UHSSP

A project of the MOHFW
funded by UK government

Urban Health Systems Strengthening Project (UHSSP)

Health Seeking Behaviour and Population Coverage of DFID's Urban Health Programme in Selected Areas

PART - I

June 30, 2016

Options

PHD
Partners in Health and Development

Contents

LIST OF FIGURES

LIST OF ABBREVIATION

ANC	Ante Natal Care
ARI	Acute Respiratory Tract Infection
BDHS	Bangladesh Demographic and Health Survey
BHHS	Bangladesh Household Survey
BUHS	Bangladesh Urban Health Survey
C-section	Caesarean section
CTG	Coordinating Technical Group
DDFP	Deputy Director of Family Planning
DFID	UK Department for International Development
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussion
FP	Family Planning
IUD	Intrauterine Device
MCHP	Maternal and Child Health Post
MCHRC	Maternal and Child Health Referral Centre
MNCH	Maternity, New-born and Child Health
MSB	Marie Stopes Bangladesh
NGO	Non-Governmental Organisation
NHSDP	NGO Health Services Delivery Project
PHC	Primary Health Care
PNC	Post Natal Care
SHC	Shurjer Hashi Clinic
U5MR	Under 5 Mortality Rate
UHFPO	Upazila Health and Family Planning Officer
UHP	Urban Health Programme
UHS	Urban Health Survey
UHSSP	Urban Health Systems Strengthening Project

HEALTH SEEKING BEHAVIOUR AND POPULATION COVERAGE OF DFID's URBAN HEALTH PROGRAMME IN SELECTED AREAS

1. PRELUDE

The report on the "Health seeking behaviour and population coverage of DFID's Urban Health Programme in selected areas" is being submitted to the UK Department for International Development (DFID) as part of the Urban Health Systems Strengthening Project (UHSSP) obligation. This report has three parts, as follows:

Part I – covers a summary of the survey report and a set of recommendations as next steps.

Part II – the main survey report with necessary details.

Part III – annex with raw data and some explanatory notes.

This particular report presents Part I.

2. BACKGROUND

The Urban Health Systems Strengthening Project (UHSSP) is a component of the UK Department for International Development (DFID) funded Urban Health Programme (UHP). DFID's overall urban health programme is designed to improve access to maternal, new-born and reproductive health services for the urban poor in Bangladesh by integrating and expanding facility-based and community outreach services. The UHP supports the delivery of urban maternal, new-born and child health(MNCH) and family planning (FP) services through three NGO partners: Marie Stopes Bangladesh (MSB), BRAC Manoshi, and Shurjer Hashi (SHC). DFID support covers 48 MSB clinics (12 Maternal and Child Health Referral Centres (MCHRC) and 36 Maternal and Child Health Posts (MCHP) in 12 urban and peri-urban areas), 11 BRAC Manoshi clinics and 392 SHC static clinics throughout Bangladesh. In addition to service delivery, UHP includes the UHSSP, thistakes a health systems approach to create a more harmonised and supportive environment for urban health in the three focal cities of Dinajpur, Jessore and Mymensingh.

The study was undertaken by UHSSP in partnership with DFID and the three NGO partners of DFID's UHP namely, BRAC Manoshi, NGO Health Services Delivery Project (NHSDP) SHC and MSB. A Coordinating Technical Group (CTG) including representatives from each of the parties provided guidance to the study and overall coordination.

3. SURVEY SUMMARY

This report presents findings from a mixed methods study undertaken in the selected cities of Dinajpur, Jessore and Mymensingh in Bangladesh. The study methods included a household survey, Focus Group Discussions (FGDs) and case stories, and a targeted survey of the access to and use of health services by floating populations in each city.

The primary objective of the study is to understand the health seeking behaviour of the urban poor, and their access to and use of primary health care services. The study aims to assess comparative utilisation of primary health services by poor and non-poor populations, and the source of their health care.

The survey took a two stage stratified random cluster sampling design. It included a sample of 2,993 households from randomly selected slums and their adjacent areas (considered as "non-slum") in the three cities where UHSSP is working. MSB and NHSDP have clinics in all three cities while BRAC Manoshi is operational in only Mymensingh. While the study design provides rich insight into the use of health services by the urban poor and near poor in the three focal cities, the limited geographical scope means that the findings cannot be generalised as an assessment of the services of the three NGO partners, which operate in many more urban areas of the country. Random selection of slums may also have failed to capture some of the services provided by the UHP NGO partners and care is needed in interpreting data.

Based on the high proportion of non-poor people found by the survey to be living in slums (47.2%) it was decided to analyse the household data by poor versus non poor rather than the originally planned axis of slum populations versus non-slum. The sample households were therefore converted into poor and non-poor following the definition used by the Bangladesh Demographic and Health Survey (BDHS) (2014), which define the lowest two out of five quintile groups as poor.

This urban health study is the first of its kind in the three cities of Dinajpur, Jessore and Mymensingh and provides new evidence of the utilisation of MNCH and family planning services in the respective cities among poor and slightly better off non-poor households. It includes data on the source of key MNCH and family planning services, payments made for those services, reasons why users choose the providers they do, and user satisfaction with services received.

Key findings

The survey found that 66% of people were aware of at least one of UHP NGO facilities. The greatest awareness of UHP NGO facilities was for SHC in Dinajpur and Jessore and for MSB in Mymensingh. Overall, private health facilities are used more often for any health service than public or UHP facilities. Preferences for different sources of care vary by service and by city, and vary for the poor and non-poor.

Family planning (FP): 67% of currently married women aged 15-49in all three cities reported that they use some form of contraception, which is slightly higher than the national contraceptive prevalence rate of 62.4% reported by the BDHS (2014). Oral pill is the most popular method accounting for 34.4% of all users across the three locations; this is a higher share than found in the BDHS for urban Bangladesh (27%). 13.6% of contraceptive users use IUD/injectables/implants of which almost half are sourced from UHP NGOs. Pharmacies and drug stores are by far the main source of total contraceptives for poor and non-poor respondents (62.1%).

Ante Natal Care (ANC): Over two-thirds of currently pregnant women have sought any ANC in the three combined locations. For women more than six months pregnant this rises to 85.7% with the gap greater among poor women. This is in the same order of magnitude as the BDHS (2014) finding that 89.5% of women who gave birth in the three years prior to the survey had received any ANC in urban areas. In terms of source of ANC, the current survey found that in Jessore the public sector is the dominant provider of ANC while in Dinajpur and Mymensingh the UHP NGOs are the leading service provider followed by the public sector.

Delivery: The survey found an aggregate facility based delivery rate of 65.6% across the three cities. This compares favourably with the BDHS (2014) finding of 56.8% for urban Bangladesh. The current survey found that poor women are less likely to deliver in a health facility than non-poor, 57.8% compared to 71.6%. When disaggregated by slum versus non-slum area this is 68.7% compared to 31.3% and compares well with the equivalent Urban Health Survey (UHS)(2013) finding of 65% and 36.7% respectively. The current survey found that poor women delivered more often in public facilities (42.2%) than private (25.2%) or UHP NGO facilities (18.4%). Some 59.8% of poor women that delivered at a UHP NGO facility did not pay anything and among those that did the median payment was Taka 2,650. In contrast, non-poor women more often chose private facilities (33.6%) than public (26.4%) or UHP (11.6%), the median payment for non-poor women at a UHP NGO facility was Taka 4,000.

Home delivery: 42.2% of deliveries among poor women and 27% among non-poor were delivered at home. The poor are more likely to deliver at home though there does not seem to be a strong association between low education and home delivery. Increasing the facility delivery rate of poor women is a priority.

C-section: The survey found an aggregate C-section rate of 38.6% for the three cities. This is similar to the BDHS (2014) finding of 38.1% for urban Bangladesh. For the non-poor, the C-section rate climbs to a very high rate of 47.7% while drops to 27% for the poor. Such high rates of C-section suggest that market forces may be driving C-section and exposing women to unnecessary risk and calls for a strong policy response. The three UHP NGOs have an aggregate C-section rate of 47.7% of deliveries ranging from a high of 80% of the deliveries at UHP NGO clinics in Jessore and a low of 21.2% in Mymensingh. Such a high C-section rate among the UHP NGOs calls for further analysis to understand the factors behind these numbers.

Post Natal Care (PNC): The aggregate rate of PNC for women within 48 hours of delivery for the three cities was found to be 76.4% which is much higher than the national rate for PNC (33.9%) reported in BDHS (2014) and is higher than the 60.4% reported for non-slum areas in the UHS (2013). UHP provided 22.9% of PNC services with SHC a major provider in Dinajpur.

Extended Programme of Immunisation (EPI):Child immunisation data is difficult to collect through household surveys and the training provided to data collectors was short compared to the training given as part of BDHSs. Data collectors recorded immunisation status according to the child's immunisation card and based on this recorded that only 49% of children (12-23 months) received all basic vaccinations[1] which is considerably less than the 62.5% reported for the country as per BDHS (2014) when using the same method. Public facilities are the overall main provider of EPI services across the three cities. UHP NGO clinics provided 30% of vaccines reported of which SHC provided 83%. In Dinajpur, SHC was the main provider of EPI to poor and non-poor children.

Acute Respiratory Tract Infection (ARI): The survey found that 8% of children under five surveyed were affected by symptoms of ARI in the past two weeks. Of them 85.6% received treatment for ARI, 33.7% from public, 36% from private, and 28.1% from UHP NGO facilities.

Growth monitoring: The majority (70.9%) of children age 0-59 months in the combined three cities did not receive any growth monitoring in the last six months. Of those who had their growth measured (29.1%), 99.5% had their weight for age measured, and only a tenth had height for age measured. Overall, most of the growth monitoring happened in a public facility (32.5%) followed by

[1]BCG, measles, and three doses each of pentavalent, PCV and polio vaccine

UHP clinics (28.3%). Out of the UHP NGOs, SHC is the larger provider of growth monitoring services (57.9%).

General sickness: Survey respondents were asked where households sought care when they were sick, it was found that public facilities provided 49.7% of care compared to 44.3% at private and only 4.4% at UHP NGO facilities.

Client satisfaction: Users of UHP services overwhelmingly reported to be satisfied with services received.

Health cards for the poor: UHP partner NGOs provide health cards for the poor which entitles them to a range of discounts and free services. The survey found only 21.8% of the poor had received a card, and 18% of the non-poor. 85% of the poor and non-poor who had ever received a card had used it. The majority of card holders reported to have paid for the card in Dinajpur and Jessore.

Floating population: There is very little data on the health seeking behaviours of floating urban populations. The study found a higher percentage of older people in the floating settlements compared to the slums and non-slum neighbourhoods. Access to health care was poor and most people relied on government facilities. Only 2 out of 30 people interviewed had a health card. There is clearly much work to be done by UHP NGO partners and municipalities to provide accessible and affordable PHC to this very vulnerable population.

Reasons for use and non-use of UHP NGO facilities:The FGDs and household questionnaire explored the reasons why users preferred particular types of facilities. Common factors are proximity, free or low cost, the availability of female doctors and well-behaved staff. UHP NGO facilities were found to be closer than public or private facilities but were less often used than either. One of the commonly reported reasons found for why people do not use UHP NGO clinics is that they do not know their location.

Clients made a range of suggestions for improving UHP NGO services including dissemination of information about their location, reduce costs, provide more health cards and increase satellite clinics. The floating population suggested free medical camps or satellite clinics near to where they sleep.

Refer to graphs (1- 21) below for a quick look at the selected key findings:

Presentation of key findings in graphs

Figure1: Percentage of households using tube-well/pump well as source of drinking water, BHHS 2016, BDHS 2014, BUHS 2013

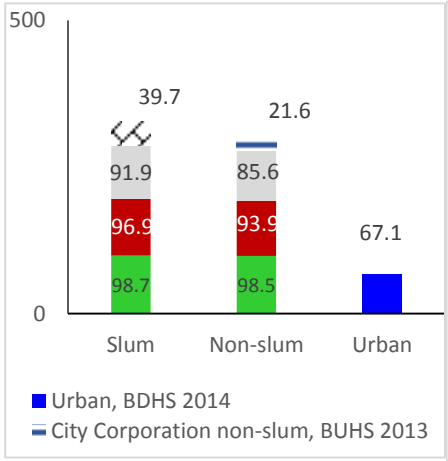


Figure 2: Percentage of households using type of toilet facility, BHHS 2016, BDHS 2014

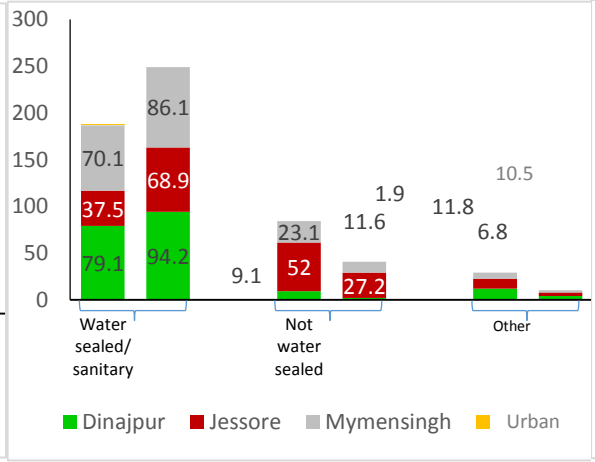


Figure 3: Household monthly income, expenditure and health expenditure (in BDT, median value)

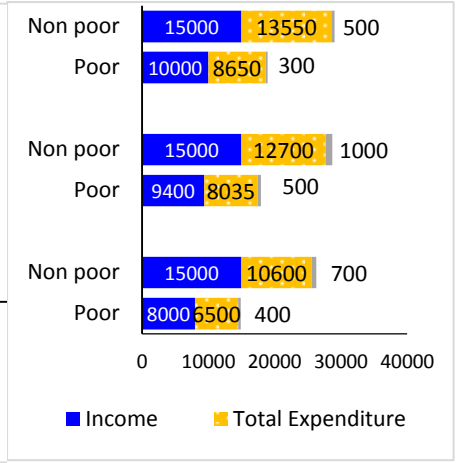
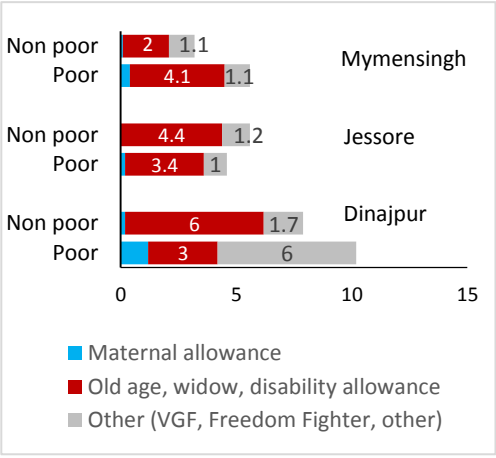


Figure 4: Percent of maternal and other allowance recipients



POOR and NON-POOR HOUSEHOLDS (from slum and non-slum areas)

Figure 5: Comparison of knowledge of type of health facilities among women (age 15-49), in 3 locations (in %)

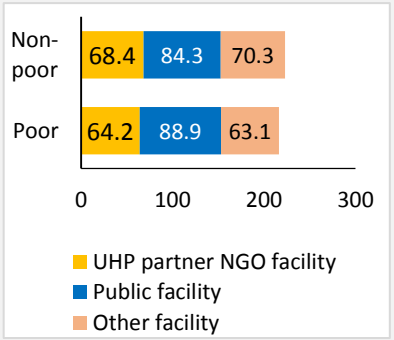
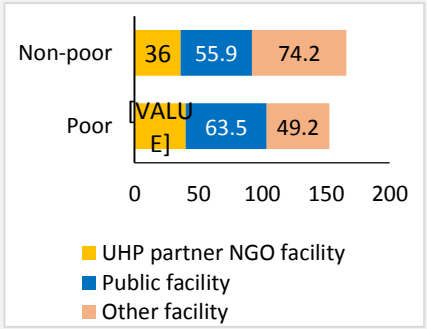


Figure 6: Comparison of women (15-49) who have visited health facilities [among those who are aware of such facilities],in 3 locations (in %)



FLOATING POPULATION

Figure 7: Knowledge of type of health facilities among floating population respondents by type of facility and in3 locations (in %)

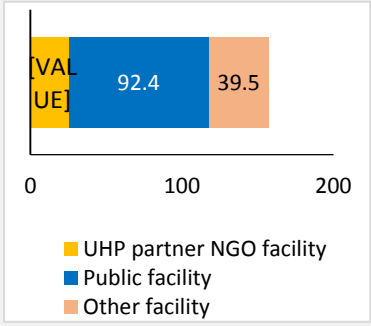


Figure 8: Floating population respondent who have visited health facilities [among those who are aware of such facilities], in 3 locations (%)

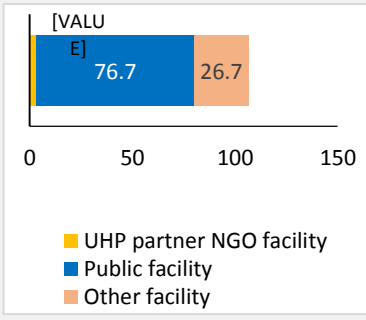
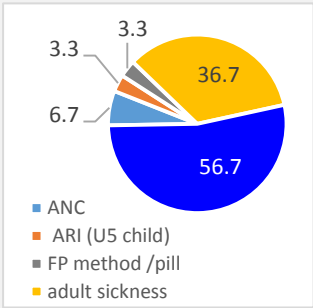


Figure 9: Percentage of floating population respondents received service from any facility



POOR AND NON-POOR HOUSEHOLDS (from slum and non-slum areas)

Figure10: Comparison of ANC seeking behaviour among currently pregnant women & those who are 6 months & above pregnant, in 3 locations (in %)

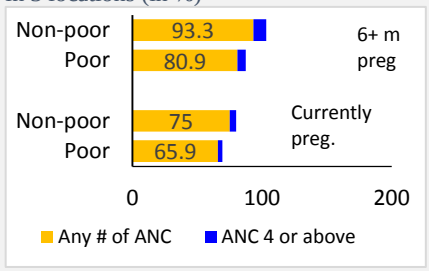


Figure 11: Source of ANC service among currently pregnant women (6 months & above), in 3 locations (in %)

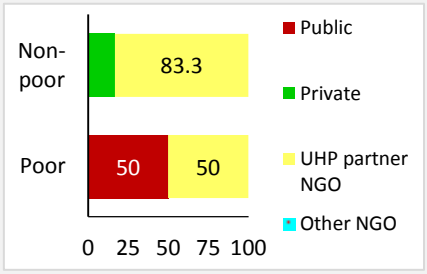


Figure 12: Percent of women that delivered in the past two years that received PNC (of mother) within 48 hours of birth, in3 locations

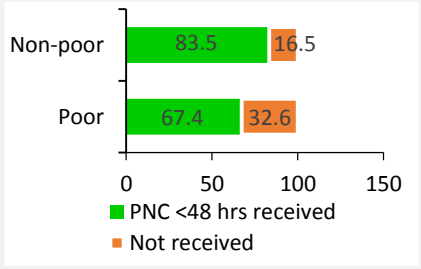


Figure 13: Place of PNC service, in 3 locations (in %)

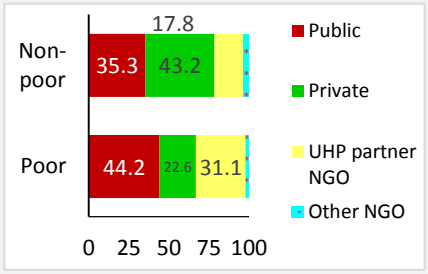


Figure 14: Comparison between home and clinic/facility based delivery (of live births), in 3 locations

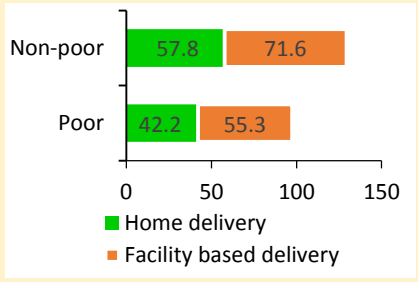


Figure15: Comparison between normal delivery and C-section by economic condition and in locations (in %)

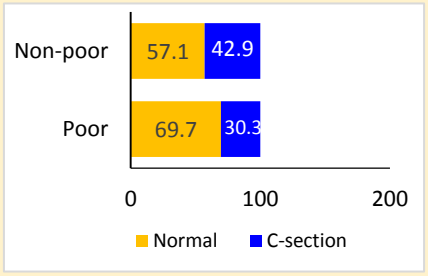


Figure 16: Place of (any type of) delivery among those who have had live births, in 3 locations (in %)

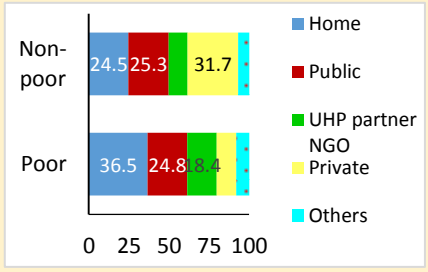


Figure 17: Percent of children between 12-23 months who received any dose of EPI vaccination, in 3 locations

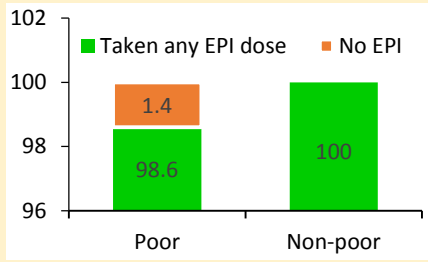


Figure 18: Source of any EPI taken, in 3 locations (in %)

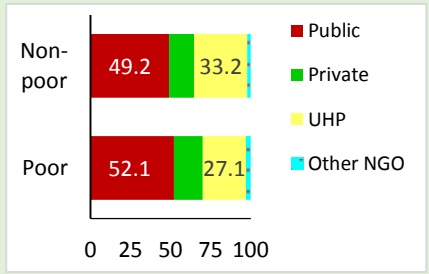


Figure 19: Source of IUD, Injectable and Implants among current users, in3 locations (in %)

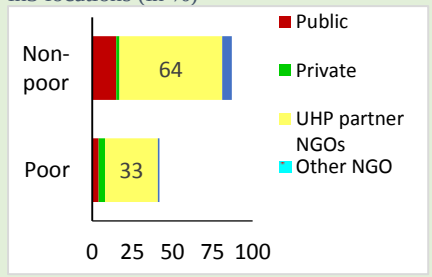


Figure 20: Percent of eligible women (age 15-49) currently using any FP method, in3 locations

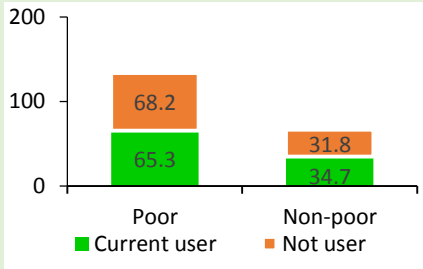
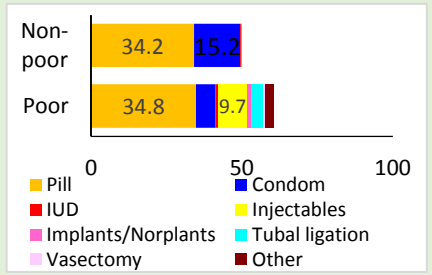


Figure21: Type of FP method used among current users, in3 locations (in %)



4. CONCLUSION AND NEXT STEPS

The current urban health seeking behaviour study meets several stakeholder needs. It provides evidence to DFID on whether UHP partner health services are reaching the poor, and informs the development of DFID's future support to the urban health sector. The study will also provide a baseline for UHSSP in its efforts to facilitate UHP partners to deliver harmonised and coordinated service provision especially to the extreme poor. The study also contributes to the evidence base on the health seeking behaviour of the urban poor and non-poor, and informs UHP partners and other health care providing organisations in developing strategies to better reach the urban poor.The findings of the household survey and qualitative data suggest the following areas for attention:

Evidence based action planning:

- Results used by DFID for its mid-term review.
- Baseline household survey results (preliminary) have informed stakeholders and respective planning processes (municipality, government, UHP partner NGOs and other actors). For example:
  - MSB is making special efforts in re-organising its satellite clinic sessions, awareness activities targeting the urban slum population, and also where appropriate, thinking about establishing a mini-clinic in order to serve a larger group of the urban poor population.
  - City Health Planning process used the findings to prepare plans for serving more poor (especially the extreme poor) and strengthening awareness programmes.
  - Area demarcation has been taken up by the Civil Surgeon, DDFP and UHFPO of the respective municipalities in order to better coordinate NGO activities.

The survey presents a rich source of data for policy makers, municipalities, UHP partners and DFID:

a) The survey found that the **concentration of poor people living in slums varies by city** with poor people making up a larger share of slum households in Jessore (69.5%) than in Mymensingh (46.9%) and Dinajpur (41.3%). Such information is important for UHP NGOs, the respective municipalities and MoH in their targeting and delivery of health services.

b) The **high proportion of poor women continuing to have home deliveries (42.2%) and the high Caesarean section rates** for the three cities (38.6%) and particularly of the non-poor (47.7%) is worrying and requires government attention.

c) The survey findings reflect **the conditions of the health market and the competition that UHP NGO partners face** from public and private facilities in serving the poor and near poor. The UHP partners have an **opportunity to translate this competition into a positive force** by forging greater collaboration and coordination among each other and untapping the potential they have as a united entity to serve more clients, and especially the poor.

d) The**very low distribution of health cards leaves the majority of poor uncovered**. Better targeting of cards to reduce the number of non-poor households with cards also needs attention though it is reasonable to expect some targeting errors as people move in and out of poverty. There is a need for UHP NGO partners to increase the distribution of health cards to poor and vulnerable groups, and to adequately inform them about the privileges they are entitled to. Similarly, service providers need to be informed and monitored on how they

interact with card holders to ensure they provide services equivalent to those provided to non-card holders and to the same standard.

e) There is a **need for more advocacy and awareness-raising of UHP NGO clinics and services** in the catchment area. Such information and awareness raising needs to include: clinic location; services, medicines and lab tests available at what price and for which category of population; privileges of having a health card; reasons for exclusion from receiving a health card; emergency contact numbers; and including male members of the family during information sharing.

f) **Poor people and particularly the floating population recommended UHP partner NGOs increase the availability of satellite clinics** to better serve their needs. For the floating population these need to be held close to where they sleep. Review of the frequency and location of satellite clinics is needed and for UHP partners to plan and coordinate these sessions together to maximise coverage and reach to the most vulnerable populations.

g) The **choice of health facility is influenced by word of mouth** recommendations. There is therefore a need for UHP NGO partners to invest in forging a *loyal group of customers* (especially from the poor) who strongly recommend the clinics to his/her family members and neighbours and bolsters the clinic's reputation.

h) Referral between clinics was found to be minimal and **there is a need to improve upon referral services**. At a minimum the referral cycle needs to be completed (refer $\rightarrow$ someone from clinic to accompany $\rightarrow$ provide ambulance if required $\rightarrow$ make payment on behalf of client) for free or discounted services, especially for the extreme poor.

i) The **potential for UHP partner facilities to function as a network needs further investigation and planning**. Such an arrangement would allow the comparative advantage of specific facilities to be utilised in an organised way and collaboration and coordination between the NGOs formalised. This could include the location of clinics and satellite clinics, referral mechanisms, use of field workers for the benefit of the network, shared marketing and joint engagement with government.

j) The **survey provides a platform for UHSSP in sharpening and strategizing** its coordination role, and also **for DFID in planning its future support** to the sector.