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Second service delivery survey

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**HEALTH AND POPULATION SECTOR PROGRAMME
1998-2003
BANGLADESH**

SERVICE DELIVERY SURVEY: SECOND CYCLE, 2000

**REPORT
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**Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh**

EXECUTIVE SUMMARY

This is the report of the second cycle of the Service Delivery Survey (SDS) monitoring process for HPSP, part of the recurrent monitoring during the five year period of the programme. The fieldwork for the main household survey was completed on 15 October 2000, with data entry and cleaning completed by 30 October. Following preliminary data analysis, the presentation and discussion of findings from the household survey in gender-specific focus groups in the sample of 218 rural communities, and with upazila health management teams in a sub-sample of 24 upazilas, took place between 21 November and 10 December. A preliminary report of key findings was prepared in November 2000 to provide an input into the HPSP Annual Performance Review and Mid Term Review.

Methods

The methodological approach was the same as in the baseline SDS, based on CIET methods (see Annex 1). The approach combines quantitative and qualitative data from households, service users and service providers. Analysis includes examination of areas where interventions might produce useful benefits.

Household survey sample (Annex 2)

The sample for the baseline SDS (a multi-stage, stratified, random, cluster sample to give representation of divisions and in 44 sample upazilas) was again used, but with 25% of the original sites in each division randomly reselected. The sample includes 218 rural sites and a separate stratum of 30 sites in the Statistical Metropolitan Areas.

Survey instruments (Annex 3)

The instruments are: household questionnaire; health service providers questionnaire; key informant interview schedules for the UHFPO in each sample upazila, the Chairman of the Union Parishad, and the Community Clinic Group chairman (or other knowledgeable person in the community); institutional review schedules for the UHC, the UHFWC, and with the HA or FWA covering the site; and guides for the community focus groups and the upazila health management team meetings.

Training, data collection, data entry, and analysis

Field coordinators, supervisors and interviewers were trained in Dhaka and in divisional centres. Fifteen data collection teams worked simultaneously, each covering three upazilas and additional metropolitan sites. Coding and data entry took place in Dhaka with a separate trained group. All data were entered twice and validated. Smaller teams of trained facilitators revisited the communities to undertake the focus groups and upazila meetings. Translated reports of focus groups and upazila meetings were coded to draw out key themes and entered. Analysis has made use of Epi Info and SPSS software and has combined household information with data from other instruments, such as institutional reviews and focus group reports.

Findings

The evidence base

The sources of information in the survey process are shown in the box.

Two indicators of household poverty were used: type of house construction and annual household income. One categorization for poverty was house construction of kutcha2 type. Another was an annual household income of less than Tk23, 899. A third of houses have kutcha2 construction and 28% of households are defined as very poor on the basis of annual income.

Information was collected from:

- 25,473 households
- 124,852 people
- 19,593 health services users
- 24,529 married women aged 10 – 49
- (24,446 married women aged 15 –49)
- 1,962 service providers
- 43 UHFPOs
- 215 UP Chairmen (or deputy)
- 215 Community Group Chairmen or other community representative
- 41 UHCs
- 172 UHFWCs
- 195 local health workers (HA/FWA)
- 436 gender segregated focus groups
- 24 upazila health service providers meetings

Household opinions of health and family planning services

- One in ten households think government health and family planning services are ‘good’, around half think they are ‘neither good nor bad’, and 41% think they are ‘bad’. Some 37% of households rated the government services as ‘good’ in the 1999 baseline SDS. The main change from 1999 is a shift from rating the services as ‘good’ to rating them as ‘neither good nor bad’. This could be a good thing if it reflects that the public is becoming more demanding of a quality service.
- As in 1999, the most commonly cited problem with government services is lack of medicines (58%), with 25% complaining about bad staff attitude.
- A quarter of households think private and NGO services (including those from unqualified practitioners) are ‘good’, two thirds think they are ‘neither good nor bad’ and 10% think they are ‘bad’.
- The most commonly cited problem with private/NGO services is expense, especially having to pay for medicines.
- Three quarters of households say they are willing to pay for an improved government service (mean Tk 5 for the ticket and Tk 15 for admission). This has increased since the 1999 baseline SDS, when the proportion willing to pay was 55%.

Household use of health and family planning services

- Less than one in ten households had a home visit from at least one government health and family planning service provider in the last month. Some 60% of the home visits were for family planning and 23% for immunizations.
- Some 14% of households have a member who has used government health services for any purpose in the last month. Just 11% used the services for treatment (the figure in 1999 was 13%).

- Very poor households are less likely to use government health services. Focus groups suggest that poor people feel government health services discriminate against them and treat them badly.
- Some 43% of households have a member who has used private or NGO services for treatment in the last month.. The figure was 32% in 1999.
- Very poor households are also less likely to visit private and NGO services.
- Some 22% of households reported an ill member who did not seek care in the last month. The figure in 1999 was 5%; the reason for the increase is not clear.
- About a tenth of households had someone ill in the last month but did not have contact with any health service; this is more common in very poor households (14%).

Experience of health service users

Service contacts

- A total of 19,670 household contacts with health services in the last month were reported in more detail: 2268 home visits and 17,402 visits to service providers.
- Just 10% of visits to health services in the last month were for preventive purposes. Among adult users, 97% are women. Government services are used especially for immunisations (55%), private services for antenatal care (41%), and unqualified practitioners for family planning (71%).
- Most users (76%) of government services for preventive purposes got the required treatment (mainly vaccine or contraceptives), and nearly all (89%) were satisfied with the providers and the service.
- Considering visits for treatment (15,565), 32% were to the village doctor, 27% to a private doctor, 12% to a drug shop, and 11% to the UHC.
- Of visits for treatment, 20% were to government health service providers, 30% to private doctors or private clinics (including just 67, 0.4% to an NGO facility), and 50% were to an unqualified practitioner (village doctor, drug shop or traditional practitioner (5%)).
- There is a deficit of very poor people among those who visited private services (15%) compared with government (24%) or unqualified practitioners (26%).
- 71% of all visits to government services were for treatment, compared with over 90% for visits to private and unqualified practitioners.

Choice of service

- Prominent reasons for choosing government health services were that it was free or cheap and that access was good.
- For private services, the reasons for the choice were a good service provider, or a well known, recommended doctor.
- For unqualified practitioners, the main reason for choosing them was easy access.

Waiting time

- Average waiting times are longer in government health facilities and patients are more likely to wait for more than 30 minutes to see the service provider.

Explanations from service providers

- Overall, two thirds of patients reported a full explanation of their problem or illness from the service provider. This means an explanation the patient felt satisfied with, not necessarily one that was objectively adequate, or even correct.
- Half of patients visiting government services reported a full explanation of their illness, compared with 71% for private services and 68% for unqualified practitioners.
- Overall, three quarters of patients considered they were given a full explanation of their treatment: 54% for government services, 78% for private services, and 78% for unqualified practitioners.

Payments for visits to health services

- About a quarter of people using government health services said they paid for a ticket. This is nearly always an unofficial payment at upazila level and below in the upazilas in our sample (which includes very few TFIPP thanas). Very poor people are less likely to pay for a ticket.
- Nearly two thirds of people who use government health services pay for medicines: 55% pay outside the facility and 8% pay inside the facility. Very poor people pay for medicines as frequently inside the facility, but a lower mean amount.
- Over a fifth of people using government health services pay a service or prescription charge – an unofficial payment. Very poor people pay this charge as frequently as less poor people but pay a lower amount. Men are more likely than women to pay this charge.
- One in five people using government health facilities reported making a personal, unexplained payment to a service worker – usually to the doctor (19%). The average amount paid (Tk 53.5) is about half the amount paid to service providers in private facilities. These payments are as frequently made by very poor people and women but they amount they pay is less than less poor people or men.
- Participants in community focus groups feel these unofficial payments are wrong and resent paying them but feel they have no choice if they want to get treatment. Service providers in upazila meetings agreed that unofficial payments sometimes do happen.

Prescription of medicines

- The rate of prescribing medicines is 88% for government services, 93% for private services, and 80% for unqualified practitioners.
- For government health services, very poor people and women are less likely to be prescribed medicines.

Availability of prescribed medicines

- Some 20% of people using government health services received all the prescribed medicines. The equivalent figure in the 1999 SDS was 33%. The difference is probably because the 2000 survey reflected a low point in the cycle of supply of medicines to government facilities.
- About a quarter of patients in government health facilities who received medicines did not receive the full amount prescribed; 19% of patients received all prescribed medicines in the full amount.

- Service users visiting UHCs with a relatively good medicines supply index (supply / patient load in the same period) are more likely to get the prescribed medicines in the facility, but this is clearly not the only factor involved.
- Patients who pay an unofficial service charge or pay the service provider are *less* likely to get all prescribed medicines in the facility; this could reflect more sophisticated prescribing for such patients.
- People from households with an illiterate head and very poor people are *more* likely to get all the prescribed medicines in the facility –for these patients the service provider may prescribe simple medicines that are in stock in the facility.
- Community focus groups think lack of medicines is due to pilferage and diversion of medicines from the government facilities; service providers in upazila meetings think it is due to poor supply and too many patients.

Satisfaction of service users

- Overall, 88% of service users are satisfied with the behaviour of the service provider towards them. The proportion satisfied is lower among users of government services (66%) than among those using private services (93%) or unqualified practitioners (92%).
- Most service users are satisfied with the overall service they receive. The proportion satisfied is lower for government services (62%) than for private services (88%) and unqualified practitioners (88%).
- The proportion of users of government services satisfied with the overall service has increased from 53% in the 1999 SDS to 62% in the 2000 SDS.
- Service users are less likely to be satisfied with visits to government health services if: they come from an illiterate household, they are very poor, they have to wait for more than 30 minutes, they have to pay for a ticket, they do not get the prescribed medicines from the facility, or they do not feel they have had a full explanation about their illness or about the treatment.
- Analysing the combined effects of these factors allows a model to be constructed to show the potential gains in patient satisfaction for different interventions. There could be a very useful gain from simply explaining to patients about their condition and the necessary treatment.

Injuries and violence against women

- Among married women aged 10-49 years, 4% reported an injury requiring treatment in the last year.
- The rate of injuries varies from 12% in Sylhet to 1% in Rajshahi.
- Some 11% of women who had an injury in the last year said (in answer to an open question) that it was due to violence. This is likely to be an underestimate because of the difficulty for women to discuss such issues in a household interview.
- About a quarter of women with an injury requiring treatment did not seek treatment. Literate women are more likely than illiterate women to seek treatment for injuries.
- Focus groups discussed the problem of violence against women more openly, revealing a serious continuing problem

- Reviews of health facilities reveal variable recording of cases of injury and assault, almost no special arrangements for dealing with such cases and little or no staff training on the issue.

Care during delivery

Place of delivery

- Nine out of ten women who delivered a baby in the last year delivered at home.
- Women in metropolitan areas are much more likely to deliver in a facility (41%) and women who are not very poor are more likely to deliver in a facility than very poor women.
- In rural areas, women are more likely to deliver in a facility if they are not from a remote upazila, if they are literate, if they are less than 30 years old, and if they live in a house of better construction than kutchha².
- Community focus groups reveal people are not in favour of delivery in facilities because of expense, perceptions of bad treatment from staff, and concerns about unnecessary interventions.

Attendant for delivery

- Only 15% of deliveries in the last year were attended by a trained person (all dais were treated as untrained in this case).
- The delivery is more likely to be attended by a trained person if the woman is below 30 years old, in metropolitan areas, if the woman lives a better house, if she is not very poor, if she is not from a remote upazila, and if she is literate.
- The most common person to decide about who will attend the delivery is the husband (60%). The woman takes or shares the decision in 22% of cases. The mother in law decides in 11%.
- When the decision is shared between the woman and someone else, the delivery is more likely to be attended by a trained person than for other decision combinations, or if the woman decides on her own.

Problems during delivery

- Some 7% of women who delivered in the last year reported a problem during delivery.
- Literate women and women from metropolitan areas are more likely to report problems during delivery: this may reflect a difference in perception of what constitutes a problem during delivery.
- Women delivering in facilities have five times more problems during delivery, reflecting that many deliveries in facilities are emergency admissions because of problems during delivery.
- A woman with a health problem during delivery is more likely to be taken to a health facility if she is from a metropolitan area, if she is not very poor, and if she is literate.

Views and knowledge of government health and family planning service providers

- Some 1962 service providers at upazila level and below completed a self-administered questionnaire. Nearly half have worked in the same upazila for more than 10 years.

Views about work and the service they provide

- About half the service workers report some difficulty fulfilling their duties. Commonly cited problems are inadequate supplies, difficult access to the area, bad behaviour of patients, inadequate human resources, and inadequate facilities.
- Suggestions for improvement include more supplies, more training, more human resources, more personal incentives, and improved infrastructure.
- Some 40% of service workers consider they are treated unfairly as employees in some way; especially problems with salary and benefits, lack of incentives for good work, and lack of recognition according to qualifications.
- Nearly half the service providers report problems with the way patients behave towards them. Problems cited are: complaints about lack of medicines, bad attitude of patients and visitors, patients asking for illegal benefits, lack of awareness or ignorance of patients, and complaints about poor quality of service.
- Nearly all (91%) service providers attribute lack of medicines available for patients to inadequate supply to the facilities. 4% cite corruption as a cause.
- Three quarters of service providers say that it is rare or non-existent for service providers to demand extra payments from patients; 7% say it is a common practice. A quarter of service workers attributed the practice to corruption, 18% cite financial reasons and frustration, and 9% say “it happens everywhere”.
- Asked for suggestions to improve government health and family planning services, half the service providers suggested educating and raising awareness of the masses.

Knowledge about HPSP and ESP

- Almost all (95%) the service providers have heard of HPSP from some source.
- 90% of those who have heard of HPSP know something about it – mainly that it is about unification of health and family planning services.
- Four out of ten service providers say they do not know anything about ESP components.
- Less than a fifth of service providers report having any training about ESP.

Health education activities

- Of service providers designated to undertake health education, a third report having had some training about the conduct of health education sessions.
- Nearly all these service providers report at least one health education during the last month.

Community clinics and community clinic groups

(Note that data collection was in September and October 2000)

Information from community based health workers

- Some 195 community based health workers were interviewed, mainly HA and FWA. Only one reported working in a functioning community clinic.
- 53% report a community clinic group has been formed and 44% that it is functioning. Some 63% say sites selection for the community clinic has been finalized, 22% that construction has started, and 8% (15) that construction is completed.
- In some communities, the site for the community clinic has been finalized even though there is no functioning community clinic group.
- Almost a third of community based health workers say they don't know about community clinic groups and how they should function. And 15% say they don't know about community clinics and how they will work.

Information from Union Parishad Chairmen

- Some 121 UP Chairmen who gave information that: 51% of the survey sites have a community clinic group covering their area, 44% of them have a group that has held meetings, and 57% have a location selected for the community clinic.

Knowledge of households

- Only one in ten household respondents knows about a community clinic group active in their community.
- Among those who know of a group's existence, 85% do not know anything about its activities, and 10% believe it does nothing.
- In communities with a functioning community clinic group (as reported by the community based health worker), 13% of the households say they know of a group, while 7% of households in sites *without* a functioning group say they know of one.
- Communities with a functioning community clinic group have a lower proportion of very poor households compared with sites that do not have a functioning group. This may suggest groups are less likely to be formed in poorer communities.

Commentary

Comparison of 1999 SDS and 2000 SDS

- As yet, there is not much evidence that the HPSP reforms are feeding through into an improved experience for the public and service users. It is really not to be expected that the big reforms of the services will have had a noticeable beneficial effect on their experience after only two years (there is less than two years between the two surveys). There are encouraging signs in the increased proportion of households willing to pay for an improved government health service and the increased proportion of service users satisfied with the overall service from government facilities.
- New areas in the 2000 SDS have been useful, especially the inclusion of a direct indicator of poverty.

Areas of focus for the 2000 SDS

- The second SDS has thrown some light on the complex issue of medicines availability in government facilities and shown some relation with supply to the facilities. There is an important difference in perception about this issue between the public and service providers.
- The survey has confirmed people's generally positive view of private health services, and shown the high use of unqualified practitioners and the very low use of NGO providers.
- The lack of arrangements in health facilities for dealing with violence against women is a concern.
- The findings about the positive effects of joint decision making about delivery attendance echo the findings from SDS 1999 about antenatal care.
- This second SDS has given service providers much more opportunity to voice their views and mention their concerns.
- Community participation is supported by the SDS process itself and we have also assessed the level of community involvement in community clinic planning.
- The survey provided an opportunity to get a baseline for the further development of community clinics.

Moving forward

The HPSP reforms still have some way to go in improving the public experience of government health services from the reforms of the HPSP. However, even to be asking ordinary people about their experiences and opinions of services and using this process to help monitor service reforms reflects an important change in attitude. There are already encouraging signs in the increased proportion of households willing to pay for improved government health and family planning services, the generally positive experience of people using services for preventive and planning purposes, and the increased proportion of users satisfied overall with their visit to a government health facility for treatment.

There remains a big gap between service providers and intended service users. They interpret the same information quite differently, as for example the differences reported here between the community focus groups and the service providers in the upazila meetings in the 2000 SDS. Bridging this communication gap and helping the public to know more about the way the services work and their limitations could remove some negative perceptions about the services. This may be most effective if done at local level, increasing public involvement in the way government health and family planning services are delivered and monitored.

The attitudes of service providers and how they treat patients are very important to the patients. In this SDS, there is evidence that satisfaction of service users could be greatly improved if providers would just give them simple explanations about their illness and treatment. This sounds like a cheap option but it will be a big challenge to change attitudes of service providers at all levels. A programme of support and BCC is needed for health service providers.

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ABBREVIATIONS AND GLOSSARY OF TERMS

Abbreviations

ANC	Antenatal care
BBS	Bangladesh Bureau of Statistics
CCG	Community clinic group
FPI	Family planning inspector
FWA	Family welfare assistant
FWV	Family welfare visitor
HA	Health assistant
HI	Health inspector
HPSP	Health and Population Sector Programme
MA	Medical assistant
MO	Medical officer
MOHFW	Ministry of Health and Family Welfare
RMO	Resident medical officer
SACMO	Sub-assistant community medical officer
SDS	Service delivery survey
SMA	Statistical Metropolitan Area (main cities)
UFPO	Upazila family planning officer
UHC	Upazila health complex (formerly THC – Thana health complex)
UHFPO	Upazila health and family planning officer (formerly THFPO)
UHFWC	Union health and family welfare centre
UP	Union Parishad

Statistical and epidemiological terms

This report is deliberately written avoiding too many specialised statistical and epidemiological terms. However, some are unavoidable. A brief explanation of the main terms used in the report is given here; readers who are interested in more detailed explanations could refer to a textbook on modern epidemiological methods.

Relative Risk:

The risk or likelihood in one group compared with another group (for example the likelihood of using government health services among very poor households compared with the likelihood in less poor households). When the actual rates in each group are known (for example, the total number of households and the number using government health services), the relative risk can be estimated either by the Odds Ratio or by the Rate Ratio (the rate in one group divided by the rate in the other group). In a case-referent study, only the Odds Ratio can be calculated. For relatively rare conditions, the two estimates of Relative Risk give a similar answer. There is discussion about which estimate of Relative Risk it is better to use. For further details, a textbook of modern epidemiology should be consulted. In CIET methodology, the Odds Ratio is used as the estimate of Relative Risk. Information is given that allows readers who wish to calculate Rate Ratios.

Odds Ratio:

One way of estimating the Relative Risk. In a 2X2 table, with cells a,b,c,d, the Odds Ratio is calculated by ad/bc .

Adjusted Odds Ratio:

When the effects of a number of variables are examined together (for example in a multiple logistic regression analysis), the Odds Ratio for each variable, taking the effects of the other variables into account, is the adjusted Odds Ratio.

Risk Difference:

The risk difference is the rate in one group minus the rate in another group. For example, if the rate of using government health services is 14% in one group of households and 9% in another group, the risk difference is 5%. The risk difference is useful for planners, as it forms part of the calculation of the potential benefits, at a population level, of different interventions. To use the risk difference in this way, it is necessary to take into account other variables that also affect the outcome in question.

Proportion Requiring Intervention (PRI):

When deciding how much population benefit could be achieved by a particular intervention, it is important to know what proportion of the population could be expected to benefit – that is, those that have an unfavourable level of the factor to be modified. For example, when estimating the likely improved satisfaction among health service users that could be achieved by making medicines more available, it is necessary to know how many service users presently do not receive medicines from the health service.

95% confidence interval:

A measure of the accuracy of an estimate, based on the normal distribution curve. The true value has a 95% chance of lying between the upper and lower values of the 95% confidence interval. The confidence interval indicates what how much bigger or smaller the true value could be. It is also an indicator of statistical significance. If the 95% confidence interval of an Odds Ratio does not include 1.00 (that is, it is entirely above or below 1.00), then the association represented by the Odds Ratio is statistically significant at the 5% level.

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3. Instruments
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8. Summary of themes from upazila service providers meetings

INTRODUCTION

This is the second cycle of the Service Delivery Survey (SDS) monitoring process for HPSP, part of the recurrent monitoring planned during the five year period of the programme. The first cycle of the SDS - the baseline survey - was carried out at the beginning of 1999 (Cockcroft et al 1999).

The survey provides updated information on the utilisation, experience and perceptions of health services by the population of Bangladesh. It generates data on a number of key indicators that are being tracked as part of the HPSP programme. This will allow monitoring of the programme effectiveness, particularly its effectiveness in making health and population services more responsive to users and more locally accountable.

A number of indicators already covered by the baseline survey are again measured. Some of those estimated in the baseline SDS do not require re-measurement so soon, and others are recently available from other sources (such as the recent DHS). In this second cycle of the SDS process, there is a special focus on several areas. These special focus issues have been identified, on the one hand, from the findings of the baseline survey and, on the other hand, from discussion with key players following the baseline survey and taking into account priorities in the HPSP.

- *Availability of medicines*

In the baseline survey, the non-availability of drugs from government health facilities was a major complaint of patients and was strongly related to the satisfaction of service users, when other factors were also taken into account.

- *Experience and perceptions of private and NGO health services*

Feedback on the baseline survey findings indicated an interest to assess the experience and satisfaction with private and NGO health services as well as government services.

- *Violence against women*

Several commentators on the baseline survey expressed an interest in examining the issue of violence against women in some way.

- *Delivery and access to EOC*

A suggestion after the baseline survey was to include something about women's access to EOC and the decision-maker in the household about delivery care.

- *Views of service providers*

In the baseline survey, only a few service providers were interviewed. It was pointed out in discussion of the findings of the baseline survey that it would be useful to hear the views of a larger number of service providers.

- *Behaviour change communication (BCC)*

One of the indicators for monitoring of the HPSP concerns the process of BCC.

- *Community participation*

Many commentators on the baseline survey findings stressed the importance of continuing to assess community participation in health and family planning services.

- *Community Clinic Groups and Community Clinics*

There is considerable interest in assessing the progress of this initiative in the 218 rural communities that are part of the SDS sample.

The fieldwork for this second cycle of the SDS was completed by 15 October, with data entry and cleaning completed by 30 October. A preliminary report covering key

findings was submitted on 13 November in time to provide an input into the HPSP Annual Performance Review and Mid Term Review. The preliminary report described the frequencies of important variables, examined in terms of poverty status and gender. Some important relationships between outcomes and possible contributing factors were also presented in this report, but more detailed analysis of these relationships to exclude confounding and investigate effect modification by other variables has since been undertaken. Most of the findings presented in the preliminary report were from the household questionnaire and the questionnaire to government health service workers.

A further piece of the work in the survey process has been undertaken since the preliminary report: the presentation and discussion of some important findings from the household survey in gender-specific focus groups in the sample of 218 rural communities; and the presentation and discussion of key findings to upazila health management teams in a sub-sample of 24 upazilas. This took place between 21 November and 10 December 2000. Qualitative information from these community and service-management sources gives insights into the quantitative findings.

This report includes findings from interviews with key informants, institutional reviews, focus groups and upazila meetings, which are not covered in the preliminary report. It also includes the findings of the more detailed analysis of relationships between important outcomes and possible contributing factors.

Dhaka
February 2001

METHODS

The second cycle of the SDS follows the same methodological approach as the baseline survey. This approach - the CIET methodology – goes beyond a survey to produce indicators, important as these may be for monitoring a programme or intervention. It also aims to produce information relevant to planners and programme managers, analysed in a way that suggests what programme interventions might help to improve a situation; it is a support for evidence based planning (Andersson 1996). Annex 1 summarises the CIET methodological approach.

The survey sample

The survey sample for the baseline SDS was drawn in collaboration with the Bangladesh Bureau of Statistics (BBS). It is a multi-stage, stratified, random, cluster sample. It is intended to give representation of the six divisions and of sample upazilas within the divisions, for rural sites. Since the HPSP has a focus on rural areas the main focus of data collection is also rural sites. Of the 248 sample sites 30 (12%) are urban sites, from the Statistical Metropolitan Areas of Dhaka, Rajshahi, Khulna and Chittagong. This gives enough data to allow reliable estimates for the metropolitan urban sites. An important reason for including some urban sites is that, with appropriate weighting, it allows comparison of certain indicators at national level from this survey with the same indicator from other sources. It could otherwise be confusing as readers of the report may not recognise that the figures were derived from an entirely rural sample.

For the main rural sample upazila representation was chosen, rather than attempting to represent all 64 districts, or even to represent the ‘greater districts’, because the upazila level is a functional unit under the HPSP (for example in the Local Level Planning initiative). This sample design allows results to be declared at national level, at divisional level and at upazila level for the sample upazilas representing each division. A further advantage of this design is that it can allow upazila level findings to be disseminated and discussed with relevant stakeholder groups at upazila level. This can make a meaningful contribution to stakeholder participation at local level and to Local Level Planning (LLP), both aspects of the HPSP.

The sample size is about 25,500 households in 248 sites (each site of around 100 households): 218 rural sites in 44 upzilas and 30 metropolitan urban sites. For this second cycle of the Service Delivery Survey, 25% of the whole original sample was randomly reselected in collaboration with the Bangladesh Bureau of Statistics. This allows assessment of any possible Hawthorne effect (due to repeat visits to the same sites). If such an effect is demonstrated it can be taken into account.

The selected upazilas and unions and villages within each upazila for the rural sample and the metropolitan sample wards in this second service delivery survey are shown in Annex 2.

Data collection instruments

In the cross-design approach used in the CIET methodology, several data collection instruments are required. Suitable instruments were developed for the baseline SDS, drawing on those used in similar surveys in other countries, and based on strong local input from people knowledgeable about the situation of health and family planning services in Bangladesh, as well as the process and aims of the HPSP. In this second cycle, the instruments built on those of the baseline survey, omitting some areas not to be covered in this cycle because they are already covered elsewhere or because they do not need to be re-measured so soon. The instruments were modified and enhanced to take into account the special focus areas defined for this second cycle and comments on the baseline survey. The instruments deliberately retain a common core with the baseline survey in order to allow tracking of certain indicators over time. The instruments are shown in Annex 3.

This list of indicators for the second cycle of the SDS, developed in conjunction with the review of the overall list of indicators for monitoring of the HPSP, is shown in Annex 4. In some aspects, such as client satisfaction and experience of services, the indicators collected in the SDS go beyond the minimum summary set of indicators for the HPSP monitoring.

Household questionnaire

This is the main instrument for quantitative data collection. It is intended to be administered in about 20 minutes to each household. Part of the interview is with a respondent (male or female) on behalf of the whole household. Another part is with each married woman (aged 10-49 years) in the household; and a further part is about each visit to public or private health services in the last month by any member of the household, to be administered to the person who used the service whenever possible, or to a proxy if necessary.

Questionnaire for service providers

This is a self administered instrument completed by health service providers at upazila level (Medical Officers, Resident Medical Officers, Nurses, Family Welfare Visitors, Health Inspectors, Pharmacists and Storekeepers), at union level (Medical Assistants, Family Welfare Visitors and SACMO's) and at community level (Health Assistants and Family Welfare Assistants). It consists of a series of questions related to the experience, training, problems and opinions of service providers. The questionnaire was entirely self-administered by workers at upazila level, but interviewers helped with the completion by workers at union and community levels.

Institutional review schedule

The institutional reviews consist of an interview with the service provider in charge of the facility as well as observation of the facility according to the schedule. In the case of the UHC and the UHFWC, the main areas covered in the institutional reviews were medicines supply, arrangements for dealing with injuries to women possibly due to violence, EOC arrangements, and charges made at the facility. In the case of

Community Clinics, the community service worker (HA or FWA) was interviewed about the progress with the clinic covering the survey site.

Key informant interview schedules

Several key informants were interviewed:

- a) A community key informant (the Chairman or a member of the Community Clinic Group if available or another knowledgeable person in the village, such as a teacher or a religious leader) for each site. This person were interviewed to give information about the site in general, including information about the type of health care providers available, as well as specific information about the Community Clinic Group if there is one.
- b) A member of the Union Parishad that covers each site. This interview includes information about the functioning of the UP as well as about progress with the Community Clinic.
- c) The Upazila Health and Family Planning Officer (UHFPO) in each of the 44 sample upazilas. The UHFPO was asked about relevant policies in the upazila, about opinions on aspects of the HPSP and about progress with the Community Clinics in the upazila.

Focus group discussion guides

In each of the 218 rural survey sites of about 100 households, two focus groups were held: one of women and one of men. The focus group discussion guides are used to facilitate the discussion in the groups, not necessarily in the order written but ensuring that all aspects are covered in the group. The discussion guides include summaries of the key findings from the household interviews, as found in the relevant upazila. Each group discussion includes 8-10 participants, a facilitator and a recorder. The facilitator moderates the discussion, ensuring that all participants give their views, seeking group consensus or noting areas of disagreement. The recorder notes down the views expressed, including relevant verbatim quotes, as well as important non-verbal issues (for example, if the participants are angry about any issues). Immediately after the group discussion, the facilitator and recorder together complete a fair copy of the discussion record, using the notes made during the discussion.

Training

Main household survey

For the main household survey, several levels of training took place, for field coordinators, for supervisors, and for interviewers. More supervisors and interviewers were trained than were actually needed, so that any who did not do well enough in the training were not used in the data collection teams. Training manuals were developed for the different survey instruments to be used in the training courses retained by the teams for reference while in the field.

Training in Dhaka took place between 10 and 14 September 2000. Training for interviewers in other centres took place from 17-19 September 2000.

Field coordinators

These four people had two days of initial training and orientation, then participated in the five days training for supervisors and interviewers in Dhaka. The field coordinators then led the training for interviewers in Rajshahi, Khulna and Chittagong.

Team supervisors

These 30 people (two per team) were *all* trained in Dhaka. They had three days training with the interviewers for Dhaka teams, followed by an additional two days training specifically for supervisors.

Male interviewers

These 15 interviewers (one per team) had specific responsibility for collecting data from upazila and union levels to go with the information collected from households in the sample sites. They were all trained in Dhaka, with three days training with the other interviewers and an additional day to cover the other instruments to be used to collect data from upazila and union levels.

Main interviewers

The interviewers for the teams covering Dhaka division were trained in Dhaka - a total of 36 from six teams. Their training took place alongside the supervisors. The training was over three days, including practising the household questionnaire in non-sample sites outside Dhaka. The interviewers for teams in other areas were trained in Rajshahi (4 teams), Khulna (3 teams) and Chittagong/Sylhet (3 teams). This training took place the week after the Dhaka training and the supervisors trained in Dhaka took part in the training of the interviewers for their areas. Each of these divisional training courses was led by the relevant field coordinator. As with the Dhaka training for interviewers, the three day training included a day for field practice with the household questionnaire.

Coders and data entry clerks

Seven coders for data entry of the quantitative instruments were trained for one day. Two data entry supervisors were also trained at the same time: each one was subsequently in charge of supervising one of the two shifts (one in the morning and one in the afternoon) of data entry. A total of 24 data entry clerks were trained for one day. They all had previous data entry experience and several had worked on the baseline service delivery survey. CIET personnel conducted all training for coders and data entry clerks, ensuring a common high standard.

Focus groups and upazila meetings

Training for this part of the survey took place after the main quantitative data collection and preliminary analysis. Separate training for the focus group field coordinators, facilitators and recorders took place in Dhaka in November 2000.

Field coordinators

Five field coordinators had three days of training (13-15 November 2000), to familiarize them with the key findings of the household survey and train them in the techniques of facilitating and recording focus group discussions, including field training. Most of the field coordinators had been involved with the household survey. They were also given training in moderation of the meetings of upazila health management teams.

Facilitators

Teams of four facilitators were trained for three days in Dhaka (17-19 November), by the field coordinators and CIET personnel. Each team comprised two women and two men. The facilitators were drawn from the team supervisors and in the household survey. Training included familiarization with the findings of the household survey and practice in facilitation and recording of focus groups, including a field practice. All were trained in both facilitation and recording of focus group discussions.

Data collection

Main household survey

There were four field coordinators, each responsible for 3 to 4 data collection teams covering Rajshahi division, Khulna and Barisal divisions, Sylhet and Chittagong divisions, and Dhaka division. Their responsibilities included training, logistic aspects and technical support for the teams. The field coordinators functioned as the key points of contact between the central team and the data collection teams.

There were a total of 15 data collection teams, consisting of 2 supervisors (1 male, 1 female), 6 household interviewers (all except 2 of the 90 interviewers were female), and one male interviewer. Most of the supervisors and over half of the interviewers in this second SDS were members of the data collection teams in the baseline SDS.



Figure 1. Interviewers and supervisors for the survey

New team members were selected on the basis of previous field data collection experience.

Each team covered three upazilas (15 rural sites) and some additional urban sites. The 15 teams worked simultaneously in different parts of the country, organised into groups of 3-4 teams for each field coordinator. In each site, the team of interviewers

covered approximately 100 households in one day, accompanied and checked by at least one of the supervisors. The male interviewers were responsible for the institutional reviews, the key informant interviews and distributing questionnaires to health service providers. Data collection took place between 17 September and 15 October 2000.

Focus groups and upazila meetings

This second phase took place from 21 November to 13 December 2000. Nine teams of four facilitators (two per coordinator except in Sylhet, with only one team) undertook two focus group discussions in each community



Figure 2. A community focus group of men

included in the household survey (one group of women, one of men). It was not possible to hold focus groups in two communities in Kakhali upazila in Chittagong, for security reasons. So a total of 432 focus group discussions were held. Female focus groups were facilitated by female facilitators and male focus groups by male facilitators. In 24 upazilas the field coordinators facilitated a meeting of the upazila health management team.

Data coding, entry and cleaning

The team of coders processed the completed household questionnaires. The responses to open-ended questions were coded using codes derived from codes used for the 1999 baseline SDS survey and from responses from the first sites. Data entry was programmed using Epi Info version 6 (Centers for disease control and surveillance, 1994). Data from the household questionnaire, Service Provider Questionnaire, Key Informants Interviews, and Institutional Reviews were all entered twice and validated using the Epi Info Validate programme. Further logical checks on the dataset were undertaken, with cross-checking against the completed questionnaires and correction as necessary. Data entry started soon after the fieldwork and took place in tandem with the data collection, so that data entry was completed by the 25th of October.

Analysis

Analysis was being undertaken using Epi Info and SPSS statistical packages. The main analysis employed Epi Info, for simple frequencies, univariate associations, and stratification to examine confounding and effect modification. The Epi Info programme CSAMPLE was used to calculate the weighted percentages of indicators at national level. National percentages given in the report are shown weighted, unless stated otherwise. In practice, there was very little difference between the weighted and unweighted percentages, since the sample distribution was close to the population distribution. The SPSS package (SPSS Inc) was used for analysing multiple responses questions, combining the responses to give overall percentages. The SPSS package was also used to perform multiple logistic regression to look at combined effects of several variables on outcome variables of interest.

Associations are expressed in terms of Odds Ratios with their 95% confidence intervals. In addition, Risk Difference is used to calculate the potential population benefits of interventions on outcomes of interest. (See section on Abbreviations and Glossary of Terms above).

FINDINGS

The evidence base

As described in the Methods, information was collected from a number of different sources in the survey process: from households in representative communities; from people within the households who had used health services in the last month; from married women aged 10-49 years in the households; from service providers in the 44 upazilas in the rural sample; and from key individuals and institutions at upazila, union and community levels.

Information was collected from:

- 25,473 households
- 124,852 people
- 19,593 health services users
- 24,529 married women aged 10 – 49
- (24,446 married women aged 15 –49)
- 1,962 service providers
- 43 UHFPOs
- 215 UP Chairmen (or deputy)
- 215 Community Group Chairmen or other community representative
- 41 UHCs
- 172 UHFWCs
- 195 local health workers (HA/FWA)

Households in the sample

The shape of the population pyramid of this second cycle sample population is similar to that of the 1999 baseline SDS sample. Both are very similar to the shape of the population pyramid in the Bangladesh Demographic and Health Survey (DHS) 1996-1997. A fifth (20%, 24,446/124,835) of the sample population are married women aged 15-49 years.

The proportion of children under 5 in the sample is 12% (15,139/124,835), which is also similar to the 1999 SDS baseline survey (11%), and the Bangladesh DHS 1996-1997 (13%).

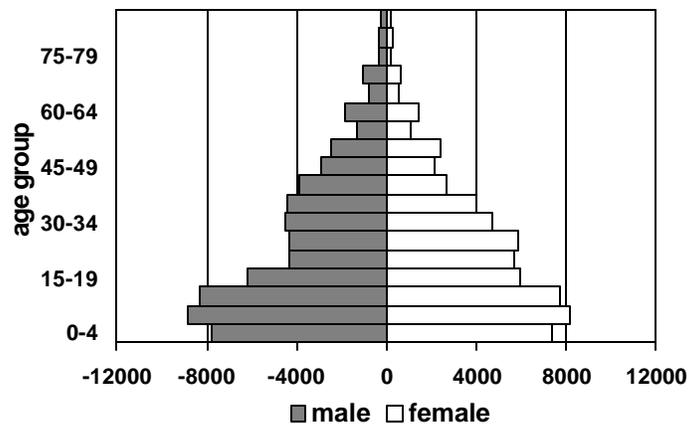


Figure 3. Age and gender distribution of the sample household population

The distribution of the sample population by age and gender is shown in Figure 3.

The sample includes a total of 25,473 households covering all six divisions in the country. The distribution of the sample by division and metropolitan areas is shown in Table 1.

Table 1 Distribution of households and mean household size by division and metropolitan area

Division/Metropolitan areas	No. of households	Mean household size
Barisal	2068	5.02
Chittagong	4014	5.61
Sylhet	1539	5.68
Dhaka	6173	4.89
Khulna	3094	4.67
Rajshahi	5513	4.33
Chittagong SMA	719	5.21
Dhaka SMA	1838	4.65
Khulna SMA	311	4.84
Rajshahi SMA	204	4.53

Household size

The mean household size is 4.90 people. The variation in mean household size by division and metropolitan area is shown in Table 1. The highest household size is in Sylhet and Chittagong.

Household heads

Some 92% (23310/25473) of the household heads in the sample are male, with a mean age of 42.9 years old. Some 46% (11989/25457) of the household heads are reported to be literate. Household heads of very poor households (annual income below Tk 23,899) are more likely to be illiterate compared with heads of less poor households¹. Male household heads are more than twice as likely to be literate, compared with female household heads².

Household respondents

The majority (86%, 21891/25469) of the household respondents are females. Interviews for the household information were conducted with an available adult (over 15 years old) household member at the time of the visit, whether male or female. The time of the day of the visit and the fact that almost all of the household interviewers were female may have lead to more female household members answering the questions for the household.

About 70% (17754/25451) of the respondents were the wives of the household heads. This is followed by the household head himself/herself (18%, 4506), the daughter or the daughter-in-law (5%, 1332), and the mother of the household head (3%, 664).

¹ 5017/7111 (71%) vs 8362/18173 (46%) Odds Ratio 2.81 (95% CI 2.65-2.98).

² 11367/23297 (49%) vs 622/2160 (29%). Odds Ratio 2.38 (95% CI 2.13-2.63)

Economic status of the households

Type of house construction

The construction of the houses in the survey was divided into four types – pucca, semi-pucca, kutcha-1, and kutcha-2. (Figure 4). Pucca houses have a tin or other solid roof, brick or concrete walls, and a concrete floor. Semi-pucca have one of these elements missing. Kutcha-1 houses have a thatched roof and solid brick walls. Kutcha-2 houses have thatched roof and bamboo or jute-stick walls. The type of house has been taken as an index of economic status of the household. A third (33%, 8229/25449) of the houses in the sample are the poorest, Kutch-2 houses.

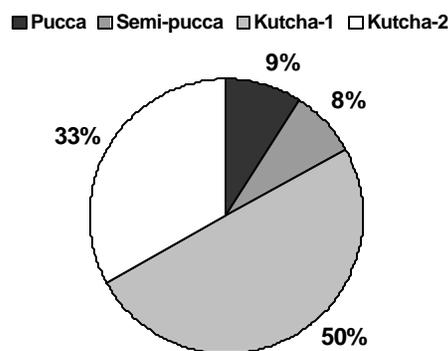


Figure 4. Economic status by house construction

Annual household income

The median annual household income of the sample is Tk 35,000. Households with an annual income of Tk 23,898 or less were defined as extremely poor. This is based on the 1994 level for extreme poverty of Tk 18,785 from BIDS (Rahman et al 1998), adjusted for inflation. By this definition, 28% (7116/25300) of the households in this survey are categorised as very poor. The household income was estimated on the basis of a response to a single question on total annual income. It is possible that households may have underestimated their income, so inflating the proportion in the very poor category. But there is no reason to expect any estimation error to be biased. The households classified as very poor by this method do show some important differences from less poor households in relation to their access to and experience of health care (see later sections). Households with a very low household income are much more likely to live in kutcha-2 houses than those with a higher income³.

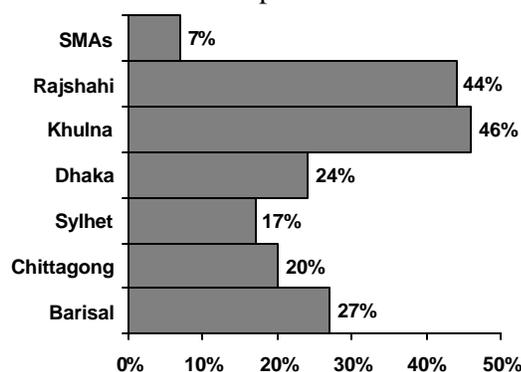


Figure 5. Proportion of very poor households by division

There are high proportions of very poor households in Khulna (46%, 1406/3066) and Rajshahi (44%, 2414/5485), while the lowest proportion in the rural areas is in Sylhet (17%, 258/1539). (Figure 5). The proportion of very poor households in metropolitan sites (7%; 204/3028) is much lower than the proportion in rural sites (31%; 6912/22272). Households with a female head are more likely to be very poor than those with a male head⁴.

³ 3667/7112 (52%) vs 4514/18164 (25%). Odds Ratio 3.22 (95% CI 3.04-3.41)

⁴ 755/2144 (35%) vs 6361/23156 (28%). Odds Ratio 1.43 (95% CI 1.30-1.59)

Household opinions of health and family planning services

Opinion of government health and family planning services

All the households were asked their opinion about the government health and family planning services, whether or not any household members had used the services provided by the government in the last month. These ratings therefore include non-users of the government services as well as users.

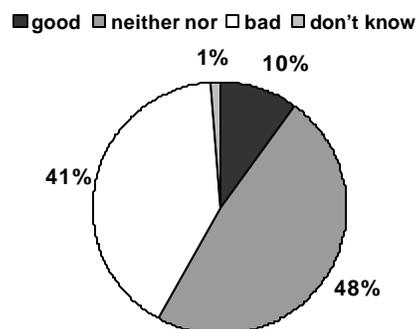


Figure 6. Household opinion about the quality of government health and family planning services

A tenth (10%; 2467/25429) of the household respondents think that the quality of government health and family planning services is good (Figure 6). About half (48%) said it is neither good nor bad, and 41% (10164) think that the health and family planning services provided by the government are bad. There was no difference in opinion of the service between male and female respondents. Respondents from households who used government health services in the last month are somewhat more likely to rate government health and family planning services as ‘good’, compared with respondents from households that did not use the services in the last month⁵.

Compared with the 1999 baseline SDS, the proportion of households who think that the government health and family planning services are good has decreased from 37% to 10% (Figure 7). The proportion of those who think that government health and family planning services are bad has only increased from 37% in early 1999 to 41% in this survey but the proportion thinking they are “neither good nor bad” has increased from 23% to 48%. Thus there seems to have been a shift in public opinion about government health and family planning services from “good” in the 1999 survey to “neither good nor bad” in the present survey. This could be a good thing if it reflects that the public is becoming more demanding of a quality service.

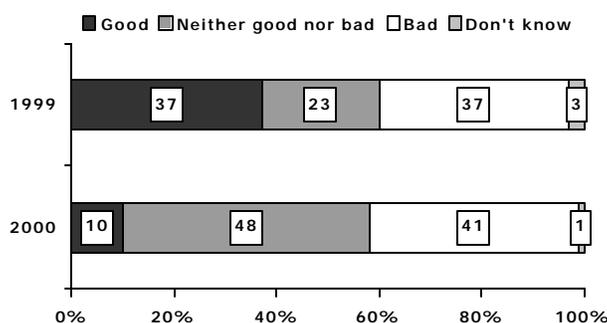


Figure 7. Household ratings of government health and family planning services in 1999 and 2000

⁵ 451/3771 (12%) vs 2015/21276 (10%). Odds Ratio 1.30 (95% CI 1.16-1.45)

Perceived problems with the government health and family planning services

Households were asked about problems they perceive in government health and family planning services. This was an open-ended question, and up to three answers were recorded per household. The problems identified are summarised in Table 2.

Table 2 Commonly identified problems in Government Health and Family Planning Services

Issues	No. (%) of respondents
Lack of/poor quality of medicines	14621 (58)
Bad service	10098 (40)
Bad staff attitude	6276 (25)
Difficult to reach	4785 (19)
Have to pay for meds/expensive	4263 (17)
Lack of docs/nurses/specialists	3561 (14)
Lack of different services	3478 (14)
Dirty, poor equipment/facility	3399 (13)
Doctors not available	3178 (13)
Extra payments to doctors/workers	3091 (12)
Too few beds/lack of facilities	1886 (7)

Lack and poor quality of medicines is the most commonly identified problem with the government health and family planning services. This was also the most commonly cited problem in the baseline SDS survey in early 1999. There was no difference in the pattern of problems identified by gender of the respondent or by poverty status.

Improvements suggested for government health and family planning services

This was also an open-ended, multiple response question. As in the 1999 baseline survey, more medicines and better quality medicines are the most common suggestions from the households (Table 3). Again, there were no apparent differences in suggestions by gender or poverty status.

Table 3 Improvements suggested for government Health and Family Planning Services

Issues	No. (%) of respondents
More/better quality medicines	11260 (44)
Better service	7803 (31)
More docs/nurses/specialists	7088 (28)
Free/fixed /price medicines	5571 (22)
Better staff attitude	4932 (20)
Clean facilities, better equipment	4201 (17)
More beds and facilities	4188 (17)
More different services	3745 (15)
More accessible facilities	2118 (8)
Better availability of doctors	1839 (7)
More female doctors	1348 (5)
Stop extra payment to doctors/workers	1187 (5)

Opinions about private and NGO health care services

As shown in Figure 8, a quarter (25%; 6173/24997) of the household respondents consider private/NGO health care facilities as good, about two thirds (63%; 15711) said that they are neither good nor bad, and a tenth (10%; 2479) consider they are bad. Some 3% (634) did not know about the quality of private/NGO health care facilities. No difference in responses was found by gender of the respondent. Very poor households are slightly more likely than less poor households to rate private and NGO health services as good⁶.

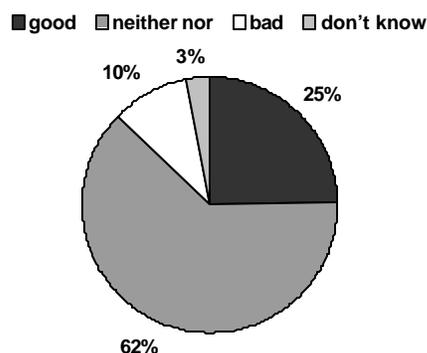


Figure 8. Household opinion about private and NGO health services

The definition of private and NGO health care services was left up to the household respondents for this question. Therefore, this category of private health care services includes all private health care providers, both qualified and unqualified, as well as all NGO providers.

Perceived problems with private and NGO health care services

An open-ended question was asked about perceived problems with private and NGO health services available to the households. Up to three answers were recorded per household.

Problems identified are summarised in Table 4. There were no differences in patterns of response to this question by gender of the respondent or poverty status of the household.

Table 4. Commonly identified problems of private and NGO health care services

Issues	No. (%) of respondents
Have to pay for meds/expensive	10146 (41)
Bad service	8202 (33)
Lack of docs/nurses/specialists	7920 (32)
Lack of different services	5881 (24)
Lack of/poor quality medicines	4405 (18)
Extra payments to doctors/workers	2689 (11)
Difficult to reach	1898 (8)
Dirty, poor equipment/facility	1862 (8)
Too few beds/lack of facilities	1759 (7)
Bad staff attitude	1500 (6)

⁶ 1876/6745 (28%) vs 4269/17452 (25%). Odds Ratio 1.19 (95% CI 1.11-1.27)

Improvements suggested for private and NGO health care services

Improvements suggested by households for private and NGO health care services are summarised in Table 5. This is a mirror image of the problems raised about private and NGO health care services by the households. There were no differences in patterns of response to this question by gender of the respondent or poverty status of the household.

Table 5. Improvements suggested for private and NGO health care services

Issues	No. (%) of respondents
More doctors/nurses/specialists	11309 (46)
Free/fixed price medicines	9884 (40)
Better service	5813 (24)
More different services	4312 (18)
More/better quality medicines	4095 (17)
Clean facilities, better equipment	2242 (9)
Don't know	2030 (8)
More female doctors	1718 (7)
Better staff attitude	1628 (7)

Willingness to pay for improved government health services

Three quarters of the household respondents (75%; 19133/25410) said they are willing to pay (or pay more if already paying) for improved government health and family planning services. Male household respondents are somewhat more likely than female respondents to say they are willing to pay⁷. Respondents from very poor households are less likely to say they are willing to pay, compared with respondents from less poor households⁸. Among very poor households, two thirds are willing to pay.

Compared with the 1999 baseline SDS survey, the proportion of the households who say they are willing to pay for improved government health services has increased from 55% to 75%. There was a minor difference in the wording of the question in the second survey, to make it clear that the issue was about paying more *officially*.

The proportion of households willing to pay for improved government health services has increased from 55% in 1999 to 75% in 2000.

Amount willing to pay for the ticket

Among those who are willing to pay, the median amount respondents are willing to pay for the ticket is Tk 5. This is the same amount as in the 1999 baseline SDS survey, and it does not differ by gender or poverty status.

Amount willing to pay for admission

Among those who are willing to pay, the median amount respondents are willing to pay for admission is Tk 15 (vs Tk 20 in the 1999 survey). Very poor households are willing to pay less (Tk 10 vs Tk 15) and women are willing to pay less than men (Tk 15 vs Tk 20).

⁷ 2785/3567 (78%) vs 16347/21839 (75%). Odds Ratio 1.19 (1.10-1.30)

⁸ 4742/7095 (67%) vs 14300/18142 (79%). Odds Ratio 0.54 (0.51-0.57)

Household access to and use of health and family planning services

Home visits by government and NGO health workers

About a tenth (9%; 2275/25459) of households in the survey had at least one government health or family planning worker visit their homes to provide services in the last month. These home visits do not include health workers' visits to houses simply to inform them about EPI centres and satellite clinics. There is no difference between very poor and less poor households in their likelihood of being visited by a government health worker in the last month.

In addition, a small number of home visits in the last month from NGO fieldworkers (101) or private health providers (38) were reported by households.

This proportion of households reporting a home visit in the last month is lower than expected, given the intended frequency of visits from government health and family planning service providers. There is variation between upazilas across the country, with up to a third of households having a home visit from a government health or family planning worker in the last month in a few upazilas. The low frequency of home visits found here merits further investigation.

Purpose of the home visits

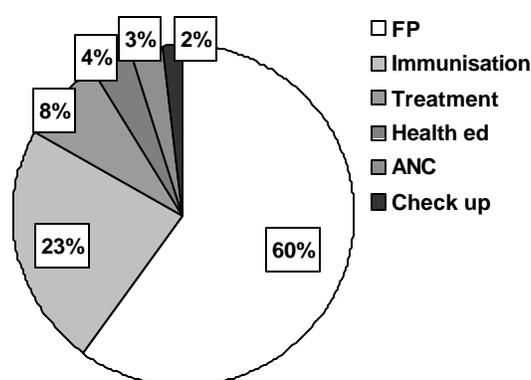


Figure 9. Purpose of reported home visits

immunization (23%) and treatment (8%).

In the great majority of these reported home visits, the person in the household using the service was female (88%; 1978/2257). Nearly a fifth of the visits were for children under five years old (19%; 433/2259) and virtually (99%) all were for people in the household below 50 years old. For females aged 15 years and over, more than three-quarters of the visits were for family planning (77%; 1297/1682).

More details of the home visits were reported for some 2259 home visits in the last month. Nearly all of these were from government health workers (94%; 2120/2257), with a few from NGO workers (4%, 94), private doctors (0.5%, 13), or traditional practitioners, mainly dais (1%, 30). The purpose of the home visits is illustrated in Figure 9. The most common purpose of the home visit was family planning (60%; 1321/2191), followed by

Use of government health facilities

Some 14% (3800/25467) of the households had at least one member who had visited a government facility, for any purpose, in the last month.

Most of the visits to government facilities were for treatment of illness. For treatment of illness, 11% (2768/25467) of the households had at least one member who

had visited a government health facility in

the last month. This figure compares with 13% of households that had at least one member who visited government health facilities for treatment of illnesses in the last month in the baseline SDS in early 1999. Thus there is no evidence so far of any increase in the number of households using government health services for treatment of illness.

Around one in ten households has a member who has visited government health services for treatment in the last month.

Which households use government health and family planning facilities?

Households with a female head are slightly less likely to have visited a government facility in the last month than households with a male head⁹. But there is no difference between male and female headed households when only visits for treatment are considered. There is no relationship between literacy of the household head and the use of government health facilities in the last month.

Very poor households are less likely to use government health facilities compared with less poor households. When visits for all purposes are considered, some 16% of less poor households visited government health facilities, compared with only 12% of very poor households¹⁰. When only visits specifically for treatment of illness are considered, there is a similar difference between less poor and very poor households¹¹.

How does poverty affect access to services?

In community focus groups (see Annex 7), the finding about less use of government health facilities by very poor households was presented and discussed, as well as possible ways to help very poor people make more use of government health facilities. The most common theme raised was not directly economic, but rather the way they feel that poor people are discriminated against and treated badly in the government facilities (mentioned by 83% of male groups and 79% of female groups).

"If you go to the doctor wearing a lungi, the doctor will not give you treatment."
Male focus group, Boalmari

"There is a lot of difference between the rich and the poor. For being poor we have committed a sin. Allah gives us diseases and Allah will cure us."

Male focus group, Austagram

⁹ 276/2161 (13%) vs 3524/23306 (15%). Odds Ratio 0.82 (95% CI 0.72-0.94)

¹⁰ 2910/18178 (16%) vs 872/7116 (12%). Odds Ratio 1.36 (95% CI 1.26-1.48)

¹¹ 2085/18173 (12%) vs 665/7116 (9%). Odds Ratio 1.26 (95% CI 1.14– 1.38)

Another common theme was the fact that at the government health facilities they do not get treatment and/or medicines without money (58% of male groups and 65% of female groups). Some groups also mentioned that people who are rich and influential are able to spend money in the facilities and get good treatment and medicines as a result. About half the groups suggested that poor people do not go to government health facilities because medicines are not available or not in adequate amount or because no free medicines are given. More than a quarter of the groups mentioned that the health facility was too far from their village with poor roads and transport to the facility. Poor people cannot bear the transport costs or loss of earnings.

"I went to the hospital to get medicines for stomach pain. They did not give me any medicines. They wanted money from me but I did not have money, so they did not give me medicine. If we have to buy medicines from the hospital then it is better to go directly to the pharmacy."
Female focus group, Islampur

"The hospital is far away and it costs a lot to travel there. We can easily buy medicines from the village doctors with this money. We spend money to go to the hospital but we don't even get medicines there, so why should we go to the hospital."
Female focus group, Tazmuddin

The same issue (low use of government health facilities by the very poor) was discussed with the health managers and staff in 24 of the sample upazilas (see Annex

"People who are very poor are usually illiterate and lack knowledge; they are ignorant about government hospitals."
Upazila meeting, Nawabganj

"Actually in the hospitals they should get good behaviour and get medicines - there's a lack of these things so they don't come."
Upazila meeting, Chhatak

8). A common perception of why poor people do not use government health facilities was lack of awareness and health consciousness among poor people; this was mentioned in all 24 meetings. Some of the same themes raised in the community focus groups were also raised in the upazila meetings: problems with medicines availability and quality;

distance from villages and problems with transport expenses; and bad staff attitudes and behaviour towards poor people (this was mentioned in half the meetings).

Improving access for the very poor

When asked for their ideas about how very poor people could be helped to attend government health facilities, community focus groups (see Annex 7) predictably called for better behaviour and attitudes of service providers, more availability of medicines and more doctors and nurses, as well as facilities nearer to their villages. Nearly half the groups (48% male groups, 40% female groups) called for better monitoring and supervision of the service providers to ensure they gave good quality service to all.

"A local committee is needed to monitor the service workers."
Male focus group, Paikgachha

“We health service providers should change our mentality. Our behaviour should be a health care service, it should not be commercial.”
Upazila meeting, Barura

There was lively discussion in upazila meetings about how to increase the access of very poor people, in particular, to government health services (see

Annex 8). Common themes were about informing the public what to expect, and improving the behaviour and attitudes of service providers, largely through additional training. In some upazilas the idea of special treatment for people identified as being particularly needy was mentioned, for example using ID cards.

Use of private and NGO health services

Some 43% (10879/25470) of the households had at least one member who visited a private or NGO health facility for any purpose in the last month. These private health facilities and providers include both qualified and unqualified health care providers. In this question about household use of services, the different private and NGO providers were not considered separately. The experience of these different providers separately was sought in questions about specific visits to services and is described in a later section.

Four out of ten households have used private or NGO health services for treatment in the last month.

While a proportion of visits to government facilities were for matters other than treatment, such as immunization, family planning etc (see above), almost all visits to private and NGO health services in the last month were for treatment. Some 42% (10564/25470) of households in the sample had at least one member who visited a private or NGO health service for treatment of illness in the last month. In the 1999 baseline SDS survey, 32% of the households had at least one member who visited a private or NGO health service in the last month for treatment of illness. Thus, if anything, there seems to be some trend for increasing use of private and NGO services, while there is no evidence of increase in use of government health services.

Less poor households are more likely to have a member who visited private or NGO health services for treatment of illness in the last month compared with very poor households¹². Households with a literate head are also more likely to have used a private or NGO facility for treatment in the last month, compared with households with an illiterate head¹³. The relationship with poverty persists when illiteracy is taken into account by stratification. The use of these private and NGO health services does not differ between households with male and female heads. Thus poverty is negatively related to use of other health services as well as government services, but the overall use of these other services is some four times higher than use of government services.

¹² 8100/18181 (45%) vs 2379/7116 (33%). Odds Ratio 1.60 (95% CI 1.51 – 1.70)

¹³ 5307/11989 (44%) vs 5249/13465 (39%). Odds Ratio 1.24 (95% CI 1.18-1.31)

Unmet need for health care

Nearly a quarter (22%; 5671/25459) of households reported at least one member who was ill in the last month but did not seek care from any source. Some 18% (4723) of the households had one person who was ill but did not seek care and 3% (948) had more than one person. The distribution of age and sex of those who were ill but did not seek care is shown in Figure 10.

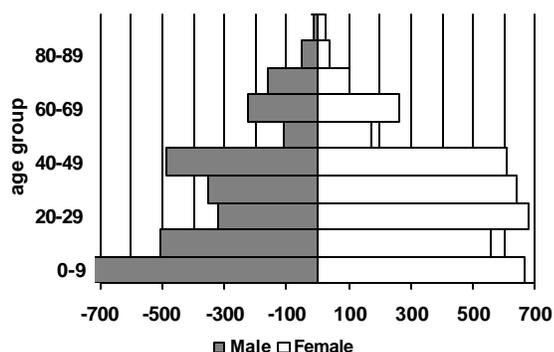


Figure 10. Distribution of age and sex of those who were ill but did not seek care

The proportion of households with at least one sick person who did not seek care was 5% in the baseline SDS in early 1999. The reason for the higher figure in this second SDS is not clear. It may be related, at least in part, to seasonal variation in morbidity patterns. The 1999 baseline SDS, conducted in February to March, reflected use of health services in January and February; whereas this second SDS reflects use of health services in August and September.

As a measure of unmet need for health care in households, some 11% (2892/25468) of households had at least one sick person but did not have any contact with any health care provider (government or private) in the last month. Using this measure, very poor households are more likely to have unmet need for health care compared with less poor households¹⁴. Similarly, households with an illiterate head are more likely to have unmet need for health care, compared with households with a literate head¹⁵. The relationship between poverty and unmet need for health care is not changed when illiteracy (associated with poverty) is taken into account by stratification.

¹⁴ 1001/7115 (14%) vs 1868/18180 (10%). Odds Ratio 1.43 (95% CI 1.31-1.55)

¹⁵ 1705/13466 (13%) vs 1185/11986 (10%). Odds Ratio 1.32 (95% CI 1.22-1.43)

Types of health and family planning services used in the last month

Some 19,670 contacts with health and family planning services in the last month were reported in detail from the households. As far as possible, information about these contacts was sought from the person concerned, or from the parent if the user was a child. In cases where the user was not available, the information was sought from another family member on their behalf. Of all the reported contacts, 2268 (12%) were home visits (see section above on home visits) and are not further considered in the following sections. Detailed information about experience of the service was sought for 17,402 visits to facilities and providers.

It is often difficult for household respondents to be sure of the type of health service facility or provider they visited. For example, they may not easily be able to distinguish between a private and NGO provider and may not know if an individual provider they have seen is a qualified doctor or not. Indeed, there is little restriction on the use of the title ‘doctor’ in Bangladesh and many local practitioners are not formally medically qualified. In order to distinguish correctly what type of practitioner each respondent had visited, we used information from knowledgeable individuals (key informants) in each site about the local health facilities and practitioners. The interviewers recorded the name of the individual or facility visited and the key informant information was then used to categorise what type of service or individual had been visited.

The service provider used among the reported visits to health facilities or individual health care providers is shown in Table 6.

Table 6. Service provider for contacts with health services in the last month (excluding home visits)

Service provider	Number (%) of visits	
	All purposes	For treatment
EPI/Satellite clinic	448 (3)	103 (1)
UHFWC	654 (4)	464 (3)
UHC	2127 (12)	1736 (11)
Government hospital	786 (4)	729 (5)
Urban government facility	20 (0.1)	15(0.1)
Government health worker	474 (3)	124 (1)
Private doctor	4391 (25)	4272 (27)
Private clinic	443 (2)	399 (3)
NGO facility	126 (1)	67 (0.4)
Village doctor	5073 (30)	5012 (32)
Drug shop	2045 (12)	1905 (12)
Dai/traditional practitioner/spiritual healer	749 (4)	739 (5)
Total	17336 (100)	15565 (100)

As shown in Table 6, the most frequent provider visited is the village doctor, whether all visits are considered or only those 15565 where the purpose was to seek treatment. Considering visits for treatment, a third were to the village doctor. The second most frequent provider is the private doctor. Note that in nearly all cases in the rural areas, these doctors are doctors working in the government service who also do private practice, rather than exclusively private practitioners. Around one in ten visits are to the UHC and about the same proportion to the drug shop. Note that this only includes

visits to the drug shop where the drug shop was considered by the household to have been the health service provider; it does not include visits to fill a prescription from another facility and probably excludes many visits simply to purchase medicines the customer has already decided he or she needs.

NGO services comprise a very low proportion of reported visits, whether considering all visits (1%) or only visits for treatment (0.4%). This low proportion is perhaps surprising, as there is a belief that NGOs are very active in the health sector in Bangladesh. However, many have activities mainly in nutrition and health education, rather than in providing clinical services.

The service providers fall into three categories, indicated by shading in Table 6: government (public) health facilities and providers; private and NGO providers; and

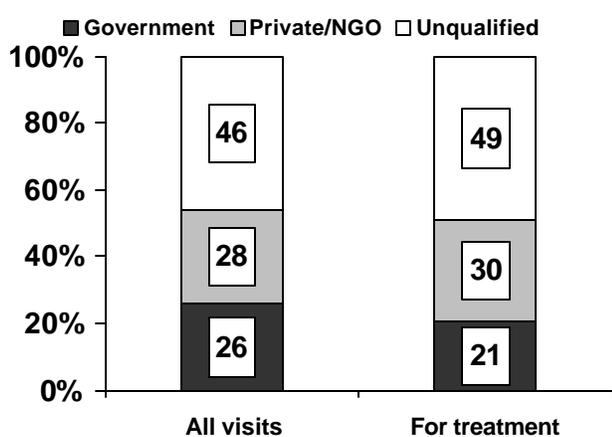


Figure 11. Service providers visited

providers with less formal training. The proportions of visits to each of these categories of service provider, for all purposes and for treatment specifically, are shown in Figure 11. The proportion of the visits that were to government facilities is somewhat lower when only visits for treatment are considered, while the

proportion to village doctors and drug shops is a little higher. This reflects the somewhat higher proportion of visits to government facilities that were for purposes other than treatment of illness, such as immunizations and family planning.

Services used for preventive purposes

Only a minority of reported visits to health and family planning services in the last month were for preventive purposes such as immunization, family planning and antenatal care. Overall, just 10% (1753/17344) of the visits were not for treatment of illness or injury.

Among reported visits to government health services, 71% (3171/4499) were for treatment, 16% (728) were for immunization or vitamin A, 9% (386) were for family planning, 4% (168) for antenatal care, and 1% (41) for delivery. In contrast, the proportion of reported visits that were for treatment is 96% (4738/4958) for private and NGO providers and 97% (7656/7859) for unqualified providers.

Most of the service users for preventive and family planning services are female (81%; 1424/1750). When service users under 15 years old are excluded, nearly all the adult users are women (97%; 1081/1114).

Among people who used preventive and family planning services in the last month, only 20% come from very poor households (annual household income less than Tk 23,899). This is notably lower than the 28% of all households in the survey categorized as very poor, and reflects the lower use of preventive services by the very poor (see above). The proportions of very poor people among those using the different types of service providers for preventive services are shown in Figure 12. There is a higher proportion of very poor people among those who used government services. This may partly reflect the different purposes of using the services (see Table 7 below).

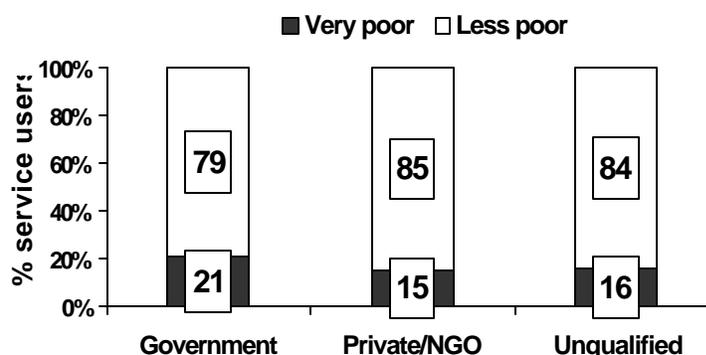


Figure 12. Poverty status and type of service used for preventive and family planning purposes

Type of service and purpose of visits (excluding treatment)

The type of service used for these visits for preventive services is shown in Figure 13. Three quarters (76%; 1328/1751) are visits to government facilities, 220 are visits to private/NGO providers, and 203 are to unqualified providers.

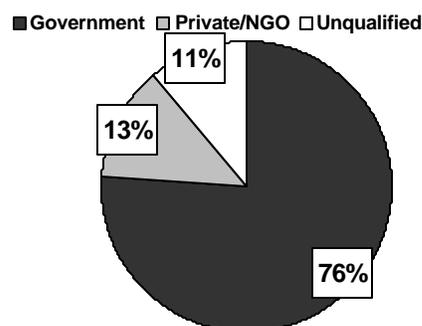


Figure 13. Type of provider for preventive services

The purpose of use of the services varied between service providers, as shown in Table 7. The main purpose in visits to government facilities was immunization (55%). On the other hand, for private and NGO services, the main purpose was antenatal care (41%) and for unqualified practitioners, the main purpose was family planning (71%).

Table 7. Reason for using different types of health and FP services, excluding treatment of illness

Purpose of visit	Number (%) of visits		
	Government	Private/NGO	Unqualified
Immunisation and Vitamin A	728 (55)	41(19)	21 (10)
Family planning	386 (29)	63 (29)	144 (71)
Antenatal care	168 (13)	91 (41)	23 (11)
Delivery	41 (3)	22 (10)	10 (5)
Check-up	3 (0.2)	3 (1.4)	5 (3)
Health education	2 (0.2)	0	0
Total	1328 (100)	220 (100)	203 (100)

Experience of service in visits for preventive purposes

Prescription and availability of medicines (for non-treatment visits)

The majority of service users (76%; 1225/1620) were prescribed or advised some form of medicine or treatment: 76% (938/1232) among those who visited a government facility; 87% (167/192) of those who used a private or NGO facility; and 61% (119/195) of those who visited an unqualified practitioner.

All the required drugs or treatments were available from the facilities in over two-thirds of visits (70%; 851/1217). This differs between types of service provider. For government facilities, all the prescribed medicines or treatments were available in 82% (760/932) visits; for private and NGO facilities, all were available from the facility in 38% (62/165) of visits; and for unqualified practitioners, all were available from the facility in 24% (28/119) of visits.

Considering visits to government facilities for purposes other than treatment of illness, the availability of all prescribed medicines and treatments was highest for immunisations (92%; 472/516). For family planning visits, all prescribed treatments were available from the facility in 76% of visits (226/296); and for antenatal care visits, all prescribed treatments were available in 51% of visits (56/110).

All prescribed treatments are available in 76% of visits to government health facilities for family planning purposes.

Explanations from service providers (non-treatment visits)

For these non-treatment visits, the explanation of the problem means an explanation of the situation, but this is difficult to interpret when the visit was for immunisation. Most service users (75%; 1206/1613) felt they received a full explanation of the problem. This means an explanation they felt satisfied with, and does not imply that the explanation was objectively good. The proportion of users satisfied with the explanation of the problem was highest among users of government services (79%; 972/1232), followed by users of private and NGO services (71%; 135/189), and

lowest among users of unqualified practitioners (51%; 98/191). The lower rate of 'explanation of the problem' among users of unqualified practitioners may partly reflect the different purposes for using the different service providers (see Table 7).

There is a very similar picture for reported explanations from service providers about the treatment or remedy required. Overall, 76% (1236/1618) of service users felt they received a full explanation of the treatment.

The figure is 80% (982/1231) for government facilities, 76% (147/193) for private and NGO providers, and 55% (106/193) for unqualified practitioners.

80% of people who use government services for preventive and family planning purposes feel they received a full explanation of the treatment.

Payments for preventive services

Very few users of government facilities (less than 5%) reported making payments for a ticket, for the service, or directly to the service providers. This contrasts with payments made by the much larger group of people using government services for treatment of illness or injury (see below).

Satisfaction with visits for preventive services

The satisfaction of service users is generally high and does not vary much between different service providers. For satisfaction with the behaviour of the service providers, the proportions are:

89% (1095/1233) for government services, 87% (167/193) for private and NGO services, and 84% (165/197) for unqualified

practitioners. The figures for overall satisfaction with the service received are similar: 89% (110/1234) for government services, 83% (160/193) for private and NGO services, and 86% (170/187) for unqualified practitioners.

Nine out of ten people who use visit government health and family planning services for preventive and family planning reasons are satisfied with the behaviour of staff and the overall service.

Services used for treatment of illness or injury

Characteristics of the service users

Nearly a quarter (23%; 3558/15564) of reported service users seeking treatment are

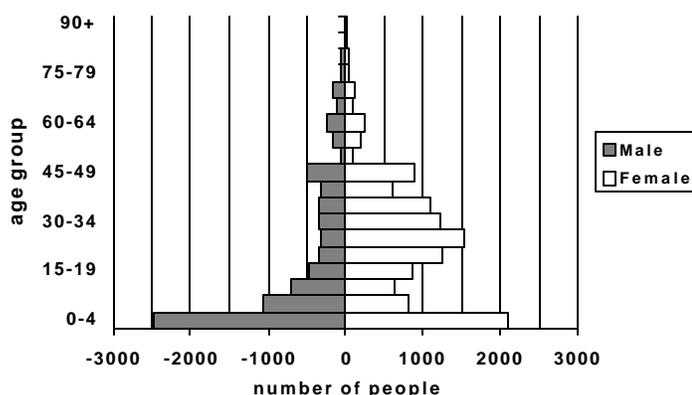


Figure 14. Age and sex of people visiting services for treatment

aged less than five years, and a third (35%; 5384/15564) are aged less than ten years. Only 15% are aged 50 years or above.

The age distribution is similar for those visiting government, private and unqualified providers. Note that the population pyramid in Figure 14 is very similar to that for people in households reported as sick but not

attending anywhere for health care, shown in Figure 10.

More than half of those reporting visits to health services for treatment in the last month are female (54%; 8434/15560). The *proportion of females* is about the same for reported visits to government, private and unqualified providers. Among adult service users (over 14 years old), some 61% (5439/8876) are women. This is in contrast to the 97% of women among adult users of preventive and family planning services (see above).

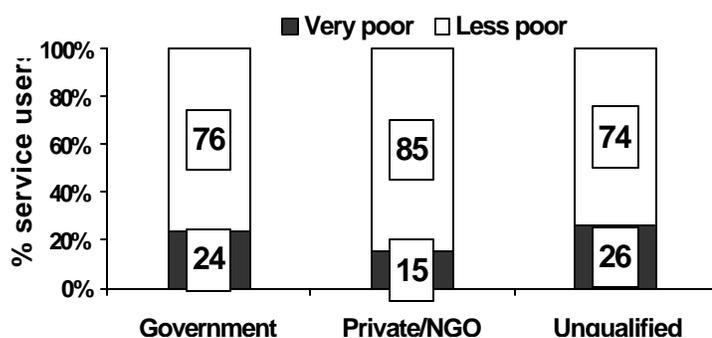


Figure 15. Poverty status of users of different services for treatment purposes

Among people who visited private services for treatment there is a relative deficit of people from *very poor households* (annual income less than Tk 23,899), compared with people who visited government services or unqualified practitioners (Figure 15). This is true in

both rural and metropolitan sites, although in metropolitan sites there are generally fewer very poor households than in rural sites. The overall proportion of people from very poor households among those who visited a health facility in the last month is 22% (3394/15464). This is less than the proportion of very poor households in the whole sample, reflecting less use of any health services by the very poor.

Reasons for choice of service

Recent service users (for treatment in the last month) were asked, in an open question, why they chose that particular service. Respondents were allowed to give more than one response and up to three reasons per respondent were recorded and subsequently coded. Table 8 shows the main reasons giving for choosing the particular service, by type of service actually visited. The top three reasons for each service are highlighted.

Table 8. Reasons for choosing a particular service, among people who visited a health service for treatment in the last month

Reason for choosing the particular service	Number (%) of those who used service		
	Government	Private	Unqualified
Good treatment, good service, good advice	1184 (38)	2184 (46)	2197 (29)
Free or cheap service, 'pay later' arrangements	1046 (33)	480 (10)	1647 (22)
Easy access to service, cheap transport	779 (25)	976 (21)	3225 (42)
Good doctor/specialist/service provider	728 (23)	1730 (37)	1457 (19)
Good behaviour or attitude of service provider	475 (15)	757 (16)	1484 (20)
No other choice	302 (10)	203 (4)	390 (5)
Medicines available, good medicines	296 (9)	314 (7)	1026 (14)
Well known doctor, family doctor, recommended	280 (9)	1188 (25)	1765 (23)
Confidence in service, reliable, good place	230 (7)	351 (8)	547 (7)
Free or cheap medicines, 'pay later' medicines	151 (5)	65 (1)	400 (5)
Available doctor or service provider	62 (2)	63 (1)	262 (3)

The reasons for choosing the particular service clearly vary by type of service used. The perception of a 'good' service was an important reason for all three types of service. For government service users, other important considerations were the fact that the service was free or cheap, and ease of access and less transport costs. For those who visited a private doctor or clinic (including the few who used NGO providers), the second and third reasons given for their choice were that the doctor, specialist or service provider was good, and that the doctor or practitioner was known to them or recommended. For the large group who visited an unqualified practitioner (village doctor, drug shop, dai or traditional practitioner), ease of access was the primary consideration, followed by perception of good treatment, the fact that the practitioner was known or recommended, and the fact that the service was free or cheap.

Service users from *very poor households* (annual income less than Tk 23899) gave a similar pattern of reasons for choosing different services compared with service users from less poor households.

Experience of health services used for treatment of illness

Most of the reported visits to health services for treatment in the last month were as outpatients. There were a few (6%; 955/15591) admissions. In these cases, no further details of the experience of the service were collected. The following analysis of experience of health services for treatment is thus based on 14636 visits for treatment in the last month, excluding admissions. Of these, 17% (2424/14614) were to government services, 31% (4557) were to private or NGO services and 52% (7633) were to unqualified practitioners (village doctors, drug shops and traditional practitioners).

Waiting time

Waiting times tend to be longer in government health facilities, compared with private services or with unqualified practitioners (village doctors, drug shops), as shown in Table 9. The actual waiting time is probably underestimated for all service providers. Patients may count waiting time from when the doctor arrived, rather than from when they arrived themselves, irrespective of official clinic times. However the comparison between types of service provider is valid.

Table 9. Waiting times for different health service providers

Measures of waiting time	Number (%) of those who used service		
	Government	Private	Unqualified
Waiting more than 30 minutes	811 (34)	1050 (23)	542 (7)
Waiting 20 minutes or more	1522 (63)	2395 (53)	1828 (24)
Mean waiting time (minutes)	41.5	30.0	13.0
Median waiting time (minutes)	30	20	5

A patient attending a government health facility for treatment is significantly more likely to wait for more than 30 minutes, compared with a patient attending a private doctor or clinic¹⁶ or with a patient attending a village doctor or drug shop¹⁷.

Poverty status and gender

Considering government health services, the very poor did not wait longer than the less poor. Overall, waiting time was not longer for female than male service users. When only adult users (over 14 years old) are considered, women are slightly more likely to reported waiting for longer than 30 minutes compared with men¹⁸.

Explanations given by service providers

Explanation about illness

Considering all service providers together, two thirds of service users (66%; 9574/14543) reported receiving a full explanation of their problems or illness from the service provider. A quarter (25%; 3642) reported receiving a partial explanation and only 9% (1327) reported no explanation at all. Note that a full explanation of the

¹⁶ 811/2415 (34%) vs 1050/4539 (23%). Odds Ratio 1.68 (95% CI 1.50-1.88)

¹⁷ 811/2415 (34%) vs 542/7578 (7%). Odds Ratio 6.56 (95% CI 5.79-7.43)

¹⁸ 339/963 (35%) vs 130/421 (31%). Odds Ratio 1.22 (95% CI 0.94-1.56)

problem means an explanation that the service user felt satisfied with; it does not imply that the explanation was objectively adequate or even correct.

The level of explanation about the problem or illness was reported as lower among patients who attended government health services than among patients who visited private services or unqualified practitioners (Figure 16).

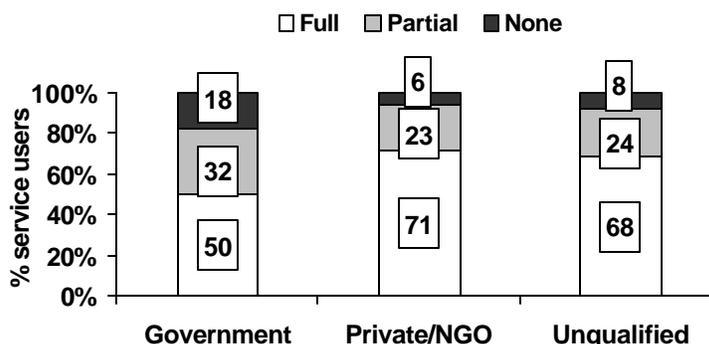


Figure 16. Explanation of illness from service providers

Patients who attended a private service or a service from an unqualified practitioner are more than twice as likely to have received a full explanation of their problem or illness from the service provider, compared with patients who attended government health services for treatment¹⁹.

Poverty status and gender

Considering government health services, very poor patients are as likely as less poor people to report being given a full explanation of their problem. Overall, there was no difference in satisfaction with the explanation of the problem between male and female service users. When only adult service users are considered (aged over 14 years), men are more likely than women to be satisfied with the service worker’s explanation of the problem²⁰.

Explanation about treatment or remedy

For explanation from service providers about the remedy, a similar picture is seen. Overall, three quarters of patients (74%; 10794/14544) reported they received a full explanation about the remedy from the service provider, 21% (3085) reported a partial explanation and only 5% (665) claimed they received no explanation at all. Again, patients who attended government health services for treatment reported a lower level of explanation about the remedy than patients attending private services or services from unqualified practitioners. The proportion reporting a full explanation is 54% (1301/2411) for government health service users, 78% (3555/4563) for users of private services, and 78% (5924/7559) for users of services from unqualified practitioners.

Poverty status and gender

Again, there is no difference in the proportion of patients who report being given a full explanation about the treatment by poverty status or by gender considering all service users. When only adults are considered (aged over 14 years), men again are slightly more likely than women to feel they have had a full explanation of the remedy²¹.

¹⁹ 8364/12110 (69%) vs 1196/2411 (50%). Odds Ratio 2.27 (95% CI 2.08-2.50)

²⁰ 234/419 (56%) vs 473/961 (49%). Odds Ratio 1.30 (95% CI 1.03-1.67)

²¹ 246/419 (59%) vs 513/961 (53%). Odds Ratio 1.23 (95% CI 0.98-1.59)

Payments for visits to health services

Service users were asked about whether they paid and how much for transport, for the ticket, for medicines from the service or service provider, for medicines they bought outside the facility, for investigations in the facility, for investigations outside the facility, and for the prescription/service. In addition, they were asked about payments direct to service providers or to other people in relation to the service. The proportion paying for the different items and the average amounts paid (among those who paid anything) for the different types of services are shown in Table 10.

Transport

Less people who visited unqualified practitioners (village doctors, drug shops, traditional practitioners) paid for transport and the amounts they did pay were lower, compared with those people who visited government or private services. This accords with easy access and low transport costs being an important deciding factor for those who used the services of unqualified practitioners. Transport costs are highest for those who visited private doctors or clinics, reflecting their need to travel further.

Table 10. Payments to different service providers

Item	Government		Private		Unqualified	
	n (%) pay	Mean (Tk)	n (%) pay	Mean (Tk)	n (%) pay	Mean (Tk)
<i>Aspects of service</i>						
Transport	1370 (57)	45.9	3101 (68)	60.9	2075 (27)	22.5
Ticket	564 (23)	7.0	138 (3)	19.0	38 (0.5)	25.3
Medicines (facility)	181 (8)	85.2	897 (21)	122.8	4548 (61)	82.5
Medicines (outside)	1338 (55)	212.8	3476 (76)	277.1	2887 (38)	128.5
Medicines (overall)	1499 (62)	200.2	4320 (95)	248.5	7337 (96)	101.7
Investigation (facility)	82 (3)	204.8	65 (1)	270.9	71 (1)	96.1
Investigatn (outside)	134 (6)	270.1	714 (16)	327.4	237 (3)	81.8
Service/prescription	542 (22)	54.6	3317 (73)	100.9	1832 (23)	28.1
All service items	1928 (80)	232.8	4485 (99)	410.8	7463 (98)	116.4
<i>Service providers</i>						
To doctor	447 (18)	52.7	3134 (69)	99.8	2052 (27)	43.5
To nurse	12 (0.5)	67.6	7 (0.2)	116.0	6 (0.1)	42.7
To aya	14 (0.6)	23.2	14 (0.3)	85.3	8 (0.1)	14.9
Other service worker	6 (0.2)	63.3	9 (0.2)	267.9	7 (0.1)	62.9
To other person	2 (0.1)	12.5	2 (0)	20.0	8 (0.1)	52.5
All service workers	469 (20)	53.5	3137 (69)	100.8	2068 (27)	43.6
Service & providers	1929 (80)		4493 (99)		7472 (98)	

Ticket

The ticket is the official payment for government health services at hospital level and in some urban facilities. Table 4 shows that around a quarter of people who visited government health services paid for a ticket, with a mean payment of Tk 7. The proportion of service users who paid for a ticket in different government health facilities is shown in Figure 17.

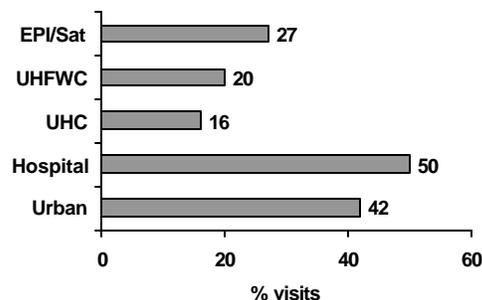


Figure 17. Payment for ticket in government health facilities

Significant proportions of service users are paying for a ticket in facilities where there is no official policy for charging such a fee, at upazila level and below. (Our sample includes very few TFIPP thanas). As in the 1999 SDS, the median amount paid for a ticket (among those who paid anything) was Tk 5. For most facilities in the present survey, the median was Tk 2, and higher in urban health facilities. The numbers visiting individual types of government health facilities are relatively small, so the estimates of proportions paying and average amounts paid in different types of facility have wide margins of error.

Poverty status and gender

Very poor people visiting government health services are only half as likely to pay for a ticket, compared with less poor people²². There is no difference between male and female service users in the proportion paying for a ticket in government health services, even when only adult service users are considered.

Medicines

It is notable that nearly two thirds of people visiting government health facilities are paying for medicines, with some 8% paying within the facility and 55% paying for medicines outside the facility (see Table 10). The amounts paid for medicines in government facilities are fairly low, but the amounts paid by government service users for medicines outside are similar to the amounts paid by people visiting private doctors or clinics.

Poverty status and gender

In government health facilities, very poor people are no less likely to pay for medicines in the facility than less poor people. But for people who do pay the mean amount they pay is less if they are very poor (mean Tk 44.5 for very poor people vs Tk 93.0 for less poor people, $p < 0.02$). Male service users are more likely than female service users to pay for medicines outside the government health facility²³. This difference between men and women is more marked when only adult service users are considered²⁴.

Investigations

Relatively few service users to any type of service paid for investigations; clearly this depends on the type of health problem they present with. Table 10 shows that people

²² 87/571 (15%) vs 472/1827 (26%). Odds Ratio 0.52 (0.40-0.67)

²³ 590/982 (60%) vs 747/1434 (52%). Odds Ratio 1.38 (95% CI 1.17-1.64)

²⁴ 277/422 (66%) vs 516/964 (54%). Odds Ratio 1.66 (1.30-2.12)

using government health services who pay for investigations are paying at around the same levels as people who use private doctors or clinics, while people using unqualified practitioners are paying significantly less. This comparison should be made with caution, however, since the type of investigations may be different between service providers and we do not have details of what investigations were undertaken.

Poverty status and gender

Very poor people visiting government health facilities are less likely to report paying for investigations in the facility than less poor people²⁵. They are also less likely to report paying for investigations undertaken outside the facility²⁶. This could be because very poor people are less often referred for investigations or are less likely actually to have the investigations even if referred. They may fail to have the investigation because they cannot afford the cost.

Male users of government health services are more likely than female users to pay for investigations outside the facility²⁷. This difference is more marked when only adult service users (aged more than 14 years) are considered²⁸. Since all investigations outside the facility have to be paid for, this probably means that more men than women have investigations outside the facility. We cannot be sure how often patients are referred for investigations but do not actually have them.

Service/prescription charges

This item was intended to seek information about other payments patients make, including in government health facilities. It may or may not be directly to the doctor but it covers a charge for the prescription. About a fifth (22%) of people attending government health facilities paid such a charge, and the average amount among those who paid (Tk 54) was about half the average amount for this charge among private service users (see Table 10).

Poverty status and gender

Considering government health services, very poor people pay for the service or prescription about as frequently as less poor people, but the mean amount paid is less for very poor people (mean Tk 41.1 for very poor people vs Tk 58.9 for less poor people, P=0.005).

Male patients visiting government health facilities are more likely than female patients to make a payment as a prescription or service charge²⁹. This difference is similar when only adult service users are considered³⁰. Among those patients who make a payment for the prescription, men pay more than women (mean Tk 65.0 for men vs Tk 46.1 for women, P=0.0007).

²⁵ 8/571 (1%) vs 72/1827 (4%). Odds Ratio 0.35 (95% CI 0.15-0.75)

²⁶ 20/571 (4%) vs 110/1826 (6%). Odds Ratio 0.57 (95% CI 0.34-0.95)

²⁷ 69/982 (7%) vs 65/1434 (5%). Odds Ratio 1.59 (95% CI 1.10-2.30)

²⁸ 42/422 (10%) vs 51/964 (5%). Odds Ratio 1.98 (95% CI 1.26-3.10)

²⁹ 243/983 (25%) vs 299/1433 (21%). Odds Ratio 1.25 (95% CI 1.02-1.52)

³⁰ 118/422 (28%) vs 216/963 (22%). Odds Ratio 1.34 (95% CI 1.02-1.76)

Payments to service workers

Service users were asked if they made payments directly to service workers. Most service users in government health facilities did not pay the service workers and, indeed, such payments in government health facilities are never official. However, as shown in Table 10, a fifth (20%) of people visiting government health facilities did report making a personal or unexplained payment to one or more service workers, most commonly the doctor (19%). The average amount they pay (Tk 53.5) is about half the average paid to service workers in private services.

Poverty status and gender

Considering government health services, there is no difference in the proportion of patients making payments to service workers between very poor and less poor people. However, the amounts paid by very poor people are lower. The mean amount paid to the doctor by very poor people is Tk 41.3, compared with Tk 55.5 paid by less poor people (p=0.039).

There is no difference between male and female service users in the proportion who make a payment to the doctor or to other service workers. This is still true when only adult service users are considered. However, among those people who report making a payment to the doctor, men pay more than women (mean Tk 59.4 for male patients vs Tk 47.6 for female patients; p=0.042).

Views about paying government health service providers

Most community focus groups (80%, see Annex 7) agreed that it is bad to make unofficial payments to government health service providers, but they feel they have no alternative (74% of male groups, 69% of female groups). About half the groups (53% male, 47% female) mentioned they have to pay to save the lives of their relatives.

“This system is very bad for us poor people. We suffer a lot to give money for treatment in government hospitals. We are forced to pay to stay alive, even though it is difficult.”
Male focus group, Kashiani

Many people believe they can only get treatment or good quality treatment if they give money to the health worker (86% male groups, 87% female groups).

“The sweetness depends on the quality and quantity of the molasses. If we give money we get good treatment.”
Female focus group, Khaliajuri

The reality is that it is cheaper to pay the providers in the government facility than to pay the same providers in their private chambers.

“When we go the doctor, he asks whether we will see him the government way or specially?”
Male focus group, Paikgachha

The issue of payments from patients to government doctors and other government health service providers was discussed in the 24 upazila health management team meetings, after giving them information about the proportion of patients in their upazila reporting such payments. Participants in two thirds of the meetings (16/24) agreed that such payments to the government health service providers are corruption.

In six upazilas the participants denied any corruption of this sort to the best of their knowledge, and in nine they commented that this is not true for all service providers.

“Sometimes patients want the health service quickly so they force the doctors to take the money. ”
Upazila meeting, Barura

In half of the upazilas (12/24) meeting participants said that it is patients who pressurise health providers to take money in order to secure extra, quick or better quality service.

“Considering our job, our salary is low. For that reason we resort to corruption. To maintain his status a doctor has to follow this path.”
Upazila meeting, Kawkhali,

A number of groups also mentioned that economic pressures such as low salary and other incentives (10/24) lead service providers into circumstances where they take money from patients.

In a third of upazila meetings the participants were of view that people feel proud when they get a service after giving money (8/24). People also give money if they feel happy with the treatment and service that they receive and the service providers do not want to make them feel unhappy.



Figure 18. Meeting of health service providers at upazila level

Prescription of medicines

Most people (86%; 12552/14562) attending any type of health service for treatment were prescribed or advised medicines. No information was collected about the number of different medicines prescribed, but it is known from other sources that multiple prescribing is commonplace in Bangladesh. The rate of prescribing or advising medicines varies between service providers, being highest for private doctors and clinics (Figure 19).

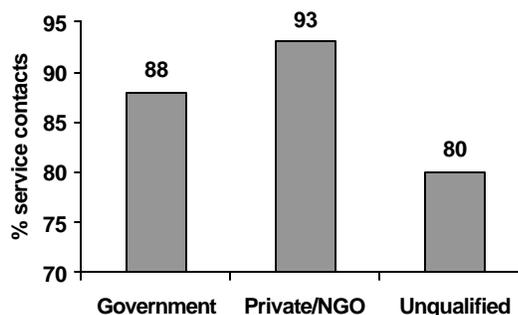


Figure 19. Proportion of service users prescribed or advised medicines

Poverty status and gender

Considering government health services, very poor people are less likely to be prescribed medicines, compared with people from less poor households³¹. Male users of government health services are slightly more likely than female users to be prescribed medicines, but the difference is not statistically significant.

Availability of prescribed medicines

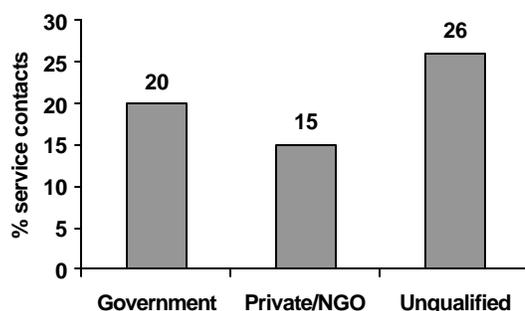


Figure 20. Proportion of service users who received all prescribed medicines from service provider

Respondents were asked about whether they received the prescribed or advised medicines from the health facility. Taking all types of health provider together, about a fifth of patients received all prescribed medicines (21%; 2565/12490), 9% (1059) received some of the medicines, and most (71%; 8866) did not receive any of the medicines.

The proportion of patients receiving all the prescribed medicines from the facility or service provider varies between different service providers

(Figure 20). It is not surprising that only 14% of patients attending private doctors or clinics received all prescribed medicines from the service provider, since most of these facilities do not have dispensaries. The proportion receiving all prescribed medicines from government health facilities is 20% (419/2128). This is lower than the figure of 33% from the baseline service delivery survey (SDS) in early 1999, but this may be due to supply cycle differences (see below).

³¹ 474/571 (83%) vs 1647/1825 (90%). Odds Ratio 0.53 (95% CI 0.40-0.70)

Medicines availability in SDS 1999 and SDS 2000

In the baseline SDS patients were asked if ‘all required medicines’ were available from the government health facility, rather than specifically prescribed medicines. The finding in the present survey of even lower availability of specifically prescribed medicines indicates that the low availability of medicines cannot be explained by patients thinking they need medicines that the doctor does not think they need. In the baseline SDS, a few of the contacts with government health services would have been for inpatient care, whereas inpatient contacts were excluded in this survey. A recent survey of patients using district hospitals in Sylhet (Cockcroft, Omer 2000) found hospital indoor patients reported lower availability of all medicines than outdoor patients (probably because of more complex drug regimes for indoor patients).

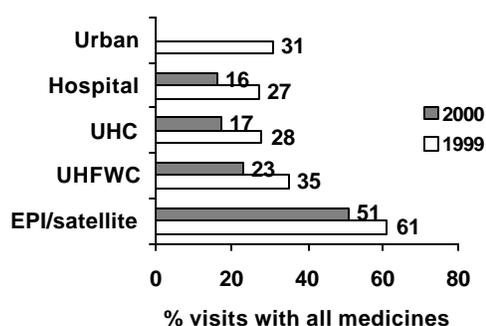


Figure 21. Patient reports of medicines availability in government health services

The availability of all medicines by type of government health facility in the 1999 baseline SDS and the present SDS is shown in figure 21. For all facilities, the proportion of patients who received all medicines from the facility is lower in 2000 than in 1999. This might be related to the timing of the survey in relation to the cycle of supply of medicines to facilities. The 1999 survey was carried out in February/March, collecting information about visits to facilities in

January/February. One supply of medicines reaches facilities in December. The 2000 survey was carried out from mid September to mid October, reflecting visits to facilities in August and September. This is just before a supply of medicines in late September. Thus the apparently lower availability of medicines in 2000 may well reflect fluctuations of supply over the yearly supply cycle rather than any year on year trend. This will need to be checked in future cycles.

Amount of prescribed medicines received

Those service users who reported getting at least some prescribed medicines from the health facility were asked if they received the *full amount prescribed*. Nearly three quarters (72%; 2528/3511) of those who received any medicines said they received the full prescribed amount. The remaining patients were given less tablets or liquid and then supplemented this from another source or took a lower dose or shorter course of medication. Combining the information about medicines received with that about the amount received reveals that 19% (2391/12442) of patients received the full dose of all prescribed medicines from the service provider. This proportion is 19% (392/2118) for government health services, 14% (586/4237) for private/NGO providers, and 23% (1412/6069) for village doctors and drug shops.

Factors related to availability of prescribed medicines

Lack of medicines from government health facilities was identified in the 1999 baseline SDS as a particular problem and concern by both the public and providers of government health services. Therefore, this issue is examined in some detail here. Individual characteristics of service users and service-related factors have been examined for their relationship, if any, with the availability of prescribed medicines experienced by service users. Interpretation is complicated because we do not know what type of medicines were prescribed to different patients: we may not be comparing like with like. The range of medicines available in government health facilities is limited. A quick prescription for a cheap medicine that happens to be available in the facility (irrespective of whether it is likely to help the patient's condition) does not represent better care than a careful history and examination and then prescription of the necessary, effective medicine that is not available in the facility. It is a different case if two patients are both prescribed the same medicine and one receives it from the facility while the other does not.

Gender

The proportion who received all the prescribed medicines from government health facilities does not differ between male and female service users. When only adult service users are considered (aged over 14 years) there is still no difference between men and women.

Poverty status

Very poor patients are apparently slightly *more* likely to report receiving all prescribed medicines, compared with less poor patients, although the difference is not significant at the 5% level². Note, however, that very poor patients are less likely to be prescribed medicines in the first place (see above). When they are prescribed medicines, they may be 'fobbed off' with whatever happens to be in stock. Indeed, one complaint of poor patients is that they are given poor medicines, and often find that people with different conditions all get the same medicines.

"I had a disease of my skin. I went to the doctor and he gave me tablets. The neighbour had a cut on her hand: she was also given the same medicine."
Male focus group, Nabiganj

Literacy of household head

Service users from households where the head is illiterate are slightly *more* likely to report receiving all the prescribed medicines from government health facilities³³. This may be because these patients are prescribed whatever happens to be available in the facility, and not because they really have more chance of getting the same medicine from the facility, compared with a someone from a more educated family.

Remoteness of upazila

Upazilas more than one hour's travel from the district town were classed as 'remote'. In non-remote upazilas, patients are more likely to get all prescribed medicines from government health facilities, compared with remote upazilas³⁴. Note that in this

³² 107/473 (23%) vs 309/1635 (19%). Odds Ratio 1.25 (95% CI 0.97-1.61)

³³ 236/1101 (21%) vs 183/1027 (18%). Odds Ratio 1.27 (95% CI 1.01-1.56)

³⁴ 265/1198 (22%) vs 103/635 (16%). Odds Ratio 1.47 (95% CI 1.13-1.91)

analysis, only rural sites are included. Service providers in facilities near to the district supply store may be more able to obtain adequate supplies of medicines for their facilities.

Explanations given by service providers

Service users who consider that they received a full explanation of their illness are twice as likely to report receiving all the prescribed medicines from the government health facility, compared with those who do not consider they received a full explanation³⁵. Those who consider they received a full explanation about treatment are more than three times as likely to report receiving all prescribed medicines, compared with those who do not consider they received a full explanation about treatment³⁶. This is complex to tease out. The association remains when the effects of other factors associated with getting the prescribed medicines are taken into account by stratification. However, not only is the type of medicine prescribed very variable, but also people will vary in how much explanation they need to feel happy that they had a 'full explanation'. Some patients may be easy to please, satisfied with a few words of explanation and a prescription for a simple medicine available in the facility.

Payments in the facility

In general, patients who make payments in government health facilities are *less* likely to receive all prescribed medicines, while

Patients who make unofficial payments in government health facilities are <i>less likely</i> to receive all prescribed medicines from the facility.

those who do not pay are more likely to receive the prescribed medicines.

- Service users who did *not* pay for a ticket are more likely to report receiving all prescribed medicines from government health facilities, compared with those who paid for a ticket³⁷.
- Patients who did *not* make a payment for the service (see above) are four times more likely to report receiving all prescribed medicines, compared with those who made a payment for the service³⁸.
- Patients who did *not* pay the doctor are four times more likely to report receiving all prescribed medicines, compared with those who paid the doctor³⁹.

A possible explanation is that people who make one of these unofficial payments expect a more detailed interaction with the doctor. This may allow the doctor to decide on which medicine they really need and prescribe it, even though it may not be available in the government facility. Patients who do not make any extra payment are seen very quickly and may simply be prescribed what is in stock. They may be getting all their prescribed medicines from the facility but the medicines may not be useful for their condition. The situation is different when patients report payments in the facilities directly for medicines. Such payments are not commonly reported (less than 10% of patients), but the service users who make them are nearly twice as likely

³⁵ 284/1082 (26%) vs 134/1040 (13%). Odds Ratio 2.41 (95% CI 1.90-3.04)

³⁶ 328/1182 (28%) vs 89/940 (10%). Odds Ratio 3.67 (95% CI 2.82-4.78)

³⁷ 356/1612 (22%) vs 63/516 (12%). Odds Ratio 2.04 (95% CI 1.51-2.76)

³⁸ 388/1624 (24%) vs 31/503 (6%). Odds Ratio 4.78 (95% CI 3.21-7.16)

³⁹ 391/1710 (23%) vs 27/410 (7%). Odds Ratio 4.21 (95% CI 2.75-6.48)

to receive all the prescribed medicines from the facility, compared with the majority who do not pay for medicines in the facility⁴⁰.

Relative supply of medicines to the health facility

For most UHCs in the sample, it was possible to calculate an index that reflects the relative supply of medicines to that facility. This is described in detail in Annex 6. It involves dividing the amount of supply of several common medicines from January to August 2000 by the number of patients attending the facility over the same period (indoor patients were weighted as they are likely to use more medicines than outdoor patients). The index is combined across the medicines to give an overall 'adequacy of supply index'. High values indicate good levels of supply of medicines relative to the number of patients using the facility and low values mean a relatively worse supply in relation to the number of patients.

Service users in the survey can be linked to the particular health facility they visited. Therefore it is possible to examine whether patients receive all prescribed medicines in relation to the medicines supply index for the facility. When this is done for patients visiting UHCs, it shows that those who visit a UHC with a high medicines supply index are about 50% more likely to receive all the prescribed medicines from the facility, compared with those who visit a UHC with a low medicines supply index⁴¹. Nevertheless, even in those UHCs with a high medicines supply index, only 19% of patients received all the prescribed medicines. This may mean that the supply of medicines is not adequate to *any* UHC, but it also suggests that other factors other than supply to the facility are involved in determining whether patients receive all the prescribed medicines from the facility. This relationship between medicines supply index of the UHC and receipt of medicines by patients visiting the UHC remains when other factors related to receipt of medicines (see above) are taken into account by stratification.

Patients who visit a UHC with a high medicines supply index are 50% more likely to get all prescribed medicines from the UHC.

The number of reported visits to UHFWCs is too small to make a similar analysis comparing relative supply to the UHFWC with whether the patients received all the prescribed medicines from the UHFWC.

⁴⁰ 48/157 (31%) vs 371/1971 (19%). Odds Ratio 1.89 (95% CI 1.30-2.78)

⁴¹ 102/540 (19%) vs 72/529 (14%). Odds Ratio 1.48 (95% CI 1.05-2.09)

Perceptions about why medicines are not available

Community perceptions

It is notable that most of the community focus groups did not express an understanding or belief that the supply of medicines to government health facilities is limited. Less than a third of community focus groups (30% male, 27% female) considered that inadequate supply of medicine by the government is a reason for prescribed medicines not being available in health facilities.

In almost all the groups (94% male, 93% female) participants expressed the view that there is pilferage and diversion of medicines from government health facilities, and this is the main reason why the patients do not get medicines.

Participants also expressed the belief that government health service providers ask for money for medicines. In many groups (57% male, 61% female) participants were of the view that although the government supplies the medicines the staff do not provide them to the patients saying that they do not get a supply.

"At first they do not give us the medicines because they want to take our money; after that if we give money then they give us the medicine."
Female focus group, Islampur

They also submitted that only those who are rich and influential get medicines at government health facilities (57% male, 59% female).

"If a man wearing a shirt and trousers goes there they certainly give him medicine. If someone has a relationship with the doctor then he will be given medicine. Even one who needs no medicine, they give him costly medicines and say, 'Keep it. You may require it later'.
Female focus group, Niamatpur

Perceptions of service providers in upazila meetings

The views expressed by health service providers in upazila meetings about the availability of medicines in government health facilities are markedly different from the views expressed in the community focus groups.

"Many unwanted patients come and crowd into the hospital. So the number of patients is very high and it is not possible to give medicine to all the patients."
Upazila meeting, Saghata

In most of the meetings the participants attributed lack of medicines to inadequate or inappropriate supply of medicines to the health facility in relation to the patient load (20/24 upazilas). They said

that the medicines are not only supplied in less quantity than is needed, but they are also of low quality. The medicines supplied do not match with the disease pattern in the area. In some upazilas (5/24) the doctors also mentioned that patients may ask for medicines by name which they do not need.

"People believe that doctors sell medicine outside instead of giving it to the patients. They may say it about us because they are illiterate and they have no idea about supply."
Upazila meeting, Tajmuddin

Regarding the opinion of the public about leakage of medicines from the health facility or medicines not being supplied to patients despite availability, in almost all upazilas

(22/24) the service providers insisted that this was a wrong impression.

They said that the public are not aware of the real situation. They do not know how much medicine facilities get or what patient loads they have to deal with. In few upazilas (5/24) the meeting participants blamed political leaders for spreading false rumours about the availability of medicines in the health facility, misleading the people.

“There is no communication with the local people directly about the facilities and our problems and how much medicine we get.”
Upazila meeting, Niamatpur

They admitted that the communication gap between service providers and the public plays a role in people’s misconceptions about the medicines situation (5/24 upazilas).

How to increase availability of medicines in government health facilities

Views of the public

Some community focus groups asked for an improvement in the quality and quantity of medicines supplied to health facilities by the government (46% male groups, 48% female groups). However, groups also emphasized the need for strict monitoring and supervision by government staff to achieve better management and distribution of medicines at the health facilities (57% male, 61% female). They asked for a change in the attitude and behaviour of the staff towards poor people (37% males, 38% females) so that they would treat rich and poor people equally. A few groups (14% male, 8% female) suggested involving community representatives in monitoring health service providers and medicines distribution.

“As well as giving medicines to the hospitals, the government should also monitor them regularly.”
Male focus group, Islampur

Some people felt that punishing service providers found guilty of misconduct and publicising this could help to change the attitudes of service providers.

“A team must come from the top and throw out the doctors who have been stealing. If one or two are given punishment like this the others will become careful.”
Male focus group, Nawabqani

Fixed price pharmacies in government health facilities

Focus groups specifically discussed the possibility of setting up fixed price pharmacies in government health facilities. Most groups liked the idea overall (78% male groups, 77% female groups). In their opinion it would be a good system as they would be able to buy medicines at cheaper rates (31% male, 37% female), and wouldn’t have to buy them from outside drug shops which are more expensive (13% male, 17% female). In a third of the groups (29% male, 33% female) people suggested that the price of medicines in these pharmacies should be lower than the market price with special lower prices for the very poor.

In one out of five groups (21% male, 19% female), participants felt the new pharmacies could even worsen the situation as they may offer more opportunity for pilferage and diversion of medicines from the government health facilities

Some groups (12% male, 19% female) were against the pharmacy idea on the grounds that medicines should be available free from government health facilities as is the current policy, at least in theory.

“But it is a problem for those who are too poor to eat. Arrangements should be made by the government to give free medicines to those who are very poor.”
Male focus group, Mehendiqani

Pointers from the epidemiological evidence

Usually it is possible to consider the combined effects of variables on an outcome and predict the possible effects on the outcome of interventions to change these variables. When this is done in terms of risk difference, it is a useful way of determining the potential population benefits of different possible interventions. In this case, the relationships do not support this sort of analysis – the outcome of ‘all prescribed medicines available’ can occur in several different ways. Without knowing the actual prescriptions, and comparing availability of similar prescriptions, it is difficult to tease this out further.

Satisfaction of users of government health services

Satisfaction with behaviour of service providers

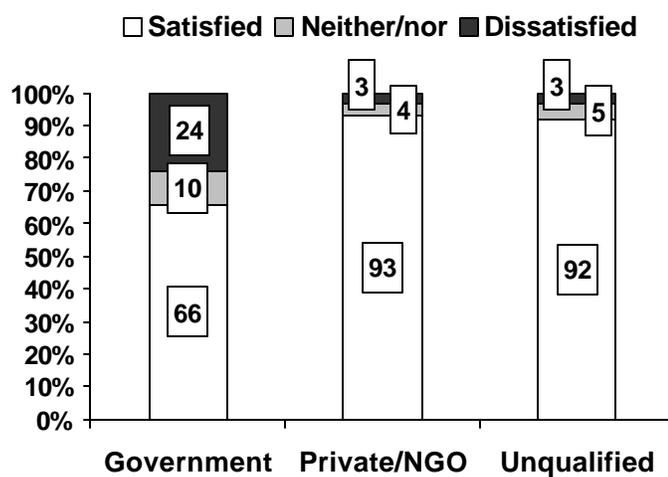


Figure 22. Satisfaction with behaviour of service providers

Among all those who reported on visits to health services for treatment in the last month, 88% (12776/14551) were satisfied with the way the service provider(s) treated them, 5% (803) were neither satisfied nor dissatisfied and 7% (972) were dissatisfied. There was variation in the degree of satisfaction depending on the type

of service provider (Figure 22). Those who used government health services are less satisfied with the behaviour of the service providers, although two thirds are satisfied, a quarter are not satisfied. People who used private or unqualified practitioners are six times more likely to be satisfied with the way they were treated compared with people who used the government health service⁴².

Poverty status and gender

Considering government health services, there is no difference in reported satisfaction with the behaviour of the service provider between male and female patients. When only adult service users (aged over 14 years) are considered, men are more likely than women to be satisfied with the behaviour of the service provider⁴³. Very poor patients are more likely to report not being fully satisfied with the way the service provider(s) behaved towards them⁴⁴.

⁴² 11166/12115 (92%) vs 1591/2415 (66%). Odds Ratio 6.09 (95% CI 5.46-6.80)

⁴³ 301/420 (72%) vs 626/963 (65%). Odds Ratio 1.37 (95% CI 1.05-1.75)

⁴⁴ 224/571 (39%) vs 597/1823 (33%). Odds Ratio 1.33 (95% CI 1.08-1.62)

Satisfaction with overall service

Most service users were also satisfied with the overall service they received. Some 84% (12158/14538) were satisfied, 7% (1087) were neither satisfied nor dissatisfied, and 9% (1293) were dissatisfied. Once again, satisfaction was lower among those who used government health services (Figure 23). Users of private or unqualified practitioners are four times more likely to be satisfied with the overall service, compared with users of government health services⁴⁵.

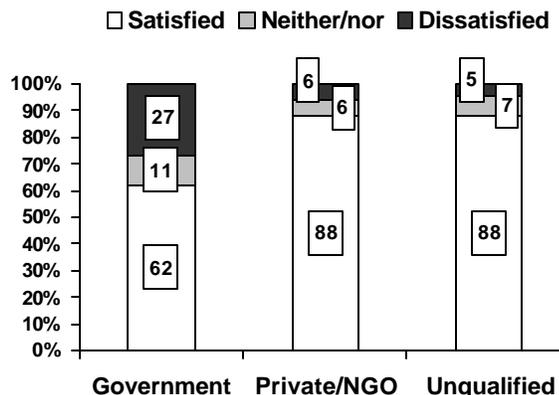


Figure 23. Satisfaction with overall service

Poverty status and gender

Considering government health services, very poor people who used the services are more likely to report being less than satisfied with the overall service, compared with less poor people⁴⁶. There is no difference between male and female patients in the proportion reporting satisfaction with the overall service from government health facilities. When only adult service users are considered (aged over 14 years), men are more likely than women to be satisfied with the overall service⁴⁷.

Comparison with 1999 SDS

The same question about satisfaction with the overall service received from government facilities was asked in the 1999 SDS. Compared with the 1999 SDS, there has been an increase in the proportion of service users satisfied with the overall service received, from 53% in 1999 to 62% in 2000. This is an encouraging sign.

The proportion of users satisfied overall with government health services has increased from 53% in 1999 to 62% in 2000.

Views of service providers about satisfaction of service users

In meetings in 24 upazilas in the sample, the health management teams were given information from the household survey in their upazila about the satisfaction of households and service users with government health services and asked for their views (See Annex 8 for a detailed description).

In more than half of the meetings (13/24), participants agreed with the findings. In four meetings their own impression of the situation was even worse than the survey results suggested.

"We thought that even more people would have said our health service facilities are not good."
Upazila meeting, Kashiani

⁴⁵ 10644/12104 (88%) vs 1495/2413 (62%). Odds Ratio 4.48 (95% CI 4.05-4.95)

⁴⁶ 236/570 (41%) vs 678/1822 (37%). Odds Ratio 1.19 (95% CI 0.98-1.45)

⁴⁷ 287/420 (68%) vs 581/962 (60%). Odds Ratio 1.41 (95% CI 1.10-1.82)

A quarter of the upazila teams (6/24) did not agree with the survey findings, considering the bad opinion of services to be exclusively the opinion of people who are not visiting the health facilities.

When the upazila teams were asked to comment about why people are dissatisfied with government health services, the most frequent reason they mentioned was lack of medicines (19/24). The behaviour of service providers was identified as a reason in some upazilas (10/24). In half the upazilas (12/24) the attitudes and ignorance of the public were cited as a reason for their being not satisfied with the services. In some meetings participants mentioned shortage of staff (10/24) as a reason that leads to overcrowding and long waiting time (9/24).

"In a month I get 1000 paracetamol but there are 3000 patients. So even simple paracetamol finishes within 15 days. For the rest of the 15 days if we cannot provide them the patients become angry."
Upazila meeting, Kawkhali

In a quarter of the meetings participants mentioned that perhaps people have very high and unrealistic expectations of the government health facilities (7/24). Being unaware of the limited resources of the service, they become disappointed and dissatisfied when their expectations are not fulfilled.

"It took a lot of money to build this health complex and people think that all sorts of treatments will be done here. They feel bad when they don't get all the treatments."
Upazila meeting, Khaliajuri

Participants in the upazila meetings had many suggestions for actions that could be taken at different levels to improve satisfaction with government health services, particularly in their upazila (see Annex 8).

Suggested local level actions

The most popular suggestion (17/24) was better communication between service providers and the public with sharing of information about the services available and the limitations of government health services.

Other suggestions included: creating awareness among people about appropriate use of health facilities at different levels (13/24); improving the behaviour of service providers (10/24); and discussions at community level about the services on offer (7/24).

"We have to behave well with the patients: check them well, examine them and give them good treatment. We have to get their trust."
Upazila meeting, Chhatak

Suggested national level actions

Common suggestions were: to increase the number and quality of services available at the health facilities (14/24); to have a medicine supply better in quantity and quality (14/24); to have more service providers in the upazila (9/24); to train service providers about dealing with patients (6/24); to improve salary and terms and conditions for staff (9/24); and to introduce an official ticket/service charge (8/24).

Factors related to satisfaction of users of government health services

The factors that are individually related to satisfaction of users with the overall service from government health facilities are:

- Poverty status. Service users from very poor households are more likely to be dissatisfied with the overall service (see above).
- Gender. For adults, women are more likely to be dissatisfied (see above).
- Illiteracy of household head. Service users from households with an illiterate head are more likely to be dissatisfied, compared with those from households with a literate head⁴⁸.
- Type of facility. Satisfaction is highest for visits to urban facilities (83%; 10/12) and individual government service providers (85%; 97/114). It is lowest for visits to the UHC (59%; 753/1287) and UHFWC (51%; 225/438). Satisfaction after visits to satellite clinics (75%; 76/102) and government hospitals (73%; 334/460) is intermediate.
- Waiting time. Service users who had to wait more than 30 minutes to be seen are more likely to be dissatisfied, compared with those who were seen more quickly⁴⁹.
- Availability of prescribed medicines. Service users who did not receive all prescribed medicines from the facility are nearly 4 times as likely to be dissatisfied with the service, compared with users who did receive all the medicines⁵⁰.
- Explanation of their illness. Service users who felt they did not have a full explanation are very much more likely to be dissatisfied, compared with those who felt they did have a full explanation⁵¹.
- Explanation about the treatment. Service users who felt they did not have a full explanation about treatment are very much more likely to be dissatisfied, compared with those who felt they did have a full explanation⁵².
- Payment for ticket. Service users who paid for a ticket (an unofficial payment) are somewhat more likely to be dissatisfied, compared with those who did not pay⁵³. But there is no statistically significant relationship between paying a service charge or paying the doctor and dissatisfaction with the service.

These variables, individually related to the risk of being dissatisfied with the service received from a government health facility, have subsequently been examined simultaneously by means of logistic regression. This allows the effects of each variable on the outcome to be examined while the effects of all the others are taken into account.

The final model from the logistic regression has been used to construct Table 11 in the following section.

⁴⁸ 571/1253 (46%) vs 347/1160 (30%). Odds Ratio 1.96 (95% CI 1.65-2.33)

⁴⁹ 381/807 (47%) vs 534/1600 (33%). Odds Ratio 1.79 (95% CI 1.49-2.13)

⁵⁰ 713/1706 (42%) vs 66/418 (16%). Odds Ratio 3.83 (95% CI 2.86-5.13)

⁵¹ 768/1213 (63%) vs 149/1196 (13%). Odds Ratio 12.13 (95% CI 9.78-15.04)

⁵² 744/1109 (67%) vs 174/1301 (13%). Odds Ratio 13.20 (95% CI 10.70-16.29)

⁵³ 255/562 (45%) vs 663/1850 (36%). Odds Ratio 1.49 (95% CI 1.22-1.81)

Potential interventions to increase satisfaction of service users with government health services.

Table 11 is from the logistic regression analysis of different variables related to the risk of service users being dissatisfied with their experience of government health services. It shows the potential gains, in terms of proportion of service users satisfied with government health service contacts, from different interventions.

Table 11. Potential gains in satisfaction of users of government health services.

Intervention	Individual benefit	Risk Difference	PRI	Gain per 1000 service users
Eliminate illiteracy of household heads	1.23	4.02%	51%	20
Reduce waiting time to under 30 minutes	1.20	3.43%	34%	12
Ensure all prescribed medicines available	1.60	8.42%	80%	67
Explain illness to patient	1.86	10.64%	50%	53
Explain treatment to patient	1.98	11.48%	46%	53

Notes:

1. The individual benefit is the adjusted Odds Ratio. For example, an individual given a satisfactory explanation about the illness is 1.86 times more likely to be satisfied with the service, compared with someone not given this explanation.
2. The PRI (proportion requiring intervention) is the proportion of service users who currently do not have the favourable value of the variable. For example, the proportion who currently do not get all the prescribed medicines is 80%.
3. The gain per 1000 is calculated by multiplying the PRI by the risk difference. This is the proportion who could potentially become satisfied with the service as a result of each intervention.

Some of the interventions in Table 11 would be difficult and costly to achieve. But the ones concerned with reducing waiting time and giving explanations to the patients about their illness and the required treatment should be much more feasible. The important gains that could be achieved from simply talking to the patients and giving them explanations are in line with the commonly voiced plea from the public for government health service workers to behave better towards them and to treat them with respect.

The proportion of service users satisfied with government health services could be usefully increased if all service providers simply explained the illness and the required treatment to their patients.

Injuries and violence towards women

Characteristics of women in the sample

Age

The sample of currently married women between 10 and 49 years old includes 24529 women. The average age of women in the sample is 30 years old. Nearly half (49%; 11958/24529) are below 30 years of age. There are 24446 currently married women aged 15-49 years, with an average age of 30 years.

Only 83 women in the sample (0.3%) are aged from 10 to 14 years, 8% from 15 to 19 (1904/24529), 41% (9971) from 20 to 29, 34% (8232) from 30 to 39 and 18% (4339) from 40 to 49 years.

Literacy of women aged 15 to 49 years

Out of all currently married women from 15 to 49 years of age in the sample, 40% (9985/24427) are literate.

In metropolitan areas, a woman is 4 times as likely to be literate compared with a woman in rural areas⁵⁴. In rural areas, the division with the highest literacy rate of currently married women is Khulna (44%, 1371/3121), while the lowest is Sylhet (27%, 358/1353).

Women who live in houses better than kutcha² are three times as likely to be literate compared with women who live in kutcha² houses⁵⁵. Similarly, women from households not classified as very poor (that is, with an annual income of more than Tk 23,899) are three times as likely to be literate as women from very poor households⁵⁶.

If the head of the household is literate, a woman is almost 13 times as likely to be literate herself, compared with a woman from a household with an illiterate head⁵⁷. Women below 30 years old are nearly twice as likely to be literate as older women⁵⁸.

Injuries to women

Of currently married women from 10 to 49 years, 4% (875/24506) reported they had suffered from an injury needing treatment in the last year.

Women over 30 years old are somewhat more likely to suffer injuries than younger women⁵⁹.

In rural areas, the division with the highest proportion of women suffering from injury in the last year is Sylhet (12%, 163/1354), while the one with the lowest is Rajshahi (1%, 58/5108). (Table 12)

⁵⁴ 2123/2993 (71%) vs 7862/21434 (37%). Odds Ratio 4.21 (95% CI 3.87-4.59)

⁵⁵ 8140/16773 (49%) vs 1834/7630 (24%). Odds Ratio 2.98 (95% CI 2.80-3.17)

⁵⁶ 8525/18198 (47%) vs 1402/6091 (23%). Odds Ratio 2.95 (95% CI 2.75-3.15)

⁵⁷ 8203/12016 (68%) vs 1777/12402 (14%). Odds Ratio 12.86 (95% CI 12.06-13.72)

⁵⁸ 5672/11868 (48%) vs 4313/12559 (34%). Odds Ratio 1.75 (95% CI 1.67-1.85)

⁵⁹ 508/12557 (4%) vs 5671/11984 (3%). Odds Ratio 1.33 (95% CI 1.16-1.54)

Table 12. No. (%) of women who suffered an injury needing treatment in the last year

Women 10-49 yrs	Barisal	Chittagong	Dhaka	Khulna	Rajshahi	Sylhet	Metro
Injured	62 (3)	140 (4)	239 (4)	124 (4)	58 (1)	163 (12)	89 (3)
Total	1986	3847	6071	3144	5108	1354	2996

Injuries due to violence

Of the 863 women who reported (in an open question) on how their injury happened, the commonest cause mentioned was unspecified accidents (37%, 318), followed by accidents while cooking (28%, 244), home accidents (20%, 172) and road accidents (4%, 33). Some 9% (73) of women said their injury was caused by violence from the husband, and 1% (7) said they were injured by violence of other family members.

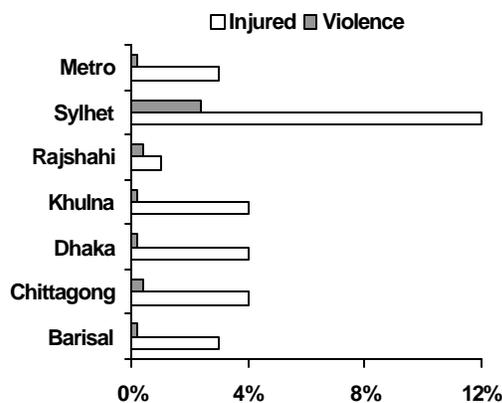


Figure 24. % women injured and suffering violence by division

Overall, 11% (96/863) of women who reported they had an injury requiring treatment in the last year said it was due to violence (by the husband, family members, unknown person, or road assault). It may well be that this is an underestimate of the proportion of injuries that are due to violence. In the situation of the household interview, it is difficult to ensure privacy for the respondent and women may not wish to admit they have suffered from violence, especially when other family members may be able to overhear the conversation.

In all divisions and in metropolitan areas, less than 0.3% (63/23141) of women suffered violence, except in Sylhet where it is 2% (33/1353). (Figure 24).

Although the numbers are small, in rural areas, a woman who is from a remote upazila is twice as likely to suffer from violence requiring treatment as a woman from a non remote upazila⁶⁰. An illiterate woman is more likely to suffer from violence than a literate woman⁶¹, as is a woman from a household with an illiterate head⁶².

Focus group discussions about violence against women

In community focus groups, of men and women separately, participants were given the findings about the proportion of women in the division who said they had an injury and how often they said it was due to violence.

Most of the groups, both male (92%) and female (87%), agreed with the presented findings from the household survey in their division. In about 5% of groups

⁶⁰ 42/6294 (6 per 1000) vs 48/14804 (3 per 1000). Odds Ratio 1.92 (95% CI 1.25-3.01)

⁶¹ 79/14473 (5 per 1000) vs 17/10017 (2 per 1000). Odds Ratio 3.23 (95% CI 1.86-5.69)

⁶² 63/12459 (5 per 1000) vs 33/12037 (3 per 1000). Odds Ratio 1.85 (95% CI 1.19-2.89)

participants denied that such incidences occurred in their communities. In another 5% of groups, people said that violence against women was more common than the household survey results suggested. Women's groups were no more likely to say this than men's groups.

When asked specifically about violence against women in their own community, two thirds of groups (69% male, 65% female) considered that these cases occur rarely in their community.

One out of five groups (18% male, 19% female) reported that such cases occur frequently in their community.

"It happens very often for the dowry. Another reason is poverty. With hunger, they get angry and become mad. That is why they beat up their wives."
Male focus group, Saidpur

One in ten groups (10% male, 14% female) said violence against women does not happen at all in their community.

"Here arbitration always takes place. So no one beats his wife. And if someone does beat his wife then others ask him why he is behaving with his wife like that."
Male focus group, Paikgachha

Although the majority of groups (both male and female) say that violence against women is rare in their community, many of these groups are nevertheless able to describe at least one local incidence of such violence. Commonly the violence is domestic, perpetrated by the husband, mother-in-law, or some other relative. Land disputes are a commonly described reason for other episodes of violence involving women.

In many cases of wife-beating, the offence of the wife seems trivial – the meal is not ready when the husband returns home, the plants are not watered, the curry is not good, there is too much salt in the curry – but often the injuries are not. Dowry disputes remain an important cause of domestic violence against young wives. A number of cases of serious injury, torture and murder were recounted in the focus groups, both male and female.

"Our neighbour came home from work and saw his wife had not finished cooking, so in anger he beat her badly and cracked her head. Finally he took her to the hospital. The doctor gave her a few paracetamols, dettol, made a bandage and sent her off. Now she is afraid to go to the doctor because of his bad comments, although it's obvious she needs to."
Male focus group, Nabiganj

Seeking treatment for injury

Of the women who suffered from injury needing treatment in the last year, 26% (226/858) did not seek treatment.

In rural areas, in Chittagong, 93% of injured women sought treatment (127/136), while in Barisal only 58% sought care (35/60). In metropolitan areas, 78% of women sought treatment (68/87). (Figure 25)

A literate woman who suffered from an injury needing treatment is more likely to seek treatment than an illiterate woman⁶³.

Of those women who sought treatment for injuries, 47% (277/588) went to unqualified practitioners (village doctor, drug shop, traditional practitioner), 32% (192/588) sought care at government facilities and 20% (119/588) sought care at private or NGO facilities.

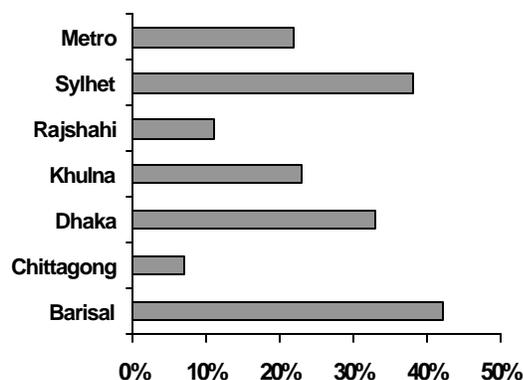


Figure 25. Women with injuries needing treatment who did not seek treatment

In rural areas, 49% (257/520) of women who sought treatment for injury went to unqualified practitioners, 34% (176) went to a government facility, and 17% (87) went to a private facility. In metropolitan areas, 29% (20/68) went to unqualified practitioners, only 24% (16/68) went to government health facilities, and 27% (32/68) went to private facilities.

Experiences of seeking treatment for injuries due to violence

Focus groups described the experiences of women who sought treatment from government health facilities for injuries due to violence. In most of the cases reported, the experience of the service was not good. The health care worker usually had to be paid for treating the injury, sometimes quite large amounts.

“After my sister-in-law’s husband died, her elder brothers-in-law turned her out and beat her. I took her to the hospital at once. At first the doctor would not touch her. After we gave him money he gave her two stitches like a cow.”
Female focus group, Pakundia

Sometimes the person causing the injury is reluctant to take the injured person to a health care facility for fear of involvement of the police.

“Husbands do beat their wives. They bring the doctor to their home. They don’t take them [the wives] to the hospital. The doctors provide good treatment for money.”
Female focus group, Shibalaya

Arrangements in health care facilities for injuries and violence against women

Cases seen in UHCs

Information about cases of injury treated in the last three months was sought during the institutional review of 41 UHCs (see Annex 6). Forty UHCs had information about injury cases and reported a total of 3620 women coming to the facility for treatment of any injury during last three months. The number of cases per UHC

⁶³ 255/317 (80%) vs 375/539 (70%). Odds Ratio 1.80 (1.27-2.55)

ranged from 0 to 280. Some 14360 of these injuries were documented by the facilities as assault cases. Some 39 UHCs had information available on the number of assault cases seen in the last three months. The proportion of injuries recorded as due to assault varied between UHCs, ranging from 0% to 100% (mean 52%). Table IR1-2 categorizes the UHCs by number of women reporting for treatment of injury and assault cases.

Thus, there is very marked variation between UHCs both in the number of cases of injuries to women they see, and in the proportion of these injuries that are recorded as assault.

Cases seen in UHFWCs

Information was also sought about injury and assault cases presenting to the UHFWCs reviewed as part of the survey (see Annex 6). Among the UHFWCs that provided the information on women reporting for treatment of injury (n=171), 45 (26%) reported that they did not see *any* woman in the centre for treatment of injury during the last year. For those who reported receiving some cases (n=126) a total of 7881 cases were reported, with an average of 63 cases per facility (range 1- 382). Among these facilities 46 (36%) did not record any of the injury cases as being due to violence. A total of 920 cases (12%) among all the injury cases (n=7881) were reported as injuries due to violence.

There is also apparently great variation between UHFWCs in the number of injuries to women they see annually. Only a small proportion of the injuries seen was recorded as being due to assault (violence).

Special support and staff training

Only eight (19%) of the UHFPOs or deputies interviewed (n=42) said they had a policy to give specific support for women who have suffered injuries due to violence. Of these seven were able to specify the type of support offered to women seeking care for injuries due to violence: this included giving them priority over other patients (3), and informing higher authorities about the incident (3). Only in two upazilas the UHFPOs reported that their staff had received any specific training about how to deal with women suffering from injuries due to violence.

Thus there is presently not much done in UHCs to encourage women to come for help when they have suffered violence. This adds to the other reasons women have (see above) for not seeking help for injuries due to violence.

Care during delivery

Out of all currently married women in the sample, from 15 to 49 years of age, 14% (3398/24442) gave birth in the last one year.

Place of delivery

Of those who gave birth, 89% (3007/3393) of them delivered at their own home or someone else's home, while 7% (241) delivered at a government health facility, and 4% (145) delivered at a private facility.

Nine out of ten women deliver their baby at home.

In metropolitan areas, the proportion of women delivering at a health facility is 41% (149/363). A woman from a metropolitan area is 8 times as likely to deliver at a health facility compared with a woman from a rural area⁶⁴.

In rural sites, the division with the highest proportion of women who delivered at a health facility in the last year is Khulna (16%), while the division with the lowest proportion is Barisal (3%). (Table 13).

Table 13. No. (%) of deliveries in health facilities out of all deliveries in the last year

Deliveries	Barisal	Chittagong	Dhaka	Khulna	Rajshahi	Sylhet	Metro
Health Facility	8 (3)	33 (5)	80 (9)	51 (16)	47 (9)	18 (7)	149 (41)
Gov facility*	7 (3)	19 (3)	56 (6)	44 (14)	39 (8)	12 (5)	64 (18)
Total	270	730	938	326	523	243	363

* Deliveries in government facilities are a sub-set of the deliveries in any health facility.

Women from households with an annual income more than Tk 23,899 are twice as likely to deliver in a facility⁶⁵.

Place of delivery in rural areas

As can be seen from Table 13, nearly all deliveries in facilities in rural areas are in government health facilities.

Considering only rural areas, a woman is more likely to deliver in a health facility if:

- She is not from a remote upazila⁶⁶
- She lives in a house with better than kutcha2 construction⁶⁷
- She is literate⁶⁸
- She is younger than 30 years old⁶⁹

Table 14 shows the number and proportions of women in rural areas delivering at health facilities in relation to remoteness of the upazila, household construction, household income, literacy, and age.

⁶⁴ 149/363 (41%) vs 237/3030 (8%). Odds Ratio 8.21 (95% CI 6.34-10.62)

⁶⁵ 331/2606 (13%) vs 52/770 (7%). Odds Ratio 2.01 (95% CI 1.46-2.77)

⁶⁶ 198/2100 (9%) vs 39/930 (4%). Odds Ratio 2.38 (95% CI 1.64-3.45)

⁶⁷ 174/1925 (9%) vs 63/1103 (6%). Odds Ratio 1.64 (95% CI 1.20-2.24)

⁶⁸ 151/1187 (13%) vs 86/1843 (5%). Odds Ratio 2.98 (95% CI 2.23-3.97)

⁶⁹ 187/2139 (9%) vs 50/891 (6%). Odds Ratio 1.61 (95% CI 1.15-2.27)

Table 14. Rural areas: no. (%) of deliveries in health facilities by remote, poor house, literacy and age of the woman

Deliveries	Remote		Poor house		Literacy of woman		Age of woman	
	Remote	Non Remote	Woman illiterate	Literate woman	Poor house kutcha2	Non poor house	15-29 years old	30-49 years old
Health Facility	39 (4)	198 (9)	86 (5)	151 (13)	63 (6)	174 (9)	187 (9)	50 (6)
Total	930	2100	1843	1187	1103	1925	2139	891

Among women who delivered at a health facility, very poor women are more likely to deliver at a government health facility (rather than a private facility) compared with less poor women⁷⁰.

Advantages and disadvantages of delivery in facilities

Focus groups discussed this issue. In nearly half of the groups (50% male, 43% female) participants considered that there is no advantage in delivering at a health facility. They cited disadvantages similar to the problems of using government health service for other purposes, including expense, having to pay service providers, lack of medicines, bad behaviour of service providers. They also had concerns about unnecessary interventions such as caesarian sections.

Focus groups in some communities could see at least potential advantages of delivering in health facilities, such as the availability of good doctors and rapid help in case of an emergency during labour.

Assistance at the delivery

Of all the reported deliveries, only 15% (508/3390) were assisted by trained personnel (doctor, nurse or FWV). It was not possible to determine accurately if the dai who attended a delivery was trained or not, so deliveries attended by a dai are not counted as being attended by a trained worker. Almost none (4%; 131/3004) of the deliveries at home were attended by a trained worker.

Only 15% of deliveries are attended by a trained worker.

The proportions of deliveries attended by different people, trained or untrained, are shown in Figure 26. Over half of the deliveries were attended by the dai.

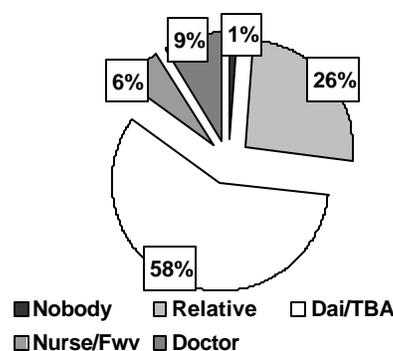


Figure 26. Person attending delivery

⁷⁰ 41/52 (79%) vs 198/331 (60%). Odds Ratio 2.50 (95% CI 1.18-5.56)

The delivery is more likely to be attended by a trained worker if:

- The woman is below 30 years old⁷¹
- The woman is from a metropolitan area⁷²
- The woman lives in a house of better than kutchha2 construction⁷³
- The woman is not very poor (annual household income more than Tk 23,898)⁷⁴
- The woman is from a non-remote upazila (rural areas only)⁷⁵
- The woman is literate⁷⁶
- The woman is from a household with a female household head⁷⁷

In rural areas, the division with the highest proportion of deliveries assisted by a doctor, a nurse, or a FWV is in Khulna (23%, 74/326), while the lowest is in Barisal (5%, 14/270).

Deliberating on the reasons why few deliveries occur with trained assistance, focus group participants (see Annex 7) cited non-availability of a trained person in or near the community as the prime reason (61% male, 58% female). In situations where trained women are available they may either ask for money or refuse to help the poor (45% male groups, 43% female groups).

"It takes Tk 1200 to make a delivery by a trained woman. We have to bring her from the next village. Often we do not find her and the situation of the patient may become serious."

Male focus group, Nabiganj

Focus groups also discussed what could help more women to deliver with trained assistance (see Annex 7). Many groups (78% male, 77% female) recommended training women in the communities to conduct deliveries, especially existing dais. The groups also suggested communication about the benefits of trained assistance for woman and baby, coming from respected members of the community as well as health workers.

⁷¹ 382/2412 (16%) vs 126/978 (13%). Odds Ratio 1.26 (95% CI 1.02-1.59)

⁷² 175/364 (48%) vs 333/3026 (11%). Odds Ratio 7.49 (95% CI 5.86-9.56)

⁷³ 412/2254 (18%) vs 96/1133 (9%). Odds Ratio 2.42 (95% CI 1.89-3.08)

⁷⁴ 433/2603 (17%) vs 71/769 (9%). Odds Ratio 1.96 (95% CI 1.49-2.59)

⁷⁵ 267/2098 (13%) vs 66/928 (7%). Odds Ratio 1.90 (95% CI 1.42-2.56)

⁷⁶ 366/1442 (25%) vs 142/1948 (7%). Odds Ratio 4.33 (95% CI 3.49-5.37)

⁷⁷ 31/145 (21%) vs 477/3245 (15%). Odds Ratio 1.58 (95% CI 1.02-2.43)

Decisions about who would assist the delivery

For deliveries in the last year, the most common person to decide who would attend the delivery is the husband, alone or with the mother in law (60%; 2027/3367). In 22% (745) the woman makes the decision herself or shares the decision. The mother in law decides alone in 11% (361). (Figure 27).

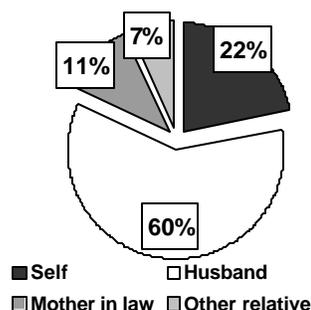


Figure 27. Decision maker about who would attend delivery

In rural areas, the division with the lowest proportion of women who had a say in the decision about who would attend the delivery is in Sylhet (15%, 35/236), while the highest is in Barisal (29%, 79/269). In metropolitan areas, the proportion of women who had a say in the decision is 25% (89/364).

Overall, 18% (590/3367) of women decided by themselves who would assist them during the delivery and 5% (155/3367) decided together with another person (husband or mother in law). For the remaining 78% (2622/3367), other people made the decision for the woman.

A woman is more likely to make a decision together with her husband or the mother is law if:

- She is literate⁷⁸
- She lives in an metropolitan area⁷⁹
- She does not live in a kutcha2 house⁸⁰

On the other hand, a woman is more likely to make a decision by herself, but alone, if:

- She lives in a rural area⁸¹
- She lives in a kutcha2 house⁸²
- She has a family income below the poverty line⁸³
- She is illiterate⁸⁴
- She is over 30 years of age⁸⁵

A woman who made the decision with someone else or who did not take part in the decision is twice as likely to be assisted by trained personnel compared with a woman that made the decision alone⁸⁶.

⁷⁸ 87/1435 (6%) vs 68/1932 (4%). Odds Ratio 1.77 (95% CI 1.26-2.48)

⁷⁹ 41/364 (11%) vs 114/3003 (4%). Odds Ratio 3.22 (95% CI 2.17-4.75)

⁸⁰ 126/2241 (6%) vs 29/1123 (3%). Odds Ratio 2.25 (95% CI 1.47-3.46)

⁸¹ 542/3003 (18%) vs 48/364 (13%). Odds Ratio 1.45 (95% CI 1.04-2.02)

⁸² 229/1123 (20%) vs 361/2241 (16%). Odds Ratio 1.33 (95% CI 1.10-1.61)

⁸³ 172/767 (22%) vs 417/2582 (16%). Odds Ratio 1.50 (95% CI 1.22-1.84)

⁸⁴ 373/1932 (19%) vs 217/1435 (15%). Odds Ratio 1.34 (95% CI 1.11-1.62)

⁸⁵ 221/969 (23%) vs 369/2398 (15%). Odds Ratio 1.62 (95% CI 1.34-1.97)

⁸⁶ 455/2774 (16%) vs 52/590 (9%). Odds Ratio 2.03 (95% CI 1.48-2.79)

However, the best situation seems to be if the woman takes part in a shared decision. Women who made the decision together with someone else are almost three times more likely to be assisted by trained personnel, compared with women who did not take part in the decision or who decided by themselves⁸⁷.

Table 15. No. (%) of deliveries by who assisted them and by who made the decision

	Woman alone	Woman shared	Someone else
Nobody	18 (3%)	0 (0%)	20 (1%)
Relative	179 (30%)	43 (28%)	641 (25%)
Dai/TBA	341 (58%)	62 (40%)	1553 (59%)
FWV	8 (1%)	1 (1%)	35 (1%)
Nurse	15 (2%)	15 (10%)	136 (5%)
Doctor	29 (5%)	34 (22%)	234 (9%)
Total	590 (100%)	155 (100%)	2619 (100%)

As it can be seen from Table 15, in the group of women who made a shared decision, the percentages of deliveries assisted by a nurse or a doctor are higher than in the other two groups.

Problems during delivery

Of all the women who delivered in the last year, some 7% (250/3372) reported they had problems during delivery.

Literate women are more likely to report they had problems during delivery compared with illiterate women⁸⁸. This could be related to different perceptions of what counts as a problem during delivery between literate and illiterate women.

Similarly, women from metropolitan areas are more likely to report they had problems during delivery compared with women from rural areas⁸⁹. This may also be due to different perceptions of what constitutes a problem during delivery, although the difference between metropolitan and rural areas persists when literacy of the woman is taken into account.

As expected, women who delivered in a health facility are five times as likely to report they had a health problem during delivery⁹⁰. This reflects the fact that many deliveries in health facilities are emergencies rather than planned admissions for delivery.

In rural areas, the division with the highest proportion of women who had problems during delivery is Sylhet with 12% (30/242). The division with the lowest proportion is Barisal with 3% (9/270).

⁸⁷ 50/155 (32%) vs 457/3209 (14%). Odds Ratio 2.87 (95% CI 1.99-4.13)

⁸⁸ 130/1432 (9%) vs 120/1940 (6%). Odds Ratio 1.51 (95% CI 1.16-2.00)

⁸⁹ 37/364 (10%) vs 213/3008 (7%). Odds Ratio 1.49 (95% CI 1.01-2.17)

⁹⁰ 89/250 (36%) vs 297/3120 (10%). Odds Ratio 5.26 (95% CI 3.85-7.14)

Help for problems during delivery

Table 16 shows where women with health problems during delivery were taken for help. About a quarter (26%) were not taken anywhere for help.

Table 16. Place where women with health problems during delivery were taken for help

Place	No.	(%)
Nowhere	64	(26)
Government Hospital	51	(21)
UHC	34	(14)
UHFWC/Sat Clinic/MA,FWV,HA	13	(5)
Private Doctor / Clinic / Hospital	52	(21)
Village Doctor	24	(10)
Other	7	(3)
Total	245	(100)

A woman with a health problem during delivery is more likely to be taken to a health facility if:

- She is from a metropolitan area⁹¹
- She not very poor (household annual income more than Tk 23,898)⁹²
- She is literate⁹³

⁹¹ 34/36 (94%) vs 147/209 (70%). Odds Ratio 7.17 (95% CI 1.59-45.16)

⁹² 154/199 (77%) vs 26/44 (59%). Odds Ratio 2.37 (95% CI 1.12-5.00)

⁹³ 105/129 (81%) vs 76/116 (66%). Odds Ratio 2.30 (95% CI 1.23-4.34)

Views and knowledge of government health and FP service providers

Characteristics of the service providers

Altogether 1962 service providers were interviewed. The proportion in each job category and the proportion of women within these categories are shown in Table 17.

Table 17. Job categories and proportion of female workers in each category

	Total (n=1960)		Female	
UHFPO	30	(2%)	1	(3%)
UFPO	28	(1%)	6	(21%)
Medical Officer / RMO	133	(7%)	14	(11%)
Dental Surgeon	10	(1%)	3	(30%)
Nurse	255	(13%)	225	(88%)
Medical Assistant	94	(5%)	17	(18%)
Pharmacist	66	(3%)	8	(12%)
Storekeeper	37	(2%)	0	(0%)
Sub-Assistant Community Medical Officer (SACMO)	101	(5%)	12	(12%)
Health Inspector	188	(10%)	1	(1%)
Family Planning Inspector	24	(1%)	3	(13%)
Family Welfare Visitor	314	(16%)	201	(64%)
Health Assistant	294	(15%)	46	(16%)
Family Welfare Assistant	386	(20%)	373	(97%)
Total	1960	(100%)	910	(46%)

The mean age of the service providers was 40 years ranging from 22 to 58 years. Figure 28 shows the age distribution of the service providers covered in the survey. Most of both male and female providers are between 31 and 50 years old, though there is relatively a larger proportion of female workers in the young age group (21-30 years).

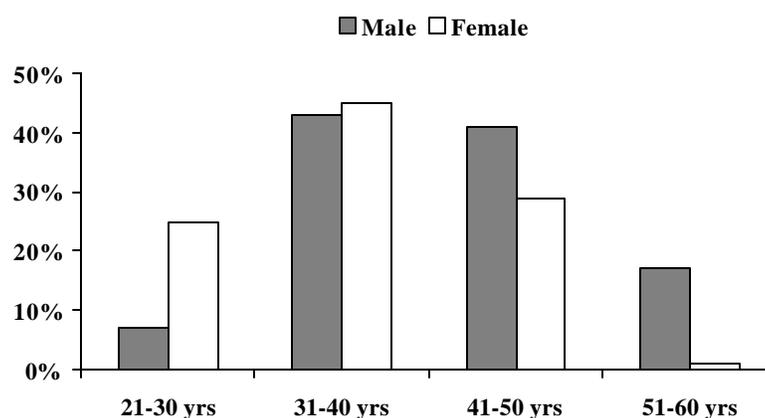


Figure 28. Age distribution of service providers

Three quarters of the service providers (74%; 1435/1924) reported working in the government health and family planning services for more than 10 years. Slightly less than half (44%; 856/1931) reported that they had worked in the same upazila for more than 10 years. This suggests a relatively stable workforce at upazila level, for these

grades of staff. Table 18 shows the work experience of service providers in their present upazila and in the government health and family planning service as a whole.

Table 18. Work experience of service providers

	Govt. H & FP service (n=1924)		In the Upazila (n=1931)	
Less than five years	183	(10%)	541	(28%)
5-10 years	306	(16%)	534	(28%)
11-20 years	764	(40%)	522	(27%)
21-30 years	529	(27%)	317	(16%)
More than thirty years	142	(7%)	17	(1%)

Difficulties faced in doing the job and suggestions for improvement

About half of the service providers interviewed (48%, 947/1958) reported they did not face any difficulty in fulfilling their duties. An equal proportion (48%, 939/1958) found it somewhat difficult while only 4% (72/1958) reported they found it very difficult. (Table 19)

Table 19: Difficulties in fulfilling their duties by gender and level at which staff work

	Total (n=1958)	Male (n=1048)	Female (n=909)	Upazila level (n=677)	Below upazila (n=1279)
Difficult	1011(52%)	511(49%)	500(55%)	356(53%)	655(51%)
Not difficult	947(48%)	537(51%)	409(45%)	321(47%)	624(49%)

Female workers are somewhat more likely to report facing some difficulties in fulfilling their duties as compared to males⁹⁴.

The main difficulties reported in fulfilling the duties of the post (in response to an open question) are summarised in Table 20.

Table 20. Main difficulties faced by gender and level at which staff work (n=1570)

	Male (n=858)	Female (n=712)	Upazila level (n=551)	Below upazila (n=1019)	Total (n=1570)
Lack of incentives/ personal benefits	104(12%)	72(10%)	77(14%)	109(11%)	186(12%)
Administrative problems	116(14%)	55(8%)	107(19%)	64(6%)	171(11%)
Inadequate human resources/trained persons	235(27%)	139(20%)	169(31%)	195(19%)	374(24%)
Inadequate supplies/logistics	324(38%)	272(38%)	170(31%)	426(42%)	606(39%)
Inadequate infrastructure /physical facilities	157(18%)	159(22%)	141(26%)	175(17%)	316(20%)
Corruption/behaviour of colleagues	37(4%)	10(1%)	26(5%)	21(2%)	47(3%)
Difficult access to area	272(32%)	168(24%)	104(19%)	336(33%)	440(28%)
Unawareness/bad behaviour of people	175(20%)	112(16%)	171(31%)	266(26%)	437(28%)

The most commonly cited problem was inadequate supply of medicines, materials and other logistics. This ties in with the common complaint from service users of inadequate medicines (see above).

⁹⁴ 500/909 (55%) vs 511/1048 (49%). Odds Ratio 1.28 (95% CI 1.07-1.54)

Service providers were asked to make suggestions (in an open ended question) about what would help them to work better (Table 21). The suggested improvements largely reflect the problems noted in Table 20. The most common request is for more supplies of medicines and other materials.

Table 21. Suggestions from service workers for what would help them to work better, by gender and level at which staff work

	Male (n=960)	Female (n=839)	Upazila level (n=636)	Below upazila (n=1162)	Total (n=1799)
More personal incentives	295(31%)	137(16%)	138(22%)	293(25%)	432(24%)
Solve administrative issues	123(13%)	80(10%)	109(17%)	94(8%)	203(11%)
Increase human resources	272(28%)	176(21%)	160(25%)	288(25%)	448(25%)
More supplies/material	349(36%)	394(47%)	224(35%)	519(45%)	743(41%)
Improved infrastructure/ equipment /communication	185(19%)	197(23%)	150(24%)	232(20%)	382(21%)
More/better training	233(24%)	231(28%)	123(19%)	331(28%)	464(26%)
Less corruption/more cooperation from colleagues	61(6%)	69(8%)	77(12%)	53(5%)	130(7%)
Improve knowledge/ behaviour /participation from people	75(8%)	92(11%)	83(13%)	92(8%)	167(9%)

Views about treatment as government employees

More than half (60%, 1175/1954) the service providers reported they were treated fairly as employees of the Government Health and Family Planning services. Female service providers are more likely than male service workers to report being treated fairly⁹⁵. A service provider working at the upazila level is less likely to report being treated fairly, compared with a service provider working below upazila level⁹⁶. Of those who considered they had not been treated fairly, the majority identified personal incentives and benefits as the major problem. The main problems of unfair treatment reported are summarized in Table 22.

Table 22: Main problems of treatment as government employee by gender and level at which staff work

	Male (n=368)	Female (n=245)	Upazila level (n=211)	Below upazila (n=402)	Total (n=613)
No incentives for good work	144(39%)	69(28%)	96(45%)	117(29%)	213(35%)
Recognition not according to qualification	101(27%)	43(18%)	56(27%)	98(24%)	144(23%)
Corruption/political pressure	7(2%)	3(1%)	5(2%)	5(1%)	10(2%)
Problems with salary/allowance/service benefits	213(58%)	174(71%)	96(45%)	285(71%)	391(64%)
Inadequate human resources/ training	44(12%)	37(15%)	39(18%)	38(9%)	77(13%)
Bad behaviour of people/ security problem	25(7%)	22(9%)	16(8%)	32(8%)	48(8%)

⁹⁵ 595/907 (66%) vs 579/1046 (55%). Odds Ratio 1.54 (95% CI 1.27-1.86)

⁹⁶ 382/673 (57%) vs 791/1279 (62%). Odds Ratio: 0.81 (95% CI 0.67-0.99)

Problems with behaviour of patients

Nearly half the service providers (45%, 866/1941) reported they had problems with the way patients behaved towards them (Table 23).

Table 23: Problems with the behaviour of patients

	Male (n=1032)	Female (n=908)	Upazila level (n=667)	Below upazila (n=1272)	Total (n=1941)
Faced problem	465(45%)	401(44%)	304(46%)	562(44%)	866(45%)
No problem	567(55%)	507(56%)	363(54%)	710(56%)	1075(55%)

The problems noted (in an open ended question) are summarized in Table 24. Bad attitude of the patients and their visitors was identified as the most common problem. Almost half of the respondents (46%, 386/845) attributed this to the inadequate supply of medicine and patients' perception that the medicines are sold outside. An 8% (64/845) acknowledged that this was due to poor quality of service provided. Some 13% (112/845) attributed the bad behaviour to the lack of awareness and ignorance on part of the patients. Service providers (14%, 115/845) also reported that patients asked for illegal benefits (such as certificates they were not entitled to), which resulted in behavioural conflicts between the provider and the patients.

Table 24: Nature of problems with the behaviour of patients by gender and level at which staff work

	Male (n=451)	Female (n=394)	Upazila level (n=296)	Below upazila (n=549)	Total (n=845)
Inadequate supply of medicines/ accused of selling of drugs	227(50%)	159(40%)	132(45%)	254(46%)	386(46%)
Bad quality of service	26(6%)	38(10%)	37(13%)	27(5%)	64(8%)
Patients asking for illegal benefits	78(17%)	37(9%)	57(19%)	57(10%)	115(14%)
Bad attitude of patients/visitors	184(41%)	193(49%)	136(46%)	240(44%)	377(45%)
Lack of awareness/ignorance among people	59(13%)	53(13%)	250(84%)	87(16%)	112(13%)

Views about availability of medicines

In the service workers questionnaire (see Annex 3) it was noted that patients frequently complain about non-availability of medicines and the service worker was asked to give their opinions about why medicines are not available in government health facilities. Only 2% (30/1908) responded that they did not agree there was a lack of medicines available to patients in government health facilities.

Of those who accepted lack of medicines as a problem, nine out of ten (91%, 1682/1847) mentioned inadequate or irregular supply of medicines as a cause. The reasons given by respondents to the open-ended question are shown in Table 25.

Table 25: Reasons from service providers for non-availability of medicines

	Male (n=991)	Female (n=856)	Upazila level (n=640)	Below upazila (n=1206)	Total (n=1847)
Inadequate supply in due time	899(91%)	783(91%)	580(91%)	1101(91%)	1682(91%)
Low budget/bad planning/ cannot take payment from people	103(10%)	47(5%)	76(12%)	74(6%)	150(8%)
Supply of inappropriate medicines	66(7%)	85(10%)	68(11%)	83(7%)	151(8%)
Corruption	46(46%)	34(4%)	16(3%)	64(5%)	80(4%)

Asked what could improve the availability of medicines for patients, 89% (1680/1897) of service providers suggested improving the supply of medicines to health facilities and asked for more medicines. The suggestions from service workers about improving the availability of medicines to patients in government health facilities are shown in Table 26. Only a few service providers (4%, 77/1897) suggested charging patients for medicines.

Table 26: Suggestions from service providers to ensure availability of medicines

	Male (n=1016)	Female (n=881)	Upazila level (n=649)	Below upazila (n=1247)	Total (n=1897)
More supply of medicine	872(86%)	808(92%)	571(88%)	1108(89%)	1680(89%)
Regular supply/better distribution system	133(13%)	112(13%)	64(10%)	181(15%)	245(13%)
Patients' Participation /subsidized charges	85(8%)	20(2%)	59(9%)	46(4%)	105(6%)
More staff/availability/ regular timings	103(10%)	94(11%)	57(9%)	140(11%)	197(10%)
Better monitoring and administration	100(10%)	81(9%)	66(10%)	115(9%)	181(10%)

Views about extra payments from patients to service providers

Service providers were asked about the common complaint of patients that they have to pay the doctors and health workers to get the service at government health facilities. When asked how common they think this practice is around three quarters said it did not happen or was very rare, and less than 10% agreed it was a common practice in government health facilities. (Table 27).

Table 27: Opinion about extra payments by gender and level at which staff work

	Male (n=959)	Female (n=821)	Upazila level (n=629)	Below upazila (n=1150)	Total (n=1781)
Very rare	722(75%)	633(77%)	486(77%)	868(75%)	1356(76%)
Not so common	169(18%)	126(15%)	93(15%)	202(18%)	295(17%)
Common	68(7%)	62(8%)	50(8%)	80(7%)	130(7%)

Asked to comment about why service workers might demand payments from patients, 30% (463/1522) of the service providers simply responded that it did not happen. (Table 28). However, a quarter agreed that it was due to corruption dishonesty or power play (24%, 368/1522). Others gave reasons suggesting justification for the

practice on various grounds, or felt it was somewhere justified because it happened everywhere (Table 28)

Table 28: Reasons for taking extra payments (by gender and level at which staff work)

	Male (n=835)	Female (n=687)	Upazila level (n=554)	Below upazila (n=967)	Total (n=1522)
Do not agree	222(27%)	241(35%)	139(25%)	323(33%)	463(30%)
Confusion/lack of guidelines/supervision	73(9%)	29(4%)	23(4%)	71(7%)	82(5%)
Corruption/dishonesty/ power play	216(26%)	168(24%)	158(29%)	196(20%)	368(24%)
It's common/everywhere/ not bad	82(10%)	51(7%)	45(8%)	86(9%)	131(9%)
Financial reasons	163(20%)	122(18%)	133(24%)	148(15%)	281(18%)
Doctor's ask for extra service/equipment	61(7%)	58(8%)	34(6%)	85(9%)	119(8%)
Patients pay to get better service	28(3%)	28(4%)	21(4%)	33(3%)	54(4%)
Ignorance/lack of motivation in service providers	48(6%)	35(5%)	32(6%)	48(5%)	80(5%)

Suggestions from service workers for improving the services

Asked for their suggestions for improving government health and family planning services, more than half (56%, 937/1792) the service providers returned the question to the patients, saying that creating awareness about health among the masses and health education were the key improvement needed (Table 29). Other suggestions were more attuned to improving the actual provision of service.

Table 29: Suggestions from service providers for improving the services

	Male (n=970)	Female (n=822)	Upazila level (n=611)	Below upazila (n=1180)	Total (n=1792)
Better administration/ planning/supervision	287(30%)	128(16%)	247(40%)	168(14%)	415(23%)
Incentives/benefits	66(7%)	31(4%)	51(8%)	46(4%)	97(5%)
Better facilities/infrastructure	201(21%)	133(16%)	94(15%)	239(20%)	334(19%)
Health education/awareness	444(46%)	493(60%)	265(43%)	672(57%)	937(52%)
Better supply of medicine/equipment	188(19%)	149(18%)	107(18%)	230(19%)	337(19%)
Provide specific health services	209(22%)	269(33%)	117(19%)	361(31%)	478(27%)
More/better human resources	262(27%)	147(18%)	161(26%)	247(21%)	409(23%)

Knowledge of service providers about HPSP

Almost all the service providers (95%; 1858/1951) had heard about HPSP from one or the other source with no significant gender difference. The proportion of those who have not heard about HPSP was lower in staff working below upazila level than in those working at upazila level⁹⁷. The sources of their information about HPSP are shown in Figure 29 and Table 30. The most common source of information was through their workplace at the Upazila level or below, followed by media, news and bulletins. A few people mentioned that they heard about HPSP from authorities at the district or central level, or from trainings and seminars.

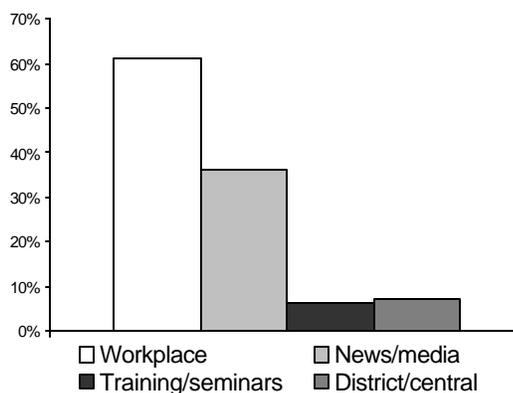


Figure 29. Source of information about HPSP

Table 30: Source of Information about HPSP by gender and level at which staff work

	Male (n=1009)	Female (n=818)	Upazila level (n=601)	Below upazila (n=1225)	Total (n=1828)
Upazila & below	575(57%)	536(66%)	274(46%)	636(52%)	1112(61%)
News and media	430(43%)	309(38%)	307(51%)	432(35%)	739(40%)
Training/seminars	78(8%)	38(5%)	62(10%)	54(4%)	116(6%)
District/central	166(16%)	64(8%)	113(19%)	117(10%)	230(13%)

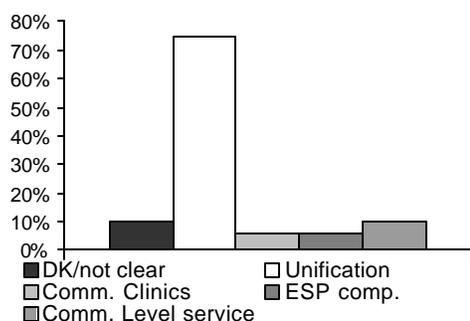


Figure 30. Knowledge about HPSP

Nine out of ten people who had heard about HPSP knew at least something about it (Figure 30 and Table 31). Most commonly they knew it was concerned with unification of health and family planning services. A few mentioned strengthening community level services or specifically mentioned community clinics and ESP components.

Table 31: Knowledge about HPSP by gender and level at which staff work

	Male (n=983)	Female (n=802)	Upazila level (n=590)	Below upazila (n=1194)	Total (n=1786)
Service at community level	93(9%)	80(10%)	71(12%)	102(9%)	173(10%)
Unified Health and Family Planning	764(78%)	577(72%)	416(71%)	924(77%)	1341(75%)
Community Clinics	75(8%)	38(5%)	34(6%)	79(7%)	113(6%)
Components of ESP	54(5%)	57(7%)	62(11%)	49(4%)	111(6%)
Don't know/not clear	81(8%)	105(13%)	66(11%)	120(10%)	187(10%)

⁹⁷ 38/1275 (3%) vs 53/674 (8%). Odds Ratio 0.35 (95 % CI 0.22-0.54)

The main changes observed by service providers as a result of HPSP are shown in Table 32. The most common response was an improvement in the quality of their own work experience, followed by unification and coordination of services, and improved quality of the service they provided.

Table 32: Changes as a result of HPSP noted by service providers by gender and level of work

	Male (n=926)	Female (n=743)	Upazila level (n=548)	Below upazila (n=1120)	Total (n=1670)
No change	155(17%)	106(14%)	109(20%)	152(14%)	262(16%)
Quality of Service improved	162(17%)	145(20%)	97(18%)	210(19%)	307(18%)
Quality of Work improved	299(32%)	214(29%)	143(26%)	369(33%)	513(31%)
Increase work load	40(4%)	28(4%)	20(4%)	48(4%)	68(4%)
/complicated					
Change in process and management	24(3%)	27(4%)	24(4%)	27(2%)	51(4%)
MIS related	25(3%)	20(3%)	21(4%)	24(2%)	45(4%)
Provide service at Grassroot level	48(5%)	40(5%)	29(5%)	59(5%)	88(5%)
Unification and Coordination	245(26%)	204(27%)	132(24%)	317(28%)	449(27%)
Don't know/Can't say	32(3%)	45(6%)	27(5%)	50(4%)	77(5%)

Knowledge of service providers about components of ESP

Four out of ten service providers (40%, 757/1898) responded that they did not know *anything* about ESP components. Table 33 shows the knowledge of those service providers who considered they knew at least one component of ESP.

Table 33: Staff's knowledge about components of ESP by gender and level at which they work

	Male (n=635)	Female (n=506)	Upazila level (n=430)	Below upazila (n=711)	Total (n=1141)
Child care	420(66%)	334(66%)	278(65%)	276(39%)	754(66%)
Communicable disease control	338(53%)	281(56%)	361(84%)	358(50%)	619(54%)
Reproductive health, FP and HIV/STDs	495(78%)	375(71%)	330(77%)	540(76%)	870(46%)
Health education	179(28%)	85(17%)	101(23%)	154(22%)	245(21%)
Limited curative care	69(11%)	30(6%)	50(12%)	49(7%)	99(9%)
PHC/public health	114(18%)	102(20%)	70(16%)	146(21%)	216(19%)
Improved availability/ access to services	52(8%)	13(3%)	29(7%)	36(5%)	65(6%)

Training about ESP

Less than a fifth (18%, 343/1885) of the service providers reported they had received some training about ESP. As one would hope, service providers who reported they had received training were much more likely to know at least one component of ESP compared with those who had not received any training⁹⁸.

Less than one in five service workers reports having had training about ESP.

⁹⁸ 327/343 (95%) vs 812/1542 (53%). Odds Ratio 18.37 (95% CI 10.73-31.95)

Health education activities of service providers

Information about health education activities was collected from the 959 service providers who have responsibility for conducting community level health education activities. The providers with health education responsibility include Medical Assistants (MA), Health Assistants (HA), Sub-Assistant Community Medical Officers (SACMO), Family Welfare Visitors (FWV), and Family Welfare Assistants (FWA). One third of these health workers (33%, 279/844) reported they had received training on the conduct of health education sessions.

Table 34 shows the mean number of health education sessions reportedly conducted by each type of service provider in the last month. Except for Medical Assistants, virtually all the service providers report conducting at least one health education session in the last month.

Table 34. Health education sessions conducted by different service providers

Service provider	Number (%) who conducted any HE sessions	Average no. of sessions per provider
MA	36 (59)	5
FWV	208 (95)	8
SACMO	86 (95)	7
HA	259 (97)	8
FWA	303 (95)	6

The number of sessions in the last month for those who conducted at least one is 7 (range 1-50). Slightly less than half (45%, 399/891) of the providers conducted one to five sessions during last month. Almost an equal proportion (43%, 381) conducted five to ten sessions. One out of ten providers (13%, 111) reported conducting more than ten sessions during the last month.

Table 35 shows the range of topics reportedly covered by the service providers in health education sessions during the last month.

Table 35. Topics covered during health education sessions, as reported by service providers (n=863)

Topic	Number (%)
Diarrhea/ARI	557 (65%)
Health education	507 (59%)
EPI/immunization	322 (37%)
Family planning	252 (29%)
Mother and child care	174 (20%)
Reproductive health	153 (18%)
Communicable diseases	164 (16%)
Parasites/worms	87 (10%)
Treatment for illness/injury	4 (0%)

Community clinics and community clinic groups

(Note that data collection was in September and October 2000)

Information from community based health workers

Health Assistants and Family Welfare Assistants were asked about the progress with establishing community clinic groups and community clinics in their communities. Some 195 of these health workers responded to the questionnaire. Among these, 53% (104/195) are Family Welfare Assistants (FWA), 44% (85) are Health Assistants (HA), and the remaining 3% (6) are Assistant Health Inspectors (AHI), Family Welfare Visitors (FWV), Medical Assistants (MA), and Sub-Assistant Community Medical Officers (SACMO).

Among the 195 community level health workers only one, in Gaznapur, Upazila Nabiganj, Sylhet reported that she is presently working in a community clinic. The remaining 194 respondents are not presently working in community clinics.

Of the 194 health workers who reported that the community clinic in the community covering the survey site is not yet functioning (Figure 31);

- 53% (102/193) said that the community clinic group has been formed,
- 44% (85) reported that the community clinic group is functioning,
- 63% (122) said that the site has been proposed,
- 55% (107) reported that the site selection has been finalised,
- 46% (89) reported that the construction plan has been included this year,
- 22% (43) reported the construction has started, and
- 8% (15) said the construction has been completed.

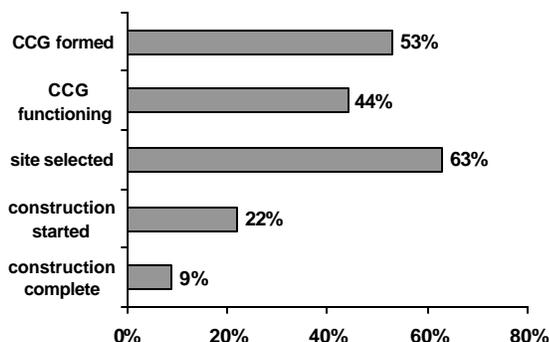


Figure 31. Proportion of sites at each stage of community clinics establishment

These figures indicate that in some communities site selection for the community clinic has been finalised without an active community clinic group. This may suggest that the community clinic establishment manual has not been followed in some communities.

Asked what have been the main difficulties in reaching this stage (whatever stage they are at), 39% (74/191) of the health workers responded that nothing has been done yet. This was followed by “no difficulties” (22%, 42), “no suitable site for community clinic available” (21%, 40), and “conflict among stakeholders on site selection” (14%, 26).

Some 43% (74/172) of the health workers consider that the co-operation of the people in general has been the main factor that has worked well to reach this stage. The co-operation by the community leaders is also raised by a third of the respondents (33%,

56), followed by co-operation from the land owner (20%, 34), efforts of the Community Clinic Group (16%, 28), and co-operation by the government officials (12%, 20). A quarter (25%, 43) responded that nothing has been done yet.

Asked what they know about the Community Clinic Group and how they should function, a third (31%, 54/174) of the health workers answered that it is a group constituted by “the community elite, health and family planning officials and public representatives”. Almost the same proportion of the health workers (29%, 50) said that they didn’t know about the community clinic group and how it should function. This was followed by “to supervise and monitor the community clinic/ ensure service delivery” (20%, 34), “to have the health assistant and the family welfare assistant work together” (10%, 18), “to have meetings” (10%, 18), “to combine health and family planning” (8%, 13), and “to supervise establishment of the community clinic/monitor the construction of the community clinic” (6%, 10).

Almost a third of community based health workers say they don’t know about community clinic groups and how they should function.

Some 45% (81/182) of the health workers said that “comprehensive services” should be provided from the community clinic. This seems to mean a range of family planning, preventive and treatment services. Over a quarter (27%, 49) mentioned that the community clinic should function as “the place where the health assistant and the family welfare assistant will work together”, 5% (9) think that community participation is important for the function of the community clinic. Some 15% (27) of the health workers did not know about the community clinic and how it should function at all. The ideas among the remaining 85% were often quite vague and non-specific.

15% of community based health workers say they don’t know anything at all about community clinics and how they will work.

Union Parishad Chairmen’s views

Of the 140 Union Parishad Chairmen (or deputy chairmen) and 75 Union Parishad members interviewed, 90% (203/208) reported that the Union Parishad has discussed about the community clinic groups at least once. The median number of times they have discussed about the community clinic groups is four, ranging from none to 36 times. Only Union Parishad Chairmen were asked about the progress about the community clinic groups and the establishment of the clinics in their union.

The median number of community clinic groups constituted per union (among the unions covered by the UP Chairmen interviewed) is three. The figure ranges from none to ten community clinic groups. Of these community clinic groups, 83% (100/120) have held meetings at least once. The median times met is three times, ranging from none to 30 meetings. The median number of sites selected for community clinics per union is three, ranging from none to ten. Half the Chairmen reported that no the community clinics are under construction in their unions. Of those who reported at least one community clinic being constructed in the union, the median number of clinics under construction was 2. This figure ranges from one to six community clinics.

Some questions about the progress with establishing community clinics, specifically the one covering the survey site, were asked. According to the 121 Union Parishad Chairmen who responded (Figure 32);

- 51% (61/120) of the survey sites have a community clinic group covering their area
- 44% (53/120) of the survey sites have a community clinic group which has held meetings, and
- 57% (69/121) of the survey sites have a location selected for the community clinic.

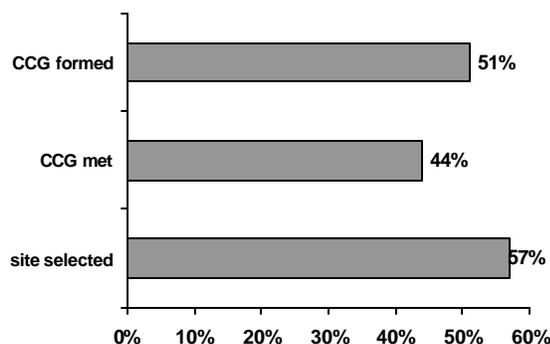


Figure 32. Proportion of survey sites at each stage of community clinic establishment, according to the UP chairman

Note that the number of Union Parishad Chairmen interviewed is less than the number of health workers interviewed, so that they gave information only on a subset of the sites.

UP Chairmen were asked about the problems they foresee in the functioning of the community clinics in their union. About half (48%, 59/120) of them responded that there would no problems. This was followed by “no or few medicines available” (17%, 20), “community clinics will be dirty” (15%, 18), “no doctors in community clinics” (11%, 13), and “appointment of the staff” (7%, 8). It may be that those who say they foresee no problems are being overly optimistic and may experience problems when they actually come to deal with the issues.

Household knowledge about Community Clinic Groups

One in ten (10%; 2254/22344) of all household respondents knew about a community clinic group active in their community. However, of those who knew about the existence of a community clinic group, 85% (1537/1817) did not know anything about the activities of the group, and a further 10% (164) think that the group does nothing. Less than 1% (15) said that the group selects the site for the community clinic, or that it supervises the community clinic.

As shown in Figure 33, the household knowledge about a community clinic group was reviewed in light of the information from the community based health worker covering the site about the progress

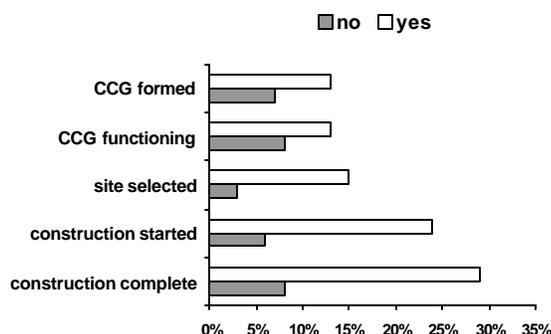


Figure 33. Proportion of households who know of a community clinic group by stage of CCG and CC establishment.

with establishing the community clinic group and community clinic (see above). More households know about the existence of a CCG with more advanced progress of establishment of a community clinic group and community clinic (as per the information from the community based health worker). Nonetheless, even in a site where the construction of the community clinic has been completed, only 29% (447/1529) of the households know the existence of a community clinic group active in their area.

In sites where the community clinic group has been formed according to the health worker, 13% (1332/10472) of the households know about a community clinic

In communities with a community clinic group in existence, only 13% of households know of it.

group active in their area. However, in sites where there are no community clinic group formed, 7% (677/9313) of the households still responded that they knew about a community clinic group active in their area. The low proportion of the households who know about the community clinic group that is established in their area suggests much more needs to be done if these groups are really to represent the views of all community members and not just a local elite.

Communities with an established community clinic group (according to the community based health worker) have a lower proportion of very poor households than communities without an established group (27% vs 32%)⁹⁹. This suggests that there could be a bias towards establishing community clinic groups preferentially in relatively less poor communities.

⁹⁹ 2354/8721 (27%) vs 3550/1100 (32%). Odds Ratio 0.78 (95% CI 0.73-0.83)

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COMMENTARY

Comparison with 1999 baseline service delivery survey

As intended, it is possible to compare directly several indicators between the 1999 baseline survey and the present survey that took place in late 2000. Table 36 summarises some comparisons between the two surveys.

Table 36. Comparison between the 1999 baseline SDS and the 2000 SDS

Indicator	1999 SDS	2000 SDS	Notes
% households rating government health services as 'good'	37%	10%	Most change is from 'good' to 'neutral'
% households using gov service for treatment in last month	13%	11%	Very poor households use less (2000 SDS)
% households using other private services for treatment in last month	32%	42%	Very poor households use less (2000 SDS)
% households with someone ill and no use of any service	5%	22%	May be related to seasonal differences
% households willing to pay for improved government health service	55%	75%	Word 'officially' added in 2000 survey
% visits to gov health services for treatment with all needed medicines available	33%	20%	Apparent decrease may be explained by different point in supply cycle
% visits with unofficial payment of 'ticket'	27%	23%	Probably comparable
% visits with unofficial payment to service provider(s)	22%	20%	2000 SDS allowed other categories of payment
% users satisfied with service on last visit	53%	62%	2000 SDS also has 66% satisfied with behaviour of service provider

The 2000 SDS did not revisit issues concerned with contraception and antenatal care—this is already well-documented from other sources and large change since the 1999 baseline SDS is not likely. However, the 2000 SDS did collect data about delivery care. It is of interest that the decision making pattern about who should assist the delivery and the influences the decision-makes has on the actual assistance during delivery mirror the findings of the 1999 SDS in regard to decision making about antenatal care. Some issues were covered in more detail in the 2000 survey and new areas were also included (see below), while still retaining a core of common questions to allow direct comparisons between the two surveys (and indeed with subsequent cycles of the SDS).

So far, there is not much evidence of improvement in access of the public to and experience of government health services, although this is an important aim of the overall five year HPSP. It is really not to be expected that the big reforms of the services will have had a noticeable beneficial effect on their experience after only two years (there is less than two years between the two surveys). There is already encouraging information in two areas: public willingness to pay for improved government health and family planning services and increased overall satisfaction of service users after visits to government health facilities. And people (mainly women) who used government health and family planning services for preventive and family planning purposes report a favourable experience, even though the number using the services in this way is relatively small. However, many people continue to hold quite

negative views of government health services and difficulties persist in the areas of availability of medicines, unofficial payments, and reported poor behaviour of service providers towards their patients.

Additional data on household income were collected in the 2000 SDS, allowing us to demonstrate the many ways in which the very poor continue to be seriously disadvantaged in their access to health care and their experience of health care when they do access the service. There is evidence of discrimination against very poor people in government health services. The 2000 SDS has produced information that not only documents the situation but also offers some pointers towards what could help to change it. Hopefully these can be used as an input into the ongoing HPSP planning and revision.

Special focus areas in the 2000 SDS

After the 1999 baseline SDS, it was agreed to retain a core set of questions, remove others that did not need to be repeated so soon, and focus on certain key areas. Data about additional indicators, not collected in the 1999 survey, are shown in Table 37.

Table 37. Summary of additional indicators in the 2000 SDS

Indicator	2000 SDS	Notes
% households rating private health services as 'good'	25%	Includes private, NGO and unqualified providers
% service visits for treatment in last month to government facility	21%	11% UHC, 5% government hospital
% service visits for treatment in last month to private/NGO providers	30%	27% private doctor – govt doctor doing private practice
% service visits for treatment in last month to unqualified providers	49%	32% village doctor, 12% drug shop, 5% traditional
% users of private providers satisfied with service on last visit	88%	
% users of unqualified providers satisfied with service on last visit	88%	
% women married women aged 10-49 years with injury requiring treatment in last year	4%	Ranges from 1% in Rajshahi to 12% in Sylhet
% women delivering at home	89%	
% women delivering with trained attendant	15%	Includes doctor, nurse or FWV
% households knowing about community clinic group	13%	In communities with a group existing

Availability of medicines in government health facilities

The low availability of medicines in the 1999 SDS was a key concern of service users and household respondents and was strongly related to people's perception of the government services. The situation has not improved since the 1999 SDS. The apparent deterioration may be explained by the fact that the 2000 SDS took place reflecting the low point of the medicines supply cycle. Nevertheless, low availability of medicines in government health facilities remains a cause for concern. Lack of medicines and poor medicines in government facilities remain key complaints of service users.

The 2000 SDS has thrown some light on the issues involved in supply of medicines reaching patients but this is a very complex area, and it can be hard to be sure of comparing like with like. For example when comparing availability of prescribed medicines it depends on what was prescribed and whether it was done with reference to the available stock in the facility or not. Access to medicines is one of the areas where the very poor and women have problems. The use of the CIET mesoanalysis technique to combine data from the UHC institutional reviews with data collected from households about visits to these facilities has allowed us to confirm that there is indeed some effect of the adequacy of medicines supply (relative to patient load) on prescribed medicines availability in the UHCs. However, the lack of medicines is also related to other factors, including leakage of medicines from the system. The public and service users remain convinced that this is the major reason for lack of medicines. Service providers describe other reasons for the lack of medicines. This is one of the areas where there is a big gap in perceptions and beliefs between government health service providers and their patients and potential patients.

Experience of private and NGO services

In the 1999 SDS, information about the experience of using the service was confined to visits to government services but this time the same information was also collected about the private and other services. A challenge in doing this was to ensure that we knew, reliably, which service was actually used. Households may have difficulty categorizing service providers. We successfully overcame this through the use of key informants in the survey sites who could confirm the nature of services visited and recorded by name by the household interviewers.

The frequent use of unqualified village doctors was of interest, as well as the relatively high levels of satisfaction of people who visit them. Half of all reported visits for treatment in the last month were to unqualified practitioners – a third to village doctors alone. This throws up a challenge. Government services could clearly not cope if all the people who use unqualified practitioners transferred to the government services so these practitioners are fulfilling a valuable role. Some people make an argument for trying to regularize the sector and introduce some form of registration and minimum standards, but others are against embarking on this route.

A rather surprising finding was the very low rate of contacts with NGO services reported in the 2000 SDS. Although NGOs in the health sector are high-profile, many either operate only in defined geographical areas, or are mainly concerned with health education and nutrition rather than actual provision of care.

Violence against women

This is clearly an important concern in a South Asian country. Many of the issues about prevention are outside the scope of the SDS process, which is concerned with monitoring reforms of the health services. However, there are relevant issues about how health services encourage, or do not encourage, women to come forward and report violence and how the services deal with women who do attend having suffered violence. The picture that emerges from the 2000 SDS is that government health services have little or no special provision for dealing with women who report violence and even their recording of cases of injuries and assault is very variable between facilities. Little wonder then that many women do not attend with injuries,

whether caused by violence or not. There are disincentives to report when people do not want to involve the police and the health services do not seem to be taking active steps to address this.

As expected, the information from women during the household interviews about injuries and violence is difficult to elicit; these are not really private interviews. The discussion of the issue in focus groups was more enlightening. Although many groups (of men and woman separately) initially said that violence was rare in their area, nearly all of them had tales to tell of episodes of violence against women, some of them harrowing. It is particularly sad to hear of the difficulties women describe with getting care for their injuries in government health services.

Delivery and access to emergency obstetric care

This area of focus was a useful counterpoint to the focus on antenatal care in the 1999 SDS. The reasons why women do not deliver with the assistance of a trained person, and the decision making arrangements in the family are really quite similar to the issues around antenatal care. As always, the difference that literacy makes to women is highlighted. In this case the effect of being very poor was also notable. As with making changes to antenatal care, it is clearly not going to be enough to run BCC programmes for women. Men need to be convinced too as they are important in making the crucial decision and service providers need to be sensitive to the concerns and requirements of women; they cannot simply 'educate them about the importance of delivery by a trained person' and wait for their behaviour to change.

Views of health service providers

In the 1999 SDS the views of some service providers were sought, but the numbers were small and there was no attempt to cover the range of different service providers. This was redressed in the 2000 SDS. Nearly 2000 service providers working at upazila level and below completed questionnaires. This has provided valuable insight into the problems faced by these workers and their viewpoint on important issues. Hopefully this is going to be a useful input into future work and communication with these workers. In addition, key findings from the household survey were discussed with the service providers' team, led by the UHFPO, in 24 of the 44 upazilas in the sample. These upazila meetings happened at about the same time as the community focus group discussions and much the same material was covered, highlighting the contrasting views of the service providers and community groups on a number of issues, despite both discussing the same findings.

Behaviour change communication (BCC)

This is notoriously difficult to measure. In the 2000 SDS we simply collected information about the amount of health education work that service providers in the communities are undertaking and the amount of training they have received.

Community participation

Several points in the 2000 SDS touched this important area. The very methodology of seeking both quantitative and qualitative information from ordinary householders and then processing some of that through community focus groups is a way of giving voice to the concerns and aspirations of these people, of building the community voice into planning. This is being further strengthened by deliberate links between

the SDS process and the Local Level Planning (LLP) initiative. Where possible, local findings of the SDS are being put forward as an input into local plans. Sometimes community participation is claimed through when elite people from an area take part in management and other processes. But this may fail to show the concerns of the most disadvantaged people, including the very poor.

The 2000 SDS included some points about community participation. We asked about community participation in the planning and construction of community clinics. It is clear that in some places the clinic planning and construction has happened with little or no community participation.

Community clinics

It was recognised at the outset the findings of the 2000 SDS about community clinics would really be serving as a zero baseline for future comparison. This indeed proved to be the case. It was noteworthy that in some communities there had been virtually no consultation about siting of the clinic. Clearly ordinary households know little if anything about the clinics or the community clinic groups, even if there was actually one nearby. There is some suggestion from the data that these groups may be less likely to be established in communities with a high proportion of very poor households.

Moving forward

The HPSP reforms still have some way to go in improving the public experience of government health services from the reforms of the HPSP. However, even to be asking ordinary people about their experiences and opinions of services and using this process to help monitor service reforms reflects an important change in attitude. There are already encouraging signs in the increased proportion of households willing to pay for improved government health and family planning services, the generally positive experience of people using services for preventive and planning purposes, and the increased proportion of users satisfied overall with their visit to a government health facility for treatment.

There remains a big gap between service providers and intended service users. They interpret the same information quite differently, as for example the differences reported here between the community focus groups and the service providers in the upazila meetings in the 2000 SDS. Bridging this communication gap and helping the public to know more about the way the services work and their limitations could remove some negative perceptions about the services. This may be most effective if done at local level, increasing public involvement in the way government health and family planning services are delivered and monitored.

The attitudes of service providers and how they treat patients are very important to the patients. In this SDS, there is evidence that satisfaction of service users could be greatly improved if providers would just give them simple explanations about their illness and treatment. This sounds like a cheap option but it will be a big challenge to change attitudes of service providers at all levels. A programme of support and BCC is needed for health service providers.