government and/or the NGO program is likely to be. The Government and the NGO health interventions should, therefore, be directed toward closing or at least reducing the AKAP gap among the target beneficiaries.

#### **3.1 Awareness of Health Care Facilities and Services**

Sustainability of health care programs depends, to a large extent, on the level of awareness of target population/beneficiaries about the need for health facilities and services. Greater awareness leads to the greater possibility for sustainability of health programs.

Quite a high proportion of the MWRAs (over 93 percent) were aware about the availability of physicians and medicines (Table 3.1). However, their awareness about facilities for laboratory tests (tests for urine, blood, stool, etc.) was quite low. Also, most of them did not know about the existence of hospitals and health counselling.

The MWRAs were highly aware about the need for a number of health-related services. They attached highest priority to the availability of such services as immunization both of children and mother, followed by accessibility to safe drinking water, oral saline to prevent rehydration, check up for pregnant mothers, accessibility to sanitary latrines, and vitamin A capsules (Table 3.2).

#### **3.2 Knowledge about Health Care Facilities and Services**

##### **3.2.1 Introduction**

This section analyses the knowledge among the MWRAs about primary health care components, availability of health care facilities and services, and availability of most competent medicare services in the SC catchment areas. The analysis would help identify the level of health-related knowledge among the MWRAs.

TABLE 3.1: PERCENTAGE DISTRIBUTION OF MWRAs BY AWARENESS ABOUT HEALTH CARE FACILITIES

(Multiple Responses)

Facilities	SC Areas				Total
	Ghior	Mirzapur	Nasirnagar	Rangunia	
Availability of physicians	96.7	94.6	94.8	98.2	95.6
Availability of medicine	78.3	94.6	96.1	94.5	93.0
Facilities for laboratory tests	5.0	-	0.9	1.8	1.6
Health counseling	28.3	27.0	12.5	9.1	15.9
N	60	37	232	55	384

TABLE 3.2: PERCENTAGE DISTRIBUTION OF MWRAs BY AWARENESS OF HEALTH SERVICES REQUIRED TO MINIMIZE HEALTH-RELATED PROBLEMS  
(Multiple Responses)

Health Services	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Immunization of children	91.7	100.0	94.8	96.4	95.1
Immunization of mothers	93.8	97.3	84.9	83.6	87.2
Check-up for pregnant mother	55.0	40.5	51.7	41.8	49.7
Accessibility to safe drinking water	60.0	64.9	69.4	60.0	66.1
Accessibility to sanitary latrines	40.0	29.7	45.7	32.7	41.4
Vitamin-A capsule	30.0	13.5	49.1	25.5	39.3
Oral saline	56.7	45.9	52.6	49.1	52.1
N	60	37	232	55	384

### 3.2.2 Knowledge about Primary Health Care

Knowledge about such primary health care components as immunization, and family planning was almost universal among the MWRAs, with all of them in Mirzapur having knowledge about immunization of mothers and about family planning and all in Rangunia about family planning (Table 3.3). Four-fifths of the MWRAs knew about Vitamin A capsules and check-up for pregnant mothers. The proportion having knowledge related to checkup of pregnant mothers was relatively lower in Nasirnagar and Ghior compared to Rangunia and Mirzapur.

The findings indicate that the basic components of primary health care are well known to most of the MWRAs. Such knowledge is likely to induce them to avail of health services, as and when needed.

TABLE 3.3: PERCENTAGE DISTRIBUTION OF MWRAs BY KNOWLEDGE ABOUT MAJOR PRIMARY HEALTH CARE COMPONENTS

(Multiple Responses)

Major Components of PHC	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Check-up of pregnant mothers	76.7	83.1	71.6	94.5	76.8
Immunization of mothers (TT)	98.3	100.0	92.2	98.2	94.8
Immunization of children (EPI)	95.0	97.3	91.4	98.2	93.5
Vitamin-A capsule	81.7	89.2	77.6	92.7	81.5
Family planning	96.7	100.0	92.2	100.0	94.8
N	60	37	232	55	384

### 3.2.3 Knowledge about Sources of Health Care Services

According to the MWRAs, NGO clinics (NC) and NGO workers (NW) were the major sources of various preventive and curative health care services such as immunization of children and mothers, pregnant mothers' check-up, Vitamin A capsule, family planning, and treatment of diseases. A relatively lower proportion of them had knowledge about the government health facilities, except that the Thana Health Complex (THC) was considered as a source for immunization and curative services by over half of the MWRAs in Rangunia, and as a source for curative services by over half of the MWRAs in Mirzapur (Table 3.4).<sup>1</sup> Village doctors were next in importance to NGO clinics and NGO workers in respect of curative services; however, they were least used for preventive health services.

Surprisingly, very few MWRAs in Nasirnagar and Rangunia (not over 7 percent) and less than one-quarter in Ghior and Mirzapur had knowledge about the availability of preventive services, including FP in the FWCs (Table 3.4). Also, government rural dispensary (RD), satellite clinic (SCL), and government health workers (GW) were not well known sources of health care services. Registered physicians were not used for preventive health services in Nasirnagar and Rangunia, although their use was not uncommon in Ghior and Mirzapur. The MWRAs did not consider spiritual healers (Imam/Moulvi/Priest, etc.) as source of preventive health care services.

1. It may be noted that there is no THC at Mirzapur. However, there is a thana level health center, known as 'Kumudini Hospital'. Henceforth, in case of Mirzapur, THC would refer to Kumudini Hospital.

TABLE 3.4: PERCENTAGE DISTRIBUTION OF MWRAs BY KNOWLEDGE ABOUT SOURCES OF HEALTH CARE SERVICES  
(Multiple Responses)

Health Care Services/ Project Areas	Sources of Health Care Services									
	THC	FWC	RD	NC	SCL	RP	VD	GW	NW	SH
GHIOR: Immunization of children	20.0	15.0	35.0	51.7	11.7	6.7	6.7	28.3	51.7	-
Immunization of mothers	16.7	23.3	33.3	58.3	13.3	8.3	6.7	28.3	50.0	-
Pregnant mother's check-up	18.3	21.7	28.3	53.3	5.0	20.0	15.0	15.0	43.3	-
Vitamin A capsule	8.3	10.0	13.3	25.0	3.3	8.3	8.3	41.7	70.0	
Family plan- ing methods	16.7	25.0	25.0	43.3	1.7	16.7	18.3	58.3	63.3	-
Treatment of diseases	16.7	10.0	38.3	56.7	1.7	21.7	70.0	18.3	20.0	8.3
N	60	60	60	60	60	60	60	60	60	60
MIRZAPUR* Immunization of children	29.7	24.3	-	91.9	-	-	2.7	21.6	48.6	-
Immunization of mothers	27.0	48.6	-	89.2	-	2.7	2.7	21.6	45.9	-
Pregnant mother's check-up	32.4	45.9	-	100.0	-	16.2	18.9	21.6	40.5	-
Vitamin A capsule	5.4	10.8	-	73.0	-	5.4	2.7	24.3	64.9	2.7
Family plan- ing methods	27.0	45.3	-	89.2	-	18.9	18.9	27.0	64.9	-
Treatment of diseases	51.4	45.9	-	81.1	-	21.6	37.8	18.9	21.9	16.2
N	37	37	-	37	37	37	37	37	37	37

\* There is no THC at Mirzapur. However, 'Kumudini Hospital' is treated as Thana level health center.

Contd...

Table 3.4 (Contd.)

Health Care Services/ Project Areas	Sources of Health Care Services									
	THC	FWC	RD	NC	SCL	RP	VD	GW	NW	SH
NASIRNAGAR Immunization of children	1.3	1.3	1.3	73.3	4.7	-	3.9	2.2	22.4	-
Immunization of mothers	-	3.0	1.3	74.1	3.9	-	3.0	1.7	19.0	-
Pregnant mother's check-up	0.4	2.6	1.7	76.7	3.0	-	2.6	0.9	13.8	-
Vitamin A capsule	0.4	-	0.9	56.9	0.4	-	2.6	10.8	34.9	-
Family planing methods	-	3.0	0.9	56.5	-	-	2.2	14.7	35.3	-
Treatment of diseases	5.6	1.7	3.9	60.3	0.4	3.9	40.9	1.7	4.7	0.4
N	232	232	232	232	232	232	232	232	232	232
RANGUNIA Immunization of children	54.5	5.5	16.4	100.0	3.6	-	-	-	-	-
Immunization of mothers	50.9	5.5	14.5	100.0	3.6	1.8	-	-	-	-
Pregnant mother's check-up	38.2	7.3	5.5	90.9	-	-	-	-	-	1.8
Vitamin A capsule	30.9	1.8	12.7	58.2	3.6	-	-	20.0	3.6	-
Family plan- ing methods	30.9	5.5	10.9	89.1	-	-	-	1.8	5.5	-
Treatment of diseases	54.5	1.8	16.4	90.9	-	41.8	50.9	-	-	5.5
N	55	55	55	55	55	55	55	55	55	55

THC= Thana Health Complex; FWC= Family Welfare Centre; RD= Government Rural Dispensary; NC= NGO Clinic; SCL= Satellite Clinic; RP= Registered Physician; ; VD= Village Doctor; GW= Government Health Worker; NW= NGO Health Worker; SH= Spiritual Healer.

Two interesting conclusions emerge from the above findings: (i) the MWRAs were mostly dependent on the NGOs for various health-related services, both preventive and curative; and (ii) the Government health facilities were not adequately utilized.

### 3.2.4 Knowledge about Sources of Most Competent Medicare Services

The NGO clinics and the THC were the two important sources of competent medicare services (Table 3.5). The NGO clinics were relatively much more important as sources of the most competent medicare services in Mirzapur and Rangunia compared to Ghior and Nasirnagar.

TABLE 3.5: PERCENTAGE DISTRIBUTION OF MWRAs BY THEIR KNOWLEDGE ABOUT SOURCES OF MOST COMPETENT MEDICARE SERVICES

Sources of competent medicare services	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Thana health complex	6.7	21.6*	37.9	7.3	27.1
Family welfare centre	-	10.8	-	-	-
Govt. dispensary	28.3	-	1.7	1.8	6.8
NGO clinic	30.0	62.2	43.2	58.2	45.0
Regd. physician	6.7	-	4.3	12.7	5.5
Village doctor	28.3	5.4	12.9	20.0	15.6
N	60	37	232	55	384

\* Relates to Kumudini Hospital.

#### **4. BEHAVIORAL PATTERN RELATED TO HEALTH CARE FACILITIES**

##### **4.1. Introduction**

Behavioral pattern of an individual concerning health-related issues can be assessed from analyses of the nature of his/her discussions with others about such issues, approach(es) adopted for taking preventive as well as curative measures, and the reasons for approaching various health centers and personnel. An assessment of behavioral pattern of the program beneficiaries was important to be able to determine the nature of health service utilization.

##### **4.2. Discussion about Health-Related Problems**

The seriousness among the MWRAs about health-related problems of their own as well as those of their family members was primarily reflected from their discussions on such issues with knowledgeable persons other than the family members. The more they discuss with non-family members, the more knowledge they were likely to acquire about the need for, and availability of, health services, leading to greater utilization of such services. As was evident from Table 4.1, the respondents discussed such issues mostly with neighbors (49 percent), followed by NGO workers (39 percent), and village doctors (18 percent). Government workers, registered physicians, and spiritual healers were least discussed with about such issues. Also, one-quarter of the MWRAs did not discuss about their health-related problems with others, and their proportion was higher in Mirzapur and Ghior. Nevertheless, the fact that the majority (over 75%) discussed their health-related problems with some persons having knowledge about health care facilities was indicative of their concerns regarding health-related issues.

##### **4.3. Pattern of Approach in Case of Health Problems**

The NGO clinics and the village doctors were the two most preferred sources of treatment, with the NGO clinics being the most preferred source of treatment for the mothers and children, and village doctors for other family members (Table 4.2).

TABLE 4.1: PERCENTAGE DISTRIBUTION OF MWRAs BY PERSONS WITH WHOM DISCUSSED ABOUT HEALTH-RELATED PROBLEMS

(Multiple Responses)

Persons with whom discussed about health-related problems	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Neighbors	56.7	54.1	44.8	52.7	48.7
Govt. workers	6.7	-	7.3	-	5.5
NGO workers	36.7	32.4	43.1	29.1	39.1
Regd. physician	15.0	16.2	4.7	3.6	7.3
Village doctors	21.7	-	20.7	16.4	18.2
Spiritual healers	6.7	5.4	1.7	1.8	2.9
Don't discuss with anybody	31.7	32.4	22.0	21.8	24.5
N	60	37	232	55	384

TABLE 4.2: PERCENTAGE DISTRIBUTION OF MWRAs BY PATTERN OF APPROACH REGARDING HEALTH CENTERS/PERSONNEL IN CASE OF HEALTH PROBLEMS OF MOTHERS, CHILDREN, AND OTHER FAMILY MEMBERS

(Multiple Responses)

Health centers/ personnel	SC Areas				Total
	Ghior	Mirzapur	Nasir- nagar	Rangunia	
FOR MOTHERS:					
Regd. physician	8.3	13.9	8.6	23.6	11.7
Village doctor	66.7	18.9	48.3	40.0	47.1
THC	-	21.6*	8.2	25.5	10.7
FWC	5.0	10.8	3.0	1.8	3.1
Govt. dispensary	18.3	-	1.3	20.0	7.3
NGO clinics	38.3	86.5	61.6	83.6	63.5
Spiritual healers	3.3	5.4	0.9	-	1.6
District-Hospital	8.3	2.7	-	-	1.6
N	60	37	232	55	384
FOR CHILDREN:					
Regd. physician	8.3	18.9	6.9	20.0	10.2
Village doctor	68.3	27.0	49.1	43.6	49.2
THC	-	13.5	8.2	29.1	10.4
FWC	1.7	8.1	2.6	-	1.8
Govt. dispensary	20.0	-	0.9	18.2	7.0
NGO clinics	38.3	78.4	63.4	80.0	63.3
Spiritual healers	-	5.4	1.7	1.8	1.8
District-Hospital	8.3	2.7	-	-	1.6
N	60	37	232	55	384

\* Relates to Kunudini Hospital.

Contd...

Table 4.2 (contd.)

Health centers/ personnel	SC Areas				Total
	Ghior	Mirzapur	Nasir- nagar	Rangunia	
FOR OTHER FAMILY MEMBERS:					
Regd. physician	10.0	18.9	7.3	20.0	10.7
Village doctor	70.0	27.0	58.6	47.3	55.7
THC	-	16.2	7.8	25.5	9.9
FWC	1.7	8.1	2.6	1.8	2.1
Govt. dispensary	16.7	-	0.9	16.4	6.3
NGO clinics	26.7	70.3	51.7	67.3	51.8
Spiritual healers	1.7	8.1	0.4	-	1.3
District hospital	8.3	2.7	-	-	1.6
N	60	37	232	55	384

Over four-fifths of the MWRAs in Mirzapur and Rangunia and about two-thirds in Nasirnagar approached NGO clinics for treatment of mothers, while two-thirds in Ghior approached village doctors. Similar trend was discernible regarding treatment of children (Table 4.2). In Ghior and Nasirnagar, village doctors were preferred to NGO clinics and government health centers for the treatment of family members. Interestingly, most of the MWRAs and their family members did not approach spiritual healers for treatment, a finding contrary to the common belief that people in rural Bangladesh generally approach spiritual healers for treatment of diseases.

The most widely contacted sources for preventive health services (such as immunization both of mothers and children, check-up of pregnant mothers, and family planning) were the NGO clinics and the NGO health workers, followed by village doctors (Table 4.3). The proportion approaching the NGO clinics and the NGO workers was highest in Mirzapur, and lowest in Rangunia. Although village doctors were a relatively important source of health service providers in Nasirnagar and Ghior, they were not so in Mirzapur and Rangunia.

The Government health centers such as the THC, the FWC, and the RD were least important for treatment; over two-fifths of the MWRAs and their family members went to the THC at critical stages of diseases (Table 4.4). Nevertheless, the NGO clinics and the village doctors were preferred to the government health centers and the registered physicians for treatment of diseases at preliminary stages.

TABLE 4.3: PERCENTAGE DISTRIBUTION OF MWRAs BY WHOM THEY CONTACT FOR PREVENTIVE HEALTH SERVICES

(Multiple Responses)

Health Service Centers/Providers Contacted	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Govt. workers	20.0	-	3.9	-	5.5
NGO workers	50.0	45.9	28.0	10.9	30.7
Govt. hospitals (THC/FWC, etc.)	11.7	10.8	8.6	16.4	10.4
NGO clinics	21.7	51.4	47.0	40.0	42.4
Regd. physicians	11.7	13.5	10.8	1.8	9.9
Village doctors	20.0	2.7	37.9	9.1	27.6
Spiritual healers	1.7	2.7	2.6	3.6	2.6
Don't approach anybody	28.3	24.3	9.1	43.6	18.5
N	60	37	232	55	384

TABLE 4.4: PERCENTAGE DISTRIBUTION OF MWRA's BY WHOM THEY CONTACT MOST OFTEN FOR TREATMENT OF DISEASES AT PRELIMINARY AND CRITICAL STAGES

(Multiple Responses)

Health centers/ personnel contacted	SC Areas				Total
	Ghior	Mirzapur	Nasir- nagar	Rangunia	
<b><u>PRELIMINARY STAGES:</u></b>					
THC	-	2.7	6.9	5.5	5.2
FWC	-	2.7	3.9	3.6	2.9
Govt. dispensary	8.3	-	0.4	14.5	3.9
NGO clinics	35.0	75.7	49.6	78.2	53.9
Regd. physicians	5.0	-	3.0	1.8	2.9
Village doctors	58.3	21.6	57.8	45.5	52.6
Spiritual healers	5.0	8.1	1.7	1.8	2.9
District hospital	6.7	2.7	-	-	1.3
N	60	37	232	55	384
<b><u>CRITICAL STAGES:</u></b>					
THC	1.7	29.7	55.6	45.5	43.2
FWC	-	8.1	1.3	-	0.8
Govt. dispensary	33.3	-	4.3	12.7	8.4
NGO clinics	25.0	56.8	29.3	20.0	28.4
Regd. physicians	8.3	2.7	9.1	38.2	12.5
Village doctors	15.0	5.4	12.9	10.9	12.2
Spiritual healers	1.7	-	0.4	-	0.5
District hospital	28.3	16.2	-	1.8	6.3
N	60	37	232	55	384

The major factors which affected the decisions of the MWRAs regarding why they went to a particular health center/health personnel were availability of competent services, nearness to residence, availability of services/medicines at cheaper prices, and convenience of transport (Table 4.5). However; about one-third of the MWRAs, both in Ghior and Mirzapur, attached importance to free availability of health services and medicines, minimum waiting time, and pleasant behavior of service providers. One-quarter in Ghior and Rangunia considered availability of services/medicines on credit as an important factor for going to health centers/personnel.

Regarding the factors which influenced the decision of the MWRAs and their family members regarding where to go for health services, least importance was given to availability of adequate quantity of medicine, behavior of service personnel, availability of medicines free of cost or on credit, and the required waiting (Table 4.5). As evident from Table 4.6, the MWRAs and their family members went most often to THC, DG, NC, RP, and VD, largely because of availability of competent services, both at the preliminary and critical stages of their illness. The FWCs were most preferred at the preliminary stage being closest to their homes compared to the other facilities. However, at the critical stage, the FWCs were contacted most often in the expectation of receiving competent services. Also, the recipients of services at the FWCs had to undergo shorter waiting time compared to other health centers/personnel. The NGO clinics were approached most often because of, in addition to competent service and nearness, availability of health services and medicines at chapter prices (Table 4.6).

The major reasons why the MWRAs did not go to the health centers/ personnel where competent services were mostly available were non-availability of adequate quantity of medicine, followed by long distance from residence, and non-availability of services/ medicines free of cost (Table 4.7).

The above findings indicate that the NGO clinics and the village doctors were overwhelmingly used by the MWRAs in case of sickness of any member in the family, although they go most often to the THC at critical stages only. That the MWRAs were dependent on the NGO clinics for appropriate treatment of diseases was evident. The Government health centers and other private providers were avoided primarily because of inadequate availability of medicine, non-availability of medicine free of cost, long distance from home, and inconvenience of transport, suggesting that health facilities should be made available at easily accessible locations, and that services should be provided free or at affordable cost in adequate quantities.

#### **4.4. Behavior Related to Adoption of Preventive Measures to Minimize Health Problems**

In addition to the nature of discussions and the sources of medicare, the behavioral pattern of the MWRAs and their family members was manifested in the preventive measures adopted by them for minimization of health problems, at their own initiatives or at the initiatives of the service providers.

TABLE 4.5: PERCENTAGE DISTRIBUTION OF MWRAs BY REASONS OF THEIR GOING MOST OFTEN TO A PARTICULAR HEALTH CENTER/PERSONNEL.

(Multiple Responses)

Reasons for going most often to a particular health center/personnel	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Competent service provided	80.0	78.4	76.3	65.5	75.5
Nearest to residence	70.0	70.3	42.7	49.1	50.5
Minimum waiting time required	11.7	32.4	9.9	25.5	14.6
Behavior of service providers pleasant (cooperative)	20.0	32.4	4.3	9.1	10.2
Service regularly available	23.3	16.2	22.0	21.8	21.6
Female service providers available	13.3	-	14.2	20.0	13.5
Service providers known to us	15.0	18.9	5.2	27.3	11.2
Adequate quantity of medicine available	18.3	13.5	9.5	1.8	10.2
Service/medicines are free	30.0	5.4	7.8	3.6	10.4
Service/medicines available on credit	23.3	5.4	7.3	25.5	12.2
Services/medicines available at cheaper prices	28.3	70.3	36.2	43.6	39.3
Convenience of transport	56.7	51.4	16.8	20.0	26.8
N	60	37	232	55	384

TABLE 4.6: PERCENTAGE DISTRIBUTION OF MWRAs BY REASONS OF THEIR GOING MOST OFTEN TO VARIOUS HEALTH CENTERS/PERSONNEL AT PRELIMINARY AND CRITICAL STAGE OF ILLNESS

Reasons	Preliminary Stage						Critical Stage					
	THC	FWC	GD	NC	RP	VD	THC	FWC	GD	NC	RP	VD
A	90	55	80	70	91	79	79	100	78	73	83	66
B	30	100	53	61	18	54	40	67	43	61	54	62
C	5	64	7	19	9	14	11	-	18	21	18	15
D	-	9	7	12	-	8	7	-	20	16	10	2
E	35	36	40	20	36	22	22	33	30	19	25	23
F	20	55	7	19	9	14	16	-	23	20	8	6
G	5	20	10	9	11	9	-	-	5	11	15	15
H	15	-	20	10	-	8	6	-	23	8	13	15
I	5	46	33	10	27	8	7	33	20	11	6	15
J	-	9	7	9	-	16	9	-	23	6	6	32
K	25	46	27	59	18	32	36	33	28	66	31	23
L	35	91	40	35	18	25	25	67	30	37	21	26

TABLE 4.7: PERCENTAGE DISTRIBUTION OF MWRAs BY REASONS FOR NOT GOING TO THE HEALTH CENTERS/PERSONNEL WHERE COMPETENT SERVICES ARE MOSTLY AVAILABLE

(Multiple Responses)

Reasons of not going to health centers/personnel	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Long distance from residence	24.4	36.4	44.1	-	28.5
Long waiting time required	13.3	9.1	19.1	-	12.2
Non-cooperative behavior of service providers	4.4	-	8.8	-	4.7
Adequate quantity of medicine not available	33.3	31.8	36.8	83.3	45.3
Services/medicines are not free	44.4	22.7	10.3	24.3	23.8
Services/medicines not available on credit	22.2	4.5	1.5	10.8	9.3
No female service providers available	11.1	-	-	-	2.9
Inconvenience of transport	15.6	9.1	14.7	-	11.0
No advice from SC doctor	8.9	31.8	19.1	2.7	14.5
N	45	22	68	37	172

Eighty percent of the mothers and the children in the SC catchment areas have been immunized, either at own initiatives or at the initiatives of the service providers (Table 4.8). Over two-thirds of the MWRAs reported undertaking regular check-up during pregnancy. Also, a similar proportion had access to safe drinking water. Majority of the MWRAs had used oral saline and Vitamin A capsules, when needed -- oral saline mostly at own initiatives, and Vitamin A capsules mostly at providers' initiatives. About one-third of the MWRAs have gotten access to sanitary latrines at their own initiatives, and over one-fifth have gotten this facility from the service providers.

That the MWRAs in all of the SC catchment areas adopted major preventive health services at the providers' initiatives, rather than at own initiatives, is discernible from Table 4.9. Thus, the practice of the MWRAs indicates lack of behavioral sustainability related to preventive health services. However, it may be noted that the health facilities and personnel available in all relation to the needs of the population (Table 4.10). All of the GOB health centers and the NGO clinics have to serve a large number of population. There is, thus, a need to increase the health facilities in all the areas of sustainability related to health behavior is to be achieved.

TABLE 4.8: PERCENTAGE DISTRIBUTION OF MWRAs BY PREVENTIVE MEASURES ADOPTED TO ENSURE MINIMIZATION OF HEALTH PROBLEMS

(Multiple Responses)

Measures	SC Areas								Total		
	Ghior		Mirzapur		Nasirnagar		Rangunia		Own Initiative	Providers' Initiative	Both
	Own Initiative	Providers' Initiative									
Immunization of mothers	25.0	45.0	5.4	59.5	33.6	54.7	14.5	50.9	26.8	53.1	79.9
Immunization of children	33.3	40.0	8.1	48.6	33.2	59.1	16.4	52.7	28.4	54.2	82.6
Pregnancy check-up	28.3	33.3	5.4	56.8	29.7	40.1	25.5	41.8	26.6	40.9	67.5
Safe drinking water	55.0	3.3	45.9	13.5	40.1	25.9	58.2	25.5	45.6	21.1	66.7
Sanitary latrine	40.0	10.0	43.2	16.2	25.9	27.6	40.0	20.0	31.8	22.7	54.5
Vitamin-A capsule	15.0	51.7	5.4	64.9	22.4	45.7	7.3	70.0	17.4	52.1	69.5
Oral saline	55.0	10.0	40.5	21.6	63.8	13.8	60.0	18.2	59.6	14.6	74.2
N	60		37		232		55		384		

TABLE 4.9: PERCENTAGE DISTRIBUTION OF MWRAs BY PREVENTIVE MEASURES ADOPTED AT THE PROVIDERS' INITIATIVES

(Multiple responses)

SC Areas	Immuni- zation (Mothers)	Immuni- zation (Children)	Pregnancy check-up	Vitamin-A capsule	N
Ghior	45	40	33	51	60
Mirzapur	60	49	57	65	37
Nasirnagar	55	59	40	46	232
Rangunia	51	53	42	71	55
Total	53	54	41	52	384

TABLE 4.10: HEALTH FACILITIES AVAILABLE IN THE SC CATCHMENT AREAS, AND POPULATION COVERAGE BY THE HEALTH CENTERS/PERSONNEL(a)

Health Service Facilities	SC Catchment Areas (Thanas)			
	Nasirnagar	Rangunia	Mirzapur	Ghior
<b>PHYSICAL FACILITIES:</b>				
<b>A. <u>GOB Health Centers:</u></b>				
THC: (a) Number	1	1	1(b)	1
(b) Population coverage	193,122	238,087	288,341	108,535
FWC: (a) Number	3	3	1	1
(b) Population coverage per FWC	64,374	79,362	288,341	108,535
Govt. Dispensary(GD):				
(a) Number	1	1	-	1
(b) Population coverage per GD	193,122	238,087	NA	108,535
<b>B. <u>NGO Clinics:</u></b>				
(a) Number	2	3	1	1
(b) Population coverage per GD	95,561	79,362	288,341	108,535
<b><u>HEALTH PERSONNEL:</u>(c)</b>				
GOB: (a) Number	19	22	12	10
(b) Population served by each	10,164	10,822	24,028	10,854
NGO: (a) Number	52	18	16	25
(b) Population served by each	3,714	13,227	18,021	4,341
Private: (a) Number	73	42	32	33
(b) Population served by each	2,646	5,669	9,011	3,289

(a) Population figures are obtained from BBS, Upazila Statistics of Bangladesh, Dhaka, 1988.

(b) In Mirzapur, 'Kumodini Hospital' is treated as THC.

(c) Includes TFPO, AFTFPO, Medical Officers, FWVs, FPIs and Medical Assistants, etc.

## **5. UTILIZATION OF HEALTH CARE FACILITIES**

### **5.1. Introduction**

The pattern of utilization of health care facilities partly determines sustainability related to health-related behavior. Adequate utilization of health services, combined with high level of felt needs and knowledge, leads to behavioral sustainability. The pattern of utilization was determined by the benefits derived from the services provided by health workers, satisfaction of the beneficiaries with the health services, proportion of household expenditures to health expenditures, distance of health centers from home, etc.

### **5.2. Benefits Received from Services Provided by Health Workers**

Almost all of the MWRAs reportedly benefitted from the health services provided by the NGO health clinics (Table 5.1). A relatively lower proportion of them reported to have benefitted from the government health workers' services. However, overall benefits derived from such services were quite high in all the areas.

The MWRAs benefitted mostly from such NGO services as child delivery, check-up of pregnant mothers, treatment of diarrhoea and worms, immunization of mothers and children, counselling on family planning, and family planning supplies and services (Table 5.2). However, the government workers mainly provided such services as counselling on family planning, family planning supplies and services, immunization, and treatment of diarrhoea. Child delivery services, and check-up of pregnant mothers, were least provided by the Government workers. Although critical, neither the Government workers nor the NGO workers accorded due importance to the treatment of ARI.

From the above discussion, it appears that the MWRAs were better served by the NGO health workers rather than by the Government health workers. This is indicative of high dependence on the NGOs, and, therefore, health behavior of the MWRAs has the least potential of being sustained, if NGO assistance is withdrawn.

### **5.3. Satisfaction with the Health Services Received**

Over 85 percent of the respondents served by the NGO workers reported that they were satisfied with the services received from the health providers; in contrast, less than half of them served by the Government fieldworkers reported of such satisfaction (Table 5.3). The reverse was true regarding the proportion expressing dissatisfaction. The evidence, thus, indicates greater satisfaction among women served by the NGO workers compared to the Government workers.

TABLE 5.1: PERCENTAGE DISTRIBUTION OF MWRAs BY BENEFITS DERIVED FROM HEALTH SERVICES PROVIDED BY HEALTH WORKERS

Responses	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
% reported to have been benefitted from NGO health workers' services	95.0	94.3	92.1	100.0	93.9
% reported to have been benefitted from government health workers' services	66.0	62.5	79.4	86.7	76.6

TABLE 5.2: PERCENTAGE DISTRIBUTION OF MWRAs BY TYPES OF SERVICES PROVIDED BY THE GOVERNMENT AND NGO HEALTH WORKERS (Multiple Responses)

Types of Services Provided	SC Areas								Total	
	Ghior		Mirzapur		Nasir-nagar		Rangunia			
	GW	NW	GW	NW	GW	NW	GW	NW	GW	NW
Child delivery	16.1	21.1	-	27.3	17.6	48.3	11.5	40.7	15.6	40.8
Pregnancy check-up	25.8	61.4	-	75.8	11.8	54.5	7.7	74.1	13.6	60.6
Treatment of ARI	9.7	19.3	-	30.3	8.2	14.8	7.7	5.6	8.2	15.6
Treatment of diarrhoea of children	32.3	61.4	-	72.7	35.3	59.3	61.5	59.3	38.1	60.9
Treatment of worms	25.8	52.6	-	69.7	34.1	64.6	11.5	57.4	27.2	62.0
Immunization of mother and children	41.9	80.7	20.0	100.0	36.5	88.0	53.8	96.3	40.1	89.2
Counselling on family planning	80.6	75.4	80.0	84.8	69.4	65.6	42.3	77.8	67.3	70.8
Providing family planning methods	90.3	47.4	40.0	72.7	41.2	48.3	19.2	50.0	47.3	50.7

Notes: GW= Government health workers; NW= NGO health workers.

### 5.4. Health-Related Expenditures

The MWRAs and their families in the SC catchment areas spent, on average, Tk.2,407 annually for health services, equivalent to nine percent of the average annual household expenditures (Tables 5.4, 5.5 and 5.6), indicating that the MWRAs and their family members have at least partial ability to pay for health services. The annual health expenditures as percent of the annual household expenditures was highest in Rangunia and lowest in Nasirnagar. About one-third of the MWRAs spent less than Tk.1,000, and 22 percent spent more than Tk.1000 but less than Tk.2,000 a year for health care. The average annual health expenditure was lowest in Nasirnagar (Tk.1,964), while it was highest in Rangunia (Tk. 3,972), suggesting that the MWRAs and their families in Rangunia attached greater priority to health care than those in Nasirnagar. Attaching relatively lower priority to health care in Nasirnagar probably results from the unfavorable socio-economic conditions prevailing in that area.

TABLE 5.3: PERCENTAGE DISTRIBUTION OF MWRAs BY SATISFACTION WITH THE SERVICES RECEIVED FROM THE HEALTH CARE PROVIDERS

Degree of satisfaction	SC Areas								Total	
	Ghior		Mirzapur		Nasir-nagar		Rangunia			
	GW	NW	GW	NW	GW	NW	GW	NW	GW	NW
Very satisfied	9.6	66.7	-	73.0	13.2	25.7	-	20.4	9.9	36.0
Satisfied	46.2	30.0	45.5	21.6	34.1	53.9	40.0	68.5	38.3	49.1
Neither satisfied nor dissatisfied	32.7	3.3	27.3	2.7	22.5	9.1	33.3	11.1	26.6	7.9
Somewhat dissatisfied	3.8	-	18.2	-	6.2	5.7	3.3	-	5.9	3.4
Not at all satisfied	7.7	-	9.1	2.7	24.0	5.7	23.3	-	19.4	3.7
N	47	60	8	35	107	227	30	54	192	376

Notes: GW= Government health workers; NW= NGO health workers.

TABLE 5.4: PERCENTAGE DISTRIBUTION OF MWRAS BY ANNUAL HOUSEHOLD EXPENDITURES

Annual household expenditures (Taka)	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
<10,000	3.3	5.4	5.6	3.6	4.9
10,000-20,000	35.0	21.6	39.2	18.2	33.9
20,000-30,000	28.3	29.7	19.8	16.4	21.6
30,000-40,000	15.0	16.2	22.4	36.4	22.7
40,000-50,000	6.7	18.9	6.5	14.5	8.9
50,000-60,000	1.7	-	2.2	-	1.6
60,000+	10.0	8.1	4.3	10.9	6.5
Mean annual household expenditure (Tk.)	28740	29270	25931	32631	27656
N	60	37	232	55	384

TABLE 5.5: PERCENTAGE DISTRIBUTION OF MWRAS BY ANNUAL EXPENDITURES FOR HEALTH CARE OF FAMILY MEMBERS

Annual health expenditures (Tk.)	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
< 1000	21.7	35.1	39.2	3.6	31.0
1000 - 2000	31.7	16.2	24.6	7.3	22.4
2000 - 3000	13.3	18.9	19.4	20.0	18.5
3000 - 4000	8.3	5.4	6.9	29.1	10.2
4000 - 5000	6.7	5.4	1.7	12.7	4.4
5000+	18.3	18.9	8.2	27.3	13.5
Mean annual health expenditure (Tk.)	2504	2694	1964	3972	2407
N	60	37	232	55	384

TABLE 5.6: ANNUAL HEALTH EXPENDITURES AS PERCENT OF ANNUAL HOUSEHOLD EXPENDITURES OF THE MWRAs IN THE SC CATCHMENT AREAS

Annual Expenditures	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Mean household expenditures (Tk.)	28,740	29,270	25,931	32,631	27,656
Mean health expenditures (Tk.)	2,504	2,694	1,964	3,972	2,407
Annual health expenditure as percent of annual household expenditure	8.7	9.2	7.6	12.2	8.7

### 5.5. Distance of Health Centers from Homes

Distance between health centers/personnel and the homes of the recipients of the service is an important determinant of health service utilization. In the socio-economic and cultural context of rural Bangladesh, it is unlikely that poor people, particularly women whose mobility outside the village is generally restricted, would go a long distance to avail of competent health services. The nearer the health center/personnel, the more likely that women and their family members would avail of such services.

In the SC catchment areas, the government health centers such as THC, FWC and RD are more distantly situated from the homes of MWRAs than the NGO clinics. While the average distances to the Government health centers ranged between 3 and 6 kms. the average distance to NGO clinics was slightly over one km. (Table 5.7). Village doctors are available at the nearest location (less than one km.). Distance from the homes to different health facilities/personnel varied by project areas. For example, the MWRAs in Ghior live farthest away from the Thana Health Complex, while those in Rangunia live closest to the Thana Health Complex. This was also true regarding the Family Welfare Center and the NGO clinics. The evidence, thus, indicates that the MWRAs in Ghior were at a disadvantaged position insofar as distance from their homes to the different health facilities/personnel is concerned.

Another important finding is that the distance from the MWRAs' homes to the NGO clinic was shorter than to any other health center (Table 5.7), indicating that if the NGO clinic are to be closed for some reason or other, it would put the community at a disadvantage insofar as access to nearby health center is concerned.

TABLE 5.7: PERCENTAGE DISTRIBUTION OF MWRAs BY DISTANCE BETWEEN HEALTH CENTERS/PERSONNEL AND THEIR HOMES

Distance between homes and health centers (Meters)	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
<b>Thana Health Center:</b>					
<1000	-	-	0.4	-	0.3
1000-2000	-	-	-	43.6	6.3
2000-3000	-	5.4	-	18.3	3.1
3000-4000	-	45.9	0.9	3.6	5.5
4000+	100.0	48.6	98.7	34.5	84.9
Average distance	10,548	3,772	5,897	2,625	5,996
<b>Family Welfare Center</b>					
<1000	3.3	-	2.6	10.9	3.6
1000-2000	13.3	48.6	2.2	21.8	11.2
2000-3000	-	32.4	1.3	12.7	5.7
3000-4000	1.7	18.9	7.8	3.6	7.3
4000+	81.7	-	86.2	50.9	72.1
Average distance	7,344	2,135	3,979	1,759	4,362
<b>Govt. Dispensary:</b>					
<1000	23.3	2.7	5.6	30.9	11.7
1000-2000	23.3	5.4	3.0	-	6.0
2000-3000	15.0	35.1	1.7	-	6.8
3000-4000	11.7	16.2	10.3	-	9.6
4000+	26.7	40.5	79.3	69.1	65.9
Average distance	2,750	3,189	4,127	476	3,337
<b>NGO Clinic:</b>					
<1000	13.3	45.9	69.4	96.4	62.2
1000-2000	31.7	54.1	20.7	3.6	23.2
2000-3000	18.3	-	2.6	-	4.4
3000-4000	1.7	-	6.5	-	4.2
4000+	35.0	-	0.9	-	6.0
Average distance	2,599	1,051	977	481	1,167

Contd...

Table 5.7:(contd.)

Distance between home and health centers (Meters)	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Registered Physician:					
<1000	30.1	35.1	16.4	43.6	24.2
1000-2000	40.0	27.0	3.4	10.9	12.5
2000-3000	18.3	5.4	1.7	12.7	6.3
3000-4000	-	21.6	2.6	5.5	4.4
4000+	11.7	10.8	75.9	27.3	52.6
Average distance .	1,857	1,885	3,075	1,656	2,350
Village Doctor:					
<1000	41.7	59.5	94.8	80.0	81.0
1000-2000	28.3	29.7	3.4	9.1	10.7
2000-3000	28.3	-	-	1.8	4.7
3000-4000	-	-	-	-	-
4000+	1.7	10.8	1.7	9.1	3.6
Average distance	1,456	1,087	459	624	701

## **6. PERCEIVED IMPACT OF HEALTH CARE FACILITIES**

### **6.1. Introduction**

Impact of health care facilities, as perceived by the MWRAs, has a direct link to the sustainability of NGO health program. An understanding among the MWRAs of the perceived impact of health care facilities in terms of the extent of their willingness to avail of such facilities at their own initiative as well as at their own cost, perceived credibility of health centers/ providers, perceptions about the impact of health facilities on their own health as well as on the community health, etc., would help assess the extent of behavioral sustainability among the MWRAs in the SC catchment areas. A health-related behavior is sustainable, when the target population uses the basic health components to maintain their own health and that of their family members.

### **6.2. Willingness to Avail of Health Facilities**

The extent of willingness to spontaneously avail of primary health care facilities partly determines behavioral sustainability. For example, immunization of children is sustainable, when parents recognize its importance and have their children immunized correctly. In the SC catchment areas, the majority of the MWRAs expressed their willingness to go to health centers/clinics to avail of, in case the Government or the NGO workers do not approach them for the purpose, such services as immunization (both of children and mothers), treatment of diarrhoea, treatment of worms, pregnant mothers' check-up, treatment of ARI, and family planning-related services (Table 6.1). However, the extent of willingness to avail of certain specified services was, by and large, most pronounced in Rangunia and least pronounced in Nasirnagar. The evidence suggests that behavioral sustainability related to such services has not been quite achieved in Nasirnagar.

### **6.3. Ability to Pay for Health Services**

Ability to pay for health facilities is determined by a number of factors, including the willingness to avail of the services as well as the financial condition of the households. Given the existing level of their family income, most of the MWRAs felt that they would not be able to avail of preventive and curative health services, except treatment of diarrhoea, at their own cost (Table 6.2). The proportion of the respondents expressing their ability to pay for certain health services was lowest in Nasirnagar. In contrast, the proportion expressing their ability to pay for certain health services was considerably higher in the other three areas. Thus, it may be difficult to imagine that health behavior can be made sustainable in Nasirnagar in the near future.

TABLE 6.1: PERCENTAGE DISTRIBUTION OF MWRAs BY THEIR WILLINGNESS TO SPONTANEOUSLY AVAIL OF HEALTH FACILITIES

(Multiple Responses)

Willingness to avail of health services	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Check-up of pregnant mothers	78.3	86.5	45.7	90.9	61.2
Immunization of pregnant mothers	90.0	89.2	58.2	98.2	71.9
Immunization of children	93.3	89.2	75.4	96.4	82.6
Treatment of ARI (pneumonia)	58.3	81.1	48.3	90.9	59.1
Treatment of diarrhoea	90.0	89.2	71.6	90.9	78.9
Treatment of worms	83.3	86.5	58.2	89.1	69.3
Family planning related services	93.3	89.2	37.5	87.3	58.3
N	60	37	232	55	384

TABLE 6.2: PERCENTAGE DISTRIBUTION OF MWRAS BY THEIR PERCEIVED ABILITY TO PAY FOR HEALTH SERVICES

(Multiple Responses)

Ability to pay for health services	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Check-up of pregnant mothers	40.0	51.4	9.9	45.5	23.7
Immunization of pregnant mothers	61.7	56.8	16.8	49.1	32.3
Immunization of children	65.0	59.5	21.6	49.1	35.9
Treatment of ARI (pneumonia)	46.7	40.5	17.7	45.5	28.4
Treatment of diarrhoea	66.7	70.3	53.4	58.2	57.8
Treatment of worms	51.7	48.6	47.4	58.2	49.7
Family planning-related services	61.7	64.9	22.4	45.5	35.9
Treatment of other diseases	51.7	35.1	16.4	47.3	28.1
N	60	37	232	55	384

#### 6.4. Perceived Credibility of Health Centers

Service users generally approach those health centers, which have credibility in terms of providing satisfactory treatment, regular availability of service providers, pleasant behavior of service providers, and adequate availability of drugs and medicines. Sustainability of health behavior is linked with the credibility of health centers. The more the health centers are able to generate credibility among the users, the more likely the users would be coming to those centers to obtain health services.

Among the MWRAs, the NGO clinics were the most credible health service institutions, followed by the THC. A great majority of the MWRAs reported that treatment in the NGO clinics was satisfactory, health services were regularly available; service providers were available; behavior of service personnel was pleasant; and drugs and medicines were adequately available (Table 6.3). In contrast, considerably lower proportions of the MWRAs made similar observations

about the various Government facilities, indicating that the NGO clinics enjoy greater credibility than the Government health centers.

## **6.5 Perceived Responsibility for Health Care**

Perceptions about the responsibility for health care of the people in a community are likely to indicate the MWRAs' attitudes toward sustainability related to health behavior. As is evident from Table 6.6, almost all of the MWRAs in Mirzapur and over four-fifths in Ghior felt that such preventive services as immunization and family planning should be availed of at individual's own responsibility. That adoption of curative health measures such as treatment of diarrhoea and other diseases is the household responsibility was almost universally perceived in Ghior and Mirzapur. However, in Nasirnagar and Rangunia, it was widely felt that both preventive and curative health care should be the responsibility of the NGO and the government providers. The evidence, thus, indicates that the MWRAs in Ghior and Mirzapur recognize the importance of availing health services at own responsibility, with no dependence on the providers, thereby suggesting relatively higher degree of behavioral sustainability among the MWRAs in these two areas. However, high dependence on the service providers for health care suggests lack of behavioral sustainability related to health behavior in Nasirnagar. Although a small proportion of the MWRAs in Rangunia reported that health care is one's own responsibility, their relatively high educational status and health-related expenditures as well as wide use of service facilities suggest the existence of potential of behavioral sustainability.

TABLE 6.3: PERCENTAGE DISTRIBUTION OF MWRA's BY PERCEIVED CREDIBILITY OF HEALTH CENTERS

Perceived Credibility of Health Centers	GHIOR				MIRZAPUR				NASIRNAGAR				RANGUNIA				TOTAL			
	TMC	FUC	RD	NC	TMC	FUC	RD	NC	TMC	FUC	RD	NC	TMC	FUC	RD	NC	TMC	FUC	RD	NC
Satisfactory treatment	16.7	15.0	40.0	90.0	67.6	43.2	-	97.3	50.0	6.5	3.4	82.3	30.9	7.3	14.5	87.3	43.8	11.5	13.0	85.7
Regular availability of service	18.3	11.7	34.7	85.0	59.5	32.4	-	97.3	47.4	6.0	3.4	71.6	41.8	7.3	16.4	76.4	43.2	9.6	12.2	76.8
Service providers are available in need	23.3	13.3	35.0	83.3	67.6	29.7	-	94.6	46.6	6.5	3.0	68.8	41.8	7.3	20.0	80.0	44.3	9.9	12.8	74.0
Good behavior of personnel	20.0	13.3	38.3	91.7	59.5	29.7	-	97.3	46.6	6.5	3.9	90.5	52.7	7.3	20.0	98.2	44.5	9.9	13.5	92.4
Medicine is adequately available	5.0	10.0	28.3	80.0	40.5	27.0	-	75.7	44.0	6.0	2.6	71.6	16.4	5.5	3.6	43.6	33.6	8.6	8.3	69.3
N	60				37				232				55				384			

TMC= Thana health complex; FUC= Family welfare center; RD= Govt. rural dispensary; NC= NGO clinic.

TABLE 6.4: PERCENTAGE DISTRIBUTION OF MWRA's BY THEIR PERCEPTIONS ABOUT THE IMPROVEMENT OF THEIR AND THEIR FAMILY MEMBERS' HEALTH BECAUSE OF THE AVAILABILITY OF HEALTH SERVICES

Perceptions	SC Areas				Total
	Ghior	Mirzapur	Nasir-nagar	Rangunia	
Health improved	70.0	75.7	80.6	100.0	81.2
Current health is same as before	28.3	24.3	17.2	-	17.2
Current health is worse than before	1.7	-	2.2	-	1.6
Total	100.0	100.0	100.0	100.0	100.0
N	60	37	232	55	384

**TABLE 6.5: PERCENTAGE DISTRIBUTION OF MWRA<sub>s</sub> BY THEIR PERCEPTIONS ABOUT RESPONSIBILITY FOR HEALTH CARE OF PEOPLE IN A COMMUNITY**

(Multiple Responses)

Service Components*	SC Areas												TOTAL		
	GHOR			HIRAPUR			BASTIBAGAR			RANGORIA					
	GR	NR	OR	GR	NR	OR	GR	NR	OR	GR	NR	OR	GR	NR	OR
A. Preventive Services: Immunization	58.3	56.7	85.0	56.8	43.2	94.6	34.5	46.6	27.6	72.7	43.6	14.5	45.8	47.4	41.1
Counselling on health	60.0	56.7	68.3	59.5	51.4	97.3	24.1	46.6	31.9	56.4	63.6	14.5	37.8	51.0	41.4
Family planning	53.3	46.7	85.0	59.5	40.5	91.9	36.2	38.8	25.4	54.5	56.4	16.4	43.8	42.7	39.8
B. Curative Service: Treatment for diarrhoea	8.3	10.0	93.3	5.4	2.7	97.3	19.8	28.4	49.1	40.0	49.1	41.8	19.5	26.0	59.6
Treatment for other diseases	31.7	26.7	93.3	40.5	24.3	100.0	20.3	28.0	47.8	69.1	54.5	30.9	31.0	31.3	57.6
<b>N</b>	60			37			232			55			384		

GR= Government responsibility; NR= NGO responsibility; OR= Own/family responsibility.

## **7. SUSTAINABILITY RELATED TO HEALTH BEHAVIOR**

### **7.1 Introduction**

High incidence of child and maternal mortality and morbidity largely results from inadequate practice of simple health protective behaviors. Women in Bangladesh, as in many other developing countries, are more vulnerable to severe health problems than men; and, their poor health condition, caused by malnutrition and poorly-spaced pregnancies, contributes, in turn, to poor health of their children. Thus, provision as well as utilization of such health measures as immunization both of mothers and children, family planning, and timely curative measures can help reduce child and maternal morbidity and mortality.

In the SC catchment areas, a number of NGO clinics and government health centers (hospitals and clinics) have been providing health care services. The SC-provided health services aim at achieving, inter-alia, behavioral sustainability by seeking to "change behaviors and attitudes at the family level that can impact on the health development of women and children" (Save the Children (USA), 1993, p.6). Such health interventions as infant feeding practices, ORT, and maternal nutrition help families learn behaviors that are within their control, while such behaviors as immunization and family planning require materials and support services from the government health centers or NGO clinics/local providers. In cases where health supplies and services from the government or other local providers are needed, the SC facilitates linkages with such providers. The linkage between the health providers and the clientele population in the community is expected to enable the latter to avail of the required services, thereby ensuring that such a linkage would be sustained.

This chapter examines the extent to which the behavior of the MWRAs and their family members have changed regarding their utilization of health services. The objective, here, is to assess the implications of health services utilization and behavioral patterns on sustainability of NGO health care approaches, insofar as health behavior is concerned. This chapter would specifically assess whether the health behavior among the MWRAs and their family members would be sustainable, if NGO services are withdrawn; leading toward formulation of recommendations related to the measures to be undertaken to ensure that the health behavior remains sustainable, in the event of the withdrawal of NGO supplies and services.

### **7.2 State of Sustainability Related to Health Behavior**

There is no single way to either define or achieve sustainability (Khuda and Barkat, 1991). Sustainability of primary health care projects should be viewed not as an end in itself, but as a matter of degree. Any analysis of sustainable program efforts should start from the understanding of the generic meaning of "sustainability", which has been defined as "the ability of the system to maintain its productivity inspite of a major stress" (Barkat and Khuda, 1993). Using this generic meaning of sustainability, the term, in the case of SC projects, would mean "maintaining the health care behavior already attained by the SC beneficiaries even after a major stress caused by the withdrawal of SC from the project areas". This behavioral sustainability is a function of various variables, encompassing both the demand and supply aspects of the primary health care programs.

On the demand side, the major criteria of behavioral sustainability relate to: (a) the level of awareness and knowledge concerning health care facilities and services; (b) behavioral pattern, among the clientele population, manifested in the nature of persons who they discuss with about health-related problems, as well as pattern of approach in case of health problems, and preventive measures adopted to minimize health problems; (c) patterns of utilization of health services; (d) willingness to avail of, and ability to pay for, health services and supplies; and (f) perceptions about credibility of health providers, and responsibility for health care. On the other hand, the supply side relates to the extent to which the providers can afford to provide the health-related services and supplies. Since this study is not concerned with the supply side of program sustainability, the demand side of sustainability related to health behavior would be the focus of discussion.

The qualitative aspects of "behavioral sustainability", identified in this study, can be synthesised, using a TOWS/SWOT matrix, which has already proved to be an useful tool for the primary health care policymakers (Khuda and Barkat, 1993; and Mannan, 1993). The TOWS/SWOT framework permits the policymakers to understand the internal and external strengths/opportunities as well as weakness/threats of the NGO health care approaches. In this respect, the relevant information obtained in this study have been analyzed using the following framework:

Internal/External Data	Positive Factors	Negative Factors
Data Internal to the NGO Health Care Approaches	STRENGTHS	WEAKNESS
Data External to the NGO Health Care Approaches	OPPORTUNITIES	THREATS

- (i) STRENGTHS- Those factors/variables related to health behavior as well as internal to NGO health interventions, which favorably affect health behavior, leading to sustainability.
- (ii) WEAKNESS- Those unfavorable or negative factors, internal to NGO health interventions, having adverse effect on sustainability related to health behavior.
- (iii) OPPORTUNITIES- Those factors, external to NGO health interventions, which are likely to create opportunities for the program to take advantage in order to achieve sustainability related to health behavior.
- (iv) THREATS- Those external factors, which are likely to impose constraints to achieving sustainability of health behavior.

An analysis of the strengths, weakness, opportunities, and threats (SWOT) would help determine the overall state of sustainability related to health behavior in the SC catchment areas. The major elements of SWOT are presented in the form of a matrix in Table 7.1. Also, supporting data related to the major SWOT elements are presented in summary form in Tables 7.2. and 7.3. All the elements of 'strengths' existed in all areas, except that 'high priority to health care in terms of health expenditures' did not exist in Nasirnagar. However, given the existing unfavorable socioeconomic conditions compared to other areas of the country, the MWRAs in Nasirnagar are quite likely to attach lower priority to health care compared to other household needs. Also, since Nasirnagar is disadvantaged in terms of locational factors, it is not unusual that the inhabitants of the area would have relatively low willingness to avail of health services at own initiatives from the Government health centers located far away from their homes.

While the elements of 'weakness' were negligible in all areas, the 'threat' elements figured prominently, thereby suggesting that sustainability related to health behavior, is not likely to be achieved, unless certain issues affecting the Government health centers are given adequate attention. It may be noted that 'threat' is apparently a problem, but it is, in fact, a circumstance that should be handled by a constructive action plan alteration (Mannan, 1993). Thus, a threat such as dependence on village quacks will adversely affect the possibility of attaining sustainability of health behavior, since remedy to such a threat is not adequately covered in the Government and the NGO health program strategies.

The elements of 'opportunities', combined with those of 'strengths', indicate that there is a certain degree of behavioral sustainability related to health practice. Although about half of the Rangunia samples reported that they are not able to pay for health services if NGO assistance is withdrawn, further probe revealed that those who expressed their inability were mostly illiterates with little involvement in income generating activities. Thus, difficulties may be encountered in achieving behavioral sustainability among the MWRAs in the lower socioeconomic strata.

Also, it would be desirable that the SC continues its operation in Nasirnagar. The 'threat' elements, combined with low priority attached to health care as well as unwillingness to avail of health services and high dependence on NGO clinics, suggest that it would take some more time to attain sustainability related to health behavior in Nasirnagar. If the SC withdraws now, it would be counterproductive to whatever positive changes have already occurred in the health behavior among the MWRAs in Nasirnagar.

In Ghior and Mirzapur, health behavior among the MWRAs, as evident from the SWOT analysis, is relatively sustainable. However, to ensure continuation of sustainability, a number of measures need to be undertaken, so that the 'threats' could be transformed into 'opportunities'.

TABLE 7.1: MATRIX SHOWING SWOT ANALYSIS FOR ASSESSING SUSTAINABILITY RELATED TO HEALTH BEHAVIOR IN THE SC CATCHMENT AREAS

SWOT Components	Elements of SWOT	SC Catchment Areas			
		Ghior	Mir-zapur	Nasir-nagar	Rangu-nia
<b>STRENGTHS</b>	1. High levels of felt-needs for health care facilities and services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Adequate knowledge about health care components, and availability of services in the NGO clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. High concerns regarding health issues in terms of discussions with knowledgeable persons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. High priority to health care in terms of health expenditures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5. NGO clinics are the most important sources of competent medicare services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. High satisfaction with the NGO health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>WEAKNESS</b>	1. High dependence on NGO clinics for health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Low willingness to avail of most health facilities at own initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

TABLE 7.1 (continued)

SWOT Components	Elements of SWOT	SC Catchment Areas			
		Ghior	Mir-zapur	Nasir-nagar	Rangu-ria
OPPORTU-NITIES	1. Little influence of spiritual healers over clientele population	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Ability to pay for at least part of the health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
	3. Walkable distance (around 1.5 kilometers) to: FWC, Govt. dispensary, NGO clinic.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. Quite satisfied with the services of Govt. health centers/workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Importance given to Government health centers (THC and RD) at critical stages of diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Wide recognition that individual households should have the responsibility for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

TABLE 7.1 (continued)

SWOT Components	Elements of SWOT	SC Catchment Areas			
		Ghior	Mir-zapur	Nasir-nagar	Rangu-nia
THREATS	1. Inadequate knowledge about the availability of health services at the government health centers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Low utilization of government health facilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Relatively less credibility of government health centers than the NGO clinics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. Low priority attached to the government health centers at the preliminary stages of diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5. Long distance between most government health centers and homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	6. Quite high priority attached to the village quacks for treatment	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicable

Not applicable

TABLE 7.2: SUMMARY INFORMATION ABOUT THE MAJOR COMPONENTS OF PREVENTIVE HEALTH CARE

Major Components of Preventive Health Care	% having Knowledge	% Adopted	% Willing to avail at own cost	% having ability to pay for
1. Immunization of mothers	94.8	79.9	71.9	32.3
2. Check-up of pregnant mothers	76.8	67.5	61.2	23.7
3. Immunization of children	93.5	82.6	82.6	35.9
4. Family Planning	94.8	-	58.3	40.0

Source: Prepared, based on Tables 3.3, 4.7, 6.1, and 6.2

TABLE 7.3: SUMMARY INFORMATION RELATED TO GOVERNMENT, NGO, AND PRIVATE HEALTH PROVIDERS

Health Centers/ Personnel	% reporting competent services available	% who approach for preventive care	% who approach for treatment (Prel. stage)	% who approach for treatment (Critical stage)
Thana Health Complex	27.1	10.4	5.2	43.2
Family Welfare Center	--	--	2.9	0.8
Government Dispensary	6.8	--	3.9	8.4
NGO Clinics	45.0	30.7	53.9	28.4
Village Doctors/ Quacks	15.6	27.6	52.6	12.2
Spiritual Healers	--	2.6	2.9	0.5

Source: Prepared, based on Tables 3.5, 4.3, and 4.4.

## **8. SUMMARY AND RECOMMENDATIONS**

Since behavioral sustainability would imply maintaining individual health behaviors after the SC involvement is phased out, it is quite important that a number of measures need to be undertaken to ensure sustenance of that behavior.

### **Strengthening Government Health Centers**

The evidence indicates that the MWRAs and their family members have inadequate knowledge of the government health services and facilities, resulting in low utilization of, as well as low priority to, such services/facilities. There is, thus, a need to increase the knowledge among the MWRAs and their family members about the services available at the government health centers such as THC, FWC, and RD. This would require strengthening of the government health centers in the SC catchment areas through wider dissemination of information regarding health-related services available at the government health centers. Such information dissemination could be done by both the government workers and the local NGO workers. This would further be facilitated, if the NGOs work in collaboration with the government health program.

Furthermore, the government health centers enjoy less credibility than the NGO health clinics in terms of the clients' level of satisfaction with treatment, availability of adequate quantities of medicines, behavior of personnel, regular availability of service, and availability of service providers. Thus, there is a need to undertake appropriate measures to close the credibility gap. Suggested measures include motivational efforts among the Government service providers to increase their efficiency in terms of providing quality service as well as improving their personal behavior with the clientele population, and establishing accountability on the part of the service personnel.

### **Developing Quality of the Village Doctors**

In all the project areas, village doctors are considered to be the second most important source of medicare services, thereby indicating high dependence on such doctors, particularly for curative services. It would, therefore, be appropriate to provide the village doctors with appropriate training in preventive health care as well as in the basic curative health services. The local NGOs, including the SC, may undertake the responsibility of providing medical training to the village doctors. Such training would enable the village doctors to improve the quality of their services, thereby contributing to the process of behavioral sustainability among the clientele population.

### **Providing Health Services at Accessible Locations**

Location of the government health centers at a long distance from homes, and inconvenience of transport were reportedly the two important reasons for not availing of health services from such centers. This is indicative of the fact that if NGO services are withdrawn, from the project areas the clientele population would be adversely affected. There is, thus, a need to make health facilities available at easily accessible locations at the village level. Toward this end, the Government has introduced the concept of satellite clinics to be held close to the homes of the villagers so that they can avail of selected MCH-FP services. Also, health services should be provided free or at affordable cost in adequate quantity, if health behavior among the clientele population is to be sustained.

### **Raising Awareness among the Clientele Population**

Most MWRAs in the SC catchment areas are not aware of the facilities for laboratory tests such as urine, stool, blood tests, etc., and health counselling. Also, the level of awareness about such health services as sanitary latrines, and vitamin-A capsules, is low. There is, thus, a need for more intensified information, education, and communication (IEC) efforts to raise the level of awareness about laboratory tests, health counselling, sanitary latrines, and vitamin A, etc..

### **Special Focus on Nasirnagar**

Behavioral sustainability related to such services as check-up of pregnant mothers, treatment of ARI, and family planning has not been quite achieved in Nasirnagar. Thus, the clientele population of Nasirnagar should be made special target group insofar motivational efforts related to health-program inputs are concerned. Also, it would be difficult to achieve behavioral sustainability in Nasirnagar, in view of the low perceived ability to pay for health services. Thus, there is need to intensify income-generation activities among the clientele population, so as to help improve their economic condition.

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# **Annex A**

## **Questionnaire**

**SAVE THE CHILDREN (USA)**

**STUDY ON HEALTH CARE SERVICES UTILIZATION AND  
BEHAVIORAL PATTERN IN THE SC CATCHMENT AREAS**

INTERVIEW SCHEDULE FOR MWRAs

Sample No.* <input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>									
Name of the respondent: _____										
Name of her husband : _____										
Address:										
Thana : Nasirnagr <input style="width: 20px; text-align: center;" type="text"/> 1	Rangunia <input style="width: 20px; text-align: center;" type="text"/> 2									
Mirzapur <input style="width: 20px; text-align: center;" type="text"/> 3	Ghior <input style="width: 20px; text-align: center;" type="text"/> 4									
Union : _____										
Village: _____										
Interview Information:										
Interview Call	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">1</td> <td style="width: 25%; text-align: center;">2</td> <td style="width: 25%; text-align: center;">3</td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> <tr> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> <td style="height: 20px;"> </td> </tr> </table>	1	2	3						
1	2	3								
Date										
Result Code*										
*Result Code: Completed =1, Respondent not available =2 Deferred =3, Refused =4, Dwelling vacant =5 Address not found = 6 Others _____ 7 (Specify)										
Supervisor Scrutinized _____	Signature of the Interviewer _____									
Date _____	Date _____									

\* First box for Area (1. Nasirnagar, 2. Rangunia, 3. Mirzapur, 4. Ghior); and the last three boxes are for Sample Number.

SECTION 1

CHARACTERISTICS OF RESPONDENTS

101. What is your present age ?  
\_\_\_\_\_ (in years).

--	--

102. What was the highest class you passed ?  
\_\_\_\_\_ class

--	--

If no class, write '00'

103. What is the number of children you gave birth ?

Living children 

--	--

 Boys 

--

 (number)

Girls 

--

 (number)

Children who died 

--

 (number)

Pregnancy wasted 

--

 (number)

Total Boy Girl  

--	--	--	--

104. In addition to household work, do you do any other job ?

1
---

 Yes

2
---

 No  
(SKIP TO 106)

--

105. What are those activities? (Circle appropriate answer)

	<u>Yes</u>	<u>No</u>	
Poultry farming	1	2	<input type="checkbox"/>
Vegetable gardening	1	2	<input type="checkbox"/>
Earth digging	1	2	<input type="checkbox"/>
Domestic service	1	2	<input type="checkbox"/>
Livestock	1	2	<input type="checkbox"/>
Others _____ (Specify)			

106. What is your religion ?

- |  |   |                          |
|--|---|--------------------------|
| <input type="checkbox"/> 1 Islam                     | <input type="checkbox"/> 2 Hinduism     | <input type="checkbox"/> |
| <input type="checkbox"/> 3 Buddhism                  | <input type="checkbox"/> 4 Christianity |                          |
| <input type="checkbox"/> 5 Others _____<br>(Specify) |   |                          |

107. What is the highest class your husband passed?

\_\_\_\_\_ class

(If no class, write '00')

108. What is the primary occupation of your husband ?

- |  |   |                          |
|--|---|--------------------------|
| <input type="checkbox"/> 1 Farming                   | <input type="checkbox"/> 3 Non-agricultural labor | <input type="checkbox"/> |
| <input type="checkbox"/> 2 Agricultural wage labor   | <input type="checkbox"/> 4 Petty business         |                          |
| <input type="checkbox"/> 5 Trading                   | <input type="checkbox"/> 6 Service                |                          |
| <input type="checkbox"/> 7 Fishing                   | <input type="checkbox"/> 6 Service                |                          |
| <input type="checkbox"/> 8 Others _____<br>(Specify) |   |                          |

109. Are you a member of SAVE's Women Savings Groups (WSG)?

- |                                |                               |                          |
|--------------------------------|-------------------------------|--------------------------|
| <input type="checkbox"/> 1 Yes | <input type="checkbox"/> 2 No | <input type="checkbox"/> |
|--------------------------------|-------------------------------|--------------------------|

## SECTION 2

## INFORMATION RELATED TO PRIMARY HEALTH CARE

201. Which health care facilities, according to you, are needed to meet the health problems of your family members?

	<u>Yes</u>	<u>No</u>	
Availability of physicians	1	2	<input type="checkbox"/>
Availability of medicine	1	2	<input type="checkbox"/>
Existence of hospitals	1	2	<input type="checkbox"/>
Facilities of laboratory tests (stools, urine, blood, etc.)	1	2	<input type="checkbox"/>
Health counselling	1	2	<input type="checkbox"/>
Others _____ (Specify)			

202. Who do you discuss with (other than your family members) in case of your health related problems ?

	<u>Yes</u>	<u>No</u>	
Neighbors	1	2	<input type="checkbox"/>
Government workers	1	2	<input type="checkbox"/>
NGO workers	1	2	<input type="checkbox"/>
Registered physician	1	2	<input type="checkbox"/>
Village doctors	1	2	<input type="checkbox"/>
Spiritual healers (Imam, etc.)	1	2	<input type="checkbox"/>



Accessibility to safe drinking water	1	2	<input type="checkbox"/>
Accessibility to sanitary latrines	1	2	<input type="checkbox"/>
Vitamin-A capsule	1	2	<input type="checkbox"/>
Oral saline	1	2	<input type="checkbox"/>
Others _____ (Specify)			

205. Do you know about the following? (Prompted)

	Right -----	Not Right -----	
What facilities are available to know about any risk which pregnant mother and her child are exposed to? (Correct Answer: Pregnancy check-up)	1	2	<input type="checkbox"/>
What preventive measures are available to a pregnant mother to protect herself and her newborn from tetanus? (Correct Answer: TT)	1	2	<input type="checkbox"/>
What measures are available to protect children from some fatal diseases? (Correct Answer: EPI/Immunization)	1	2	<input type="checkbox"/>
Is there any medicine, other than appropriate food, to protect children from blindness (Correct Answer: Vitamin-A capsules)	1	2	<input type="checkbox"/>
Do you know about any measure or medicine that can be used to stop pregnancy or to take children at certain intervals? (Correct Answer: Family Planning/ birth control)	1	2	<input type="checkbox"/>

206. Who do you approach for health services prior to facing any health problems/sickness?

	<u>Yes</u>	<u>No</u>	
Government workers	1	2	<input type="checkbox"/>
NGO workers	1	2	<input type="checkbox"/>
Govt. hospitals (THC/FWC, etc.)	1	2	<input type="checkbox"/>
NGO clinic	1	2	<input type="checkbox"/>
Registered physician	1	2	<input type="checkbox"/>
Village doctors	1	2	<input type="checkbox"/>
Spiritual healers (Immam, etc.)	1	2	<input type="checkbox"/>
Don't approach anybody	1	2	<input type="checkbox"/>
Others _____ (Specify)			

207. What measures do you and your family members adopt to ensure minimization of your health problems) (Prompted)

	<u>Self initiative</u>		<u>Initiative by service providers</u>			
	<u>Yes</u> 1	<u>No</u> 2	<u>Yes</u> 1	<u>No</u> 2		
Immunization of mothers	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Immunization of children	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy check-up	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Safe drinking water	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Sanitary latrine	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>



209. Where do you think competent medicare services (competent services for treatment of diseases) are mostly available in your area?  
 (Answer should be only one)                      Yes                      No

Thana health complex(THC)                      1                      2

Family Welfare Centre (FWC)                      1                      2

Government Dispensary(GD)                      1                      2

NGO Clinic                      1                      2

Registered physician                      1                      2

Village doctor                      1                      2







210. How far away are the following health centers from your residence?

Health Centers                      Distance from residence(meters)

-----  
 Thana health complex                      \_\_\_\_\_

Family Welfare Center                      \_\_\_\_\_

Government Dispensary                      \_\_\_\_\_

NGO Clinic                      \_\_\_\_\_

Registered doctor                      \_\_\_\_\_

Village doctor                      \_\_\_\_\_

211. Where do you go most often for the treatment of diseases at preliminary and critical stages?

	At Preliminary Stage		At Critical Stage			
	<u>Yes</u>	<u>No</u>	<u>Yes</u>	<u>No</u>		
Thana health complex	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Family Welfare Center (FWC)	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Govt. dispensary	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
NGO clinic	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Registered physician	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Village doctor/quack	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual healers	1	2	1	2	<input type="checkbox"/>	<input type="checkbox"/>
Others _____ (Specify)						

212. Why do you go there most often?

	<u>Yes</u>	<u>No</u>	
Competent service provided	1	2	<input type="checkbox"/>
Nearest to our residence	1	2	<input type="checkbox"/>
Minimum waiting time required	1	2	<input type="checkbox"/>
Behavior of service providers pleasant (cooperative)	1	2	<input type="checkbox"/>
Service regularly available	1	2	<input type="checkbox"/>
Female service providers available	1	2	<input type="checkbox"/>

Service providers known to us	1	2	<input type="checkbox"/>
Adequate quantity of medicine available	1	2	<input type="checkbox"/>
Service/medicines are free	1	2	<input type="checkbox"/>
Service/medicines available on credit	1	2	<input type="checkbox"/>
Services/medicines available at cheaper prices	1	2	<input type="checkbox"/>
Convenience of transport	1	2	<input type="checkbox"/>
Others _____ (Specify)			<input type="checkbox"/>

213. (If her answers to Q. 209 and 211 are different, ask her: why don't you go to the health centre/service provider where, according to you, competent services are mostly available?)

Long distance from residence	1	2	<input type="checkbox"/>
Long waiting time required	1	2	<input type="checkbox"/>
Non-cooperative behavior of service providers	1	2	<input type="checkbox"/>
Adequate quantity of medicine not available.	1	2	<input type="checkbox"/>
Services/medicines are not free	1	2	<input type="checkbox"/>
Services/medicines not available on credit	1	2	<input type="checkbox"/>

No female service providers available 1 2

Inconvenience of transport 1 2

Others \_\_\_\_\_  
(Specify)

214. Has any government worker (health/family welfare worker) ever visited your house ?

Yes  No  
(Skip To 217)

215. Do you think her visits benefitted you?

Yes  No  
(Skip To 217)

216. In what ways did she help you?

Child delivery Yes 1 No 2

Pregnancy check-up 1 2

Treatment of ARI 1 2

Treatment of diarrhoea of children 1 2

Treatment of worms 1 2

Immunization of mother and children 1 2

Counselling on family planning 1 2

Providing family planning methods 1 2

Others \_\_\_\_\_  
(Specify)

217. Has any NGO worker ever visited your house?

Yes  No

(Skip To 220)

218. Do you think her visits benefitted you?

Yes  No

(Skip To 220)

219. In what ways did she/he help you?

	<u>Yes</u>	<u>No</u>	
Child delivery	1	2	<input type="checkbox"/>
Pregnancy check-up	1	2	<input type="checkbox"/>
Treatment of ARI	1	2	<input type="checkbox"/>
Treatment of diarrhoeas of children	1	2	<input type="checkbox"/>
Treatment of worms	1	2	<input type="checkbox"/>
Immunization of mother and children	1	2	<input type="checkbox"/>
Counselling on family planning	1	2	<input type="checkbox"/>
Providing family planning methods	1	2	<input type="checkbox"/>

Others \_\_\_\_\_  
(Specify)

220. To what extent are you satisfied with the services offered by the health care providers?  
(Circle appropriate answer)

Answer Code: Very satisfied=1, Satisfied=2,  
Neither satisfied nor dissatisfied=3,  
Somewhat dissatisfied=4, Not at all satisfied=5,  
Not applicable = 9

Government worker 1 2 3 4 5 9

NGO worker worker 1 2 3 4 5 9

221. What is your family's total annual household expenditure?  
(INTERVIEWER: If the respondent is unable to estimate annual expenditures, ask her to give you rough estimate of monthly expenditure. You yourself should, then, be able to calculate the yearly expenditure, and then record it).

Annual household expenditure

Tk.

222. How much money is spent annually for health care of your family members?

(INTERVIEWER: Try to have an approximate figure. Ask her to tell specifically about expenses for medicine, doctor's/healer's fee, etc., and then you estimate the total expenses).

Average annual expenditures for health:

Tk.

223. If the Government or NGO workers do not come to you to provide the following services, would you go to health centres/clinics to avail of them?

	<u>Yes</u>	<u>No</u>	
Check-up of pregnant mothers	1	2	<input type="checkbox"/>
Immunization of pregnant mothers	1	2	<input type="checkbox"/>
Immunization of children	1	2	<input type="checkbox"/>
Treatment of ARI (pneumonia)	1	2	<input type="checkbox"/>
Treatment of diarrhoea	1	2	<input type="checkbox"/>
Treatment of worms	1	2	<input type="checkbox"/>

Family Planning-related services 1 2

Others \_\_\_\_\_  
(Specify)

224. Given the existing level of your family income, do you think that you would be able to avail of the following services at your own cost?

	<u>Yes</u>	<u>No</u>
Check-up of pregnant mothers	1	2
Immunization of pregnant mothers	1	2
Immunization of children	1	2
Treatment of ARI (pneumonia)	1	2
Treatment of diarrhoea	1	2
Treatment of worms	1	2
Family Planning-related services	1	2
Treatment of other diseases	1	2

225. What is your opinion about the services provided in the health centers/clinics ?

	Treatment	Availability of service	Availability of service providers in need	Behavior of personnel	Availability of medicine
	Satisfactory=1 Not satisfactory=2	Available regularly=1 Not available regularly=2	Available = 1 Not available = 2	Good =1 Not Good =2	Available adequately=1 Not available adequately=2
a. Thana Health Complex	1 2	1 2	1 2	1 2	1 2
b. Family Welfare Center	1 2	1 2	1 2	1 2	1 2
c. Govt. dispensary	1 2	1 2	1 2	1 2	1 2
d. NGO clinic	1 2	1 2	1 1	1 2	1 2

<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

226. Do you think that the health services provided by the government health centers have improved the health situation in your area ?

1 Yes     
  2 No     
  9 Not applicable

227. Do you think that the health services provided by the NGO clinics have improved the health situation in your area ?

1 Yes     
  2 No     
  9 Not applicable



230. What kinds of health problems, do you think, you would face if NGO services are withdrawn from your locality ?

Health counselling would not be available

Medicine would not be available

Treatment problem would be acute

Medicine would not be available at cheaper prices

Long distance to go for treatment

There would be problems for immunization of children

There would be problems for immunization of mother

Facilities for pregnancy check-up would not be available

Medicine will not be available free of cost

Family planning methods will not be easily available

Others \_\_\_\_\_  
(Specify)

INTERVIEWER: Please check and recheck that all relevant questions are asked and all 'SKIP' instructions are correctly followed, 'THANK' the respondent for her time followed, 'THANK' the respondent for her time and cooperation

INTERVIEWER'S NAME: \_\_\_\_\_

DATE OF INTERVIEW: \_\_\_\_\_