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Urban FP/MCH Working Paper No. 12

Health Facility Survey in Selected Dhaka Slums

Nancy Fronczak
Selina Amin
Quamrun Nahar

Urban Health Extension Project

International Centre for Diarrhoeal Disease Research, Bangladesh

October 1993

The International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) is an autonomous, non-profit organisation for research, education, training and clinical service. It was established in December 1978 as the successor to the Cholera Research laboratory, which began in 1959 in response to the cholera pandemic in southeast Asia.

The mandate of the ICDDR,B is to undertake and promote research on diarrhoeal diseases and the related subjects of acute respiratory infections, nutrition and fertility, with the aim of preventing and controlling diarrhoeal diseases and improving health care. The ICDDR,B has also been given the mandate to disseminate knowledge in these fields of research, to provide training to people of all nationalities, and to collaborate with other institutions in its fields of research.

The Centre, as it is known, has its headquarters in Dhaka, the capital of Bangladesh, and operates a field station in Matlab thana of Chandpur District which has a large rural area under regular surveillance. A smaller rural and a large surveyed urban population also provide targets for research activities. The Centre is organised into four scientific divisions: Population Science and Extension, Clinical Sciences, Community Health, and Laboratory Science. At the head of each Division is an Associate Director; the Associate Directors are responsible to the Director who in turn answers to an international Board of Trustees consisting of eminent scientists and physicians and representatives of the Government of Bangladesh.

The Urban Health Extension Project (UHEP) is a follow-on activity of the Urban Volunteer Program (UVP). In 1981, the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) began training women volunteers in urban Dhaka in the use of ORS packets for diarrhoeal disease on the assumption that community women could play an important role in teaching others about the home treatment of diarrhoea with ORS. The United States Agency for International Development (USAID) began funding the project in 1986 with a mandate to provide primary health care services to the urban slums and conduct research on child survival related issues. UHEP continues to focus on health and family planning issues of the urban slums with an overall goal to strengthen the ability of the government and non-governmental agencies to provide effective and affordable family planning and selected maternal and child health services to the urban poor through research, technical assistance, and dissemination of its research findings.

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Foreword

I am pleased to release these reports on urban health and family planning issues which are based on the activities of the Urban Health Extension Project (UHEP). UHEP is a follow-on activity of the former Urban Volunteer Program, a pilot project funded by the United States Agency for International Development (USAID).

The poor health status and the health needs of the urban poor continues to be an important emerging public health issue in the Developing World. Bangladesh is no exception. Despite the constraints of poverty and illiteracy, there are proven strategies to provide basic health and family planning services to the urban poor. In Dhaka alone, aside from the Government health care facilities, there are numerous NGOs and private sector providers giving needed services to the urban population. The Centre's own Urban Health Extension Project continues to focus on the urban poor, especially the slum populations, in providing basic family planning and health services through outreach activities (viz. health education, ORS distribution and referral services to service points).

However, enormous challenges remain in providing an optimum level of services to the urban poor. The UHEP, with the support of the USAID, will focus on health and family planning services delivery strategies in reaching the needed services to the urban poor. We certainly look forward to learning more about the health and family planning needs of the urban poor, testing sustainable strategies and applying these proven strategies in collaboration with other partners in government, NGOs and the private sector.

Demissie Habte, MD
Director

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Summary

To document the health facilities and providers known of and used by urban slum population and to provide an insight into the awareness of the slum women as to what services were available through different health providers, a survey was conducted from June to August 1992 of women in a representative sample of the slum households of five *thana* in Dhaka. Three women from each of the 238 research clusters of the Urban Surveillance System (USS) of the Urban Health Extension Project (UHEP) were interviewed as a group using a structured questionnaire. They were asked about health providers and facilities which provided home visits, traditional health services, medicines, other treatment, private pharmacies, and other private health services. They also were asked about health providers which were used by the cluster populations for specified health needs. The survey focused on health needs for maternal and child health, and sought information regarding the distance to the facility, types of services provided, and personnel who provided services. The health facilities were later visited and a check list was used to verify information regarding available services and staffing. Household health visitors were reported to provide regular services (usually provision of contraceptives or vitamin A capsules) in 92% of the surveyed clusters. Immunization services were available within an easy walking distance or a short rickshaw ride to 73% of the surveyed clusters. Thirteen percent of the women in clusters reported receiving outreach service for immunization. Seventy-nine percent of the clusters reported that contraceptives were available on a regular basis through home visitors, whereas 16% reported that they had access to satellite clinics that provided injectable contraceptives. Three-quarters (74%) of the areas surveyed reported that women most frequently used traditional *Dais* for (home) delivery. Spiritual healers and herbal healers were reported to be readily available and used by most clusters. Pharmacies were available

within an easy walking distance for essentially all of the clusters. About 80% of the clusters reported that pharmacies were the primary source of treatment for minor illnesses in adults as well as children. Major government hospitals were reported as the primary source of treatment for seriously ill adults in 76% of the clusters, and in 83% of the clusters for seriously ill children.

There were *thana*-specific differences in utilization of government or NGO services for minor and major illnesses which seemed generally to reflect geographic proximity to facilities. The survey also indicated, however, that services which were further away from the slum areas and which cost more were sometimes chosen over closer, free services. Thus, despite poverty in the population being surveyed, perceptions of quality and non-official barriers to use may be important issues to address when planning health services.

This information should help health providers and planners better understand what health services the slum populations perceive as available and what they most commonly use. Gaps in availability or utilization may reflect actual service availability problems, or may reflect perceived or real "quality of service" issues. More information on why and when certain providers are chosen is necessary to help planners to provide services which are not only available, but are also actually used.

Introduction

Dhaka has seen a rapid increase in urban population over the past ten years. A large proportion of this population lives in slum areas, earning minimal income and living under conditions which contribute to poor health (1,2). Although the urban slum population is estimated to be over three million people (3), there is little systematically collected and representative information available on this population.

The Urban Health Extension Project (UHEP) is seeking to provide health personnel and planners with information which will contribute to a better understanding of the urban slum population. While a few studies have been conducted on health-seeking behavior for particular illnesses in Dhaka (4,5), a basic description of the health services which are available to and used by the Dhaka slum population for maternal and child health needs does not exist. The urban slum populations have been found to have higher infant and child mortality than those in rural areas (6). Thus, an important area which needs further research is the current availability and use of maternal and child health services among the urban poor. There is currently no public policy of urban health care and most services are provided by the private sector, Non-government Organizations, and the government's EPI (Expanded Program on Immunization) program.

It was determined that a survey to describe the health services which mother use for common health needs of children and delivery care would be useful as one step in better understanding the gaps in health service availability as perceived by the slum population. The purpose of this survey was to gather descriptive information about the health facilities and providers which women in the slums know of and use. The purpose of the survey was NOT to describe health-seeking behavior or to look for reasons different services are used at different times. An additional aspect of the survey was to form a better understanding of the variation in service availability and utilization differences between *thana*.

Methodology

Sample Selection

The survey was conducted in the Urban Surveillance System (USS) research clusters of the UHEP of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) from June to August 1992.

The USS research clusters were selected in 1990 (and are periodically updated as population shifts occur) using a multi-stage probability sampling technique, stratified according to water and sanitation conditions (1). Slums consisting of 20 or more households were included in the sampling frame. The sampling units were clusters of average size of 33 households. The USS sample is drawn from slum populations of five *thana* (administrative districts) in Dhaka. These are Lalbagh, Kotwali, Sutrapur, Demra, and Mohammadpur. There were 238 clusters under surveillance at the time of the survey -- 33 clusters in Sutrapur, 77 in Lalbagh, 87 in Mohammedpur, 9 in Kotwali, and 32 in Demra.

The health services of primary interest were those relating to maternal and child health, so it was determined that the interviewees should be women. USS information was used to identify women who had lived in the USS cluster for at least one year. One of these women was randomly selected for interview. Two additional women from the cluster were also selected at the time of the interview, with the criteria being women who lived near the randomly selected woman and who had also lived in the cluster for at least one year. The three women were interviewed as a group.

The single group interview for each cluster was selected as the data collection method for two reasons. First, it was not practical (and was not

deemed necessary) to interview all households for the purposes of the survey. It was believed that by interviewing the women as a group, the consensual answers to the questions asked would reflect the knowledge and utilization patterns of the cluster population better than if a sample of women were interviewed separately. If there was no agreement for the answer to any question, the women were asked to discuss it further and probing questions were asked until a consensus was reached.

Data Collection

Experienced USS interviewers received a two-day training to administer a structured questionnaire. In addition to questioning the women on health service availability and utilization, verification of the services available at the facilities mentioned was conducted through a visit to the facility, using a check list. The verification visits to private doctors and pharmacies were conducted by the interviewers after completing the interview in the cluster. Only pharmacies and doctors near the cluster were visited. Where there were many pharmacies, several were visited to verify what types of services were available.

Health facilities such as clinics or hospitals for each *thana* were visited by the Community Health Coordinator for the UHEP for that *thana.* Hospitals were visited by a physician to facilitate access and cooperation in filling in the verification check list.

Health providers or facilities were categorized as those who provide house-to-house services, as traditional health care providers, pharmacies and private physicians, and health facilities that provide in-patient care (clinics and hospitals). While some other information was gathered, the

questionnaire focused on information regarding immunization, family planning, curative care for minor or serious illnesses, and maternity services.

For all questions the interviewer emphasized that we were looking for health facilities and providers which were near the cluster and which were used by the neighboring population. The women were told that even if they did not have experience with some of the types of services being asked about, that they should tell what they thought was normal for people living in their area. Thus, the emphasis was on facilities within walking distance of the cluster (used or not used) and facilities which were further away but which were used.

Information was gathered on distance to the service centers (walking distance, medium, or far). During key informant interviews and pre-testing it was found that there was a consensus on "walking distance." When the cost of round-trip transportation was approximately Tk. 6[a] or less, the women discussed and argued whether the location was within walking distance or not, or qualified the answer depending on the health of the person, etc. Thus, this was deemed to be a medium distance. "Far" meant that a rickshaw ride was necessary. The round-trip cost of the rickshaw or baby taxi was gathered for "far" distances.

The information being reported in this survey was provided by the slum women. In some cases, the women did not know the name of the organization serving them or of the health facility which they were describing. There were also cases of organizations being identified as providing a service which was not verified as available. Where the name of the organization was wrong but the facility being described could be identified during the verification visit, the name of the service provider was

[a] Tk. 39 = US$1.00.

corrected. Wrongly reported services or lack of knowledge about services, however, were not corrected, but were compared with the verified information and are discussed in this report.

Results

Home Visitors

Home visitors were defined as health workers providing services door-to-door or through satellite (mobile) clinics. Home visitors who visited less frequently than every 6 months were not classified as providing home visitation services. Questions were asked about the services which were provided door-to-door as well as about mobile services which came periodically to the slum area.

A review of the reports on home visitors showed that women from 79% of the clusters reported receiving door-to-door services for family planning (pills and condoms), as well as advice and referral for other methods of family planning[b]. About 30% of the clusters reported receiving oral rehydration packets at the household[c], and 62% reported receiving vitamin A capsules through home visitors[d]. In addition to home visitors, women from 16% of the clusters reported receiving satellite clinic services (organized services that come to the cluster area) for injectable contraception[e], and 13% for immunizations[f] (Table 1).

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[b] The main organizations for pill/condom were: Concerned Women for Family Planning (80/238 clusters); Mohila Samaj Kallyan Samity (40/238 clusters); Community Health Care Project (23/238 clusters); and the government (37/238 clusters).

[c] ORS was distributed by the "Urban Volunteers" from the Urban Health Extension Project.

[d] Vitamin A was primarily distributed from World Vision and Concerned Women for Family Planning.

[e] Injectable contraceptives were reported to be available through satellite outreach services from Mohila Samaj Kallyan Samity in Demra, and the Community Health Care Project, in Mohammadpur *thana*.

[f] The organizations that provided immunization satellite outreach services were World Vision, Community Health Care Project, and the government. These were reported in Demra, Kotwali, and Mohammadpur *thana*.

Table 1. Home Visitors and Satellite Clinics: USS Clusters Reporting Availability of Services, by *Thana*

Services	*Thana* (number of USS clusters)					
	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Immunization*	0	3 (9%)	0	2 (20%)	27 (31%)	32 (13%)
Pill/Condom	31 (94%)	28 (88%)	61 (78%)	6 (70%)	62 (71%)	188 (79%)
Injectable*	0	0	0	0	37 (43%)	37 (16%)
ORS	16 (49%)	3 (9%)	25 (32%)	3 (30%)	26 (30%)	73 (31%)
Vitamin A	11 (33%)	7 (22%)	51 (65%)	6 (70%)	75 (86%)	150 (63%)

Note: Figures in parentheses indicate column percentage.
* Satellite clinic services

Women from eight percent of the clusters reported that their neighborhoods received no health services from home visitors and another 8% reported receiving household level services only every six months (usually distribution of vitamin A only). Only one cluster reported that their only home visitor was an Urban Volunteer affiliated with the UHEP, but over one-third of all clusters (39%) had home visiting services from more than one organization (the second organization often was the UHEP volunteers).

In addition to the above services, cluster women reported on special programs which brought services into their areas. The World Vision

sponsorship program is active in Mohammadpur, and provides family planning services and basic curative care, as well as community development support to some families. Other special outreach activities were also reported to be provided on an irregular basis for screening for diabetes and hypertension (e.g. Project Aid).

Traditional Services

Women were interviewed about the availability and utilization of traditional birth attendants (*Dais*), *Kobirajs* (traditional herbal medicine providers), and *Fakirs* (spiritual healers). In addition, questions were asked regarding any other type of traditional healers used by the cluster population (Table 2).

Dai

A *Dai* was defined as a person who conducted deliveries outside of her family, and who usually received some compensation. In describing the services the *Dais* offered, 51% of the women from the clusters reported the *Dais* provided antenatal consultation if requested, 37% reported that *Dais* provided spiritual intervention (e.g. Jharfuk, holy water), and 7% provided herbal interventions; 2% reported that *Dais* provided herbal contraceptive intervention. Almost all (97%) of the clusters reported having at least one woman within walking distance who was recognized as a *Dai*. Over one-quarter (27%) had two *Dais* and 20% had three *Dais* within walking distance. All clusters reported to have *Dais* said that the *Dais* were used frequently and that the *Dais* expected payment, though the amount depended on what the family could afford.

Table 2. Traditional Healers: USS Clusters Reporting Availability and Service, by Type of Healer

Services	Type of Traditional Healer (number of clusters reporting access to each type of healer)			
	Dai (n=231)	*Kobiraj* (n=103)	*Fakir* (n=177)	Others (n=95)
Health Advice	30 (13%)	33 (32%)	134 (76%)	7 (7%)
Herbal Medicine	16 (7%)	99 (99%)	87 (49%)	24 (25%)
Spiritual (including *Jharfuk****)	86 (37%)	62 (60%)	177 (100%)	86 (91%)
Modern Medicine	6 (3%)	1 (1%)	0	0
Antenatal Check	117 (51%)	2 (2%)*	0	0
Delivery Care	231 (100%)	1 (1%)	2 (1%)	0
Contraception	5 (2%)	5 (5%)	3 (2%)	1 (1%)

Note: Figures in parentheses indicate column percentages.

* These were identified as female.

** Herbal interventions only.

*** *Jharfuk* is a treatment provided primarily by religious leaders which involves the use of holy water or blowing "incantations" on the body to dispel illness.

Kobiraj

The community definition of *Kobiraj* was also used and questions were asked about the services provided by the *Kobiraj*s. Over 40% of the clusters reported knowing of a *Kobiraj*.

Of the clusters where *Kobiraj*s were known, herbal medicine was reported to be provided by the *Kobiraj*s in 96% of the clusters, spiritual intervention in 60%, and health advice in 32% of the clusters. Two female *Kobiraj*s were reported to provide antenatal care and one other female *Kobiraj* was reported to provide delivery service. Only one *Kobiraj* was reported to provide modern medicine. Special services which the *Kobiraj* provide included herbs for contraception (5%) and for jaundice (4%).

Of the 103 clusters knowing of *Kobiraj*, 50% of them reported that the *Kobiraj* was within easy walking distance. Almost one-quarter (23%) of the *Kobiraj* were at a medium distance, and the rest were far enough away that a rickshaw was required. Essentially all of the *Kobiraj*s charged a fee.

Of all the clusters with a *Kobiraj*, 42% reported using the *Kobiraj* frequently. Over one-quarter (29%) of the clusters reported knowing female as well as male *Kobiraj*s. Almost three-quarters (71%) of the clusters which reported knowing *Kobiraj* reported knowing only one; 16% reported knowing two.

Fakir

The category of traditional healer *Fakir* was not defined for the study as there appeared to be a consensus that the title *Fakir* referred to someone providing spiritual healing. Thus, the community definition of *Fakir* was accepted. Women from the clusters were asked to describe the types of

services provided by *Fakirs*. Women from 177 (74%) of the clusters reported knowing a person recognized as a *Fakir*.

All of the *Fakirs* were reported to provide spiritual interventions, with 49% also providing herbal interventions. None were reported to provide allopathic medicine. Two of the female *Fakirs* were reported to provide delivery services, and a few *Fakirs* (two male and one female) were reported to provide herbal contraceptive interventions.

Of the 177 clusters where *Fakirs* were mentioned, 81% reported that the *Fakirs* were within easy walking distance. Almost all (97%) women in clusters reported that the *Fakirs* charged fees. About 11% of the clusters with *Fakirs* reported having access to female *Fakirs* only, while 16% reported having access to both male and female *Fakirs*. The majority (66%) of clusters reported going frequently to a *Fakir*; 31% reported using the *Fakir* only occasionally. About half (49%) of the clusters which reported knowing *Fakirs* knew of only one, and 40% knew of at least two different *Fakirs*.

Other Services

There were other miscellaneous types of traditional providers who had recognized titles within the communities which were different from those mentioned previously, although the services provided were often similar to those of the *Fakir* or *Kobiraj*. These included *Huzur* and *Moulavi* (providing spiritual interventions) who were commonly available, and snake charmers and "medicine men" who came through occasionally. Special services (circumcision, dental care) were mentioned as provided by some of these practitioners (Table 3).

Table 3. Other Traditional Healers: USS Clusters Reporting Availability and Types of Services Provided (n=238)

Healers	Number (%) of Clusters Mentioning (Access to Providers)	Services Provided
*Huzur**	39 (16%)	Amulet/Talisman
*Moulavi**	30 (13%)	Amulet/Talisman
*Sadhu/Pir**	2 (1%)	Amulet/Talisman
*Imam**	5 (2%)	Not Mentioned
*Hajam***	9 (4%)	Circumcision
Snake Charmer	8 (3%)	Dental/Amulet
Bedini	8 (3%)	Dental/Amulet
Ojha	3 (1%)	Not Mentioned

* Considered to be a religious healer

** Several providers who were not mentioned by title, but were mentioned specifically for circumcision were included in this category.

Most (91%) of the clusters having other traditional providers reported that they provided spiritual interventions. One-quarter of the other traditional practitioners provided herbal treatment. About 20% of these other traditional providers were female.

Pharmacies, Private Doctors, Homeopaths

Pharmacy Without Doctor

Women from almost all clusters (94%) reported knowing of a pharmacy where there was a compounder or pharmacist, but not a doctor present. Three clusters (1%) reported having female pharmacists or compounders. Typically, pharmacies supplied modern medicine, including intravenous fluids and injections (96%). Oral contraceptive pills and condoms were also available at almost all pharmacies.

Eight percent of the clusters reported pharmacies where immunization could be received. If immunization was available at pharmacies, it was primarily tetanus toxoid. When the pharmacies were visited, most reported that there was a refrigerator for maintaining the cold chain in the pharmacist's home. These claims could not be verified, however it is probable that a cold chain was not always maintained by the pharmacies. Two pharmacies were reported to provide menstrual regulation using herbal medicine (Table 4).

Pharmacy With Doctor

Most (94%) of the clusters knew of and used pharmacies where there was also a doctor present. The majority (83%) of these were within easy walking distance; only 4% of them were far enough to require a rickshaw costing more than Tk. 6 round-trip.

One-half (50%) of the clusters which knew pharmacies with doctors reported using them frequently. While most clusters did not mention female doctors, it was found during verification visits that 21% of the clusters had

female doctors with a pharmacy attached within an easy walking or medium distance.

Table 4. Pharmacies, Private Doctors and Homeopaths: USS Clusters Reporting Availability and Types of Services (n=238)

Services	Pharmacy/ No Doctor	Pharmacy/ With Doctor	Homeopath
Home Visit	207 (87%)	156 (66%)	56 (24%)
Modern Medicine	223 (94%)	224 (94%)	13 (5%)
Herbal Medicine	41 (17%)	26 (11%)	4 (2%)
Injections	221 (93%)	224 (94%)	4 (2%)
Intravenous Fluids	213 (89%)	224 (94%)	4 (2%)
Homeopathic	2 (1%)	2 (1%)	231 (98%)
Emergency Service	60 (25%)	44 (18%)	12 (5%)
Immunization	17 (7%)	20 (8%)	0
Not available	15 (6%)	14 (6%)	7 (3%)

Note: Figures in parentheses indicate column percentage. Percentages do not add to 100, because services are not mutually exclusive.

All pharmacies with doctors provided curative care, injections and intravenous medicines. Essentially all had pills, condoms, and oral rehydration salts. Three of the clusters reported having doctors who performed male sterilization, and only 6 clusters reported doctors that would provide female sterilization. Seven clusters had doctors (female) in pharmacies who also conducted deliveries. Seventeen (80%) of the clusters having doctors in pharmacies reported that menstrual regulation was performed (Table 4).

There was no increased availability of immunizations in pharmacies with doctors compared to pharmacies without doctors. Again, doctors at pharmacies usually reported that they had a refrigerator for the vaccine in their homes, though some locations admitted to having no refrigerator.

Emergency service late at night was reportedly available to 20% of the clusters, and 70% reported that the doctor would make a home visit if there was a serious illness. All were said to charge fees.

Homeopath

Almost all (97%) of the clusters reported homeopathic service providers with homeopathic medicine shops. Most (84%) were within easy walking distance. These rarely provided any service except homeopathic medicine. Five clusters reported knowing female homeopaths. Only 53% of the clusters who knew of homeopaths reported using them frequently, however. Three clusters reported homeopaths who did not have their own medicine shop. These providers wrote prescriptions.

Private Doctors Without Pharmacy

Only 25 clusters reported knowing private doctors that were used by the community, but did not have a pharmacy. These clusters were mostly from Lalbagh and Kotwali *thana*. The doctors were usually described as persons accepting the fee that the slum population could pay. More than half of the doctors (56%) were within an easy walking distance. One female physician provided menstrual regulation and delivery services. People used the private physicians most frequently for receiving prescriptions for curative care.

Most Frequently Used Service Provider

The respondents were asked where the people in the cluster went most often for an indicated service. After the most frequently used service was mentioned, they were asked if any other providers were also used for the same service. The women were then asked to describe other services available at the particular provider mentioned.

Immunization

All clusters reported that they knew places to go for immunization. All sites reported to provide immunizations were verified. Almost half (48%) of the clusters reported either using a facility within an easy walking distance or receiving satellite clinic services on a routine basis. About one-quarter (27%) of the clusters reported that the facility providing immunization services was too far away to reach by walking. A median round-trip rickshaw fare of Tk. 12 (Table 5) was reported necessary to reach these facilities. Only 9% of the immunization services utilized from government sources were from hospital clinics (Table 6).

Table 5. Distance to Most Frequently Used Service Providers for Immunization, by *Thana*

Distance	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Walking	11 (33%)	4 (13%)	35 (46%)	3 (33%)	48 (55%)	101 (42%)
Medium*	9 (27%)	13 (41%)	30 (39%)	3 (33%)	18 (21%)	73 (31%)
Far**	13 (39%)	15 (47%)	12 (16%)	3 (33%)	21 (24%)	64 (27%)

* ≤ Tk. 6 round-trip rickshaw fare.

** > Tk. 6 round-trip rickshaw fare.

Table 6. Most Frequently Used Service Providers for Immunization, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Government	17 (52%)	18 (56%)	74 (96%)	9 (100%)	19 (22%)	137 (58%)
NGO/Private	16 (48%)	14 (44%)	3 (4%)	0	68 (78%)	101 (42%)

Family Planning

As mentioned previously, the majority of clusters reported receiving pills and condoms at the household from home visitors (Table 1). Fifty percent of the clusters women reported people receiving injectable contraceptives from government services, 48% from NGOs; only 2% did not know where the injectable contraceptives were available. There was wide variability regarding the source of injectable contraceptives among *thana*, however (Table 7). Only 29% of the clusters reported that the source of injectable contraceptive was within easy walking distance (Table 8).

Table 7. Most Frequently Used Facilities for Injectable Contraceptives, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Government	8 (24%)	7 (22%)	66 (86%)	4 (44%)	35 (40%)	120 (50%)
NGO/Private	23 (70%)	24 (75%)	11 (14%)	5 (56%)	50 (57%)	113 (48%)
Don't Know	2 (6%)	1 (3%)	0	0	2 (2%)	5 (2%)

Table 8. Distance to Most Frequently Used Facilities for Injectable Contraceptives, by *Thana*

Distance	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Walking	7 (21%)	0	24 (31%)	0	38 (44%)	69 (29%)
Medium*	11 (33%)	9 (28%)	24 (31%)	3 (33%)	13 (15%)	60 (25%)
Far**	13 (39%)	22 (69%)	29 (38%)	6 (67%)	34 (39%)	104 (44%)
Don't know	2 (6%)	1 (3%)	0	0	2 (2%)	5 (2%)

* ≤ Tk. 6 round-trip rickshaw fare.
** > Tk. 6 round-trip rickshaw fare

The women reported that government services were used most often for intra-uterine devices (IUDs), but women in 65% of the clusters reported that a rickshaw ride was required to reach the government sources providing IUDs. Only 11% of the government sources where IUDs were available could be reached within an easy walking distance. Nine clusters (4%) reported not knowing where women could go for IUD services.

Most clusters reported only a few locations where male sterilization was available. These were most often Dhaka Medical College or other major hospitals. Female sterilizations were reported as being performed at special centers or the major referral hospitals[8]. The cluster women also

[8] For female sterilization, women in 33% of the clusters go to Mohammadpur Fertility Center, 22% to Azimpur Maternity Center, 15% to Dhaka Medical College, and 9% to Mitford Hospital for female sterilzation.

reported facilities for sterilization at NGO and government family planning clinics. At these centers, however, the sterilizations are often not actually done; clients are referred to a larger center (most often Dhaka Medical College) for sterilization. Only women in 10 clusters (4%) reported not knowing where women or men could go for sterilization.

Just over half (52%) of the clusters reported knowing where Norplant services were available and many of these wrongly identified centers where they thought Norplant was received. They most often reported the major family planning centers which they used for other types of contraceptive services, but these did not provide Norplant.

Facilities where menstrual regulation (MR) was provided were reported by almost all clusters, but were often wrongly attributed to centers which provide other family planning. Upon verification, the facilities were found to refer clients to other locations for MR or not to provide the service because of restrictions from the donor agency. Government services were most often used for MR, again most likely because of donor restriction on NGO services. Most clusters reported that MR service sources were too far to walk to.

Minor Illnesses

Minor illnesses were described as fever, cough, or common cold. Most cluster women (80%) reported that people went to pharmacies for children with minor illnesses. Fourteen percent of the pharmacies mentioned had private doctors. In Mohammadpur, 32% of the clusters reported using NGO services or other private sources for children with minor illnesses (Table 9). Almost all adults with minor illnesses were reported to use either a pharmacy or a private doctor with a pharmacy (Table 10). Most clusters reported a pharmacy within walking distance (Table 11).

Table 9. Most Frequently Used Facilities for Minor Illness of Children, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Pharmacy	23 (70%)	27 (84%)	59 (77%)	7 (78%)	32 (37%)	148 (62%)
Private Doctor/ Pharmacy with Private Doctor	5 (15%)	2 (6%)	12 (16%)	2 (22%)	11 (13%)	32 (14%)
Homeopath	2 (6%)	3 (9%)	1 (1%)	0	2 (2%)	8 (3%)
Other Private Sources/NGOs	1 (3%)	0	0	0	28 (32%)	29 (13%)
Other Government Sources	2 (6%)	0	5 (7%)	0	14 (16%)	21 (9%)

Table 10. Most Frequently Used Facilities for Minor Illness of Adults, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Pharmacy	26 (79%)	30 (94%)	61 (79%)	7 (78%)	66 (76%)	190 (80%)
Private Doctor/ Pharmacy with Private Doctor	6 (18%)	2 (6%)	12 (16%)	2 (22%)	11 (13%)	33 (14%)
Other Private Sources/NGOs	1 (3%)	0	0	0	7 (8%)	8 (3%)
Other Government Sources	0	0	4 (5%)	0	3 (3%)	7 (3%)

Table 11. Distance to Most Frequently Used Facilities for Minor Illness of Children, by *Thana*

Distance	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Walking	19 (58%)	23 (72%)	74 (96%)	9 (100%)	71 (82%)	196 (82%)
Medium*	12 (36%)	3 (9%)	2 (3%)	0	8 (9%)	25 (11%)
Far**	2 (6%)	6 (19%)	1 (1%)	0	8 (9%)	17 (7%)

* ≤ 6 Taka round-trip rickshaw fare.
** > 6 Taka round-trip rickshaw fare.

Serious Illnesses

A serious illness was described as an injury with much bleeding, difficult breathing, severe pain, high fever, or unconsciousness. For serious illnesses in children it was reported that most are taken to government hospitals, either Shishu (35%) or Dhaka Medical College (32%) (Table 12).

Table 12. Most Frequently Used Facilities for Serious Illness of Children, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Government	30 (91%)	29 (88%)	74 (96%)	9 (100%)	56 (64%)	198 (83%)
Other Private Sources/NGOs	2 (6%)	4 (12%)	1 (1%)	0	7 (8%)	14 (6%)
Pharmacy	1 (3%)	0	0	0	2 (2%)	3 (1%)
Homeopath	0	0	0	0	1 (1%)	1 (<1%)
Private Doctor	0	0	3 (3%)	0	21 (24%)	23 (10%)

For serious illnesses in adults, most reported using government hospitals (Table 13). Dhaka Medical College was reported as used by 47% of the clusters. Other hospitals named by respondents varied depending on geographic proximity to the cluster being surveyed. Only 16% of the clusters reported that the adults go to a private doctor (either with or without a pharmacy attached) for serious illnesses.

Table 13. Most Frequently Used Facilities for Serious Illness of Adults, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Government	31 (94%)	31 (97%)	69 (90%)	9 (100%)	42 (48%)	182 (76%)
Other Private Sources/NGOs	1 (3%)	1 (3%)	0	0	7 (8%)	9 (4%)
Pharmacy	1 (3%)	0	2 (3%)	0	4 (5%)	7 (3%)
Homeopath	0	0	0	0	3 (3%)	3 (1%)
Private Doctor	0	0	6 (8%)	0	31 (36%)	37 (16%)

On an average, over 70% of the clusters reported having to take a rickshaw to get to the facility for serious illness, though this varied substantially by *thana* (Table 14). The median round-trip cost was reported to be Tk. 20, with the average being Tk. 33. Thirty-one clusters (13%) reported that their source for treatment of serious illness would require a round-trip cost of Tk. 60 or more. It was noted that costs were often reported for baby taxis, which are more expensive than rickshaws. Thus, these data cannot be interpreted in terms of actual distance. There was much variation in reports of whether people used rickshaws or baby taxis.

Table 14. Distance to Most Frequently Used Facilities for Serious Illness of Children, by *Thana*

Distance	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Walking	1 (3%)	0	4 (5%)	1 (11%)	41 (47%)	47 (20%)
Medium*	1 (3%)	0	3 (4%)	4 (44%)	7 (8%)	15 (6%)
Far**	31 (94%)	32 (100%)	70 (91%)	4 (44%)	39 (45%)	176 (74%)

* ≤ Tk. 6 round-trip rickshaw fare.
** > Tk. 6 round-trip rickshaw fare.

Almost all clusters knew of special centers for broken bones, with 46% reporting going to *Pongu* (orthopaedic) hospital (in Mohammadpur *thana*) and 37% going to Manda (Demra *thana*), a traditional center for treatment of bone problems.

Normal Deliveries

While most women reported that normal deliveries (those without complications) occur with a *Dai* at the woman's home, there were clusters reporting that women would go to a facility for a normal delivery (Tables 15 & 16). Most of these clusters mentioned a special maternity facility (not a public hospital maternity unit). These special facilities were primarily in Sutrapur (near Red Crescent Maternity Hospital) and Mohammadpur (near Al Falah and Rabita Maternity Services). All clusters reported using the maternity units of hospitals (most often Dhaka Medical College or the nearest hospital with services) for complicated deliveries.

Table 15. Most Frequently Used Facilities for Normal Delivery, by *Thana*

Facilities	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Home/*Dai*	16 (49%)	21 (66%)	62 (81%)	6 (67%)	70 (80%)	175 (73%)
Home/ Relative	8 (24%)	7 (22%)	9 (12%)	1 (11%)	0	25 (11%)
Maternity Center	9 (27%)	2 (6%)	6 (8%)	1 (11%)	16 (18%)	34 (14%)
Other (general hospital, etc.)	0	2 (6%)	0	1 (11%)	1 (1%)	4 (3%)

Table 16. Distance to Most Frequently Used Facilities for Normal Delivery, by *Thana*

Distance	Sutrapur (n=33)	Demra (n=32)	Lalbagh (n=77)	Kotwali (n=9)	Mohammadpur (n=87)	Total (n=238)
Walking	24 (73%)	28 (88%)	71 (92%)	8 (89%)	82 (94%)	213 (89%)
Medium*	1 (3%)	0	1 (1%)	0	2 (2%)	4 (4%)
Far**	8 (24%)	4 (13%)	5 (7%)	1 (11%)	3 (3%)	21 (9%)

* ≤ 6 Taka round-trip rickshaw fare.
** > 6 Taka round-trip rickshaw fare.

Discussion

Home Visitors

Most home-visiting services were provided by NGOs; the most common service provided was family planning (distribution of condoms and oral contraceptives). Women from almost 80% of the clusters knew of a home visitor coming regularly to their neighborhoods at least every three months; women from 16% of the clusters reported receiving either no home visitor or only a visitor every six months, usually for distribution of vitamin A.

There is scope to review the allocation of target areas to different NGOs or government centers to see where and why coverage gaps are occurring. Most of the clusters reporting no home visitor were in Sutrapur, with two in Kotwali and one in Demra. The clusters which reported receiving home visitors only every six months were in Mohammadpur (18 clusters) and Demra (2 clusters).

The reported frequency of household visits by cluster women was not the same as that reported by organizations in all cases. Many clusters reported receiving services every three months, while the service organization reported visits every two months.

There may be several reasons for the discrepancies in the reporting of services received and the reporting of frequency of visits. The survey was conducted in clusters of households within slum areas. While these clusters are in the working area for NGOs or government clinics, in reality, pockets of households may be missed. It is also possible that the field worker may not visit particular households known by the women being interviewed, or

they visit but are not known as health workers. There may also be gaps in the regularity of service provision due to vacations, sickness of workers, or poor performance. These discrepancies need further investigation before conclusions can be drawn regarding either community awareness of service or services available.

None of the women in clusters surveyed indicated that they knew of government outreach for injectable contraceptives, yet this is a service provided through satellite clinics which operate from the government fixed clinics either weekly or biweekly. Anecdotal information was gathered from several government Family Welfare Visitors (FWV) to try to understand this lack of reported activity. One FWV stated that people only came to her satellite clinic for medicines (there should be a basic medicine supply at the satellite clinic), but she had been out of medicines for the past two months so had not held her satellite clinic. Other FWVs indicated the same trouble with medicines, reporting that they often ended up with only supplies of iron tablets and metronidazole in their medical kits. They did report, however, that they continued to make their field visits regularly. The FWVs indicated that there was normally no shortage of family planning supplies. They stated that women preferred oral contraceptives over injectables, and showed patient records which supported that oral contraceptives were being distributed from satellite clinics more than injectable contraceptives. The fact that government satellite clinics were not mentioned as a source for injectable contraceptives during the interviews, may indicate a lack of awareness on the part of the cluster women that the injectables were available from the government satellite clinic operation.

Of the 51 clusters in which women reported that they did not receive door-to-door contraceptive services, 67% reported that pills and condoms were available within an easy walking distance (either pharmacies or clinics), 14% reported the availability at a medium distance (≤ Tk. 6 round-trip by

rickshaw). Only 18% of these 51 clusters, or 4% of all clusters (n=238), reported that pills and condoms were only available from sources a "far" distance away (i.e. a rickshaw would cost >Tk. 6; median cost round-trip being Tk. 10).

During the most part of 1992, there was a shortage of vitamin A for household distribution as reported by the NGOs. A gap in either distribution or supply is reflected in the low percentage of clusters reported as receiving vitamin A door-to-door in Sutrapur and Demra.

Traditional Healers

Almost all clusters knew of a *Dai* (traditional birth attendant) within a walking distance. A little more than half of these *Dais* also provided some type of antenatal visit "if requested." For normal deliveries, the *Dais* were reported to be used most often. Information was sought on whether the *Dais* were trained or not, but the majority of women being interviewed did not know.

The services provided by *Fakirs* and *Kobirajs* were not specific to their title. There was a trend toward a larger percentage of the *Fakirs* providing spiritual treatment and a larger percentage of the *Kobirajs* providing herbal medicine, but there was much overlap in the types of services provided. The *Fakirs* were reported to be available in a higher percentage of the clusters than were *Kobirajs*. Female *Fakirs* and *Kobirajs* were not uncommon: 20-30% of the clusters with herbal or spiritual healers reported knowing female healers.

Thus, the use of traditional healers for traditional services remains high in the urban slums of Dhaka. It is not known whether the use of herbal medicine is less than that of in rural areas. It would be interesting to know if patterns of use of herbal medicine are changing with urbanization and closer access to more allopathic health services.

Pharmacies, Private Doctors, and Homeopaths

Almost all clusters had a pharmacy within an easy walking distance. Some of the pharmacies were staffed by doctors, some only by pharmacists or compounders. There was no cluster which did not know of a pharmacy. Only 5 clusters (2%) reported that there was no pharmacy within an easy walking distance. Of these 5 clusters, 4 had pharmacies which required more than a Tk. 6 round-trip rickshaw fare to reach. Pills, condoms, and basic curative medicines were readily available from pharmacies. Only 20% of the clusters having a pharmacy and/or doctor reported the availability of a female pharmacist or a doctor.

It appears from this survey that most clusters have an easy access to medicines, either through a pharmacist or a doctor with a pharmacy attached. There was only one cluster in Sutrapur which was isolated and reported no home visitor and no pharmacy or doctor within a medium distance.

Women's knowledge of the services available at the pharmacy varied. Many women stated that they did not know about different services available, often because they did not use the pharmacy. Often the husband or other male relatives went to the pharmacies for needed medicines. Six clusters (3%) reported that oral contraceptives and condoms were not available at a pharmacy mentioned, but it was verified that these items were, in fact, available from that pharmacy. These clusters either received their

contraceptives door-to-door, or had an NGO clinic nearby which supplied pills and condoms.

The immunization services available at pharmacies should be evaluated for the quality of vaccine and the maintenance of the cold chain. Though many pharmacies may be providing a good service, the comments about refrigerators raise questions regarding the maintenance of the cold chain.

Most Frequently Used Service Providers

There were many reports from the cluster women of not knowing the specific services available at facilities they mentioned. As expected, the tendency was to know the specific services which were used at a facility , and not to know about other services at the same facility. For example, women from many clusters erroneously reported a lack of family planning services, or not knowing what family planning services were available at hospitals which were far away and were reported usually only used for serious illness. Most of the women from these clusters reported receiving family planning services from clinics near their homes.

There were several NGOs or charitable institute services in Sutrapur providing local clinic services which were not mentioned by women in these clusters. Facility visits were made to verify services and to try to understand why these services were not reported. The lack of reporting of these facilities may reflect either lack of use, or low perception of the significance of the service.

While the actual utilization of the existing but not mentioned service providers needs further investigation, there are special circumstances which

might account for these discrepancies. Several of the clinics which were not mentioned by the clusters are considered to be "religiously affiliated." One service site primarily serves Hindus. The others are Christian-sponsored but provide service to people of all religions. Long waiting periods are also common as these centers provide medicines and focus on the very poor.

While the USS clusters in the survey are considered slum households, they are not the poorest, (ie. such as the "floating" population who live on pavements rather than in defined slum areas). Thus, it may be that the cluster populations prefer to pay a pharmacy rather than spend long hours at a clinic. The clinics which were mentioned either did not provide services during normal clinic hours or had registration requirements that make getting care inconvenient and time-consuming (e.g. one is open 3-7 pm, another is open only one day per week; one requires registration in the morning and provides service in the afternoon). One of the clinics has a male doctor providing services. The women said that they do not like this, especially when there are alternatives nearby.

Information was sought on some of the clinics providing curative care to gain a better understanding of factors which might be related to use or non-use. Several government clinics were mentioned in particular as those used for curative care for minor illnesses. One explanation given for the popularity of the clinics was that medicines were usually available. When two of the most commonly mentioned facilities were visited, we found that there were medicines available. Anecdotal comments from people at the clinics also indicated that the community people respected the particular staff person who was diagnosing and prescribing for the patients.

Other anecdotal comments indicated that the practice at some of the clinics (both government and NGO) was to write prescriptions which the patient would purchase from a pharmacy because the supply or type of

medicine required was not regular. While some clusters indicated that the slum populations would go to government clinics even if medicines were not available, the large percentage reported going directly to pharmacies first before considering other options.

Analysis of most frequently used service providers, by *thana,* showed a larger percentage of clusters reporting use of private or NGO services in Mohammadpur than in other *thanas.* Women in Mohammadpur clusters reported greater access to more comprehensive clinic services. Organizations such as Rabita, New Life Center, and Al Falah, all have centers in Mohammadpur. They routinely operate clinics with physicians who provide common medicines and basic treatment. The Community Health Care Project has outreach which provides basic treatment for common illnesses and has a referral clinic in Mirpur with a doctor. In addition, World Vision has a large Child Sponsorship Program which offers medical treatment for sponsored children, many of whom live in the cluster areas which were surveyed. Through their Child Survival Program, World Vision also operates clinics which provide treatment for minor illnesses. While there are NGO clinics in other *thana,* they receive clients referred to by the outreach workers primarily for family planning, antenatal care or immunization. Their curative component is small and doctors are not always available.

While many of the differences in reported utilization of health providers and facilities between *thana* can be explained by looking at distance, some, such as the increased reported reliance on private physicians for serious illness in Mohammadpur and the lack of reporting of charity clinics in Sutrapur, cannot be explained by geographic availability or even by price. The least expensive or nearest service was not always the one reported by the cluster women as used by the population.

The geographic proximity of immunization and non-surgical family planning services are, by objective measures of geographic proximity and official cost, convenient and accessible to most cluster populations. Yet the contraceptive prevalence rate (modern methods) in the urban slums is estimated at 31% (7) and the immunization rate of children for oral polio and DPT (three injections) range from 40 to 50% (8). Many of the immunization and family planning centers provide curative services as well, yet pharmacies are the location of first resort for most minor illnesses. Thus, prior to initiating additional service activities it is important to have a better understanding of why the existing services have not been used.

Anecdotal information suggested dissatisfaction with services (e.g. unexpected charges, long waiting time, absence of staff, poor attitude of staff, non-availability of basic medicines) as relevant factors in whether a service (either government, NGO, or private) is used or not. These factors have been cited in studies of health service utilization in other locations as well (9).

The lack of reporting of injectable contraceptives from satellite clinics may be indicative of a lack of active counseling regarding this method of family planning. Several clusters which reported receiving door-to-door pills and condoms also reported that women most often received their supply from the pharmacy or from a nearby clinic. Discussion with slum women indicated that this reporting may be true. Some women indicated that they knew women who preferred the brand of pill offered at a pharmacy. When asked why they were willing to pay for an item that was otherwise available free from the government or at less cost from the NGO, they could give no specific answer except "preference" and belief in a better quality.

Anecdotal comments from slum women, specifically regarding family planning, indicate uncertainty about the normal side-effects, complications,

and pros and cons of the various methods of contraception offered which they have cited as reasons for not accepting services. These factors might indicate that it is time to address the quality of service more actively.

The high number of cluster women who reported going to a pharmacist first for minor illness for their children or for adults points to the need to look at the actual practices of the population when planning services and training. An evaluation of the most common illnesses treated by pharmacists or compounders, and their practices would indicate areas where selective intervention to change practices (including promoting referrals to qualified medical personnel) might result in improved medical care.

The gaps in knowledge of services available from various providers when the cluster does not normally use the provider for that particular service is not surprising. The same results would be expected in surveys of wealthier or better educated populations. It does serve as a reminder, however, of the need to publicize the availability of services and promote specific service characteristics that might increase utilization (e.g. availability of female doctors, hours when services are offered, official fees).

Further studies on the impact of factors such as easy access, cost, and perceived quality of service and how the interaction of these factors impact on actual utilization of services by poor populations might inform health planners about how to change current health service strategies to be more cost-effective and efficient (e.g. high, but appropriate utilization). The verification of location and actual services available should assist health planners in identifying gaps in the availability of basic service facilities. More in-depth studies to understand why and when certain providers are chosen are necessary to enable planners to provide services which are available geographically and financially, and actually used.

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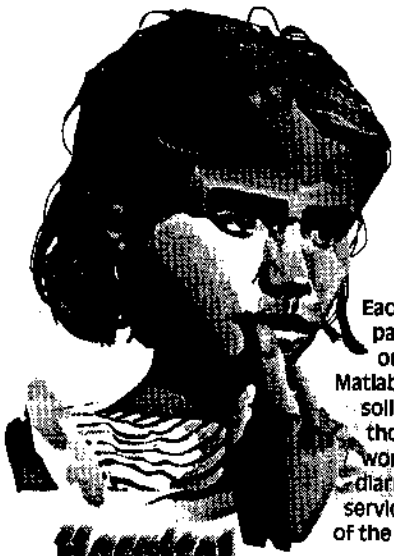

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