# FORMATIVE RESEARCH ON REACHING POOREST IN NSDP CLINIC

*Identification of Perceptions and Barriers of the Poorest in Accessing NSDP Services*


Abul Barkat,
Sasanka Das Gupta, Mohammad Mahbub Alam,
Irene Zabeen Zaman, Matiur Rahman, Abdul Halim,
Moniruzzaman, Umme Salma, Mominur Rahman, Kamrul Abedin,
Shahana Nazneen Sayeed, Imtiazul Islam, Farhana Ahmad

**Research Implementation Team**


*Prepared for:*

**NGO Service Delivery Program (NSDP)**

**&**

**Save the Children, USA**


**Human Development Research Centre**
House # 59, Road # 8/A, Dhanmondi R/A, Dhaka 1209
Tel.: 8116972, Fax: 88-02-8620229, E-mail: hdrc@bangla.net



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# EXECUTIVE SUMMARY

## THE RATIONALE

Bangladesh is one of many countries confronting the challenge of implementing the expanded approach of Health and Family Planning Program through a huge network of health facilities, both in rural and urban areas. NGOs and private sectors are playing crucial roles in meeting the challenge. Due mainly to the resource constraints of the government, the NGO sector has been mandated to provide quality services to the people in the un-served and under-served areas.

Based on the experiences of the first phase of USAID-funded National Integrated Population and Heath Project the NGO Service Delivery Program was launched with 8 partner organizations to serve the poorest of the poor–a daunting task. This formative research is a step towards mitigating this challenging task.

NSDP needs to develop strategies to serve the poor and poorest through the NSDP clinics. This strategy building necessitates understanding of various issues pertaining to the relatively low utilization of NSDP clinics by the poor and the poorest including their perceptions and barriers. The development of such a strategy will be of high utility for the NSDP-NGOs in their designing of sustainable program, and for instituting the process of two way accountability between the NGOs and the community.

## RESEARCH OBJECTIVES

Based on the above rationale, the specific objectives set for the formative research were as follows:

1. To identify the perceptions of the poorest about the NSDP NGO clinic
2. To identify the barriers of those in accessing NSDP health services
3. To identify a set of ways and means to increase utilization of NSDP services by the poorest people
4. To develop capacity of the NGOs in using participatory approaches to identity and remove the identified barriers on way to utilization of ESP services provided by the NSDP NGOs.
5. To enhance the process of interaction between NGOs and the community, especially the poor.

## METHODOLOGY

The study was conducted using a **participatory approach by involving the poorest and the NGOs.** Three techniques were used to collect information: Participatory Rapid Appraisal (PRA including social mapping, wealth ranking, health seeking mobility, and venn diagram), Focus Group Discussion (FGD), and In-depth Interview.

A total of eight NGOs– four rural and urban each– were selected for this two-phase study with 4 NGOs in each phase. A total of 24 clinics were covered by taking three clinics from each sample NGO. From each sample clinic two villages (“poverty strickness” criteria was used) were selected. One village was selected from among the villages close-to-static clinic, and another from villages under satellite clinic. A total of 48 villages were covered. From each selected village 200-300 households were covered.

At first, the poorest were identified through PRA using social mapping and wealth ranking techniques. The participants were drawn from all walks of life. Two PRA sessions were organized in one village of a catchment area under each sample clinic. In the first PRA sessions, 20-35 participants were engaged in social mapping and wealth ranking. In the second stage, another PRA session was organized with the poorest of the poor in which health seeking mobility and venn diagram tools were used. They were identified through wealth ranking in the first PRA. Participants themselves explored and documented their health seeking behavior, their perceptions regarding NSDP clinic, and identified the barrier in accessing the NSDP clinic. They also discussed about the solutions and have suggested means and ways to overcome the barriers in accessing NSDP clinic.

There are special communities in the society who are marginalized, socially isolated, most disadvantaged, and neglected. These include fishermen, potter, nomadic *Bede* (river gypsy), untouchable *Horijon*, washerwomen, and sex workers. Special PRAs were conducted with these marginalized groups. The purpose of conducting such PRA with this group was to identify the perception and barriers faced by these special communities in accessing to NSDP clinic. Social mobility and Venn diagram techniques were used.

## KEY FINDINGS

Participatory Rural (Rapid) Appraisal findings documented a widespread feeling among the poor women who rely in free health care that they lack adequate access to health care and face discrimination in most types of facilities. The poorest women said they prefer to go to the govt. facilities because of free medicine and service. One PRA participant in rural area put her opinion, “we are poor, we will go wherever we can get medicine for the least amount of money”. Most PRA participants in the rural areas mentioned that the care in the health care facilities depends much on nepotism, favoritism, and discrimination against poor are widespread. But in urban areas some analysts told that NGOs service delivery was beneficial to them as poor.

It is was found that the poor women receive more health services from unqualified doctor, kabiraj, homeopath, traditional healers, upazila health complex, registered doctor and government hospitals than from the NSDP clinics. According to the participants, satellite clinic provide immunization for children; family planning commodities and ORS packet are found with Depot Holder. The PRA participants described that almost all of them reside within 1 km distance of quack, kabiraj, homeopath, traditional healers, and receive health care services from them.

PRA participants–in the session of perception and barrier–pointed out that in accessing NSDP clinic personal relationship plays important role. They believe that well-off families have a good relation with the NSDP clinic staff or have family ties (relations) with them and receive better health care services than the poor. The participants preferred not to charge customers for essential services as government does not formally charge users for most primary health care services. They opined that NGOs should waive fees on the basis of need, and NSDP NGOs should adopt policy that no client should be refused due to inability to pay, and free services to be established. The poor women suggested to make health services more accessible, and NGO health providers should be made accountable to the poor.

It was both encouraging and interesting to learn that the NGO staffs themselves are eager to continue the Field Research (FR) exercises. They have expressed their interest to have further scopes and opportunities to learn more and utilize similar kind of participatory techniques and approaches. The formative research (FR) exercise was also considered to be an important input

in understanding local needs to improve upon various dimensions of servicing the poor through NSDP clinics as well as in designing local BCC.

All members of the NGO research teams were unanimous about the usefulness of the formative research. Some of them mentioned that over the last three years they were trying to motivate the community people to come to the NSDP clinic but the customer flow was not meeting their expectation. But this time the FR process has helped them to understand the factors associated with relatively low community response for the clinic services.

Most immediate tangible effect of field research intervention in the 8 NGO catchment areas was that the client flow increased in both the static and satellite clinics. The immediate client flow increased in one static clinic; in another of the satellite clinic the increase was from 20-22 per day to 36 after conducting the FGD there. In a upgraded clinic in Sylhet, the number of customer immediately after the day of the 1st PRA, reached to 68– the highest number of customer ever in that clinic. NSDP clinic staff reported that since the commencement of this clinic this figure was a record mark. It was also observed that the in-depth interview in some places had motivated people to advocate about the clinic to their neighbors and peers. As for instance, after interview, one of the commissioners decided to send his mother to the clinic and again informed one of his neighbors whose wife is expecting to go to the clinic for ANC check-up.

This Formative Research process helped the NSDP clinic personnel to identify the resources and solving the barriers for reaching poorest in NSDP clinic. They took it to realize the importance of working with the community in responding to crucial community issues and needs. Above all, the NGOs achieved high level of confidence about their abilities and scopes for addressing and reaching the poor in NSDP clinic. This will take them several steps to advance towards their goal of reaching the poor. Both NSDP and NGO have been benefited much through the process.

This Formative Research process can be seen as a process of initiation of relations of accountability between the providers and community members as well as a process of building community ownership of the clinics.

In order to inform the participant about the immediate results a restitution was arranged at the end of preparation of the draft report. The poor people (men and women) in the community who took part in the PRA, FGD and in in-depth interview were invited in restitution meetings. They witnessed their feelings listed on the brown papers and displayed before them. Their information on perceptions, barriers and suggestions–as they gave earlier–were read out loudly before them as they could check and add some what they missed. They listened to and observed the major components of the action plan developed by the service providers of the NSDP clinics. The participants were keen to know about the changes as to how are they going to be treated better that before as suggested in the PRA, FGD and in-depth interview. After sharing and validation of collected information by the participants, the NGOs personnel prepared the action plan for future implementation.

This type of dialogues opened an avenue in sharing information as well as removed misunderstanding too, to a large extent. This spirit of openess in sharing problems and concerns as well as giving explanation has opened up a congenial atmosphere of mutual respect and accountability among the providers and customers.

## SUGGESTIONS FOR FUTURE

Based on the findings of this Formative Research the following suggestions are forwarded for consideration of NSDP:

01. This process of learning from the poor to identify the relevant problems an their solutions shall continue.

02. This process paves the way for strengthening knowledge-based planning to serve the poor thru NSDP system.

03. Appropriate use of qualitative learning tools– PRA, FGD, and In-depth Interview– improves knowledge-base of NSDP-NGO providers and stimulates their concern, commitment and competence to serve the poor.

04. PRA, FGD and In-depth interview in the community minimizes distance– (both psychological and physical– between the poor and NSDP providers, which enhanced community participation in NSDP-NGO health services. Therefore, community level PRA with the poor can be seen as a major route to the success of NSDP (# clients/ services recipients increased immediately after the PRA, FGD, II).

05. The PRA outcomes can be gainfully utilized for pro-poor BCC design.

06. Further refinement of the methodology is required. This includes devoting more time to site clinic, more number of NGO personnel at site clinic, seasonal availability of participants, participants' incentive, PRA logistics, limited transfer of know-how due to short time. Therefore, in order to develop more the technical skill among the providers more time and efforts should be given.

07. Community should be involved in monitoring and improving various dimensions of quality of NSDP-NGO health services.

08. Community should participate in identifying unserved, under-served and drop-outs. This would be possible with the efficient and effective functioning of the support groups.

09. Active involvement of community should be ensured in planning and implementation. This will empower the poor and minimize the mental gap between the poor and the providers; this will contribute to the institutionalization of relationships of accountability, which is a *sine-qua-non* for future sustainability of NSDP NGO clinic programs.

10. Workshops/meetings (as learned form the Restitution meetings) at different levels would be useful in developing the strategy to reach the poor.