



# Bangladesh

## 2014 Health Facility Survey

### Policy Brief



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The 2014 Bangladesh Health Facility Survey (2014 BHFS) was implemented by the National Institute of Population Research and Training (NIPORT). ICF provided technical assistance. Associates for Community and Population Research (ACPR), a private research agency, collected the data. The 2014 BHFS is part of the worldwide DHS Program, which assists countries in the collection of data to monitor and evaluate population, health, and nutrition programs. The survey was funded by the government of Bangladesh and United States Agency for International Development (USAID).

The policy brief in this publication is based largely on the results of the BHFS as well as on other international, regional, national and divisional sources of data. The brief provides critical policy and program recommendations to the Government of Bangladesh (GOB), program managers, NGOs, and international donors with the goal of improving the health status for all citizens of Bangladesh.

Additional information about the 2014 BHFS may be obtained from the National Institute of Population Research and Training (NIPORT), 13/1 Sheikh Shaheb Bazar Road, Azimpur, Dhaka-1205 Bangladesh. Telephone: 88-02-5861-1206; Internet: <http://www.niport.gov.bd>.

Additional information about The DHS Program may be obtained from ICF, 530 Gaither Road, Suite 500, Rockville, MD 20850, USA (telephone: 301-407-6500; fax: 301-407-6501; e-mail: [info@DHSprogram.com](mailto:info@DHSprogram.com); Internet: [www.DHSprogram.com](http://www.DHSprogram.com)).

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# ACHIEVING QUALITY HEALTH CARE IN BANGLADESH: 2014 BANGLADESH HEALTH FACILITY SURVEY (BHFS)

## Quality care is essential for universal health care. Preparedness is the key.

Bangladesh and other countries have committed to achieving Sustainable Development Goal (SDG) 3 by 2030, ending preventable maternal and child deaths and nearly eliminating preventable diseases, such as tuberculosis [1]. Achieving this ambitious goal depends on fulfilling two objectives: (1) making essential services available and accessible to everyone in need and (2) ensuring standards of quality for these services to sustain universal health care (UHC). In its journey to attain UHC by 2030, Bangladesh has developed several health care programs. The first of these, the Health, Population, and Nutrition Sector Program (HPNSP), will focus on access to health care, quality of health care, and equity along with financial protection [1].



Preparedness, or the readiness of service delivery points to provide care, is fundamental to ensuring quality. Preparedness means that facilities have all essential elements in place to provide quality services, including basic client amenities, necessary equipment and medicines, and trained staff. These essential elements differ by the specific type of health service and service delivery point. Service preparedness is a continuous process; it evolves as standards for service delivery change.

Bangladesh has made tremendous achievements in public health over the last few decades as health care facilities gradually replace home-based care. As Bangladesh navigates through the next 15 years and completes the SDGs, the trend for facility-based care is expected to continue. Both public and private facilities must prepare to handle the projected case load [2]. Many countries have seen greater use of health facilities but have failed to improve public health because these facilities were not prepared to offer high quality services [2].

The 2014 Bangladesh Health Facility Survey (BHFS) provides a baseline for health care planning. The survey was conducted at an opportune time, not only at the beginning of the SDG era but also at the outset of designing the 4th Health, Population, and Nutrition Sector Program. The 2014 BHFS findings are revealing in terms of presenting the depth and the diversity of challenges in facility preparedness and the volume of remaining tasks.

The 2014 BHFS was designed to assess public, NGO, and private health care facilities in Bangladesh. The survey provided information on the availability of basic and essential health care services and the readiness of health facilities to provide high quality services in child health, maternal and newborn care, family planning, tuberculosis, and non-communicable diseases. The survey collected information from 1,548 health care facilities and 4,298 health care providers nationwide and provided representative results for the country as a whole, seven administrative divisions, seven types of public facilities, NGO static clinics/hospitals, and private hospitals. Additional information about the 2014 BHFS is available from the National Institute of Population Research and Training (NIPORT): telephone: 88-02-5861-1206; website: [www.niport.gov.bd](http://www.niport.gov.bd).

## Bangladesh's health facilities are not fully prepared to provide quality services.

The 2014 BHFS findings clearly show that many facilities are not prepared to provide the minimum standard of care. Key survey findings are noted in the following paragraphs.

### Items used to provide standard care for specific health services are not widely available.

In child health services, for example, more than four-fifths of facilities have oral rehydration solution (79%), amoxicillin (81%), and thermometers (94%). Other essential elements, such as growth charts (44%), integrated management of childhood illness (IMCI) guidelines (51%), and adequately trained staff (54%), are far less available. Only 9% of facilities had all necessary items and staff required to provide quality child health services. Similarly, many facilities lack basic amenities such as electricity, improved water sources, a latrine for clients, a functioning landline or mobile phone, a computer with an Internet connection, and a private space for counseling. Only 58% of district- and upazila-level facilities have at least 5 of these basic amenities, compared with only 6% of union-level facilities and 4% of community clinics.

### Primary health care facilities are least prepared to provide services.

Community clinics (CCs) and upazila health and family welfare centers (UH&FWCs), the first entry points into the health care system, are meant to provide preventive and primary care, including screening, antenatal care, and normal deliveries, as well as health promotion and health education. Only 36% of UH&FWCs and only 17% of CCs have all of the equipment, medicines, and trained staff to provide family planning services. Only 3% of UH&FWCs and 1% of CCs are prepared to provide antenatal care. None of the union-level facilities meet the preparedness standards for providing normal delivery care.

Each tier of the health care system must prepare to provide services in order to achieve universal health care coverage. The current effort to develop an Essential Services Package (ESP) for each service delivery tier is the first step to universal health care in Bangladesh [1].





*Bangladesh failed to meet several key Health, Nutrition, and Population Sector Development Plan (HNPSDP) 2011-16 targets.*

For example, in 2014, only 45% of facilities had latrines for women, far short of the target of 75%. Similarly, only 54% of facilities providing family planning services, excluding CCs, provide at least four temporary contraceptive methods; this falls short of the target of 75%. Just 1% of union-level facilities provide basic emergency obstetric care (BEmOC) services compared with the target of 50%. These results may indicate that targets were not realistic, that action plans were not aligned with set targets, or that in-course monitoring and adjustments were not done during the implementation of the sector program.

*Service readiness does not match program priorities.*

Readiness of facilities needs to correspond with program priorities. Reduction of maternal mortality is at the top of the national agenda [1, 3]. Bangladesh Call for Action 2013 calls for prevention and treatment of the two major causes of maternal deaths—postpartum hemorrhage (30%) and pre-eclampsia (22%) [3, 4]. According to BHFS results, however, only 36% of district and upazila public facilities are prepared to provide basic emergency maternal and obstetric care (BEmOC) care, and only 31% of all facilities providing antenatal care, excluding CCs, are prepared to test urine for protein, an essential test for pre-eclampsia. Similarly, only 44% of the health facilities have growth charts to monitor growth of children, even though childhood stunting is a major national concern, affecting 37% of children younger than age 5 [2, 5].

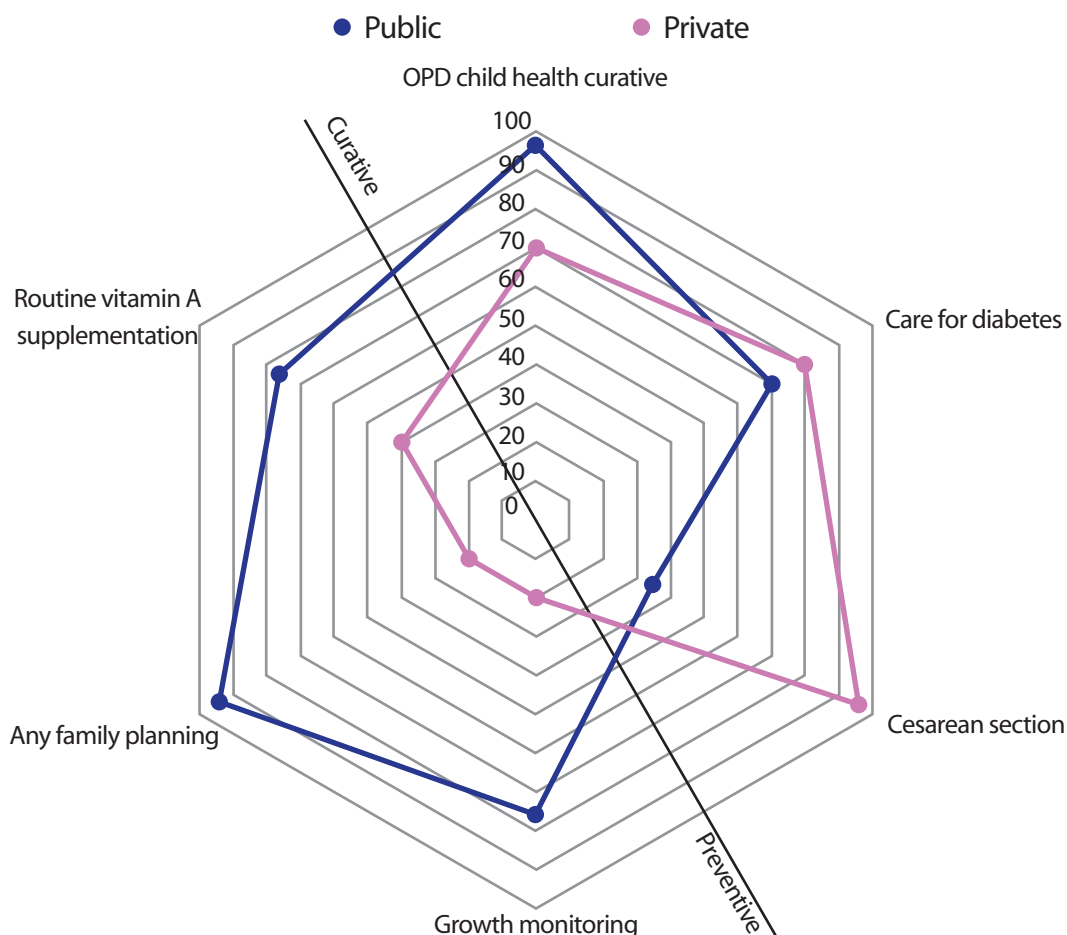
## Private sector growth is unplanned, and facilities are unregulated.

The growth of private sector hospitals follows market dynamics, and in most situations, external selection of hospital locations is minimal. According to the BHFS, there is a pronounced regional disparity in the concentration of private sector hospitals [BHFS tables 2.1 and 2.2]<sup>1</sup> [6]. Dhaka division, home to one-third of the country’s population, has more than half of the private sector hospitals in Bangladesh. In terms of population size, Khulna has 11% of the population but 8% of the hospitals, Rangpur has 11% of the population but 3% of the hospitals, Rajshahi has 13% of the population with 6% of the hospitals, and Barisal has 6% of the population with 3% of the hospitals. Divisions have disproportionately lower percentages of private sector hospitals. This disparity must be addressed in the national planning processes to ensure equitable coverage and availability of advanced care.

The BHFS data show that 90% of private sector facilities have all six necessary basic amenities—improved water sources, a latrine for clients, a functioning landline or mobile phone, a computer and Internet connection, and a private space for counseling—indicating the sector is invested in maintaining a minimum level of preparedness.

Private sector facilities are less likely than public sector ones to offer primary health care and preventive services. Figure 1 compares private and public sector availability of three curative and three preventive care services. Obvious reasons for the relative scarcity of services in the private sector are less demand for preventive than curative services and less profit for providers.

**Figure 1: Availability of selected curative and preventive care services between public and private facilities**



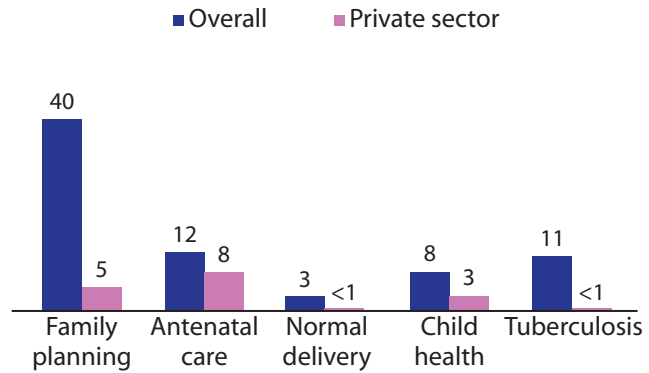
1

See 2014 Bangladesh Health Facility Survey final report, Tables 2.1 and 2.2.

More money does not necessarily bring in more quality. Generally, the cost of health care services from the private sector is higher than the cost of services from the public and NGO sectors. Private sector services cater to the wealthy. Thus, the quality of health care is expected to be high. Though the private sector appears to provide more than the other two sectors in basic amenities and equipment, in critical areas like infection prevention, the services do not differ. Private sector facilities have the same or less preparedness than public facilities in infection control, antenatal care, normal and emergency obstetric care, child health, and tuberculosis care. Figure 2 provides a snapshot of preparedness of selected services in the private sector compared with services in all facilities. Unfortunately, in all service areas, the private sector hospitals' level of preparedness is well below 10%, and no facilities meet standard levels of preparedness for normal delivery and tuberculosis care. Levels are well below the national averages for all facilities. Thus, with a high out-of-pocket expenditure, Bangladeshis are buying substandard products.

Private sector hospitals lag behind public and NGO facilities in availability of several services. For example, family planning services are available in 94% of district and upazila facilities and in 88% of NGO facilities compared with only 21% of private facilities. Outpatient curative care for sick children is available in 97% of district and upazila facilities and in 83% of NGO facilities compared with only 68% of private facilities. These are unexplored markets for the sector to invest in, particularly for the urban population, which has greater access to private hospitals.

**Figure 2: Preparedness of all health facilities (excluding community clinics) compared with private sector hospitals that provide selected services**



## Maternal and child health services do not have enough trained staff.

Nationwide the family planning, child health, and maternal health services lack both service-specific guidelines and appropriately trained staff (Table 1). Providing facilities with guidelines is the first step. Encouraging providers to use the guidelines is more challenging. Staff must have the basic knowledge and aptitude needed to consult guidelines when required.

**Table 1: Availability of trained staff and guidelines in all health facilities**

Readiness parameters	Family planning	Child health	Delivery services
Guidelines	54%	51%*	27%**
Appropriately trained staff	57%	54%*	39%**
<i>*Training and guidelines on integrated management of childhood illness (IMCI)</i>			
<i>**Training on integrated management of pregnancy and childbirth (IMPAC) and guidelines on BEmOC or CEmOC</i>			

Lack of appropriately trained staff is a complex problem with implications for the quality of care and possible short- and long-term health consequences for clients. For example, integrated management of childhood illness (IMCI) and antenatal care are two high priority programs to improve child and maternal health. But only 54% of facilities providing child health services have staff who have ever received training in IMCI, and only 49% of facilities providing antenatal care have staff who have ever received training in antenatal care. Currently there is no comprehensive training plan for the entire sector of maternal and child health services; most training has been designed as stand-alone sessions that are not based on a comprehensive training needs assessment.

Except for lack of training and availability of guidelines, overall preparedness for family planning in the public sector seems good. About three-quarters of facilities provide at least two temporary contraceptive methods. The picture differs for child health services. While most public sector and NGO facilities offer child health services, preparedness in all types of facilities offering child health services is poor.





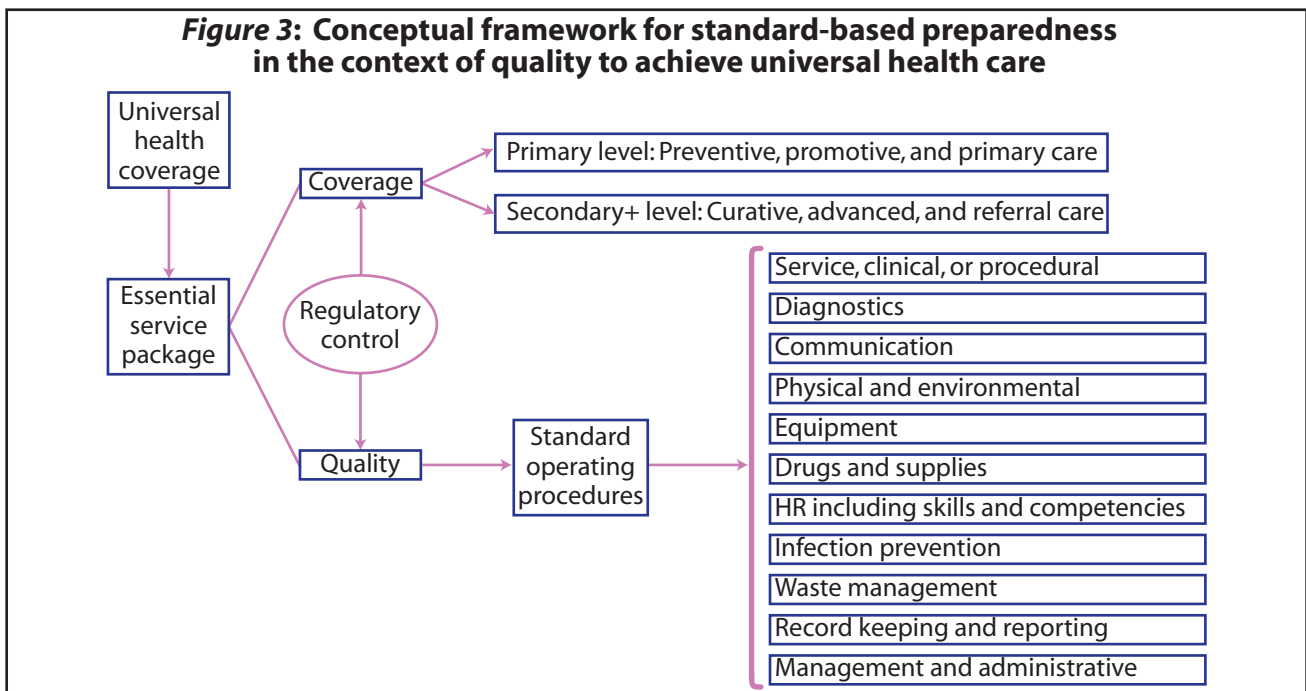




## KEY RECOMMENDATIONS

### Improve planning and operations.

- A comprehensive, national quality improvement plan is required. The plan should include both a preparedness plan and standards for each thematic service at every service delivery point as defined in the Essential Service Package (ESP). It is important that the proposed plan and standards be based on the ESP and the national program priorities. Figure 3 provides a conceptual framework for the holistic approach where preparedness is seen as an integral part of quality improvement and deals with multiple sets of standards and mechanisms.
- As shown in Figure 3, ensuring optimal quality of care for every component of ESP means that comprehensive standards must be established in the following 11 areas: (1) service or clinical or procedural, (2) diagnostics, (3) communication, (4) physical and environmental standards, (5) equipment, (6) drugs and supplies, (7) human resources, with skills and competencies, (8) infection prevention, (9) waste management, (10) record keeping and reporting, and (11) administration and management.



- The MOH&FW and the directorate generals need to identify staff focal points to plan, ensure, coordinate, and monitor preparedness at all levels. Relevant operational plans should develop respective preparedness and subsequent procurement plans based on the standard operating procedure.
- A comprehensive database of all service delivery points of public, private, and NGO sectors needs to be developed. This live database should be the reference point for planning, continuous monitoring, replenishment, maintenance, registration renewal, and accreditation purposes.
- The training plan for health care providers needs to be revisited.
  - Existing training courses must be (1) updated to incorporate state-of-the-art developments, (2) aligned with the ESP and program strategy, and (3) competency-based and hands-on, like the Helping Babies Breathe training that had a recent national roll-out.
  - Many countries have handheld electronic devices loaded with technical guidelines as well as other job aids and tools, including interactive, behavior change communication modules. These items could be made accessible through the Internet. Smart phone-based applications are a good solution for Bangladesh.

## Improve regulation and stewardship.

- The government should consider policy modifications to regulate and monitor health care services. Options include providing incentives to the private sector, including open clinics in underserved areas; mandating that the private sector offer certain basic preventive services such as family planning; and requiring NGOs to fill gaps in service delivery.
- Figure 3 provides a comprehensive list of areas where (1) standards need to be defined and (2) systems and procedures need to be in place and functional to ensure standards are followed. This will require a regulatory framework and bodies with the necessary authority. For example, if Bangladesh Standards Testing Institute (BSTI) works to regulate quality and standards for commercial products, who is to ensure the quality of health care that saves lives and enhances the quality of life? If the Bangladesh Medical and Dental Council (BMDC) is the keeper of the standards in health care as a whole, a thorough structural and functional review must be undertaken to identify the health care regulatory needs of the country.
- To achieve a much stricter control on quality of health care, every health facility, from every sector, needs to be brought under a standard accreditation system. Protocols and mechanisms to implement the accreditation system should be developed as soon as possible. Necessary regulatory systems must be reformed quickly so immediate enforcement is possible.

Bangladesh has significantly improved the health of its population in the past three decades. Further progress may falter, however, unless health care services are more widely available and facilities improve the quality of the services they provide. The Government of Bangladesh must act immediately to acknowledge the problems in service delivery, develop concrete and action-oriented preparedness plans, and regularly monitor service delivery. The Bangladesh Health Facility Survey as well as other national research provide benchmarks for evaluating progress.





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