

The Quality of Care Provided at Union Health and Family Welfare Centres in Bangladesh: Clients' Perspectives

*IEC materials focusing on reproductive
health need to be improved and the technical
competence of paramedics enhanced*

**By Parveen A. Khanum, Helene Wirzba, Indrani Haque,
Tanjina Mirza and Therese Juncker***

The Government of Bangladesh attempts to provide reproductive health services that emphasize maternal and child health (MCH) and family

* Parveen A. Khanum, Operations Researcher; Helene Wirzba, former Consultant; Indrani Haque, Programme Analyst; Tanjina Mirza, Coordinator on Injectables; Therese Juncker, former Health Scientist, all of whom are or were working with the Operations Research Project, International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), G.P.O. Box 128, Dhaka 1000, Bangladesh. Any correspondence concerning this article may be directed to the first author at the following email address: parveen@icddr.org or fax (880)-2-881-1568.

planning at different service delivery tiers through a variety of service providers. For this purpose, it has established an extensive network of reproductive health services that reaches almost every village in the country. Female field workers, known as family welfare assistants (FWAs), work at the grassroots level and provide information and counselling on various aspects of reproductive health and refer clients when necessary to clinics. They also distribute oral contraceptives and condoms at the homes of married women of reproductive age, identify pregnant women and refer them to static points of service delivery, i.e. health and family welfare centres, for ante-natal care and for obtaining clinical contraceptives.

The country's maternal and child health programme was launched in the 1950s with the provision of obstetrical care in urban-based hospitals. Under this programme, mother and child welfare centres, run by paramedics, were established in the late 1950s. However, it was soon evident that those centres, numbering about 95, at the *thana* (subdistrict) health complexes (hospitals) were not covering sufficiently well the population living in rural areas. Therefore, to ensure continuous and sustained delivery of primary health care to mothers and children, the government established static MCH and family planning (MCH-FP) service centres at the union level (a union is composed of a group of villages). Eventually, these centres came to be known as health and family welfare centres (FWCs).

These centres are the focal point for providing MCH and clinical contraceptive services to the population of a union. Each centre covers, on average, a population of about 24,000. They are staffed by two paramedics: a female, known as the family welfare visitor (FWV), and a male, known as the medical assistant (MA). The female paramedic receives 18 months of basic training in maternal and child health and family planning and periodic refresher courses. FWVs are supposed to give health education, provide care to pregnant and post-partum women, treat mothers and children suffering from minor ailments, and offer family planning services. FWVs also organize satellite clinics twice a week at various sites within each union. The tasks of the medical assistant are to treat minor diseases irrespective of the age and sex of patients, refer serious cases to clinics and provide surgical first aid. They also have to conduct health education sessions in schools and other public places twice a week (ICDDR,B, 1991). MAs receive basic medical training for a period of three years.

Several studies (Ali and others, 1988; Sabur and Hug, 1989; Ahmed and others, 1994; Juncker, 1994; Wirzba and Juncker, 1995) have been

carried out to assess the role of FWCs in the country's MCH-FP programme. Most of these studies have shown that, although the rural population is aware of the existence of FWCs, relatively few people actually use the services. Further, a majority of the recipients of FWC services do not have a clear idea about the MCH-FP services provided through these centres. Most consider the centres to be only for family planning services. Others feel that the FWCs are mainly for child care and the treatment of minor diseases of women. Sabur and Hug (1989) reported that women who knew about the types of services available were more likely to use the services than those without such knowledge. A review of the above-mentioned studies also revealed that the services offered at FWCs are underutilized. Describing the characteristics of those who do use the FWCs, the studies concluded that users comprise mostly clients who live close to an FWC and come from the poorer and less educated sections of the community. Further, the studies found that the FWCs were involved mainly in the provision of health care services to women and their young children.

Irregular attendance by the paramedics, ineffective treatment, inadequate supplies of drugs and unsatisfactory behaviour of the members of the staff have been attributed to the low utilization of these centres, but very little has been mentioned about the clients' perceptions of the knowledge of FWC staff and the quality of their services. However, if the clients themselves continue to be unaware of the types of services offered or are dissatisfied with the quality of those services, increasing the efficiency of service delivery and the FWCs, improving the competence of the service providers and ensuring the availability of drugs would all be ineffective in increasing the utilization of FWC services.

This study was undertaken because it is important to know how much the clients attending the FWCs know about the types of services available, how they assess the quality of the services being offered and whether they leave the centres feeling satisfied or dissatisfied. The assessment of the users' knowledge and their perceptions about the quality of services provided was obtained through "exit interviews" and the use of a simple framework (Bruce, 1990) to measure those perceptions. The overall objective of the study was to examine service delivery at the FWCs from the clients' perspective and to make recommendations for improving the quality of care and thus increase the use of the reproductive health services available in Bangladesh, as called for by the Programme of Action adopted by the 1994 International Conference on Population and Development.

Methodology

A cross-sectional exploratory study was designed to determine the use of services and the quality of the services offered at union FWCs from the users' perspective. Two rural subdistricts, namely, Abhoynagar in Jessore District and Sirajganj *Sadar* (Headquarters) in Sirajganj Subdistrict, were selected. These two areas are field sites of the Maternal and Child Health and Family Planning (MCH-FP) Extension Project (Rural) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). According to the 1991 census, the estimated population in Sirajganj was around 389,160 and in Abhoynagar about 210,000. The literacy rate in Sirajganj was 27 per cent, with female literacy being 20.2 per cent, which was lower than the national average of 32.4 per cent for that year. In Abhoynagar, the literacy rate was slightly higher than the national average (BBS, 1992). In Sirajganj, the majority of the labour force work in small weaving factories and in agriculture; the majority of households own no arable land. In Abhoynagar, a sizeable proportion of the labour force work in mills and factories. In 1992, the contraceptive prevalence rates were around 48 per cent in Abhoynagar and 40 per cent in Sirajganj (Mozumder and others, 1994). Government health care facilities provide the same services in both areas. To ensure normal working conditions and an adequate supply of equipment and drugs, only fully constructed FWCs were selected. Six of the eight unions of Abhoynagar Subdistrict and seven of the 11 unions of Sirajganj Subdistrict met those criteria. (Two *Sadar* FWCs located in urban areas were excluded, because the data may not be representative of a rural setting.)

A total of 650 clients were interviewed for the study, i.e. 50 from each FWC. Every fifth client was interviewed once he or she was ready to leave the centre, regardless of who provided the treatment, i.e. the FWV or MA. If the fifth person leaving the centre was unwilling to be interviewed, then the sixth or seventh person would be interviewed. If the client was a child, his or her attendant was selected as the respondent. If the respondent received services for himself or herself as well as for one or more of his or her children, information was collected from all of them, but was considered as a single record. To reduce recall bias, the women who had received services from the FWC that day were interviewed immediately after they had received the services. A structured questionnaire was designed with both open- and close-ended questions. This was pre-tested and necessary adjustments were made based on the results of the pre-test. Information on selected indicators was also collected from the daily record-keeping registers of the FWCs.

Table 1. Presence of paramedics at health and family welfare centres during the days of data collection, Bangladesh

Presence of providers	Number of days interviews conducted		
	Abhoynagar	Sirajganj	Total
	52 days (%)	82 days (%)	82 days (%)
Family welfare visitor and medical assistant	21.1	23.3	22.0
Only family welfare visitor	32.7	33.3	32.9
Only medical assistant	36.5	43.3	39.0
No providers	9.6	0.0	6.1

The interviews were conducted by four senior field research assistants, previously designated as lady family planning visitors. All of them had the same educational and work background as senior FWCs and were well trained in the techniques of data collection; they had conducted several interviews previously. Analysis was carried out using the SAS statistical software package. The presence of service providers at the FWCs was observed during the interview days (table 1). Over 90 per cent of the time at least one paramedic was present. The main reasons for the absence of paramedics were their attendance at satellite clinics, vacant positions, maternity leave, official and unofficial leave, and collection of supplies at subdistrict offices.

It should be mentioned that this study considered only those women who used the FWC services during the days when the interviews were carried out. There was no attempt to collect information from past users and non-users of the FWC. Thus, this study has the limitation of presenting only the FWC users' opinions regarding the services received.

Results

Background characteristics of respondents

The majority of the respondents in Abhoynagar were in the age group 20-25, while in Sirajganj most respondents were aged between 25 and 30 years (figure 1).

Almost two thirds of the respondents (63 per cent) in Abhoynagar and 79 per cent in Sirajganj never attended school. Those with a primary education (1-5 years of schooling) accounted for 22 and 14 per cent of the respondents in Abhoynagar and Sirajganj respectively; very few had any secondary education (figure 2).

Figure 1. Age of respondents by subdistrict, Bangladesh

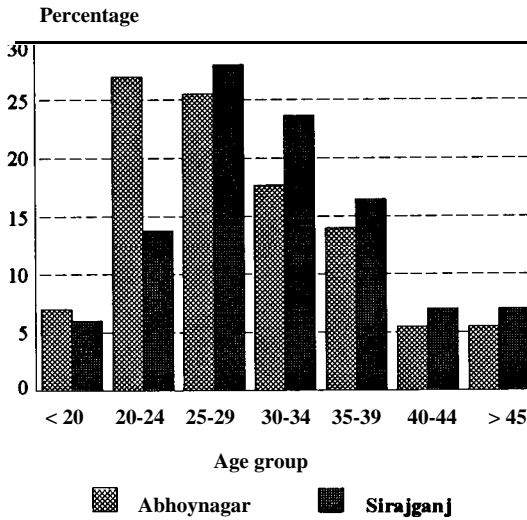


Figure 2. Years of schooling by subdistrict, Bangladesh

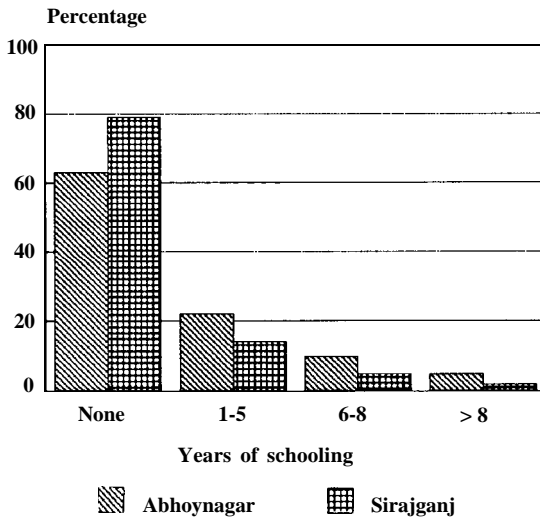
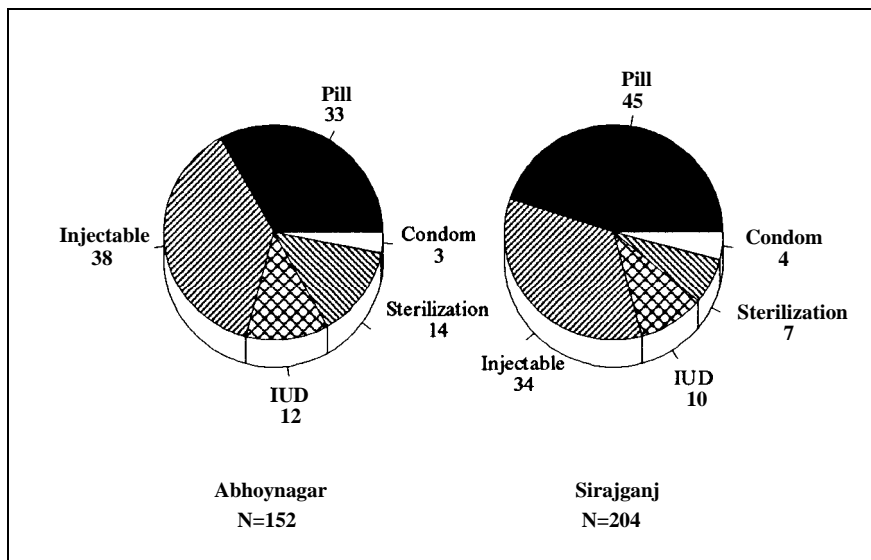


Figure 3. Percentage of family planning method-mix by subdistrict, Bangladesh



More than 90 per cent of the respondents were married and had had 2-3 pregnancies. The majority of them lived very close to the FWC. Over half of the recipients were users of modern contraceptive methods. The respondents in Abhoynagar were more likely to be using long-term methods, whereas the clients in Sirajganj had a tendency to use short-term methods. [Figure 3](#) shows the distribution of contraceptive use by area.

Knowledge of services offered

In this study, knowledge refers to the respondents' ability to mention different types of services offered at the FWC known to them. Findings show that, even without prompting, 83 per cent of the respondents knew about the curative services offered at FWCs, and over 50 per cent of them were aware of family planning and child care services (treatment of minor illnesses, provision of advice etc.). When respondents were prompted for more information, more than 90 per cent mentioned curative care for women and children, antenatal care and family planning services. Respondents' knowledge of menstrual regulation and post-natal care was found to be poor even with prompting ([table 2](#)).

Table 2. Percentage of respondents aware of services offered at FWCs, Bangladesh

Service	Respondents (N = 650)	
	Without prompting	After prompting
Curative care	83.1	92.9
Ante-natal care	20.1	93.3
Post-natal care	1.2	72.6
Family planning	56.8	95.0
Child care	53.2	97.4
Expanded programme on immunization	5.5	71.7
Health education	1.4	52.5
Deliveries	0.3	17.5
Menstrual regulation	1.1	28.8

The respondents' knowledge of the services offered at the FWCs was checked along with their level of education; the results are presented in table 3. Since EPI (expanded programme on immunization), health education, delivery and menstrual regulation represent a very small percentage of cases, those responses are not presented here. Except for knowledge of the necessity of ante-natal care, no significant difference in knowledge was found among the respondents with different education levels. Women having some education were more likely to have more knowledge about the care required during pregnancy.

Table 3. Percentage of respondents' awareness of services offered at FWCs in Bangladesh by level of education

Service	No education	Years of schooling	
		1-5 years	> 5 years
General treatment			
Yes	71.3	18.9	9.7
No	74.4	11.9	13.7
Ante-natal care^a			
Yes	58.8	28.2	12.9
No	75.1	15.3	9.8
Post-natal 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

^a p value = .0001

Table 4. Reasons for seeking services at health and family welfare centres, Bangladesh

Reasons given	Respondents' reason N = 650 (%)
Curative care for woman herself	68.2
Curative care for children	51.1
Ante-natal care	8.3
Post-natal care	0.5
Seeking new family planning method	2.0
Seeking family planning supplies	1.2
Suffering from family planning complications	3.1
Immunization	1.5
Menstrual regulation	0.5

Note: More than one response was accepted.

Reasons for seeking services

The respondents were asked what kind of services they had received from the FWC on the day of the interview. They were allowed to give more than one answer. The findings are presented in table 4. General curative care for personal illness (68 per cent) and child care (51 per cent) were the most common reasons mentioned for seeking services, which suggests that the respondents regarded the FWC as a health centre where they could obtain general health care services. A negligible percentage of the respondents visited the FWCs for reproductive health services such as ante-natal care (8 per cent) and post-natal care (0.5 per cent) with only 6 per cent seeking family planning services (table 4).

Investigation was carried out on the types of multiple services received. It was found that more than two thirds (70 per cent) of the clients came for a single specific reason: treatment of a personal illness, or the illness of a child, or immunization of a child; 30 per cent of them came for treatment of both a personal illness and child care. Analysis of the data to determine the combination of general health care and reproductive health services which clients were seeking produced the following results: general care combined with ante-natal care (1.4 per cent), general care combined with post-natal care (0.2 per cent) and general care combined with family planning services (1.2 per cent). This outcome indicates the degree of under-utilization of reproductive health care services at the FWCs, even though the centres are equipped to offer these services.

Table 5. Number of new family planning acceptors, by method sought and received at FWCs, Bangladesh

	Family planning method	
	Method wanted	Method received
Pill	0	1
Injectable	6	6
IUD	7	6

Family planning services

The respondents coming to the FWCs for family planning services, including new acceptors and current users coming for supplies or for management of family planning complications, represented only 6.3 per cent of all clients. There were 13 new acceptors: 10 in Abhoynagar and three in Sirajganj. Table 5 shows a comparison of the methods chosen by the new acceptors and the methods received. Twelve of the 13 respondents (92.3 per cent) received the method of their choice.

Eight respondents (1.2 per cent) were family planning acceptors seeking additional supplies; five of them (1.7 per cent) came from Abhoynagar and three (0.9 per cent) from Sirajganj. Supplies included oral contraceptives for three respondents, injectable contraceptives for two and condoms for three.

Nineteen family planning acceptors (3.1 per cent) were suffering from complications and came to the FWCs for reproductive health services. Table 6 lists the method-related complications. Over half of the

Table 6. Complications by family planning method used in Bangladesh

Method	Complication	Number 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

complications listed in [table 6](#) are related to the use of IUDs and about one third to injectables; bleeding was reported as a major complication. Of the 19 respondents seeking medical attention for complications, 16 received drugs and three received counselling only. Although 16 of the 19 were willing to continue with the same family planning method, three dropped the method.

Health education activities

Although health education in a group setting would be expected to be a normal component of everyday activity at FWCs, the practice was observed only four times in Abhoynagar: three times in one union and once in another. While group health education was almost non-existent in Sirajganj, about 70 per cent of the respondents said that they got individual health education which was easy for them to understand.

Complaints recorded

A total of 403 complaints were recorded in Abhoynagar and 583 in Sirajganj from the FWCs' record-keeping register. The term "complaint" refers to whatever the paramedics recorded, which includes symptoms, syndromes or diagnosis of a particular case; the term refers to the illness of the mother, or her children, or both. The average number of complaints was 1.6 per respondent. The five most common complaints accounted for 70 per cent of all complaints: weakness/malnutrition, diarrhoeal diseases, fever, skin problems and intestinal parasites. The next most frequent complaints included respiratory problems, gynaecological and obstetrical problems, and ear, nose and throat complaints.

Drugs received

When respondents were asked whether they received any drugs, 93 per cent of them said that they received one or more types of drug; the remaining respondents received a prescription. When asked about the persons for whom the drugs had been dispensed, 45 per cent of the respondents said that the drugs were for themselves, 30 per cent for themselves and their children, 24 per cent for their children only, and 1 per cent for their spouse.

Access to chosen service provider

The respondents were asked to name the person from whom they had hoped to receive services and the paramedic who actually provided the

Table 7. Percentage of clients receiving services from health care provider of their choice, Bangladesh

	Health care providers			Number
	Family welfare visitor (%)	Medical assistant (%)	Anyone (%)	
Respondents' request for provider	49.4	29.8	20.8	650
Actual service provider	47.7	52.3	–	650

consultation and/or services. Table 7 shows the percentage of clients who received services from the provider of their choice. Nearly half of the respondents selected the family welfare visitors who actually provided the services for them. Medical assistants were selected by only 30 per cent of the respondents, but provided half of the services. It is worth mentioning that more than one fifth of the respondents did not have any choice of provider, and consulted with whomever was available.

Perception of quality of services

To understand the clients' perceptions regarding the quality of services received at the FWCs on interview days, they were asked various questions. In this regard, enquiries were made to determine specific indicators of the quality of care, such as the users' opinion of the services they received, clinical examination carried out, drugs received, counselling, behaviour of the staff members, waiting time, privacy and overall quality of treatment. However, no attempts were made to assess the actual quality of the services provided at the FWCs. The results presented here describe only what the users said they felt about the FWC services. The respondents were asked to give their opinion on the services they received. Thus, because the responses were subjective, they should be viewed with caution. For example, waiting time was considered very good by those who enjoyed talking with other clients, but too long for those who had other activities planned for the day. Clients who received a limited number of tablets were not satisfied with the availability of drugs, whereas those who were given relatively large quantities of tablets did not complain.

Since the respondents were from two different subdistricts and it would be interesting to know their perceptions of the services they had received on that day, the findings are presented by subdistrict. In Abhoynagar, more than three quarters of the respondents said that they

Table 8. Respondents' opinion about the quality of services received, by selected variables, Abhoynagar Subdistrict, Bangladesh

Indicators of quality of services	Percentage of respondents N = 300		
	Yes	No	No opinion
Expected services were provided	77.4	22.6	–
Clinical examination was good	45.0	36.2	18.8
Drugs were available	57.9	29.6	12.5
Counselling was good	74.2	18.7	7.1
Staff were well behaved	91.5	8.2	.3
Waiting time was satisfactory	76.9	22.1	1
Privacy was respected	85.4	13.9	.7
Treatment provided was good	80.4	5.4	14.2

were satisfied with the services provided, the waiting time, the behaviour of the members of the staff and their respect for the clients' privacy, and the treatment provided. However, over half of the respondents were not happy or did not give any opinion about the clinical examination. The provision of drugs was identified as a weak point by 40 per cent of the respondents (table 8).

The respondents' opinions of the quality of services they had received were investigated and compared with their level of education (table 9). The respondents who did not have any opinion about the quality of the services they had received were excluded from the analysis.

No significant differences were found between the respondents' opinions regarding the quality of services and their level of education, except with regard to counselling and the quality of treatment received, the expectations about which varied according to the education level of the respondents.

Table 10 shows that more than 90 per cent of the women in Sirajganj were happy with their expected services and were satisfied with staff behaviour, waiting time, privacy and the quality of treatment. The only service that was not appreciated, however, was the clinical examination, i.e. 40 per cent of the respondents were dissatisfied. About 20 per cent of the respondents expected more drugs to be provided. Although 65 per cent were satisfied with the information given, i.e. counselling, the rest of the respondents did not receive their desired level of attention from the health care providers (table 10).

Table 9. Respondents' opinion, by education, Abhoynagar Subdistrict, Bangladesh

Indicators	Years of schooling		
	No education (%)	1-5 years (%)	> 5 years (%)
Expected services were provided			
Yes	63.7	21.8	14.4
No	62.1	22.7	15.2
Clinical examination was good			
Yes	62.1	20.9	16.4
No	66.5	23.8	10.6
Drugs were available			
Yes	65.5	18.9	15.5
No	60.2	26.1	13.6
Counselling was good^a			
Yes	59.3	24.4	16.3
No	71.9	17.5	10.5
Staff were well behaved			
Yes	62.0	22.6	5.3
No	76.0	16.0	8.0
Waiting time was satisfactory			
Yes	61.9	21.21	16.8
No	68.2	25.76	6.6
Privacy was respected			
Yes	63.6	21.7	14.7
No	55.0	27.5	17.5
Treatment provided was good^b			
Yes	59.3	23.7	17.0
No	81.3	18.8	-

^a P = 0.014

^b P = 0.048

The quality of services perceived by the respondents is presented by education level in [table 11](#). In Sirajganj, no significant difference was found between the respondents' level of education and the perceived quality of services received at the FWCs.

The fact that the clients in Abhoynagar were much less satisfied with the services provided, except for counselling, than the clients in Sirajganj could mean that the service providers in Abhoynagar were not as qualified as their counterparts in Sirajganj, or that the respondents in Abhoynagar had higher expectations about the services. It could also be that the women in Abhoynagar are better educated and of a different socio-economic status than the respondents in Sirajganj.

Table 10. Respondents' opinion about the quality of services received, by selected variables, Sirajganj Subdistrict, Bangladesh

Indicators of quality of services	Percentage of respondents N = 350		
	Yes	No	No opinion
Expected services were provided	90.0	10.0	–
Clinical examination was good	59.5	38.7	1.8
Drugs were available	80.4	18.7	.9
Counselling was good	65.2	32.7	2.1
Staff were well behaved	96.2	3.5	.3
Waiting time was satisfactory	91.0	8.5	.5
Privacy was respected	94.0	5.3	.7
Treatment provided was good	94.0	5.3	.7

Discussion

Six hundred and fifty respondents, mainly female, were interviewed about their perceptions of the services offered at the union health and family welfare centres. Their responses were analysed with a view to formulating recommendations that would result in improvements in the quality of care and increased use of the services offered at such centres.

Knowledge of services offered

As in previous studies (Sabur and Hug, 1989; Ahmad and others, 1994) the majority of the respondents were aware of the curative care for women and children offered by the FWCs. However, few mentioned family planning services, and antenatal and postnatal care. Almost none of them talked about the delivery of babies. The findings of the present study are similar with regard to women's knowledge about the services offered at the FWC level, which indicates that the respondents were not fully aware of the aforementioned reproductive health care services offered and did not make use of them. An evaluation of the performance of field workers shows that they gave emphasis to family planning activities at the door-step and somewhat less importance to maternal health care services (Farida, 1987). Thus, there is a need for IEC (information, education and communication) activities focusing on clients' reproductive health needs and the types of related services offered at these centres. Field workers as well as the paramedics could play an important role in educating rural women and their families about the types of health services that are available. They could emphasize the importance of reproductive health care services and motivate people of reproductive age to use these services.

**Table 11. Respondents' opinion, by education,
Sirajganj Subdistrict, Bangladesh**

	Education		
	None (%)	1-5 years (%)	>5 years (%)
Expected services were provided			
Yes	90.4	9.6	—
No	89.6	10.4	—
Clinical examination was good			
Yes	58.2	39.7	2.1
No	60.7	37.8	1.5
Drugs were available			
Yes	78.1	20.5	1.4
No	82.6	16.9	0.5
Counselling was good			
Yes	63.7	34.2	2.1
No	66.7	31.3	2.0
Staff were well behaved			
Yes	95.9	3.4	0.7
No	96.5	3.5	—
Waiting time was satisfactory			
Yes	91.8	7.5	0.7
No	90.0	9.5	0.5
Privacy was respected			
Yes	94.5	4.1	1.4
No	93.5	6.5	—
Treatment provided was good			
Yes	94.5	4.1	1.4
No	93.5	6.5	—

Reasons for coming to FWCs and services received

A number of studies reviewed (Wirzba and Juncker, 1995; Sabur and Hug 1989; Juncker, 1994) showed that curative services comprised the main activity of the health care providers working at FWCs. While the majority of respondents mentioned personal illness or child care as the reasons for visiting the FWCs, the utilization of reproductive health care services such as family planning and antenatal care of pregnant women was low, i.e. only 15 per cent of the women sought such services. There may be several reasons for this situation; for example, rural women may not feel any need for such care, socio-cultural factors may inhibit them from seeking

such care outside their home, or they may not be aware of the availability of such services at FWCs. An evaluation of the services offered at the FWCs was conducted in five subdistricts (Rahman and others, 1996); it covered both the users and non-users of the FWCs. The evaluation found that reproductive health services were poorly used. Similar findings were also reported in another study conducted in two rural subdistricts of Bangladesh (Juncker, 1994). Evaluations of MCH-FP programmes showed that the majority of users of FWCs complained of diarrhoeal diseases, intestinal parasites and scabies (Ali and others; Rahman, 1989). However, it is recommended that a retrospective study be carried out in the future to determine the precise reasons for low use of reproductive health services.

Although a high proportion of the respondents were users of family planning methods, very few of them came to the FWCs for family planning-related purposes. The provision of family planning services, especially for new users and for supplying current users, was negligible. This situation suggests that the respondents do not depend on the FWC for their family planning needs, particularly for temporary contraceptive methods such as pills and condoms, as they may receive supplies at home, or buy them from a pharmacy. It could be that the service providers were not capable of screening clients properly for IUD insertion, which may be one of the reasons for discontinuation of this method. Similar findings were reported in the 1993/94 Bangladesh Demographic and Health Survey (NIPORT, 1995) and an annual IUD evaluation report (Kamal and others, 1992). Thus, the technical competence of the service providers needs to be improved through proper skills development training, particularly for inserting IUDs. Special emphasis should be given to screening and counselling clients in order to reduce the discontinuation of methods.

Perception of services

An overwhelming majority of the respondents were satisfied with the quality of care offered at the FWCs. Services that were perceived as poor by respondents include counselling and clinical examination. In Abhoynagar, the respondents said that they were not satisfied with the provision of drugs. The respondents considered the services offered by medical assistants and family welfare visitors to be equal in quality. They were generally satisfied with the behaviour of the staff, which suggests that respondents who had been received cordially by clinic personnel are more likely to report satisfaction with their services. With regard to waiting time at the FWCs, the reactions were mixed: nearly a quarter of the respondents in Abhoynagar

were not happy, but only a few respondents in Sirajganj complained about this aspect of the service. While this reflects the subjective judgement of the respondents about the quality of services they had received, the actual waiting time at the clinics was not observed. Such information could have given an indication of the duration of waiting times correlated with the level of the respondents' satisfaction. Satisfaction of the respondents was found to be related to their being given an adequate supply of drugs. It is commonly believed that more drugs will effect a quicker cure. These findings are similar to those of a study of a nationally representative sample of clients, i.e. those who received adequate quantities of medicine were 15 times more likely to be satisfied than those who received an inadequate quantity of medicine or none at all (Ahmed and others, 1994).

The respondents questioned the technical competence of the health care providers, especially in the area of clinical examination and counselling. However, it should be noted that most of the respondents who had received a clinical examination were not pleased with the services they had received. It should be mentioned that the perceived quality of counselling and quality of services received at the FWCs in Abhoynagar were found to be associated with the respondents' level of education. It could be that they were expecting to receive more empathy and attention, and more drugs from the providers, but were disappointed when they did not. That observation aside, the interpersonal communication skills of the service providers are weak since counselling was found to be the weakest point of service delivery in both areas. This could reflect on unclear health education messages or instructions for taking drugs. Also, it could be that the clients felt they were in a position where they could not ask further questions of the service providers. Thus, the service providers need to be oriented towards developing better interpersonal communication skills. Improvements in the quality of these services would be likely to increase their use.

Programme implications

Health and family welfare centres were designed to improve maternal and child health by making services available to people in rural areas. Although these service centres are utilized for curative care of mothers and children, very few women use them for reproductive health care purposes. Further, women's knowledge about the availability of reproductive health services at these centres is inadequate. Thus, there is a need for IEC activities focusing on clients' needs. Field workers and the paramedics at

FWCs should educate community members about the availability of and the need for utilizing the services they offer. Appropriate IEC and health education materials, focusing on priority reproductive health problems and the availability of services at FWCs to address those problems, need to be designed to educate women and men in the rural communities and motivate them to use FWCs. In addition, the technical competence of the health care providers should be improved in terms of reproductive health care and curative care. The provision of technical guidelines and the organization of refresher courses would be prerequisites for improving the quality of such services. However, further study of the under-utilization of the FWCs for ante-natal and post-natal care, delivery and other reproductive health care services also needs to be undertaken.

Acknowledgements

The MCH-FP Extension Project (Rural) is a collaborative effort of ICDDR,B and the Ministry of Health and Family Welfare of the Government of Bangladesh, supported by the Population Council. This study was funded by the United States Agency for International Development (USAID) under Cooperative Agreement No. 388-0071-A-00-3016-00. ICDDR,B is supported by many countries and agencies. The authors would like to acknowledge with gratitude the helpful comments of Shameem Ahmed, Health Scientist, and Aye Aye Thwin, Operations Research Scientist, both of the MCH-FP Extension Project (Urban and Rural).

References

- Ahmed, S., N.N. Islam, N.R. Sircar and S. Rahman (1994). "Evaluation of MCH services and designing innovative intervention for community involvement in MCH programme". Associates for Research Training and Computer Processing Ltd. and the National Institute of Population Research and Training. Dhaka, January.
- Ali, S., B. Rahman and A. Ahmed (1988). "Evaluation of MCH services programme". Population Development and Evaluation Unit Series 44. Dhaka, February.
- Bangladesh Bureau of Statistics (BBS) (1993). *Statistical Yearbook of Bangladesh 1992*. Thirteenth edition, Dhaka.
- Bruce, J. (1990). "Fundamental elements of the quality of care: a simple framework" *Studies in Family Planning* 21.
- Farida, M. (1987). "Evaluation of training performance of family planning field workers". National Institute of Population Research and Training, Dhaka.

- ICDDR,B (1991). "Increasing the effectiveness of satellite clinics: improving the supply of drugs and equipment". MCH-FP Extension Project. Briefing Paper No. 15, January.
- Junker, T. (1994). "Clientele and types of services at the Family Welfare Centres and Satellite Clinics in rural areas of Bangladesh". ICDDR,B MCH-FP Extension Project (Rural) Working Paper No. 109, December.
- Kamal, G. M., A. Ahmed and S. Rahman (1992). *IUD Annual Evaluation Report 1990*. Associates for Community and Population Research (ACPR Publication No. 32), January.
- Mozumder, A.B.M.K.A., G.J. Haaga, A. Hossain and M.D.M. Rahman (1994). "Demographic changes in field sites of the MCH-FP Extension Project 1983-92". MCH-FP Extension Project, ICDDR,B Working Paper No. 100, May.
- NIPORT (1995). "Bangladesh Demographic and Health Survey (BDHS) 1993-94". National Institute of Population Research Training (NIPORT), Mitra and Associates and Macro International Inc. Dhaka.
- Rahman, K.M.A. (1989). "An observational evaluation of performances of the Medical Assistants". Population Development and Evaluation Unit Series No. 52, July.
- Rahman, M., B.E. Khuda and B.M. Hossain (1996). *An Assessment of Health and Family Planning Needs in Rural Chittagong* Special Publication – Volume 1. MCH-FP Extension Project (Rural) Health and Population Extension Division, ICDDR,B. Dhaka.
- Sabur, S. and N. Hug (1989). "Determinants of the utilization of services of Health and Family Welfare Centers (HFWCs) and Maternal and Child Welfare Centers (MCWCs)". National Institute of Population Research and Training, Dhaka.
- Wirzba, H. and T. Juncker (1995). "Disease patterns, treatment practices and drug requirements in rural MCH-FP government facilities of Bangladesh". Special Publication No. 41, MCH-FP Extension Project (Rural), ICDDR,B, May.