

**STUDY ON  
HEALTH SEEKING BEHAVIOR AND  
DEMAND FOR HEALTH SERVICES IN  
AREAS SERVED BY BWHC**

Abul Barkat  
Matiur Rahman  
Murtaza Majid  
T R Noor

*Prepared for*

**Bangladesh Women's Health Coalition (BWHC)**

*Prepared by*

**Human Development Research Centre (HDRC)**

June 29, 2002

# **EXECUTIVE SUMMARY**

## **BACKGROUND**

Bangladesh Women's Health Coalition (BWHC), founded in 1980, is one of the prime non-governmental reproductive health services provisioning organization in Bangladesh. BWHC, based on clients' demand, gradually shifted its focus from a single service program (initially provisioning of menstrual regulation services) towards an integrated program that combines various aspects of reproductive health with women's empowerment and community development. BWHC with its 12 base-clinics is located in nine districts and follows a model of two-prong clinic and community-based approach and provides many of the essential services package (ESP including reproductive health care, child health care, communicable disease control, limited curative care and behavioral change communication) in line with the government's Health and Population Sector Program (HPSP). BWHC runs integrated programs including Reproductive and Sexual Health Program (both in rural area and in urban slums), HIV/AIDS Prevention and Control Program, Urban Primary Health Care, Adolescent Program, Older Women Health Project, Training Program, and BCC.

In order to improve efficiency in resource use in the delivery of health care and other services, and to prepare the organization to face the future challenging environment of the Health and Population Sector and to improve the sustainability of the organization, the need was felt by BWHC to organize conduction of a study on "Health Seeking Behaviour and Demand for Health Services in the Areas Served by BWHC". The accompanying report provides the findings along with analyses.

## **OBJECTIVES**

The overall objective of the study was to examine the dynamics of health care seeking behavior and demand for health services of the people living in the catchment areas of BWHC. The specific objectives were to assess the health seeking behavior of the catchment population of health facilities; analyse the demand for health services; examine the impact of social intervention and community education intervention on health seeking behaviour, knowledge about health care and health status in the areas served by BWHC; compare socio-economic status-wise willingness and ability to pay for the health services provided by the BWHC clinics; and examine the clients' perceptions of quality of care.

## **METHODOLOGY**

The study covered both users<sup>1</sup> and non-users of BWHC residing in the BWHC's catchment areas, and thus the study falls under quasi-experimental design. The study provides information on health seeking behaviour and demand for health services by

---

<sup>1</sup> 'User' has been defined as those households in which at-least one family member was available who visited BWHC clinic for health care services in last one year preceding the survey.

user and non-user (of BWHC service facilities) and by urban and rural. The components to health services covered are in line with the essential services package of HPSP, namely, reproductive health care, child health care, communicable disease, limited curative care, and behavioral change communication.

The following broad groups of variables were covered: Knowledge about various components of ESP as well as knowledge about sources of services, illness episodes/disease conditions, use of resources by illness, household health care expenditure, health care options used by illness episodes and expenses incurred, willingness to pay by service components by facilities (BWHC, government, private), ability to pay by service components, perceptions about quality of care.

The survey included catchment population of five health facilities with two in urban (Agargaon and Narayangonj) and three in rural (Palash, Chouddagam and Zakiganj) areas. Sample size covered were as follows: 1500 married women in reproductive ages (divided equally by user and non-user; 600 urban and 900 rural), 60 exit clients (including BWHC, UHC, UHFWC and Private), 48 health providers (BWHC, government and private), and 44 community leaders (elected and non-elected).

The primary data were generated by administering interview schedules and group discussions.

The survey was implemented in three broad steps:

- Step 1: Conduction of several brain-storming sessions with the officials of BWHC. The brainstorming sessions discussed about the goals of this study. The sessions also dealt with operational issues regarding the selection of study locations, variables and indicators, as well as means and ways of conducting the survey.
- Step 2 : Development of draft data collection instruments (DCIs); Bangla translation and pre-testing of all draft DCIs; finalization of DCIs and reproduction/printing of necessary copies; training of field staff; actual field data collection; coding, editing, and data processing.
- Step 3 : Analysis and writing of the survey report.

All data collection instruments were pre-tested and necessary revisions were made after review of the pretest results.

A 25-member field-team was responsible in data collection. A five-day intensive training was imparted to the field staff. All core team members served as trainers. The field-team members were split into five groups. Each group comprises of one quality controller, one supervisor, and three field investigators. The male-female ratio was 2 : 3.

## KEY FINDINGS

The key findings having implications in terms of policy and strategy formulation for the further improvement of BWHC are presented below:

### Background Characteristics

Majority of MWRAs is in the age group 20-39 years. Illiteracy is high (over 44 percent) among MWRAs and it is more in rural areas. Average male member and female member per household is 2.5. Number of U-5 children is mostly one. In terms of married members 79.5 percent households have two married members and it is 77.6 percent among users and 81.5 percent among non-users.

Women empowerment status is not encouraging in terms of organizational membership and freedom of movement and spending money. Protesting violence against women by sample women is not at all prominent enough.

### Knowledge of MWRAs about Health Issues and Service Availability

Regarding all the **safe motherhood issues**, the 'users' of BWHC Clinics (or 'user' category) were found to be relatively more knowledgeable and informed than the non-user groups. Although 80 percent reported to have knowledge on delivery care, user-nonuser difference was 15 percentage points. Regarding PNC, 60 percent of users were aware and the user-nonuser difference was 19 percentage points. Almost all the MWRAs were aware of TT immunization, and vitamin A supplementation and EOC were known to three-fourths. The user-nonuser difference of knowledge was more than 12 percentage points for vitamin A supplementation and EOC.

'Users' as compared to the non-users were found to be more knowledgeable regarding all the **FP methods**. 'MR and Post-abortion Care' was a less known subject; awareness reported by two-thirds. 'Side Effect of FP and Management', an important issue in FP counseling was also known to a little above 50 percent of them.

'**Counseling on RTI/STD/AIDS**' and '**supply of condom at low price**' were the least known issues. Although the users were consistently found to be more knowledgeable about issues of RTI/STD/AIDS, their user-nonuser difference was in the range of 10 to 20 percent. The knowledge difference was the highest in case of counseling.

The issue of **maternal nutrition** including supply of iron-folic acid and vitamin A was relatively more known to the users; a knowledge difference of 16 percentage point was observed between the users and nonusers.

'Users' of BWHC Clinics were consistently found to be relatively more knowledgeable regarding all the **adolescent health care issues**. Only one-third of the MWRAs were aware of adolescent nutrition, education and hygienic practices and the other two issues namely 'puberty, safe sex and avoid risk, including STD/HIV/AIDS' and 'reproductive health services for adolescents' were known to one-fifth of each of them. In rural areas the user-nonuser difference was higher.

**Infertility** was known to only a little above one-third of the MWRAs. Higher proportion of BWHC-users compared to non-users were consistently seen to have knowledge on the issue of diagnosis and treatment of infertility.

Among the various issues of **neonatal care** three-fourth of the MWRAs were aware of mother's health education, counseling on breast feeding, and diagnosis and treatment of neonatal illness. Referral was known to only 41 percent of them. Here also higher proportion of BWHC-users than the non-users was seen knowledgeable on its various issues.

Almost all the MWRAs could report about the need for **diagnosis and treatment of ARI**. The major service providers reported were government doctor, private doctor, and NGO doctor. Most sited SDP for diagnosis of ARI was private clinic followed by district hospital or medical college hospital, UHC and BWHC Clinic.

Almost two-thirds of the MWRAs, with a higher proportion in rural areas, knew of **counseling on ARI**. BWHC users of rural areas were found to be more knowledgeable on this issue. The major service providers reported were FWV/Paramedic, government doctor, CHV, NGO doctor FWA/HA as the proper person.

More than half of the respondents had knowledge on **referral of ARI**. The service delivery points mentioned were private clinic, BWHC clinic, and district hospital or medical college hospital.

Almost all the MWRAs were found to be aware of **treatment of diarrhoeal diseases** and **ORS preparation**. Government doctor, private doctor and NGO doctors were cited as the principal service providers. The service delivery points mentioned were private clinic, UHC, district hospital or medical college hospital, and BWHC Clinic.

Almost three-fourths of the MWRAs, with a higher proportion in rural areas were found to be knowledgeable of the issue of counseling on prevention and referral of diarrhoea. Among the sub-groups, the proportion of BWHC users of rural areas was found to be more knowledgeable on this issue. The service providers reported were CHV, FWA/HA, government doctor, and FWV/Paramedic. The service delivery points mentioned were BWHC clinic, Satellite clinic, district hospital or medical college hospital and UHC.

Regarding **service providers**, the prime persons reported for referral of diarrhoeal cases were government doctor, followed by FWA/HA, private doctor, and FWV/Paramedic. The service delivery points mentioned were district hospital or medical college hospital, UHC, private clinic, and Satellite Clinic.

Irrespective of rural-urban and user-nonuser, almost all the MWRAs were found to know **provision of vaccine for children**. Polio as the disease preventable through immunization was known to two-thirds of MWRAs. Measles and Tetanus was known to more than half of them; and Tuberculosis, Diphtheria and Whooping Cough to one-third.

Only one-third of MWRAs could tell **correct number of vaccine** (5) for child less than one year old.

Regarding **service providers for provision of different vaccines** for children, about half (49%) reported FWV/Paramedic as the appropriate person. The other major service

providers reported were government doctor (42%), CHV (20%), and FWA/HA (18%). The service delivery points mentioned in this respect were BWHC clinic (58%), Satellite clinic (27%), district hospital or medical college hospital (22%) and UHC (18%).

About 80 percent of MWRAs, with a higher proportion in rural areas were found to know **counseling for vitamin A supplementation**. BWHC users of rural areas were found to be more aware on this issue. FWW/Paramedic was mentioned as the major service provider followed by government doctor, CHV and FWA/HA. Majority mentioned BWHC clinic as the service delivery points for this purpose.

Almost 85 percent of the MWRAs were knowledgeable of treatment and two-thirds of them were aware of **counseling for prevention of childhood malnutrition**. Referral for childhood malnutrition was known to half of them. The referral points mentioned by majority was BWHC clinic.

More than two-thirds of the MWRAs were aware of **basic first aid** and treatment of infectious disease, and **pain relief and advice** was known to 45 percent of them. BWHC clinics, district hospitals and medical college hospitals were reported as the **prime service delivery points** for this purpose.

### ***Health Seeking Behavior***

In the present survey, a total of 44 categories of illness episodes and services were mentioned by 1500 MWRAs to cover a total of 2285 episodes (for which treatment was sought), during the last one year. These were grouped into seven categories, in line with the major ESP elements. Among these seven categories of ESP elements, limited curative care had the highest demand (51 percent), followed by child health care (22 percent) and reproductive health (9.2 percent). For the 2285 illness episodes mentioned, BWHC clinic, followed by private clinic is the major source of care for reproductive health, RTI/STD, limited curative care as well as child health care.

In case of the user category, the BWHC clinic was the most preferred one for services like reproductive health (66 percent), followed by RTI/STD (55 percent), limited curative care (46 percent) and child health (45 percent). However for non-users, private clinic was the most favorite source for different health care services. Although government facilities were next in preference, a large proportion used pharmacies for this purpose.

The health-seeking pattern varied a lot due to their residence in rural or urban areas. Whereas, for most of the ESP services the rural people used BWHC clinics, followed by private clinics, the scenario was almost opposite in case of urban respondents. In urban areas, a higher proportion used government facilities for child health care and the same proportion used BWHC clinic and private clinic for RTI/STD (31 percent) and casualties (50 percent).

In case of BWHC users medical assistant or paramedic was the most common person, followed by private doctor and NGO doctor for reproductive health care, child health care and limited curative care. Higher proportion of non-users preferred private doctors in case of most of the ESP elements, followed by government doctors, except RTI/STD.

In rural areas people mostly preferred medical assistant or paramedic, followed by private doctor, except for child health care, limited curative care and communicable disease control in which the scenario was opposite.

In urban, higher proportion preferred private doctor except for child health care, for which they prefer medical assistant or paramedic.

Regarding main reasons for choosing different health care options higher proportion of the respondents mentioned 'better QoC/good services'. They cited 'better QoC/good service' for more than 60 percent UHC/MCWC, private clinic and BWHC clinics. 'Service cheaper' and 'nearby/close proximity' are the other reasons for choosing the health care options by a good proportion of respondents. In urban areas 'service cheaper' was mentioned for choosing district hospital by 57 percent of the respondents, whereas, in rural areas it was only 4 percent.

A strong association was found between health seeking behavior (on various health issues) and socio-economic groups of agents. For example, at 5 percent level of significance with 1 d.f. a very strong association has been revealed by contingency chi-square test of association between education level and knowledge on ANC and where and to whom to go for it. Similar results are valid for most of the health issues. But, in case of some issues like EPI and CDD for which universal programs are in operation, education does not bear much association. Again, presumption of association between occupation and knowledge status on health issues has turned out to be true by contingency chi-square test. Interestingly, the present study reveals some results, which one theoretically expects to be true. For example, exposure to mass media and knowledge on health issues, persons and places to contact has been identified to bear strong association. This is the case with health issues like Vit-A supply, RTI/STD and treatment of infectious diseases. Similarly, association has also been identified between financially better off respondents and knowledge on health issues. Such factor not only affects people's knowledge but also on practice.

For example, chi-square test results suggest that there is a very strong association between income level and choice of places and persons to approach.

Likewise, one would expect that attachment with social organizations provide more opportunities to know more about health issues. Such expectation has turned out to be true in this study and such association has been identified by contingency chi-square test.

## **Health Care Expenditure**

### ***Annual Expenditure***

- The BWHC user groups are more conscious about seeking health care and spending on health than the non-user groups.
- The BWHC user groups are more cost conscious about spending on health than the non-users groups. Both in the rural and urban areas, the user groups average expenditure were less than their counterpart non-user groups.

***Cost by Components:***

- The lower share of spending on medicine by user group is indicative of rational use of drugs by the BWHC facilities.
- The higher share of wage loss by the user group is indicative of relative poverty of the user groups compared to the non-user group.

***Health Care Expenditure by Broad Areas of Illness (disease conditions):***

- Household health care expenditure, irrespective of residence and user status (user/non-user of BWHC) is concentrated in curative care and biased towards limited curative care. Including 'Casualties' and 'other' into the category of curative care, about 58 percent of household health care expenditure is directed towards curative care. This indicates that people are already paying a substantial amount for curative care.
- Households are already spending to treat communicable diseases (18 percent of total treatment expenses including RTI/STD). However, they spend relatively less on reproductive health and child health care (specially in case of non-user groups). All these indicate that people are more ready to pay for curative health services, and less ready to pay for preventive health care, especially for reproductive health care.

***Health Care Expenditure by Sex:***

- There exists a distinct male-female disparity in health care expenditure. Household level health care expenditure favors the male.
- Male-female disparity in health care expenditure is more pronounced in the rural than in the urban areas. Household health care expenditure is not only male-biased, but also urban-biased.
- The disparity in male-female health care expenditure is relatively less pronounced for the BWHC-user category than the non-user category. This implies that BWHC, in its catchment area, has addressed the issue of ameliorating male-female disparity in health care expenditure.

***Health Care Expenditure by Income Groups:***

The general trend of health care expenditure is more or less a linear one: expenditure increases with the increase in income.

***Health Expenditure for each visit (per visit) by broad areas of illness and by types of Service provision:***

Relatively low cost/comparatively less cost of treatment possibly constitute one of the strongest reasons for people's choosing the BWHC clinics for the treatment of RHC, CHC, RTI/STD, CDC and LCC. This conclusion is further substantiated by the relative good quality service by BWHC (compared to other available facilities) and close proximity of BWHC clinics and availability of service providers.

**Willingness and Ability to Pay Vis-a-vis Existing Charges:**

- Existing charges for specific services are less in BWHC than in the government facilities; such charges are much higher in the private facilities.
- Respondents can afford almost all services of BWHC clinic and governmental facilities; they are hardly in a position to purchase services under private facilities.
- Respondents are very much willing to pay higher prices than existing charges for services that BWHC used to offer.
- Respondents are indifferent of SDPs in case of RTI/STD related services.
- Compared to other SDPs, respondents are more willing to pay for BWHC services.
- Willingness to pay more for specific services increases with the increase in income.
- Increased willingness to pay is associated with the expectation for enhanced quality of care.

**Impact of Social and Community Education Interventions on Health Seeking Behavior**

Salient features of impact of BWHC's social and community interventions are at par with what one rationally expects although may not be true in all cases. Quite expectedly those who are in some way associated with BWHC social activities appear to be satisfactorily aware of various health issues. Although many other factors may play role in it but role of attachment with BWHC can't be ruled out altogether. The above is more true for those who are regular attendants of courtyard meetings.

Through statistical test of association it has been revealed that in case of most health issues, attachment with social and education intervention plays a prominent role in increasing knowledge on health issues, service delivery points and persons to contact for services. In other words, association with BWHC's social and educational interventions acts as a determinant of positive health seeking behavior and conducive to the creation and crystallization of demand for health services.

**Quality of Care**

- According to the perceptions of the service recipients, quality of care of BWHC clinic is as good as private facilities
- Respondents identified 14 indicators of quality of care; Out of 14 QoC indicators, respondents considered cordial behavior, attentiveness towards patients' problems, availability of medicines, giving enough time to patient and cleanliness as most important indicators.
- Though overall quality of care score for BWHC clinic and private facilities are same (2.9 in a 1-4 score), but the lowest score for BWHC (2.7) is higher than that of private facilities (2.5). It implies, quality of services rendered by BWHC is relatively better than that in the other SDPs.

- BWHC needs to improve its quality of care situation as the highest score for quality of care for private facility (3.3) is greater than that of BWHC (3.2).
- Respondents prefer BWHC mainly for reproductive health services.

## **Lessons Learned**

The study results reveal that there are several lessons to be taken into account by BWHC for strengthening and extending its services. Such lessons are in various dimensions such as, socio-economic domain, knowledge on health issues, health seeking behaviour, expenditure pattern and willingness to pay. These are discussed below in sequence.

### **Socio-economic:**

1. Women empowerment status in terms of organizational membership, freedom of movement and freedom for participating in expenditure decision making as well as protesting VAW seems to be unaddressed. BWHC can take effective measures to address these important gender issues.
2. According to the study, average income of rural women was much less than that of the urban women. Therefore, there should be a price discrimination in favor of the rural women in the BWHC clinics for expanding its services. This will address the equity issue of services.

### **Knowledge on health-FP:**

3. Compared to many other components of reproductive health, knowledge on MR and post-abortion care is remarkably less. Similar is the case with counseling on RTI/STD/AIDS and supply of condom at low price.
4. It is also evident from the study that not many MWRAs are aware of adolescent nutrition, adolescent hygienic practices, puberty, safe-sex to avoid STD/HIV/AIDS and reproductive health services for the adolescents.
5. Infertility was found to be a less known subject among the MWRAs.

BWHC should take appropriate measures to address the above-mentioned issues of health-FP in its BCC activities. Adolescent reproductive health and infertility are new elements of RH, and should be dealt with caution.

### **Health Seeking Behaviour:**

6. In BWHC urban areas higher proportion used government facilities, which need to be thought about and services of BWHC to be extended and promoted in urban areas also, especially among the urban poor (in low-income settlement areas including slums).

7. Regarding different health care options higher proportion of respondents desired better QOC, cheaper service and service at close proximity. These should be taken into account for further improvement upon high quality services by BWHC.
8. Exposure to mass media and organizational association appeared to bear a strong relationship with knowledge on health issues, service providers and service delivery points. Thus, BWHC can take necessary measures in this respect as well.

**Health Care expenditure:**

9. Higher opportunity cost for availing health care services (for travelling, waiting time, haulage etc.) indicates that provision of services within easy reach of the clients should be taken care of.
10. BWHC users are to pay a substantial amount for availing curative care. So, BWHC can think of delivering the curative services at low cost in its clinics.

**Willingness and ability to pay:**

11. Respondents are very much willing to pay higher prices for quality services. This indicate that with provision of quality services at a reasonable price, a higher proportion of the population can be brought under the BWHC service umbrella. However, such willingness to pay should not be viewed as synonymous with the ability to pay. The whole service pricing issue should be designed keeping in mind the equity considerations so that poor are not denied of services due to their inability to pay for health services.