

PN-ACN-487

Working Paper No. 22

Rapid Appraisal of Urban Health Needs and Priorities

Aye Aye Thwin
Shamim Ara Jahan

MCH-FP Extension Project (Urban)
Health and Population Extension Division

1996



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ICDDR,B Working Paper No. 67

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Editing: M. Shamsul Islam Khan

Layout Design and Desktop Publishing: SAKM Mansur
Roselin Sarder

Cover Design: Asem Ansari

ISBN: 984-551-074-4

© 1996. International Centre for Diarrhoeal Disease Research, Bangladesh

Published by:

International Centre for Diarrhoeal Disease Research, Bangladesh

GPO Box 128, Dhaka 1000, Bangladesh

Telephone: 880-2-871751 (10 lines): Cable: CHOLERA DHAKA, Telex: 675612 ICDD BJ;

Fax: 880-2-883116, 880-2-886050 and 880-2-871568

Printed by: Adprint in Dhaka, Bangladesh

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Foreword

I am pleased to release this publication on the assessment of health and demographic profile of the urban population of Bangladesh, as part of the research agenda of the MCH-FP Extension Project (Urban) of ICDDR.B. Over the years, the Centre has acquired unique expertise on urban development matters that ranges from research on reproductive health, child survival and environmental issues to providing technical assistance for capacity building to service delivery organizations working in urban areas.

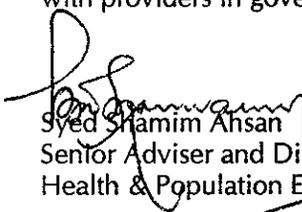
This work has produced important findings on the health status and conditions of city dwellers, particularly the poor and those living in slums in the entire country. The research has also identified service delivery areas in which improvements need be made to enhance effectiveness. Together, these research findings form the basis in designing interventions to be applied in government and non-government settings.

In order to carry out this innovative work, the Centre has established a partnership effort known as the Urban MCH-FP Initiative, with agencies of the Government of Bangladesh and national non-government organizations, notably Concerned Women for Family Planning, a national NGO with wide experience in the delivery of MCH-FP services.

From the government side, this initiative to improve health in cities has the active support and participation of the Ministry of Local Government, Rural Development and Cooperatives, the Directorates of Health and Family Welfare of the Ministry of Health and Family Welfare and Dhaka City Corporation. The partnership receives financial and technical support from the United States Agency for International Development (USAID).

The overall goal of the partnership is to contribute to the reduction of mortality and fertility in urban areas. In practice, this joint work has already resulted in the development and design of interventions to improve access, coordination and sustainability of quality basic health services to urban dwellers with emphasis on the needs of the poor and those living in slum areas.

The Centre looks forward to continuing this collaboration and to assist in the wider dissemination and application of sustainable service delivery strategies in collaboration with providers in government, the NGOs and the private sector.


Syed Shamim Ahsan
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Acknowledgements

This study was funded by the United States Agency for International Development (USAID) under grant No. 388-0073-A-00-1054-00 with the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), with technical assistance from the School of Hygiene and Public Health, Johns Hopkins University, through additional USAID funds from the Johns Hopkins Child Survival Cooperative Agreement and the Health and Child Survival Fellows Programme. The ICDDR,B is supported by the aid agencies of the governments of Australia, Bangladesh, Belgium, Canada, China, Denmark, Germany, Japan, the Netherlands, Norway, Republic of Korea, Saudi Arabia, Sri Lanka, Sweden, Switzerland, Thailand, the United Kingdom, and the United States; international organizations, including Arab Gulf Fund, Asian Development Bank, European Union, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), and the World Health Organization (WHO); private foundations including Aga Khan Foundation, Child Health Foundation, Ford Foundation, Population Council, Rockefeller Foundation and the Sasakawa Foundation; and private organizations including the American Express Bank, Bayer A.G, CARE, Family Health International, Helen Keller International, the Johns Hopkins University, Macro International, New England Medical Centre, Procter Gamble, RAND Corporation, SANDOZ, Swiss Red Cross, the University of Alabama at Birmingham, the University of Iowa, and others.

The study was a collaborative effort between two institutions - the International Centre for Diarrhoeal Disease Research, Bangladesh, and the School of Hygiene and Public Health of the Johns Hopkins University in Baltimore, MD, USA. The authors acknowledge the contribution of other researchers and professionals at those institutions who have assisted tangibly in producing the report. Particularly, the contributions of the following persons deserve special mention:

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- (vii) Sangeeta Mookherji, MHS, Operations Research Manager, Concerned Women for Family Planning and Health and Child Survival Fellow, The Asia Foundation

The field staff of the MCH-FP Extension Project (Urban) worked hard during data collection, transcription and analysis. Their efforts were highly appreciated in terms of both competence and efficiency. We would like to thank Hazera Nazrul, Monowar Jahan, Meghla Islam, Shawkat Ali and Feroz Heyder for the fine quality of their work.

We received advice and counsel from the Director of ICDDR,B, Prof. Demissie Habte, and value the guidance given by Syed Shamim Ahsan, Senior Adviser and Divisional Director, Health and Population Extension Division. Last, but not the least, we express our gratitude and appreciation toward all those who have given critical comments and advice on the preliminary findings in numerous occasions during 1995-96, especially our external reviewers Ms Nancy Piet-Pelon, Consultant, Population Council, Prof. Nazrul Islam, Director, Centre for Urban Studies, Dhaka University, and Syed M Hashemi, Project Director, Programme for Research on Poverty Alleviation, Grameen Trust, Grameen Bank.

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Summary

Rapid urbanization and urban population growth in Bangladesh over the past two decades have triggered the interest and commitment of the Government and donors to improve health care for the poor and the disadvantaged. In such instances, consumer participation is essential in sustainable development of urban health systems. These approaches also inform perceived needs of the urban population, their willingness to pay for services and their satisfaction with service delivery. A rapid appraisal of health and health-related needs and priorities was conducted in Dhaka City, sampling four zones and interviewing key informants. A total of 60 interviews were conducted with 32 respondents who comprised both slum and non-slum residents, ward commissioners and health service providers from the government, non-governmental and private sector.

The urban poor struggle to survive on a fragile economic base. The signs of poverty are evident with an urgent need for money to exist in a largely cash-driven society. Payments are required daily to have access to basic needs, such as water, shelter, food, clothing, a clean environment and medical care, priorities specified by urban dwellers. The slum population experiences shortage of clean water, and the lack of latrines and bathing facilities. River and pond water are being used for household purposes. Other environmental problems such as deficient garbage disposal, drainage and sewerage are also prevalent. Consumers stated the need for WASA (Water and Sewage Authorities), the City Corporation and the government to take action, and expressed their willingness to pay standardized fees. Noise and air pollution - prominent problems in most cities - are probably "Western" concepts. Most people in Dhaka City neither notice, nor complain of them as hindrances of urban life.

Fever, diarrhoea, cold and cough, and scabies are reported as health problems in the city. Urban dwellers prioritize treatment for common illnesses and immunization services as essential. It is apparent that free services do not always mean free care, there were reports of baksheesh (i.e. tips), and donations for immunization services, etc. Nevertheless, the

information signifies a willingness to pay and a sustainable demand for health services even with all hidden costs. Local leaders and service providers spoke of the need to enhance access to antenatal care, postnatal care, Vitamin A distribution, treatment for scabies and skin infections and family planning services. Consumers complain about insufficient medicines, long waiting time at public hospitals and high expenses at private facilities. Health service utilization patterns among women and men differ; women seem to be confined to private for-profit clinics, whereas men often just buy medicines at the pharmacy for some form of self-care. This reflects the cultural barrier preventing women to purchase health services at pharmacies, and highlights the popularity of the private sector in health service delivery. The urban health care system is viable and self-sustaining; its effectiveness should be ensured.

Reproductive health care in the urban areas should be strengthened significantly. Slum women do not consider antenatal health care a priority, and cannot always afford routine check-ups. Ward commissioners and service providers advocate free services for the poor, but suggest charging user fees for the rich. Childbirth and home deliveries by dais are commonly practiced and would probably continue in the future. Women in urban areas are not proactive towards obtaining routine postnatal check-ups, they often seek care for minor problems from the NGO clinics and pay high costs for major problems to private doctors and at clinics. Ward commissioners and service providers propose home visits as a strategy to motivate the use of routine postnatal care at subsidized non-profit centres. Unwanted pregnancies seem common in Dhaka City, and the need for good quality MR and abortion services was strongly advocated. Consumers are willing to pay, but ward commissioners and providers recommend free services. Pharmacies, shops, field workers and NGO facilities are the main sources of family planning services, specifically for temporary modern methods. All respondents expressed the need to increase family planning use by males, recommending advertisement and motivation through the media.

Generally, community leaders tend to perceive that the poor should not - and cannot afford to - pay for some of their daily needs. However, people in the slums are actually paying for almost everything, either through rent for commodities like water and sanitation, or separately for others, e.g. health services. The capacity for, and feasibility of community financing mechanisms in the urban areas should be further examined. The informal networking and the role - and effectiveness - of local government leaders such as ward commissioners should be explored.

The findings highlight the need to focus on slum dwellers and urban poor communities for the improvement of family income, living conditions and access to health and family planning services through special strategies. The role of the private sector in urban health service delivery is substantial and sustainable and requires regulation to improve their effectiveness. This signifies the role of government to establish standards and monitor the quality of urban health service delivery. The local government also needs to be empowered to coordinate health resources available in urban areas. The ability of the community to mobilize funds should neither be ignored nor taken for granted. Payments, both explicit and hidden, are taking place, and the willingness to pay for essential items was evident. A future role of the urban local government may be to standardize prices and fees, in order to maintain social and medical equity among the urban consumer population.

1. Introduction

As the urban population in developing countries increases at a rapid pace, the access to, availability and provision of basic services become an important development agenda for governments, donors and non-government agencies. Imperative in the plans to address this agenda is information that represents the views and perspectives of urban consumers regarding both their current practices and their expectations in relation to their basic needs. Recent advances in planning for sustainable development require client participation in identifying problems and feasible solutions, through practical approaches that permit the consumer to lead the process of information gathering. Such participatory approaches are now used in developing countries quite extensively by donors and programme managers jointly with customers (or clients) of development aid. The present study is a rapid appraisal of urban health needs, including access to, and utilization of services among both slum and non-slum populations in Dhaka City. The findings pave the way to identifying further areas for programme development.

The study is mainly exploratory and concerns an overall perspective of primary health resources at the community level. The areas covered are as follows:

- a. basic needs and problems as defined by community members,
- b. access to and willingness to pay for water supply and sanitation,
- c. access to and willingness to pay for prevention and treatment of common illnesses and reproductive health services, including abortions and family planning.

The focus of this study was on identifying problems, and discerning the capacity of the community to manage and finance services, mostly from the perspectives of urban residents. Two other key informant groups, ward commissioners (elected political representatives at the lowest electoral units and formal leaders of the urban community) and health service providers were included for their roles as leaders and professionals constantly in touch with community-level situations. The comparison of information gathered from residents, including the latter two groups of key informants permitted the analyses of differing views and opinions.

2. Literature Review

2.1 The Problem Context: Urban Health in Bangladesh

Bangladesh's urbanization process produced the growth of cities and municipalities at three times faster than the country as a whole, i.e., at 6 percent versus 2 percent nationally. At present, one out of four Bangladeshis lives in urban areas, in contrast to one out of twenty, thirty years ago. Within the same period, the population in the nation's capital reached 6 million from 0.5 million, with major consequences of the burgeoning of slum and squatter settlements. Approximately, 30 percent of Dhaka City's population reside in slums in sub-optimal living conditions, and at least half fall below the poverty line (Arifeen and Mookherji, 1995). With continued rapid growth of the city's population, residents in both slum and non-slum areas experience the consequences of having to depend on an infrastructure that can no longer cope with increasing needs.

Previous analyses of the health situation in urban Bangladesh discussed the occurrence of diarrhoea, respiratory tract infections, scabies, helminthiasis, fever, typhoid, whooping cough and eye diseases. These reports speculated the causal effect of environmental conditions, especially water and air pollution. (Task Force on Bangladesh Development Strategies for the 1990s, 1991, Centre for Urban Studies, 1990) The quality of the urban physical environment was reported to be at sub-optimal level. The majority of people living in urban areas does not have adequate access to municipal piped water supply, modern sanitation and sewerage systems, amidst inadequate arrangements of collection and disposal of garbage.

The issue of intra-urban differentials of health service utilization has been illuminated by other studies as well. The slum population is often equated with lower immunization coverage rates and lower knowledge and use of contraception compared to non-slum urban populations (Laston et al., 1993, Jamil et al., 1993). Some of the health indicators in slum areas are equivalent to those in rural areas, and in some cases, as with infant mortality, is even higher.

Studies have also highlighted the situation of unmet need for contraception, the importance of male involvement in reproductive health decisions and the problem of unwanted pregnancies especially among slum women (Thwin et al., 1996). The issue of user fees for maternal and child health and family planning services, in terms of who should pay, for what level of quality was also raised. (Salway et al., 1993) The inadequacy of information on salient aspects of reproductive health, especially regarding utilization of antenatal, postnatal and delivery care justifies inquiry in the appraisal.

In this context, the assessment of primary health care needs in the urban areas of Dhaka covers the following issues:

- a. supply of water at the household level
- b. provision of safe sanitation at the community and household level that includes interventions towards environmental pollution
- d. immunization against major infectious diseases
- e. utilization of medical care services
- f. reproductive health services with particular reference to maternal and child health and family planning. Relevant issues include access and availability of prenatal care, delivery, postnatal care, etc.

The focus of the present study is on examining preferences and opinions regarding quality of care, satisfaction, and willingness to pay for basic health and health-related services and the capacity for community financing for some of these services.

2.2 The Framework of Responsibilities: Delivery of Urban Health Services

Dhaka City lacks an organized health service delivery system, which results in deficient health care at local or community levels. The urban poor have limited access to good quality medical care, and the high expenses of time and money in acquiring care at public centres push them to seek services from pharmacies, traditional medical practitioners, and even quacks (CUS, 1990, Fronczak et al., 1993). Thus, the private for-profit sector dominates the

urban market in terms of medical care provision, and a certain amount of preventive care especially for maternal and child health and family planning is available from health service systems of non-profit non-governmental organizations (NGOs). The system of service delivery of NGOs varies from clinics, satellite clinics and field workers. Some organizations have had the experience of working with community volunteers in the slum areas of Dhaka (Paljor et al., 1994, Laston et al., 1993). Non-profit health service providers in Dhaka City offer a wide variety of services differing in type and level of delivery, for both preventive and curative care. According to a recent urban health facility survey by the MCH-FP Extension Project (Urban) of ICDDR,B, there are a total of 115 EPI centres, 140 MCH-FP clinics/centres, 99 government-run dispensaries, 17 satellite clinics, 84 hospitals, 127 medical care clinics in Dhaka City alone (Majumder et al., 1996). There are at least 115 NGOs working in the DCC areas, operating a total of 184 health facilities, with 555 field workers in addition to 72 field workers from the MOHFW.

However, there is not enough effective coordination among providers, with gaps and overlaps in access and availability of services to the catchment populations. There is a dire need to combine efforts in ensuring optimal distribution of services, especially for the slums and the urban poor. Some programmes have exhibited success using a multi-sectoral approach, such as, the Urban EPI programme which was a concerted effort of the Dhaka City Corporation, the Directorates of Health and Family Planning, the technical assistance agencies, and the NGOs. The inputs of the local administrative and political bodies towards programme success were noted.

Coordinating health resources at the local level - among local government representatives, NGO and private sector - is a major undertaking. Mechanisms for planning, information exchange and joint problem solving on health issues of local interest are needed and are currently initiated by several agencies. Similar attention is also given to ward-level issues. The essential task, at present, is to increase awareness of consumers' preferences and interest regarding health needs and priorities, and then, to foster an exchange of issues between consumers and providers of urban health services.

The examination of urban primary health care needs should ideally be complemented with a review of policies and structural analyses of service delivery. The ordinances of corporations and municipalities give a sense of systems and regulations that currently substitute for policy and legislative framework for urban services delivery in Bangladesh.

The Paurashava (municipality) Ordinance was institutionalized by the Government in 1977. Alongwith the 1983 ordinance of Dhaka City Corporation (DCC), these specify the responsibilities and areas of authority for basic service provision within the jurisdiction of the municipality. The ordinances feature administrative functions and areas of responsibility for the Dhaka City Corporation and the municipalities. The Paurashava and city corporation's functions encompass areas of public health, water supply and drainage, management of articles of food and drink, among other aspects of urban living such as town/ development planning, building control, public safety, etc.

2.2.1 Public Health Responsibilities of the City Corporations and the Paurashavas

The public health functions include ensuring city sanitation, providing and maintaining public facilities for bathing and latrines. The authorities have the responsibility to register all births, deaths and marriages within city limits. The ordinances further state that the DCC and the Paurashava administration should implement measures to prevent infectious diseases and to restrain infection within the city as "the rules and by-laws may provide." Thus, the document describes that the corporation and the municipal system should establish and maintain one or more hospitals for management of infectious diseases and that it may frame and implement programmes for prevention and control of infectious diseases.

The ordinances also hold the city/municipal administration to be responsible for managing and maintaining health centres, maternity centres, centres for the "welfare of women, infants and children," providing training for

dais, providing promotion of family planning and implementing other measures that promote health and welfare of women, infants and children. Other assigned activities include health education and public health promotion and establishing and maintaining hospitals and dispensaries in accordance with prescribed scale and standards.

The last part of the public health functions relates to the following areas:

- i) provision and maintenance of first aid centres
- ii) provision and maintenance of mobile medical aid units
- iii) promotion and encouragement of societies for the provision of medical aid
- iv) promotion of medical education
- v) payment of grants to institutions for medical relief, and
- vi) inspection of health status of school children.

2.2.2 Water Supply and Drainage Responsibilities of the City Corporations and the Paurashavas

The primary responsibilities of the City Corporations and the Paurashavas to providing safe water supply for "public and private purposes" were prescribed together with collecting payments for piped water supply. There is further mention of control, regulation and inspection of private sources of water supply to ensure safety standards, with particular reference towards drinking water sources. WASA (Water and Sanitation Authority) produces the supply of water that is distributed by the authorities among the urban population.

The ordinances also include constructing and maintaining "an adequate system" of public drains. Other issues include the provision of bathing and washing places and *dhobi ghats* (laundry facilities).

Many of the responsibilities of the city corporations and paurashavas are neither performed by them nor do they currently have the capacity to bear the brunt of delivering services for a rapidly expanding urban population. As

many of these services are currently provided by non-governmental organizations (NGOs) and the private sector, the role of the Government may be most useful in establishing standards, and coordinating between different providers and the community to ensure quality and equity through effective distribution of resources.

2.3 The Methodology: The Use of Rapid Appraisal in Urban Health Planning

Rapid appraisal in the urban areas is a hybrid of original approaches first used in the 1970s for agricultural development, such as Rapid Rural Appraisal (RRA), Participatory Rural Appraisal (PRA) (Chambers, 1980, 1983), and in later times, the Rapid Assessment Procedure (RAP) initially used for nutritional programmes (Scrimshaw et al., 1987). Since then, the original methodology has been retooled for data collection in urban poor settings, by the Urban Health Programme of the World Health Organization (WHO, 1988). This particular methodology was adapted and tested in Mbeya, Tanzania in 1992 (Rifkin, 1992). The basic concepts relate to the following issues:

- i) collecting information rapidly, concentrating only on relevant and necessary information
- ii) the use of multiple sources of information, i.e. documents, key informants and observations
- iii) adopting a multidisciplinary approach towards problem analyses
- iv) extending data collection towards a process on which a plan of action can be formulated to improve living conditions of people, through their participation.

Thus, a series of activities took place, in which problems were identified first, and further analyzed by order of priority. Then, the choice of solutions based on health benefits, community capacity, sustainability, equity, cost and time frame were explored. Finally, recommendations were given for a plan of action and responsible people were specified (Rifkin et al. ,1992).

Other experiences with this methodology included the information gathering for a pilot project on slum improvements in Bangladesh with assistance from WHO. These exercises prompted recommendations by development agencies to undertake RAs for problem identification and solutions for urban health programmes in South and South East Asia.

Applications with rapid appraisal techniques in urban areas are also noted in the United Kingdom, stemming from the reorganization of the Regional Health Authorities in the early 1990s.

B N Ong in South Sefton documented the experiences with using rapid appraisal to gauge the health needs of an urban poor community through key informant interviews and observations by a team comprising local health and social service personnel, including administrators, practitioners and researchers. The study reported significant differences of priorities between community members and health providers, which facilitated providers to gain a better understanding of the community's perceptions and needs.

Murray et al. (1994, 1995) used rapid appraisal in defining health and social needs of the community in Edinburgh, through record and document reviews, interviews and focus group discussion with a range of informants, and direct observations. The appraisal revealed that there was little community cohesion, with stress and ill health from unemployment, poor diet, smoking, drug use and isolation, and difficulties faced in contacting the local general practitioner. Health facilities were unevenly utilized; some were hardly used, and others were overloaded. The need for information on coping with stress, medication, smoking was revealed, and providers learned that there was a higher percentage of elderly people in the community which necessitated special efforts designed to address their problems. The appraisal permitted a process where providers gained awareness of consumers' perspectives, and the community members could participate in identifying problems and solutions.

Thus, the present study is actually the first stage in applying the whole range of techniques in rapid appraisal methodology to examine the health needs of the urban population in Dhaka, which may further lead to more in-depth analyses and re-examinations that may fully describe urban health problems and indicate relevant interventions.

3. Design and Methodology of the Present Study

The study was an assessment of urban health needs in Dhaka City, and the sample included four out of ten zones of the DCC areas selected randomly, with further sampling of two wards from each zone. (Approximately, one zone comprises nine wards on average.) The data collection took place between May-June 1995. A number of key informant interviews were held with men and women residing in slum and non-slum areas of Dhaka, to elicit their own views and perspectives regarding problems of urban life, and to examine their access to, and utilization of primary health care services.

Thus, 32 key informant interviews were held with men and women residing and working in the selected wards of Zones 2, 4, 6 and 8, to obtain information regarding basic needs and current problems encountered through urban living. The sample size of ward commissioners interviewed were twelve, i.e. eight men elected to the post, and four women who were appointed to fulfill the development goal of women's participation in political progress. The type of health and family planning service providers refers to those who are based at ward and neighbourhood level, i.e. who are directly - and constantly - in contact with community members. Eight NGO providers (four doctors and four auxiliary personnel), four government providers (one doctor, one FWV, one FWA, and one vaccinator), and four private doctors, from pharmacies and local practice chambers were interviewed. The entire range of interviews numbered sixty, and the information gained from the appraisal is summarized in the following sections. (See Annex A for detailed information on the design and methodology of the study, and Annex B for the study instruments).

As the main purpose is to discern the views and opinions of urban dwellers, the study does not include all the different methodologies of rapid assessment, such as observations and the review of service records. The data gathering is also confined initially to key informant interviews to obtain an overview of problems and therefore, does neither include stages of prioritization, nor the development of solutions.

4. Findings

The findings are organized to highlight first, the identification of basic needs by urban residents. Later sections present utilization and willingness to pay for those basic needs, health beliefs, illness profile, and coping mechanisms for illness and reproductive health. Information in italics concern individual experiences that may not be considered generalizable, but could nevertheless be either exemplary or characteristic of a general trend, or could follow a trend to an extreme.

4.1 Identification of Basic Needs, Current Priorities and Problems in Dhaka

The first part of the interviews concerned an open, unprompted session for key informants to identify their own priorities and needs for health and daily living. This was followed by more specific inquiry on specific health-related issues.

4.1.1 Consumer-specified Basic Needs

Most men and women, in both slum and non-slum areas consider money as the most important item necessary for daily existence and survival. Money is essential in facilitating access to water, shelter, food, clothing, a clean environment and medical care for common ailments, items identified as basic needs by urban dwellers. The same items were also specified by ward commissioners and health service providers. Slum residents exist in poverty; their economic base is minimal and unstable, reflected in their limited access

to a number of basic items, such as adequate nutrition, clothing, water and sanitation services, adequate shelter, and health services.

One slum man said, "I need money to solve all my problems. We need food for survival, then clothes and housing. My children need to be educated to grow up as proper human beings. We need water urgently. For all these things, I need money, as only money can get me all that I need."

One slum woman said, "Food, clothes and shelter are priorities. We always need water, no one can survive without it."

Irregular supply of electricity is another problem faced in urban areas, with reduction in productivity of some businesses, and lack of water due to inability to use water pumps (in non-slum areas). Urban residents seemed concerned for personal safety, especially for women, when they venture outside home settings, and expressed the need to improve law and order in the city. There is a certain amount of apprehension, insecurity that crime increases with electricity failure. Violence, hijacking, etc, by thieves and mastans tend to occur more during these episodes, and also in areas without street lights. Other problems include the inability of fire service vehicles to enter slum areas during emergencies.

Other problems faced by urban dwellers include traffic jams, and road conditions in areas without road paths, where it becomes almost impossible to walk safely in the city. Residents stated the need for the Government to repair roads and maintain traffic rules and responsibilities.

Urban dwellers indicated the inconvenience of having to go far in times of severe illness, when hospital care is desired. An additional need specified was that some efforts should also be taken towards ensuring adequate schools for children in the neighbourhood. Details concerning specific health-related issues are presented in the following sections.

4.2 Environmental Conditions in the Urban Areas

4.2.1 Water Supply

There is an urgent need for regular and sufficient water supply in the city. Slum residents experience bathing and washing problems, due to insufficient water supply and the lack of bathing facilities. They report of having to use river and pond water for household use.

One slum woman said, "The people in this neighbourhood are facing serious problems with water. There is no regular supply of water, except at night, and then, there is no supply throughout the day. We have to collect water at night, and that is not sufficient for daily household use."

There was a considerable number of complaints regarding the quality of tap water supply. Residents spoke of "dirty tap water with a bad smell" as often the only source available from communal water sources. Ward commissioners feel that slum people do not always have access to drinking water supply sources, and the quality of drinking water is not satisfactory, due to proximity with sewerage lines.

Slum residents have an additional problem, indirectly related to water shortage, that concerns the lack of bathing facilities. Most slum dwellers bathe in rivers and ponds, and some complain of the inconvenience and the lack of privacy in such places.

One slum woman shared her experience. She said, "There is a water supply source down the road, and we collect water there. All the women in this area have to bathe in the river. There are no bathrooms nor water taps near our houses. We get pushed by men when we bathe in the river. However, this is essential; we can skip meals or eat only vegetables to save money, but we need bathrooms, rich and poor alike."

One slum man complained, "We do not get sufficient water, the supply stops in the morning but comes again at 2:00 pm. Some days, there is no water supply at all. One day, we, both husband and wife, went to bathe at the water pump located at the Jahural Islam project compound, but the guard closed the gate. I bathed with some dirty water near the road, but my wife did not. There is only one bathroom for 25-26 families. We need more bathrooms, men can bathe out in the open, but women need covered area. The landlord should provide bathrooms. "

People are currently paying for water supply, through water bills (in non-slum areas) and through house rent in the slums. Normally, urban residents do not pay for water separately; usually payment is done by the landlord and respondents were not able to specify the amount. *One resident in squatter areas on government property reported having to pay "tips" around Tk. 5 -10 every month to prevent government authorities from cutting the water supply.* The present rate of payment for water is Tk.1.00 per pitcher, with a daily estimated use of 5 pitchers, at a monthly rate of Tk. 150 for most slum residents. This situation occurs mostly in "unauthorized" slums, i.e. illegal squatters on government-owned land, with no particular landlord to take responsibility for water supply and sanitation needs of the residents. In such cases, the dwellers buy water, especially drinking water from other sources. Generally, people did convey a sense of willingness to pay for water, and that they would pay even more if latrines and bathrooms be included. The amount that slum dwellers were willing to pay for water ranged from Tk. 5-20 to Tk. 100-300 per month.

The Water and Sewerage Authority (WASA), the City Corporation and the Government are considered the main agencies that had the capacity to solve the "water crisis". Residents specified that ward commissioners should take the responsibility in informing higher authorities to rectify the situation. The commissioners in turn, discussed that financial aid from NGOs and donors would be needed as the DCC has budgetary limitations.

Slum residents stated that landlords and other rich people in the neighbourhood can, and should provide water supply lines, pumps and tanks for better water supply provision. Ward commissioners also supported that there is need for tubewells, and water pumps in most urban areas, especially in the slums. They had the opinion that slum residents may not be able to pay for water, but that non-slum people should pay water bills. The range of payments possible were specified around Tk. 150 per family per month, with special rates at Tk. 10 - 20, 30 - 60 for the poor.

4.2.2 Sanitation Services

There is inadequate garbage disposal and good latrine systems in the urban areas. People in the slums complain of long queues to obtain water and to use common latrines, shared often among 50-60 families. Sometimes, the only type of communal latrine available is the open, hanging type.

"There are only two latrines for 500 people. If we stand in line in early morning, then we can get our turn at 8:00 am. No one is allowed to break the queue. It does not matter if someone cannot control their urge, even if they spoil their clothes."

In some areas, there is a lack of proper drainage system blocked by excreta and garbage. Urban residents discussed both the lack of dustbins, and the lack of proper use of dustbins by some community members who throw garbage haphazardly and not in proper sites. Smaller streets are often blocked with garbage piles, that are never cleared at regular schedules, causing constant bad odour in the neighbourhood. Ward commissioners informed that there is no regular time for garbage collection, and no proper system for disposal. Garbage is often thrown in the ditches in the slums, which leads to drainage problems. In some places, children defecate in the drains. There is also no proper sewerage system in most areas, which cause flooding during the rainy season.

"The condition of latrines is worst. Human excreta passes through open drains. The drains flow right in front of our house."

"If it rains for four to five days, then the latrine gets clogged up, making it difficult to use. The rain water also enters our rooms. At such times, I go to my mother's house nearby."

There seems to be a common belief that "bad smell" from unsanitary latrines causes diseases. Also, that "contamination" from the unhygienic environment results in illness. A lot of respondents stated that indiscriminate disposal of garbage, solid waste and open latrines cause flies and mosquitos to spread diseases, such as diarrhoea and dysentery in the community.

"People throw garbage everywhere and this affects the health of our family. Dogs, cats, crows and rats stir the garbage and solid waste. Flies sit on any food item that is left in the open. How can one maintain hygiene in such settings? My baby has got diarrhoea. Yesterday, my baby had five episodes of loose motion and today he had three."

At present, there is no consistent system of payment for garbage disposal, drainage and sewerage systems by urban residents (both slum and non-slum), except, for those who are paying municipal taxes. There seem to be a willingness to pay for these services, should there be charges for everyone in the community. Slum residents reported having to pay Tk. 20 per month to get their latrines cleaned.

One slum man said, "Some people pay one taka each time to use latrines owned by others. The price for urinating is 50 paisa."

Informants stated that community members should be made aware of, and be motivated to use dustbins properly, and that the DCC should clean

garbage and drains regularly. Women, both from slums and non-slum areas, proposed that residents can also contribute financially for sanitation activities, especially for garbage disposal and latrine construction. Slum dwellers proposed household-level financial contribution towards building bathrooms. Respondents clearly stated that all community members have a responsibility to maintain cleanliness of latrines and dustbins.

Private health service providers conveyed that certain communities, such as the Geneva camp residents, will never pay for basic services. NGO service providers offered to provide slabs for latrines, and to motivate local leaders and slumlords on environmental issues.

In general, health service providers in the City indicated that a system needs to be developed by the Government, DCC or NGOs to address community infrastructural problems, which also requires awareness of, and participation by community members. It was felt that financial contribution by urban residents can be made for water supply and sanitation.

Urban residents spoke of the need for other sanitation services, such as mosquito control. It seems that spraying for mosquito control does occur in Dhaka City. However, spraying is usually done only at roadside locations, but not inside the homes. *Some reported having to pay "tips" to get the workers to spray inside the house.* Slum residents felt that spraying measures did not really reduce the number of mosquitoes in the community. There is willingness to pay for mosquito control, but only on a systematic basis where charges are uniform and shared throughout the community.

Ward commissioners reported having participated in mosquito control programmes, ensuring regular spraying, cleaning water hyacinth, cleaning ditches and breeding small "gapti" fishes to kill larvae. In general, most ward commissioners were quite knowledgeable about the types of larvicides and pesticides used for mosquito control, including the types of machinery required for spraying.

4.2.3 Other Environmental Issues

Other forms of pollution such as noise and air quality were discussed. Residents living close to the river such as in Shadarghat, complained of disturbance and inability for children to study and difficulty to sleep at night from ships' horns. Others complained of noise from trains. However, noise pollution was not observed as a crucial problem that affects too many people in an adverse way, and a lot of people spoke of having become quite used to it. Air pollution was also not specified strongly, and people complained more of "bad smell" from garbage and drains, than from smog and smoke. However, male respondents did report negatively about "black smoky air" from the traffic. *One slum resident discussed the experience of smoke pollution from burners (wood-burning "chulas") in the neighbourhood, which were perceived to be causing respiratory problems.*

Ward commissioners spoke of smoky air quality in most urban areas, due to factories, transport, tanneries, cooking with firewood, etc. They also report that people complain of "bad smells" from drains, open latrines, overflowing sewerage lines, open septic tanks, garbage dumps, etc. The commissioners discussed the need to reduce air pollution in the city, or relocate people from places where pollution is quite serious, such as in Geneva Camp.

Overall, the types of urban environmental pollution specified by ward commissioners include: smog and smoke; sanitation problems related to garbage; sewerage and latrines; ditches and drains clogged up with water hyacinth; dirty water and garbage; and the lack of septic tanks in the community. Generally, ward commissioners feel that the poor and slum dwellers do not have the capacity to pay for basic services, but that other people may be mobilized to provide labour, etc, aside from paying required taxes. Most commissioners seem unaware that people pay for basic services except through municipal taxes. They did indicate that community members have the capacity to invest in medical care, drains, latrines, water supply either by giving land, labour or money.

In summary, study findings imply that the urban population can give financial contribution for community development activities such as ensuring water supply, garbage disposal, and for building latrines. The amount of contribution might vary according to affordability, but there would also be some people who can at least contribute labour towards these efforts.

4.3. Health Needs, Illness Profile and Coping Mechanisms for Ill Health

4.3.1 Health Needs

Food, housing, water and a clean environment are the basic items considered necessary for maintenance of good health by most urban residents. The majority of respondents stated that children and mothers are the most important target group for health care and resources - children, because they are vulnerable, and represent the future, and mothers, because they are the caretakers of children and the rest of the family.

Women in both slum and non-slum neighbourhoods discussed the need to ensure good food and nutrition for those that are pregnant and breastfeeding, as these conditions require extra energy. There seem to be a common belief that if the mother is healthy, the child would also be healthy. Some respondents - both men and women - indicated that husbands should get priority for household health resource allocation, being the main earners of the family.

One slum woman reported, "I think my husband's health is important because he has to earn for the whole family. If he is sick and unable to work, then we have no other means to support ourselves. Men need better health care than women."

One slum man said, "I do manual work so I need more food. I work hard under the sun and I need strength. If I have good health, I can work for my family; but if I am not well, then I won't be able to work."

Slum residents specified the elderly as being vulnerable to disease and illness, and needing special attention for health care. Ward commissioners named women and children, especially pregnant women, as being priority groups for health services and programmes, and that the elderly also require special attention.

The most important types of health services necessary for maintenance of household health were identified as treatment for minor illnesses, followed by immunization. Interestingly, male respondents indicated the importance of family planning services. According to ward commissioners, the most essentially needed health services in the community are: medical care, immunization, antenatal care, Vitamin A distribution programmes, treatment for scabies and family planning services. Service providers also indicated other problems, such as lack of accessibility to ambulance services. Overall, health education, proper and inexpensive treatment services and community-based field worker systems were indicated as being necessary to ensure equitable health care.

4.3.2 Illness Profile

Diarrhoea was identified as the most prevalent illness in the urban areas, followed by "fever", "colds" and "cough". Other than that, people spoke about the occurrence of measles, chicken pox, worm infections, jaundice, dysentery and scabies. Children were identified as being the most frequently afflicted ones with these problems. These issues were confirmed by ward commissioners and service providers, who also spoke of the prevalence of malnutrition, hepatitis, tuberculosis and pneumonia among the urban poor.

Diabetes, hypertension and heart disease were named additionally, which indicates a certain amount of awareness - and could also imply occurrence - of chronic disorders more reflective of lifestyle and stress. The target groups for these conditions were identified to be in the 30 - 40 years age group. Some respondents indicated that urban adults suffer from rheumatism, asthma and peptic ulcers.

4.3.3 Health Service Utilization and Expenditures

Non-slum people usually obtain medical care from private doctors. Slum women indicated the preference and practice of going to private doctors or government dispensaries, and men usually go to pharmacies, during illness. Other sources of health care are Dhaka Medical College Hospital, Shishu Hospital, Radda Barnen, Mitford Hospital and private doctors. Ward commissioners said that some people would not actively seek care outside for minor illnesses and injuries, which would more or less be treated at home with available medicine or remedies.

Most urban residents, both slum and non-slum, named Dhaka Medical College Hospital, Mitford Hospital, the ICDDR,B Hospital and the Institute of Post-graduate Medical Research (IPGMR) Hospital as places most commonly contacted during times of serious illnesses. Women spoke of private doctors as the alternative. Some slum residents prefer the Kabiraj (traditional healer) as a source of care for major illnesses, and sometimes for other needs.

One slum woman reported, "After the birth of the next child, I have not conceived for the next four years. I took a tabiz (talisman), and spent Tk.500 for medicine from kobiraj (quack doctor). After that, I became pregnant with the second child."

Generally, people were unable to say, offhand, how much they would be willing to spend to treat a serious condition. This implies a certain amount of unpreparedness for medical catastrophes, and probably relates to uncertainties of prices, and values relative to type of illness, severity and familial position of the ill person.

Non-slum residents complained that private doctors prescribe too much medicine, which could be potentially harmful for children. They also stated that treatment is usually very expensive, and not always of good quality. There is a general perception that private doctors prioritize profit over providing appropriate care. Non-slum informants further indicated that the

quality of treatment at some public centres such as Dhaka Medical College Hospital is good. Generally, all urban residents interviewed complained that the waiting period at public centres was too long. Insufficient medicine and having to bear the extra cost of buying medicines elsewhere than at the treatment facility add to the main reasons of dissatisfaction and inconvenience of getting medical treatment at the public centres. Slum men stated that treatment and medicine provided at the local pharmacies are good and that free medical care would be welcome.

One slum woman indicated, "My child is sick, and I took him to Dhaka Medical. But there was a long line of what seemed to be a thousand people. The rich usually come with references from the staff, they never stay in the queue and are always treated with preference; but the poor have to stand in line. It is also very difficult to get medicines there."

Ward commissioners indicated the absence of facilities equipped to handle serious health problems in the community, except for Dhaka Medical, the PG hospital, ICDDR,B Hospital, Surhwaddy Hospital and private clinics. Most ward commissioners reflected that the quality of medical services at most providers is generally poor, and that the Government should exercise some regulatory mechanisms in issuing licenses to service providers. They stated that the quality of services is good at Radda Barnen, Mitford, Dhaka Medical College Hospital and the National Hospital, but that no equivalent facilities exist at the ward level.

Most slum residents spend anywhere from Tk. 10 to 100 for acute, minor illness episodes, which sometimes amount to Tk. 200 - 400 per month. Key informants perceive that urban dwellers spend about Tk. 200-300 on medical care costs for an illness episode, a rate which is unaffordable for the poor and for slum residents. Respondents indicated a willingness to pay around Tk. 50 - 150 per month for minor treatment. Free services at public centres also do not exclude paying for medicines, or "baksheesh" for services, which ultimately ends up being quite expensive for poor people. Slum dwellers reported

having gone through financial difficulties in times of illness, being unable to work and discussed that free medical treatment for the poor is preferable. *Some people in the slums have had to pay for medical treatment by taking loans.*

One slum woman said, "I had to borrow a lot of money for treatment for my illness. It would be difficult for me to pay the loan off. I have no savings, and my husband is disabled; he has no legs. He sells paan (betel leaf), cannot walk nor do any hard work. It is difficult even for a healthy man to survive these days."

There was discussion on the potential to create a fund for medical treatment among people in the neighbourhood, which was positively viewed by urban residents. They indicated that commissioners, as community leaders, should take an active role in mobilizing the community to set up such financing mechanisms.

They also named imams, headmasters of primary schools, senior respected members of the communities as other informal leaders that can contribute financially - or otherwise - towards community mobilization efforts.

Health service providers were dubious whether there is enough interest and willingness among the community members to create such systems and mobilize resources. Different views of providers from various sectors were noted. The NGO service providers, in general, seemed to have more positive thoughts. They acknowledged that community participation is necessary and people need to be motivated to invest in such ventures. Some suggested young adults in the neighbourhood, others suggested local leaders such as social workers, imams and ward commissioners be the focal persons for such activities. NGO service personnel shared the progress of their own efforts in group formation activities, orientation and setting up revolving funds for developmental activities, and discussed the considerable time and effort that was invested to reach to this stage. There were also speculation that proper monitoring and supervision are necessary for effective implementation.

Government service providers discussed the need to have a local leader/commissioner take charge, and other providers discussed the option of having community members take responsibility to collect money or donations which would help set up drug revolving funds for the urban poor in times of illness. Private providers interviewed felt that people should be prepared financially for illness, and a community welfare organization should take responsibility to establish such systems.

There were mixed responses among the commissioners towards setting up a drug revolving fund. Some ward commissioners state that giving money towards such systems would be difficult for the lower income groups, and that it would not be easy to mobilize funds in the community. Others said that it would be possible to collect monthly payments of Tk. 10 each in the community and to set up the scheme that enables members to obtain health services, medicines, etc.

Ward commissioners acknowledged the importance of having some kind of prepayment mechanisms that financially prepare people for times of illness, especially for the urban poor. Some were dubious as to whether the poor can actually afford to pay the initial investments for establishing the system. *One commissioner recalled having taken the initiative to develop such a fund, that later decapitalized when people stopped the payments.* Additionally, the respondent commissioners indicated the possibility of forming ward-level health committees. They discussed that such committees would be the venue to generate suggestions to improve health services in the community, and can also be used for mobilizing money, labour and ideas. *One commissioner suggested that the community be motivated for these developmental efforts through a documentary film, which could potentially be made by an NGO.*

In general, the notion was regarded as important, but with uncertain outcome, as to whether financial contribution could be shared equally among everyone in the community. There was also an element of mistrust towards government officials and ward commissioners among urban dwellers.

Respondents insist that the local government and elected leaders should take initiative in resource mobilization, but had doubts regarding their capacity to achieve practical results.

"The ministers promise a lot. They say they will do this and that for the people. But, in fact, they do nothing."

4.3.4 Preventive Care, Immunization and Child Health

Most urban residents obtain immunization services from government-run centres, and NGO centres such as Nari Moitree and Radda Barnen. Mitford Hospital and community EPI centres were also named as sources of EPI services by non-slum respondents. Slum residents in the old part of Dhaka City reported obtaining immunization services at Sumona Clinic, a private facility that houses a DCC EPI centre. Non-slum respondents also reported obtaining EPI services at other private clinics. The combined location of private curative care centres with public preventive services present ample scope for innovative ways of developing referral networks and delivering an integrated urban basic services package.

Most people receive free services, but reported having to pay either for card purchase, or for "tips". Some stated that the vaccine was free, but charges were taken for the service. *One slum respondent spoke of having to pay Tk. 10 "baksheesh for paan" to the vaccinator.* Overall, payment for EPI ranged from Tk. 2 - 10.

Well-baby check-ups are usually done through home visits by health workers from NGOs that provide a broad range of services, at no cost. Few people in the urban areas have had some form of check-up for their babies. Among those who did, most babies were seen at home. Others were taken to NGO clinics for weighing and examination, after the mothers were motivated and persuaded by health workers during home visits. These services are free except for card fees. The situation implies that people are less proactive toward obtaining regular well-baby check-ups, unlike EPI

services, indicating the need to consider integrating services and combining service delivery points. This would also enhance the availability of well-baby services.

4.4 Attitudes, Choices and Preferences for Reproductive Health Care

The key informant interviews devoted considerable attention toward access and utilization of reproductive health care services among the urban population. Both men and women were interviewed on different aspects of delivery care, family planning and measures taken for unwanted pregnancies. The discussions revealed the following issues:

4.4.1 Antenatal Care, Delivery, Postnatal Care

Routine antenatal (AN) care was not considered a priority among most women, who indicated going for check-ups only if there is a problem during pregnancy. However, some women do obtain AN care services, but chose the least expensive options for doing so. Slum women who obtained antenatal care, did so from places like Nari Moitree clinics that provide free services. Slum men stated that it was not possible for the poor to spend money on routine "check-ups", but non-slum men expressed the willingness to invest in antenatal check-ups for their wives.

Service providers had the opinion that women should pay for routine antenatal check-ups. There is a general feeling that AN care would not be valued, and not given due importance when it is provided free of cost. Some providers stated that only those who are capable of paying should be charged fees, and others had the opinion that everyone should pay at least a small amount of money, and that there should be some partial payment systems to enable those who cannot pay to get proper care.

Government providers discussed that there should be sufficient health education, counselling and motivation to women on breast feeding, immunization, diarrhoea and family planning during the antenatal period.

There were different attitudes among ward commissioners toward payment for regular antenatal check-ups. Most commissioners implied that everyone, except the poor, should pay for AN care. They proposed that AN care be free for the poor, and that awareness be created through the media, e.g., radio and TV programmes.

Most women - both slum and non-slum - prefer delivering their babies at home. Dais are commonly used for childbirth and delivery by most urban women, in both slum and other areas. Non-slum residents tend to choose professional practitioners such as nurses and doctors for delivery, but slum dwellers often deliver with the help of relatives (mothers, aunts, sisters, mothers or grandmothers-in-law). Women (both slum and non-slum) often return to their village homes for deliveries, and a few deliver at Dhaka Medical College Hospital, Mitford and the Institute of Post-graduate Medical Research Hospitals. Generally, urban women are quite satisfied with being delivered by dais and relatives. Women from the non-slum areas complained of adverse staff behaviour, lack of space and unclean surroundings at Dhaka Medical College Hospital.

"All my children were born at home with dais. I did not go to any doctor. Why should I go to a doctor? They do not care for the poor. Staff in hospitals do not treat poor people well. Their services are not satisfactory, no one can feel satisfied after being insulted ."

Overall, urban women - and men - indicated that, in future, they would prefer to continue delivering their babies at home.

Service providers agree that deliveries occur commonly at home with dais, and some state that educated clients prefer to deliver at private clinics or government hospitals such as Dhaka Medical College Hospital, Surrawadhy Hospital, Holy Family Hospital and Azimpur Maternity Centre. NGO providers stated the occurrence of home deliveries with TBAs trained by Concern (Bangladesh), Nari Moitree, etc. Ward commissioners also

acknowledged that most deliveries are conducted at home and not always in safe conditions. They further stated that delivery costs, especially at the hospitals and clinics; are too expensive for the urban poor, which is probably why most people choose to deliver at home.

People usually spend Tk. 150 - 300 for either a sari, or some food, or as cash payment for a delivery. *One slum respondent spoke of paying a total of Tk.700, i.e. Tk.500 in cash payment and Tk.200 for a sari to the dai. Another slum woman revealed having spent Tk. 4000 - 5000 for a complicated delivery at the PG hospital, mostly for transport and medicine. Most people do not wish to spend more than Tk. 500 for delivery.*

Providers indicated that payment for dai services range from 100 - 200 Tk. and that people pay 400 - 500 Tk. for hospital deliveries, at rates quite expensive for the poor. They further implied that the quality of delivery services is good at the hospitals and clinics, but expensive for slum and urban poor residents, especially at private clinics. NGO providers feel that the quality of trained TBA services is quite good, and is affordable for most people. Government providers state that delivery care at public maternity centres is good, and recommends that it should be free for slum women, and that dais are unable to provide emergency obstetric care. They feel that there should be oxygen ready to resuscitate the baby, medicine to control post-delivery haemorrhage, and the capability to suture vaginal tears if necessary. They claim that few complications occur when delivery is conducted by trained professionals, which is indicative of good quality services.

Urban dwellers feel that the quality of postnatal care at the NGO clinics is quite good, but that coverage is low, and that there are sociocultural barriers - mostly from the mother-in-law and husband - that forbid the women to go outside the home setting after delivery. They implied that, in the absence of field worker services for postnatal care in some urban areas, most women do not get access to postnatal services.

Urban women report "weakness", "anaemia" and "lack of energy" after delivery, and having to obtain treatment at high costs for these problems. One woman experienced pain in lower abdomen, went to a private doctor who gave her an injection and some oral medicine (capsules), and paid Tk.700 for the services. Another had a similar problem, and was given capsules and ointment by a private doctor, which cost almost Tk. 2000. One woman had jaundice after delivery, and both mother and baby were treated at Shishu hospital, where they paid Tk. 500 for room rent alone for 7 days. Another reported getting treatment for weakness and lethargy from the "doctor" in the village, which cost Tk. 2000 and one other revealed paying almost Tk.3000 for both blood tests and medicine for the same complaints. Others reported paying Tk. 40 - 50 for allopathic treatment for stomach pain, and Tk. 40 at the "Sadona Oushadhalaya", a herbal medicine clinic for treatment to produce breast milk. Most women from low-income households report going to Nari Moitree and Radda Barnen clinics for post-partum care that was free of charge, but mostly for "minor" problems.

Men also substantiated these facts, reported having paid anywhere from Tk. 350 to Tk. 3,500 for post-partum problems of their wives. (*The higher limit was quoted by the husband of a woman who had undergone a Caesarian and had problems at the suture site.*) Some respondents - both slum and non-slum - reported having spent almost 2,000 Tk. on treatment expenses for post-delivery "weakness."

A few respondents stated of being willing to pay up to 500 Tk. for post-partum services. However, most were unclear of how much they would be willing to spend, not being able to predict what future needs there would be for post-natal period.

In general, health service providers advocate regular post-partum check-ups, that include treatment of iron deficiency anaemia for the mother, measuring height, weight and health status of the baby, and providing sufficient information on breast feeding, immunization, diarrhoea and family planning during both the antenatal and postnatal periods. They acknowledged

the importance of post-natal care, but discussed the need to increase community-based personnel that can provide door-to-door delivery of postnatal care.

According to the interviewed commissioners, postnatal care is necessary for women after delivery, and there are some places, such as Radda Barnen, which provide treatment at low cost for these purposes. They stressed the need for women field workers to create awareness of postnatal care in the community, and to have effective medical facilities to provide services. Ward commissioners also articulated that the health service providers conduct home visits to examine the mother and baby, as they are unable to go outside during the postpartum period.

4.4.2 Unwanted Pregnancies, Abortions, MRs

With increasing reports of abortions and menstrual regulation service utilization in recent years, the next task was to discern the attitudes and experiences of the urban population regarding unwanted pregnancies. A number of residents in both slum and non-slum areas report having sought MR / induced abortion services in the past. *One woman was persuaded by the doctor to keep the baby. Another went to a "doctor," took the prescribed "medicine," which did not really abort the pregnancy, and the woman also ended up keeping the baby. Two women - from the slums - actually aborted their pregnancies, one at Mohammadpur Fertility Centre, and the other at Mitford Hospital. Anecdotal evidence from another parallel study also reports of a slum woman who ended up keeping the baby because she was not able to afford the stated price of abortion services (Thwin, Baqui, Reinke, 1996).*

Men also discussed having sought abortion services for their wives. One man from the non-slum areas recounted his wife's abortion with a private doctor at two months gestational period. Another spoke of trying first to find ways to terminate his wife's pregnancy, but finally kept it, because of "religious" reasons. One man - from the slums - revealed going to Mohammadpur Fertility Centre where they were rejected for MR because the

pregnancy progressed past the required time limit. Another spoke of going to Mitford, where they were persuaded by the doctor to keep the baby and avoid the adverse effects of the abortion process. One other man, also from the slums, professed wanting to have his wife abort the baby, but was persuaded otherwise by his wife, and they ended up keeping the baby.

There were mixed views of whether abortion services are necessary. Most urban women (and men) felt that abortions are needed for those who either have too many children already, or for those who have frequent pregnancies, i.e. if the pregnancy interval is very short and the youngest child is too small. Some felt that abortions have serious health consequences, are prohibited for religious reasons, and is best prevented by means of protection against getting pregnant.

One slum woman said, "I became pregnant when my daughter was one and a half months old. Someone suggested that I go to Mitford for MR. I had no other alternative. The baby came unwanted, an accident. After washing it, I chose to have the coil (IUD)."

Slum respondents indicated that they are willing to pay anywhere from Tk. 100 - 500 for an abortion, and non-slum respondents gave a higher limit of up to Tk. 600. Men (non-slum) stated that free MR and abortion services should be provided by the Government.

All service providers interviewed discussed that unwanted pregnancies are quite common among the urban population. The majority stated that good quality MR services should be available, and that service delivery at public centres should be free of charge. Some indicated that the quality of services is good at the Family Planning Services Training Centre (FPSTC) and Mohammadpur Fertility Centre, and that there should be more facilities like these. Others considered MR as a family planning method, and discussed the need to increase the number of family planning clinics where these services could be provided by doctors or nurses. Some providers recommended

improving family planning services to stem the magnitude of MRs and abortions.

Ward commissioners spoke of the occurrence of unwanted pregnancies, and the need to have good quality MR and abortion services in the community. They specified that the quality of abortion services at private clinics is not good, and that it is important to have health centres that can provide effective services to prevent death and accidents through unsafe abortions.

The responses of service providers were divided on the issue of charging prices for MR. Some respondents, from private, government and NGO sectors felt that MR and legal abortion services should be provided free of charge, and some stated that there should be charges depending on the capability to pay. Some providers feel that attaching prices would deter some clients and cause the number of abortions to decrease. Some surmise that abortion prices should range from Tk. 50 (for the poor) to Tk. 100 - 200 on the average. Others said that, at present, people are paying Tk. 250 - 400, with variation from clinic to clinic.

Commissioners speculate that people can pay Tk. 100 - 200 for a safe abortion, maybe up to a maximum of 500 Tk., among those who are better off. Payments according to affordability was also discussed, where most respondents thought that the poor should be charged according to their ability to pay.

4.4.3 Family Planning Services

a. Utilization, Payments and Satisfaction

The practice of contraception is less common among slum residents than in non-slum residents. Male method use is more evident in the non-slum areas; in fact, pills and condoms were identified as the most popular form of contraception in these areas, whereas, slum dwellers use mostly pills and injectables.

The majority of respondents specified obtaining contraceptives from shops, pharmacies and the market. Others mentioned Mitford Hospital, field workers, Nari Moitree workers, Radda Barnen and government FP centres as sources of contraceptive supply.

Non-slum women and men preferred having field workers come regularly to the house and some disliked the notion of having home visits reduced. Most urban dwellers are satisfied with NGOs' family planning services and some feel that contraceptives and permanent method services should be free for the poor. Slum residents seem quite satisfied with services at the clinics, pharmacies and small shops.

Most people pay Tk. 2 - 3 for a packet of condoms, Tk. 6 for a cycle of pills, and nothing for IUDs. Some pay Tk. 10 - 15 for a clinic registration card. Ward commissioners speculate that people spend at least Tk. 40 - 50 per packet of pills, and that the rich might even spend up to Tk. 200 - 250 on family planning services. Some commissioners were not able to indicate the exact amount that people pay for contraceptives.

Service providers indicate that family planning methods can be obtained through field worker and clinic services from the government and NGO facilities. Private practitioners are quite ignorant of where clinical family planning services would be available, implying the need to increase awareness of the importance of family planning, and the nearby sources of supply, for better coordination and effective referral services.

There is a certain amount of referral from the NGO clinics to the public hospitals such as Dhaka Medical College Hospital and Mohammadpur Fertility Centre regarding clients seeking permanent methods. Some providers also mention the availability of pills and condoms from the pharmacies and small shops. Government personnel speculated that a substantial proportion of the urban population do not get access to family planning services, and that the level of service provision in the slums is below standard expectations.

The NGO service providers interviewed, recommended that there is a need to increase clinical method use, by targeting to counsel especially post-partum women within 40 days after delivery, to ensure sufficient supply of contraceptives, to ensure good quality maternal and child health care provision alongwith family planning services, and to have regular follow-up of clients. Generally, service providers indicate that the quality of family planning services in urban areas is quite satisfactory, but that more field workers and clinics are necessary to ensure adequate coverage in the community.

NGO providers also spoke of addressing social attitudes such as son preference, and making people aware of some benefits for girls such as free education by the government. Other NGO workers discussed the need to improve the quality of services, to strengthen follow-up mechanisms according to clients' need, to provide appropriate measures for side effects, to address specifically drop-outs, and to elicit male participation. Most providers proposed enhancing the collaboration between NGOs and government. Residents suggested that service providers should organize gatherings for couples that enable people to share information, communicate and endorse the need to practice family planning.

Some government providers spoke of the need to have door-to-door motivation of both male and female clients, to increase the number of field workers, field supervisors and clinics, to improve supervisory systems, to involve medical personnel in supervision, to supply Vitamin A and ORS together with contraceptives, to provide training on motivation to both FWAs and FPIs, to increase the frequency of FW visits in the slum areas, to ensure proper attendance of FWVs at the clinics and to increase the number of clinic days.

Private doctors recommended that there should be enhanced motivational efforts by the field workers, more motivation for permanent method use, better supervision and intensified motivational and service delivery efforts by both government and NGO providers, to elicit better

involvement and participation of the community and to ensure regular supply of contraceptives by both government and NGO channels.

Most providers indicated that consumers pay Tk. 10 or less, for most modern, temporary methods, i.e. pills, condoms and injectables. There are also service charges for registration, different rates between first clinic visit and revisits. Private practitioners had the opinion that the charges for IUDs are quite high, and that the poor would not be able to afford more than Tk. 20 - 30 for the service. This issue indicates the lack of awareness among private providers that, in reality, clients are actually paid for using IUD. Nevertheless, there are hidden costs for those services normally considered to be free.

One slum woman said, "I have taken a coil (IUD) after getting rid of my baby. It did not cost me any money. They gave me a slip (prescription) and I had to buy medicine worth Tk. 85. They wanted some money for the service, about Tk. 5 - 10, but I did not give this. I was satisfied at first, but when they asked for money, I got quite annoyed. We came so far for the free service. If we do not pay, they make us sit outside for hours. If we pay, then we are taken inside to the doctor."

Ward commissioners indicate that family planning services are easily available in the community, and the most widely used sources are from pharmacies, shops, field workers and certain NGOs like Nari Moitree and Radda Barnen. They report that the quality of family planning services is not satisfactory, except for one female commissioner who spoke positively of NGO services. The majority of complaints concerned the inadequacy of access to services in some areas and insufficient time given by field workers for motivation.

b. Perspectives on Male Participation

Urban residents - both men and women - stated that there should be more male participation in family planning. Women from both slum and non-slum groups indicate that they wish to avoid side effects commonly

experienced by female users, and that males should share the responsibility by using methods themselves. Non-slum women also felt that men should use condoms for protection against AIDS. *One woman stated that using contraceptives causes women to become unhealthy and unattractive, causing the men to remarry.* There is a general opinion that using contraceptives causes physical problems. Slum women stated that women with health problems (such as those with heart and kidney diseases), and working women, physically burdened with both work and child care, should not use contraceptives.

Urban men interviewed stated that using male methods prevent inflicting hormonal side effects on women. Slum men indicated the need for male involvement with reasons that they have the responsibility to decide on family size. They stated that they are more likely to use methods properly since women often forget to use pills correctly.

Men who are against male involvement stated that condom use is unreliable, and that male methods - both condoms and vasectomy - cause men to lose energy, work less and earn less. Perceptions and misconceptions relating to contraceptive use were common. Slum women stated that using condoms necessitates men to have good food to remain healthy, and thus, is more suitable for rich people. Non-slum women feel that men have to work hard, and therefore, it is better for women to use contraceptives as they can stay at home, if there are side-effects. Slum men also indicate that there are less method choices for men.

The majority of respondents - both slum and non-slum - suggested that advertisement and motivation through radio and television would be necessary to involve more urban men in using contraceptives, a view also shared by ward commissioners. Non-slum women specified that male field worker services, meetings by ward commissioners and local leaders, and information provided by government workers at household levels are necessary. Slum women stated that women should motivate and convince

their husbands to use methods. They indicated the need to expand choices for men, and to use male workers to inform men about family planning issues.

Men from both slum and non-slum groups suggested having motivational meetings with local leaders at men's worksites, increasing publicity and educating them of side effects associated with female methods, as means to persuade more men towards contraceptive use. They also voiced the need to develop "more male methods" in the style of injectables or pills, and that men should have full information of the merits and demerits of contraceptive use either through the media (e.g., newspapers, etc.) or other means.

An overwhelming proportion of providers stated that more male participation in family planning is necessary, and there should be intensified efforts to motivate men to use family planning services. So far, the media and other channels of communication have concentrated on women and female methods, and that comparable attention should be given toward male motivation.

Likewise, the types of motivational strategies suggested by service providers were: to have male field workers communicating directly with male clients; to conduct group meetings of men; and to have more publicity through radio, TV, and other forms of advertisement; to provide financial incentives to the client for permanent methods. Generally, the feeling was that men should understand the joint responsibility of couples toward family planning and that there should be sufficient supply of male methods in the community. Some service providers feel that men should also be warned about side-effects of male methods, and there should be some annual gathering and acknowledgement of the regular users. Some providers also discussed the need to correct women's misconceptions on male method use to reduce women's objection toward their husband's adoption of family planning methods.

Ward commissioners expressed the need to increase male participation in family planning and the importance of motivating men to use family

planning methods. The commissioners suggested recruiting male field and clinic workers for motivation, increasing publicity for male methods use, educational programmes to enable men to understand the benefits of vasectomy, and to "discover new contraceptives" for men.

Supplying contraceptives at low cost was recommended by ward commissioners, together with providing more ward-level family planning clinics, providing good training to field workers for effective communication and motivation and reducing the number of households assigned to field workers to enable better rapport with the clients.

4.5 Summary of Key Findings

The following issues were raised:

- a. The urban population defined their priorities as money, water, adequate housing, food, clothing, a clean environment and access to medical care.
- b. At present, there is an urgent need to improve water supply, garbage disposal, drainage, and the availability of sanitary latrines, especially in the slum areas.
- c. WASA, DCC and the government were specified as being responsible for these services, but urban dwellers also indicated the potential of community financing.
- d. Air pollution is apparent, caused by smog and smoke from factories, tanneries, motorized vehicles and wood-burning chulas, but not yet a concern to residents.
- e. Urban residents stated the need to have adequate and affordable medical treatment and immunization services as a precondition to good health; ward commissioners and service providers add antenatal care, postnatal care and health education to the list.

- f. Urban residents mostly report fever, diarrhoea, cold and cough as common ailments; ward commissioners and service providers also report scabies, in addition to the rest.
- g. Pharmacies are the main source of medical care, followed by private doctors and government dispensaries.
- h. The main complaints about medical care relate to insufficient medicine, long waiting time, at public facilities and high expenses, at private facilities.
- i. There are no facilities at community level for serious illnesses, and inadequate provision of tertiary care.
- j. Slum women would prefer free antenatal services; ward commissioners and service providers suggest fees for antenatal care, except for the poor.
- k. Childbirth and deliveries at home by dais are most common and likely to continue in the future.
- l. The need for postnatal care was noted; however, urban women are less proactive towards obtaining routine check-ups, commissioners and providers propose home visits.
- m. Unwanted pregnancies in the urban areas prompt all respondents to express the need for good quality MR and abortion services. Urban residents profess a willingness to pay, while commissioners and providers recommend free services.
- n. Pharmacies, shops, field workers and NGO facilities are the main sources of family planning services, specifically for resupply methods.

- o. Service providers feel that the quality of urban family planning services is satisfactory, except for the need to expand coverage. Ward commissioners do not agree.
- p. Most non-slum men and women prefer home-based family planning service delivery by field workers.
- q. All respondents expressed the need to increase the use of male contraceptive use, recommending advertisement and motivation through the media.

5. Discussion

5.1 Reflections on the Study Findings

The presence of urban poverty is quite apparent. Slum residents specify "money" as being the most important basic need for daily survival. Further probing into what money was required for, revealed the commodities of water, food, clothing, shelter, etc; which reflects the pressure faced by slum dwellers to acquire (and/or maintain) these items on a daily basis. There was considerable discussion of payments made for various items ranging from water to medical care, which illuminates that the cost of basic needs is often higher in proportion to income of slum dwellers and the urban poor. However, prices and expenditures reported in the rapid appraisal are provided by a small sample of respondents and therefore, would not represent accurate average price ranges. The information reflect a wide variation of fees charged by providers, either formally or informally, and a considerable degree of uncertainty regarding price levels. This makes it difficult for consumers to plan ahead, even if they try to do so, as with serious illness and medical catastrophes. The information presented in the study indicates the willingness to pay, rather than the actual amounts paid at a generalizable scale. The expenditure data reflects largely, out-of-pocket costs, and does not inform on opportunity costs of time and money invested in seeking care and waiting for services. It was also apparent that free services do not always mean free care, as with reports of *baksheesh* (i.e. tips) for vaccination services, etc.

Nevertheless, the information signifies a willingness to pay and a sustainable demand for immunization services even with all hidden costs.

Ward commissioners seem unaware that slum dwellers pay for most of their basic needs. It could also be that elected officials cannot afford to state that the poor should pay for services; their positions almost require that they maintain the stance of "giving to the people". This stand is interesting, particularly when most urban residents, slum and non-slum, are paying for services.

A general perception noted among the ward commissioners and service providers is that payment means value accorded to the commodity. Such perceptions should be further explored, and requires more in-depth analyses of consumers' attitudes and behaviour toward the less popular forms of health care, especially preventive measures for women's reproductive health such as antenatal and postnatal care. Setting up user fee systems for such health measures should *not* take place without careful consideration of consumers' needs, preferences, expectations and the willingness to pay.

The differing points of views of the different key informant groups are evident. Community leaders tend to surmise that the poor should not - and cannot afford to - pay for some of their daily needs such as water and sanitation, medical care, reproductive health services particularly for abortions. Discussions with urban residents reveal that people in the slums are actually paying for almost everything, either through the rent, or separately.

There is a definite need for further information on the capacity for, and feasibility of community financing mechanisms in the urban areas. The description of communal life in the urban areas is complex, requiring the redefinition of "community", "community members" and "community leaders" sensitive to describe how far it stretches and who is actually included. Such definitions entail distinctive differences between slum and non-slum areas. The power structures, informal networking and the role of local government

leaders such as ward commissioners should be explored. Findings of the present study imply uncertainty in identifying a viable group (or person) that could take the lead in organizing community financing activities. Differing views between local leaders and the residents were recorded; it seems that residents are concerned with equal sharing of the inputs, and the commissioners are dubious of the affordability of urban dwellers towards such schemes, and therefore, the sustainability of such efforts. Nonetheless, there is ample scope for further research that informs the means to explore options of forming committees, for awareness raising and advocacy.

Most key informants share a general view that women and children are the priority groups to receive health care. The answer is fairly normative, and respondents may have stated what they thought was the expected answer. Nevertheless, some women, both in slum and non-slum areas, consider men to be the most important persons in the family that need to be prioritized for health resource investments, indicating the dependency on men for their survival. The issue necessitates deeper comparisons between slum and non-slum areas. In the slums, women are often more mobile, contribute to the family's income pool, and function as head of households in higher proportion compared to non-slum areas. Intra-household resource allocations structures are bound to be different between these two groups.

There also seem to be an awareness of the elderly and their needs; future programmes would need to examine the size and growth potential of this sub-population and the requirements to address their health needs. Even so, the slum population is relatively younger than the other urban segments, with nuclear families (Thwin et al., 1996). This indicates that the health of children, and women of reproductive age should still be immediate priorities.

One issue that was emphasized quite clearly, concerns the supply and distribution of water and sanitation services, which urban dwellers specified as the domain and responsibility of the Government, i.e. the local government and WASA. It seems that the urban population - both rich and poor - insist on the contribution of the government, particularly for these services, though they

would continue to find their own means to cope with the rest of their basic needs. Noise and air pollution - prominent problems in most cities - may be considered as still being "Western" concepts, and people in Dhaka City neither notice, nor complain of them as hindrances faced in living. However, "bad smell" was often stated as a problem to the inquiry of "air quality", which was probably associated with garbage and latrines rather than air pollution. Service providers and ward commissioners seem more aware of the problems of smog and smoke, which reflects the need for community education and awareness building through community leaders, school programmes, etc.

Health service utilization patterns of women and men differ, women seem confined to seek care at clinics in times of illness, whereas men often just buy medicines at the pharmacy for some form of self-care. This reflects two main issues, the first concerning the cultural barrier preventing women to purchase health commodities at pharmacies for minor illnesses, and the other highlighting the popularity and contribution of the private sector in terms of health services provision. Thus, the urban health care system on a holistic scale is viable and self-sustaining, and the main concern is to improve its effectiveness.

It seems that home deliveries are likely to continue in the future for most urban households. The data imply the need to examine the cost concerns of deliveries in relation to choices made between home and elsewhere. Such issues involve defining - and understanding - consumers' preferences in terms of perceived quality and accessibility on both sociocultural and economic dimensions. The findings indicate low utilization of routine health services and check-ups, in contrast to high expenditures for problems faced during postpartum period. Women seek care for minor problems from the NGO clinics and pay high costs for major problems at private doctors and clinics. This is definitely an area of concern, and further research is necessary to identify the extent of maternal morbidity in the urban areas, especially among the slum and urban poor women.

The occurrence of induced abortions in the urban areas and the demand for good quality services are a common feature, reflecting an important but probably under-estimated health problem in Dhaka City. There is a vicious cycle amongst slum women who usually end up keeping the baby, because they have fewer choices in terms of seeking abortion services. The additional burden of another mouth to feed in the family creates a worse situation of poverty. Non-slum women are more likely to use a wider range of choices regarding abortion providers. There is a dire need to examine the magnitude and variety of abortion service providers and their practices. Interventions for counselling for post-abortion contraception and prevention of septic abortions from unsafe and harmful practices would have to consider also the role of the male partner. The situation calls for efforts to target women (and their partners) with history of abortions in providing information and counselling for effective family planning services.

It seems that non-slum women still expect receiving contraceptive supply and services through home visits by field workers. On the other hand, slum residents obtain family planning commodities from pharmacies, the marketplace and shops. The mobility of slum women also enables them to obtain IUDs and injectable contraceptives at clinics, whereas non-slum women may be limited to use pills and condoms either supplied by field workers or their husbands. In this context, it is necessary to provide sufficient information to slum women of the range of choices that exist for family planning, where these may be obtained from and how this would benefit them. The findings also indicate the possibilities of exploring alternative roles for family planning field workers, other than just supplying contraceptives. The need to have community case-workers who concentrate on those who either do not have access to, or do not wish to use family planning methods may be the agenda for the future in terms of increasing cost-effectiveness of urban family planning programmes in Bangladesh.

The private sector supplies a substantive volume of contraceptives in the city. There is an abundant supply of temporary methods from pharmacies and shops, and thus, the urban setting provides ample scope for designing family

planning service delivery systems that are alternative to the conventional trend of home delivery. However, such alternative approaches would still require careful consideration of how to factor in side effect management, and how a woman can be advised and facilitated to move on to longer acting methods which could be more effective and appropriate for her reproductive cycle.

Women in the urban areas bear the burden of birth spacing and control to a large extent. The need to enhance male involvement was expressed and the findings indicate that motivational efforts might require individual counselling for men to address their misconceptions and apprehensions. The use of media for informing and educating men toward further participation in family planning was also stated.

One common area where the views of service providers and consumers differ is the subject of quality of care. Providers' perceptions of "good" quality usually concerns services by appropriate standards and protocols of medical procedures, such as oxygen for the baby, height and weight measurement, treatment of iron-deficiency anaemia at postnatal care, etc. In contrast, patients expect minimal waiting time, courtesy from the staff and to be served without discrimination between the rich and the poor. Narrowing the gap between providers and consumers in urban health care systems is truly a formidable challenge and requires tremendous investment and commitment from decision makers. A mass of issues were unearthed and discussed either to identify interventions to alleviate the problem and/or to further examine the depth, magnitude and causes of the problems. The most critical areas are summarized in the following section.

5.2 Identifying the Areas of Concern

- a. The urban poor fight a daily struggle to survive with limited income in an environment that demands cash payments for almost every basic need. Empowerment strategies that alleviate urban poverty, improve family income and enable access through information and subsidies should be a national priority.

- b. There is an urgent need to improve water supply and environmental sanitation in Dhaka City. The expectations from the City Corporation and WASA was clearly indicated by urban residents and ward commissioners, and in fact, was the one area where residents were specific.
- c. Although the problem was not specified very strongly, the findings indicate that air pollution in Dhaka is quite prevalent, from multiple sources such as chulas, factories, leather tanneries and transport. A careful examination of the health hazards of people living in the nearby areas would be necessary.
- d. The role of the private sector, especially that of pharmacies in providing services for both medical care and family planning is quite substantial. Interventions to coordinate their services with the public and NGO providers at the community level are necessary to ensure optimal distribution of health resources in the city.
- e. Childbirth and deliveries are likely to continue at home, and community education and effective IEC programmes are necessary to inform women on when and where to seek help from trained personnel. Such efforts should also include information and motivation toward antenatal and postnatal care.
- f. The high demand for abortion services is an area for concern. Critical issues include the quality of care, especially amongst the private and traditional providers, the costs involved and the coordination with other health services such as family planning and the management of reproductive tract infections.

5.3 Recommendations for Future Research

- a. The present study explores the perceived needs of the urban population, and their willingness to pay for those needs. Further

work is necessary to understand whether they would pay for alternative services, in conjunction with the reasons for different degrees of willingness to pay.

- b. The behaviour of slum communities needs to be analyzed further, to understand the distribution of power among different sub-groups, how gender and socioeconomic differences affect perceptions, choices and the intra-household allocation of resources.
- c. The perceptions of slum dwellers regarding certain concepts such as "cleanliness," "pollution," and "quality" need to be defined in the slum context, as these often form the basis for choices and decisions to produce health at the household level.
- d. The urban environment needs to be described further, particularly on issues such as the urban dimensions of poverty, crime, social instability, and the effect on quality of life.

6. Conclusions and Policy Implications

The environmental problems in Dhaka City are widespread, especially in the slums. The effectiveness of most urban health development programmes can be enhanced if these are coordinated with measures to improve water supply and sanitation.

The slum and urban poor communities are in critical need for targeted programmes regarding their living conditions and access to health and family planning services. Special efforts and strategies may be necessary to provide them with the necessary basic services.

The role of the private sector is substantial and sustainable. Specific attention is required to enhance their effectiveness. Their role and contribution toward urban health development requires monitoring and regulation.

The role of government, through ordinances and charters, involves establishing standards and quality control for health maintenance and the provision of basic services, tasks that may be too diverse and complex beyond their current capacity. There is a dire need to empower the local government in coordinating the different resources available in the community such that the range of community needs is effectively addressed.

Last, but not the least, the ability of the community to mobilize funds for their basic concerns should neither be ignored nor taken for granted. Payments, both explicit and hidden, are taking place, and the willingness to pay for essential items was evident. An expected role of urban local government may be to establish systems for fees, as the urban consumer is not unwilling to pay, except that he or she would prefer to do so with an acceptable schedule.

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Annex A

Detailed Study Design and Methodology

The present study was undertaken to elicit the urban residents' own definition of their needs, priorities and problems, including preferences, choices and willingness to pay for services. Thus, the first part of the study consisted of an open opportunity for urban dwellers, to specify their immediate problems, basic needs required for daily existence and health maintenance. The next part of the study was more structured towards acquiring their reactions and experiences regarding access, attitudes and willingness to pay on the following issues:

- a. the supply of safe and potable water
- b. sanitation including garbage disposal, latrines, sewerage
- c. mosquito control programmes
- d. basic medical care services, immunization and child health care
- e. reproductive health care, including antenatal care, delivery and postnatal care, menstrual regulations and abortions, family planning.

A.1 Study Design

This study was conducted in Dhaka with a sample of slum and non-slum areas within the old, new and intermediate sections of Dhaka City. The respondents were residents in the selected areas (both men and women), ward commissioners (both elected and appointed) and service providers who are based in those communities. The study design is cross-sectional and data collection was accomplished between May - June 1995.

The Urban Health Extension Project (UHEP) of ICDDR,B modified the CUS definition, by defining the size of a slum to at least 10 households, in order to identify more pockets of urban poor communities in Dhaka. (Arifeen and Mahbub, 1993) Thus, slums are settlements or areas with the following criteria, that provide the basis of the USS data:

- i) poor housing, e.g. shacks ("jhupris"), flimsy structures (katcha), semi-pucca flimsy structures (flimsy structure with brick or concrete floors), and dilapidated buildings
- ii) very high gross area density (over 300 persons per acre) and high room crowding (3 or more adults per room)
- iii) poor sewerage and drainage
- iv) inadequate water supply
- v) irregular or no clearance of garbage
- vi) little or no paved streets
- vii) insufficient or absence of street lighting
- viii) little or no access to gas facility.

For operational purposes, the following characteristics were applied in order of importance, to identify slum settlements:

- i) predominantly poor housing
- ii) very high housing density, and
- iii) poor sewerage and drainage facility.

The term "squatter" was given to slums that are located illegally on property belonging to governmental, semi-governmental, autonomous and other organizations. A slum household is defined as one that is located in a slum settlement, uses shared water and latrine sources.

A.2 Methodology

Key informant interviews were held to elicit views and perspectives on basic needs indicators in the sample areas. An interview guideline was used and all interviews were conducted by experienced professional research staff members of the Urban MCH-FP Extension Project. Special male interviewers were also recruited through contractual terms to interact with male respondents. The guideline contained mostly unstructured, open-ended questions, that permit respondents to lead the interviews, and discuss freely on opinions and choices with interviewers facilitating and probing for clarification of problems, attitudes and rationale. The interview guideline focussed on priorities as defined by respondents, the present situation of access and utilization of essential services, perceptions of quality, expenditures incurred, and intentions of future practices regarding those services and opinions of the capa of urban communities to address problems.

The interviews took place mostly during the day, except for the interviews with male respondents which had to done on Fridays, Saturdays and in the evening. The interviewers used tape recorders and sometimes, were assisted by note-takers to record the maximum information generated. Translation, transcription and analysis of qualitative data was done with the help of UEP researchers.

A.3 Sample Selection

A multi-stage sample selection procedure was used for this study. The details are clarified as follows:

a. Selection of Zones

Out of a total of ten zones in Dhaka City, a random selection of four were chosen. (Zone 10 - Uttara - was excluded as not being typical urban Dhaka, as only one section was truly new and modern, and most of the zone was still peri-urban.) Out of the remaining nine zones, four, i.e. Zones 2, 4, 6 and 8 were selected by systematic random sampling.

b. Selection of Wards

In the selected Zones of 2, 4, 6 and 8, there were three wards i.e. 26, 46 and 15 that were mostly peri-urban, and thus, were excluded purposively to permit analyses of a truly urban situation. Then from the remaining wards, two each were selected from each zone by simple random sampling.

c. Selection of Sample Areas

c.1 Slum Areas

The slum list from 1991 Dhaka Metropolitan Slum Survey, conducted by the Urban Health Extension Project, ICDDR,B, was used to identify the slums. The available list with addresses was actually based on old ward demarcations, and thus, the list was adjusted with an updated list of new ward demarcations and the relevant ward maps. These were obtained through an on-going mapping exercise of the Urban MCH-FP Extension Project, which permitted the identification of slums for selection. From the identified slum areas in the eight selected wards, one slum from each ward (eight slums altogether) was selected by simple random sampling method.

c.2 Non-Slum Areas

Currently, there is no area listing of non-slum residential areas, these were selected by locating areas comprising at least 10 households, located within a distance of a five minutes rickshaw ride. The rickshaw ride was taken to allow a reasonable distance between slum and non-slum areas. Should there be no residential area after the first five minute rickshaw ride, they proceeded for the next five minutes. The decision to select the area was made if a non-slum residential area is located within this subsequent five minutes. In this manner, a total of eight non-slum residential areas were chosen.

The final list of areas selected are as follows:

Table 1: Sampling Areas Chosen for the Key Informant Interviews

Zones	Wards #	Slums Existing	Slums Chosen	Non-Slum
2	69	26	1	1
	73	3	1	1
4	25	4	1	1
	28	11	1	1
6	39	18	1	1
	45	10	1	1
8	7	17	1	1
	8	27	1	1
4	8	116	8	8

d. Selection of Key Informants

d.1 Selection of Urban Residents

From each selected slum and non-slum areas, two community members (one male and one female) were selected according to the following criteria:

- a. age within 20 - 40 years
- b. having at least one child under 2 years
- c. duration of having lived in the area for minimum of 6 months
- d. willingness to discuss the community-level issues with the interviewers.

To conduct the interviews with the male respondents, the interviewers returned to the same sites from where the female respondents were chosen. A total of 32 urban residents were selected. Usually, the first man or woman encountered - that fit the criteria - was requested to give time for the interview. Should the person turn out to be uncooperative, the next person seen was asked to discuss with the interviewers. The mean age of slum women selected were 25 years, and non-slum women 25.5 years. Slum men chosen were 30 years old on average, and non-slum men, 36 years. The mean age of the last child of the slum residents was 16 months, and the non-slum equivalent was 15 months. Both slum and non-

slum respondents interviewed have two children each (2.3 for slum and 1.9 for non-slum). On average, slum respondents have resided in their communities for 13 years, and the non-slum ones for 10 years.

d.2 Selection of Ward Commissioners

The elected male ward commissioners from each selected ward was interviewed. Appointed female ward commissioners at each of the zones were also contacted, and out of a total of 10 female ward commissioners, one each were interviewed in the selected four zones. The current distribution of female Ward Commissioners are as follows:

- Zone 2 - Two female Ward Commissioners
- Zone 4 - Four female Ward Commissioners
- Zone 6 - Three female Ward Commissioners
- Zone 8 - One female Ward Commissioner.

From the list stated above, one female Ward Commissioner was selected to represent each sample zone, and a total of 12 Ward Commissioners (eight men and four women) were interviewed.

d.3 Selection of Service Providers

There are three main types of health (and family planning) service providers in Dhaka City, i.e. the government service providers, the NGO workers and the private practitioners. Within each ward, two providers each, one from NGOs with either community-based clinic facilities or field workers, and one government or private provider were chosen for interview. A total of 16 providers were identified as key informants. The list is as follows:

- NGOs: eight personnel (one from each ward), from Concerned Women from Family Planning, Nari Moitree, Concern Bangladesh, Community Health Care Project, Dhaka Urban Integrated Child Survival Project (World Vision), Monisha and Radda Barnen
- GOB: one doctor from government dispensary, one FWV from a GOB FP static clinic, one FWA from the Thana Family Planning Office, and one vaccinator from the DCC EPI centre
- Private: two doctors with clinic chambers, and two at pharmacies in the community.

The total number of key informants are listed as follows:

Table 2: Sample Size of Key Informants by Areas Chosen

Zone	Ward	Slums		Non-slums		Ward Coms		Service Providers		
		Men	Women	Men	Women	Male	Female*	NGO	GOB	Private
2	69	1	1	1	1	1		1	1	-
	73	1	1	1	1	1	1	1	-	1
4	25	1	1	1	1	1		1	-	1
	28	1	1	1	1	1	1	1	-	1
6	39	1	1	1	1	1		1	1	-
	45	1	1	1	1	1	1	1	-	1
8	7	1	1	1	1	1		1	1	-
	8	1	1	1	1	1	1	1	1	-
Total	8	8	8	8	8	8	4	8	4	4

*Chosen at Zonal level

A.4 Observations during Field Work

Some technical issues during the field implementation period of the study were recorded, as they illuminated certain issues relevant to the urban scene. The issues are discussed as follows:

1. *Four out of eight selected slums do not exist anymore, different from the 1991 UHEP list. Construction was taking place in two of them, one had become a factory, and the remaining one had become a marketplace. Thus, these four slums had been abolished, signifying the impermanence of such communities in the urban context. (Alternate slums, second on the list in the same areas, were chosen as substitutes.)*
2. *On the other hand, the interviewers were not able to trace one slum area, as the location number was changed. Finally, the area was located through the help of community members who had resided in the same area for a long time, indicating recognition and communal identity among the urban dwellers.*
3. *In some cases, the landlords and also the structures of the selected slums had changed in a period of four years.*

4. *Often, it was quite difficult to find residents with children less than two years in the non-slum areas.*
5. *In comparison, non-slum women were less cooperative than slum women. The interviewers had to persuade and motivate considerably, and it was quite difficult to get their interest to conduct the interviews.*

These observations during field data collection provide a glimpse into the impermanence and mobility of slum population, and the difference in behaviour between slum and non-slum communities.

Annex B

Guidelines for Identifying Health Needs in Urban Areas from Consumers' Perspectives

B.1 Outline for Key Informant Interviews with Urban Residents

Part I (A): Identification of Basic Needs

1. What are the basic items essential for your daily needs, for example, water, housing, food, etc?
2. What are the most urgently needed items (e.g. water, garbage disposal, latrines) in the community?
3. How do those problems affect the well-being of your family and the neighbourhood?
4. What are the problems that you think, are possible to be solved in the immediate future, like in the next six months to one year? How can they be solved?
5. What are the basic services (e.g. water supply, latrine construction, medical treatment, etc) for which some investment (in the form of either time and/or money) from the community can be provided? What are the items for which payment can be made individually (or as a family) on a need basis?

Part I (B): Identification of Health Needs

1. What are the most important health problems that you are facing? If you do not have any health problems now, did you have any in the last six months? (If no health problems, go to #3.)
2. How severe is your condition? Did it keep you from working normally, did you have to take bed rest? If so, how long? Did it hurt you financially to have this condition? Is it because of inability to work, because of medical costs incurred?

3. What are the most important items required for the health of your family members? For whom should these be given and why?
4. What are the most important health services required for your family? Who is the most important person in your household that should have access to essential health services? Why?
5. What are the common diseases in your neighbourhood? Who are most commonly afflicted?

Part II: Opinions on Access and Availability of Primary Health Care Services

1. Access to Safe Water Supply

- 1.1 Do you have sufficient water for the following household uses, i.e. for drinking, washing, bathing and cooking? What is/are the source(s) of water for those purposes?
- 1.2 Are you paying for water? If so, how much?
(If they do not have enough water supply, ask the following question.)
Would you be willing to pay for water supply? If so, up to how much?

2. Access to Environmental Sanitation

- 2.1 What is the condition of drainage systems in your neighbourhood? Do you get garbage and solid waste disposal services in the community? Are you satisfied with the schedule and the quality of service delivery?
- 2.2 Are you paying for those services? If so, how much?
(If there are no services, ask the following question.) Would you be willing to pay for drainage, garbage and solid waste disposal? If so, up to how much (for each)?
- 2.3 Have you noticed/experienced any measure to reduce the number of mosquitos in your community? Have there been any spraying or fumigation in your community within the last six months? Would you pay for such kinds of measures?
- 2.4 Are you troubled by the noise (traffic, factory, construction noise, etc) of the? What is your opinion regarding air quality (smell, smoke, etc) in your surrounding areas?

3. Access to Medical Care

- 3.1 Where do you usually obtain health care during illness, or for minor injuries? What is your opinion regarding the quality of services and treatment?
- 3.2 How much do you usually pay for treatment of such conditions? Is this a reasonable price? How much are you willing to spend for an illness episode?

3.3 Where would you obtain services for serious health problems? How much would you be willing to pay for this type of care?

4. Access to Reproductive Health Services

4.1 (If respondent does not want any more children, go to 4.2.) Would you be willing to pay for regular check-ups, and care for prevention against complications to you and your baby through pregnancy and childbirth?

4.2 Where (and with whom) did you deliver your previous babies? Were you satisfied with the quality of the services? Did you pay for delivery before? If so, how much? (If respondent does not want any more children, go to 4.3.) Where (and with whom) do you intend to deliver your next baby? How much would you be willing to pay?

4.3 Did you require any health care for yourself, after delivery? If so, for what, from which provider? Did you pay for those services? (If respondent does not want any more children, go to 4.4.) Would you pay for those services if you require, in future? If so, how much would you be willing to pay?

4.4 Did you take your newborn baby (or did anyone come to your house) for EPI and check-ups (other than EPI) during the first three to six months after delivery? If so, where and by whom? What kind of services did you receive? Did you pay for those?

4.5 Have you had any unwanted pregnancies? If yes, what did you do then? Where did you go and what kind of services did you receive? Do you think abortions are necessary? If so, up to how much, would you be willing to pay for one?

4.6 Are you using any family planning methods? Where do you obtain those services? Do you pay for them? Are you satisfied with the quality of the services?

4.7 Do you think more men should use family planning methods? If not, why? If so, why and how can we motivate them to do so?

Guidelines for Identifying Health Needs in Urban Areas from Consumers' Perspectives

B.2 Outline for Key Informant Interviews with Service Providers

The type of respondents for this component of the study are NGO clinic personnel, field workers.

Part I: Identification of Basic Needs

1. What are the basic needs essential for daily existence of the community members in your area of jurisdiction, for example, water, housing, food, etc?
2. What are the most urgently needed items (e.g. water, garbage disposal, latrines, etc) in the community? What do people complain most about?
3. How do those problems affect the well-being of your clients and the neighbourhood?
4. What are the problems that you think, are possible to be solved in the immediate future, like in the next six months to one year? How can they be solved?
6. What are the basic services (e.g. water supply, latrine construction, medical treatment) for which some investment in the form of either time and/or money from the community can /should be provided? What are the services for which payment can be made individually (or as a family) on a need basis?

Part I (B): Identification of Health Needs

1. What are the common diseases in your neighbourhood? Who are most commonly afflicted?
2. What are the most important items required to improve the health status of the community members?
3. What are the most important health services required for the neighbourhood? Who should be the target groups for receiving essential health services? Why?

Part II: Opinions on Access and Availability of Primary Health Care Services

1. Availability of Safe Water Supply

- 1.1 Do you think that there is sufficient water for household use among your catchment population? Is the quality of water up to standards?
- 1.2 Do you think that people can afford to pay for water? If so, up to how much?

2. Availability of Services for Environmental Sanitation

- 2.1 Is there any problems with drainage systems in the community? Are there sufficient garbage and solid waste disposal services in the community? Is the schedule and the quality of service delivery satisfactory?
- 2.2 Have you provided (or noticed/heard of) any measures for mosquito control in the community? How often is spraying or fumigation done in the community?
- 2.3 Do you know if people are paying for all those services? If there are people who do not have access, should they pay for the services? If so, up to how much?
- 2.4 What is your opinion regarding air quality (smell, smoke, etc) in the and particularly, your neighbourhood? How important do you think it is necessary to lessen the air pollution?
- 2.5 What other forms of pollution (especially sewage and surface water) are there in your ward? Should people invest in controlling this type of pollution?

3. Availability of Medical Care

- 3.1 Where do people usually obtain health care for illness, or for minor injuries? What is your opinion regarding the quality of services and treatment?
- 3.2 How much do people usually pay for treatment of such conditions? Do you think this is affordable?
- 3.3 Are there facilities to handle serious health problems? Should there be systems to prepare people financially for this kind of problems?
- 3.4 Is there capacity among the community members to set up a drug revolving fund that collects capital and invest in drugs supply to the local public (NGO, GOB) clinics?

4. Availability of Reproductive Health Services

- 4.1 Should women pay for regular check-ups, and care for prevention against complications through pregnancy and childbirth?
- 4.2 Where (and with whom) do women normally obtain childbirth care? Are the quality of delivery services available in your area up to standards? Would you consider them expensive for slum residents or urban poor households?
- 4.3 What can be done to provide more effective services for post-partum women? Are you satisfied with the quality and coverage of well-baby check-up services within your jurisdiction?

- 4.4 Do you think there are a lot of unwanted pregnancies among your client population? Do you think good quality abortions and MR services should be more accessible to women? Should people pay for them, if so, up to how much?
- 4.5 Are family planning methods easily available among your clientele? Where do they usually obtain those services?
- 4.6 How much do they normally pay for them? Do you think the quality of services is satisfactory?
- 4.7 Do you think that there should be more male participation in family planning use? If so, what can be done to promote more male methods? If not, why?
- 4.8 What can be done to increase family planning method use and continuity in your community?

Guidelines for Identifying Health Needs in Urban Areas from Consumers' Perspectives

B.3 Outline for Key Informant Interviews with Ward Commissioners

Part I: Identification of Basic Needs

1. What are the basic needs essential for daily existence of the community members in your area of jurisdiction (for example, water, housing, food, etc)?
2. What are the most urgently needed items (e.g. water, garbage disposal, latrines) in the community? What do people complain most about?
3. How do those problems affect the well-being of the people in your community?
4. What are the problems that you think are possible to be solved in the immediate future, i.e. in the next six months to one year? How can they be solved?
5. What are the basic services (e.g. water supply, latrine construction, medical treatment) for which some investment - in the form of either time and/or money - from the community can /should be provided? What are the services for which payment can be made individually (or as a family) on a need basis?

Part I (B): Identification of Health Needs

1. What are the common diseases among the people in your ward? Who are most commonly afflicted?
2. What are the most important items required to improve the health status of the people in your ward?
3. What are the most important health services required for the neighbourhood? Who should be the target groups for receiving essential health services? Why?

Part II: Opinions on Access and Availability of Primary Health Care Services

1. Access to Safe Water Supply

- 1.1 Do you think that people in your area have sufficient water for all household uses? Are you satisfied with the quality of water supply that they receive?
- 1.2 Do you think that people can afford to pay for water? If so, up to how much can they afford to pay?

2. Access to Services for Environmental Sanitation

- 2.1 Are there any problems with drainage systems in the community? Do you get garbage and solid waste disposal services in the community? Are you satisfied with the schedule and the quality of service delivery?
- 2.2 Have you noticed any measures for spraying or fumigation in the community? Are there any services for mosquito control?
- 2.3 Are your community members paying for all those services? If so, how much? If there are people who do not have access, should they pay for the services? If so, up to how much?
- 2.4 What is your opinion regarding air quality (smell, smoke, etc) in the city and particularly, your neighbourhood? Do you think it is necessary to lessen the air pollution?
- 2.5 What other forms of pollution (especially sewage and surface water) are there in your ward? Should people invest in controlling this type of pollution?

3. Access to Medical Care

- 3.1 Where do people usually obtain health care for illness, or for minor injuries? What is your opinion regarding the quality of services and treatment?
- 3.2 How much do people usually pay for treatment of such conditions? Do you think this is affordable?
- 3.3 Are there facilities to handle serious health problems? Should there be systems to prepare people financially for this kind of problems?
- 3.4 Do you think that community leaders should take an active role in planning and quality control of health services in your area?
- 3.5 What possible kinds of participation would be feasible? Would you be able to form a ward level health committee?
- 3.6 Is there capacity among the community members to set up a drug revolving fund that collects capital and invest in drugs supply to the local public (NGO, GOB) clinics?

4. Access to Reproductive Health Services

- 4.1 Should women pay for regular check-ups, and care for prevention against complications through pregnancy and childbirth?
- 4.2 Where (and with whom) do women normally obtain childbirth care? Are the quality of delivery services available in your area up to standards?
- 4.3 Would you consider them expensive for the slum residents and urban poor households? What can be done to provide more effective services for women after delivery?
- 4.4 Do you think there are a lot of unwanted pregnancies among your client population? Do you think good quality abortions and MR services should be more accessible to women? Should people pay for them, if so, up to how much?
- 4.5 Are family planning methods easily available among your community members? Where do they usually obtain those services? How much do they normally pay for them?
- 4.6 Do you think the quality of services is satisfactory?
- 4.7 Do you think that there should be more male participation in family planning use? If so, what can be done to promote more male method use ? If not, why?
- 4.8 What can be done to increase family planning method use and continuity?

MCH-FP Extension Project (Urban) Working Papers:

- 1 Paljor N, Baqui AH, Lerman C, Silimperi DR. **"Reaching the Urban Poor-the Case of the Urban Volunteers in Dhaka, Bangladesh"**. September 1994
- 2 Baqui AH, Kanil K, Jahangir NM, Nahar Q, Paljor N, Silimperi DR. **"Urban Surveillance System-Dhaka Methods and Procedure"** September 1994
- 3 Jamil K, Baqui AH, Paljor N **"Knowledge and Practice of Contraception in Dhaka Urban Slums: A Baseline Survey. May 1993"**
- 4 Baqui AH, Paljor N, Silimperi DR. **"The Prevention and Treatment of Diarrhoea in Dhaka Slums"**. May 1993.
- 5 Laston SL, Baqui AH, Paljor N, Silimperi DR. **"Immunization Beliefs and Coverage in Dhaka Urban Slums"**. May 1993
- 6 Baqui AH, Paljor N, Nahar Q, Silimperi DR. **"Infant and Child Feeding Practices in Dhaka Slums"**. May 1993
- 7 Chowdhury N, Mohiuddin QN, Momtaz S, Ghosh KR, LILI FB, Leena MM. **"Violence in the Slums of Dhaka City"**. May 1993
- 8 Baqui AH, Paljor N, Lerman C, Silimperi DR. **"Mothers' Management of Diarrhoea: Do Urban Volunteers of Dhaka have an Impact? May 1993"**
- 9 Salway S, Jamil K, Nahar Q (editors). **"Issues for Family Planning in the Urban Slums of Dhaka, Bangladesh: Opinions and Perceptions of Field-Level Workers"**. May 1993
- 10 Fronczak N, Amin S, Laston SL, Baqui AH, **"An Evaluation of Community-Based Nutrition Rehabilitation Centers"**. May 1993
- 11 Arifeen SE, Mahbub AQM (Editors), Baqui AH, Islam N, Jahangir, NM, Mahbub AQM, Paljor N, Siddiqi SM (Contributors) **"A Survey of Slums in Dhaka Metropolitan Area, 1991"**. October 1993
- 12 Fronczak N, Amin S, Nahar Q. **"Health Facility Survey in Selected Dhaka Slums. October 1993"**
- 13 Laston SL, Baqui AH, Paljor N. **"Urban Volunteer Service in the Slum of Dhaka: Community and volunteer Perceptions"**. October 1993
- 14 Baqui AH, Arifeen SE, Amin S, Black RE. **"Levels and Correlates of Maternal Nutritional Status and Consequences for Child Survival in Urban Bangladesh"**. October 1993

- 15 Salway S. Jamil K. Nahar Q. Nurani S. **"Perceptions of Pregnancy Risk and Contraceptive use in the Postpartum Period Among Women in Dhaka Slums"** November 1993
- 16 Jamil K, Streatfield K Salway S. **"Modes of Family Planning Service Delivery in the Slums of Dhaka: Effects on Contraceptive Use"** *October 1995*
- 17 Salway S, Nahar Q, Ishaque Md. **"Alternative Ways to Feed Infants: Knowledge and Views of Men and Women in the Slums of Dhaka City."** May 1996
- 18 Salway S, Nahar Q, Ishaque Md. **Women, Men and Infant Feeding in the Slums of Dhaka City: Exploring Sources of Information and Influence.** May 1996
- 19 Quaiyum MA. Tunon C. Baqui AH. Quaiyum Z. Khatun J. **"The Impact of National Immunization Days on Polio Related Knowledge and Practice of Urban Women in Bangladesh"** May 1996
- 20 Perry HB 111. Begum S. Begum A. Kane TT. Quaiyum MA. Baqui AH. **"Assessment of Quality of the MCH/FP Services Provided by Field Workers in Zone 3 of Dhaka City, Bangladesh: An Strategies for Improvement"** May 1996
- 21 Mookherji S. Kane T T. Arifeen SE. Baqui AH. **"The Role of Pharmacies in Providing Family Planning and Helath Services to Residents of Dhaka Bangladesh"** May 1996

MCH-FP Extension Work at the Centre

An important lesson learned from the Matlab MCH-FP project is that a high CPR is attainable in a poor socioeconomic setting. The MCH-FP Extension Project (Rural) began in 1982 in two rural areas with funding from USAID to examine how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first years, the Extension Project set out to replicate workplans, record-keeping and supervision, within the resource constraints of the government programme.

During 1986-89, the Centre helped the national programme to plan and implement recruitment and training, and ensure the integrity of the hiring process for an effective expansion of the work force of governmental Family Welfare Assistants. Other successful programme strategies scaled up or in the process of being scaled up to the national programme include doorstep delivery of injectable contraceptives, management action to improve quality of care, a management information system, and developing strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, this project started family planning initiatives in Chittagong, the lowest performing division in the country.

In 1994, the Centre began an MCH-FP Extension Project (Urban) in Dhaka (based on its decade long experience in urban health) to provide a coordinated, cost-effective and replicable system of delivering MCH-FP services for Dhaka urban population. This important event marked an expansion of the Centre's capacity to test interventions in both urban and rural settings. The urban and rural extension projects have both generated a wealth of research data and published papers.

The Centre and USAID, in consultation with the government through the project's National Steering Committees, concluded an agreement for new rural and urban Extension Projects for the period 1993-97. Salient features include:

- To improve management, quality of care and sustainability of the MCH-FP programmes
- Field sites to use as "policy laboratories"
- Close collaboration with central and field level government officers
- Intensive data collection and analysis to assess the impact
- Technical assistance to GoB and NGO partners in the application of research findings to strengthen MCH-FP services.

The Division

The reconstituted Health and Population Extension Division (HPED) has the primary mandate to conduct operations research to scale up the research findings, provide technical assistance to NGOs and GoB to strengthen the national health and family planning programme.

The Division has a long history of accomplishments in applied research which focuses on the application of simple, effective, appropriate and accessible health and family planning technologies to improve the health and well-being of the underserved and population-in-need. There are several projects in the Division which specialize in operations research in health, family planning, environmental health and epidemic control measures which cuts across several Divisions and disciplines in the Centre. The MCH-FP Extension Project (Rural), of course, is the Centre's established operations research project but the recent addition of its urban counterpart - MCH-FP Extension Project (Urban), as well as Environmental Health and Epidemic Control Programmes have enriched the Division with a strong group of diverse expertise and disciplines to enlarge and consolidate its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. First, the public health research activities of these Projects focus on improving programme performances which has policy implications at the national level and lessons for international audience. Secondly, these Projects incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructures; dissemination of research findings to the highest levels of policy makers as well as recipients of the services at the community level; application of research findings to improve programme performance through systematic provision of technical assistance; and scaling-up of applicable findings from pilot phase to the national programme at Thana, Ward, District and Zonal levels both in the urban and rural settings.



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