

Coping with changing conditions: alternative strategies for the delivery of maternal and child health and family planning services in Dhaka, Bangladesh

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The door-to-door distribution of contraceptives and information on maternal and child health and family planning (MCH-FP) services, through bimonthly visits to eligible couples by trained fieldworkers, has been instrumental in increasing the contraceptive prevalence rate and immunization coverage in Bangladesh. The doorstep delivery strategy, however, is labour-intensive and costly. More cost-effective service delivery strategies are needed, not only for family planning services but also for a broader package of reproductive and other essential health services.

Against this backdrop, operations research was conducted by the Centre for Health and Population Research at the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) from January 1996 to May 1997, in collaboration with government agencies and a leading national nongovernmental organization, with a view to developing and field-testing alternative approaches to the delivery of MCH-FP services in urban areas. Two alternative strategies featuring the withdrawal of home-based distribution and the delivery of basic health care from fixed-site facilities were tested in two areas of Dhaka.

The clinic-based service delivery strategy was found to be a feasible alternative to the resource-intensive doorstep system in urban Dhaka. It did not adversely affect programme performance and it allowed the needs of clients to be addressed holistically through a package of essential health and family planning services.

Keywords: delivery of health care, methods; family planning, supply and distribution; contraceptive agents, supply and distribution; maternal-child health centers, utilization; cluster analysis; Bangladesh.

Mots clés: délivrance soins, méthodes; contrôle naissances, équipement et distribution; contraceptifs, équipement et distribution; centre protection maternelle et infantile, utilisation; sondage en grappes; Bangladesh.

Palabras clave: prestación de atención de salud, métodos; planificación familiar, provisión y distribución; agentes anticonceptivos, provisión y distribución; centros de salud materno-infantil, utilización; análisis por conglomerados; Bangladesh.

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Introduction

Despite underdevelopment and widespread poverty, Bangladesh has achieved considerable success in family planning and immunization. Nevertheless, the country is facing problems associated with mounting

population pressure. There are 122 million people in the country and the population density is approximately 800 per square kilometre (1). The prospects for donor support are declining and national

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resources are limited. In these circumstances the priorities of the health and population programme have been adjusted in order to ensure the continuation and consolidation of its benefits. The former Urban MCH-FP Extension Project, now merged with the Operations Research Project of the ICDDR,B – Centre for Health and Population Research, has conducted operations research in Dhaka with a view to developing strategies for the cost-effective delivery of maternal and child health and family planning (MCH-FP) services which would serve as alternatives to resource-intensive, door-to-door, community-based distribution (CBD).

The work on developing and field-testing alternative service delivery strategies for urban areas was conducted in partnership with government agencies and Concerned Women for Family Planning (CWFP), a national nongovernmental organization. The study lasted from January 1996 until May 1997.

Overview of the conventional MCH-FP service delivery strategy

In order to reduce the alarming rate of population growth in Bangladesh, MCH-FP services were extended in the mid-1970s to married women aged 15–49 years on the basis of a national movement involving door-to-door CBD of contraceptive commodities and health information and education. The sociocultural environment was such that, in a relatively conservative population, most women were confined to their homes and were unable to seek MCH-FP services for themselves from outside sources. The national programme therefore adopted a supply-led strategy to ensure effective motivation and easy access of fecund women to modern family planning methods and health services.

Under the conventional doorstep strategy, some 23 000 female fieldworkers in the government programme and 12 000 fieldworkers attached to programmes of nongovernmental organizations make routine two-monthly visits to all the married women of reproductive age (MwRA) within specified catchment areas. On average each fieldworker is responsible for 700–800 eligible women. In addition to the door-to-door community-based outreach services, about 4000 static government-run clinics and 200 static clinics run by nongovernmental organizations deliver MCH-FP services.

The role of the doorstep service delivery strategy has been widely recognized as the key factor in the success of the country's family planning programme (2, 3). The contraceptive prevalence rate (CPR) rose from 8% in the mid-1970s to its present level of 49%; modern methods have been adopted by 42% of users. In the urban population the average rate of contraception use is 62%. During the same period the total fertility rate declined from 6.3 to 3.3 (4). The doorstep strategy has also contributed to the achievement of an immunization coverage of 58% among urban children aged 12–23 months, as

opposed to 54% nationally. Two or more doses of tetanus toxoid are received by 59% of mothers during pregnancy. Knowledge of family planning and immunization is now much more widespread than formerly, and a vast majority of couples favour family planning (4).

The investment in this large-scale national programme was considerable. With the maturation of the MCH-FP programme, however, priorities have evolved so as to consolidate and continue its benefits under increasing resource constraints. Because of concerns about financial and programmatic sustainability, operations research became necessary on new service delivery strategies that would enhance cost-effectiveness by producing the greatest and most effective possible output at the lowest possible cost.

Rising costs

Expansion of the health and family planning services is required to match the increase in the population. For example, to achieve the national goal of replacement level fertility by 2005, i.e. a total fertility rate of 2.2, family planning services will have to reach 40 million families as opposed to 27 million at present, the number of contraceptive users will have to increase from 12 to 28 million, and the CPR will have to rise to 70%. Similarly, to attain an infant mortality rate of 50 per 1000 live births by 2005, immunization coverage will have to be raised from the current level of 4.2 million infants per year to approximately 6.3 million per year (5). If the service delivery strategies were to remain unchanged these changes would require an annual increase of US\$ 10 million in the cost of the country's family planning programme alone; the total current figure of US\$ 120 million would have to rise to US\$ 220 million by 2005 (6).

As of now, the national MCH-FP programme is heavily dependent on donor contributions, the government share being around 37%. Donor funding is likely to stagnate or decrease in the future. Even if the external contributions remained the same they would certainly not meet the growing demands. The development of cost-effective and sustainable service delivery alternatives has therefore become crucial. This is particularly important in urban areas for the following reasons.

- The population in the cities and municipalities is growing three times faster than in the country as a whole, at about 6% per annum compared to 2%; around a quarter of the country's population lives in urban areas, Dhaka having a population of more than six million (7).
- MCH-FP services in the urban areas are delivered predominantly by nongovernmental organizations that are funded by donors.

An analysis of CWFP expenditure showed that the proportion of labour costs in the total programme costs ranged between 70% and 80%. The doorstep delivery system, i.e. the salaries of fieldworkers,

accounted for 60–65% of the programme costs. Labour costs accounted for around 80% of the unit costs of services provided by the fieldworkers in people's homes (8). The corresponding components are similar for government programmes and other nongovernmental organization programmes. The greatest effect of any shrinkage of funding is therefore likely to be on the doorstep system.

Decreasing effectiveness of the system

Most urban fieldworkers were responsible for some 800 eligible couples. On average, 21 visits were undertaken daily by each fieldworker. The average duration of the visits was about nine minutes. Half of the visits, however, lasted five minutes or less. Of the time spent on home visits, 60% involved family planning activity, mostly concerning the resupply of pills and condoms (7). Because of their high client load the fieldworkers seemed to have little or no time to motivate women who were not using family planning methods and other basic health care.

Despite the overall success in contraceptive use the doorstep service delivery strategy was not very effective in increasing the use of clinical contraceptives, which are considered to offer cost-effective family planning with sustainable demographic effects. Analyses of the 1985 Contraceptive Prevalence Survey and the 1996–97 Bangladesh Demographic and Health Survey showed that the use of pills and condoms had risen from 6.9% in 1983 to 24.7% in 1996–97. The use of longer-acting methods (intrauterine devices and Norplant) and permanent methods (male and female sterilization, such as vasectomy and tubectomy), however, did not show a similar increase (4, 9). As a result of being offered services at home by fieldworkers, instead of attending clinic facilities, many women continued to be passive users of only nonclinical means of family planning, such as pills and condoms. The explicit goal of the national primary health care programme, in line with recommendations of the International Conference on Population and Development held in Cairo in 1994, has evolved to ensure broader reproductive health services to the population. The provision of a wider range of essential health services clearly requires an increased emphasis on clinics as the main hub of service delivery. It is important that urban women should achieve greater mobility and that fewer traditional barriers should prevent them from going out of their homes to seek health and family planning services.

Alternative service delivery strategies

The main goal of operations research on alternative service delivery strategies was to develop less costly systems based on the provision of services from static facilities. It was intended that this would result in higher utilization of essential health and family planning services among the country's urban population. The main feature of the alternative strategies

was to reduce dependence on the conventional doorstep CBD system and promote service delivery from clinics. Two alternative strategies were designed and field-tested in two areas of Dhaka.

Alternative strategy based on distribution of services from community service points

This service delivery strategy was tested in Gandaria, with a population of approximately 20 000, including some 3500 MWRA, served by CWFP. There was no distribution of commodities and services to the homes of clients. Routine home visits to all MWRA were withdrawn. Contraceptive commodities, e.g. pills and condoms, and MCH-FP counselling services were provided to clients by female fieldworkers at locations in the community, e.g. schools and clubs, rather than in people's homes. Each such community service point (CSP) served around 250–300 MWRA.

Each fieldworker covered three CSPs and visited them once a week. During the remaining working days, selective home visits were made to non-users with a view to motivating them. The cessation of routine home visits to all MWRA made it possible to reduce the number of fieldworkers from five to three in the intervention area. This strategy was conceptualized on the premise that the doorstep strategy had been in place for about two decades and that an abrupt shift to a clinic-based strategy might adversely affect programme performance. The CSP strategy was considered to be a transitional approach leading towards static clinic-based service delivery.

Delivery of services from a static primary health care clinic

As a second alternative to doorstep CBD an entirely clinic-based service delivery strategy was tested in Hazaribag, an area of Dhaka with a population of about 25 000 including some 4000 MWRA, served by the same nongovernmental organization. As with the previous alternative, home-based distribution was stopped. Routine home visits to MWRA were withdrawn. A range of MCH-FP services, such as clinical and nonclinical family planning, antenatal care, postnatal care, sick child care (including treatment of diarrhoea and acute respiratory tract infections) and sick mother care were delivered from a primary health care clinic (PHCC). Before the intervention this had been a satellite clinic organized once a week by a paramedical worker, a fieldworker and a clinic aide. For the purposes of the intervention the satellite clinic, housed in a community centre of Dhaka City Corporation, was transformed into a regular clinic functioning on all working days. Service provision at the clinic was strengthened with the regular attendance of a paramedical worker, a health assistant and a clinic aide. Furthermore, a doctor provided services at the clinic on three days a week.

Here too the number of fieldworkers was reduced from five to three. They worked as service promoters and undertook selective home visits to

non-users to provide them with motivation. This option was considered as a radical shift from the conventional CBD strategy towards static clinic-based service delivery.

Research design, indicators and hypothesis

The intervention followed a quasi-experimental nonequivalent control group design with pretest and post-test measurements. Two CWFP programme areas, Siddiquebazar and Wari in Dhaka, with conventional CBD, served as controls. The problem investigated was whether a shift from the doorstep strategy to the provision of MCH-FP services from fixed sites had a detrimental effect on the utilization of these services in the urban population. It was tackled by analysing the changes in the following indicators of programme performance before and after the intervention: the CPR, the contraceptive method mix, the source of contraceptive services, and trends in the utilization of the MCH-FP services offered from the static clinics.

The working hypothesis of the study was that a shift from the core strategy of providing services through home visits to a static site-based alternative would result in a decline in the CPR, an increase in the use of less reliable methods in the contraceptive method mix, a decreased use of clinics as a source of family planning methods, and a decrease in the utilization of MCH-FP services provided from static clinics.

Methods

The effects of the alternative strategies were assessed through population-based surveys and analyses of service statistics in the intervention and comparison areas. The population-based sample surveys were conducted using a modified EPI 30 cluster methodology. The sample size for the population-based surveys was calculated on the basis of indicators, such as the CPR and the utilization rate of clinics and private sources for services at the 5% to 7.5% precision levels, with a design effect of 1.5. It appeared that a sample of about 400 would be adequate to measure the above indicators at the 95% confidence level. It was therefore decided to use a sample size of 400 for each survey in the intervention and comparison areas.

Independent samples were drawn in each survey, using a cluster sample methodology. The selected intervention and comparison areas were divided into a number of clusters corresponding to the number of couple registration books of the fieldworkers. Each book contained records pertaining to 80–100 eligible women. Each cluster was assigned a measure of size according to the number of households in it. This was the sampling frame from which periodic samples were drawn for each area. A two-stage cluster approach was adopted for selecting

the samples. In the first stage, 40 clusters were systematically selected using the “probability proportional to size” method. Ten women were then randomly selected for interview from each of these clusters using a standardized methodology.

Results

Changes in contraceptive use, method mix and source mix

Family planning is a concern of paramount public health importance in a densely populated country, particularly in a highly congested city such as Dhaka. It was widely presumed that a shift from the door-to-door distribution strategy would lead to a considerable decrease in the use of modern family planning methods. However, the CPR increased over the test period in both the alternative strategies. This was evident from the records of the service providers and also from the population-based sample surveys. Table 1 shows that in the PHCC strategy at Hazaribag the CPR increased from the preintervention level of 60% to 64% in May 1997. Similarly, in the CSP strategy tested at Gandaria the CPR increased from the preintervention level of 55% to 56%. Compared to the CSP strategy and the doorstep strategy, the increase in the CPR under the static clinic-based strategy was most impressive.

Table 1 further reveals that while the pre-intervention and postintervention relative shares of clinical contraceptives in the overall method mix of contraception showed little change in the other strategies under consideration, the clinic-based PHCC alternative resulted in a sizeable increase in the use of clinical methods, with a rise from 30% to 36% at the end of the intervention. The PHCC was providing only nonpermanent clinical methods of family planning, e.g. injectables and intrauterine devices. The increase in the utilization of these methods was remarkable for the PHCC strategy: from 20% before the intervention to 26% after it. It was encouraging to find that the cessation of doorstep supplying of commodities in the clinic-based strategy facilitated switching to less costly and more reliable clinical methods.

In both the alternative strategies there was no door-to-door distribution of contraceptive pills and condoms by fieldworkers. Instead of resulting in drop-outs among the users of these items, this led to a significant increase in the use of social marketing/commercial sources like pharmacies, drug stores and grocery shops in order to obtain contraceptive commodities ($p < 0.05$). The substitution effect was pronounced in both alternative service delivery strategies, thereby reducing the dependence of users on nongovernmental and government-subsidized sources. It is worth mentioning, however, that only 11% of users obtained contraceptive items from CSPs, i.e. only a third of the users who, before the intervention, had been receiving their supplies in their homes from fieldworkers. Although women were

Table 1. Family planning performance indicators before and after intervention, January 1996 and May 1997

Indicators	Intervention areas				Comparison areas			
	Hazaribag (clinic-based PHCC strategy)		Gandaria (CSP strategy)		Siddiquebazar (doorstep CBD strategy)		Wari (doorstep CBD strategy)	
	Before	After	Before	After	Before	After	Before	After
Contraceptive prevalence rate (%)	60	64	55	56	61	61	60	61
<i>n</i>	400	400	400	400	400	400	400	400
Family planning method mix (%)								
Pill/condom	70	64	72	73	68	67	71	69
Injection/intrauterine device/ Norplant	20	26	14	13	15	16	13	14
Sterilization	10	10	14	14	17	17	16	17
Sources of family planning methods (%)								
Fieldworkers (doorstep)	25	–	34	–	34	34	32	27
Community service points	–	–	–	11	–	–	–	–
Pharmacies/shops	42	51	38	63	33	33	39	42
Clinics	33	49	28	26	33	33	29	31
<i>n</i>	240	255	219	225	245	242	241	242

PHCC = primary health care clinic.

CSP = community service point.

CBD = community-based distribution.

Source: population-based sample surveys.

travelling to sources away from their homes, they were apparently not interested in going to CSPs with the sole purpose of replenishing their supplies of pills and condoms.

In contrast to the decline, stagnation or meagre increase in the proportion of fixed-site clinics as sources of contraceptive items in the other strategies, the clinic-based alternative produced an increase from 33% before intervention to 49% after intervention.

Use of static clinics

Details on the utilization of static clinics under the various options of service delivery by types of client and service are presented in Table 2. The overall trends in daily averages of clients' attendance and services provided increased considerably in the service delivery strategy based on static clinics. On average, 18 clients attended the PHCC every day during the first six months of the intervention, and during the last six months the number rose to 30, i.e. within about a year. Moreover, increased numbers of women and children attended the PHCC. There was also a significant increase in the services provided daily from the PHCC ($p < 0.01$). While the utilization of all services (family planning, maternal health, child health, and pathological and other services such as male and adolescent health care) increased in the PHC clinic in comparison to the CSP and doorstep strategies, the most significant rise was in the utilization of maternal health care ($p < 0.05$). Women who went to the PHCC for the replenishment of

contraceptive commodities also availed themselves of the maternal services offered there.

Table 3 gives the results obtained in population-based sample surveys on the effects of the changed strategies on the utilization of the clinical services in the community. No major difference in clinic utilization between the intervention and comparison areas was reported by clients. The increase in use of clinical services by women during the reference period was modest within the CSP alternative in comparison with the other strategies: by 2% at Gandaria as against 3–4% in the rest of the experimental sites. This was possibly because of unreported visits by some respondents to CSPs in order to obtain pills and condoms. The CSPs, served by fieldworkers, were not considered by the respondents to be clinical facilities.

There was an increase from 18% to 31% in the demand for family planning services at clinics in the PHCC intervention area. Also, the percentage of women seeking maternal and child care at clinics during the test period increased in the PHCC strategy at Hazaribag. The alternative strategies had no discernible adverse effects on the utilization of clinics and the MCH-FP services provided by them.

Discussion

In the static clinic (PHCC) strategy the reduced intensity of counselling associated with the abandon-

Table 2. **Static clinic performance indicators during intervention, January 1996 to May 1997**

Indicators	Intervention areas				Comparison areas			
	Hazariabag (clinic-based PHCC strategy)		Gandaria (CSP strategy)		Siddiquebazar (doorstep CBD strategy)		Wari (doorstep CBD strategy)	
	1 ^a	2 ^b	1 ^a	2 ^b	1 ^a	2 ^b	1 ^a	2 ^b
Average attendance (per day)	18	30	16	17	20	22	14	13
Women	14	19	12	13	17	17	11	10
Children	3	6	2	2	2	2	2	2
Others	1	5	2	2	1	3	1	1
Services provided (per day)	22	42	20	21	30	31	22	21
Family planning	12	16	14	11	16	16	10	10
Maternal health	4	12	1	5	8	6	6	6
Child health	3	6	2	2	3	4	3	2
Pathology tests and others	3	8	3	3	3	5	3	3

PHCC = primary health care clinic.

CSP = community service point.

CBD = community-based distribution.

^a Daily averages during the first six months of intervention, i.e. January to June 1996.

^b Daily averages during the last six months of intervention, i.e. December 1996 to May 1997.

Source: service records.

Table 3. **Respondents who reported visiting clinics during the six months before interview, by reasons for visits^a**

	Intervention areas				Comparison areas			
	Hazariabag (clinic-based PHCC strategy)		Gandaria (CSP strategy)		Siddiquebazar (doorstep CBD strategy)		Wari (doorstep CBD strategy)	
	Before	After	Before	After	Before	After	Before	After
Visited clinics (%)	55	59	55	57	60	63	61	65
<i>n</i>	400	400	400	400	400	400	400	400
Reasons (%)								
Family planning services	18	31	7	10	6	6	7	7
EPI services	11	12	6	15	10	18	7	16
Child health	33	43	31	51	39	58	30	56
Maternal health	63	70	57	57	57	63	49	33
Other ^b	3	5	4	6	4	8	6	6

PHCC = primary health care clinic.

CSP = community service point.

CBD = community-based distribution.

^a Multiple responses occurred.

^b Includes accompanying another person to a clinic.

Source: population-based sample surveys.

ment of routine home visits to all eligible women in the intervention areas evidently did not lead to negative consequences with respect to contraceptive use, method mix and source mix of contraceptives, and the use of clinical services. For the PHCC alternative, the results did not support the hypothesis that a shift from the conventional doorstep strategy would adversely affect programme performances.

Urban women were willing to travel to outside sources but were probably not adequately motivated

to attend CSPs for the sole purpose of obtaining pills and condoms. Numerous pharmacies and shops in the urban areas dispense pills and condoms. A broader range of MCH-FP services provided from outside service delivery points seemed to motivate urban women more effectively to go to these facilities and ensure their better use. The transitory alternative strategy based on CSPs did not appear to be effective.

There were increasing trends in the numbers of clients attending the static clinic (PHCC) and in the

services used. These indicators were quite high in the PHCC compared to those in the CWFP clinics in the CSP and doorstep strategies. In addition to the increased use of contraception, the PHCC-based strategy also produced an increase in the utilization of clinical family planning items, e.g. injectables and intrauterine devices. The method mix of users at the PHCC-based service delivery site resulted in considerable changes in favour of clinical contraceptives. This should facilitate the attainment of sustainable demographic effects.

In both alternative strategies the proportion of clients obtaining their family planning methods from commercial sources and static clinics increased markedly. Clients became more proactive in seeking MCH-FP services, indicating a positive trend from supply-induced demand, generated in the doorstep CBD, to effective demand. Furthermore, the attendance of clients at the clinics in order to obtain contraceptive commodities gave them the opportunity to use a wide range of MCH-FP services. The clinic-based system provides a holistic approach to addressing clients' needs through a package of essential services. Taken together, all these factors are conducive to improved programme sustainability.

Operations research revealed that, because of strengthened clinic activities, the relative share of clinic-related costs initially increased in the PHCC strategy. However, the reduced numbers of fieldworkers and the increased use of PHCC services meant that the unit costs of services in the PHCC strategy were much lower than those in the strategy based on CSPs and in the conventional strategy based on fieldworkers. In terms of births averted and quality of life years gained, the PHCC-based strategy was the most cost-effective alternative.^a Replacement of the doorstep distribution strategy with the clinic-based service delivery alternative seemed feasible in urban areas without adverse effects on MCH-FP programme performance.

Higher utilization of the services provided from the clinics was critical in the cost-effectiveness of the clinic-based service delivery strategy. It is consequently necessary to have an effective mechanism for promoting clinic services in the community. The role of effective and appropriate behavioural change communication and community mobilization is of paramount importance in this connection. Community mobilization activities are required so that the perspectives of consumers can be incorporated into the alternative service delivery systems, with a view to contributing to further sustainability of MCH-FP programmes. The participation of community groups in planning and organizing programmes therefore needs to be explored further.

^a Further details on the cost and cost-effectiveness implications of the alternative approaches may be found in our paper, "Economic appraisal of alternative service delivery strategies for the delivery of MCH-FP services in urban Bangladesh", *International Journal of Health Planning and Management*, 2000, 15: 115-132.

In the absence of routine home visits to all eligible couples in the programme areas the refinement of the clinic-based information system should be continued. This is necessary in order to identify non-users of clinical services and socioeconomically vulnerable groups of public health concern (e.g. the poor, children under 5 years of age and pregnant mothers) at the lowest possible cost. It is important to develop an information system for a clinic-centred service delivery structure with a community-based component geared to case detection and referral to clinic services. The key issue is to link clinic and community and to ensure continuity of care for individual clients and their families.

Because of limited national resources, stagnation in donor support associated with altered priorities, and the increased responsibility of national programmes to ensure a broader range of reproductive and other essential family health services, many countries are now investigating less costly but effective service delivery strategies to cope with changing conditions. In Bangladesh a major change in the national health and population programme is taking place. The experiences of the Thana Functional Improvement Pilot Project of the Ministry of Health and Family Welfare and the operations research studies of the Rural MCH-FP Extension Project of ICDDR,B have demonstrated the prospects for clinic-based service delivery in sustaining the use of contraception and ensuring increased use of basic health care provided at static centres and PHCCs (10, 11). These findings contributed to the formulation of a new national programme involving the delivery of a package of essential health and family planning services by a system of static clinics. Lessons learnt from the intervention will help in the operational development and further refinement of the clinic-based service delivery strategies adopted by the government and nongovernmental programmes in urban areas. ■

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Résumé

S'adapter aux changements de conditions : stratégies de rechange pour la prestation de services de santé de la mère et de l'enfant et de services de planification familiale à Dhaka (Bangladesh)

La distribution à domicile de contraceptifs et d'informations sur les services de santé de la mère et de l'enfant et les services de planification familiale, dans le cadre de visites bimestrielles aux couples concernés effectuées par des agents de terrain spécialement formés, a joué un rôle utile en augmentant la prévalence de l'utilisation des contraceptifs et la couverture vaccinale au Bangladesh. Cette stratégie est toutefois coûteuse en temps et en argent. Il est nécessaire de disposer de stratégies ayant un meilleur rapport coût-efficacité pour la prestation non seulement des services de planification familiale mais aussi d'un ensemble plus vaste de services de santé génésique et autres services essentiels en matière de santé.

Compte tenu de cette situation, le Centre de recherche sur la santé et la population de l'ICDDR,B (Centre international de recherche sur les maladies diarrhéiques, Bangladesh) a conduit une recherche

opérationnelle de janvier 1996 à mai 1997 en collaboration avec des organismes officiels et une grande organisation non gouvernementale nationale, dans le but d'élaborer et d'expérimenter sur le terrain de nouvelles approches de la prestation de services de santé de la mère et de l'enfant et de services de planification familiale en zone urbaine. Deux stratégies de rechange comportant la suppression de la distribution à domicile et assurant la prestation des soins de santé de base en un lieu fixe ont été testées dans deux secteurs de la ville de Dhaka.

La stratégie avec prestation de services en dispensaire s'est révélée une alternative réalisable au coûteux système de distribution à domicile en usage en ville de Dhaka. Elle n'a pas entraîné de perte de performance du programme et a permis de répondre de façon holistique aux besoins des clients grâce à un ensemble de services de santé essentiels et de services de planification familiale.

Resumen

Adaptarse a los cambios: estrategias alternativas para la prestación de servicios de salud materno-infantil y planificación familiar en Dhaka (Bangladesh)

En Bangladesh, un factor que ha contribuido a aumentar la prevalencia del uso de anticonceptivos y la cobertura inmunitaria son las visitas bimensuales casa por casa efectuadas por trabajadores sobre el terreno a las parejas que reúnen los requisitos establecidos para distribuirles anticonceptivos y suministrarles información sobre los servicios de salud materno-infantil y planificación familiar. Esa estrategia de visitas domiciliarias, sin embargo, es costosa y requiere abundante personal. Es preciso disponer de estrategias asistenciales más eficaces con relación al costo, no sólo para los servicios de planificación familiar, sino también para un más amplio conjunto de servicios de salud reproductiva y otros servicios de salud básicos.

Ante esta situación, entre enero de 1996 y mayo de 1997, ICDDR,B – Centro para la Investigación en materia de Salud y Población, en colaboración con organismos

gubernamentales y con una destacada organización no gubernamental nacional, llevó a cabo una investigación operativa a fin de desarrollar y ensayar sobre el terreno formas alternativas de prestación de servicios de salud materno-infantil y planificación familiar en zonas urbanas. En dos áreas de la ciudad de Dhaka se ensayaron dos estrategias alternativas caracterizadas por la suspensión de la distribución domiciliar y la prestación de atención sanitaria básica a partir de centros de salud fijos.

Se comprobó que esa estrategia de prestación de servicios ambulatorios constituía una alternativa viable al costoso sistema de visitas en las zonas urbanas de Dhaka. No menoscabó la eficacia de los programas, y permitió abordar de forma global las necesidades de los usuarios mediante un paquete de servicios básicos de salud y planificación familiar.

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