

Shifting Family Planning Services from Home to the Clinic: Evidence from Urban Bangladesh

Based on the report “From Home to the Clinic: The Next Chapter in Bangladesh’s Family Planning Success Story” by Sidney Ruth Schuler, Md. Khairul Islam, and Lisa Bates, Empowerment of Women Research Program, JSI Research and Training Institute. The research was supported by POLICY’s Global Policy Research Program, with supplemental funding received from the William and Flora Hewlett Foundation, the Summit Foundation, and the Moriah Fund. The Frontiers Project of the Population Council is supporting a continuation of the study. Karen Hardee prepared this brief.

Background

Many countries have used community-based delivery of contraceptives to improve women’s access to family planning. For the past two decades, Bangladesh’s family planning program has been based on door-to-door contraceptive delivery, in part to work within gender-related constraints on women’s mobility. In 1997, the government issued the Health and Population Sector Strategy, which included reproductive health services as part of an essential services package (ESP) designed to be provided primarily through clinics. Clinics displaying the green umbrella logo offer the essential services package.

The higher quality and greater range of services available in “one-stop shopping” clinics is intended to attract clients as well as increase the impact of the services on health. Donors and nongovernmental organizations (NGOs) now support the new strategy. NGOs in particular are working to improve the quality of services at clinics, make the services more responsive to clients, and increase sustainability by

- Expanding the satellite clinic system;
- Implementing standards for maternal and child health services and training programs to support an expanded service package;
- Establishing clinic-based pharmacies and revolving drug funds; and
- Instituting management reforms.

The change in program emphasis raises questions about the strength and nature of demand for family planning and other health services. Decision making about the use of family planning and other

health services becomes more complex when women must go out of their homes for services and must incur added social, logistic, and direct costs. The shift to clinic-based delivery systems may create barriers for women who need reproductive health services, or it may promote women’s strategic interests by drawing them into the public sphere, where other opportunities exist. By making it necessary for clients to take initiative in seeking out and paying for services, the new requirements may also produce a better informed, more discriminating clientele.

In pioneering the difficult task of making the transition from door-to-door family planning to clinic-based essential services, NGOs in Bangladesh have demonstrated both the potential of the new program strategies and the challenges inherent in such a major reorientation. Bangladesh’s experience—which highlights important programmatic as well as social issues around the introduction of new service delivery strategies—is relevant to other countries undergoing sweeping program changes.

Findings

This paper presents findings from study sites where the transition from home to clinic-based services is underway.¹ It documents how communities

¹ This study is being conducted in two urban sites in Dhaka and Satkhira districts and in three rural sites. This brief presents findings from only the urban sites. The study was conducted in areas around the NGO and satellite clinics. Researchers conducted semi-structured interviews with individuals, which were supplemented with group interviews and observations in clinics and satellite clinics. Data were collected throughout 1999, but the reference period spans several years.

and programs are responding to 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 are adapting to the new program norms.

Demand for Family Planning and Access to Contraceptives

Response to the discontinuation of door-to-door services illustrates the strong demand for family planning that now exists. The study sites varied in how abruptly door-to-door services were withdrawn and in the amount of information provided to women regarding the new program. Initial gaps in supply and temporarily discontinued use were attributed more to poor information about the new program than to dependence on home delivery. For most women, home delivery of contraceptives was more a convenience than a necessity. In areas where workers took individual initiative to inform women of the program change and suggest alternative sources for contraceptive methods, women were able to shift immediately to clinic services. One former door-to-door worker took many women to the NGO clinic, after which they stopped coming to her. Under the new program, families must either send a male to obtain contraceptives or be willing to incur any social as well as monetary costs associated with women traveling outside the home.

Women were virtually unanimous in saying that women's freedom to move about to avail themselves of the services is now a well-established community norm even if not a family norm. Restrictions that exist are imposed most frequently on young brides, women in extended families, and women in high-class families; however, exceptions are often made especially when women are seeking health care. "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." 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."



Photograph from JHU/CCP Photoshare

Men's Roles in Accessing Services

Men played an important role in sustaining oral contraceptive use during the program shift. One former door-to-door worker noted, "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." More men became involved in family planning as a result of the program change by, for example, buying pills for their wives for the first time; however, many resumed a passive role once their wives accessed services on their own or switched to a long-term method. Some women were ambivalent about their husband's participation often because men were not reliable in this role. Most women, however, were happy to share the burden of family planning and even proud of what they often perceived as a demonstration of their husband's care and concern.

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Men's objections to, or lack of support for, women's clinic use usually centered around cost issues, including the cost of accessing the services and paying for treatment of side effects. 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."

Client Perceptions of Quality

Overall, reactions to the new, clinic-based services have been highly favorable. With some caveats, the redesigned NGO service delivery systems are emphasizing many aspects of quality of care that clients genuinely value. 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 whereby 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 the equal treatment. 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.

Issues Affecting Willingness and Ability to Pay

The government has provided free or highly subsidized services for many years, and clients often did not know the difference between government and NGO programs. All door-to-door family planning workers 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.

Some clients expressed confusion about the charges levied at NGO clinics. Even among clients who understood the difference between NGO and government services, 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. Use of the green umbrella logo (indicating that clinics offer all ESP services) may actually contribute to the confusion.

Many respondents thought the umbrella was a government logo.

Generally, clients who were able to pay seemed willing to pay when they were reasonably sure that the charges were legitimate and that the clinics were run by NGOs, not by the government. But in addition to the strategies already in place to inform clients and potential clients about the prices of services, special strategies may be needed to make it clear that the clinics are not government-operated and to explain certain features of the system, such as registration.

The new NGO clinics have a policy that no one should be denied services because he or she 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. Clients often receive discounts and free services in the NGO clinics, but there is no organized system of subsidies, only failures to collect fees and small acts of benevolence bestowed upon the poor. Clinics are not set up to offer credit as family planning workers did in the door-to-door system. Developing a systematic and transparent system for charging fees on a sliding scale is an ongoing challenge.

The fact that medications are now available at the clinics is important to clients. In a few cases, however, clients felt frustrated because, after paying the consultation fee, they could not afford to fill any prescriptions they were given. One woman 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! Nobody shows any compassion for the poor ... !"

Legacy of the Past Program

Women are clearly benefiting from the new program by gaining access to a wider range of contraceptive methods, but Bangladesh's past policy and service delivery culture will take some time to change. Clients are still somewhat suspicious of providers' motives. Some clients thought they were being pressed to use a particular method, as they might have been under the old system. As a result, they fear that if they use the provider-suggested methods, their side effects or requests for removal will go unheeded. This pattern of fear and suspicion of clinical method providers is less

evident among clients of the new NGO clinics, but its persistence nonetheless warrants attention.

Previous research has shown that clients have felt that they were adopting family planning not only for themselves but also for the good of the country. In return, many have come to expect free services and commodities as well as free treatment for side effects and even compensation for adopting clinic methods. Many clients also think that the NGO clinics should bear responsibility for treating their health problems or side effects for free.

Policy Implications

Given the difficulty of making a sweeping program shift, Bangladesh's NGOs have made impressive progress in a short time. Clearly, this analysis has shown that men and women are strongly committed to fertility control and that women are no longer stigmatized for visiting clinics. Many women were assertive about their entitlement to health services and proactive in seeking out such services, even if at times they had to resist social norms or individual opposition.

NGOs should continue to provide information and support so that existing demand for services and the loosening restrictions on women's mobility translate into effective and satisfactory service utilization. Community outreach efforts to men are a promising vehicle for NGOs to promote messages about men's important role in reproductive health care. It is still premature to assess what empowering effects the program may have on gender roles, but some evidence suggests that the new program model facilitates women's greater exposure to the public realm and access to the benefits that follow.

Many of the challenges facing the new program, particularly as related to cost recovery, are a function of norms from the past and of incongruities between government and NGO policies and practices. Clinic staff recognize the complexity of pursuing cost recovery while making services accessible to even the poorest. Experience from other countries shows that it is no simple matter to design a needs-based subsidy system that is transparent and effective in reaching the poor.