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Health and population sector programme
Baseline service delivery survey

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BASELINE SERVICE DELIVERY SURVEY
HEALTH AND POPULATION SECTOR PROGRAMME
1998-2003
BANGLADESH

FINAL REPORT
June 1999



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

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Executive Summary

This first service delivery survey (SDS) of the Health and Population Sector Programme (HPSP) is a baseline for recurrent annual monitoring during the five-year programme. The baseline includes use, experience and user perceptions of health and family planning services by the population of Bangladesh. It provides key indicators that can be tracked during the HPSP, to monitor programme effectiveness and the extent to which health and population services become more responsive and accountable to users.

One aim of monitoring the HPSP is to give reliable estimates of selected key outcome and process indicators (Annex 1). It also aims to produce information for evidence-based planning (what actions may help to achieve the aims of the programme), throw light on reasons for any lack of progress, and suggest ways of modifying the programme (both locally and nationally) to increase the chance of achieving intended objectives. The process itself is intended to encourage stakeholder participation in the planning and monitoring of services and foster dialogue between service users and service providers.

METHODS

The survey represents collaboration between CIETcanada, an international NGO with wide experience of community surveys of this sort, and counterparts in Bangladesh. Counterparts were drawn from the Ministry of Health and Family Welfare (MOHFW) and other individuals with experience of undertaking field surveys in Bangladesh.

Instruments

Several data collection instruments were developed for the baseline Service Delivery Survey, in accordance with the CIET methodology used (see Annex 2). The instruments drew on those used by CIET in similar surveys in other countries, but taking into account the specific requirements of this survey in Bangladesh. The survey instruments were designed by a sub-group of the Technical Group and agreed by the Technical Group, as well as circulated to the Steering Group for comments. The survey instruments comprise: the household questionnaire, focus group guides, key informant interview schedules and schedules for institutional reviews of Union Health and Family Welfare Centres (UHFWCs) and Thana Health Complexes (THCs).

The sample

The sample was developed in collaboration with the Bangladesh Bureau of Statistics (BBS). For rural areas, it represents the six divisions in Bangladesh and a sample of *thana* within the divisions. The first stage rural sample were randomly selected *thana* within each division, the number proportional to the population of the division. In this stage, 44 *thana* were selected. Five sites were then selected within each *thana*. One site was randomly selected from among the villages listed in each of the five *unions* in the *thana*. In three *thana*, only four sites were selected as they have only four *unions*.

Since the HPSP has a rural focus, the emphasis of data collection was on rural sites, with 217 rural sites in the sample. A further 30 sample sites were selected in the four statistical metropolitan areas (SMAs), with the number of sites in each SMA proportional to the population size. Weights were calculated to take into account differences in population distribution between the sample and the actual population of Bangladesh. These weights were

then applied when declaring national indicators and for mapping purposes.

Data collection, entry and analysis

Supervisors and interviewers were trained to administer the instruments and supervisors were trained to facilitate and to record the focus groups. Training included a field test of administering and recording the household questionnaire. There were a total of 15 data collection teams, each of six interviewers and three supervisors (the supervisors also undertook the focus group discussions, the key informant interviews and the institutional reviews).

A team of six coders and 20 data entry operators were trained in Dhaka, using public-domain software Epi Info(1). Household questionnaire and the key informant interviews and institutional reviews were entered twice and validated. Further logical checks and cleaning were carried out on the validated data sets.

Analysis relied on Epi Info and SPSS(2). The Epi Info CSAMPLE was used to calculate the weighted national indicators. The SPSS package was used for analysing multiple response questions, combining the responses to give overall percentages. SPSS was also used for multiple logistic regression to look at combined effects of several determinants on outcome of interest.

RESULTS

Nearly all the household heads (95%) are male. Just under half of them (47%) are literate by self-report. About a third of the houses in the survey are of the poorest, kutchha-2, type. The average household size is 5.09 people.

The sample includes

- 26,207 households
- 134,926 people
- 25,285 married women aged 15-49 years
- 15,418 children under 5 years old

1. Government health facilities available to rural communities

As part of the survey process, the UHFWC serving each site and the THC for each sample *thana* were visited and reviewed.

Thana health complexes

In the 44 sample *thanas*, 43 THCs were reviewed. A third of the THCs do not have a separate room in the outpatient area for consultation and examination, and in a third patients are not examined in private or even behind a screen. In a quarter of the THCs visited, the area for insertion of IUDs and for deliveries is frankly dirty. While most (88%) of the THCs have toilets in the outpatient area, only two thirds of these include a separate toilet for women.

Basic equipment items are not always present. For example, paediatric measuring boards are only present in a third of THCs. And nearly a quarter of the THCs visited do not have any urinalysis kits.

Most of the THCs visited do not have a full quota of staff in post. For doctors, the mean number allocated per THC is 8, with 6 of these posts filled on average (with 5 men and one woman).

Union Health and Family Welfare Centres

Of 225 facilities visited for the 217 sites, 161 facilities were reviewed. The main reasons for not getting information from other facilities were: the centre was never built (28), it was closed or unmanned (16), it was demolished (2), the community was covered by the THC (7), an interview was refused (7). In 7 communities there was a separate Health Centre and Family Welfare Centre and both were visited.

Half of the facilities visited have a separate consultation/examination room and only a third have screens around the examination couch. A third of the UHFWCs have no functional water supply and two-thirds have no electricity supply. Some basic equipment is commonly missing. Nearly a quarter of facilities have no scales for weighing children. Less than half have an autoclave or a supply of kerosene. Less than half have urinalysis kits and a quarter have no IUD insertion kits.

2. Women's awareness of government health and family planning services

The services women are mainly aware of (in open-ended questions) from the EPI clinics and outreach services are immunisation and provision of vitamin A capsules. One in seven (14%) women are not aware of any of the services provided from EPI clinics and outreach services.

The main services women are aware of from the UHFWC are family planning and curative care. More than one quarter (29%) of the women interviewed are not aware of any services from the UHFWC.

The services from the THC that women are most commonly aware of are curative care (treatment) and delivery care. Some 30% of women are not aware of any services from the THC.

Women are more likely to be aware of services from the different facilities if:

- " They are literate
- " The household has used government health services in the last month
- " The community is within 5 km of the THC, or within 3 km of the UHFWC
- " The household has a good opinion of government health services (for knowledge of THC services only).

3. Use of health services

In 13% of households, at least one member used government (public) health services for treatment of illness in the last month. In nearly a third (32%), at least one member visited other (private) health service providers in the last month. In a few households (5%), someone was ill during the last month but no health service was used.

Households use private health services for illness more than twice as often as they use government health services.

- ☒ Gender is not apparently a factor in which service is used: 56% of government health service users are female, and 56% of private health service users are female. Some 60% of family members ill but not using any service are female.
- ☒ The poorest households are somewhat more likely to have used government health services, but less likely to have used private health facilities. They are more likely to have had an ill member who did not use any type of health service.
- ☐ When the household head is literate, private health services are more likely to have been used for illness of a family member.
- ☐ Rural households are more likely to have used government health services but households in metropolitan locations are nearly 50% more likely to have used private health service providers.
- ☐ Households in communities that are 3km or less from the UHFWC, or 5km or less from the THC, are more likely to have used government health services in the last month.

Reasons for use and non-use of services

The conditions for which treatment was sought in government and private services are similar. The type of illness does not seem to be a factor in the choice between government and private health services.

Most of the reasons given in community focus groups for non-use of government services are concerned with problems encountered with use of the service, such as lack of medicines, poor treatment, bad behaviour of staff and staff demanding payments. Some are concerned with access: the service is said to be too far away or transport costs are too high. Women themselves are sometimes blamed for not using the service due to ignorance, lack of education. And sometimes religious reasons are cited as a reason for women not using services.

4. Experience of government health services

Just over half of the reported visits are to the THC and a quarter are to the UHFWC.

Availability of health workers

For 13% of reported visits to government health services for illness in the last month, the person using the service reported in the household interview that there was *no health worker* there to attend to them. In focus groups, both men and women mentioned problems with availability of doctors and other health workers.

Availability of medicines

For visits in the last month, all medicines needed to treat the case are available in only a third (33%) of visits. There is no difference in reported availability of medicines between male and female service users.

The availability of all the medicines required for treatment is lowest for visits to the THC and District Hospital and highest for visits to satellite clinics/EPI centres. This is probably because many of the cases seen for illness in satellite

Service users report that all the necessary medicines are available in only a third of visits to government health services.

clinics/EPI centres need little or no medication,

whereas those visiting the THC or District Hospital need more medication.

Basics -- such as iron/folate tablets and paracetamol -- are almost universally stocked in both THCs and UHFWCs (when visited). For antibiotics, stocks of metronidazole are present in nearly all facilities but ampicillin syrup stocks were *not* present at the time of the review in a fifth of THCs and a quarter of UHFWCs.

The great majority (96%) of service users obtain the medicines not available in government facilities from private pharmacies.

In most of the experiences of unavailable medicines related in focus groups, the participants reported *receiving a prescription but having to buy the medicine to fill it outside*, because the medicine needed was not available in the health facility. So it seems likely that most of the reported unavailable medicines are ones that a health worker considers necessary for the case; this is an actual lack of medicines, rather than a reflection of inappropriate desires for medication of service users.

Costs of visiting government health services

As expected, transport costs are more likely to be incurred when visiting facilities more distant from the community. The highest transport costs are incurred for visits to the District Hospital.

Nearly half (40%) of service users report paying a registration fee (ticket) on their last visit to a government health facility. More than a quarter (27%) of those visiting rural government health facilities paid a registration fee where *no* official fee is charged.

A fifth (22%) of people make an extra payment to the worker(s) when they visit government health services and 27% pay an unofficial registration fee.

For all facilities, over a fifth (22%) of patients report an extra (unofficial) payment to the health worker(s).

- ❑ There is no difference between male and female service users in their likelihood of paying extra to the health worker(s), or paying an unofficial registration fee.
- ❑ People from poorer households (kutchi-2 construction) have the same risk of making extra and unofficial payments as those from richer households.
- ❑ There is no significant difference in the risk of making extra and unofficial payments between houses where the head is literate and those where the head is not literate.

5. Opinions of the public about government health services

Service users' ratings of visits to service

About one half (53%) of those who used government health services for illness in the last month rate the service they received as 'good'. The service is least positively rated for visits to UHFWCs (45% 'good'), and most positively rated for visits to satellite clinics/EPI sites (68% 'good').

Half (53%) of recent users of government health services rate the service they received as 'good'.

The visit to the service is more likely to be rated as ‘good’ if:

- The service user is male
- The service user is under 5 years old
- The household head is literate
- The house is not of the poorest type
- The house is in a metropolitan area
- A health worker was available
- All required medicines were available
- The service user did not have to make an extra payment to the service worker(s).

When the effects of all factors in combination are examined by logistic regression, it is issues about the service received, rather than personal characteristics, which have the strongest influence on the ratings of the service by users. The strongest influence is availability of medicines.

Taking the effects of the other variables into account;

- service users are two and a half times more likely to rate the service as good if all the required medicines are available and provided.
- They are 50% more likely to rate the service as good if they do not have to make an extra payment to the health worker(s).
- They are 25% more likely to rate the service favourably if a health worker is available.

Household ratings of government health services

Households are more likely to rate government health services as ‘good’ if:

- They live in a house of the poorest type
- The household respondent is male (unusually)
- The household head is literate
- The house is in a rural area
- The *thana* is less than an hour from the district town
- The community is within 5 km of the THC
- The household used government health facilities in the last month

Only a third (37%) of households rate government health services as ‘good’.

When the effects of these factors are examined in combination, the ones that remain with effects are rural location, recent use of government health services, literacy of the household head and living in the poorest type of house. None of the effects is large. Among the fairly small group of households (13%) that used government health services in the last month, those who rated that visit positively are very much more likely to rate government health services in general as ‘good’. People’s impression of the services is coloured by personal experiences or experiences of neighbours or friends.

Public perceptions of problems with government health services

The most common problem cited in the household interview is lack of medicines and perceived poor quality of medicines (too diluted and wrong dosage etc). Some of the problems relate to the state of the facilities and the level of provision but some relate specifically to the health workers. The ‘bad attitude’ of workers is quite often mentioned, as well as having to make extra payments to staff for a service supposed to be free (except for a small registration fee in some facilities).

Experiences and perceived problems with government health services were discussed in the community focus groups.

“There is never medicine available. Without money nobody pays any heed. The staff behave very rudely.”

Focus group of women, Nawabganj.

Public suggestions and views about future provision of government health services

Common household suggestions include: more medicines (64%), more doctors and specialists (35%), better quality service (34%), more accessible facilities (24%). Similar suggestions were made in the focus groups.

Most of the focus groups, both women and men, are not in favour of the proposal to stop household visits by health workers, especially if no suitable alternative was provided. About half the men’s groups but only a quarter of the women’s groups thought there would be ‘no problem’ for women to visit community clinics or HFWCs, in place of household visits by health workers.

The proposal to have all services (health and family planning) from one place (community clinics) was generally welcomed by the focus groups of both sexes. However, the idea of women getting family planning advice from a man was not popular with either men’s or women’s focus groups. Many groups expressed the view that the idea was completely unacceptable.

Public willingness to pay for improved government health services

Just over half (55%) of households are willing to pay (or pay more) for improved government health services. Households are more likely to be willing to pay for improved services if:

- They are not in the poorest houses
- They have used government health services for illness in the last month
- The household head is literate
- The house is in a metropolitan area
- They rate existing government health services as ‘good’.

Over half (55%) of households are willing to pay for improved government health services: 5 Tk for registration and 20 Tk for consultation.

These effects remain when examined in combination. Households likely to be willing to pay (or pay more) for improved government health services are those with a literate head, in metropolitan areas, of better economic status, who use government health services and who already rate the services as good.

Among people willing to pay, the median amount they say they would be willing to pay for a registration fee is 5 Tk and 20 Tk for a consultation fee.

6. Opinions of health service providers

Views of members of Union Parishad Councils

Some 202 UP Council members were interviewed; 184 of them (91%) are women. On average, some 20% of council members are women. Some 84% of the UP councils are said to

have discussed health services issues in the last year.

The majority (72%) of UP Council members interviewed think that health workers in the Union provide a proper, regular service. The problems perceived by UP council members are similar to those perceived by households and expressed in community focus groups. In particular, lack of medicines is again the most commonly perceived problem. UP council members want to see more medicines available and more staff available: specialist doctors, women doctors, general doctors and other staff groups.

Views of health workers in UHFWCs and THCs

Most UHFWCs and THCs have *no* arrangements for hearing complaints from service users. Nevertheless, health workers do become aware of the views of patients, since the criticisms they say they heard from patients agree with the views expressed directly from the service users and general public interviewed in the survey.

The concerns of service providers in the UHFWCs are quite similar to those of the service providers in the THCs and to those of service users. However, financial and administration problems are cited more often by service providers at THC level. As with service users, the problem most commonly cited by service providers is lack of medicines. This issue is also accorded high priority by service providers as an area for change to improve services.

Views of Thana Health and Family Planning Officers (THFPOs)

Only about half or less of THFPOs consider they have enough staff in their facilities to provide a service during normal opening hours.

Most of the THFPOs say they think the current division of health and family planning services is bad thing. They think it is bad for the country (53%), bad for the service (14%) and a waste of time and money (9%). Nearly all (95%) are in favour of unification of health and family planning services, with only one being against the change. Although some administrative and other difficulties are foreseen, nearly a third of THFPOs say they do not foresee *any* difficulties with the unification of health and family planning services in their thanas.

7. Women's reproductive health care

25,285 currently married women aged 15 to 49 years were interviewed in the household survey. Some 38% (9719/25198) of the women respondents can read and write a simple letter.

Use of contraception

The contraceptive prevalence rate (CPR) for modern methods among married women aged 15-49 years is 46%. Considering only modern temporary methods, the CPR is 40%. The CPR for longer-lasting and permanent methods is 15%.

The Contraceptive Prevalence Rate for modern methods among married women aged 15-49 years is 46%.

The CPR is notably lower in Chittagong and especially Sylhet than in other parts of the MOHFW & CIET

country. Women are more likely to use contraception (modern methods) if:

- ❑ They live in metropolitan areas
- ❑ They are literate (they are especially more likely to use the contraceptive pill)
- ❑ The household head is literate
- ❑ They do not live in the poorest houses

Considering the factors related to CPR in combination, women are more likely to use modern temporary methods of contraception if they are literate, if their husbands are literate and if they live in metropolitan sites.

Antenatal care

Of all the women interviewed, 90% have had at least one full term pregnancy and 51% have had a pregnancy in the last five years.

Considering pregnancies in the last five years, 59% of women had at least one ANC visit and 54% had at least one visit in the first six months of pregnancy. Women are more likely to attend for antenatal care if:

- ❑ They are literate
- ❑ They are younger than 26 years
- ❑ They do not live in the poorest houses
- ❑ They live in metropolitan areas
- ❑ The community is closer to the UHFWC or THC

Over half (54%) of women have at least one visit for antenatal care during the first six months of pregnancy.

Considering the combined effects of factors, the women more likely to attend for ANC are those who are literate, younger than 26 years, living in better houses and living in metropolitan areas. The women who need to be reached with services better are poor, illiterate, older women in rural areas.

Among women who went for any ANC visits for pregnancies in the last five years, 77% used government services. In rural areas a higher proportion of women used government services (84%), while in metropolitan areas half (49%) went to private services for ANC.

Nearly all women (94%) who received any antenatal care for pregnancies in the last five years rated the quality of the service they received as 'good', irrespective of area of residence, service providers, literacy, age and economic status.

Among women who did not go for any ANC for pregnancies during the last five years, the main reason cited (70%) is that they did not feel any need to have ANC.

Two thirds of women say their husband makes the decisions about antenatal care. In metropolitan sites it is more likely that a joint decision will be taken between the husband and wife together; in metropolitan areas the woman participates in the decision in 46% of cases. Women are more likely to participate in the decision if:

- ❑ They live in a metropolitan area
- ❑ They are literate
- ❑ The household head is literate
- ❑ They do not live in the poorest houses

Women are most likely to attend for antenatal care when the decision is taken *jointly* by the wife and husband together.

After examining combined effects by logistic regression, it is in metropolitan areas and in households with literate women and better economic status that women are more likely to participate with their husbands in decision making about antenatal care. Women are most likely to attend for antenatal care when the decision is taken *jointly* between the husband and wife. Women making the decision on their own may be unsupported and may lack information about the benefits of antenatal care.

8. Child health care

Information was collected on 15,418 children under 5 years old.

Coverage with vitamin A capsules

85% of children aged 12-60 months received two vitamin A capsules in the last 12 months.

Children are more likely to receive 2 capsules of vitamin A if:

- They are boys (slight but significant difference)
- The mother is literate
- The household head is literate
- They do not live in the poorest houses
- They live in metropolitan areas
- The community is within 5 km of the THC

Considering all factors in combination, the children most at risk of not receiving two vitamin A capsules in the last 12 months are those living in rural areas, in households where the head is illiterate and where the mother of the child is illiterate.

Coverage with measles vaccine

85% of children aged 12-23 months have received measles vaccine. Children are more likely to receive measles vaccine if:

- The mother is literate
- The household head is literate
- They do not live in the poorest houses
- They live in metropolitan areas

Considering all factors in combination, the children most at risk of not receiving measles vaccine are those with illiterate mothers in the poorest households.

Acute lower respiratory infection (ALRI) prevalence and care

9% of children under 5 years suffered an ALRI in the two weeks before the survey. The factor that is associated with the rate of ALRI is area of residence. Children in rural areas have more than twice the risk of having ALRI in the last two weeks compared with children in metropolitan sites.

Most (87%) of the children with reported symptoms of ALRI in the two weeks before the survey were taken to a health care provider of some sort for treatment. They are more likely to be taken for treatment if the household head is literate. Among those who sought any treatment, 62% of families sought treatment from private providers and 19% visited specific government health facilities. In metropolitan sites, 81% sought treatment from private providers.

Three quarters (77%) of families who took their child with ALRI for treatment are satisfied

with the treatment the child received. Two thirds (63%) of families who took the child to a government health facilities said they are satisfied with the services they received, lower than the level of satisfaction with private services. This is not explained by area of residence, economic status or literacy of the household head.

Diarrhoea prevalence and oral rehydration therapy (ORT)

9% of children under 5 years old had diarrhoea in the two weeks before the survey. The diarrhoea prevalence is higher in rural sites than in metropolitan sites.

When examining ORT, only children over 23 months old are included, to avoid confusion with breast feeding. Most of the children with diarrhoea (70%) were given more fluid than usual and half (48%) were given the same or more food than usual. However, only 36% were given the correct ORT: both more fluid *and* more or the same amount of food as usual.

The chances of a child with diarrhoea being given correct ORT do not vary by area of residence (rural or metropolitan), by economic status, or by literacy of the household head. Children with literate mothers are more likely to be given correct ORT.

Commentary

Behind the indicators: pointers for action

The data collected in the survey have allowed estimates at national and divisional level, and in the sample *thana*, of the intended indicators.

Knowing the level of an indicator is not all that is needed to plan the most effective actions to improve the conditions reflected by the indicator. Knowing the actionable factors related to the indicator – what increases the risk of a bad outcome and what increases the chances of a better outcome – can help to direct efforts towards interventions. From the analysis of these factors in this survey, and from listening to the views of the public in the survey, it is possible to identify some pointers for action, to fine-tune the HPSP during the coming years.

Increasing the use of government health services

“The hospital is too far. So the patient dies before he can be taken there.”

Focus group of men, Ajmirignaj

Physical access is an issue: communities further from the UHFWC or from the THC are less likely to use government health services. The proposal for creating community clinics may be one way of tackling this problem of access and so improving the use of services. It is a popular suggestion in communities.

“Our experience is not good. We don’t think the health clinic does minor operations properly, so we don’t go to it.”

Focus group of men, Assasuni

Bad experiences of the services are an important reason for not using them. Improving the quality and experience of services could lead to more people using them.

31% of male focus groups and 18% of female focus groups consider ignorance and lack of education of women is a reason for them not using government health services.

Programmes to improve female literacy could improve the use of services by women. Most women have to take permission from their husbands or other family members before using health services, so education about the benefits of health care services for women should also be aimed at men.

Increasing satisfaction with government health services

In deciding how to improve the satisfaction of service users, the question arises about what the perceptions of service users really indicate. If they are incorrect, then a programme to inform and educate service users is needed. If they seem likely to reflect a real problem with service delivery, then management action to tackle the problem is needed.

“The doctor only prescribes, he does not supply any medicines, and he tells us which drug store to buy the medicines from.”

Focus group of women, Basail

It seems there is a real lack of medicines considered necessary by the health workers as well as the patients. Lack of medicines is a major cause of dissatisfaction with the service. The reason for this lack of medicines at the point of service provision needs investigation.

“Government staff take money for doing their duty”

Focus group of men, Mirzaganj

Making extra payments to service workers is a widespread complaint and is strongly related to dissatisfaction with the service. The issue of workers demanding extra payments from service users will require management action at all levels. Improving the behaviour of doctors, in particular, towards patients may require attention during medical training.

Some service users are less satisfied than others: women from poor households with an illiterate household head fare especially badly. It may help to let service users (especially women from poor households) know about their rights to service and what they should expect from the service. This could form part of the BCC element of the HPSP.

“We do not want to criticise the system because we are afraid that if we do the THC will stop helping us altogether”.

Focus group of men, Gaffargaon

It would be a positive step to establish complaints procedures in facilities and monitor the complaints received and action taken. Patients will have to be actively encouraged to complain if they are not satisfied with their experience.

Increasing use of contraception

The women to target to increase the use of contraception are illiterate women in rural communities. If there is a concern that more longer-acting and permanent methods should be encouraged, women will need to be convinced to choose these methods and they will need to be widely available.

“Some of us women are suffering since they did ligation. We have constant pain in the lower abdomen. But the doctors don't care.”

Focus group of women, Mehendiganj

Improving facilities for insertion of IUDs and for performing tubal ligations may encourage more use of these methods of contraception.

Increasing use of antenatal care

The women to target to increase the coverage of antenatal care are illiterate women over 26 years old living in the poorest houses in rural areas. The husband most often makes the decisions about antenatal care, so men also need to be targeted with information about the benefits of antenatal care.

Increasing vaccination and vitamin A coverage

Children most at risk of not receiving vitamin A capsules are those in rural areas where the mother and household head are illiterate. Children most at risk of not receiving measles vaccine are those with illiterate mothers from the poorest households. These disadvantaged children need to be reached with immunisation programmes more effectively.

Dissemination and use of the findings

The findings from this baseline survey need to be communicated to planners and programme managers nationally and locally. They also need to be discussed with communities. Effective dissemination of findings should encourage dialogue between service providers and service users about improving the delivery of health services. Such a dialogue would itself be a contribution towards increased responsiveness and accountability of health services.

Baseline Indicators for the HPSP

Reproductive health care

- w CPR (modern methods): 46%
- w Use ANC in first 6 months of pregnancy: 54%
- w Reasons for non-use of ANC: 70% 'no need'
- w ANC users satisfied with service: 94%

Child health care

- w children given 2 doses vitamin A in last year: 85%
- w children 12-23 months given measles vaccine: 85%
- w children <5 with diarrhoea in last 2 weeks: 9%
- w children with diarrhoea given correct ORT: 36%
- w children <5 with ALRI in last 2 weeks: 9%

Limited curative care

- w children with ALRI taken to health facility: 87%

Behaviour change communication

w women aware of health services available at local level; women aware of at least one service from:

- Outreach clinics: 86%
- UHFWC: 71%
- THC: 70%

Use and experience of health services; meeting felt needs of clients

w households using health services in last month

- government services: 13%
- private services: 32%

w Reasons for choice of service: see text

w Reasons for not using government services: Too far, poor medicines/treatment, lack of medicines/staff

w visits with all needed medicines available: 33%

w visits with trained staff available: 87%

w visits with extra/unofficial payments

- extra payment to worker(s): 22%
- unofficial registration fee: 27%

w households willing to pay for improved government health services: 55%

w users satisfied with last visit to service: 53%

w households satisfied with govt health services: 37%

w UP councils discussed health services in last year: 84%

w *thana* with health service improvement committee: 88%

w perceived problems with services: lack of medicines main concern of users and providers

w priorities for changes in services: more medicines, more workers are priorities of users and providers

Building on success: the next steps for the survey process

This baseline survey has been successful. It has gathered information on a range of indicators as a baseline for tracking the progress of the HPSP and it has begun the process of giving people in the communities of Bangladesh a voice in the sort of health services they will be offered in the future. The further annual surveys that are planned offer an opportunity for building on this initial success. There are a number of considerations to be borne in mind for these further survey cycles:

1. Sentinel communities are not ‘special’ communities

The sentinel communities in the sample are intended to reflect the situation in other communities that they represent. If special actions are taken in these sentinel communities as a result of the findings of the baseline survey, this will invalidate their representativeness in future survey cycles. To guard against the temptation to do this, the names of the sample communities are not given in this report, although the full details of the sample are available for technical discussions of the sampling process. To check that any programme impact detected in future cycles is not confined to the sample communities (or even to the sample thana), the design should allow for some new thana and communities not in the present sample to be added or substituted for existing sample sites.

2. Tracking of indicators

The core indicators included in this baseline survey should be included in future cycles of the survey, even if not all of them annually. This will allow development of a score card of the indicator changes as a way of tracking the progress with the HPSP and noting areas that are more successful or less successful.

3. Examination of issues in more detail

In this baseline survey there was a need to cover a broad range of issues and this limited the depth of investigation that was possible for each issue. In future cycles, as well as continuing to gather information on key indicators, it will be important to investigate some issues in more depth. One example from the baseline survey is the problem of non-availability of medicines prescribed when people visit government health services. It should be possible to investigate what medicines are involved and the reasons why they are not available, perhaps combining the survey with other forms of service-based investigation at the same time. Another example might be the issue of women’s choice of contraceptive method, exploring in more detail why women choose the pill rather than longer-acting or permanent methods.

4. Building accountability: feedback and discussion of findings

In this baseline cycle of the survey, the immediate findings in each community were briefly discussed in community meetings at the end of the data collection in each place. However, much more should be done to involve communities and service providers in the process of acting on the survey findings. Future cycles of the survey should therefore allow for a process of feeding back the analysed findings to community groups and hearing their views about actions that could be taken. The follow-up process should also include holding joint meetings of service providers and community representatives at local level and perhaps national level to discuss the findings and their implications for future service provision. This will be an important step towards the accountability of services that is one of the key aims of the HPSP.

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Abbreviations and definitions of terms

ABBREVIATIONS

ANC	Antenatal Care
BBS	Bangladesh Bureau of Statistics
CPR	Contraceptive Prevalence Rate (among married women aged 15-49 years)
HPSP	Health and Population Sector Programme
MOHFW	Ministry of Health and Family Welfare
ORT	Oral Rehydration Therapy
SMA	Statistical Metropolitan Area
THC	Thana Health Complex
THFPO	Thana Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Centre

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.

95% confidence interval:

A measure of the accuracy of an estimate, based on the normal distribution curve. The true value is 95% likely to lie between the upper and lower values of the 95% confidence interval.

Relative Risk:

The risk or likelihood in one group compared with another group (for example the likelihood of using contraception in literate women compared with the likelihood in illiterate women). When the actual rates in each group are known (for example, the total number and the number using contraception), 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.

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.

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INTRODUCTION

This is the first cycle of the SDS monitoring process for the Health and Population Sector Programme (HPSP), intended as a baseline for recurrent annual monitoring during the five year period of the programme. The survey aims to provide baseline information on the present utilisation, experience and perceptions of health and family planning services by the population of Bangladesh, mainly from the point of view of the intended service users. It has generated data on a number of key indicators that can be tracked during 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.

This report outlines the background to the survey and the methodological approach. It describes the survey sample and methods and the findings of the survey. It compares the findings with those of other national surveys, where relevant. The implications of the survey findings for the implementation of the HPSP are also discussed in this report.

BACKGROUND

Health services in virtually all countries, including Bangladesh, have recourse to volumes of data generated by routine information systems. But this tends to be introspective, concerned with the view from the health care institution rather than the clients, the stakeholders. Those who are most in need of services are often left out of the information loop used for planning and managing the services. Conventional planning, since it begins from the institutions rather than from the clients, does not contemplate key parameters like *coverage* or *impact* of the services. Insofar as the reform is based on evidence from the users, in the sense both of *which* data are collected and *how* the data are collected and analysed, that is a healthy contribution towards client-driven institutional reform.

The Health and Population Sector Programme (HPSP) in Bangladesh places strong emphasis on monitoring and evaluation, of both process and outcome indicators. The service reorganisation in the HPSP is explicitly aimed at achieving a more client-oriented service, improving accountability of services, and increasing local participation in the planning and prioritisation of services. The Health and Population Sector Strategy (HPSS) emphasizes the need to address gender issues in the access to and provision of health and family planning services, to ensure access for the poorest sections of society, and to create sustainable local participation. One aim of monitoring the HPSP is to give reliable estimates of selected key outcome and process indicators (Annex 1). It also aims to produce information for evidence-based planning (what actions may help to achieve the aims of the programme), throw light on reasons for any lack of progress, and suggest ways of modifying the programme (both locally and nationally) to increase the chance of achieving intended objectives. The process itself is intended to encourage stakeholder participation in the planning and monitoring of services and foster dialogue between service users and service providers.

Methodological approach

The essence of CIET support for public sector reform is to generate community-based evidence on impact, coverage and costs of public services; at the same time building skills, habits and confidence for results-based management. The CIET Methodology (Annex 2) uses reiterative, cyclical data gathering and analysis; the methods provide a substrate for ongoing

interaction between managers and each programme as it improves over time. The idea is to contribute to a culture of quality service delivery based on evidence of results.

Gender issues

The HPSP has a focus of ensuring women's access to acceptable health services. The SDS for monitoring of the HPSP also has a strong gender perspective. In this baseline survey most of the household respondents are women; it is also possible to analyse differences by sex of respondent. In each community separate female and male focus groups were conducted to ensure that women's interpretation of the situation is heard. The experience and use of health services can be analysed by gender of the user. The field teams were composed mostly of women: all the interviewers and at least one supervisor per team were women.

METHODS

Organisation of the survey

The survey represents a collaboration between CIETinternational, an international NGO with wide experience of community surveys of this sort, and counterparts in Bangladesh. Counterparts were drawn from the Ministry of Health and Family Welfare (MOHFW) and other individuals with experience of undertaking field surveys in Bangladesh. The HPSP Project Coordination Cell (PCC) was a key point of contact with the MOHFW for the survey, and acted as the government focal point.

A Steering Group was convened by the Secretary of the MOHFW to oversee the survey. A Technical Group was formed, comprising individuals with technical skills and knowledge to contribute to the process. The survey design, sample and instruments were discussed and agreed initially with the Technical Group and approved by the Steering Group. The agreed design, sample and survey instruments were described in a survey Inception Report, prepared and circulated to the Technical and Steering groups in January 1999. The Preliminary Report of the main quantitative findings of the survey was considered by the Technical Group and subsequently by the Steering Group in April 1999. Comments and suggestions from both groups have been incorporated into the final report of the survey.

In implementing and supervising the survey, CIET personnel were assisted by a number of Resource Persons. These are experienced and skilled persons who joined the survey implementation team. It is expected that many of them will continue to work with the survey process over the five year programme, thus providing an opportunity for solid skills transfer and institutionalisation of the process in Bangladesh.

DATA COLLECTION INSTRUMENTS

In designing the data collection instruments, attention was paid to the need to collect indicators that could be followed to track the progress of the HPSP. A list of indicators was produced (Annex 1), based on the indicators proposed for the monitoring of the HPSP and also incorporating indicators related to service use and perceptions suggested by participants in the December 1997 Dhaka workshop on the Service Delivery Survey. In each case, it was noted whether the indicator was available from other sources and whether it was feasible to collect it within the baseline SDS. It is important to stress that the main purpose of the baseline SDS is to collect information about service use, experiences and perceptions rather than health status indicators, although some of these were considered for inclusion.

Several data collection instruments were developed for the baseline Service Delivery Survey, in accordance with the CIET methodology used (see Annex 2). The instruments drew on those used by CIET in similar surveys in other countries, but taking into account the specific requirements of this survey in Bangladesh. The survey instruments were designed by a sub-group of the Technical Group and agreed by the Technical Group, as well as circulated to the Steering Group for comments. In each case the instrument was designed in English, then translated into Bengali. The instruments were pre-tested in rural communities near Dhaka and minor adjustments to improve their understanding by respondents were made as a result.

The final Bengali instruments were back-translated into English to check the meaning had been preserved. The survey instruments are shown in Annex 3.

The household questionnaire

This is the main instrument for quantitative data collection, administered in about 20 minutes to each household in the survey. Part of the interview is with a respondent on behalf of the whole household. Another part is with each married woman of childbearing age (15-49 years) in the household; and a further part is about each child aged less than 5 years in the household, answered by the mother of the child.



Figure 1. A household interview

The focus group discussion guides

In each of the survey sites of about 100 households, two focus groups were held: one of married women with children under five years of age; and one of men with children under



Figure 2. A focus group of women

five years of age. The focus group guides were used to facilitate the discussion in the groups. Each group discussion included 8-10 participants, a facilitator and a recorder. Immediately after the group discussion, the facilitator and recorder together completed a fair copy of the discussion record, using the notes made during the discussion. The Bengali records of the focus groups were subsequently translated into English for coding, data entry and other analysis of the themes expressed.

The institutional review schedule

In each of the survey sites, supervisors of the visiting team undertook an institutional review of the Union Health and Family Welfare Centre serving the site. They also visited the Thana Health Complex. The institutional reviews include an interview with the health worker in charge of the facility as well as observation of the facility by the visiting team. The review schedule includes information about the scope and condition of the facilities and equipment and the stocks of certain key medicines and other supplies.

Key informant interview schedules

The key informants interviewed were: a knowledgeable person in the community (such as a teacher or religious leader) for each site, a female member of the Union Parishad Council for each site, and the Thana Health and Family Planning Officer (THFPO) in each sample thana. The community key informant gave information about the site applicable to all the

households in the site that can be related to the household views and experiences of the health services. This includes, for example, the access to the health facility and the actual opening hours of the facility.

The survey sample

The survey sample was drawn in collaboration with the Bangladesh Bureau of Statistics (BBS). It is intended to give representation of the six divisions and of sample thana within the divisions, for rural sites. The first stage was to select randomly a number of thana within each division, the number proportional to the population of the division. By this means, 44 thana were selected. Then five sites were selected within each thana, each one randomly selected from a union. In three thana only four sites were selected as there were only four unions. Since the HPSP has a focus on rural areas the main focus of data collection was on rural sites, with 217 rural sites in the sample. A further 30 sample sites were selected in the four statistical metropolitan areas (SMAs), with the number in each SMA proportional to the population size. The sample design and the selected thana and wards are shown in

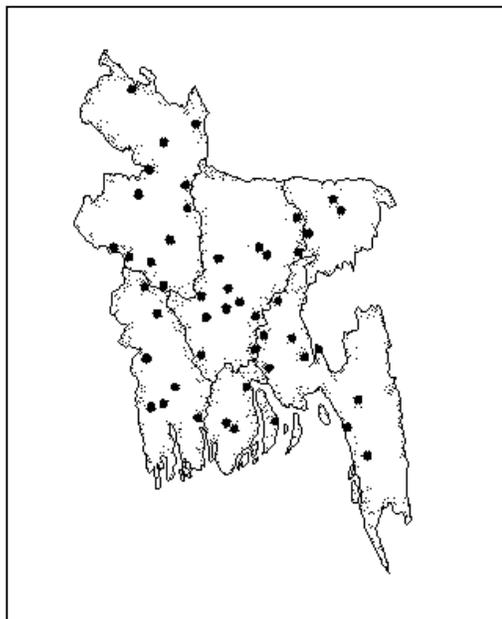


Figure 3. Sample thana and SMAs

Weights were calculated to take into account differences in population distribution between the sample and the actual population of Bangladesh. The calculation of these weights is shown in Annex 5. These weights were then applied when declaring national figures. Annex 5 shows the weighted and unweighted figures for key indicators from the survey.

For the main rural sample thana representation was chosen, rather than attempting to represent all 64 districts, or even to represent the ‘greater districts’, because the thana level is a functional unit under the HPSP. This sample design allows results to be declared at national level, at divisional level and at thana level for the sample thana representing each division. A further advantage of this design is that it can allow thana level findings to be disseminated and discussed with relevant stakeholder groups at thana level. This can make a meaningful contribution to stakeholder participation, one aspect of the HPSP. The findings of the SDS will make a concrete starting point for stakeholder discussions; they offer a substrate for dialogue between service providers and service user and non-users.

DATA COLLECTION

The training for the supervisors was carried out over five days and included training on how to facilitate and record the focus group discussions. The training for interviewers was carried out over three days and concentrated on the administration of the household questionnaire. It included a field test of administering and recording the household questionnaire. More supervisors and interviewers were trained than were required, allowing those who did best in the training to be selected for the work.

There were a total of 15 data collection teams, each consisting of six interviewers and three supervisors (the supervisors also undertook the focus group discussions, the key informant interviews and the institutional reviews). Six teams were trained in Dhaka, four in Rajshahi, three in Khulna and two in Chittagong. All the supervisors came to Dhaka for training. Training of supervisors and interviewers in Dhaka began on 27 January, shortly after Eid, and training of interviewers in the three regional centres (Rajshahi, Khulna and Chittagong) took place at the beginning of February. Field data collection then took place from early February to mid March. As well as the team supervisors, frequent supervisory visits were made to the different field teams from resource persons in Dhaka throughout the fieldwork.

DATA CODING AND DATA ENTRY

A team of six coders and 20 data entry operators were trained in Dhaka. A number of the questions in the various instruments were open-ended. The responses were coded, using codes derived from responses to the field pre-test of the instruments and responses in the first sites. Data entry was programmed using Epi Info(1). Data from the household questionnaire and the key informant interviewers and institutional reviews were entered twice and validated using the Epi Info Validate programme. Further logical checks and cleaning was undertaken on the validated data sets. Data entry began soon after the fieldwork and took place in tandem with the data collection, so that data entry was completed by 25 March.

ANALYSIS

Analysis was undertaken using Epi Info(1) and SPSS(2) statistical packages. The main analysis employed Epi Info, for simple frequencies and univariate associations. The Epi Info programme CSAMPLE was used to calculate the weighted percentages of indicators at national level (see Annex 5). The SPSS package 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.

RESULTS

1. The population in the sample

The sample includes:

- 26,207 households
- 134,926 people
- 25,285 married women aged 15-49 years
- 15,418 children under 5 years old

The proportion of married women aged 15-49 years in the sample is 19% (25,285/134,926). This is similar to the proportion of 20% for married women aged 15-49 years calculated from 1996 projections from the 1991 census. The proportion of children under 5 years old in the sample is 11% (15,418/134,926), again similar to the proportion of 12.6% calculated by Bangladesh Bureau of Statistics (1996), based on extrapolations from the 1991 census.

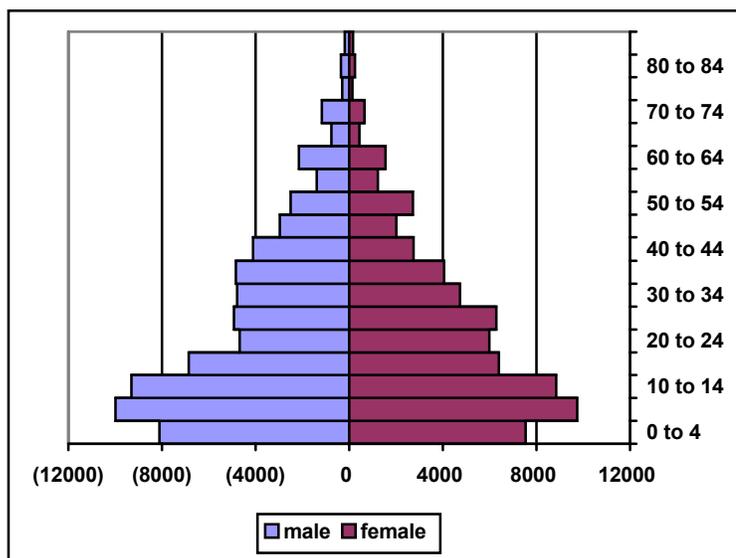


Figure 4. Age and gender distribution of the sample population

The age and gender distribution of the sample population is shown in Figure 4.

The distribution of the sample by division and metropolitan areas is shown in Table 1.

Table 1. Distribution of households by division and metropolitan area

Division/metropolitan area	No. households
Barisal	2314
Chittagong	3959
Sylhet	1734
Dhaka	6238
Khulna	3310
Rajshahi	5618
Chittagong SMA	714
Dhaka SMA	1801
Khulna SMA	319
Rajshahi SMA	200

Household heads

Nearly all the household heads (95%; 24,976/26,198) are male. Just under half of them (47%; 12,314/26,148) are literate by self-report. The most common main occupations of the household head are shown in Table 2.

Table 2. Main occupation of household head

Main occupation	No. (%) households
Agriculture (own land)	6498 (25)
Sales/business	4873 (19)
Unskilled labour	3848 (15)
Tenant farmer	3500 (13)
Teacher	3368 (13)
Skilled labour	1743 (7)
Foreign labour/service	768 (3)
Fisherman	452 (2)

Household respondents

The general part of the household interview was intended to be with the senior woman in the household, using another respondent if that woman was not available. In practice, 98% (25,660/26,198) of the household respondents were women. Most of them (85%; 22,283/26,123) were the wife of the household head. The household head responded to the interview in 6% (1,469/26,123) of households and the mother of the household head in 4% (1,062/26,123) of households. For the sections of the interview about women's reproductive health, each woman aged 15-49 in the household was interviewed. For the section about children's health, the mothers of children under 5 years were interviewed.

Economic status – type of house

The houses in the survey have been divided into four types: Pucca, semi-pucca, kutcha-1 and kutcha-2. 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 a thatched roof and bamboo or jute-stick walls. The type of house has been taken as an index of economic status of the household. About a third of the houses in the survey are of the poorest, kutcha-2, type (Figure 5).

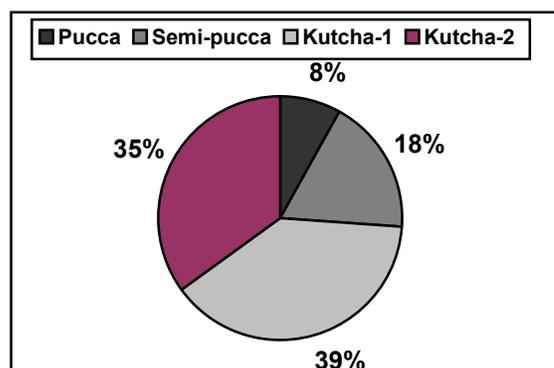


Figure 5. Economic status of households

Households of the poorest type (kutcha-2) are much more common in rural sites (38%; 8,760/23,121) than in metropolitan sites (11%; 333/3027)

Household size

In this survey, a household was defined as “people who eat from the same pot”. The average household size for the whole sample is 5.09 people. The household size by division and metropolitan areas is shown in Annex 7. The highest household sizes are in Sylhet and Chittagong.

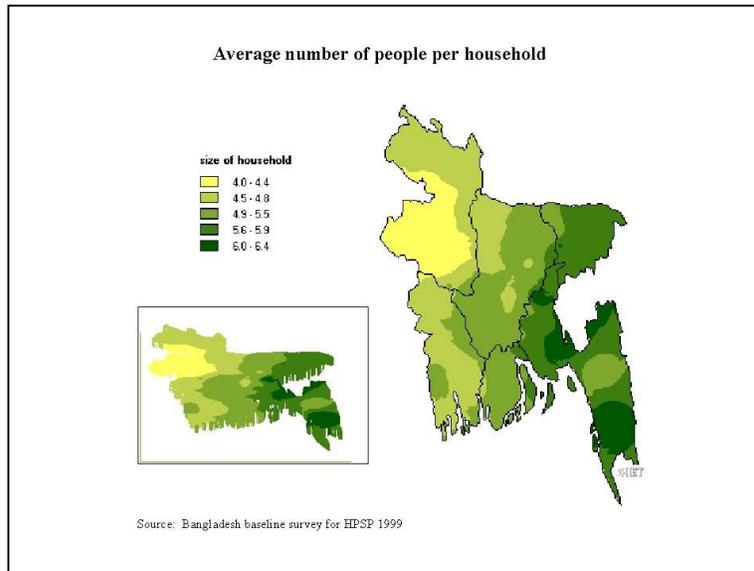


Figure 6. Map of average household size in different parts of Bangladesh

Maps showing the distribution of different indicators across Bangladesh, similar to Figure 6, are included in Annex 7.

2. Government health facilities available to rural communities

As part of the survey process, the UHFWC serving each site and the THC for each sample thana were visited and reviewed. The most important information from these reviews is given in the following section. Further detailed information from the reviews is shown in Annex 8.

Thana Health Complexes

Key informants in each community in the survey were asked about the distance of the community from the THC. This information is available from 212 of the 217 rural communities. The distance of communities in the survey from the THC is shown in Figure 7.

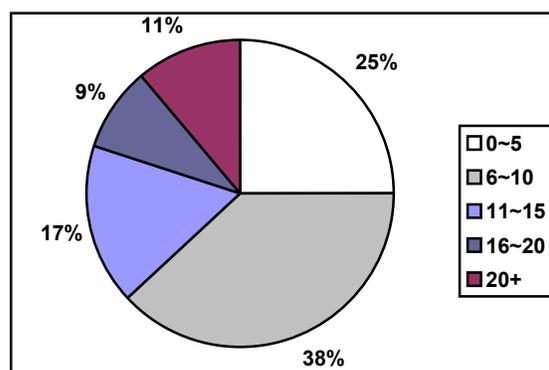


Figure 7. Distance (Km) of communities from the THC

In total, 43 THCs were visited in the 44 sample thana of the survey. Data from the THC review in one thana are missing. The level of facilities and their state of maintenance is variable (Table 3).

Table 3. Facilities and maintenance in the THCs, observed by visiting team

Facility and state of maintenance	No. (%) THCs
Separate consultation/examination room for outpatient area	28 (65)
Consultations are held in private	29 (67)
Curtain/screen around the examination couch	29 (67)
Consultation/examination area very clean	11 (26)
Consultation/examination area adequately clean	25 (60)
Consultation/examination area dirty	6 (14)
Separate room for delivery/IUD insertion	30 (70)
Area for delivery/IUD insertion very clean	10 (31)
Area for delivery/IUD insertion adequately clean	17 (53)
Area for delivery/IUD insertion dirty	5 (16)
Functional water supply	37 (86)
Toilet facilities in the outpatient area	38 (88)
Separate toilet for women	25 (66)
Toilet for women is NOT being used	5 (20)

A third of the THCs do not have a separate room in the outpatient area for consultation and examination, and in a third patients are not examined in private or even behind a screen. Privacy is not an issue specifically mentioned by households or focus groups as a problem with government health services. However, bad behaviour and attitude of staff are both areas of dissatisfaction for service users and provision of privacy is part of showing respect for patients.

Cleanliness is an issue, both for proper clinical practice and avoidance of infections, and for showing respect for patients. The room or area used for consultations and examinations is

‘very clean’ in a quarter of the facilities and frankly dirty in 14%. Some 70% of the THC’s visited have a separate room for insertion of IUDs and deliveries. One in six (16%) of the rooms or areas for insertion of IUDs and deliveries are frankly dirty.

While most (88%) of the THC’s have toilets in the outpatient area, only two thirds of these include a separate toilet for women. Even when there is a separate toilet for women, in a fifth of cases this is not in use.

The presence and working order of a range of equipment and kits in the THC was checked by the visiting team. Their findings are summarised in Table 4.

Table 4. Presence of equipment in the THC, checked by visiting team

Items of equipment, kits	No. (%)	
	Present	Working
Adult scales	40 (93)	36 (90)
Paediatric scales	40 (93)	36 (90)
Paediatric measuring boards	16 (37)	14 (88)
Growth monitoring charts	29 (67)	27 (93)
Foetal stethoscope	31 (72)	31 (100)
Sphygmomanometer	41 (95)	41 (100)
Adult stethoscope	40 (93)	40 (100)
Autoclave	38 (88)	36 (95)
Supply of kerosene	37(86)	--
Urinalysis kit	33 (77)	--
IUD insertion kits	35 (81)	--
Rani (delivery) sets	7 (16)	--
Blood transfusion equipment	10 (23)	10 (100)
Refridgerator	40 (93)	37 (93)
Freezer	38 (88)	38 (100)
Microscope	41 (95)	41 (100)
Surgical kits	31 (72)	--
O&G kits	31 (72)	--
Lights in the operating theatre	28 (65)	23 (82)
Air conditioning in the operating theatre	4 (9)	4 (100)

There are some notable items not always present. For example, paediatric measuring boards are only present in a third of THC’s. These are needed if stunting (low height for age; chronic malnutrition) and wasting (low weight for height; acute malnutrition) are to be properly assessed. And nearly a quarter of the THC’s visited do not have any urinalysis kits, important in assessment of a number of medical conditions.

Table 5. Stocks of medicines present in the THC’s

Medicine	No. (%)THC’s with stock
Ampicillin syrup	35 (81)
Chlorhexidine	32 (74)
Ergometrine	25 (58)
Iron/folate tablets	43 (100)
Paracetamol	40 (93)
Benzyl benzoate	34 (79)
Mebendazole	36 (84)
Metronidazole	41 (95)

As shown in Table 5, basics such as iron/folate tablets and paracetamol are almost universally stocked in THC’s. For antibiotics, stocks of metronidazole are present in nearly all facilities

but ampicillin syrup stocks were not present at the time of the review in a fifth of THCs. This might indicate that ampicillin, a very commonly used antibiotic, goes out of stock more quickly than metronidazole.

The interviewee in each THC was asked what action would be taken if stocks of antibiotics were running out (Figure 8)

More than half the THC respondents (59%) say they would prescribe if running low on antibiotics. This confirms the reports of service users that they commonly receive a prescription rather than medicines from government health services (see section 5, Experience of government health services).

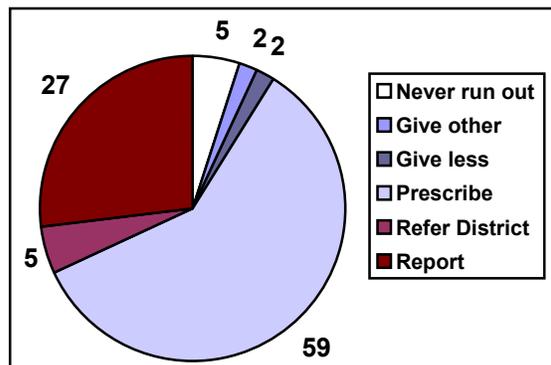


Figure 8. Action by THC if antibiotics running out (% THCs)

The practice of prescribing rather than providing medicines is a common source of complaint among service users.

“Medicine is not provided at the THC. Medicines have to be bought from outside with the prescription.”
Focus group of men, Barura

Most of the THCs visited do not have a full quota of staff in post. For details see Annex 8b. For doctors, the mean number allocated per THC is 8, with 6 of these posts filled (with 5 men and one woman).

Union Health and Family Welfare Centres

The distance of communities from the nearest UHFWC, as reported by the community key informants, is shown in Figure 9.

Some two thirds of the communities are within 3 Km of the UHFWC, and only 5% are 10 Km or more away from the UHFWC.

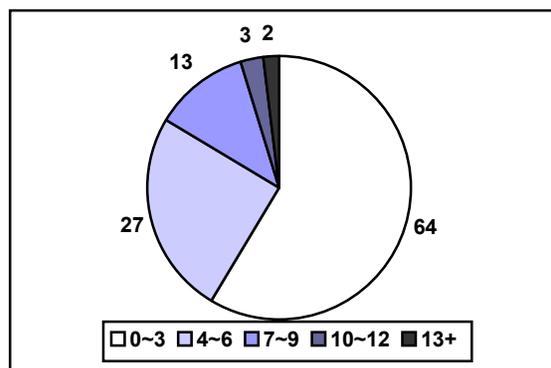


Figure 9. Distance (Km) of communities from UHFWC (% of communities)

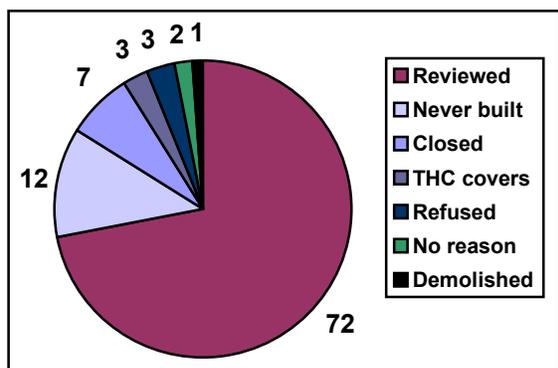


Figure 10. Availability of information from UHFWCs (% of UHFWCs identified)

Out of 225 facilities visited, 161 facilities (serving 154 communities) were reviewed. In seven communities, both Union Health Centres and Family Welfare Centres were visited. The reasons why information was not available from facilities are illustrated in

The facilities observed in the reviewed UHFWCs and their level of maintenance are shown in Table 6.

Table 6. Facilities and maintenance in UHFWCs, as observed by visiting team

Facility, level of maintenance	No. (%) of UHFWCs
Separate consultation/examination room for outpatient area	85 (53)
consultations are held in private	83 (52)
curtain/screen around the examination couch	52 (32)
consultation/examination area is very clean	16 (10)
consultation/examination area is adequately clean	94 (58)
consultation/examination area is dirty	40 (25)
separate room for delivery/IUD insertion	99 (62)
area for delivery/IUD insertion is very clean	10 (6)
area for delivery/IUD insertion is adequately clean	68 (42)
area for delivery/IUD insertion is dirty	32 (20)
functional water supply	103 (64)
electricity supply	51 (32)
Mean number of hours of electricity supply	15 hours
toilet facilities in the outpatient area	132 (82)
separate toilet for women	71 (54)
toilet for women is NOT being used	18 (25)

Barely more than half of the facilities visited have a separate consultation/examination room and only half of consultations are held in private, with only a third having screens around the examination couch.

A third of the UHFWCs have no functional water supply and two-thirds have no electricity supply.

The availability of equipment and kits in the UHFWCs reviewed is shown in Table 7.

Table 7. Presence of equipment in the UHFWC, checked by visiting team

Equipment items	No. (%)	
	Present	Working*
Adult scales	133 (83)	116 (87)
Paediatric scales	124 (77)	111 (90)
Paediatric measuring boards	41 (26)	38 (93)
Growth monitoring charts	106 (66)	94 (89)
Foetal stethoscope	99 (62)	85 (86)
Sphygmomanometer	146 (91)	119 (82)
Adult stethoscope	140 (87)	123 (88)
Autoclave	68 (42)	48 (70)
Supply of kerosene	79 (49)	--
Urinalysis kit	79 (49)	--
IUD insertion kits	121 (75)	--
Rani sets	20 (12)	--

Some quite basic equipment is commonly missing. Nearly a quarter of facilities have no scales for weighing children. Less than half have an autoclave or a supply of kerosene, so proper sterilisation of equipment will not be possible. Less than half have urinalysis kits and a quarter have no IUD insertion kits.

Drug stocks in the UFWCs are shown in Table 8. Nearly a quarter had no stock of ampicillin syrup at the time of the visit and nearly half had no chlorhexidine (an antiseptic for cleaning working surfaces and topical application).

Table 8. Stocks of medicines in the UFWCs reviewed

Medicines	No. (%)UFWCs with stock
Ampicillin syrup	122 (76)
Chlorhexidine	90 (56)
Ergometrine	127 (79)
Iron/folate tablets	154 (96)
Paracetamol	152 (94)
Benzyl benzoate	141 (88)
Mebendazole	133 (83)
Metronidazole	151 (94)

Most (80%) of the UFWC interviewees say they run short of antibiotics between supplies. The actions they take if they run short of antibiotics are shown in Table 9.

Table 9. Reported action by UFWCs if antibiotic supply is running out

Action	No. (%)
Nothing/wait	12 (8)
Prescribe	88 (55)
Inform authorities	24 (15)
Give other medicine	10 (6)
Give less	6 (4)
Never run out	5 (3)
Refer to THC	2 (1)
Get from THC	2 (1)
Don't know/missing	12 (7)

As for THCs, over half of UFWC respondents say they prescribe when they run short of antibiotics, while some say they substitute another drug or reduce the dosage given. The frequency of running low and the tendency to prescribe when this happens are in accordance with the reported experience (and complaints) of service users (see section 5, Experience of government health services).

Nearly all the UFWCs visited provide curative care and family planning services but only 61% provide immunisations and 50% vitamin A. Less than half provide delivery care and only 56 provide ORS. Most of the facilities do *not* follow protocols for treatment of diarrhoea, childhood ALRI or persistent cough in an adult. For further details, see Annex 8b.

3. Women’s awareness of government health and family planning services

One aim of the HPSP is to increase women’s awareness and use of government health and family planning services. One of the indicators for evaluation of the HPSP is women’s awareness of the services provided by the different government health facilities. This is a difficult issue to evaluate because the questions have to be left open rather than asking women from a ‘menu’ which services are provided from each level of facility. On the other hand, women may only mention some services although they would know of others if prompted. In this baseline survey we decided to leave the questions open; even if this gives an incomplete picture of awareness it should give a basis for assessing improved knowledge and awareness of services over time.

Awareness of services from EPI clinics and outreach services

Table 10 shows the services married women aged 15-49 years are aware of as being provided from EPI clinics and outreach services. Up to four responses were recorded.

Table 10. Women’s knowledge of services provided by the EPI clinics/outreach services

Services mentioned	No. (%) women
Immunisation/VitA capsules	16338 (74)
Family Planning	4409 (20)
Treatment	2047(9)
Medicines/ORS	1956(9)
ANC	848 (4)
Health Education	126 (1)
Other	77 (0)
Don’t know	3023 (14)
<i>Total</i>	<i>28824 (130)</i>

Up to 4 answers were recorded

The services women are mainly aware of from the EPI clinics and outreach services are immunisation and provision of vitamin A capsules.

Indicator

86% of married women aged 15-49 years are aware of at least one service from EPI clinics/outreach services

Economic status of households makes no difference to whether women know of services from EPI clinics/outreach services. But women who are literate are more likely to know of at least one service from these facilities¹. This is illustrated in Figure 11.

¹ Among literate women, 89% (6695/7552) know of at least one service from EPI clinics/outreach services, compared with 85% (12378/14539) of illiterate women. Odds Ratio 1.36 (95% CI 1.25-1.49)

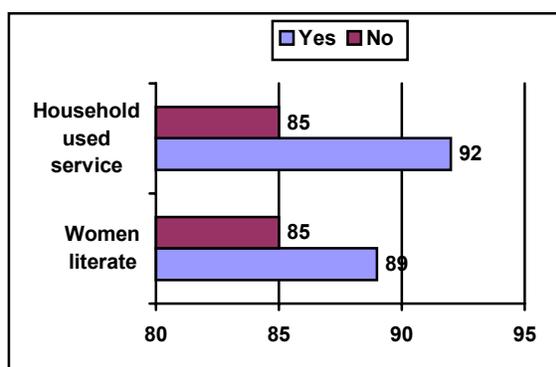


Figure 11. % of women aware of at least one service from EPI/outreach clinics

Women from households who have used government health services for illness in the last month are twice as likely to be aware of at least one service from EPI clinics/outreach services² (Figure 11).

The awareness of women about services from the EPI clinic/outreach services is not related to the household opinion about government health services (see section 6 below).

Awareness of services from the UHFWC

Table 11 shows the services married women aged 15-49 years are aware of as being provided from UHFWCs.

Table 11. Women's knowledge of services provided by the UHFWC

Services mentioned	No. (%) women
Family Planning	10076 (47)
Treatment	3588 (17)
Immunisation/Vit A	2437 (11)
Medicines/ORS	2106 (10)
ANC	894 (4)
Delivery	219 (1)
Health Education	164 (1)
Surgery	161 (1)
Consultation	131 (1)
Other	12 (0)
Don't know	6206 (29)
Total	25994 (120)

Up to 4 answers were recorded

The main services women are aware of from the UHFWC are family planning and curative care.

Indicator

71% of married women aged 15-49 years are aware of at least one service from UHFWCs

Economic status of the household is not related to women's awareness of services from the UHFWC. Literate women are more likely to know of at least one service from the UHFWC³.

² 92% (3083/3342) of women from households who have used government health services in the last month know of at least one service from EPI clinics/outreach, compared with 85% (16040/18803) of women from households who have not used government services in the last month. Odds Ratio 2.05 (95% CI 1.79-2.35)

³ Among literate women, 75% (5595/7431) know of at least one service from the UHFWC, compared with 69% (9821/14174) among illiterate women. Odds Ratio 1.35 (95% CI 1.27-1.44)

Women from households that used government health services in the last month are more likely to be aware of at least one service from the UHFWC⁴.

Women from communities within 3km of the UHFWC are more likely to be aware of at least one service from the UHFWC⁵. The percentages of women aware of at least one service from the UHFWC are illustrated in Figure 12.

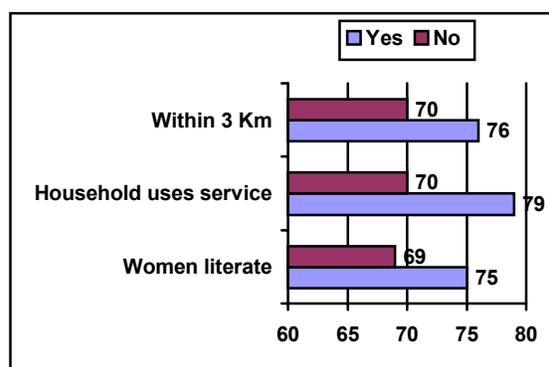


Figure 12. % of women aware of at least one service from the UHFWC

The awareness of women about services from the UHFWC is not related to the household opinion about government health services.

Awareness of services from the THC

Table 12 shows the services that married women aged 15-49 years are aware of as being provided by the THC.

Table 12. Women's knowledge of services provided by the THC

Services mentioned	No. (%) women
Treatment	10828 (50)
Delivery	3156 (14)
FP	2022 (9)
Medicines/ORS	1832 (8)
Surgery	1282 (6)
Immunisation/VitA	866 (4)
ANC	564 (3)
Consultation	118 (1)
Other	194 (1)
Don't know	6632 (30)
Total	27494 (126)

Up to 4 answers were recorded

The services from the THC that women are most commonly aware of are curative care (treatment) and delivery care.

Indicator

70% of married women aged 15-49 years are aware of at least one service from the THC

⁴ 79% (2559/3249) of women from households who have used government health services in the last month are aware of at least one service from the UHFWC, compared with 70% (12894/18408) of women from households who have not used government services in the last month. Odds Ratio 1.59 (95% CI 1.45-1.74)

⁵ 76% (8996/11821) of women from communities within 3 Km of the UHFWC are aware of at least one service from the UHFWC, compared with 70% (4739/6807) of women from communities further away. Odds Ratio 1.39 (95% CI 1.30-1.49)

Economic status of the household is not related to women’s awareness of services from the THC. Literate women are more likely to know of at least one service from the THC⁶.

Women from households that have used government health services in the last month are twice as likely to be able to mention at least one service from the THC⁷.

Women from communities within 5 km of the THC are nearly twice as likely to be aware of at least one service provided by the THC, compared with women from communities further from the THC⁸.

In contrast to awareness of the other facilities, women’s awareness of the services provided by the THC is greater in households where the opinion of government health services is good⁹. The reason for this association is not clear. More knowledgeable people may have a more positive experience of the services available from the THC.

The percentages of women aware of at least one service from the THC are shown in Figure 13.

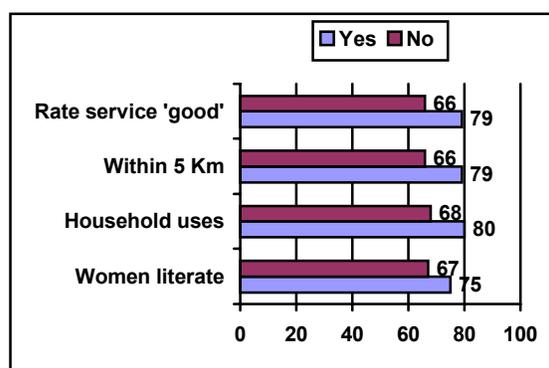


Figure 13. % of women aware of at least one service from the THC

⁶ 75% (5592/7479) of literate women are aware of at least one service from the THC, compared with 67% (9619/14351) of illiterate women. Odds Ratio 1.46 (95% CI 1.37-1.55)

⁷ 80% (2662/3311) of women from households who used government health services in the last month are aware of at least one service from the THC, compared with 68% (12591/18572) of women from households that have not used government health services in the last month. Odds Ratio 1.95 (95% CI 1.78-2.14)

⁸ 79% (4241/5367) of women from communities within 5 Km of the THC are aware of at least one service from the THC, compared with 66% (10613/16008) of women from communities further from the THC. Odds Ratio 1.91 (95% CI 1.78-2.06)

⁹ 74% (6368/8558) of women from households that consider government health services as ‘good’ know of at least one service from the THC, compared with 58% (8669/12733) of women from households who do not consider government health services as ‘good’. Odds Ratio 1.36 (95% CI 1.28-1.45)

4. Use of health services

Households were asked about their use of government (public) and other health services in the last month and about any members of the household who had been ill but who had not used any sort of health service. In this analysis, we have considered use of health services for illness rather than for immunisations, family planning or antenatal care. The ‘other’ health services used are a variety of private health services, ranging from visits to the local village doctor (who may well not be a qualified doctor) to visits to private clinics (mainly in metropolitan areas).

The definition of “illness” was left to the household, and it is not known what threshold they have for illness and how this may vary with age or sex or other factors. The aim of this part of the interview was not to establish the level of illness in the population, either in general or for specific types of illness, but rather to examine where households choose to seek help for household members that they perceive to be ill.

For services other than government (public) health services, the only information sought was the number of visits in the last month, the age and sex of the service user and the reason for using the service (what type of health problem). For the last visit to a government (public) health service in the last month, more detailed information was sought about the experience of the visit. This more detailed information about experiences of government health services is described in the next section.

In 13% (3,398/26,200) of households, at least one member used government (public) health services for treatment of illness in the last month. In nearly a third (32%; 8,262/26,158), at least one member visited other (private) health service providers in the last month. In a few households (5%; 1,287/26,149), someone was ill during the last month but no sort of health service was used.

Indicator

In the last month:

w 13% of households used government health services

w 32% of households used private health services

The proportion of households using government and private health services in the last month varies quite a lot by geographic area. The variation is shown in tables and maps in Annex 7.

Factors related to use of health services

Age and sex of service users

Gender does not seem to be a factor in whether government or private health services are chosen when a service is visited for treatment. Over half of those using government health services in the last month are female (56%; 2238/3983). A similar proportion of those using private service providers are female (56%; 5449/9809). Among household members said to be ill in the last month but not using any service, 60% (893/1486) are female.

The age distribution of those household members using government and other services and those not using any service is shown in Table 13.

Table 13. Number (%) of people using different health services by age group

Age (years)	Used government service*	Used other service	Ill but no service used
0-4	698 (27)	1983 (20)	173 (12)
5-10	340 (13)	1324 (14)	214 (14)
11-20	300 (11)	1297 (13)	209 (14)
21-30	395 (15)	1449 (15)	240 (16)
31-40	350 (13)	1326 (14)	236 (16)
41-50	241 (9)	1012 (10)	173 (12)
51 plus	328 (12)	1448 (15)	243 (16)

*For government services, the *last* use in the last month is shown, if there was more than one use by the household.

For both government and private service users there is a higher proportion of children under five years. This pattern is different from that seen among those said to be ill in the last month but not using any service. It seems that illness in young children is more likely to trigger a visit to a health service than illness among older people. However, age does not seem to be a factor in the choice between government and private services.

Economic status of households

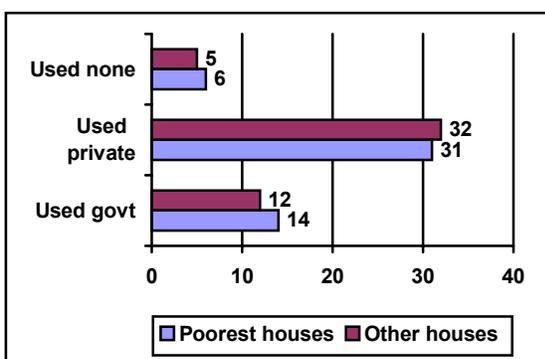


Figure 14. % of households using different health services by economic status

The poorest households (those living in houses of kutchra-2 construction) are somewhat more likely to have used government health services¹⁰. They are less likely to have used private health service providers¹¹. And they are more likely to have had a member ill in the last month who did not use any type of health service¹². Although the associations between household economic status and use of different types of health service are statistically significant, the differences in rates of use between the poorest households and others are not large.

The percentages of households using different health services, by economic status, are shown in Figure 14.

Literacy of household head

Households with a literate head are somewhat less likely to have used government health services in the last month. However, this association is no longer found when the site of the community (rural or metropolitan) is taken into account. The apparent relationship between

¹⁰ Among the poorest households, 14% (1298/9088) used government health services in the last month, compared with 12% (2091/17053) among other households. Odds Ratio 1.19 (95% CI 1.11-1.29)

¹¹ Among the poorest households, 31% (2770/9067) used government health services in the last month, compared with 32% (5478/17032) among other households. Odds Ratio 0.93 (95% CI 0.88-0.98)

¹² Among the poorest households, 6% (500/9064) had a member ill who did not use any health service, compared with 5% (785/17026) among other households. Odds Ratio 1.21 (95% CI 1.07-1.36)

illiteracy of the household head and use of government health services is because more households in metropolitan sites have literate household heads.

Households with literate heads are more likely to have visited private health service providers in the last month¹³, and less likely to have had an ill member and not sought any care¹⁴. These relationships are not changed when the site (rural or metropolitan) is taken into account, or when the economic status of the household is taken into account. The use of services in relation to literacy of the household head is shown in Figure 15.

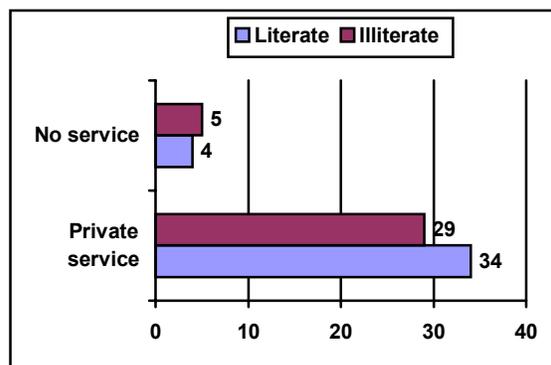


Figure 15. % of households using health services by literacy of head

Rural and metropolitan locations

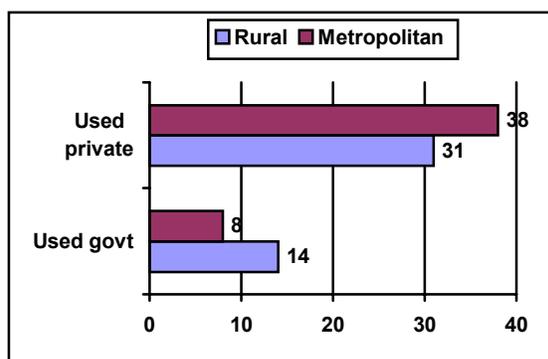


Figure 16. % of households using health services in rural and metropolitan sites

The pattern of use of health services is different between rural and metropolitan sites. Households in rural sites are nearly twice as likely as households in metropolitan sites to use government health services for illness of a family member¹⁵. They are one and a half times less likely to use private health services¹⁶. There is no difference between rural and metropolitan sites in the non-use of services for an ill family member. The use of health

services in rural and metropolitan sites is shown in Figure 16.

The association between location and type of service used is unchanged when literacy of the household head and economic status (house construction) are taken into account. The probable explanation for the difference between rural and metropolitan sites is the greater availability of private services in metropolitan areas. Also, government facilities such as UHFWCs and THCs are a rural provision only.

Distance from government health facilities

For rural sites only, it is possible to examine the use of government and private health services in relation to the distance from the government health facilities (UHFWC and THC).

¹³ 34% (4227/12298) of households with a literate head used private health services in the last month, compared with 29% (4021/13801) of households with an illiterate head. Odds Ratio 1.27 (95% CI 1.21-1.34)

¹⁴ Among households with a literate head, 4% (523/12285) had an ill member who did not use any health service in the last month, compared with 5% (761/13805) among households with an illiterate head. Odds Ratio 0.76 (95% CI 0.68-0.86)

¹⁵ 14% (3171/23167) of households in rural sites used government health services in the last month, compared with 8% (227/3033) of households in metropolitan sites. Odds Ratio 1.96 (95% CI 1.70-2.26)

¹⁶ 31% (7107/23124) of households in rural sites used private health services in the last month, compared with 38% (1155/3034) of households in metropolitan sites. Odds Ratio 0.72 (95% CI 0.67-0.78)

In some communities, the informant was unable to give information about the distance to the UHFWC, sometimes because the ‘local’ one was non-functional. In the following analysis, those without information are counted as ‘missing data’ although they might in some cases represent communities without access to facilities.

Households in communities that are 3km or less from the UHFWC are rather more likely to have used government health services in the last month¹⁷. The distance from the UHFWC is not related to the use of private health service providers, nor to non-use of services for ill household members.

Households in communities that are 5km or less from the THC (about 25% of households in the survey) are more likely to have made use of government health services for illness in the last month¹⁸. The distance from the THC is not related to the use of private health service providers, nor to non-use of services for ill household members.

Thus access to facilities does make some difference to the rate of using government health facilities. The measure of access used here (distance) does not take into account the difficulty of the journey to the facility. The relationship between use of government health services and distance from facilities is shown in Figure 17.

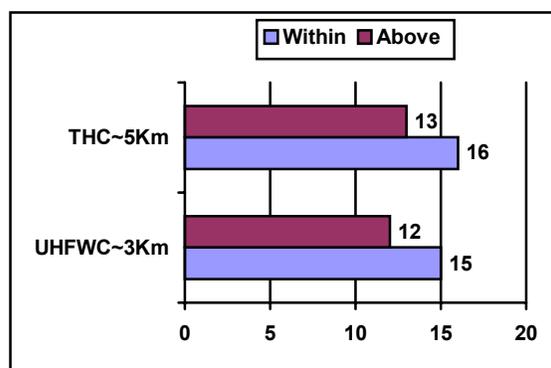


Figure 17. % of households using government health services by distance from facilities

Conditions for which treatment was sought from health services

Details about the most recent visit to government health services for illness in the last month were sought (in some houses there was more than one use of the service in the last month). Those who used other (private) services in the last month were asked the reason they went to the service. The pattern of conditions for which treatment was sought in government and private services is similar, as shown in Table 14.

¹⁷ 15% (1816/12411) of households in communities within 3Km of the UHFWC used government health services in the last month, compared with 12% (885/7235) in communities 4Km or more from the UHFWC. Odds Ratio 1.23 (95% CI 1.13-1.34)

¹⁸ 16% (876/5570) of households in communities within 5Km of the THC used government health services in the last month, compared with 13% (2188/17068) in communities 6Km or more from the THC. Odds Ratio 1.27 (95% CI 1.16-1.38)

Table 14. Conditions for which treatment was sought in government and private health services

Condition	No. (%) of visits	
	Government services	Private services
Fever, malaria, EPI diseases	532 (20)	2236 (24)
ARI	442 (17)	1803 (19)
Diarrhoea	442 (17)	1498 (16)
Eye, ENT, musculo-skeletal problem	389 (15)	1416 (15)
Other GIT problem	245 (9)	1039 (11)
Injury	202 (8)	176 (2)
Cardiovascular, cancer, diabetes	121 (5)	478 (5)
Illness not specified	65 (3)	165 (2)
STD/GU problem	57 (2)	113 (1)
Nutrition/vitamin A deficiency	44 (2)	158 (2)
TB/leprosy	40 (2)	35 (0.5)
ANC, delivery	37 (1)	180 (2)
Parasites	29 (1)	46 (0.5)
CNS/mental problems	7 (0.3)	21 (0.2)

*Note that for government health services, only the *last* use in the last month is included. For the private services, all visits in the last month are included.

Perhaps a higher proportion of those using private services went to the service provider because of fever or childhood specific fevers (24% v 20%). And a higher proportion of those using government services went because of injury (8% v 2%). But in general the pattern of problems is remarkably similar between users of government and private services. Thus, for treatment of illness, the type of illness does not seem to be an important factor in the choice between government and private health services.

Reasons for not using government health services

The reasons for not using any health service when a household member was ill in the last month were not explored in the household interviews. However, the community focus groups discussed how often women in the community use government health facilities and explored why they do not use these services more often. The amount of use of services and the reasons for non-use of services suggested by the focus groups of men and women separately are shown fully in Annex 9. The main themes raised by the groups on the issue of how much women use government health services are shown in Table 15.

Table 15. Themes about use of government health services by women, from men's and women's focus groups

Use of services	No. (%) of groups	
	Men	Women
Very few use	74 (35)	80 (38)
Most of them use	38 (18)	46 (22)
Use for children only	38 (18)	12 (6)
Use for FP/EPI only	50 (24)	58 (27)
Some use, some not	26 (12)	39 (18)
No service available	23 (11)	3 (1)
None use	11 (5)	23 (11)

The reasons commonly cited by focus groups for women not using government health services are shown in Table 16. Further detail is shown in Annex 9. Most of the reasons are concerned with problems encountered with use of the service, such as lack of medicines, poor treatment, bad behaviour of staff and staff demanding payments. Some are concerned with access: the service is said to be too far away or transport costs are too high. Women themselves are sometimes blamed for not using the service due to ignorance, lack of education. And sometimes religious reasons are cited as a reason for women not using services.



Figure 18. A focus group of men

Table 16. Common reasons for women not using government health services, cited by men's and women's focus groups

Reason for not using services	No. (%) of groups	
	Men	Women
Too far/transport costs	70 (33)	62 (30)
Ignorance/uneducated	66 (31)	38 (18)
Bad medicines/treatment	56 (27)	46 (22)
No medicines available	51 (24)	71 (34)
Can't afford costs	30 (14)	25 (12)
Staff not available	27 (13)	28 (13)
Religious reasons	25 (12)	12 (6)
Staff behave badly	21 (10)	36 (17)
No service there to use	19 (9)	21 (10)
Have to pay doctors/HWs	19 (9)	36 (17)
Side effects of treatment	18 (9)	25 (12)

“The distance is too far. The behaviour is bad, medicine is not available.”

Focus group of women, Saghatta

Indicator

Reasons for not using government health services: too far, poor medicines & treatment, lack of medicines & staff

Bad experiences of government health services are an important reason for women and men not using them, as well as issues such as access and religious taboos. Many participants of the focus groups related bad experiences they had with government health services. Their reports of experiences are reproduced in Annex 9.

“Those who went for service in the past did not receive good services from the government health centres. So we all go to private providers for getting health services.”

Focus group of women, Nangalkot

In order to encourage more people to use government health services, it is not only necessary to educate people and urge them to use the services. Their experience of the services also has to improve, as personal bad experiences and bad experiences heard about from others clearly have an important negative effect on the use of services.

5. Experience of government health services

Type of government service visited

The type of government service used in the most recent health service visit during the last month is shown in Figure 19.

Just over half of the 2455 reported visits are to the THC and a quarter are to the UHFWC. Since the THCs and UHFWCs serving the sites were visited and reviewed, this allows information from the health facility to be linked to information from the household service users in over three quarters of the reported visits (77%).

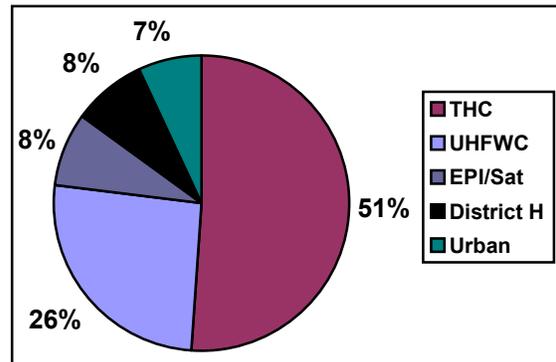


Figure 19. Type of government health facilities visited

Availability of health workers

For most (87%) reported visits to government health services for illness in the last month, the person using the service reported in the household interview that there was a health worker there to attend to them.

Indicator

In 87% of visits to government health services there is a trained worker available to attend the patient.

There is no difference in reported availability of a health worker by gender of the service user. There is some variation by type of facility visited (Figure 20).

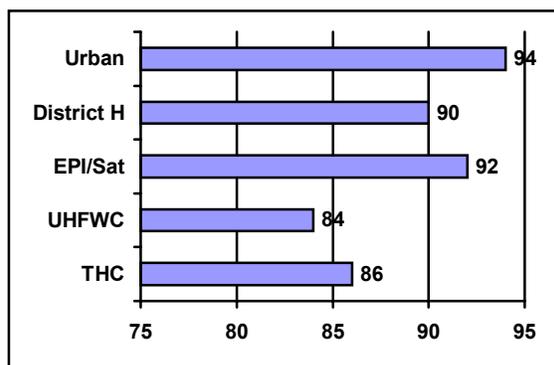


Figure 20. % of visits with health worker available, by type of facility

Reported availability of a health worker is quite high for all facilities, but rather lower in the THCs and UHFWCs than in the other facilities.

However, this high reported availability is not the whole picture. In rural communities, people come to learn about when health workers are likely to be available, even if this is not throughout the full intended opening hours of facilities. They tend to try to make their visits when they expect a health worker to be available. Focus groups noted

unavailability of health workers (especially doctors) as one reason for women not making use of government health facilities (see Table 16).

When reporting their experiences of government health services, both men and women mentioned problems with availability of doctors and other health workers (see Annex 9).

“I took my child to the hospital for treatment. After a long wait I did not get any doctor and returned. I went three consecutive days but did not get treatment”

Focus group of men, Bishwanath

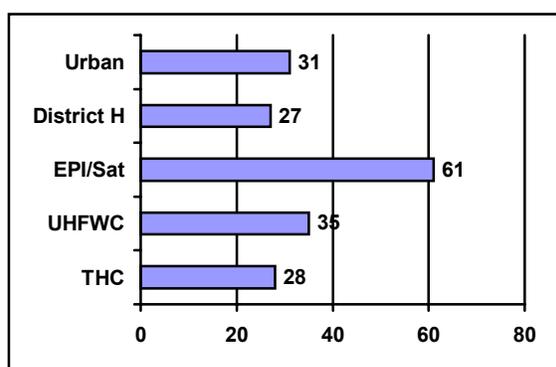
Availability of required medicines

According to the experience reported in household interviews, medicines needed for treatment are often lacking in government health facilities. For all reported visits for illness in the last month, all medicines needed to treat the case are available in only a third (33%) of visits. There is no difference in reported availability of medicines between male and female service users.

Indicator

All required medicines are reported to be available in 33% of visits to government health services.

The availability of medicines by type of facility is shown in Figure 21.



As shown in Figure 21, the availability of all the medicines required for treatment is lowest for visits to the THC and District Hospital and highest for visits to satellite clinics/EPI centres. This is probably because many of the cases seen for illness in satellite clinics/EPI centres need little or no medication, whereas those visiting the THC or District Hospital need more medication.

Figure 21. % of visits with all required medicines available, by type of facility

Lack of medicines is a major concern about government health services voiced by service users and households. It is one of the commonest reasons cited in focus groups for women not making more use of government health services (see Table 16). It is also the commonest problem with government health services cited by households (see below).

Lack of medicines in health facilities is very often part of the experiences of government health services related in focus groups (see Annex 9b). Many people are unhappy because they are not given medicines in the facility but have to buy them from outside.

“I went to the UHFWC for treatment of jaundice. There I was advised to go to the THC doctor. But the doctor only gave a prescription but no medicine. I had to buy all the necessary medicines from outside.”

Focus group of women, Bhyaya

Alternative sources of medicines

When it was reported that not all the medicines were available in the government health facility, the person was asked where they got the medicines. Their responses are shown in Table 17.

Table 17. Source of medicines not available in government health facilities

Source of medicines	No. (%) of cases
Private pharmacy	1628 (96)
Government pharmacy	34 (2)
Private clinic	11 (0.6)
Private doctor	8 (0.5)
Traditional healer	6 (0.4)
NGO clinic	2 (0.1)
Nowhere	12 (0.7)

The few people who mentioned getting the medicines from a government pharmacy (2%) presumably mean that they were unable to get the medicines needed in one government facility but could get them in another. For example, perhaps they had to travel to the THC from the UHFWC.

Why are medicines not available?

The presence of a stock of ampicillin can be used as an indicator of how well stocked a facility is. This might be expected to be associated with the reported availability of medicines by service users. In fact, for reported visits to the THC or UHFWC in the last month, there is no relationship between the presence of a stock of ampicillin syrup in the facility (on review) and the reported availability of medicines needed on the visit for treatment. This may be because the use of ampicillin syrup stocks as an indicator of stocking levels generally is too crude. It may also be that the availability of medicine to the patient is not directly related to whether or not a stock is present in the facility.

“A patient went to the government centre and was prescribed medicine. He was told to buy the medicine from the shop even though there was enough medicine at the centre.”

Focus group of men, Chhatak

It may be that some of the perceived lack of medicines is because patients expect medicines that are not actually necessary for their condition.

“I took my child for diarrhoea treatment. I was given a packet of saline, nothing else. I had to buy the rest of medicines from outside”

Focus group of women, Domar

For diarrhoea, as in the above experience, it may be that rehydration was all that was necessary. Indeed, adding other treatments can even be harmful in cases of simple diarrhoea.

However, in most of the experiences of unavailable medicines related in focus groups, the participants mention being given a prescription but having to buy the medicine to fill it from

outside, because the medicine needed was not available in the health facility. So most of the reported unavailable medicines are ones that a health worker considers necessary for the case.

There is a belief in communities that one reason for medicines being unavailable in health facilities is ‘system leakage’. They believe that health workers divert the medicines supplied to the government facilities and sell them privately, either actually in the facility or in private shops outside the facility.

“The THC has a medicine shop in front of it. All the free government medicines are sold here stealthily. The patients are advised at the hospital to buy medicine from this shop. Once there was fighting with the public.”

Focus group of men, Bhyaya

“I went to the UHFWC during official time. The doctor refused to see me. When I objected about the centre being closed today, the doctor shouted at me and drove me out of the room. That doctor was selling the hospital’s medicine in front of the patients’ eyes.”

Focus group of women, Hakimpur Alihat

Further examination of the reasons for the widespread perceived lack of medicines will require detailed enquiry about which medicines are needed for different conditions, which of them are supplied to the health facilities, and why it is proving necessary to prescribe rather than provide medicines to service users (see section 2, the review of health facilities, above). From this survey, it is possible to examine the reported availability of required medicines in relation to the condition for which treatment is being sought. This is shown in Table 18.

Table 18. Conditions for which treatment was sought and availability of required medicines in visits to government health services

Condition	No. (%) with all medicines available
Fever, malaria, EPI diseases	233 (44)
ARI	139 (32)
Diarrhoea	149 (34)
Eye, ENT, musculo-skeletal problem	113 (29)
Other GIT problem	60 (25)
Injury	75 (37)
Cardiovascular, cancer, diabetes	19 (16)
Illness not specified	11 (17)
STD/GU problem	12 (21)
Nutrition/vitamin A deficiency	10 (23)
TB/leprosy	16 (40)
ANC, delivery	11 (30)
Parasites	18 (62)
CNS/mental problems	0 (0)

The availability of required medicines is rather higher (44%) for the common conditions of fever, EPI diseases and malaria. In many cases these will only require an anti-pyretic and sometimes an antibiotic. Nevertheless, these simple medicines are reported to be available in less than half of visits. It is understandable that all required medicines are rarely available (16%) for less common and more complicated conditions like cardiovascular problems, cancer and diabetes. But they should be available for acute respiratory infections (ARI) and are only reported to be available in a third of visits (32%).

Costs of visiting government health services

Service users were asked about how much they paid for transport, for registration (ticket), for x-rays and for extra (unofficial) payments to service workers. They were not asked about payments for medicines, either those they received from government health facilities (which are supposed to be free of charge) or those they had to buy from outside the facility.

Transport costs

Over half (60%) of services users report paying for transport to reach government health facilities. The proportion paying for transport varies between the types of facility visited (Figure 22).

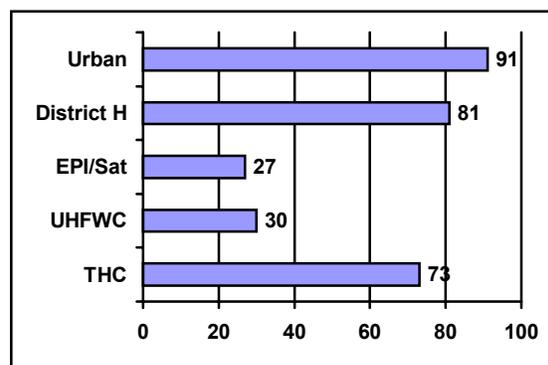


Figure 22. % of service users paying for transport to facilities

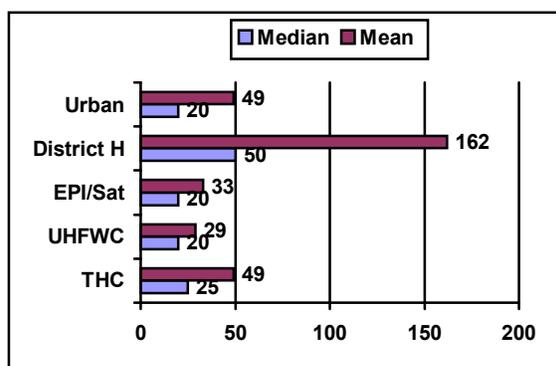


Figure 23. Mean and median payments (Tk) for transport to government health facilities

The median and mean amounts paid for transport to government health facilities, amongst users who paid anything, are 60 Tk and 24 Tk. Mean and median transport payments to the different types of government health facilities visited are shown in Figure 23.

As expected, transport costs are more likely to be incurred when visiting facilities more distant from the community. The highest costs are incurred for visits to the District Hospital, which may often be quite distant from the community.

For visits to the THC and UHFWC it is possible to examine the effect of the distance of the facility from the community (linking information from the community key informant with information from the household interviews). This is shown in Table 19.

Table 19a. Costs of transport for visits to THC and distance of THC from community

Distance of THC	No. (%) who paid	Amount paid (Tk)	
		Mean	Median
Up to 5km	364 (74)	35	20
6km plus	525 (76)	58	30

Table 19b. Costs of transport for visits to UHFWC and distance of UHFWC from community

Distance of UHFWC	No. (%) who paid	Amount paid (Tk)	
		Mean	Median
Up to 3km	127 (25)	31	20
4km plus	525 (76)	25	12

For visits to the THC, the proportion of patients who pay for transport is not related to the distance of the community from the THC but the amounts paid (among those who pay) are higher when the distance is 6km or more. For visits to the UHFWC, more people pay for transport when the UHFWC is more than 3km from the community. But, if anything, the amount paid is higher when the community is nearer to the UHFWC (the difference is not statistically significant).

Transport costs and long distances are one of the most common reasons given by focus groups for people not making more use of government health facilities (see Table 16).

“The hospital is too far. So the patient dies before he can be taken there”
Focus group of men, Ajmiriganj

Costs of x-rays

Facilities equipped to take x-rays make a charge for this. No x-rays are undertaken in UHFWCs or in EPI/satellite clinics. The proportion of patients paying for x-rays and the amounts they paid are shown in Table 20. Note that the UHFWC and satellite clinics/EPI sites are not included in Table 20.

Table 20. Costs of x-rays in visits to government health facilities

Facility visited	No. (%) who paid	Amount paid (Tk)	
		Mean	Median
THC	98 (8)	202	115
Dist hosp	51 (26)	296	200
Urban facility	33 (19)	197	150
All facilities	182 (12)	216	135

The highest proportion of patients paying for x-rays is among those visiting a District Hospital and the amount paid for x-rays is also highest in District Hospitals. This is not surprising, since the more complex cases are seen in the District Hospital.

Registration fees and extra payments

Registration fees

Nearly half of service users (40%) report paying a registration fee (ticket) on their last visit to a government health facility (Figure 24).

Among service users who paid a registration fee, the mean amount was 20 Tk (median 5 Tk). The amounts paid for registration fee vary by the facility visited (Figure 25).

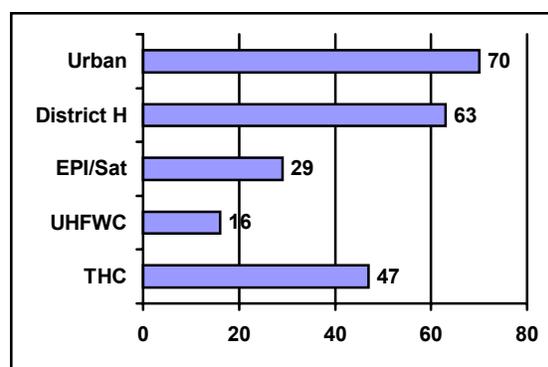


Figure 24. % of service users who paid a registration fee to different facilities

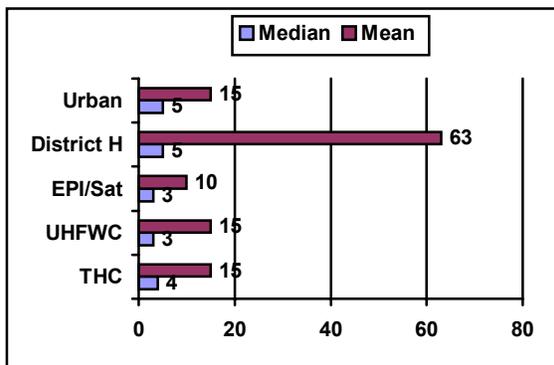


Figure 25. Mean and median payments (Tk) for registration fee in different facilities

Not all of these registration fees are official charges. Satellite clinics/EPI sites do not officially charge a registration fee. Generally UHFWCs do not charge an official registration fee. Those serving the survey sites were visited and reviewed as part of the survey (see Annex 8). Nearly all of them (96%) said they did not charge a registration fee. Among those visited by households in the survey, none of them reported charging a registration fee. The THC in the sample thana were also reviewed (see Annex 8). Most (81%) said they did not charge a registration fee; those that did

charged 2 or 3 Tk. Some urban facilities may make registration charges. Since urban these facilities were not visited in the survey, it is not possible to estimate what proportion of the 70% of users who paid a registration fee were paying an official fee to these urban facilities.

The big difference between mean and median payments for registration fees suggests that a few people pay much more than others, again indicating that these are not all official fees.

Unofficial registration fees

Excluding urban facilities, and linking household data with data from the institutional reviews of the THCs and UHFWCs, it is possible to calculate what proportion of service users visiting different facilities paid an *unofficial* registration fee. Excluding visits to urban facilities, 27% of service users paid an unofficial registration fee. The proportion paying an unofficial registration fee to different facilities is shown in Figure 26. It is assumed that all registration fees paid in District Hospitals are official, although the amount paid may be higher than the official charge.

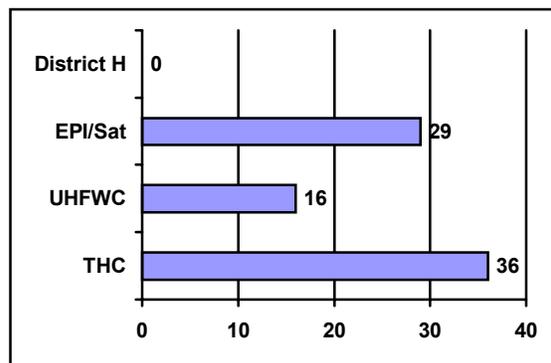


Figure 26. % of service users paying an unofficial registration fee, by type of facility

Indicator

27% of service users pay an unofficial registration fee to government health facilities (excluding urban facilities)

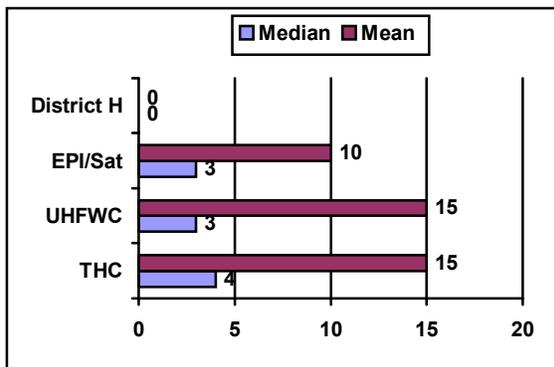


Figure 27. Mean and median (Tk) unofficial registration fees to different facilities

The mean and median amounts paid for unofficial registration fees are shown in Figure 27. This only includes amounts paid when *no* official fee should have been charged at all. Other service users will have paid (unofficially) amounts higher than the official fee.

More than a quarter of people visiting rural government health facilities paid a registration fee where no official fee is charged. This does not seem to be a case of the facilities making a charge that is not ‘official’ but nevertheless goes towards running the facility. Certainly in

the case of the THCs and UHFWCs, the actual facilities visited themselves confirmed that they make no registration charge. This seems more likely to be a charge levied by individual doctors and health workers. It is akin to the ‘extra’ payments described below, but without the patient necessarily being aware of the unofficial nature of the payment.

Extra (unofficial) payments to health workers

For all facilities visited (including urban facilities), over a fifth of patients report making an extra (unofficial) payment to the health worker(s).

Indicator

22% of service users report making an extra payment to the worker(s) in government health facilities

The proportion of service users making an extra payment to the service worker(s) is shown by type of facility visited in Figure 28.

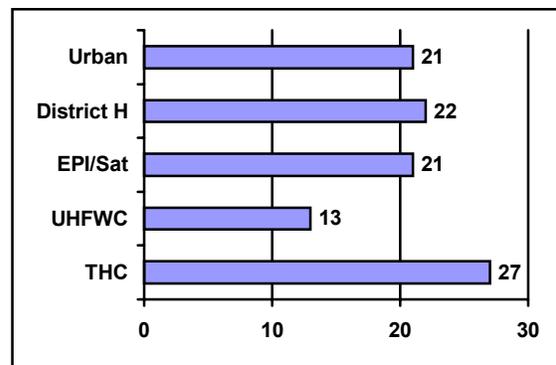


Figure 28. % of service users who make an extra payment to workers, by type of facility

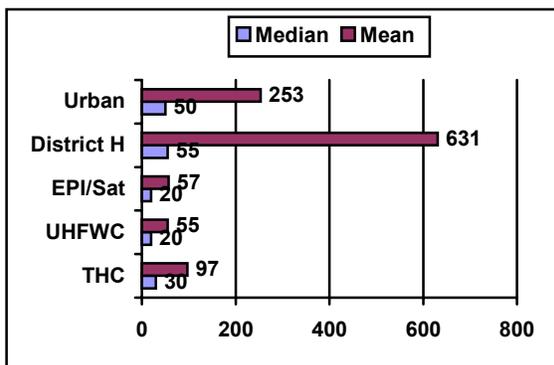


Figure 29. Mean and median (Tk) extra payments to workers in government health facilities

The mean extra payment to the service worker(s) is 139 Tk (median 30 Tk). Again, the difference between the mean and median suggests that a few people are making much higher payments than the majority. The mean and median extra payments to the service worker(s) reported by service users are shown for the different government health facilities in Figure 29.

Factors related to making extra and unofficial payments

There is not much variation in the proportion of service users making extra payments and paying unofficial registration fees between different conditions for which they seek treatment Table 21.

Table 21. Extra payments, unofficial registration fees and condition of service users

Condition	No. (%) made extra payment	No. (%) paid unofficial registration
Fever, malaria, EPI diseases	83 (16)	127 (26)
ARI	84 (19)	92 (24)
Diarrhoea	82 (19)	97 (24)
Eye, ENT, musculo-skeletal problem	81 (21)	75 (23)
Other GIT problem	44 (19)	47 (22)
Injury	64 (33)	55 (33)
Cardiovascular, cancer, diabetes	2 (29)	34 (33)
Illness not specified	22 (34)	12 (22)
STD/GU problem	17 (30)	16 (30)
Nutrition/vitamin A deficiency	15 (34)	11 (28)
TB/leprosy	9 (23)	9 (26)
Delivery	12 (34)	9 (38)
Parasites	3 (10)	8 (28)
CNS/mental problems	2 (29)	0 (0)

As shown in Table 21, there is perhaps less likelihood of making an extra payment for the common conditions such as fevers and ARI. For these conditions there also seems to be less chance of paying an unofficial registration fee.

There is no difference between male and female service users in their likelihood of paying extra to the health worker(s), paying an unofficial registration fee or both.

People from poorer households (kutchha-2 construction) have the same risk of making extra and unofficial payments as those from richer households. Nor is there any significant difference in the risk of making such payments between houses where the head is literate and those where the head is not literate.

Public concerns about payments to government health facilities

The problem of making extra payments to health workers was not often directly cited in the household interviews as a major problem with government health services (see below). However, it featured often in the focus group discussions.

“My son was taken to the THC for his head injury. There the child was not attended by the doctor at first. The doctor first took 300 Tk and then treated the child.

Focus group of women, Domar

The costs associated with government health services and the need to pay extra to doctors and other health workers were given as reasons for not using the services (see Table 16). Participants described doctors and others refusing to see and treat patients without first demanding payments from them.

“Without payment no services are rendered. Even if the patient is critically ill, without money she cannot get any service or be admitted”.

Focus group of men, Mirpur

As a related issue, some focus group participants described experiences of favouritism and discrimination in favour of well-off and well-connected patients.

“The staff treat poor people inhumanely. Only the rich people get service”

Focus group of women, Char Badrasan

“Those who are related or know the health officer well receive health care services and others do not”.

Focus group of women, Kurigram Sadar

6. Opinions of the public about government health services

Service users' ratings of visits to service

Those who had used government health services in the last month were asked their opinion of the service they received on that visit. Their responses are shown in Figure 30. About half of services users (53%; 1330/2565) rated the service they received as 'good'.

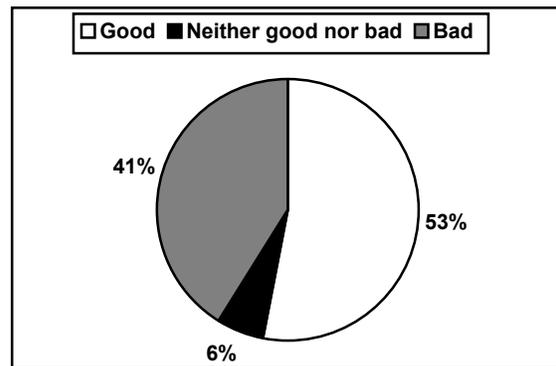


Figure 30. Service users' ratings of last visit to government health services

Indicator

53% of service users rate the service on their last visit to a government health facility as 'good'.

The rating of the service received varies between different types of government health facility visited (Table 22).

Table 22. Rating of service on last visit for different types of government health facility

Facility visited	No. (%) rating service as:		
	Good	Neutral*	Bad
THC	614 (51)	71 (6)	529 (44)
UHFWC	274 (45)	26 (4)	310 (51)
Sat/EPI	129 (68)	11 (6)	49 (26)
District hospital	118 (61)	13 (7)	63 (33)
Urban facility	96 (57)	7 (4)	66 (39)

*Neutral=neither good nor bad

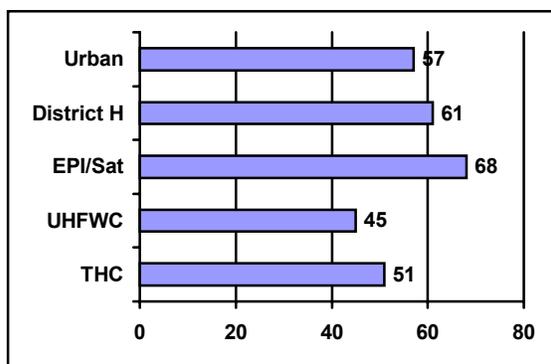


Figure 31. % service users rating service as 'good' for different government facilities

The service is least positively rated for visits to UHFWCs, and most positively rated for visits to satellite clinics/EPI sites. The proportion of users rating the service as 'good' for different types of government facilities is shown in Figure 31.

A number of positive experiences of government health services were related by both men and women in focus groups (see Annex 9b).

“I was admitted into the hospital. I was very pleased at the behaviour of the attending physicians. After recovery I left the hospital and afterwards my overall impression/attitude about the government hospital is very good”.

Focus group of men, Assasuni

“I went to the hospital and received good service”.

Focus group of women, Paikgachha

Factors related to rating of service received

A number of factors may potentially change the rating of the service given by service users and the relationships between these factors and the rating of the service received have been examined.

Gender of service user

Male service users are slightly more likely than female users to rate the service received as ‘good’, although the difference could be due to chance¹⁹. Any gender effect might be distorted because, for children service users, the adult who took the child gave the rating of the service. Often this adult will be female, even though the service user (the child) is male. In fact, an examination of the gender effect including only service users 15 years old and above gives much the same pattern as when all ages are included.

Age of service user

The service is rated slightly more favourably when the service user is under 5 years old, although the difference could be due to chance²⁰. The service rating for children service users is made by the adult who took them to the facility, so is not a direct rating as for adult service users.

Literacy of household head

Services users from households with a literate head are slightly more likely to rate the service they received as ‘good’²¹. It could be that more literate people actually receive a better service. However, there is not much evidence for that in this survey. For example, they are not more likely than people from households where the head is illiterate to report that all medicines needed were available, nor less likely to have made an extra (unofficial) payment to the health worker(s) (see section 5 on experience of government health services).

¹⁹ 54% (598/1111) of male service users rated the service as ‘good’, compared with 50% (729/1449) of female service users. Odds Ratio 1.15 (95% CI 0.98-1.35)

²⁰ For service users less than 5 years old, the service was rated as ‘good’ in 54% (366/679) of visits, compared with 51% (964/1886) of visits for service users 5 years old and above. Odds Ratio 1.12 (95% CI 0.93-1.34)

²¹ 54% (612/1134) of service users from households with a literate head rated the service as ‘good’, compared with 50% (715/1422) of services users from households with an illiterate head. Odds Ratio 1.16 (95% CI 0.99-1.36)

Economic status of household

People from the poorest houses (kutcha-2 construction) are slightly less likely to rate the service they received as ‘good’, although the difference could be due to chance²².

Location of site

The variation in proportion of service users rating the service they received as ‘good’ across different thana and divisions is shown in Annex 7. Service users from rural sites are less likely to rate the service they received as ‘good’, compared with those from metropolitan areas, although the difference could be due to chance²³. People in urban sites have generally used government urban health facilities or occasionally the district hospital, so their higher ratings reflect the higher rating for these facilities

The ratings of the service on the most recent visit in relation to the personal characteristics of service users examined above are shown in Figure 32.

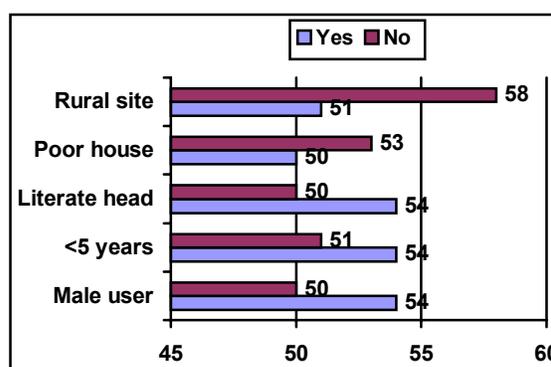


Figure 32. % users rating service as ‘good’ in relation to personal characteristics

Condition for which treatment sought

There is some variation in the proportion of service users who rate the service as ‘good’ depending on the condition for which they sought treatment (Table 23).

Table 23. Condition for which treatment sought and satisfaction with service

Condition	No. (%) users rating service ‘good’
Fever, malaria, EPI diseases	297 (58)
ARI	212 (50)
Diarrhoea	216 (51)
Eye, ENT, musculo-skeletal problem	169 (45)
Other GIT problem	119 (51)
Injury	98 (50)
Cardiovascular, cancer, diabetes	67 (58)
Illness not specified	30 (48)
STD/GU problem	33 (59)
Nutrition/vitamin A deficiency	25 (57)
TB/leprosy	25 (64)
Delivery	16 (44)
Parasites	20 (69)
CNS/mental problems	3 (43)

²² 50% (485/966) of service users from the poorest households rate the service as ‘good’, compared with 53% (840/1591) of service users from other households. Odds Ratio 0.90 (95% CI 0.76-1.06)

²³ 51% (1218/2371) of service users from rural sites rate the service as ‘good’, compared with 58% (112/194) of service users from metropolitan sites. Odds Ratio 0.77 (95% CI 0.57-1.05)

Satisfaction seems to be relatively high for simple common conditions such as fever, perhaps related to the higher availability of medicines in these cases.

Availability of health worker

Service users who report availability of a health worker are twice as likely to rate the service as ‘good’, compared with those who report the health worker not available²⁴. Clearly, non-availability of the doctor or other health worker gives users a negative impression of the service from a facility.

Availability of medicines required

When the medicines needed for treatment of the condition are available and supplied in the health facility, service users are seven times more likely to rate the service as good, compared to visits when the medicines needed are not available²⁵. This strong association between availability of medicines and positive rating of the service by users reflects the high priority given to medicines by households (see below) and their major concern about lack of medicines in government health facilities.

Payments to the service

There is no difference in rating of the visit to the service between service users who paid a registration fee and those who did not pay. There is also no difference in ratings of the service between users who paid and unofficial registration fee and those who either did not pay or who paid an official fee. Probably many people are not aware whether a registration fee is unofficial or not.

Service users who report making an extra payment to the service worker(s) are three times less likely to rate the service on the visit as ‘good’, compared with those who did not pay extra²⁶.

This relationship between extra payments to the health worker and satisfaction with the service received reflects the anger about these extra payments expressed in focus groups.

The proportions of service users rating the service as ‘good’ in relation to the service factors examined above are shown in Figure 33.

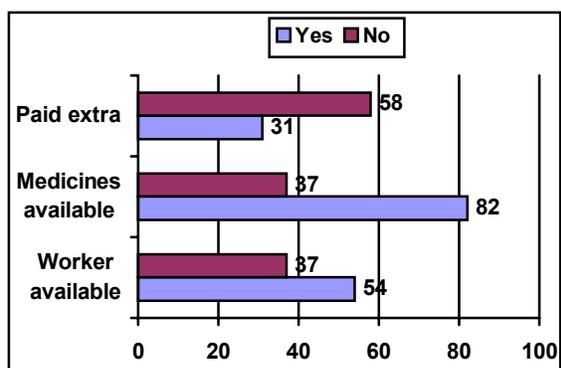


Figure 33. % users rating service as 'good' in relation to service factors

²⁴ 54% (1197/2204) of service users who report a health worker available rate the service as ‘good’, compared with 37% (131/356) of service users who report a health worker not available. Odds Ratio 2.04 (95% CI 1.61-2.60)

²⁵ 82% (687/840) of service users who report all required medicines available rate the service as ‘good’, compared with 37% (641/1720) of service workers who report all medicines not available. Odds Ratio 7.56 (95% CI 6.14-9.31)

²⁶ 31% (171/550) of service workers who make an extra payment rate the service as ‘good’, compared with 58% (1137/1977) of service workers who do not make an extra payment. Odds Ratio 0.33 (95% CI 0.27-0.41)

Combination of factors and rating of service on last visit

Service factors (availability of staff, medicines, extra payments) seem to be more strongly related to the rating of the service by users than personal characteristics of the service users (gender, literacy, economic status). The strong associations between each of these service factors and ratings by service users remain unchanged when the effects of the personal characteristics and the other service factors are taken into account separately by stratification. The effect of all the variables in combination was calculated by means of logistic regression analysis (using SPSS). A step-down method from a saturated model was used .

Table 24 is taken from the final model of the logistic regression analysis. The association between location of residence (rural or metropolitan) and rating of the service is no longer significant when the effects of the other variables in combination are taken into account.

Table 24. Adjusted effects of variables on the likelihood of service users rating the service on last visit as 'good'

Variable and level	Adjusted Odds Ratio*
Medicines available	2.58
Did not pay extra to health worker(s)	1.50
Health worker available	1.25
Not poorest type of house	1.13
Male service user	1.11
Head of household literate	1.08

*See section on epidemiological and statistical terms at the beginning of the report.

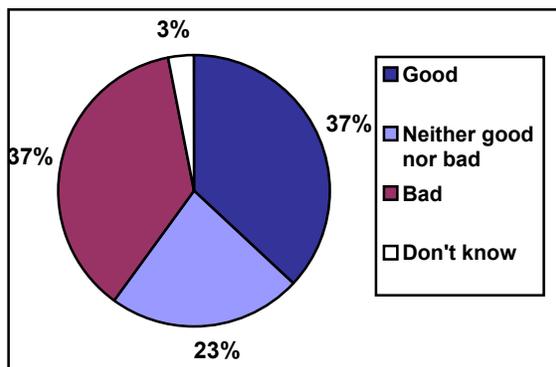
It is clear from Table 24 that it is issues about the service received, rather than personal characteristics, which have the strongest influence on the ratings of the service by users. The strongest influence is availability of medicines. Taking the effects of other relevant variables into account, service users are two and a half times more likely to rate the service as good if all the required medicines are available and provided. And they are one and a half times more likely to rate the service as good if they do not have to make an extra payment to the health worker(s). They are 25% more likely to rate the service favourably if a health worker is available.

Tackling the issues of availability of medicines, availability of health workers, and extra payments to service worker(s) could make an important improvement in the rating of government health services by users.

Household ratings of government health services

Rating of the available services

All the households interviewed were asked their opinion of the government health services, *whether or not someone in the household had used the services recently*. These general ratings therefore include non-users of government health services. This is in contrast to the ratings of the last visit to a government health facility, which only includes service users. It may be that non-users do not use the services because they think they are bad services. The ratings by households are shown in Figure 34.



The proportion of households rating government health services as ‘good’ (37%) is clearly less than the proportion of service users who rated the service they received on the last visit as ‘good’ (53%; see Figure 30). This supports the idea that some non-service-users are not using the government health services because they think they are bad services.

Figure 34. Household ratings of government health services

Indicator

37% of households rate government health services as ‘good’.

Factors associated with household ratings of government health services

A number of factors might be expected to affect the rating of government health services by households. The relationships between these factors and the rating of services have been examined separately and in combination.

Economic status of household

People living in the poorest houses (kutchra-2 construction) are somewhat more likely to rate government health services as ‘good’, compared with people in other types of houses²⁷. The difference, although statistically significant, is not very great.

Gender of household respondent

Nearly all household respondents are female (see section 1 above). The few male respondents tend to rate government health services more positively than the female respondents, although the difference could be due to chance²⁸.

Literacy of household head

Households with a literate household head have a slightly more positive view of government health services than those where the head is illiterate²⁹. The difference in rating between households with literate and illiterate heads, although statistically significant, is small.

Location of residence

People living in rural communities are more likely to give a positive rating of government health services than those living in metropolitan sites³⁰. This is in contrast to the more

²⁷ 41% (3582/8822) of the poorest households rate government health services as ‘good’, compared with 38% (6234/16637) of other households. Odds Ratio 1.14 (95% CI 1.08-1.20)

²⁸ 42% (210/500) male household respondents rate government health services as ‘good’, compared with 39% (9623/25009) of female household respondents. Odds Ratio 1.16 (95% CI 0.96-1.39)

²⁹ 40% (4765/12054) households with a literate head rate government health services as ‘good’, compared with 38% (5050/13408) households with an illiterate head. Odds Ratio 1.08 (1.03-1.14)

³⁰ 39% (8864/22516) of households in rural sites rate government health services as ‘good’, compared with 32% (972/3002) of households in metropolitan sites. Odds Ratio 1.36 (95% CI 1.25-1.47)

positive rating of an individual visit to a government health service in metropolitan sites (see above). The less positive rating in metropolitan sites may reflect higher expectations in metropolitan than in rural areas.

Remoteness of thana

Some of the *thana* in the rural sample are classed as remote, defined as being more than one hour's journey from the district town. People living in remote *thana* are slightly less likely to rate government health services as good³¹, suggesting that ease of access to higher level services may play a part in this judgement in rural sites.

Distance from government health facilities

People living in rural communities within 5km of the THC rate government health services more positively than those living in rural communities further from the THC³².

On the other hand, people living in rural communities closer to the UFWC tend to rate government health services less favourably than those living further away³³. This suggests that in rural communities better access to the THC improves the impression of government health services but better access to the UFWC does not.

Use of government health services

Those households with at least one member who used government health services for illness in the last month can be compared with households who did not use government health services for treatment in the last month. Households who have recently used government health services are more positive about their rating of these services than households who have not used the services recently³⁴.

It may be that those households who think the government health service is bad are avoiding using it. Or people who are unable to use the service for one reason or another (such as distance or costs) feel that they are poorly served.

³¹ 37% (2937/7844) of households in remote thana rate government health services as 'good', compared with 40% (5927/14672) of households in non-remote thana. Odds Ratio 0.88 (95% CI 0.83-0.94)

³² 44% (2405/5508) of households within 5Km of the THC rate government health services as 'good', compared with 38% (6272/16488) of households further from the THC. Odds Ratio 1.26 (95% CI 1.19-1.34)

³³ 39% (4677/12087) of households within 3KM of the UFWC rate government health services as 'good', compared with 42% (2985/7041) of households further from the UFWC. Odds Ratio 0.86 (95% CI 0.81-0.91)

³⁴ 42% (1416/3370) of households who used government health services in the last month rate the services available as 'good', compared with 38% (8417/22141) of households who did not use government services in the last month. Odds Ratio 1.18 (95% CI 1.10-1.27)

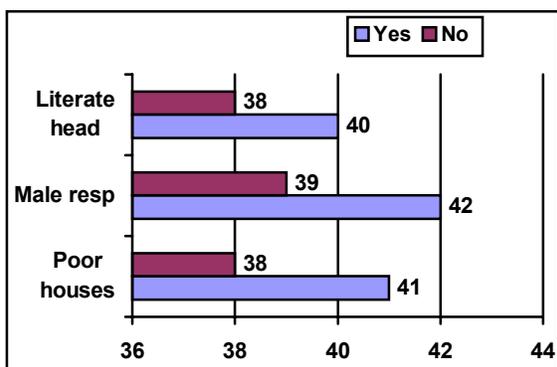


Figure 35. % households rating government health services as 'good' in relation to personal characteristics

Figure 36 shows the proportions of households rating government health services as 'good' in relation to the other factors discussed above.

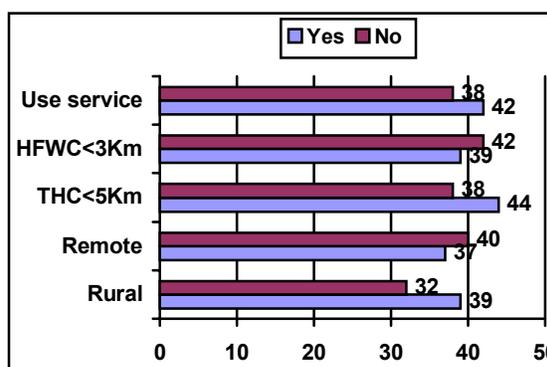


Figure 36 % households rating government health services as 'good' in relation to other factors

Combination of factors and household ratings of government health service

Household ratings of government health services seem to be related to several factors, both individual household characteristics (such as literacy of the household head and economic status) and to location and service access factors. None of the variables alone has a very big effect on the rating of the service. The effect of the variables in combination has been examined by logistic regression (using SPSS). In order to include all households in the logistic regression, variables applying only to rural sites (such as distance from the THC, remoteness of the thana) were not included in the initial model. Information from the final model is shown in Table 25.

Table 25. Adjusted effects of variables on the likelihood of households rating government health services as 'good'

Variable and level	Adjusted Odds Ratio*
Rural residence	1.17
Male household respondent	1.08
Head of household literate	1.08
Use government health service	1.08
Poorest type of house	1.06

*See section on epidemiological and statistical terms at the beginning of the report.

None of these variables in combination has a large effect on the likelihood of households rating government health services as 'good'.

On a more positive note, among the fairly small group of households (13%) that used government health services in the last month, those who rated that visit positively are very much more likely to rate government health services in general as ‘good’³⁵.

Two thirds (65%) of households with a member who had a positive experience of a health service visit rate government health services in general as good. On the other hand, of those with a member who had a poorly rated visit, only 7% rate government health services as good.

An important way to improve public perceptions of government health services is to improve individual experiences of the services.

Public perceptions of problems with government health services

All households were asked, in the household interviews, to say what problems they perceived with the government health services. This was an open-ended question and up to three responses per household were recorded. The problems households mentioned are shown in Table 26.

Table 26. Household perceptions of problems with government health services

Perceived problem	No. (%) Households
Difficult to reach	5650 (25)
Lack of /poor quality medicines	14248 (63)
Have to pay for medicines	2213 (10)
Lack of doctors/ specialists/ nurses	4710 (21)
Doctors not available	1880 (8)
No female doctors	1197 (5)
Bad staff attitude	4043 (18)
Extra payments to doctors	2385 (11)
Dirty, poor equipment / facilities	4015 (18)
Too few beds/lack of facilities	1843 (8)
Lack of different services	1486 (7)
Bad service	7686 (34)
No problem	1679 (8)

Up to three answers per household were recorded

Access to facilities is mentioned as a problem by a quarter (25%) of households. Problems with medicines – availability, quality, having to pay – are cited by three quarters (73%) of households. A third (34%) are concerned about lack of staff (especially doctors) or non-availability of staff. The bad attitude of doctors or having to pay doctors (and other staff) to secure treatment is a complaint of more than a quarter (29%) of households. A third (33%) of households complain about poor facilities and lack of different services. And a third (34%)

³⁵ Among households who used government health services in the last month, 65% (1278/1967) of those who rated the visit as ‘good’ rate government health services in general as ‘good’, compared with 7% (86/1254) of those who did not rate the visit as ‘good’. Odds Ratio 25.19 (95% CI 19.69-32.27)

simply consider that the service is ‘bad’. Only 8% of households specifically say there is no problem with government health services available to them.

The main groups of problems mentioned by households are illustrated in Figure 37. For more details about the problems mentioned, see Table 26.

The types of problem noted by households reflect the experience of services reported by service users (see section 5 above). For example, some two thirds of service users report lack of required medicines and the most commonly perceived problem with health services is with lack of medicines and quality of medicines.

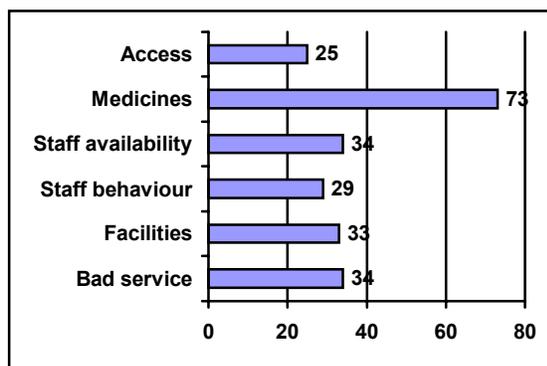


Figure 37. % of households mentioning different types of problems with government health services

Indicator

Lack of medicines is the most common problem with government health services perceived by households.

The ‘bad service’ mentioned by household respondents is illustrated in the experiences related by focus group participants (see Annex 9b).

“I took my 2½ year old child to the THC for pneumonia. After 2 days there the child did not get any proper treatment. So I took the child to a private clinic. There the child got proper treatment and was cured.”

Focus group of men, Lohagara

Examples of bad staff attitudes and behaviour are also commonly related in focus groups.

“The doctor almost always behaves in a very rude manner with us poor people”

Focus group of women, Parshuram

Having to make payments to doctors is a common experience related in focus groups. Sometimes, as in the example here, the experience of being forced to pay is combined with experience of callousness or neglect.

“My daughter was taken to the THC for delivery. But she was not admitted immediately. She lay on the veranda in a very critical condition for neglect. After I paid 200 Tk she was admitted. The doctors did not come to visit her unless I paid up every time. Eventually the baby was born but not alive. The new mother also died a day later.”

Focus group of women, Banchharampur

Having to pay for medicines is also a frequent feature of related experiences.

“I went to the government health centre and was prescribed medicine. I was told to buy the medicine from the shop even though there was enough medicine at the centre”

Focus group of men, Chhatak

Public suggestions and views about future provision of government health services

Suggestions for service improvements

Households were also asked for suggestions about improvements they would like to see in government health services. This was also an open-ended question and up to three responses per household were recorded. The household suggestions are summarised in Table 27.

Table 27. Household suggestions for improvement of government health services

Suggested improvement	No. (%) households
More accessible facilities	5224 (24)
More /better quality medicines	14288 (64)
Free or fixed price medicines	4403 (20)
More doctors/specialists/nurses	7847 (35)
Better availability of doctors	1033 (5)
More female doctors	1749 (8)
Better attitude of staff	3004 (14)
Stop extra payments to doctors	42 (0)
Clean facilities/good equipment	4589 (21)
More beds and facilities	2365 (11)
More different services	1969 (9)
Provide a better service	7527 (34)
No suggestions	291 (1)

Up to three answers per household were recorded

The suggestions for improvement in Table 27 largely mirror the perceived problems shown in Table 26. Again, issues concerned with medicines are the most common suggestion from households for improvement in government health services. As shown above (Table 24), the chances of satisfaction among service users are two and a half times greater if all medicines are available when they attend for treatment. So increasing the availability of medicines from government health facilities, as suggested by households, really would make a difference to satisfaction with the services.

Figure 38 summarises the main areas for improvement shown in Table 27.

Not all the improvements shown in Table 27 and Figure 36 would necessarily be expensive to implement. Some would require provision of more facilities. Others are more to do with better management and staff training. Many of these suggestions from households are in line with the aims of the HPSP to improve accountability and accessibility of services.

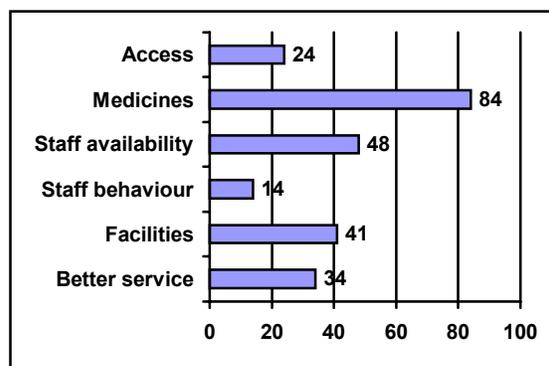


Figure 38. % households suggesting areas for improvement of government health services

Indicator

The most common suggestion from households to improve government health services is to improve the availability and quality of medicines.

In the women’s focus groups, the participants were asked about what features would make a ‘good’ health service for them (see Annex 9a). The commonest suggestions from women’s focus groups are shown in Table 28.

Table 28. Suggestions from women’s focus groups about what would make a ‘good’ health service for them

Suggested service feature	No. (%) groups
Nearby service	29 (14)
All medicines available	100 (49)
Free medicines	20 (10)
Doctors available and free	80 (39)
Good, caring staff behaviour	54 (26)
Good equipment and facilities	24 (12)
Proper diagnosis and care	82 (40)
Child health services	33 (16)
Family planning services	27 (13)
Women’s health services	26 (13)
Antenatal and delivery services	21 (10)
Health education/nutrition advice	17 (8)

Many of the areas highlighted in Table 28 are the same as those mentioned by households, as shown in Table 27. In addition, women in focus groups mention a number of specific services they would like to have readily available to them. This is a sort of ‘wish-list’ for women as potential users of government health services. This and the suggestions from households together give a picture of priorities from the viewpoint of the intended service users. It may not be possible to fulfil all the aspirations of the public immediately but at least knowing them makes a starting point for a dialogue between service planners and providers and the public.

Views about proposed service changes

Reactions to proposed changes in public health service provision were explored in the focus groups.

The views expressed by focus groups about the possibility of stopping household visits by health workers are shown in Table 29.

Table 29. Views of focus groups about proposal to stop household visits by health workers

View about proposal	No. (%) groups	
	Women	Men
Bad idea – unspecified	87 (43)	96 (47)
Good idea	40 (20)	36 (18)
OK: visits not provided anyway	24 (12)	26 (13)
OK, so long as there is an alternative provided	18(9)	26 (13)
Bad: present service poor but better than nothing	18 (9)	9 (4)
Bad for women and children	10 (5)	26 (13)

Most of the focus groups, both women and men, were not in favour of stopping the visits, certainly if no suitable alternative was provided.

Focus groups had mixed views about women going to community clinics or UHFWCs (Table 30).

Table 30. Views of focus groups about women visiting community clinics or UHFWCs

View about women visiting the facilities	No. (%) groups	
	Women	Men
No problem	48 (24)	103 (51)
OK if place is close by	40 (20)	34 (17)
Problem: poor transport	38 (19)	28 (14)
Problem: transport costs	21 (11)	3 (2)
Not easy: women can't go alone	4 (2)	39 (19)
Difficult, unspecified	35 (18)	1 (0.5)

About half the men's groups but only a quarter of the women's groups thought there would be 'no problem' for women to visit community clinics or UHFWCs, in place of household visits by health workers. The view that women would not be able to go alone was more often voiced in the men's groups.

The proposal to have all services (health and family planning) from one place (community clinics) was generally welcomed by the focus groups of both sexes (Table 31).

Table 31. Views of focus groups about proposal to provide health and family planning services from the same place

View about proposal	No. (%) groups	
	Women	Men
Good idea – unspecified	159 (72)	138 (67)
Good to have all services together	21 (10)	23 (11)
Good if place is close by	18 (9)	23 (11)
Only good if provide good service	12 (6)	15 (7)
Good if long opening hours	8 (4)	9 (4)
Good if not corrupt	7 (3)	3 (1)

However, the idea of women getting family planning advice from a man was not popular with either men's or women's focus groups (Table 32). Many groups expressed the view that the idea was completely unacceptable. Others were less dogmatic but nevertheless felt it was a bad idea, not least because women would not be able to give all the necessary information to a man and so would not get a proper service. Some 8% of the men's groups thought it would be 'no problem' for their wives to have family planning advice from a man but none of the women's groups thought this.

Table 32. Views of focus groups about women having family planning advice from a man

View about idea	No. (%) groups	
	Women	Men
Completely unacceptable	78 (38)	83 (41)
Women would not give full information so good advice would not be given	47 (23)	33 (16)
Would not like it	33 (16)	20 (10)
Male doctors would need female to accompany	9 (4)	14 (7)
OK: quality of service is what matters	7 (3)	10 (5)
No problem	-	16 (8)

Public willingness to pay for improved government health services

Willingness to pay for health services is a complex issue. In this survey, just one question was asked about this matter. Households were asked if they were willing to pay (or pay more if already paying) in order to have an improved quality of government health services. Some 55% of households are willing to pay; this means that nearly half are *not* willing to pay.

Indicator

55% of households are willing to pay (or pay more) for improved government health services.

Factors related to willingness to pay for improved health services

The geographic variation in willingness to pay for improved government health services is shown in Annex 7. The proportion of households willing to pay (or pay more) for improved health services is lower in Sylhet than in other parts of the country.

Economic status

People living in the poorest houses (kutchra-2 construction) are less likely to be willing to pay for improved government health services than those in better houses³⁶. Almost half (48%) of the poorest households are not willing to pay for improved services. The relationship between type of house construction and willingness to pay is more marked in metropolitan sites than in rural sites.

Gender of household respondent

There is no significant difference in expressed willingness to pay for improved health services between the few male household respondents and the majority female household respondents.

Use of government health services

Households with at least one member who has used government health services for illness in the last month are more likely to be willing to pay for improved services than households who have not used the services recently³⁷.

Literacy of household head

Households with a literate household head are nearly twice as likely to be willing to pay for improved government health services, compared with those with an illiterate head³⁸. More than half of households with an illiterate head are *not* willing to pay. The relationship between literacy of the household head and willingness to pay is present in both rural and metropolitan sites, more marked in metropolitan sites.

³⁶ 52% (4631/8922) of the poorest households are willing to pay for improved government health services, compared with 57% (9684/16872) of other households. Odds Ratio 0.80 (95% CI 0.76-0.84)

³⁷ 58% (1956/3368) of households who used government health services in the last month are willing to pay for improved services, compared with 55% (12378/22478) of households who did not use services in the last month. Odds Ratio 1.13 (95% CI 1.05-1.22)

³⁸ 64% (7747/12165) of households with a literate head are willing to pay for improved government health services, compared with 48% (6561/13630) of households with an illiterate head. Odds Ratio 1.89 (95% CI 1.80-1.99)

Remoteness of the thana

Among rural households, those in sites in remote thana (more than one hour away from the district town) are less likely to be willing to pay for improved government health services³⁹. Over half (52%) of households in remote thana are *not* willing to pay.

Location

Households in rural sites are only half as likely to be willing to pay for improved government health services, compared with households in metropolitan sites⁴⁰. The association of location of residence and willingness to pay for improved services is mainly among households with a literate head.

Rating of government health services

Households who rate government health services as ‘good’ are more likely to be willing to pay for improved health services⁴¹. The relationship between rating of the present service and willingness to pay for improvement is more marked in houses where the head is illiterate. It may seem surprising that households who rate the existing service as ‘good’ are more willing to pay for an improved service. It may be that those who rate the present service as ‘bad’ feel unwilling to ‘throw good money after bad’ and have no hope that the service will improve even if they pay more.

Figure 39 shows the proportion of households willing to pay for improved government health services in relation to the factors examined above. Note that, in most cases, the proportion of households *not* willing to pay is more than 40% and sometime more than 50%.

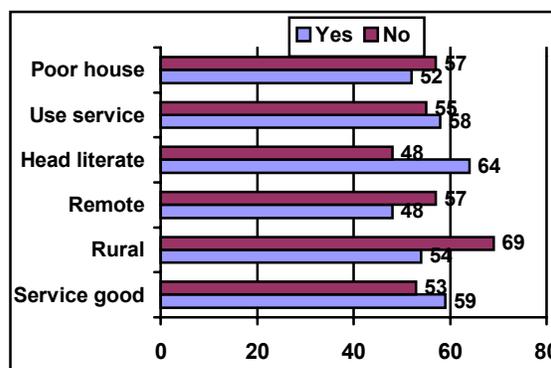


Figure 39. % households willing to pay in relation to other factors

³⁹ Among rural households, 48% (3773/7894) of those in remote thana are willing to pay for improved government health services, compared with 57% (8477/14938) of those in non-remote thana. Odds Ratio 0.70 (95% CI 0.66-0.74)

⁴⁰ 54% (12250/22832) of households in rural sites are willing to pay for improved government health services, compared with 69% (2091/3021) of households in metropolitan sites. Odds Ratio 0.51 (95% CI 0.47-0.56)

⁴¹ 59% (5763/9756) of households who rate government health services as ‘good’ are willing to pay for improved services, compared with 53% (8324/15579) of households who do not rate services as ‘good’. Odds Ratio 1.26 (95% CI 1.19-1.33)

Combined effects of the different factors

Logistic regression (SPSS) was used to examine the combined effects of the variables associated with being willing to pay for improved government health services. The variables left in the final model are shown in Table 33.

Table 33. Adjusted effects of variables on the likelihood of households being willing to pay for improved government health services

Variable and level	Adjusted Odds Ratio*
Head of household literate	1.32
Metropolitan residence	1.27
Rate govt health services 'good'	1.13
Used government health service	1.09
Not poorest type of house	1.03

*See section on epidemiological and statistical terms at the beginning of the report.

In summary, households likely to be willing to pay (or pay more) for improved government health services are those with a literate head, in metropolitan areas, of better economic status, who use government health services and who already rate the services as good. On the other hand, households of poorest economic status, in rural areas, with an illiterate household head, who do not use government health services and who do not rate the services as good, are more likely to be *not* willing to pay for improved government health services. There is a risk of further marginalising these already poor and marginalised members of the society if more charges are introduced for government health services.

Amounts people would be willing to pay

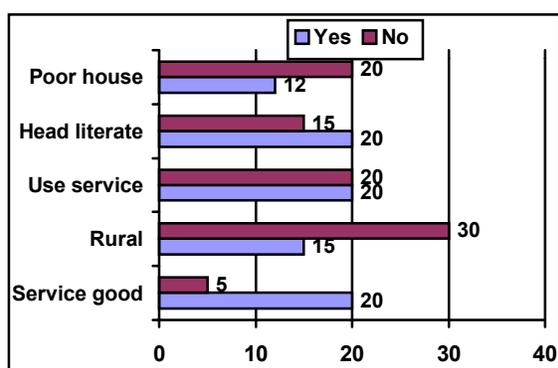


Figure 40. Median amounts households willing to pay for consultation, in relation to other factors

Households who expressed willingness to pay for improved health services were asked how much they would be willing to pay for registration and for a consultation fee. The median amount households are willing to pay for a registration fee is 5 Tk and the median amount for a consultation is 20 Tk. The median amounts households are willing to pay for registration is 5 Tk in all groups, except for metropolitan households who are willing to pay 10 Tk. The amount households are willing to pay for a consultation in relation to relevant factors is shown in Figure 40.

The same categories of households that are more likely to be willing to pay for improved services (Table 33) are also willing to pay more (Figure 40).

7. Opinions of health service providers

The main focus of this survey is on the views of the public and their experiences and opinions as service users. This is intentional, as an important aim of the HPSP is to make government health services more accountable and responsive to the needs and wishes of the public, including those not currently using the services. However, the views of the service providers and service planners are also important. Therefore some key individuals were interviewed. These include: the service workers in the health facilities visited, a member (preferably a female member) of the Union Parishad Council for each community, and the Thana Health and Family Planning Officer in each of the sample thana. The UP Council member is not a service provider but has insights into the provision of services beyond those of the general public.

Views of members of Union Parishad Councils

Full information from the interviews with UP Council members are given in Annex 8a. Some relevant information is summarised in the following section. Some 202 UP Council members were interviewed; 184 of them (91%) are women.

The council composition and the frequency of discussing health services matters is shown in Table 34.

Table 34. The UP council and discussion of health services matters

Issue	Frequency
Frequency of Council meetings	
Mean	Every 26 days
Range	Every 7 days – never
Number of members	
Mean	13 members
Range	9 – 13 members
Number of female members	
Mean	3 members
Range	0 – 9 member
Discussed health services matters during the last year	
Mean	5 times
Range	0 – 25 times
Last discussion on health services matters	
Mean	66 days ago
Range	3 – 400 days ago
Never discussed	18 (10)

On average, 3 of 13 members are women. Some 84% of the UP councils are said to have discussed health services issues in the last year. The health services issued reportedly most commonly discussed by the council are health and sanitation, immunisation and vitamin A provision, and diarrhoea and ORT.

Indicator

84% of Union Parishad Councils discussed health services in the last year.

The majority (72%) of UP Council members interviewed think that health workers in the Union provide a proper, regular service. The main problems with government health services perceived by UP council members are shown in Table 35.

Table 35. Problems with government health services in opinion of UP council members

Perceived problem	No. (%) members
Difficult to reach facilities	73 (36)
Lack of medicines	128 (63)
Doctors not available	35 (17)
Lack of skilled workers	35 (17)
No female doctors	10 (5)
Bad attitude of staff	13 (6)
Lack of / poor equipment	9 (5)
No toilets in facilities	14 (7)
No services / too few services	42 (21)
Bad services	39 (19)

These problems are similar to those perceived by households and expressed in community focus groups. In particular, lack of medicines is again the most commonly perceived problem.

The main categories of problems with government health services, perceived by the UP council members interviewed, are shown in Figure 41. Note that the pattern of perceived problems is similar to that expressed by households (Figure 37).

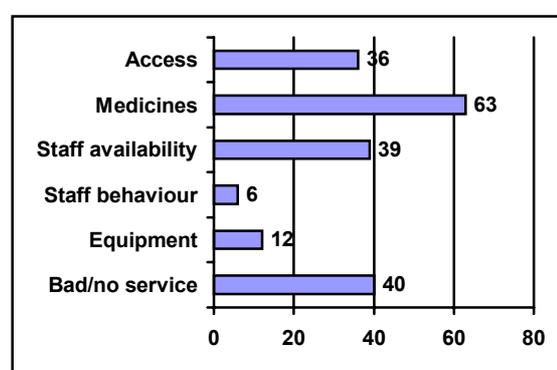


Figure 41. % UP council members citing types of problem with government health services

The main improvements that the interviewed UP council members would like to see are shown in Table 36.

Table 36. Improvements to government health services wanted by UP council members

Improvement wanted	No. (%) members
Easier access to services	44 (22)
More/better quality medicines	119 (59)
More specialists	49 (24)
More doctors	24 (12)
More female doctors	23 (11)
Better availability of doctors	15 (7)
More staff generally	13 (6)
Better staff attitudes	11 (5)
More facilities	78 (39)
Better equipment	19 (9)
More services from facilities	38 (19)
Better quality service	37 (18)
More family planning services	10 (5)

The overall impression is that UP council members want to see more medicines available and more staff available: specialist doctors, women doctors, general doctors and other staff

groups. They are not service providers themselves, so may not take into account the financial and other difficulties of increasing the level of service provision in the way they want.

Views of health workers in UHFWCs and THCs

The senior worker available was interviewed at the time of the visit to the UHFWCs and THCs. Full details are shown in Annex 8b. The person interviewed in the THC was often the Thana Health and Family Planning Officer (THFPO) who was also specifically interviewed in his own right (see below).

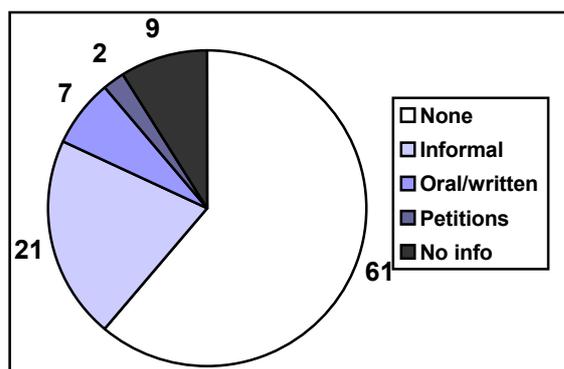


Figure 42. % THCs with different complaints procedures

Most UHFWCs and THCs have *no* arrangements for hearing complaints from service users.

The service providers were asked what arrangements (if any) they had for hearing complaints from service users. The proportions of facilities with different arrangements for hearing complaints are shown in Figure 42 and Figure 43.

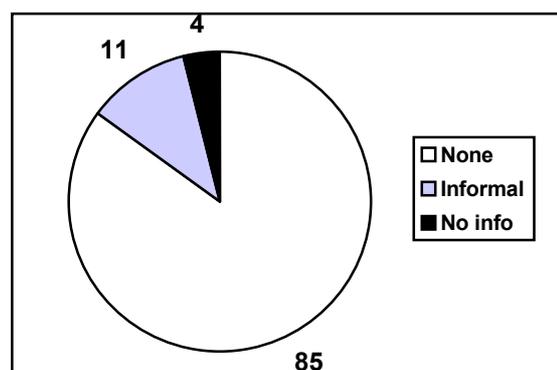


Figure 43. % UHFWCs with different complaints procedures

Despite this lack of any arrangements for hearing complaints from service users, the health workers interviewed were able to say what criticisms of the service from their facility they heard from patients (Table 37).

Table 37. Common criticisms from service users reported by health workers

Criticism	No. (%)	
	THC	UHFWC
Quality/availability of medicines	34 (79)	124 (77)
Too few specialists/skilled staff	5 (12)	11 (7)
Doctors not available	8 (19)	11 (7)
Corruption/favouritism	7 (16)	21 (13)
Bad staff attitudes	3 (7)	6 (4)
Lack of equipment	4 (9)	5 (3)
Poor quality of service	14 (33)	24 (15)
No criticisms	2 (5)	17 (11)

The criticisms mentioned in Table 37 suggest that health workers do become aware of the views of patients, since the pattern reflect quite well the pattern of views expressed directly from the service users and general public interviewed in the survey (see section 6 above). It

is of note that the health care providers specifically mention that patients are critical about corruption and favouritism. This is not often mentioned as a problem in the household interview but is commonly reported in community focus groups.

The health workers in THCs and UHFWCs were asked for their own views of the problems with provision of government health services in the thana or union (Table 38).

Table 38. Main perceived problems with government health services, as expressed by service providers

Problem	No. (%)	
	THC	UHFWC
Difficult to reach facilities	4 (9)	32 (20)
No ambulance	7 (16)	10 (6)
Lack / poor quality of medicines	22 (51)	77 (48)
No staff housing	7 (16)	28 (17)
Lack of equipment	13 (30)	29 (18)
Lack of facilities	8 (19)	29 (18)
Lack of services	4 (9)	4 (3)
Financial/administration problems	16 (37)	12 (7)
Poor infrastructure	4 (9)	-

The concerns of service providers in the UHFWCs are quite similar to those of the service providers in the THCs. However, financial and administration problems are cited more often by service providers at THC level. This probably reflects their seniority and broader overview of the causes of service provision difficulties (most of the interviewees in the THCs were the THFPOs). On the other hand, difficulty with access to facilities is cited more often by service providers at UHFWC level. Lack of medicines is not such a prominent concern as in households, but is nevertheless the most common single problem mentioned.

The priorities for changes to improve the delivery of health services mentioned by service providers at THC and UHFWC levels are shown in Table 39.

Table 39. Priorities for change to improve government health services, as expressed by service providers

Priority area	No. (%)	
	THC	UHFWC
Provide ambulance services	7 (16)	10 (6)
Provide more medicines	16 (37)	64 (40)
Provide more staff	18 (42)	43 (27)
Provide more & better equipment	6 (14)	34 (21)
Improve state of facilities	15 (35)	64 (40)
Increase service efficiency	5 (12)	2 (1)
Improve finance and administration	19 (44)	17 (11)
Unify health and family planning	4 (9)	-
Increase public awareness and participation	7 (16)	18 (11)

The issue of lack of medicines is again accorded high priority by service providers as an area for change to improve services. The concordance between service users and service providers on lack of medicines as an issue offers the opportunity to focus on this as an area for improvement. Service workers could be expected to cooperate with efforts in this area as they recognise it as a problem. And success in improving the availability of medicines in government health facilities should lead to an improved opinion of the services by the public

at large and by service users specifically (see above sections: 5 on public experience and 6 on public opinions of services). It is encouraging to note that at least a few service providers mention increasing public awareness and participation as a priority for improving government health services.

Views of Thana Health and Family Planning Officers (THFPOs)

In 38 of the 43 thana with available data the THFPO was interviewed; in the remaining 5 the RMO or MO was interviewed when the THFPO was not available. All except one of the interviewees were male.

The views of the THFPOs about the problems of health services in the thana and improvements they would like to see are covered in the preceding section.

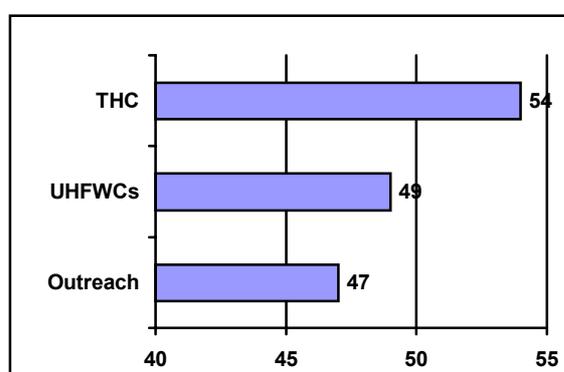


Figure 44. % THFPOs who think staffing is adequate in different facilities in the thana

The THFPOs were also asked whether they consider the staffing levels in the different facilities in the thana sufficient to provide a service during the full official opening hours. Their responses are shown in Figure 44.

Only about half or less of THFPOs consider they have enough staff in their facilities to provide a service during normal opening hours. This accords with the lack of health workers cited as a problem by households and community focus groups.

Most of the THFPOs say they think the current division of health and family planning services is bad thing. They think it is bad for the country (53%), bad for the service (14%) and a waste of time and money (9%). Nearly all (95%) are in favour of unification of health and family planning services, with only one being against the change.

The THFPOs do, however, foresee some difficulties at thana level with the unification of health and family planning services (Table 40).

Table 40. Difficulties in unification of health and family planning services foreseen by THFPOs

Difficulty	No. (%)
None	13 (30)
Problems in cadre management	12 (28)
Work/jobs distribution	8 (19)
Managers' sincerity & cooperation	5 (12)
Powers/authority transfer	4 (9)
Behaviour and attitude change	4 (9)
Managers' leadership	3 (7)
Administrative workload	3 (7)

Nearly a third of THFPOs say they do not foresee *any* difficulties with the unification of health and family planning services in their thana.

8. Women's reproductive health care

25,285 currently married women aged 15 to 49 years were interviewed in the household survey. The average age of the women interviewed is 29 years. Some 38% (9719/25198) of the women respondents can read and write a simple letter. The literacy rate among these women in rural areas (34%; 7641/22282) is much less than in metropolitan areas (71%; 2078/2916).

The interview with the women was concerned with several areas: awareness of government health services (see section 3); use of contraception; and antenatal care.

Use of contraception

Among the married women aged 15-49 years interviewed, nearly half (49%; 11862/25154) are using some form of contraception. The methods of contraception used are shown in Table 41 and figure 45.

Table 41. Contraceptive methods used by married women aged 15-49 years

Method	No. (%)
None	13292 (51)
Traditional	488 (2)
Pill	7167 (29)
Condoms	627 (3)
Injection	1697 (7)
IUD	316 (1)
Norplant	69 (0.3)
Ligation	1468 (6)
Vasectomy	20 (0.1)

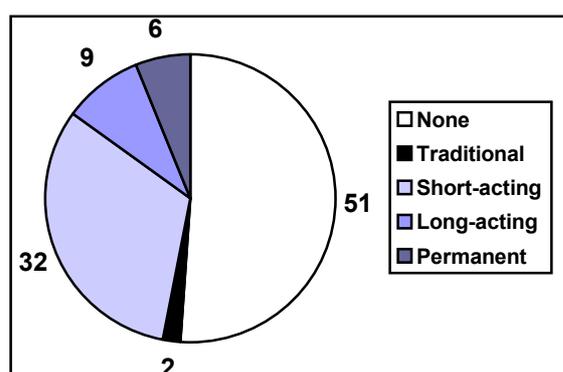


Figure 45. % of women using different contraceptive methods

The reported use of traditional methods is quite low at just over 2%. The most common modern methods, used by nearly a third of eligible women in the survey, are short-acting (pill and condoms). Long-acting and permanent methods (mainly injectables and tubal ligation) are used by 15% of eligible women. Overall, 46% (11374/25154) of women report using a modern method of contraception.

Indicator

The contraceptive prevalence rate (CPR) for modern methods among married women aged 15-49 years is 46%.

Considering only modern temporary methods, the CPR is 40% (9886/25154). This rate excludes sterilisation (tubal ligation and vasectomy). In practice, the rate of vasectomy is very low.

Due to the relatively high failure rate of temporary methods, there is a programme aim to encourage more women to use longer-lasting and permanent methods of contraception. These include IUDs, injectables, norplant, ligation and vasectomy. The CPR for longer-lasting and permanent methods is 15% (3570/25154).

Factors related to use of contraception

The contraceptive prevalence rate (CPR) varies by geographical area (see Annex 7). The CPR is notably lower in Chittagong and especially Sylhet than in other parts of the country.

Area of residence

The proportion of women using a modern method of contraception is higher in metropolitan areas than rural areas⁴¹. The proportion of women using modern temporary methods is also higher in metropolitan areas⁴².

Women's literacy

Women who are literate are slightly more likely to be using a modern method of contraception than women who are illiterate⁴³. The difference between literate and illiterate women is more marked for modern temporary methods of contraception⁴⁴. Among literate women a higher proportion take the pill (32%) than among illiterate women (26%).

Literacy of household head

Women from households with a literate household head are more likely to use modern methods of contraception than those from households with an illiterate head⁴⁵. They are also more likely to use modern temporary methods of contraception⁴⁶. The association between literacy of the household head and use of modern methods of contraception is more marked for modern temporary methods of contraception. If the household head is literate, their wives and other women in the household are more likely to use the contraceptive pill.

⁴¹ 44% (9874/22240) of eligible women in rural areas use a modern method of contraception, compared with 52% (1500/2914) of eligible women in metropolitan areas. Odds Ratio 0.75 (0.70-0.81)

⁴² 38% (8547/22240) of eligible women in rural areas use a modern temporary method of contraception, compared with 46% (1339/2914) of eligible women in metropolitan areas. Odds Ratio 0.73 (95% CI 0.68-0.79)

⁴³ 47% (4501/9684) of eligible women who are literate use a modern method of contraception, compared with 45% (6850/15408) of eligible women who are illiterate. Odds Ratio 1.08 (95% CI 1.03-1.14)

⁴⁴ 43% (4152/9684) of eligible women who are literate use a modern temporary method of contraception, compared with 37% (5713/15408) of eligible women who are illiterate. Odds Ratio 1.27 (95% CI 1.21-1.34)

⁴⁵ 47% (5708/12197) of eligible women from households with a literate head use a modern method of contraception, compared with 44% (5637/12894) of eligible women from households with an illiterate head. Odds Ratio 1.13 (95% CI 1.08-1.19)

⁴⁶ 42% (5136/12197) of eligible women from households with a literate head use a modern temporary method of contraception, compared with 37% (4722/12894) of eligible women from households with an illiterate head. Odds Ratio 1.26 (95% CI 1.20-1.33)

Economic status

Women living in the poorest houses (kutchha-2 construction) are slightly less likely to use modern methods of contraception⁴⁷ or modern temporary methods of contraception⁴⁸.

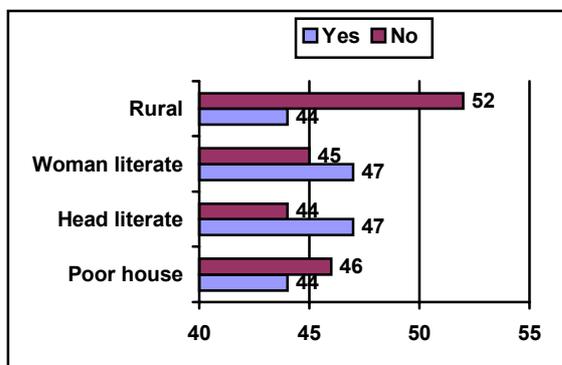


Figure 46. % eligible women using modern methods of contraception, by different factors

The proportions of eligible women using modern methods of contraception in relation to the factors examined above are shown in Figure 46.

The proportions of eligible women using modern temporary methods in relation to the same factors are shown in Figure 47. In most cases, the differences in relation to the factors are greater for modern temporary methods than for all modern methods together.

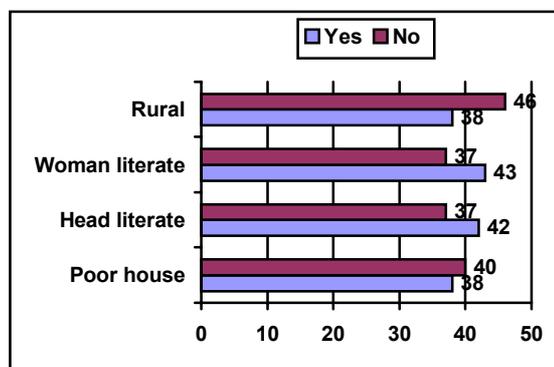


Figure 47. % eligible women using modern temporary methods of contraception, by different factors

Combined effects on likelihood of using contraception

The combined effects of the variables associated with the use of modern contraception and modern temporary contraception were examined by logistic regression. The effects of variables in the final models are shown in Tables 42 and 43.

⁴⁷ 44% (3745/8480) of eligible women from the poorest households use a modern method of contraception, compared with 46% (7600/16620) of eligible women from other households. Odds Ratio 0.94 (95% CI 0.89-0.99)

⁴⁸ 38% (3211/8480) of eligible women from the poorest households use a modern temporary method of contraception, compared with 40% (6649/16620) of eligible women from other households. Odds Ratio 0.91 (95% CI 0.87-0.97)

Table 42. Adjusted effects of variables on the likelihood of women using modern contraception methods

Variable and level	Adjusted Odds Ratio*
Metropolitan residence	1.14
Head of household literate	1.04

*See section on epidemiological and statistical terms at the beginning of the report.

Table 43. Adjusted effects of variables on the likelihood of women using modern temporary contraception methods

Variable and level	Adjusted Odds Ratio*
Metropolitan residence	1.11
Woman literate	1.07
Head of household literate	1.06

*See section on epidemiological and statistical terms at the beginning of the report.

The effect of economic status of the household is explained by the combined effects of the other variables in the model. Women are more likely to use modern temporary methods of contraception if they are literate, if their husbands are literate and if they live in metropolitan sites. The women who are less likely to use modern temporary methods of contraception are those who are illiterate, whose husbands are illiterate and who live in rural areas.

Antenatal care

Of all the women interviewed, 90% (22656/25219) have had at least one full term pregnancy and 51% (12872/25219) have had a pregnancy in the last five years.

Coverage with antenatal care

Of all women who have had a full term pregnancy, 46% (10576/22549) went at least once for antenatal care (ANC). This percentage is higher (59%; 7648/12804) among women who had their last full term pregnancy within the last five years.

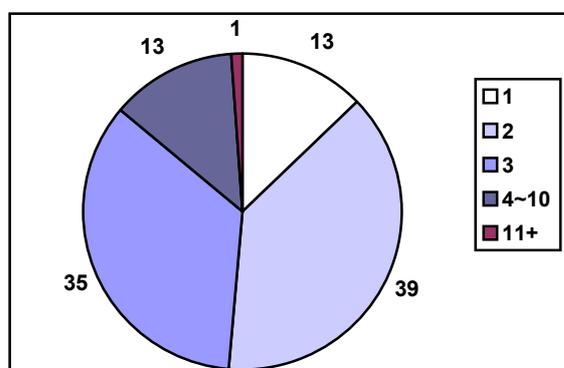
Ideally, the first visit for antenatal care should be within the first six months of pregnancy. Among the women interviewed, 42% (9699/22482) went for ANC at least once in the first six months of pregnancy. For pregnancies in the last 5 years, the proportion of those who went at least once for ANC in the first six months is 54% (6974/5777).

Indicator

Considering pregnancies in the last five years, 54% of women had at least one visit for antenatal care in the first six months of pregnancy.

One visit for antenatal care is unlikely to be helpful. It is generally considered that at least three or four visits are necessary. In this survey, women were asked about how many visits for antenatal care they attended. Among those women who went for any antenatal care for

pregnancies in the last five years, the average number of visits is three. The proportions of women with different numbers of antenatal care visits are shown in Figure 48.



Note that Figure 48 only includes the 59% of women who went for any antenatal care visit during their last pregnancy in the last five years. Just over a third (39%) have two visits and a third (35%) have three visits. It is unusual to have only one visit (13%) or more than three visits (14%).

Figure 48. % women with any antenatal care having different numbers of visits

Factors related to coverage with antenatal care

Literacy of women

Literate women are three times as likely as illiterate women to have had antenatal care in their last pregnancy, considering pregnancies in the last five years⁴⁹. Three quarters (75%) of literate women had at least one ANC visit during their last pregnancy within the last five years.

Age of women

Women younger than 26 years are somewhat more likely to have had at least one visit for antenatal care during their last pregnancy than older women, considering pregnancies during the last five years⁵⁰. This association between younger age and use of antenatal care is partly explained by the association of literacy with use of antenatal care, as younger women are also more likely to be literate than older women.

Economic status

Women living in houses of the poorest type (kutchra-2 construction) are less likely than women living in better houses to have attended for antenatal care⁵¹. The relationship between type of house and antenatal care of the women is more marked in metropolitan sites.

Area of residence

Women in metropolitan areas are more than three times as likely as women in rural areas to have attended for any antenatal care, considering pregnancies in the last five years⁵².

⁴⁹ 76% (3616/4782) of literate women attend for antenatal care, compared with 50% (4015/7990) of illiterate women. Odds Ratio 3.07 (2.83-3.33)

⁵⁰ 63% (4214/6716) of women under 26 years attend for antenatal care, compared with 56% (3433/6085) or older women. Odds Ratio 1.30 (1.21-1.40)

⁵¹ 53% (2463/4678) of women in the poorest households attend for antenatal care, compared with 64% (5172/8100) of women in other households. Odds Ratio 0.63 (95% CI 0.58-0.68)

Distance from health facilities

In rural sites, women from communities nearer to the THC and nearer to the UHFWC are more likely to have had antenatal care in their last pregnancy, considering pregnancies within the last five years⁵³. There is a similar relationship between the distance of the community from the UHFWC and the likelihood of having antenatal care.

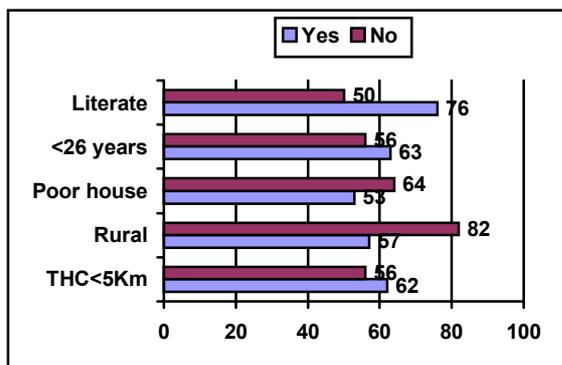


Figure 49. % of women attending for antenatal care in relation to other factors

Figure 49 shows the proportions of women attending for antenatal care, for pregnancies during the last five years, in relation to the factors examined above.

The difference between rural and metropolitan areas is particularly marked; 82% of women attended for antenatal care in their last pregnancy during the last five years.

Combined effects on the likelihood of having antenatal care

Table 44 is from the final model of a logistic regression to examine the effects of variables in combination on the likelihood of women attending for antenatal care for pregnancies in the last five years. Distance from the THC and UHFWC was not included in the model since this information is only available for rural sites.

Table 44. Adjusted effects of variables on the likelihood of women attending for ANC for pregnancies in the last five years

Variable and level	Adjusted Odds Ratio*
Woman literate	1.62
Metropolitan residence	1.54
Not poorest type of house	1.12
Woman younger than 26 years	1.10

*See section on epidemiological and statistical terms at the beginning of the report.

The strongest effects in the combined model are from literacy of the woman and living in a metropolitan area. Women more likely to attend for ANC are those who are literate, younger than 26 years, living in better houses and living in metropolitan areas. The women who need to be reached with services better are poor, illiterate, older women in rural areas.

⁵² 57% (6556/11471) of women in rural areas attend for antenatal care, compared with 82% of women in metropolitan areas. Odds Ratio 0.29 (95% CI 0.25-0.34)

⁵³ 62% (1705/2761) of women in communities within 5Km of the THC use antenatal care, compared with 56% (4749/8451) of women in communities further from the THC. Odds Ratio 1.26 (95% CI 1.15-1.38)

Source of antenatal care

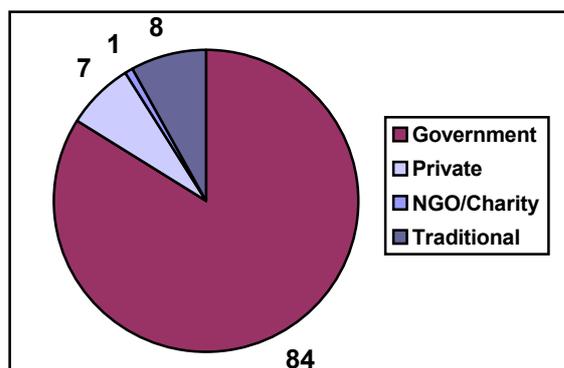


Figure 50. % women in rural areas with ANC from different sources

Considering only antenatal care in government facilities, 34% (7763/22549) of eligible women had at least one ANC visit in their last pregnancy. This figure is 45% (5790/12804) if only pregnancies in the last five years are considered.

Among women who went for any ANC visits for pregnancies in the last five years, 77% (5798/7493) used government services.

The sources of antenatal care in rural and metropolitan areas are shown in Figures 50 and 51. In rural areas a higher proportion of women used government services (84%), while in metropolitan areas half (49%) went to private services for ANC.

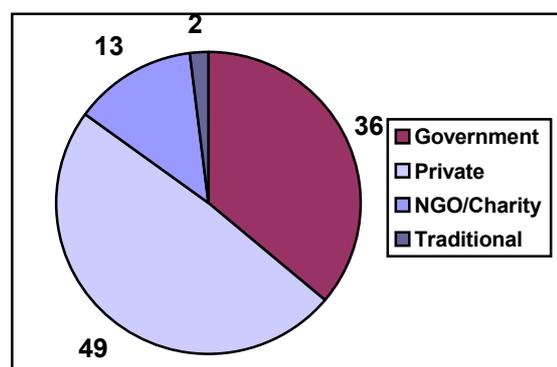


Figure 51. % women in metropolitan sites with ANC from different sources

Opinions about antenatal care received

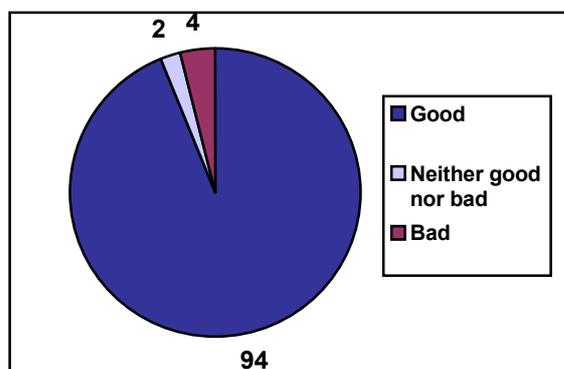


Figure 52. Women's opinions (%) of antenatal care

Nearly all women (94%; 7141/7564) who received any antenatal care for pregnancies in the last five years rated the quality of the service they received as 'good' (Figure 52). This percentage does not differ between rural and metropolitan areas, nor between government and other service providers. It is not different between literate and illiterate women, women from poor and less poor households, nor younger and older women.

Indicator

94% of women who attended antenatal care in the last five years rate the service as 'good'.

Reasons for not having antenatal care

Women who did not go for antenatal care during their last pregnancy were asked why not. Among women who did not go for any antenatal care for pregnancies during the last five years, the main reason cited (70%) is that they did not feel any need to have antenatal care (Table 45). The proportion of women who said they did not go for antenatal care because the service was not available or difficult to reach is 8%.

Table 45. Reasons why women did not go to ANC for pregnancies in the last five years

Reason for not having ANC	No. (%) women
No need	3505 (70)
Not available	389 (8)
Too expensive	262 (5)
Didn't know about it	253 (5)
Not allowed	175 (4)
Shy, afraid	135 (3)
Bad service	109 (2)
Don't know	100 (2)
Went to TBA	58 (1)

Indicator

The main reason (70%) for women not attending antenatal care is that they do not perceive a need to attend.

Decisions about antenatal care

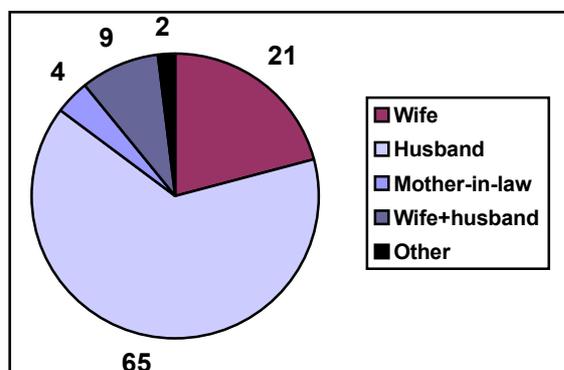


Figure 53. % household decision makers about antenatal care

Women were asked who in the household decides about whether to attend for antenatal care. The household decision makers about antenatal care are shown in Figure 53. Two thirds of women (65%; 14157/21853) say their husband makes the decisions about antenatal care.

The woman herself makes the decision in a fifth of cases (21%). Perhaps surprisingly, the mother-in-law is said to make the decision in only 4% of cases.

There is a difference between rural and metropolitan sites: in metropolitan sites it is more likely that a joint decision will be taken between the husband and wife together. In metropolitan sites the woman participates in the decision in 46% of cases. The decision makers in rural and metropolitan sites are shown in Figure 54.

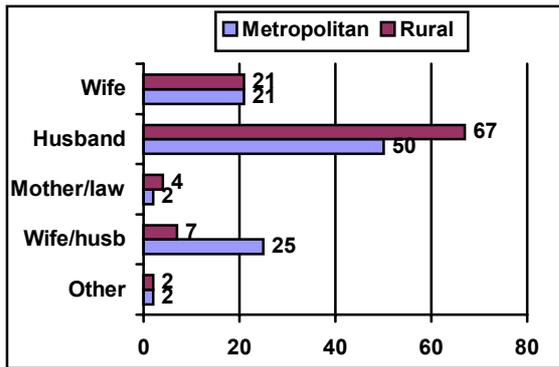


Figure 54. % decision makers about ANC by area of residence

The main difference between rural and metropolitan areas is the higher proportion in metropolitan area of families where the wife and husband make the decision about antenatal care together (Figure 54).

Factors related to wife's participation in decisions about antenatal care

Area of residence

The wife is more than twice as likely to be involved in the decision about antenatal care (alone or with her husband) in metropolitan areas⁵⁴. This is mostly because there are more joint decisions in metropolitan households.

Literacy of woman

Literate women are more likely to participate in decisions about antenatal care⁵⁵. The association between women's literacy and their involvement in decisions about antenatal care is particularly marked in metropolitan areas.

Literacy of household head

When the head of the household is literate, women are more likely to participate in decisions about antenatal care⁵⁶.

Economic status

Women living in the poorest houses (kutcha-2 construction) are less likely to participate in the decision about antenatal care⁵⁷. The association between type of house and the wife's participation in decision making is particularly marked in metropolitan areas.

⁵⁴ 28% (5376/19358) of women in rural areas participate in decisions about antenatal care, compared with 46% (1155/2495) of women in metropolitan areas. Odds Ratio 0.45 (95% CI 0.41-0.49)

⁵⁵ 34% (2729/8032) of literate women participate in decisions about antenatal care, compared with 28% (3789/13770) of illiterate women. Odds Ratio 1.36 (1.28-1.44)

⁵⁶ 33% (3421/10516) of women in households with a literate head participate in decisions about antenatal care, compared with 27% (3091/11285) of women in households with an illiterate head. Odds Ratio 1.28 (95% CI 1.20-1.36)

⁵⁷ 26% (1964/7484) of women from the poorest households participate in decisions about antenatal care, compared with 32% (4558/14323) of women from other households. Odds Ratio 0.76 (95% CI 0.72-0.81)

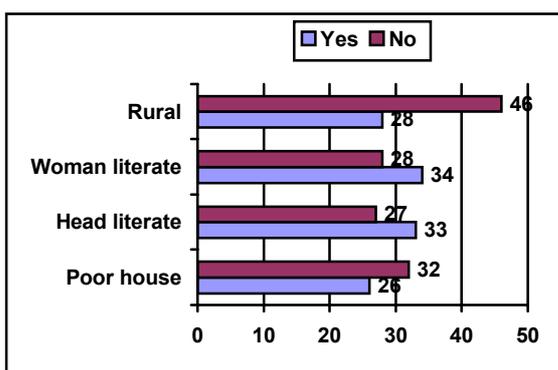


Figure 55. % women who participate in decisions about ANC, by other factors

The proportions of women who participate in decisions about antenatal care in relation to the factors examined above are shown in Figure 55.

The biggest difference is between rural and metropolitan areas. In metropolitan areas, nearly half of women (46%) participate in decisions about antenatal care, either alone or with their husbands.

Combined effects

A logistic regression analysis of the factors related to the woman being involved in decision making was carried out. In the final model, the effect of literacy of the household head was accounted for by the effects of the other variables in combination. The effects of variables in the final model are shown in Table 46. Note that when women are more involved the increase is almost entirely due to an increase in the proportion of cases where husbands and wives make a *joint* decision about antenatal care.

Table 46. Adjusted effects of variables on the likelihood of women participating in decisions about antenatal care

Variable and level	Adjusted Odds Ratio*
Metropolitan residence	1.43
Woman literate	1.08
Not poorest type of house	1.08

*See section on epidemiological and statistical terms at the beginning of the report.

Thus it is in metropolitan areas and in households with literate women and better economic status that women are more likely to participate with their husbands in decision making about antenatal care. In rural households women are less likely to participate with their husbands in the decision, especially if they are illiterate and the household economic status is poor.

Why the decision maker about antenatal care matters

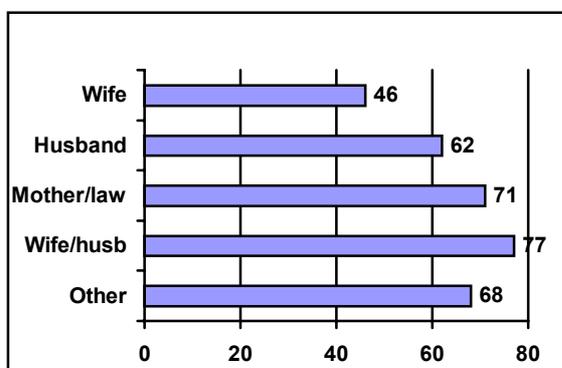


Figure 56. % women attending ANC, by household decision maker about ANC

Perhaps surprisingly, when the woman reports that she makes the decision about antenatal care herself, she is less likely to have attended for antenatal care for pregnancies in the last five years than if the decision is made by others or other combinations (Figure 56). The pattern shown in Figure 56 is consistent between rural and metropolitan areas and for literate and illiterate women.

Women are most likely to attend for antenatal care when the decision is taken jointly between the husband and wife.

Women making the decision about antenatal care on their own may be unsupported and may lack information about the benefits of antenatal care (see Table 45). When the decision is taken jointly between husband and wife it suggests a supportive home environment. Such households may provide more support for the woman to assist her to attend for antenatal care.

This information about the decision makers in the household can help for planning educational programmes to encourage more women to attend for antenatal care. First, it is important to target women, especially illiterate women, living in poor houses in rural areas. Second, the programme should address not only women but also men. Men are important decision makers about antenatal care. If husbands can be convinced about the benefits of antenatal care, and encouraged to discuss it with their wives, this should have the best chance of increasing the rate of women's attendance for antenatal care.

9. Child Health Care

Information was collected on 15,418 children under 5 years old. Some 52% of the children are boys (8006/15415) and 48% (7409/15415) are girls. Questions on child health care were asked of the mother of the child, or the prime caretaker of the child. These questions do not attempt to cover all aspects of child health and health care. They are intended to give information about indicators for the HPSP evaluation (Annex 1) and factors associated with these indicators.

Coverage with vitamin A capsules

All children under 5 years old are supposed to receive two capsules of vitamin A each year. Mothers were asked how many capsules of vitamin A each child under 5 years received in the last year. In the following analysis, children aged less than 12 months have been excluded as they may not have been old enough to receive two capsules over the last 12 months.

Among children between the ages of 12 and 60 months, 85% (10542/12503) received two or more vitamin A capsules, and 93% (11566/12503) at least one capsule, during the last 12 months.

Indicator

85% of children aged 12-60 months received two vitamin A capsules in the last 12 months.

Factors related to coverage with vitamin A capsules

A number of factors are associated with an increased likelihood of the child having received two vitamin A capsules in the last year.

Gender of the child

Among children 12-60 months old, boys are slightly more likely than girls to have received two vitamin A capsules in the last 12 months⁵⁸.

Literacy of the mother

If the mother is literate, the child is more likely to have received two vitamin A capsules in the last 12 months⁵⁹.

Literacy of the household head

A child from a household with a literate head is more likely to have received 2 vitamin A capsules in the last 12 months⁶⁰.

⁵⁸ 85% (5463/6429) of boys aged 12-60 months received 2 vitamin A capsules, compared with 84% (5079/6023) of girls aged 12-60 months. Odds Ratio 1.11 (95% CI 1.00-1.22)

⁵⁹ 87% (3725/4282) of eligible children of literate mothers received 2 vitamin A capsules, compared with 83% (6648/8018) of eligible children of illiterate mothers. Odds Ratio 1.38 (95% CI 1.24-1.54)

⁶⁰ 87% (4767/5504) of eligible children in households with a literate head received 2 vitamin A capsules, compared with 83% (5750/6971) of eligible children in households with an illiterate head. Odds Ratio 1.37 (95% CI 1.24-1.52)

Economic status of household

Children from the poorest houses (kutcha-2 construction) are slightly less likely to have received 2 vitamin A capsules in the last 12 months⁶¹.

Area of residence

Children from households in rural sites are less likely to have received 2 vitamin A capsules in the last 12 months, compared with children in metropolitan households⁶².

Distance from THC

In rural sites, children from communities within 5 km of the THC are more likely to have received two vitamin A capsules in the last 12 months⁶³.

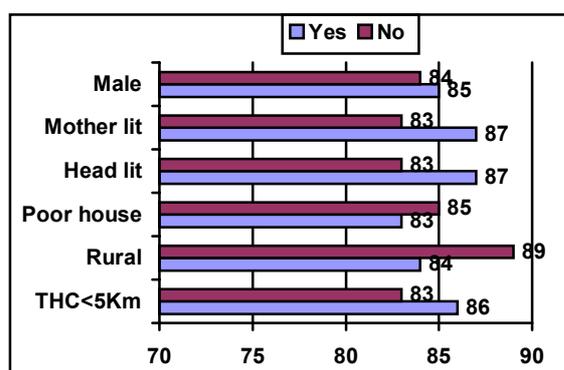


Figure 57 shows the proportions of children aged 12-60 months who received two vitamin A capsules in the last 12 months, in relation to the factors examined above.

The biggest difference is in relation to area of residence, with 89% of children from metropolitan area receiving two vitamin A capsules.

Figure 57. % children receiving 2 doses vitamin A, by other factors

Combination of factors

The combined effects of these different factors on the likelihood of a child receiving two vitamin A capsules in the last 12 months were examined using logistic regression. The effects of variables in the final model are shown in Table 47.

Table 47. Adjusted effects of variables on the likelihood of children 12-60 months receiving 2 vitamin A capsules in last 12 months

Variable and level	Adjusted Odds Ratio*
Metropolitan residence	1.16
Head of household literate	1.11
Mother literate	1.09

*See section on epidemiological and statistical terms at the beginning of the report

The children most at risk of not receiving two vitamin A capsules in the last 12 months are those living in rural areas, in households where the head is illiterate and where the mother of the child is illiterate. In rural areas, access to facilities also makes a difference as children living closer to the THC are more likely to receive two doses of vitamin A.

⁶¹ 83% (3877/4652) of eligible from the poorest households received a vitamin A capsules, compared with 85% (6644/7826) of eligible children from other households. Odds Ratio 0.89 (95% CI 0.80-0.98)

⁶² 84% (9466/11293) of eligible children in rural areas received 2 vitamin A capsules, compared with 89% (1076/1210) of eligible children in metropolitan areas. Odds Ratio 0.65 (95% CI 0.53-0.78)

⁶³ In rural communities, 86% (2353/2745) of eligible children in communities within 5 Km of the THC received 2 vitamin A capsules, compared with 83% (6882/8281) of eligible children in communities further from the THC. Odds Ratio 1.22 (95% CI 1.08-1.38)

Coverage with measles vaccine

The majority of children between the ages of 12 and 23 months old have received measles vaccine (85%; 2367/2797).

Indicator

85% of children aged 12-23 months have received measles vaccine.

Factors related to measles vaccination

Several factors were examined for their relationship to a child's likelihood of having had measles vaccine.

Gender of the child

There is no significant difference between girls and boys in their chances of having had measles vaccine⁶⁴.

Literacy of the mother

Children aged 12-23 months whose mothers are literate have more than twice the chance of being vaccinated against measles, compared with children whose mothers are illiterate⁶⁵.

Literacy of the household head

Children aged 12-23 month from households where the head is literate have one and a half times the chances of being vaccinated, compared with children from households where the head is not literate⁶⁶.

Economic status

Children living in the poorest types of houses (kutchra-2 construction) have less chance of being vaccinated against measles than children living in less poor houses⁶⁷.

Area of residence

Children in rural areas are less likely to have been vaccinated against measles than children in metropolitan sites⁶⁸.

Distance from health facilities

In rural sites, the relationship between distance of the site from the THC and the UHFWC and coverage with measles vaccine was examined. There is *no* consistent significant relationship between distance from these facilities and coverage with measles vaccine.

⁶⁴ 85% (1216/1430) of boys aged 12-23 months have received measles vaccine, compared with 84% (1151/1367) of girls aged 12-13 months. Odds Ratio 1.07 (95% CI 0.86-1.32)

⁶⁵ 91% (900/994) of children of literate mothers have received measles vaccine, compared with 81% (1437/1770) of children of illiterate mothers. Odds Ratio 2.22 (95% CI 1.72-2.86)

⁶⁶ 88% (1068/1217) of children from households with a literate head have received measles vaccine, compared with 82% (1296/1577) of children from households with an illiterate head. Odds Ratio 1.55 (95% CI 1.24-1.94)

⁶⁷ 82% (857/1049) of children in the poorest households have received measles vaccine, compared with 86% (1508/1745) of children in other households. Odds Ratio 0.70 (95% CI 0.57-0.87)

⁶⁸ 84% (2108/2505) of children in rural areas have received measles vaccine, compared with 89% (259/292) of children in metropolitan areas. Odds Ratio 0.68 (95% CI 0.45-1.01)

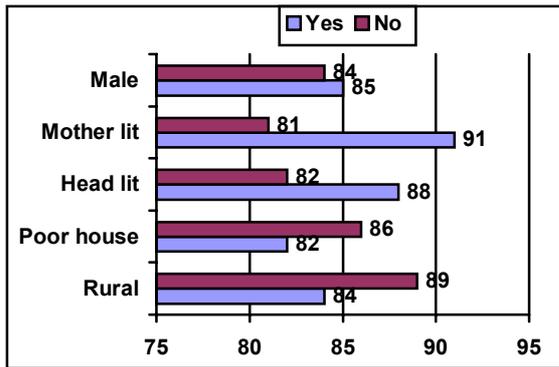


Figure 58. % children who received measles vaccine in relation to other factors

Figure 58 shows the proportions of children aged 12-23 months who have received measles vaccine in relation to the factors examined above.

The biggest difference is in relation to literacy of the mother. The rate of measles vaccination among children of literate mothers is 91%.

Combination of factors

The effects of the combination of factors on the chances of a child being vaccinated against measles were examined in a multiple logistic regression. The effects of the remaining factors in combination in the final model from the regression are shown in Table 48.

Table 48. Adjusted effects of variables on the likelihood of children 12-23 months having received measles vaccine

Variable and level	Adjusted Odds Ratio*
Mother literate	1.45
Not poorest households	1.12

*See section on epidemiological and statistical terms at the beginning of the report

The children most at risk of not receiving measles vaccine are those with illiterate mothers in the poorest households. Efforts need to be made to reach these children if the coverage with measles vaccine is to improve beyond the present level.

Acute lower respiratory infection (ALRI) prevalence and care

Nearly one in ten children (9%; 1329/15323) under 5 years old suffered from an acute lower respiratory infection (ALRI) in the two weeks before the survey. In the household questionnaire, ALRI was defined as an episode of coughing, chest indrawing and rapid breathing. This is a standard way of defining ALRI in questionnaires but 'cases' identified this way may well include some children with upper respiratory infections. The ALRI rate estimated from questionnaires tends to be higher than the rate from studies with individual observations of children by trained workers.

Indicator

9% of children under 5 years suffered an ALRI in the two weeks before the survey.

The reported prevalence of childhood ALRI is not different between literate and illiterate mothers, nor between households with literate heads and illiterate heads. It is also not different between the poorest houses and less poor houses. The rate is only marginally higher

for boys than girls (9% vs 8%). However, the rate does differ between rural and metropolitan sites. Children in rural areas have more than twice the risk of having ALRI in the last two weeks compared with children in metropolitan sites⁶⁹.

Treatment for children with ALRI

ALRI is an alarming illness in young children and most (87%; 1119/1296) of the children with reported symptoms of ALRI in the two weeks before the survey were taken to a health care provider of some sort for treatment.

Indicator

87% of children under 5 years with ALRI are taken to a health care provider for treatment.

There is no difference in the chances of a child with ALRI being taken for treatment by economic status of the household, by area of residence (rural or metropolitan) or by sex of the child. However, if the child with ALRI lives in a household where the household head is literate, the child is twice as likely to be taken for treatment, compared with a child from a household where the head is illiterate⁷⁰. There is also an apparent association with literacy of the mother, but this is no longer found when literacy of the household head is taken into account.

Source of treatment for children with ALRI

Among those who sought any treatment for the child with ALRI, 62% (690/1119) of families sought treatment from private providers and 19% (212/1119) visited government health facilities (Figure 59).

The pattern of where children with ALRI are taken for care is similar for households of different economic status and for those with literate or illiterate household heads.

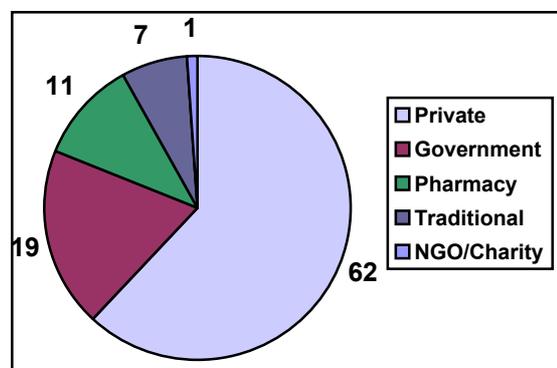


Figure 59. % children with ALRI taken to different sources of treatment

However, there is a difference between rural and metropolitan sites. In rural sites compared with metropolitan sites, the children are more likely to be taken to a government facility or pharmacy and less likely to be taken to a private facility.

⁶⁹ 9% (1274/13831) of children under 5 years in rural areas had an ALRI in the last two weeks, compared with 4% (55/1492) of children under 5 years in metropolitan areas. Odds Ratio 2.65 (95% CI 1.99-3.54)

⁷⁰ 91% (501/549) of children with ALRI are taken to a health care provider for treatment if the household head is literate, compared with 83% (615/741) of children if the household head is illiterate. Odds Ratio 2.14 (95% CI 1.48-3.10)

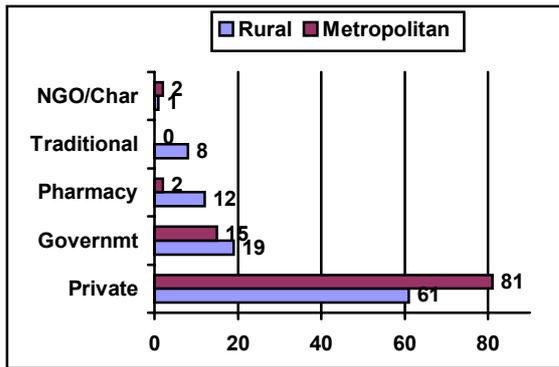


Figure 60. % children with ALRI with different sources of care in rural and metropolitan areas

The proportion of children with ALRI taken to different health care providers in rural and metropolitan areas is shown in Figure 60.

In metropolitan areas, 81% of the children with ALRI taken for treatment are taken to private providers.

Satisfaction with treatment for child with ALRI

Overall, three quarters (77%; 820/1084) of families who took their child with ALRI for treatment are satisfied with the treatment the child received. There is some difference between type of service provider (Table 49). Two out of three (63%) of families who took their child suffering from ALRI to government health facilities are satisfied with the services they received. This compares with 85% who are satisfied with the treatment from private providers. The other providers are less commonly used, but satisfaction with treatment from traditional sources and NGO/charity sources is apparently high.

Table 49. Satisfaction with the services received for treatment of child with ALRI

Source of treatment	Proportion satisfied
Private	554 (85)
Government	129 (63)
Pharmacy	59 (51)
Traditional	68 (87)
NGO/charity	8 (92)

This variation in satisfaction between providers might be confounded by the difference in pattern of service use between rural and metropolitan areas (see Figure 60), since households in metropolitan areas are also more likely to be satisfied with the treatment the child received. However, a similar pattern of satisfaction with the different services is found in rural and metropolitan areas, although the number of service users in metropolitan areas is low (Table 50).

Table 50. Satisfaction with the services received for treatment of child with ALRI in rural and metropolitan areas

Source of treatment	No (%) satisfied	
	Rural	Metropolitan
Private	519 (84)	35 (97)
Government	124 (62)	5 (71)
Pharmacy	58 (46)	1 (100)
Traditional	68 (86)	-
NGO/charity	7 (88)	1 (100)

The pattern of satisfaction with the different services for ALRI is also similar between very poor households and other households. So it does not seem that the lower satisfaction with

government than with private treatment is explained by area of residence, nor by economic status of the household or literacy of the household head.

Diarrhoea prevalence and oral rehydration therapy (ORT)

Nearly one out of every ten children under five years old (9%; 1424/15321) suffered from diarrhoea during the two weeks prior to the survey. The rate in boys and girls is the same.

Indicator

9% of children under 5 years old had diarrhoea in the two weeks before the survey.

The rate of diarrhoea is not different between children from the poorest houses and children from other houses. However, the chance of a child having diarrhoea in the last two weeks is higher in rural sites than in metropolitan sites⁷¹.

Oral rehydration therapy (ORT)

The correct oral rehydration therapy for diarrhoea is to give more fluid and feed more or the same amount as usual. To estimate the knowledge of correct ORT, mothers were asked whether they gave the same, less, or more fluid and food than usual during this episode of diarrhoea. To avoid confusion with breast feeding (which the survey did not ask about), the following analysis is confined to children over 23 months old.

Most of the children with diarrhoea (70%; 523/756) were given more fluid than usual and half (48%; 361/750) were given the same or more food than usual. However, only 36% (266/749) were given the correct ORT: both more fluid *and* more or the same amount of food as usual.

Indicator

A third (36%) of children with diarrhoea are given correct ORT: increased fluids and the same or more food.

The chances of a child with diarrhoea being given correct ORT do not vary by area of residence (rural or metropolitan), by economic status, or by literacy of the household head. Children with literate mothers are rather more likely to be given correct ORT, although the difference could be due to chance⁷².

⁷¹ 10% (1330/13829) children under 5 years in rural areas had diarrhoea in the last two weeks, compared with 6% (94/1492) children under 5 years in metropolitan areas. Odds Ratio 1.58 (95% CI 1.27-1.98)

⁷² 40% (83/207) children aged 24-60 months with diarrhoea with a literate mother are given correct ORT, compared with 33% (177/532) children with diarrhoea with an illiterate mother. Odds Ratio 1.34 (95% CI 0.95-1.90)

Commentary

1. The indicators

Information on the indicators is given in the report at national level in the main text, and by geographic divisions (down to the thana level for the sample thanas) in Annex 7). The indicators are given at the appropriate places in the Results section of the report. They are shown here again for convenience, in the order used in the list of indicators in Annex 1.

Baseline Indicators for the HPSP

Reproductive health care

- wCPR (modern methods): 46%
- wUse ANC in first 6 months of pregnancy: 54%
- wReasons for non-use of ANC: 70% 'no need'
- wANC users satisfied with service: 94%

Child health care

- wchildren given 2 doses vitamin A in last year: 85%
- wchildren 12-23 months given measles vaccine: 85%
- wchildren <5 with diarrhoea in last 2 weeks: 9%
- wchildren with diarrhoea given correct ORT: 36%
- wchildren <5 with ALRI in last 2 weeks: 9%

Limited curative care

- wchildren with ALRI taken to health facility: 87%

Behaviour change communication

- w women aware of health services available at local level; women aware of at least one service from:
 - Outreach clinics: 86%
 - UHFWC: 71%
 - THC: 70%

Use and experience of health services; meeting felt needs of clients

- whouseholds using health services in last month
 - government services: 13%
 - private services: 32%
- wReasons for choice of service: see text
- w Reasons for not using government services: Too far, poor medicines/treatment, lack of medicines/staff
- wvisits with all needed medicines available: 33%
- wvisits with trained staff available: 87%
- wvisits with extra/unofficial payments
 - extra payment to worker(s): 22%
 - unofficial registration fee: 27%
- whouseholds willing to pay for improved government health services: 55%
- wusers satisfied with last visit to service: 53%
- whouseholds satisfied with govt health services: 37%
- wUP councils discussed health services in last year: 84%
- wthana with health service improvement committee: 88%
- wperceived problems with services: lack of medicines main concern of users and providers
- w priorities for changes in services: more medicines, more workers are priorities of users and providers

2. Behind the indicators: pointers for action

Knowing the level of an indicator is not all that is needed to plan the most effective actions to improve the conditions reflected by the indicator. Knowing the actionable factors related to the indicator – what increases the risk of a bad outcome and what increases the chances of a better outcome – can help to direct efforts towards interventions. From the analysis of these factors in this survey, and from listening to the views of the public in the survey, it is possible to identify some pointers for action, to fine-tune the HPSP during the coming years.

Increasing the use of government health services

“The hospital is too far. So the patient dies before he can be taken there.”

Focus group of men, Ajmirignaj

Physical access is an issue: communities further from the UHFWC or from the THC are less likely to use government health services. The proposal for creating community clinics may be one way of tackling this problem of access and so improving the use of services. It is a popular suggestion in communities.

“Our experience is not good. We don’t think the health clinic does minor operations properly, so we don’t go to it.”

Focus group of men, Assasuni

Bad experiences of the services are an important reason for not using them. Improving the quality and experience of services could lead to more people using them.

31% of male focus groups and 18% of female focus groups consider ignorance and lack of education of women is a reason for them not using government health services.

Programmes to improve female literacy could improve the use of services by women. Most women have to take permission from their husbands or other family members before using health services, so education about the benefits of health care services for women should also be aimed at men.

Increasing satisfaction with government health services

In deciding how to improve the satisfaction of service users, the question arises about what the perceptions of service users really indicate. If they are incorrect, then a programme to inform and educate service users is needed. If they seem likely to reflect a real problem with service delivery, then management action to tackle the problem is needed.

“The doctor only prescribes, he does not supply any medicines, and he tells us which drug store to buy the medicines from.”

Focus group of women, Basail

It seems there is a real lack of medicines considered necessary by the health workers as well as the patients. Lack of medicines is a major cause of dissatisfaction with the service. The reason for this lack of medicines at the point of service provision needs investigation.

“Government staff take money for doing their duty”

Focus group of men, Mirzaganj

Making extra payments to service workers is a widespread complaint and is strongly related to dissatisfaction with the service. The issue of workers demanding extra payments from service users will require management action at all levels. Improving the behaviour of doctors, in particular, towards patients may require attention during medical training.

Some service users are less satisfied than others: women from poor households with an illiterate household head fare especially badly. It may help to let service users (especially women from poor households) know about their rights to service and what they should expect from the service. This could form part of the BCC element of the HPSP.

“We do not want to criticise the system because we are afraid that if we do the THC will stop helping us altogether”.

Focus group of men, Gaffargaon

It would be a positive step to establish complaints procedures in facilities and monitor the complaints received and action taken. Patients will have to be actively encouraged to complain if they are not satisfied with their experience.

Increasing use of contraception

The women to target to increase the use of contraception are illiterate women in rural communities. If there is a concern that more longer-acting and permanent methods should be encouraged, women will need to be convinced to choose these methods and they will need to be widely available.

“Some of us women are suffering since they did ligation. We have constant pain in the lower abdomen. But the doctors don't care.”

Focus group of women, Mehendiganj

Improving facilities for insertion of IUDs and for performing tubal ligations may encourage more use of these methods of contraception.

Increasing use of antenatal care

The women to target to increase the coverage of antenatal care are illiterate women over 26 years old living in the poorest houses in rural areas. The husband most often makes the decisions about antenatal care, so men also need to be targeted with information about the benefits of antenatal care.

Increasing vaccination and vitamin A coverage

Children most at risk of not receiving vitamin A capsules are those in rural areas where the mother and household head are illiterate. Children most at risk of not receiving measles vaccine are those with illiterate mothers from the poorest households. These disadvantaged children need to be reached with immunisation programmes more effectively.

3. Dissemination and use of the findings

The findings from this baseline survey need to be communicated to planners and programme managers nationally and locally. They also need to be discussed with communities. Effective dissemination of findings should encourage dialogue between service providers and service users about improving the delivery of health services. Such a dialogue would itself be a contribution towards increased responsiveness and accountability of health services.

4. Building on success: the next steps for the survey process

This baseline survey has been successful. It has gathered information on a range of indicators as a baseline for tracking the progress of the HPSP and it has begun the process of giving people in the communities of Bangladesh a voice in the sort of health services they will be offered in the future. The further annual surveys that are planned offer an opportunity for building on this initial success. There are a number of considerations to be borne in mind for these further survey cycles:

1. Sentinel communities are not ‘special’ communities

The sentinel communities in the sample are intended to reflect the situation in other communities that they represent. If special actions are taken in these sentinel communities as a result of the findings of the baseline survey, this will invalidate their representativeness in future survey cycles. To guard against the temptation to do this, the names of the sample communities are not given in this report, although the full details of the sample are available for technical discussions of the sampling process. To check that any programme impact detected in future cycles is not confined to the sample communities (or even to the sample thana), the design should allow for some new thana and communities not in the present sample to be added or substituted for existing sample sites.

2. Tracking of indicators

The core indicators included in this baseline survey should be included in future cycles of the survey, even if not all of them annually. This will allow development of a score card of the indicator changes as a way of tracking the progress with the HPSP and noting areas that are more successful or less successful.

3. Examination of issues in more detail

In this baseline survey there was a need to cover a broad range of issues and this limited the depth of investigation that was possible for each issue. In future cycles, as well as continuing to gather information on key indicators, it will be important to investigate some issues in more depth. One example from the baseline survey is the problem of non-availability of medicines prescribed when people visit government health services. It should be possible to investigate what medicines are involved and the reasons why they are not available, perhaps combining the survey with other forms of service-based investigation at the same time. Another example might be the issue of women’s choice of contraceptive method, exploring in more detail why women choose the pill rather than longer-acting or permanent methods.

4. Building accountability: feedback and discussion of findings

In this baseline cycle of the survey, the immediate findings in each community were briefly discussed in community meetings at the end of the data collection in each place. However, much more should be done to involve communities and service providers in the process of acting on the survey findings. Future cycles of the survey should therefore allow for a process of feeding back the analysed findings to community groups and hearing their views about actions that could be taken. The follow-up process should also include holding joint meetings of service providers and community representatives at local level and perhaps national level to discuss the findings and their implications for future service provision. This will be an important step towards the accountability of services that is one of the key aims of the HPSP.

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Note: References 3-8 also appear as references 1-6 in Annex 2 of this report.