BANGLADESH
HEALTH WATCH

Assessment of Users' Perspective of Public Health Services in Bangladesh

Second Draft Report

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ACRONYMS

ANC	Ante Natal Care
BBS	Bangladesh Bureau of Statistics
BEmOC	Basic Emergency Obstetric Care
BHW	Bangladesh Health Watch
CC	Community Clinic
CHCP	Community Health Care Provider
CHW	Community Health Worker
CPR	Contraceptive prevalence rate
DSF-MHVS	Demand Side Financing – Maternal Health Voucher Scheme
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
ESP	Essential Service Package
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant
HI	Health Inspector
HNP	Health, Nutrition and Population
HPNSP	Health, Population and Nutrition Sector Programme
HRH	Human Resources for Health
IRT	Independent Review Team
KMC	Kangaroo Mother Care
LAPM	Long Acting and Permanent Method
LARC	Long Acting and Reversible Contraception
LGD	Local Government Division
MOHFW	Ministry of Health and Family Welfare
MOLGDR&C	Ministry of Local Government, Rural Development and Cooperatives
MTR	Mid Term Review
NCD	Non-Communicable Diseases
NIPSOM	National Institute of Preventive and Social Medicine
NIPORT	National Institute of Population Research and Training
NVD	Normal Vaginal Delivery
PNC	Post Natal Care
PPFP	Post-Partum Family Planning
QoC	Quality of Care
SACMO	Sub Assistant Community Medical Officer
SCANU	Special Care Newborn Unit
SO	Strategic Objective
SSK	Shasthyo Surokksha Karmasuchi
SWAp	Sector Wide Approach Programme
UH&FWC	Union Health and Family Welfare Centre
UHFPO	Upazila Health and Family Planning Officer
UHC	Upazila Health Complex
UP	Union Parishad
USC	Union Sub Centre

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EXECUTIVE SUMMARY

Introduction

Ministry of Health and Family Welfare (MOHFW) is in the process of implementation of 4th Health, Population and Nutrition Sector Programme (4th HPNSP), for which, the Midterm Review (MTR) is underway. Opinions of the recipients are vital inputs in the MTR process. This assessment is an effort taken by Bangladesh Health Watch, an independent civil society platform, to collect opinion of healthcare recipients, particularly those from disadvantaged and underserved communities, to support the MTR of the 4th HPNSP. Scope of work for the assessment included with – (a) Understand the access to and utilization of government healthcare services, particularly for marginalized people; and (b) Understand the perception of the recipients on extent and quality government healthcare services.

Methodology

Extensive literature review was carried out to understand the context of HNP sector in Bangladesh using "rapid review" method. The main findings were derived from primary data collection using qualitative methodology. A team of multidisciplinary researchers, including anthropologists, health systems expert and physician and public health expert designed and implemented the study. Data collection was undertaken by a team of anthropology graduates. The assessment considered two categories of recipients as respondents – (a) the common citizens or "mainstream recipients" (b) the citizens that were termed as "hard-to-reach and vulnerable" and "marginalised" in getting the public health services, or "disadvantaged recipients". Marginalised respondents were taken purposively from six different districts of Bangladesh, based on the criteria including geographically isolated (i.e. those living in haor, island chars and Chittagong hilltracts), flatland ethnic minorities, tea garden workers, industrial workers, slum dwellers and low income urban communities. Mainstream respondents were also taken purposively from six unions, each belonging to a different district. Data were collected from both recipients, as well as community people and community leaders. Exit interviews (26) and Focus Group Discussions (FGD) (23) were used for data collection. For triangulation purpose, data was also collected from a few service providers and health managers using methods including Key Informant Interview (KII) (11) and In-depth Interview (IDI) (12). Spot observations (23) and informal discussions were also used for data collection. Thematic and content analysis were undertaken, using Atlas-ti 7.5 to organize the data.

Users' access to and utilisation of HNP services

Mainstream recipients reported taking services from government, as well as from non-government facilities. They reported visiting the community clinics (CCs) and union facilities mainly to collect free medicines and FP commodities and basic health problems. They could not always distinguish between CC and union level facilities. Recipients did not report going to union facilities for normal deliveries or perceiving these facilities as 24/7 accessible facilities. Recipients depicted Upazila Health Complex (UHC) as their first point of contact with a government facility for comprehensive care if they did not get a solution at the community level. Limited availability of medicines and diagnostic services, long waiting time and delays in providing care, staff not available or neglecting or behaving bad, doctors accessible only for a limited time of the day, informal payment for services, unavailability of C-section services, and unclean environment were frequently mentioned complaints about UHCs. Recipients mentioned visiting hospitals at the district level for critical problems, which could not be solved at lower levels, for example disease specific care requiring specialized consultants, C-section and other surgeries, and critical care. Complaints about district level hospitals were similar to UHCs, i.e. long waiting time, doctors' not giving enough time to patient, staff behavior, informal payments and unclean environment. Mainstream recipients mentioned receiving services in the community from NGOs mostly through domiciliary visits. Some NGOs also provided normal delivery and vaccination services. They mentioned seeking care from private clinics for services that they could not avail from government, such as, diagnostic services and C-section delivery services. Some recipients also mentioned that those, who could afford, went for private clinic for prompt service,

personalized care and clean environment. Recipients also mentioned visiting doctors in private practice at their chambers for convenient location, availability and timing.

Access to and utilization of health services varied across different categories of disadvantaged recipients. While the workers at the teagarden and garment industry and the flatland ethnic minority community were found to have access to multiple healthcare facilities provided by government and private providers, including additional options than the mainstream recipients, the low-income communities belonging to urban areas were found to depend largely on private and NGO facilities. On the other hand, geographically isolated communities were found to have least access to any healthcare option amongst all communities studied.

Physical Facilities (Infrastructure, Medicine and Equipment)

During the field observations, new infrastructures were seen in almost all sites. However, these infrastructures were not observed to be used optimally. In spite of having the infrastructure and supplied with equipment, majority of the facilities at district and upazila level were found not providing most of the diagnostics and laboratory services, resulting in recipients going to the private sector to avail the service. Crowded, unclean environments, inadequate supply of medicines and compromised privacy were overarching complaints by users of government health services from all sites. Issues of physical facilities were almost similar regardless of the mainstream and disadvantaged communities living close to mainstream communities. Private clinics, on the other hand, were appreciated for cleanliness and availability of diagnostic services. No such physical facilities were seen in the vicinity of the geographically isolated population.

Healthcare Providers

From all sites, mainstream recipients complained about behavior of staff at the district and upazila levels, especially nurses and support staff. Absence of empathy in behavior and lack of counseling were frequently reported. However, for facilities at the union level, there was a mix of reaction regarding the behavior of staff. There were complaints about some specific individuals, while some others were well accepted in the community. In most sites, recipient reported good behavior from staff at CCs. Lack of manpower was reported by both mainstream recipients and providers from all sites for all levels of public service facilities. As a consequence of this shortage, excessive workload on the existing staff and unequal distribution of responsibilities affecting the quality of care were also frequently perceived. Recipients did not report any behavior issue for private clinics, rather appreciated the personalized care and promptness of service. The ethnic minorities did not report any discrimination based on ethnicity by the service providers. Neither members of the sweeper colony nor the geographically isolated population or low-income urban communities reported being treated unequally at the government healthcare facilities. The only discrimination reported was between behaviors with rich and poor patients or favoring people who were known to or connected with the staff or were influential, which was similar to the reporting of the mainstream population.

Transparency and Accountability

There were concerns related to transparency and accountability noted at different tiers of government facilities, uniformly reported by respondents from both mainstream and various disadvantaged communities. An overarching concern was ‘informal payment’ for better service, more medicine and commodities or for good behavior. Some of these were triangulated with the frontline providers and managers, who also admitted most of those and shared some steps taken by them to minimize those. However, despite managers’ willingness and efforts to bring positive changes infrastructure, considerable issues were found in the field which reflected lack of transparency and accountability in the health system.

Community Participation

Mainstream respondents across all sub-districts informed about community participation in management of CC through CGs and CSGs. Local resource generation seemed to be the most common form of community participation. Monitoring of CC proceedings, particularly ensuring receipt of the variety and quantity of medicine was another area in which community were participating across the districts. The CGs and CSGs also resolved any conflicts between community and CHCP from time to time. Community participation was not reported by the mainstream recipients in case of the union level facilities. Disadvantaged communities living in close proximity of mainstream communities were aware of the contribution that are being encouraged, however, do not know the purpose of the contribution. Geographically isolated communities neither mention about any such community participation, nor were aware of the existence of such CG or CSG in community clinics near them.

Structured Referral

Referral was seen quite common in all the sites. Whenever the lower tier facilities could not provide a particular care, they referred the patients (i.e. the recipients) to a higher tier facility. The scenario was same for the disadvantaged recipients. Government facilities were the typical point of referral for all recipients. Private facilities and NGOs also refer to patients to government facilities, in case of any emergency or depending on the severity of the issue. A more structured form of referral was seen in CCs in two out of six sites. In both areas, the patients were given a referral form from the CC with which they went to the UHC, where they could directly go to the CC corner, bypassing the usual patient queue of the UHC. From health managers' point of view, structured referral was an effective way to manage the patient load in UHC, and increase utilisation of the CCs.

Changes observed by the recipients

Changes observed by the recipients from mainstream recipients were mostly positive and primarily regarding the infrastructure improvement. Some recipients mentioned about the improved cleanliness, added services and improvement in quality of care. A few of the respondents also noted the positive changes in behaviour and attitude of the health workers. Some improvements were identified in the supply chain of medicine as well by the recipients. However, some of the recipients thought the situation did not improve that much. Disadvantaged population with some access mentioned positive changes, primarily in the physical facilities related issues. Geographically isolated population could not report any change.

Satisfaction of the recipients

Mainstream recipients at CC and union level facilities were quite satisfied for the fact that they received medicine and treatment for free or nominal price, and near their home. For recipients of services from upazila and district hospitals, buying medicine from outside of the facility was unsatisfactory. They also complained of not getting proper treatment and being harassed at government hospitals, which they did not face in private clinics. Disadvantaged communities were dissatisfied with the public facilities. Hill tracts ethnic minority could not comment, as they did not have appropriate access to the government facilities.

Suggestions of the recipients

Suggestions from mainstream recipients included 'employing doctors, increasing equipment and services, particularly diagnostic services, increasing supply of medicine and improving behaviour of the providers. Suggestions from the disadvantaged population included arranging delivery facilities closer to the homes.

Conclusion

The assessment showed areas in which reviewers, including the MTR team should further explore. Due to the exploratory nature of this research, and predominant focus on the service recipients – there was no recommendations furnished by the team. However, based on this report – the MTR team may come up with recommendations to address the priority issues for the remaining period of the 4th HPNSP.

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CHAPTER ONE: INTRODUCTION

1.1 Context of the Assessment

Bangladesh has made significant improvement in Health, Nutrition and Population (HNP) sector, particularly in the areas of increase of life expectancy, improvement in maternal health, and reduction in under 5 and newborn child mortality (BBS, 2019). Ministry of Health and Family Welfare (MoHFW) is responsible for delivery of HNP services, strengthening the systemic compoents and ensuring governance and stewardship in HNP sector in the country, although Local Government Division (LGD) under Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C) is responsible for delivery of primary healthcare only in the urban areas. MOHFW primarily provides the HNP services through a Sector Wide Approach Programme (SWAp) modality, although it also has other discrete projects. Currently, MOHFW is in the process of implementation of the 4th SWAp, known as the 4th Health, Population and Nutrition Sector Programme (4th HPNSP). Midterm Review (MTR) is a management instrument in SWAp modality to monitor progress in the implementation and to verify whether management and policy objectives are met. To facilitate that review process, it is important to know the views of the recipients, regarding delivery of public health services from the implementing agencies under MOHFW.

"Civil Society Participation in Review of Government Programmes" is an initiative of Bangladesh Health Watch (BHW), with the goal to strengthen the healthcare system so that is more responsive to people's needs and demands. Through this project, BHW intends to support the MTR through systematically collection of opinion of the stakeholders. Assessment of Stakeholder Perception of Government Health Services in Bangladesh is an effort taken by BHW to collect opinion of healthcare recipients, particularly those from disadvantaged and underserved communities, to support the MTR of 4th HPNSP.

1.2 Situation Assessment of Public Health Services in Bangladesh

This section presents an overview of the public health services in Bangladesh. This has been developed based on a thorough literature review, methodology of which is presented in chapter 2 and detailed findings are presented in annex 1.

Focus of MOHFW during 2017-22 period was concentrated on three major areas - (a) strengthening MOHFW's governance and stewardship roles in the HNP sector; (b) strengthening systems/ institutions for efficient service delivery; and (c) expanding HNP services and emphasizing service quality both in public and private sectors (MOHFW, 2016). The programme design incorporated these three major focuses into eight strategic objectives (SO) (MOHFW, 2016) –

- SO 1: To strengthen governance and stewardship of the public and private health sectors;
- SO 2: To undertake institutional development for improved performance at all levels of the system;
- SO 3: To provide sustainable financing for equitable access to health care for the population and accelerated progress towards universal health coverage;
- SO 4: To strengthen the capacity of the MOHFW's core health systems (Financial Management, Procurement, Infrastructure development);
- SO 5: To establish a high quality health workforce available to all through public and private health service providers;
- SO 6: To improve health measurement and accountability mechanisms and build a robust evidence-base for decision making;
- SO 7: To improve equitable access to and utilization of quality health, nutrition and family planning services; and
- SO 8: To promote healthy lifestyle choices and a healthy environment

In the systemic component of the 4th HPNSP, around 30% investment of the SWAp budget has been allocated for physical facilities development, procurement and supply chain management, i.e. component

4 (MOHFW, 2016). As a direct outcome of this, the number of facilities and patient intake capacity has been increased quite significantly (DGHS, 2018). All of these facilities were designated to provide maternal and child health services, including Ante Natal Care (ANC), Post Natal Care (PNC), Basic Emergency Obstetric Care (BEmOC), outpatient curative care for sick children, child vaccination services and child growth monitoring (NIPORT, ACPR and ICF, 2018). However, quite a number of facilities are yet to have the readiness to provide BEmOC services (NIPORT, icddr,b and Measure Evaluation, 2017) and lack the equipment and supplies for child health services (NIPORT, ACPR and ICF, 2018). Very limited facilities provide Long Acting, Reversible Contraception (LARC) or Permanent Methods (PM) (NIPORT, ACPR and ICF, 2018). In terms of equipment, the focus is always on procurement of new ones instead of repair/maintenance of existing ones (Project Hope, 2014). Standardised protocols are sometimes not followed in procurement and installation, resulting even the newly purchased equipment becoming non-functional and obsolete (Himel, 2014) ((Begum & Islam, 2015). Similarly, in infrastructure, the focus is on new constructions rather than repair and maintenance of existing ones (IRT, 2018). Three key components of physical facilities in healthcare, namely infrastructure, equipment and human resources are often not done together, resulting in physical facilities being non-functional (IRT, 2018).

Considering the human resources of health (HRH), Bangladesh is experience a significant shortage, as well as imbalanced skill mix (HR Branch, 2019). This is a vital impediment in ensuring services provision, particularly in emergency obstetric care in public facilities (Biswas, et al., 2018), newborn care and newborn complication management (Billah, et al.) and domiciliary visits for counseling and primary healthcare (NIPORT and ICF, 2019). There is also equity issue, since present deployment of HRH is significantly skewed in favour of urban areas (WHO, 2018). Workload estimation, distribution and management for health workers in the public facilities also does not seem to be at optimum level (Joarder, et al., 2019). A vital component in service delivery under the present lean structure of HRH of MOHFW is the community health workers (CHW), particularly in ensuring quality maternal health services (Hossain, et al., 2020). However, system for development CHW is, neither institutionalised nor need-based (Talukder, Yasmeen, Nazneen, Hossain, & Chowdhury, 2014).

In terms of service delivery, as mentioned before, the extent of service coverage, particularly for maternal healthcare services like ANC, and PNC has been increased significantly (BBS, 2019). Facility deliveries have increased, although the prevalence is more in urban areas and among higher wealth quartile (NIPORT, 2017). There is a sheear dominance of private facilities in the areas of facility-deliveries over public ones, and bulk of these are C-section deliveries (NIPORT and ICF, 2019), and bulk of these private facilities do not have the required readiness (NIPORT, icddr,b and Measure Evaluation, 2017). MOHFW is providing kangaroo mother care (KMC) for low birthweight and premature babies, and Care of critically ill newborn at Special Care Newborn Unit (SCANU) (DGHS, 2018), effectiveness of which is too early to comment, since the interventions are in very early stage of implementations (Taylor, Manuel, Bhattacharjee, & Ali, 2017). There have been community-based and ICT-based interventions under practice to reduce neonatal mortality, and evidences suggest these have positive impacts (Baqui, et al., 2016) (Schaeffer, et al., 2019).

Results in family planning indicators like Contraceptive prevalence rate (CPR) and unmet need for family planning services are in a plateaued state for quite some time (NIPORT and ICF, 2019), one of the vital reasons for which is the decreased domically visit due to shortage of HRH (NIPORT and ICF, 2019). Failure of the FP fieldworkers in effective counseling for developing demands for FP services has also been identified as one of the reasons for plateaued FP status in the country (Das T. , 2016). Considerable improvement could be achieved in nutrition sector through reduction of stunting, wasting and underweight among children (NIPORT and ICF, 2019), although there are miles to go in addressing issues like further reduction of stunting among children, prevalence of micronutrient deficiencies among women and children and emerging overnutrition in adult women (MOHFW, 2016). Quality of Care (QoC) remains a concern, however, in service delivery, particularly in maternal healthcare (Biswas, Sujon, Rahman, Perry, & Chowdhury, 2019). The revised ESP provides a model of care that allocates service functions to facilities at different levels within the system, sets out the resources and capabilities required for each level of facility,

and takes an integrated approach to service delivery, but does not explicitly link the services to be provided with the expected standards of care (Hort, Cruz, & Sultan, 2017). Poor quality service in Bangladesh has been found strongly associated with low utilization of services, especially by low-income groups (Naheed & Hort, 2015), so there seems to be no other alternatives but to improve QoC to ensure equity in healthcare service delivery in the country.

Bangladesh is currently going through an epidemiological transition, and the burden of non-communicable diseases (NCDs) is emerging as a public health challenge (DGHS, 2018). NCDs like diabetes, hypertension, cardio-vascular diseases, kidney diseases, accidents, injuries, etc. are not only primary the cause for around 600,000 deaths in Bangladesh, but also a major cause for detrimental socio-economic status for the citizens (WHO, 2017). Major determinants of the increase in NCDs was found to be increased prevalence of being overweight, low fruits and vegetable consumption, insufficient physical activities and high tobacco consumption (NIPSOM, 2018). Healthcare facilities, particularly the primary healthcare facilities do not have appropriately trained health workers to manage NCDs, do not have proper equipment to screen the NCDs, lacks required medicine and supplies and put more emphasis on cure than prevention of NCDs (BHW, 2016). Mental health is another issue of growing concern, since 16.8 percent people aged above 18 suffer from any of the mental health conditions ranging from depression, anxiety to neurodevelopmental disorders and sexual dysfunction (NIMH, 2019). Stigma related to mental illness remains a significant barrier to treatment, which is only available at the tertiary level in the country (Hossain, Rehena, & Razia, Mental Health Disorders Status in Bangladesh: A Systematic Review, 2018). Drug addiction and drug abuse is another growing NCD concern, primarily related to peer pressure, anger, impulse and easy availability (Kamal, Huq, Mali, Akter, & Arafat, 2018). Antimicrobial resistance is a worldwide problem and Bangladesh is a major contributor to this owing to its poor healthcare standards, along with the misuse and overuse of antibiotics (Ahmed, Rabbi, & Sultana, 2019). Continuing care required for these NCDs and often expensive treatment interventions can result in immense pressure on the health system and potentially catastrophic costs to families through out-of-pocket expenditure (WHO, 2017).

Accountability and transparency is an issue in health sector in Bangladesh, as the existing structure and management of health organization does not facilitate health system accountability, which has been reflected in the high absenteeism of doctors in rural areas, corruption, poor service quality, and above all, the poor performance of service providers (Ahmed, et al., 2015). There are irregularities in supply chain management resulting in occasional stock-out of drugs, the use of public-sector medical equipment in private practices, trading of human organs, and private practice during office hours (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018). Though consultations are free in the public health facilities, there are instances in which recipients have to pay (Abdallah, Chowdhury , & Iqbal , 2015).

Unnecessary C-Section delivery in private facilities is another concern, since there are evidences of recipients being influenced by government primary health care providers and clinic agents (brokers) to undergo C section delivery even though the patients had specific preference for normal vaginal delivery (NVD) (Begum, Sarker, Rostoker, Anwar, & Reichenbach, 2018). Unethical practices by pharmaceutical industry in influencing prescribing behaviours of physicians which may not in patients' best interest have been observed (Mohiuddin, Rashid, Shuvro, Nahar, & Ahmed, 2015). There are other corruption issues that negatively affect resource use, increasing costs of treatment, medicines and equipment, decreasing quality of care and treatment outcomes; and deteriorating trust in the health system and service providers. (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018).

Breach of transparency has direct impact on limiting access to healthcare for poor and vulnerable groups (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018), i.e. affecting the equity in access to healthcare services. There are evidences of medical malpractice and exploitation disproportionately affecting the poor and less educated (Shafique, Bhattacharyya, Anwar, & Adams, 2018) – which is another example of lack of transparency having negative impact on equity in health care. In general, results of healthcare improvement have not been uniform throughout the country, in the form of hard-to-reach districts lagging behind other areas; rural areas lagging behind urban areas; poorer demographic groups behind richer ones; and women

behind men (Save the Children, 2018), (Kamal, Curtis, Hasan, & Jamil, 2016), (Akter, Rich, Davies, & Inder, 2019), and (Jonge, et al., 2018).

High out-of-pocket payments still persist in Bangladesh, which is increasing, with financing coming primarily out of the poor (Molla & Chi, 2017). This heavy reliance on OOP payments, particularly from poor, reduces household living standards and lead to poverty or ultimately push households to deeper poverty (Molla & Chi, 2017). There have been initiatives taken from government in ensuring equity in the 4th HPNSP, some of which have proven to be successful, including engagement of CHWs in urban slum areas (Angeles, Ahsan, Streatfield , El Arifeen, & Jamil, 2019), Demand Side Financing – Maternal Health Voucher Scheme (DSF-MHVS) of MOHFW (Das A. C., 2015) and Maternal and Neonatal Health Initiatives in selected districts of Bangladesh (MNHIB) (Haider, et al., 2017). There are some initiatives including Shasthyo Surokksha Karmasuchi (SSK) for which the evidence collection is in the process for identification of effectiveness.

While the above discussions provide a situation analysis of the public health system and services of Bangladesh, the findings of the assessment, presented from chapter three to six, detail out the perspective of the recipients of these services.

1.3 Rationale and scope of work for the Assessment

MTR is a vital process for government to review the approved operational plans as to their progress, relevance and feasibility of planned activities, emerging priorities, available budget in the context of the remaining implementation period, based on which, MOHFW make necessary changes in the SWAp mechanism in the context of changing epidemiology and emerging issues. To plan for an efficient health service delivery system, it is important to identify the experiences of the relevant stakeholders, particularly the service recipients for who the services are designed for, about their perception of the current health service delivery system and to gather their suggestions regarding how to address the gaps and unfinished agenda. Incorporating stakeholders' perspective into the program planning is an important step towards planning on effective and sustainable public sector health service delivery programs. This particular assessment has been designed to be a background paper for the MTR team that can be used as input for quick turnaround analysis to produce meaningful recommendations, not only in improving equitable access to and utilization of services, but also in increasing efficiencies in the systemic components. Particularly, it is expected that the assessment would systematically collect opinion of the disadvantaged and underserved communities and ensure their voices are heard and taken into account of in the appraisal and subsequent modification of 4th HPNSP.

Scope of work for the assessment include:

- Understand the access to and utilization of government healthcare services, particularly for marginalized people
- Understand the perception of the recipients on extent and quality government healthcare services

CHAPTER TWO: METHODOLOGY

Extensive literature review was carried out to understand the context of HNP sector in Bangladesh using "rapid review" method. The findings from this literature review is detailed in annex 1 of this report. The main findings were derived from primary data collection using qualitative methodology. A team of multidisciplinary researchers, including anthropologists, health systems expert and physician and public health expert designed and implemented the study. Data collection was undertaken by a team of anthropology graduates from two renowned universities of the country.

2.1 Rapid Review

The assessment systematically reviewed and included all available literature that provided information on health services of the government of Bangladesh link to the revised changes after 2014 year[1]. The search was done through PUBMED, MEDLINE and WORLDCAT databases for the article published between 1 January, 2014 to 22 January 2020, although, in a very few cases, some of the literature published before this timeline were used, primarily to define some of the issues included in this document. The search term included 'health services' and Bangladesh; 'health services' and Bangladesh and government; 'health services' and Bangladesh and government and SWAp/ HPNSP/ 'hard-to-reach'/ 'community participation'/ 'community involvement' / 'community engagement' / 'equitable access' / 'behavior change communication'/ 'universal health coverage'/ 'maternal health'/ 'reproductive health'/'child health'/ 'non communicable diseases'/'nutrition'/'transparency'. Search was limited by English language and for WORLDCAT some key words were limited to book and archival material. Since the assessment aimed to review information regarding the government health services of Bangladesh, the team considered peer reviewed article, and reports and other articles that were not peer reviewed. Some reports and articles were also manually included from the websites of MOHFW, DGHS, DGFP, NIPORT, BBS and WHO based on expert consultation to ensure incorporating all the information regarding policy documents and other gray literature. All articles were combined into a single list and duplicates were excluded. The detail criteria of 122 articles were included in the following figure.

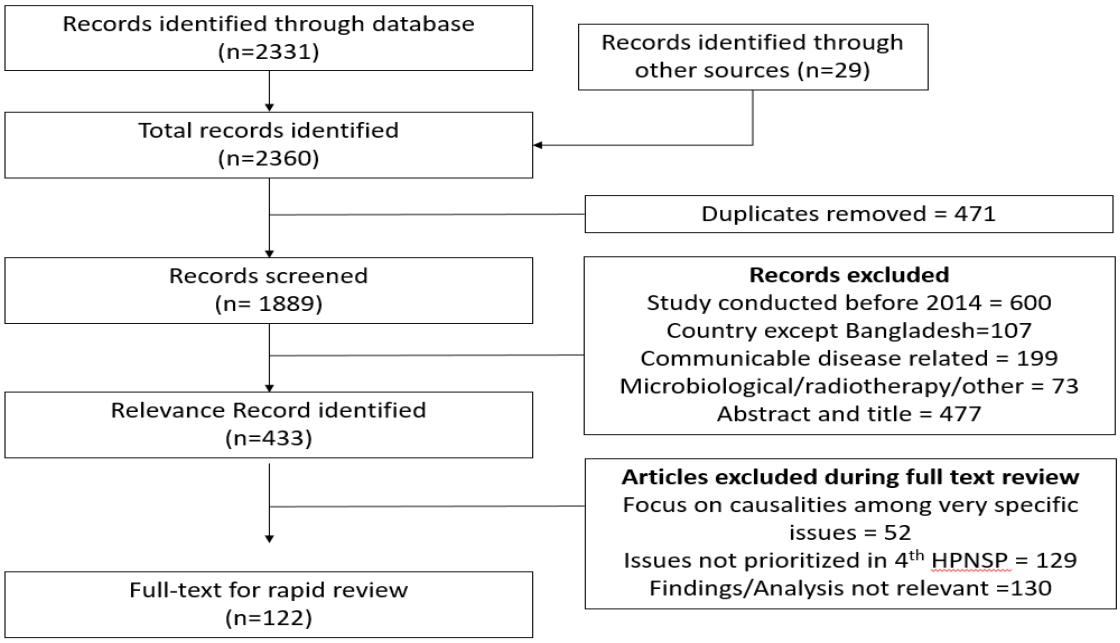


Figure 1: Flow diagram for Rapid Review

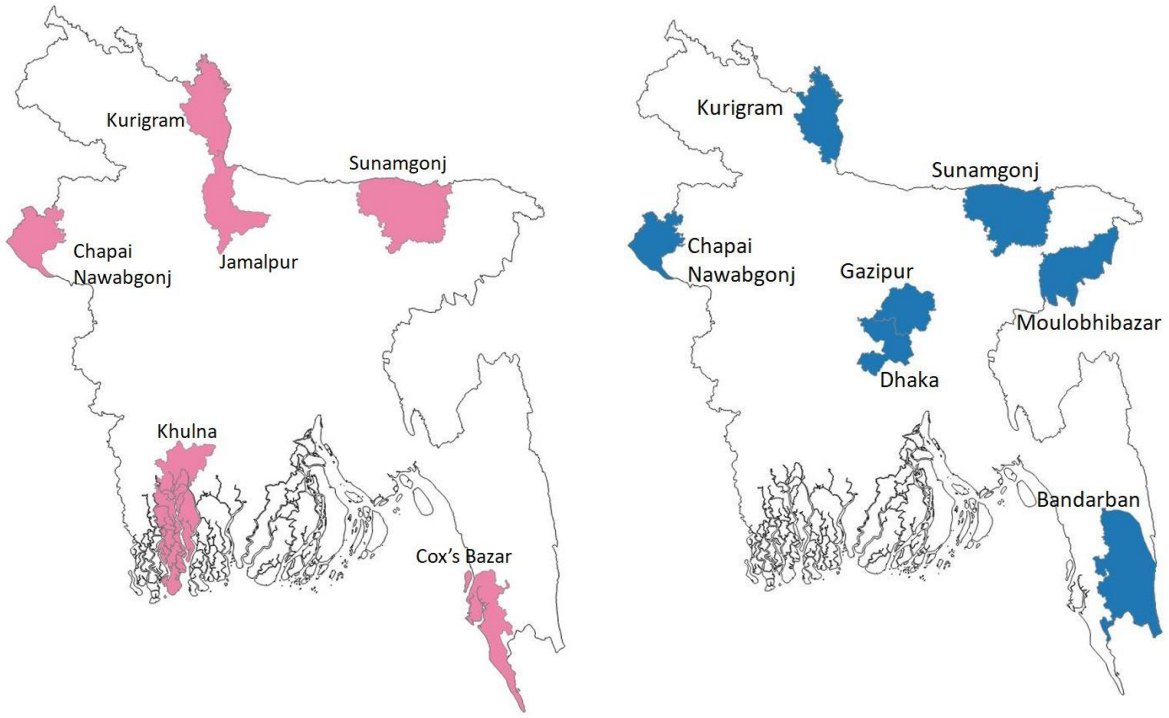
[1] This was the year in which the MTR of the 3rd SWAp, i.e. HPNSDP was conducted and major changes were made in the Program Implementation Plan (PIP), bulk of which have been carried forward to the current SWAp

2.2. Qualitative data collection

2.2.1 Study population and sites

The study was aimed at understanding the perspective of the recipients of public health services, i.e. that provided mainly by the entities under MOHFW and some limited services provided by MOLGRD&C (predominantly the primary healthcare in urban settings). In line with the PIP of 4th HPNSP, the assessment considered two categories of recipients – (a) the citizens that were termed as "hard-to-reach and vulnerable" and "marginalised" in getting the public health services, hereinafter being referred to as "disadvantaged recipients", and (b) the common citizens who are not marginalised or vulnerable and hereinafter being referred to as "mainstream recipients". Throughout the document, the words "users" and "recipients" have been used as synonymously.

While selecting the geographical locations, inclusion of divisions having different levels of performance in different health and family planning indicators (as per the SVRS, 2019 report) – high, medium and low and inclusion of diverse disadvantaged recipient group of people was ensured. Thus recipients that have been left behind and or difficult to reach (including population groups historically facing difficulties in accessing services, people with special needs, low-income urban population, slum dwellers, char dwellers, population living in haor areas, industrial workers, flatland ethnic minority and hill tract ethnic minorities) were purposefully included in the study sample.



Study districts for mainstream communities **Study districts for marginalized communities**

Figure 2: Study sites for mainstream and disadvantaged communities

2.2.2 Data collection

A group of 10 anthropologists collected data from January 12 to February 13, 2020 using a range of qualitative research methods, including focused group discussions (FGDs), in-depth interviews (IDIs), key informant interviews (KIIs), exit interviews, spot observations, informal conversations and informal observations (Table 1). Since the purpose of the assessment was to understand users' perspective, information collected were mainly from the recipients. However, information were also collected from some providers to triangulate and contextualize finding from the recipients. Respondents taken into the

assessment, were mostly women, pregnant or mothers of young children (preferably below five years of age), as they are the recipients of majority of services included in the 4th HPNSP. However, male and elderly were included in some of the FGDs. Table 1 below shows different data collection methods used, frequencies of the tools and number of participants.

Table 1:Data collection tools used for mainstream and disadvantaged recipients

Users	Frequency [No of participants]	Providers	Frequency
Tools used for mainstream recipients			
Exit interview with users of GoB services	23	In-depth interviews with GoB frontline workers	12
Exit interview with users of private health services	3	Informal interviews with GoB health managers	3
Focus group discussion (FGD) with users (recipients from communities)	6 sessions [51]	KII with workers at private clinic/facilities	2
FGDs with CG/CSG	6 sessions [43]		
Total respondents from mainstream recipient group	**120**	**Total providers for mainstream recipients**	**17**
Tools used for disadvantaged recipients			
FGD with ethnic minority (flatland and CHT)	2 sessions [17]	KII with NGO workers	2
FGDs with *Haor* population	1 session [8]	KII with NGO workers	1
FGDs with *Char* population	1 session [9]	KII with NGO workers	1
FGDs with tea garden population	1 session [8]	KII with NGO workers	1
FGDs with disadvantaged recipients in urban settings[2]	6 sessions [44]	KII with NGO workers	4
Total respondents from disadvantaged recipient group	**86**	**Total providers for disadvantaged recipients**	**9**
Total FGD Participants	**206**	**Total KII/IDI**	**26**

In addition to the above, a total of 23 spot observations were carried out in government health and FP facilities from different tiers.

[2] Slum dwellers, industrial workers, sweeper communities, and low-income urban communities

Figure 3: Exhibit of an FGD conducted with community people in the assessment

2.2.3 Data analysis

Thematic and content analysis were undertaken, using Atlas-ti 7.5 to organize the data. To enrich rigor and validity of the data, triangulation was made among different methods, between users' and providers' perspective, among different geographical regions, among high, medium and low performing areas, among different users' group and finally between the findings of literature review and primary data (Figure 4).

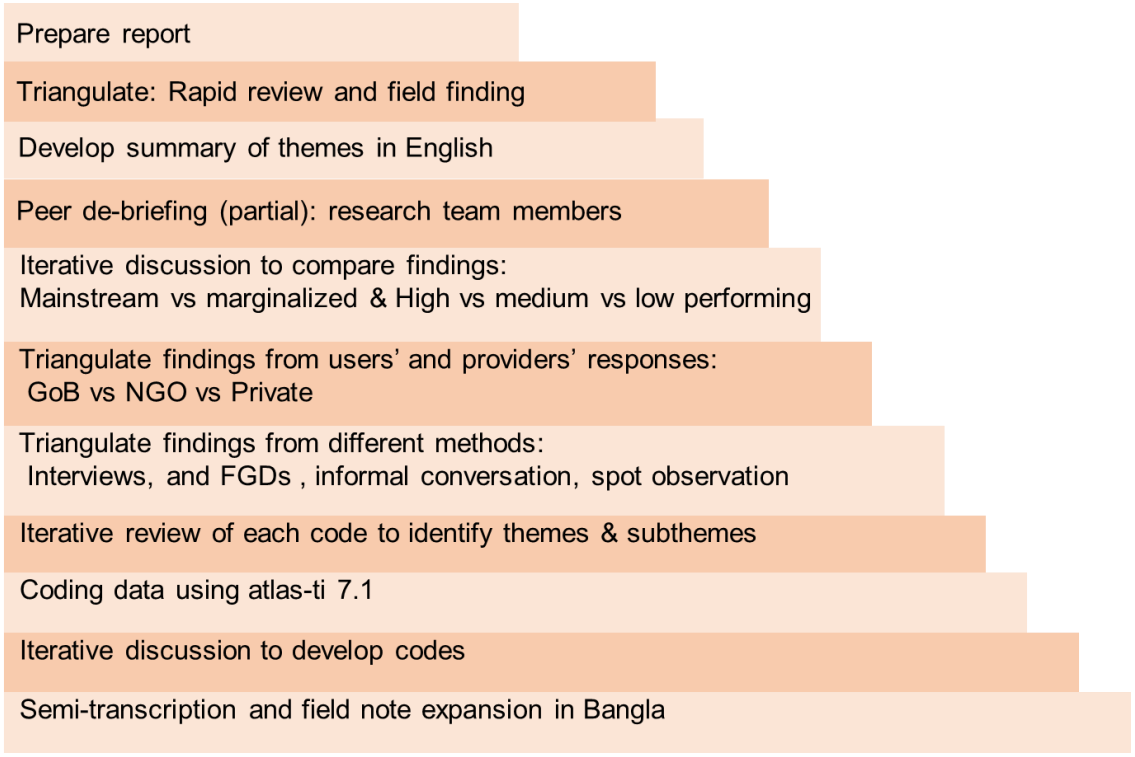


Figure 4: Data organising and analysis procedure

2.2.4 Ethical Considerations

The data collection team obtained verbal informed consent from all the respondents before conducting interviews and focus group discussions. To maintain the confidentiality if the respondents and make the data anonymous, all the identifiers were removed during data analysis. Verbal consent was taken from the respondents before recording the interviews and permission was taken before taking photos.

2.2.5 Limitations of the study

- In order to inform the MTR group for further investigation, the study was conducted in a very short duration (less than two months). It was challenging for the research team to accomplish in-depth qualitative data collection and analysis.
- We conducted this study in a small sample size; hence, the findings may not be generalizable to the population level or all other communities under similar categories. However, these findings provide a picture/an in-depth understanding of user's perspective of different health services provided and we view these perspectives as typical, particularly of the mainstream communities, as found in other studies included in the rapid review.
- Data were collected from users of the government healthcare services, who were mostly from lower socio-economic group (according to the respondents' own accounts), which may not represent the perception and practices of users from middle and upper socio-economic groups.
- Users included in exit interviews were mostly female, who visited the service facilities or lived near the facilities, thus their perspective was highlighted in the findings, creating an imbalance from gender perspective. However, focused groups with community groups included mostly men, who also provided information from users' perspective.
- Only a few exit interviews were conducted in the private clinics, therefore triangulation of findings for private clinic/facilities is sub-optimal. However, users of government facilities also shared experiences for private clinics, thus increasing the validity of the data.
- As the study focused on collecting users' perspectives, only limited number of providers were interviewed opportunistically for triangulation of the data. Providers at the district level facilities and managers from all facilities could not be included. Therefore, triangulation of the district level data could not be done from the providers' and managers' perspective.

CHAPTER THREE: USERS' ACCESS TO AND UTILISATION OF HNP SERVICES

3.1 Findings from Mainstream Recipients

Mainstream recipients reported taking services from government, as well as from non-government facilities (i.e. run by NGOs or private entities). Their purposes of receiving services from different providers have been shown in table 2. **At the community level, their first point of contact in healthcare services were the medicine shops (which they refer to as '*pharmacy*') or medicine sellers or village doctors for basic care.** They also mentioned seeking care at government facilities at the community level (i.e. CC), as well as at union level (UH&FWC or USC) for basic problems. They mentioned NGOs providing primary services through domiciliary visits. For more serious or complicated problems, which could not be solved at the community level, they reported going to government facilities or private clinics or doctors providing consultations at their chambers at the upazila (sub-district) level. If a service was not available at the upazila level, they mentioned going to the district level.

Selection of a certain facility or service point depended on the type of service and recipients' perception of availability of the services, capacity of the facility to provide care for the service required, expenditure to be incurred by the recipient for the service (i.e. out of pocket expenditure), distance to the facility, waiting time, recipients' perception of quality of care and environment of the facility including cleanliness, staff behavior, privacy and comfort. The team did not find noticeable difference across high, medium and low performing districts. Respondents from both recipient and provider groups reported that mostly those, who were poor, visited government facilities and those, who could afford, chose private clinics. The following sub-sections include further details on recipients' perspectives about government facilities at different tiers as well as NGO healthcare service providers and private clinics.

Table 2: Different service sought at government, NGO and private facilities (spontaneous responses from recipients)

Services	GoB Facilities	NGO**	Private clinic
	N=74	N=74	N=74
ANC checkup and medicine*	42	24	11
Primary health care and medicine*	30	7	4
Family planning	27	4	3
Counseling	19	22	0
Normal delivery	9	6	0
PNC	3	0	2
Child treatment and medicine*	7	7	10
NCD treatment	2	8	8

* Medicine was not expected while seeking care from private facilities

** NGOs mostly provided domiciliary visits

3.1.1. Government facilities

Community Clinic (CC)[3]:

Recipients reported visiting the **CCs mainly to collect free medicines** for ANC (mentioned as *care during pregnancy* by the recipients) and basic problems. For ANC, they mentioned collecting iron, vitamins, calcium and folic acid, sometimes along with checking blood pressure and weight. As basic problems, they

[3] CCs are the lowest tier of health service providing facilities, each designed to serve 6,000 population. Built in a public-private partnership model – the land of the CCs were donated by private landowners on which MOHFW built building and provided a service provider – known as Community Healthcare Provider (CHCP). There are community-based committees to manage CCs, known as Community Group (CG) and Community Support Group (CSG). Currently, there are around 14,500 CCs all around the country, providing primary healthcare services, including maternal, child and adolescent healthcare, basic screening for NCDs, and counseling for health, nutrition and family planning.

mentioned cold, cough, fever, vomiting, headache, body ache, itching, acidity and loose stool or diarrhea. Recipient also reported receiving FP commodities, only shot-term methods, such as pills and condoms, free of cost. When they went to the CC for medicines and FP commodities, sometimes they also received counseling on ANC, nutrition, family planning and child health. Normal delivery service was not reported to be available at CCs, except in one area, which was considered as a model CC. Home delivery by birth attendants (locally known as '*dai*') or experienced family members was preferred. However, respondents from some areas mentioned that 3-5 years ago, delivery services used to be provided in the CC. **Not having female staff was mentioned as a barrier to provide delivery service or service to adolescent and other female patients** both by recipients and frontline service providers. Recipient also did not frequently mention going for neonatal care or PNC (mentioned as *care after delivery* by the recipients) at CCs and only visited for vaccination and if their children had any minor health issues. Few CCs were also reported to run satellites at the CCs on certain days of a week. During these satellites, FWVs provided FP methods, such as injection, and health education on reproductive health, such as ANC, delivery and use of family planning methods. A CHCP mentioned that NGOs provided services through their CC.

> *For basic health problems, we go to the CC for paracetamol, histacin, etc. for cold, fever and cough.… We first go to CC, then we go to the UHC if we don't get the service at the CC... People don't come to CC for major problems because CCs don't provide with treatment.*
>
> FGD with community people in a CC in Chapai Nawabganj district

> *We counsel on condom, pill, injection, copper T, vasectomy, IUD, tubectomy. We refer long term (tubectomy, IUD, copper T and vasectomy) to UHC and distribute condom, pills and injection from here.*
>
> IDI with a frontline worker at a upazila in Khulna district

> *The CCs were not created to provide medicine. Government created the CCs to provide people with health counseling. But people won't come only for counseling. That's why they started distributing some medicines. But people are considering medicines as the primary cause now-a-days.*
>
> FGD with community people at a CC in Kurigram district

Unlike for other health facilities (as discussed in the subsequent sections) recipients did not complain about distance or waiting time or cleanliness for CCs. From the field visits, researchers also observed that CCs were located within the communities and were less crowded. Since the CC was close to their houses, recipients mentioned that **there was not much expectation for toilet facilities or privacy for breastfeeding**.

The **most frequent complaint about CC was unavailability of medicines** or not getting medicines in required quantities and preferential distribution. Some recipients also complained about unavailability of staff, poor staff behavior, staff favoring known people in providing care and some other issues related to transparency and accountability [Issues related to medicines, staff, transparency and accountability are presented in greater details in the following chapters]. Recipients of some areas also complained that the CC remained closed most of the times, which was also confirmed by our observation. Although staff from a few CCs reported FWA and HA doing home visits, recipients frequently mentioned **absence of domiciliary services** by the government staff, which used to be done 3-5 years ago. We found volunteers in only one of the six CCs.

> *Nobody comes to our homes from govt. One woman used to come 4-5 years ago... Although we get medicines from govt. for free, we don't get enough. That's why I go to local doctors. Even though I have to buy, I can get medicine on credit.*
>
> FGD with community people at Chapai Nawabganj

CCs were mostly perceived as **a facility for women**, not for men.

> *I don't go but I send my wife to the CC for medicine for cold, cough, fever, loose stool. Medicine for all diseases are not available here. For pneumonia, we had to buy medicine from the pharmacy.*
>
> FGD with community people at a CC in Cox's Bazar district

Figure 5: One of the CCs taken in the assessment

Union facilities - USC and UH&FWC[4]

Recipients of the exit interviews at the union facilities reported similar reasons for visiting as the CC, i.e., mostly to collect free medicines for ANC and basic care and FP commodities. Some general services were also reported be available, such as checking blood pressure, blood sugar and weight. However, FGD participants **could not always distinguish between CC and union level facilities** and often merged these two tiers when they shared experiences about the nearest government facilities. Although staff at these facilities recorded two to seven normal deliveries in their register for the previous month, **recipients did not report going to these facilities for normal deliveries or perceiving these facilities as 24/7 accessible facilities.** Visiting for neonatal care or PNC was also infrequently reported. An FWV shared,

> *Neonates come but less frequently. When mothers come to my satellite for EPI, they bring their babies and share about their health problems… I give IUD and copper T but not implant or surgery. That is done at the UHC.*
>
> IDI with a frontline worker at a UH&FWC in Chapai Nawabganj district

Unlike CCs, some recipients shared that due to long distance to the union level facilities, they did not prefer visiting unless they come nearby for some other purpose. Recipients also complained about unavailability or **shortage of medicines** and staff behavior for these facilities.

> *I didn't come (for follow up visit). My house is away (from here). It takes taka 10 (to come to this place). I collect medicines (from the FWC) when I come (nearby) for some other purposes…*

[4] Union level facilities of MOHFW, predominantly providing outdoor services. While USCs are under DGHS, majority of the UH&FWCs (also known as simply "FWC" are under DGFP. UH&FWCs have recently been designated as 24/7 delivery centres.

There's no rush (of patients) here. People don't come here frequently because medicines are not available in plenty. They go to the UHC more frequently, since any treatment is available there

Exit interview with a recipient of UH&FWC in Chapai Nawabganj district

> Excerpts from field notes of informal conversation and observation: The FWA was misbehaving with the recipients When the BHW team arrived, she called the recipients inside her room and ask them to sit and pretended to provide them with counseling and medicine. Recipients came out with a smiling and medicine in their hands. One of them said, "*I got medicine for cold because you came here. Otherwise she doesn't want to give medicines".*

As CCs, these facilities were also viewed **as facilities for women**.

Men also come but very few, as they don't get medicine here. They get demoralized and go elsewhere

Exit interview with a recipient in Cox's Bazar district

In one area, the union facility was situated near the UHC and many people were not even aware of the presence or functions of it.

Figure 6: One of the union facilities taken in the assessment

Upazila Health Complex (UHC)[5]

Recipients depicted **UHC as their first point of contact with a government facility for comprehensive care** if they did not get a solution at the community level. They also mentioned UHCs being their point of service in case of emergency. They mentioned going to UHCs for a range of services, including collecting free of cost medicines, blood and urine tests, visiting doctors in outdoor for prescription, pregnancy care,

[5] Secondary level healthcare facilities of MOHFW. These are comprehensive care providing facilities, having both indoor and outdoor services. UHCs are considered as the first tier of hospitals under the hospital network of MOHFW, with minimum of 31-bed intake facility, although 50-bed intake facility is the most common. While, in general, UHCs are under DGHS, most of the offices of UPFOs of DGFP are situated within the UHC, providing MCH, and in many cases, clinical contraception services.

normal delivery, especially with complications, child health, especially diarrhea and pneumonia, injuries, family planning, especially long-term methods, and disease specific treatment requiring hospital admission. Staff at these facilities recorded several 20-25 normal deliveries in their register for the previous month. Apart from these, healthcare providers at UHCs mentioned providing care for non-communicable diseases, adolescent health and nutrition. One UH&FPO also reported to have telemedicine facility. Recipients appreciated getting delivery services and consultancy from UHCs.

> *For pregnancy care, we go to the CC first, but CC remains closed most of the times. Then we go to UHC. The UHC is good for delivery. If there is any problem, then we can get a solution at the UHC*FGD with community people in a CC in Jamalpur district

> *For emergencies, we come here (UHC)… I come here (because) even if I don't get medicine, they prescribe medicines which I can buy from outside. If I go to a private clinic, it will cost me taka 500-1000. This is the benefit of coming here.*

Exit interview with recipients of a UHC in Cox's Bazar district

Despite acknowledging the range of services the UHCs were accessed for, recipients also mentioned a range of **complaints regarding access and quality of care provided**. Most frequently mentioned complaints were unavailability or **limited availability of medicines and diagnostic services**, such as ultrasound and sometimes X-ray, long waiting time and delays in providing care, staff not available or neglecting or behaving bad, doctors accessible only for a limited time of the day, informal payment for services, unavailability of C-section services, and unclean environment, including crowd and smelly toilets [Some of these issues are presented in greater details in the following chapters]. These factors had a negative impact on recipients' perception of quality of care from these facilities. Distance was also mentioned by some respondents as a barrier to access UHCs for healthcare services.

Figure 7: Mothers queuing to take services from the mother's corner in a UHC

> *UHC is supposed to have complete service but we don't get complete service because doctors neglect… (another respondent) We don't get medicines properly. If doctors prescribe five medicines, hospital will provide one or two and rests will have to be bought from pharmacies outside… (another respondent) They have ultrasound, ECG and X-ray machines but not in use. Doctors tell us to get the ECG done from outside, then we have to go to private clinic for ECG. This causes harassment.*

FGD with community people in Chapai Nawabganj

> *I came on Thursday of the week before. I stood in the queue at the ticket counter huddling with the crowd. Then I left. Then I came again Thursday this week and left again because I was towards the end of the serial/list for appointment. That's why I came at 7 this morning. I collected the ticket and am waiting for the doctor (midwife) for about an hour.*

Exit interview with recipients at a UHC in Cox's Bazar

A poor pregnant woman went to the UHC. It was Friday. Doctor would have come if nurses had called over phone. But they didn't admit the patient. They sent the patient to the district hospital. Babies leg came out. Then they fixed an ambulance which wouldn't go for less than taka 500. It took a long time for all these negotiations and the baby died on the way

FGD with community people in a CC in Khulna district

District Hospital (DH) and General Hospital (GH) at district level[6]

Recipients mentioned visiting hospitals at the district level for critical problems, which could not be solved at lower levels, for example disease **specific care requiring specialized consultants, C-section and other surgeries, and critical care**. They either went by themselves, as they knew that the service would not be available elsewhere or were referred by the lower level facilities or the village doctors or MBBS doctors doing private practice in chambers. Staff of a hospital reported that 26 normal deliveries was recorded last month. These facilities were also reported to have 13-40 C-sections last month. Besides, they also visited district hospitals for ANC, delivery, PNC, neonatal and child health, family planning, especially long-term methods, such as vasectomy, and other services mentioned for UHC. There was no mention of mental healthcare service for any facility.

For serious illness, for example chest pain, heart disease, TB, stroke, we go to district hospital or private clinic.

FGD with community people in a CC in Jamalpur District

We come here in case of serious issues. Once my father had a fight with one of my uncles and he was hit in his head. Then we came here.

Exit interview in Kurigram district hospital

My condition was critical. A 'dai' was arranged. I was under severe pain. Water broke but the baby wasn't coming out even after trying for 2 hours. Then all took me to the UHC. They said that it would require C-section and referred to the DH. In DH, they injected a medicine and then the baby came out! Then they gave me 2 saline and some medicines. They assisted the baby for breathing with a machine and gave an injection to stop the green defecation.

Exit interview at a UHC in Kurgiram district

Similar to UHCs, recipients complained about long waiting time, doctors' not giving enough time to patient, staff behavior, informal payments and unclean environment.

My child got cough and fever… We have to get a ticket for taka 5 and keep waiting in the serial (i.e., queue). This serial is the problem. Doctors come at 11 am but we have to queue for the serial since 8 am otherwise doctors wouldn't see the patient many time… Today doctor even didn't check (my baby) properly. (The doctor) only listened to what happened and checked on the back with something and said that it was pneumonia.

Exit interview in Kurigram district hospital

[6] These are tertiary level of hospitals, depending on the size and level of specialty. District hospitals typically have 100-bed intake capacity, while general hospitals can have up to 250-bed intake capacity. Both district and general hospitals have advanced and specialty-care facility. Both of these hospitals are under the hospital service management of DGHS

3.1.2 Non-governmental Organization (NGO) facilities

Mainstream recipients mentioned receiving services in the community **from NGOs mostly through domiciliary visits**. Women from NGOs visited households in the communities to provide counseling mainly to pregnant women and sometimes mothers of young children and adolescents. They provided recipients with counseling on ANC, PNC, nutrition, family planning, adolescent health and child health. They also provided medicines, especially iron, calcium, vitamin and folic acid, distributed pills, condoms and sanitary pads, and measured blood pressure either free of cost or in exchange of nominal charges or membership fees. Some recipients mentioned visiting NGOs in their locality for free medicines and checkup. Some NGOs also provided normal delivery and vaccination services. Some NGO workers also visited patients **in their households on call in emergencies** or when needed. Women frequently mentioned preferring buying suitable pills from NGO women or medicine shops over collecting free pills from government facilities, since they experienced side effects of the pills supplies by the government, such as dizziness and becoming lean and dark.

> *If we get membership card for taka 100, we get free treatment for a year. Then they come home and check blood pressure, weight, and diabetes. When their doctors come, they prescribe medicines (without any visit), which we have to buy from outside. They also provide counseling on nutrition.*
>
> Exit interview in a CC in Khulna

Recipients sometimes could not differentiate between NGO and government service, especially for domiciliary visits (for vaccination and counseling). Sometimes they also confused NGOs with private clinic, when they talked about 'non-government' facilities.

> *My baby was born at home. A lady used to come for (ANC) checkup every month or every alternative month but I don't know whether she was a government employee or NGO worker. I never asked. She came after 4-5 months of pregnancy. She gave me iron and calcium tablet since 5 months of pregnancy. I didn't have to pay for medicines. She also gave me counseling.*
>
> Exit interview at Kurigram district hospital

However, some NGO workers were reported to sell the commodities among the community recipients. A recipient also reported that if they called the NGO worker in their area **for normal delivery, she charged taka 3,000-4,000**. Some NGO workers **received taka 30-50 for every visit of ANC checkup**. Recipients also mentioned that NGO services were only available for a certain day of a week or a month. Some NGO workers sold medicines at a subsidized rate than the medicine shops, for example taka 50 for a strip of medicine worth taka 60.

> *Both CC and NGO facilities are good but we cannot get service from NGO all the time. We get medicine from the CC. We get service all the time from CC.*
>
> Exit interview at a CC in Khulna

3.1.3 Private facilities

Community recipients frequently mentioned seeking care at the medicine shops or from medicine sellers for primary health problems. For more serious issues, they also visited village doctors or private practitioners practicing in their chambers in the local markets or at medicine shops.

They mentioned seeking care from private clinics for services that they could not avail from government, such as, **diagnostic services and C-section delivery services**. They also reported visiting private clinics because the government hospitals did not have **female gynecologists or specialized doctors**, who were available at those private facilities. Some recipients also mentioned that those, who could afford, went for

private clinic for **prompt service, personalized care and clean environment**, which they could not consider availing at the government facilities.

> *We went to the UHC; they don't go ultrasound. This clinic does. Doctor checked in the UHC and suggested that we should come to this clinic for ultrasound… **Govt. is govt.** Clinic is different… Govt. hospital service is slow. Clinic does 10 days' job in 5 days. It runs on money. Those, who can bear (in govt. hospital), stay; those, who cannot, pay money and leave… Poor people mostly go to govt. hospital. As I have money, I prefer staying 5 days in clinic than 10 days in govt. hospital. The clinic is safe and clean. All good. That's why we come here.*
>
> Exit interview in a private clinic in Jamalpur district

> *District hospital does normal delivery. There's no arrangement for C-section here. C-sections are only done at the private clinics.*
>
> FGD with community people at a CC in Kurigram

> *A government facility is a government facility. They do provide service but take time. If a patient is taken there and the doctor comes after 11pm, the patient may even die. That's why we take the emergency patients to private clinics.*
>
> FGD with community people at Cox's Bazar district

Recipients also mentioned visiting doctors in private practice at their chambers for convenient location, availability and timing.

> *Dr. XXXX sits in the chamber. He is a govt. doctor. He checks patients from his home. I go to his chamber… We can go to the chamber at a convenient time. It takes time to go to the DH. Then they don't see patients after 2pm. If we have to reach there before 2 pm, we have to start very early. It's better to go to the chamber.*
>
> Exit interview at a CC in Kurigram

> *We go to Dr. XXXX's (a doctor from the UHC doing private practice at a medicine shop for a visit of taka 300) chamber because it is nearer and the UHC is far from my home and it requires same money for transportation cost.*
>
> FGD in a upazila in Kurigram

3.2 Findings from Disadvantaged Recipients

Access to and utilization of health services varied across different categories of disadvantaged recipients. While the workers at the teagarden and garment industry and the flatland ethnic minority community were found to have access to multiple healthcare facilities provided by government and private providers, including additional options than the mainstream recipients, the low-income communities belonging to urban areas were found to depend largely on private and NGO facilities. On the other hand, geographically isolated communities were found to have least access to any healthcare option amongst all communities studied. A brief description about healthcare access of the recipients from each category of communities has been provided in the sub-sections below.

3.2.1 Workers at teagarden and garment industry

Workers from the teagarden and garment industry taken as respondents in the assessment reported that they had access to all government and other healthcare facilities, as observed for the mainstream recipients. In addition, they **had workplace-based healthcare service facilities** run by their employers. The workers, who participated in the FGDs, shared that these facilities **provided free healthcare services** to the workers and their families. The respondents mentioned services from these facilities included mainly basic curative care, such as treatment for fever, cold, cough, diarrhea, etc. and primary management of NCD like hypertension first aid for minor injuries. **For more serious illnesses, they reported going to**

government hospitals or private clinics. They also said that if anyone was referred to UHC or DH from the teagarden hospital, then teagarden authority bore the transportation cost and 50% of the treatment cost. In the garment factory, the authority referred serious cases to private clinics and bore all costs, including transportation. **Female healthcare workers were available within the facilities of the teagarden and garments** and authorities kept checking on the condition of their employees. The enlisted employees also got medicines from the teagarden and garment facility. However, since we only included one facility under each category in this assessment, these features may not be generalizable to the entire tea garden or garment industry of the country.

> Excerpt from the observation note of the teagarden health facility: There was a hospital in the teagarden with arrangement of separate toilet, water in toilet, cabin, curtain, bed and separate queue for collecting medicine in exchange of token. The facility was not open/functional at the

(For ANC checkup) We go to XXXX clinic. We go during office time, they (the garments authority) sanction us leave. We have to wait there (in the clinic) for the doctor. If we take a slip from our office, then we don't have to queue. There are people (from the garment authority), they drop us (at the clinic) through their vehicle. They also keep checking on our condition and come to take us back when recovered. We join back if we recover, otherwise, they sanction us leave.

FGD with garments workers at Gazipur

Figure 8: A non-government healthcare facility available for the tea garden workers within the teagarden premise owned by the teagarden authority

The workers reported that in both communities, 100% of the expenditure had to be borne by the patient if anyone goes to private clinics or other facilities without referral. Most workers underwent **normal delivery at home through *dai*** or in the facility at teagarden and **C-section, on the other hand, took place at private clinics**. The workers mentioned that if they remained admitted in government hospitals, then they would be absent from duty at the garden for a longer period and lose wage. So, they preferred treatment from the private sector to get well quickly.

We go to private more often because government hospitals take longer time and requires collecting ticket, queueing and someone to accompany. By that time, I can be home after getting treatment from the private clinic… We know doctors outside that's why we don't go to government hospitals. We go to private clinic for service during pregnancy.

FGD with garments workers at Gazipur

One day when I went home for lunch I saw 2 ladies came from Marie Stopes to give me a card and said that the treatment is free. I said that I don't have time for treatment. I work at the garments and they provide us with treatment facilities.

FGD with garments workers at Gazipur

3.2.2 Flatland ethnic minority

For the flatland ethnic minority living amongst the mainstream communities, **access to healthcare facilities was the same as the mainstream communities**. Moreover, they mentioned receiving healthcare services from an additional facility, which was a **missionary hospital that provided subsidized treatment to the ethnic communities**. They mostly accessed missionary hospital services for healthcare and expressed their resentments towards the doctors of government facilities.

> *In government hospitals, Muslims even don't get service after queueing, let alone us – Hindu indigenous communities. What service we can expect there?... They became doctors only to show pride. They don't consider people as human beings. If they did, they would've provided us with service. Patients keep waiting day and night but they don't care… Those, who can show power, medicals are for them… I bought an injection and kept requesting to give it to my patient for 3-4 hours. Are they doctors or something else?*
>
> FGD with the ethnic minority recipients at Chapai Nawabganj

3.2.3 Low-income urban communities in Dhaka

Recipients from low-income urban communities reported homogenous access to and utilisation of services across all five sites. For basic care, they depended on medicine shops. They frequently received **healthcare from NGO providers for ANC, delivery, PNC and family planning services**. For **more serious issues, they visited private clinics or MBBS doctors** doing private practice at their chambers. **Government facilities was infrequently mentioned as a service point**, although for extremely critical problems, they visited specialized tertiary care government facilities. However, they **complained about harassment in being referred to too many places**. They preferred to spend the money required to go to government hospital at a nearby private facility.

> *For fever, cold and cough, we go to medicine shops. For severe illness, we take our children to the doctors. They take taka 300 as visit… Private is good. They take money but do not harass. In government, they take money and also harass people.* FGD with a low-income urban community in Dhaka

Recipients did not complaint about environment or staff behavior of the NGO facilities. However, **most frequent complaint about NGO service was that NGOs charged money for services and medicines**, which they did not use to do earlier. A trend was observed across responses from different communities that **NGOs first started with free or subsidized service but after some time they started charging** to keep the facility running after the external funding was exhausted. People also shared that there were some better health facilities in their villages compared to Dhaka.

> *When I was pregnant, I used to go (to the NGO) for ultrasound and I didn't require any money. But now they take taka 500. They first say that it won't require money. And then they claim money. When we show them the card, they say, 'this card is valueless, money is required'… (another respondent) My baby is 9 months old, was born at the NGO. It was a C-section. It took taka 11,000. The baby had jaundice and had to be given two injections for taka 10,000.* FGD with a low-income urban community in Dhaka
>
> *They (NGO workers) come for domiciliary visit and patients also visit for vaccine, healthcare service for pregnant women. Earlier they used to provide calcium and iron, now they don't. We have to purchase those. They receive taka 100-200 now… (another respondent) We all use injection (for FP). Ladies come and give injection for taka 50 and medicine for taka 200. We say, 'Why would we pay you money for these? Government has given you these to give us for free.' They say, 'I'll give you calcium but you have to buy it with money.' In our village, they rather give food – 2 eggs, money after every 30 months and lot more things… If I earn taka 5,000 a month, then do I pay for house rent or medicine or food?*

FGD with a low-income urban community in Dhaka

The participants did not report any discrimination due to being engaged in a specific profession (e.g. sweeper).

3.2.4 Geographically isolated communities

For the Bengali Muslim communities living **at geographically isolated sites, healthcare options were very limited and hard to reach**. They preferred **visiting the nearest medicine shops or local doctors in private practice** in the local markets (which were also hard to reach) over government facilities. They did not report **domiciliary visits by any government staff**. Workers from a couple of NGOs visited the communities, but infrequently and mainly for reproductive health services. Since CCs were far away, people rarely visited these unless there was anything serious. Respondents of the FGD in one site were not even aware of the presence of any government facility below the level of UHC. Only one respondent mentioned about a CC in the union, but mentioned that they didn't go there, since it took about same time to go there as it took to go to the UHC – about an hour. At times, they faced even the extreme consequence of a patient dying on way to the health facility.

> *During rainy season, it takes 2 hours and taka 20 if we go by boat and taka 60 and 15-20 minutes if they get a motorbike to go to the UHC. In emergencies, if we reserve an engine boat, it takes taka 600-700 and about an hour.*

FGD with haor population

> *My baby was 2.5-years old. He had breathing difficulty. They didn't provide care at UHC (probably referred), then my baby passed away on the way to the DH.*

FGD with haor population

Among all our study communities, ethnic minority community of the Chittagong hill tracts was the most marginalized in terms of access to healthcare services. The c**losest government facility required one hour walk**, with no available transportation. **No domiciliary visit** was reported by government or NGO staff, except for a single staff of a program, who had two-days training for malaria and TB. Basic service and medicines were available at an NGO located within several kilometer distance (yet hard-to-reach) but catered only its employees and their families free of cost. Some mentioned that they **did not go anywhere for health service because they did not have money. Women did not perceive requirement of any special care during pregnancy**. Only one mentioned that her name was listed through the chairman of their area for which she was called at the government facility and received taka 9,000 and two types of medicines. Her delivery was done at home by her mother-in-law. Nobody followed up and she also did not go anywhere post-delivery. No doctor was available on call for emergencies. For family planning, one respondent said that the money required for transportation to go to government facility can be rather used to buy FP commodities. Elderly people who go to the local market bring medicines for them according to the symptoms.

> *It is difficult for us to pay for transportation to go to the hospital. The money needed to pay for transportation could be used to buy medicines.*

FGD with community people in among Chittagong hill tracts ethnic minorities

No awareness or screening of non-communicable diseases was reported by any of these isolated communities.

Key findings

- Medicine shops, medicine sellers and village doctors were first point of contacts for recipients at rural communities in case of basic healthcare
- Recipients visited CC and USC/FWC mainly to collect free medicines and FP commodities and could not distinguished between these two types of facilities
- UHCs were appreciated for delivery and consultancy services but criticized for limited availability of medicines and diagnostic services, delays in providing services, staff behavior and unclean environments.
- Recipients depended on district hospitals for specialized consultants, C-section and other surgeries, and critical care but complained about long waiting time, doctors' not giving enough time to patient, staff behavior, informal payments and, unclean environment.
- NGO services were recognized for domiciliary visits in rural sites
- Private clinics were frequently visited for diagnostic services and C-section delivery services, appreciated for prompt service, personalized care and clean environment but criticized for high charges
- Disadvantaged population had varying access to public health facilities, and it was found to be more for those living close to mainstream population but less for geographically isolated communities

CHAPTER FOUR: PUBLIC HEALTH SYSTEM

4.1 Physical facilities

During the field observations, new infrastructures were seen in almost all sites. However, these infrastructures were not observed to be used optimally. In spite of having the infrastructure and supplied with equipment, majority of the facilities at district and upazila level were found not providing most of the diagnostics and laboratory services, resulting in recipients going to the private sector to avail the service. Crowded, unclean environments, inadequate supply of medicines, lack of required healthcare personnel and compromised privacy were overarching complaints by users of government health services from all sites. Issues of physical facilities were almost similar regardless of the mainstream and disadvantaged communities living close to mainstream communities. Private clinics, on the other hand, were appreciated for cleanliness and availability of diagnostic services. However, no such physical facilities were seen in the vicinity of the geographically isolated population. The study team conducted spot observations, primarily on physical facilities aspects, results of which are shown in table 3.

Table 3: Spot observation findings on physical facilities

Physical Facilities Issues	CC n=6	USC n=6	UHC n=6	DH n=3	Total N=23
Presence of Citizen Charter	5	6	5	5	21
Presence of pharmacy	0	1	6	5	12
Presence of complaint box/number	0	2	6	5	13
Privacy (Screen) during checkup	2	4	5	5	16
Number of Copper T done*	0	2	4	2	8
Breast feeding corner	1	N/A	4	5	10
Nutrition corner	N/A	N/A	4	4	8
Adolescent corner	N/A	1	2	2	5
Dental unit	N/A	N/A	3	5	8
Tele medicine	N/A	N/A	1	0	1
TB corner	N/A	N/A	4	2	6
NCD corner	N/A	N/A	6	3	9
Pathology chart	N/A	N/A	5	5	10
VIA test room	N/A	N/A	6	3	9
CC corner	N/A	N/A	3	0	3
Presence of waste bin (color bin for UHC and DH)	4	4	6	4	18
Separate row for male & female in ticket counter	N/A	N/A	5	5	10
Separate row for male & female in pharmacy	N/A	N/A	6	4	10
Presence of sitting arrangement	6	6	6	4	22
Separate row for male & female sitting arrangement	N/A	N/A	5	4	9
Presence of toilet in outdoor	6	6	4	2	18
Separate row for male & female toilet in outdoor	N/A	N/A	4	2	6
Presence of normal delivery arrangement	4	5	6	5	20

4.1.1 Mainstream users' perspective on infrastructure

Majority (8/11) of the district and upazila hospitals were being **operated from both new and old buildings,** as observed during field visits. All the **new buildings were** observed being **partially used** with some (most in some cases) sections running from the old buildings. In two hospitals (one district and one upazila), new building construction was ongoing since last 2-3 years. In another district, the hospital was operating from old building. Some facilities mentioned flooding as a crisis when the ground floor became unusable or they had to keep all stuffs on the tables or elevated platforms.

Overcrowding remained a problem at the district hospitals. Patients frequently reported sharing beds. A recipient shared,

I managed the release letter forcefully. These two days, ***four patients stayed in one bed****. We couldn't sleep at night, kept sitting whole night taking the baby on lap. Doctors allocate patients in the same bed. What would they do? No seat available. If my child stays here, he will get sicker. They prescribed medicines, which we can give at home.*

Infrastructure supportive of equitable access, privacy and comfort: Most district and upzila hospitals were observed to **have separate infrastructure for men and women to queue at the ticket counter, pharmacy and the waiting place** (Table 4). Separate arrangements were also observed in the consultancy rooms of a few facilities. In district hospitals, the arrangements were usually maintained but in most UHCs, these arrangements were not maintained. **Men and women were seen huddling together in the same queue or waiting arrangement** despite visible identification labels. No separate arrangement for men and women was found at the facilities of union or CC. Ramps for disabled persons were available for wheelchair and trolley movement in most DHs and UHCs but no such provision at the lower levels. One recipient shared that few days ago he took his sick father to the district hospital, where the patient had to go to the third floor and the lift wasn't working. Then he had to lift his father on his shoulder and climb up to the third floor because there was no ramp in the new building. Recipients also **complained about privacy during check-up**. During an FGD, respondents shared,

Figure 9: Separate queue arrangements for, among others, collection of medicine from dispensary for men and women is quite common in upazila and district hospitals

Two doctors sit in two tables in the room where patients are checked – one male and one female. Female patients cannot discuss their problems openly because there are many male patients just beside them… (another respondent) *there's also no separate sitting arrangement for elderly patients…* (another respondent) *There is no scarcity of rooms in the UHC, still service is not provided separately to male and female patients.*

Different corners for example, breastfeeding corners, nutrition corner, adolescent corners, CC corner were also visible in the facilities. In one UHC, the breastfeeding corner was used only for staff. In another UHC, although it was written in the wall, there was no isolated corner and the mothers were breastfeeding their babies sitting on the benches in that place. In a hospital, we also found kangaroo mother care (KMC), beds allocated for freedom fighters and disabled, and stomach wash corner. CC corner was found in three UHCs but it was observed to be functional only in one. In one of the FGDs, recipients mentioned,

The ward they assigned us is a male ward. Breastfeeding in that ward is very troublesome but they assigned most of the children in this ward.

Infrastructure of toilet was available in most of the health facilities (Table 4). **Separate toilets for female and male at the outdoor facilities was not available** in all the district and upazila health facilities (Table 4). Separate toilets for men and women were not found in facilities at the community and union level. **Gender specific use was observed only in one district hospital and in one upazila** h**ealth facility** and in the rest of the facilities common use was observed both by male and female users. Four of the six union facilities and three of the six CCs did not have functional toilets. Most toilets at union and community levels **did not have functional taps or water pot**s. However, since the recipients visit CC or union facilities for short time and are mostly from locality, **there was no demand for separate or functional toilets from**

the community in these facilities. Complaints about cleanliness of toilets were frequently reported for DHs and UHCs.

A mother of a child patient shared at a UHC shared,

> *The toilet is very dirty. We have to hold our breath while using it… All the children have diarrhea. I cannot bear the smell of feces anymore. There is no tap in the washbasin. No arrangement for washing hand and face.*

Figure 10: There are separate toilets for men and women at upazila and district hospitals - however, most of these are not cleaned

Figure 11: Waste disposal in one of the UHCs, not maintaining the standard and guideline of medical waste disposal

Overall, **unclean environment was observed in most DHs and UHCs**. All kind of wastes, including medical wastes, paper, food remnants, spit, soot and animals (cats and dogs) were observed inside the facilities. Facilities at lower levels were comparatively cleaner, especially the CCs. All DH and UHCs had colored bins, except one DH, although majority did not maintain the recommended use and wastes were observed to overflow or being dumped around the bins. CCs and union facilities did not have colored bins but had other bins for waste disposal.

Infrastructure for C-section was reported to be available and functional at the district level. **None of the UHCs reported a functional facility for C-section**. Infrastructure for normal delivery was found in most facilities at the union and community level and few were functional. Facilities for long term family planning methods were available at the UHCs. Operation theatre for family planning was also available in some UHCs, but reported to be used two times a month during camp.

Excerpts from the observation note: (Presence of) DOTS corner/T.L.C.A. room (locked); posters on TB, malaria and AIDS; pricelist for services, pathology list' X-ray room (locked, the service was withheld at that time and mentioned in the pathology charter); pathology laboratory room; unclean environment, ditch, abundance of mosquitoes (probably from stagnated water); separate queues for men and women, long queue of women in front of the outdoor but only 2-3 persons in the queue for men; long queue in front of the medicine distribution counter, although there were separate queues for men and women, some women also queued in the queue for men; crowd of women and children in this hospital, since services are available more for the women and children; some old men standing in front of the doctor's room for cold, cough and breathing difficulty; list of medicines in the medicine distribution counter; complain box and a number to SMS directly to the ministry; posters with health messages on diarrhea, smoking, waste disposal, AIDS.

4.1.2. Mainstream users' perspective on diagnostics – pathology laboratory

Pathology laboratories were found functional for majority of the UHCs. **Unavailability of the services for X-ray, ultrasound, ECG was reported frequently** by the recipients of the exit interviews, especially from low performing sites.

One recipient at a district hospital said,

> *Although there are equipment for blood test, ultrasound and X-ray in this hospital, none of the services are functional. That's why they give us 'slips' to refer outside.*

Excerpts from the observation note: I checked and found that the rooms were locked and not in use for a long time. A staff informed that no skilled staff had been recruited for those services and that's why there was nobody to operate the machines.

At the union level facilities, service for measuring blood pressure and weight was available. However, **recipients frequently reported not getting any service for testing diabetes, blood or urine**. In one of the FWC, a recipient reported that a 'gas machine for breathing' (nebulizer) was given from the government but it was not yet functional. Service for checking weight and blood pressure were functional at all CCs. However, diabetes tests were not available in any of the CCs.

4.1.3 Mainstream users' perspective on medicine

The one area where community recipients from all facilities from all sites were found most vocal and demanding was the **'medicine'**. Pharmacies were available in all the district and upazila health facilities but not in all union or community clinic facilities (Table 4). **Inadequate supply of medicines and unavailability of some types of medicines that the recipients expect or demand** – was an overarching complaint at all levels of government facilities from all sites. In facilities at the union and community levels, **medicines were not available after two weeks of supply**, which was reported by the recipients. Recipients went to government facilities for medicines and became demoralized because medicine was not available; they bought medicine from the drug-store with money. Recipients were also not satisfied with the partial doses provided.

> *We get treatment here but they only prescribe medicines and we have to buy those from outside. I am poor. I come here with the hope of getting (free) treatment and medicine. If I have to buy from outside, why would I come here then?*
>
> Exit interview at a UHC in Chapai Nawabganj

Some recipients also complained about paying money at the government facilities for medicines and were not aware about the purpose of receiving money from the recipients for medicines at the CC. During an exit interview at a CC, a recipient shared,

> *I took medicines for myself and my mother. I had to pay 10 taka for the medicines. I don't know why but if I don't pay, the Member (representative of local administration) rebukes.*

4.1.4 Provider's perspective regarding infrastructure, equipment and other physical facilities

During informal discussions[7], managers admitted majority of the issues observed for the physical facilities. One manager at a UHC shared that the hospital infrastructure was not patient-friendly. They claimed that some of the improvements took place because of their own initiatives. They also shared that despite reporting the issues to their higher authorities several times, most of their problems sustained over years. A manager shared,

> *When I first came here, I wondered, this department is so poor that I have to buy water pots and light bulbs for toilets, let alone water! I started sending letters to every place and talking over phone. (Then received some money and) I set up a pump with the money that came in by the June closing. Now attendants of the patients also take shower and wash clothes because it's in the North Bengal (dry area) – water is very scarce here.*

Managers reported **not having technicians for laboratory and X-ray**. At the UHCs, service providers reported that equipment were going out of order for not being optimally utilized due to lack of technicians (e.g., OT, X-ray, ultrasound, ECG). These factors affected providing quality care to the patients.

In one CC, staff reported that NVD used to be done in that CC earlier but did not serve anyone in last six months. In the other two CCs, staff reported **NVD was not done due to unavailability of electricity and water or FWA**. Staff also reported that **birthing arrangements were not utilized because patients did not come to CCs** for normal delivery. A CHCP shared,

> *When he calls pregnant women for delivery in the CC, their family refuses saying, "there's no MBBS doctor or ambulance in the CC. The UHC is about 10 km away from the clinic and the roads are bad. If the patient is critical, then how can she be transferred elsewhere?" That's why nobody comes to the CC for delivery.*

A facility manager at a UHC shared,

> *This facility will not be able to score for C-section or blood transfusion because these facilities are not available here. Facility for blood bank is also not available – only for lack of human resource. There are only two posts for pathology. Ministry has to create posts, only then blood bank could be initiated. These problems have been reported (to the higher authority) and still continuing for a long time.*

Unavailability of medicines after two weeks of supply was admitted by the providers. **Providers also admitted that they did not provide recipients with full doses** and some mentioned that this is how they coped with limited supply. Staff at a union facility shared,

> *In case of a 7-day course of antibiotics, I give 4-6 doses for 3 days because if I give the full amount to one patient, then the stock will be short for others. If the patient doesn't recover in three days, s/he comes again, then we give the antibiotics again if available.*

A manager at the UHC also justified why the patients were not provided with antibiotics in full doses –

[7] Although this was a users' perspective assessment, in applicable cases, the team took the opportunity to discuss with some providers to triangulate some findings, such as "physical facility" The perspectives presented here are only of those who participated in the assessment and may not be generalizable to all/most health facility managers of Bangladesh.

We don't give the complete doses of antibiotics for 10 days altogether. We give those for 3-4 days and ask the patient to come again (for follow up). This is the system. In some cases, the antibiotics are not required but patients are not satisfied. In those situations, counseling is required.

4.1.5 Disadvantaged recipients' perspective

Similar to mainstream users, users from disadvantaged communities also reported lack of different services in the government hospitals. For the teagarden workers, staff from the health facilities of the teagarden authority collected blood, urine and mucus samples from the workers and took those to a diagnostic center at the nearby local market. The **teagarden workers mentioned that the district hospital had CT Scan facility but it was not functional; X-ray and ECG tests were also done from outside**. Even if they did any test from the district hospital, it could not identify the disease. Then they had to go to the divisional hospital. They also mentioned that the UHC does not have any facility at all, for example X-ray. They also reported being harassed at the government facilities. Disadvantaged communities in urban areas **reported getting the diagnostic services either from NGOs or private clinics**, however, all NGOs do not have all diagnostic services. Geographically isolated communities relied mostly on informal providers at the medicine shops or clinics. Ethnic communities did not report any discrimination in accessing any facility.

4.1.6 Physical facilities at private clinics

Utilization of private facilities was reported both by mainstream users' and disadvantaged communities in absence of certain services in the government facilities. Recipients reported **delays in delivering service for the tests at the government facilities**, for which those who could afford, preferred doing those at private facilities.

It takes taka 220 to do ultrasound from the DH and taka 400 to do it from outside. I still did it from outside because it will take a long time (one to one and a half hours) to do it from here (DH)

Exit interview at a private facility in Khulna

Private clinics rendered a range of different kinds of services and facilities with rapid delivery of services. A private clinic was observed to have 3 colored bins, pharmacy, sample collection room, gynae section, X-ray room, a toilet and an office room. They provided services for ENT, C-section, ultrasound, appendicitis, gallbladder stone, NVD, blood test, X-ray, urine test and all kinds of service within a short time. They had psychiatrist, gynae and ENT specialist, orthopedic. The environment was also apparently clean. **Recipients of the private clinics praised the cleanliness of the toilets**, which was also supported by observation. **Recipients expressed satisfactions about the promptness of services** but **acknowledged that the prices were much higher than the government facilities**. A recipient shared that she did all the tests outside –

Does govt. facilities do tests properly? My son's father said that the tests will be done outside. Govt. facilities take time.

Exit interview at a private clinic in Cox's Bazar

However, a few also complained about the quality of the service.

X-ray service has been started in a private clinic since last two years but the picture doesn't come out good'... (another respondent) 'My son fell down and got hurt in his legs. We thought the leg broke. When we went to the Upazila (private clinic) and took picture (i.e., X-ray), nothing could be detected in the report. They only prescribed medicine. Later, we went out (at the district level) and found out that the leg got broken.'

Exit interview at a private clinic in Jamalpur

4.2 Healthcare providers

The users' perception about health systems issues reflected the healthcare provider issues found from secondary literature review (please see annex in the Human Resources for Health section). Both

mainstream and disadvantaged communities perceived shortage of health workers and excessive workload of the existing ones as a major problem. There are overarching complaints from the recipients regarding the attitude and behavior of government health workers. The managers and providers also echoed users for majority of the issues. The recipients identified a clear difference in the attitude and behaviour of the providers from private sector and government sectors, which seems to be a major reason for which recipients went for private facilities.

4.2.1 Mainstream recipients' perspective on attitude and empathy of government service providers

From all sites, recipients complained about behavior of staff at the district and upazila levels, especially nurses and support staff. They complained that the staff did not show care unless they were provided with some informal payment. Absence of empathy in behavior and lack of counseling were frequently reported. Recipients also reported that staff discriminated between rich and poor patients. Some staff were also accused of having issues with competency**.** All these factors affected the quality of care provided by the government healthcare service providers as reflected in the following quotes from the recipients.

> Lack of care: *When the saline was exhausted, I went to the nurse. Doctor wouldn't wake up. Blood started coming through the tube. They (nurses) didn't come and told me to stop the key (i.e., stopper) of the saline tube. It was 2 am at night. Then an attendant from another bed closed the saline… Then in the morning, I called the nurse again but she didn't come at all.*
>
> FGD at a upazila in Kurigram

> Discrimination*: Those, who are rich, are at different level. Those, who are known, receive better service. For poor, the service is like that – dur chhai, dur chhai kore.*
>
> Exit interview in Khulna general hospital

> Incompetency: *My grandfather had diarrhea 2-3 months ago. We took him to Tahirpur hospital. He needed (IV) saline and my uncle was attempting to place it. A nurse came and misbehaving with my uncle. But then she was not able to do it. Then my uncle did it himself.*
>
> FGD at Sunamganj district

However, for facilities at the union level, there was a mix of reaction regarding the behavior of staff. There were complaints about some specific individuals, while some others were well accepted in the community.

> *Sometimes the SACMO is good, sometimes bad. He gets angry sometimes. He doesn't trust patients. He says, 'You don't have any disease, still you came for medicine telling lies'.*
>
> Exit interview at a USC in Jamalpur

> *All type of patients come here because the doctor is good. He provides good medicine and good treatment. He doesn't discriminate between rich and poor. He speaks less but listens to our needs.*
>
> Exit interview at a USC in Khulna

In most sites, recipient reported **good behavior from staff at CCs**. They were also appreciated for their counseling, though some were criticized for not providing complete message during counseling.

> *This doctor (CHCP) is serving here for a long time (since 2011). She is good. We get service when we come here.*
>
> Exit interview at a CC in Cox's Bazar

An FWA shared her acceptance in the community and lack of resources hindering her to provide NVD services –

If you give us all required medicines for normal delivery, then this CC will become the first among the upazila as it was once. I am the daughter and daughter-in-law of this area. Everyone knows me. With their cordial support, I did a lot of deliveries here. Now, we don't have medicine, saline, oxytocin, injection, syringe, pad, which are required. If these are available, the care will be improved, the clinic will be developed… Last July, I handled a delivery in the veranda of the CC and bought the medicine from outside.

Another FWA informed that the CC remains closed for four days and even if it is opened for a day, the CHCP left after sitting for half day. Committee members decided that they will recruit the person who can stay six days a week.

UH&FPOs informed **attempts taken to improve quality care**. During informal interview, one of them mentioned that sometimes FWAs accompany the patients themselves to the UHC, which shows their care to the patients.

We take ultimate care about providing good care, especially the patients of delivery section – what they want, their convenience, care, whether or not doctors are checking and behaving well. When the patient can rely on us, only then they will come.

IDI at a UHC in Khulna

Another UH&FPO shared,

Patient don't recognize tablet. They recognize words (i.e., good behavior). I am holding the post to provide service. I'm involved everywhere but there's no enjoyment from inside, there's only exchange. My feeling is 'you're a client for 30 minutes'. This attitude is not reducing the service burden, rather reducing the quality of care… I tell my subordinates to provide service on priority basis… But they think, 'I'll provide service to those, who will give me more benefit.' Equitable distribution can only be ensured if the staff are morally dedicated. But they cannot be brought to this level.

4.2.2 Mainstream recipients' perspective on number and workload of government service providers

Lack of manpower was reported by both recipients and providers from all sites for all levels of public service facilities. As a consequence of this shortage, **excessive workload** on the existing staff and **unequal distribution of responsibilities affecting the quality of care** were also frequently perceived. During an informal discussion, staff of a district hospital shared that 44 doctors were available out of 92 posts, leaving 48 posts vacant. A UHFPO in a UHC informed, only two doctors were available, when 7-8 doctors were required. Human resource structure was not reported to be consistent with the intake capacity of the hospital – **50-bed hospitals were running with a human resource structure with 31-bed at the UHCs,** as mentioned by a UHFPO. According to the managers, existing capacity did not support authority to provide prioritized service to marginalised population, e.g. disabled. Below are some issues shared by the managers at the Upazila level on different aspects of number and workload of health workers.

Lack of the doctors is the main problem with HR: *A big problem in the hospital is lack of doctors. We're managing by pulling the doctors and SACMOs from the union sub-centers to work in this hospital. There is no infrastructure at the union level but doctors are posted there. There are posts of two medical officers here but no post for emergency medical officer. This is the main challenge.*

There's no consultant, whereas there are eight posts. There's no indoor medical officer. There's a post for RMO but vacant... If I bring a consultant here, then I'll also need a medical officer to assist… In absence of indoor medical officer, emergency and outdoor medical officers are used to do rounds in indoor. As a result, the outdoor becomes crowded and SACMOs have to handle that.

Lack of efficient manpower in each sector: *There is no head assistant or statistician. There are 3 office assistants, one of whom is in deputation and rest two have been promoted from the MLSS position – one was a night guard and the other one was MLSS. As a result, they don't understand even Bangla, let alone English. So, I'm having the cashier do all the jobs, including the monthly report… Outsourcing is not functional here. That's why no new cleaner is being recruited separately. We have to manage with whatever we have. Recruitment should be specific – sweepers should be recruited as 'sweepers', and they should be from this area... There are only 10 HA in the place of 20. We cannot let others do their work because they received the training for vaccination.*

UHCs do only normal delivery because C-sections are not possible due to unavailability of anesthesiologist.

Posts of technicians are also important, but mostly vacant now: *New incubators are arranged in the district hospitals for the babies but no technician has been assigned. As a result, those have been unused and have become out of order… Doctors are scapegoats here. Whereas the flaw is in the system. Nobody says that a doctor cannot function without required staff or equipment.*

Health system is working as reverse pyramid – *more decision makers than implementers: There are more doctors compared to staff… HAs are not being recruited since 1994. Our senior people who are making decisions are positioned for a year. DGs don't come from upazila. They don't have the mindset to listen (to our problems) - I don't need doctors, give me some staff!*

Corruption in community participation to fill in the gap: *A program on identifying disabled has been initiated in this upazila. Disabled have to come to UHC for treatment. Earlier 7-8 disabled persons used to come earlier. Now, 30-40 persons are coming. We don't have support staff to support them. Volunteers from the adjacent areas where summoned for assistance. Now they're taking money from the disabled patients!*

Staff at the union level facility mentioned that the facility **required a medical officer, a pharmacist and night guards**. A SACMO shared,

I have to submit monthly report to the upazila level by 1st or 2nd of the month. I have to work on register and report and alongside I also have to serve the job of a pharmacist, since none is available in that position. No pharmacist is assigned here. Two years ago, a medical officer was assigned here. He left. One is still assigned but he works at the upazila, as they lack manpower.

During an FGD with the CG and CSG, members shared that there was a lack of manpower in the CC and so many people visited the CC that they could not manage. They compared the crowd with the UHC. In this situation, the committee members had to come to help the CHCP. The CHCP shared,

This month the CC was visited by about 18-20 pregnant women and three women after delivery. Adolescents come but they are still shy; they cannot openly share their problems here. That's why the CC needs a women provider. FWA is posted and her presence is very important but she doesn't remain available… FWA and HA should sit here regularly.

During an FGD with the recipients, a woman shared that the CHCP checked blood pressure and took weight but **there was no woman to check baby's position at that CC**. There used to be a woman earlier but not anymore, so they could not check baby's position. A member of another CSG mentioned,

This clinic doesn't have the environment for delivery. It would have been very good if there were a women provider for the pregnant women; it could help avoiding risk during delivery because many times, they don't have the time or money to go to the UHC. It takes a maximum of 2-5 minutes to bring a woman here (CC) from her house but it takes 20-25 minutes to take a woman to the UHC. Both the mother and child may die within this time. It would've been good if the service were available here… The clinic also requires a 4th class staff and money to support these staff.

4.2.3 Mainstream users' perspective on the providers of private clinics

Recipients of services from private clinic did not report any behavior issue, rather **appreciated the personalized care and promptness of service**. A recipient appreciated the way a clinic managed personalized care without creating resentments among other patients. A staff from a private clinic reported that they were **instructed by the owner of the clinic not to misbehave** with anyone, especially to behave more nicely with the poor. A recipient shared,

> *We go to private clinics more than the government facilities because they have more manpower.*
>
> Exit interview at a private clinic in Kurigram

Private clinics managed their lack of resources by outsourcing expertise. Staff of a private clinic mentioned that the facility recruited 22 staff but currently 9 are working – 2 full-time doctors, 2 nurses, 3 ayas, one receptionist and the owner, who supervise everything. Besides, on Fridays and Saturdays a gynae specialist and a surgeon provided service from the clinic. An experienced doctor from the UHC conducted ultrasound from 12 to 2 pm. A staff at a union facility shared that when they could not provide any service, they referred the patient to a private clinic, since they got expedited and quality service there. He also referred to UHC but it didn't always have staff to provide service.

> *I don't go to the govt. facilities. I went to those many times but do not get services/facilities. They neglect people. They harass people.*
>
> Exit interview at a private clinic in Cox's Bazar

4.2.4 Perspective of disadvantaged communities on service providers

The **ethnic minorities did not report any discrimination** based on ethnicity by the service providers, neither by those at the government facilities, nor by those at the missionaries or tea garden in-house facilities. No discrimination in staff behavior was reported based on religion or gender. A CHCP reported serving a transgender that morning, who was very happy for being able to receive service from that facility. Communities working at a teagarden or a garment factory instead were entitled to utilize manpower, equipment and support from the healthcare facilities run by the authority.

> *When my husband was sick, I called the teagarden doctor. He checked and prescribed medicine. When his condition aggravated, the teagarden doctor referred him to the UHC. We took him there and they gave injection. Doctors at the UHC then referred him to the Sadar Hospital. Then I told the teagarden doctor that they'd neglect my husband at the Sadar Hospital and requested him to refer to a private clinic. Then we all took him to a private clinic. He recovered and retuned home in three days.*
>
> FGD at with tea garden workers

Neither members of the sweeper colony nor the geographically isolated population or low-income urban communities reported being treated unequally at the government healthcare facilities. The only discrimination reported was between behaviors with rich and poor patients or favoring people who were known to or connected with the staff or were influential, which was similar to the reporting of the mainstream population.

Key findings

- Infrastructure supportive of equitable access, privacy and comfort at DH and UHCs, however, management of these infrastructure not effective to ensure the desired privacy and comfort
- Overarching complaint regarding medicine in government facilities – inadequate supply and unavailability of some types that the recipients expected or demanded
- Government healthcare providers, at the DHs and UHCs criticized for lack of care and empathy, discriminatory and bad behavior and sometimes, incompetency.
- Lack of manpower was reported by both recipients and providers from all sites for all levels of public service facilities resulting in excessive workload on the existing staff and unequal distribution of responsibilities affecting the quality of care, and in cases, underperformance, even non-functionality of laboratory equipment
- For private clinic service providers – no behavior issue reported, rather the personalized care and promptness of service was appreciated; they managed their lack of resources by outsourcing expertise, including government doctors
- No discrimination reported in accessing any facility or behaviour from providers on ethnicity, religion, gender or profession by disadvantaged communities

CHAPTER FIVE: USERS' PERSPECTIVE ON TRANSPERANCY, ACCOUNTABILITY, COMMUNITY PARTICIPATION AND REFERRAL

5.1 Transparency and Accountability

There were concerns related to transparency and accountability noted at different tiers of government facilities, uniformly reported by respondents from both mainstream and various disadvantaged communities and also across high, medium and low performing sites. An overarching concern was 'informal payment' for better service, more medicine or commodities or for good behavior (Table 4). Some of these were triangulated with the frontline providers and managers, who also admitted most of those and shared some steps taken by them to minimize those. Citizen charter was found in most of the government facilities at all layers (Table 3), although some were not located to catch the sight in some facilities. Vision, mission and goals were also displayed in most facilities. Finger print attendance also installed to ensure availability of staff in office time. Complaint boxes or at least a note with a phone number to inform complaints, concerns or comments through SMS were available during spot observation in all district hospitals and UHCs. However, despite managers' willingness and efforts to bring positive changes infrastructure, considerable issues were found in the field which reflected lack of transparency and accountability in the health system.

5.1.1 Comparison of costs for different services

Recipients reported a range of costs for various health care services by government, NGO and private service providers (Table 4). For government services, only nominal payments were made at the community and union levels, mostly as fixed charges for the token to use for maintenance of the facility. However, for normal delivery services at home, FWAs and FWVs received payments. As an FWA shared,

> *"If I go to home for NVD, I receive taka 500-2,000, sometimes 3,000, as per their ability. But if I do it at the CC, then I receive whatever they give willingly."*

At the higher level facilities, more complex modes of payments were reported, especially at the DH. Most of these payments were made as informal fees for a service or good behavior. For NGO providers outside Dhaka, payments were mostly nominal, sometimes with some extra margin of benefit for the frontline workers serving at the community levels while selling a commodity or providing a service. NGO providers within Dhaka were frequently reported to charge high rates for services over time, which started with nominal amounts as observed outside Dhaka. Respondents mentioned removal of donor funding as a reason behind this hike in charges. The private sector, including private clinics, private practitioners and informal providers, was found to have a variety of rates for any specific service.

Table 4: Reported costs of different services provided by the government, NGO and private service facilities/providers

Categories	Range of amount spent for service by govt. facilities/ employees (taka)				Range of amount spent for service by NGO facilities/ employees (taka)	Range of amount spent for service by private facilities/ practitioners/ informal providers (taka)
	CC	*USC*	*UHC*	*DH*		
Reported by the recipients						
Normal delivery at home	500–1,000	1,000			1,000–4,000	500–1,000
Normal delivery at facilities			1,000	500–1,000	3,000–6,000	
C-section					5,000–11,000	13,000–20,000
Placing IV saline			500			60–100
Urine test			20–50			150–200
Blood test					400	
Ultrasound				220	350–500	350–800
ECG			100	80		
X-ray			100			
Informal fees for release				2000		
Informal fees to staff for cleaning/good behavior/bed allocation/NVD service			5–50	50–5,000		
Admission			10	15		3000
Nebulization						50
Injection				50		120–130
Medicine/ticket for medicine	2–10	5	3–5, 300-350	5	20–1500	300–1000
Ticket for checkup			10	5	2–50	200
Checkup/Fees for practitioners			50			300–1000
ANC checkup		50			5–100	
FP injection		50			20–100	
Vaccine					60–3,000	
FP counseling/Condom/Pills	2–5	5			10–20	30
Ambulance			500–2,500			
Surgery for tumor						80,000
Injection for jaundice						10,000
Reported by the providers						
Normal delivery at home	500–3,000					
Normal delivery at facilities						3,000
C-section						11,000–12,000

Categories	Range of amount spent for service by govt. facilities/ employees (taka)				Range of amount spent for service by NGO facilities/ employees (taka)	Range of amount spent for service by private facilities/ practitioners/ informal providers (taka)
	CC	*USC*	*UHC*	*DH*		
Ultrasound						500–600
Medicine/ticket for medicine	5					
Nebulization						150
Donation collected from the CG members monthly	20					
Informal fees for cleaning/NVD service			50			
Checking blood sugar	30					
Ticket/payment for checkup per episode	2				30	300
Membership for card					50–100	60
Checkup/Fees for practitioners					50–100	500
ANC checkup						150-500
Sanitary pads					60	
Safety kit for NVD					90	

5.1.2 Users' perspective of transparency and accountability

Personal connection to get better service and more medicine: One of the most frequent complaints from the recipients was about government service providers favoring people, who were known to the providers or had connections with people at higher level or authority. Personal relationships with the service providers had direct impact on the promptness of the service. Recipients also reported observing favours during allocation or distribution of medicines, queue for ticket and informal payment for services. This was commonly reported across all the study sites, including the marginalized communities[8].

> *One day, we, 3-4 women, were sitting there and collecting medicines. Two doctors came and they told us to wait outside. Then we came out and saw that those two doctors stashed some medicine inside their bags and left after chatting for a while. One of us was left to receive medicine. When she went inside to collect it, they gave her a little and said that there was no more medicine. We didn't say anything then, otherwise they will not give us medicine next month.*
>
> FGD with community people

> *CHCP provides medicines to his known people. He gives medicines to strangers when he wants or doesn't give at all if he is not willing… You can tell who's known to him. When we go, we see that they're chatting with medicines in hand. That's how you know that they're known to him – those who mingle with him, whom he fears, who are outspoken and can complain against him.*
>
> Exit interview at a CC

> *General people don't get any service at all. Those, who have money and connection with influential people, they get good service. Those, who can threaten over a phone call, get good service. One cannot get good service if one goes alone.*
>
> FGD with a marginalized community

***Informal payment for good behavior*:** Another frequently reported complaint from the recipients was the need of making informal payments to ensure good behavior from the providers. This was reported especially for nurses and support staff at the district hospitals or UHCs.

> *Nurses are not good here. They only want money. If they're not given money, they misbehave and do not provide treatment, sometimes even call names …Doctors behave well. They listen to us. … When doctors come, the nurses put a smile on their faces. When doctors leave, nurses make faces and misbehave… You have to pay money right after admission, then you can get good service, otherwise not.*
>
> Exit interview in a district hospital

> *Their (aya, guard) behavior is not good. They misbehave whenever they get a chance. Then if they're given taka 5-10 sneakingly, they become very happy. Then they don't misbehave with that person… They don't claim money but they become annoyed if not given money, which becomes apparent from their expression and behavior.*
>
> Exit interview in a UHC

Government doctors not attending patients properly in public facility but doing so in private clinics/chambers: For doctors, the most frequent complaint was that they did not take much care at the government facility, whereas the same doctors checked each patient carefully at their chambers. A recipient shared,

[8] Due to the sensitivity involved, name of geographical locations in which the facilities were situated have been omitted from section 5.1 in case of referencing the Exit interviews, IDIs with service providers and KIIs with managers

When I went to the hospital (the doctor) didn't speak well, when I came out of the hospital (visiting doctor's private chamber) the doctor behaves well.

Informal payment for service: Informal payments received by the providers for providing medicines and various services was reported by the recipients. Recipients reported paying for medicines that were otherwise flagged as 'unavailable', ANC services at the union hospital, NVD services at the hospital, NVD services at home and CC by FWA, releasing patients from hospital, allocating bed, urgent service during emergency, and other regular services, such as placing or removing canula and nasogastric tube and distributing food (Table 4). This was reported mostly for the nurses and support staff at the district hospitals and UHCs, and some FWCs at the union facility and FWAs at the CC.

The compounder is known to my aunt. If we give taka 10-20 along with taka 5, then we can avail all medicines. We don't need to buy from outside.

Exit interview in a district hospital

She always takes money but didn't take today because you're here (indicated presence of data collection and BHW teams). She gives five of each of two types of medicines for taka 5. She also receives money for checkup and indoor delivery (NVD)… She doesn't even give us a chance to speak. She will only work for benefit. She'd say, 'don't you receive treatment in exchange of money at the Upzila (she meant private clinic)? So, bring money here as well. Then I'll give medicine.'

Exit interview in a UHC

Nurse receives money, if admitted through a known nurse… I went to the hospital 6 months ago. They released right after the delivery. We spent taka 5,000. We bought soap, detergent and savlon and gave those to the nurse. They don't even accept taka 1,000. They wouldn't have let me get off the bed, if we hadn't paid them. Nurses claimed, 'We gave our labor. Pay us for our labor.' They take money from all. Those, who have connections, pay less money.

FGD with a marginalized community

I had to bribe taka 200 to a staff to manage a bed.

Exit interview in another district hospital

Recipients of exit interviews also complained about charging for tests, for example taka 50 to test blood sugar at a USC and taka 100 for X-ray in a DH (Table 4).

Government medicines sold at the pharmacies: Community recipients complained **about staff selling medicines outside** from a few facilities, especially USCs and/or CCs. This was frequently reported in **one low performing site**. This was also linked to recipients' overarching complaint about not getting medicines as required. When they did not get sufficient medicine, they assumed that the staff sold those to the medicine shops. A recipient mentioned during an exit interview at the USC,

We don't get medicines. If people don't get medicines, what do they do with those? They sell those… I didn't witness it but heard from people from my neighborhood.

Exit interview in a USC

Another exit interview recipient at the UHC from the same site provided with further details to justify her statement.

The medicines that are provided in the hospitals, are also sold at the pharmacies. If doctors or hospital authority do not sell those, how do they (sellers at the medicine shop) get them? If we tell the seller that 'this is govt. medicine!', they smile. [When probed how does govt. medicine looks like, she took a red and green medicine out of her bag] Won't I recognize govt. medicine? I'm not illiterate.

***Government doctors doing private practice*:** Some recipients reported government doctors referring patients to go to their chamber or clinics they sit for private practice. A few also complained about doctors not checking properly in the government hospitals but take better care at the clinics in the evening.

> *A known patient went for a service at the govt. hospital. Then the doctor asked the patient to go to his chamber in the evening.*
>
> KII with an NGO worker

> *I stayed at the UHC for many days but I did not get service (shubidha) there. Need to keep queuing for a token. They don't check properly even after paying money. The doctors from those govt. facilities sit in private clinics in the evening, where they check properly. One such doctor sits in this clinic from the UHC.*
>
> Exit interview with a recipient at a private clinic

***Positive practices to maintain transparency*:** Some positive practices were also observed. Medicines were distributed in front of members of community support group to maintain transparency and accountability in the CC. The CSG in a high performing area mentioned during an FGD that they also mediate during conflicts between providers and recipients over medicines. They conduct regular meetings to monitor the stock and other problems and documents the discussion after each meeting.

> Excerpt from informal observation notes: We observed an event of opening of medicine supply at the CC. The CHCP kept waiting since 9 am in the morning along with the chairman and CSG members. About 12 pm, the *Member* of that area came and then the medicine boxes were opened in front of them.

5.1.2 Providers' perspective[9]

During informal discussion, the managers informed that they were aware of some transparency issue. They shared steps taken by them to minimize those. However, for some, they attempted to rationalize or shared barriers to prevent the practices and expressed that it was not possible to resolve all those issues instantly. During informal discussions, the UH&FPOs/hospital managers provided us with some scenarios for when and why staff claimed informal payments and also information on some **initiatives to control these behaviors.** The following are quotes of managers during informal discussions.

> *There are 100 patients admitted but food is cooked only for 50 patients. The rule is to provide food to the first 50 patients. Now, staff give food to some, some they don't. If someone puts taka 10 in staff's pocket, they provide him/her food. We are not being able to control such things.*

> *Earlier a payment used to be required for normal delivery but not anymore. I bought a fetal opener machine with the condition that no one will take money. If there is a lot of bleeding during normal delivery, then the sweeper wouldn't clean without taka 50. Not just doctors, all these are interlinked. That's why I wrote in a paper 'no payment is required here for normal delivery' with my name and mobile number and hung on the wall. That's why neither anyone receives money for normal delivery, nor anyone pays.*

Some frontline workers expressed their resentments about recipients' blaming them for selling medicine.

> *General people come for medicine. If we say, 'there is no medicine', they think, 'they sold those. Govt. gave medicine, then why are we not getting them?' Now, we can only give what we get from the govt. We cannot give more than that… Sometimes they take medicine at the beginning of the month. Then at the end of the month, if they don't get medicine, they will say, 'No medicine?! What did you do? Did you sell those?' Then we say, 'Yes, we sold them. Whatever you think is right.*

[9] Similar to physical facilities, perspective of providers was taken to triangulate the findings

Check with our officer that how much medicine we get and how much we can give.' They say these on our back, don't say these up front. IDI with a frontline staff at a CC

An NGO staff complained that government staff at the USC or CC removed some medicine for themselves, while some they sold.

Govt. supplies medicine but people don't get medicine… Deworming medicine, Napa, histacin these are kept open but antibiotics are kept in the Almira. They sell costly medicines because they cannot consume 10-12 antibiotics in a day. That's why they have to transfer those elsewhere (hinting that they consume the ones they need and sell the ones they cannot consume).

A manager reported the practice of staff and **some members of community support groups taking medicines** for themselves and reported taking action against such practice.

There used to be a bad reputation about staff taking medicines for themselves. But now I strongly banned these practices. If anything is still happening, might be happening behind me. There are some support group members in the community clinics who take away some good medicines themselves. I visit the CCs myself to check if CHCPs are maintaining the registers well.

5.2 Community Participation

Community participation exists through Community Group (CG) and Community Support Group (CSG) at the CCs among the mainstream population

Mainstream respondents across all sub-districts informed about community participation in management of CC through CGs and CSGs. The prevalence was common regardless of the high, medium and low performing sub-districts**. Local resource generation seemed to be the most common form of community participation.** Local resources were generated through collecting voluntary contribution or mandatory nominal fees for medicine from the recipients, matched with the contribution from the president and members of the CGs and CSGs. The resources generated were used for cleaning, maintenance of the CC or purchase of amenities (e.g. solar, fan), depending on the local need. Sometimes the contributions were used to support poor patients' treatment or transportation to higher tier facilities. Resources (e.g. wheelchairs, wait benches, etc.) were also generated by the CG or CSG from development projects or NGOs.

(One respondent) need to pay 5 taka for medicine….(another respondent) 5 taka for children, even for adult….(another recipient while answering the question of why this money is taken) "to get the electricity connection (for this CC) there was a huge expense – government will not give that money. This will be incurred from this contribution fund of 5 taka. Ceiling fan was bought for the clinic – the doctor (CHCP) will not pay it on her own, would she? Neither the government will pay.

FGD with community people in Sunamganj district

There is a contribution box that contain the development fund for this CC. The fund is used for paying the transportation cost of poor patients. Financial assistance is also extended from this fund to those who need assistances in case of severe and chronic disease. The key for donation box is with three individuals. They open the box periodically, calculate the contribution and inform everyone.

FGD with community people in Sunamganj district

According to the study participants, monitoring of CC proceedings, particularly ensuring receipt of the variety and quantity of medicine was another area in which community were participating across the districts. As mentioned in the previous sub-section, CHCPs opened the medicine box, counted those and recorded in their register in presence of community people and/or the CHCP. Community people through CG and CSG also monitored the activities of the CHCP. Informing community people about the services of

the CC was another important contribution of the CGs and CSGs. The CGs and CSGs played an important role in ensuring continued supply of medicines. They also resolved any conflicts between community and CHCP from time to time. In some cases, community people supervised the maintenance activities being conducted in the CC to ensure the quality of work.

> *Role of CG committee include oversee if CHCP distributes medicine, to ensure the quantity of medicine received at CC and to ensure that there is no quarrel between the CHCP and the local people*
>
> FGD with a community people in Chapai Nawabganj district

> *CG group regularly looks after the service delivery from the CC. Since the poverty in this region is high, apart from service, the demand of medicine is also very high. People come to the CC whenever feel sick. Recipients get disappointed and angry when they cannot get medicine. In that situation, CG leaders calm them down and explain the situation*
>
> FGD with community people in Kurigram district

> *There are three support groups for this CC. They inform everyone about the services provided from the CC. They also encourage community people in taking services*
>
> FGD with community people in Sunamganj district

Figure 1: CG members opening the medicine box at a CC to ensure the contents

CG and CSG members also reported to liaise between the community and local government representatives and government officials to mobilize resources.

> *We (CG committee) meet together within 1st to 5th of every month. Meeting invitations are sent via letter or phone. In the meetings, we discuss about the problems of the CC. We also discuss about the needs, supervision of medicine distribution, etc. and try to resolve the problems from these issues… (CG group president) If we cannot resolve those, we inform others, like the UHC, Union Parishad, Ward Member, Upazila Nirbahi Officer… (another respondent) Sometimes there are recipients who cannot buy medicine…… (President of CG) I arranged 6,000 taka from the Union Parishad, with which, painting of the CC was done.*
>
> FGD with community people in Khulna district

On asking, community people shared that they own the community clinics, and hence they should be involved with the management of the CC.

Government said that citizens are the owners of the community clinics. So, to ensure the effectiveness of the community clinic, participation of the citizens is necessary.

FGD with community people in a subdistrict in Khulna district

Community participation was not seen in case of the union level facilities from both DGHS and DGFP

Similar to community clinics, committees exist for the union level facilities like UH&FWC and USC. However, none of the community participants mentioned about these committees. Service providers, however, informed about the existence of these committees.

Meetings were held at a minimum of two months interval, sometimes that did not even took place. The meetings were held at the Union Parishad, not at community level. Also, since the local resource mobilisation was neither encouraged nor necessary (as there were allocations from Union Parishad), community participation was not prominent through these committees at union level. Unlike CCs, recipients rarely recognized or mentioned about such committees at the union levels.

There is a committee here in this UH&FWC in which the union parishad chairman is the president. FWAs and FPIs are members, one CHCP is also the member. Then there are members from community – teachers, one adolescent member, representatives from Ansar & VDP – are all members. SACMO organizes the meeting. Meeting is held in every two months. Different issues are discussed in this meeting…. In last meeting, the issue of the ditch behind this center was discussed and it was decided that this will be filled in. The president will inform the higher authority (Union Parishad). It will be done from government's fund, not personal fund.

IDI with a provider from a union facility in Chapai Nawabganj

The committee was supposed to call meeting if they feel any need or issue. The committee would inform the chairman, who would call the meeting. There was supposed to be a meeting in each two months. I have not seen any such meeting till now.

IDI with a provider at a union in Sunamganj district

Disadvantaged communities were not aware of community participation modalities like CG or CSG

Disadvantaged communities living in close proximity of mainstream communities were aware of the contribution that are being encouraged, however, do not know the purpose of the contribution. For example, the flatland ethnic minority community participants were aware of the nominal fees that recipients had to pay for receiving medicine, however, they did not know the purpose for which the fee was being taken. Geographically isolated communities neither mention about any such community participation, nor were aware of the existence of such CG or CSG in community clinics near them.

5.3 Structured Referral

Referral was seen quite common in all the sites. Recipients used the exact English word "Refer" or "Referred" while describing the issue. Whenever the lower tier facilities could not provide a particular care, they referred the patients (i.e. the recipients) to a higher tier facility. Typically, the referrals were done from CC or union facilities to UHC, and from UHC to DH or medical college hospital. Sometimes patients were referred from CC to DH. Referral from CC to union facilities was not mentioned in any cases.

When they cannot treat here, they send to upazila (health complex), or district hospital (mentioned the name) or medical college hospital (mentioned the name of a divisional city).

Exit interview with a recipient of a CC in Chapai Nawabganj

Say if there is any patient with serious issue, like poison ingestion, they (UHC) refer to the district hospital. Even private hospitals refer to the district hospital. Sometimes they refer to (mentioning

the name of a divisional city) medical college hospital, even Dhaka. I mean depending on situation of patient they refer so that the patient can live.

Exit interview in a private hospital in Jamalpur

First, we come to community clinic. If we do not get the service, then they (CHCP) tell us to go to the district hospital. … As this treatment (for heart diseases) is not possible at upazila, they send us to district. If they cannot treat, they refer, depending on their policy.

FGD with community people in Jamalpur

The scenario was same for the disadvantaged recipients –the government health facilities were the point of referral.

If we take any serious patient to the (UHC) hospital, they refer to the district hospital or (mentioned a divisional city) medical college or (mentioned another divisional city) medical college. They don't refer to private hospitals.

FGD with char people

Private facilities and NGOs also refer to patients to government facilities, in case of any emergency or depending on the severity of the issue.

If there is any heart patient, then we send the patient to the district hospital or the divisional headquarter. This referral is verbal, i.e. we tell the patients to go there. There is no system of structured referral. In case if any patient comes with major injury, we provide primary service and then refer (to government facilities). People in char often come here with injuries from conflicts – to avoid police hassle, we refer them (to government facilities).

KII with provider at a private clinic in Jamalpur

In case of pneumonia or chest issues, we treat the patient for a day. If situation does not improve, we refer the patient to the district hospital.

KII with provider at a private clinic in Kurigram

Say a patient had caesarean, and there are complications that we cannot manage, and we see the patient can get better treatment at Dhaka medical college, then we have to refer. We have a separate pad and slip for referral.

KII with provider at a NGO facility in Dhaka

A more structured form of referral was seen in CCs in Chapai Nawabganj and Cox's Bazar. In both areas, the patients were given a referral form from the CC with which they went to the UHC, where they could directly go to the CC corner, bypassing the usual patient queue of the UHC. They also did not have to buy tickets at the UHCs, they could get the service showing the referral form of CC. The recipients mentioned getting importance while going to the UHC with this form.

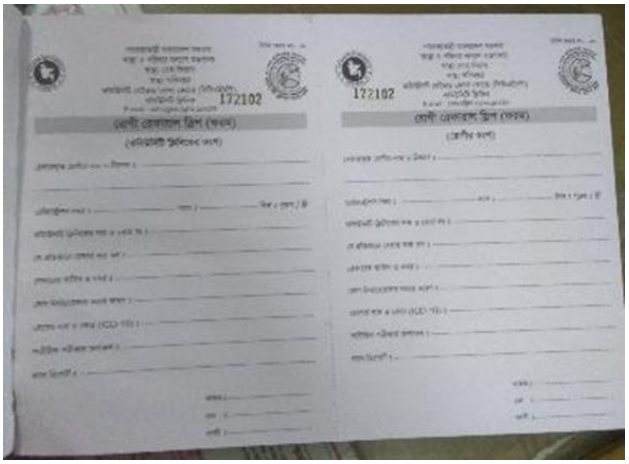


Figure 12: Sample form for structured referral used in two of the six CCs visited

(One FGD participant) My two children got pneumonia. But CC did not have any medicine for pneumonia. Then CHCP gave us a slip and told us to go to UHC. When we took that slip to the UHC, the doctors gave us service with a lot of attention.

FGD with community people at Cox's Bazar

From health managers' point of view, structured referral was an effective way to manage the patient load in UHC, and increase utilisation of the CCs.

This is a nice system. I have a CC corner here, but there is no special HR allocation for that. What I do, I have 44 CCs under my jurisdiction – I have made a roaster for each CHCP to sit one day at this corner. They bring their glucometer, strips and pressure measuring machine. All CCs are given referral forms. When the CC refers, they fill up this form and sends the patient to this UHC. But the patient does not have to stand in queue. The patient goes directly to the CC corner. The CC corner then sends the patient to different corners of the hospital. And the CC corner advises the patient to go to the respective CC for follow up. It saves time for the patients, and on the other hand, reduces patient load at the UHCs – unnecessary queuing is not needed. My NCD corner is also benefitted from this – as some NCD screenings are done in the CC corner – so if there are excessive load of patients, they are sent to the CC corner from the NCD corner.

KII with a health manager in Cox's Bazar

Key findings

- Recipients reported having personal relationship with providers or informal payments resulting in better services, more medicines and good behaviour from providers
- Recipients complained government doctors not attending patients properly in government facilities but doing so in private facilities
- Some recipients reported government medicine being sold at private medicine stores
- Some recipients reported government doctors referring patients to go to their private chamber or clinics
- Providers acknowledged most of the complaints of the recipients regarding transparency and accountability issues, and at the same time, informed the steps taken by them to address these
- Significant community participation was seen through the CG and CSG models at CC level for local resource generation, and management and maintenance of CCs
- Community participation was not seen in case of the union level facilities
- Disadvantaged communities were not aware of the community participation
- Structured form of referral was seen in CC to UHC in two out of six sites of mainstream communities, which was found to be convenient for recipients in saving waiting time, as well as helpful for providers in managing crowds

CHAPTER SIX: CHANGES OBSERVED BY THE USERS AND THEIR SATISFACTION

6.1 Changes Observed in Last Two Years

6.1.1 Changes observed by Mainstream Recipients

Changes observed by the recipients from mainstream recipients were mostly positive. The changes observed by them were **primarily regarding the infrastructure improvement**. Some recipients also mentioned about the **improved cleanliness in the government facilities**.

> *There has been a new building in which there are separate arrangements to provide treatment to mothers. Water was dirty before, now they have supply water, and there is a tubewell for clean water. Behaviour of doctors and nurses have been better.*
>
> Exit interview at a UHC

> *The facility is cleaner now. There is (celling) fan. When I was with my son (conceived, previously) then there was no fan here. There were no waiting arrangements – now there are waiting area. Everyone can sit now.*
>
> Exit interview at a CC

> *Bathrooms used to stink but now bathrooms are a lot cleaner. In addition, staff number increased, there is a new 7 storied building, bed number increased, clean water is available.*
>
> Exit interview at a district hospital

Added services and improvement in quality of care were also mentioned by the recipients. Some of the respondents also noticed the increase in patient flow to the facilities.

> *Quality of care has been improved. Patient number and staff number improved. Before there was no doctor – now there is a doctor at emergency. They do a round in the ward in the morning. All time there are nurses here. Before there was no VIA test – now it is available*.
>
> Exit interview in a UHC

> *…there was no operation here in this hospital – now there are operation facilities. Lot of patients now – people come for fever, headache and diabetes too.*
>
> Exit interview in Khulna district hospital

> *Only 2/3 years earlier, this clinic used to be open 2/3 days a week. Now it is open 6 days a week. If the CHCP wants to go for training or need leave, he needs to inform to the (CG) committee.*
>
> FGD with a mainstream community in a upazila in Sunamganj

> *Doctors and nurses are more serious now. (another respondent) when a patient is admitted – doctors and nurses stay there with him/her. It was not like this before – sometimes they used to come, sometimes they did not.*
>
> FGD with a mainstream community in a upazila in Jamalpur

> *Maternal mortality has reduced. Also there was no child death. That is because the pregnant women are all visiting CC. They take the pregnancy (ANC) period services and after delivery services (PNC) from the CC. Quality of care has been improved. Doctors take care a lot.*
>
> FGD with community group members in one upazila in Kurigram

There were **improvements identified in the supply chain of medicine** as well by the recipients.

> *Earlier medicine used to come in a small quantity. Calcium and vitamin were not available. Patients*

didn't used to get medicine in a quantity that they get now. Earlier, there were only 5 types of commodities – now there are 30 to 40 types of products (medicine) come here. Earlier, few people used to come, now particularly women come here to take services. Medicine is available now. Antibiotic is available now.

FGD with community groups and leaders in a upazila in Chapai Nawabganj

However, some of the recipients thought the **situation did not improve that much**.

Situation did not improve, rather got worse. There used to be normal delivery here 4/5 years back – but that has been stopped now……Medicine supply got decreased. Previously, there used to be 31 types of medicine supplied – now its 27 types. Metronidazole used to come 3,000 a month earlier, now it is only 750. Antibiotics are not supplied now.

FGD with community in Khulna

What improvement! After last flood, there is no normal delivery here. CC does not even open (sometimes).

FGD with one upazila in Jamalpur

There used to be pressure machine, temperature measuring machine (Thermometer) and weight machine in the CC, but these are not here anymore.

FGD with a community in a upazila in Jamalpur

6.1.2 Changes observed by disadvantaged recipients

As mentioned before, not all disadvantaged communities had the same access to public health facilities as the mainstream communities. Disadvantaged population with some access mentioned **positive changes, primarily in the physical facilities**.

…. Earlier men and women used to queue in the same line – now there are separate lines.

FGD with tea garden workers

(Government) hospital is as same as before – a new building has been constructed.

FGD with flatland ethnic minority

XXX hospital (a government hospital) has everything now – x-ray, ultrasono. Earlier, they only used to write ultrasono but we had to do it from outside. Now the hospital has gone bigger – from 50 bed to 250 bed.

FGD with garments workers

There were, mixed reactions from them as well for the changes observed in services.

XXX hospital (a government hospital) is open even in Fridays. Government hospital now provides good service. Emergency is open in Friday, lot of patients come, senior doctors are there.

FGD with garments workers

(Discussing on a NGO-driven facility under the LGD's urban primary healthcare project) Back then we used to get calcium and iron (for free), now we do not, we have to buy it.

FGD with urban floating population

However, **geographically isolated population could not report any change**.

We do not know because we do not go. We heard from those, who go, that the hospital is improved now, good treatments are being provided, brought caesarean instruments 3-4 years back.

FGD with char people

We do not know. Earlier health workers from CC used to come to hills to provide services. Now they don't come.

FGD with the Chittagong hill tracts ethnic minority

6.1.3 Changes observed by service providers

Providers also predominantly mentioned about **changes in physical facilities**.

Road beside the USC was not good – it has been improved through the Union Chairman. USC is regularly cleaned now. There is a trained midwife now. There was no electricity 4 years back – now there is electricity.

IDI with providers in a USC in Sunamganj

There was no water, electricity and bed. Now there are water, electricity and bed. This CC is ready for normal delivery now. IDI with CHCP at a CC in Chapai Nawabganj

Government has given solar (solar lighting system), union parishad chairman constructed the wall. There was no gate – now there is a gate, chairman constructed it costing 200,000 taka. Government made tiled floor in the bathroom. Water filter was given – it lies idle here.

IDI with a CHCP in Jamalpur

Providers also noticed **some positive changes in the attitude of the recipients and community**.

Previously patients didn't want to take iron tablet – they thought iron tablet would increase the size of the baby in womb….. Earlier, people thought the clinic's medicine is not good. People used to take treatment from village doctors and dispensaries. After awareness, people come to clinic to receive services. Different information of the clinic and services are spread through word to mouth among the community people….People didn't use to come for family planning – now they come. People used to have misconception like injection will result in headache, pill would result in stone in womb, etc.

IDI with a CHCP in Chapai Nawabganj

Providers also mentioned their **increased activities, as well as accountability**.

During last two years, the 24/7 delivery system has been introduced and since one year the adolescent friendly service have been introduced in which free sanitary pads are given to girls of 13-19 years and FWVs teach them on how to use those and what to do during that period. It was not here previously (2 years ago). Now, we have to report every month to the upazila on what services we provide. Activities are increasing as well as responsibility and accountability.

IDI with a provider in a FWC in Jamalpur

6.2 Satisfaction of the Recipients

6.2.1 Mainstream recipients

Recipients at CC and union level facilities were **quite satisfied** for the fact that they **receive medicine and treatment for free or nominal price, and near their home** – which saved them time and money. Recipients also had quite a **reliance on the quality of medicine provided**. They could **talk openly and freely with the providers** in these facilities – with which they were quite satisfied.

Since this is close (to home) it only cost me 10 taka. To go to (mentioned a name of a place), it would require 40 taka. So the transportation cost is less. You do not need to stand in line (i.e., queue). You do not need to pay for medicine. For this I like this place.

Exit interview at a union facility in Chapai Nawabganj

I can talk whatever I want to say. The doctor (CHCP) is very skilled. If you discuss your problems, she gives you medicine. Got good treatment.

Exit interview in a CC in Kurigram

However, there were some exceptions in some CCs, particularly those in which the CHCP is irregular. Recipients were not satisfied with the services in those.

> *Local seniors and patients from faraway places come here (and see the CC is closed, or remain open maybe only one hour) and tell me "Donating land, have you made a 'one hour hospital'?"*

Discussion with a land donor in a FGD with the CG in Jamalpur

Recipients of services from upazila and district hospitals shared some negative impressions. **Buying medicine from outside of the facility**, as these were not available at the hospital, was one of the reasons behind this. They also complained of **not getting proper treatment and being harassed** at government hospitals, which they did not face in private clinics, since they pay there.

> *(Talking about the UHC in the locality) that is government – government is not good for us. We do not get treatment over there… (medicine) is not available. And it is very difficult to get a token (admission ticket) – they are harassing people (at the UHC). This is private hospital – they take money but provide good treatment. My neighbours said government hospital's medicine is good. That is why I went there (at the UHC). Stood in line for whole day but did not get medicine. They do not behave well. But outside (at private clinics) their behaviour is good.*

Exit interview with a recipient of private clinic

> *You have to buy a ticket for 5 taka and stand in serial (queue). This serial is the problem. Doctor comes around 11, but you have to stand in serial since 8 in the morning – otherwise doctor won't see you. … today doctor saw (examined) me. But today did not even see me very well – only heard the problems. Check my back with something (stethoscope) and told me that I have caught pneumonia. Wrote 5 injections and medicine. Told me to get admitted here.*

Exit interview with a recipient in Kurigram district hospital

6.2.2. Disadvantaged recipients

Flatland ethnic minority interviewed seemed to be **very dissatisfied with the public facilities**. Since they had other alternatives, they had decided not to go to the government hospital. In one of the FGDs, a respondent mentioned this, with which, others agreed,

> *You can't get service from government hospital – that is a slaughterhouse. I experienced it when I took my daughter last time. Will I go there anymore? I won't go there even if I have very minor problem. My daughter had pneumonia. Knocked the gates many times (but didn't get the service). Could not find a doctor at night, could not find a nurse in government medical.*

Teagarden workers taken into the assessment also seemed to be quite **unhappy with government health facilities, primarily because doctors were not available there**. In a FGD, they mentioned,

> *Government (hospital) is like the government (implying not effective). Whenever we go to government hospital, they say doctor is not here – will come from Dhaka. Within this time (until the doctor comes) people can die. Doctors are available all the time at private – whenever you go there, you will get service. (In UHC) they don't even admit the patient – even worse than the district hospital. In district hospital, they will at least admit the patient. In this UHC, they would not admit the patient if doctor is not there.*

Those, from chars, thought that they did not get good service from government facilities just because they were from char areas, implying they were poor. In the FGD, they said,

> *We are from riverine area, so we have no importance (to them), they do not value us, do not give time. Not because religion or race. But those who have money get good service.*

Hill tracts ethnic minority could not comment about satisfaction with government services, as they did not have appropriate access to the government facilities.

Garments workers **did not find it convenient to go to government facility, for being time consuming**.

> *I usually do not go to government hospital because it takes a lot of time. I went there last time but it took a lot of time. You need to have someone with you, you have to buy ticket, get into a serial. In private I can take the service quickly and come back home.*

Slum population **did not have government primary healthcare facilities**. They went to tertiary level hospitals, however, they felt **inconvenient, even being harassed in these places**. In a FGD, the respondents mentioned the following,

> *Went there 5/6 months back… do not know the doctor's name. Went there at 6 am in the morning, bought the slip – it took till 2 pm to see the doctor. Doctor said you cannot effort here – go to Mohakhali or Agargaon, go to Mohammadpur – they only harass us… (Another respondent) XXXX (a public tertiary hospital) is a slaughterhouse. Told the doctor – you send me to many places, won't you give me medicine? Then they wrote down the medicine (didn't give). Went there with a CNG (autorickshaw, implying how costly the transportation was), only got 4 saline. I won't go to there anymore, I will go to private, even if it costly, it is not painful. If you go to government hospital, it is painful and it is expensive.*
>
> FGD with slum population in Dhaka

6.3 Suggestions of the Recipients

6.3.1 Suggestions from mainstream recipients

Recipients, assuming all providers were doctors, suggested **employing "senior" doctors**, even at CCs. There were also suggestions regarding **increasing equipment and services, particularly diagnostic services** at facilities.

> *If there was a senior doctor, and equipment then that will be good for us. In that case, we would not have to go to (mentioning nearby large cities) for treatment. Then we can easily get the service near our home. Now, for any serious issue, they send us to (mentioning nearby large cities). And to go there, we need time and money.*
>
> Exit interview at a CC in Chapai Nawabganj

> *In every two or three months, there can be campaign arranged with MBBS doctors….(Another respondent) 80% of the patients are women – so a gynae expert is necessary. CHCP in the CC should be trained so that they can perform normal delivery. Digital X-ray machine should be given in the UHC. Also there needs to be an ECG machine. There should be better monitoring to see if patients are getting right service and right medicine.*
>
> FGD with community leaders at a CC in Chapai Nawabganj

> *There should be an ambulance in the hospital. For emergency, a lot of people cannot get ambulance out poverty…… if poor people can get free-of-cost medicine then that would be nice*.
>
> Exit interview at a UHC in Chapai Nawabganj

> *Pressure measuring and diabetes screening – if these were here, then it will be beneficial for everyone.*
>
> Exit interview in a union facility in Khulna

There were suggestions from the recipients on **increasing the quantity and variety of medicine**.

> *Children have a lot of problem – increasing treatment and quantity of medicine will be good. Supply of saline needs to be increased.*
>
> Exit interview at a FWC in Chapai Nawabganj

It would be good if patients could be given medicine for diabetes and pressure (hypertension) from this CC.

FGD with community at a upazila in Sunamganj

Also, there were suggestions to **improve the behaviour of service providers** and **timeliness of the doctors**.

If all diagnostic services were available here, if the behaviour of nurses were better, if we would not have to buy medicine from outside – then people would be very happy.

Exit interview at a district hospital

If doctor could take more time in examining us, if we would not have to wait for doctor, if doctor could come on-time – it would have been helpful.

Exit interview at a district hospital

There were suggestions on improving the modality on how the CG and CSG are formed and in operation.

More training is needed for the CHCP…capacity of CG and CSG should be increased. To ensure the awareness increase of the health services, their (CG/CSG) skills need to be improved.

FGD with community leaders in Khulna

6.3.2 Suggestions from disadvantaged recipients

Suggestions from the disadvantaged population having some access to public health facilities were similar to the mainstream population. In addition, there were suggestions for arranging delivery facilities closer to the home.

Supply of medicine from the hospital – if we get medicine for all our problems then we shall go. Also if the medical (hospital) is clean, if there are more doctors and if the nurses behave better.

FGD with flatland ethnic minority

Geographical isolated population suggested **hospital facilities near their home** so that they could avail the necessary services.

If there was a CC or a (govt.) doctor in this char then we could get the service for free.

FGD with char population

If there was delivery facility in (mentioned the village's name) near our home, then it would be beneficial for us. Also if there were services for malaria, TB, etc.

FGD with haor population

It would be good for us if there was medicine supply to us (from a government facility). (Another respondent) They (government providers) should come here to give vaccines to our children. If there was saline, Flagyl tablet available here, then it would be good for us. If there was a hospital in our village then that would be the best – now we have to go a long way.

FGD with hill tracts ethnic minority

Key findings

- Mainstream recipients, in general, observed changes in infrastructure development, while some mentioned added services, improvements in quality of care and positive changes in behaviour and attitude of the providers
- Disadvantaged population with some access mentioned positive changes, primarily in the physical facilities related issues
- Geographically isolated population could not mention any changes
- Recipients at CC and union level facilities were satisfied for free/nominal priced medicine and treatment near their home. They also could talk openly and freely with the providers in these facilities – with which they were quite satisfied.
- In cases of recipients of services from upazila and district hospitals, there were mixture of feelings. Buying medicine from outside of the facility, as these were not available at the hospital, was one of the reasons behind this. They also complained of not getting proper treatment and being harassed at government hospitals, which they did not face in private clinics since they pay there
- Flatland ethnic minority and tea garden workers interviewed seemed to be very dissatisfied with the public facilities
- Hill tracts ethnic minority could not comment about satisfaction with government services, as they did not have appropriate access to the government facilities
- Garments workers did not find it convenient to go to government facility, for being time consuming
- Slum population felt inconvenient, even harassed in going to government health facilities

CHAPTER SEVEN: CONCLUSION

The assessment was conducted to identify an in-depth insight of the users' perspectives on the government health services, particularly those from the disadvantaged communities, which was further triangulated by some providers. The assessment identified a general awareness among the people across all areas and population groups regarding the service providing facilities of government and the specific services the facilities provide. From the user's perspective, drug stores/pharmacies are the first point of contact for minor health issues. People visited facilities at the upazila level and upwards only for serious cases. Selection of a certain facility or service point depended on the type of service and recipients' perception of availability of the services, capacity of the facility to provide care for the service required, cost, distance to the facility, waiting time, quality of care and environment of the facility including cleanliness, staff behavior, privacy and comfort. There was no noticeable difference seen across the different districts among mainstream population in terms of access to and utilisation of services. For disadvantaged population, this was found to be depended on their category of "marginalization". Those living close to mainstream population (e.g. tea garden workers, garments workers, flatland ethnic minority) as well as affiliated with an organization had the access to all the existing government facilities, and even some additional options (e.g. Christian missionary hospitals or healthcare facilities within the organizations). However, those living in geographically isolated areas, like chars or hill tracts, had very limited access to go to government health facilities or avail any healthcare facility.

The users across the study sites mentioned improvement in physical facilities, including new infrastructure, and equipment. However, the spot observations found the infrastructure management not being at optimum level for which the recipients were not getting the expected benefits. Discussions with the providers and managers revealed the shortage of human resources, particularly at the technicians and assistant level for which the medical equipment cannot be utilised at the optimum level. These were seen having negative impact on user's satisfaction, since these resulted in long waiting time, unavailability services like diagnostic services and availability of medicine. At the time, because of a shortage in frontline health and FP workers, the domiciliary visits from government was found to be almost absent, although, in cases, some NGOs provide it, extent of which was not within the scope of the assessment to measure. The assessment identified some transparency issues including preferential treatment to known patients and informal payments, resulting in increased cost and inconveniences for the recipients, and having overall impact on decreasing satisfaction. This in turn drove people to private facilities where they were seen quickly and diagnostic facilities could be availed during the same visit, thus saving time and trouble of making repeated visits.

Users viewed the CCs and union level facilities primarily as a source of free medicine. They felt the supply of medicine in terms of quantity and variety not adequate to meet the demand. Users also could not differentiate between the services provided from CCs and union level facilities. Some of the services provided from these facilities did not seem to have considerable demand among the communities, e.g. normal delivery. The structured referral from CC to UHCs seemed to be working well for both recipients and providers. Further explorations might need in this regard to see how this can be scaled up.

The assessment showed areas in which reviewers, including the MTR team should further explore. Due to the exploratory nature of this research, and predominant focus on the service recipients – there was no recommendations furnished by the team. However, based on this report – the MTR team may come up with recommendations to address the priority issues for the remaining period of the 4th HPNSP.

ANNEX ONE: FINDINGS OF RAPID REVIEW

Based on the relevance of our topic, 122 records were selected for full-test for rapid review. Table 1 shows topic-wise number of articles and reports reviewed in this rapid review procedure.

Topic	Number of Articles/Reports Reviewed
Physical Facilities in Government Health Facilities in Bangladesh	11
Human Resources for Health (HRH) in Government Health Facilities	17
Community Participation in Management of Healthcare in Bangladesh	11
Transparency in Government Healthcare in Bangladesh	9
Equity in Government Health Services	18
Delivery of Maternal Healthcare Services	13
Delivery of Neonatal and Child Healthcare	12
Delivery of Family Planning (FP) and Reproductive Health (RH)	10
Delivery of Non-Communicable Disease Control (NCDC) Services	25
Delivery of Nutrition Services	12
Social and Behavioural Change Communications (SBCC)	10
Quality of Care (QoC) in Service Delivery	6

Subsequent sections detail out the major findings of the rapid review in purview of the point of interest of the MTR of 4th HPNSP. 20590

Physical Facilities in Government Health Facilities in Bangladesh

Physical facilities under MOHFW include primary healthcare centres like community clinics (CC), Union Sub Centres (USC), Union Health and Family Welfare Centres (UH&FWC), Urban Dispensaries, etc. as well as the secondary hospitals (Upazila Health Complex or UHC), tertiary level hospitals (district hospitals, general hospitals, and medical college hospitals), and specialised hospitals/research institutes. There are 424 UHCs and 62 other hospitals at upazila level and below under Directorate General of Health Service (DGHS), having a total capacity of 20,194 beds (DGHS, 2018). At district level and above, 254 different types of hospitals under DGHS have the capacity of 32,613 beds, resulting around 1.94 beds per 10,000 population (DGHS, 2018). If compared to the 2008 situation[10], there has been around 58% increase in bed availability for indoor patient admission in facilities under DGHS. Apart from these in-take facilities, all the aforementioned hospitals, 60 upazila health offices, 1,312 USCs, 87 UH&FWCs, 35 urban dispensaries, 23 school health clinics and 13,779 community clinics (all under DGHS) provide PHC services on outpatient department (OPD) basis (DGHS, 2018). There are two specialised service, research and training institutes under Directorate General of Health Service (DGHS), namely Maternal and Child Health Training Institute (MCHTI) at Azimpur and Mohammadpur Fertility Services and Training Centre (MFSTC), with a combined intake capacity of 500 patients (MOHFW, 2016). In addition 70 Mother and Child Welfare Centres (MCWC) provide in-patient services[11]. Both the specialised centres, all 96 MCWCs (including the 70 providing in-patient services), 427 Maternal and Child Health (MCH) units, and 3,860 UH&FWCs provide PHC services on OPD basis (MOHFW, 2016). Evidence supports that almost all the facilities of MOHFW provide ANC and PNC services (NIPORT, ACPR and ICF, 2018). However, readiness of the public facilities still is not up to the expected level, as, in spite of designated to provide Basic Emergency Obstetric Care (BEmOC) in 4th HPNSP, only 36% of facilities at Upazila and above can provide the seven signal functions of BEmOC (NIPORT, icddr,b and Measure Evaluation, 2017).

In terms of child health services, majority of the facilities under MOHFW provide three vital care components – outpatient curative care for sick children, child vaccination services and child growth monitoring. However,

[10] DGHS, 2008, Health Bulletin, Directorate General of Health Services, Mohakhali, Dhaka
[11] Overview of MCH-FP Unit, retrieved from https://www.dgfpbd.org/, accessed on 28 January, 2020

only 38% of health facilities offering outpatient curative care for sick children have four basic items of equipment (child scale, length or height board, thermometer, and stethoscope) (NIPORT, ACPR and ICF, 2018). Availability of all six medicines considered essential to child health care (oral rehydration solution (ORS), amoxicillin syrup, paracetamol syrup/suspension, vitamin A capsules, mebendazole/albendazole, and zinc tablets) decreased in facilities from 42% in 2014 to 33% in 2017 (NIPORT, ACPR and ICF, 2018). Only 1 in 20 health facilities that treat sick children have all the WHO recommended tracer indicators (guidelines, trained staff, drugs, and equipment) on site.

Considering the reproductive health and family planning services, 25% health facilities in Bangladesh are providing Long Acting and Reversible Contraception (LARC)/Permanent Method (PM) services, and less than 5% of all health facilities provide PM services (NIPORT, ACPR and ICF, 2018). Overall, only 22% of facilities that provide FP services have readiness to provide services, i.e. equipped with FP guidelines, at least one trained staff person, a blood pressure apparatus, and three modern contraceptive methods (i.e. an oral pill, injectables, or condoms) (NIPORT, ACPR and ICF, 2018).

Leslie et al identified that the health facilities in Bangladesh are insufficiently equipped to provide basic clinical care (Leslie, Spiegelman, Zhou, & Kruk, 2017). Around 30% of the total development budget of the 4th HPNSP has been allocated for physical facilities development, procurement and supply chain management (MOHFW, 2016). Yet, procurement and supply chain management continues to be an issue, resulting in stock out of essential medicines and supplies (IRT, 2018). Poor performance in supply chain management has been identified as one of the main hindrances in ensuring required commodities at government facilities in district, upazila and below, in spite of the heavy investments on the procurement (Himel, 2018). In a review of the Implementation, Monitoring and Evaluation Division (IMED), only 7% of the patients coming to government hospitals were seen receiving medicine in full (Begum & Islam, 2015). In comparison to the extent of investment for medical equipment, the level of utilization is low (IRT, 2018). The hospital authorities at the secondary and tertiary levels procure a wide range of equipment, and medical and surgical instruments without ensuring the standard and quality of the medical equipment (IRT, 2018). As a result, quite a number of these equipment become non-functional. A review of IMED found significant numbers of important equipment like X-ray machines, Ultra Sonogram Machines and CT Scan machines non-functional (Begum & Islam, 2015). While there is a tendency of procuring new equipment, repairing and maintenance of the existing equipment are not given priority in government hospitals (Project Hope, 2014). With the very limited capacity of MOHFW to repair the existing and installation of new ones, often medical equipment in government hospitals remain uninstalled and become obsolete (Himel, 2014). Like the equipment, there is a tendency to pursue new construction of hospital buildings, however, without linking with the equipment supply plan of Central Medical Stores Depot (CMSD) or the human resources plan of Human Resources (HR) branch of MOHFW, resulting in non-functional physical facilities (MOHFW, 2015). Repair and maintenance works are neglected in each and every constructed physical facility under health services and the high resources allocated under this head remains unutilized (IRT, 2018).

Human Resources for Health (HRH) in Government Health Facilities

According to the Rules of Business, MOHFW is responsible for policy development and reform initiatives in the Health, Nutrition and Population (HNP) sector (Cabinet Division, 2017). Moreover, the stewardship and regulatory responsibilities in HNP sector fully lies on MOHFW, including setting standards of services, ensuring quality medical education, regulating and monitoring quality and standard of drug production and management, regulation of clinics and diagnostic centers, and regulation of professional practices (MOHFW, 2016). Responsibility of service delivery among the citizens lies within two of its largest directorates, namely – DGHS and DGFP. Another large directorate, Directorate General of Nursing and Midwifery (DGNM) supports both DGHS and DGFP in provision of facility-based services.

DGHS has around 103,743 positions, out of which, around 28% are vacant (DGHS, 2018). Among these, positions, the Civil Surgeon (CS) is responsible for leading the health service delivery at district level and Upazila Health and Family Planning Officer (UHFPO) at upazila level. There are around 25,539 positions for physicians, 5,368 positions for Sub Assistant Community Medical Officers (SACMO), 5,630 positions for first line supervisors in the form of Health Inspectors (HI) and Assistant Health Inspectors (AHI) and

20,908 positions for domiciliary workers in the form of Health Assistants (HA) (DGHS, 2018). In addition, DGHS have around 7,920 positions for Medical Assistants (MA), 1,911 positions for Alternative Care Professionals and 13,588 positions for community clinic-based Community Health Care Providers (CHCP) (DGHS, 2018).

DGFP has got around 41,242 sanctioned positions, out of which, around 23% are vacant. (HR Branch, 2019). Among these, there are around 1,055 positions for physicians, 485 Family Planning Officers, and 485 Assistant Upazila Family Planning Officers and 464 Assistant Family Planning Officers (MCH). In addition, there are 2,500 positions for SACMO, 5,710 positions for Family Welfare Visitors (FWV), 4,500 positions Family Planning Inspectors (FPI), 23,500 positions for Family Welfare Assistants (FWA), and 1,455 positions Family Planning Assistants (FPA) (HR Branch, 2019). DGNM has 36,376 sanctioned posts, out of which, around 5% are vacant (HR Branch, 2019). Bulk of these positions (29,108 Senior Staff Nurse, 2,000 Staff Nurse, 487 Assistant Nurse and 2,996 Midwives) are allocated in upazila, district, specialised and tertiary level hospitals (HR Branch, 2019).

Overall, Bangladesh is experiencing a significant shortage of health workforce (HWF), evident from only 8.3 doctors, nurses and midwives available for 10,000 population against the global benchmark of 44.5 (HR Branch, 2019). The skill mix in the form of HWF ratio of doctors, nurses and allied professionals 1:0.6:0.3 is also not favourable in comparison with the global benchmark of 1:3:6 (HR Branch, 2019). Although there have been increased numbers of medical colleges, nursing institutes, Medical Assistants Schools (MATS) and Institute of Health Technicians (IHT) in recent times, experts suggest absolute shortages of health workers will continue in the coming years (El-Saharty, Sparkes, Barroy, Ahsan, & Ahmed, 2015). The shortage of HRH has a direct impact on the extent and quality of care in the government hospitals. Evidence suggest insufficient HRH in emergency obstetric care in public facilities, particularly in the evening and night shifts (Biswas, et al., 2018). Vacancy in the positions of medical officers and nurses in government facilities was found to be a constraint for provision of newborn care and newborn complication management (Billah, et al.). Domiciliary visit reduced to around 20% in 2017 from 43% in 1993/94, which has been directly attributed towards one of many reasons for stagnant status in FP and RH services (NIPORT and ICF, 2019).

Not only the number of HRH is concerning, but the fact that majority of those are providing services at urban areas, is also an issue for service provision for rural people. It has been estimated that less than 20% of health workers serve over 70% people living in rural areas (WHO, 2018). There are significant challenges associated with retention of the HRH in rural areas (WHO, 2018). Applicant with relevant expertise not being leveraged in recruitment, late promotions often contingent on post-graduation, porous and unplanned career tracks, people without necessary expertise or experience being deployed to high positions by lateral migration from unrelated career tracks or ministries, and politically motivated promotions have been cited as some of the challenges for retention of HRH in rural areas (Joarder, Rawal, Ahmed, Uddin, & Evans, 2018). Darkwa et al added poor living conditions in rural areas (e.g., poor housing facilities and unsafe drinking water); overwhelming workloads with poor safety and insufficient equipment; and a lack of opportunities for career development, and skill enhancement as other constraints for retention of the HRH at rural areas (Darkwa, Newman, Kawkab, & Chowdhury, 2015). Inadequate opportunities for private practice in rural areas and lack of sufficient authority for the managers to undertake disciplinary measures for absenteeism also were cited as challenges (Darkwa, Newman, Kawkab, & Chowdhury, 2015).

A vital component of delivery quality services in health is the workload estimation and management. In a recent study, majority of the HRH engaged in government health facilities were found to have high workload, particularly the obstetrics and gynecology consultants, medicine consultants, general physicians, nurses, and domiciliary workers like FWA (Joarder, et al., 2019). However, the same study also found relatively low workload for a few other categories of HRH (Joarder, et al., 2019), which indicates the workload estimation, distribution and management for health workers in the public facilities not being at the optimum level.

As shown above, community health workers (CHW), including HA, FWA, FWV and CHCP constitute the bulk of the service delivery workforce of MOHFW. These CHWs are involved in delivery of PHC, particularly maternal health, child health (including immunisation), family planning, reproductive health, nutrition services, screening of NCDs, etc. (MOHFW, 2019). They are also involved in health education and

promotion, and collection of evidence for monitoring and supervision (MOHFW, 2019). CHWs are vital in increasing access to health services and reduction of healthcare costs (MOHFW, 2019), particularly with the situation in which the retention of physicians are quite difficult. While there are formal education and training institutes for health technicians and medical assistants, there is no formal education system to produce CHWs like HA, FWA and CHCP (Talukder, Yasmeen, Nazneen, Hossain, & Chowdhury, 2014). Unlike other professionals in HRH, CHWs acquire their skills through on-the-job training after recruitment, rather than through pre-service education and training. As per Talukder et al, the CHW development system is neither need based, nor institutionalised in Bangladesh (Talukder, Yasmeen, Nazneen, Hossain, & Chowdhury, 2014).

To address the gaps in HRH, 4th HPNSP allowed for deployment of Multi-purpose Volunteers (MPV) in supporting HNP services, particularly in rural and hard-to-reach areas (MOHFW, 2016). Already a few of the Operational Plans like Community Based Health Care (CBHC), Family Planning Field Service Delivery (FPFSD) and Clinical Contraceptive Service Delivery (CCSD) deployed volunteers at the field level (PMMU, 2018). However, since these are not full time staff of DGFP, use of standard guidelines by them are largely missing (PMMU, 2018). Public-private partnership seems to be an effective alternative for production and deployment of CHWs to ensure quality care at community level. In a recent evaluation of private community skilled birth attendant (P-CSBA) model, developed through the GSK-CARE Frontline Health Worker Programme, improvements were seen in the areas of birth planning and the use of key maternal health services among the community people (Hossain, et al., 2020). APR, 2018 recommended use of such public-private initiative, along with proper enabling environment, regulation and supervision could be further explored as a mechanism to improve health provider availability and accessibility (IRT, 2018).

Community Participation in Management of Healthcare in Bangladesh

Community participation is a concept that was gradually surfaced during 1950's and 1960's during a time in which the UN agencies were looking for mechanisms to involve people in decisions about development, and became one of the main principles of Primary Health Care (PHC) strategy in the Alma Ata declaration (WHO, 1978). Alma Ata declaration defined community participation as the process by which community people assume responsibility of the health and welfare of the community and develop capacity to contribute towards community's development[12]. Rifkin argued that the declaration could enable community peoples' involvement in both delivery of and decisions about health and health services (Rifkin, 1986).

Community participation in healthcare management in public sector is in implementation for over two decade in Bangladesh. The "Chowgacha Model" initiated by Dr. Emdadul Huque and implemented from 1996 to 2012 helped to develop upazilla level standard services in the Chowgacha Health Complex in Jessore district, and mobilised 46 additional workers from the local community (Ahmed M. , 2016). The model was later implemented in Jhenaidah district hospital with the support from local member of parliament and other members of hospital management committee, and improvement could be seen in the areas of hospital cleanliness and waste management (MOHFW, 2016). The key features of the dynamics in these two models include - hospital-centric initiatives of community mobilisation for hospital improvement, adoption of evidence-based decision making, and enabling a participatory mechanism for hospital management involving local administration, elected representatives and community people. DGHS, later, issued an instruction for all government hospitals at upazila and district level to adopt the Chowgacha-Jhenaidah model for facilitating community participation to improve accountability, increase transparency and increase local resource generation[13]. The instruction also laid guideline for development of community support committee in the respective upazila and district level hospitals. There has not been any progress review for the formation of these committees or the effectiveness of the model implementation in

[12] https://www.who.int/publications/almaata_declaration_en.pdf

[13] Letter signed by Additional Director General (ADG) Administration, DGHS, reference 45.01.0000.029.05.001.18.5, date 3 July, 2018

the respective hospitals. So this will be an interesting issue of investigation for the Midterm Review of 4th HPNSP.

Another interesting model for community participation is the community groups (CG) and community support groups (CSG) associated with the community clinics in Bangladesh. CG and CSG are community-led mechanisms for management of community clinics in which the role of CG include daily management of CC operation and resource mobilization, and the role of CSG include promotion of CC services, providing support to patients/clients, and raising awareness on health among community people (Faiz, 2014). Evidence support that government is considering the CSG as a good example of public-private partnership in ensuring primary healthcare in Bangladesh and as platform for community mobilisation (IRT, 2018). It seems that the CG members are already aware of their roles and responsibilities regarding management of community clinics (CBHC and WHO, 2019). Gai et al found improved utilisation of services as a direct result of community mobilisation, particularly in the maternal services like antenatal, delivery and postnatal services (Gai, Islam, Yoshimura, & Hossain, 2019). Donation of land and management of CG and CSG also seem to enhanced ownership of community over the community clinics (Islam K. , 2017).

The potentials of community participation was quite acknowledged in the PIP of 4th HPNSP, and the continuation and expansion of initiatives like Chowgacha model and community groups have been assured during the remaining period of the programme (MOHFW, 2016). The PIP also mentioned motivating communities to mobilize local resources for repair and maintenance of community-based infrastructure (including community clinics). This is crucial for sustenance of these community health facilities, as, unlike the union, upazila and district level hospitals, the Health Engineering Department (HED) is not responsible for maintenance of the community clinics. Although these clinics were built by HED, but on land donated by the local land owners, and by policy, the community is responsible for maintenance (MOHFW, 2016). However, no evidence of such local resource mobilization found in the literature review. In the programmatic updates provided by different OPs through the Annual Program Implementation Review (APIR), no such evidence of local resource generation for the maintenance of community clinics was seen for the Community Based Health Care (CBHC) OP (PMMU, 2018). In a recently conducted independent review of community clinics, ability to support aspects of management that required funding was seen as a major challenge for the CGs (CBHC and WHO, 2019). The review found some local government authorities providing limited supports in payment of utility bills and cleaning services, however, the extents are quite limited and more on ad hoc basis. So, there needs to be a systemic approach to support the CGs and CSGs in, among others, mobilising resources for maintenance of the community clinics.

Transparency in Government Healthcare in Bangladesh

Healthcare transparency has been defined as “making available to the public, in a reliable, and understandable manner, information on the health care system’s quality, efficiency and consumer experience with care, which includes price and quality data, so as to influence the behavior of patients, providers, payers, and others to achieve better outcomes (quality and cost of care)” (American College of Physicians, 2010). Accountability and transparency has been a concern in health sector in Bangladesh for quite long. Evidence suggests that the existing structure and management of health organization does not facilitate health system accountability, which has been reflected in the high absenteeism of doctors in rural areas, corruption, poor service quality, and above all, the poor performance of service providers (Ahmed, et al., 2015). Study identified a rising trend in irregularities and informal practices in the health sector in Bangladesh, in both public and private sector, including stock-out of drugs, the use of public-sector medical equipment in private practices, preferential contracts with pharmaceutical companies and laboratories, trading of human organs, and absenteeism and private practice during office hours (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018). Though consultations are free in the public health facilities, Abdullah, Chowdhury and Iqbal showed 41% of the patients visiting public health facilities paid about US$2 as a consultation fee, which is about 16% of their total medical expenditure (Abdallah, Chowdhury , & Iqbal , 2015).

Another concerning form of transparency is the unnecessary C-Section delivery in private facilities, which is a significant financial burden, particularly for the poor and vulnerable. A recent study identified the rural women, in spite of having preferences for normal vaginal delivery, get influenced by government primary

health care providers and clinic agents (brokers) in going for C-section delivery (Begum, Sarker, Rostoker, Anwar, & Reichenbach, 2018). The same study found that obstetricians, having preferences for caesarean section, receive more patients from these brokers, than those not preferring C-section delivery (Begum, Sarker, Rostoker, Anwar, & Reichenbach, 2018). Another form of irregularity rises from the unethical interactions between pharmaceutical industries and, that lead to physicians' professionalism influenced in the form of focused and costly prescribing behaviours, which are not in patients' best interest (Mohiuddin, Rashid, Shuvro, Nahar, & Ahmed, 2015). Serious incidents of medical malpractice and exploitation have been reported, that disproportionately affect the poor and less educated (Shafique, Bhattacharyya, Anwar, & Adams, 2018).

A number of reasons have been attributed for corruption in health sector, including poor work and living conditions, local political pressure and threats to personal safety, limits to higher study, promotion and transfer due to political patronage, lack of supervision and monitoring in different tiers of health system, poor patient documentation and lack of awareness among communities about services availability (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018). Impact of corruption was found on limiting access to healthcare for poor and vulnerable groups, negatively affecting resource use, increasing costs of treatment, medicines and equipment, decreasing quality of care and treatment outcomes; and deteriorating trust in the health system and service providers. (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018).

Anti-Corruption Commission (ACC) of Bangladesh has recently submitted a set of recommendations to the MOHFW. Among these, some of the vital recommendations include – public display of citizen charters and status of stock of the available medicine in hospital premises; public display of list of medicine and price of individual diagnostic tests; electronic stock register in hospital and connecting it to the public display; formation of hospital based vigilance/monitoring team; formation of surveillance team under the leadership of CS to monitor private hospitals and clinics at district level; introduction of a well-defined transfer policy; introduction of policy to set fees of doctors; mandatory prescription of generic names of drugs instead of commercial drugs; installation of, complaints and suggestions hotlines at hospitals, etc. (ACC, 2018). Evidence suggests that use of ICT-based modern technology, such as the internet and electronic devices for record keeping, contribute significantly to enhancing health service transparency (Islam M. S., 2015). Awareness building of the patients and involvement of local communities and local government have also been recommended to address corruption and ensure transparency in health sector of Bangladesh (Naher, Hassan, Hoque, Alamgir, & Ahmed, 2018).

Equity in Government Health Services

Braveman and Gruskin defined equity in healthcare as the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged at further disadvantage with respect to their health (Braveman & Gruskin, 2003). Despite the tremendous success in recent times, the results of healthcare improvement have not been uniform throughout the country (Save the Children, 2018). The inequity comes in different forms across the country and society, including hard-to-reach districts lagging behind other areas; poorer demographic groups behind richer ones; and women behind men (Save the Children, 2018). Islam and Biswas think inequity as a serious problem affecting the health care system (Islam & Biswas, 2014). Healthcare utilisation across socioeconomic groups is one of the indicators to measure if a country has progress towards Universal Health Coverage (UHC). Khan et al opined that such utilisation should be more on poorer groups as a greater need for healthcare is generally more concentrated in these groups (Khan, et al., 2017). Evidence shown by Molla and Chi suggest that high out-of-pocket payments still persist in Bangladesh, which is increasing, with financing more concentrated among the poor (Molla & Chi, 2017). This heavy reliance on OOP payments, particularly from poor, reduces household living standards and lead to poverty or ultimately push households to deeper poverty (Molla & Chi, 2017).

The extent of inequality varies depending on location and service category. Equity has improved at a faster rate in urban areas, and this appears to be at least partially reflective of the different service environments

in urban and rural domains of the country (Kamal, Curtis, Hasan, & Jamil, 2016). For example, ANC from medically trained providers increased, however gap in use between the rich and poor remained unchanged in rural areas whereas improved in urban areas (Kamal, Curtis, Hasan, & Jamil, 2016). Use of facilities for deliveries has increased by a greater margin in urban areas than in rural areas resulting in a widening of the urban–rural gap in equity issues (Kamal, Curtis, Hasan, & Jamil, 2016). The use of facilities for delivery among the urban poor increased rapidly and the rich-poor ratio in facility delivery coverage in urban areas had narrowed considerably (Kamal, Curtis, Hasan, & Jamil, 2016). Evidence also suggests that the prevalence of accessing maternal healthcare services is lower among Indigenous women in the Chittagong Hill Tracts compared with national average (Akter, Rich, Davies, & Inder, 2019). Jonge et al found newborn care better in higher socioeconomic groups than in lower socioeconomic groups in rural areas of Bangladesh (Jonge, et al., 2018). Chowdhury et al showed that children from low asset category households had on an average 1.17 times higher mortality rate than those from high asset category households (Chowdhury, Hanafi, Mia, & Bhuiya, 2017). Evidence also suggest a greater than two percentage point difference in prevalence between urban and rural areas in Bangladesh in treatment of childhood illnesses (Chakraborty & Sprockett, 2018).

Access to health care, defined as "dismal" in past for poor urban people, particularly for those living in urban slums (Afsana & Wahid, 2013), got improved, as evident from a DiD analysis, showing the gap between slum and non-slums for skilled birth attendant (SBA) during delivery and use of modern contraceptives significantly decreasing (Angeles, Ahsan, Streatfield , El Arifeen, & Jamil, 2019). Availability of community health workers in urban areas engaged through the NGOs under the development project of Local Government Division (LGD) was found to be playing significant role in reducing these gaps (Angeles, Ahsan, Streatfield , El Arifeen, & Jamil, 2019). MOHFW initiated the piloting of Demand Side Financing – Maternal Health Voucher Scheme (DSF-MHVS) to increase demand and utilization of maternal health services, to improve access to and utilization of safe delivery, to encourage institutional delivery and to improve equity in the utilization of maternal health services (Khan & Khan, 2016). Evidence suggest that the voucher scheme improved access to safe delivery and improved overall health status of the poor women (Das A. C., 2015). Government of Bangladesh (GOB) with technical assistance from United Nation Population Fund (UNFPA), United Nation Children's Fund (UNICEF) and World Health Organization (WHO) started implementing Maternal and Neonatal Health Initiatives in selected districts of Bangladesh (MNHIB) in 2007 with an aim to reduce inequity in healthcare utilization (Haider, et al., 2017). Documents suggest overall use of maternal health care services increased in post-MNHIB year compared to pre-MNHIB year and inequity in maternal service utilization declined (Haider, et al., 2017). The accreditation of 4 Districts Hospitals and 3 Upazilla health complexes as Women Friendly facilities (MOHFW, 2016) is an important step in the right direction for MOHFW in ensuring gender equity. However, with the issues like limited availability of hospital beds and social barriers to women's independent access to health care facilities are limiting the benefits of the initiative (Begum & Islam, 2015). The one-stop crisis centres to address violence against women in 6 divisional medical college hospitals also could not be expanded in lower tiers of health facilities due to limitations of appropriately trained service personnel (Begum & Islam, 2015). Shasthyo Surokksha Karmasuchi (SSK) has been a pilot initiative of MOHFW for the below-poverty line (BPL) population to ensure the equity issues by reducing the OOP (Ahmed, et al., 2018). An evaluation of the initiative is underway, and it will be interesting to understand how the initiative have been successful in addressing the equity issues of the BPL in Bangladesh.

Delivery of Maternal Healthcare Services

MOHFW is implementing the facility-based Emergency Obstetric Care (EOC) Programme in all districts of Bangladesh to improve the maternal health situation (DGHS, 2018). The obstetric care provided can be classified into two categories in this programme - Comprehensive Emergency Obstetric Care (CEmOC) (provided from all medical college hospitals, 59 district hospitals, 3 general hospitals, 132 UHCs and 71 MCWCs) and Basic Emergency Obstetric Care (BEmOC) (rest of the UHCs) (DGHS, 2018). As per the Sample Vital Registration System (SVRS) survey of 2019, the Antenatal Care (ANC) visits of the pregnant women have been increased (75.2% pregnant women taking it at least once and 36.9% pregnant women

taking it at least four times in 2019 in comparison to 58.7% and 24.7% respectively in 2012-13) (BBS, 2019). Post Natal Care (PNC) visit also have been increased to 66.7% in 2019 from 41.2% in 2012-13 (BBS, 2019). However, the Quality of Care (QoC) remains a concern, as Biswas et al found ANC services in district hospitals and MCWCs below the acceptable level (Biswas, Sujon, Rahman, Perry, & Chowdhury, 2019). This is quite surprising, since there has been substantial investments on increasing QoC. The APR, 2018 identified the investments resulting only pocket of improvement, but not any systematic impact (IRT, 2018). Cost of ANC visits (direct cost and indirect costs like transportation, loss of wage/income, etc.) has been seen quite high at district level facilities (USD 2.75) than the community level facilities (USD1.62) (Jo, et al., 2019). Institutional deliveries have been increased to 53.4% in 2019 in comparison to 31.% in 2012-13 (BBS, 2019), however, there remain a considerable gap in terms of rural-urban (59.3% facility deliveries in urban areas vis-à-vis 39.4% in rural areas) and wealth quartiles (23.5% in lowest quartile vis-à-vis 72.8% in highest quartile) (NIPORT, 2017). There is a shear dominance of private facilities for institutional deliveries over the public facilities (28% in facility deliveries in private facilities while 14% in public facilities), however, there is extremely high rate of C-Section deliveries in private facilities (84% of all deliveries are being C-Section deliveries in private facilities) (NIPORT and ICF, 2019). Unfortunately, in spite of the large incidents of C-section deliveries, only 32% private facilities have the readiness to conduct these (NIPORT, icddr,b and Measure Evaluation, 2017). There also seems to be a lack of functional referral system to ensure effective BEmOC services since 18% of maternal deaths occur at transit (NIPORT, icddr,b and Measure Evaluation, 2017). Lack of reliable transportation has been cited as a significant barrier to accessing care during pregnancy, delivery, and postpartum by women in Bangladesh (Alam, et al., 2016). Because of all these factors discussed, the maternal mortality ratio is “being in plateauing state” as defined by the APR, 2018 (IRT, 2018).

There has been introduction of mobile phone based mHealth services in Bangladesh and there are evidences showing improvement of knowledge and practice of maternal health services (Chowdhury, Shiblee, & Jones, Does mHealth voice messaging work for improving knowledge and practice of maternal and newborn healthcare?, 2019). Gai et al showed improvement in maternal health services through strengthening of community support groups (CSG) (Gai, Islam, Yoshimura, & Hossain, 2019). Study of Mahmud et al showed women utilise maternal healthcare services in a facility, if it is staffed with encouraging, respectful healthcare providers and provide the required drugs (Mahmud, et al., 2019), so these are clear indications for policy stakeholder to consider for improvement of maternal health delivery.

Delivery of Neonatal and Child Healthcare

As shown before, there has been significant decline in under 5 mortality and infant mortality, primarily due to high coverage of immunization and vitamin A supplementation, and use of oral ORS (oral rehydration salt) for treatment of diarrhoea (BBS, 2019). As a matter of fact, Bangladesh achieved the MDG 4 targets in reduction of under-five mortality well ahead of stipulated time period (DGHS, 2018). However, the pace in decreasing the neonatal death is quite slow, considering the last ten years (IRT, 2018). There has been a significant shift in the epidemiological pattern of under-five mortality. Majority of the neonatal deaths are still from preventable causes (birth asphyxia, prematurity, severe infection and acute respiratory infection which together account for almost 75 percent of neonatal deaths), with about 80 percent of these deaths occur during the first week of life, 50 percent within the first 24 hours (NIPORT and ICF, 2019). Estimated number of still births is similar to neonatal deaths and are largely unrecorded (IRT, 2018). Study suggests the prevalence of getting essential new born care is quite low in case of home deliveries (Kim & Singh, 2017), which still constitute a considerable proportion of the total deliveries in Bangladesh. However, studies also suggested the new born care in government facilities is not significantly good, with around two-thirds of the positions for medical officers and half of the positions for nurses was found vacant in government facilities, and 55% of the available staff not being trained on newborn complication management (Billah, et al.).

Bangladesh has Baby Friendly Hospital Initiative (BHFI) revitalised in 4th HPNSP (MOHFW, 2016), however, evidence shows there are very small number of trained staff to operate as per global criteria of UNICEF/WHO on BFHI, and the motivation level of the staff also was found to be low (Akhtar, et al., 2017).

Under the National Newborn Health Program (NNHP) and Integrated Management of Childhood Illness (IMCI), MOHFW is providing kangaroo mother care (KMC) for low birthweight and premature babies, and Care of critically ill newborn at Special Care Newborn Unit (SCANU) (DGHS, 2018). Study found no UHC equipped with SCANU and only 8% of the UHCs equipped to provide KMC (Billah, et al.). This maybe because these are resource intensive interventions and hence currently district level hospitals have more priorities than the UHCs. It seems that it is quite early to experience measurable outcomes of KMC and SCANU in hospitals, as both the interventions are in very early stage of implementations (Taylor, Manuel, Bhattacharjee, & Ali, 2017).

Evidence shows neonatal mortality significantly decreases for newborns whose mothers' attended antenatal care services (Akter, Dawson, & Sibbritt, 2017), which means improvement of ANC visits through maternal healthcare can decrease neonatal deaths. Study also suggest that neonatal deaths due to infection during home delivery can substantially be reduced through introduction of community-based neonatal health interventions, focusing primarily on infection prevention and management (Baqui, et al., 2016). A mobile application based on Bangladesh's Comprehensive Newborn Care Package national guidelines (mCNCP) was developed to aid CHWs in identifying and managing small and sick infants and study shows CHWs using mCNCP are more likely to identify correctly classify 7 out of 16 newborn critical conditions, including severe weight loss, poor movement, hypothermia and feeding intolerance (Schaeffer, et al., 2019).

Delivery of Family Planning (FP) and Reproductive Health (RH)

Total Fertility Rate (TFR) in Bangladesh has decreased from 5.21 in 1982 to 2.11 in 2011, which is quite remarkable, however, thereafter, the rate is quite stagnant and was found to be 2.05 in 2018 (BBS, 2019). Contraceptive prevalence rate (CPR) remains unchanged since 2014 at around 62% (NIPORT and ICF, 2019). The unmet need for family planning services have been at the same (12%) since 2014. Among the service provision facilities, only around half have FP guidelines, and around 95% of the private facilities do not even have FP guidelines available (NIPORT, ACPR and ICF, 2018).

One of many reasons attributable for the stagnant status in FP and RH services is the shortage of skilled FP workers, for which the domiciliary visit reduced to around 20% in 2017 from 43% in 1993/94 (NIPORT and ICF, 2019). Failure of the FP fieldworkers in effective counseling for developing demands for FP services has also been identified as one of the reasons for plateaued FP status in the country (Das T. , 2016). Point to be noted here that integrated FP counseling and services during home visits has already proven to increase CPR, particularly the Postpartum CPR (Ahmed, et al., 2015).

Government of Bangladesh modified the regulatory restrictions, increasing the allowable time to adopt Menstrual Regulation (MR) services in 2014. National Guideline for MR was also developed in the same year. Both number of facilities providing services and QoC was seen being improved in case of MR (Rana, Sen, Sultana, Hossain, & Islam, 2019). However, the MR service seems to be more prevalent among women with children, women from higher socio-economic status (SES) group and less prevalent within those from Chittagong and Sylhet Divisions (Rana, Sen, Sultana, Hossain, & Islam, 2019). There are considerable barriers in availing MR services in the country, including low knowledge and awareness of those who need it, in spite of the fact that the service is free of cost in public facilities, providers' unsanctioned rejection of women seeking services and unauthorized charging for service, judgmental attitudes on the part of providers, and stigma and shame surrounding the procedure (Hossain, et al., 2017). Services provided from public facilities, particularly from the union level facilities were seen dropping, with an increase from the private facilities, though private facilities lack basic equipment and trained providers (Guttmacher Institute, 2017). Around one-third requiring facility-based treatment do not receive the Post Abortion Care (PAC) that they need (Guttmacher Institute, 2017).

Due to issues in procurement and supply chain management, high prevalence of stock-out of FP commodities has been reported in the BDHS 2017. Although the Postpartum Family Planning (PPFP) has been recognized in the National Action Plan for PPFP, however, overall the PPFP service delivery and counseling was found to be quite low in Bangladesh (IRT, 2018). Regional disparity still exists in Sylhet and Chittagong divisions, while the new Mymensingh division emerged as another low performing division with a TFR of 2.5 (IRT, 2018). Contraceptive usage among young married couples aged 15-19 is much

lower (49%) compared to the national average of 62% causing a large number of unintended pregnancies among these couples. A recent study identified strong correlation between contraception use by women and their education attainments and employment, which indicate a potential improvement in these indicators might have a good impact on the contraception prevalence among women (Islam, Khatun, Rahman, Mostofa, & Hoque, 2016).

Delivery of Non-Communicable Disease Control (NCDC) Services

Bangladesh is currently going through an epidemiological transitions, and the burden of non-communicable diseases (NCDs) is emerging as a public health challenge (DGHS, 2018). NCDs like diabetes, hypertension, cardio-vascular diseases, kidney diseases, accidents, injuries, etc. are not only primary the cause for around 600,000 deaths in Bangladesh, but also a major cause for detrimental socio-economic status for the citizens (WHO, 2017). Continuing care required for these diseases and often expensive treatment interventions can result in immense pressure on the health system and potentially catastrophic costs to families through out-of-pocket expenditure (WHO, 2017). SVRS estimated that cardio- and cerebrovascular diseases combined are the major causes of death, followed by asthma and respiratory diseases (BBS, 2019). Major determinants of the increase in NCDs was found to be increased prevalence of being overweight (BMI ≥ 25 kg/m^2), low fruits and vegetable consumption, insufficient physical activities and high tobacco consumption (NIPSOM, 2018). The situation is even worse in relatively lower wealth quantile, as seen in a community-based cross-section survey that prevalence of hypertension was found among 18.6% men and 20.7% women, and prevalence of diabetes was found among 15.6% men and 22.5% women (Khalequzzaman, et al., 2016). Mortality and morbidity caused by accidents and injuries (mainly due to road accidents but also due to bum, drowning, acid and accidents at work) are also in the rise in Bangladesh (WHO, 2015). Healthcare facilities, particularly the primary healthcare facilities do not have appropriately trained health workers to manage NCDs, do not have proper equipment to screen the NCDs, lacks required medicine and supplies and put more emphasis on cure than prevention of NCDs (BHW, 2016).

Hypertension is one of the most significant public health challenge in Bangladesh. While, adults have been considered to the demographic groups, recent studies suggest the young adults are equally in risk of hypertension. A recent study identified 49.4% of young adults being stage I hypertensive, 22.4% being stage II hypertensive and 28.3% being pre-hypertensive (Paul, Karmoker, Hussain, Hasan, & Khan, 2020). The major risk factor was found to be tobacco smoking (46.0%), obesity (29.2%), dyslipidaemia (25.2%), high salt intake 21.8% and use of chewable tobacco (13.7%). Physical inactivity has also been associated with high prevalence of hypertension, obesity and type II diabetes in Bangladesh (Khanam, Hossain, Mistry, Afsana, & Rahman, 2019). Fast food and soft drinks consumption leading to excess calorie intake coupled with lack of acceptable physical activity have been strongly related to overweight and obesity among Bangladeshi youths (Al Muktadir, et al., 2019). Unless there are effective interventions taken to improve lifestyles and increase physical activities, the NCDs issues of young adults may become severe.

Mental health is another issue of growing concern, since 16.8 percent people aged above 18 suffer from any of the mental health conditions ranging from depression, anxiety to neurodevelopmental disorders and sexual dysfunction (NIMH, 2019). Mental health is generally a neglected, under-researched and largely hidden public health problem in Bangladesh. Cabinet enacted the “Mental Health Act” in the country in 2018 to replace the age-old Lunacy Act, 1912, however, with a very limited availability of psychiatrists, very low healthcare budget for mental health (only 0.44% of total healthcare expenditure), low awareness regarding confidentiality, accountability, and human rights aspects of mental illnesses make it difficult to improve the mental healthcare provision (Hossain, Ahmed, Chowdhury, Niessen, & Alam, 2014). Traditionally mental illness has not been well understood by the general public, resulting in poor attitudes towards persons with mental illness and stigmatization. Mental illness stigma remains a significant barrier to treatment, which is only available at the tertiary level in the country, not at primary and secondary level facilities (Hossain, Rehena, & Razia, Mental Health Disorders Status in Bangladesh: A Systematic Review, 2018).

Suicide is a neglected preventable public health problem across the globe and Bangladesh is not an exception. About one million people die each year by suicide over the world with a global mortality rate of 16 per 100,000 and 39.6 per 100,000 in Bangladesh (Arafat, 2017). Suicide is still under-addressed in Bangladesh as there is no surveillance for suicide and nationwide study. Moreover, suicide is considered

as a criminal offence and religious factors and social factors as well as legal consequences hindering the disclosures. A study identified the risk of suicide being significantly higher among 15 to 24 old, and among married adolescents (Salam, et al., 2017). The low status of women in the society, child marriage, economic dependence on, and oppression from, husbands and in-laws, and illiteracy are some of the few reasons that have been previously reported for increased suicide rate in females. It is crucial to initiate changes in the society by enforcing legislation, focusing on girls' education and creating opportunities to empower women to improve their status in society, and to curb intimate partner violence. Some researchers have called for more multidisciplinary research exploring the intersection of adolescent mental health and reproductive health and rights to adequately understand the underlying causal factors for suicide (Petroni, Patel, & Patton, 2015).

Autism and Neurodevelopment Disorders (AND), once considered to be a niche, has become quite a concerning NCD issue in the country. While the wide scale awareness about autism in Bangladesh is indeed noteworthy and has garnered praise from the international community, that awareness has unfortunately not been matched with a similar growth of institutionalized public services and supports for persons with these disorders (Institute for Community Inclusion at University of Massachusetts, 2016). Moreover, the awareness campaign has yielded an undesirable but unintended situation where the common people confuse all other NDDs (i.e. cerebral palsy, Down Syndrome and intellectual disability) as well as almost any mental health problem as being autism. A study found age specific autism (18-36 months) in children higher in rural community of the country, where the early detection systems are not established, particularly in the primary healthcare facilities (Akhter, Hussain, & Biswas, 2018). To improve the scenario, the National Strategic Plan for Neorodevelopment Disorders 2016-21 have been introduced, along with the formation of Autism Cell within the MOHFW. Centre for Neurodevelopment and Autism in Children (CNAC) has been established at Bangabandhu Sheikh Mujib Medical University (BSMMU). Bangladesh has also formed a National Advisory Committee for AND. However, limited coordination among different public entities, lack of organized referral system, and lack of reliable information continuously hindering the success in management of AND in the country (Tanjir, 2018).

Drug addiction and drug abuse, chronic or habitual use of any chemical substance to alter states of body or mind for other than medically warranted purposes. Addiction is more often now defined by the continuing, compulsive nature of the drug use despite physical and/or psychological harm to the user and society and includes both licit and illicit drugs, and the term "substance abuse" is now frequently used because of the broad range of substances (including alcohol and inhalants) that can fit the addictive profile. Psychological dependence is the subjective feeling that the user needs the drug to maintain a feeling of well-being; physical dependence is characterized by tolerance (the need for increasingly larger doses in order to achieve the initial effect) and withdrawal symptoms when the user is abstinent (Shazzad, et al., 2014). Peer pressure, anger, impulse, availability and getting pleasure are the primary contributing factors for substance abuse in Bangladesh (Kamal, Huq, Mali, Akter, & Arafat, 2018). At present, punitive actions like law enforcements, that are being the primary actions against substance abuse, may not be enough to address the issue. The use and trade of harmful drugs should be reviewed more from the social health aspect rather than being handled by the criminal justice system. Evidence-based prevention, awareness raising, education, and interventions, including treatment and rehabilitation needs to be implemented in a coordinated way.

Drowning contributes to incapacity and early death in many countries. In low- and middle-income countries, children are the most susceptible to fatalities. Annual global death due to drowning accounts for 372,000 lives, over 50 % of which occur among children aged under 15 years old with children aged between 1 and 4 years of age being most at risk (Hossain, Mani, Sidik, Hayati, & Rahman, 2015). In Bangladesh, drowning rates are 10 to 20 times more than those in other developing countries. Living and geographical conditions in Bangladesh expose children to a high risk of drowning. Life in Bangladesh exposes adults and children to may water bodies for daily household needs, and as a result drowning is common (Hossain, Biswas, Mashreky, Rahman, & Rahman, 2017). There is a need to educate Bangladeshi parents and encourage behavioural change concerning supervision. Policies should

focus on increasing supervision by mothers/care persons, swimming skills, and should target illiterate mothers.

Antimicrobial resistance is a worldwide problem and Bangladesh is a major contributor to this owing to its poor healthcare standards, along with the misuse and overuse of antibiotics (Ahmed, Rabbi, & Sultana, 2019). This is occurring at an alarming rate and is outpacing the development of new antimicrobials, which threatens patient care, economic growth, public health, agriculture, economic security, and national security. A recent study identified significant percentage of enterotoxigenic *Escherichia coli* (ETEC) and enteropathogenic *Escherichia coli* (EPEC) strains developing multidrug resistance to commonly prescribed antibiotics (Rahman, et al., 2020). Unchecked use of antibiotics in poultry, fish and veterinary feeds, and their unplanned use in treating diseases contribute to the increase in antibiotic resistance. Antimicrobial resistance threatens the effective prevention and treatment of an ever increasing range of infections caused by bacteria, parasites, viruses and fungi. Besides, irrational use of antibiotics in humans, little awareness among people and drug sellers, a weak surveillance process, and dearth of information about the health situation of the country are also contributing to the spread of antimicrobial resistance in Bangladesh. The combined efforts of four stakeholders, i.e. pharmaceuticals industry, intermediary groups for selling and supplying of drugs (including antibiotics), end user groups like clinicians and veterinarians and Directorate General of Drug Administration (DGDA) as the regulatory authority, can only ensure high level of safety, efficacy and quality of drugs in the country. However, the failure of the stakeholders at any level will foster development and spread of antimicrobial resistance throughout the country.

Delivery of Nutrition Services

Bangladesh has made steady progress in child nutrition over the past decade, evident from stunting reducing from 43% in 2007 to 31% in 2017 and underweight declining from 41% in 2007 to 22% in 2017 (NIPORT and ICF, 2019). After years of a critically high level of around 15%, prevalence of wasting came down to 8% in 2017 (NIPORT and ICF, 2019). Around 65% of infants under age 6 months were exclusively breastfed, while 34% of children age 6–23 months were fed appropriately according to the recommended infant and young child feeding (IYCF) practices (NIPORT and ICF, 2019). Much of the improvement in nutrition in Bangladesh in recent years is explained by what can be seen as nutrition-sensitive drivers within a wider enabling environment of pro-poor economic growth, including improving incomes; smaller family sizes and greater gaps between births; parental - and particularly women's - education and wider health access (Nisbett, Davis, Yosef, & Akhtar, 2017). However, there are miles to go in achieving expected outcomes in nutrition, as the stunting among children still being quite high, considerable prevalence of micronutrient deficiencies like anaemia among women and children; and emerging overnutrition (overweight and obesity) problem in adult women giving rise to a double burden situation in the country (MOHFW, 2016).

Although the prevalence of stunting and underweight reduced among Bangladeshi women, nearly one-fourth of women are underweight and one-fifth of women are stunted (Hasan, Sutradhar, Shahabuddin, & Sarker, 2017). On the other hand, there are high prevalence of obesity and overweight, particularly among women from urban areas, married women and those from higher wealth quantile (Tanwi, Chakrabarty, & Hasanuzzaman, 2019). Even, there are considerable existences of coexistence of overweight or obese mother and underweight or stunted or wasted children in the same household in the country (Das, et al., 2019). Study shows a high proportion of non-pregnant and non-lactating women is deficient in zinc and iron, vitamin B 12 and vitamin D, while nearly half of the pregnant and lactating women in Bangladesh anaemic (Ahmed, Prendiville, & Narayan, 2017). The situation is even worse among the working women, evident from eight in ten female readymade garment (RMG) workers in Bangladesh suffer from anemia (Hossain, et al., 2019). Chowdhury et al showed the importance of health education and awareness raising to use health services and iron supplementation to improve the haemoglobin levels in pregnancy (Chowdhury, et al., 2015). Although there is IFA Supplementation Programme under the National Nutrition Services (NNS) OP (MOHFW, 2016), however insufficient IFA supplies and inadequate counselling to encourage consumption, are major barriers to both coverage and adherence of the programme in

Bangladesh (Siekmans, Roche, Kung'u, Desrochers, & De-Regil, 2018). The government of Bangladesh has developed inpatient and outpatient guidelines for the management of Severe Acute Malnutrition (SAM). Currently, inpatient management of SAM is available in 288 facilities across the country, however, only 2.7% doctors and 3.3% auxiliary staff are trained on facility based management of SAM (Ireen, et al., 2018). In functional facilities, uninterrupted supply of medicines and therapeutic diet are not available (Ireen, et al., 2018). Apart from these, there are challenges in delivering nutrition services, including poor quality maternal and infant nutrition counselling as per technical standards set by NNS, ownership concerns due to absence of dedicated nutrition managers at district and upazila level, and quality of monitoring and supervision (IRT, 2018).

Social and Behavioural Change Communications (SBCC)

MOHFW defined SBCC as the use of communication to influence individual and collective behavior to have impact on diseases/health conditions (MOHFW, 2016). Bangladesh has an approved Comprehensive Social and Behavior Change Communication Strategy and the recommended methods of communications include interpersonal, community mobilization by using mass media, ICT and others (MOHFW, 2016). Evidence support that SBCC interventions, particularly the interpersonal communications and entertainment educations are effective and appreciated by the community people and influenced them in taking maternal, neonatal and child health services (Rahman, Leppard, Rashid, Jahan, & Nasreen, 2016). SBCC interventions also seems to enhance awareness and knowledge of women regarding maternal, neonatal and child health service providing facilities and specific services provided from the facilities (Department of Population Sciences, University of Dhaka, 2016). Kim et al showed SBCC interventions like interpersonal communications, community mobilisation and mass media improved nutrition services as well, including early initiation of and exclusive breastfeeding, timely introduction of foods, and consumption of iron-rich foods (Kim, et al., 2018).

PIP of 4th HPNSP showed clear intension for innovative use of mobile technology, other ICT platforms and social media to disseminate SBCC messages (MOHFW, 2016). Already there are initiatives from MOHFW in enhancing awareness of community people, including mothers via SMS (DGHS, 2018). Another MOHFW endorsed mobile phone-based mHealth service is in operation that use customized voice messages for expectant (6–42 weeks pregnancy) and new mothers (1–52 weeks after delivery) for promotion of recommended healthcare practices (Chowdhury, Shiblee, & Jones, Does mHealth voice messaging work for improving knowledge and practice of maternal and newborn healthcare?, 2019). Study shows that longer exposure (at least 6 months) to these mobile technology-based platforms increase the knowledge of women regarding maternal and neonatal health significantly (Chowdhury, Shiblee, & Jones, Does mHealth voice messaging work for improving knowledge and practice of maternal and newborn healthcare?, 2019). Another study shows that women who use mobile phones for health communications are more likely to use ANC and professional delivery services than those who do not (Tang, Ghose, Hoque, Hao, & Yaya, 2019). Mobile phone based communications like text messages and voice messages have been found to be effective communication channels to reach out for menstrual regulation clients for information about family planning and contraception methods (Eckersberger, et al., 2017). However, despite successful implementations of some of these pilot interventions, progress in adopting eHealth strategies in Bangladesh has been slow, mostly due to lack of common standards on information technology for health, which causes difficulties in data management and sharing among different databases (Islam & Tabassum, 2015). Limited internet bandwidth and the high cost of infrastructure and software development are barriers to adoption of these technologies (Islam & Tabassum, 2015).

Quality of Care (QoC) in Service Delivery

Quality of healthcare in Bangladesh has been defined by MOHFW as delivery of timely, safe and effective care acceptable to the service recipients (MOHFW, 2017). The National Strategic Planning on Quality of Care for Health Service Delivery in Bangladesh considered six determinants of quality of healthcare – staff motivation, staff competence, adequate resources, appropriate content of care, good flow

and organisation of care and participation of client/community in the process of care (MOHFW, 2017). There has been substantial investments made by government of Bangladesh in increasing QoC in the country, however, so far, there has been only pockets of improvements, not any systematic impact (IRT, 2018). Bangladesh experiences both types of quality problems, i.e. undertreatment (failure to access or receive essential care or elements of essential care, or receiving essential care late) and overtreatment (provision of unnecessary or inappropriate or ineffective services, particularly diagnostic tests, procedures and medication) (Hort, Cruz, & Sultan, 2017). Studies identified problems ranging from providers being unfriendly and non-responsive to patients, uncleaned health facilities, inadequate physical facilities like waiting room and toilets (Rahman M. L., 2018) to provider complaints of lack of staff and supplies, lack of training and supervision, and large volumes of patients constraining quality (Islam, et al., 2015).

Poor quality service in Bangladesh is strongly associated with low utilization of services, especially by low-income groups (Naheed & Hort, 2015). Major problems affecting utilization are lack of sufficient drugs, supplies and equipment; staff shortages and absenteeism, and low levels of competence; poor prioritization of spending; and pervasive problems of management and coordination (Naheed & Hort, 2015). Quality improvement requires facility or system managers who have the capability and authority to assess and identify problems in service delivery, make plans to address them, provide or realign resources to implement the plans, and are held accountable for the results. Despite some discussions on decentralization of authority to upazila level, and on reforms of public financial management, in practice, the capacity and authority of upazila-level managers is limited and focuses on individual facilities rather than the upazila network, while central levels retain control of human resource allocation, and provision of supplies and drugs (Hort, Cruz, & Sultan, 2017). The revised ESP provides a model of care that allocates service functions to facilities at different levels within the system, sets out the resources and capabilities required for each level of facility, and takes an integrated approach to service delivery. This provides a basis for the allocation of resources across facilities consistent with their service function, but does not explicitly link the services to be provided with the expected standards of care (Hort, Cruz, & Sultan, 2017).

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