

The Persistence of a Service Delivery ‘Culture’: Findings from a Qualitative Study in Bangladesh

By Sidney Ruth Schuler, Lisa M. Bates and Md. Khairul Islam

Context: A new initiative in Bangladesh has shifted the emphasis in service delivery from door-to-door contraceptive distribution to delivery of a broader package of essential services, primarily through clinics. If the revised approaches are to result in more cost-effective services and better reproductive health, clients will need to take more initiative and bear more costs, and providers will have to become more responsive to clients’ priorities.

Methods: In-depth, semistructured interviews, group interviews and observations in service delivery settings were conducted in three rural and two urban sites, to examine how clients, communities and program staff were adapting to the new service delivery norms. The analyses in this article draw from about 125 interview transcripts.

Results: Community reactions to the service delivery changes generally have been favorable, and suggest that family planning clients and their families are willing to adapt to the new approaches. However, responses to the policy changes on the part of clients and communities appear to be shaped by norms that developed under the previous family planning program model. Increased charges for services appear to have exacerbated people’s confusion and resentment over payment for services and the right of clients to receive free care. Moreover, providers and clients seem to find it difficult to shed habits and assumptions surrounding the provision of specific methods, with some providers still feeling that women need to be “motivated” to practice family planning and with some clients fearing that providers will try to induce them to use certain methods. Clients also often feel that since service providers furnished them with a method, these providers should bear some responsibility for treating their health problems or side effects free of charge. And some have come to expect not only discounted or free services, but also compensation for adopting clinical methods. Fear and suspicion of clinical methods—and of providers’ reasons for offering them—persist, although perhaps to a lesser extent than was the case before the service delivery model was changed.

Conclusions: Lingering ideas about entitlements, the role of government and the agenda of the national family planning program create obstacles for nongovernmental organizations as they try to build a sustainable network of family health services in Bangladesh that is both client-focused and effective in terms of its public health impact. The new policies need to be persistently reinforced throughout the service delivery system. In addition, providers need to translate and communicate policy changes to make them more comprehensible in the communities affected by them. International Family Planning Perspectives, 2001, 27(4):194–200

In 1997, the Government of Bangladesh adopted a Health and Population Sector Strategy that reflected many of the policies outlined in the Cairo Programme of Action, which was approved at the International Conference on Population and Development in 1994. The strategy calls for a number of changes: Family planning is to be more completely integrated with health services; stakeholders are to be involved in the design and monitoring of the program; the program is to focus on users of services rather than on demographic targets; quality of care is to be improved; and a wider range of reproductive health services is to be made available, with increased attention to maternal and adolescent health care, as part of an “essential services package.”¹

As the new strategy is gradually im-

plemented, women will be required to come out of their homes to receive reproductive health services. The government is creating “community clinics” where contraceptive services and information will be available, along with other selected primary health care services that have been included in the essential services package. The government family planning workers who now go door-to-door will receive additional training and will be based in the community clinics.

Nongovernmental organizations (NGOs) involved in family planning have traditionally offered services that closely resemble those provided by the government. Following government and donor priorities of the past, they often focused their efforts on door-to-door family planning delivery. Recently, as part of a coor-

dated, donor-funded effort, many NGOs have moved ahead of the government in implementing the essential services package approach, by discontinuing or cutting back on door-to-door distribution and by offering a wider range of services through clinics and satellite clinics, with village depots for resupplying contraceptives in rural areas.

NGOs are employing a variety of measures to improve the quality of services, to make them more responsive to clients and to increase their sustainability. These include expanding satellite clinic services, setting new standards for maternal and child health services, creating training programs to support an expanded service package, establishing clinic-based pharmacies and revolving drug funds, improving management and monitoring practices, and increasing service charges. The higher quality and greater range of services available in static and satellite clinics is intended to attract clients, as well as increase the impact of the services on health.²

However, clients, families and communities, as well as service providers, will have to modify their behavior if the revised service delivery approaches are to result in more cost-effective services and

Sidney Ruth Schuler is director of the Empowerment of Women Research Program, JSI Research and Training Institute, Arlington, VA, USA. Lisa M. Bates is a doctoral student at the Harvard School of Public Health, Harvard University, Boston, MA, USA. Md. Khairul Islam is director for program development support, PLAN International, Dhaka, Bangladesh. The authors are grateful to the Pathfinder International/Dhaka Rural Service Delivery Partnership, and in particular to Mohammed Alauddin, as well as to Ahmed al-Kabir and colleagues at the JSI Urban Family Health Partnership, for their collaboration in this research. The data were collected by Shefali Akter, Shireen Akhter, Shamsul Huda Badal, Khurshida Begum, Rabeya Begum, Mahbuba Hoque, Rasheda Khan and Tofazzal Hossain Monju, with support from Nabeel Ashraf Ali. Catherine Spaur and Sarah Martin contributed to the data analysis. The authors thank Barbara Crane for her comments on earlier drafts of this article. The research on which this article is based was supported by the U.S. Agency for International Development, through The Futures Group International POLICY Project Global Research Awards Program and the Population Council Frontiers Program, as well as by The William and Flora Hewlett Foundation, The Summit Foundation, and The Moriah Fund. The interpretations and conclusions contained in this article do not necessarily reflect those of the funding agencies, however.

better reproductive health. Service providers will need to become more responsive to their clients' priorities, and clients will have to take more initiative and bear a greater share of the costs of service delivery.

We have completed the third year of a long-term, multimethod qualitative study examining the effects of these policy changes on household-level decision-making regarding the use of family planning and other reproductive health services, on patterns of service utilization and on client-provider relations and client satisfaction. This article describes how clients, communities and program staff are responding to the policy changes and adapting to the new program norms. The findings illustrate some of the difficult challenges that the NGOs face in trying to implement radical policy changes in a short time, particularly when the changes entail increased costs for clients.

Data Sources

Our data come from three rural and two urban sites where the transition from home-based to clinic-based services was underway; these sites are served by five different NGOs. Within each site, in-depth research was focused in 2–3 subareas: one area within a one-mile radius of the NGO clinic, and one or two areas 2–4 miles away, where satellite clinics are regularly held. Interviews were designed to elicit the perspectives of those affected by the changing reproductive health policies, as well as the underlying social dynamics that mediate the impact of the changes. Respondents were asked about their experiences and their perceptions of the range of service providers available, including but not limited to the NGOs implementing the new service delivery model, and about decision-making, attitudes and norms regarding women's mobility and use of services.

The data were collected between January 1998 and July 2000, but cover a somewhat longer time span, as respondents were also asked about their experiences with health and family planning services prior to the time of the study. Because there were several rounds of data collection, we were able to capture temporal changes in both program implementation and community responses. Changes over time were also examined through follow-up interviews with individual respondents.

The data are qualitative, consisting primarily of in-depth, semistructured interviews with individuals, and supplemented with a few group interviews and

observations in clinics and satellite clinics at each site. In addition to formal transcripts from the interviews and observations, we collected and analyzed our unstructured ethnographic field notes. Respondents were identified through a combination of convenience and purposive sampling, the use of key informants and service records. Most were married and 15–50 years of age. Although participants were not randomly selected, we tried to ensure that key population subgroups were represented. Both users and nonusers of the services were interviewed, as were current and former service providers.

Interviews lasted between 30 minutes and two hours or more, depending on the nature of the interview and the willingness and time constraints of the respondent. A few transcripts were from repeat interviews with individuals, such as the women who manage the village supply depots (referred to as depot holders), whose perspectives were sought at more than one point in the study. This article draws on several hundred transcripts from interviews and observations in the five sites, with most of the material coming from about 125 transcripts. Almost all of the data presented here emerged from unprompted, open-ended questions. We coded the data thematically using an ethnographic database program, SPData.

The Service Delivery Culture

For most of its history, the Bangladesh family planning program was organized vertically (rather than being integrated into existing health services), and had a specialized staff, facilities, equipment and other resources. Both government and NGO family planning workers were expected to "motivate" individuals (usually women) to adopt methods of contraception, and women who elected to practice contraception were referred to as "acceptors." The program was based on the principle of informed choice, but the government set method-specific targets, and in some cases remunerated on a per-capita basis those who recruited clients.

The following exchange, observed in a rural clinic that did not belong to one of the NGOs in which the service innovations are being undertaken, is typical of how service provision took place under the previous system. The service provider found a client's identification number in her registration book, and after looking at her card, said:

You have been taking [contraceptive] injections for about five years. It is time

you got sterilized—we can't keep giving you the injections. Your youngest child is 10 years old. What would you do with more children, when you have five already?

When the woman explained that she did not want to be sterilized, saying that she was afraid she might not receive a proper Muslim burial if she did, the provider told her:

You have five children, if they become thieves and robbers won't they drag you out of the grave? Then you will be punished even more. OK, I am writing it here on your card, and you will have the operation the next time you come. Come after talking with your husband.

The family planning service delivery "culture" that had evolved in Bangladesh was one in which the interests of service providers and clients were distinct but often overlapping. For example, when the interviewer later asked the client why she did not complain or ask them to stop, she said: "The apas* do their job, and I do mine...talking is part of their job."

While the woman did not appear to feel threatened by the "hard sell" tactics of the service provider, nor did she seem to feel coerced to adopt sterilization, she also understood that the priorities of the service delivery system and of those employed in it differed from her own, and she had developed a strategy for getting what she wanted. Similarly, in some cases, the government's efforts to motivate people to use contraceptives may have enabled women to act on their own preferences to limit their fertility without seeming to assert themselves. In speaking with their husbands about family planning, women could allude to recommendations made by government workers.³

Under the new system, these norms are expected to change. Family planning services are being provided as part of a package of basic health services that most families want and need. NGOs must gear their promotional efforts toward building up a clientele for basic family health services, not toward motivating women to accept family planning. As clients must pay for the services, it is up to them to decide what they need and what they want to pay for. Clinics' viability thus will depend on their ability to provide quality services at competitive prices. Although increasing the use of clinical methods is an objective of the new program, method choice is emphasized, and it is expected that clients will

*Literally, "sisters"—a polite term of address common in Bangladesh.

use contraceptives because they want to, not because providers persuade them to.⁴

Reactions to the New Policies

Positive Responses

With some exceptions, our data suggest that community reactions to the policy changes have been favorable, and illustrate peoples' readiness to adapt to the new service delivery approaches. Families seem willing to develop new strategies for obtaining contraceptive supplies, and clients have reacted positively to the upgraded, expanded service package.⁵

An initial period of adjustment followed the cessation of door-to-door contraceptive distribution, during which there was some confusion as to whether the door-to-door system would continue.⁶ Subsequently, the majority of those interviewed did not perceive access to services under the new system to be a significant problem. In rural sites, many women preferred a contraceptive supply depot to home delivery of contraceptives because they felt it was more reliable. In addition, in both urban and rural sites, clients appreciated the greater accessibility and reliability of the new satellite clinics. Both clinic clients and staff liked the orderly, "first-come, first-served" system, where wealthier clients or those having personal relationships with clinic staff are not seen ahead of others. Most staff did not find it difficult to be respectful and courteous to all clients, regardless of the clients' wealth or status, and clients noticed and appreciated this. Clients also said they liked the friendliness of the clinic staff, and the way the staff asked them questions and listened attentively to what they said. They also felt that the paramedics and doctors were careful and thorough in examining and treating clients.

The positive responses to the new service delivery approaches suggest that strategies developed by the NGOs to improve both access and quality are appropriate from the perspective of most clients. Not all that is happening in the clinics and satellite clinics is new, though, and some attitudes and practices that developed under the previous service delivery regime may also be contributing to the effectiveness of the new approach.

For example, under the old program, many service delivery staff were very dedicated to their work (in some cases, motivated as much by the desire to help others as by the salary they received), and this is still evident in interviews with clinic staff and with women who maintain supply depots. One woman who had been a

door-to-door family planning worker and is now a depot holder under the new strategy told the interviewer:

I developed sympathy for them [her clients] after doing this job for such a long time....I performed my duty from my heart.

Moreover, service providers continue to establish personalized, friendly relationships with their female clients. Similarly, women still assist others in accessing services and accompany one another to clinics. This is important, because many women are hesitant to go to an unfamiliar place alone, and often fear they will be unable to communicate with providers with whom they are not personally acquainted. Many women whom we interviewed felt comfortable returning to the clinics alone after one or two visits in the company of someone familiar with the clinic and more accustomed to using health services. Women have also continued to help one another obtain oral contraceptives when they run short.⁷

While some aspects of the previous service delivery culture have carried over and are contributing to the effectiveness of the new service delivery model, other, less functional modes of thought and behavior that developed under the old model coexist with these, and present a serious challenge for NGOs. These include widespread, persistent ideas about entitlements, about the role of government and about the agenda of the national family planning program, as well as the behaviors associated with these ideas.

Charging for Services

Confusion and resentment over charges for family planning and health services are not a new phenomenon in Bangladesh, and occurred in various types of service settings prior to the program changes. In the new program, however, service charges have increased, and such problems appear to have been exacerbated. A substantial minority of the study participants felt that the service charges were too high, unwarranted or unfair.

The expectation that government services should be free, coupled with widespread confusion about the relationship between government and NGO services, led many clients to resent or question the NGOs' service charges. For example, a young rural woman said:

It is not right [for the NGOs] to charge for the pill because it comes from the government. And we should get government things free of cost.

Some people imagined that the

providers were wrongly keeping the money for themselves. Rural depot holders complained about the difficulties they faced in doing their work because women were suspicious and therefore reluctant to pay. Even to people who understood the role of the NGOs, the coexistence of free or lower cost services in nearby government facilities often made the NGOs' charges seem arbitrary and unfair.⁸

The Motivation Mentality

One of the new program's objectives is to increase the use of clinical methods (injectables, IUDs and the hormonal implant), in the context of expanded family planning and reproductive health services. Some women said they had tried to switch from the pill to clinical methods under the old program, but services were irregular or inconveniently located, or they received inadequate support from service providers when they experienced side effects. In contrast, many now are actively seeking out and successfully using clinical methods, which are available on a more reliable basis and are supported by higher-quality services.⁹ Others who had not previously considered clinical methods are doing so with the encouragement of service providers.

These improvements notwithstanding, both providers and clients appear to find it difficult to shed habits and assumptions surrounding the provision of specific family planning methods. Under the old service delivery model, comprehensive information, contraceptive choice and family planning follow-up were sometimes compromised by the emphasis on keeping acceptor numbers high. For example, in describing her work during the doorstep delivery program, a former family planning worker at a rural research site (who was not retained in the new program) said she purposely did not always provide thorough information about possible side effects:

I did not tell all of them in the same way (about the possible side effects). Because if I told them, many women would not take this injection. Besides this, our office gave us a target to increase the injection clients. So for this reason we did not always tell them about the problems.

It is impossible to discern from retrospective interviews with clients exactly what service providers said, but it is clear that even now some think they are being "motivated" to use a particular method, and that some providers still perceive this to be their role. For example, a woman

who now operates a contraceptive supply depot, and who had been a family planning worker in the previous program, said that a significant part of her new responsibilities is to increase the number of injectable and IUD users, both for the good of the program and for her own status:

I will persuade half the ladies of this village to adopt the Copper-T (IUD). This will create my fame.

Such a statement illustrates how the norms and imperatives of the past coexist in many peoples' minds with the new program strategies. Depot holders said they thought efforts to increase contraceptive use should not come at the expense of service quality or go against the wishes of the client. Moreover, we encountered no examples of women reporting that they felt pressured to accept a method by NGO staff. However, the continued emphasis on method-specific motivation was apparent in a number of ways. One rural NGO service provider attributed an increase in clinical method use under the new program to the fact that the NGO clinic staff and nearby government workers were urging everyone to adopt clinical methods. Other respondents described being encouraged by the depot holder to use an IUD or tubal ligation, even as they heard from women using these methods that it was better to use the pill or injectable. They reported that while the depot holder was not forceful in her efforts, she "tells everyone to take these methods," and was happy when women used them.

Responsibility for Treating Side Effects
Clients often thought that service providers should bear responsibility for treating their health problems or side effects free of charge, since they had provided the method. This attitude was particularly evident among clients who had difficulty in paying for follow-up visits and prescriptions. When they agreed to use a family planning method, these clients expected to be taken care of; they did not expect to have to pay for follow-up consultations, despite conspicuously posted prices. A rural woman who felt that the NGO clinic (which she thought was a government clinic) was not fulfilling its obligation to users said:

I have heard that they hardly give medicine to the women for the side effects of family planning. Most of the medicines have to be purchased in the market. I think that as the government supplies methods, they should also

provide treatment for side effects... If the government provides us with the rice then they must provide the curry also.

Paternalistic ideas are subtly reflected in the work of the service providers. For example, a supply depot operator quoted earlier said she often told women and their husbands that she would take full responsibility for any problems that might occur. If a woman had excessive bleeding, she would bring a paramedic to the woman's home or she would personally take her to a clinic. She said she often accompanied IUD clients to the clinic, paying from her own pocket for their transportation.

When a woman stopped taking the pill because people in the community told her that it would make her infertile, a provider with a rural NGO argued:

What do they know? We are the people who help with family planning... The government does this for you. Can the government do wrong?

Such statements and actions reinforce the notion that the government and NGOs are responsible for individuals' contraceptive behavior and outcomes.

Expectations About Payment

The program staff's continuing "motivation" orientation reinforces the idea that the NGOs have reasons of their own for wanting women to use contraceptives. In this context, when clients find out that they must pay, they feel slighted or unfairly treated. For example, one rural service provider reported that of three IUD "acceptors" in one month, two had come "by motivation" and the third had come on her own. She said that the first two women had refused to pay, since they had agreed to take the method at the encouragement of the provider; the third woman paid, although not the full amount.

Longstanding government practices have led some people to expect not only discounted or free services, but also compensation for adopting clinical contraceptive methods. Clients may feel that they should be paid for using clinical methods, or at least receive them free, even though they do so by their own volition and for their own benefit. This expectation can be particularly strong if clients feel they were "motivated" to adopt a method.

One young urban client had expected to receive 300 taka after adopting the implant because this had been the case with several relatives and acquaintances who received the method from government clinics:

Last month my husband could not work at all, and I had no money left and I couldn't buy milk for my child. I thought that I would get 300 taka and then I could use money to buy him milk. But after I took the method the apas didn't give me any money—in fact they told me to go out and buy medicine for myself.

When she asked the paramedic if she would be given any money, the provider said:

No money is given here... that only happens in government hospitals.

The client explained:

When poor people like us get money, it helps us. We are being operated on, and so the government gives us money to buy fruits and good food. This system was created for poor people.

The client had freely chosen the implant and was having no problems with it; moreover, she liked the clinic and trusted the staff. They had recommended the implant to her because she was poor and would save money if she did not have to travel to the clinic every three months for injections. Like many clients, she report-

"Clients often thought that service providers should bear responsibility for treating their health problems or side effects free of charge, since they had provided the method."

ed that she had allowed the clinic staff to select a contraceptive method for her:

I said, "Apas, you know better than I do which method is good and which method is bad. Whichever method you think is best, please give me that very one! We are illiterate people, we don't know enough [to decide for ourselves]. My husband won't object."

The passivity reflected in this statement is revealing, as the woman was clearly intelligent and elsewhere in the interview had articulated several reasons for choosing the implant. She may already have decided on this method, and meant to communicate to the clinic staff that her welfare was their responsibility and that they

should help her because she was poor. She had wanted to use the implant, but she also needed the 300 taka she thought she would receive.

In another case, a client did not expect to be compensated for using the implant, but had expected the clinic to pay her rickshaw fare home:

I asked for money from the apa who took me there by rickshaw, but she told me that she had no money with her, and that there was no system in the clinic for giving money [to clients].

The woman then felt humiliated when the doctor came out and scolded her and the clinic staff for even discussing the matter.

Fear and Suspicion of Providers

Clients' assumptions about service providers' motives sometimes discourage them from seeking care. For example, an implant client had a variety of troubling symptoms that she attributed to the method, which she wanted very much to have removed. But each time she returned to the clinic, the doctor said that her prob-

lems were not caused by the implant and prescribed medicines for her symptoms, which nevertheless persisted. Her husband was angry at having to spend so much money on medical consultations and medication, and pressured her to have the implant removed. She reported that before inserting the implant, the doctor had clearly stated that she could have it removed if she wanted. She even asked the interviewer to intervene on her behalf, but she never directly asked the clinic staff for a removal, assuming that the doctor would not want to do it and fearing that he would be angry with her. She respected the doctor and viewed him as competent, but she did not believe him when he told her that her symptoms were not caused by the implant. It was clear from

the interview that she felt the doctor had a vested interest in having her continue to use this method, and she was afraid to challenge him. The underlying fear and mistrust that influenced this woman's view of the doctor is echoed in an urban woman's story of an experience a year or two prior to the program change. Two weeks after having had an IUD inserted, she decided to have it removed, because her husband complained that he could feel the string during intercourse, and because she thought she was becoming weak and unhealthy from blood loss. Rather than ask the paramedic to remove the IUD, she pulled it out herself. She explained:

The doctor [paramedic] would have rebuked me. She would have said, "Why are you so inclined to have a baby?"

Out of shame over that, I did not go to the doctor. I removed it myself within 15 days of having it inserted....After removing the Copper-T I did not use any method for a year.

Yet the same woman told interviewers that the clinic staff were very good, highly competent and very courteous, and that she liked the clinic very much.

When a woman who has recently started using a new contraceptive method reports minor side effects or presents health complaints that from a medical point of view clearly are not caused by the

method, the standard practice is to treat or refer her for any medical problems and to advise her that the side effects are not serious and may resolve or diminish over time. While this advice may be perfectly sound, some clients with side effects may interpret it as reluctance to follow their own wishes. In a study conducted when the implant was in clinical trials in Bangladesh, researchers noted that "while counseling clients about common side effects is important, providers walk a fine line between encouraging clients to continue using [the implant] in the face of nonthreatening side effects and refusing outright to remove the implants. Providers may view such counseling as reassurance, while clients perceive it as pressure to continue using the method."¹⁰

Many women appear afraid to try the IUD or to become sterilized, even though these methods might be appropriate for them, in light of their desire to stop bear-

ing children.¹¹ In some cases, women seem to feel threatened when service providers suggest that they might try these methods. In our study, an urban woman using the injectable explained that she had been having side effects and told the clinic staff that she did not want to continue:

Then they told me to insert the Copper-T, and for fear of that I did not go back to the clinic for three months.

This pattern of fear and suspicion of clinical methods is less evident among clients of the new NGO clinics than it had been earlier, but its persistence is sufficiently common to warrant attention. One contributing factor may be a longstanding and widespread perception that family planning service providers are employed not only to promote their clients' welfare, but also to serve the priorities of the system under which they work—a system they assume is designed mainly to increase numbers of contraceptive users.

Conclusions

The family planning service delivery culture in Bangladesh reflects policies promoted by the government, NGOs and donors. Our interview transcripts contain many examples of how this deeply entrenched culture persists even after policies and procedures have been modified. The institutional and social norms associated with the previous program model influence how service providers currently relate to one another and to clients, and how clients relate to them.

Under the previous program, the role of door-to-door family planning workers—and, where they existed, depot holders—was defined as one of transmitting contraceptives from the government to individuals and of motivating clients to use them. NGO clinics, like government family welfare centers, were thought to exist to serve this purpose. Many users of reproductive health services still believe that the family planning program has its own agenda, and that couples who decide to practice contraception not only are helping themselves, but are also helping the national family planning effort and the local program staff who are charged with motivating them. Some clients also feel that they are owed something in return—that family planning providers are responsible for making sure there are no adverse consequences for or significant costs to them, the "acceptors."

It is easy to understand how family planning clients have come to feel this way. Informational campaigns developed in the context of a vigorous population sta-

"Many women appear afraid to try the IUD or to become sterilized, even [when] these methods might be appropriate for them... In some cases, women seem to feel threatened when service providers suggest that they might try these methods."

lems were not caused by the implant and prescribed medicines for her symptoms, which nevertheless persisted. Her husband was angry at having to spend so much money on medical consultations and medication, and pressured her to have the implant removed. She reported that before inserting the implant, the doctor had clearly stated that she could have it removed if she wanted. She even asked the interviewer to intervene on her behalf, but she never directly asked the clinic staff for a removal, assuming that the doctor would not want to do it and fearing that he would be angry with her. She respected the doctor and viewed him as competent, but she did not believe him when he told her that her symptoms were not caused by the implant. It was clear from

*This is still the case in government facilities, although the amounts have not been adjusted in recent years to keep pace with inflation.

bilization effort often emphasized the benefit of small families to the nation as well as to the family. For many years, family planning workers visited homes to persuade women to practice family planning, and sometimes to promote a particular method. To make sure that cost would not be an obstacle, the government provided contraceptive methods and services free of cost and provided a stipend to cover transportation and other costs for women adopting clinical methods.* Local family planning workers would accompany a woman hesitant to travel alone to an unknown clinic, and if a client was reluctant to use an unfamiliar method for fear of side effects, they would promise her that she could rely on them to ensure that she got adequate treatment for any problem. The assumption was that she should not have to pay for this service: She was *their* family planning acceptor, and her well-being was their responsibility. Our current findings suggest that some front-line service providers still see their primary role as one of recruiting family planning clients, and that many clients still assume this to be the case.

In accounting for the persistence of outmoded contraceptive regimes, one researcher described a process in which institutional practices become “locked in” and are perpetuated long after removal of the factors that prompted the initial policies.¹² The result is patterns of contraceptive use that seem incongruous, given the options available. Similarly, India’s efforts to shift to a “target-free” family planning model have been hampered by the persistence of top-down, numbers-oriented approaches that are deeply rooted in the service delivery system. Despite an explicit emphasis on enabling clients to make informed choices in method selection, the paternalistic assumption that providers know what is best for their clients continues to influence program strategies, and services beyond family planning have often received inadequate attention. As observers of India’s experience have noted, “well-entrenched practices and messages established over 25 years” do not change overnight.¹³ A recent review of changes in service guidelines and practices argues that revising guidelines is only one of several ways to improve practices, and recommends a variety of actions to disseminate and institutionalize new policies and practices within service delivery programs.¹⁴

In Bangladesh, the widespread perception that family planning services are offered as part of a national fertility re-

duction agenda underlies many of the difficulties that the NGOs now face in trying to implement a sustainable, client-centered essential services model. As well as influencing clients’ attitudes regarding the legitimacy of charges for family planning methods and services, such perceptions foster mistrust between clients and providers. These longstanding assumptions and the practices and modes of communication associated with them need to be confronted, particularly when new contraceptive methods are introduced and access to them is expanded. As others have warned, donors and implementing agencies need to exercise extreme caution in introducing new contraceptives, to avoid giving the message that clients must be recruited to use them.¹⁵ The Bangladesh government’s practice of paying subsidies to users of clinical methods certainly reinforces the perception that this is the role of service providers.

Despite the potential advantages of the essential service package model, there is a risk that outreach efforts employing even subtle forms of motivation may perpetuate modes of provider-client communication that developed as part of a target-oriented program and that are inconsistent with a client-centered approach. Much of what family planning workers have done in the past to “motivate” clients was helpful, and clients appreciated it. The challenge now is to reinforce manifestations of personal commitment and helpfulness, while replacing the framework within which these behaviors often developed.

NGOs also need to continue their efforts to translate and communicate the new service delivery policies to make them more comprehensible to the communities the clinics serve and to increase the policies’ perceived legitimacy. To do this, it will be necessary to come to terms with prevailing ideas about entitlements and about payment for services. Among other things, the NGOs must distinguish themselves from the government. Better communication will be needed to explain how the new services are set up and to dispel expectations related to the previous family planning program model. Effective steps to resolve these issues will require close coordination between NGOs and government, additional measures to “mainstream” the essential principles of the Health and Population Sector Strategy within both government and NGO service delivery systems, and continued emphasis on communication between service providers and users.

References

1. Government of the People’s Republic of Bangladesh, *Health and Population Sector Strategy*, Ministry of Health and Family Welfare, Government of the People’s Republic of Bangladesh, Dhaka, 1997; and Germaine A, Addressing the demographic imperative through health, empowerment, and rights: ICPD implementation in Bangladesh, *Health Transition Review*, 1997, 7(Suppl. 4):33–36.
2. JSI Research and Training Institute, Urban service delivery design and result package, Arlington, VA, USA: JSI Research and Training Institute, 1997; JSI Urban Family Health Partnership, *Annual Report 1997/98*, Dhaka, Bangladesh, 1998; U.S. Agency for International Development (USAID), Urban and rural service delivery components of the New Initiatives in Population and Health (NIPH) Project, RFA-USAID/Bangladesh-96-P-001, Washington, DC: USAID, 1996; and USAID, National Integrated Population and Health Program (NIPH) design workshop report, Dhaka: USAID, 1996.
3. Schuler S et al., The advent of family planning as a social norm in Bangladesh: women’s experiences, *Reproductive Health Matters*, 1996, 7:66–78.
4. JSI Urban Family Health Partnership, 1998, op. cit. (see reference 2).
5. Bates LM, Schuler SR and Islam MK, From home to the clinic: the next chapter in Bangladesh’s family planning success story: rural sites, report prepared for USAID and the Frontiers Project, JSI Research and Training Institute, Arlington, VA, USA, 2000; and Schuler SR, Bates LM and Islam MK, From home to the clinic: the next chapter in Bangladesh’s family planning success story: urban sites, report prepared for USAID and the Frontiers Project, JSI Research and Training Institute, Arlington, VA, USA, 2000.
6. Bates LM, Schuler SR and Islam MK, 2000, op. cit. (see reference 5); and Schuler SR, Bates LM and Islam MK, 2000, op. cit. (see reference 5).
7. Bates LM, Schuler SR and Islam MK, 2000, op. cit. (see reference 5); and Schuler SR, Bates LM and Islam MK, 2000, op. cit. (see reference 5).
8. Schuler SR, Bates LM and Islam MK, Paying for services in Bangladesh: intersections between cost, quality and culture, paper presented at the annual meeting of the Population Association of America, Washington, DC, March 29–31, 2001.
9. Bates LM, Schuler SR and Islam MK, 2000, op. cit. (see reference 5); and Schuler SR, Bates LM and Islam MK, 2000, op. cit. (see reference 5).
10. Hardee K et al., Contraceptive implant users and their access to removal services in Bangladesh, *International Family Planning Perspectives*, 1994, 20(2):59–65.
11. Schuler SR and Hossain Z, Family planning clinics through women’s eyes and voices: a case study from rural Bangladesh, *International Family Planning Perspectives*, 1998, 24(4):170–175 & 205.
12. Potter JE, The persistence of outmoded contraceptive regimes, *Population and Development Review*, 1999, 25(4):703–739.
13. Visaria L, Jejeebhoy S and Merrick T, From family planning to reproductive health: challenges facing India, *International Family Planning Perspectives*, 1999, 25(Suppl.):S44–S47.
14. Hardee K et al., What have we learned from studying changes in service delivery practices? *International Family Planning Perspectives*, 1998, 24(2):84–90.
15. Simmons R et al., The strategic approach to contra-

ceptive introduction, *Studies in Family Planning*, 1997, 28(2):79–94; and Diaz M et al., Expanding contraceptive choice: findings from Brazil, *Studies in Family Planning*, 1999, 30(1):1–16.

Resumen

Contexto: Una nueva iniciativa lanzada en Bangladesh ha cambiado el énfasis del servicio de distribución de anticonceptivos de puerta a puerta a un sistema de distribución mediante un paquete más amplio de servicios esenciales, principalmente a través de las clínicas. Si este cambio de enfoque resulta en servicios más costo-eficaces y en una mejor salud reproductiva, las clientas deberán tener más iniciativa y pagar costos más elevados, y los proveedores deberán responder en mejor forma a las prioridades de sus clientas.

Métodos: Para examinar la forma en que las clientas, las comunidades y el personal de los programas se fueron adaptando a nuevas normas del servicio de distribución, se realizaron entrevistas minuciosas y semiestructuradas, y entrevistas y observaciones de grupos, en clínicas de distribución de servicios ubicados en tres lugares rurales y dos urbanos. Los análisis que se presentan en este artículo se basan en las transcripciones de 125 entrevistas.

Resultados: Las reacciones de la comunidad a los cambios del sistema de distribución de servicios en general han sido favorables y sugieren que las clientas de planificación familiar y sus familias están dispuestos a adaptarse a nuevos enfoques. Sin embargo, las respuestas a los cambios de política de las clientas y sus comunidades parecen estar determinadas por las normas que se formularon bajo el modelo de planificación familiar previo. El incremento del costo de los servicios parece haber exacerbado la confusión y resentimiento de la gente con respecto al pago de los servicios y al derecho de las clientas a recibir atención en forma gratuita. Además, tanto los proveedores como las clientas encuentran difícil abandonar la costumbre ya establecida de suministro de métodos específicos, y algunos proveedores aun consideran que es necesario que la mujer sea "motivada" para practicar la planificación familiar y algunas clientas temen que los proveedores tratarán de inducirles el uso de ciertos métodos anticonceptivos. Las clientas también consideran que como los pro-

veedores les han suministrado un método anticonceptivo, ellos tienen cierta responsabilidad por el tratamiento de problemas de salud o efectos secundarios, el cual debería ser gratuito. Y algunas clientas incluso han esperado no solamente que se les suministre servicios de costo reducido o gratuitos, sino también que se les compense por haber adoptado un método clínico. Persiste el temor y la sospecha con respecto a los métodos clínicos—y de las razones de los proveedores para ofrecerlos—aunque quizá en menor medida que fue el caso antes de que se cambiara el modelo de distribución de servicios.

Conclusiones: Las persistentes ideas sobre los derechos adquiridos, el papel del gobierno y la agenda del programa nacional de planificación familiar crean obstáculos a las organizaciones no gubernamentales a medida que tratan de crear una red sostenible de servicios de salud familiar en Bangladesh, que sean concentrados en la atención a la clienta y que creen un impacto eficaz en la salud pública. Las nuevas políticas deben ser reforzadas persistentemente a través de todo el sistema de distribución de servicios. Además, los proveedores deben traducir y comunicar los cambios de políticas para que la comunidad afectada por ellos los comprendan mejor.

Résumé

Contexte: Une nouvelle initiative au Bangladesh a fait passer l'accent des prestations de livraison de la distribution contraceptive de porte à porte à un ensemble plus vaste de services essentiels, principalement à travers les cliniques. Si les nouvelles approches doivent être source de services plus rentables et d'une meilleure hygiène de la reproduction, il faudra, de la part des clientes, une plus grande initiative et une plus grande participation aux coûts et, de la part des prestataires, une plus grande sensibilité aux priorités des clientes.

Méthodes: Des interviews en profondeur semi-structurées, des interviews de groupe et l'observation de contextes de prestations ont été organisées en trois sites ruraux et deux sites urbains, pour examiner l'adaptation des clientes, des communautés et des effectifs du programme aux nouvelles normes de prestation. Les analyses présentées dans cet article repo-

sent sur environ 125 transcriptions d'interview. **Résultats:** Les réactions des communautés aux changements venus affecter les prestations de services ont généralement été favorables, laissant entendre que les clientes du planning familial et leur famille sont disposées à s'adapter aux nouvelles approches. Toutefois, les réponses initiales aux changements politiques, de la part des clientes et de leurs communautés, semblent toujours le produit des normes développées sous le modèle du programme de planning familial antérieur. Le coût accru des services semble avoir exacerbé la confusion et le ressentiment des populations à l'égard du paiement des services et du droit des clients à recevoir des soins gratuits. Il semble du reste difficile, pour les prestataires et les clientes, d'abandonner leurs habitudes et présomptions relatives à l'offre de certaines méthodes: certains prestataires estiment que les femmes doivent être «motivées» à la pratique du planning familial, tandis que certaines clientes craignent les pressions des prestataires au profit de certaines méthodes. Souvent, les clientes estiment aussi que les prestataires qui leur ont fourni une méthode devraient assumer, dans une certaine mesure, la responsabilité du traitement gratuit de leurs problèmes de santé ou effets secondaires éventuels. D'aucunes s'attendent même, plus encore qu'à des services à prix réduits ou gratuits, à être compensées en échange de l'adoption de méthodes cliniques. La peur et la méfiance à l'égard des méthodes cliniques—et de la motivation des prestataires qui les proposent—persistent, bien que dans une moindre mesure, peut-être, qu'avant le changement du modèle de prestation.

Conclusions: Les idées persistantes concernant les droits, le rôle du gouvernement et la motivation du programme national de planning familial compliquent la tâche des ONG désireuses d'établir un réseau durable de services de santé familiale au Bangladesh à la fois sensible aux besoins de sa clientèle et efficace dans son impact sur la santé publique. Les nouvelles politiques doivent bénéficier d'un renforcement constant à tous les niveaux du système de prestations. De plus, les prestataires doivent traduire et communiquer les changements pour en faciliter la compréhension dans les communautés affectées.