Collecting feedback from the community on primary health care services in selected areas of the Regional Chapters of Bangladesh Health Watch

Research Report

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Acknowledgment

This research report provides a brief narrative of the demand side challenges experienced by rural, disadvantaged people seeking medical care in selected government primary and secondary healthcare facilities and supply side challenges exist in those facilities. The report also sheds light on the initiatives undertaken by Bangladesh Health Watch, a multi-stakeholder civil society advocacy and monitoring network dedicated to improve the health system in Bangladesh, through establishing the Regional Chapters for overall improvements of the health facilities to increase patient satisfaction and reduce the inequity in access to health services.

We would like to extend our gratitude to the study participants for their participation in the research and for sharing their experiences, perceptions, thoughts, and suggestions on how to improve functioning of healthcare facilities in the study sites, where the Regional Chapters work. We are also grateful to the health care professionals and health facility managers for their time during the interviews and assistance during facility assessment of the study.

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List of Abbreviations

AHI	Assistant Health Inspector
BHW	Bangladesh Health Watch
CC	Community Clinic
CHCP	Community Health Care Provider
DH	District hospital
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
FGD	Focus Group Discussion
GoB	Government of Bangladesh
HA	Health Assistant
HI	Health Inspector
KII	Key Informant Interview
PHC	Primary Health Care
PSQ- 18	Patient Satisfaction Questionnaire (short form)
RC	Regional Chapter
RCHCIB	Revitalization of Community-based Healthcare Initiatives in Bangladesh
SACMO	Sub-Assistant Community Medical Officer
SARA	Service Availability and Readiness Assessment
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
UHC	Upazila Health Complex
UH & FWC	Union Health and Family Welfare Centre
WHO	World Health Organization

Executive summary

Background

Over the past two decades, Bangladesh has achieved tremendous progress in improving various health indicators including major progress in the reduction of infant mortality rate, under-5 mortality rate, maternal mortality rate, childhood undernutrition, and improvement of continuum of care for mothers and children. Despite these achievements, inequalities in access to healthcare services persist with the rural, disadvantaged and hard-to-reach population groups rarely enjoy equitable healthcare services.

The public health services in Bangladesh are currently being delivered by Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), and the Revitalization of Community-based Healthcare Initiatives in Bangladesh (RCHCIB) project of the Ministry of Health and Family Welfare in three tiers: primary level health care, secondary level health care and tertiary level health care. There are 14,890 Community clinics (CCs) run under the RCHCIB project. These CCs are the lowest tier health facilities in rural areas providing basic and primary health care (PHC), family planning, vaccination and nutrition services. Although it is often argued that the establishment of CCs has tremendously improved PHC service delivery in rural settings, most of the CCs are yet to become fully functional in terms of the availability of skilled healthcare providers and supply of drugs/logistics. In addition, there are 431 Upazila Health Complexes (UHCs), hosting 31- 50 beds and providing indoor and outdoor PHC services at the Upazila level. Besides, 64 district hospitals (one in each of the districts) provide health services as secondary tier health facilities ensuring more advanced and critical care to the health needs of the population.

Although the government has established different types of healthcare facilities all over Bangladesh, proper functioning of these facilities and equitable access to them are not yet a reality. Besides, patients' dissatisfaction with health care providers and healthcare itself remain important concerns that are yet to be addressed. As we know, there are two aspects of service delivery- demand-side and supply-side. Various existing problems on the supply side to deliver healthcare and challenges on the demand side to access health services often affect patient satisfaction at health care facilities.

Established in 2006, Bangladesh Health Watch (BHW) is a multi-stakeholder civil society body, pursuing different initiatives to help the Government of Bangladesh strengthen the health system and health service delivery. BHW is dedicated to improving the health system of Bangladesh through critical review of policies and programmes and recommendations of appropriate actions or changes. A Working group and an Advisory group direct and guide the activities undertaken by the BHW. In order to identify the challenges of health service delivery at the local level and to bring about changes, BHW established eight Regional Chapters (RCs) in eight districts under eight divisions of the country. The main activities of the RCs include maintaining close contact with citizens and government authorities of selected districts, sub-districts (Upazilas), and unions to inform them about significant shortages in the health facilities and advocate to improve the condition.

Overall, there is a lack of research evidence in Bangladesh on patient satisfaction and the quality of services provided in the Community Clinics, Upazila Health Complexes and District hospitals. This research aims to generate evidence on the demand and supply-side challenges of delivering equitable health services in selected health facilities in the catchment areas of the Regional Chapters of BHW. We expect that the generated findings would assist the BHW Regional Chapters in minimizing the gaps in PHC service delivery in the study sites.

Objectives of the Study

- To identify the demand-side challenges and assess patient satisfaction with the health services provided in the Community clinics, Upazila Health Complexes and District Hospitals in the catchment areas of the Regional Chapters of BHW.
- To identify the supply-side challenges of providing quality healthcare services in the Community Clinics, Upazila Health Complexes and District Hospitals in the catchment areas of the Regional Chapters of BHW.
- To document the initiatives undertaken by the Regional Chapters to improve the health situation in the respective region, the challenges they experienced during the implementation of the activities and strategies they adopted to mitigate the challenges.
- To develop a data collection manual/ interview guideline/ SOP to guide and assist future researchers and programme implementers for feedback collection from the community on primary health care service delivery around the year.

Methodology

In order to achieve the above-mentioned objectives, a mixed- method research was conducted encompassing a representative survey and qualitative interviews. The survey was conducted among 412 patients to examine their level of satisfaction with the health services. A total of 23 Focus Group Discussions (FGDs) were conducted with the community people to understand the demand-side challenges. In addition, 23 Key Informant Interviews (KIIs) were conducted with healthcare providers/ health facility managers and 23 health facilities were assessed in eight catchment areas of the BHW Regional Chapters.

Development of data collection tools and pretesting: Different data collection tools were developed and utilized for collecting data from different groups of study participants. Questions around background information, household distance from the health facility, costs associated with receiving treatment, expectations from doctors and other health professionals and household expenditure were included in the exit interview questionnaire. In addition, the Patient Health Questionnaire (PSQ- 18) was contextualized and incorporated in the exit interview questionnaire. FGD guidelines were developed to explore the demand side challenges whereas KII guidelines focused to explore the supply-side challenges to delivering healthcare services. The World Health Organization's Service Availability and Readiness Assessment (SARA) tool was modified to assess the conditions of health facilities. The data collection tools were further modified and finalized considering the feedback obtained through the pretesting.

Training of BHW youth volunteers: As one of the aims of this study was to develop the capacity of the Bangladesh Health Watch volunteers and to train them for repeated data

collection, data collection activities were undertaken by them. With the assistance from the BHW host organizations in each RCs, youth volunteers were selected for the data collection training. The number of volunteers in each of the Regional Chapters varied from 2- 6 depending on the data collection strategy and distance to the health facility. A day-long training with the assigned volunteers was organized at the host organization office in each catchment area. Project aims and objectives, target populations, data collection methods, data collection tools, and strategies were discussed with them during the training sessions. Ethical aspects of research, including obtaining consent from the study participants, maintenance of confidentiality and privacy of the study participants were also explained to them.

Exit interviews: Exit interviews were conducted with randomly selected adult patients (age 18 to 69 years) who have received health services from any of the three types of healthcare facilities - Community Clinic (CC), Upazila Health Complex (UHC), and District Hospital (DH) in each catchment area. The sample size for the exit interview survey was calculated as 432 which was further divided into eight separate catchment areas (54 for each catchment area/Regional Chapter). As there were three different types of healthcare facilities in each catchment area, this number (54) was again divided into three to collect data from all three types of healthcare facilities. As per the calculation, a total of 18 exit interviews were planned to be conducted for each health facility type (CC, UHC and DH). Even though we expected to collect data from 432 participants, a total of 412 exit interviews were conducted in eight catchment areas. In Sunamganj, the CC went under water due to flooding and only 10 exit interviews were conducted there. In Barguna, no UHC was included under the activities of the Regional Chapter and hence exit interviews were not conducted.

Focus Group Discussions: A total of 23 FGDs were conducted with the community people to understand the demand-side challenges to access healthcare services. Three FGDs were conducted per site (1 at the union level around the CC, 1 at the upazila level around the UHC and 1 at the district level around the DH), except in Barguna, where only 2 FGDs were conducted at the district and union level. Participants for the FGDs were selected conveniently based on their willingness to participate in the research. Both adult males and females were invited to participate and only those who voluntarily agreed to participate were included.

Key Informant Interviews: A total of 23 KIIs were conducted with the health care providers/ health facility managers to explore the supply side challenges at the facility level (one KII in each type of healthcare facility). With the assistance of the host organization in each catchment area, key informants were contacted beforehand, and interviews were scheduled as per their convenience.

Facility assessment: A total of 23 health facilities were assessed- one from each type of healthcare facility- CCs, UHCs and DHs from each catchment area. The main aim of the facility assessment was to observe several key aspects of service delivery at the facilities and document the challenges and gaps that exist there. Host organizations communicated with the appropriate authorities in each type of health facility beforehand to schedule a time for the facility assessment and core research team members did the assessment as per the scheduled time without interrupting the usual workflow of the facilities.

Documentation of the initiatives undertaken by the Regional Chapters: The research team members documented the initiatives that have been undertaken by the Regional Chapters to improve the situation of healthcare facilities in each catchment area. Relevant representatives of the District, Upazila and Union Health Rights Forums were interviewed to gather information on the different actions and advocacy activities undertaken as part of the initiatives. A total of nine interviews were conducted with the representatives from host organizations in each catchment area.

Data Analysis: Exit interview data were analyzed using STATA, version 16. Descriptive statistical analyses were performed considering variable types and the distribution of variables. The PSQ- 18 questionnaire yielded separate scores for each of the seven different subscales - General satisfaction, Technical quality, Interpersonal manner, Communication, Financial aspects, Time spent with the doctor, and Accessibility and convenience. The facility assessment findings and quality of healthcare services were presented through tables and bar graphs by performing descriptive analysis.

FGDs and KIIs recordings were translated into English and transcripts were coded manually. Findings were aggregated under specific themes and sub-themes in the data matrix. Findings generated from the FGDs were triangulated with the findings of exit interviews to understand the demand side challenges, whereas findings from KIIs were triangulated with the findings from facility assessment to identify and document the supply side challenges.

Ethical Consideration: Ethical approval for the research was obtained from the independent ethical review board of James P Grant School of Public Health, BRAC University (IRB approval number: IRB-09 January' 22-002). Informed consent was obtained from all the study participants. We got approval from the DG health, as well as the Civil surgeon from the RCs. Additionally, permission from the Civil Surgeon office and responsible officials of primary health care facilities were sought before conducting the observational assessment and KIIs.

Study Findings

Key findings from the exit interviews, KIIs, FGDs, and facility assessment are discussed under four major themes: socio-demographic characteristics of the study participants, demand-side challenges (with findings from the FGDs and exit interviews), supply-side challenges (with findings from the KIIs and facility assessment), and initiatives undertaken by Bangladesh Health Watch.

Socio-Demographic Characteristics: A total of 412 exit interviews were done with patients who have taken health services from health care facilities in eight Regional Chapters of Bangladesh Health Watch.

More than half of the exit interview participants (57.35%) were female and 42.7% were male. More females (69.3% and 55.6%) received health services from CCs and UHCs, compared to DHs where, male participants were 52.3%. Approximately one-third of the participants (31.1%) were between 18- 27 years of age followed by 26.5% from the age group 28- 27 years. Of those 412 exit interview participants 348 had an opportunity to avail education. Among these 348 participants, one-third (30%) completed their secondary education at the time of survey data

collection. A majority (47.3%) of the participants were housewives, followed by 34.7% (n= 143) who were employed. Of those 143 study participants who were employed, one-third (30.7%) were engaged in the agriculture, fisheries, and forestry sector. The average monthly family expenditure of the Exit interview participants was BDT 12,103.16 (USD 127.4 USD), and the average monthly income of them was BDT 15,441 (USD 162.5).

A total of 23 FGDs were conducted with service users and community people around the selected healthcare facilities in the study sites. Interviews were conducted at all levels- Village, Upazila, and District. The number of participants in each FGDs varied from 4-8.

A total of 23 KIIs were conducted with the healthcare providers and health facility managers from eight different RCs catchment areas. Healthcare professionals and representatives who were interviewed include Superintendents at the DHs, Medical Officers at the UHCs, and Community Health Care Providers (CHCPs) at the CCs of the selected health facilities. Nine out of twenty- three key informants were between 30 to 39 years of age, nineteen of them were males and almost half of them (12) had working experience of less than 5 years. Eight CCs, seven UHCs, and eight DHs were assessed as part of the facility assessment.

3.2 Demand side challenges

Patients in different types of health facilities: Out of 412 exit interview participants, 33.2% received services from CCs, 30.6% from UHCs, and 36.2% from DHs. Similar to the findings from exit interviews, the majority of the FGD participants usually went to the CCs to seek general health care. Almost all the female FGD participants preferred CCs as the first point of service delivery as that was convenient to go, closest from the households, and services and medicines were free of cost.

Distance to the health facilities, approximate travel time, and associated transportation costs: More than half (65.7%) of the exit interview participants from CCs said the distance is less than 1 Km, followed by 23.4% who said between 1- 3 Km. More participants reported higher distance for DHs. The approximate travel time from place of residence to the health facility ranged from 5- 130 minutes with a mean of 24.7 minutes and the travel time varied depending on the type of facilities. DHs required more time to travel, whereas, CCs required less time. More than two-thirds of the participants from UHCs (79.4%) and DHs (93.96%) responded that transportation cost was involved to travel to the health facility. Among the 284 participants, for whom transportation cost was required, 28.9% spent less than 15 BDT (USD 0.16) for transportation cost, followed by 26.4% who spent 16- 30 BDT (USD 0.17 – 0.32).

At most locations visited for the purposes of this study, CCs were found to be positioned close to the vicinity of the households that they serve. In most sites, the fare for local residents to travel to a CC was found to be around BDT 10-15 (USD 0.11-0.16) per person on an easy bike (which was found to be the preferred mode of commute in most locations), or a local van car. Traveling by rickshaw to a CC was found to be more expensive, with fares reaching up to BDT 50 (USD 0.55) in Netrokona. In the flood-prone area of Shoronkhola Upazila of Bagerhat district, traveling to the local CC was found to be difficult throughout a significant portion of the year, even though the distance between the served households and the clinic never exceeded the transport fare cost of BDT 10 (USD 0.11).

Availability of healthcare providers, medicine and diagnostic tests: Out of 412 exit interview participants, many (45.4%) said the waiting time was less than 10 minutes, followed by 18.2% (n= 75), who reported waiting time to be between 11- 20 minutes. Findings suggest that waiting time increased from CCs to UHCs and then to DHs. Of the 46 participants who waited more than 60 minutes to receive services, 82.6% were from DHs due to huge patient load and no one was from CCs. A total of 360 (87%) exit interview participants were prescribed medicines when they accessed the health facilities. Of the 109 participants who got medicines from CCs, more than half (58.7%) said they got all the medicines (100%). For UHCs (n= 115), 40.9% reported that they got 50- 75% of the prescribed medicines. Only 10.3% (n= 14) of the participants who received services from the DHs said that they got all the medicines/ 100% prescribed medicines from the facility.

CCs service recipients reported that at times the CHCPs were not available at the CCs and the clinics were closed due to some personal problems of the CHCPs or if they had to go attend different meetings, workshops, and seminars at the UHCs. Usually, healthcare providers were present in the UHCs and DHs mentioned by the majority of the participants. But when it comes to seeing a specialized doctor or consultant the scenario is not the same. Due to the relative remoteness of the location, doctors (who, according to the community members, travel to the location from Khagrachori district town) were found to be present at the facility 3 days a week, according to service seekers, making the process of availing healthcare services difficult for residents of the locality. The problems of understaffing (relative to the designated number of personnel for the facility, not relative to the volume of patients seen) was observed to be less acute in DHs than UHCs. Service users of the CCs shared that they usually get all the medicines from the CCs. In most sites, community members stated that the allotment of many medicines that CCs receive tend to run out 20-25 days into any given month. Similar concern was shared by the FGD participants interviewed at the upazila and district level. However, all the participants discussed the shortage of medicines at the health facilities. Only a few of the basic tests are conducted at the CCs and if they need any specialized test or services, they are referred to the UHCs or DHs. Basic equipment such as weight machines and blood pressure machines are also missing in the CCs. All the participants shared their frustration about unavailability of X-ray and Ultrasonography in a few of the UHCs and DHs.

Costs associated with healthcare and out of pocket expenses: Out of 137 participants who received services from the CCs, 47.4% reported they were not required to pay any ticket fee. Whereas 32.3% and 46.8% participants from UHCs and DHs said they had to pay a ticket fee to avail the service. Majority of the participants (95.6%) who received services from CCs paid less than 5 BDT (USD 0.053), whereas 20.4% from DHs paid between 10- 15 BDT (USD 0.11-0.16) as a ticket fee.

A general estimate of the extra out of pocket expenditure that this necessitates for prescribed medicines was not possible to ascertain from discussions with community members, as the expenditure varies according to distance to nearest pharmacy, and type of medicine needed. In general, commuting via easy bikes would cost up to BDT 20 (USD 0.22) per person from a residential locality to the nearest “bazaar”. From the UHC level onwards, service seekers have to acquire tickets and a serial number to see doctors and have to wait in queue for their serial to receive services. Some community members stated that middlemen *(“dalals”)* try to take

advantage of this process by charging service seekers a fee with the promise of ensuring that they do not have to wait in queue. Middlemen also try to steer service seekers to undertake medical tests outside healthcare facilities in private clinics or chambers, stating that the quality of service at the public facilities are not adequate.

Patient Satisfaction at the health facilities: Patient satisfaction was assessed utilizing PSQ-18, under which positive and negative questions were asked to the exit interview participants in seven different domains. For the positive statement under the 'Communication' domain, 313 (75.97%) patients agreed with the statement "Doctors are good at explaining the reason for the medical tests", whereas for the negative statement "Doctors sometimes ignore my opinion while taking decisions about my treatment" 260 (63.1%) disagreed. For the negative statement under the 'Technical quality' domain "I am not very confident about the diagnosis of the doctors at times", 79.4% participants disagreed, whereas, for the positive statement "When I go for medical care, they are careful to check everything when treating and examining me", almost three-fourths (75.7%) of the participants agreed. Under the 'General satisfaction' domain, most of the participants (75.97%) agreed with the positive statement "I am very satisfied with the medical care I receive here", whereas more than three-fourths (78.8%) disagreed with the negative statement "I am dissatisfied with something about the medical care I receive". Under the "Financial aspects" domain, more than half of the participants (59.2%) agreed with the statement "I am confident that I can get the medical care I need without being setback financially". Under the "Interpersonal manner" domain, a total of 299 (72.57%) participants agreed with the statement "My doctors treat me in a very friendly and courteous manner", whereas about half of the participants (48.30%) disagreed with the negative statement "I don't think the health care provider was careful about my privacy while examining me".

The perception of community members regarding the quality of healthcare provided at the CCs in all sites was generally positive. Community members were found to understand the limited scope of care that can be provided at the CCs, and their expectations of the care that they can receive was found to be attuned to the same. In the instance that the necessary care for a patient was not possible to be delivered at a CC, the patient is referred to the nearest "hospital" (which was the term used by almost all community members spoken to, to refer to the nearest UHC).

A proportionate decrease in the sense of mistrust or dissatisfaction amongst service seekers however could not be observed, as the experience of waiting in long queues, the sense of not having been given sufficient attention by a doctor and general dissatisfaction with the services provided by hospital staff other than doctors was observed to be present. Participants of an FGD in Kurigram shared experiences of having to visit the local DH on multiple occasions before they were able to secure a consultation with a doctor, for example. At the same time, service seekers from areas adjoining DHs who were accustomed to visiting the hospital for healthcare services often, were found to have preferences for particular healthcare providers whom they deemed to be "actually good doctors".

3.3 Supply side challenges to delivering health services

Challenges related to lack of human resources and patient overload: CHCPs were found to be responsible for overall coordination, management, and service delivery at the CCs; FWAs managed the family planning services; HAs took care of the vaccination services. As the sole healthcare provider at the facility, oftentimes it becomes very difficult for the CHCPs to maintain the functional opening hours of CC, especially when they fall sick or if there is a family emergency. All seven key informants from the UHCs shared that previously there was a shortage of medical doctors at their facilities, however, the scenario has improved in recent times. However, there is a huge patient load leading to long waiting times and less consultation time for the patients. Findings from KIIs suggest that on average, healthcare providers could allocate only 2-3 minutes for consultation with the patients. On average, 300- 400 patients visit outdoor facilities within a short time span of only 4 hours, whereas they have the capacity to manage 100 patients outdoors every day. Another major challenge was vacant posts for technicians, support staff, and cleaners at the facility. KIIs findings suggest that in DHs, medical doctors face challenges to deliver satisfactory health services to the service users due to patient overload, which varies between 400- 600 at outdoor facilities. Due to a large number of admitted patients, healthcare providers cannot accommodate them in beds, and patients are kept on the floors of the wards or in the corridors affecting patient satisfaction, shared by six out of eight key informants. There is a constant lack of skilled laboratory technicians in the DHs and cleaner/ support staff.

Facility assessment documented that twenty-one out of twenty-three health care facilities were functional during operational hours. Six out of eight CCs were open on the day of data collection and the rest two were closed, as there were some emergency/ personal issues with the CHCPs. In UHCs and DHs, the crowd of patients was noticeable as well. Long waiting times, long queues at the ticket counters and at the pharmacy, and crowds in waiting rooms were observed in all facilities. In indoor facilities, patients were seen to be on the floors of different wards and in the corridors due to the number of admitted patients surpassing the original capacity.

Shortage of medicine and equipment at the health facilities: CCs receive medicines every 2- 3 month based on the population coverage area (around 6000 people). However, often supplied medicines are not enough due to the huge patient load and pose a challenge for the CHCPs. Findings from the KIIs also revealed the challenges CHCPs experience regarding the availability of necessary equipment such as a thermometer, stethoscope, blood pressure machine, diabetic strip, gauge, and bandages.

The stock and frequency of medicine supply have increased since the beginning of 2022 in UHCs. However, challenges still exist due to the extreme patient load at UHCs, same as the CCs. In terms of equipment, UHCs are self- sufficient, mentioned by the key informants, except for specialized orthopedic equipment.

With a sufficient stock of medicines, DHs try to provide free medicines to all the patients in need. However, the majority of the patients treated in DHs are usually in critical conditions and require long term medications support as compared to the CCs and UHCs. Five out of seven UHCs and seven out of eight DHs had an X-ray machine and USG machine.

Infrastructure and utility related challenges: Another challenge shared by the CHCPs to deliver healthcare services at the CCs was the insufficient number of rooms in the health facilities. There is no separate area to store medicines and equipment. CHCPs also shared that sometimes they have to provide consultation to 3 or 4 patients at the same time because of patient load. Cleanliness of the CCs and medical waste management need to be improved as per the CHCPs' opinion. Consultation rooms are not adequate or functional (in some cases), considering the number of patients and medical doctors in the UHCs. Facility assessments noted similar findings as the KIIs in terms of the number of rooms in the health facilities. CCs rarely had all four rooms as per provision- consultation room, waiting room, ANC check-up room, and washroom. Oftentimes, there is more than one patient in the consultation room, and due to the lack of an ANC check-up room, CHCPs use the same room for ANC/ PNC care exposing the patient.

Lack of proper information dissemination system and feedback mechanism: Lack of Citizen Charter or information boards at the CCs lead to a lack of information dissemination and thus patients directly inquire about these services to the CHCPs. UHCs try to disseminate information through Citizen Charters and service-related notice boards and posters. Four out of seven key informants discussed that even though there are notice boards/ Citizen Charters etc., only a few of them are readable due to placement issues, font and colors of the boards, and language barriers.

KIIs findings revealed that UHCs and DHs had the provision of a 'Complaint box'- where service users can share their feedback in written format. A few of the key informants shared that they have never seen patients using the complaints box or providing any constructive feedback. The main reason behind this was found to be a lack of knowledge about the existence of such a complaint box in the facility, and lack of trust among community people that any appropriate actions will be taken against their complaints.

The key challenges from both demand-side and supply-side are shared in the table below.

Key challenges	
Demand side	**Supply side**
• Patient overload at healthcare facilities • Distance to the health facilities and associated transportation costs • Lack of consultants/ specialized doctors • Shortage of technologists, sonologists and support staff • Lack of medicine availability at the CCs • Lack of basic equipment at the CCs • Non-functional X-ray and USG machine in a few of the UHCs and DHs • Out of pocket expenditure for buying unavailable medicines, and performing diagnostic tests • Very less information available on Citizen Charters and service-related notice board at the healthcare facilities • No mechanism to provide feedback	• Lack of human resources leading to increase workload, especially at CCs • Patient overload at all types of healthcare facilities • Vacant posts of the technologists, support staff, and cleaner in UHCs and DHs • Insufficient stock of medicines at the CCs • Inadequate laboratory test facilities at the CCs • Non- functional USG machine in a few DHs • Inadequate number of rooms for consultation at all health facilities • No place to store medicines and equipment at the CCs • Frequent power cuts, lack/ no water supply at the CCs • Water clogging during rainy season due to placement of the facility • Lack of information dissemination system for

	the service users

3.4 Initiatives undertaken by BHW in Regional Chapters

Established in 2006 as a citizen's forum concerned with the health sector of the country, Bangladesh Health Watch has been expanding the scope of its operations since 2019 to become more involved with evidence-based advocacy regarding health issues. BHW started its journey with the objectives to create a platform for drawing in the voices/ opinions of citizens and other stakeholders; generate/ identify new evidences for changing policies and practices; actively engage with Government of Bangladesh (GoB) and other parties to reform policies; and to develop technology-based mechanism for collecting feedback for optimal delivery of health services.

The forums, with the support of the Regional Chapter organizations, organize meetings and workshops with relevant stakeholders to conduct advocacy for the betterment of health rights at their local levels. They also identify gaps in the existing situation towards the full realization of health rights at the local levels and organize need-based and area-specific activities (such as awareness raising amongst the community on the necessity for regular checkups during pregnancy, awareness raising on testing to identify blood groups, organizing registration of COVID-19 vaccination for community people, etc.). The Regional Chapters, collectively, also work toward health goals at the national level, having held human chains in 6 of the 8 districts as part of an effort to advocate for changes in the national health budget for the upcoming fiscal year (2022-2023). Since September 2021, the Regional Chapters and forums across the country have held meetings with key government stakeholders in the health sector of their respective areas, in order to build close working relationships. Resident Medical Officers, hospital management authorities, civil surgeons have been some of the selected officials with whom workshops, and meetings have been held across the country. Two of the RCs were formed at a very initial stage and more initiatives were undertaken. Whereas, other six RCs were formed later in 2021 and number of initiatives are limited compared to others.

Discussion and conclusion

The present study explored both demand and supply side challenges at the DH, UHC and CC levels across Bangladesh.

Demand- side challenges

- Access to CCs in most locations across the country (notably, except for in the hill tracts) was easier for most community members. Distance to UHCs and DHs was on average greater and often involved significant travel expenses
- Across all types of healthcare facilities, awareness regarding the existence of citizen charters, other information boards and information centres were found to be low
- At multiple study sites, service users were found to have incurred costs of several thousand Bangladesh Taka for diagnostic fees (some of which were found to be not available at facilities such as UHCs and DHs), buying medicines and even surgical items. These costs were unanimously recognized by study participants to be overwhelming for their households

- Due to the large number of service users at all facilities relative to the facility's ability to provide services, long waiting times were found to be problems at both UHCs and DHs.

Supply- side challenges

- Shortage of medicine and medical equipment ranging from blood pressure machines to weight machines at the CCs, lab testing equipment at the UHCs and diagnostic machines at the DHs was a major challenge
- Every facility visited across the country reported lacking skilled technologists disrupting diagnostic and radiological tests that the facilities are supposed to be able to undertake
- Huge patient load leading to long waiting time and less consultation time affecting the quality of care and patient satisfaction at all types of healthcare facilities reported by almost all the key informants
- Cleanliness of facilities was observed to vary greatly across the study sites. The number of cleaning staff per facility, at all UHCs and DHs across the country, was found to be low relative to the scope of work necessary to keep the facilities clean
- There was a lack of proper mechanism for information dissemination and feedback mechanism across all type of health facilities, especially at the CCs

Ensuring access to essential quality health care services for all, without any financial risk is the main goal of Universal Health Coverage. As a member country, Bangladesh is also committed to achieving Universal Health Coverage, under which the country needs to attain at least 80% essential health-service coverage for the entire population irrespective of their economic status, gender, or place of residence. However, without ensuring health equity and addressing the gaps in existing primary health care service delivery, attaining these goals will not be possible. Bangladesh Health Watch with establishment of the Regional Chapters has taken several initiatives to improve the health service situation in primary health care facilities serving the poor and marginalized population groups in rural Bangladesh. The present study findings can assist the BHW team and the RCs to address some of the demand-side and supply-side barriers identified in the present study in different study sites and in different healthcare facilities.

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Chapter 1: Introduction

1.1 Background

Over the past two decades, Bangladesh has made significant progress in improving various health indicators. Infant mortality rate reduced from 102 deaths per 1,000 live births in 1982 to 24 deaths per 1,000 live births in 2017.[1, 2] Under-5 mortality rate reduced from 94 deaths per 1,000 live births in 1999 to 45 deaths per 1,000 live births in 2017-18.[3,4] In parallel, maternal mortality ratio reduced from 434 deaths per 100,000 live births in 2000 to173 deaths per 100,000 live births in 2017.[5] The main contributing factor behind declining maternal and childhood mortality was found to be reduced fertility rate among reproductive-aged women (2.3 in 2017- 2018 as compared to 3.3 in 1999- 2000).[4] The country has also witnessed major progress in the reduction of childhood undernutrition and in the improvement of continuum of care for mothers and children.[6, 7] The prevalence of stunting decreased from 60 % to 41·2 %, underweight from 52·2 % to 36·2 % and wasting from 20·6% to 15·5 % from 1996 to 2011.[7] Life expectancy at birth increased from 58 years in 1990 to 72 years in 2021.[8] However, despite these achievements, inequalities in access to health care services persist within the rural, disadvantaged and hard-to-reach population groups, who rarely enjoy equitable health care services.[9, 10] There are also a number of health system-related challenges including inadequate public health facilities, skilled health workforce crisis and weak health financing.[11] Bangladesh is yet to ensure equitable primary health care services for all in order to achieve Universal Health Coverage (UHC) and several of the Sustainable Development Goals (SDGs) related to health by 2030.

The health services in Bangladesh are currently being delivered by various government and private sector actors. Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), and the Revitalization of Community- based Healthcare Initiatives in Bangladesh (RCHCIB) project of the Ministry of Health and Family Welfare, Government of Bangladesh (GoB) provide health care services throughout Bangladesh in three tiers: primary level health care, secondary level health care and tertiary level health care.[12] The RCHCIB project is responsible for operationalizing 14,890 CCs (CCs),[13] which are the lowest tier health care facilities in rural areas. They serve as one- point primary service outlets for basic and primary health care (PHC), family planning and nutrition services.[13] Each CC is established to serve around 6,000 people. The main beneficiaries of CCs include: women, children and the most disadvantaged poor people residing in rural and hard-to-reach areas of Bangladesh.[12, 13] An estimated 13,822 full-time community health care providers (CHCPs) are placed in the CCs

to provide health care services covering whole Bangladesh.[12] In addition to the CHCPs, domiciliary staff members [20,908 health assistants (HAs), 4,220 assistant health inspectors (AHIs), and 1,410 health inspectors (HIs)] from the DGHS and DGFP also work 3-days per week in the CCs.[12] Basic health care services such as maternal and child health care, reproductive health and family planning, immunization, nutrition education, micronutrient supplementation, health education and counseling, communicable disease control, treatment for minor ailments and first aid, and referral to higher-level health care facilities for all population groups are provided in the CCs.[12, 13] Besides, few of the CCs are equipped with community Skilled Birth Attendants (SBAs) and hence offer normal delivery care. An estimated 10 million service seekers visit CCs all over the country per month, of which 2% are referred timely to the next level health care facilities for better management.[12, 13] All these CCs are equipped with laptops and internet access in order to report daily service utilization by local community people, ensuring real-time data monitoring and improvement.[12] A 5-17 member management committee, comprising of representatives from the community, local government representatives, and health care providers manage the functioning of a CC.[12, 13] Three community support groups, each comprising 15-17 members contribute as unpaid health volunteers and assist the management committee.[13, 15] Although it is often argued that the establishment of CCs has tremendously improved primary health care service delivery in rural settings,[14] most of the CCs are yet to become fully functional in terms of availability of skilled health care providers, supply of drugs/logistics, and quality of care.[14, 15]

In addition to the CCs, there are 3,219 Union Health Centres, 1,322 Union Sub-Centres, and 431 UHCs (UHCs) that provide primary health care services in rural areas.[16, 17] Union Sub-Centres are 10- 20 bed health facilities that provide outpatient services through Sub-Assistant Community Medical Officers (SACMOs) and Health Assistants (HAs).[12] These Sub-Centres provide basic health care services like antenatal care, postnatal care, child nutrition and immunization, family planning and general health care.[12] UHCs are 31-50 bed health facilities that provide both indoor and outdoor primary health care services. They are equipped with medical officers, resident medical officers, anesthesiologists, radiologists, trained nurses, SACMO and other health facility staff. A variety of primary health care services including antenatal care, delivery care (both normal delivery and cesarean section), postnatal care, child immunization, reproductive health and family planning, and primary burn and trauma management are provided in the UHCs.[12] Besides, there are 792 Union Health & Family Welfare Centres (UH&FWCs) that operate under the DGFP.[16] These UH&FWCs provide sexual and reproductive health including maternal, neonatal, and child health services to women and children in rural areas.

Although the Government of Bangladesh has established different types of primary health care facilities in rural areas, proper functioning of these facilities and equitable access to them are not yet a reality. Besides, patients' dissatisfaction with health care service providers and healthcare itself remain important concerns that are yet to be addressed.[18, 19] Patient satisfaction is a loosely defined concept; however, it is a useful measure to assess the quality of health care services.[20] Patient satisfaction can be defined as *'the extent to which patients are happy with their healthcare, both inside and outside of the doctor's office. A measure of care quality, patient satisfaction gives providers insights into various aspects of medicine, including*

the effectiveness of their care and their level of empathy.[21] As we know, there are two aspects of service delivery- supply side and demand side. Various existing problems on the supply side to deliver health care and challenges on the demand side to access health services often affect patient satisfaction at health care facilities.

One of the main challenges in the supply side is a lack of a skilled health workforce. Besides, disparity in distribution of health care providers, and a lack of supervision for existing healthcare professionals are also some of the major challenges faced. [22, 23] As per the World Health Organization (WHO) guideline on health workforce requirements, Bangladesh is still facing a shortage of 90,000 doctors, 27,3000 nurses, and 45,5000 technologists due to attrition of professional workers as there are frequent postings, brain drain, and failure to retain doctors in rural areas. [23] This leads to lack of timely health care at the facility level, long waiting time for the service users, and insufficient consultation time by the doctors with the patients.[22, 24] Even though there is provision of free medicines for patients at the primary level health care facilities, often time health facilities struggle to supply the required amount of medicines to the patients due to shortage of medicine supply from the central.[24,25] More than 70% of rural health care facilities also do not have all six basic equipment items: thermometers, stethoscopes, blood pressure gauges, weighing scales for infants and adults, and torchlights, as per Bangladesh Health Facility Survey, 2017. [12]

Earlier studies in Bangladesh documented the influence of long waiting times, long queues in ticket counters, fewer consultation times, and negative attitude of the health providers on patient satisfaction and service access at the primary level. [22, 24] Feedback mechanisms are almost non-existent at the primary health care facilities, especially in rural and hard-to-reach areas. There is no formal protocol that can support and deal with the feedback service users/ patients provide after they receive health services. On the contrary, this feedback can contribute to improving service delivery if considered. [24, 27, 28] Majority of the primary health care facilities also lack proper drinking water, lavatory facilities, waiting rooms, and breast-feeding corners. [26]

Overall, there is a lack of research evidence in Bangladesh on patient satisfaction and the quality of services provided in the CCs, Union sub-centers, UH&FWCs and UHCs. Bangladesh Health Watch (BHW), a multi-stakeholder civil society body, is pursuing different initiatives to help the Government of Bangladesh strengthen the health system and health service delivery. BHW has established 8 Regional Chapters (RCs) in eight districts under 8 divisions of the country to establish a citizens' activism mechanism to act as the local watchdog body in their catchment areas. Under each RC, District Health Rights Forum, Upazila Health Rights forum and Union Health Rights forum have been formed. Besides, youth groups have been formed to support the different health rights forums. The main activities of the RCs include maintaining close contact with citizens and government authorities of selected districts, upazila and union including one or more CCs so that they can remain informed of the health situation in those sub-regional levels and collect any significant observations from those areas for discussion and action at the regional to national level[1].

[1] Bangladesh Health Watch. Regional Chapters: Making Bangladesh's Healthcare Systems More Responsive and Participatory.

This research aims to generate evidence on the demand and supply-side challenges of delivering equitable health services in the catchment areas of the Regional Chapters of BHW. The study also aims to document the initiatives undertaken by the Regional Chapters to improve the health situation in the respective region.

1.2 Objectives of the Study

- To identify the demand-side challenges and assess patient satisfaction with the health services provided in the CCs, UHCs and DHs in the catchment areas of the Regional Chapters of BHW.
- To identify the supply-side challenges of providing quality health services in the CCs, UHCs and DHs in the catchment areas of the Regional Chapters of BHW.
- To document the initiatives undertaken by the Regional Chapters to improve the health situation in the respective region, the challenges they experienced during the implementation of the activities and strategies they adopted to mitigate the challenges.
- To develop a data collection manual/ interview guideline/ SOP to guide and assist future researchers and program implementers for feedback collection from the community on primary health care service delivery around the year.

Chapter 2: Methodology

This chapter describes the methodology adopted for the study. In order to achieve the above-mentioned objectives, a mixed-method research was conducted. A cross-sectional survey was conducted among 412 patients (between 18- 69 years of age) to examine their level of satisfaction with the health services. A total of 23 Focus Group Discussions (FGDs) were conducted with the community people to understand the demand-side challenges. In addition, 23 Key Informant Interviews (KIIs) were conducted with health care providers/ health managers and 23 Facility assessments were undertaken on the selected three types of health facilities from eight catchment areas of BHW Regional Chapters.

2.1 Developing data collection tools

Appropriate data collection tools were developed and used for collecting data from different target groups. Questions around background information, household distance from the health facility, costs associated with receiving treatment, expectations from doctors and other health professionals and household expenditure were included in the exit interview questionnaire. In addition, Patient Satisfaction Questionnaire (PSQ- 18) [23] was contextualized and incorporated in

the exit interview questionnaire. Along with the standard 18 questions of the PHQ- 18 scale, 9 new context-specific questions were incorporated that had a focus on financial aspects, interpersonal manner, technical quality of the services, time spent with doctors, accessibility and convenience, communication and general satisfaction while receiving health services by the patients. FGD guidelines were developed to explore the demand side challenges and included aspects like willingness to pay, out-of-pocket expenditure, the stigma associated with any disease conditions, and expectations from doctors.

KII guidelines and Facility assessment checklist were developed with a focus on documenting the supply-side challenges that hinder healthcare facilities providing equitable healthcare services. Aspects like geographical accessibility of health facility, availability of health workers, drugs and equipment, waiting time, cleanliness of the health facility, management/staff efficiency including supervision and feedback mechanism, interpersonal skills/attitude of health professionals, referral system, availability of Citizen Charter/information on what services are provided in the health facility and their costs, opening hours of health facilities, staff availability and absenteeism, free service provision for poor and marginalized population groups such as persons with disabilities, provision and functioning of integrated outreach activities, and availability of emergency transport were included in the KII guideline whereas the facility assessment checklist had a focus on the accessibility, human resources, supply of medicine and equipment and cleanliness of the health facilities. The World Health Organization's Service Availability and Readiness Assessment (SARA) checklist was modified for this purpose. All the data collection tools were further modified based on the feedback from experts and reviewer comments.

2.2 Pretesting of data collection tools

Data collection tools, including the exit interview questionnaire, were pretested to check their validity and acceptability at the field level among the target groups. The questionnaire and facility assessment checklist were pretested on 5th April 2022, in Durgapur sub-district of Mymensingh division. The questionnaire and facility assessment checklist were further modified and finalized considering the feedback obtained through the pretesting.

2.3 Training of Bangladesh Health Watch Volunteers at Regional chapters

As one of the aims of this study was to develop the capacity of the Bangladesh Health Watch volunteers and to train them for repeated data collection, data collection activities were undertaken by these volunteers. In each of the Regional Chapters, there is a host organization, responsible for implementing different activities as per the suggestions of Bangladesh Health Watch Secretariat in order to bring positive changes in selected health care facilities in their areas. These host organizations from the Regional Chapters were communicated before commencement of the data collection activities. With their help and suggestions, volunteers were identified for training and data collection with the support from the core research team. The number of volunteers in each of the Regional Chapters varied from 2- 6 depending on the data collection strategy and distance to the health facility.

Before starting off the data collection procedure in each of the Regional Chapters, a day-long training with the assigned volunteers was organized at the host organization office. Initially, the

theoretical concepts were introduced to them, in order to improve their understanding on the overall research project, and its main objectives. Different types of data collection methods that need to be utilized for this research were discussed and they were briefed on how to conduct interviews, especially the exit interviews with the patients. Once the discussion was completed, they were trained on how to collect data using Tablets. Ethical aspects of research, including obtaining consent from the study participants, maintenance of confidentiality and privacy were also discussed with the volunteers.

2.4 Field data collection

Exit interviews: Exit interviews were conducted with randomly selected adult patients (age 18 to 69 years) who have received health services from three types of healthcare facilities in the study sites/ Regional Chapters. The purposes of the exit interviews were to explore patients' perspectives about service accessibility, appropriateness, quality of care, competency and attitude of health care professionals among other things. The sample size for the exit interview survey was calculated as 380 considering 44.2% patient satisfaction (obtained from a previous study conducted in a primary health centre in rural Bangladesh),[24] 95% confidence level and 5% margin of error. Considering a non-response rate of 12%, a total of 432 patients were approached to take part in the research. This sample size of 432 was then further divided into eight separate catchment areas (54 for each catchment area- Regional Chapter). As there were three different types of healthcare facilities in each catchment area- CC, UHC, and DH- this number (54) was again divided into three to collect data from all three types of health facilities. As per the calculation, a total of 18 exit interviews were planned in each health facility type (DH, UHC, and CC).

Even though we expected to collect data from 432 participants, a total of 412 exit interviews were conducted in eight catchment areas. In the Catchment area of Sylhet division- Sunamganj, CC went under water due to flood and only 10 exit interviews were conducted in that health facility. In Barguna, no UHC was included under the activities of Regional Chapter and hence exit interviews were not conducted.

Focus Group Discussions: Focus Group Discussion (FGDs) were conducted with community people around the health facilities from eight catchment areas to explore the demand-side challenges experienced by them in accessing health services. One FGD around each type of health facility was conducted, making it a total of 23 FGDs. No FGD was conducted at the Upazila level of Barguna RC, as that health facility was not included under the BHW initiative.

Core research team members facilitated the FGDs with the support from trained youth volunteers. Majority of the FGDs were conducted in the surrounding areas of the health care facilities- in the common field/ school playground or at the tea stalls. Participants for the FGDs were selected conveniently based on their willingness to participate in the research. Participants who voluntarily agreed to participate were included in the FGDs. The FGD guideline included questions related to factors influencing the ability of people to use health services. These factors included: Household location and distance of household from the health facility, lack of

awareness among community people on what services are available in which types of health facilities, and financial aspects.

Key Informant Interviews: Key Informant Interviews (KIIs) were conducted with health care providers/ health facility managers to explore the supply side challenges at the facility level. Like the FGDs, three KIIs were conducted per site. No KII was conducted at UHC of Barguna district, as this facility was not included as part of the BHW initiative. Thus, the total number of KIIs conducted were 23. With the assistance of the host organization in each catchment area, key informants were contacted, and interviews were scheduled as per their convenience. The core research team members conducted the KIIs mostly at the health facilities on the scheduled times. The KII guideline included questions around availability, accessibility, financial aspects of the health services in a particular health facility along with the infrastructural situation. They were also asked about the challenges they experience in their daily life to provide services and about the aspects where improvements or initiatives are warranted.

Facility assessment: A total of 23 health facilities were assessed utilizing modified WHO SARA checklist. One from each type of health facility- CC, UHC and DH from each catchment area were assessed as part of the facility assessment. The main aim of the facility assessment was to observe several key aspects of service delivery at the facilities and document the challenges and gaps that exist there. Host organizations communicated with appropriate authority in each type of health facility beforehand to schedule a time for the facility assessment and core research team members did the assessment as per the scheduled time without interrupting the usual workflow of the facilities. Facility assessment checklist included aspects like, availability of healthcare providers, drugs and equipment, cleanliness of the facility, feedback mechanism, availability of Citizen Charter/ information board, availability of emergency transport, accessibility in the facility etc.

Documentation of the initiatives undertaken by the Regional Chapters: The research team members/youth volunteers documented the initiatives that have been undertaken by the Regional Chapters to improve the situation of health facilities in each catchment area. Relevant representatives of the District, Upazila and Union Health Rights Forums were interviewed to gather information on the different actions and advocacy activities undertaken as part of the initiatives. A total of seven such interviews were conducted with the representatives from host organizations in each catchment area. Perception about the initiatives taken, challenges to implement the initiatives and mitigation strategies were discussed with the representatives to understand the overall situation in place.

2.5 Data Analysis

Exit interview data were analyzed using STATA, version 16. Descriptive statistical analyses were performed considering variable types and the distribution of variables. Socio-demographic and other health care-related findings are presented in the report through tables, graphs and other visual representations by each type of health facility type.

The PSQ- 18 questionnaire yielded separate scores for each of the seven different subscales- General satisfaction (items 3 and 17), Technical quality (items 2,4,6, and 14), Interpersonal

manner (items 100 and 11), Communication (items 1 and 13), Financial aspects (items 5 and 7), Time spent with the doctor (items 12 and 15), and Accessibility and convenience (items 8,9,16 and 18). Basic features of facility assessment and quality of healthcare services were presented through tables and bar graphs by performing descriptive analysis.

FGDs and KIIs were recorded with informed consent from the study participants. The recordings were later translated into English. An a-priori codebook was prepared based on the main themes of the guideline such as geographical location of health facility, availability of services, cost of health services, transportation costs, accessibility in the health care, health human resources, supply of medicine and equipment, information availability, cleanliness of the health facility, and scope of improvement. Transcripts were coded manually, and findings were aggregated under specific themes and sub-themes in the data matrix. Findings generated from the FGDs were triangulated with the findings of exit interviews to understand the demand side challenges, whereas findings from KIIs were triangulated with the findings from facility assessment to identify and document the supply side challenges.

2.6 Ethical Consideration

Ethical approval for the research was obtained from the independent ethical review board of James P Grant School of Public Health, BRAC University (IRB approval number: IRB-09 January' 22-002). The research protocol and all data collection tools were meticulously reviewed by two independent external reviewers and the IRB team members. All relevant comments and suggestions from the reviewers were incorporated accordingly into the research protocol and data collection tools.

Informed consent was obtained from all the study participants who participated in the Exit interviews, FGDs, and KIIs. Study participants were briefed about the aims and objectives of the research, research plan, and types of questions they would be asked prior to the informed consent. They were also assured that their confidentiality and anonymity will be maintained throughout the research process and afterward data collection. They were also informed that they have the right not to answer any question and withdraw from the interview process at any point in time. Required permission and approval from the Directorate General of Health Services (DGHS) was sought to undertake the facility assessment and KIIs with the health care providers. Additionally, permission from the Civil Surgeon office and responsible officials of primary health care facilities were sought before conducting the observational assessment and KIIs. Given the busy schedule of the health care providers/ health facility managers, interviews with them were pre-scheduled as per their convenience. Facility assessments were undertaken without interrupting the normal workflow in the healthcare facilities. During qualitative interviews, recorders were only used when the study participants agreed.

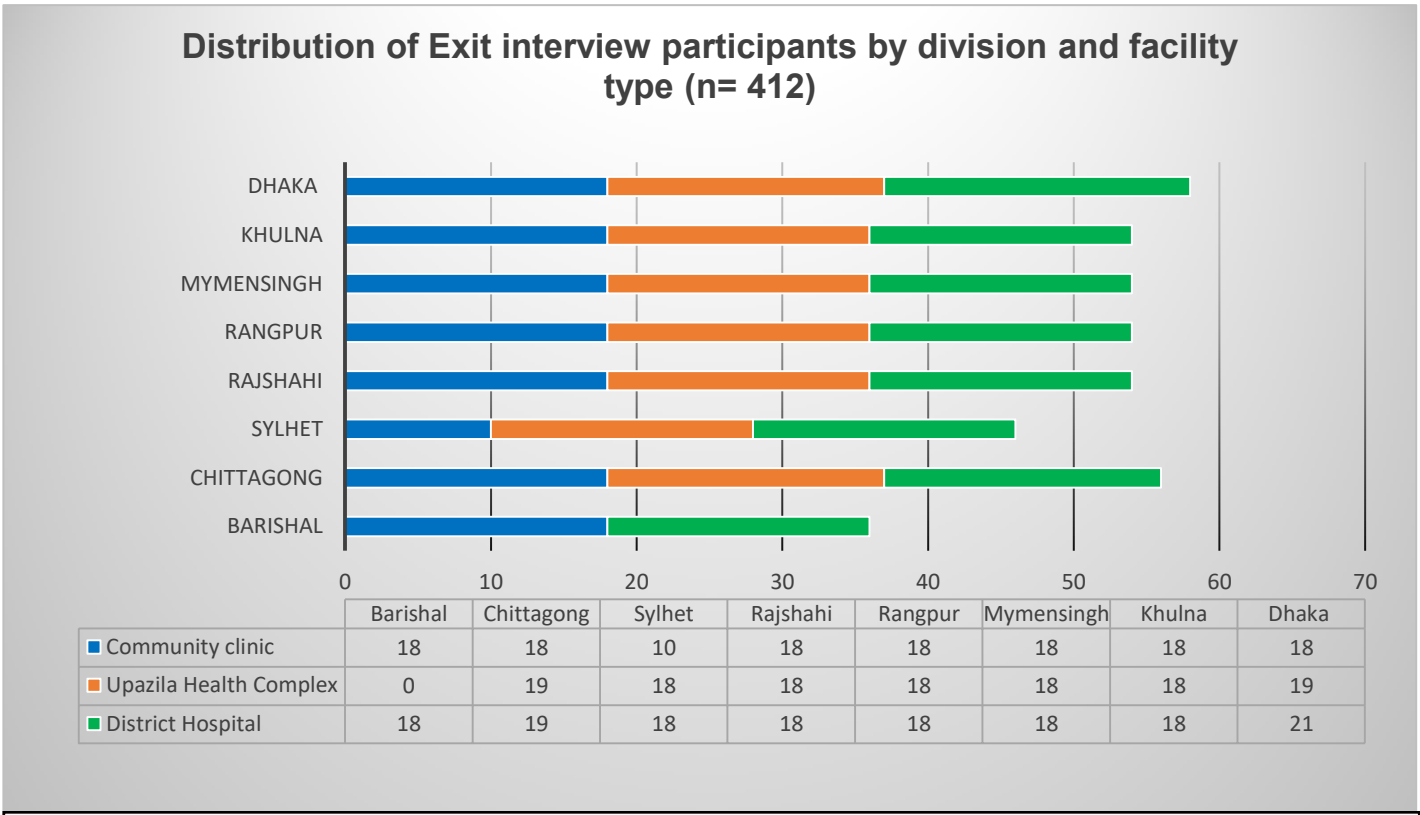
Chapter 3: Research findings

This chapter discusses the key findings from the exit interviews, KIIs, FGDs, and facility assessments. The findings are presented under four major themes: socio-demographic characteristics of the study participants, demand-side challenges (with findings from the FGDs and exit interviews), supply-side challenges (with findings from the KIIs and Facility assessment), and initiatives undertaken by Bangladesh Health Watch. The major themes are further subdivided into subsections to discuss the challenges currently experienced by both the healthcare providers and service users in terms of healthcare services for all three types of healthcare facilities: CCs, UHCs, and DHs in the Regional Chapters of Bangladesh Health Watch.

3.1 Socio-Demographic Characteristics of the Study Participants

Socio-demographic characteristics of the exit interview participants

A total of 412 exit interviews were done with patients who have taken health services from health care facilities in eight Regional Chapters of Bangladesh Health Watch from eight administrative divisions of the country. As mentioned earlier in the methodology section, the



	Barishal	Chittagong	Sylhet	Rajshahi	Rangpur	Mymensingh	Khulna	Dhaka
Community clinic	18	18	10	18	18	18	18	18
Upazila Health Complex	0	19	18	18	18	18	18	19
District Hospital	18	19	18	18	18	18	18	21

Figure 3.1.1: Distribution of exit interview participants by division and health facility type

Table 3.1.1 presents the demographic characteristics of the exit interview participants by health facility types. More than half of the participants (57.35%) were female and 42.7% were male. More females (69.3% and 55.6%) received health services in CCs and UHCs compared to DHs where male participants were 52.3%. Approximately one-third of the participants (31.1%) were between 18- 27 years of age followed by 26.5% from the age group 28- 27 years. Mean age of the study participants is 36.32 years with a standard deviation of 12.8 (minimum age 18 years and maximum age 69 years). Majority of the participants (78.9%) were married. A total of 348 participants (85.5%) got an opportunity to avail education.

Table 3.1.1 Background characteristics of the study participants by health facility type (n= 412)

Background characteristics	Type of health facility			Total
	CC n (%)	UHC n (%)	DH n (%)	
Gender				
Male	42 (30.7%)	56 (44.4%)	78 (52.3%)	176 (42.7%)
Female	95 (69.3%)	70 (55.6%)	71 (47.7%)	236 (57.3%)
Age				

18- 27 years	44 (32.15)	39 (31%)	46 (30.95)	129 (31.1%)
28- 37 years	34 (24.8%)	34 (27%)	41 (27.5%)	109 (26.5%)
38- 47 years	30 (22%)	27 (21.4%)	28 (18.8%)	85 (20.6%)
48- 57 years	20 (14.65)	17 (13.5%)	20 (13.4%)	57 (13.8%)
59 years and above	9 (6.65)	9 (7.1%)	14 (9.4%)	32 (7.8%)
Religion				
Islam	117 (85.4%)	110 (87.3%)	131 (88%)	358 (87%)
Hinduism	9 (6.6%)	12 (9.5%)	15 (10%)	36 (8.7%)
Buddhism	11 (8%)	4 (3.2%)	3 (2%)	18 (4.3%)
Marital status				
Unmarried	17 (12.4%)	18 (14.3%)	33 (22.1%)	68 (16.5%)
Married	113 (82.5%)	103 (81.8%)	109 (73.1%)	325 (78.9%)
Separated	0 (0)	1 (0.8%)	1 (0.7%)	2 (0.5%)
Divorced	0 (0)	1 (0.8%)	0 (0)	1 (0.2%)
Widow/ Widower	7 (5.1%)	3 (2.3%)	6 (4.1)	16 (3.9%)
Opportunity to avail education				
Yes	113 (82.5%)	106 (84.35)	129 (86.6%)	348 (85.5%)
No	2 (17.5%)	24 (15.9%)	20 (13.45)	64 (15.5%)
Total	137 (100%)	126 (100%)	149 %)	412 (100%)

Figure 3.1.2 shows the highest educational attainment of the exit interview participants. Of those participants who had an opportunity to avail education (n=348), one-third (30%) completed their secondary education at the time of survey data collection, followed by 24% who did not incomplete secondary education.

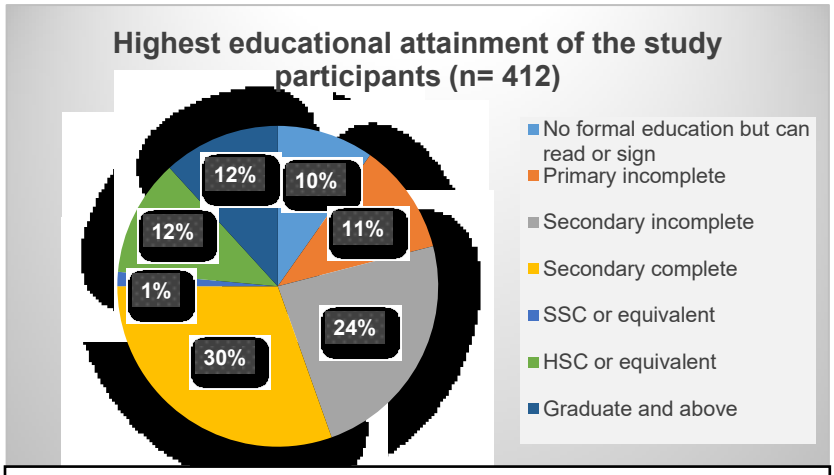
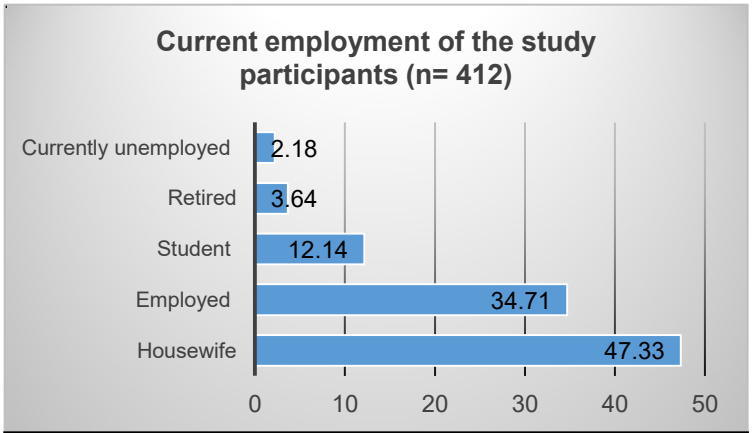


Figure 3.1.2: Highest educational attainment of the study participants



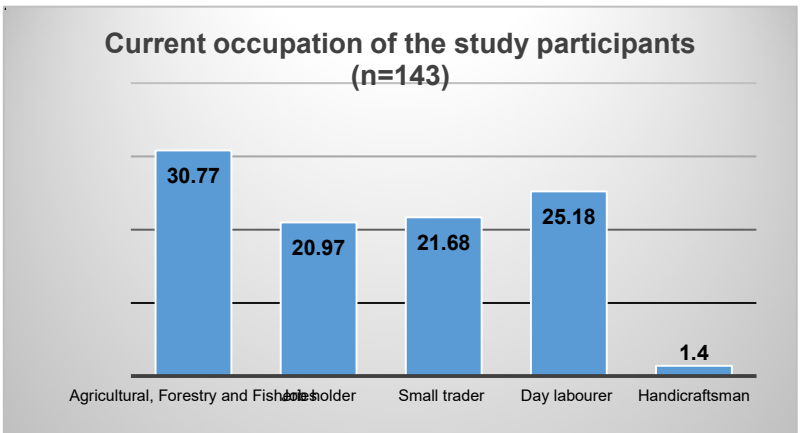


Figure 3.1.3 shows the employment status of the exit interview participants. A majority (47.3%) of them were housewives, followed by 34.7% (n= 143) who were employed. Of those 143 study participants who were employed, one-third (30.7%) were in agriculture, fisheries, and forestry (Figure 3.1.4).

The average monthly family expenditure (mean) of the exit interview participants was BDT 12103.16 (USD 127.4 USD), with a standard deviation of 5778.31 BDT whereas the average monthly income of the exit interview participants was BDT 15441 (USD 162.5), with a standard deviation of 6837.6 BDT.

Table 3.1.2 shows the decision-makers in the family about health care expenditure. A total of 156 participants (37.8%) mentioned that their husband/ wife takes the decision of health care expenditure in the families, followed by 134 (32%) mentioned they themselves take the decision.

Table 3.1.2: Decision maker for health care expenditure

Decision maker	Frequency	Percentage (%)
Husband/ wife	156	37.86
Self	134	32.52
Father	69	16.75
Son/ Daughter	40	9.71
Brother/ sister	13	3.16
Father-in-law	11	2.67
Total	412	100

Characteristics of the FGD participants

A total of 23 FGDs were conducted with service users and community people around the selected healthcare facilities in the study sites. Interviews were conducted at all levels- Village, Upazila, and District. FGD participants were selected purposively based on their gender, age, knowledge about the health facility and health services, and willingness to participate in the interview. As shown in Table 3.1.3, the number of participants in each FGDs varied from 4-8 and.

Table 3.1.3: Characteristic of FGD participants

	Location	Total number and gender of the participants
1.	Community clinic Manikganj	5 females
2.	Community clinic Chapainawabganj	8 females
3.	Community clinic Barguna	4 females
4.	Community Clinic, Khagrachari	5 females
5.	Community clinic Sunamganj	4 females
6.	Community clinic Kurigram	4 males
7.	Community clinic Shoronkhola	6 males
8.	Community clinic Netrokona	6 females
9.	Upazilla Health Complex, Chapainawabganj	6 females
10.	Upazilla Health Complex, Manikganj	6 females
11.	Upazilla Health Complex, Netrokona	5 females
12.	Upazilla Health Complex, Kurigram	7 males
13.	Upazilla Health Complex, Sunamganj	6 males
14.	Upazilla Health Complex, Khagrachori	1 male 4 females
15.	Upazilla Health Complex, Shoronkhola	6 males
16.	District hospital, Manikganj	4 females 2 males
17.	District hospital, Chapainawabganj	5 females
18.	District hospital, Netrokona	4 males
19.	District hospital, Sunamganj	5 females
20.	District hospital, Kurigram	6 females
21.	District hospital, Barguna	5 females
22.	District hospital, Bagerhat	6 males
23.	District hospital, Khagrachari	4 males

Characteristics of the KII participants

A total of 23 KIIs were conducted with the healthcare providers and health facility managers from eight different catchment areas. Interviews were conducted in all three types of health facilities in each of the catchment areas. Key informants were selected purposively based on their designation, gender, working experience, and interest to participate in the interview. As shown in Table 3.1.4, healthcare professionals and representatives were interviewed such as Superintendents at the DHs, Medical Officers at the Upazilla Health Complexes', and Community Health Care Providers (CHCPs) at the CCs of the selected health facilities.

Table 3.1.4: Key informants with health facility types

Type of health facility	Designation	Number of interviews
Community clinic	Community health care provider	8
Upazila Health Complex	Medical Officer	7
District hospital	Superintendent of District hospital	8

Table 3.1.5 shows the demographic characteristics of the key informants. Nine out of Twenty-three key informants were between 30 to 39 years of age, nineteen of them were males and almost half of them (12) had working experience of less than 5 years.

Table 3.1.5: Demographic characteristics of the KII participants

Background characteristics	Number of the participants
Age	
20 to 29 years	5
30 to 39 years	9
40 to 50 years	7
50 to 60 years	2
Gender	
Male	19
Female	4
Educational level	
H.S.C and Diploma	8
Graduation and BCS	7
Post-graduation	8
Work Experience	
1 to 5 years	12
6 to 10 years	7
10 years and above	4

Characteristics of facilities assessed

With the aim to explore the supply side challenges, three types of healthcare facilities were assessed. A total of 23 healthcare facilities were assessed in eight Regional Chapters of Bangladesh Health Watch, among which eight were CCs, 7 were UHCs and eight were DHs. As mentioned earlier in the methodology section, no UHC was assessed in the Barguna RC as that is not covered by the BHW activities.

3.2 Demand side challenges

Patients in different types of health facilities

Exit interviews were conducted with patients who have received services from any of the three types of health facilities in the study sites. Out of 412 exit interview participants, 33.2% (n= 137) received services from CCs, 30.6% (n= 126) from UHCs, and 36.2% (n= 149) from DHs. Among the 412 participants, the majority (94.2%) came directly to the health facility for seeking healthcare, and 5.8% (n= 24) were referred to the health facility from another health centre (Table 3.2.1). 10.1% of the participants from DHs were referred from other health centres.

Table 3.2.1: Study participants referred from any health care centre by type of health facility

Referred from any health care facility	Type of health facility			Total
	Community clinic n (%)	Upazila Health Complex n (%)	District Hospital n (%)	
Yes	0 (0%)	9 (7.1%)	15 (10.1%)	24 (5.8%)
No	137 (100%)	117 (92.9%)	134 (89.9%)	388 (94.2%)
Total	137 (100%)	126 (100%)	149 (100%)	412

Similar to the findings from exit interviews, the majority of the FGD participants usually went to the CCs to seek general health care. Almost all the female FGD participants preferred CCs as the first point of service delivery as that was convenient to go, closest from the households, and services and medicines were free of cost. Women felt safe to travel less distance to seek healthcare services. On the other hand, male FGD participants mentioned about directly going to the UHCs or DHs, however, their decision about service seeking majorly depended on their travel time and availability of services. At the same time, males were found to be more comfortable to seek care from male providers, hence they preferred UHCs or DHs.

Distance to the health facilities, approximate travel time, and associated transportation costs

Study participants were asked about the distance between their place of residence and health facility from where they were availing the services. Figure 3.2.1 shows that more than half (65.7%) of the exit interview participants from CCs said the distance is less than 1 Km, followed by 23.4% who said the distance is between 1- 3 Km.

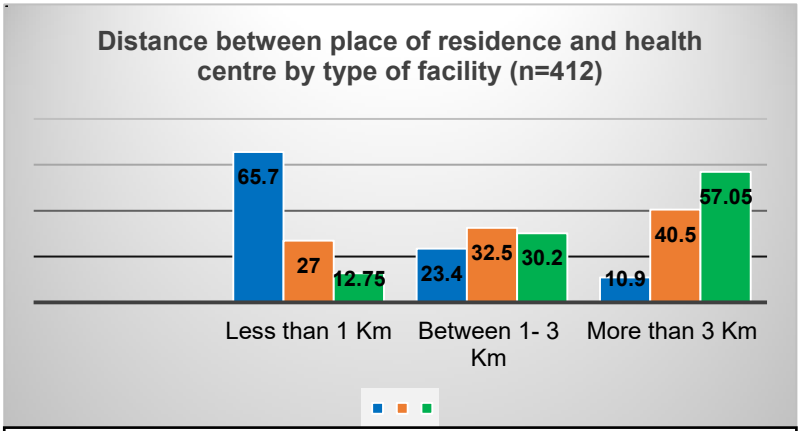


Figure 3.2.1: Distance between place of residence and health centre by type of health facility

Similarly, more than half of the participants (57%) from DHs said the distance to the health facility from their place of residence was more than 3 km.

The approximate travel time from place of residence to the health facility ranged from 5- 130 minutes with a mean of 24.7 minutes. Out of 412 exit interview participants, a total of 145 (35.2%) required less than 10 minutes to travel to the health facility, followed by 110 (26.7%) who reported needing 11- 20 minutes. Table 3.2.3 shows the travel time required for the exit

interview participants based on the health facility type. Of the 137 participants, who went to the CCs, 68.6% required less than 10 minutes. For UHCs, the majority (31.7%) required 11- 20 minutes, followed by 21- 30 minutes (29.4%). Only 10.7% (n= 16) study participants reported that they required more than 60 minutes to travel to DHs.

Table 3.2.3: Approximate travel time required to visit health facility (n=412)

Approximate travel time to the facility	Type of Health facility			Total
	Community Clinic n (%)	Upazila Health Complex n (%)	District hospital n (%)	
Less than 10 minutes	94 (68.6%)	33 (26.2%)	18 (35.2%)	145 (35.2%)
11- 20 minutes	34 (24.8%)	40 (31.7%)	36 (24.2%)	110 (26.7%)
21- 30 minutes	7 (5.1%)	37 (29.4%)	35 (23.5%)	79 (19.2%)
31- 40 minutes	0 (0%)	4 (3.2%)	17 (11.4%)	21 (5.1%)
41- 50 minutes	1 (0.7%)	7 (5.6%)	5 (3.2%)	13 (3.2%)
51- 60 minutes	1 (0.7%)	3 (2.4%)	22 (14.8%)	26 (6.3%)
More than 60 minutes	0 (0%)	2 (1.6%)	16 (10.7%)	18 (4.4%)
Total	137 (100%)	126 (100%)	149 (100%)	412 (100%)

Exit interview participants were also asked if any transportation cost was involved to travel to the health facility to which majority of the participants who received services from the CC (67.9%) responded that no cost was involved for transportation. On the contrary, more than two-thirds of the participants from UHCs (79.4%) and DHs (93.96%) responded that transportation cost was involved to travel to the health facility (Figure 3.2.2)

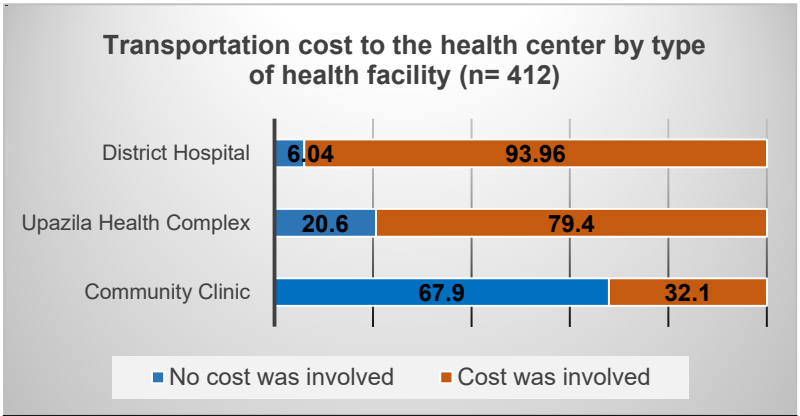


Figure 3.2.2: Transportation cost to the health centre by type of health facility

Among the 284 participants, for whom transportation cost was required, 28.9% spent less than BDT 15 (USD 0.16) for transportation cost, followed by 26.4% who spent BDT 16- 30 BDT (USD 0.17 – 0.32). Transportation cost for travelling to DHs was higher compared to CCs and UHCs (Table 3.2.2).

Table 3.2.2: Transportation cost to travel to the health facility (n= 284)

Transportation cost to the health centre	Type of Health facility			Total
	Community Clinic n (%)	Upazila Health Complex n (%)	District hospital n (%)	
Less than 15 BDT	35 (79.5%)	26 (26%)	21 (15%)	82 (28.9%)

16- 30 BDT	8 (18.2%)	31 (31%)	36 (25.7%)	75 (26.4%)
31- 45 BDT	0 (0%)	12 (12%)	23 (16.4%)	35 (12.3%)
46- 60 BDT	0 (0%)	23 (23%)	25 (17.9%)	48 (16.9%)
61- 75 BDT	0 (0%)	0 (0%)	2 (1.4%)	2 (0.7%)
76- 90 BDT	0 (0%)	2 (2%)	5 (3.6%)	7 (2.5%)
More than 90 BDT	1 (2.3%)	6 (6%)	28 (20%)	35 (12.3%)
Total	44 (100%)	100 (100%)	140 (100%)	284 (100%)

At most locations visited for the purposes of this study, CCs were found to be positioned close to the vicinity of the households that they serve. In most locations, it was observed by the research team, and also confirmed upon discussion with the local community members, that it is possible to reach a CC on foot from most households in the area. The Mohalchori CC in Khagrachori district was the only site that was found to be hard to reach on foot from the nearest residential locality. Rickshaws, motor rickshaws and battery-run “easy bikes" were also found to be available at all sites to take community members to the nearest CC. In most sites, the fare for local residents to travel to a CC was found to be around BDT 10-15 (USD 0.11-0.16) per person on an easy bike (which was found to be the preferred mode of commute in most locations), or a local van car. Traveling by rickshaw to a CC was found to be more expensive, with fares reaching up to BDT 50 (USD 0.55) in Netrokona. In the flood-prone area of Shoronkhola Upazila of Bagerhat district, traveling to the local CC was found to be difficult throughout a significant portion of the year, even though the distance between the served households and the clinic never exceeded the transport fare cost of BDT 10 (USD 0.11), regardless of where one is coming from. One FGD participant stated:

> *“The road that you’ve come here by, that’s the main road, right? When it rains, this road becomes very muddy. But all these inner roads become almost unusable. Those become completely covered with water and running mud. In the rainy season, that canal over there overflows and this entire area is flooded. We need to travel by boat to the clinic in the rainy season. It’s very hard for women to come to the clinic when it rains”. [45 years male, Shoronkhola CC, FGD]*

Located mostly in town centres at the Upazilla level, UHCs are generally further away from the residences of most of the people that visit them to take services than CCs. Easy bikes and motor rickshaws were found to be the preferred mode of transport to reach these centres for most people spoken to. Local buses are also availed by some individuals to reach the town centres where UHCs are located. Given the wide variation in distances that health care seekers travel to reach these centres, an estimate of the average cost of travelling to these centres could not be ascertained during the FGDs.

Located at district towns, DHs receive patients through referrals from both UHCs and CCs, as well as patients from nearby areas seeking healthcare. Besides these formal chains of referral (and the instances of individuals who live nearby seeking services), informal chains of referral to DHs were also observed.

In Netrokona, some FGD participants stated that since a new road has been built from their locality to the district town and the commute has become easy and comfortable, they sometimes go directly to the DH instead of seeking services at the UHC as well. The costs borne by visitors to DHs vary greatly, as they come from all around the district, and sometimes from other

districts as well (if the DH is closer to residents from the other district than the hospital of their own). Mode of transport availed by service seekers also varies widely from rickshaws to vehicles hired on reserve, including cars and micro-buses. The average distance and cost to travel to a DH for service seekers is higher than the average distance or travel cost to any other health facility. This is especially true for residents of hard-to-reach areas. Participants of an FGD at the DH in Sunamganj (Sylhet) stated

> *"It costs me BDT 200-300 (USD 1-2) whenever I have to come to the hospital and the condition of the roads is horrific. It was even worse before, and mothers would often have to give birth on the way to the hospital". [31 years male, DH Sunamganj, FGD]*

Availability of healthcare providers, medicine and diagnostic tests

Participants were also asked if a healthcare provider was present at the facility when they sought services. Figure 3.2.3 shows the majority of the participants reported healthcare providers were present at the time when they sought services at the facility.

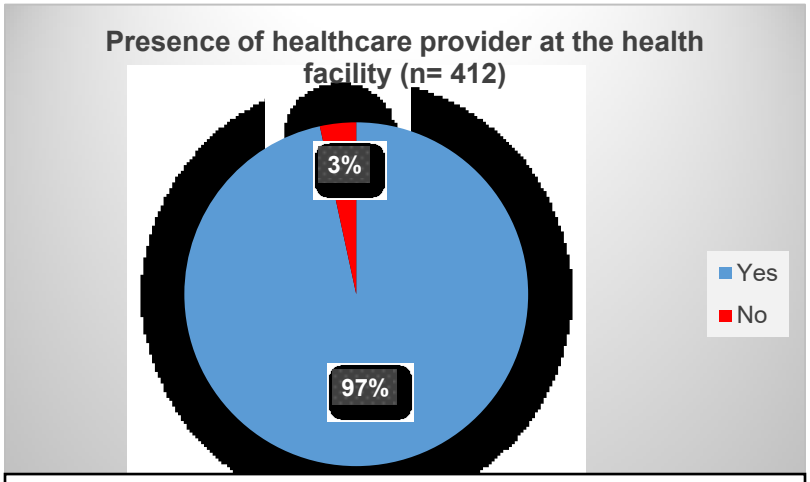


Figure 3.2.3: Presence of health care providers at the health facility

Table 3.2.4 shows approximate waiting time to get services at the health facility reported by the exit interview participants. Out of 412 participants, many (45.4%) said the waiting time was less than 10 minutes, followed by 18.2% (n= 75), who reported waiting time to be between 11- 20 minutes.

Table 3.2.4: Approximate waiting time to receive services at health facility (n= 412)

Waiting time at the facility	Frequency (percentage)
Less than 10 minutes	187 (45.4%)
11- 20 minutes	75 (18.2%)
21- 30 minutes	53 (11.9%)

31- 40 minutes	14 (3.4%)
41- 50 minutes	11 (2.7%)
51- 60 minutes	26 (6.3%)
More than 60 minutes	46 (11.2%)
Total	412 (100%)

Figure 3.2.4 explains the approximate waiting time of the study participants to receive services by type of health facility. It shows how the waiting time increased from CCs to UHCs and then to DHs. Of the 187 participants who waited less than 10 minutes, 56.68% of them were from CCs, followed by 28.3% from UHCs. Of the 46 participants who waited more than 60 minutes to receive services, 82.6% were from DHs and no one was from CCs.

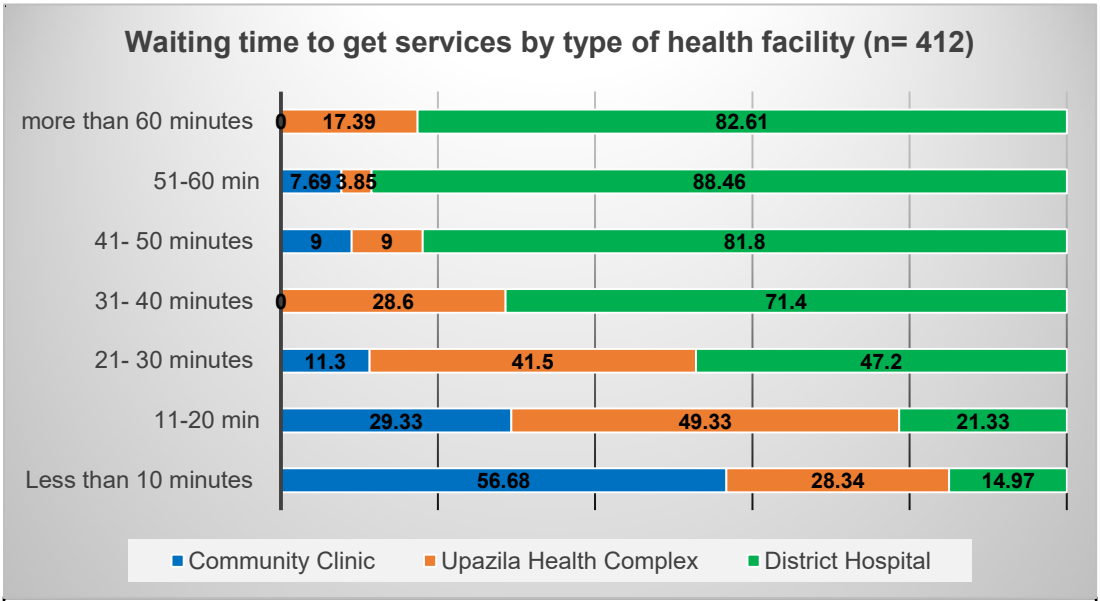


Figure 3.2.4: Waiting time to get services by type of health facility

Figure 3.2.5 shows that 87% (n= 360) of the exit interview participants were prescribed medicines when they accessed the health facilities.

Table 3.2.5 shows the availability of prescribed medicine by type of health facility. Of the 109 participants who

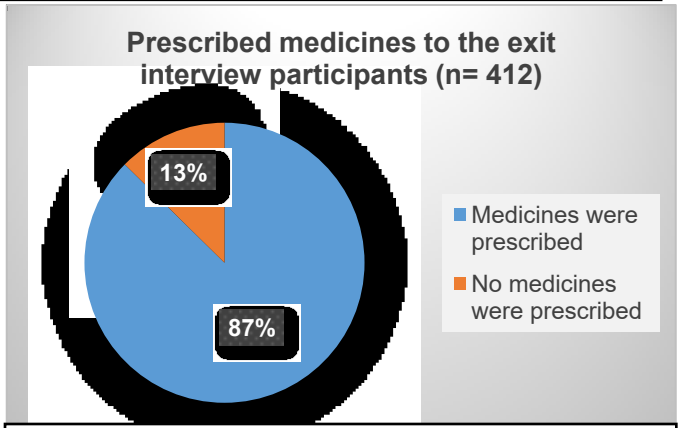


Figure 3.2.5: Prescribed medicines to the exit interview participants

received services from the CCs, more than half (58.7%) said they got all the medicines (100%). For UHC (n= 115), 40.9% reported that they got 50- 75% of the prescribed medicines, followed by 23.5% who got 100% of the prescribed medicines. Only 10.3% (n= 14) of the participants who received services from the DHs said that they got all the medicines/ 100% prescribed medicines from the facility.

Table 3.2.5: Availability of prescribed medicines in the health facility (n= 360)

Availability of prescribed medicine	Type of Health facility			Total
	Community Clinic n (%)	Upazila Health Complex n (%)	District hospital n (%)	
Less than 25%	8 (7.3%)	9 (7.8%)	22 (16.2%)	39 (10.8%)
25- 50%	5 (4.6%)	8 (7%)	22 (16.2%)	25 (9.7%)
50- 75%	15 (13.8%)	47 (40.9%)	48 (35.3%)	110 (30.6%)
75- 90%	17 (15.6%)	24 (20.9%)	30 (22%)	71 (19.7%)
100%	64 (58.7%)	27 (23.5%)	14 (10.3%)	105 (29.2%)
Total	109 (100%)	115 (100%)	136 (100%)	360 (100%)

More than half of the FGD participants shared that healthcare providers were present when they sought services at the CCs. Whereas, FGD participants from Shoronkhola union differed with this statement. At times the CHCP was not there at the CC and the clinic was closed. They mentioned that the CHCP was sick, so there was no one to run the clinic. On another instance, CHCP experienced some family issues and he had to keep the CC closed for three days. FGD participants near the Mohalchari CC mentioned that the clinic remains closed several days during festive times (such as during the Bengali new year). At times, the health care providers are not present at the CCs as they attend different meetings, workshops, and seminars at the UHCs. Usually, healthcare providers were present in the UHCs and DHs mentioned by majority of the participants. But when it comes to seeing a specialized doctor or consultant the scenario is not the same. One of the participants near Khagrachari UHC shared,

> *"You will not get any eye or ENT consultants here at the UHC. At times, you will not even find a Gynae consultant due to shortage of specialized doctors. Now, I am not aware of the exact reason. Is it because the specialized doctors don't come to the facility, or they are not placed here…Only the authorities are able to enlighten you on this." [A 37 years old male, Khagrachari UHC, FGD]*

A degree of mistrust and dissatisfaction with healthcare providers was observed from community members at the UHC level at multiple sites visited. This was primarily due to the experience of having to wait in queues to see a doctor, and a feeling that the amount of time given to each individual patient by doctors at these facilities is low. At Mohalchori (Khagrachori), the dissatisfaction was primarily since doctors were not found to be available at the facility all the time. Due to the relative remoteness of the location, doctors (who, according to the community members, travel to the location from Khagrachori district town) were found to be present at the facility 3 days a week, according to service seekers, making the process of availing healthcare services difficult for residents of the locality. The problems of understaffing (relative to the designated number of personnel for the facility, not relative to the volume of

patients seen) was observed to be less acute in DHs than UHCs. Participants shared their dissatisfaction about long waiting time due to shortage of healthcare providers and huge patient load; long queue at the ticket counters, as only a few of the ticket counters were functional and rest remains closed; and long queue in the pharmacies as one pharmacist struggled to manage this huge number of patients.

All the FGD participants are aware that certain medicines are provided free of costs from the health centres, but they couldn't mention any particular names. Service users of the CCs shared that they usually get all the medicines from the CCs, if those are common. If their illness requires some expensive medicines (by which they meant antibiotics), healthcare providers request them to get the medicine from a nearby pharmacy. In most sites, community members stated that the allotment of many medicines that CCs receive tends to run out 20-25 days every month. FGD participants at upazila and district level also shared a similar type of concern. They expressed their dissatisfaction about the medicine shortage and couldn't mention the reasons behind this medicine shortage. Five of the participants however differed with the statement and opined that health professionals including doctors might have sold the medicines to the pharmacies or prioritized some patients for providing drugs. That is why they do not provide free medicines to all the patients. Community members in most sites also opined that the quality of medicine provided in CCs is often not the best of its class. Generic drugs such as paracetamols or antacids available at CCs were stated by some community members to not be of the same quality as other drugs of the same category that can be purchased at pharmacies.

Similar to the medicine availability, participants expressed their thoughts on the diagnostic test availability at health facilities. Only a few of the basic tests are conducted at the CCs and if they need any specialized test or services, they are referred to the UHCs or DHs. In the CCs, basic equipment such as weight machine, and blood pressure machines are also missing and the healthcare providers request patients to check their blood pressure and blood sugar from the nearby pharmacy. On the contrary, different types of diagnostic tests are available at the UHCs and DHs and participants seemed satisfied with the laboratory tests available at these facilities. However, all the participants shared their frustration about unavailability of X-ray and Ultrasonography in these facilities. Participants from Netrokona DH discussed that the only USG machine is not in use for more than 18 months. The reason behind it as also identified by them as,

> *"There was a sonologist in the facility earlier, who could use this machine. Then he was transferred to another health facility as he had some issues with the Civil Surgeon. That's why he made this transfer happen. But who are suffering for this now, the general people like us. Every time we need USG, we are requested to go outside to a clinic to do it." [A 33 years male participant, Netrokona DH, FGD]*

However, the KIIs and facility assessment findings revealed that the only USG machine in Netrokona DH is non- non-functional for more than 18 months and as the sonologist had nothing to do here, he was transferred to another health facility. This overall scenario illustrates the discrepancy of information at the supply side and demand side and how this misinformation can affect patient satisfaction.

Costs associated with healthcare and out of pocket expenses

Out of 137 participants who received services from the CCs, 47.4% reported they were not required to pay any ticket fees, whereas, 32.3% and 46.8% participants from UHCs and DHs said they had to pay a ticket fee to avail the service (Figure 3.2.6). Figure 3.2.7 shows the amount of fees paid by the exit interview participants for a ticket by type of health facilities. Majority of the participants (95.6%) who received services from CCs paid less than BDT 5 (USD 0.053), whereas 20.4% from DHs paid between BDT 10- 15 (USD 0.11-0.16). However, it is important to mention here that there is no ticket fee at the CCs for any patients, followed by BDT 5 ticket fee at UHCs, and BDT 15 at DHs as per the government protocol. The possible reason behind ticket fees at the CCs or higher ticket fees in other health facility types were explored in the FGDs.

FGD findings documented, medicine is not always available in the facilities. Community members opined that medicine prescribed from CCs are usually always available at local pharmacies. In locations such as Mohalchori (Khagrachori) where a pharmacy was not located close to the CC, or the nearest residential locality, community members need to travel to the closest marketplace ("bazaar") to find a pharmacy. A general estimate of the extra out of pocket expenditure that this

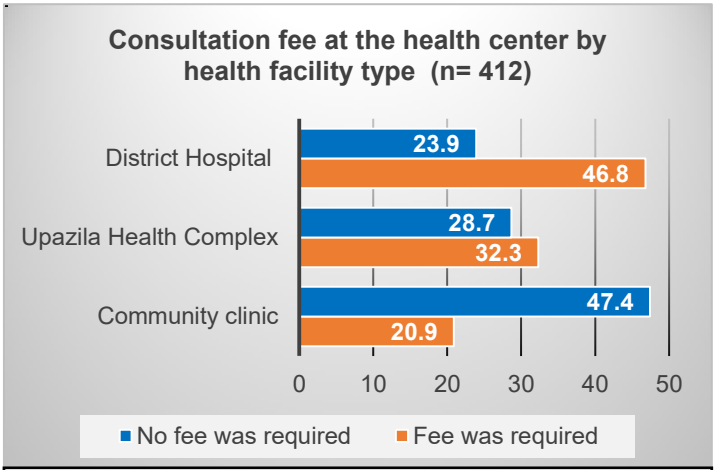


Figure 3.2.6: Ticket fees in the health centre by type of facility

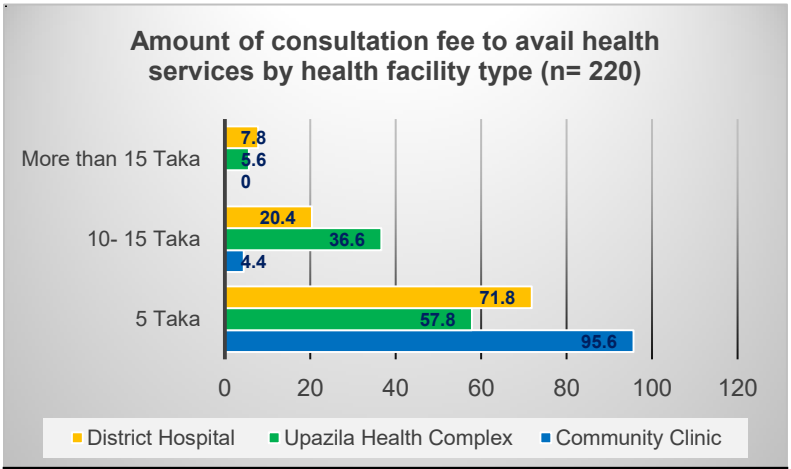


Figure 3.2.7: Amount of ticket fee in the health centre by type of facility

necessitates was not possible to ascertain from discussions with community members, as the expenditure varies according to distance to nearest pharmacy, and type of medicine needed. In general, commuting via easy bikes would cost up to BDT 20 (USD 0.22) per person from a residential locality to the nearest "bazaar".

Families with members who suffer from chronic illnesses mentioned having consistent health costs. A study participant from Manikganj stated:

"We need to spend a lot of money on medicines. My mother is a diabetic patient, and she also has blood pressure. My father has high blood pressure. My grandmother has an elderly disease. For this, my family has to spend 4,000 to 5,000 (USD 42-48) BDT. We have to spend a lot of money on tests. For each doctor, a minimum of 500 BDT (USD 4.8) is required for the visit. The visit can be more than 500 BDT (USD 4.8). The medicine cost is also there". [31 years female, DH Manikganj, FGD]

Much of the medicine prescribed to patients from UHCs were found to be medicine that patients had to purchase by themselves from pharmacies. From the UHC level onwards, service seekers have to acquire tickets and a serial number to see doctors and have to wait in queue for their serial to receive services. Some community members stated that middlemen *("dalals"*) try to take advantage of this process by charging service seekers a fee with the promise of ensuring that they do not have to wait in queue. Middlemen also try to steer service seekers to undertake medical tests outside healthcare facilities in private clinics or chambers, stating that the quality of service at the public facilities are not adequate. Even where middlemen are not involved, service seekers often do have to undertake tests at private facilities when the tests are not possible to be conducted at a public facility due to an absence of the appropriate technicians, absence of the equipment necessary for testing or the equipment being out of order. Community members also opined that some doctors also encourage testing at their own private chambers or clinics. Depending on the tests, costs at private facilities could range from several hundred to several thousand Bangladeshi Taka.

Wealthier community members in Netrokona, for example, were found to prefer testing and also taking services at private facilities, citing the shorter queues and a perceived higher degree of attention and care as reasons for the preference, while service seekers spoken to at the UHC itself lamented the possibility of having to incur extra out of pocket costs. For example, the community members spoken to for a focus group discussion at Netrokona resided in a relatively affluent neighbourhood primarily of mid-sized business owners located near the UHC, stated that they do not prefer going to the UHC despite its proximity to their residence and prefer seeking healthcare from private doctors' chambers. The comparison here is drawn from conversations with service seekers at the UHC itself. In other sites, doctors were not found to be present at the UHC every day. At Mohalchori, Khagrachori, community members stated that doctors came in from Chittagong and Khagrachori town thrice a week (once a week for a gynecologist), and there are no full-time doctors available at the UHC other days of the week. Patients requiring immediate attention need to be taken to either Khagrachori or Chittagong via a hired vehicle, which could cost between BDT 2000 and 3000 (USD 21 to 31), depending on type of vehicle and duration of reservation, according to community members.

A lack of free testing facilities was reported consistently by study participants at both the UHC and DH levels. An FGD participant from the Bagerhat DH stated,

"I didn't have to pay anything to see the doctor but had to pay BDT 200-300 (USD 0.21 to 0.31) to other staff for various things in the hospital today. I was with my mother for the CT test here, and that cost BDT 2000 (USD 21). And her other tests were done in private clinics, I don't know about those. But her tests, checkups and other costs are usually around BDT 5000 to 8000 (USD 51 to 81) a month. Some tests have to be done at this hospital, some outside". [37 years male, DH Bagerhat, FGD]

Patient satisfaction at the health facilities

Patient satisfaction was assessed utilizing PSQ- 18, under which positive and negative questions were asked to the exit interview participants in seven different domains.

Domain 1: Communication

Table 3.2.7: Patient satisfaction for the Communication domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors are good at explaining the reason for the medical tests					
CC	5 (3.65)	119 (86.86)	8 (5.84)	5 (3.65)	0 (0)
UHC	9 (7.14)	98 (77.78)	1 (0.79)	13 (10.32)	5 (3.97)
DH	8 (5.37)	96 (64.43)	9 (6.04)	35 (23.49)	1 (0.67)
Total	**22 (5.34)**	**313 (75.97)**	**18 (4.37)**	**53 (12.86)**	**6 (1.46)**
2. Doctors sometimes ignore my opinion while taking decisions about my treatment					
CC	6 (4.38)	45 (32.85)	5 (3.65)	81 (59.12)	0 (0)
UHC	1 (0.79)	20 (15.87)	5 (3.97)	99 (78.57)	1 (0.79)
DH	3 (2.01)	55 (36.91)	8 (5.37)	80 (53.69)	3 (2.01)
Total	**10 (2.43)**	**120 (29.13)**	**18 (4.37)**	**260 (63.11)**	**4 (0.97)**

Table 3.2.7 shows the overall responses to both the positive and negative questions asked to the participants under the communication domain. For the positive statement “Doctors are good at explaining the reason for the medical tests”, 313 (75.97%) patients agreed, and 22 strongly agreed, whereas, for the negative statement ‘Doctors sometimes ignore my opinion while taking decisions about my treatment”, 63.1% disagreed and 29.1% agreed.

Domain 2: Technical Quality

Under the “Technical quality” domain, for the negative statement “I am not very confident about the diagnosis of the doctors at times”, 79.4% of the participants disagreed whereas for the positive statement “When I go for medical care, they are careful to check everything when treating and examining me”, almost three- fourth (75.7%) of the participants agreed.

Table 3.2.8: Patient satisfaction in the technical quality domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. I think this health care facility has everything needed to provide complete care					
CC	4 (2.92)	19 (13.87)	9 (6.57)	78 (56.93)	27 (19.71)
UHC	5 (3.97)	45 (35.71)	12 (9.52)	48 (38.1)	16 (12.7)
DH	11 (7.38)	63 (42.28)	8 (5.37)	50 (33.56)	17 (11.41)
Total	**20 (4.85)**	**127 (30.83)**	**29 (7)**	**176 (42.72)**	**60 (14.56)**
2. I am not very confident about the diagnosis of the doctors at times					
CC	0 (0)	15 (10.95)	16 (11.68)	103 (75.18)	3 (2.19)
UHC	3 (2.38)	13 (10.32)	5 (3.97)	102 (80.95)	3 (2.38)
DH	2 (1.34)	10 (6.71)	10 (6.71)	122 (81.88)	5 (3.36)

Total	**5 (1.21)**	**38 (9.22)**	**31 (7.52)**	**327 (79.37)**	**11 (2.67)**
3. When I go for medical care, they are careful to check everything when treating and examining me					
CC	12 (8.76)	115 (83.94)	4 (2.92)	3 (2.19)	3 (2.19)
UHC	4 (3.17)	103 (81.75)	3 (2.38)	13 (10.32)	3 (2.38)
DH	10 (6.71)	94 (63.09)	3 (2.01)	40 (26.85)	2 (1.34)
Total	**26 (6.31)**	**312 (75.73)**	**10 (2.43)**	**56 (13.59)**	**8 (1.94)**
4. I have some doubts about the ability of the doctors who treat me					
CC	3 (2.19)	11 (8.03)	17 (12.41)	103 (75.18)	3 (2.19)
UHC	0 (0)	7 (5.56)	7 (5.56)	103 (81.75)	9 (7.14)
DH	0 (0)	8 (5.37)	3 (2.01)	122 (81.88)	16 (10.74)
Total	**3 (0.73)**	**26 (6.31)**	**27 (6.55)**	**328 (79.61)**	**28 (6.8)**

Domain 3: General Satisfaction

Under the "General satisfaction" domain, one positive statement and one negative statement were provided to the participants. The majority of the participants (75.97%) agreed with the positive statement "I am very satisfied with the medical care I receive here", whereas the majority (78.8%) disagreed with the negative statement "I am dissatisfied with something about the medical care I receive".

Table 3.2.9: Patient satisfaction for General satisfaction domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. I am very satisfied with the medical care I receive here					
CC	7 (5.1)	108 (78.8)	11 (8)	11 (8.03)	0 (0)
UHC	2 (1.59)	100 (79.37)	2 (1.59)	20 (15.87)	2 (1.59)
DH	6 (4.03)	105 (70.47)	4 (2.68)	31 (20.81)	3 (2.01)
Total	**15 (3.64)**	**313 (75.97)**	**17 (4.13)**	**62 (15)**	**5 (1.21)**
2. I am dissatisfied with something about the medical care I receive					
CC	1 (0.73)	10 (7.3)	3 (2.19)	122 (89.05)	1 (0.73)
UHC	4 (3.17)	21 (16.67)	2 (1.59)	99 (78.57)	0 (0)
DH	2 (1.34)	36 (24.16)	3 (2.01)	104 (69.8)	4 (2.68)
Total	**7 (1.7)**	**67 (16.26)**	**8 (1.94)**	**325 (78.8)**	**5 (1.21)**

Domain 4: Financial aspects

Under the "Financial aspects" domain, one positive statement "I am confident that I can get the medical care I need without being setback financially" and one negative statement "I have to pay for more of my medical care than I can afford" were given to the participants. Majority of the patients agreed (6.3% strongly agreed and 62.62% agreed) with the positive statement, whereas the majority disagreed (3.16% strongly disagreed and 59.2% agreed) with the negative statement.

Table 3.2.10: Patient satisfaction for financial aspects domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. I am confident that I can get the medical care I need without being setback financially					

CC	12 (8.76)	94 (68.61)	12 (8.76)	17 (12.41)	2 (1.46)
UHC	5 (3.97)	75 (59.52)	12 (9.52)	26 (20.63)	8 (6.35)
DH	9 (6)	89 (59.7)	20 (13.42)	24 (16.11)	7 (4.7)
Total	**26 (6.31)**	**258 (62.62)**	**44 (10.68)**	**67 (16.26)**	**17 (4.13)**
2. I have to pay for more of my medical care than I can afford					
CC	6 (4.38)	30 (21.90)	1 (0.73)	92 (67.15)	8 (5.84)
UHC	3 (2.38)	44 (34.92)	3 (2.38)	74 (58.73)	2 (1.59)
DH	15 (10.07)	52 (34.9)	1 (0.67)	78 (52.35)	3 (2.01)
Total	**24 (5.83)**	**126 (30.58)**	**5 (1.21)**	**244 (59.22)**	**13 (3.16)**

Domain 5: Accessibility and convenience

Under the "Accessibility and convenience domain", two positive statements and two negative statements were used to collect data from the participants. Majority of the patients (74% and 67.9% respectively) agreed with the two positive statements ("I get the healthcare providers whenever I need in this facility" and "I can avail health services from this health facility, whenever I need" respectively), whereas majority of the patients (57.2% and 75.9% respectively) disagreed with the two negative statements ("I had to wait a long time to get medical care" and "I face challenges to receive need-based health services from this facility" respectively).

Table 3.2.11: Patient satisfaction for accessibility and convenience domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. I get the health care providers whenever I need in this facility					
CC	9 (6.57)	105 (76.64)	8 (5.84)	14 (10.22)	1 (0.73)
UHC	7 (5.56)	93 (73.81)	4 (3.17)	21 (16.67)	1 (0.79)
DH	12 (8.05)	107 (71.81)	8 (5.37)	19 (12.75)	3 (2.01)
Total	**28 (6.8)**	**305 (74.03)**	**20 (4.85)**	**54 (13.11)**	**5 (1.21)**
2. I had to wait a long time to get medical care					
CC	0 (0)	21 (15.33)	1 (0.73)	108 (78.83)	7 (5.11)
UHC	4 (3.17)	40 (31.75)	2 (1.59)	76 (60.32)	4 (3.17)
DH	9 (6.04)	87 (58.39)	0 (0)	52 (34.9)	1 (0.67)
Total	**13 (3.16)**	**148 (35.92)**	**3 (0.73)**	**236 (57.28)**	**12 (2.91)**
3. I can avail health services from this health facility, whenever I need					
CC	24 (17.52)	89 (64.96)	2 (1.46)	20 (14.60)	2 (1.46)
UHC	18 (14.29)	94 (74.6)	3 (2.38)	9 (7.14)	2 (2.59)
DH	34 (22.82)	97 (65.1)	2 (1.34)	16 (10.74)	0 (0)
Total	**76 (18.45)**	**280 (67.96)**	**7 (1.7)**	**45 (10.92)**	**4 (0.97)**
4. I face challenges to receive need-based health services from this facility					
CC	5 (3.65)	24 (17.5)	1 (0.73)	103 (75.18)	4 (2.92)
UHC	3 (2.38)	16 (12.7)	3 (2.38)	101 (80.16)	3 (2.38)
DH	4 (2.68)	26 (17.45)	5 (3.36)	109 (73.15)	5 (3.36)
Total	**12 (2.91)**	**66 (16.02)**	**9 (2.18)**	**313 (75.97)**	**12 (2.91)**

Domain 6: Interpersonal manner

Under the "Interpersonal manner" domain, one positive statement "My doctors treat me in a very friendly and courteous manner" and one negative statement "I don't think the health care provider was careful about my privacy while examining me" were stated to the exit interview participants. A total of 52 (12.6%) participants strongly agreed and 299 (72.6%) agreed with the positive statement. At the same time, more than one- third of the patients (36.9%) agreed with the negative statement.

Table 3.2.12: Patient satisfaction for interpersonal manner domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. My doctors treat me in a very friendly and courteous manner					
CC	20 (14.60)	108 (78.83)	3 (2.19)	3 (2.19)	3 (2.19)
UHC	15 (11.90)	95 (75.40)	0 (0)	11 (8.73)	5 (3.97)
DH	17 (11.41)	96 (64.43)	5 (3.36)	31 (20.81)	0 (0)
Total	**52 (12.62)**	**299 (72.57)**	**8 (1.94)**	**45 (10.92)**	**8 (1.94)**
2. I don't think the health care provider was careful about my privacy while examining me					
CC	5 (3.65)	41 (29.93)	4 (2.92)	84 (61.31)	3 (2.19)
UHC	2 (1.59)	46 (36.51)	4 (3.17)	61 (48.41)	13 (10.32)
DH	1 (0.67)	65 (43.62)	10 (6.71)	54 (36.24)	19 (12.75)
Total	**8 (1.94)**	**152 (36.89)**	**18 (4.37)**	**199 (48.3)**	**35 (8.5)**

Domain 7: Time spent with doctor

Under the "Time spent with doctor" domain, 6.8% of the participants strongly agreed, and 75.4% agreed with the positive statement "Doctors spent plenty of time with me". Only 19.4% of patients agreed with the negative statement "Those who provide my medical care sometimes hurry too much when they treat me".

Table 3.2.13: Patient satisfaction for time spent with doctor domain

Questions	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors spent plenty of time with me					
CC	13 (9.49)	117 (85.40)	3 (2.19)	4 (2.92)	0 (0)
UHC	8 (6.35)	97 (76.98)	1 (0.79)	17 (13.49)	3 (2.38)
DH	7 (4.7)	97 (65.1)	2 (1.34)	38 (25.5)	5 (3.36)
Total	**28 (6.8)**	**311 (75.49)**	**6 (1.46)**	**59 (14.32)**	**8 (1.94)**
2. Those who provide my medical care sometimes hurry too much when they treat me					
CC	0 (0)	14 (10.22)	3 (2.19)	118 (86.1)	2 (1.46)
UHC	2 (1.59)	19 (15.08)	0 (0)	97 (76.98)	8 (6.35)
DH	3 (2.01)	47 (31.54)	1 (0.67)	93 (62.42)	5 (3.36)
Total	**5 (1.21)**	**80 (19.42)**	**4 (0.97)**	**308 (74.76)**	**15 (3.64)**

The perception of community members regarding the quality of healthcare provided at CCs in all sites visited was generally positive. Community members were found to understand the limited scope of care that can be provided at CCs, and their expectations of the care that they can receive was found to be attuned to the same. With this understanding of the scope of care they

can receive at these facilities, community members in most sites stated that they thought the healthcare providers at these facilities were sufficiently devoted to their duties, provided the patients with enough consultation times and showed positive attitudes towards them. They also mentioned that the healthcare providers at the CCs were to be reached whenever they needed any help even through phone calls.

In Netrokona however, community members stated that the healthcare providers at their CC change frequently, and that not all healthcare providers who join the facility provide satisfactory services. A frequent changing of healthcare providers at CCs was not observed to be the case in all sites however, with the CHCP in the CC visited in Ulipur (Rangpur) stating that she had been acting in this role at her facility for almost 11 years, in a KII.

Some CCs visited, in particular the Shoronkhola CC, also suffered from infrastructural problems i.e, being constructed lower than street level. This causes problems of waterlogging during the rainy season, when water enters the clinic itself. This was not found to be a problem only with CCs, as the Ulipur (Rangpur) Upazilla Health Complex was also found to have the same problem (although the complex does not face the problem of water entering the complex itself, as it is raised above ground level and is also multi-storied). In Barguna (Barisal), a community member stated about their local CC:

> *"We need a person who can perform deliveries here. The clinic has equipment for performing deliveries, but no one to do it." [31 years female, CC Barguna, FGD]*

In the instance that the necessary care for a patient was not possible to be delivered at a CC, the patient is referred to the nearest "hospital" (which was the term used by almost all community members spoken to, to refer to the nearest UHC). Community members in Shoronkhola mentioned that the healthcare providers in their CC refer them to specific doctors at the Shoronkhola UHC, when referral is necessary.

The problems of understaffing (relative to the designated number of personnel for the facility, not relative to the volume of patients seen) was observed to be less acute in DHs than UHCs. A proportionate decrease in the sense of mistrust or dissatisfaction amongst service seekers however could not be observed, as the experience of waiting in long queues, the sense of not having been given sufficient attention by a doctor and general dissatisfaction with the services provided by hospital staff other than doctors was observed to be present. Participants of an FGD in Kurigram shared experiences of having to visit the local DH on multiple occasions before they were able to secure a consultation with a doctor, for example. At the same time, service seekers from areas adjoining DHs who were accustomed to visiting the hospital for healthcare services often, were found to have preferences for particular healthcare providers whom they deemed to be "actually good doctors". Trust and satisfaction with the care received therefore, was found to vary across different instances of receiving healthcare from a DH, even for the same individual

3.3 Supply side challenges to delivering health services

In order to identify the supply-side challenges, a total of 23 KIIs with healthcare providers/ health facility managers and 23 facility assessments were undertaken in all three types of healthcare facilities in the study sites.

Challenges related to lack of human resources and patient overload

CCs are placed at the grassroots level of Bangladesh. KII findings suggest that CHCPs were the prime healthcare providers at the CCs in all eight catchment areas. They were accompanied by Family Welfare Assistants (FWAs) and Health Assistants (Has), but only for 3 days a week. CHCPs were found to be responsible for overall coordination, management, and service delivery; FWAs managed the family planning services; HAs took care of the vaccination services at the CCs. During the interviews, all the CHCPs shared that they were not being able to perform efficiently due to workload as they had to manage three times more patients than their capacity due to insufficient number of CHCPs in the CCs. A CHCP shared,

> *"Ward numbers 1, 2, and 3 fall under the coverage area of this Community clinic. But I get patients from six other wards of this area, as they don't have a community clinic. On paper, the coverage population is 6000, but it reaches to almost 18000 people for this facility. Three times the workload for us."* [CHCP, Manikganj, CC, KII]

Seven out of eight CHCPs also shared that they struggle to fulfill their responsibilities due to a lack of staff at the facility. Only one CHCP is posted per CC, which is not enough given the responsibilities they need to fulfill. One CHCP mentioned,

> *"Three staff members are posted here including me. But FWA and HA are stationed at the facility only for three days a week. In reality, they come to the facility once or twice a week as they have other responsibilities to fulfill. Especially during the EPI season, HAs can barely manage time to come here. It is absolutely difficult to manage the workload at that time…"* [CHCP, Chapainawabganj CC, KII)

As the sole healthcare provider at the facility, oftentimes it becomes very difficult for a CHCP to maintain the functional opening hours of the CC, especially when they fall sick or if there is a family emergency. While exploring more, five out of eight CHCPs mentioned that they had to keep the facility closed for a day or more due to personal reasons as there was no one else to replace them. KII participants also shared the need for female CHCPs or healthcare providers at the CCs. Given the rural context, at times it is challenging for the male CHCPs to provide services (especially family planning and SRH) to female users.

> *"Women cannot ask for 'Shukhi' tablets or condoms from a male provider. They feel shy about it. I have an assistant, and patients ask her about these. I have a personal assistant who is not appointed by the government. I have to pay her salary personally."* [CHCP, Chapainawabganj, CC, KII]

Health care services (both indoors and outdoors) at the UHCs are delivered mainly by the medical officers. Also, there are other healthcare personnel such as Sub Assistant Community Medical Officer (SACMO), nurse, technician, pharmacist etc. One senior medical officer monitors and supervises all the activities along with his/her regular duties of serving the patients. All seven key informants from the UHCs shared that previously there was a shortage of medical doctors at their facilities, however, the scenario has improved in recent times.

There is patient load leading to long waiting times and less consultation time for the patients. Findings from KIIs suggest that on average, healthcare providers could allocate only 2-3 minutes for consultation with the patients, whereas they understand they should have provided at least 10 minutes to each of the patients. On average, 300- 400 patients visit outdoor facilities

within a short time span of only 4 hours, whereas they have the capacity to manage 100 patients outdoors every day.

KII findings also suggest that the number of consultants available at the UHCs was not enough, making it challenging to deliver the required health services. Key informants from Khagrachari UHC reported that there were never any ENT or Eye specialists at their health facility. As a result, many users prefer to go to the DHs rather than coming to the UHC, even though it is closer to their homes. Another major challenge was vacant posts for technicians, support staff, and cleaners at the facility. One of the key informants shared,

> *"If you talk about a lab technician, this position has been vacant for 7-8 years. Since January, the one currently working here mainly carries out malaria and dengue tests. As we did not have a lab technician for many years, resources were not allocated in the labs. Thus, many tests could not be carried out."* [Medical Officer, Chapainawabganj, UHC, KII]

The superintendent at the DH takes care of the administrative and financial duties of the facility. Resident Medical Officers (RMOs) from three DHs mentioned that along with their responsibilities of providing health services, they also handle the hotline phone number of the hospital (a hotline number that is available for general people to call for hospital-related information). This added responsibility acts as a burden for the medical officers to concentrate on his/her primary responsibilities. During an informal discussion of 15 minutes with one RMO, the research team observed that six phone calls from service users came to him, and he responded to all those calls. Sufficient number of health care providers are posted at DHs and at present there are no vacant posts for medical doctors. One of the key informants from DHs shared,

> *"Previously, the facility faced immense challenges with human resources but at present, the situation has improved. An adequate number of doctors have been appointed after the placement of 42nd and 44th BCS cadres. In addition, this facility is being upgraded to a 250-bed hospital from 100 beds, so consultants are being placed here- even though the full up-gradation process will take some time."* [Superintendent of DH, Netrokona, KII]

KIIs findings suggest that in DHs, medical doctors face challenges to deliver satisfactory health services to the service users due to patient overload, which varies between 400- 600 at outdoor facilities. Similar to the outdoor, there is patient overload in indoor wards. Due to a large number of admitted patients, healthcare providers cannot accommodate them in beds, and patients are kept on the floors of the wards or in the corridors affecting patient satisfaction, shared by six out of eight key informants. One of them illustrated,

> *"People come here from several districts and Upazilas. Though this facility has a capacity of 250 beds, there were times when we had 400 admitted patients. There are 17 lacs people living in the Manikganj district. There are service users from neighboring districts as well. So around 20 lakhs people receive healthcare services from this hospital."* [Superintendent of DH, Manikganj, KII]

Similar to the UHCs, key informants at the DHs also mentioned not being able to provide sufficient consultation time to the patients. KIIs findings also revealed that there is a constant lack of skilled laboratory technicians in the DHs who can undertake the diagnostic tests, radiologists for X-ray and Ultrasonography (USGs), and cleaner/ support staff. In two of the

DHs, USGs couldn't be performed due to the absence of a sonologist. Even after having an ICU-equipped ambulance, it is nonfunctional in Netrokona, due to a lack of trained technologists.

Facility assessment documented that twenty-one out of twenty-three health care facilities were functional during operational hours. Six out of eight CCs were open on the day of data collection and the rest two were closed, as there were some emergency/ personal issues with the CHCPs. The team had to visit the facility on a subsequent day to conduct KII and facility assessments. Patient load was notably high in all three types of health facilities. In CCs, CHCPs were seen to receive patients one after the other without any interval. In UHCs and DHs, the crowd of patients was noticeable as well. Long waiting times, long queues at the ticket counters and at the pharmacy, and crowds in waiting rooms were observed in all facilities. In indoor facilities, patients were seen to be on the floors of different wards and in the corridors due to the number of admitted patients surpassing the original capacity.

Two of the eight CCs lacked HAs and only one CC did not have any FWA. FWA was present in only one of the CCs, even though it was the day for FWAs to be present at the facilities in three other CCs. The current positions were filled but they were absent from the facility on the designated day, which added pressure on the CHCPs. Number of medical doctors and nurses were sufficient in the UHCs and DHs. However, the lack of technicians and radiologists were evident in the majority of the UHCs and DHs. In three of the UHCs, USGs couldn't be performed as there were no radiologists. A similar situation was observed in two of the DHs. Assessments also noted an overall insufficiency of specialized doctors in UHCs and DHs. It was clear in the case of Khagrachari DH, where no ENT and Eye specialist were ever placed to fill the position.

Provision of health services at the health facilities

CCs deliver very basic and primary healthcare services to common people. Basic primary healthcare services like, diagnosis and treatment of minor illnesses, antenatal care, postnatal care, normal delivery care (not in all CCs), nutritional counselling, menstrual counselling, and vaccination services are delivered at the CCs. Along with these, skin and eye care and referral services are also provided. One of the focus areas of the CCs are family planning services, where FWAs are engaged extensively. However, none of the CHCPs could mention any specific facilities for any special groups of people, such as persons with disabilities. They did not get any disability-specific training and thus experience challenges when they get patients with disabilities. As they do not offer any advanced management and treatment for persons with disabilities, such patients are referred to UHCs or DHs.

All the key informants from the UHCs mentioned that their facilities provide services through emergency, outdoor, and indoor departments. Management of pregnancy and delivery related complications, management and treatment of cancer patients, dental care, eye care, ENT care, mental health services, diagnosis of breast cancer etc. are the additional services that are available in the UHCs. UHCs are also responsible for the management of COVID-19 vaccinations, which at times is an added burden for them. One of the Key informants from an UHC shared,

"We are already overburdened with so many responsibilities and patients. Now we must take care of the COVID-19 vaccines as well. You see, the vaccines need to be preserved in a specific temperature and if you do not maintain it, the effectiveness will no longer be there. We do not have that facility at the UHC, still we are trying…" [Medical Officer, Netrokona UHC, KII]

When the research team explored if the UHCs provide any specialized services or facilities for any marginalized groups such as persons with disabilities, the key informants mentioned they do not provide such services. Like the CHCPs, medical doctors at the UHCs do not receive any disability-specific training. However, they mentioned that they have heard about these initiatives. Three out of seven were hoping to get this training soon which will likely minimize the challenges to provide disability-friendly health services at the UHCs.

Similar to the UHCs, DHs provide services through the Emergency department, indoor and outdoor facilities. Emergency patients are taken directly to the emergency care, whereas, all other patients are managed at the outdoor allied chambers as per their need. The main features of the indoor section are Surgery (including Eye, ENT, and Orthopedics), Medicine (including Psychiatry, Cardiology, Pediatrics, and Internal medicine), and Gynecology and obstetrics. The indoor wards are further subdivided into male and female wards. Along with these, DHs have some specialized services which are not available at the UHCs- High Dependency Unit (HDU), Coronary Care Unit (CCU), and Intensive Care Unit (ICU) (in a few of the DHs). Three of the eight key informants shared that even though they have a provision to have ICU beds, ICU was only installed a few months back during the COVID-19 pandemic. One of them mentioned,

"There are two ICU beds here which were opened during the surge of the covid-19 pandemic and were designated only for the covid-19 affected patients. During the peak of the outbreak, it was a dedicated hospital for the treatment of COVID-19." [Superintendent, Manikganj, DH, KII]

DHs also have some special facilities for persons with disabilities (discounts for laboratory tests and operations) and they are prioritized during receiving services, as mentioned by four out of eight key informants. However, two of them shared that they do not have any special facilities for any special group. One of them said,

"…no, persons with disabilities do not receive any special services. They can avail the services like all other patients. Special treatment for patients with Autism like physiotherapy or speech therapy is not available in this hospital. There was a project under DRRA, funded by the USAID to assist persons with disabilities. They used to provide physiotherapy. But the project has ended." [Superintendent, Manikganj, DH, KII]

Availability of health services documented during the facility assessments are shown in Table 3.3.1. Health services available at the CCs are available at the UHCs, and DHs but in an upgraded and more specialized format. Few of the health facilities from each type lack some of the services provisions, due to challenges like lack of specialized doctors or lack of any specific service protocol. Under each of the cells of health services and health facility types, availability is highlighted with green, if delivered from at least four out of eight facilities. Whereas, the cells are highlighted in red with the number of facilities not providing the services. Few of the health facilities are not designed to provide few of the health services (for example: CCs are not designed to do Caesarean sections), those cells are kept empty without any highlights.

Table 3.3.1: Availability of health services by type of health facilities

Available health services at the facility	*Health facility type*		
	Community Clinic	*Upazila Health Complex*	*District hospital*
1. Antenatal care			
2. Postnatal care			
3. Delivery care			
Normal vaginal delivery	*Unavailable in four out of eight CCs*		
Caesarean section			
Assisted normal vaginal delivery			
4. New-born care			
5. EPI vaccination			
6. Nutritional counselling			
7. Family planning services			
Short-term temporary family planning services			
Long-term temporary family planning services			
Permanent family planning services			
8. Menstrual hygiene-related counselling			
9. Health education through a community outreach program		*Unavailable in five out of eight facilities*	
10. Identify and manage obstetric emergencies			
Pre-eclampsia	*Identification and referral*		
Eclampsia	*Identification and referral*		
Antepartum haemorrhage	*Identification and referral*		
Postpartum haemorrhage	*Identification and referral*		
11. Menstrual regulation			
12. Post-abortion care and management		*Unavailable in three out of seven facilities*	
13. Diagnosis and management of sexually transmitted diseases	*Diagnosis and referral*		
14. Diagnosis and management of non-communicable disease			
15. Adolescent-friendly health services			
16. Mental health services		*Unavailable in three out of seven facilities*	
17. Eye care		*Partially available*	
18. Dental care			
19. Emergency healthcare			
20. Outpatient services			
21. Inpatient services			
22. Coronary Care Unit (CCU)		*Nonfunctional in 3 out of 7 UHCs*	
23. High Dependency Unit (HDU)		*Nonfunctional*	

		in 3 out of 7 UHCs	
24. Intensive Care Unit (ICU)			
25. Referral services			
26. Ambulance services			
Health services available in at least four or more of the health facilities			
Health services unavailable in at least four or more of the health facilities			

Shortage of medicine and equipment at the health facilities

CHCPs mentioned during the interviews that 28 types of medicines are provided free of charge to the patients as per their needs. Directorate General of Drug Administration of Bangladesh Government is responsible for medicine supply for the CCs based on the requisition they received from the CHCPs. CCs receive medicines every 2- 3 month based on the population coverage area (around 6000 people). However, often supplied medicines are not enough due to the huge patient load and pose a challenge for the CHCPs. During the interviews, one of them shared,

> "The medicines that we prescribe are very minimal. The supply we get is based on the coverage area. In order to manage an extra load of patients with this stock of medicine, we supply a few doses for free and the rest are advised to buy from outside. I understand that this is a burden for the patients, as they are very poor. But I do not have any other alternatives." [Community Health Care Provider, Shoronkhola, CC, KII]

Findings from the KIIs also revealed the challenges CHCPs experience regarding the availability of necessary equipment such as a thermometer, stethoscope, blood pressure machine, diabetic strip, gauge, and bandages. Five out of eight CHCPs shared that this struggle has been conveyed to the higher authorities many times, but improvements are yet to happen. One of them shared,

> "We only have a weight machine and a blood pressure machine. Earlier, we were given first aid kits for stitching wounds but that's no longer available. If we were given a regular supply of this equipment, we would have been able to provide better services and refer a smaller number of patients to UHCs." [Community Health Care Provider, Mohalchari, CC, KII]

Along with the essential medicines, UHC provides free medicines for diabetes, high blood pressure and a few skin diseases. These free medicines can be availed from the hospital pharmacy with the prescriptions provided by the medical doctors. The stock and frequency of medicine supply have increased since the beginning of 2022. However, challenges still exist due to the extreme patient load at UHCs, same as the CCs. In terms of equipment, UHCs are self- sufficient, mentioned by the key informants, except for specialized orthopedic equipment. They usually ask the patients to get such equipment from outside or refer them to the DHs.

With a sufficient stock of medicines, DHs try to provide free medicines to all the patients in need. However, the majority of the patients treated in DHs are usually in critical conditions and require long term medications support as compared to the CCs and UHCs. As a result, all types of medicines cannot be provided to them. One of the key informants shared-

> "We have a list which we need to follow to provide free medications. All other prescribed medicines out of the list need to be purchased by the patients. They need to buy these from outside. Sometimes, they require heavy doses of antibiotics which are costly. We understand

that. But we do not have the supply of these medicines to give them free of charge. As a result, patients do not buy all the medicines as prescribed leading to non- compliance and later blame the doctors for their medical situation." [Superintend, Shoronkhola, DH, KII]

Three key informants reported that sometimes important medical equipment is not functional in the DHs, which causes another challenge. In one of the DHs, it was documented that advising USG especially for pregnant mothers was tricky, as the only USG machine was not functional. Anyone who needed an USG, had to go outside to do the test from private facilities. This added financial burden on those patients. Considering this, oftentimes the healthcare providers resisted to advise USG, even if it was warranted for proper diagnosis of the patient. One of the key informants shared,

"Many such patients never came back to follow up. Either they went to another doctor, where radiological tests are available, or they just chose not to do the test and see the doctor anymore." [Resident Medical Officer, DH, Netrokona, KII]

The only way to assess the supply of medicines was the information shared by the key informants as the number of medicines could not be observed directly. However, the equipment and materials were observed, and quantity and quality of each item were documented in the checklist. Five out of seven UHCs and seven out of eight DHs had an X-ray machine and USG machine. The only USG machine in Netrokona DH was nonfunctional for more than 18 months and couldn't be replaced due to bureaucratic complications. Findings for other equipment and material are shown in Table 3.3.2.

Table 3.3.2: Material and equipment by type of facility

Facility type	Materials and equipment		Quantity		Condition
		Not seen	Not enough	Enough	
Community Clinic	1. Gloves	Three out of eight	Four out of eight	Only in one	
	2. Syringes and needles	-	Five out of eight	Three out of eight	
	3. Blood pressure cuffs	Three out of eight		Five out of eight	
	4. Thermometers	Two out of eight		Six out of eight	
	5. Weight scales	-	Three out of eight	Five out of eight	Three of those weight scales seems nonfunctional
	6. Gauze	One out of eight	Three out of eight	Four out of eight	
	7. Stethoscope	One out of eight	Four out of eight	Three out of eight	Seems nonfunctional
	8. Neonatal resuscitation kit	Five out of eight		Three out of eight	
	9. Measuring tape			All eight	
	10. Glucometer	Two out of eight	Three out of eight	Three out of eight	

Facility type	Materials and equipment	Quantity			Condition
		Not seen	Not enough	Enough	
Upazila health complex	1. Gloves, Syringes and needles, Blood pressure cuffs, Thermometers, Weight scales, Gauze, Catheters	-	-	All eight	
	2. Delivery kit for childbirth	-	One out of seven	Five out of seven	
	3. Neonatal resuscitation kit	-	One out of seven	Five out of seven	
	4. Laboratory equipment and supplies	-	Two out of seven	Five out of seven	
	5. ECG machine	One out of seven	Three out of seven	Three out of seven	Machines seem to be very old with technical faults. Needs improvement
	6. Xray machine	One out of seven	Two out of seven	Four out of seven	One UHC had nonfunctional X-ray machine
	7. USG machine	Two out of seven	-	Five out of seven	
	8. Operation theatre equipment		All seven		
District hospital	1. Gloves, Syringes and needles, Blood pressure cuffs, Thermometers, Weight scale, Gauze, Catheters	-	-	All eight	
	2. Delivery kit for childbirth, Neonatal resuscitation kit			All eight	
	3. Laboratory equipment and supplies		One out of eight	Seven out of eight	
	4. ECG machine		Three out of eight	Five out of eight	Few of the nonfunctional ECG machines were seen
	5. Xray machine		Two out of eight	Six out of eight	One of the X-ray machine was nonfunctional
	6. USG machine			All eight	One of the USG machine was nonfunctional
	7. CT Scan machine	Two out of eight		Six out of eight	
	8. Operation theatre equipment		Two out of eight	Six out of eight	Light source of OTs needs to be improved

Infrastructure and utility related challenges

Another challenge shared by the CHCPs to deliver healthcare services was the insufficient number of rooms in the health facilities. At the CC level, the facility is usually constructed with only one consultation room and one waiting room, even though there are provisions for an antenatal checkup room and washroom. Shoronkhola CC building is established in a low land

and much below from the main road which is flooded during the rainy season or any other time when it rains due to water clogging and patients can not access the health facility. Sunamganj CC is also built in a low-lying area making it flood prone and inaccessible during the rainy season. Khagrachari CC is built in an area that is far from the main locality and difficult to reach by foot.

There is no separate area to store medicines and equipment. CHCPs also shared that sometimes they have to provide consultation to 3 or 4 patients at the same time because of patient load. Cleanliness of the CCs and medical waste management need to be improved as per the CHCPs' opinion. Some of them also shared that although there should be a cleaner in each CC, this post remains vacant in most of the cases. Five out of eight CHCPs shared that there is no proper waste disposal mechanism, and this duty is an added burden for them. One CHCP shared,

> *"The used syringes from EPI services are collected and sent to the Upazila Health Complex for proper disposal. The other wastage that we collect is burnt and then buried under the ground. We don't have any other mechanism to ensure waste disposal."* [CHCP, Chapainawabganj, CC, KII]

KII participants also shared that there are utility-related challenges in the CCs such as constant power cuts and insufficient to no water supply. Due to constant power cuts, many times they cannot take care of the patients properly. One CHCP stated,

> *"Look at the electricity bills. I am already concerned with an insufficient water supply, and power cut issues. Now, I do not know where to go with these electricity bills. There is no one who can help."* [CHCP, Shoronkhola CC, KII]

CCs are established based on a public-private partnership where the Government is responsible for the supply of human resources, medicines, and equipment whereas other responsibilities related to functioning/operation lie with the management committee and local people. However, none of the CHCPs were clear on which body of the partnership is responsible to deal with the utility-related challenges they are experiencing.
Another challenge shared by the key informants was the insufficient number of rooms in the UHCs, which include consultation room, waiting area, washroom, breastfeeding corner, diagnostic room, and adequate number of beds in the indoor wards. Consultation rooms are not adequate or functional (in some cases), considering the number of patients and medical doctors. Two or three doctors share the same consultation room, which is a distraction during providing services for the health care providers and not always comfortable for the patients.

Facility assessments noted similar findings as the KIIs in terms of the number of rooms in the health facilities. CCs rarely had all four rooms as per provision- consultation room, waiting room, ANC check-up room, and washroom. Oftentimes, there is more than one patient in the consultation room, and due to the lack of an ANC check-up room, CHCPs use the same room for ANC/ PNC care exposing the patient. None of the UHCs had adequate consultation rooms for the medical doctors. Two- three doctors were seen to provide services in the same room, violating the privacy and confidentiality of the patients. At times, there were five to six patients along with their attendants in the consultation rooms.

The key findings from facility infrastructure and cleanliness were obtained from the facility assessments, which are discussed in Table 3.3.3 by type of health facility.

Table 3.3.3: Facility infrastructure by type of health facility

Type of health care facility and rooms	Availability and number	Condition
Community clinic		
Consultation room	Available in all eight CCs	● Four of the consultation rooms were good in condition with good lighting sources and equipment ● Two lacked good lighting sources and need improvement ● Two were placed in the waiting area rather than utilizing the consultation room
ANC check-up room	Available in four out of eight CCs	● ANC check-up rooms lacked proper ANC check-up bed and stairs for pregnant mothers ● The remaining four out of eight CCs were being used as a storeroom for medicine storage
Waiting room	Available in all CCs	No proper seating arrangements and chairs
Washroom	Available in two out of eight CCs	● Lack of water supply, the door lock was not working, and proper cleanliness was not ensured
Upazila health complex		
Emergency room	Available in all seven UHCs	Rooms were not enough. Extremely crowded with an inadequate number of beds and examination areas; cleanliness not maintained properly in four of the UHCs
Outdoor consultation room	Available in all seven UHCs; inadequate in number	Crowded with patients as three to four doctors share the same consultation room
Patent examination rooms	Available in all seven UHCs; inadequate in number	Separate examination rooms were observed only in three UHCs; others were shared with the consultation rooms and overcrowded with patients and attendants
ANC/ PNC room	Available in all seven UHCs	Improvements are required to ensure the privacy of the patients
Labor room	Available in all seven UHCs; inadequate in three UHCs	● Labor rooms were not well maintained ● Improvements required in terms of cleanliness ● Number of beds in labor rooms were not enough
Delivery room	Available in all seven UHCs	Lack enough lighting and cleanliness
Operation theatre (OT)	Available in all seven UHCs; inadequate	● Three out of seven UHCs lack an adequate number of Operation theatre ● OT in one of the UHC was not being used due to non-functional lighting sources
Male ward- Female ward	Available in all seven UHCs; Inadequate number of beds	● Number of beds in each ward was not enough ● Patients were seen to be on the floor or in the corridors
Waiting room	Available in all seven UHCs	● Cleanliness was not maintained ● Chairs and other seating arrangements were faulty ● No separate waiting areas for persons with disabilities were observed in a few of the UHCs
Breastfeeding corner	Available in six out of seven UHCs; condition not good	● Four out of six available breastfeeding corners were locked ● Two were open but no one was observed to be utilizing the room ● Cleanliness was not maintained
Washrooms	Available in all seven	● Separate washrooms for males and females were

	UHCs, condition requires improvement	not observed in one of the UHCs ● Separate washrooms for persons with disabilities were not observed in five out of seven UHCs ● Washrooms lacked proper water supply, lighting, and door locks ● Cleanliness was not maintained in any of the UHC washrooms
District hospital		
Emergency room	Available in all eight DHs; inadequate in number	Extremely crowded rooms and privacy of the patients were not being ensured
Outdoor consultation room	Available in all eight DHs; inadequate in number	Crowded with patients as two to three doctors share the same consultation room
Patent examination rooms	Available in all eight DHs	Separate examination rooms were observed in five DHs; others were shared with the consultation rooms
ANC/ PNC room	Available in all eight DHs	Improvements required to ensure the privacy of the patients
Labor room	Available in all eight DHs	Labor rooms were not well maintained in terms of cleanliness
Delivery room	Available in all eight DHs	Improvements required in terms of cleanliness
Operation theatre	Available in all eight DHs	OT in three of the DHs needs improvements in terms of equipment and light sources
Male and Female wards	Available in all eight DHs	Number of beds were inadequate; patients were observed to be on the floor or in the corridors
Waiting room	Available in all eight DHs	Separate waiting areas for males and females and persons with disabilities are required
Breastfeeding corner	Available in seven out of eight DHs	● Four of the breastfeeding corners were non-functional and were locked ● Three lacked comfortable seating areas for the lactating mothers
Psychosocial counselling room	Available in seven out of eight DHs; nonfunctional	● Three of the counselling rooms were locked ● Two were open but were being used for other purposes
Adolescent counselling room	Available in three out of eight DHs	Rooms were locked and were not seen to provide any services
VIA/ PAC room	Available in seven out of eight DHs	● Locked in two DHs ● Improvements required in the rest of the DHs in terms of cleanliness
USG room	Available in all eight DHs	● Locked in one of the DHs, as the machine was non-functional
Blood transfusion room	Available in all eight DHs	-
Pharmacy	Available in all eight DHs	-
Washrooms	Available in all eight DHs; improvement required	● Separate washrooms for males, females, and persons with disabilities lacked in two of the DHs ● Washrooms lacked proper water supply and lights ● Cleanliness was not ensured

Lack of proper information dissemination system and feedback mechanism

Majority of the key informants shared that lack of information about the service availability among the service users is a big challenge. Lack of Citizen Charter or information boards at the CCs lead to a lack of information dissemination and thus patients directly inquire about these services to the CHCPs. A proper Citizen Charter or information board with available services and diagnostic tests are required in every CC, mentioned by several CHCPs.

UHCs try to disseminate information through Citizen Charters and service-related notice boards and posters. Four out of seven key informants discussed that even though there are notice boards/ Citizen Charters etc., only a few of them are readable due to placement issues, font and colors of the boards, and language barriers. Also, most of the service users are not literate enough to read through the boards and hence try to discuss their queries with healthcare providers. Health providers also try to disseminate service- related information during their consultations. One of the medical officers shared,

> *"Citizen Charter is available as you can see. Such as in VIA, there are notices about why VIA needs to be done. If we find any patients in the outdoor section, we explain to them through counseling and do tests. We have targets regarding these treatments."* [Medical Officer, UHC, Khagrachari, KII]

KIIs findings revealed that UHCs had the provision of a 'Complaint box'- where service users can share their feedback in written format. These complaint boxes are being actively taken care of during the committee meeting and they try to address all the complaints or issues charged against the health facility.

Three of the key informants from UHCs shared a different view, that they have never seen patients using the complaints box or providing any constructive feedback. The main reason behind this was found to be a lack of knowledge about the existence of such a complaint box in the facility, and lack of trust among community people that any appropriate actions will be taken against their complaints.

DHs disseminate information about health services through information desk/hub, Citizen Charters. Also, there are monitors displaying necessary information on health services. DHs also have the provision of hotline numbers for the patients, where they can call for assistance during an emergency. Three out of eight key informants from DHs shared, they have notice boards, monitors, and Citizen Charters. However, only a few of them are readable, due to very old boards with coloring problems, language barriers, and placement issues and those boards don't really serve the purpose for which these are meant for. However, with the assistance and guidance from the BHW initiative, they are trying to bring about some changes to this. Superintendent of one of the DHs explained-

> *"There is a monitor in the reception area with all information about the available services written on it. The facility is also planning to make Citizen Charters about their services to inform people about the services available along with the costs associated with it. We have also planned to replace the old charts and boards, which are no longer readable with new boards."* [Superintendent of DH, Khagrachari, KII]

In order to disseminate health related information to a wider network, DHs have also circulated their hotline numbers through social media, newspaper, and website. Even though this strategy

is helping the service users, this is a new challenge from the supply side. There is no designated person to handle this hotline number and one resident medical officer/ medical officer carries the phone with him. He answers to all the calls, as mentioned earlier affecting his responsibilities as a doctor.

Similar to the UHCs, DHs also have the provision of a 'Complaint box'- where service users can share their feedback in written format. During the KIIs, it was shared that the complaint boxes are being actively taken care of during the committee meeting and they try to address all the complaints or issues charged against the health facility.

> *"If any patient wants to give recommendations or complaints, there is a complaint box. Our head of this clinic set up the complaint boxes. He visits our hospitals once every month and collects the complaints."* [Superintend, Chpainawabganj, DH, KII]

There is a quality improvement committee with representatives from all cadres of health care providers in the DHs. This 15- member committee organizes a meeting once a month, where previous reports are reviewed, and new plans are undertaken for improvement of the facility. Committee members who attend the meeting, give their feedback in a written format for further documentation. Key informants from DHs also shared their utility related concerns. Even though water supply is adequate, the main challenge is the frequent and long duration of power cuts- affecting diagnostic tests, blood preservation, radiological procedures, and ongoing operations. Many a time, this has been conveyed to the upper-level officials through this quality improvement committee, but no drastic changes have taken place yet, shared during the KIIs. One on them mentioned,

> *"We are trying to improve the overall condition of the health facility. But we don't know what the patients want in a facility. We don't have any representatives from their end. Including one or two members from the community might enlighten us about the requirements from the service users and reduce the challenges we both (service users and healthcare providers) face."* [Superintend of DH, Sunamganj, KII]

To disseminate information about service availability, CCs, UHCs, and DHs had notice boards and Citizen Charters. In addition to these, digital monitor broadcasting information could be seen in only one of the UHCs and five out of eight DHs. However, different aspects were noted during the assessments which made it difficult to serve the purpose of these boards/ Charters. Table 3.3.4 shows the situation of information dissemination strategies by types of facility. Areas requiring improvements are highlighted in red.

Table 3.3.4: Current situation of information dissemination strategies by types of facility

Information dissemination strategies	Community Clinic	Upazila Health Complex	District hospital
Citizen Charter/ Information board			
Placement of the charter/ board at the facility	Only one at the gate of the facility	Multiple charters at different places of the facility	Multiple charters at different places of the facility
Language and wording of the charters/ boards	Hazy, small fonts, and not reader friendly in four out of eight CCs	Few of the boards and charters are hazy and not reader friendly in five out of seven UHCs	Few of the boards and charters are hazy and not reader friendly in four out of eight DHs
Font size and colors			
Overall condition	Old charters and	Old boards need to be	Old boards need to be

	boards need to be replaced and requires overall improvement	replaced and requires improvement	replaced and requires improvement
Posters/ banners related to health conditions			
Placement of posters at the facility	Posters were not placed in a place where users can see it in five out of eight CCs	Posters are placed within service user's visibility	Posters are placed within service user's visibility
Language and wording Font size, colors, and pictures	Hazy, small fonts, and not reader friendly in three out of eight CCs	Few of the posters are old and colors, fonts, pictures have faded	Few of the posters are old and colors, fonts, pictures have faded
Overall condition	Requires repositioning and replacement	Partial improvement required	Partial improvement required
Digital monitors			
Placement of the monitors	No digital monitors at CCs	Observed only in one of the UHC- reception area	Observed in five out of eight DHs
Completeness of the information		Only the name of services was being displayed	Cost of the services, name of the doctors was not incorporated
Sound and quality		Difficult to heard beyond a distance of 8- 10 meter	Difficult to heard beyond a distance of 8- 10 meter
Overall conditions		All UHCs needs digital monitors	Subsequent improvement in sound and quality is required

In order to assess the feedback mechanism, the complaints boxes in each facility were checked and their conditions were documented. Table 3.3.5 explains the feedback mechanism seen at each type of facility.

Table 3.3.5: Assessments of the feedback mechanism by types of facility

Criteria	Community Clinic	Upazila Health Complex	District hospital
At least one complaint box at the facility	No complaint boxes were seen any of the CCs during the facility assessments	Observed in five out of seven UHCs	Observed in six out of eight DHs
Placement of the complaint box	-	Three of the boxes were visible and placed at the entrance; rest two could be found at the end of the facility in a narrow corridor	Five were seen at the entrance- beside the main stairs/ reception area; one found beside the consultation rooms
Condition	Complaint boxes needs to be installed	Locks of the boxes are broken, surrounded by cobwebs, seems to be non-functional	Locks of four boxes were broken, one was filled with dirt, and one seemed to be functional

3.4 Initiatives undertaken by Bangladesh Health Watch

Established in 2006 as a citizen's forum concerned with the health sector of the country, Bangladesh Health Watch has been expanding the scope of its operations since 2019 to become more involved with evidence-based advocacy regarding health issues. BHW started its journey with the objectives to create a platform for drawing in the voices/ opinions of citizens and other stakeholders; generate/ identify new evidences for changing policies and practices; actively engage with GoB and other parties to reform policies; and to develop technology-based mechanism for collecting feedback for optimal delivery of health services.

The activities and initiatives of BHW are directed by a Working group (WG) and an Advisory group (AG). The WG is led by a Convener and other ten members from the health sector of Bangladesh who are dedicated to approve plans, provide directions and guidance, and review the implementation progress through regular meetings. Identifying priority issues for advocacy, monitoring and implementation of work plans, thematic groups formation, and regional chapters formation are overseen by the WG members. Whereas, the AG provides overall direction, guidance, and support to the WG while carrying out different activities from time to time. To carry out the activities, a secretariat has been formed and is now housed at JPGSPH premises.

BHW developed a strategy in 2019 to revisit their objectives and strategies to achieve goals in the current health scenario. Key members of the WG and external participants developed the strategy of a project titled, "Making Bangladesh's Healthcare System More Responsive and Participatory". Through this strategic plan the WG thought about the need for a stronger role in influencing policies and bringing citizen's voice at front. As part of this strategy several priority areas were identified and modifications were done in the form of strengthening BHW's WG, AG and secretariat; establishment of thematic groups; establishment of Divisional chapters; and initiative to organize Bi- annual BHW conference.

Establishment of Thematic groups:

Four different thematic groups were formed to carry out targeted advocacy activities along with media- based dissemination of research/ review findings and public discussions and debates of specific issues. These groups were formed with members from the WG and other members co-opted from among experts to carry issues forward and they work voluntarily. They are also accountable to develop appropriate advocacy strategies and support to implement different strategies. As per the plan, the groups will be dissolved once the advocacy agenda is completed in the divisional chapters/ Regional chapters. These parallelly active thematic groups are:

i) Thematic group on Vaccination: to track, know, and follow- up the vaccination campaign
ii) Thematic group on National budget: to discuss the national budget on the expenditure of healthcare and discuss the election manifesto
iii) Thematic group on health law and policy: A legal apparatus to contribute to the objectives of the project of improving transparency, equity, accountability, and thereby quality of health services in Bangladesh
iv) Thematic group on COVID- 19 research: To conduct and document the research articles on COVID- 19

Regional Chapters

As part of the new strategies, Divisional Chapters were formed to extend the activities of BHW at a sub- national level. The main agenda is to identify key gaps in service delivery in Bangladesh healthcare system and priority areas for advocacy through regular meetings with citizens, government officials, and NGOs. One of the key roles of these chapters is to find solutions to different challenges/ problems which can be implemented at a local level.

In 2021, Bangladesh Health Watch with the assistance of an external third party selected 8 local organizations, known as host organizations in 8 districts of Bangladesh to act as Regional Chapters. Objectives of the RCs are to monitor the health service situation in their catchment areas as watchdog body; maintain close contact with remote upazilas and unions in the area; bring about significant observations from sub- regions for discussions at the regional/ national level; to gather public opinion including women and girls; and initiate actions to mitigate the unheard issues. With the support of the Regional Chapters, Bangladesh Health Watch has established forums called Health Right Forums and Health Right Youth Forums.

District Health Rights Forum (DHRF)

Formed with active citizens interested to play an active role in improving the quality of health services at local level, DHRF is a robust, effective, and sustainable citizens platform. There are two Health Rights Forums in each RC: District Health Rights Forum at district level, and Upazila Health Rights Forum at Upazila level. Representation from all sectors of the community has been retained in this 9- 13 members committee, including participation of women, and members from ethnic minority groups. Any permanent citizen of the district who is physically active and has the interest to work with the health institutions, having no direct or indirect political involvement, with no criminal records, and with a clear concept of citizen's rights and responsibilities can be considered as a member of DHRF.

The main responsibility of DHRF is to carry out advocacy issues at district level with support from the secretariat and host organizations. DHRF and UHRF work with selected healthcare facilities: DHs at district level, Upazila Health Complex at Upazila level, and CC at Union level. These healthcare facilities were selected after discussion with relevant government health authorities and approvals from BHW secretariat. DHRFs are liable to carry out the following activities in their catchment areas:

1. Organizational Function: Organize meetings as per the need and action plans
2. Advocacy: Local level advocacy with the selected healthcare facilities based on the observation, information, user feedback, and experience to ensure equitable and better-quality health services from the facility
3. Campaign: Arrange activities (rally, mass gathering, press briefing, local level planning meetings, seminar, distribution of Information Education and Communication materials etc.) to aware general people about their health rights. As part of these activities, DHRF also arranges different day observations (Safe motherhood day/ Worlds Health Day).

4. Networking: Pursue other civil society organizations and initiatives to work collaboratively with other professionals like journalists, doctors, NGO communities etc.

District Health Rights Youth Forum (DHRYF)

Health Rights Youth Forums are formed at both district and Upazila levels with 15- 25 active and enthusiastic youths involved in social activism. These forums have been formed for a wider community engagement, data and information collections for BHW research, and mass campaign on health rights. Major activities of the DHRYFs are as follows:

1. Meeting: Regular meetings for planning, survey and campaign activities
2. Assisting BHW research: As a frontliner of the RCs, youth volunteers will assist the BHW team to collect data and information for their research related works
3. Campaign: The forum will assist DHRF to organize different campaign activities for mass awareness

Initiatives undertaken by BHW in Regional Chapters

The forums, with the support of the Regional Chapter organizations, organize meetings and workshops with relevant stakeholders to conduct advocacy for the betterment of health rights at their local levels. They also identify gaps in the existing situation towards the full realization of health rights at the local levels and organize need-based and area-specific activities (such as awareness raising amongst the community on the necessity for regular checkups during pregnancy, awareness raising on testing to identify blood groups, organizing registration of COVID-19 vaccination for community people, etc.). The Regional Chapters, collectively, also work toward health goals at the national level, having held human chains in 6 of the 8 districts as part of an effort to advocate for changes in the national health budget for the upcoming fiscal year (2022-2023). Since September 2021, the Regional Chapters and forums across the country have held meetings with key government stakeholders in the health sector of their respective areas, in order to build close working relationships. Resident Medical Officers, hospital management authorities, civil surgeons have been some of the selected officials with whom workshops, and meetings have been held across the country. Two of the RCs were formed at a very initial stage and more initiatives were undertaken. Whereas, other six RCs were formed later in 2021 and number of initiatives are limited compared to others. Details of the RC wise initiatives are listed in Table 3.4.1.

Table 3.4.1: Regional Chapter wise initiatives undertaken by BHW

SN	Regional chapter and host organization	Undertaken Initiatives
1.	**Manikganj** Host organization: BARCIK	i) *Health Rights Youth Forum formation and information meeting* was organized in September 2021 ii) *Formation and orientation meeting of District*

		Health Rights Forum: With the slogan, "We want equality, accountability, and participation in improving the quality of health services" DHRF was formed with distinguished civil society activists in September 2021 iii) *Observation of 'World Health Day'* on April 2022 comprising of activities like rally, discussion sessions, blood donation campaign, and Diabetes camp to raise awareness among the community people iv) *Training on Health Journalism:* With the slogan, "Equality, accountability, and participation in health services", recently a training session for journalists was organized. The training focused on what is health, why health journalism is needed, what are the importance and weaknesses of health journalism, and how to report it
2.	**Khagrachari** Host organization: Zabarang Kalyan Samity	i) *Formation and orientation meeting of District Health Rights Forum:* With the slogan, "We want equality, accountability, and participation in improving the quality of health services" DHRF was formed ii) *Formation and orientation of Upazila Health Rights Youth Forum* was formed in October 2021 iii) *Launching of DHRF* in October 2021 iv) *Planning meeting* to improve the quality of healthcare: Annual action plan meeting was organized in January 2022 engaging health sector actors and key stakeholder along with DHRF and DHRYF to discuss the and identify the key gaps in health services v) *Observation of 'Safe motherhood day 2022'* in January 2022 in the Dhumnighaat CC. Discussions were undertaken about the importance of motherhood, does and don'ts of pregnant and lactating mothers and why they should access facility delivery rather than seeking informal care to create awareness among pregnant mothers and general service users vi) *Training on Health Journalism*

3.	Bagerhat Host organization: Rapantar	i)	*District Health Rights Youth forum formed* in October 2021 with a commitment to protect the citizens
		ii)	*Launching and orientation meeting of DHRF*
		iii)	*Meeting with the health authority*: DHRF organized a sharing meeting with the health authority of Bagerhat district in October 2021. Objectives and activities if BHW and the RCs were shared with the participants. On behalf of the health authorities, Civil Surgeon welcomed the initiatives and requested the DHRF to work collectively to achieve health goals of the government
		iv)	*DHRF Meeting* was organized in October 2021 to discuss the strategies, activities and future plans of BHW. Through a participatory discussion, decision about youth forum formation was taken at district and Upazila level
		v)	*Training on Health Journalism*
4.	**Sunamganj** Host organization: Efforts for Rural Advancement- (ERA)	i)	*District Health Rights Forum started its journey* with the vision to ensure primary health care of the poor and marginalized people in the area
		ii)	*Health Right's orientation and planning meeting:* Orientation and planning meeting was organized in June 2021 with DHRF which discussed the goals, objectives, strategies, and scope of work of the DHRF. Future plans of the DHRF and BHW was also discussed during this meeting
5.	**Chapainawabganj** Host organization: PROYAS	i)	*Launching of District Health Rights Forum* in October 2021
6.	**Netrokona** Host organization: Sabalamby Unnayan Samity (SUS)	i)	*District Health Rights Forum formation and orientation meeting* in September 2021
		ii)	*District Health Rights Forum and District Health Rights Youth Forum meeting* in November 2021 to discuss different health services issues to identify the gaps and also to meet the Civil Surgeon for further discussions
		iii)	*Meeting with Civil Surgeon*: It identified key gap areas like understaffing, lack of specialist doctors,

		and patient overload iv) *Upazila Health Rights Forum and Upazila Health Rights Youth Forum meeting* in November 2021 to discuss the purposes of these forums and how they can contribute to improve the health quality of their area v) *Meeting with NGOs and CSOs*: A meeting engaging representatives from different NGOs like: BRAC, SHERA, BNPS, Red Crescent; and Social and cultural group representatives was organized in November 2021. Discussions were undertaken around issues like functioning of the CCs, improvement of the hospital waste management, improvement of information dissemination system, increased human resources at the health facilities, and need of equipment vi) *Planning meeting* to improve the quality of healthcare was organized to ensure efficient use of existing equipment in healthcare facilities, ensuring waste management, improving hygiene situation, and regular delivery system at the Upazila level vii) *Training on Health Journalism*
7.	**Kurigram** Host organization: SOLIDARITY	i) *District Health Rights Forum started its journey* with the vision to ensure primary health care of the poor and marginalized people in the area ii) *Launching of DHRF* with the commitment to improving the quality of health services in September 2021 iii) *Orientation and planning meeting* was organized in June 2021 and discussed the goals, objectives, strategies, and scope of work of the DHRF iv) *Formation of Upazila and Union Health Rights Forum* in July 2021 v) *Vaccination of marginalized people*: Lack of proper information, awareness, health education and less or no access to technology persists for marginalized population groups. To combat this situation, DHRF and DHRYF motivated people to

		get vaccinated and helped them to register in the Surokkha app for vaccination. In addition, a campaign was initiated, as part of which a two-day long announcement through microphone was made; and banners and festoons were hung in 10 most crowded places. Female volunteers were assigned to help the women. Printed vaccine cards were also provided for free vi) *DHRF assisted in COVID- 19 vaccination registration* during mass vaccination by the government vii) *Planning meeting* to improve quality of health services was organized in February 2022 viii) *Opinion and experience sharing meeting*: With a commitment to change the quality of health services DHRF organized this meeting in March 2022 ix) *Training on Health Journalism*
8.	**Barguna** Host organization: JAGONARI	i) *Formation of DHRF* in September 2021 ii) *Launching of District Health Rights Forum* in September 2021 iii) *Meeting with District Commissioner* was organized in October 2021 to introduce the DHRF members and their proposed activities. During the meeting, doctors and other staff shortage of Barguna General Hospital, construction of a floating hospital in Barguna, recruitment of manpower in district 250 bed hospital and Taltoli Upazila Health Complex were discussed iv) *Training on Health Journalism*

At present, there is no central or core allocation of funding for the various activities of the Regional Chapters and forums. Plans for activities are shared by forums and Regional Chapters with the Secretariat of Bangladesh Health Watch in Dhaka and are initially financed through the general funds of the respective Regional Chapter organizations. Activity-wise bills are then shared with Bangladesh Health Watch and recompensed accordingly.

Chapter 4: Discussion and conclusion

Existing evidence suggests that common people or service users are not fully aware of available health services, and the cost/ fees of consultation or diagnostic tests due to a lack of Citizen Charter or information board in the primary health care facilities. [23, 24, 26] With the initiative of the Ministry of Health and Family Welfare, the Citizen's Charter of Rights was developed in 2004, which was further modified in 2007. [27] Individual charters covering citizen's right to health and available services at health facilities were incorporated into the charter. However, lack of an institutional and legal mechanism for use, lack of awareness of its existence by both health care providers and service users, and lack of engagement and involvement of the community people while developing this charter were identified as the major drawback. [27] At present, the Citizens' Charter of Rights display information only in a few health facilities. [27]

There is no user fee for consultation at CCs and in UHCs and DHs, for outpatient consultation, the fee is minimal (BDT 10/ USD 0.11 per visit). Essential drugs are free of cost at primary health care facilities. [27] While medical and surgical supplies are provided free of charge, it is common for patients to have to purchase items like syringes, intravenous fluids, plaster, x-ray plates, and even surgical items such as suture material or dressings when supplies in the facility are inadequate. [24, 27] These extra costs have also been documented as a demand-side challenge in Bangladesh Health System Review-2015, as it increases the out-of-pocket expenditure.[27] An extensive review of patient healthcare service satisfaction in Bangladesh in 2020, also reported that 67% of the healthcare cost is being paid by common people, whereas the global standard is below 32%.[28]

The present study explored both demand and supply side challenges at the DH, UHC and CC levels across Bangladesh. The key observations with respect to these two major areas of challenges are discussed below.

Demand side considerations and challenges:

- Access to CCs in most locations across the country (notably, except for in the hill tracts) was observed by the research team to be easy for most community members, with respect to the location and distance of their households from the nearest facility. Distance to UHCs and DHs were on average greater and often involved significant travel expenses, with travel costs exceeding several hundred Bangladesh Taka for individuals in remote locations of Sunamganj (for example) to get to the nearest UHC. The condition of roads in multiple locations was found to be bad and difficult to use for travel, especially for severely ill individuals or pregnant mothers. Seasonal flooding and waterlogging were also found to be major barriers for individuals seeking health services in areas like Sunamganj of Sylhet or Shoronkhola in Khulna. Major roads were found to be completely inundated in these areas during seasonal floods, and travel by boat was stated by community members in Khulna to be required during the rainy season.
- Across all types of healthcare facilities, awareness regarding the existence of Citizen Charters, other information boards and information centres were found to be low. Service seekers in all types of healthcare facilities were found to be primarily from lower-income families, many of whom could not read and write. This meant both that service seekers were unaware if there was a Citizen Charter at a given facility at all, and also that even if there was a Citizen Charter or information board available, they would not

have sought it out to avail information. Some service seekers stated that it would have been helpful for them if information regarding available services and tests, floor and room numbers of doctors etc. could be announced via loudspeakers since they cannot avail information from the boards and charters. Not all facilities were found to have functional information desks to assist service seekers either. Ensuring that all facilities from the Upazila level upwards have functional information desks could also better ensure that service seekers receive necessary information.

- CCs are officially the first point of service seeking for individuals suffering from health complications. This present study found that factors such as distance to the nearest healthcare facility (for example, if an UHC is closer to a household than a CC, household members are likely to simply go to the Complex to seek services), having known and trusted healthcare providers at a particular facility (community members were found to refer and even accompany their neighbours and acquaintances to doctors at a DH who were known to them in Khagrachori) also influence decision making regarding the health seeking behaviour of people. In Netrokona, a belief that quality of services at the DH is better was found to be prevalent. Following the construction of a new road that made travelling to the Mymensingh district town easier, some study participants spoke to state that they often chose to simply travel to the DH to seek care, regardless of the type of illness, even though their households were located close to an UHC.
- Travelling to the nearest CC was not found to be overly cost-prohibitive in most study sites. Rickshaws, auto-rickshaws, battery-run “easy-bikes", and vans were found to be available in all study sites to take service seekers to a CC at costs of up to BDT 50/ USD 0.55 (if travelling by rickshaw), with costs usually being lower per person (BDT 10/ USD 0.11 per person) if travelling by easy-bikes or vans. Costs to travel to UHCs and DHs however varied greatly. Study participants in Sunamganj reported having to spend hundreds of BDT, on several types of transportation, to travel to an UHC. In Khagrachori, healthcare seekers at an UHC reported that doctors were not available at the facility every day, and in case of emergencies on days when no healthcare providers are available, they need to rent CNG’s, cars or microbuses to travel to the district town. These rentals are done for a whole day and can cost up to BDT 4,000 (USD 41.9), depending on the type of transport.
- Healthcare seekers at all public healthcare facilities were found to be largely from lower income households. Community members from relatively more affluent backgrounds were found to seek services at private clinics and doctor’s chambers rather than at public facilities, even when public facilities were located close to their households. The healthcare seekers at public facilities however, were found to think of the outpatient consultation fees and ticket prices at these facilities as acceptable. At multiple study sites however, healthcare seekers were found to have incurred costs of several thousand BDTs for diagnostic fees (some of which were found to be not available at facilities such as UHC and DHs), buying medicines and even surgical items. These costs were unanimously recognized by study participants to be overwhelming for their households.
- The present study explored whether COVID-19 or any other diseases were particularly feared or stigmatized in the communities where the study took place. In most locations

however, study participants reported that COVID-19 had not had a significant effect on their communities, and no diseases or health conditions could be recognized which were generally feared or stigmatized across all sites. Diabetes, heart disease, cancer were some of the responses to diseases that the community fears, suggesting that community members mostly feared diseases that are chronic, incurable and expensive to manage.

- Responses varied across the different study sites regarding the satisfaction with the care provided by healthcare providers at various facilities. Some CCs were found to have frequently changing healthcare providers, which community members found to be disruptive to the process of receiving quality care, whereas other CCs had long serving healthcare providers who had good rapport with the community members. In general, a greater degree of mistrust existed regarding quality of care provided by healthcare providers at UHCs and DHs. Absenteeism was found to be a problem at both these facilities, in various sites. In an extreme case, doctors were found to only be available 3 days a week at an UHC in Khagrachori, since they were not local residents and had to travel from the district town to provide services. This caused major difficulties for the community that relies on the UHC for health services. Due to the large number of service seekers at all facilities relative to the facility's ability to provide services, long waiting times were found to be problems at both UHCs and DHs, where some service seekers reported that they had to go several days in a row in order to secure a consultation. In Rangpur, community members also reported feeling like their lower socio-economic status made doctors and other DH staff feel entitled to treating them poorly and without respect.

Supply-side considerations and challenges:

- Across all levels of healthcare facilities visited, providers reported shortages of provisions such as medicine and equipment of all kinds from blood pressure machines and weight machines at CCs to lab testing equipment at UHC to diagnostic machines at DHs. At UHC levels and above, equipment was more often likely to have become out of order due to age and wear and tear. Diagnostic testing at UHC level and above was also found to be hindered by shortages and lack of trained technicians to undertake diagnostic testing. Every facility visited across the country reported lacking technicians for multiple types of tests that the facilities are supposed to be able to undertake. Healthcare providers cited an insufficient number of doctors and technicians being trained at the national level, a lengthy and complex process between doctors or technicians being requested by a facility and being assigned one, and an unwillingness by assigned personnel to take up their posts and carry out duties at remote locations as some reasons behind this shortage.
- Cleanliness of facilities was observed to vary greatly across the facilities and sites. The number of cleaning staff per facility, at all upazila and district level facilities across the country, was found to be low relative to the scope of work necessary to keep the facilities clean. Levels of cleanliness at facilities however, did vary widely, even for facilities at the same tier across sites. Even though UHCs did generate medical waste, most facilities were not found to have an adequate system to dispose of these wastes.

- Complaint boxes were observed by the research team in most facilities. Service seekers however, were found to be mostly unaware that these exist and that these can be utilized to voice their concerns. At an UHC, the representative official stated that complaints from the complaint box there go directly to the Deputy Commissioner's office, from where the facility is instructed to take remedial measures, if complaints are recorded. None of the service seekers at the same facility spoken to however, were aware of the box, and were not aware of anyone having utilized it. Given this lack of awareness among service seekers, it was evident that a functional and robust complaint or feedback system is not operational at the facilities visited. Because no study participant could share an example of a complaint being lodged however, it was difficult to ascertain whether stopgaps to the process exist at the level of officially managing a complaint that is received, or if it primarily exists at the level of lack of awareness.
- DHs were found to have ambulances in all locations visited. Emergency transport however was not found to be available at multiple UHCs. In some locations, one or more ambulances under a health facility was found to be under the control of influential individuals who charged a steep price to service seekers for hiring the vehicles. Hospital management committee members reported being unable to prevent such situations, and not being able to lodge a complaint with relevant higher authorities as well.

Ensuring access to essential quality health care services for all, without any financial risk is the main goal of Universal Health Coverage. World Health Organization (WHO) has defined a set of indicators and targets for Universal Health Coverage under SDG 3, which need to be achieved by 2030 by all member countries.[22] As a member country, Bangladesh is also committed to achieving Universal Health Coverage, under which the country needs to attain at least 80% essential health-service coverage for the entire population irrespective of their economic status, gender, or place of residence.[22] However, without ensuring health equity and addressing the gaps in existing primary health care service delivery, attaining these goals will not be possible. Bangladesh Health Watch with establishment of the Regional Chapters has taken several initiatives to improve the situation in primary health care facilities serving the poor and marginalized population groups in rural Bangladesh. The present study findings can assist the BHW team and the RCs to address some of the demand-side and supply-side barriers identified in the present study in different study sites and in different healthcare facilities.

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