From Home to the Clinic:
The Next Chapter in Bangladesh's
Family Planning Success Story Urban Sites

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The Bangladesh Government's 1997 Health and Population Sector Strategy reflects many of the policies outlined in the ICPD Programme of Action. The Strategy calls for greater integration of family planning with health, ongoing stakeholder involvement in design and monitoring, a focus on users of services rather than demographic targets, improved quality of care, and a wider range of reproductive health services, with increased attention to maternal and adolescent health care, provided as part of an "essential services package" (ESP) (Government of Bangladesh Ministry of Health and Family Welfare, 1997). The current thinking within the government is that women should come out of their homes to receive reproductive health services. Plans are being developed to create "community clinics" where contraceptive services and information will be available along with other selected primary health care services that have been included in the ESP. The community family planning workers who now go door-to-door will receive additional training and will be based in the community clinics.

The United States Agency for International Development (USAID) directs a large share of its assistance in the health and population sector to NGOs in Bangladesh. Following a series of evaluations, assessments, and consultations with the Bangladesh government, USAID launched a new 7 year bilateral assistance program in health and family planning in mid-1997 which attempts to operationalize some of the fundamental elements of the Sector Strategy. Technical support is being provided by a group of national and international agencies led by Pathfinder International and the JSI Research and Training Institute. Many of the NGOs, in line with government and donor priorities of the past, had programs focusing on door-to-door family planning. Now that they have adopted the government's ESP approach, the NGOs have discontinued door-to-door contraceptive distribution. Services are being offered through clinics and satellite clinics, with village depots for re-supplying contraceptives in rural areas. The NGOs are employing a variety of measures to improve the quality of services, to make the services more responsive to clients, and to increase their sustainability: the satellite clinic system has been expanded; standards for maternal and child health services, and training programs to support an expanded service package are being developed and implemented; clinic-based pharmacies and revolving drug funds are being established; the number of NGOs has been consolidated and management reforms have been instituted. The higher quality and greater range of services available in static and satellite clinics (with the opportunity for "one-stop shopping") is intended to attract clients as well as increase the impact of the services on health (Alauddin, 1999; Government of Bangladesh, 1996a, 1996b; Jamil et al., 1996; JSI Research and Training Institute. 1997; JSI Urban Family Health Partnership, 1998, 1999; Pinkham et al., 1995; USAID, 1996a, 1996b, 1996c).

The validity of several assumptions underlying these program changes has yet to be systematically demonstrated – for example, (1) that demand for family planning is not "fragile," (2) that constraints related to gender inequality will not prevent women from using the reconfigured services (and that the program changes will, in turn, not have negative social consequences for women); (3) that client priorities, and criteria for assessing quality in health care are well understood (and that they prefer "one-stop shopping"); (4) that clients and families are willing and able to pay for services; and (5) that longstanding programs and their clients are able to adapt to new models and ways of thinking. (Findings related to each of these assumptions are presented in separate sections of the report.) Earlier strategies sought to minimize the direct and indirect costs of family planning. By bringing contraceptive information and methods directly to women in their homes, the previous door-to-door system reduced both the time and money costs of contraceptive use for users to almost nothing – as long as there were no side effects or other problems. Even if they did not have cash at their disposal, women were able to adopt contraception with minimal involvement of men (Simmons et al., 1988;

Schuler et al., 1995, 1996). The withdrawal of home-based services, provision of family planning in the context of other reproductive and family health services, and the introduction of cost-recovery measures such as higher service charges, have provoked concerns in various policy circles about possible detrimental effects on contraceptive prevalence and fertility rates, and on quality of care (cf. Hossain et al., 1995; Hossain and Phillips, 1996; Phillips et al., 1996).

The changes raise questions about the strength and nature of demand for family planning and other health services, and about balancing the goals of cost recovery with the needs of the poorest, most vulnerable groups. If the revised service delivery approaches are to result in more cost effective services and better reproductive health, substantial behavioral changes will be required on the part of clients, families and communities, as well as service providers. It is not yet clear if, and under what circumstances, clients will avail themselves of the various services that the redesigned program offers. Decision-making about the use of family planning and other health measures becomes more complex when women must go out of their homes for services, and must incur added social, logistic, and direct costs. These various costs bring up issues regarding how much a particular service is valued by the intended clients and their families, and how much importance women's needs should be given. The changes may create barriers for women who need reproductive health services. Or, alternatively, they may promote women's strategic interests by drawing them to clinics, and into the public sphere, where a variety of services and opportunities exists. By making it necessary for clients to take initiative and exercise their own judgment about what services to seek out, and to pay for, the new requirements may also produce a better informed, more discriminating clientele.

We are beginning the third year of a multi-method, qualitative study looking at the effects of these policy changes on household-level decision-making regarding the use of family planning and other reproductive health services, on patterns of utilization of the services, and on client-provider relations and client satisfaction. This paper presents preliminary findings from sites where the transition from home to clinic-based services is underway. It documents how communities and programs are responding to the policy changes in a dynamic service environment and social context: how women who previously relied on home delivery now obtain contraceptives; how clients and families are responding to NGOs' efforts to improve quality and cost-recovery; and how clients and staff are adapting to the new program norms. The paper shows how responses to the policy changes are shaped to a large extent by the experiences and norms of the previous family planning program.

METHODS AND DATA

We have been working in two urban sites, in Dhaka and Satkhira districts, and three rural sites. This paper presents findings from the urban sites which were selected in collaboration with USAID and the JSI Urban Family Health Partnership (UFHP). It was decided that the sites should be in areas where implementation of the new program had taken place more or less on schedule, and where there were no special problems. In selecting the sites we only considered areas where door-to-door services had been in place and were discontinued under the new program. Each of the sites is served by a different USAID-supported NGO. To reflect the diversity of program experiences we chose one site in which an NGO previously working in the area continued under the new program, and another site in which a new NGO had begun working. Within each site the in-depth research is focused in 2-3 sub-areas, one area closer to the NGO clinic (within a one-mile radius), and 1-2 areas farther from it (2-4 miles away), where satellite clinics are held. (For descriptions of the sites see attachment) The data are qualitative, consisting primarily of in-depth, semi-structured interviews with individuals, and supplemented with group interviews and observations in clinics and satellite clinics in each site.

The data were collected by two teams of three interviewers each—two men and a woman in each site. All of the interviewers have several years of previous experience in qualitative research; and several have MA degrees in the social sciences. The principal investigators provided additional specific training for this research project when it started, with periodic reinforcement. The field research team contributed to the development of many of the guidelines used, as well as adding spontaneous questions to probe on topics that arose in the course of the interviews. Data were collected throughout 1999, but the period of reference spans several years, as respondents were asked retrospective questions about the door-to-door family planning period and the transition, which began in 1997. The interviews and observations were focused on the following topics:

- Sources of health and family planning services, and sources of contraceptives accessible to each village; knowledge and opinions about these various sources, patterns of utilization, utilization decision-making, and costs of services
- (Among women recently and currently using oral contraceptives) past and current sources of supply; initial understanding of, and reactions to, the transition; sources of information, knowledge of, and strategies for accessing alternative supply sources
- Men's knowledge and opinions about the program transition, and roles in obtaining oral contraceptives
- Service delivery and client provider interactions in NGO static and satellite clinics, as well as other facilities near the study sites
- Attitudes of NGO clinic staff regarding the services offered, their relations with clients, and problems they face in implementing the new service delivery policies
- Experiences of recent clients, including decision-making in the home prior to the clinic visit, and assessments of the services they received
- Men's attitudes regarding women's use of clinics and satellite clinics
- Situations and perceptions of women who have not visited the NGO clinics and/or other clinical services

Three rounds of data collection yielded 236 interviews with 188 women, 45 men, and 7 group interviews (one with men, six with women), using a variety of semi-structured guides.

	Manikdi	**Satkhira**
Total Number of Interviews (with individuals)	108	128
Women	93	95
Men	12	31
Group Interviews	3	4
(Individual Interviews)		
Clinic Observations	6	4
Former CBD Workers	1	5
Client Interviews and Observations in clinics	18	19
Clinic Workers	2	4
Former Door to Door Clients	30	17
Husbands of former Door to Door Clients	6	7
Recent Clinic Clients	18	13
Husbands of Recent Clinic Clients	3	4
Community Perspectives*	20	45

Data analysis is done on a continuous basis so that preliminary findings can be further explored in the field. Ongoing consultation with USAID and the implementing agencies has helped the investigators to contextualize the findings, as well as to provide information that may be used in the ongoing design and implementation process. The objective of this study is not to test hypotheses, but to understand the perspectives of those affected by the changing reproductive health policies, and the social relations that mediate the impact of the changes. The principle limitation of our study design and methodology is its lack of representativeness. It is being undertaken in a limited number of sites, and the number of interviews and observations of any particular type in each site is relatively small. The advantage of this study design is that it yields insights in a short period of time regarding the implementation of policy changes, which can be applied as implementation proceeds and expands beyond NGOs to the government sector. The incipient changes provide a rare opportunity to examine the dynamic between service delivery strategies and the ways in which these strategies are understood by clients and communities, as the NGOs continue to modify their approaches to incorporate what is learned in the implementation process.

* Includes interviews with non-users of NGO clinics, shopkeepers, teachers, elites.

THE CBD PROGRAM PRE- AND POST-TRANSITION

The findings show considerable variation in clients' and communities experiences of the service delivery transition, despite the small number of sites included in the study. This is partly because service delivery models in the study sites and subsites varied even prior to the transition. Under the old program there were differences among sites in the implementation of the door-to-door system, particularly in the frequency and location of visits by family planning workers, and the range of services and information provided. For example, in many cases workers did not visit every home; especially when the workers resided in the community where they worked, women often went to their homes to pick up supplies of oral contraceptives. Some workers were more regular than others in their visits. Such variation was documented in our previous research (Schuler et al., 1997), it is reflected in the findings from large sample surveys (e.g., Mitra et al., 1997), and it is well known among program implementers. There were also differences among the study sites in pricing policies and the degree of flexibility in their implementation.

Under the new program, former clients of the home delivery system are expected to obtain contraceptives from pharmacies, or from clinics or satellite clinics where they can also get broader reproductive health services. In rural sites, in addition to satellite and static clinics, village-level depot holders have been established to sell pills, condoms, and basic medicines and to help organize satellite clinics in designated areas of approximately 120-150 households. Although door-to-door family planning had been officially discontinued in all sites in the late summer of 1997 (and replaced by selective visitation in rural sites), during the research period the sites varied in the extent to which innovations in the clinic-based services were in place. In one case the NGO providing services in the locality changed.

Sites and subsites also varied in how abruptly door-to-door services were withdrawn, and in the amount of information provided to women prior to, and immediately following, the cessation of door-to-door contraceptive distribution. In none of the study sites were there official, systematic efforts to inform the community, although the NGOs in some cases did ask the workers to inform their clients of the need to find alternative supply sources. Some family planning workers took individual initiative to warn their clients and direct them to alternative sources for contraceptives, while others did not.

Somewhat perversely, the dedication and loyalty of the former door-to-door workers to their clients, and their refusal to believe that the work they were so committed to could really end, may have contributed to confusion and misunderstanding about the NGOs' new policies in the communities they served. In one urban site where a new NGO took over, former door-to-door workers reported that when their contracts came to an end the NGO gave them access to a fairly large supply of leftover contraceptives. Although they say they told their clients that the door-to-door system was ending, neither they nor their clients necessarily believed this; indeed, there had been rumors before that this would happen. In the other urban site a former worker reported that she and several colleagues obtained contraceptives from a nearby NGO, and continued to provide them to clients for four or five months after their employment had been terminated. She had attended a training program for traditional birth attendants, and now earns an income by attending deliveries and providing oral and injectable contraceptives from her home, which she purchases in the market and resells at a higher price. One of her former colleagues, who later found a new job in health program in a nearby area, admitted that she was intentionally vague with her former clients when her last job was terminated. She had heard

year after year, she said, that the NGO's funding might be cut off, and that they would all lose their jobs, but it never happened. So even after they received official letters and stopped receiving their salaries they did not lose hope. It would have been embarrassing to resume their work after telling their clients that they would not be coming back, and so she said only that she did not know when she would be coming back, and advised her clients to go to the NGO clinic for contraceptives.

DEMAND FOR FAMILY PLANNING AND ACCESS TO CONTRACEPTIVES

The findings from this study, like those from our previous research, show that women and, increasingly, men and families are committed to fertility control (Schuler et al., 1996, 1997). By their own accounts, many women have used contraceptives despite bothersome side effects and opposition from husbands and in-laws because of their strong desire to limit or space their pregnancies. Some have taken risks by adopting contraception secretly, knowing that their husbands would find out eventually. When this was discovered, they often took further risks by insisting that they would continue. In many cases husbands tolerated their wives' use of contraceptives as long as their were no monetary costs, and the women were sometimes denied money for treatment of illnesses or other problems which they believed were side effects. A comparison of interviews with women in the early 1990's with more recent interviews suggests that men, and the parents of young couples are much more inclined to support family planning than they were a decade or more ago, although some are still resistant to the idea of spending money for it (Schuler et al., 1995, 1996, 1997).

Responses to the discontinuation of door-to-door services also illustrate the strong demand for family planning that now exists. This demand is reflected in the resourcefulness that women and couples have shown in responding to the withdrawal of door-to-door services, as well as to the shortcomings of the previous system. Even under the home delivery system, many clients had to devise strategies to adapt to its unpredictability and other limitations, and to sustain their supplies of pills or to get injectable contraceptives on time. After the withdrawal of the door-to-door workers, women resorted to many of the same strategies that they had used previously to deal with shortages in supply: obtaining supplies from neighboring areas served by door-to-door family planning, buying or borrowing pills from family members or neighbors (some of whom may have been acting as informal depot holders), stocking up on pills in advance (if they could afford it), and procuring supplies from the market through husbands, other relatives, or female neighbors with greater freedom of mobility. Women often helped one another to get contraceptives. Use of these alternative sources was very common during door-to-door family planning. Among women in the two urban sites who had relied on door-to-door pill distribution, 35 were asked directly whether they had also obtained oral contraceptives from one or more other sources prior to the transition. Almost all (33) said that they had, the most common source being pharmacies and shops. Most often it was the women's husbands who purchased the pills from pharmacies or shops, but in a few cases it was the women themselves. An interview with the proprietor of a medical shop in one site confirmed that it is no longer unusual for women to purchase contraceptives in the market, although his male customers thought so. All in all, the findings suggest that for most women home delivery of contraceptives was more a convenience than a necessity.

Where family planning users experienced initial gaps in supply after the cessation of domiciliary services, and temporarily discontinued use, this was due to poor information as much as dependence on home delivery. It was clearly not a symptom of weak demand or passivity vis-a-vis family planning.[1] The problem for many women was that they lacked the information to distinguish the withdrawal of door-to-door services from a temporary disruption. Many women imagined that the family planning workers would be coming back and, so, did not realize that they needed to develop reliable alternative supply systems. In contrast, in areas where family planning workers took individual initiative to inform women of the program change and suggest alternative sources for contraceptive methods, women did not wait needlessly for the worker to arrive and in most cases did not experience a gap in supply immediately after the program transition. In both cases, when women realized that door-step services had been discontinued,

they typically turned to one of the stop-gap measures they had used in the past, or they obtained left-over supplies from the former door-to-door workers. Using these strategies, women had varying levels of success in sustaining their supplies until the new services were in place. One former door-to-door worker reported that after she stopped visiting their homes a large number of her former clients managed to find her house, and began coming directly to her to ask for contraceptives or advice regarding side effect management. She took many of them to the NGO clinic, and once they became familiar with the clinic they stopped coming to her.

Many women recruited their husbands to obtain supplies from retail outlets after home delivery stopped, often after other strategies had been exhausted. Many of these men had played this role previously at some time or another, and often they continued to purchase oral contraceptives for their wives even after satellite clinics were in place. Because of their prior experience in obtaining contraception through their husbands from retail outlets, the cessation of door-to-door family planning was relatively uneventful for such women, especially in the urban sites.

All things being equal, the majority of the women we interviewed who were using oral contraceptives would have preferred to have their supplies of pills delivered free of cost directly to their homes. Considering pill supply only, as opposed to the wider package of essential services that the NGOs now offer, many women considered the old system to be better than the new one. Obviously getting pills at home is more convenient for women, and often cheaper, than buying them in the market. But for most women the issue was one of relative cost and convenience rather than substantial barriers to access. A somewhat extreme example illustrating a common attitude was Fatema[*] who made her living by taking the train to India and smuggling saris back into Bangladesh. She explained that under the old system the family planning worker would leave cycles of pills for her with her sister-in-law:

> "*I used to go out in the morning and return in the evening. I never had to worry about getting pills, because Apa would always deliver the pills to my home."*

[*] All names of respondents are pseudonyms.

CONSTRAINTS RELATED TO GENDER

Under the new program, families must either deploy a male family member to bring contraceptives or (in case of illness) private practitioners to the home, or they must be willing to incur any social as well as monetary costs associated with women traveling outside of the home. The extent to which this situation is new or burdensome, varies both among and within the study sites, depending on social class and other factors. Over the past ten years or so, women have deviated increasingly from *purdah* norms to work outside of the home, participate in credit programs, and obtain health care. As described earlier, many women also went out of their homes to get contraceptives when home delivery periodically lapsed. The complete withdrawal of contraceptive home delivery under the new program, however, tests the extent to which women are willing and able to travel and pay for contraceptives and reproductive health services, and how socially acceptable it is for them to do so on a regular rather than exceptional basis. It also tests the value attached to women's health by families, who will be required to provide resources and support to ensure women's access to services.

The program changes themselves also have the potential to foster new gender dynamics that could ultimately lead to greater opportunities for women or, alternatively, exacerbate hardship. It is too early to the extent to which increased opportunities for women to access services outside the home may translate into broader social benefits, or how the potential need for men's greater involvement in obtaining contraceptives and in helping women get access to services may improve roles and relationships within the home. It is also conceivable that women's control over reproduction could be diminished, or that conflicts related to family planning will increase, as a result of the requirement that women leave the home and/or men's greater involvement.

Men's Roles in Contraceptive Supply

Men played an important role in sustaining oral contraceptive use in the interval between the withdrawal of door-to-door distribution and the establishment of new services in the study sites. According to one former door-to-door family planning workers,

> *"The men have been tested by the end of the [door-step] program. Before, the women would continue family planning without the participation of the men. But husband's cooperation became important when [home-visits] stopped. Especially those women who take pills do not have the hardship of going to the clinic if their husbands cooperate with them."*

Indeed, many women highlighted the role of husbands as the primary factor in determining women's continuity of contraceptive use following the discontinuation of door-step services. Interviews with both key informants and individual women indicated that among those who were regular or exclusive users of home-delivery, women with "uncooperative husbands" along with very poor women had the most difficulty accessing family planning.

Men's roles in response to the program change took many forms. Some became actively involved in what they perceived to be an urgent situation, only to resume a passive role once a viable alternative source was in place. Sabera's experience is typical of this short-term "crisis" participation where men are not really assuming a new responsibility, but rather helping their wives in a difficult situation. When his wife told him she could no longer get pills from the "apa", he said there was "nothing to discuss". He reported that he does not like to buy pills but that

there is no doubt he has to be “active” and manage the pills “if there is a problem”. He bought pills from the pharmacy as he had during gaps under the old door-step program, but once the satellite clinic was established, and his wife told him he did have to go anymore, he stopped buying pills.

In contrast, many urban men are involved in family planning now on a more long-term basis. For some this is a new role mandated by the program change, but in many cases the involvement of husbands in sustaining family planning supply after the cessation of door-to-door services was in large part a continuation and/or routinization of their previous roles. As noted above, the majority of women in urban areas did not depend exclusively on home-delivery. Many women had obtained pills elsewhere even during the door-to-door family planning period—some routinely and others during supply gaps - and husbands were instrumental in accessing family planning from alternative sources. Few women feel it is worthwhile to go to clinics for pills only, if they have a choice. Furthermore, those who can afford it tend to prefer the more expensive market brands of oral contraceptives, and use them regularly or intermittently, believing them to be of higher quality. Women typically feel they need a male family member (usually the husband) to obtain market pills because market places are still not commonly frequented by women. For these men, therefore, the influence of the program change on their roles was less significant, though there is evidence that many did in fact become more proactive and conscientious once they realized that without the door-to-door family planning workers their involvement in family planning procurement would now be required regularly (rather than just as an occasional stop-gap measure).

Implications of greater reliance on men

The impact of more involvement of men in family planning to date has been mixed. For some women the new or increased reliance on their husbands for family planning supply was clearly not a satisfactory alternative. Avoiding the discomfort of having to leave the house to obtain supplies was not worth the social cost of repeatedly reminding their husbands, who often were not reliable in this role.

> *“After the departure of that lady [the door-to-door family planning worker] I was continuing with pills from the market through my husband. I had to ask my husband continuously to buy pills. It was a difficult situation because my husband does not want to buy pills regularly”.*

Some women reported that even husbands who are very willing to help are not reliable enough to ensure a completely uninterrupted supply of contraception. Others were cynical about men’s willingness to begin with. They would have liked more support but did not expect it.

> *“Husbands do not do anything [about family planning] as all the responsibility is ours. They only earn money“.*

Similarly, a woman who was having problems with oral pills and had been recommended by a doctor to not take them was resigned that her husband would not be cooperative:

> *“He [husband] does not use condoms. He realizes nothing but to earn money. It is all my duty to look after my family and to take the pills.”*

For other women, increased reliance on men is not a satisfactory option because they do not feel entitled to greater support from their husbands and appear to prefer to keep them less involved. A small minority of women in the urban sites felt uncomfortable asking their husbands to engage in what they perceived to be their exclusive concern, and something a man cannot be expected to care about or be responsible for. In some cases this inhibition appeared to be in the absence of any manifest resistance on the part of their husbands (according to the respondents) and for at least one woman it resulted in a substantial gap in contraceptive supply. Yet most women, uncomfortable charging their husbands with family planning responsibilities, are nevertheless able to overcome their ambivalence in order to sustain supplies. Speaking of the previous door-step program, one urban woman commented that*, "though we felt shame to always bring pills through the husband, it was more dependable*" because the door-to-door family planning workers did not come regularly. Our current research indicates that this is still the case for the majority of women, particularly in urban areas.

However, not all women are uncomfortable or unsatisfied with men's participation in family planning, or at least the idea of it. Most urban women seem to think that help in managing family planning supply is a reasonable thing to ask of their husbands, particularly if it is a stop-gap measure or if there is no alternative that a woman feels comfortable using. When they receive it, this support is something the majority of women seem to value highly. They explained their ability to sustain supplies in terms of their husband's "cooperation" or "attentiveness" and conversely attributed problems to the fact that husbands are "negligent" or "unaware". Several women interviewed stressed that "all males/husbands" are not equal - "good" husbands are those who do more than "earn money" and are responsive to women's needs. Women whose husbands took initiative in obtaining contraceptives, or went beyond what was minimally required of them, often seemed proud of this, as if it reflected on their own worth. For example, an urban woman described insisting to her husband that he bring the pills from the market that are inexpensive. The fact that he "does not listen" and brings the pills that cost more anyway is a source of pride to her. According to her this shows that her husband is very cooperative and cares about her a great deal.

Most women also seemed to view positively men's greater involvement in family planning as a result of the program changes. They reported, for example, that in contrast to the previous system when they felt exclusively responsible for family planning, now their husbands had become more "interested" and "concerned." As one woman put it,

> *"Men never used to worry about this. They knew that [pills] would be brought to the household. But now since the apas do not come they have become interested in going out and getting the pills."*

Talking about her personal experience, one urban women reported happily that her husband had become more "interested" in and proactive about family planning since the program change,

> *"Before only I would be scared about whether I was pregnant because only I was responsible for preserving pills. But today he is also concerned about whether I am pregnant….Nowadays he asks me when I need pills, and whether I am taking them regularly or not."*

Many women reported that they like or would like their husbands to make even small, caring gestures such as reminding them to take their pills. Such sentiments suggest that men's

increased participation in family planning may prove to be an unintended positive effect of the program changes in urban areas.

Barriers to/determinants of male involvement

A number of factors emerged from the urban findings that seem to affect both men's willingness to adjust to the new program demands, as well as their efficacy in these new roles. In urban areas, men's lack of or inadequate involvement in family planning was rarely due to absolute or explicit resistance or abdication of responsibility. According to both men and women, men's limitations in this role were more a function of "shyness" or "forgetfulness".

To deal with the discomfort of publicly procuring something that is associated with "women's concerns" and/or sex, some men travel to distant shops where they can remain anonymous, and others will alternatively go only to a "known" shop where they can obtain supplies without the embarrassment of having to ask for them explicitly in front of others. One pharmacist described how he and male customers try to deal with the discomfort experienced by some men. A substantial minority (mostly young, newly-married or older men) will either wait until the crowd in the shop disperses before requesting supplies, or those who are familiar with the pharmacist will simply stand in the shop and say nothing, and the pharmacist will understand what they want and hand over the method in generic wrapping.

Both husbands and wives commented on how difficult it can be for men to remember to get pills, and often tied their "forgetfulness" to the demands of work and poverty. For example, Sabera's husband bought pills for 2-3 months and never got angry when she asked. But it became difficult for her to get pills through him. She said,

> *"Can it be told to the male person again and again to purchase pills? The husband carries the load of bricks and soil throughout the whole day, leaving early in the morning and returning, tired, late at night. Can he remember to purchase pills? I tell him once, twice, how many times?"*

Indeed, many people spoke of men's involvement in class or economic terms. There seems to be a fairly widespread perception that the husbands of well-off women are more "cooperative" and that poor men, because of time constraints or "ignorance", are less likely to be positively involved. In describing the sole burden she faced in keeping her family small, Nasreen said,

> *"Our husbands [poor people's husbands] do not know much about these things. Our husbands can only meet [have sexual relations] with their wives, and we have to do the rest.*

On the whole, we found in urban areas that the influence of extended families over reproductive health issues, particularly family planning, was limited. Mothers-in-law, for example, were often not part of decision-making about family planning or, if they opposed, their views were ignored. When family planning had been initiated in the absence of a door-to-door family planning workers, usually the husband was more instrumental than the mother-in-law. However, there were a few examples in our research in urban sites of extended family members discouraging, directly or indirectly, husbands' participation. As one women described her situation,

> *"My guardian is my mother-in-law. She would of course be angry if my husband took*

me [to the clinic]. She would say, 'I am the guardian - why would he take her?'"

Subtle or explicit social and familial pressures, though less prevalent (or relevant) in urban areas, can discourage the new roles for men implied by the program changes. This tension points to the need for broader normative change to support male involvement, in addition to encouraging individual men to adopt new behaviors.

Women's Mobility and Autonomy

In our research, we did encounter varying degrees of restrictions on women's mobility, usually applied more stringently in the case of young, new brides (*bou*) and on women in extended families. But on the whole, women were very matter of fact about the acceptability of going out of the house to obtain family planning and other types of healthcare. Women frequently reported that they needed "permission" from husbands and/or other family members to leave the house to go to a clinic, but for most this was a show of proper respect and deference (and a formality) rather than a request that might actually be denied. They were virtually unanimous in saying that women's freedom to move about to avail themselves of these services is now a well-established norm within the community at large, if not within every individual family. Men as well as women described the women's increased use of healthcare services outside the home as a reflection of education, and of greater self-confidence, sophistication and awareness of the outside world.

> *"Previously women would not go out alone. But back then only a few women had education. Now there are many more and women have become courageous. Everybody moves about alone. No one thinks badly of it."*

Women also repeatedly described the increased freedom as a function of the overall greater level of "understanding", "awareness", and "education" in the community, and the fact that family planning and healthcare are now widely perceived as necessities and legitimate reasons to travel. Asked if anyone objected to her going out for family planning, one woman exclaimed, *"Why would they say anything bad? They know that we are going there for a reason."* Another responded, *"Shouldn't everyone take [family planning] methods as they wish?"*

Women often reported that they travel with other women, such as sisters-in-law, mothers-in-law, or neighbors (some apparently for the company as much as or more than the social approval), but many also do travel alone, some quite comfortably. Although some women interviewed in the urban sites did report that they cannot or do not go out alone, this did not emerge as a substantial barrier to service use; very few women who used to obtain their contraceptive supplies from door-to-door workers have been unable to get contraceptives from other sources because their families prevent them from going out of the house. Among women with more limited mobility, going to a "known" clinic was often the exception to familial restrictions and one of the few places to which they could travel completely alone.

The ability and willingness to travel unaccompanied may also be class-specific. For example, according to one man, poor, working women have no restrictions on going to clinics or hospitals;

> *"If they hear filthy comments from people they can respond with filthy words if necessary. But women from decent families should not go out alone. If anyone says anything (bad) to them they are dishonored and they would not be able to retort."*

Similarly, the role of men in particular in accompanying women to clinics is perceived to vary by socioeconomic status. As one respondent noted, "*rich women take their husbands along*" but when it comes to poor women,

> *"Would their husbands work or go with their wives?….If they take their husbands to the doctor in the morning, then what would they do for food?"*

Many urban men do accompany their wives to clinics. Others do not because of time or work constraints, but also because of "shame" or "shyness". The clinics are still overwhelmingly perceived by men (many of whom have not gone to the clinics) as places for women where they do not belong. It is also a matter of preference for many women we interviewed who reported that they themselves felt shy going to clinics with their husbands and would rather be accompanied by other women.

In addition to greater mobility and freedom to access healthcare outside of the home, increases in women's overall autonomy in urban areas suggests that women's dependence on male acceptance and support in accessing clinics may be waning. This greater independence is again linked by respondents to women's overall "advancement". One respondent claimed that educated women can make their own decisions about where to go for treatment. Another tied women's autonomy in clinic use to their earnings, The husbands of the income generating women accept the decisions made by their wives whether willingly or unwillingly. In this regard, they have nothing to say to their wives about their clinic use.

Dynamics around women's increasing autonomy in family planning and reproductive health should also be seen as part of a broader evolution, again related to new roles for women: When asked if she felt more confident mentally compared to other women because of her earnings as a hawker, Sufia, a woman who lives in a slum, said,

> *"Yes, of course I feel confident. My husband does not ask me how I spend my own money. On many occasions husbands beat and scold their wives wrongfully. But if I earn myself then I can say a few words courageously to my husband. Because I am earning my own bread myself."*

As noted above, examples of explicit male or familial opposition to women using or accessing family planning were rare. Where these cases did occur, however, we found that the response of women was much more often defiance than submission. A few women we interviewed had resorted to clandestine use of family planning and the withdrawal of home-delivery made it very difficult (if not impossible) to continue using. But in the majority of cases women persuaded their husbands to change their minds or else defied them openly. For example, Ayesha was being pressured by her husband and in-laws to not use family planning. She however did not want another baby until her husband's financial condition had improved and while he was away she starting taking injectables. When she informed him when he returned he became very angry, and she responded defiantly that it was too late, it had already been done. She reported that she would continue taking methods despite her family's objections.

Some women frame their defiance as a legitimate response to unfairness. Despite a great deal of opposition from her husband and mother-in-law, Jahanara decided that she would start injectables after her menstrual cycle. She explained,

> *"The wives have to bear all the sufferings and pain in the family. I wanted to take family planning method/contraceptive after the birth of my first child. But everybody including my husband forbade me. Now I will take it. If I don't take then I will conceive more children".*

Defiance is also described in light of deviations from traditional gender roles in supporting the family. When talking about the decreasing objections of men in urban areas to women's clinic use and mobility, one woman in a group discussion said to the interviewer,

> *"See these women who earn by working as laborers? Do you think they listen when their husbands resist? They will quarrel and say, 'Do you provide me with clothes?'"*

Another woman in the group elaborated by explaining that once a woman is earning money "by herself, for herself", her husband loses his "right" to resist her.

Many women interviewed in the urban sites do appear to be "empowered" healthcare consumers – they are assertive about their entitlement to health services and proactive in seeking them out, even if at times it requires defiance against social norms or individual opposition. It is not yet clear whether and to what extent these characteristics are attributable to program changes, nor whether there will be any empowering effects that go beyond use of family health services. The need to go outside of the home to access services does not appear to have led to substantially greater freedom of movement for women in our urban sites, where women's mobility was already fairly high. However, it could be a considerable benefit for rural women where overall mobility is usually less and where women may have fewer legitimate "excuses" to leave the home.

Barriers Related to Cost, Access to Resources, and the Valuation of Women's Health

With very few exceptions, men's objections to and lack of support for women's clinic use in the urban sites usually concerned cost issues at some level. As one male respondent described it,

> *"Now-a-days no man prevents his wife from going to the clinic. But the problem arises when the husband cannot pay for the treatment. Now-a-days the women demand money from their husbands for their treatment."*

Indeed, one urban woman described how her husband never prevented her from getting medical treatment as long as she herself paid for it, "but if I ask him to spend money he won't."

Many respondents reported that on the whole men have become more "conscious" and now give more importance to women's health problems than in the past, but there is often a disconnect between their concern or emotional support and their willingness to pay. Reluctance to pay for women's health problems seems to underlie some of men's ambivalence about contraceptive use. In many cases men's strong support for family planning use is juxtaposed by an apparent lack of sympathy and support for women when they experience related side effects. Many women reported that husbands are not supportive of women's "sufferings" associated with family planning use, and often blame their wives for the problem, even if they had agreed to use contraception. One woman who switched to injectables from pills because of side effects was warned by her husband*, "you never know what type of problems may arise*" but he did not forbid her from using the method. When she then had menstrual problems in the months following her first injection her husband became very angry and scolded her repeatedly, despite her own efforts to improve her condition by resuming pills. Her husband refused to take her to a doctor as she requested saying,

> *"You have taken injection, so you suffer."*

Similarly, in cases where distance impeded women's access to contraceptives and services the issue was usually cost rather than social restrictions. To use clinics and satellite clinics women must take time away from childcare and domestic work, and often must pay the cost of transportation, as well as any charges for the contraceptives and services they receive. Many commented that the travel time and especially the cost of transportation is a serious consideration and often a constraint in accessing family planning and other clinical services. Charges for contraceptives and services were another impediment for a substantial minority of women in the study.

Even during the home delivery period, lack of funds (either due to the extreme poverty of the family, or because the women did not control family money) prevented some women from stocking up on oral pills as a way of dealing with supply gaps, and prevented them from using the market as an alternative source. For some, extreme poverty is an obstacle to the use of any health service. As one woman stated,

> *"We are poor. Shall we eat rice or shall we save it to buy pills?*"

We do not have hard data on the economic status of the participants in our study, so it is difficult to judge how many are "really" unable to pay the current prices set by the static and

satellite clinics. However, we still have examples of women who could not avail themselves of the services because of the cost, and of respondents who are forced to use what they consider to be a less than optimal family planning method because of cost.

Because of the irregularity in their access to cash, for many women the main issue is availability of credit, rather than the actual charges they have to pay for services. Indeed, clients in the NGO areas had to pay for contraceptives even when the door-to-door system was in effect, but prior to the program transition many women worked out informal credit arrangements with the door-to-door workers so that they could pay for supplies when they had cash available, rather than when they received their contraceptives. The withdrawal of this option created hardship for many. It appears that some women have been able to get contraceptives on credit under the new program, but this practice is clearly not as widespread as it was in the past.

It is too early to judge at this stage the implementation of the new program model, what additional strategies may be needed to help women overcome cost-related barriers to use of health services in the project areas. It is clear from our research that some women have difficulty paying for contraceptives and services simply because of their poverty, and for others financial barriers are more a manifestation of gender inequality and women's lack of access to family money.

The Ongoing Role of Health Programs in Supporting Women

Even among just urban areas there is substantial variation in the degree to which women have the support of their husbands and families and/or can access health services without it. The realities of the majority of women will obviously fall somewhere between the two extremes of absolute freedom on the one hand and restriction without exception on the other. As women increasingly seek services outside of the home, most will have to negotiate a middle ground that is often ambiguous, conditional, and highly fluid, and one of the challenges for the new program is to incorporate enough flexibility in the service design and implementation to meet these varied and changing needs. The comments of one respondent illustrate women's complex realities and how conditional their successful adaptation to the new service delivery model can be. Munni was discussing the advantages of having the new NGO satellite clinic near her home:

> *"I have two children, but my husband is somewhat the stupid type and he says, let there be one or two more. But I don't want that. But my husband is not allowing me to go outside (the neighborhood). [Because] the clinic is nearby, and I can spend my own money, then my husband has no objection."*

This woman clearly has a strong desire for family planning and, while her husband does not, he is not actively opposing her. She does not require home delivery of free services, but her ability to access the new services reliably depends, perhaps heavily, on her access to cash and the proximity of the clinic. If, for example, the clinic had not wound up in this woman's neighborhood, she probably would have been able to develop alternative strategies, but perhaps not without unacceptable social costs and/or gaps in family planning supply. The NGOs' efforts to identify women in the communities who are having problems adapting to the new program, and providing them with additional support, are therefore critical and may continue to be important for quite some time.

Another implication of the program changes relates to the inhibitions some men feel about taking on more active roles in reproductive health. For example, if the increased reliance on pharmacies and husbands for supply of pills and condoms (particularly in urban areas) is going to continue, the amount and quality of information available to women may suffer. For regular, established users, this may be less of a problem, though many women turned to the family planning worker with problems related to side effects and other health concerns. For newer users of family planning, however, even basic information about proper usage may be inadequately conveyed, especially if young, newly-married men are among those most likely to be shy and reluctant to speak to pharmacists. As women become more aware of and familiar with the new services over time, their reliance on men for access to services and information outside of the home will likely continue to decrease, even if men are still the primary conduit for family planning methods. However, government and NGO efforts to improve pharmacists' dispensing practices should nevertheless include special emphasis on family planning counseling and communicating with men about reproductive health issues. Since these measures will obviously have limited impact on the men who are too inhibited to use such services, the NGOs' ongoing outreach strategies and group meetings for men can help to encourage them to take on these new roles. It will also be important to cultivate new norms of male involvement more broadly by, for example, incorporating messages about men's roles into all forms of community outreach and education.

CLIENT SATISFACTION AND PERCEPTIONS OF QUALITY

Under the old program women's primary contact with the formal health care system was the domiciliary family planning worker. Prior to the transition some women also had comparatively extensive experiences with a variety of government, NGO, and private clinic-based services, while others had little or no contact with services other than those provided by the door-to-door family planning workers. Under the new program women are regularly accessing services in a more public setting (in their communities or in clinics) and they interact with staff who are unfamiliar, who may belong to a different social class, and who are trained to approach their work in a more formal, professional manner. Clinic facilities have been upgraded and new systems have been introduced regarding payment, patient flow, and the regularity of services.

Overall, reactions to these innovations have been very favorable. With some caveats, which we discuss briefly here and later in more detail, the findings suggest that the redesigned NGO service delivery systems are emphasizing many aspects of quality that clients genuinely value. These include: convenience, reliability, clinic environment and amenities, access to a variety of services and contraceptive methods, support to contraceptive users, technical capability of service providers, client-provider relations, social equity, and availability of discounts and free services for those in need. Although some respondents seemed to feel alienated from, or excluded by, the new program this was often based on speculation rather than direct experience. For example, there were people who had never visited the new clinics and satellite clinics but made unfavorable comments about them based on experiences in other health facilities: namely that the clinic staff are not accessible, or that they do not provide good care to poor people or to those without a personal connection.

As most services are now provided through clinics and satellite clinics, the study included interviews with women who had been recent clients of these facilities. The transcripts available to date include 30 such interviews with women in the two urban sites: 16 from fixed clinics and 14 from satellite clinics.[2] Three members of the research team independently read these transcripts and rated the quality of the client's experiences in the clinics, in light of the client's own description and any evaluatory remarks (that she was or was not satisfied, would or would not return there, etc.) Each rater also made notes when she felt that the client's own evaluation was either more or less favorable than the rating she herself might have given, based on the description provided by the client, but such discrepancies were relatively few. The researchers' ratings were consistent in most cases, and scores were adjusted or averaged after discussion in the few cases where there was disagreement. The resulting rating based on clients' perspectives of the fixed clinics was 14 scores of good to very good, one mixed to good, and one poor (in this case the woman felt that the technical quality of the services was inadequate, an aspect which we are unable to evaluate in this study).

The ratings of satellite clinics were good in six cases, mixed to good in five cases, mixed to poor in two cases, and poor in one case. The lower satellite clinic scores came mostly from one site, and mostly reflected the sub-standard facility in which the clinics were held—the porch of a house with no furniture other than a mattress, and no waiting area at all (clients sometimes literally had to stand out in the rain). Under the circumstances, the raters felt that the women's generally favorable assessments of this satellite clinic reflected low expectations.

Quality of Clients' Experiences in Clinics, Urban

Clinic sites	Good to very good	Mixed to good	Poor to mixed	Poor
Fixed	14	1	-	1
Satellite	6	5	2	1

Clinic Environment and Amenities

There were many positive statements about the environment of the new NGO clinics compared to others clinics and to the past. Numerous respondents praised the new clinics for their cleanliness and amenities. Clearly impressed with the physical environment of the clinic she visited, one satisfied client commented

> *"[The clinic] has improved compared to the earlier one. There is a water filter and also beautiful, clean glasses. And there are beautiful chairs and a place to sit for everyone."*

She also appreciated the separate seating arrangement for women. Others noted that there was a latrine for clients to use, and that was clean and did not have a bad smell.

These favorable comments are very typical of clients of the static facilities. Clients of satellite clinics had more mixed perceptions, including complaints about the physical space, namely that the site was crowded and there was very limited seating out of the sun or rain for those waiting. As mentioned above, judging from the clients' descriptions, the physical environment of one urban satellite clinic in particular was clearly substandard. The site of this clinic is an impoverished slum where it was probably difficult to find better accommodations. One client described the clinic as a small room with no fan and no seating, where clients and providers alike had to crowd in and stand in the heat. Her only consolation, she said, was that the "doctor" had to suffer as much as the clients did.

Convenience and Clinic Procedures

Most women found the hours of the regular clinics to be convenient. Some felt that the satellite clinics were too infrequent, or found them inconvenient because they were only open on certain days. The majority who used satellite clinics, however, were grateful to have a such a clinic nearby, and some said they would not be able to visit more distant facilities for routine needs; they would only be able to justify the time and transportation costs when they had serious health problems.

Many women appreciated the orderly system in which clients sign in and are seen on a first come, first served basis; they prefer not having to behave aggressively or exploit personal contacts to be noticed and served in a clinic. A woman who observed an increase in the number of clients following the program change at the urban clinic she had been using for some time. She was impressed that even though there were more people, there was little noise and chaos. Perhaps the orderly atmosphere of the clinic had influenced the behavior of clients:

> *"Everyone remains seated quietly and does not hurry,"* she said, *"Everybody goes according to their serial number." "Everybody was following the serial number system.*

There was no trouble. There was a crowd, but you didn't feel that the place was crowded. I liked it."

Our interviews confirmed that many women are indeed willing to pay more money for the convenience of less waiting time. On the other hand, many reported that they waited for what we would consider a long time (an hour or more) but did not mind. (We have no way to verify how long they actually waited.) Their explanations included: that this was a short wait compared with other health facilities they had visited; that others also had to wait a long time; that it was worth it, to get the services; and that the atmosphere of the clinic was agreeable (especially when the TV or video was on).

In satellite clinics a serial number system was not always maintained. Instead, clients were sometimes seen in batches; in one satellite clinic infants and children were first, since they made a lot of noise, women receiving injectable contraceptives second, and pregnant women last, because they required more time. Clients seemed relatively tolerant of this system too, although women who came for antenatal care were somewhat inconvenienced by it. One pregnant woman received a brief check-up but was told that she would have to save her questions until after other patients had been seen, so she left without having the opportunity to ask questions. In another case, on a busy day, satellite clinic staff suggested to a pregnant client that she might want to return home and come back to the clinic later when they would have more time for her, a suggestion that she did not follow but did not resent. In several other cases clients were sent home to get their money, or containers for medicine, but in most cases they also did not seem to mind. Our impression was that many of these women are used to being inconvenienced at health facilities, and so they notice and appreciate whatever efforts are made to accommodate them.

Access to a Variety of Methods and Services

Contraceptive options

Previously pills were the only viable contraceptive option for many women, despite their frequent dissatisfaction with side effects. Since the national program moved away from its sterilization emphasis of the 1970's, family planning services in Bangladesh have been heavily skewed toward pill distribution through door-step delivery. Many women in our study had tried under the old program to switch to clinical methods such as injectables and found that services were irregular or not conveniently located – or they again suffered side effects that were not adequately addressed. Some women alternated between injectables and pills or condoms, depending on availability, often with gaps in contraceptive protection. One woman who had been suffering from side effects of the pill for some time had informed the door-to-door family planning worker, who suggested she start injectables once her current cycle of pills was finished. After telling her this, however, the worker did not return in time. The woman waited a month without using any method and then sought out injectables at the NGO clinic. She was told she would receive the next dose at home, but again, the worker did not show up on time. After the new program started she adopted an IUD and she is happy with both the method and the follow-up provided.

Many women say that they have access to a broader range of contraceptive methods under the new program. One woman commented,

"I feel it is better to go to the office [clinic] because many different methods are available there. You can learn about the methods and choose one according to your own liking. When the apas used to come to the houses, they would go away after giving out pills, and nothing more was available."

Many women shifted from pills or condoms to clinical methods after the program change, often because they had side effects or other complaints with their previous methods. By making a broader range of family planning methods more accessible to women, and providing users with adequate follow-up care for side effects, the new program may therefore be filling a previously unmet need. The clients' descriptions of their decision-making processes and knowledge of various contraceptive methods, however, suggest that ongoing education regarding the characteristics of various methods is still needed. When they became dissatisfied with a method and decided to switch, women often seemed to select an alternative method merely because it was the first one recommended, or because a friend or acquaintance used it. They typically did not consider the full range of methods available.

"One-stop shopping"

The integrated, ESP model upon which the new program is based provides a broader range of reproductive and family health services to communities, and may improve utilization and cost effectiveness by offering a variety of services in the same location. In theory clients should be attracted by the convenience of "one-stop shopping", and clinic staff should be able to introduce clients to services they may need but are not aware of, or do not seek out. Our preliminary findings suggest that women are indeed interested in having access to a broader range of health services through clinics and satellite clinics. For example,

"Previously the apas would come house to house, but they would only bring pills and no treatment was available for other diseases. But in the clinic [of the new program] we can get other care, not just pills and condoms. So getting our methods from the clinic is much better."

The obvious appeal of one-stop shopping for health services is that it saves time, which many women seem concerned about. In describing how they decided where to go for contraceptives and health care women often mentioned travel time, waiting time, and whether they could obtain medicines at the clinic rather than having to make a separate trip to a pharmacy. As these factors often have cost implications, it was not always clear to what extent these women were concerned about the expense of the services, as opposed to the time cost alone. In some instances, interest in saving time does lead women to avail themselves of combinations of services (e.g., purchasing pills when visiting a clinic for another purpose). For very poor women, however, cost is clearly the overriding consideration in choosing sources for health services; the very poor typically have to look for the lowest cost source for any service they need, even if this is inconvenient.

It is premature to assess how far families will take advantage of "one-stop shopping" under the new program, since many people are still not aware of what is available through the redesigned clinics and satellite clinics.[3] The findings point to a number of program-related barriers to utilization of the integrated service package, in addition to poverty. For example, most women we interviewed associated the new satellite clinics primarily with family planning; only in response to detailed probing did they mention other things (such as oral saline or basic drugs)

that they thought might be available there. In contrast people in the study communities generally do associate the static clinics with a broader range of services (if only because their staffs include qualified doctors or paramedics), but many of those interviewed had never heard of the clinics, or they had heard of them but did not know what was available there. This included women who had attended satellite clinics. Thus, many prospective clients probably do not have enough information to take advantage of one-stop shopping. The staff appeared to be doing little to undermine the prevailing association of the NGO services with family planning alone, and in some instances they seemed to be reinforcing it. Family planning (what the clinics are widely known for) could be an entrée to other services, but many women do not use the clinics for family planning supply. Even where they do, more outreach by NGO staff would be needed to make family planning an effective link to other services, especially at satellite clinics where the availability of services beyond family planning is often not apparent. We found only a few examples of service providers actively promoting the one-stop concept by linking women with other services in clinics or satellite clinics.

The NGOs are experimenting with promotional strategies that may help attract clients as well as encourage them to use more of the services that the NGOs offer. Some clinics have introduced a pre-paid "Family Health Card" which can be used to obtain unlimited services throughout the year for all family members. This strategy seems to be having the intended effect. The clients we interviewed who had purchased the card were happy with this system, and they had begun to use the clinic for most if not all of their own and their families' healthcare needs. One woman said,

"I went so many times and I did not need to pay anything because I had already paid the 100 taka. I got all sort of different kinds of treatment: vaccinations for my children and for me, check-ups during pregnancy, measurement of blood pressure…"

She gave the impression that because of the card she had made an effort to find out what services were available at the clinic, and to take advantage of them. The NGOs have started giving these cards out for free to families in slum areas (70 areas within Dhaka, so far.)[4] These and other special strategies should help the clinics to exploit the potential public health impact of the ESP approach.

Reliability

Women using oral contraceptives greatly appreciated the reliability of contraceptive supply under the new program. Most women would have preferred the convenience and privacy that the door-step model offered in theory, but they recognized that the system as it actually functioned was far from ideal. As described earlier, in urban areas the reliability of the main supplier of pills (husbands) was mixed, but on the whole women seemed to find it as convenient or more so than the door-to-door family planning system. In a few cases women went to satellite clinics and found them closed, possibly because they were misinformed regarding the days of operation. Women commented that they liked the hours of the fixed clinics. They saw them as always available for health care as well as family planning services.

Technical Capability of Staff and Support Available to Contraceptive Users

Clients appreciate what they perceive to be enhanced technical knowledge and capability of the new staff, or of old staff re-deployed under the new program. They seem to judge this based on

the way the staff behave—whether the staff seem careful and methodical in performing examinations and in giving injections. Some women also noted that they were happy about the presence of a female physician at one of the NGO clinics.

> *"We are lucky to have a female doctor there because women feel comfortable enough to talk about female diseases and family planning,"* said one client.

Many women commented that they like having a qualified provider available at local satellite clinics with whom they can discuss their problems with contraceptive methods. For example,

> *"This system is good because one can get a method when one wants it.…The Copper-T causes various problems during menstruation. There was no one to ask about this problem before [during door-to-door family planning]. We were helpless. But now they insert Copper-T and from time to time they come for follow up. They do not put us aside."*

> *"The previous ladies [door-to door family planning workers] were not regular…they only supplied pills and then they left at once. But the newer ladies are very good….. their behavior is good, they talk to everyone. They ask about your problems, tell women to come to the clinic if they have difficulties, measure your weight and blood pressure."*

We were struck by the extent to which respondents distinguished between accredited (MBBS) doctors and paramedics, and (in the government system) between higher and lower ranking doctors. A few years ago the women in particular seemed to view most clinic-based healthcare providers as "doctors" (Schuler et al., 1997). This is a positive development insofar as well-informed consumers are likely to make more intelligent choice in allocating their resources for health care, and they may even demand higher quality services. Unfortunately, potential clients may not always realize that physicians (as opposed to paramedics) are not often needed to provide certain types of basic services such as routine maternal and child health care and family planning.

Client-provider Relations

In speaking about the innovations under the new program, the study participants often compared it to the previous system, or to governmental or other clinics. Many clients had had unpleasant experiences elsewhere. Commenting on a recent experience in an NGO clinic not supported by the USAID program, for example, one woman said:

> *"When they talk to us it sounds like they're talking to cows or goats!"*

In contrast, many women spoke positively about the attentiveness, consideration, and well-mannered behavior of the providers in the new NGO clinics and satellite clinics. They mentioned small gestures such as the respectful terms of address the clinic staff used with clients, expressions of concern and sympathy when they were ill, admonishments to eat more, and to take care of themselves. The following comments by clients are typical:

> *[The clinic] is very good. The doctors' behavior is very nice, and that's why so many patients come here. Doctors in other places do not behave well and so people don't like going to those places. Patients can talk freely with the doctors here."*

"They asked me very sweetly to sit down...They examined the patients with care. I most liked the way they talked with patients. [By contrast] The woman [staff member] at the Maternity Hospital spoke in very rough language."

Many women remarked that the Apas in the new clinics listen to carefully to what they, the clients, say. This is significant in a context where women, especially those lacking in education, sometimes feel that it would be impossible for them to communicate effectively with unfamiliar people of higher status, especially in an institutional setting. Several respondents commented that poor, uneducated women are afraid of being scolded or demeaned because they do not know how to talk properly with service providers. In interviews with informal intermediaries who accompany women to clinics, as well as with women who (in most cases previously) would not dare to go to a health facility without an intermediary, and asked why an intermediary was needed, one of the answers usually was that the intermediary knew how to talk with service providers. (Another was that they had connections and, so, could help the client to get better services or lower prices.) As suggested earlier, to some extent it is the women are changing, i.e., becoming more bold and accustomed to interacting in public, but it is also clear from women's comments about provider behavior in the new clinics that these service providers have come a long way in fostering better communication with clients.

Social Equity

Most users of both satellite and static facilities see the NGO clinics as equally accessible and fair to rich and poor alike. That clients in the NGO clinics receive equally good services and respectful treatment regardless of who they are and whom they know was a theme that came up repeatedly in the interviews. For example,

"I am on familiar terms with all of the staff because I have been there so many times, but I don't think they do extra favors for me just because I am familiar. They treat me as they treat others. Whoever comes first is seen first. They see me according to my serial number. It doesn't matter if someone is rich or poor, known or unknown to them."

The widespread agreement among the NGO clients on this point is particularly striking in light of the very common view (documented abundantly both in this study and in our previous research as well) that only the wealthy can get good services and courteous treatment in health facilities. Themes related to class differences and discrimination emerged in many different types of interviews, but when these issues were raised in connection with the new NGO programs the respondents' comments were usually based on speculation rather than direct experience. Similarly, people who had never visited the new clinics tended to make unfavorable comments about them based on experiences in other health facilities: namely that the clinic staff are not accessible, or that they do not provide good care to poor people, or to those without a personal connection. Impressions such as these are probably diminishing over time, but the tendency in economically disadvantaged communities to assume that there will be social distance between clients and providers is important to bear in mind in designing communication strategies.

Waiving Fees for Those in Need

Many people believe that the poor are entitled to receive discounted or free health services, but the unfortunate reality in many public as well as private health service settings is that the poor must bargain or beg for this entitlement; often discounts are given only after providers yield to persuasion and grant special favors. In this context, many view the provision of discounts on compassionate grounds (without humiliating the client) as an important aspect of service quality. Speaking of a non-accredited local doctor (*quack*), who practiced in her community, one woman explained,

> *"If I am very ill I go to a local [non accredited] doctor. He charges ten taka, and if I don't pay it he doesn't say anything. He understands how poor we are….Or if I give him what I can and tell him that I'll pay the rest later he doesn't object. He is sympathetic because of my distressed situation."*

Clients often receive discounts and free services in the NGO clinics. As discussed below, however, developing an efficient and transparent system for charging fees on a sliding scale is an ongoing challenge.

PAYING FOR SERVICES

Attitudes about paying for services varied depending on the type of provider and/or service and the historical or relative standard in the community, as well as the individual's ability to pay, and they can sometimes appear contradictory. It is also important to bear in mind that attitudes of people in this study regarding NGO charges are not based exclusively on direct experience with the NGO clinics and services; they often reflect assumptions based on prior experiences with a variety of service providers. For example, in many areas medical practitioners (some accredited, others not) make their living by running medical shops. They often examine patients for free, and charge only for the medicines they prescribe. It appears that the widespread existence of these practitioners has contributed to an attitude (expressed repeatedly in our interview transcripts) that it is often unnecessary or extravagant to pay for a medical consultation.

Other recurrent themes that emerged from general discussions about peoples' views of health and family planning services included the idea that those in need are entitled to free health and family planning services from the government; that private providers (and, more generally, those who are more fortunate) should show compassion and help economically distressed people meet their health needs, especially if they are personally acquainted with them; that, nonetheless, only the wealthy and those with connections can get adequate health services; and that, if you are poor, the way to get health services at lower cost is to beg and bargain.

The data on health care decision-making also suggest that the poor are used to sacrificing considerable time and effort to get health services free or at the lowest possible cost; thus, they may travel long distances, often on foot, undergo long waits in crowded government facilities, and go to a variety of different places for different health needs in order to get the lowest prices. Or they may simply let a disease run its course because they lack money for treatment. As noted earlier, many respondents in this study, as well as in our previous research, indicated that when men oppose women's contraceptive use this is often because they are afraid that the methods will have side effects and that they will have to pay for their wives' treatment. Thus women often fear side effects because they are afraid their husbands may become angry and blame them, and expenditures for treating problems (believed to be) caused by contraceptives are seen as unjustified in some families, even if the family is not under severe economic stress.

Cost and Quality

The majority of clients who had direct experience with the NGO clinics and satellite clinics felt that the charges were fair or even under-priced. In particular, they noted that the charge for a consultation with an accredited (MBBS) doctor was low compared with what they would have to pay elsewhere. (The exception to this is government hospitals, where well-qualified doctors are present but, many respondents felt, often do not give adequate time and attention to patients.) Several women who had purchased cards entitling them and their families to unlimited services for 12 months were very sure that this arrangement was beneficial, and a real bargain.

At times attitudes about charges for services appear contradictory. On the one hand, people generally associated higher prices with higher quality services. Some respondents also commented that the NGOs offer "cheap, government" oral contraceptives which they consider inferior to the more expensive market brands. The idea that commercial brands contain vitamins appears to be widespread.

This reasoning also led a few people to wonder whether the NGO services were substandard because the cost of seeing a doctor is low compared with the private sector. Thus setting prices at levels that lower-middle and lower class clients can afford may raise questions about the quality of the services, but this is mainly an issue for potential clients who have never used the clinics. Ironically, others criticized the clinics for being too focused on money and "not caring about the poor." These contradictory attitudes highlight the difficulty that the NGOs are facing in trying to establish pricing structures that will promote cost recovery while building up a clientele among the low income groups most in need of the services they offer.

Confusion between Government and NGOs

A substantial minority of people in the study felt that the charges were either too high, or unwarranted or unfair. Confusion between NGOs and government, and ideas about the government's responsibility to provide certain services had a strong influence on peoples' thinking in this regard. Even among those who understood that the NGOs were NGOs, the coexistence of free or lower cost services provided in nearby government facilities often made the charges levied by the NGOs seem arbitrary and unfair, especially if they traveled to the government facilities and were turned away and told to use the NGO services in their own administrative area.

The expectation that government services in particular should be free, coupled with widespread confusion about the relationship between government and NGO services leads some to resent or even be suspicious about the NGOs' service charges. Many assume that the latter are in fact government services, or they are aware that NGO services are publicly subsidized.

> *"It is not right [for the NGOs] to charge for pill because it comes from the government. And we should get government things free of cost."*

Some imagine that the providers are wrongly keeping the money for themselves.

Use of the green umbrella logo (showing that the clinic offers all services included in the ESP) may, unfortunately, be contributing to the confusion. Many respondents thought that this was a government logo, in some cases because they had seen advertisements on television in which the ESP is being provided in a Thana Health Complex.

Talking about Paying

In some cases the way that fees were discussed and collected in the clinics struck clients as rude and unseemly, especially when payment was demanded up front. An urban woman complained,

> *"They used to provide treatment according to government policy (free of charge) but now they say 'give me ten taka and I will examine you!'"*

Since we first reported this finding, the urban clinics have been addressing the problem by coordinating client flow so that payment always comes at the end of the visit, and simply by being more sensitive to the issue. This seems to be helping, and clients do not appear to mind

being reminded in advance about the charges for services, as long as this is done gently and diplomatically.

Ability to Pay and Willingness to Pay

Clients (who were able to pay) generally seemed willing to pay when they were reasonably sure that the charges were legitimate, and that the clinics were being run by NGOs, not the government. Even then some were apparently confused regarding what they were paying for (for example, some did not seem to understand the one-time charge for registration). The misunderstandings over charges were somewhat surprising, given the variety of strategies that the NGOs are using to inform people about prices. The prices are clearly posted in the clinics (although many clients cannot read); staff often tell clients what the charges will be when they enter a clinic; community promoters talk about the charges when they inform people about the clinics and encourage them to visit, and prices are mentioned in various types of advertising. Many women also learned about the charges by word of mouth. Those who knew about the charges before going to the clinic usually brought money with them, and did not seem to question the charges as many first-time clients did. Hence, issues related to paying are likely to diminish as more and more clients become repeat clients. But in addition to the strategies already being used to inform clients and potential clients about the prices of services, special strategies may be needed to make it clear that these are not government clinics, and to explain certain features of the system, like registration.

The researchers reviewed transcripts from 37 interviews with recent clients of the urban NGO clinics and satellite clinics, and sorted them into four groups: (1) clients who found the charges to be reasonable and had no problem paying; (2) clients who were willing and able to pay but needed credit because they did not have enough money with them when they went to the clinic; (3) clients who were able to pay but felt they were too high or possibly unjustified; (4) clients who appeared to need a subsidy.

The results show that over half (20) had no problem paying and no questions or reservations about the charges. Another 7 women thought the charges were reasonable but needed credit because they did not have enough money on the day they visited the clinics (3 of them were given credit, 3 were refused, and 1 did not ask for it). One woman needed credit and also thought the charges were too high (and did not receive credit). Four women paid, and probably could afford the charges but they wondered why they had to pay the amounts they paid, or they felt that the clinic was charging too much. Only five women clearly needed a subsidy and, of these, two received free services. Thus it would appear that the current prices were within reach of most of this (small, non representative) sample of clients, but that nearly half would have benefited from better information, credit, or subsidized services.

Among the women who needed either subsidies or credit, 8 left the clinic without getting all of what they came for or needed. All but two later returned with the money and received services, but three of the women were unable to fill prescriptions from the clinic and one could not afford a test that had been recommended.

Client Views of Charges in Urban Clinics N=37

Clinic Type	Reasonable and could pay	Probably could pay but questioned charges	Needed credit	Needed subsidy
Fixed	11	1	3	3
Satellite	9	3	5	2

It was obvious that clients were more willing to pay when they clearly understood that the clinics were being run by NGOs, and that the charges were legitimate.

Cost as a Factor in Contraceptive Choice

For some women the relative cost of contraceptive methods was clearly a factor in their choice of a contraceptive method. The most frequent example was the choice among brands of oral contraceptives. Other women were afraid to risk the possible cost of treating side effects or problems, for example:

> *"I know that if my health fails my husband will not arrange treatment for me. I have to manage it myself, maybe by secretly taking something from the house and selling it to pay for the treatment. That's why I am afraid of the injection. I have to choose something [a contraceptive method] after considering all the pros and cons"*

Need-based Subsidies

Although many people believe that the poor are entitled to receive discounted or free health services, and in theory they can in government facilities, research findings suggest that charges are often collected informally (Government of Bangladesh, 1999).[5] The unfortunate reality in many public as well as private health service settings is that the poor must bargain or beg for what they see as an entitlement. Often discounts are given only after providers yield to persuasion and grant special favors, and bargaining over the price of health services is a well-established practice to which the poor often resort in times of difficulty. This aspect of the prevailing health service delivery culture in Bangladesh is well-known, and the providers in the new NGO clinics probably assume (correctly) that their own policies and practices in providing subsidized services will be understood in terms of these norms.

The new NGO clinics have a policy that no one should be denied services because they cannot pay, and average revenues in the urban clinics are only about half what they would be if all clients were charged the posted prices (personal communication with NIPHP staff). The clinic staff find it difficult to provide these subsidies openly and systematically, however. They fear that openly waiving or adjusting fees for some would raise concerns about fairness, and make it difficult to enforce the posted prices for the majority of clients. Some of the service providers in the study had improvised ways to implement the flexible charges policy by, for example, telling the client to pay the balance "next time," and making a show of writing what is owed on her receipt. Usually it is assumed that she will not pay this and, in fact, some clients then make the argument that, since they only paid "x" amount the previous time, they should pay the lower amount again on subsequent visits. One respondent showed the interviewer how she carried a

small bag with only five taka in it in order to make the provider realize that she really had very little. She kept her rickshaw fare and money for buying household necessities in her sari.

Thus despite the NGOs' official policy of providing subsidies, the NGO clinics that we observed did not give subsidies openly and transparently. There was no organized system of subsidies, only failures to collect fees, and small acts of benevolence bestowed upon the poor. The practice of bargaining over prices in clinics, and the granting of individual favors to the needy, may be so familiar to both clients and providers that they sometimes engage in this behavior without thinking much about it. This does not mean that the interaction leading up to the decision to give a subsidy is necessarily unpleasant for the client. The following comment by a woman in one of the urban clinics (substantiated by data from other interviews) suggests that in some facilities staff demean clients who ask for free or discounted services, but that this is not common in the NGO clinics. In this case the interviewer asked the woman how she felt about the fact that the staff charged other clients while she got services for free. She answered,

> "*They ask me for money too, but I have none, so I can't give it to them. If I did have money I certainly would pay. But they do not misbehave with me because I can't pay. I like that about them."*

It may not always be apparent when a client needs a subsidy. The problem the NGOs face is that people in need of subsidies may not ask for them, probably for a combination of reasons: shame, assumptions based on previous experiences elsewhere, and lack of information about the availability of subsidies. One woman said she had spent three or four hours waiting with her children in another clinic (not part of the USAID-supported program) and had been unable to get treatment for them because the clinic would not reduce their charges. Asked whether she had ever taken her children to the NGO clinic in our study, she said

> *"The apas of the family planning office* [note that she associated this clinic with family planning and, like many, referred to it as an "office"] *sometimes come [to my area] to give oral vaccination to children. They told me to come to their clinic. They said if I go there they would provide free treatment, but I know that they will not even speak to me if I do not have money. No matter what they say, they will not provide treatment without money. This is why I do not go."*

Our field research team felt that in many cases the slightly better off among the poor tended to be more self-confident and were more likely to bargain or ask for discounted fees compared with the very poor, but this observation is based on informal impressions and we do not have data to substantiate it. A substantial number of respondents told the interviewers that it was not possible to bargain or to get services, family planning methods or medications at reduced prices in the new clinics (while many others did receive credit or subsidies) but we are unable to classify these people by economic level, at least not with a comfortable level of certainty.

One recent client told the interviewer that she pointed out to the clinic staff a fellow client who needed a subsidy, and the staff waived the fee for that client. This was a sociable woman who said she enjoyed going to the clinic and would stay there and gossip with the staff when they weren't too busy. She said she liked to listen and watch them interacting with other clients. She herself didn't have any problem paying for services, she told us, but she questioned whether they should be charging the poor (and she thought that it was a government clinic). She believed that there were many people who did not use the clinic because they could not afford the fees, and when she recognized a beggar woman who was being asked to pay for medicine

she said to the clinic staff,

> *"Apa, this woman begs from door to door. She has no husband, she has no one. She can't even support herself. She doesn't even get ten paisa when she goes to someone's house (to beg)—where will she get ten taka to pay you?"*

The paramedic then wrote her a prescription without charging her. (Presumably the woman got the medicine without paying for it, although this is somewhat unclear from the interview. Clients often seem to think that the clinics are charging them for writing a prescription—they do not necessarily see it as a charge for examination and consultation.)

Interviews with the clinic staff show that they recognize the complexity of pursuing cost recovery while making their services accessible to even the poorest. And it is evident from experience in other countries as well that it is no simple matter to design need-based subsidy systems that are at once transparent and effective in reaching the poor. Add References

Credit

The use of "credit" as a camouflage for discounts or free services in the comparatively anonymous clinic setting contrasts with the community-level norms that evolved under the old program in the context of door-to-door contraceptive distribution and satellite clinics. At the community level informal credit was a way of dealing with temporary shortages of cash, not a way to avoid paying, and for some women this was the main advantage of doorstep services compared with the market as a source of pill supply. As noted, above the clinics and satellite clinics are also giving informal credit in some cases, and this practice may spontaneously increase as personal relationships between clients and providers develop over time. The frequent requests for credit, however, put the service providers in a difficult position. There is no formal system for providing credit, but they do not want to turn clients away. They also complain that they do not particularly like being paid in kind (for example, with eggs or vegetables) when they hold satellite clinics.

Pharmaceuticals

In our previous research on clients' experiences and views of family planning clinics issues of access to medicines and charges for medicine came up repeatedly. Many if not most client-provider interactions seemed to revolve around medicine or vitamins, and client requests for medications often became a focal point for mutual mistrust and bad feeling between clients and providers (Schuler and Hossain, 1998). In this study as well, access to medicine was frequently mentioned in general interviews about health care utilization and decision-making. A substantial number of informants commented that it was difficult for the poor to get access to medicines, and that their inability to get free medicines even in government clinics was unfair. We did not find the same level of acrimony in connection with access to medicines in the NGO clinics, but medicine was, nonetheless a concern.

The fact that medications are now available at the clinics is important to clients (several who were interviewed before the pharmacies were in place commented on the inconvenience and expense of having to go elsewhere to fill prescriptions). In a few cases, however, clients felt frustrated because after paying the consultation fee they could not afford to fill the prescriptions

they were given. Since the poor often are unable to buy medicines, or unable to purchase enough to comply with the full course of treatment prescribed, it may not occur to them to ask the clinics for subsidies. A woman who worked as a domestic servant had borrowed money from her employer and gone to one of the urban clinics for problems with excessive menstruation and weakness. According to her, the consultation cost her 20 taka (part of this may have been a registration charge), and the doctor (or paramedic—she did not seem to know the difference) wrote her a prescription that she thought would cost her 150-200 taka to fill. Asked whether it was difficult for her to pay the consultation fee, she complained,

> *"I have paid the doctor just to talk to her about my illness….They don't give you medicine here. They don't give medicine anywhere anymore, not even at the government hospital! All of the medicines are being sold outside [i.e., government supplies are sold illegally]. Nobody shows any compassion for the poor. I did not ask her for medicine because I had heard before that they did not provide [free] medicine….It is senseless to write prescriptions for poor people like us. If we can't buy the medicine then what good is a prescription?!"*

This woman's outburst contains several interesting themes. One is the frustration and resentment that poor people often feel because they believe they do not have access to healthcare, and their feeling that they are entitled to some level of care, but that they do not receive it because of corruption and prejudice against the poor. Second, is the tendency to equate healthcare with medications. Third, it seems that this woman did not bother to ask the clinic staff for assistance in obtaining the medication they had prescribed, because she assumed she would not get it. Ironically, later in the interview she praised the doctor's nice behavior towards her. Like the earlier examples, this suggests that the NGOs should not assume that those who most need subsidies will make this known to the clinic staff without being encouraged to do so.

LEGACIES OF THE PREVIOUS PROGRAM MODEL

Population Policy and Service Delivery Culture

Over the years, the national family planning program in Bangladesh developed a very distinctive "service delivery culture" which reflects the class and gender-based social inequality found in the society at large and the paternalistic attitudes that often pervade the practice of medicine, as well as policies promoted by the government, NGOs and donors. Our interviews and observations contain many examples showing how this deeply entrenched culture persists even after policies and procedures have been modified. The institutional norms associated with the previous program model influence the way that service providers relate to one another, and to clients, and how their clients relate to them.

The Bangladesh family planning program evolved in the context of a very strong worldwide population stabilization effort supported by international donors. In Bangladesh, as in many other countries, family planning program services were organized vertically rather than being integrated into health services, the idea being that this would be a more efficient way to achieve quick results in the face of the urgent problem of rapid population growth, given an inadequate health infrastructure. The family planning program had a specialized staff, facilities, equipment and other resources and employed a special terminology. Family planning workers were charged with "motivating" individuals (usually women) to adopt methods of contraception. Women who elected to use contraception were referred to as "acceptors." The program had method-specific targets, and in some cases recruitment of clients was remunerated on a per capita basis.

The following exchange, observed in a clinic that does not belong to one of the NGOs in which the service innovations are being undertaken, is quite typical of the previous system:

> *"The service provider found the woman's ID number in her registration book, and after looking at her card, said to her, 'You have been taking [contraceptive] injections for about five years. It is time you got sterilized--we can't keep giving you the injections. Your youngest child is ten years old. What would you do with more children, when you have five already?' [The woman explained that she didn't want to be sterilized, saying she was afraid she might not receive a proper Muslim burial if she did so.] The provider told her: 'You have five children, If they become thieves and robbers won't they drag you out of the grave? Then you will be punished even more. OK, I am writing it here on your card, and you will have the operation the next time you come. Come after talking with your husband.'"*

Later the interviewer asked the client about her experience, and whether she had felt annoyed. The woman replied,

> *"The apas tell me these things whenever I come here. I don't like to hear this all the time, but I don't pay any attention, I just keep my mouth shut."*

Asked why she didn't complain or ask them to stop she said,

> *"The apas do their job, and I do mine….talking is part of their job."*

Clearly the woman was not afraid to go back to the clinic. She did not feel threatened by the "hard-sell" tactics of the service provider, and she did not feel coerced to adopt sterilization. But she understood that the priorities of the service delivery system, and those employed in it, were different from her own and she developed a strategy for getting what she wanted from the provider.

Related to the perception among many users of reproductive health services that the family planning program has its own agenda, is the idea that people who follow this agenda deserve special consideration. Findings from this study as well as our previous research suggest that women, and couples, who decide to use contraception often feel that they are not only helping themselves, but also helping the national family planning effort, and the local program staff who are charged with motivating them.[6] They also feel that they are therefore owed something in return -- that the family planning providers are responsible for making sure there are no adverse consequences or significant costs to them, the acceptors. It is no wonder that family planning clients have come to feel this way. Informational campaigns have often emphasized the benefit of small families to the nation, as well as to the family. For a long time, methods and services were provided free of cost, and often brought to the home. In our study areas family planning workers used to visit homes to persuade women to practice family planning, and sometimes to promote a particular method. Since cost was often an obstacle, the government provided a stipend to cover transportation and other costs for women adopting clinical methods. Many women were hesitant to travel to an unknown clinic alone, so the local family planning worker would accompany them. If a woman was reluctant to use an unfamiliar method for fear of side effects, the local family planning worker as well as the clinic-based staff typically would assure her that she could rely on them—they would take responsibility for ensuring that she got adequate treatment if she had any problem. The assumption was that she should not have to pay. She was their family planning acceptor and her well-being was their responsibility. Often clients were disappointed, but this what they expected or hoped for from the old system.

Another aspect of the service delivery culture associated with the previous program model was the often very personalized nature of the relationship between provider and client, both in homes and in clinics. Having heard many negative stories and rumors about the bad experiences of others, there was a general sense that one was likely to receive poor treatment in reproductive health or medical facilities without the intervention of a personal friend, relative or other advocate connected with the facility. Indeed, many aspects of life in Bangladesh are shaped by patron-client relationships; a poor person's ability to get access to resources requires a link with someone more influential (see Hassan, 1999). The community level worker was often seen as an intermediary, in the sense that she knew the system and the clinic staff, and could use her influence to help the client get what she needed.

Under the norms of the new NGO system much of this is supposed to change. Family planning services are being provided as part of a package of basic health services that most families want and need. The clinics' promotional efforts are aimed at building up a clientele for basic family health services, not motivating women to accept a family planning method. As clients must pay for the services, it is up to them to decide what they need and what they want to pay for. It is assumed that the clinics' viability will depend on their ability to provide quality services at competitive prices. Although increasing the use of clinical methods is an objective of the new program, method choice is emphasized and the expectation is that clients will use contraceptive methods because they want to, not because service providers persuade them to do so. Clients should not need to rely on personal relationships to get adequate services. As noted earlier, clinic facilities have been upgraded and new systems have been introduced regarding payment,

patient flow, and the regularity of services. Staff are trained to approach their work in a consistent, professional manner.

Reactions to the New Policies and Program Norms

As described above, reactions to these changes in the study communities have generally been very favorable, and illustrate a readiness to adapt to new service delivery modalities that offer a broader range of services and emphasize quality. Clients appreciate the greater accessibility and reliability of the new satellite clinics. Clinic clients, as well as staff like the orderly first-come first -served system where wealthier clients or those with personal relationships to clinic staff are not seen ahead of others. Most staff do not seem to find it difficult to be respectful and courteous to all clients, rich or poor, friend, relative or stranger, and clients notice and appreciate this. Clients say they like the friendliness of the clinic staff, and the way the staff ask them questions and listen attentively to what they say. They feel that the paramedics and doctors are well-qualified and that they are careful and thorough in examining and treating clients. The findings suggest that clients do not necessarily prefer using personal connections to get access to services; when they try to exploit connections it is usually because they think this is the only way to get good treatment. The findings suggest that they are quite pragmatic in assessing the benefits offered by the new clinics and satellite clinics, and generally seemed to value quality, access to a range of services, and technical competence over preferential treatment, as long as the staff are pleasant and courteous.

Change and Continuity

The positive responses to the new NGO service delivery approaches confirm that the strategies developed by the NGOs to improve both access and quality are appropriate from the perspectives of clients. But obviously not all that is happening in the clinics and satellite clinics is new, and the preliminary findings suggest that some of the attitudes and practices that developed under the previous service delivery regime are contributing to the effectiveness of the new approach, even though they are not necessarily being emphasized or specifically supported through the new NGO program. For example, many service delivery staff under the old program were very dedicated to their work—in some cases motivated as much by the desire to help others as by the salary they received—and this is still evident in interviews with clinic staff and supply depot holders. Service providers are also continuing to establish personalized, friendly relationships with their female clients, as they often did in the past. Similarly, women continue to assist others in getting access to services, and accompany one another to clinics. This is important because many women are hesitant to go to an unfamiliar place alone, and often they are afraid that they will not be able to communicate with providers with whom they are not personally acquainted. By being friendly, and making each client feel personally recognized and welcomed, the service providers often manage to break down this barrier very quickly. Many women that we interviewed felt comfortable returning to the clinics alone, after one or two visits in the company of someone familiar with the clinic, or more accustomed to using health services. As noted earlier, women have continued to help one another obtain oral contraceptives when they run short, and men appear to be purchasing oral contraceptive for their wives in the market as they did in the past, and now more frequently.

Thus, aspects of the previous service delivery culture have carried over, and are contributing to the effectiveness of the new NGO service delivery model. Other, less functional continuities

from the past, however, coexist with these traditions, and present a serious challenge for the NGOs. Widespread and persistent ideas about entitlements, the role of government, and the agenda of the national family planning program underlie many of the difficulties that the NGOs now face in building up a sustainable network of family health services that is both client-focused and effective in terms of its public health impact.

Entitlement and the Role of Government

The government has provided free or highly subsidized services for many years, and the NGO programs of the past were so similar to those of the government that many clients did not know the difference. The door-to-door family planning workers and, where they existed, depot holders who were employed by the program were seen as agents of the government, whose duty it was to bring the free or nominally priced contraceptives to the women who needed them. These workers were seen as part of a national program which had its own urgent mission—to reduce population growth. The workers were paid by the government to serve this larger goal and they were not supposed to be compensated by clients. Rather, their role was to transmit contraceptives from the government to individuals, and to motivate clients to use them—for the clients' own good and for the good of the country. NGO clinics, like government Family Welfare Centers, were similarly seen as part of a larger government program goal of increasing contraceptive use. Dissatisfaction with prices and price changes for health and family planning services is by no means a new phenomenon in Bangladesh (Ciszewski et al, 1995) and it is clear from our data that in the research sites confusion and resentment over charges for family planning and health services, and negotiation over charges, was common in various types of service settings even prior to the program change. However the finding that dissatisfaction and confusion over charges persists in the areas served by the NGOs suggests a need for intervention.

Client and Provider Roles and Responsibilities in Relation to Clinical Methods

Increasing the use of clinical methods (in the context of expanded family planning and reproductive health services) is one of the new program's objectives, and the NGOs are introducing new clinical methods such as Norplant on a pilot basis. Many women are actively seeking out and successfully using clinical methods now that they are available on a more reliable basis and in the context of higher quality services, and others who had not previously considered clinical methods are deciding to try them at the encouragement of the providers. The NGOs are addressing some of the barriers to access which existed in the past; a substantial minority of women in the study reported that they had tried previously to switch from oral contraceptives to clinical methods and found that services were irregular or inconveniently located, or they suffered side effects and did not receive adequate support from service providers. Thus, the program's emphasis on clinical methods responds to an unmet demand for these methods. However it seems to be difficult for providers as well as clients to shed some of the habits and assumptions which have long surrounded the provision of clinical family planning methods (injectables, IUDs, and now Norplant) in Bangladesh, habits which contribute to suspicion and dissatisfaction among women who use or who potentially may want to use these methods.

The Motivation Mentality

It is impossible to discern from retrospective interviews with clients exactly what the service providers say to the clients, but it is clear that some of the clients in this study thought that they were being motivated to use a particular method, as they might have been under the old system, and that some providers still perceive their role as one of motivating clients. This mentality illustrates how the norms and imperatives of the past coexist in many peoples' minds with the new program strategies. Women are clearly benefiting by gaining access to a wider range of contraceptive methods under the new program, but there is a risk that outreach efforts may perpetuate modes of communication between providers and clients that were developed in the context of a target-oriented program, and which are inconsistent with a client-centered approach.

Responsibility for Treating Side Effects

Clients often think that the NGO clinics should bear responsibility for treating their health problems or side effects free of cost because, after all, it was they who provided the method. The clients are especially likely to feel this way if they have been introduced to a particular method by program staff. In a few cases that we documented, clients really did not have the money to pay for follow-up visits and prescriptions (to treat problems which they saw as side effects, but which may or may not have been). When they agreed to use a family planning method these clients expected to be taken care of, and they did not expect to have to pay for any follow-up consultations needed — despite the conspicuously posted prices in the clinics.

Government Subsidies to Contraceptive Users

Experiences under the government system have led some clients to expect not only discounted or free services, but also compensation for adopting clinical contraceptive methods. Clients may feel that the government should pay them for using clinical methods even though they do so on their own volition and for their own benefit. When they find out that they have to pay they feel slighted or unfairly treated. We were particularly surprised to find how powerfully this aspect of the service delivery culture influenced client-provider relations when women adopted Norplant, since Norplant is a comparatively new method in Bangladesh, and few women have had any experience with it. In all of the following cases, the norms that developed over the years in connection with voluntary sterilization and IUDs (e.g., see Schuler and Hossain, 1998) are clearly influencing provider behavior and client expectations.

One recent client had been confused because she thought the green umbrella logo meant that the NGO clinic was a government clinic. She expected that she would receive 300 taka after adopting Norplant because this had been the case with several relatives and acquaintances who received the method from government clinics:

> *"Last month my husband could not work at all, and I had no money left and I couldn't buy milk for my child. I thought that I would get 300 taka and then I could use money to buy him milk. But after I took the method the apas didn't give me any money—in fact they told me to go out and buy medicine for myself….I asked the apa, 'aren't you going to give me any money,' and she said 'no money is given here…that only happens in government hospitals'….When poor people like us get money it helps us. We are being*

operated on [when we get sterilized or use another clinical method] and so the government gives us money to buy fruits and good food. This system was created for poor people. The rich have money. They buy [contraceptive] injections or pills with their money, but we are poor, we don't have enough, and that's why the government developed this method that lasts five years [Norplant]…The money is given [so we can build ourselves up] to compensate for the blood deficiency [resulting from use of contraceptive methods]."

The woman who said this had freely chosen Norplant and was having no problems with it. She liked the clinic and trusted the clinic staff. They had recommended Norplant to her on the grounds that she was poor, and would save money because she would not have to spend money coming to the clinic every three months to get contraceptive injections. Like many clients, she reported that she had let the clinic staff to select a contraceptive method for her:

"Apas, you know better than I do which method is good and which method is bad. Whichever method you think is best, please give me that very one! We are illiterate people, we don't know enough [to decide for ourselves]. My husband won't object."

The passivity reflected in this statement is interesting, because the woman was clearly quite intelligent, and elsewhere in the interview she had articulated several reasons for choosing Norplant—cost, side effects and risks with other methods, the fact that her friends and relatives were using it and liked it. One suspects that she had already decided on Norplant and what she meant to communicate to the clinic staff was that her welfare was their responsibility, and that they should help her because she was poor. She had wanted to use Norplant, but she also wanted, and badly needed, the 300 taka she thought she would receive.

In another case, the client did not expect to be compensated for using Norplant, but she did expect the clinic to pay her rickshaw fare home. She had traveled to the clinic with clinic staff, and the staff clearly felt bad for not being able to pay her fare home. The woman felt humiliated when the doctor came out and scolded her and the clinic staff for even discussing it:

"I asked for money from the apa who took me there by rickshaw, but she told me that she had no money with her, and that there was no system in the clinic for giving money [to clients] '…so you will have to pay your own way home. None of the other apas here have any money with them, otherwise I would borrow from them and give it to you'…Then the male doctor came over and said 'What is the matter?' The apa told him, 'She is asking for the rickshaw fare to go home' and then the doctor got angry and said, 'No money will be given—money for what!?' …Apa, my home is in the village and there are many illiterate people living there, but no one behaves this way with anyone. [Only] seeing this doctor did I realize that educated people behave badly with others. When the doctor spoke to me in such an angry way, tears came to my eyes. Maybe I am poor, but I do not have to beg for ten taka."

Fear and Suspicion of Providers

Another Norplant client was suffering from a variety of troubling symptoms that she attributed to the method, and she wanted very much to have the method removed. She had been back to the clinic several times. Each time the doctor told her that the problems were not caused by the Norplant, and prescribed medicines to treat her various problems, but her symptoms persisted

and she continued to believe that it was because of the Norplant. Her husband was angry at having to spend so much money on medical consultations and medication, and was pressuring her to get rid of the method. She reported that before inserting the Norplant the doctor had clearly stated that she could have it removed if she wanted to. She went so far as to ask the interviewer to intervene on her behalf, but she had never directly asked the clinic staff for a removal. She assumed that the doctor would not want to remove it, and feared that he would be angry with her if she asked him to do so. She respected the doctor and viewed him as competent, but she did not believe him when he told her that her symptoms were not caused by the Norplant. She seemed to assume that he had a vested interest in having her continue using the method, and she was afraid to challenge him.

The underlying fear and mistrust that influenced this woman's view of the doctor who inserted Norplant is echoed in an urban woman's recounting of an experience that took place a year or two prior to the program change. The woman had an IUD inserted in the NGO clinic. After two weeks she decided she wanted it removed because her husband complained that he could feel the string during intercourse, and because she thought she was becoming weak and unhealthy from blood loss. Rather than ask the doctor to remove the IUD, she pulled it out herself. She explained that she was afraid of what she imagined the doctor would say to her:

> *"The doctor would have rebuked me. She would say, 'Why are you so inclined to have a baby?' Out of shame over that, I did not go to the doctor. I removed it myself within fifteen days of having it inserted. I went to the latrine with a jug full of water, drank the water, and pulled it out. When I did that I felt an intense pain in my abdomen. After removing the Copper-T I did not use any method for a year."*

And yet she told the interviewers that the doctors [and paramedics] in the clinic were very good, highly competent, and very courteous, and that she liked the clinic very much and these comments seemed sincere. Even after the program change several clients reported delays in getting their IUDs removed.

When a woman who has recently started using a new contraceptive method reports minor side effects, or presents health complaints that from a medical point of view clearly are not caused by the method, it is standard practice to treat her or provide a referral for any medical problems, and to advise her that the contraceptive side effects are not serious and may resolve or diminish with time. We suspect that what, on the face of it, may be perfectly sound advice to women with side effects from Norplant or IUDs is interpreted by some clients as a reluctance to follow their own wishes with regard to removal of the method. As Hardee and colleagues (1994) noted several years ago in a study conducted when Norplant was still at the clinical trials stage in Bangladesh, "While counseling clients about common side effects is important, providers walk a fine line between encouraging clients to continue using the Norplant in the face of non threatening side effects and refusing outright to remove the implants. Providers may view such counseling as reassurance, while clients perceive it as pressure to continue using the method."

In our current, as well as in our past research, we encountered many women who were afraid to try the IUD, or to get sterilized, even though these methods might have been appropriate for them in the light of their desire to stop bearing children. In some cases the women seemed to feel threatened when service providers suggested that they might try these methods. An urban woman in the current study explained, for example, that she had been having side effects, and she told the clinic staff that she did not want to continue using contraceptive injections.

> "*Then they told me to insert the Copper-T, and for fear of that I did not go back to the clinic for three months."*

Among a small sample of clients from our earlier research, we documented several cases in which clients reported difficulty in getting their IUDs removed or felt that the providers were reluctant to remove their IUDs, and one client suspected that a paramedic had only pretended to remove hers (Schuler and Hossain, 1998).

This pattern of fear and suspicion of clinical method providers is less evident among clients of the new NGO clinics than it was in our earlier samples, but its persistence nonetheless suggests that it is still sufficiently common to warrant attention. There may be a variety of factors behind women's fears of IUDs or sterilization (or other medical procedures, for that matter). But we believe that one factor is a longstanding and widespread perception that family planning service providers are employed not only to promote their clients' welfare, but also to serve the priorities of the system under which they work, a system they assume, even now, is concerned with numbers of contraceptive users.

CONCLUSIONS

The findings presented here should be interpreted in light of several considerations. First, the phenomena that we are studying - the new program model and peoples' reactions to it - are still rapidly evolving; new services and strategies are still being introduced and utilization patterns are still in flux. Although the phase of the research conducted as part of the POLICY Project is coming to an end, we are continuing both data collection and analysis through the Frontiers Project, and we expect that results from this ongoing work in urban sites, as well as additional comparisons with the findings from the rural sites, will allow us to further understand the responses and processes described in this report, and the variations that exist. Second, the data presented here come predominantly from two urban sites; barriers to service utilization based on gender, geographic constraints, inadequate information, and other factors may be more severe elsewhere. Third, it is important to note that this study is not intended to serve as an evaluation of the effectiveness of the new program strategies. The research documents the perspectives and responses of users, communities, and providers as the new service delivery model is introduced, and tries to understand these reactions in light of the socioeconomic, cultural, and historical context. To derive useful policy lessons about the management and impact of the program transition, the findings presented here should be considered along with other ongoing efforts by USAID and the NGO partners to describe the effects of the new program in more quantitative terms.

Bangladesh is one of many countries struggling to narrow the gap between policy and implementation of the expanded approach to reproductive health agreed to at the International Conference on Population and Development (ICPD) (Hardee, et al 1999). Many of the ICPD goals are embodied in the government’s Health and Population Sector Strategy (GOB 1997). In the Sector Strategy the Bangladesh government has laid out an agenda for change that is in some ways quite radical, and the USAID-supported NGOs are moving ahead to implement these changes. In doing this the NGOs face problems shared by health programs worldwide who are pursuing reform policies. So far there are few if any documented health sector strategies that have succeeded on a large scale to simultaneously expand access for the poor, improve the quality of services, and increase cost recovery and sustainability. Given the difficulty of the task, the progress that the NGOs have made in a relatively short period of time is impressive.

The new NGO program is important as a test case of the new strategies because of both the nature of the changes made, and the speed with which they have been introduced. As described in this report, many of the assumptions behind the changes had not been systematically proven, and some were controversial — for example, the assumption that demand for family planning is not too "fragile" to withstand the withdrawal of home-supply and that norms related to *purdah* will not prevent women from utilizing services outside the home. On those two points we think our findings are clear and unequivocal: men and women are strongly committed to fertility control, and women are no longer stigmatized for visiting clinics — at least not in our research sites. The NGOs have been able to capitalize on these changing norms, but they are also developing strategies to address the exceptions that persist. It will be important that NGOs continue to provide information and promote behavioral change so that the strong existing demand for services and the loosening restrictions on women’s mobility translate into effective and satisfactory service utilization. The NGOs’ community outreach efforts to men are one promising vehicle for promoting messages about men’s important roles in ensuring access to family planning, clinical services, and information. It is still premature to assess what, if any, “empowering” effects the program may have on women’s broader welfare

and strategic interests, but there is some evidence to suggest that the new program model can facilitate women's greater exposure to the public realm and access to the psychosocial and material benefits that follow.

Have policy makers and program implementers succeeded in understanding what "quality" consists of from the client perspective? Considerable research and programmatic interventions have been undertaken in recent years to strengthen the quality of reproductive health services, both in Bangladesh and worldwide, and quality is the central focus of the new NGO strategies. Based on our findings so far, we would say "yes"—that the new service delivery model emphasizes many aspects of quality that are important to clients. In addition to substantial upgrades in the technical capacity and physical environment of services, program staff have managed impressively to make improvements in the more nebulous and challenging interpersonal aspects of service quality.

The findings also suggest, however, that there is at least one dimension of quality from the client perspective that is very complex, and which is not yet being adequately addressed. This is the problematic area of charging for services. We have found that most clients think the current charges are reasonable, even while some have problems paying, but there is the danger that *potential* clients are not seeking out the services based on a perception that the cost is prohibitive. The NGOs are concerned about this possibility and they are working to find ways to identify individuals or groups who may be most in need but also most difficult to reach. Strategies such as giving free vouchers for unlimited clinic use to disadvantaged women and their families are an important immediate step, both for alleviating an actual cost barrier, and simply for getting people into the clinics -- people who may be assuming that what appear to be high quality services are more expensive than they actually are. The NGOs have also commissioned studies to generate detailed information so that pricing structures can be developed to maximize the public health impact of the services for the poor as well as promoting cost recovery (personal communication with NIPHP staff). One important component of this, supported by our findings, will be a transparent and clearly structured system of need-based subsidies. A more formalized system could also be developed for extending credit to women whose families can and are willing to pay but who do not always have access to cash.

The final assumption -- that program staff and clients are able to adapt to new ways of thinking -- has been partly but not fully demonstrated in this study. Perhaps the most striking positive finding in this regard is that rich and poor are treated alike, and with respect, in the clinics. Other evidence, however, points to the persistence of norms and expectations from the past. As our findings demonstrate, the legacy of the previous program model and the prevailing service delivery norms affect the new program strategies in several ways. For example, promoting the use of the integrated ESP more effectively and encouraging clients to take advantage of "one-stop shopping" requires that providers no longer think in terms of a vertical family planning model and actively look for opportunities to connect clients with the broader array of services. Similarly, it will be necessary to come to terms with prevailing ideas about entitlements, and about paying for services. In this connection, the NGOs need to distinguish themselves from the government and to explain why fees are collected and how this income is used. Clients clearly value quality and in many cases are willing to pay more for what they perceive to be higher quality services, but better communication is still needed to explain how the new services are set up and to dispel expectations that developed in relation to the previous family planning program model.

The still widespread perception that family planning services are offered as part of a national fertility reduction agenda underlies many of the challenges that the NGOs now face in trying to implement a sustainable, client-centered essential services model. As well as influencing clients' attitudes regarding the legitimacy of charges for family planning methods and services, it fosters mistrust between clients and providers. Donors and implementing agencies need to exercise extreme caution as they try to expand the range of family planning methods available, to avoid the interpretation by providers that clients should be recruited to use these methods (Diaz et al., 1999; Simmons et al., 1997). The government's ongoing practice of paying subsidies to users of clinical contraceptive methods is inconsistent with the new client-centered approach and may reinforce the perception that clients need to be motivated to accept specific services and, in turn, deserve compensation. Such longstanding practices and assumptions formed in the context of the previous family planning program need to be taken into account as new methods are introduced and access to them expanded through service delivery programs.

Again, Bangladesh is not alone in struggling to institute major reforms in health service delivery that require a substantial reorientation in the mind-sets of providers and clients alike. India's efforts to shift to a "target-free" family planning model over the past few years have been hampered by the persistence of top-down, numbers-oriented approaches. Despite an explicit emphasis on enabling clients to make their own informed choices in method selection, the paternalistic assumption that providers know what is best for their clients continues to influence program strategies, and services beyond family planning have often received inadequate attention. As observers of India's experience have noted, "well-entrenched practices and messages established over 25 years" do not change overnight (Visaria, et al, 1999). They have recommended additional training for health workers as well as efforts to ensure that the program overall is not evaluated in terms of individual providers' performance. In the case of Bangladesh, resolving these issues will require improved coordination between NGOs and government, additional measures to "mainstream" the essential principles of the government's Health and Population Sector Strategy within both government and NGO service delivery systems, and continued emphasis on communication between service providers and users. The new service delivery policies need to be translated and conveyed in ways that make them more comprehensible to the communities that the NGO clinics are meant to serve, and increase their perceived legitimacy.

In conclusion, our findings strongly support the policy changes reflected in the government's integrated, clinic-focused approach and the new USAID NGO program. Clients and communities are responding favorably to many aspects of the new model, and there do not seem to be intractable social barriers to service utilization. Clear and timely information would have made the transition from door-to-door services easier for many women, but once they were aware of the new system most of them adapted quickly. The NGOs have developed innovative strategies to deal with the inevitable challenges in such a radical shift, and these appear to be having a positive effect. It is also likely that many of the issues the NGOs continue to struggle with as they introduce new services and program strategies will resolve themselves as a function of time, particularly if the NGOs are able to sustain the level of service quality achieved so far.

Many of these challenges, particularly related to cost recovery, are a function of expectations and norms from the past, and of incongruences between government and NGO pricing policies. As the NGOs, and the Bangladesh government, proceed with implementation of the integrated, essential health services model, additional strategies will be needed to erode the paternalistic service delivery culture that evolved in the context of a vertical planning program. In pioneering

the difficult task of transitioning from door-to-door family planning to clinic-based essential services, the NGOs' have demonstrated both the potential of the new program strategies and the challenges inherent in such a major reorientation. As the government moves forward with its own transition, much can be learned from the NGOs' experiences in dealing with the complex challenges of pursuing simultaneously goals of quality, access, integrated service delivery, and cost-recovery.

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Attachment: Site Descriptions
(by Mahbuba Hoque and Rashida Khan)

Urban Site, Dhaka District

The clinic in the Dhaka District site occupies the ground floor of a two-storied building, which has five rooms with no windows. As a result, the environment inside is stuffy, and when there is no electricity the clinic becomes extremely dark. Since the clinic is in the middle of a market, shops of various kinds surround it. Most of the inhabitants in the immediate area are involved in some kind of business. Several families have built houses for rental. The cantonment is nearby, and a number of retired army personnel live as tenants in this area. Many residents here have migrated from other regions of the country in order to find work in Dhaka. This migrant population includes the rickshaw pullers, day laborers, baby-taxi drivers and the like. Our impression is that the percentage of middle class and lower class is almost the same.

We observed two satellite clinics associated with the main clinic, and interviewed clients. The first is a couple of kilometers away from the clinic. This locality is less heavily populated than the site of the main clinic, with clusters of houses here and there. Although there is a brick road leading to the spot where the satellite clinic is located, beyond this point the roads are not paved, which gives one the impression of a village, though it is not far from Dhaka City. During the rainy season most of the roads get submerged under water, making boats the only mode of transportation. During the door-to-door period the family planning workers could not go to all the houses because of this transportation problem. Like the area surrounding the main clinic, this area is populated by recent immigrants from outside Dhaka who work as rickshaw pullers, baby-taxi drivers, day laborers, and in other low-paid jobs. The satellite clinic itself is a small room (about five square feet) made of bamboo and tin, where only five people can sit at a time. Often they sit out on the street with a curtain around them. When we observed this clinic there were about 10-12 clients in attendance.

The second satellite clinic is situated in a poorer slum area. The bamboo and tin roof house that used to house the satellite clinic was recently renovated, but it is still very meager and reeks of the smell of garbage from a nearby dump. Almost everyone we talked to in this slum area knew of this satellite clinic, and a lot of them said they visited it on a regular basis. Virtually all clients of this satellite clinic come from economically depressed circumstances. Family members' occupations include rickshaw pulling, taxi driving, vegetable vending, day labor etc. A number of women in this area work as vendors and some do a bit of embroidery work.

Urban Site, Satkhira District

The clinic in Satkhira District is situated in a sparsely populated, fairly well-to-do area, in a spacious, one-storied building. It is kept clean, and people seem comfortable there. When we observed the clinic during the morning hours there were lot of clients, and many appeared to be economically well off. We worked in three sub-sites in Satkhira, one near the main clinic and two near satellite clinics.

As subsite 1 is situated in the middle of the township, the residents have a variety of nearby health facilities to choose from, including a MCWC and the Sadar Hospital. There is also a shopping center nearby, where a number of private clinics and doctors are located. This area

contains a mix of lower and middle income groups, residents, perhaps more in the middle income group. People use a variety of health care providers, including the static clinic.

Subsite 2 is about 2 kilometers from the main clinic. The area is divided into several *paras* and is primarily low income. We observed a variety of occupational groups, including service holders, small business owners, employees of fisheries, day laborers etc. Separate satellite clinics are held in each *para* on different days. We observed two such satellite clinics during our research, and they crowded with clients. Few that we interviewed knew of the main clinic in Satkhira.

Subsite 3 is situated outside the township of Satkhira. This site has almost no health care facilities near by. The nearest hospital is the TB hospital, about three or four kilometers away. Most people in this area make their living from agricultural activities. Among those we interviewed, few people knew of the UFHP clinic, and only a few knew of the satellite clinic (those living near the primary school where it is held.

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[1] Women also discontinued family planning during this time due to non-supply related reasons, such as side effects, a desire for pregnancy, incorrect knowledge, and improper method use.

[2] Two additional cases were excluded because the women did not speak in sufficient detail about their experiences.

[3] At the time of writing, service statistics on multiple service use per visit or per client were not available from the clinics.

[4] One very poor woman had received a free card but had lost it before she managed to visit the clinic, and she clearly assumed that she had also lost her opportunity to get subsidized services at the clinic. She It might be helpful to inform card recipients that a lost card can be replaced.

[5] Among clients of 55 different Thana Health Complexes, between 25% and 50% reported paying unofficial charges for services. About half thought that these were official charges (Government of Bangladesh, Ministry of Health and Family Welfare Thana Functional Improvement Pilot Project, 1999.)

[6] Indeed, this attitude has often been encouraged by providing official awards or special recognition for couples who have only one or two children, or to recently married couples who agree to postpone their first child.