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# Healthcare-Seeking Behaviour and BCC Needs for Urban Population: A Qualitative Study

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## Acronyms

ADB	Asian Development Bank
ANC	Antenatal Care
ARI	Acute Respiratory Tract Infection
BCC	Behaviour Change Communication
BP	Blood Pressure
BWHC	Bangladesh Women's Health Coalition
CS	Civil Surgeon
DD	Diarrhoeal Diseases
DCC	Dhaka City Corporation
DGHS	Directorate General of Health Services
ECDC	ESP Committee for Dhaka City
ELCOS	Eligible Couples
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FP	Family Planning
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
GOD	Government Outdoor Dispensary
HPSS	Health and Population Sector Strategy
HPSP	Health and Population Sector Programme
HSC	Higher Secondary School Certificate
ICDDR, B	International Centre for Diarrhoeal Disease Research, Bangladesh
LHV	Lady Health Visitor
MO	Medical Officer
NGO	Non-government Organization
ORP	Operations Research Project
PHC	Primary Healthcare
PNC	Postnatal Care
RTI	Reproductive Tract Infection
SSC	Secondary School Certificate
STD	Sexually Transmitted Diseases
UNICEF	United Nations Children Fund
UPHC	Urban Primary Healthcare
WASA	Water and Sewerage Authority

## Executive Summary

**Introduction:** In Bangladesh, the health status of the urban poor presents a dismal picture. Although at the aggregate level the urban population appears to be healthier than their rural counterparts, there is a significant intra-urban differential in health and family-planning status. In urban slums, neonatal tetanus and measles cause 19% and 5% of infant deaths respectively, and measles causes 16% of all deaths among children aged 1-4 years. There is a varying degree of malnutrition in urban slums. The slum population often has lower rates of immunization coverage and lower use of contraception compared to the non-slum urban population. There are also higher infant and child mortality rates and lower use of antenatal care in slum areas.

The urban healthcare delivery system is characterized by the presence of multiple providers, and is yet to make headway in attracting the urban poor population for use of services offered by them. A model to provide essential services by the public sector providers in urban areas was implemented at the Sher-e-Bangla Nagar Government Outdoor Dispensary with technical assistance from the Operations Research Project (ORP) of the ICDDR,B: Centre for Health and Population Research. This Model ESP Clinic has been designed to deliver essential health and family-planning services (for immunization, vitamin A, acute respiratory tract infection, diarrhoeal diseases, antenatal care, postnatal care, family planning, reproductive tract infections, and sexually transmitted diseases) with acceptable quality to the urban poor. The Model ESP Clinic has been in operation at Sher-e-Bangla Nagar in Ward 40 of Zone 6 of Dhaka City Corporation (DCC) since 1997.

The challenge of providing health and family-planning services through the Model ESP Clinic intervention is two-fold: (i) ensuring quality services to the urban poor and (ii) maximum use of available services by the population for whom these are intended. It is, therefore, important to discern views of the population of the catchment area regarding how the use of the Model ESP Clinic can be increased. The study has been designed to provide in-depth qualitative information about how people perceive their health and health needs, how and at what stage they decide to go to health providers for treatment or medical consultation and also to discern their views about the Model ESP Clinic. It is important to understand behavioural and cultural paradoxes in healthcare seeking behaviour and to assess the behaviour change communication (BCC) needs of this population. It is expected that information generated through this study will help developing intervention strategies for better use of health services.

**Design and Methodology:** The people who are using ESP services (henceforth called model clinic clients) as well as those who are not using (henceforth called non-user of model clinic) constituted the sample of the study. Forty informants,

comprising 15 model clinic clients and 25 non-users of model clinic, were selected for interviews. Thirty were women, and 10 were men. In addition, 3 private and 2 NGO providers identified in the area were interviewed. The Ward Commissioner of Ward 41 was also interviewed. A judicious combination of several qualitative research techniques was used for data collection. These include in-depth interviews, group discussion, and interviews with key informants.

All informants were interviewed following 6 guidelines. The guidelines constituted issues formulated both in question and non-question form, and the questions were open-ended. They were pre-tested on 2 model clinic users and 2 non-users. After reviewing transcripts of the interviews, some issues were dropped, new issues were incorporated, and many questions were rephrased. During the training, the interviewers were also instructed to ask follow-up questions when and if necessary.

**Findings and Discussions:** The informants were poor urban dwellers with various occupations, such as rickshaw pullers, van drivers, vendors, low-paid government staff. Slum informants live mostly in houses made of tin-roofs; walls made of bamboo slits and mud-floors. The family size of the informants was small which can be described as a nuclear type of family consisting of a husband, wife, and 2 children. The monthly income of the 22 informants ranged from TK 2,000.00 to 5,000.00. Most informants were young. Twelve females belonged to the 21-25 years age group while 6 males were in the 36-40 years age group. One-third of the slum female informants was illiterate, while others had several years of schooling. Comparatively, males were more literate in both slum and non-slum areas.

During the in-depth interviews, the informants could not describe, "What is health" in concrete terms, but they were quite aware that "health is wealth." The distinction between good and bad health was made by the absence and presence of disease. Thirty-three informants said that the absence of any disease (*asuk/bishuk na thaka*) was considered good health, while 37 informants revealed that the presence of any disease was an indication of bad health. No mentionable difference was found between the responses of females and males. The informants also linked good health with the ability to work, eat food and also with the state of mind. The reasons for emphasizing health with *kaj* (work) were that all the informants in the sample selected from the slum and non-slum low-income areas were mostly rickshaw pullers, vendors, drivers, guards, tailors, and low-paid government service holders. For them, loss of work due to bad health means loss of income that sometimes leads to starvation.

The awareness of the link among living conditions, cleanliness, and health was revealing. The concept *poriskhar o porichhannata* (cleanliness) was quite apparent to them, and various expressions were used for emphasizing this. However, they were not sure whether within existing living condition, it was

possible to maintain good health. Basic civic amenities, such as water, sanitation as well as proper housing were absent. It was gathered that in the slum, 7 families were using one latrine, and 5 families were sharing one kitchen.

Results of in-depth interviews showed that people were used to wait before they sought medical treatment. The main reason was the poor economic status of the informants. Another important reason was that, at the initial stage, people considered a disease as mild, which may go away automatically. One informant said that *opheka korle rog pake* (when you wait the disease matures). This type of response was frequently found irrespective of slum and non-slum clients. The general notion was that medical care should not be sought at an early stage of disease but at a later stage.

The first preference for healthcare providers was nearby doctors/pharmacies due to easy access, less-waiting time, low cost and also their previous bad experience in public hospitals. The Model ESP Clinic or any other public hospitals were not their first choice. The model clinic clients first obtained information about the Model ESP Clinic from their neighbours. Both females and males reported that when someone in the family was sick, they first discussed the issue with their spouses.

By and large, informant's knowledge, assessment, and expectation regarding facilities available in their neighbourhood were good. Thirty-three informants, comprising both users and non-users of model clinic, were aware of the existence of the Model ESP Clinic in their area.

The assessment of different services at the Model ESP Clinic by the informants was mixed: from 'dissatisfaction' to 'satisfaction'. The issues relating to negative assessment included: non-availability of medicines, long waiting time, lack of attention by service providers, a limited number of doctors, etc. The positive ones mentioned included: free treatment, good EPI service, and overall good service.

The reasons for a higher number of women using the Model ESP Clinic were investigated. Multiple responses were obtained. Some major responses were: men work outside the house during the day, mothers are responsible for looking after their children, females become sick more often, and the facility is for females. Most female informants first discussed sickness in the family with their husbands.

Another important fact emerged from this study: people generally think that the Model ESP Clinic is a 'hospital' which caters to the needs of women, and provides EPI services. People further think that since all doctors and other service providers are women, it is considered a woman's clinic, and they naturally get preference. This is an idea, which is deeply rooted among the people in the area.

Results of the in-depth interviews showed that 28 of 40 informants were willing to pay for medical services at the Model ESP Clinic. However, they

attached a precondition that before any payment is made, there should be an adequate supply of medicines, good doctors, good prescriptions, good treatment, etc. The informants, in general, believed that services at the government facilities should be provided free of charge.

The informants offered different suggestions on how to improve the current state of the Model ESP Clinic to make this more accessible and client-friendly. The informants mentioned that they expect good behaviour from the healthcare providers, 'good services', and provision for adequate medicine. It was further revealed from the providers' responses that the more male client flow has increased from 4-6 to 12-14 per day. People mainly come for free medicines. Counselling was another aspect of services which attracted people to the clinic.

**Suggestions for Intervention:** Review of the results of this in-depth qualitative study suggests the following areas for intervention:

- BCC activities should be strengthened focusing on services available and in what ways the Model ESP Clinic is different.
- Existing health education and counselling system should be further strengthened by including more issues within the counselling and education programme.
- Since people have a general suspicion about public hospitals that these places are full of corruption, some measures should be undertaken to dispel this notion. This can be done through counselling and community mobilization. The healthcare clinic should inquire of the clients whether they have any problems, queries, and complaints. If they have, these should be properly explained. The task is to build mutual trust and confidence.
- All hospital staff should be careful and behave properly with clients. Most complaints are against lower-level staff. Supervisors should monitor staff activities through surprise visits, talking with clients, and also ensure quality-services.
- The clients who come for services at the ESP Clinic can be used as 'information agents.' The counselor and other healthcare providers should request clients to inform their neighbours about the services of Model ESP Clinic.
- Community leaders, both formal and informal, should be used as 'mobilizing sources' for dissemination of information about the Model ESP Clinic. In this respect, the roles of informal leaders, comprising some key or knowledgeable women in the area, will be useful. Community leaders can be occasionally invited to the clinic and requested to encourage people to attend the clinic.

- At least one male medical doctor should be appointed to remove the view that it is a woman's clinic.
- Efforts should be made to provide minimum civic amenities, such as water and sanitation to the slums. It is not enough to say that people should drink pure water, and should not defaecate in public place without making enough provision for water and latrines. The problem of slum people should be approached with a humane attitude.

## **Introduction**

Population in the urban areas of Bangladesh is growing at a very rapid rate. In 1995, approximately 20% of the total population lived in urban areas. With the current rate of 5-6% population growth per annum, the urban population is expected to double by 2010, i.e. 40% of the total population of the country are expected to reside in urban areas (1). It is estimated that in Dhaka city about 30% of the population live in slums and squatter settlements without having any basic services. Although at the aggregate level, the urban population appears to be healthier than their rural counterparts, there is a significant intra-urban differential in health and family-planning status. In the urban slums, neonatal tetanus and measles cause 19% and 5% of infant deaths respectively, and measles causes 16% of all deaths among children aged 1-4 years (2). There is a varying degree of under-nutrition in urban slums. The slum population often has lower immunization coverage rates and lower use of contraception compared to the non-slum urban population (3). There is also higher infant and child mortality rates and low use of antenatal care in slum areas.

## **Background**

### **Concept of ESP**

In urban areas, various agencies of the Government of Bangladesh (GoB) and non-government organizations (NGOs) provide health and family-planning services. The commercial sector holds the major share of service outlets in urban areas comprising pharmacies, private practitioners, and clinics. The multiplicity of providers, with the absence of appropriate coordination, leads to gaps and duplication, which results in leaving the urban poor grossly under-served (4). Even at the primary level, the delivery of basic health and family-planning services within the public sector is fragmented: the Directorate General of Health Services supervises medical officers and provides limited curative care; the Directorate of Family Planning supervises family welfare visitors (FWVs) and provides family-planning methods, antenatal care (ANC), postnatal care (PNC), etc. and the City Corporation (municipality) supervises the vaccinators who provide immunization to children and tetanus toxoid (TT) to women of reproductive age. The consequent fragmentation of services not only increases the cost of providing these services, but also limits access to these services as the opportunity costs for clients go up.

The lowest tier of service-delivery in urban areas was doorstep delivery provided by the GoB and NGOs. Doorstep services have recently been withdrawn by different NGOs and shifted to static service-delivery sites. Fixed sites at the lowest tier are the satellite clinics organized by NGOs and are staffed by paramedics. As a whole, the urban poor in Bangladesh suffer from the worst health status. The GoB seeks to address these key health issues of the population

through a customer-centred approach as stated in its Health and Population Sector Strategy (HPSS).

Since July 1998, the GoB has been implementing the Health and Population Sector Programme (HPSP). The HPSP was formulated to provide an Essential Services Package (ESP), which should be responsive to clients' needs especially those of children, women, and the poor, and to achieve a quality of care with adequate delivery capacity and financial sustainability. Universal access, reduction of maternal and infant mortality and morbidity, improvement of nutrition status, and reduction of fertility will be the most important aspects of this plan. The concept of an ESP is based on the notion that all sectors of the population should have access to a set of minimal health and family-planning services that addresses their most important health problems at all levels (Annexure A).

### Model ESP Clinic Intervention

The concept of ESP delivery has been operationalized by Operations Research Project (ORP) of the ICDDR,B: Centre for Health and Population Research through establishing a Model ESP Clinic at an existing government outdoor dispensary. It was planned to pilot ESP delivery by the public sector healthcare providers in urban area at the Sher-e-Bangla Nagar Government Outdoor Dispensary, situated near to the Ward 41 of Zone 7, a predominantly slum-inhabited area of Dhaka city, with technical assistance from the ORP.

Dhaka city is divided into 10 administrative zones. Each zone is further divided into wards, the lowest administrative urban unit. The Sher-e-Bangla Nagar Government Outdoor Dispensary of Agargaon Pucca Market is located in Ward 40 of Zone 6 of Dhaka City Corporation (DCC) (Map-Annexure B). In this facility, service providers from 3 different government organizations (Directorate General of Health Services, Directorate of Family Planning, and Dhaka City Corporation) are there, dispensing 3 different kinds of services. This dispensary is located close to the largest slum settlement of Dhaka city. Table 1 shows the distribution of population for Ward 40 and 41. The community profile of the area has been described elsewhere in this paper.

**Table 1.** Population profile of selected wards of the ESP intervention area

Zone	Ward	Total population (1991)	No. of estimated population (1998)	No. of slum population (1997)	No. of infants	No. of children (<5 years)	No. of ELCOS	No. of pregnancies
7	41	49,010	66,696	38,975	2,001	11,338	12,005	2,668
6	40	56,258	76,569	18,737	2,297	13,015	13,781	3,062
Area total		1,05,268	1,43,265	57,712	4,298	24,353	25,786	5,730

ELCOs = Eligible couples

Source: ICDDR, B working paper no. 125 (5).

Keeping in mind the essential elements of the ESP, the existing infrastructure, future needs and on the basis of a situation analysis performed by the ORP, the key features of a Model ESP Clinic were designed, and needed major activities were identified (5). The Model ESP Clinic is, therefore, a service-delivery centre with the following features: (a) appropriate physical facilities, (b) appropriate staffing, (c) availability of integrated essential services (health and family planning) of an acceptable quality, (d) appropriate counselling and health education, (e) appropriate strategy for tapping missed opportunities, (f) appropriate referral linkage, and (g) cost-effective services.

The salient activities within the intervention include the following steps:

- Reorganization of the service-delivery system
  - Revised job description
  - Introduction of client-flow system
  - Restructuring physical facilities, e.g. waiting space, drinking water, etc.
- Capacity enhancement of the providers
  - Job-aids were adapted, updated, and expanded
  - Training of service providers on job-aids
- Strengthening delivery of ESP, broadening the range of services
  - Introduction of routine counselling and health education sessions by trained counsellors
  - Strategy and mechanism for addressing missed opportunities of attending clients, accompanying persons, and unaccompanied family members
  - Routine supervision by using standard supervisory checklist
  - IEC materials for health education and counselling developed and adapted
- Needs assessment for BCC activities and developing a communication strategy
- Reviewing activities through inter-provider meetings at the facility level and through ESP Committee for Dhaka City (ECDC) meetings involving supervisors
- Development of an effective referral mechanism
- Baseline survey
- Regular monitoring by collecting service use data, observations, exit interviews, and by interim evaluations.

From the above discussion, it is seen that there has been an endeavour to provide health services to poor urban dwellers. However, the challenge of providing health services through the Model ESP Clinic intervention is two-fold:

- Ensuring quality services to the urban poor
- Utilization of available services by the population for which it is intended.

It is, therefore, important to discern the views of the population of the catchment area regarding how the use of the Model ESP Clinic can be increased.

The present study has been designed to provide in-depth qualitative information for developing intervention strategies for increasing the use of health and family-planning services. Rapid urbanization and population growth, inadequate health services, and lack of knowledge about services available might have acted as constraints to the proper use of health services. Some of these reasons relate to the delivery mechanism, while other reasons are mostly behavioural and cultural. An understanding of these behavioural and cultural paradoxes in healthcare-seeking behaviour is needed.

## **Analytical Framework and Objectives**

### **Major Research Issues**

By and large, people possess imprecise and wrong perceptions about their health. It has been found that people are indifferent to their health needs, and in most cases, they defer or delay treatment by conscious choice when they are sick and need medical support. It is, therefore, important to understand how people perceive their health and health needs, and how and at what stage they decide to go to health providers for treatment or medical consultation.

The use of health and family-planning services provided by the Model ESP Clinic depends, to a large extent, on how effectively information can be disseminated to the target population about the availability of services and how this can be presented in a client-friendly way. It is possible that the people of the area may have little knowledge and inadequate information and explanation about what services are available, and also how they can access these services. Access refers to whether services are beyond the reach of potential clients because of location, cost, past experience, or dissatisfaction with previous services received.

It has been found from a previous assessment that 80% of model clinic clients are women (5). However, it is not yet understood from the clients' perspective the reasons for the high use of the Model ESP Clinic by women. The pertinent questions in this respect are:

- Do women care more for health of their family members than men?
- Are women good in delivering information about healthcare?
- Are facilities for men limited?
- Do men care less about their health?
- Do men hide their diseases?
- Are the services available at the ESP clinics women-focused?

These issues were also pursued.

## **Objectives**

Keeping the above research issues in context, the study was conducted with the following general and specific objectives:

### ***General objectives***

- Generate in-depth information regarding healthcare-seeking behaviour of people around the Model ESP Clinic, and suggest intervention strategies for using services provided by the Model ESP Clinic through strengthening the BCC.

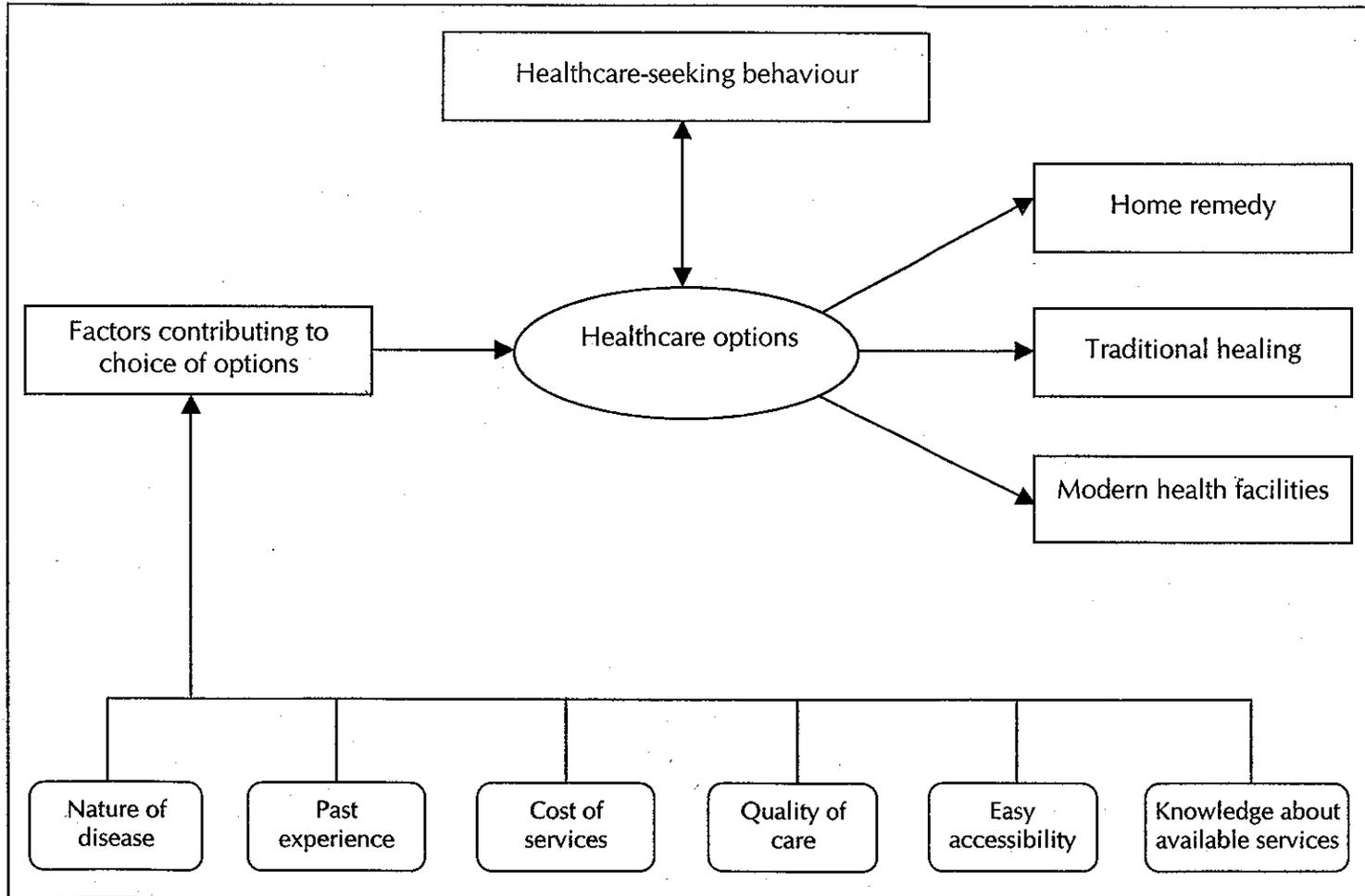
### ***Specific objectives***

- Identify the perceptions of people regarding 'good' and 'bad' health and also how they define their health needs.
- Identify the factors that influence healthcare-seeking behaviour of people.
- Assess current knowledge of the community regarding the availability of services and the source of such knowledge.
- Generate information as to whether there is any gender difference in healthcare-seeking behaviour and also in using the existing ESP services.
- Learn from the study participants how access and use of the ESP services can be ensured.

## **Analytical Framework**

Information collected in this study has been presented in a descriptive manner. However, in describing a particular issue the emphasis was on analyzing and discerning a particular point from the perspectives of informants. While processing information from the in-depth interviews, we categorized some responses and counted the frequency of those responses from the interview transcripts. These responses, along with frequency, are presented in some tables. However, since this was a qualitative study, we emphasized not on the number, but on the different types of responses which provided the insiders' perspectives. The conceptual framework of the study is presented in Fig. 1. In the figure, it is demonstrated that the healthcare-seeking behaviour of people depends upon existing health systems as well as how people perceive them. The choice of a particular system is, however, affected by several factors which are categorized as 'factors contributing to the choice of options.'

Fig. 1. Conceptual framework of healthcare-seeking behaviour



## **Methods and Procedures**

The study was conducted in the area served by the Model ESP Clinic. The clinic is located in Ward 40 of Zone 6 of DCC. Due to its location, its catchment area also includes the adjacent area of Ward 41 of Zone 7 of DCC. Most clients, who use the Model ESP Clinic, live in the slums of Ward 40 and 41 and in the adjoining areas (5). However, more of the clients live in Ward 41.

### **Sample Selection**

Keeping the objectives of the study in mind, it was decided to include persons who are using ESP services as well as those who are not using ESP services within the purview of this study. Forty informants, comprising 15 model clinic clients and 25 non-users of model clinic, were selected for in-depth interview. Thirty informants were women, and 10 were men.

The rationale for the selection of non-users of model clinic is to find out why people do not go to the Model ESP Clinic, what their knowledge and views about Model ESP Clinic and services are, and what their suggestions are regarding how the use of ESP facilities can be increased. It is expected that the views of the non-users of model clinic will give different perspectives on the use and non-use of the ESP facilities and assist in designing an effective intervention strategy.

The study coverage, including methods of information collection, is presented in Table 2. The selected informants were from 15 slums and 4 non-slum areas. In Ward 40, there were 9 slums, and in Ward 41 there were 28 slums with overlapping names and areas. In the selection process, 47 clients of Ward 40 and 41 were initially identified with addresses from exit interviews of clients visiting the Model ESP Clinic. Selected informants residing in slums were chosen systematically from this list.

However, in the selection process one problem was encountered. Since the list was prepared several months ago, some model clinic clients were found to be relocated. In such cases, another model client from the same slum was chosen. The selection of clients was done in such a way so that one model clinic client and 2 non-users of model clinic were selected from the same slum. The non-slum informants were mostly selected from different adjacent areas of the Agargaon Government Staff Quarters.

In addition, 3 private healthcare providers and 2 NGO providers located in the area were interviewed. The Ward Commissioner of Ward 41 was also interviewed. Group discussions were held with 3 medical officers, and 4 other service providers of the Model ESP Clinic, and ESP clients were also interviewed in a group and one-to-one basis.

Considering the nature and the objectives of the study, it was felt that the study coverage was comprehensive.

**Table 2.** Sample and study coverage

Qualitative approaches for collecting information from informants	No. of informants
<b>In-depth interviews</b>	
<b>Slum</b>	
Female model clinic clients	8
Female non-users of model clinic	12
<b>Non-slum</b>	
Female model clinic clients	3
Female non-user of model clinic	7
<b>Slum</b>	
Male model clinic clients	2
Male non-users of model clinic	3
<b>Non-slum</b>	
Male model clinic clients	2
Male non-users of model clinic	3
<b>Providers</b>	
Private providers	3
NGO providers	2
	1
<b>Ward Commissioner</b>	
	1
<b>Group discussion</b>	<b>Group</b>
Medical Officers	1
Non-medical staff	1
Female model clinic clients	1

### Research Techniques

In this study, a strategy for a judicious combination of several qualitative research techniques was used for data collection. These included in-depth interviews, group discussions, and key-informant interviews. The use of several techniques complemented and supplemented the information collection procedure.

Forty in-depth interviews were conducted with the model clinic clients and non-users of model clinic. In addition, 3 private healthcare providers, 2 NGO providers, and one Ward Commissioner were also interviewed. It was expected

that the in-depth interviews would provide insiders' views on issues, such as perceptions of health, healthcare-seeking behaviour, views about quality of services, knowledge of services available, etc. Three group discussions, involving medical officers, other service providers of the model ESP Clinic, and model clinic clients, were also conducted by a consultant and a researcher of the ORP.

Information was collected about the people living in Ward 40 and 41 from both primary and secondary sources, which provided a community profile of the study areas. Some information on the community profile was collected by interviewing 2 key informants, 2 shop-keepers, and one pharmacist.

### **Interview Guidelines**

All the informants were interviewed following 6 guidelines (Annexure C). The guidelines constituted issues formulated in both question and non-question forms. The questions were open-ended. Specific instructions were given to the interviewers regarding how to ask/phrase a particular question and also the reason behind asking that question. The interviewers were also instructed to ask follow-up questions if and when necessary. Before the inception of the study, the interviewers were trained by a consultant. Guidelines were pre-tested on 2 model clinic clients and 2 non-users of model clinic. Later, after reviewing the transcripts some issues were dropped, new issues were included, and many questions were rephrased. In this way, interview guidelines were developed.

It appears from the guidelines in Annexure C that there were some important issues, which were common to all types of informants. This was done willfully, because these needed to be pursued by all to get comparative views on issues relating to healthcare-seeking behaviour.

In most cases, the interviewers used a tape-recorder with the consent of the informants, but when refused, they took notes. These notes were later expanded into several pages of field notes. On an average, an interview lasted 45-60 minutes. By and large, the informants were cooperative, but problems occurred in the informants' understanding of some questions. Many informants also thought that some questions were irrelevant and amusing.

## **The Study Population**

### **Community Profile**

The clinic is located in Ward 40 of Zone 6. There is a large slum settlement nearby under Ward 41 (Annexure B). Most clients of the clinic come from slums located in Ward 41 and also from a few adjoining areas. It was, therefore, expected that a general community profile would help understand the community situation in the area and findings. The general community profile was prepared obtaining information from key-informant interviews, group discussion with

researchers of the ORP, located in the Shaymoli field office and from the existing statistics available with the ORP. In the community profile, a general description of infrastructural facilities, the occupational patterns of the population, housing patterns, composition of the family, health services facilities, etc. were incorporated.

### **General Community Profile**

Both Ward 40 and 41 have quite a large population. The total population of these 2 Wards is estimated to be about 1,43,000. People from various low-income occupations live in these slums. Some of them are: rickshaw pullers, van drivers, baby-taxi drivers, daily labourers, hawkers, cooks, small shop-owners, garment workers, etc. Their monthly income varies from Tk 2,000.00 to 5,000.00 per month. Males head the majority of the families. In some cases, women were found to be the head of the household, but the usual reason for that was death or desertion by husbands.

Most houses in the slums have mud-floors, walls made of bamboo slits, and tin-roofs. A few houses have tin-walls and cemented floors, but these are quite rare. There are a few structures that are totally made of concrete. The rent of these houses depends on the position of the structures and on construction materials also. The huts, built on relatively high ground, tend to be more expensive than those built on lower lands. The rent varies from Tk 150.00 to 600.00 per month. There is no gas supply in the slum. Electricity is available but connected illegally. There are a few slab-toilets connected by a long pipe to the main sewerage line under the main road. Some hanging toilets can also be seen. Drinking water is collected from the main line of Water and Sewerage Authority (WASA).

Most cannot read or write, and some can only sign their names. The school drop-out rate is very high. However, a large number of adults and children receive informal education.

Healthcare facilities around the slum are good. There are several large-scale secondary and tertiary-level healthcare institutions in adjoining areas, operated by both GoB and NGOs: Suhrawardi General Hospital, Paediatrics Hospital (Shishu Hospital), Orthopaedics Hospital (Pangu Hospital), TB Clinic, etc. People from surrounding slums also obtain services from these institutions. In some cases, people go to the ICDDR,B hospital too. Those who live near the Sher-e-Bangla Nagar Model ESP Clinic go there to meet various health needs; others go to nearby NGO facilities.

### **Socio-demographic Characteristics of Informants**

Socioeconomic information about the 40 informants, collected during in-depth interviews, are presented in Table 3. It is expected that this will give a general

profile of the informants who provided valuable information that is reported later in the report.

**Table 3.** Socio-demographic characteristics of informants

Characteristics	Female (n=30)	Male (n=10)	Total (n=40)
<b>Age (in years)</b>			
15-25	18	1	19
26-35	6	2	8
36+	6	7	13
<b>Education</b>			
Illiterate	12	2	14
Up to primary level	4	1	5
6-10 class	5	4	9
SSC and above	5	2	7
<b>Length of marriage</b>			
5 years or less	5	1	6
6-10 years	13	1	14
11 or more years	8	3	11
<b>Family size</b>			
4 or less	21	4	25
5 or more	9	5	14
<b>No. of children</b>			
2 or less	23	4	27
3 or more	7	5	12

Table 3 shows that ages of the informants (both slum and non-slum) of this study range from 15 to 40 years. Most females were young. Twelve females belonged to the 21-25 years age group, whereas 6 males were in the 36-40 years age group. One-third of the female informants was illiterate, while others had several years of schooling. The education level of the males is similar.

All the informants in this study were married. The length of marriage is revealed from Table 3. The table shows that 13 female informants were married for 6 to 10 years, and 5 were married for 2 to 3 years. Three males were married for 11 to 15 years. All the informants had a nuclear type of family consisting of husband, wife, and 2 children. There were only 2 instances where husbands had deserted their wives, and the women had been living with their children. The family size of the informants was also small. Twenty-five (21 females and 4 males) of the informants had families consisting of 3-4 persons. The number of children

of each of the informants was few (Table 3). Twenty-seven (23 females and 4 males) informants had one or two child(ren).

Among other background characteristics, it is important to note that most informants had fewer children and a small family. With the exception of the non-slum residents, 22 of the informants lived in houses made of tin-roofs, walls made of bamboo slits, and mud-floors. Thirteen informants lived in *pucca* houses, which were government quarters or privately-rented houses. The informants were engaged in various types of occupations, but most were rickshaw pullers, van drivers, and vendors. The monthly income of the 22 informants, who mostly belonged to slum, ranged from Tk. 2,000.00 to 5,000.00.

## Findings and Discussions

### Perceptions and Healthcare-seeking Behaviour

#### *Perceptions about 'good' and 'bad' health*

It is important to know how people interpret their health, its relation to physique (*sharir*) and living conditions before designing any programme or intervention for encouraging people to use different healthcare facilities both in private and public sectors. It is also necessary to understand the mindset regarding how people look at health problems, and when, how, and where they go for treatment.

Keeping this primary objective in mind, the interviewer started the interview by asking the informants what they understand *sharir* (body) and *shashtya* (health) to mean. This question itself was a surprise to them, and the general impression was that they were not able to describe *sharir* and *shashtya*. It seems that it is an abstract entity and difficult to concretize, and they never thought of this. One informant said that *shashtya holo shashtya* (health is health), and another informant said that *shashtyai sampad* (health is wealth).

Since health was an abstract entity to the informants, it was thought that people will be able to distinguish between different state of health in a descriptive way. Therefore, the informants were asked to distinguish between *bhalo shashtya* (good health) and *kharap shashtya* (bad health). Different expressions, phrases, and statements to explain these were used. However, the similarity in 'inner meanings' of these responses was revealing. Generally, people described good and bad health by the presence and absence of different diseases. The diseases range from simple bodyache or headache to serious diseases, such as jaundice, typhoid, hyperacidity (gastric), etc. The informants gave multiple answers in describing 'good' and 'bad' health.

The answers are presented in Table 4. Thirty-four informants stated that the absence of any disease (*asuk/bishuk na thaka*) was considered 'good' health, while 36 informants said that the presence of any disease was an indication of

'bad' health. No mentionable difference was found between responses from females and males. It was generally viewed that good health played an important role in one's life, and without good health a person cannot do anything or prosper in life. A typical response about the perception of 'good' and 'bad' health by the informants follows:

When there are no diseases (*rog-sok*) in one's body, he/she possesses good health. This is not to say that if someone is fatty or huge in size he/she is in good health. Good health comprises many things, such as no disease, eating regularly (*khaowa dawa neomita kora*), bathing properly (*neomita gosol kora*), and sleeping properly (*thikmoto ghumano*). If someone is in good health, he/she will look fresh (*chehara taza thakbey*). A sick person will never look fresh. He will be gloomy all the time (*sob somoi chehara kalo thakey*).

When the components of good health are absent, one may be said to possess bad health. In a state of bad health, a person will have sickness; it does not matter whether it is mild sickness (*alpo oshuk*) or severe one (*marattok oshuk*).

In Table 4, a list of different responses regarding the perceptions of good and bad health is provided.

**Table 4.** People's perception about health

<p><b>A. Good health</b></p> <ul style="list-style-type: none"><li>- Absence of disease</li><li>- Able to work/move</li><li>- Can eat good food</li><li>- Remaining clean</li><li>- Few children</li><li>- Children can play</li><li>- Looks good</li><li>- Mind remains fresh</li></ul> <p><b>B. Bad health</b></p> <ul style="list-style-type: none"><li>- Presence of disease</li><li>- Cannot work</li><li>- Unable to eat</li><li>- No peace in the family</li><li>- Looks bad</li><li>- Weak body</li><li>- Mentally sick</li><li>- More children</li></ul>
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Seven female and 3 male informants linked their state of health with the ability to work. It was mentioned that when people had good health, they could work and when they were in bad health, they could not work. Another feature of the responses was that condition of health with appetite for food (whether one could or could not eat) was linked. *Bhalo bhalo khabar khaita parlo na, bhalo laglo na etai kharap sasthya* (could not eat good food, felt bad, it is bad health). Linking health with the ability to eat was important, because if one cannot eat and maintain normal health, he/she would not be able to work.

The reasons for emphasizing health with *kaj* (work) are that all the informants in the sample selected from the slums and non-slum low-income areas were mostly rickshaw pullers, vendors, drivers, guards, tailors, and low-paid government service holders. For them, loss of work due to bad health means loss of income that may cause starvation. For example, a rickshaw puller who had four family members and was the only earning member in the family could not go for work for 2 days. Good health is linked with the ability to eat, capacity to work, and ultimately, income earning for the family's survival. Some interesting quotes which reveal different ways in which the informants described good and bad health are provided in Box 1.

**Box 1.** Perceptions of good and bad health

- ➔ "If you live in good environment, you will not suffer from any disease, you will remain good to all, then it is good health. If there is disease, it is bad health." (Female Model Clinic Client-Slum)
- ➔ "One can work if he/she has good health, and cannot work if he/she has bad health. He/she will always feel bad." (Female non-user of Model Clinic-Slum)
- ➔ "If there is no disease, one can eat and move properly, then it is good health." (Female Model Clinic Client-Slum)
- ➔ "Unable to eat good food and always feel bad--this is bad health." (Female non-user of Model Clinic-Slum)
- ➔ "Those who have any physical problem possess bad health and those who are free from this have good health." (Female Model Clinic Client-Slum)
- ➔ "When there is disease, it is bad health, and when there is no disease, then it is good health. When you have good health, body (*sharir*) remains good, and one feels good to work. In case of bad health, one does not like to work and talk, and likes to stay alone." (Female non-user of Model Clinic-Slum)

Contd...

**Box 1 (contd.)**

- ➔ "Good health means to have less children and peaceful family life and also appetite for food. If there is shortage in the family, you are not mentally happy, no peace in the family and even disharmony and dissension in the family life. This is bad health." (Female non-user of Model Clinic-Slum)
- ➔ "Those who have money can eat better, can live and sleep better, and also can get better treatment. Their health can be considered good." (Male Model Clinic Client-Slum)
- ➔ "Sometimes you live with diseases, and sometimes there is no disease with you. Between these, the human health remains. If you are living with diseases, you are sick and you are in bad health. When there is no disease in your body, you are in good health." (Male Model Clinic Client-Slum)

The informants linked the concept of good and bad health with the present solvency and economic condition of the family. Although responses were a few, it could be discerned from some responses that there were more disagreements and quarrels within the family members if the family was poor and lived from hand-to-mouth. It ultimately affects the health of the family. One informant described this as follows: "Lack of peace in the family is a reflection of bad health." Another informant said, "if there are economic problems, people remain depressed, and conjugal life become awful. This is bad health."

***Living conditions, cleanliness, and health***

After pursuing issues relating to good and bad health, how informants relate living conditions, cleanliness, and health was explored. This is considered important, because it ultimately affects health and healthcare-seeking behaviour. During the fieldwork, it was found that people were living in very unhealthy conditions. There was a lack of sufficient drinking water and proper sanitation and drainage. It was found that in slums, 5 families shared one kitchen, and 7 families used a common latrine.

In the study, 15 informants said that there was a direct relationship among cleanliness, living conditions, and health. The remaining informants used different expressions, and also mentioned different ways of keeping themselves clean and healthy. From all these responses one can conclude that people were aware of this issue.

We have summarized these responses in Table 5.

**Table 5.** Perceptions of the relationship between cleanliness, health, and living conditions

- Keeping the house clean
- Cover food
- Boil drinking water
- Wash/clean clothes
- Wash hands before eating
- Uncleanliness leads to illness
- Norms and values
- Environment is alright
- Health and environment are linked

Thus, people were found familiar with the concept of *pariskar o parichhannata* (cleanliness). They realized the effects of uncleanliness, but they were not sure to what extent it was possible to remain clean and maintain proper health within the existing physical conditions of slums where there were acute shortages of basic civic amenities. Two quotes regarding how the informants conceptualized this issue are:

- a. Cleanliness means that everything around you should be washed, kept clean, and should be covered, otherwise flies will sit. Lack of cleanliness results in various types of diseases.
- b. Cleanliness means regular bathing and washing hands and utensils before taking meals. It is important because it prevents us from various diseases, like *gota* (boil), fever, and scabies.

Another informant stated:

Cleanliness means certain *achar neom* (norms and rules). It is good to follow these norms but one will become sick if he/she does not follow this. Some of these norms are: boiling water before you drink and also keeping all your work neat.

The responses and quotes are good indicators of people's awareness regarding health and living conditions as well as their concern that if they live in an unclean environment, they may suffer from various diseases. It is also mentioned by the informants that current living conditions are not conducive to good health, but they feel that they do not have any choice. Therefore, within the existing constraints, they try to keep themselves free from any disease. The following 2 quotes are pertinent:

- a. We are poor. We have to live here, and if it is bad, what can we do? Still we try to keep ourselves clean. My baby is small, and I need to clean his clothes, cook and do not get time.

- b. What can we do? We are poor and have to live here. Though it is bad, but we have no choice. We live in low land. The land is not ours? If we can leave here, well it is good, but this is not possible for us.

In sum, people were aware of their health situation, which they considered important for their survival. However, they were not sure whether the maintenance of good health in their existing living conditions is possible or not.

### ***Choice for health services***

It is normally expected that if a person is sick, he/she will go to a doctor or seek medical support, so that he/she is relieved and becomes well. It is, therefore, necessary to understand how people decide to undergo medical treatment when they are sick. Relevant issues in this respect are: What is the process of decision making? Where do the people go? Do they have any preferences? Is it possible to discern any pattern in the choice for health services? An understanding of these issues is important, because the use of different health services both in private and public sectors depends on it. In this study, healthcare-seeking behaviour of people in the light of the issues raised above was explored.

To understand healthcare-seeking behaviour, it is necessary to find out how people look at different types of diseases. It is also important to have a clear knowledge of how people define and perceive disease. It is linked with what was earlier described as 'good' and 'bad health'. If good and bad health is basically perceived as the presence and absence of disease, the critical issue is 'disease' and consequent 'sickness.'

From in-depth interviews, it was found that people suffer from various types of diseases ranging from simple headache and bodyache to diarrhoea, typhoid, hyperacidity (gastric), scabies, cancer, TB, etc. Generally the informants were indifferent, and did not take any medicine unless these became serious. From this research, it was observed that informants distinguish between *alpo oshuk* (mild sickness) and *marattak oshuk* (severe sickness). Mild sickness was considered normal, tolerable and could be cured by self-medication or just by staying at home. In severe sickness, medical support becomes necessary. One informant described mild and severe sickness as follows:

Sometimes we suffer from *matha-betha* (headache). After a few hours of taking rest, it goes away or sometimes after taking one or two Paracetamol tablet(s). In case of *jor* (fever), it goes away within one or two day(s). It is a mild disease. When people are unable to work due to sickness, it is a severe disease. If headache reaches to migraine stage, it is a severe disease.

### ***Behaviour during sickness***

Information was gathered regarding informants' behaviour when they sought medical support. Twenty-four female and 8 male informants reported that they

waited for 3-4 days before they decided to go to a doctor. The average time was 3 days. Table 6 provides information about different actions taken by the informants.

**Table 6.** Behaviour during sickness

<ul style="list-style-type: none"><li>- Wait for some time</li><li>- Go to doctor/pharmacy</li><li>- Go to pucca hospital (Model ESP clinic)</li><li>- Go to hospital</li><li>- Go to private clinic</li><li>- Homeopathy</li></ul>
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From the interviews, several reasons were found why people had waited before they went for medical treatment. The main reason was economic considerations. At the initial stage, people considered disease as mild which, they believed, would go away, automatically. There were 12 responses which revealed that some of the informants also went to *kabiraj*. One informant said that *ophékha korle rog pake* (when you wait, the disease gets matured). Wait to mature means the disease will be full-blown and will help the provider for proper diagnosis. This type of responses was frequently found among people irrespective of slum and non-slum areas that medical care should be sought not at an early stage of disease, but at a later stage. Sometimes a simple disease becomes serious due to waiting. This can become serious for children. The following quotes reveal the reasons for waiting:

- a. If someone becomes sick, we go to doctors for treatment after waiting 3 days. It is not possible to go to a doctor because we are poor.
- b. I do not go to a doctor immediately. We wait for 2-3 days, then go to a doctor. We wait for any remission of fever, use water to keep the head of the patient cool, so that fever decreases.

This study revealed that the informants normally did not take any medical support when their sickness was mild. The existing norm is waiting for a few days, then go to a nearby 'doctor.'

### ***Choice for healthcare providers***

Twenty-seven female and 8 male informants reported that they visited doctor first. It is important to mention what 'doctor' means to them. People of both slums and non-slums go to pharmacies in the neighbourhood where medicine-sellers or doctors prescribe medicines. In some pharmacies, there were qualified doctors. Some informants mentioned some common names of healthcare providers who appeared to be very popular. One informant said that if the disease had been

severe, she went to a *boro* doctor (big doctor). Only 9 informants mentioned that in the past they went to the *Pucca Hospital* (Model ESP Clinic).

The results from in-depth interviews showed that, normally, people did not go to a *kabiraj* and other traditional healers. Seven informants reported that they did not trust them. Twelve female informants (mostly slum dwellers) stated that they went to a *kabiraj*, whereas 8 reported that they went to traditional healers for *jhurfuk*. It was also found that those who went to *kabiraj* or traditional healers normally went for the treatment of jaundice. There were some cases where women went to a *kabiraj* for the treatment of measles too.

### ***Sources of information***

Issues relating to sources of information about healthcare providers, how the decision to go to any doctor was made, and whom the informants told or consulted when some one in the family was sick were also pursued. It revealed that normally the informants got information from husbands, relatives, and neighbours regarding the availability of healthcare facilities in their vicinity. For example, the informants obtained information from their neighbours regarding local pharmacy and private providers and their quality. It was also observed that most model clinic clients got information from their neighbours regarding the Model ESP Clinic. When the Model ESP Clinic was visited to conduct interviews, it was discovered that some model clinic clients got information from their neighbours regarding the clinic. In one instance, the daughter of one woman's neighbour accompanied the woman to the clinic.

### ***First person consulted***

It also revealed that both female and male informants informed someone in the family when they were sick. Twenty-four female informants stated that they first discussed the sickness (of herself or children) with their husbands. Similarly, 6 male informants reported that they shared their health problems with their spouses.

The issue of why women first discussed problems with their husbands was pursued. The informants stated several reasons which reflect that, although husbands did not accompany them to the health providers, they were important in decision-making for healthcare. Some reasons stated by the informants were as follows:

- Husband knows location
- Husband controls money
- If husband does not know, he will be angry
- Husband is knowledgeable
- Husband is educated

No pattern could be discerned of how the decision to go to a provider was taken when someone in the family was sick. However, in most cases, women attended the sick member of the family after discussing it with a male member of the family. The women informed the men, but the men rarely accompanied the women to the doctor or to the Model ESP Clinic unless it was extremely serious. This suggests that women were more responsive to the needs of the family.

### ***Reasons for preference of healthcare providers***

It was observed that people were aware of different public facilities in and around the study area. The question is: Why don't the people go to these places? Several reasons for preference of the nearby doctors and pharmacies were identified by the informants (Table 7).

**Table 7.** Reasons for preferring nearby healthcare providers

- Easy access
- Close to house
- Low cost
- Waiting time is less
- Excessive time
- Standing in queue at the hospital
- Need to cross the main road
- Pharmacies/doctors have reputation
- Don't provide medicine
- Need to pay
- Bad experience in hospital

A close examination of the reasons for preference revealed that the main factors that affected the choice of healthcare providers were: easy access and less waiting time which, in most cases, were absent in public hospitals. Therefore, it was possible to say that personal convenience of people was critical in the choice of healthcare providers. This is confirmed when the responses relating to the assessment of ESP services provided later in the report and the responses regarding suggestions on how to improve services of the Model ESP Clinic are also analyzed.

From the above discussion, it can be said that there is a similarity between the model clinic clients and non-users of model clinic. From this, a descriptive flow diagram of healthcare-seeking practices is presented in Fig. 2. In the diagram, a logical sequence of different healthcare-seeking practices of informants is presented.

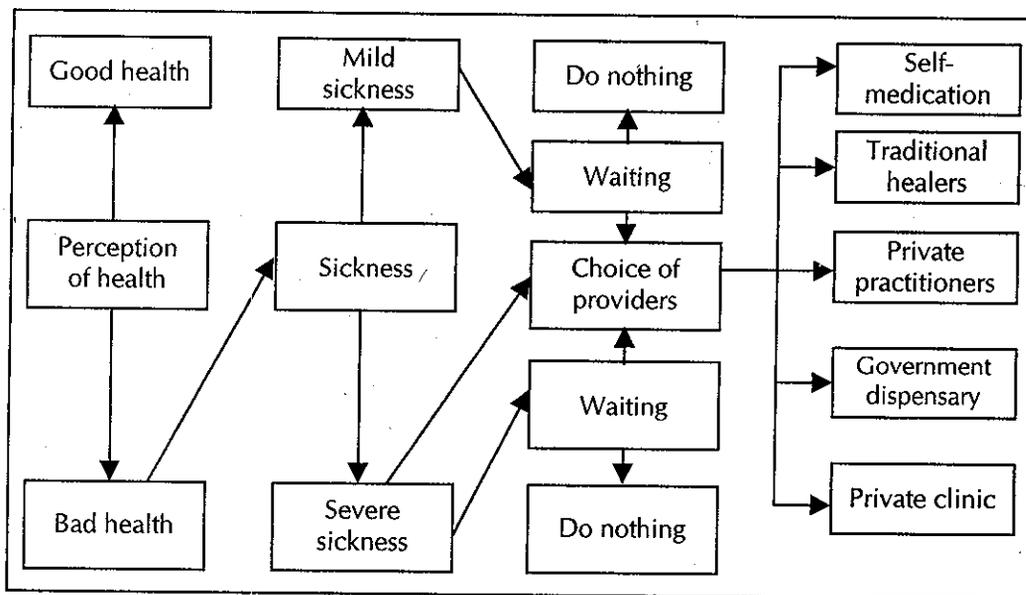


Fig. 2. Flow chart of healthcare seeking practices

### Knowledge, Assessment, and Expectations

Since the Model ESP Clinic and the healthcare-seeking behaviour of people in the catchment area are the main focus of the study, an attempt was made to find out whether people were aware of the existence of the Model ESP Clinic as well as their views regarding performance of the clinic. People were also asked to suggest ways to improve the Model ESP Clinic. Findings on these and other issues are presented below.

#### *Knowledge about services available*

The Model ESP Clinic is popularly known as the *Pucca Market Dispensary*, since it is located in a market building. Therefore, in pursuing the issue of whether people are knowledgeable about the Model ESP Clinic, both these identities to determine the level of people's knowledge were used. In general, it was noted that people have a good knowledge about the Model ESP Clinic. This includes both model clinic clients and non-users of the model clinic. Even those who do not come to the clinic are familiar with the Model ESP Clinic. It was found that 33 of 40 informants, had knowledge of the Model ESP Clinic, while 5 had no knowledge of the clinic.

#### *Types of services available*

From the in-depth interview it was revealed that the informants had limited knowledge about the different services provided by the clinic (Table 8). Only 10

female and 3 male informants knew that general healthcare was available at the Model ESP Clinic. One interesting feature of this finding is that most informants thought that the Model ESP Clinic only provides EPI and family-planning services. Generally, the males thought that since all the service providers in the clinic were women, women get preference for treatment. For example, one male informant stated, "I know that the clinic of the Pucca market is a family-planning office and family-planning services are given to the females." Seven informants (mostly female) stated that the clinic provide antenatal care.

**Table 8.** Knowledge of services provided by the Model ESP Clinic

Services*	No. of responses			
	Female		Male	
	Non-slum	Slum	Non-slum	Slum
Antenatal care	2	4	1	0
Child care	0	2	0	0
EPI	1	2	1	1
TT (general)	0	2	0	1
Family planning	3	2	2	1
General healthcare	4	6	2	1

\* Multiple responses were recorded.

From in-depth interviews, it was further found that the informants had a very good knowledge of different facilities available in their area. They mentioned different hospitals, pharmacies, and specialized facilities, such as Lion's Eye Hospital and TB Clinic (Table 9).

**Table 9.** Knowledge of facilities situated in the area

Type of facilities*	Female		Male	
	Slum'	Non-slum	Slum	Non-slum
Pucca market	6	12	3	5
Suhrawardi Hospital	7	8	2	2
Shishu Hospital	7	13	2	4
Orthopedic Hospital	6	6	2	1
Pharmacy	4	2	3	2
Lion's Hospital	0	1	0	0
ICDDR,B Hospital	0	1	0	0
TB Hospital	5	0	1	0
Old Age Home	2	0	0	0

\* Multiple responses were recorded.

## **Assessment**

The results of in-depth interview showed that the informants had mixed attitude when they were asked to give opinions and assess different types of services provided by the Model ESP Clinic. There were numerous responses and expressions which showed both satisfaction and dissatisfaction, and also appreciation and criticism. Some of these responses were quite candid, while others reflected clients' frustration. A number of informants also failed to give any opinion about services. These responses are provided in Table 10.

**Table 10.** Assessment of ESP services

<p><b>Satisfied</b></p> <ul style="list-style-type: none"><li>- Free treatment</li><li>- Better treatment than before</li><li>- Good EPI service</li></ul> <p><b>Dissatisfied</b></p> <ul style="list-style-type: none"><li>- Long-waiting time</li><li>- Non-availability of medicines</li><li>- Only give prescriptions</li><li>- Limited doctors</li><li>- Inadequate space</li><li>- Did not examine properly</li></ul>
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From in-depth interviews, it was discerned that the informants were satisfied with EPI and family-planning services. They were critical about long-waiting time, inadequate supply of medicines, and lack of attention by the healthcare providers. Some informants did not understand why medicines, which were prescribed by the doctors, were not available in the clinic. They were also critical about the fewer number of doctors in the clinic. One informant said that the hospital space was inadequate. It is pertinent to quote, what a male informant said about the clinic:

About this clinic what can I say. It does not matter whether it is a clinic or hospital, sick people go there. The environment should be neat and clean. One day, I saw that one kid had defaecated in front of the medicine counter of the clinic. There was no one to clean this. If you go to any government hospital—Mitford or Dhaka Medical College Hospital—the environment is found unclean. Doctors and nurses should give minimum attention to the patients, but there is no one to listen to this."

### ***Reasons for higher number of female than male clients***

At the outset of the study while delineating the research issues, it was mentioned that 80% of the clients of the Model ESP Clinic were women. This fact is linked with the bigger issue of gender participation in the use of healthcare facilities and also male involvement in tackling different health problems. Therefore, this issue was intensively pursued. Findings of the study revealed that it was still thought by both males and females that family health and procuring contraceptives were the concern of women only. The patriarchal ideology was quite strong, and is embedded within the mindset of both sexes. Table 11 provides perceived reasons by both male and female informants regarding why women go to the ESP Clinic more.

**Table 11.** Reasons why more women go to the ESP clinic

<ul style="list-style-type: none"><li>- Women have more diseases</li><li>- Men have less diseases</li><li>- Men work outside</li><li>- More treatment facilities are available for women</li><li>- Men buy medicine from pharmacies</li><li>- Mothers take care of babies more than men</li><li>- Women know more about the clinic</li><li>- Women are free in the morning</li><li>- Family-planning services are available for women</li><li>- Women are more aware about illness</li><li>- Services are cheap</li><li>- All providers are women</li><li>- Pregnant mothers have many problems</li><li>- No treatment is available for men at the <i>pucca</i> market</li><li>- Imposition by men</li><li>- Men don't like to stand in a queue</li></ul>
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From a review of the responses, it was found that most responses related to the role of the male and female in the family. Females felt that they were more responsible to look after their children. Men also stated that when children were sick and mothers were more concerned, they brought their children to the hospitals. This was in spite of the fact that 24 female informants first discussed any sickness in the family with their husbands.

Two important reasons were cited by the female informants as to why more women go to the ESP Clinic. These were: mothers brought their babies, and women had more diseases. Men said that they had no time, because they work outside. This view was also echoed in the women's responses. Another

interesting reason was mentioned by a few women that men suffered less, and if they had any illness, they bought medicines from a nearby pharmacy. Another reason that requires due attention is that men viewed that it was a women's clinic, mostly providing family-planning and ANC services; therefore, they had less facilities for men. Some interesting quotes are provided in Box 2.

**Box 2. Why more women go to Model ESP Clinic?**

- ➔ Women have more diseases, they need more help, and they have more pressure (Female non-user of Model Clinic-Slum)
- ➔ Men are always busy and stay outside for work. They go less to the clinic. Women have problems. Even if the children are sick, it is imposed on women (Female Model Clinic Client-Slum)
- ➔ Men do not like to stand in queue and buy tickets. In the government hospitals, they are shy to talk to female doctors. The rich people are not shy. Poor are always afraid and shy (Female Model Clinic Client-Slum)
- ➔ Women go because they suffer more from various diseases. Money is not charged in the hospital. Husbands spend money for themselves, but women don't have money. They don't earn, so they go because they get free treatment (Female non-user of Model Clinic-Slum)
- ➔ Men go less because they suffer less. Even when they are sick they go to a doctor themselves. They don't want to go to a hospital spoiling time (Female non-user of Model Clinic-Slum)
- ➔ Men do not go unless they have serious problems. They have money in their pockets. So they buy medicines from pharmacies. I also buy medicines from shops (Male Model Clinic Client-Slum)
- ➔ To some extent, it seems normal to me because the women manage the house, children, and husband. Mothers are worried when children are sick. Mothers know about this before fathers know. Men are busy outside the house to earn bread for the family (Male Model Clinic Client-Slum)

***Willingness to pay***

Of the total informants, 28 informants stated that they were willing to pay for healthcare at the Model ESP Clinic. All the male informants belonging to both slums and non-slums stated that they were willing to pay, whereas 10 of 20 female informants belonging to slums stated that they were not willing to pay. Those who were willing to pay attached certain conditions which should be met before any payment. These included availability of good medicines, more doctors, better treatment, appropriate prescriptions, and adequate space in the clinic. The informants, in general, believe that services at the government facilities should be provided free of charge.

Comments of the informants about their intention to pay are presented in Box 3. In fact, all these responses show the informants' mindset regarding their willingness to pay.

### Box 3. Willingness to pay

- ➔ If necessary, we will pay, but it will be good for us if we need not to pay. We are poor; if it is free, it is good for us. Since we are poor if we save even one taka it is good for us. If it is free, more people will go (Female non-user of Model Clinic-Slum)
- ➔ If we have money, we could have gone to a large hospital (Female non-user of Model Clinic-Slum)
- ➔ If they ask, we will give. If they give good medicine why should we not pay. We will pay. Some people think that they are poor, it is good for them if they need not to pay. However, I think they are giving good medicine- -why should we not pay. We will pay (Female Model Clinic Client-Slum)
- ➔ Since we are poor, it is good for us if we do not need to pay, but if it is necessary, we will pay. If there is good treatment, there is no problem in giving money (Female Model Clinic Client-Slum)
- ➔ "I don't want free medicine. Free medicine is not good." (Female non-user of Model Clinic-Slum)

### Expectations: Suggestions for Improvement

The informants were asked to suggest ways to improve the Model ESP Clinic to make it more accessible and client-friendly. Numerous responses were obtained. These are provided in Table 12.

A large number of informants mentioned that to improve the Model ESP Clinic, they expect good behaviour from service providers. This response was followed by the suggestion of 'good service' and provision for adequate medicines. A close look into different responses showed that most responses overlap with the responses relating to assessment in Table 10. Therefore, the informants were quite consistent in their responses as far as their assessment and expectations were concerned.

**Table 12.** How to improve the ESP clinic

<ul style="list-style-type: none"><li>- Good behaviour of providers</li><li>- Good service</li><li>- Adequate medicines</li><li>- More good doctors</li><li>- Keep the clinic clean</li><li>- Listen to patients with care</li><li>- Male doctors should be appointed</li><li>- Easy access to services</li><li>- Less-waiting time</li><li>- Free medicine</li><li>- Provision for all types of health services</li><li>- More space</li><li>- Provide medicines according to prescriptions</li><li>- Adequate tables and chairs</li><li>- Increase consulting hours</li></ul>
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### **Service Provider's Views**

It was thought that the perspectives of the service providers, along with the clients, would help in understanding various issues relating to this study. Three medical officers, 3 non-medical staff (a vaccinator, a family welfare visitor, and a counsellor of the Model ESP Clinic) were brought within the purview of this study. There were both group and individual interviews. During group discussions, issues relating to the background of people who come for treatment, why they come, what attracts people to the clinic, why more women come, and also their assessment of the current state of the Model ESP Clinic were pursued. In addition to this, 2 NGO service providers and 3 private providers who practise near the Agargaon slums were also interviewed.

#### ***Service providers of the Model ESP Clinic***

Both medical and non-medical service providers reported that since the ESP intervention, there has been an increase in the client-flow. Previously 40-60 clients attended per day but now it is around 100 per day with 60 new clients. One of the main reasons for this was that people now had more knowledge about the different types of services provided by the clinic.

Both slum and non-slum people were using the clinic, but the percentage of non-slum people was very low. According to the ESP providers, there were many reasons for this. First, the non-slum people were not aware of the recent changes in the clinic. However, another important reason is the mentality of the

non-slum people who think that it is a poor people's clinic: They were not interested in waiting in a queue and attending counselling sessions with slum clients. One medical officer stated her experience as this: "Once I requested one non-slum client to wait. She became annoyed with me and replied that she could not wait in the same line with the female beggars meaning the slum people. The client left the place without taking any service."

People mainly come to the clinic for free medicines. Counselling is also another factor that attracts people. There were several reasons for the high number of women coming to the clinic. Most men in the slum work outside which coincides with hospital hours. Women come for themselves as well as for their children. Medical officers did not think that the existence of female providers was the main reason for the low male turn out. For example, one doctor mentioned that recently she saw a male client having urethral discharge. The service providers did not agree with the views that the clinic caters mostly to the needs of women's medical problems. They also contradicted the women's suggestion (Table 11) that men suffer less, but agreed that men prefer to go to a pharmacy, which is more convenient for them.

It was suggested by the providers that to attract males, more counselling is needed, and the female clients need to be convinced that they should bring their husbands and other family members if they suffer from any disease. In recent months, the number of male clients has increased from 4-6 to 12-14 per day.

People normally come for treatment after 3-4 days of onset of an illness/disease. Clients with serious problems that require referral elsewhere were rare.

The service providers thought that clients were now happy with the services of the clinic. Good behaviour and availability of medicines were attracting more people to the clinic. To increase the client-flow, people should be informed about the types of services rendered as well as the availability of free medicines at the clinic.

### ***NGO service providers***

Representatives from 2 NGO service providers--one belonging to the Bangladesh Women's Health Coalition (BWHC) and another to World Vision--have been interviewed. The purpose of those interviews was to obtain their views regarding the nature and the type of services provided and their impressions about clients. The BWHC works in the slums of Agargaon area. Different types of services, such as expanded programme on immunization (EPI), family planning (FP), acute respiratory tract infection (ARI), reproductive tract infection/sexually transmitted disease (RTI/STD) and general health services are provided by them. They also have a number of ARI patients. There are also patients with fever, blood dysentery, and skin diseases. They also provide health education to their clients.

The World Vision provides more or less the same number of services as provided by the BWHC. However, their services are mostly limited to sponsored families, but they also occasionally provide services to both men and women of adjoining areas.

It was learnt that patient-flow to the BWHC clinic was 40-50 persons per day. Most patients were female. They were satisfied with the client-flow. Service providers felt that clients were also satisfied with their services. Clients were required to pay half of the actual price of medicine. At the World Vision clinic, people have to buy a ticket which costs twenty taka for any type of medicine during the first visit, and at subsequent visits, only ten taka is charged. Both the NGO service providers were aware of the Model ESP Clinic, but they referred to it as a government dispensary/hospital where people get their medicine free of charge.

### ***Private service providers***

Three private health service providers whose names were frequently mentioned by the study informants were interviewed. All 3 providers were qualified doctors, and have been practising in the area for 12-15 years. One healthcare provider stated that he gets 30-40 patients per day, while another said he gets 15 patients per day. All the providers stated that most of their patients come from the adjoining slum areas. All 3 providers were aware of the Government Dispensary at the Pucca market, but they did not know about the services provided there. One private provider said that he charged Tk 50 for well-off patients but charged no fees for poor patients. Similar views were expressed by the 2 other providers. Therefore, it appeared that they did not provide services free of charge but still had many patients. The private providers cited the following reasons for why there was low turnout of patients at the GoB clinic:

- People think good treatment is not available at a government hospital
- Doctors do not give time to patients
- People are not satisfied with prescriptions and medicines
- Doctors' behaviour toward patients is bad
- People think that free treatment is not good

### **Ward Commissioner**

The Ward Commissioner of Ward 41, who is a woman, was interviewed. Although the Ward Commissioner knew about the Model ESP Clinic, she was not aware of the activities of the clinic. She was there only once when the Mayor of DCC inaugurated the clinic. She did not know who were patients and also why people go there. The Ward Commissioner was not in favour of free treatment. She said, "People think that free treatment is not good and they undervalue this." She mentioned that the behaviour of lower-level staff of government hospital is

bad which was not always true among medical officers and other service providers. The Ward Commissioner suggested that to popularize the Model ESP Clinic in the area, steps should be taken to let people know about when and what types of services are available.

## **Conclusions and Suggestions for Intervention**

Conclusions have been drawn based on the results of the study and discussions made in this paper. Measures for intervention, which may make the Model ESP Clinic more useful and popular are suggested.

### **Conclusions**

Sociodemographic background of the informants shows that slum-dwellers were the major clients of the model clinic, and the non-slum people were not very enthusiastic to use the facilities provided by the Model ESP Clinic. The non-slum people considered the clinic as a poor people's clinic. Non-slum people did not want to be classified in the same 'class' as slum-dwellers. Therefore, they feel that it is not desirable to stand in the same line and wait in queue with them for medicines. This is an issue (though not acceptable) that is embedded within the mindset of the section of people who are likely to be potential users of the clinic.

Since the clinic is located adjacent to the Agargaon slum, it is likely that the majority of potential clients will come from this slum. Therefore, the use of the Model ESP Clinic depends on the level of success in pursuing these people to use the clinic.

The different types of informants who were interviewed could not describe, in concrete terms, what health is, but they were quite aware that health is wealth. The distinction between good and bad health was made by the absence and presence of a disease. However, the informants linked good health with the ability to work, to eat food, and to their state of mind. The linking of good health with work reveals the mindset of the informants that good health is linked with the capacity to work and to earn for the family's survival.

The awareness of the link among living conditions, cleanliness, and health is revealing. The idea of what is called *parishkar o parichannata* (cleanliness) very much exists in the minds of the people, and various expressions have been used for emphasizing this. However, they are not sure as to whether, within the existing living conditions, it is possible to maintain good health. Basic civic amenities, such as water sanitation and proper housing, are absent. It was observed that 7 families were using one latrine, and 5 families were using one kitchen in the slums.

A pattern has emerged regarding healthcare-seeking behaviour of the people. It is observed that normally the people waited before they went for medical treatment. Two main reasons can be discerned. One is economic, and the other one is that, at the initial stage, people consider a disease mild, and think that this will go away automatically. They go to healthcare providers when the disease 'matures', and, in some cases, it becomes serious.

The first preference for healthcare providers is the nearby doctor/pharmacy due to easy access, less-waiting time, low cost, and also their previous bad experience in public hospitals. It was observed that the Model ESP Clinic or any other public hospitals were not their first choice. It revealed that the model clinic clients first obtained information about the Model ESP Clinic from their neighbours. Both females and males reported that when someone in the family was sick, they first discussed the issue with their spouse.

By and large, knowledge, assessment, and expectations of the informants regarding the facilities available around the neighbourhood were good. Thirty-three informants, comprising both users and non-users of model clinic, were aware of the existence of the Model ESP Clinic in their area. Twelve informants were not aware of the services provided by the Model ESP Clinic. The existence of the Model ESP Clinic was well-known, but the range of services provided by them were not known to them. The healthcare providers of the model clinic stated that the non-slum people were not aware of the different services provided by the clinic and also did not know about recent changes at the clinic.

When assessing the impressions of different services provided by the ESP Clinic, mixed responses were obtained. The spectrum of responses varied from negative to positive assessment. The issues relating to negative assessment include: non-availability of medicines, long-waiting time, lack of attention of the providers, limited number of doctors, etc. The positive assessment includes: free treatment, good EPI service, and good service, in general.

Another important fact that emerged from this study is that people generally think that the Model ESP Clinic is a 'hospital', which caters to the needs of women, and provides EPI services only. People further think that since all the doctors and other providers are women, it is considered a 'woman's clinic', and women naturally get preference. This idea is deep-rooted among the people in the area.

It appears from the review of the findings that people are willing to pay for service, but attach pre-conditions which should be met before any payment is made. These include: ensuring good behaviour from staff, adequate supply of medicines, good doctors, good prescriptions, good treatment, etc. They also believe that the government health facilities should be provided free of charge.

## **Suggested Areas for Intervention**

- BCC activities should be strengthened focusing on services available and in what ways the Model ESP Clinic is different.
- The existing health education and counselling system should be further strengthened by including more issues within the counselling and education programme.
- Since people have a general suspicion about public hospitals that these places are full of corruption, measures should be taken to dispel this notion. This can be done through counselling and community mobilization. The clinic should inquire of the clients as to whether they have any problems, queries, and complaints. If they have, these should be properly explained. The task is to build mutual trust and confidence.
- All hospital staff should be careful and behave properly with clients. Most complaints are against lower-level staff. Supervisors should monitor staff activities through surprise visits, talking with clients, and also ensure quality services.
- The clients who come for services at the ESP Clinic can be used as 'information agents.' The counsellor and the other healthcare providers should request clients to inform their neighbours about the ESP Clinic, changes in the clinic, and extended services.
- Assistance of the community leaders, both formal and informal, should be sought as 'mobilizing sources' for dissemination of information about the Model ESP Clinic. In this respect, the roles of informal leaders, comprising some key or knowledgeable women in the area, will be useful. The community leaders can be occasionally invited to the clinic and requested to encourage people to attend the clinic.
- At least one male medical doctor be appointed to remove the view that it is a women's clinic.
- Efforts should be made to provide minimum civic amenities, such as water and sanitation to the slums. It is not enough to say that people should drink pure water, and should not defaecate in public places without making enough provision for water and latrines. The problem of slum people should be approached with a humane attitude.

## **Suggested BCC Needs**

The future BCC activities should encompass the aforesaid areas, and programmes should be targeted at the following levels:

- a. Individual level
- b. Community level
- c. Institutional level
  - Health service providers
  - Management
  - Services
- d. National level: Future need

**a. Individual level**

At the individual level, the following areas should be emphasized:

- Role of an individual in one's own health or family health
- Involvement of male
- Early treatment
- Availability of ESP services at the clinic
- Dissemination of information to others regarding the nature and scope of services by Model ESP Clinic

**b. Community level**

- Identification and involvement of key informants (formal and informal) in disseminating information
- Key informants should be oriented and provided with BCC materials

**c. Institutional level**

***Service provider***

- Strengthening the role of counsellor
  - Focus on general hygiene
  - More male involvement in family health
  - Ranges of services and quality of the Model ESP Clinic
- Missed opportunity addressed by all service providers
- Maintaining high level of self-motivation
- Attention to individual client need
- Maintaining client-friendly atmosphere

***Services***

- More attractive visual display at the waiting place
- Comfortable sitting arrangements with provision for drinking water, hygienic toilet, etc.
- Audio-cassette messages during waiting
- Providing quality service by following standard job-aids

***Management***

- Routine supportive supervision by respective supervisors
- Monthly review meeting among providers
- Occasional review of clients' opinions through exit interview, etc.

**d. National level: Future need**

- Dissemination of information on the availability of ESP services through mass media.

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## **Essential Services Package (ESP)**

Within the overall context of the Health and Population Sector Strategy and based on the interventions identified by the 1993 World Development Report, the elements of the ESP are summarized and grouped into the following 5 areas:

### **1. Reproductive Healthcare**

- ◆ Safe motherhood services, i.e. antenatal care, safe delivery, obstetric first-aid and referral services, postnatal care
- ◆ Family-planning services to increase distribution of pills and condoms, emphasis on clinical contraception with particular attention to low-performing areas and under-served groups
- ◆ Prevention and control of RTIs/STDs/AIDS, especially in behaviour change communication, and condom promotion
- ◆ Maternal nutrition
- ◆ Adolescent care, emphasizing behaviour change messages on proper nutrition and hygienic practices, information regarding puberty, safer sexual behaviour, and avoidance of health risks, including STD/HIV/AIDS
- ◆ Services that address problems of infertility, particularly if caused by RTIs and STDs, such as sexually transmitted chlamydia infection.

### **2. Child Healthcare**

- ◆ Provision of basic preventive and curative care for infants and children for ARI, CDD, vaccine-preventable diseases, and vitamin A
- ◆ Integrated Management of Childhood Illnesses (IMCI) as a child survival strategy directed at improved prevention and case management of measles, malaria, malnutrition, diarrhoea, and bacterial pneumonia
- ◆ Services to address malnutrition, especially chronic energy deficiency, protein-energy malnutrition, low birth-weight, and micronutrient deficiency
- ◆ School health services, such as first-aid and periodic health check-ups of school children.

### **3. Communicable Disease Control**

- ◆ Services that prevent and manage infectious diseases that have severe health impact (TB, leprosy, malaria, kala-azar, and other emerging and re-emerging diseases).

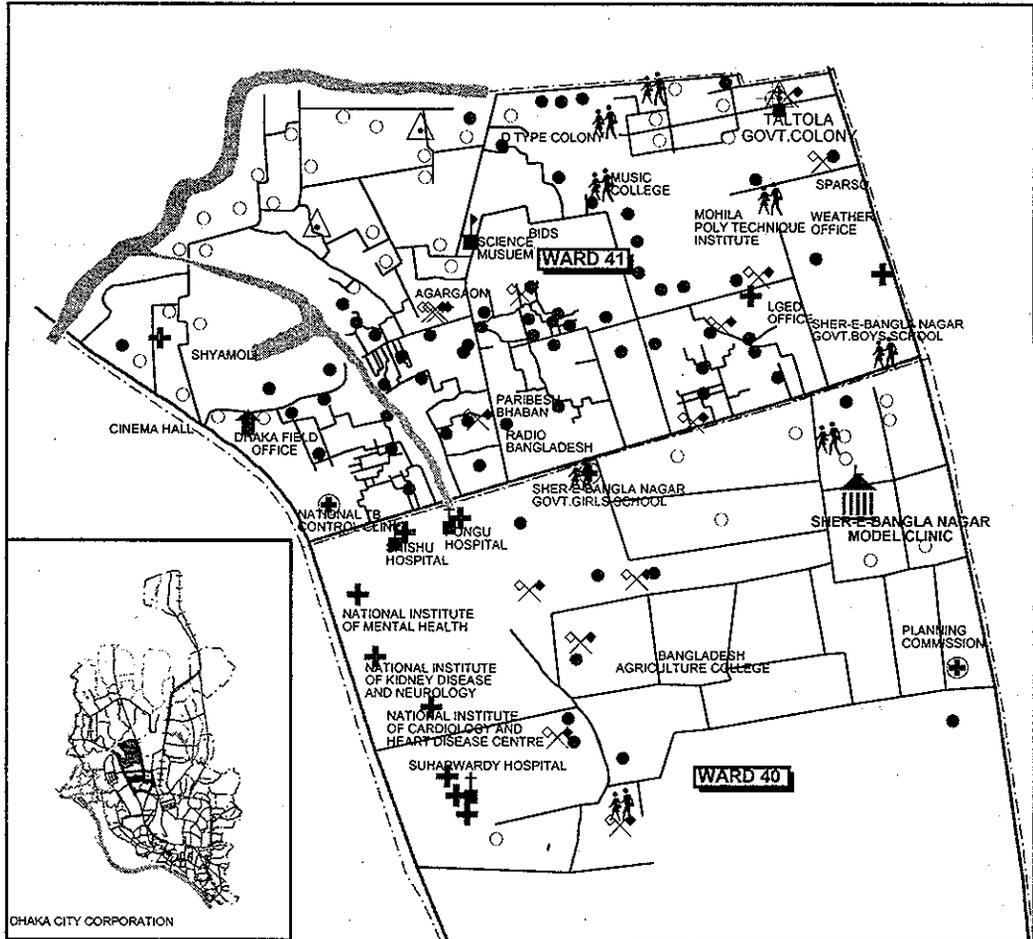
### **4. Limited Curative Care**

- ◆ Care for common illnesses and injuries (first-aid, treatment for medical emergencies, pain relief and advice, especially for those in poverty).

### **5. Behaviour Change Communication**

- ◆ Provision of information, education and communication (IEC) services to support access to and use of the ESP and to promote healthy behaviour change.

# Map of Sher-e-Bangla Nagar

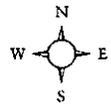


**LEGEND**

- - - - - Ward boundary
- Road
- - - - - Railway
- ~ ~ ~ Canal
- — — Embankment
- ⌚ ESP Model Clinic

- 👤 Educational Institution
- 🏛️ Commissioner's Office
- Cluster slum
- Cluster non\_slum
- ⊕ Hospital
- ⚠️ Static Clinic

- ⚪ Family planning Centre
- ⊕ EPI Centre
- ⚡ Satellite Clinic
- ⊕ Dispensary
- 🏠 Dhaka Field Office



Operations Research Project, ICDDR,B  
**GIS MAP**

## Interview Guidelines

### I. Guideline for Clients and Non-users for Model Clinic

#### 1. Perceptions about health and health problems

At the outset of the interview, the interviewers should collect information on the socioeconomic background of each informant. This information will include: age, occupation, education level, type of family, family size, marital status, source of income, monthly income, length of stay in the city, type of house, etc. In the field notes, the interviewers should also describe the interview setting. The description of the setting should include where and how the interview was taken, who was there during the interview, whether there was any interference, etc.

The discussion will start with some general queries relating to health and living conditions. The emphasis will be on what people think about their health, and whether they are aware of the link among living conditions, environment, and health conditions.

- People's ideas and concerns about health: their thinking about 'good' and 'bad' health?

(Note: In Bangladesh, people are generally not concerned about their health. It is, therefore, important to know how they perceive health in general and also good and bad health. Getting answer(s) on this point is difficult. However, the interviewers should start asking the informants when they consider their health is good or bad, whether they can give any example of this, etc.)

- What do they normally do when they face health problems? Do they normally try any home remedies, traditional healer, or self-medication?

(Note: Attempts should be made to discern actual behavioural patterns and also to identify cultural factors in this process.)

- Living conditions/environment and its relation to health.

(Note: The interviewers should make attempts to find out whether the informants can link their living environment with their existing health situations. This issue is important, because if they do not understand this relationship, any attempt to encourage them to seek health services will be futile.)

## 2. Factors affecting choice: reasons for going and not going for health services

Before asking any specific question about choice, ask some general questions: whether the informants were sick recently, the nature and the type of sickness, major and minor. Also try to find out what they normally do if they are sick.

It is also important to know whether the informants consult anybody in the community. If they consult someone, please ask the following questions:

- From whom you normally get your medical/health information? (Describe the persons).
- With whom do you first speak? (Who does specify: husband, mother-in-law, neighbours? Or who else?) What did they say?
- Reasons for talking? (List the reasons.)
- What do they normally suggest?
- Does anybody come to you for consultation? Who?
- Is there any particular individual(s) to whom people go for consultation?
- Do you suggest them to go anywhere? (Take detailed notes on this. Ask any follow-up question that will enrich your interview.)

[After asking the above questions the interviewers should ask whether the informants obtain health services outside the house: From whom and where? The informants may or may not go for any outside service. Whatever the answers, attempts should be made to discern the reasons *for going and not going* for healthcare. Attempt should also be made to understand *how decisions* regarding particular health facilities outside the house are taken. Pursue these issues with the following questions. These questions are not exhaustive. The interviewers must pursue follow-up questions regarding the decision-making process.]

### Reasons for going

- What makes you think (and also at what stage) that your family need healthcare?
- Where do you normally go for treatment of yourself and your family members?  
(Find out what the informants do and also their activities in detail.)
- When you are sick, how do you decide where to go? (i.e. suitable location, good facilities, kind and caring service, it suits work time and financial capabilities, neighbours, kins, friends suggested, or any other reasons.)
- In this connection, describe how you decided where to go for treatment when you were sick last time?
- Describe the nature of services you have received from the Model ESP Clinic.
- Describe the types of treatment that you get for different types of diseases.

- Will you suggest/did you suggest your friends/families/kins to avail facilities of ESP services?

[It does not matter whether the answer is positive or negative. The interviewers must try to get an explanation.]

### **Reasons for not going to the Intervention Clinic**

(In situations when the informants do not seek treatment)

- Why are you not interested to go to see a doctor or to visit a government dispensary?
- Is it because you think it is a minor problem or you think you have better options? If yes, what are those? Give details.
- Have you found it difficult to avail of? If difficult, what are the reasons? (Possible reasons may be timing, unfriendly staff, cost, administrative factors, lack of information, good for others but not for the informants, etc.)

[The interviewers should try to discern the process of decision making in availing of different healthcare facilities.]

### **3. Healthcare-seeking behaviour: knowledge, assessment, and expectations knowledge**

- What services are available in your area (name)?
- How do you know about these services and sources?
- Tell us about the services provided by them.
- What types of services are provided by the Model ESP Clinic?
- Do you find any difference in services provided by these organizations? Describe the differences (if the informants mention the Model ESP Clinic, ask them to tell the differences, if any).

#### **Assessment**

- Give your opinion on the following services available through the ESP:
  - General medical
  - Antenatal
  - RTIs/STDs
  - Child health
  - Chronic illness
  - Family planning
  - Any other services
- Are you satisfied with the services of the ESP? (Probe: behaviour of service providers, waiting time, drugs availability, cost, distance, etc.)

- [It revealed that 80% clients of the ESP clinic are women. What do you think about this situation? Can you speculate any reasons? Wait for the informants' reply, and later, probe into the following reasons:]
  - Is it a women-focused programme?
  - Women care for their family
  - Women are good in delivering information among themselves
  - Women are service providers
  - There are few facilities for men
  - Men do not care about their health
  - Men normally hide their illnesses

#### **Expectations**

- What do you normally expect from an organization providing services (general)?
- What was your expectation when you come to the ESP clinic (specific)?
- Can you rely on the ESP? (Probe: repeat visit, advising others to go, faith in service providers, etc. Please explain the answer).

#### **4. Attitude toward payment for health services**

- Did you pay for this service?
- Do you normally pay for medical services? If not, why?
- If you need to pay will you pay? If not, why?

#### **5. Service provided by NGOs**

- Knowledge about NGOs (*samity*) working in this area
- Types of service provided by them
- Can you compare the services of NGOs with other providers?
- Are these good? If yes/no (reasons)
- Do you need to pay for this?
- What you normally pay for this?

[At the end of interview, interviewers should ask informants if they were given the responsibility to improve the ESP facilities what they would do?]

## **II. Guidelines for Service Providers (Medical Officers)**

[The medical officers who are the core personnel in the Model ESP Clinic will be interviewed. During these interviews, the views of MOs, not only regarding the services available, but also their backgrounds and also how the use of the ESP facilities can be increased, will be discerned.

Interviewers should first take the background of the providers, their qualifications, training undergone during the tenure of their service, working hours, working conditions. Also they should try to identify problems they face in carrying out their activities.]

- Describe the backgrounds of the people who come to the clinic for treatment.
- Why do they come?
- What attracts people to visit this clinic?
- Do they come spontaneously or are they motivated by anyone?
- Eighty percent of the patients of the clinic are women. Can you speculate the reasons for this?
  - Is it a women-focused programme?
  - Women care for their family
  - Women are good in delivering information among themselves
  - There are few facilities for men
  - Men do not care about their health
  - Men hide their illnesses
- How can clients be increased, particularly more males? Give your suggestions.
- Describe the nature and the type of diseases you treated in the last 6 months.

### **General assessment**

- What do people say about this clinic?
- Do you think that people are aware of their health problems? Are they health conscious? Give your general assessment.
- If you were given the responsibility to design a programme to increase the use of the ESP clinic, what steps would you take? Give details.

## **III. Guidelines for Providers (Vaccinator and Family Welfare Volunteer)**

The DCC vaccinators and Female Welfare Visitors (FWVs) who provide some essential services to the people at the Model ESP Clinic will also be interviewed. During the interviews, attempt will be made to discern the views of these core personnel regarding different services available and also their views regarding how the use of the ESP facilities can be increased.

Interviewers should take the backgrounds of the providers, their qualifications, training undergone during the tenure of their service, working hours, and working conditions. Also try to identify problems they face in carrying out their activities.

- What are the backgrounds of the people who come to the clinic for treatment?
- Why do they come?
- What attracts people to the services you provide?
- Do they come spontaneously or are they motivated by anyone?
- Eighty percent of the patients of the clinic are women. Can you speculate the reasons for this:
  - Is it a women-focused programme?
  - Women care for their family
  - Women are good in delivering information among them
  - There are few facilities for men
  - Men do not care about their health
  - Men hide their illnesses
- How can more clients, particularly males, be attracted to the clinic? Give suggestions.

#### **General assessment**

- What do the people say about this clinic?
- Do you think that people are aware of their health problems? Are they health conscious? Give your general assessment.
- If you were given the responsibility to design a programme to increase the use of the ESP clinic, what would you do? Give details.

#### **IV. Guidelines for NGO Service Providers**

In recent years, NGOs have emerged as important providers of healthcare in both urban and rural areas. It is learnt that in this study area, a number of NGOs have been providing different health services for some time. Although the task will be difficult, efforts will be made to locate some exclusive NGO beneficiaries to get their views about services available in the area. The purpose will be to find out how the people in the study area evaluate the activities of NGOs when compared with facilities provided by the intervention clinic.

- What types of services do you provide?
- How do you provide these services? (actual mechanism)
- Who does normally come to you for your services? (From what locations, their socioeconomic backgrounds, etc.)

- Are you satisfied with the turn out?
- Do you find any differences in services provided by other organizations? (Describe and explain this difference)
- Are you aware of the Model ESP Clinic? What do you know about this? Describe the activities of this clinic in detail.

## **V. Guidelines for Private Providers**

Private practitioners also provide important services to both slum and non-slum people of the area. It is, therefore, important that their views about the nature of services they provide, types of complaints with which people come to them, backgrounds of people who come to them for medical support are obtained. It is also important to discern their views about the Model ESP Clinic, such as what they normally say about the Model ESP Clinic to the public. Some tentative issues that may be pursued with private practitioners are as follows:

- What types of services do they provide?
- Who does normally come to you for your services? (From what location, their socioeconomic backgrounds, etc.)
- Do you think that people are aware of their health situation? If not why?
- When do they come for medical support?
- Are you satisfied with the turnout?
- Do you find any differences in services provided by other organizations? (Describe and explain this difference.)
- Are you aware of the Model ESP Clinic? What do you know about this? Describe the activities of the clinic in detail.

[Please try to pursue some other issues that the interviewer might feel necessary considering the overall objectives of the study.]

## **VI. Guidelines for Collecting Community Information**

Different types of community information will be required to get some general ideas about the community, which form the context of the study. In collecting information about the community, it should be explored who in the community are the principal leaders or locally-recognized leaders. What are their qualities? Do they have any role in influencing the healthcare-seeking behaviour of people?

Community information will be collected from the existing information available from the ORP field station, Ward Commissioners' office, Bangladesh Institute of Development Studies (BIDS), which conducted several studies in the area, and also interviewing some permanent residents and other persons who are

knowledgeable about the area. The ORP personnel who were involved in mapping may be helpful in this respect.

Since most clients of the ESP Clinic come from Ward 41, an attempt will be made to gather information about this ward. The following information is expected to be collected:

- Size of the area: population, housing pattern, the nature and the type(s) of housing, age, sex and educational level of the people, etc.
- General economic conditions: income and occupational pattern, etc.
- Infrastructural facilities: availability of gas, electricity, water and sanitation
- Structure of the community: how is the community organized, kinship, home district, or politics. Are there any community leaders? Who are they? Why are they leaders? What are the roles of these leaders in the community?
- Health situation: prevalent diseases, healthcare facilities, healthcare-seeking behaviour (where and how do they go for treatment).
- Types of health providers: who are they, their working mechanism, and types of services they provide.

## List of Slums and Non-slums

Name of slum	Ward/ Zone	No. of in- depth done	Non-slum	Ward/ Zone	No. of in- depth done
1. Amborer <i>basti</i>	41/7	MSNM-1	1. Agargaon Government Staff Quarter in front of pucca market	40/6	MNSM/ NM-5
2. ShahiderTeq/ <i>basti</i>	41/7	MSM-1 FSM-1 FSNM-1	2. Agargaon Government Staff Quarter in front of the Planning Commission Office behind pucca market	40/6	FNSM-1 FNSNM-2
3. Darogar Teq/ <i>basti</i>	41/7	MSNM-1 FSNM-1	3. Agargaon Government Staff Quarter near the girls high school	40/6	FNSM-2 FNSNM-3
4. Maleqer <i>basti</i>	41/7	MSNM-1	4. Taltola Government Staff Quarter.	41/7	FNSNM-2
5. Comilla <i>basti</i>	41/7	MSM-1 FSNM-1			
6. Bottola slum	40/6	FSM-2			
7. Hatemer <i>basti</i>	41/7	FSM-1 FSNM-1			
8. Taltola <i>basti</i>	41/7	FSM-1 FSNM-1			
9. <i>Basti</i> near Police phari	41/7	FSM-1			
10. Selimer <i>basti</i>	41/7	FSM-1 FSNM-1			
11. Haruner <i>basti</i>	41/7	FSM-1 FSNM-1			
12. Faridpur <i>basti</i>	41/7	FSNM-1			
13. Beltola <i>basti</i>	41/7	FSNM-1			
14. <i>Basti</i> near Madrasah Road	41/7	FSNM-1			
15. Khaleqer <i>basti</i>	41/7	FSNM-2			

## **List of Persons Contacted**

### **Dhaka Field Office, ORP**

1. Mr. Ahsan Kabir Sikder
2. Ms Mahmuda Faruque
3. Ms Monowara Begum
4. Ms Sadia Nilufa
5. Ms Nasima Khanam
6. Mr. Shafique Islam
7. Mr. Atique Iqbal Chowdhury

### **Sher-e-Bangla Nagar Model ESP Clinic**

#### **Medical providers**

1. Dr. Madina Akhtar, In-Charge Medical Officer
2. Dr. Nazneen Akhtar, Medical Officer
3. Dr. Meher Parveen, Medical Officer

#### **Other providers**

1. Mrs. Shahnewaz, Counsellor
2. Mrs. Rashida Khan, FWV
3. Mrs. Manju Ara, Vaccinator
4. Mr. Sunil Kumar Sarker, Pharmacist

#### **Private practitioners**

1. Dr. Rafiuddin Babul, MBBS
2. Dr. Abdur Rashid, LMF
3. Dr. Shahidul Islam, MBBS

#### **NGO service providers**

1. Dr. Anisa Fahmida, Medical Officer, BWHC
2. Mrs. Archina Ribero, Nurse, Health Supervisor, World Vision

### **Ward Commissioner**

Mrs. Rokeya Sahabuddin

## MCH-FP Extension Work at the Centre

In 1982, the MCH-FP Extension Project with funding from USAID began to examine in rural areas how elements of the Matlab programme could be transferred to Bangladesh's national family planning programme. In its first year, the Extension Project set out to replicate workplans, and record-keeping and supervision systems, 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, management information systems, and strategies to deal with problems encountered in collaborative work with local area family planning officials. In 1994, the project started family planning initiatives in Chittagong, the lowest performing division in the country.

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 1993-1997. Salient features include: improving management, quality of care and sustainability of the MCH-FP programmes, and providing technical assistance to GoB and NGO partners. 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 in international scientific journals.

In August 1997 the Centre established the Operations Research Project (ORP) by merging the two former MCH-FP Extension Projects. The ORP research agenda is focussed on increasing the availability and use of the high impact services included in the national Essential Services Package (ESP). In this context, ORP has begun to work with partners in government and NGOs on interventions seeking to increase coverage in low performing areas and among underserved groups, improve quality, strengthen support systems, enhance financial sustainability and involve the commercial sector.

ORP has also established appropriate linkages with service delivery partners to ensure that research findings are promptly used to assist policy formulation and improve programme performance.

## The Division

The Health and Population Extension Division (HPED) has the primary mandate to conduct operations research, to disseminate research findings to programme managers and policy makers and to provide technical assistance to GoB and NGOs in the process of scaling-up research findings to strengthen the national health and family planning programmes.

The Division has a long history of solid accomplishments in applied research that focuses on the application of simple, effective, appropriate and accessible health and family planning technologies. HPED has built up a considerable body of research and constituted the established operations research element for child and reproductive health in the Centre. The Operations Research Project (ORP) provides the Division with a strong group of diverse expertise and disciplines to significantly consolidate and expand its operations research activities. There are several distinctive characteristics of these endeavors in relation to health services and policy research. For one, the public health research activities of the Division are focused on improving programme performance which has policy implications at the national level and lessons for the international audience also. Secondly, HPED incorporate the full cycle of conducting applied programmatic and policy relevant research in actual GoB and NGO service delivery infrastructure, 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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