

SERVICE DELIVERY AT THE UNION HEALTH AND FAMILY WELFARE CENTRE: The Clients' Perspective

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ABSTRACT

The union-level Health and Family Welfare Centres (FWCs) provide family planning (FP) services, care to pregnant and postpartum women, and treatment of minor illnesses. Two paramedics, a Family Welfare Visitor (FWV) and a Medical Assistant (MA), are posted at each FWC. In addition to their duties at this fixed centre, each of the two paramedics also performs outreach activities.

Most clients of FWC are women and young children. Curative services represent the bulk of services provided at FWC, while FP and other preventative services account for only a small percentage of activities.

Although the community members are often aware of the presence of FWC, their knowledge about the services offered is minimal. FWC users usually have a rather positive perception of the paramedics, although they often mention an irregular attendance of personnel, unsatisfactory behaviour of the members of the staff and an inadequate supply of drugs as drawbacks.

Interviewing clients right after the reception of services at FWC would allow the MCH-FP Extension Project (Rural) of ICDDR,B to explore in more detail the reasons for clients' dissatisfaction, and to make recommendations for improving services.

Most respondents were young women, living less than half a mile away from FWC. Two-third of the respondents never attended school. They had an average of 3.75 previous pregnancies, and 55 per cent of them were currently using a FP method.

Personal sickness and child care were by far the most common reasons for seeking services at FWCs. Many respondents did not remember or were not told the dosage of drugs they received. Antenatal care was provided to 8 per cent and FP services to 6 per cent of the respondents. Half of the FP complications were found among the IUD users.

Clients did not make any distinction between the quality of services provided by FWVs or MAs. According to the respondents, poor services from both the paramedics are: clinical examination, counselling and to a lesser degree, the provision of drugs.

Most clients of FWC expected to receive curative services and drugs. Provision of health education in group settings, FP services, and care of pregnant women were marginal. The respondents were also not fully aware of the preventative services offered at FWCs, which mainly include: antenatal care, postnatal care, and FP. This demands to strengthen the use of reproductive health services.

The respondents pointed out the services offered by MAs and FWVs were of equal quality, and were generally satisfied with the behaviour, the privacy offered, and the waiting time at FWCs, but questioned the technical skills of the paramedics, especially in the area of curative care.

According to the respondents, the technical and communication skills of the paramedics were weak. This is not surprising, considering that MAs are never offered any refreshers courses, and FWVs are not adequately trained to provide curative services on a large scale. No technical guidelines are available at FWC to help the paramedics make correct diagnoses and dispense appropriate treatment either. It has been evident that refreshers courses, the provision of diagnostic and treatment guidelines, and appropriate supervision should be the prerequisites to the improvement of services.

INTRODUCTION

Background

Bangladesh has an extensive network of health and family planning services which has reached almost every village of the country. The Mother and Child Health (MCH) Programme was launched in Bangladesh in the 1950s for providing obstetrical care in the urban hospitals. Under this programme, the Mother and Child Welfare Centres (MCWC), run by paramedics, were established in the late 1950s. However, it was soon evident that these MCWCs, numbering about 95, at the *Thana* Health Complexes were not sufficient to cover the population living in rural areas. Therefore, the government established the static maternal and child health and family planning (MCH-FP) service-providing centres at the union level. Eventually, these centres came to be known as the Health and Family Welfare Centres (H&FWC, or just FWC). Each FWC covers, on an average, about 24,000 population.

FWC is the focal point for providing the MCH and clinical contraceptive services to the population of a union. Two paramedics, a female, known as the Family Welfare Visitor (FWV), and a male, known as the Medical Assistant (MA), are posted at each FWC. The tasks of a FWV are to give health education, provide care to pregnant and postpartum women, treat mothers and children suffering from minor ailments, and to offer family planning (FP) services. Whereas the tasks of an MA are to treat minor diseases of patients irrespective of age and sex, refer serious cases and provide surgical first aid. Due to the large catchment area of this fixed point, FWVs are mandated to organize Satellite Clinics (SC) twice a week at various sites within each union. Likewise, MAs conduct health education sessions in schools and other public places twice a week (1).

Literature Review

Several studies (1-6) were carried out to assess the role of FWCs in the country's MCH-FP programme. Most of these studies showed that, although

the rural population is aware of the existence of FWCs, very few people actually use the services. A majority of the recipients of services from FWCs do not have a clear idea of the MCH-FP services provided through these centres. Most consider the centre to be only a family planning service centre. Others feel that FWCs are mainly for child care and treatment of minor diseases of women. A study (4) reported that women who knew about the types of services available are more likely to use the services than those without such knowledge.

Describing the characteristics of the users of FWCs, these studies concluded that clients mostly live close to an FWC spot and come from the poorer and less-educated sections of the community.

While reporting the pattern of FWCs use, these studies pointed out that the provision of health care to women and their young children represented the main activity of FWC. Very few clients (less than 20 per cent) come for antenatal care, family planning supplies, or treatment of FP complications. The most common diseases treated at FWCs are: diarrhoeal diseases, anaemia, intestinal parasites, skin infections, and respiratory infections. It was found that the daily attendance at FWC ranged from 20 to 40. Over 90 per cent of the clients leave FWC with at least one medicine.

Problem Statement and Rationale

Review of the above studies reveal that the services offered at FWCs are under-used. An irregular attendance of the paramedics, ineffective treatment, inadequate supply of drugs, and unsatisfactory behaviour of the members of the staff have attributed to low use of these centres, but very little was mentioned about the knowledge and the quality of the services as perceived by the clients.

Increasing efficiency of the services delivered, improving competence of the service providers, and ensuring the availability of drugs will be ineffective in increasing service use at FWCs if the clients themselves continue to be unaware of the types of services offered and are dissatisfied with the quality of the services. Therefore, it is very important to know how

much the clients coming to FWCs actually know about the types of services available, how they assess the quality of the services offered and whether they leave the centres with satisfaction or dissatisfaction. Hence, this study was undertaken to gauge the knowledge of the service users and their perception of the quality of services provided at FWCs.

This study was conducted through 'exit interviews' to assess the users perception of the quality of services provided at FWCs by both FWVs and MAs. To measure the quality of services offered at FWCs, Judith Bruce's framework (7) has been followed. On the basis of that, the quality of care issues, such as providers' technical competence, information given to clients, and client-provider interaction, were considered.

OBJECTIVES

The overall objective of the study was to assess the quality of services received at FWC, from the clients' perspective.

The specific aims of the study were to assess:

- The reasons for visiting FWCs;
- Clients' knowledge of services offered;
- The quality of the services received at FWCs as reported by the clients;
- User satisfaction with the services received.

METHODOLOGY

A cross sectional study was designed to investigate the quality of services received at the union FWCs from the users' perspectives.

Source of Data

The source of data was women who had received services from FWCs. A structured questionnaire was designed to conduct exit interviews with clients immediately after they had received services from FWCs. Clients who received services from FWCs that day were interviewed about the type and the quality of services received to reduce recall bias.

Criteria of Inclusion

Data were collected from two rural *thanas* of Bangladesh – Abhoynagar and Sirajganj, the field sites of the ICDDR,B's MCH-FP Extension Project (Rural). These two *thanas* were selected purposively and hence may not be generalized to other *thanas*.

The *Sadar* FWCs, located at the *thanas*, were excluded because the data may not be representative of a rural setting. To ensure normal working conditions and an adequate supply of equipment and drugs, only constructed FWCs were selected.

Six of the eight unions of Abhoynagar *thana* and seven of the 11 unions of Sirajganj *thana* met those criteria. A list of selected unions in Abhoynagar and Sirajganj is attached as Appendix A.

Sample Size

A total of 650 (i.e. 300 from Abhoynagar and 350 from Sirajganj) clients were selected for the study – 50 from each FWC. The clients were given serial number on a slip on their entering the FWC. Every fifth client was interviewed once s/he was ready to leave the centre, regardless of who treated her/him - FWV or MA. If s/he was unwilling to be interviewed, the

sixth or seventh user was interviewed. If the client was a child, her/his attendant was selected as a respondent. If a respondent received services for herself/himself, as well as for one or more of her/his children, information was collected from all of them, but was considered as one single record.

Data were collected between July and September 1993. Interviews for each FWC were usually initiated on a Sunday and continued until the target of 50 was reached. No interviews were conducted during holidays.

The respondents were selected only from FWCs; not from the Satellite Clinics.

Instruments and Data Collection Procedures

Questionnaires were chosen as the method of data collection to collect individual responses from the clients. The questionnaire used in this study was designed with both open- and close-ended questions. It was pretested in the field, and necessary adjustments were made according to the results of the pretest.

The interviews were conducted by four Senior Field Research Assistant (SFRAs), previously designated as Lady Family Planning Visitors (LFPVs) of the MCH-FP Extension Project (Rural). SFRAs have the same training background and work experience as a Senior Family Welfare Visitor (SFWV) of the government. They are well trained in the techniques of data collection and have conducted interviews before. Selected interviewers were oriented on the questionnaire during the pretesting phase.

The information was coded by the investigators, and cases in dispute were discussed with SFRAs who conducted the interviews. The information was then computerized using the dBase IV software and analyzed using the SAS statistical software package.

Variables

Data were collected in the following areas:

- Background characteristics of clients;
- Reasons for seeking services and types of services requested;
- Clients' knowledge of the services offered at FWCs;
- Provision of health education, both in group settings and at individual level.
- Types of FP services provided and drugs received;
- Clients' satisfaction with the services received.

Potential Biases and Limitations

FWVs and MAs were aware of the study and may, therefore, have given their best performances. An attempt was made to minimize this bias by having the interviewers stay at each FWC for several days, and select only every fifth client.

Although the activities of ICDDR,B have been going on in Abhoynagar and Sirajganj for a long time, very few interventions involved the paramedics. Their skills and performance are probably similar to those in the non-intervention areas.

This study considered only those women who used the FWC services on the days of interviews. Information from past users and non-users of FWC was not collected. This study has the limitation of presenting only the FWC users' opinions regarding the services received.

RESULTS

Characteristics of FWCs and Respondents

Characteristics of FWCs

The number of clients receiving services at Abhoynagar ranged from 31 to 54 and those receiving services at Sirajganj ranged from 42 to 81.

During the interview days, the presence of service providers at FWCs was observed and the results are presented in Table 1.

Table 1. Presence of paramedics during the days of data collection

	Abhoynagar 52 days (%)	Sirajganj 30 days (%)	Total 82 days (%)
Presence			
FWV and MA	21.1	23.3	22.0
Only FWV	32.7	33.3	32.9
Only MA	36.5	43.4	39.0
Nobody	9.6	0.0	6.1

Over 90 per cent interview days, at least one paramedic was present at FWCs. The main reasons for the absence of paramedics at FWCs were SC attendance, vacant posts, maternity leave, official and unofficial leaves and meetings, and collection of supplies at the thana office.

Background characteristics of respondents

The majority of the respondents in Abhoynagar were in the 20-25 years age group, while in Sirajganj most respondents were aged between 25 and 30 years. More than 90 per cent of the respondents were married women. Most of the respondents had 2-3 pregnancies, and the majority of them live very close to FWCs.

Almost two-thirds of the respondents (63 per cent in Abhoynagar and 79 per cent in Sirajganj) never went to school. Access to primary education (1 to 5 years of schooling) was limited to 22 and 14 per cent of the respondents in Abhoynagar and Sirajganj respectively, and very few had any secondary education (6 to more than 8 years of schooling). The distribution of the respondents' age and education by area is presented in Fig. 1 and 2.

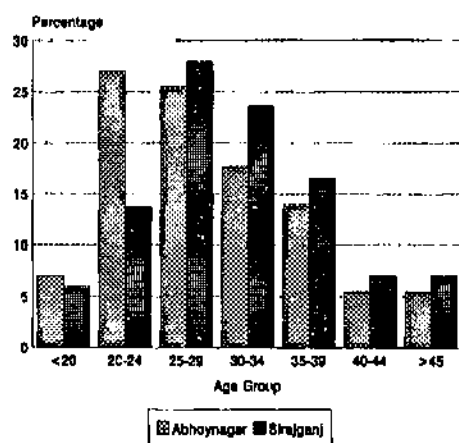


Fig. 1. Age of respondents by *thana*

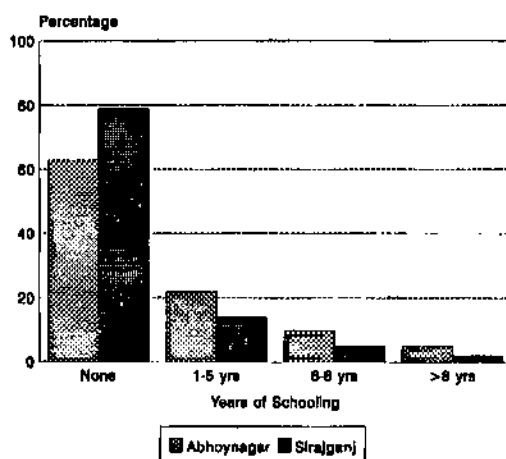


Fig. 2. Years of schooling by *thana*

Over half of the recipients (i.e., 51% in Abhoynagar and 58% in Sirajganj) were users of the modern contraceptive methods. The respondents in Abhoynagar were more likely to use the long-term methods, while the clients of Sirajganj had a tendency to use the short-term methods. The distribution of contraceptive use by area is presented in Fig. 3.

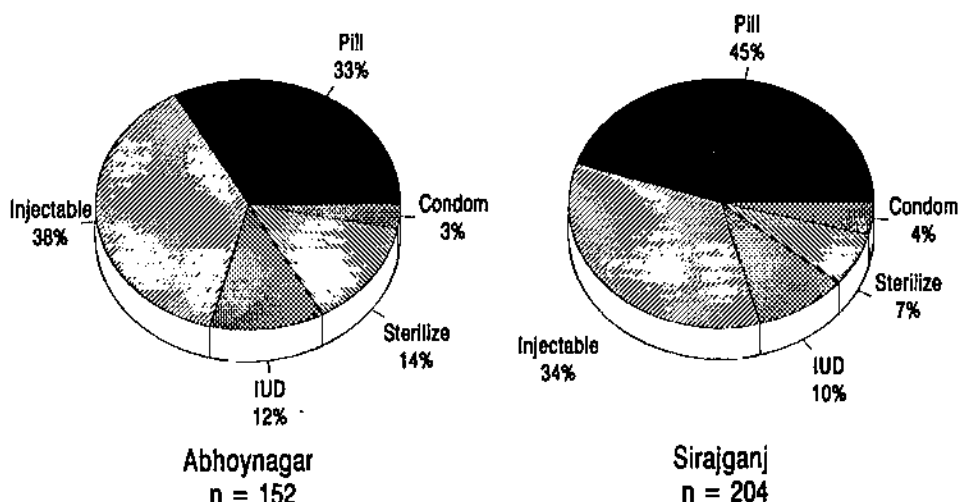


Fig. 3. FP method-mix by thana

Reasons for Visiting FWCs and Services Received

The reasons for visiting FWCs and the services received by the clients are described here. Since the disease pattern has been found to be slightly different in the two *thanas*, each *thana* is presented separately. Although family planning services represent a small percentage of the services, the investigators felt that they merited thorough investigation.

Reasons for seeking services at FWCs

The respondents were asked what kind of services they had received from FWCs on the day of the interview. More than one reason was accepted. The findings are presented in Table 2.

Table 2. Reasons for seeking services at FWC (n = 650)

Reasons given	% of clients giving reasons*
Personal illness	68.2
Child care	51.1
Antenatal care (ANC)	8.3
Postnatal care (PNC)	0.5
Seeking new FP method	2.0
Seeking FP supply	1.2
Suffering from FP complications	3.1
Immunization	1.5
Menstrual regulation	0.5

* Total percentage is > 100 as more than one responses was accepted.

It is observed that general medical care i.e., personal illness and child care are the most common reasons for seeking services at FWC. The use of ANC, PNC and FP services are found to be negligible. Among the FP service users, relatively more women came to seek services for FP complications.

Investigation on the types of **multiple services** received, reveal that two-thirds of the users came for a single and specific reason: either personal illness, or illness of a child, or child immunization. Thirty per cent of the users came for both personal illness and child care. However, the combination of general care with antenatal care (1.4%), general care with postnatal care (0.2%), and general care with family planning services (1.2%) were found to be negligible. This indicates the under-use of maternal health care services at FWCs.

Family Planning Services

New FP acceptors

There were 13 new FP acceptors - 10 in Abhoynagar (3.3% of respondents) and 3 in Sirajganj (0.9% of respondents).

In addition to those new acceptors, three respondents were given services for menstrual regulation. Table 3 shows the comparison between the methods chosen by the new acceptors and the methods received. Twelve of 13 respondents (92.3%) received the method of their choice.

Table 3. New FP acceptors by method sought and received (n = 13)

	FP method		
	Pill	Injectable	IUD
Method sought	0	6	7
Method received	1	6	6

FP users needing additional supply

Eight respondents (1.2%) were FP users seeking an additional supply. Five of them (1.7%) came from Abhoynagar and 3 (0.9%) from Sirajganj. Supplies included oral contraceptives for three respondents, injectable contraceptives for two, and condoms for three respondents.

Respondents consulting for FP complications

Nineteen respondents (2.9%) were FP users suffering from complications. Twelve of them came from Abhoynagar (4%) and eight from Sirajganj (2.3%). The methods and the related complications are listed in Table 4.

Table 4. Complications of FP by method used

Methods	Complications	No. of cases
IUD	Excessive bleeding and/or spotting	5
	Vaginal discharge, lower abdominal pain	5
	Missing thread	1
Injectable	Bleeding problems	4
	Amenorrhea	1
	Headache	1
Oral Pill	Dysmenorrhea	1
Condom	Vaginal itching	1

Over half of the complications listed here are related to IUD and about one-third to injectable contraceptives.

Of the 19 respondents consulting for FP complications, 16 received drugs and three received counselling only. Sixteen were willing to continue with the same method, while three dropped the method.

The respondents coming for FP services, including new acceptors, current users coming for supplies or for management of FP complications represent only 6.3 per cent of all clients (9% in Abhoynagar and 4.1% in Sirajganj).

Curative Services

Findings on the diseases recorded and drugs prescribed are presented here.

Complaints of respondents

Complaints of the respondents or their children were computed from the FWC registers. The word "complaints", used here, reflects whatever the paramedic recorded and includes symptoms, syndromes, or diagnosis of a

particular case. The database allowed for a maximum of four complaints by the respondents. Those complaints may reflect the illness of both a mother and her child(ren); it is, therefore, not possible to present the findings by individual clients or by the age group.

Four hundred and three complaints were recorded in Abhoynagar and 583 in Sirajganj, i.e. an average of 1.3 complaints per respondent in Abhoynagar and 1.7 in Sirajganj.

The most common complaints found in the two thanas are presented in Table 5.

Table 5. Percentage of disease pattern by *Thana*

Complaints	Abhoynagar (n = 403)	Sirajganj (n = 583)
Weakness/malnutrition	19.1	13.9
Diarrhoeal diseases	14.6	28.5
Fever	11.0	11.5
Skin problems	10.7	15.3
Intestinal parasites	9.1	12.7
Pain	8.9	3.4
Respiratory problems	6.3	3.1
Gyne-obstetrical problems	4.7	1.9
Anaemia	4.4	0.0
Eye problems	3.7	4.6
Ear/nose/throat problems	1.8	1.9
Injury	0.5	0.3
Other	5.2	2.9

The first five complaints – weakness/malnutrition, diarrhoeal diseases, fever, skin problems, and intestinal parasites – are almost the same in both the thanas, though in a different order. They represent 65 per cent of all complaints in Abhoynagar, and 82 per cent in Sirajganj.

Drugs received

The dispensing of drugs was checked to know the types and quantity received. Each respondent was asked to show the drugs received to the interviewers, who were trained to recognize drugs by their shape and colour.

One thousand two hundred and forty-five (1,245) drugs were received by 605 respondents (93.1%). On an average, each respondent received 2.05 drugs. Seven per cent of the respondents received a prescription.

When asked for whom the drugs had been dispensed, 45 per cent of the respondents said that it was for themselves, 30 per cent said for themselves and their children, 24 per cent said to have taken the drugs only for their children and, one per cent for their spouses.

Health Education Activities

Although health education in a group setting is a normal component of every day activity at FWC, it was observed only four times in Abhoynagar *thana*, three times in one union and one time in another union during the interview period. About 17 per cent of the clients received health education individually.

Knowledge of Respondents

Awareness of the availability of services provided at FWCs may lead to the use of services better. The respondents' knowledge about the services offered at FWCs are presented below.

Awareness of services offered at FWC

Table 6 shows the percentage of respondents who are aware of the specific services available at FWC.

Table 6. Percentage of respondents' awareness of services offered at FWC

Services	Abhoynagar (n = 300)		Sirajganj (n = 350)		All respondents (n = 650)	
	WOP	AP	WOP	AP	WOP	AP
Treatment	93.3	98.1	73.4	87.7	83.3	92.9
Antenatal care	22.7	96.7	18.0	94.0	20.3	95.3
Postnatal care	5.1	64.3	3.1	79.7	4.1	72.0
FP	55.3	93.0	58.0	96.6	56.8	95.0
Child care	37.7	96.0	66.6	98.6	52.2	97.4
EPI	6.7	75.7	4.6	68.3	5.7	71.7
Health education	1.0	47.0	1.7	57.1	1.4	52.5
Deliveries	0.3	7.0	0.3	28.0	0.3	17.5
MR	2.0	21.0	0.3	35.4	1.1	28.2

WOP = without prompting;

AP = after prompting

Even without prompting, 83 per cent of the respondents knew of the curative services offered at FWC, and over 50 per cent of them were aware of FP and child care services (treatment of minor illnesses, immunization, advice).

Prompting is necessary to remind the respondents of antenatal, postnatal care and immunization. The respondents lacked knowledge about health education, deliveries and MR, even when prompted.

The respondents' awareness of the services offered at FWCs was investigated by their level of education and the results are presented in Table 7.

Table 7. Percentage of respondents' awareness of services offered at FWC by level of their education

Service	No education	Year of schooling	
		1-5 years	> 5 years
General treatment			
Yes	71.3	18.9	9.7
No	74.4	11.9	13.7
Antenatal care *			
Yes	58.8	28.2	12.9
No	75.1	15.3	9.8
Postnatal care			
Yes	62.9	22.2	14.8
No	72.2	17.5	10.3
Family planning			
Yes	73.0	18.5	8.4
No	70.3	16.6	13.0
Child care			
Yes	73.9	15.8	10.3
No	69.7	19.7	10.6

* $p < 0.0001$

The respondents' knowledge of the services offered at FWCs was checked with their level of education. Since EPI, health education, delivery and MR represent a very small percentage of cases, these responses are not presented. Except for antenatal care, no significant difference in knowledge was found among the respondents with different education levels. Women having some education are more likely to have more knowledge about the care required during pregnancy.

Knowledge about immunization and vitamin A

The respondents who received immunization from FWC on the day of the interview were asked which disease the injection was supposed to prevent, and when the next dose was due. The respondents whose child received vitamin A were asked the name of the drug dispensed and the purpose of giving vitamin A.

Since the sample size is very small, results by location or by FWC performances are not shown in Table 8.

Table 8. Knowledge about immunization and vitamin A

Question	% of respondents who gave correct answer
Respondents who received immunization (n = 16)	
Knowledge of the disease to be prevented	62.5
Schedule for next dose	68.7
Respondents whose child received vitamin A (n = 11)	
Name of medicine dispensed	36.4
Purpose of vitamin A	27.3

About two-thirds of the respondents had correct information about vaccination, but one-third of them were aware of the vitamin A health messages.

Dosage of drugs dispensed

The respondents were asked to show the drugs they received and explain the dosage (number of times per day to be used) for each preparation.

Table 9 and 10 summarize the answers given for each of the drugs in Abhoynagar and Sirajganj thanas. The correct dosages have been determined according to the guidelines recommended by the FWC manual. When more than one kind of dosage was acceptable, more than one answer was accepted as correct.

Table 9. Percentage of respondents' knowledge of correct dosages of drugs (Abhoynagar thana)

Drugs	Do not remember	Were not told	Right dosage	Wrong dosage	Total No.
Iron tablets	3.1	1.0	72.4	23.5	98
Mebendazole	2.9	0.0	76.5	20.6	34
Eye ointment	18.2	0.0	27.3	54.5	11
Paracetamol	8.5	0.0	60.6	30.9	71
Eye drops	0.0	0.0	40.0	60.0	5
Metronidazole	7.0	0.0	54.4	38.6	57
Whitfield	12.5	6.2	50.0	31.3	16
Hyoscine	0.0	8.3	66.7	25.0	12
Ampicillin	3.3	3.3	56.7	36.7	30
Penicillin	2.3	0.0	30.2	67.5	43
Benzyl benzoate	14.3	0.0	42.9	42.8	7
Cotrimoxazole	0.0	0.0	40.0	60.0	5
ORS	-	33.3	-	-	3

Note: The dosage of ORS depends on the severity of dehydration; the percentage of correct dosage, therefore, could not be determined.

Table 10. Percentage of respondents' knowledge of correct dosages of drugs (Sirajganj *thana*)

Drugs	Do not remember	Were not told	Right dosage	Wrong dosage	Total No.
Iron tablets	1.6	4.7	57.8	35.9	64
Mebendazole	5.9	1.5	88.1	4.5	67
Eye ointment	9.1	0.0	72.7	18.2	11
Paracetamol	7.1	6.0	56.0	30.9	84
Eye drops	71.0	0.0	71.4	21.5	14
Metronidazole	5.9	1.3	68.6	24.2	153
Whitfield	8.3	4.2	12.5	75.0	24
Ampicillin	4.5	0.0	27.3	68.2	22
Penicillin	12.3	0.0	12.3	75.4	56
Benzyl benzoate	20.0	0.0	10.0	70.0	10
Cotrimoxazole	7.7	0.0	76.9	15.4	13
ORS	50.0	33.3	-	-	10

Note: The dosage of ORS depends on the severity of dehydration; the percentage of correct dosage, therefore, could not be determined.

For almost all the drugs, some respondents claimed that either they did not remember (between 0 and 14%) or were not told (between 0 and 8%) the right dosage. Both statements indicate that the communication between the paramedic and the clients was not satisfactory.

In both *thanas*, the people were least aware of the appropriate dose for eye ointment, whitfield ointment, benzyl benzoate and oral rehydration solution (ORS). The first three drugs are for external use, to be effective they need to be applied regularly. ORS is essential to prevent and treat dehydration; however, as many as 88 per cent of the respondents in Sirajganj had no idea how to use it.

Knowledge of the correct dosage of drugs depends upon the accuracy of the prescription by the service provider, the quality of the message delivered, as well as the memory and comprehension of the client.

In case of penicillin tablets, where less than 30 per cent of the respondents mentioned the right dosage (4 times daily), it may be assumed that the service providers did not dispense the drug correctly. There is also a strong suspicion of faulty prescriptions in case of ampicillin, benzyl benzoate or whitfield ointment because half of the dosages mentioned were inaccurate in both thanas. Poor communication may explain the mistakes recorded for other drugs.

The fact that over half of the ampicillin and penicillin, as well as 25 per cent of the cotrimoxazole were dispensed to the respondents who may take them in wrong dosage is alarming. The wrong dosage instead of curing the diseases, will create resistance to those antibiotics.

Perception of Services

Quality of health education

Although group health education was almost non-existent (given in 2 unions only for 3 days and 1 day respectively), about 70 per cent of the respondents said that they got individual health education and that it was easy to understand. Ninety-four per cent of the respondents also said that they received instructions on the dosage of drugs dispensed.

Access to chosen service providers

The respondents were asked to name the person they had hoped to receive service from and the paramedic who gave them consultation.

Table 11 shows the percentage of clients who received services from the provider of their choice.

Table 11. Percentage of clients receiving services from provider of their choice

	Providers					Total No.
	FWV	MA	Any one	Phar-macist	FWV + MA	
Respondents' selection of provider	49.4	29.8	20.8	-	-	650
Actual service provider	47.4	52.0	-	0.3	0.3	650

Half of the respondents selected FWV who actually provided almost half of the services. MA was selected only by 30 per cent of the respondents, but provided half of the services.

Since 95 per cent of the respondents were females, it was interesting to find out which women chose to receive services from MAs who are mostly male, and if there were any differences between the 2 *thanas*.

All 6 male respondents from Abhoynagar *thana* wanted to see MA. In Sirajganj, of the 21 male respondents, 19 per cent wanted to see FWV, 67 per cent wanted to see MA, and 14 per cent did not have any preference.

Findings from the female respondents are presented in Table 12 by *thana* and by age group.

Table 12. Percentage of selected provider by female respondents and by age groups

Age in years	Abhoynagar				Sirajganj			
	FWV	MA	Any one	Total No.	FWV	MA	Any one	Total No.
< 25	55.2	22.4	22.4	67	61.2	18.4	20.4	103
25-34	40.6	36.0	23.4	175	61.0	22.0	18.0	118
> 34	42.2	39.7	18.1	83	54.1	27.0	18.9	74

The younger women are more likely to consult with FWV than MA. It is noteworthy that the older the woman, the more likely they were to choose to be treated by MA. Around 20 per cent of the women in all age groups did not have any set preference for a FWV or MA.

Perception of services offered at FWC

To understand the clients' perception regarding the quality of services received at FWCs on interview days, various questions were asked to the respondents. In addition, enquiries were also made regarding specific indicators of the quality of care, such as the users' opinion of the services they received, clinical examinations, drugs received, counselling, behaviour of the members of staff, waiting time, privacy, and overall quality of treatment. No attempts have, however, been made in this study to assess the actual quality of the services provided at FWCs. The results presented here describe only what the users feel about the FWC services.

The respondents were asked to give their opinion on the services they received. Responses were subjective and should, therefore, be looked at with caution. For example,

- The waiting time was considered very good for those who enjoyed talking with other clients, but too long for those who had other plans for the day.

- Clients who received a limited number of tablets were not satisfied with the availability of drugs, while those who were dispensed large quantities of tablets did not complain.

The findings are, however, presented by *thana* and by service providers in Table 13 and Table 15.

Table 13. Respondents' opinion about the quality of services received by service providers in Abhoynagar thana

	Yes	No	No opinion
Expected services were provided			
FWV's clients	79.2	20.8	-
MA's clients	75.5	24.4	0.1
Clinical examination was good			
FWV's clients	43.8	39.5	16.7
MA's clients	46.0	32.8	21.2
Drugs were available			
FWV's clients	57.4	27.2	15.4
MA's clients	58.4	32.1	9.5
Counselling was good			
FWV's clients	66.7	23.5	9.8
MA's clients*	81.7	13.9	4.4
The staff behaved well			
FWV's clients	88.9	10.5	0.6
MA's clients	94.2	5.8	-
Waiting time was satisfactory			
FWV's clients	76.5	21.6	1.9
MA's clients	77.4	22.6	-
Privacy was respected			
FWV's clients	91.9	7.4	0.6
MA's clients**	78.8	20.5	0.7
The treatment provided was good			
FWV's clients	78.4	4.3	17.3
MA's clients	82.5	6.6	10.9

Note: No statistical differences were found between the assessments of MAs and FWVs, except for: *counselling: $p < 0.001$; **privacy: $p < 0.002$.

Satisfaction with services was generally good. More than three-quarters of the respondents were satisfied with the services provided, behaviour of the members of staff, waiting time, respect of privacy, and treatment provided. However, over half of the respondents were not happy or did not give any opinions about the clinical examination. The provision of drugs dispensed to the respondents was identified as a weak point. Either the clients expected a larger quantity of drugs or were in doubt as to the effectiveness of those drugs.

A significant difference in counselling and privacy was found between the assessments of FWVs and MAs. It is interesting that the services provided by MAs were considered good as those of FWVs, and even better regarding counselling. On the other hand, MAs scored much lower where privacy was concerned.

The respondents' opinions about the quality of services they had received were investigated with the level of education and are presented in Table 14.

Table 14. Respondents' opinion by education in Abhoynagar thana

	No education	1-5 yrs	> 5 yrs
Expected services were provided			
Yes	63.8	21.8	14.4
No	62.1	22.7	15.2
Clinical examination was good			
Yes	62.7	20.9	16.4
No	66.1	23.8	10.1
Drugs were available			
Yes	65.5	19.0	15.5
No	60.2	26.1	13.6
Counselling was good			
Yes	59.3	24.4	16.3
No	72.0	17.5	10.5
The staff behaved well			
Yes	62.1	22.6	15.3
No	76.0	16.0	8.0
Waiting time was satisfactory*			
Yes	62.0	21.2	16.8
No	68.2	25.8	6.0
Privacy was respected			
Yes	63.6	21.7	14.7
No	55.0	27.5	17.5
The treatment provided was good			
Yes	59.3	23.7	17.0
No	81.3	18.8	-

* $p < 0.10$

No significant differences were found between the respondents' opinions regarding the quality of services received at FWC and their level of education. Only waiting time for getting services was found significant at <10% level.

Table 15. Respondents' opinions about the quality of services received by service providers in Sirajganj *thana*

	Yes	No	No opinion
Expected services were provided			
FWV's clients	90.4	9.6	-
MA's clients	89.6	10.4	-
Clinical examination was good			
FWV's clients	58.2	39.7	2.1
MA's clients	60.7	37.8	1.5
Drugs were available			
FWV's clients	78.1	20.5	1.4
MA's clients	82.6	16.9	0.5
Counselling was good			
FWV's clients	63.7	34.2	2.1
MA's clients	66.7	31.3	2.0
The staff behaved well			
FWV's clients	95.9	3.4	0.7
MA's clients	96.5	3.5	-
Waiting time was satisfactory			
FWV's clients	91.8	7.5	0.7
MA's clients	90.0	9.5	0.5
Privacy was respected			
FWV's clients	94.5	4.1	1.4
MA's clients	93.5	6.5	-
The treatment provided was good			
FWV's clients	94.5	4.1	1.4
MA's clients	93.5	6.5	-

Note: No significant difference was found between assessment of the services provided by MAs and FWVs.

In Sirajganj, the only service that was not appreciated was the clinical examination, with less than 60 per cent of the respondents satisfied. About 40 per cent may have expected more drugs. Although sixty-three per cent

to 65 per cent were satisfied with the information given, i.e. counselling, almost 40 per cent respondents did not receive their desired level of attention.

The quality of services perceived by the respondents is presented by level of education in Table 16.

Table 16. Respondents' opinions by education in Sirajganj *thana*

	No education	1-5 yrs	> 5 yrs
Expected services were provided			
Yes	79.2	13.1	7.7
No	78.4	21.6	
Clinical examination was good*			
Yes	76.6	12.9	10.5
No	83.7	14.8	1.5
Drugs were available			
Yes	78.3	13.5	8.2
No	81.5	17.0	1.5
Counselling was good**			
Yes	78.6	12.2	9.2
No	79.8	17.5	2.6
The staff behaved well			
Yes	79.8	13.4	6.8
No	61.5	30.8	7.7
Waiting time was satisfactory			
Yes	78.3	14.5	7.2
No	90.0	6.7	3.3
Privacy was respected			
Yes	78.4	12.1	9.5
No	79.1	15.6	5.3
The treatment provided was good			
Yes	80.2	12.8	7.0
No	65.0	30.0	5.0

* $p < 0.005$; ** $p < 0.05$

In Sirajganj, no significant difference was found between the respondents' levels of education and the perceived quality of services received at FWCs except for clinical examination and the availability of counselling. The expectation of counselling and clinical examination varied with the level of education of the respondents.

The fact that, besides counselling, clients in Abhoynagar were much less satisfied than the clients in Sirajganj could either mean that the service providers in Abhoynagar were not as qualified as their counterparts in Sirajganj, or the clients in Abhoynagar have higher expectations for services. This may also indicate that the interviewers influenced the respondents towards one direction or the other.

It is obvious, however, from both locations that the clients do not perceive any difference in the quality of services provided by FWVs or MAs. This may be due to the fact that most clients come for general medical care either for themselves or for their children. MAs are usually qualified in this regard, and may be even better than FWVs. However, the weak points, according to the respondents, are the clinical examination, counselling, and may be the provision of drugs.

DISCUSSION

Six hundred and fifty respondents, mainly female, were interviewed about their perception of the services offered at the union Health and Family Welfare Centres. Their responses were analyzed to make recommendations for improving of the quality of care provided by FWVs and MAs.

Reasons for Coming to FWCs and Services Received

As in previous studies (1,4,6), provision of curative services was found to be the main activity of both FWVs and MAs. This study has also found that reproductive health care services, including family planning and care to pregnant women, were provided to only 15 per cent of the women. Low use of the reproductive health care services at FWCs may be due to several reasons: rural women do not feel the need for such care; there are sociocultural factors inhibiting them to seek such care outside their home; or, they are not aware of availability of such services at FWCs. Special attention needs to be given, so that reproductive health care services are used better.

Although a high proportion of the respondents were family planning method users, very few of them came to FWCs for FP-related reasons. The provision of FP services, especially for new users and supply of current users, was negligible. This suggests that the respondents do not depend on the FWC for their FP needs, or receive supplies at home. Moreover, half of the respondents coming for FP-related reasons came for the management of complications related to IUD use. The service providers at FWCs must be properly trained to provide IUDs. Special emphasis must be given to screening and counselling.

Health education sessions in group settings were observed in two FWCs only on one and three occasions during the 82 days of interview. It is, therefore, not surprising that the respondents did not list health education as a common service provided at the FWC.

Most of the FWC clients expected to receive curative services and drugs. Provision of health education in group settings, FP services, and care of pregnant women were marginal services. The reasons for under-use of such services need to be investigated.

Knowledge of Respondents

Knowledge of services offered at FWC

As like of previous studies (4,5) a majority of the respondents were aware of curative care for women and children. Few mentioned FP services, and antenatal and postnatal care. Almost none of them talked about deliveries. It may be possible that the service providers are not fulfilling their responsibility to inform and motivate women to use the reproductive health care services.

The service providers at FWCs, with the help of the field workers, must inform rural women of reproductive age and their families about the importance of the reproductive health care services and motivate them to use these services.

The respondents were not fully aware of the reproductive health care services offered at FWC, mainly ANC, PNC and FP, and did not make use of them. There is a need for the field workers, as well as the paramedics, to educate the community about these services. On the other hand, the improvement in the quality of these services provided may enhance their use.

Dosage of Drugs

As mentioned previously, the drugs dispensed were not properly recorded in the registers. In addition, the respondents were not fully aware of the dosage of these drugs. A sizable percentage of them claimed that they were not told or did not remember the dosage. As many as one quarter of them were at the risk of taking antibiotics in wrong dosage, this leads to a strong suspicion of the lack of knowledge and communication skills of the dispensers. In addition, no technical guidelines were available at FWC to help the paramedics make correct diagnoses and dispense appropriate treatments.

The technical and communication skills of the paramedics were poor. This is not surprising, considering that MAs are never offered any refreshers courses, and FWVs are not really trained to provide curative services on this scale. There should be a provision for skill development training.

Perception of Services

Services that are perceived as poor by the respondents included counselling, clinical examination, and provision of drugs. It is again interesting that answers were similar for the female and male providers, who have different training backgrounds. Lack of privacy was frequently mentioned by the respondents as a problem. The facilities at the FWC centres must be adjusted to provide greater privacy, and the service providers must try to maintain privacy for the individual clients. However, no substantial difference was found between the level of respondents' education and their satisfaction except in counselling and clinical examination.

The respondents were generally satisfied with the behaviour, treatment and the waiting time at FWC, but questioned the technical skills of paramedics, especially in the area of curative care.

It was found in a previous study that women had no serious objection to receiving services from a male Medical Assistant (1,6). Here, no major difference was found between the perception of services provided by MAs and FWVs, and in some cases, especially counselling, MAs scored better than FWVs. We must be careful about drawing conclusion that MAs are better counsellors, because the female clients may be more easily convinced by males. However, the counselling skills of the service providers need to be strengthened as counselling was the weakest point of service delivery in both the thanas.

The respondents considered the services offered by MAs and the FWVs of equal quality but feel comfortable consulting with the female providers. The service providers need to develop better interpersonal communication skills.

CONCLUSIONS

The main findings regarding the quality of services as perceived by the clients can be summarized as follows:

1. Those who use the FWC services are mostly rural women and their children. A majority of them are illiterate. The services of these FWCs are mainly used for general medical care for women and children. Family planning services, and antenatal and postnatal care represent a very small proportion of the activities performed by FWVs and MAs.
2. Health education sessions are almost nil at FWCs, though they should be a component of every day FWC activities.
3. The respondents' knowledge of the services offered at FWCs, particularly maternal health care services, was inadequate. Very few respondents knew of all the available services offered at FWCs.
4. The skills of the paramedics are weak, especially with regard to curative services, and provision of drugs to the clients. Although 93 per cent of the respondents received drugs, about half of them were not aware of the proper drug dosage, including antibiotics.
5. The majority of the respondents had a positive opinion of the quality of services received from that day's consultation. It was also found that the perception of services received is not dependent on the level of respondent's education, or the sex or the training of the paramedic consulted. Although there was no significant difference between the FWV and MA's services, the respondents rated them differently depending on which services they received.

RECOMMENDATIONS

Based on these findings, the following recommendations may have a positive impact on the quality of services offered by the paramedics at FWCs.

1. Awareness of FP services, ANC, and PNC should be enhanced in the community. The field workers and the paramedics at FWCs should educate the community members about the availability of and the need for these services.
2. Appropriate health education materials, focusing on the priority reproductive health problems, need to be designed and supplied to educate the community women and men.
3. The skills of the paramedics should be improved, both in reproductive health care and in curative care. The provision of technical guidelines and refresher courses are prerequisites to the improvement of the quality of services.
4. The issue of under-use of ANC, PNC, delivery, and other reproductive health care services needs to be further investigated.

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Appendix- A

Selected unions, posting of paramedics and average clients attended in Abhoynagar and Sirajganj

Union	Paramedics	Interview days	Average daily attendance
Sirajganj:			
Ratankandi	♀ MA ♀ FWV	5	58 clients
Bagbati	♀ MA ♀ FWV	5	64 clients
Sialkol	♀ MA ♀ FWV	5	42 clients
Kaliahoripur	♀ MA ♀ FWV	3	165 clients
	♂ MA* (Health)		
Sngacha	♂ MA ♀ FWV	4	72 clients
Soydabad	♂ MA ♀ FWV	4	81 clients
Bohuli	♂ MA ♀ FWV	4	76 clients
Abhoynagar:			
Rajghat	♂ MA ♀ FWV	8	31 clients
Baghutia	♂ MA ♀ FWV	7	45 clients
Mohakal	♂ MA ♀ FWV	11	38 clients
Paira	♂ MA ♀ FWV	9	50 clients
Suborara	♂ MA ♀ FWV	7	54 clients
Siddipasa	No MA ♀ FWV	10	39 clients

* Since there was no building for rural dispensary (RD) in Kaliahoripur union, the MA posted at the RD was also working in the FWC.

MCH-FP Extension Work at the Centre

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

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

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

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

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

The Division

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

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



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